Multicultural Chaplaincy through First Korean Immigrants' Perspective

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Abstract

This project is about multicultural chaplaincy. We have learned the importance of cultural differences during CPE programs and other training, yet we have a hard time approaching this cultural barrier effectively in practice. In this Project, I develop a practical theological approach through Korean immigrant cases. There are cultural barriers related to using the healthcare system among Korean immigrants in America as well as cultural differences that can result in mental health issues such as depression and cultural trauma. I use three Biblical wisdoms from the Protestant perspective related to cultural issues to provide better spiritual support for patients, their families, and staff in hospital settings. From the perspective of patient-centered care, cultural issues are essential and have an important position in a multicultural society. Chaplains in medical settings should know how to effectively give spiritual care to patients of various cultures. Through greater attention to Korean immigrants, we can practice the principles of multicultural chaplaincy, which are relevant to anyone who struggles with cultural barriers. Here, Anderson's five steps are particularly helpful from which I develop eight guidelines for multicultural chaplaincy from a Korean immigrant perspective.

Definition & Presenting Problem

Having grown up in Korea and moved to America as an immigrant, I have experienced various cultural barriers and witnessed the hardships Korean immigrants face in the dominant European American culture. In this project I ask how a chaplain can support their patients, their families, and staff who are struggling with cultural differences within a hospital setting. I will trace how living in an increasingly multicultural society can lead to a high possibility of stress, depression, and traumatic experiences due to cultural barriers that interfere with well-being and resilience which lead to mental health issues. Then I will examine the growing Korean immigrant population, their cultural values, and barriers they face within the hospital. I will demonstrate specific cultural issues faced by first generation Korean immigrants through the examination of the following questions: "Why is multicultural chaplaincy important?", "What are cultural barriers among Korean immigrants and how are they impacting their well-being?", "How can we understand the connections between culture and spirituality?" Turning to

constructive theological resources, I focus on biblical wisdom grounded in the stories of the metaphor of incarnation, Moses and the burning bush, and the story of Naomi for multicultural chaplaincy. Finally, I argue that chaplains can develop their own cultural sensitivity through the web of meaning and 5 steps for spiritual/cultural competencies which are best served by attending to eight guidelines for multicultural chaplaincy.

A. Introduction

Cultural issues can be a source of conflict for many Korean immigrants because of a lack of support in helping them integrate into their new communities. Many immigrants feel isolated and find it difficult to make friendships of the same emotional degree as they do back home. This is because feelings of anxiety and fear can result from cultural differences in the unexpected responses they receive from others. Despite these struggles, many immigrants may choose to keep their own cultural boundaries even though it may not be as effective as when they were living in their own countries. These disturbing experiences can cause emotional stress and feelings of depression and loneliness. Like a river wearing down a rock, the multicultural society can slowly chip away at an individual's well-being and resilience without them recognizing the day-to-day accumulation of the cultural damages.

B. Changes Towards a Multicultural Society

1. A growing Asian population.

Multicultural chaplaincy is particularly important in light of the change of demographics within the United States. The population of Asian people in the United States has been steadily increasing over the years. According to the United States Census Bureau, the number of Asians

has almost doubled in the last 20-year period. Furthermore, the number of Asians in combination has grown 3 times greater over a 20-year period. (See table 1). Large communities of Asians can be found in big cities like Los Angeles, CA; New York City, NY; Atlanta, GA; and Chicago, IL. An expanding population of Asians not only means an increasing number of people, but also an increase in interaction and influences between different cultures.

Table 1. Asian Population From 2000, 2010, and 2020

	2000[1]	2010[2]	2020[3]
Asian alone or in combination	11,898,828	17,320,856	24,000,998
Asian alone	10,242,998	14,674,252	19,886,049
Asian in combination	1,655,830	2,646,604	4,114,949

Another point of view to consider is the linguistic perspective. According to the United States Census Bureau, of the diverse languages spoken in America, 23 come from Asia.

> In acknowledgment of the diversity of languages spoken in the United States, the Census Bureau disseminated materials for the 2020 Census in 59 different languages other than English, including 23 languages that originated in Asia: Bengali, Burmese, Chinese, Khmer, Gujarati, Hindi, Hmong, Ilocano, Indonesian, Japanese, Korean, Lao, Malayalam, Marathi, Nepali, Punjabi, Sinhala, Tagalog, Tamil, Telugu, Thai, Urdu, and Vietnamese.[4]

Furthermore, second-generation Asians also face unique challenges as they have to learn two different languages and cultures at the same time. Sometimes, Asian children who learn their

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[1] Nicholas A. Jones, "The Asian Population in the United States: Results from the 2010 Census," May 2, 2012, https://www.ssa.gov/people/aapi/materials/pdfs/2010census-data.pdf.
[2] Jones.
[3] Lindsay M. Monte and Hyon B. Shin, "20.6 Million People in the U.S. Identify as Asian, Native Hawaiian or Pacific Islander," May 25, 2022, https://www2.census.gov/programs-surveys/decennial/2020/data/redistricting-supplementary-tables/redistricting-supplementary-table-01.pdf.
[4] Monte and Shin.

own languages from their parents and are educated in English by the school system can experience cultural conflict from childhood. Oftentimes they may not recognize these cultural barriers until later in life with second-generation immigrants developing their own unique identities.

2. Korean immigrants' cultural values

Given these shifts in population, the key starting point for multicultural chaplaincy that pays particular attention to Korean immigrants is asking "What are cultural barriers in U.S. medical care among Korean immigrants?". Despite living in America, Korean immigrants often maintain strong cultural boundaries. They keep their own cultural values, teach their cultures to subsequent generations, and ask the next generation to practice cultural behavior even if it causes them cultural stress. As Nyengele notes, in Korean culture, the most important connection is the personal identity within the group identity, which Koreans call "Woori."[5] Korean culture is strongly connected to this community-based perspective and often view neighbors as part of a larger family.

From my own experience, I have seen different manifestations of these struggles. When I first came to America, I lived in Chicago, IL for 5 years which has a large Korean population before spending the last 15 years in Jacksonville, FL where the Korean population is small. While living in Chicago, the Korean immigrants often seemed to live without connecting with the larger American communities. They would gain information from other Korean groups, eat at Korean restaurants, visit Korean markets, use Korean banks, and go to hospitals that have Korean medical doctors and nurses. Cities like these have strong Korean enclaves that allow

[5] M. Fulgence Nyengele, "A Postcolonial Self: Korean Immigrant Theology and Church," *Journal of Pastoral Theology* 26, no. 1 (2016): 72, https://doi.org/10.1080/10649867.2016.1178993.

these individuals to retain their old personal and collective identities rather than adopting the greater American culture. This can be helpful during the initial transition to America but restricts one's opportunity to integrate and find one's meaning of living in America. This discomfort prevents immigrants from gaining influence or being reoriented by different cultural values which can result in conflicts in crisis situations. Furthermore, these immigrants also lose out on valuable information on how to be successful in this new country as they are not connected to the major society. As a result, although limiting exposure to new cultural values through these communities may be the most comfortable in the short term, it limits perspective and can lead to cultural conflicts of further isolation in the long term.

On the other hand, in communities with smaller Korean populations, there are less opportunities of these cultural safeguarding which increase chances of meeting people of different languages and cultures. In these environments, immigrants can easily be isolated and struggle with loneliness due to the loss of connection to their home community. Language barriers and differences in cultural values and behaviors result in significant cultural stress. This can be further exacerbated when individuals face discrimination caused by the color of their skin which can result in individuals to form more negative self-identities of themselves. Theologian Nyengele mentioned, "The experience of racism, sexism, and classism greatly influences the formation of the marginalized self that causes Korean immigrants, like other immigrants, to recognize their marginalized position in American society and their struggle for assimilation".[6] As I will detail below, these influences can lead Korean immigrants to develop both diagnosed and undiagnosed mental health issues such as loneliness, depression, and cultural traumatic experiences.

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[6] Nyengele, 73.

Another important value to consider is the family's role as a support structure. Each culture influences family dynamics which includes the boundary and function of each member in the family. Many Korean families believe that it is the parents' role to support their children through college fees, housing, and living expenses until their children have a full-time job or get married. Many Korean people believe that parents should support their children and in return, the children will support the parents until they die. The first son in particular has a large responsibility towards their parents. For example, in the hospital setting, the first son usually will receive the power of attorney even though they may not know about their patient's will or values. In much of American culture, it is the child who knows their parents the best who attain the power of attorney. These cultural conflicts can manifest in various other forms. For example, cultural elements like filial piety and care for one's elders may not be shared with children who are educated in American schools. This can lead to issues as many first-generation Koreans immigrants, who often run their own businesses like coin laundromats, dry cleaning, or Korean markets and restaurants, are not able to prepare their retirement funds effectively. They are also less likely to be aware of programs like company retirement plans and rely solely on their children when they get older. This can result in financial burden on the children who may already be struggling with discrimination or other cultural conflicts.

3. Barriers to healthcare faced by Korean immigrants

There are many barriers to approach health care for first-generation Korean immigrants such as insurance issues, language barriers, and traditional Korean medicines. Regarding insurance, Koreans have the lowest rates of coverage. A study by ASPE, using data from 2019, revealed that 10% of Korean Americans were uninsured, which was significantly higher than

other Asian ethnic groups--including those from Japanese Americans (2.8%), Indian Americans (5.2%), Filipino Americans (5.5%), Chinese Americans (6.0 %), and Vietnamese Americans (8.3%).[7] Oh and Jeong argue that this under-enrollment is primarily related to Korean cultural backgrounds as studies revealed that these health disparities could not be understood by demographic and socioeconomic attributes alone.[8] Therefore, they contend this healthcare phenomenon can be best understood by employment type and the homogenous network through which cultural influence could be more widely distributed.[9]

Korean immigrants also tend to be self-employed which reduces the chance for them to obtain insurance information when compared to employees who receive insurance plans from their employers. Korean immigrants often require special effort to find the right plan for them as the various types of coverage and policies can get quite complicated. One qualitative study by Choi demonstrated that Korean immigrants often hesitate in asking for information like healthcare policies from both English information sources and non-Koreans.[10] The result of no insurance also indicates a number of social issues. First, Korean immigrants have to pay more out-of-pocket which causes these patients to usually visit free medical care centers in the community. They may also rely on over-the-counter medicines like aspirin or ibuprofen rather than making a visit to the doctor's office. Furthermore, Korean immigrants often will use Hanbang which, having originated in China, is used in Korea as a traditional, oriental, and folk

[7] ASPE, "Health Insurance Coverage Changes Since Implementation of the Affordable Care Act: Asian Americans and Pacific Islanders," ASPE, May 23, 2021, 3, https://aspe.hhs.gov/sites/default/files/private/pdf/265581/aspe-uninsured-trends-aapi-ib.pdf.
[8] Hyunsung Oh and Chung Hyeon Jeong, "Korean Immigrants Don't Buy Health Insurance: The Influences of Culture on Self-Employed Korean Immigrants Focusing on Structure and Functions of Social Networks," *Social Science & Medicine (1982)* 191 (2017): 195, https://doi.org/10.1016/j.socscimed.2017.09.012; Duy Nguyen, Sunha Choi, and So Young Park, "The Moderating Effects of Ethnicity and Employment Type on Insurance Coverage: Four Asian Subgroups in California," *Journal of Applied Gerontology* 34, no. 7 (2015): 871, https://doi.org/10.1177/0733464813481849.
[9] Oh and Jeong, "Korean Immigrants Don't Buy Health Insurance," 195.
[10] Jin Young Choi, "Negotiating Old and New Ways: Contextualizing Adapted Health Care-Seeking Behaviors of Korean Immigrants in Hawaii," *Ethnicity & Health* 18, no. 4 (2013): 358–59, https://doi.org/10.1080/13557858.2012.734280.

medicine. According to a study by Hill et al. (2006), 23% of males and 29% of females report using traditional remedies as a healthcare option in California.[11]

In many cases, Korean immigrants get their information from their social networks which include friends, churches and online communities for Koreans. Although these homogeneous networks may provide some middle ground between the two cultures, it also exacerbates the cultural isolation experienced by these immigrants. In regards to the aforementioned uninsurance rates, Oh and Jeong writes, "it is plausible that self-employed Korean immigrants are not able to acquire sufficient information from their social networks to help them decide whether to buy health insurance".[12]

For Korean immigrants, the largest barrier to formal healthcare is poor English proficiency. A lack of language competencies leads to three barriers within healthcare "(1) difficulty in understanding medical terminology in English, (2) difficulty in describing symptoms in English, and (3) difficulty in communicating with non-Korean doctors."[13] Due to these problems in understanding questions and explaining bodily symptoms, it makes it difficult to build rapport and trust with doctors. This is especially problematic when patients present to the hospital with serious illnesses.

Korean immigrants prefer to have doctors who share the same culture, language, and race/ethnic backgrounds to them but the chances of having such a physician are low in an emergent setting. Sou Hyun Jang's analysis of survey/interview data reveals a significant preference for Korean doctors (64.5%) compared to non-Korean doctors (5%).[14] Finally,

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[11] Linda Hill et al., "Koreans' Use of Medical Services in Seoul, Korea and California," *Journal of Immigrant and Minority Health* 8, no. 3 (2006): 276, https://doi.org/10.1007/s10903-006-9332-4.
[12] Oh and Jeong, "Korean Immigrants Don't Buy Health Insurance," 196.
[13] Sou Hyun Jang, "First-Generation Korean Immigrants' Barriers to Healthcare and Their Coping Strategies in the US," *Social Science & Medicine (1982)* 168 (2016): 95, https://doi.org/10.1016/j.socscimed.2016.09.007.
[14] Sou Hyun Jang, *Medical Transnationalism: Korean Immigrants' Medical Tourism to Home Country*, Korean Communities across the World (Lanham, Maryland: Lexington Books, 2018), 43.

although Korean immigrants tend to go back to Korea for various medical treatments as the healthcare system is cheaper, familiar, and convenient for them, when faced with serious illness or emergent situations, they rely on the medical systems in America.[15] These findings reveal the cultural biases held by Korean immigrants and help to provide the foundation on which we can begin to improve patient care.

C. Illnesses and Barriers to Health Faced by Korean Immigrants

1. Korean Immigrants and Mental Health

These challenges in language and knowledge lead to the question of how these cultural barriers can impact mental health in Korean immigrants. In general, the importance of mental health within our modern society is increasing which comes along with a need to further develop support systems. Yet, according to statistics, Asian Americans have low usage rates of mental health services.

> Asian American adults with any mental illness ranked the lowest in their use of mental health services (18.1 percent) among various racial groups, including White (46.3 percent), American Indian or Alaska Native (41.6 percent), Black or African American (29.8 percent), and Hispanic (27.3 percent) (Substance Abuse and Mental Health Services Administration, 2015). Similar findings were reported in the National Latino and Asian-American Study (NLAAS). AbeKim and her colleagues (2007) found that only 8.6 percent of Asian American participants of the NLAAS who met mental disorder diagnostic criteria used professional mental health services. In another study using the NLAAS data, the percentage of Asian Americans who had mental health needs and sought professional mental health services was 5.8 percent (Ihara, Chae, Cummings, & Lee, 2014). Furthermore, very few Asian Americans with mental illness complete their treatment even when they seek mental health services. According to Augsberger, Young, Dougherty, and Hahm (2015), over 80 percent of Asian women with moderate to severe depression and suicidal thoughts did not complete minimally adequate care in outpatient settings."[16]

[15] Jang, "First-Generation Korean Immigrants' Barriers to Healthcare and Their Coping Strategies in the US," 96.
[16] Eun Koh et al., "Korean Immigrants' Perception of Mental Well-Being and Help-Seeking Behaviors," *Health & Social Work* 46, no. 3 (2021): 199, https://doi.org/10.1093/hsw/hlab009.

Many Americans may believe that the limited use of the mental health system is due to Asian Americans not being as susceptible to severe mental health problems and are not vulnerable to disparities in mental health. However, from my own experiences as an Asian immigrant, I have met many Asian Americans who struggle with mental health symptoms but very few of them get help from existing support systems. Many Asians often deny their symptoms or choose not to visit psychiatrists for diagnosis even if they face mental health symptoms. Cultural influences can play a critical role in Asians' experience of mental illness and help-seeking behaviors. Recent research indicates that Koreans might actually have a higher risk of experiencing mental health issues with a study by M.T. Kim et al. (2015) noting that older Korean adults have higher rates of depression than the normal US population.[17] Furthermore, Korean immigrants are more likely to experience depression (33.3%) than other East Asian ethnic groups like Chinese (15.7%) and Japanese (20.4) immigrants.[18]

There is also a misconception that people in different countries all express the same mental health symptoms and help-seeking behaviors. The range of symptoms and conditions is diverse and can be caused through work-related, social or environmental stressors. In Asian culture, mental health problems can be taboo which has led to difficulty in both finding professional mental health services and holding discussions about mental health concerns with family. Many Korean immigrants have a hard time accepting that mental health problems are illnesses like cancer, diabetes, etc. Therefore, when mental health problems begin to interrupt normal life, Koreans often bring issues up with their family and friends instead of professional mental health experts.

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[17] Miyong T. Kim et al., "Factors Associated With Depression Experience of Immigrant Populations: A Study of Korean Immigrants," *Archives of Psychiatric Nursing* 19, no. 5 (2005): 218, https://doi.org/10.1016/j.apnu.2005.07.004.

[18] Koh et al., "Korean Immigrants' Perception of Mental Well-Being and Help-Seeking Behaviors," 200.

This can be compounded within an American context as there are added stressors of discrimination and microaggressions for immigrants. For immigrants visiting counselors, one crucial factor to determining immigrant use of mental health services is cultural sensitivity. One study found that 82% of Asian American women reported that they faced a "lack of culturally appropriate mental health interventions" when trying to find professional help with their mental health.[19] Participants noted a lack of "dual-culture" practitioners and were frustrated by ignorance from professionals and a general lack of knowledge about the stigmas that are present within Asian American society.[20]

2. Depression Among Korean Immigrants

The World Health Organization reports depression as a common mental health condition that can happen to anyone with more than 75% of people with mental disorders in low- and middle-income countries not receiving treatment.[21] Zhou et al. reports that depression is the leading cause of disability worldwide while the CDC estimates that one in ten women in America had an episode of major depression.[22] Korean immigrants also face high rates of depression with a study from Bernstein et al. mentioning how researchers "have noted that Korean immigrants to the USA reported higher levels of depressive symptoms and elevated levels of psychological distress compared with other Asian ethnic groups".[23] A study by Shin

[19] Astraea Augsberger et al., "Factors Influencing the Underutilization of Mental Health Services among Asian American Women with a History of Depression and Suicide," *BMC Health Services Research* 15:542, no. 1 (2015): 8, https://doi.org/10.1186/s12913-015-1191-7.
[20] Koh et al., "Korean Immigrants' Perception of Mental Well-Being and Help-Seeking Behaviors," 201.
[21] World Health Organization, "Depression," accessed January 7, 2024, https://www.who.int/health-topics/depression.
[22] Jiani Zhou et al., "Treatment of Substance Use Disorders Among Women of Reproductive Age by Depression and Anxiety Disorder Status, 2008-2014," *Journal of Women's Health (Larchmont, N.Y. 2002)* 28, no. 8 (2019): 1068, https://doi.org/10.1089/jwh.2018.7597.
[23] Kunsook Song Bernstein et al., "Symptom Manifestations and Expressions among Korean Immigrant Women Suffering with Depression: Korean Immigrant Women and Depression," *Journal of Advanced Nursing* 61, no. 4 (2008): 394, https://doi.org/10.1111/j.1365-2648.2007.04533.x.

notes that "Koreans immigrants have the highest prevalence of depression (14.4 %), followed by Filipinos, Japanese, and Chinese Americans" with high rates of depression having existed for several decades.[24] There are multiple reasons for the high rates of depression among these immigrants. Shin argues that one of the main contributors is due to cultural conflict, "Despite the growing interest in examining cultural variations in the experience and expression of depression among immigrants, many mental health professionals still fail to consider the cultural and social backgrounds of Asian immigrants."[25] The culture that Koreans grow up in may not align with the dominant culture in America. As Kiefer (1974) suggests, there may be "structural confusion, cultural conflict, and cultural alienation that occur in the acculturation process would disturb the drives toward clarity, consistency, and continuity, thus becoming sources of stress."[26] This stress due to incoherence in norms can be described as "acculturative stress, or stress arising uniquely from the process of acculturation."[27] Many Korean immigrants also have decreased self-efficacy as they may believe their values and behaviors are not as effective within American society. The work by Bernstein (2008) indicates that Korean women are particularly susceptible as they can experience cultural tensions in regard to gender roles. For example, Korean immigrant women often maintain societal expectations of being homemakers from their country of origin which can conflict with financial/social needs that they may face while living in America.[28]

Similarly, another cultural motif immigrants struggle with is difficulty in maintaining cultural values and functions that they bring from Korea. Mercado (2002) notes that Koreans can

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[24] Jinah K. Shin, "Understanding the Experience and Manifestation of Depression Among Korean Immigrants in New York City," *Journal of Transcultural Nursing* 21, no. 1 (2010): 73, https://doi.org/10.1177/1043659609349065.
[25] Shin, 73.
[26] Yunjin Oh, Gary F. Koeske, and Esther Sales, "Acculturation, Stress, and Depressive Symptoms Among Korean Immigrants in the United States," *The Journal of Social Psychology* 142, no. 4 (2002): 512, https://doi.org/10.1080/00224540209603915.
[27] Oh, Koeske, and Sales, 512.
[28] Bernstein et al., "Symptom Manifestations and Expressions among Korean Immigrant Women Suffering with Depression," 394.

experience shame and guilt when they are not able to maintain traditional norms and roles within their family and the greater society.[29] Manifestation of this shame can result in guilt and emotional distance from one's family and community which can escalate further into broken relationships. Dr. Rogers-Vaugn provides insight into how we manifest failure and notes that individuals are "great at crediting ourselves for our victories, but we are just as good at blaming ourselves for failure."[30] These self-tendencies are exacerbated due to isolation and loneliness felt within their families and communities from cultural conflicts, language barriers and economic hardships.

Older Korean immigrants are particularly at risk as they have consistently higher rates of depression when compared to non-hispanic whites and other minority ethnicities like Chinese, Filipino, and Vietnamese.[31] The main cultural driver of higher depression rates among older Koreans are failures involving cultural adjustment.[32] Elders are prone to suppressing their emotions, avoiding direct confrontation, and will see depression as both a normal part of aging as well as a sign of weakness. These cultural biases can also be seen in the misunderstandings surrounding the use of antidepressants. One study by Kyeung Mi Oh, et al. reveals these misconceptions with their survey reporting that 86% believe antidepressants have a rapid effect on symptoms, 82.6% believe individuals can stop taking antidepressants once symptoms improve, and 66.3% believe that antidepressants are addictive.[33] Furthermore, only 17-33% of

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[29] Melissa M. Mercado, "The Invisible Family: Counseling Asian American Substance Abusers and Their Families," *The Family Journal* 8, no. 3 (2000): 268–69, https://doi.org/10.1177/1066480700083008.
[30] Bruce Rogers-Vaughn, "Depression: Mental Illness or Spiritual Struggle?" VDS Doctor of Ministry Program, December 16, 2021, Video, 30:24. https://vanderbilt.app.box.com/s/2sly4hq5oalirb6em5vk51w3ivtbfae2.
[31] Kyeung Mi Oh et al., "Exploring Levels and Correlates of Depression Literacy Among Older Korean Immigrants," *Journal of Cross-Cultural Gerontology* 37, no. 3 (2022): 297, https://doi.org/10.1007/s10823-022-09461-3.
[32] So-Youn Park and Kunsook Song Bernstein, "Depression and Korean American Immigrants," *Archives of Psychiatric Nursing* 22, no. 1 (2008): 15, https://doi.org/10.1016/j.apnu.2007.06.011.
[33] Oh et al., "Exploring Levels and Correlates of Depression Literacy Among Older Korean Immigrants," 295.

older Korean immigrants believe antidepressants are effective for depression compared to 54% of Latino younger men and 49% of Americans.[34]

Finally, the rate of undiagnosed depression may be even higher than current estimates. Studies have demonstrated that Koreans often can express distress via bodily sensation, ie. somatization, rather than psychologizing emotional conflict.[35] Pang used Kangs study and said, "In one study by Kang which involved 148 outpatients with depressive neurosis, the primary symptoms noted were somatic in nature with digestive difficulties being the leading presentation."[36] Pang took these studies and specified names for the symptoms of patients noting that "Han (a form of regret or resentment syndrome), Hwabyung (an anger syndrome), and Shingyungshayak (similar to neurasthenia) (Kleinman 1982) appear to be holistic symptomatic phenomenological representations of expressions of depression."[37] Examples of symptoms of Han or Hwabyung experienced by Koreans were also noted. "Every day I felt heavy in my chest and felt choked. I could not breathe while sleeping. It became severe enough at the time of menopause that I was almost hospitalized. I felt like something was stuck in my chest, and it hurt me."[38] There were also some statements that related to depression both directly and indirectly: "I have a stomachache," "I have a headache," "The feeling is always something like cloudy and rainy days," "My mind is wrapped with fog," and "I feel depressed on cloudy days and about the time when the sun sets or leaves are falling."[39]

3. Cultural Trauma in Korean Immigrants

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[34] Oh et al., 307.
[35] Kwang-Iel Kim and Bou Young Rhi, "A Review of Korean Cultural Psychiatry," *Transcultural Psychiatric Research Review* 13, no. 2 (1976): 107, https://doi.org/10.1177/136346157601300201.
[36] K. Y. Pang, "Symptoms of Depression in Elderly Korean Immigrants: Narration and the Healing Process," *Culture, Medicine and Psychiatry* 22, no. 1 (1998): 94, https://doi.org/10.1023/A:1005389321714.
[37] Pang, 96.
[38] Pang, 107.
[39] Pang, 105.

Finally, another important concept that should be considered in multicultural chaplaincy is cultural trauma. This can best be understood by defining culture and trauma individually before examining their interaction in forming cultural trauma within a Korean immigrant context.

A) Culture

Culture manifests differently in different countries and are defined as a shared values, beliefs and norms between a group of people. Per Pigozzi, culture is also shared from one generation to the next and is the framework for how individuals think, make decisions and solve problems.[40] Individuals develop their own values and manners based on effective and successful experiences with their cultural groups that can result in disturbing experiences when facing conflicts caused by cultural differences. There are many conflicts in medical systems that can come from individuals of different backgrounds. For example, there was a Caucasian doctor in the palliative care team who was complaining about a patient. The doctor had complained that the patient, who was an Asian man, was unable to make a decision for himself. The patient had a serious illness with a clear mind but at the time had no power of attorney. The doctor wanted to know whether he wanted aggressive care or hospice care but the patient was not able to make a decision and waited for the doctor's opinion. The doctor asked, "What do you want to do?" and the patient replied, "What do you want me to do?" The doctor struggled to understand these cultural differences and that the patient did not understand the difference between aggressive care and hospice care. The patient's experience resulted in frustration and a loss of trust in the doctor. As the chaplain, I intervened to serve as a mediating role to help the two parties better

[40] Laura Maria Pigozzi, *Caring for and Understanding Latinx Patients in Health Care Settings* (Philadelphia, PA: Jessica Kingsley Publishers, 2020), 45.

understand each other. After explaining the patient's position within cultural contexts, the doctor had a better understanding of the barriers that may exist in taking care of this patient. Working together, we spoke with the patient and worked through the implications of hospice vs aggressive care in a manner that both addressed the patient's anxiety and provided them time to figure out which option was best for them.

While collaborative understanding can serve to provide better holistic care, the underlying cultural biases if unchecked can break personal relationships and lead to both conscious and unconscious discrimination. Dr. Phillis Sheppard identifies the harm of unconscious bias as it "impairs our empathy and understanding, impedes compassion and capacity for reflective, meaningful responses, and distorts the humanity of those for whom we are called to care."[41] Even if these biases do not reach the level of discrimination, they can still present themselves as microaggressions. Yarborough describes microaggressions as an unconscious bias that are "indirect, subtle, or unintentional discrimination, against members of a marginalized group."[42] Korean immigrants can experience microaggressions when Americans don't recognize their inherent biases. But inversely, Americans can also feel the same way about Korean cultural manners. The key distinction here is the power differences where dominant cultures tend to control minority ones. As Williams puts it, "Like microaggressions, everyday racism and everyday discrimination including covert prejudice, are commonplace, and are rooted in power differentials between groups."[43] These unconscious biases can destroy our community and lead to people losing trust in one another. Many Korean immigrants complain about how different relationships in America are when compared to relationships they have in America.

[41] Phillis Isabella Sheppard, "3.5.1: Culturally sensitive care," Integrative Mental Health, Oct 28, 2022, Video, 6:43-7:11, https://www.youtube.com/watch?v=O7kBzZ9bYU0.
[42] Crystal Yarborough, "3.5.2: Contextualizing mental health care," Integrative Mental Health, Nov 6, 2022, Video, 10:54. https://www.youtube.com/watch?v=mqBVIhrLwvg.
[43] Monnica T. Williams, "Microaggressions: Clarification, Evidence, and Impact," *Perspectives on Psychological Science* 15, no. 1 (2020): 5, https://doi.org/10.1177/1745691619827499.

Therefore, as Yarborough put it, " Providers should acknowledge, affirm, and seek to understand another's worldview in order to establish trust."[44] By understanding group-level identity we are able to build trusting relationships with one another that helps us protect from traumatic experiences such as microaggressions.

B) Trauma

Within the context of hospice care, trauma can involve personal hardship, loss of trust, depression and difficulties in finding personal meaning. The American Psychological Association defines trauma as the following.

> Trauma is any disturbing experience that results in significant fear, helplessness, dissociation, confusion, or other disruptive feelings intense enough to have a long-lasting negative effect on a person's attitudes, behavior, and other aspects of functioning. Traumatic events include those caused by human behavior (e.g., rape, war, industrial accidents) as well as by nature (e.g., earthquakes) and often challenge an individual's view of the world as a just, safe, and predictable place.[45]

Trauma is related to disturbing experiences faced in a person's daily life. These experiences can either be one-off or repeated. Interestingly, trauma can be understood as passing from generation to generation which implies that trauma may be caused by social structures, economic conditions, race and ethnicity.[46] Trauma is particularly relevant in end-of-life care as if patients and their families are not given the opportunities to work through these events, it could lead to downstream problems. Therefore, by addressing problems like trauma through a sociocultural context, it may allow for opportunities and innovations to provide compassionate care.

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[44] Crystal Yarborough, "3.5.2: Contextualizing mental health care." Video, 13:06.
[45] APA Dictionary of Psychology, "Trauma," accessed March 3, 2024, https://dictionary.apa.org/.
[46] Phillis Isabella Sheppard, "Spiritual Care Practice for Intimate and Cultural Trauma Experiences," VDS Doctor of Ministry Program. December 1, 2023, Video, 48:11. https://vanderbilt.app.box.com/s/xwtbcpxfikhzvei4e5gk2ks1rd8hwkem/file/891055019082.

C) Cultural Trauma

Cultural trauma examines trauma within the context of cultural issues mentioned above. This can involve societal structures that may systematically affect individuals or the cultural group that they belong to. This can include the "loss of language, cultural values, racial, and ethnic sources of meaning-making and direct acts that inflict violence."[47] Korean immigrants are also susceptible to this as many struggle to maintain their languages and cultural values to survive in America. As previously mentioned, one way to assess these conflicts is through discrimination and microaggressions caused by the different power levels of majority cultures.

However, Polish scholar Piotr Sztomplka presents a different perspective in defining cultural trauma without concerning the power dynamic. His work which focuses on cultural issues itself, defines "cultural trauma as the culturally defined and interpreted shock to the cultural tissue of society, and presents a model of the traumatic sequence, describing typical conditions under which cultural trauma emerges and evolves."[48] Cultural traumas are often not easily recognized because the people with the trauma believe that emotional stress and tensions are a natural process in adjusting to cultural differences from repeated disturbing experiences. Sztompka emphasizes three points to avoid misunderstanding cultural trauma:

> first such events need not all evoke trauma (although under some conditions all of them *can,* and some of them actually *do*): second, the resulting trauma may be of radically unequal strength, duration, and significance; and the last, a cultural trauma need not always appear (The effects of potentially traumatizing events may be diverse, going beyond or not reaching the level of cultural trauma.)[49]

[47] Sheppard, "Spiritual Care Practice for Intimate and Cultural Trauma Experiences," Video, 7:00.
[48] Piotr Sztompka, "Cultural Trauma: The Other Face of Social Change," *European Journal of Social Theory* 3, no. 4 (2000): 449, https://doi.org/10.1177/136843100003004004.
[49] Sztompka, 452.

D. Lack of cultural sensitivity in medical settings.

Although understanding cultural differences is a crucial part of patient care, there is still much that can be done by hospitals to better include cultural awareness with mental, physical, and spiritual impact to improve holistic care of patients and their families. I will discuss three issues commonly found in hospital settings: The issue of autonomy, the issue of languages, and the lack of education regarding cultural bias and microaggressions.

First, is the issue of autonomy. This is particularly relevant in palliative care due to different cultural attitudes in families and medical professionals that surrounds the right to autonomy. In South Korea and other Asian countries like China, the Philippines and Japan, the doctor makes the final decision for the patients. Mo et. al. writes how "patient autonomy might be a less critical factor of well-being at the end of life in Korea than it is in Western countries."[50] They mention how "qualitative studies performed in Japan suggest that Japanese patients prefer to entrust decisions to their physicians rather than maintaining their own autonomy."[51] This contrasts with medical movements in America which have prioritized patient autonomy and the ability for them to make decisions that best align with their personal beliefs. However, Korean immigrants often maintain a belief that doctors know better than the patients in curing their bodies and generally are less likely to have a strong opinion in regards to quality of life. As a result, many Korean immigrants have a hard time when a doctor asks them about treatments because they are not used to answering these types of questions as they are not familiar with the American medical system.

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[50] Ha Na Mo et al., "Is Patient Autonomy a Critical Determinant of Quality of Life in Korea? End-of-Life Decision Making from the Perspective of the Patient," *Palliative Medicine* 26, no. 3 (2012): 226, https://doi.org/10.1177/0269216311405089.
[51] Mo et al., 223.

Then there is the issue of languages which considers complications regarding written documentation and interpretation services. In how many different languages does a general hospital offer regarding written documents besides English? In my hospital, it is standard practice to only provide English documentation. There is still a dearth of translation services that translate medical documentation from English to other languages. In the spiritual departments, chaplains provide the Bible and meditation books in both English and Spanish, but we lack books from any other language. Many immigrants struggle to learn English and are not familiar with medical terminology which can cause them to miss out on important information. Some interpretation services may use telephonic interpretation (also known as "blue phone"). This is an improvement, but telephonic interpretation can still be uncomfortable to use. After the covid-19 pandemic, IT technology was developed to be able to use tablets for communication. However, these tablets are limited and require support like increasing the number of interpreters as only a few translators cover multiple hospitals. However, when I worked at Baptist hospital six years ago, the hospital had their own trained translator in several languages. From my personal experience, I found that the patients were more satisfied and comfortable with having in-person interpretation services as the staff could provide better service.

Finally, there is often a lack of educational training regarding cultural bias and microaggressions. I have worked at my current hospital for three years, yet I have not had any required educational training regarding cultural issues. The hospital staff are required to undergo training related to working in a hospital setting but this does not include cultural competency modules. Therefore, the staff has had no chances to learn how to approach different cultures which can lead to increased stress when dealing with cross-cultural situations. For example, there are also different familial expectations when it comes to healthcare. In many Asian cultures, the

sons and children as a family make decisions for their parents medically and financially. Additionally, older Korean immigrant seniors believe that their sons and daughters have a responsibility to their parents after retirement and want to live with them rather than move to a nursing home. Many parents can feel a sense of betrayal if their children ask them to move into a nursing home as they prefer to live near or with their children. Hospice care is a new phenomena in South Korea with the right for terminally ill patients to refuse life-sustaining treatment only being passed in 2016.[52] Therefore, Korean immigrants generally have a lack of knowledge regarding hospice care.[53] If the staff know the cultural barriers, they approach the Korean immigrant patients differently and more easily.

Lack of educational training prevents development of sensibility with staff and, therefore, hinders optimal support for the wellbeing of Korean immigrant patients. The need for greater competencies can be illustrated in examples where the different systems cause traumatic experiences for patients with serious illnesses. For example, elder Kim was an 87-year-old Korean Christian who had stage 4 stomach cancer. He had a son who was educated in Korean and had a business running a Korean restaurant. When his son had a meeting with the doctor about treatment options for his father, he was not able to understand what was going on. There are various reasons for this. First, the son was used to following the doctor's opinion because the concept of autonomy was not well developed in Korea. Second, the son did not know about the hospice system and could not have a solid understanding of quality of life due to these cultural differences. Finally, he had a strong assumption that he had no say with medical decisions as he fully trusted the hospital and said yes when the physician told him surgery was the right choice.

[52] Hyun Sook Kim and Young Seon Hong, "Hospice Palliative Care in South Korea: Past, Present, and Future," *The Korean Journal of Hospice and Palliative Care* 19, no. 2 (June 1, 2016): 99, https://doi.org/10.14475/kjhpc.2016.19.2.99.

[53] Hye-Young Shim et al., "Do Korean Doctors Think a Palliative Consultation Team Would Be Helpful to Their Terminal Cancer Patients?," *Cancer Research and Treatment : Official Journal of Korean Cancer Association* 49, no. 2 (April 2017): 437, https://doi.org/10.4143/crt.2015.495.

However, the surgeon was not able to complete the surgery as the cancer had spread in his body and the patient passed away a few days later. After he passed, the son finally learned what it meant to undergo hospice care. He cried and regretted his decision as he was left with feelings of guilt, shame, and depression. He noted that the experience impacted his life for a long time as he wished he could have spent the final moments of his father's life being there with him. But instead, he lost valuable time to the ceaseless activity of medical care with a surgery that never happened. If the hospital staff could have supported him better throughout this time and laid out the options in a more culturally sensitive manner, it could have helped to alleviate some of the guilt he feels today and provided him peace to embrace the final moments of his father's life.

E. Biblical approaches to Multicultural Chaplaincy.

1. The multicultural approach in the USA.

In 1999, the first National Multicultural Conference and Summit was held in order to challenge psychologists to examine issues, identify barriers, and forge alliances that would promote multiculturalism within the field.[54] Since then many healthcare organizations have developed multicultural competencies to better serve the increasingly diverse US population through a focus on "culture-centered" care.[55] These competencies extend to chaplains as well with the Association for Clinical Pastoral Education (ACPE) developing competencies in order to better provide care to diverse populations.[56] These competencies have helped expand chaplain

[54] Derald Wing Sue et al., "The Diversification of Psychology: A Multicultural Revolution," *The American Psychologist* 54, no. 12 (1999): 1061, https://doi.org/10.1037/0003-066X.54.12.1061.
[55] American Psychological Association, "Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists," *The American Psychologist* 58, no. 5 (2003): 380, https://doi.org/10.1037/0003-066X.58.5.377.
[56] K. Samuel Lee, "Toward Multicultural Competencies for Pastoral/Spiritual Care Providers in Clinical Settings: Response to Anderson, Fukuyama, and Sevig," in *Ministry in the Spiritual and Cultural Diversity of Health Care : Increasing the Competency of Chaplains*, ed. Robert G. Anderson and Mary A. Fukuyama (New York: Routledge, 2009), 44.

care outside solely Christianity and signifies the beginning of the shift we have seen over recent decades in multiculturalism and the growing acceptance of people from diverse backgrounds. With the movement, the question of how we can understand the connections between culture and spirituality becomes ever more important and an urgent issue.

Furthermore, the importance of a multicultural approach is not exclusive to the current generation. In the mid-20th century, theologian Paul Tillich described how "The encounter with reality on which one language is based differs from the encounter with reality in any other language, and this encounter in its totality and its depth is the substance in the cultural self-creation of life."[57] Tillich recognized that different languages and different lifestyles impact one's thinking and in finding meaning and purpose in life. Russell Manning acknowledges Tillich's work and remarks on the intertwined essence of culture and religion by noting "Tillich's proposals for and writings in the theology of culture are a powerful affirmation of the religious significance of culture and the cultural significance of religion".[58] Thus, acknowledgment of one's culture can serve to help understand one's own functions, values, and spiritual needs, but these same beliefs can act as a barrier to an outsider looking in. As chaplains we should continue to explore methods to bridge these barriers. By aiming to understand how people think within the context of culture, rather than solely being aware of cultural differences, we can begin addressing patient's underlying spiritual and emotional needs in earnest.

Kevin Vanhoozer further argues that culture does not exist without a spiritual dimension. In his work *Everyday Theology*, he builds on Tillich's famous maxim on culture and religion.

> The spiritual dimension of culture. Culture is hardly a faith-freezone. On the contrary, in programming its members to live a certain way, culture also

[57] Paul Tillich, *Systematic Theology III: Life and the Spirit History and the Kingdom of God.* (Chicago, Il: The University of Chicago Press, 1963), 60.
[58] Russell Re Manning, "The Religious Meaning of Culture: Paul Tillich and Beyond," *International Journal of Systematic Theology : IJST* 15, no. 4 (2013): 438, https://doi.org/10.1111/ijst.12020.

> predisposes them toward a certain kind of faith. Nobody perceived this better than Tillich, who observed that "religion is the substance of culture, culture is the form of religion.[59]

The importance of culture is related to our interpretation of the Bible and its application in our daily lives. The Bible was written with cultural influences from its own time which is distinct from the culture we live in today. Therefore, one's understanding of the Bible and the ministry has to be viewed through an understanding of cultures. Vanhoozer indicates this as well.

> … (1)How our faith is affected by the world we live in and (2) how we are to embody our faith in shapes of everyday life. The reason why theology must study God and contemporary culture is the same reason why preaching must connect both with the biblical text and the listener's context: because disciples do not follow the gospel in a vacuum but wend their Christian way through particular times and places, each with its own problems and possibilities.[60]

Culture therefore is related to our spiritual life as they work together to adjust our perception of reality. They can make us more or less sensitive to negative pressures and affect the principles that we value in life. This is the reason why chaplains should develop their own sensitivities to multicultural situations.

Knowledge of culture is the key to understanding a person's or group's faith. Perriman notes how that culture can be viewed "as part of a system of signs" which can be understood as either a comprehensive 'spirit' that defines the times, or a more nuanced 'soul' that is at the core of what drives a culture.[61] Therefore, when approaching culture from a theological point of view we cannot rely solely on 'explicit messages' but also appreciate the 'implicit moods' or the

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[59] Kevin J. Vanhoozer, "What Is Everyday Theology? How and Why Christians Should Read Culture," in *Everyday Theology: How to Read Cultural Texts and Interpret Trends*, ed. Kevin J. Vanhoozer, Charles A. Anderson, and Michael J. Sleasman (Grand Rapids, Mich: Baker Academic, 2007), 34.
[60] David G. Thompson, "The High Price of Unity: The Universal Declaration of Human Rights," in *Everyday Theology: How to Read Cultural Texts and Interpret Trends*, ed. Kevin J. Vanhoozer, Charles A. Anderson, and Michael J. Sleasman (Grand Rapids, Mich: Baker Academic, 2007), 16.
[61] Andrew Perrriman, "Everyday Theology: How to Read Cultural Texts and Interpret Trends Edited by Kevin J. Vanhoozer, Charles A. Anderson and Michael J. Sleasman Grand Rapids: Baker Academic. 2007. 287 Pp. Pb. £15.99. ISBN 978-0-8010-3167-0," *Evangelical Quarterly* 2009, 81, no. 2 (2009): 183, https://doi.org/10.1163/27725472-08102016.

underlying attitudes, beliefs, and reasonings that lead to these explicit dialogues.[62] Faith is not only one's understanding of the Bible, but also the belief systems of a person or group within the context of culture. Perriman explains how "Christians bring their presuppositions to the reading of cultural texts no less than to the reading of biblical texts."[63] Oftentimes, as casual readers we will take the explicit stories and actions of the Bible and apply them within our own cultural framework. While this is not inherently bad, and can be useful in an individual's exploration of their faith, it can become a barrier when trying to understand the true underlying messages within the context of the writer's cultural frameworks.

In my own personal religious experiences, the Korean Presbyterian church has different systems of faith when compared to the PCUSA. Despite the same doctrines, there are differences in interpretation of religious concepts caused from both cultural biases and translational differences. For example, on Ash Wednesday American Christians often emphasize the ash on one's head, which is not an important practice in Korean churches. As a former pastor, I am still not comfortable with having ash placed on my forehead. Another example is the difference in focus between the Korean and American interpretations of Good Friday. Koreans tend to emphasize a common sharing of Jesus Christ's pain and suffering through a week-long fast while in America, interpretations tend to emphasize how Jesus suffered so that we do not need to.

Winedt explains how processes like intersemiotic translation can result in a 'hegemonic' imposition of the dominant culture to the translated one.[64] In the context of Korean immigrants, it is important not to impose a western-based cultural framework on these patients. Some may even provide rhetoric like "if you are living in this country, it should be your responsibility to

[62] Jeff Astley, "Book Review of Everyday Theology: How to Read Cultural Texts and Interpret Trends Edited by Kevin J. Vanhoozer, Charles A. Anderson and Michael J. Sleasman," *Implicit Religion* 11, no. 2 (2008): 203, https://doi.org/10.1558/imre.v11i2.202.
[63] Perrriman, "Everyday Theology," 183.
[64] Marlon Winedt, "Bible Translation as Incarnation of the Word of God: Transformational Power through Form and Meaning," *The Bible Translator* 72, no. 2 (2021): 233, https://doi.org/10.1177/20516770211027624.

understand its culture". However, as chaplains and caretakers, this is a dangerous attitude that can result in disastrous consequences in the treatment of our patients. As Vanhoozer writes, "No one culture is allowed to claim for itself the sole rightful possession of what 'Christian' means" and that "every 'translation' of Christianity into another culture enhances our understanding of what the gospel means."[65] Values of faith are strongly connected to and formed by the culture they come from. It is therefore crucial to understand these theological templates and to tailor the treatment for our patient's spiritual needs accordingly.

2. The power issues between cultures.

In cultural chaplaincy, we must also consider the issues involving power among cultural differences. Individuals within dominant cultures may ignore people within the minority either consciously or unconsciously due to cultural biases or microaggression that are driven by the values, manners, and lifestyles of the dominant culture. Although Christians believe that "human dignity" "stems from the belief that we have been created in the image of God"[66], we must also recognize the difficulty in overcoming cultural biases or microaggressions within our society. Individuals are often accustomed to their own customs and have difficulty in accepting other unknown or unlearned cultures. The judgment that arises from feelings of superiority from one culture to another can result in the aforementioned conscious/unconscious cultural biases and microaggressions.[67] Lingenfelter and Mayers also note that "each culture defines its own paths to recognition and self-fulfillment. Yet this pursuit of significance stands in opposition to the career

[65] Kevin J. Vanhoozer, "What Is Everyday Theology? How and Why Christians Should Read Culture," 42.
[66] David G. Thompson, "The High Price of Unity: The Universal Declaration of Human Rights," 110.
[67] David F. D'Amico, "Word about Recent Book: III. Ministerial Studies: Ministering Cross-Culturally: An Incarnational Model for Personal Relationships," *Review & Expositor* 102, no. 4 (2005): 753, https://doi.org/10.1177/003463730510200415.

of servanthood that God has for all believers."[68] As chaplains, how can we help our patients who are hurt from microaggressions, lose their trust from cultural barriers, and are struggling from mental health issues such as depression and cultural trauma? We should focus on comprehensive guidelines that can help us develop our toolbox to support our patients. This way, we can understand the various paths each individual travels down rather than assert one path as superior over another.

3. Three Biblical Metaphors for Grounding Multicultural Chaplaincy

So how can we develop our approach for multicultural chaplaincy in the context of the Bible? I argue we can learn to model our care from the following three biblical metaphors: The metaphor of incarnation, the burning bush and the story of Naomi.

A) Metaphor of Incarnation.

When we discuss cultures, it is easy to say that one "knows the culture". However, an important question to ask is "How much do you know about the culture?" Do you know 100 percent? Or 50%? Or 10%?[69] In my personal experience, I would say that "I know Philippine culture less than 10%" even though I had lived in the Philippines for five years. Therefore, when I need to support my Filipino patients, I make sure to ask for information from a Filipino nurse who grew up in the Philippines to avoid assumptions. In doing so, I discover new cultural values, manners, and behavior I was not previously aware of each time. Even though I have lived in America for 20 years and worked as a chaplain for 5 years, I like to say, "I know less than 50 %

[68] Sherwood G. Lingenfelter and Marvin K. Mayers, *Ministering Cross-Culturally: A Model for Effective Personal Relationships*, Third Edition. (Grand Rapids, Michigan: Baker Academic, a division of Baker Publishing Group, 2016), 90.
[69] Lingenfelter and Mayers, 3.

of the dominant culture" because I get new information all the time from my chaplain colleague and my children who grew up in America. Moreover, we can't know other cultures 100 % because there are unknown and uneducated cultural values and behaviors that we may not be aware of. Culture also is not static but grows and changes over time.

Many Christians believe in the incarnation of Jesus Christ. Tillich mentions "God has become man" and adds "A modifying interpretation of the term 'Incarnation' would have to follow the Johannine statement that the 'Logos became flesh.' 'Logos' is the principle of the divine self-manifestation in God as well as in the universe, in nature as well as in history."[70] The *Dictionary of Pastoral Care and Counseling* edited by Rodney J. Hunter notes that "Martin Luther interpreted the implication of the Incarnation to mean that it is the task of Christians to be 'little Christs to our neighbors.'"[71] So how can we be little Christ to our neighbor who has different cultural values, means, and behaviors? Lingenfelter and Mayers used the word "Jesus: The 200 Percent Person"[72] to understand the incarnation of Jesus from a cultural perspective. They paid attention to two significant facts: "The first significant fact about the incarnation is that Jesus came as a helpless infant" and "The second significant fact about the incarnation is that Jesus was a learner. He was not born with knowledge of language or culture."[73] This means that Jesus Christ was an infant who didn't know anything about human life and spent time learning the Jewish language, Jewish culture, Jewish lifestyle, and Scripture from childhood. From the other perspective, Jesus Christ is God, so He already knew what was going on in Heaven and the language, the culture, and the lifestyle it is associated with. Lingenfelter and

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[70] Paul Tillich, *Systematic Theology II: Existence and The Christ* (Chicago, IL: The University of Chicago Press, 1963), 94–95.
[71] Rodney J. Hunter et al., eds., *Dictionary of Pastoral Care and Counseling* (Nashville: Abingdon Press, 1990), 573.
[72] Lingenfelter and Mayers, *Ministering Cross-Culturally*, 3.
[73] Lingenfelter and Mayers, 4.

Mayers express that "In sum, he was 100 percent God and 100 percent Jew – a 200 percent person." Lingenfelter and Mayers use the metaphor of incarnation to explain the importance of culture by noting how culture is a shared process where individuals in a culture interact with culture in "conditioned ways".[74] Thus if we don't learn the different cultures we have cultural blindness. That is why Jesus Christ learned the Jewish culture so He could serve effectively. Lingenfelter and Mayers indicated that "This cultural blindness makes us ineffective in communicating in alien contexts and leads us to assume that the problem lies with others rather than ourselves."[75] It is also important to recognize that what a patient doesn't say is as valuable as what they say. Therefore, silent communication by cultures via facial expressions, gestures, and moods should also be considered important. Jesus knew that, so He learned the Jewish culture from His childhood and Christians who want to serve people with different cultures should therefore follow His way. Lingenfelter and Mayers clearly mentioned, "It is because of cultural blindness that we must begin as learners in the other culture and adopt many of the priorities and values of the people we wish to serve."[76] Jesus Christ is a model for intercultural chaplaincy which is why the metaphor of incarnation is an important wisdom for chaplains.

B) Metaphor of Moses and the Burning Bush

Regarding power issues, we have a question of how to overcome both conscious and unconscious microaggression between two different cultures. The answer is to hold humble and kind attitudes toward these differences. Many chaplains believe that chaplains are a representation of God as they are knowledgeable about God and are able to deliver God's love and peace to the patients. But a chaplains' attitude can be misinterpreted in different ways by

[74] Lingenfelter and Mayers, 9.
[75] Lingenfelter and Mayers, 10.
[76] Lingenfelter and Mayers, 10.

cultural differences. In addition, patients, who have bad experiences with cultural barriers, can misunderstand the chaplains' unthinking behaviors. Therefore, in regard to power issues, I would like to change the imagery to a chaplain meeting Jesus in a patient's room.

I borrowed this from my colleague Chaplain Stephen, who tells the story about how the Son of Man will separate people like how a shepherd separates sheep and goats in Matthew 25. The message is about "eschatological judge's division", eternal punishment, and as Wendland notes, "the great separation between "the righteous" and the rest (25:46)."[77] Jesus puts the sheep on his right, but the goats on the left. These mentioning of separation is important as these imagery is "strengthened by the appearance of the verb aphorize" or 'separate' which only appear twice in the Gospel, in reference to the separation of the good and useless fish (13:49) and to the separation of the sheep and goats (25:32)."[78] Furthermore, the audiences of Matthew understand the meaning of sheep and goat in the metaphor despite sheep and goats having various symbolic meanings in different cultures, places, and times.[79] Within this familiar cultural imagery and oral tradition, Jesus explains why he separated the people by saying "I was hungry, and you gave Me something to eat; I was thirsty, and you gave Me something to drink; I was a stranger, and you invited Me" in Matthew 25:36. Chaplain Stephen made a point that "I was sick, and you visited Me" in Matthew 25:36. A chaplain who visits a patient can be seen as visiting Jesus Christ who is one of the Persons of the Trinity. This changes our formation because a chaplain's visit is then not only the presentation of God but also the moment to meet God.

Chaplain Stephen provides the story of Moses who meets God in the Burning Bush. According to Exodus 3:1-6, Moses went to Hebron, the mountain of God, and found the bush

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[77] Kathleen Weber, "The Image of Sheep and Goats in Matthew 25:31-46," *The Catholic Biblical Quarterly* 59, no. 4 (1997): 657; Ernst Wendland, "Whose Side Are You on? Structure and Rhetoric in Christ's Parable of the Sheep and the Goats (Matthew 25: 31-46), with Special Reference to Bible Translation," *Scriptura* 80, no. 1 (2002): 312.
[78] Weber, "The Image of Sheep and Goats in Matthew 25," 658.
[79] Weber, 661.

was burning with fire, yet the bush was not being consumed. The place, Hebron, is God's land which is also commonly known as Mountain Sinai. Adamo indicated "There are two revelations or vision accounts on Mountain Sinai in Exodus. The first one is in Exodus 3–4 and the second one is in Exodus 19–34. The scene of the two accounts is Mount Horeb and Sinai which appear to be the same location."[80] Fire is an important symbol of God. Adamo said, "Fire is frequently used as a medium by which God shows himself in the scripture as said above."[81] Fire in the Bible has two functions which are "destroy" in the case of Sodom and Gomorrah or "purify" as is in Isaiah 6.[82] In the burning bush, fire purifies the bush and the land.

Furthermore, God called to him from the midst of the bush and God said, "Do not come near here; remove your sandals from your feet, for the place on which you are standing is holy ground." Moses didn't know what "heavenly culture" was, so God taught him to take his shoes off and ordered what he needed to do. God asked Moses to take off his sandals because taking sandals off is "a sign of respect for the holy".[83] The metaphor of Moses taking his sandals off is the humility faced by God's order. In Matthew 25:36, to visit a patient means to visit Jesus Christ. We can then extend this metaphor to say that our patients' room is the holy ground in which we can meet Jesus. Humility is important in intercultural chaplaincy because the dominant culture has more power than minority cultures. Moses in front of God didn't assert his opinion and thoughts but he listened to only God. His listening wasn't easy as he didn't want to lose the words God spoke to him. He deeply paid attention because he knew God was different from him. Intercultural chaplaincy requires a deeper listening akin to Moses when he stood in front of God. In the same sense, patients with minority cultures have different meanings in facial expressions,

[80] David T. Adamo, "The Burning Bush (Ex 3:1–6) : A Study of Natural Phenomena as Manifestation of Divine Presence in the Old Testament and in African Context," *Hervormde Teologiese Studies* 73, no. 3 (2017): 2, https://doi.org/10.4102/hts.v73i3.4576.
[81] Adamo, 2.
[82] Adamo, 2.
[83] Adamo, 3.

gestures, and moods compared to the dominant culture therefore the approach to empathy is not the same among different cultures. Multicultural chaplaincy therefore needs to be humble and utilize sensitive approaches.

C) Metaphor of Naomi as a model of a multicultural chaplain

In regards to cultural differences, we often talk about Jonah in Nineveh, the Good Samaritan story, Jesus's ministry with the Syro-Phoenician woman or the woman at Jacob's well but in this thesis I use the story of Naomi as a model of multicultural chaplaincy due to two reasons. First, the story shows the immigrants' life as Ruth is an immigrant from Moab culture to Israel culture. The second reason is that the approach of Naomi to Ruth is similar to Asian cultural behavior. In Korean culture there is a word, "Jo-eon" that is widely used among Koreans as a way to take care of each other. Jo-eon is a kind of giving advice and information to others. Usually, seniors or caregivers use Jo-eon for people who are in suffering, grief, and mental issues. Even though many in Western cultures emphasize not giving advice, the cultural behavior of Jo-eon is important in China, Japan, and Korea. In the case of the Caucasian doctor and Asian patient mentioned previously, the Asian patient was waiting for Jo-eon from the doctor. The doctor gave information including Jo-eon to the patient and then the patient could decide for himself. As a chaplain however, I don't suggest giving advice directly but giving more information that the patients don't know but might be beneficial for them. Thus I turn to The Book of Ruth, which is rarely examined within a multicultural perspective, to understand how Ruth navigated both Moabite and the Jewish culture. In particular, how Ruth helped Naomi successfully overcome cultural differences by building trust between the two of them.

In fact, many scholars call the Book of Ruth "the Naomi Story" because Naomi has a very important function in the book.[84] Furthermore, as Giles and Doan note, the way the story is written, "all point toward the conclusion that the Naomi Story was told by women for women. The Naomi Story was part of the female performance tradition of ancient Israel."[85] The loss of Naomi's two sons to Ruth's successful childbirth, represents "the transition from childlessness to motherhood."[86] This said, scholars like Gale Yee have used words like "perpetual foreigner" and "model minority" to describe Asian Americans.[87] The lives of Asian women in particular often involve issues of ethnicity, economic exploitation and racist attitudes regarding sexuality of foreigners.[88] Biblical scholar Athalya Brenner has analyzed the book of Ruth from the perspective of a migrant worker in Israel.[89] Her interpretation provides an alternative view on how to interpret the Naomi story versus the interpretative traditions I use to explore the Naomi story as a model of chaplaincy.[90]

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[84] Terry Giles and William J. Doan, *The Naomi Story-the Book of Ruth: From Gender to Politics*, Biblical Performance Criticism Series 13 (Eugene, Oregon: Cascade Books, 2016), 4.
[85] Giles and Doan, 13.
[86] Giles and Doan, 69.
[87] Gale A. Yee, "'She Stood in Tears Amid the Alien Corn': Ruth, the Perpetual Foreigner and Model Minority," in *They Were All Together in One Place?*, ed. Randall C. Bailey, Tat-Siong Benny Liew, and Fernando F. Segovia, vol. 57 (United States: Society of Biblical Literature, 2009), 120.
[88] Yee, 127.
[89] Athalya Brenner, "From Ruth to the 'Global Woman': Social and Legal Aspects," *Interpretation (Richmond)* 64, no. 2 (2010): 168, https://doi.org/10.1177/002096431006400204.
[90] Not all academic interpreters are comfortable embracing the story of Ruth and Naomi. From a feminist perspective, Gale Yee understands that the text supports the "perpetual foreigner" and "model minority" stereotypes that plagues many contemporary Asian American. She also has concerns endorsing a text that includes economic and sexual exploitation. Relatedly, biblical scholar Athalya Brenner reads the book of Ruth from the perspective of a migrant worker in Israel and offers perspective through the question "Will it not be beneficial to allow for a two-way traffic, that is, not only to read the Bible as an exemplum for our 'reality,' whatever that might be, but also to read our own reality as a guide for reading the Bible?" These theological perspectives aim to make sense of the suffering faced by immigrant women in today's modern society. Yet I follow other interpretive traditions to draw on the Naomi story as I understand it through the viewpoint of two women (who both are not part of the dominant culture, albeit in different ways) navigating through the dominant culture and political norms to survive. This collaboration under pressure is the inspiration that I, and other academic interpreters, drew from this story. As with any biblical story, we must be careful to understand the nuances so as to not perpetuate harm as we seek to gather lessons from the text.

In the Book of Ruth, there were Elimelech and Naomi who were Ephrathites of Bethlehem in Judah who moved to the land of Moab with their two sons. Elimelech died in the land of Moab and Naomi accepted two daughters-in-law (Ruth and Orpah) via her two sons. From a cultural perspective, Naomi was familiar with her own culture, Judaism, as well as the Moab culture from living in Moab as well as having two daughters-in-law who were Moabites. Nevertheless, after Naomi lost her two sons she decided to return to Bethlehem for food. Ruth followed Naomi but Orpah left her mother-in-law. Naomi and Ruth lived together in Bethlehem which was dominated by Jewish culture. Although Naomi knew the Jewish culture well, Ruth was a stranger and was unfamiliar with the Jewish culture. Naomi, through four main communications, helped Ruth as a mentor/supporter. By examining these four scenes, Naomi can serve as a model of chaplain who is willing to help immigrants to accept the dominant culture.

The first scene is in the book of Ruth 2:2-3. Ruth was worried about food and needed to find a way to survive. Roop mentioned how "She comes as much to inform Naomi as to ask her permission. Ruth decides to obtain food by using the customary practice of gleaning, picking up grain left in the field after harvesting."[91] Immigrants often rely on other immigrants who understand the culture better to address one's lack of certainty in their life. Ruth too was uncomfortable with what she should do but through her initiative she found a way to gain food. Naomi meanwhile understood Ruth's desire and the meaning of her acts. Ruth said, "Please let me go to the field and glean among the ears of grain following one in whose eyes I may find favor." (Ruth 2:2) Naomi replies, "Go, my daughter." This had two meanings: Naomi both gave Ruth permission to go and also signified belief in Ruth that she would be able to gain some food

[91] Eugene F. Roop, *Ruth, Jonah, Esther*, Believers Church Bible Commentary (Scottdale, Pa: Herald Press, 2002), 46.

from her work within the Jewish culture. This faith and trust in Ruth would help inspire her to follow through with her intentions.

The second scene is in the Book of Ruth 2:19-23. Naomi asks Ruth where she worked and what was going on with her. Ruth told Naomi about what was going on by mentioning Boaz. Naomi gave Ruth some information about Boaz and she said, "The man is our relative; he is one of our redeemers." (Ruth 2:20) Roop indicates "This is the first mention of the word redeemer (go'el), a word that will play a central role in the episode at the threshing floor (3:1-18), leading to the decision at the city gate (4:1-12)."[92] Ruth therefore through Naomi was able to understand her relationship with Boaz as one of the redeemers. This is pivotal as in many cases, immigrants are in the dark when it comes to information and therefore cannot act properly. Naomi also explained the meaning of Boaz's words "You are to stay close to my servants until they have finished all my harvest." (Ruth 2:21) Ruth might not know why Boaz asked her to stay with his servants but Naomi knew the situation and was able to explain it to Ruth. "It is good, my daughter, that you go out with his young women so that others do not assault you in another field." (Ruth 2:22) Naomi knew Jews can easily ignore or assault foreigners so Boaz wanted to make sure Ruth was protected. Thus, Naomi helped Ruth to understand the meanings of Boaz's words within Jewish cultural values.

In the third scene, Naomi taught Ruth how to approach Boaz for redemption regarding Jewish cultural behaviors. Naomi asked Ruth to wash herself, to put on her best clothes, and to go down to the threshing floor.[93] Naomi told her to be careful not to be discovered by Boaz until

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[92] Roop, 52.

[93] Scholars have noted significant ethical issues regarding this situation. Particularly from a feminist perspective, Ruth may have been sexually exploited which makes understanding her agency of vulnerability crucial to interpreting this text. Historical differences here can be stark, but we know the Bible mentions that their choice was God's blessing for them and encourages us to follow Ruth's example. I do not believe that God condones sexual exploitation. Yet, we learn here that across different perspectives in different times that there are different cultural differences. George Savran notes, "And in Chapter 3, in following Naomi's advice about approaching Boaz on the threshing floor, she seems to have fully accepted Naomi's way of thinking about a woman's dependence upon male

he had finished eating and drinking. Naomi requested Ruth to do things that were strange to her: Naomi said, "And it shall be when he lies down, that you shall take notice of the place where he lies, and you shall go and uncover his feet and lie down; then he will tell you what you should do." (Ruth 3:4) In a cultural perspective, what does Naomi's request mean? Roop says

> This plan is fraught with all manner of danger. Circumstances have forced Ruth the Moabite into the role of foreign woman, a fact the narrator continues to call to our attention (2:10, 21). Now her mother-in-law adds the corollary to that role: the temptress (Brenner, 1985:90). Israelite tradition has warned that the foreign temptress can compromise Hebrew men and their faith (Num. 25:1)[94]

Thus Naomi's plan is very dangerous as prophets speak out the warnings to Israel's men not to be close to Moab women. Some contemporary scholars note, this instructive behavior may also be acquiescing to the dominant culture. At the society level, chaplains need to join the movement to change society toward justice. On a personal level, immigrants are struggling with cultural barriers and can't find their own meaning and purpose in life because their values don't work in the communities. When the immigrants know more about the dominant culture's values and manners, they can move toward well-being in their life through understanding the cultural barriers. The chaplains' function can include the support of the patients to understand the dominant culture. I like to call Jo-eon for that process. The immigrants will make a decision by themself to accept, adapt, or to be against the domain cultural values after clearly knowing them. In cultural issues, the Korean ethnic self can be called "Woori (we)" but the Western ethnic self can be called "I".[95] That means many Korean lifestyles are following community values but

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prerogative. Indeed, the entire trajectory of Ruth's story can be read as a Bildungsroman, in which Ruth's idealization of female solidarity in 1:16-17 becomes tempered by the realities of life under a patriarchal regime. The story's progression reveals Ruth's gradual acceptance of the necessity of finding a male benefactor to sustain her and Naomi. In wishing that Boaz would spread his kanaf--his robe-over her, Ruth explicitly voices Naomi's agenda for finding a husband as redeemer." (George Savran, "The Time of Her Life", 17) The feminist criticism is not necessarily of Boaz's direct exploitation of Ruth and Naomi, but rather exploitation guided by the dominant patriarchal structures of the day.

[94] Roop, *Ruth, Jonah, Esther*, 58–59.

[95] Hee An Choi, "A Korean Ethnic Self (We)," in *A Postcolonial Self* (United States: State University of New York Press, 2015), 27–28.

many American lifestyles are following personal values as an independent lifestyle. After knowing the difference between the cultures, the Korean immigrant can accept, adapt, or be against the domain cultural values. Ruth also didn't know how Boaz would respond to a midnight approach by her. Naomi in Jo-eon taught Ruth how she could achieve her dreams through the Jewish culture to escape the poverty she faced in her life. Ruth agreed with Naomi and said, "All that you say I will do" (Ruth 3:5).[96] In face of different cultural values, Ruth trusted Naomi and accepted her advice. Savran notes, "And in Chapter 3, in following Naomi's advice about approaching Boaz on the threshing floor, she seems to have fully accepted Naomi's way of thinking about a woman's dependence upon male prerogative."[97] Ruth accepted the different cultural attitude by Naomi's words, Jo-eon, and the difference between men's and women's life. Savran indicated "The pattern of a woman's life is determined entirely by how men look upon her and treat her."[98]

In the fourth scene, Ruth went to Naomi after finishing her mission and then told her what Boaz had done to her. Ruth brought the six measures of barley and told Naomi what Boaz said. In the scene, Naomi explained what was going on with Boaz in the context of Jewish culture. Naomi said, "Wait, my daughter, until you know how the matter turns out; for the man will not rest until he has settled it today." (Ruth 3:18) As Ruth was following Naomi's advice, she may have been in the dark herself about what was going on between her and Boaz. But Noami seemed to know what was going on due to her cultural awareness. As Giles and Doan said, "Our interest in the performance of the Naomi Story recognizes the important role that

[96] In this scene, Naomi seems to tell Ruth what she needs to do. This is contrary to how chaplaincy is understood today. Rather than telling patients what to do, chaplains should aim to support patients and help them find their own paths through their cultural values. Here, Naomi suggests one method to escape their poor life via Israel's cultural background by finding a redeemer for a woman. Ruth thus had a choice to follow Naomi's opinion or not.
[97] George Savran, "The Time of Her Life: Ruth and Naomi," *Nashim : A Journal of Jewish Women's Studies & Gender Issues*, no. 30 (2016): 17, https://doi.org/10.2979/nashim.30.1.01.
[98] Savran, 13.

performance plays in cultural memory."[99] Ruth was comforted because she understood the meaning of Boaz's words in his cultural values and knew what would be going on with Boaz. Naomi, as a model of chaplaincy, knew what Ruth needed, interpreted the meaning of the acts and situations from the dominant culture to the minority culture, and helped Ruth find her way through the dominant culture. Like Naomi, chaplains should serve as mentors to support communication between caregivers and patients.

F. Standardizing Approaches to Multicultural Chaplaincy

With this biblical perspective about culture in mind, the question of "What are effective methods for chaplains to support their own people through these cultural challenges in their practice?" is essential. In the perspective of multicultural chaplaincy in a hospital setting, we need to discuss the importance of patient-centered care, biopsychosocial-spirituality, spirituality in culture, and a web of meaning in spirituality. I will close by discussing the five steps and eight guidelines to multicultural chaplaincy.

1. Patient-centered care

Evidence-based practice is important for chaplaincy in providing effective care. This evidence-based practice includes "patient-centered care" by Carl Rogers in respecting patients' personal experiences, values, cultures, belief systems, and personalities. Puchalski notes that the use of patient centered care can improve patient health outcomes through engagement in shared decision-making.[100] Donohue and Klasco describe the Picker model that focuses on engagement

[99] Giles and Doan, *The Naomi Story-the Book of Ruth*, 44.
[100] Christina M. Puchalski, "Restorative Medicine," in *Oxford Textbook of Spirituality in Healthcare* (Oxford University Press Inc: New York, 2012), 198.

of patients by the use of eight dimensions for better care.[101] Chaplains can improve care of patient's concerns and sufferings by changing their behaviors in relation to their own values and stories. In multicultural chaplaincy, listening to patients' stories is crucial in assessing the patient. As Cook writes, narratives should be listened to unbiasedly and be a major component of any cultural approach.[102] As Overvold underscores "Almost everything the chaplain does with respect to patient care can be described in terms of patient-centered care".[103] One important factor to consider when providing patient-centered care is the consideration of cultural values. As Puchalski and Ferrel mentions, spirituality is deeply related to personal culture and practitioners need to make sure they understand their own implicit biases and be willing to "step away from his or her own cultural or spiritual reference points."[104] Chaplains in patient-centered care should be sensitive to the suffering that occurs from the conflicted experiences, particularly when one's cultural values do not work and patients find difficulty in finding meaning in different cultures.

2. Biopsychosocial-spirituality model

In the hospital setting, the biopsychosocial-spirituality model is developed from the biopsychosocial model which is developed from the biomedical model. The biomedical model focuses on the usage of medications as a primary method to improve both physical illness and

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[101] Ryan Donohue and Stephen K. Klasko, *Patient No Longer: Why Healthcare Must Deliver the Care Experience That Consumers Want and Expect*, Management Series (Ann Arbor, Mich.) (Chicago, Illinois: HAP, 2021), 10–12. The eight dimensions are (1) respect for patients' values, preferences, and expressed needs, (2) coordination and integration of care, (3) information, communication, and education. (4) physical comfort, (5) emotional support and alleviation of fear and anxiety, (6) involvement of family and friends, (7) continuity and transition, (8) access to care.

[102] Stephen W. Cook, "Definitions, Obstacles, and Standards of Care for the Integration of Spiritual and Cultural Competency Within Health Care Chaplaincy," *Journal of Health Care Chaplaincy* 13, no. 2 (2004): 63, https://doi.org/10.1300/J080v13n02_05.

[103] Jon Overvold, "Quality Improvement: A Chaplaincy Priority," in *Professional Spiritual & Pastoral Care: A Practical Clergy and Chaplain's Handbook*, ed. Stephen B. Roberts (Nashville, TN: SkyLight Paths Pub., 2012), 376.

[104] Christina M. Puchalaki and Betty Ferrell, *Making Health Care Whole* (West Conshohocken, PA: Templeton Press, 2010), 87.

mental disorders which are caused by the interplay between brain biochemistry and environmental factors.[105] But we know many patients don't want to take medications due to various reasons which can include religious issues.[106] Therefore, the biomedical model is not sufficient on its own in supporting patients.

The biopsychosocial model by Engel focuses on the social context to deal with the disruptive effects of illness.[107] Relationships are an important part of human experiences as people find their values, identities, and lifestyles through them.[108] Therefore, the sense of belonging to others, to our place, and a sense of completeness in ourselves are important factors to one's health.[109] However, the biopsychosocial model does not address spiritual factors. Many healthcare workers don't concern the importance of spiritual needs as a priority for patients.[110] But spirituality is the core issue to find the value and meaning of their life, suffering, and death.[111] Per Puchalski and Ferrel, "Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose, and the way they experience their connectedness to the moment, to self, to others, to nature and to the significant or sacred."[112] Clearly we know that good religious involvement increases a person's well-being.[113] The

[105] Michele J. Guest Lowery, "Behavioral Health Basics for Chaplains," *Health Progress* 99, no. 1 (2018): 6, https://search.proquest.com/docview/2061491932?pq-origsite=primo.
[106] Warren Kinghorn, and John Forbes, "2.1.3: Pharmacotherapy," Integrative Mental Health. June 16, 2014. Video, 33:04. https://www.youtube.com/watch?v=EWW4DYpubzA.
[107] George Engel, "The Need for a New Medical Model: A Challenge for Biomedicine," *Psychodynamic Psychiatry* 40, no. 3 (2012): 386, https://doi.org/10.1521/pdps.2012.40.3.377.
[108] Jaco Hamman, "3.2.3: Approaching research within chaplaincy," Integrative Mental Health. Sep 18, 2022. Video, 32:06, https://www.youtube.com/watch?v=VyMq78kzXkQ.
[109] Keith Meador, Jason Nieuwsma, Chris Smith, and Dayle Friedman, "2.4.1 Upstream Suicide Prevention: Human Flourishing," Integrative Mental Health. Oct 30, 2019. Video, 28:15.
https://www.youtube.com/watch?v=JM3l7jjvRfE.
[110] George Handzo, "The Process of Spiritual / Pastoral Care: A General Theory for Providing Spiritual / Pastoral Care Using Palliative Care as a Paradigm," in *Professional Spiritual & Pastoral Care: A Practical Clergy and Chaplain's Handbook*, ed. Stephen B. Roberts (Nashville, TN: SkyLight Paths Pub., 2012), 23.
[111] Daniel P. Sulmasy, "A Biopsychosocial-Spiritual Model for the Care of Patients at the End of Life," *The Gerontologist* 42 Spec No 3 (2002): 26.
[112] Christina M. Puchalaki and Betty Ferrell, *Making Health Care Whole*, 26.
[113] Hisham Abu-Raiya and Kenneth I. Pargament, "On the Links between Religion and Health: What Has Empirical Research Taught Us?," in *Oxford Textbook of Spirituality in Healthcare*, ed. Mark Cobb, Christina M. Puchalski, and Bruce Rumbold (New York: Oxford University Press, 2012), 337.

biopsychosocial-spirituality model works for traumatic experiences in addressing spiritual struggles.[114]

3. Spiritual Care with multicultural situations

In finding the meaning of life, culture is a core fact and the key point is understanding the cultural impact on spiritual care in multicultural chaplaincy.[115] Spirituality is related to our cultural identity.[116] Culture is crucial to understanding the person's belief system and individual identity and meaning.[117] Fukuyama and Sevig said, "Spiritual and religious beliefs are embedded in culture, and may be discussed in the context of understanding the 'worldviews' of culturally diverse clients or patients."[118] Chaplains' essential contribution at medical settings is an interpreter of spiritual/cultural dynamics of the patients.[119] Chaplains help patients to find answers to their religious questions.[120] Chaplains help them find the answer with their own cultural values. As Fukuyama and Sevig note, "Religious affiliation is an important component of cultural identity. The challenge for caregivers is to be comfortable in their own cultural and religious identity and open to working with and understanding different cultural and religious worldviews.[121] The spirituality can be understood by personal cultural views.

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[114] Joseph M. Currier, Kent D. Drescher, and J. Irene Harris, "Spiritual Functioning Among Veterans Seeking Residential Treatment for PTSD: A Matched Control Group Study," *Spirituality in Clinical Practice (Washington, D.C.)* 1, no. 1 (2014): 13, https://doi.org/10.1037/scp0000004.
[115] Phillis Isabella Sheppard, "Spiritual Care Practice for Intimate and Cultural Trauma Experiences," Video, 48:11,
[116] Stephen W. Cook, "Definitions, Obstacles, and Standards of Care for the Integration of Spiritual and Cultural Competency Within Health Care Chaplaincy," 61.
[117] Robert G. Anderson, "The Search for Spiritual/Cultural Competency in Chaplaincy Practice: Five Steps That Mark the Path," in *Ministry in the Spiritual and Cultural Diversity of Health Care: Increasing the Competency of Chaplains*, ed. Robert G. Anderson and Mary A. Fukuyama (New York: Routledge, 2004), 2.
[118] Mary A. Fukuyama and Todd D. Sevig, "Cultural Diversity in Pastoral Care," in *Ministry in the Spiritual and Cultural Diversity of Health Care: Increasing the Competency of Chaplains*, ed. Robert G. Anderson and Mary A. Fukuyama (New York: Routledge, 2004), 27.
[119] Robert G. Anderson, "The Search for Spiritual/Cultural Competency in Chaplaincy Practice: Five Steps That Mark the Path," 5–6.
[120] Patricia Resick, "2.5.2: Evidence-Based Psychotherapy for PTSD," *Integrative Mental Health.* August 24, 2017. Video, 57:10-1:03:56. https://www.youtube.com/watch?v=MaUMBStW5Mo
[121] Mary A. Fukuyama and Todd D. Sevig, "Cultural Diversity in Pastoral Care," 14.

4. A web of meaning

In traditional chaplaincy, chaplains have used the theory of the living human document by Anton Boisen.[122] The metaphor of the living human document can be used widely yet I want to add a web of meaning by being changed as a globalized and diverse context. Anderson describes the difference between the living human document and a web of meaning like this.

> The living human document is clothed by such a myriad identity. The story of that cloth's weaving is our life narrative. "Spiritual/cultural competency" is the capacity to read the cloth, to know one's own life narrative and hear the life narrative of another. Through the spiritual care encounter, the chaplain can bridge the gap and offer understanding and comfort in keeping with the context.[123]

For multicultural chaplaincy, we should think about the "web of meaning". Anderson describes the web of meaning as all the characteristics of a patient woven together "in the context of particular cultural, spiritual and religious elements." and factors can include "features of age, gender, race, ethnicity, family of origin, chosen family, generational realities, spiritual and religious beliefs and practices, lifestyle, social abilities, economic resources, sexual preference and physical and emotional gifts, limits, and characteristics."[124] Understanding personal cultures is thus an essential resource for healing.[125]

5. The five steps for spiritual/cultural competency

Chaplains know the importance of developing cultural sensitivities but many chaplains have a hard time approaching pastoral care practices effectively. Therefore, in multicultural

[122] Henri J. M. Nouwen, "Anton T. Boisen and Theology through Living Human Documents," *Pastoral Psychology* 19, no. 7 (1968): 49–63, https://doi.org/10.1007/BF01788381.
[123] Robert G. Anderson, "The Search for Spiritual/Cultural Competency in Chaplaincy Practice: Five Steps That Mark the Path," 9.
[124] Robert G. Anderson, 7.
[125] Stephen W. Cook, "Definitions, Obstacles, and Standards of Care for the Integration of Spiritual and Cultural Competency Within Health Care Chaplaincy," 65.

chaplaincy, the question of how chaplains can develop their own cultural sensitivity is essential. Moreover, multicultural chaplaincy is not limited to Korean immigrants but also anyone who struggles with cultural barriers. In what follows, I also discuss Fukuyama and Sevig's five steps for the development of cultural sensitivity.[126]

The Five Steps to Spiritual/Cultural Competency[127]	
I.	Awareness of personal biases
II.	Recognizing the uniqueness of others
III.	Ability to learn and demonstrate cultural attitudes, approaches and skills
IV.	Identifying barriers in communication
V.	Willingness to learn from others

1) Fukuyama and Sevig's first step is **personal awareness**. This can be defined as "awareness of self as a member of social groups and of self in a system of oppression".[128] The awareness of self is important in chaplaincy related to the chaplain's own cultural values. Self-awareness is most important fact for chaplaincy, and it is required to have self-reflection in diverse spiritual, racial, ethnic, and cultural backgrounds.[129] Because Korean culture is so homogenous, I did not understand the inherent differences/uniqueness of my culture until I came to America. I found that we are able to know our own cultures better when we find interest in examining our culture next to others. In relation to understanding the web meaning of a patient, chaplains must also understand themselves in a web of meaning. Self-awareness includes

[126] Mary A. Fukuyama and Todd D. Sevig, "Cultural Diversity in Pastoral Care," 33.
[127] Robert G. Anderson, "The Search for Spiritual/Cultural Competency in Chaplaincy Practice: Five Steps That Mark the Path," 11–15.
[128] Mary A. Fukuyama and Todd D. Sevig, "Cultural Diversity in Pastoral Care," 33.
[129] Robert G. Anderson, "The Search for Spiritual/Cultural Competency in Chaplaincy Practice: Five Steps That Mark the Path," 12; Marsha Wiggins Frame, "Forging Spiritual and Cultural Competency in Spiritual Care-Givers: A Response to Fukuyama and Sevig and Anderson," in *Ministry in the Spiritual and Cultural Diversity of Health Care: Increasing the Competency of Chaplains: Increasing the Competency of Chaplains*, ed. Robert G. Anderson and Mary A. Fukuyama (New York: Routledge, 2004), 52.

understanding my strengths and weaknesses, comfort zone and discomfort zone, literal and symbolic consequences, attitude, awareness, and lack of skill or knowledge.[130]

2) The second step is **knowledge** defined by information of differences in other cultures.[131] Chaplains should have knowledge of other cultural values and differences to engage cultural barriers and the hardship of cultures to find concrete ways in one's work.[132] Knowledge is crucial and chaplains should analyze other's cultural identity[133] but there is no right and wrong in the differences of cultures. Chaplains should accept and embrace differences.[134] Knowledge is related to interpreting a person in a web of meaning with chaplains having a capacity to assess and understand "the spiritual/cultural constellation in a web of meaning."[135]

3) Third step is **cultural skills** which "facilitat[e] change in individuals, groups, and systems; managing critical incidents; strategic analysis/action."[136] Chaplains must have abilities to communicate effectively with others who are different from ourselves.[137] These skills are required to address the clients' needs with multicultural chaplaincy noting and addressing contextual and relational barriers.[138]

4) Fourth step is **passion** which is defined as "deep personal reason for caring about/doing this work and the ability to articulate this to others".[139] This passion from chaplains

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[130] Robert G. Anderson, "The Search for Spiritual/Cultural Competency in Chaplaincy Practice: Five Steps That Mark the Path," 15.
[131] Mary A. Fukuyama and Todd D. Sevig, "Cultural Diversity in Pastoral Care," 33.
[132] Susan Koehne Wintz, "The Chaplain's Path in Cultural and Spiritual Sensitivity: A Response to Anderson, Fukuyama, and Sevig," in *Ministry in the Spiritual and Cultural Diversity of Health Care: Increasing the Competency of Chaplains*, ed. Robert G. Anderson and Mary A. Fukuyama (New York: Routledge, 2004), 80.
[133] Robert G. Anderson, "The Search for Spiritual/Cultural Competency in Chaplaincy Practice: Five Steps That Mark the Path," 10.
[134] Frame, "Forging Spiritual and Cultural Competency in Spiritual Care-Givers: A Response to Fukuyama and Sevig and Anderson," 54.
[135] Robert G. Anderson, "The Search for Spiritual/Cultural Competency in Chaplaincy Practice: Five Steps That Mark the Path," 3.
[136] Mary A. Fukuyama and Todd D. Sevig, "Cultural Diversity in Pastoral Care," 33.
[137] Frame, "Forging Spiritual and Cultural Competency in Spiritual Care-Givers: A Response to Fukuyama and Sevig and Anderson," 54–55.
[138] Frame, "Forging Spiritual and Cultural Competency in Spiritual Care-Givers: A Response to Fukuyama and Sevig and Anderson," 55.
[139] Mary A. Fukuyama and Todd D. Sevig, "Cultural Diversity in Pastoral Care," 33.

to want to learn more about multicultural differences drives empathy and helps caretakers develop the confidence to get involved in areas that may be uncomfortable to them. Multicultural chaplains therefore should consider their own resources to learn cultural differences.

5) The Fifth Step is **action** which defines the "ability to behave/act in a manner consistent with awareness, knowledge, skills, passion"[140] in constructive changes. Once a chaplain has become passionate about a patient's care they can then take a more comprehensive multicultural approach to support their patients.

Case study with the 5 steps.

Developing sensibilities towards different cultural values is crucial to effective chaplaincy. Most of my examples thus far have been in regards to Korean immigrant clients, because I understand the cultural contexts behind their struggles due to a shared background. However, in this case study, I will demonstrate the five steps through a Filipino woman who has a different culture to my own. This process demonstrates how to develop one's sensibility and illustrates that these five steps can be applied not only to Koreans but other cultures as well. We can then see the relevance of these five steps and the need for chaplain development in cultural sensibility.

Situation: A client wanted to meet a chaplain due to her family issue. The client was a nurse in her mid-40s, a Catholic believer, and a Filipino woman who has a husband (15 years marriage life) and a daughter (14 years old). She came to America almost 30 years ago and her family strongly connected with the Filipino community, but her husband is a white American. Her husband asked for a divorce because he has another woman in his life. The client comes

[140] Mary A. Fukuyama and Todd D. Sevig, 33.

from a complicated situation due to concerns regarding divorce in her culture and Catholic values. The client asked to see a chaplain as she couldn't find answers to her spiritual questions, was depressed, and felt she had lost her meaning and purpose in life. She said, "My husband is a good Christian. How could he betray us? Why does God allow that?" She struggled with her religious beliefs and her situation. In her case, her spiritual struggles directly impacted her physical condition and general well-being.

I, the chaplain, am a Korean immigrant man who grew up and was educated in Korea. I have a wife and two college students and lived in America for 20 years (5 years in Chicago, IL and 15 years in Jacksonville FL). I served at Korean churches for 15 years as a member of PC(USA). I am a Board Certified chaplain and have 5 years of chaplain experience. I lived in the Philippines for 5 years.

In the first step, I had to recognize there was a well-defined context of family life within the faith community and respect for adults based upon this cultural tradition. I believe that a man should have responsibility to support their family and the wife needs to take care of their children as per the Korean cultural way. Yet, I am also influenced by American culture that people can divorce when they have marriage issues as I have experienced supporting church members who are divorced and have a better life after their divorce during his ministry in Korean churches.

In the second step, I recognize the differences compared to the client's culture. The client follows the Filipino culture which her parents taught her even though she has lived in America for about 30 years. Her husband doesn't have a job and she works to support the whole family, which is not an unusual dynamic in many family systems within the Philippines. So the woman does not complain about these responsibilities in her relationship. The client has two jobs

to support her family while her husband stays home and takes care of her daughter who is home schooled. The client wants to keep her marriage life even though her husband has a girlfriend. This is also influenced by her deep Catholic beliefs.

In the third step, I help the patient to have a trusting relationship with the chaplain. Even though my family structure and the function of the husband are different compared to the patient's family structure, I provide emotional support and understands the difficulties of the patient with the crisis of divorce and the guilt of her Catholic belief, which she understands places a lot more restrictions on her for whether she can remarry following a divorce.

In the fourth step, I discover her uncomfortable zone where the client is too worried about being blamed by others. I understand the traumatic experience as a broken marriage, but I cannot understand why she was worried about the blame from others rather than her pain and suffering in her broken relationship and her difficulties of future life after divorce. I know she lived for about 30 years in America and she has few friends who were divorced. Thus, I found an immigrant nurse at the hospital who grew up in the Philippines as a resource. The nurse explains much about Filipino culture about marriage life. In most Filipino cultural values, divorce is not allowed and even though a husband has another woman and lives with her. The spouses will often live separately without divorce and all blame comes to the woman. In many Filipino values, a good woman should keep her marriage life well. Even though the client has lived in America over 30 years, she keeps her Filipino cultural values, so she blames herself and is anxious to meet her Filipino friends. Thus, her spiritual desires are not related solely to Catholic doctrine, but also impacted by her cultural values.

In the fifth step, I understand her community cultures and possibly provide empathy to the client's feelings of shame. I remind the client to think about the different cultural values of

marriage in America. I can provide better empathy and better spiritual care related to her cultural values. This therefore illustrates the five steps that help the chaplain better develop their own cultural sensitivity.

6. The Eight Guidelines to Multicultural Chaplaincy

To better understand these issues, we first need to break down the healing process. When I trained as a moral injury coworker under the supervision of Dr. Rita Nakashima Brock at the Shay Moral Injury Center, I was made aware of the idea that healing involves the development of inner strength or power that can help patients move towards a better life. Painful experiences never really go away, so the only way to overcome these challenges is to develop the skills that can lead to acceptance rather than avoidance of our issues. So what are effective methods for chaplains to support their own people through these cultural challenges? Here, I propose a novel approach to address these issues which I term "The Eight Guidelines to multicultural chaplaincy'" with each part geared to overcoming common barriers that are often present in multicultural care.

The Eight Guidelines to Multicultural Chaplaincy	
I.	Learn different cultural values, meanings, and behaviors
II.	Use Certified Translators
III.	Recognize knowledge gaps about medical systems
IV.	Accept differences and recognize variability in cultural values
V.	Be aware of microaggressions in cultural power
VI.	Help patients speak on their life stories
VII.	Explore patient's web of meanings
VIII.	Provide coping skills tailored to patient's cultural values

Guideline 1: Learn different cultural values, meanings, and behaviors.

In order to provide holistic care, it is important for chaplains to have initiative in making an effort to learn different cultural values, meanings, and behaviors. In my hospital, a doctor met a Korean immigrant patient who was mentally clear and communicated well with other staff. The doctor wanted to talk about his future treatment but the patient called and asked his son to be involved in their communication. The son was busy so it was hard to arrange the meeting. The doctor was not comfortable with the situation but he understood the situation after my explanation of dominant Korean cultural values. In many cases, staff may want patients to make their own decisions for a treatment plan but in Korean culture, grown children often contribute in deciding treatment plans for their senior parents.

This learning can come from a personal level where the chaplain is open to learn from other cultures and to approach it from an unbiased position. But this individualized process is not easy and takes a long time, so chaplains should be provided support from spiritual departments. From a hospital level, the spiritual department should be composed of a multicultural chaplain team. This allows for a team environment where chaplains can learn from one another's culture while creating a supportive environment. For example, in my current hospital there is a great amount of multicultural diversity which allows for greater support when dealing with cultures that we may not be as familiar with. Meanwhile, my old hospital was predominantly white which resulted in limited resources to learn how to approach other cultures.

Guideline 2: Use certified translators

Multicultural chaplains should make use of certified translators when they visit patients who speak a different language. Especially with developments in video conferencing technology, certified translation is more accessible than it has ever been in the past. The term "certified" is also important as these translators are often trained to translate the meaning behind conversations clearly rather than just the words themselves. For example, when I visited my church member who was in hospital, the family member translated a doctor's words to Korean but the family member interpreted the disease name as something else, so the patient misunderstood his illness. Thus, a certified translator is important to provide the right information and good communication.

Guideline 3: Recognize knowledge gaps regarding medical systems

Multicultural chaplains should be aware of any knowledge gaps that patients may have about the medical system by taking the time to make sure the patient understands their situation fully and are not being pushed to make a certain decision. For example, many Korean immigrants are more nervous because of the different hospital systems that ask many questions for medical evaluations and require personal opinions for treatment compared to the Korean medical system in which a doctor decides for the patients. Many Korean immigrants miss properly timed treatment due to the uncomfortable situation.[141] Furthermore, they miss free services available to patients like how insurance provides for free shingle shots to individuals over the age of 50 years old. Many immigrants are not aware of this information until after they have already contracted the disease which emphasizes the importance of increasing medical awareness.

[141] Scott D. Rhodes et al., "Identifying and Intervening on Barriers to Healthcare Access among Members of a Small Korean Community in the Southern USA," *Patient Education and Counseling* 98, no. 4 (2015): 489, https://doi.org/10.1016/j.pec.2015.01.001.

Guideline 4: Accept differences and recognize variability in cultural values

Multicultural chaplains should recognize that right and wrong are relative and should aim to approach patients by keeping these biases in mind. Instead, a trained chaplain should try to understand differences without a judgmental perspective that categorizes a trait or behavior as good or bad. This is especially important when chaplains face challenges in providing effective spiritual care. If they categorize something as negative, it can lead to chaplains feeling less motivated in providing the best possible care for their patients. As a result, it is important to recognize that these barriers caused by differences are exactly that: barriers to overcome through mutual understanding, rather than dismissing them from frustration. For example, Korean immigrant seniors expect doctors to decide their care plan and may want their grown children to be involved in the decision-making process even in the presence of certified translators. This attitude can come off to others that patients are giving up their autonomy and their independent lifestyle, but this is not necessarily true as these may just be consequences of different cultural influences.

Guideline 5: Be aware of microaggressions in cultural power

An important aspect to consider in multicultural chaplaincy is the awareness of microaggressions when dealing with privilege and power dynamics.[142] Chaplains may consciously or unconsciously believe that their cultural values work in other cultures which may or may not be the case. This can be problematic as patients may not speak up when they are uncomfortable which can lead to feelings of inferiority due to microaggressions that make patients feel like they are being looked down upon. For example, Koreans will only address

[142] Mary A. Fukuyama and Todd D. Sevig, "Cultural Diversity in Pastoral Care," 28.

someone by their first name based on subordinate socio-cultural dynamics like when addressing children or junior staff members. Another cultural consideration is that Korean immigrants may feel that they are being looked down upon when the staff talk very slowly to help a patient with a second language. Jang uses the words "Moreover, since I am a female patient and younger than almost all American doctors, I felt they looked down on me. (Ji-Min Lee, 34, artist, Manhattan, New York)"[143] This can be compounded with cultural factors as many Korean immigrants may not speak up even when they feel uncomfortable.

Guideline 6: Help patients speak on their life stories

Multicultural chaplains should be supportive and actively listen to patients speaking about their life stories. There are various methods to conduct deep listening like through Acceptance and Commitment Therapy (ACT), Problem Solving Therapy (PST), and Motivational Interviewing (MI). For many Korean immigrants, it is hard to speak out one's own feelings and thoughts. We never ask the question "how are you feeling today?" in Korean. Many cultural conflicts can therefore arise when they arrive in America. Good questions to ask immigrant patients may be "Why did you come to America?" "What are the good things about living in America?" and/or "What are the hardships living in America?" to open and develop trust relationships. Pang mentions the outcome after the interview like this: "I feel so good and light in my heart because I was able to talk for the first time with someone about the stories. I have accumulated in my body all my life."[144]

Guideline 7: Explore patient's web of meanings including cultural conflicts

[143] Sou Hyun Jang, *Medical Transnationalism*, 94.
[144] Pang, "Symptoms of Depression in Elderly Korean Immigrants," 117.

Multicultural chaplains should help immigrants address issues in a web of meanings. The web of meanings is particularly useful in understanding cultural conflicts to understand these issues in the context of the patient's culture rather than the dominant culture. Take the story presented by Pang about a 76-year-old widow with no formal education.

> My husband died at a young age. It was distressful to lose a spouse. One of my in-laws went to someone's home and spoke ill of me to others. When I heard that story, I passed out, and my heart was broken. In the past I was always ill when I held the Korean traditional ancestor worship ceremony.[145]

The widow's story is hard to understand without understanding some cultural background. The widow had Hwabyung (emotional suffering) and high blood pressure and she was ashamed of her situation due to Koreans cultural values.

Guideline 8: Provide coping skills tailored to patients' cultural values

Multicultural chaplains should aim to find coping skills tailored to a patient's cultural values. Different cultures have different beliefs and values and therefore need to find methods that align with their cultural background. Koreans, for example, often say "Life is a troubled sea" (Insang eun gohae da), which states that negative events will happen to everyone eventually. This can lead people to have inner power to move forward even though they are in suffering. Per Pang, this can provide an "adaptive capability which provides spontaneous self-care practices."[146] Korean immigrants find coping skills that align in their cultural values, and we should help them to find and explore these cultural resources.

G. Conclusion

[145] Pang, 103.
[146] Pang, 114.

Multicultural chaplaincy is important in taking care of our patients in an era of globalization, but it is not so easy in practice. My project is an answer to the challenge of developing multicultural chaplaincy from the perspective of first-generation Korean immigrants who are struggling with cultural barriers. I developed the eight guidelines from my personal experience as a first-generation Korean immigrant and as a board-certified chaplain in BCCI. I believe that the eight guidelines can be used not only in Korean cultures but also other multicultural situations in chaplaincy. Many people who are in dominant cultures cannot understand the people who are from minority cultures and bear the hardship of cultural conflicts. In order to take care of immigrants, chaplains must know cultural conflict between dominant cultural values and non-dominant ones (perhaps their own values) as a key point to multicultural chaplaincy. I hope this project can be a resource to support immigrants in better ways.

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