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Be Still Method: A Mindful Intervention for Meaning-making and Whole Person Care

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Dedication and Acknowledgment

Jesus says, "Come to me, all of you who are weary and carry heavy burdens, and I will give you rest. Take my yoke upon you. Let me teach you, because I am humble and gentle at heart, and you will find rest for your souls. For my yoke is easy to bear, and the burden I give you is light."

—Matthew 11:28-30

I dedicate this work, my life, and my heart to the One who set me free and lights my path. Abba, I love You, and nothing brings me more joy than spending time in Your Presence. You ask me to be still and trust You, and I'm grateful for all the ways You show me, with each new day, that You are trustworthy and that Your love never fails.

Mom, thank you for your encouraging words of hope and faith and for your loving prayers that have helped carry me through many difficult moments. I will always remember the inspiration you provided for the Be Still Method many years ago. Dad, thank you for all the lessons that have strengthened my faith. You helped make this journey possible, giving me the opportunity to pursue the dreams Jesus placed on my heart. I love you both.

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Finally, I want to thank someone who placed a mirror in front of me at the beginning of my healing journey, helping me discover the incredibly meaningful and transformative impact of suffering. The excruciating and inescapable pain I experienced brought me to my knees and into the arms of Jesus. He freed my mind and heart, and then, I found my voice.

Abstract

Numerous studies have demonstrated the efficacy of mindfulness-based interventions (MBIs) in promoting holistic health and well-being. Mindfulness supports whole person care by moving away from an allopathic approach to medicine, which treats only symptoms and disease, and considers the diverse physical, psychological, and spiritual needs of each patient. This paper examines the psychological and spiritual dimensions of whole person care in relationship to suffering and the transformative impact of integrating mindfulness practices to alleviate patient distress. Additionally, a mindfulness-based intervention supporting meaning-making and considering the needs of the whole person—body, mind, and spirit—will be introduced. Responding to the need for a neutral, simplified approach to introducing mindfulness, the Be Still Method (BSM) was developed to improve patient care in a multicultural and multifaith society. A comprehensive exploration of the BSM, including practical guidance for its implementation and insights for future research, will be presented to demonstrate how the Be Still Method may enhance holistic well-being within a hospital setting.

Keywords: Mindfulness, mindfulness-based interventions, hospital, whole person care, healthcare, spiritual needs, trauma-informed, meaning-making, suffering, patient distress.

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For several decades, mindfulness-based interventions (MBIs) have been implemented in medicine and psychology as an adjunct to pharmacological measures to improve mental and physical health outcomes (Shulman, 2018). Described as an approach to "step out of the war" of thoughts and feelings, mindfulness helps alleviate suffering associated with experiential avoidance strategies. It has been further conceptualized as a clinical approach to address stress and distress (Bishop et al., 2004, p. 237). Bishop et al. (2004) proposed an operational definition of mindfulness consisting of two key components: the self-regulation of attention to present-moment experience and the adoption of curiosity, openness, and acceptance toward whatever arises in the moment.

When T.W. Rhys Davids initially translated the Pali word *sati* as 'mindfulness,' he may have been influenced by an Anglican prayer emphasizing the importance of being "mindful of the needs of others" (Bhikkhu, 2007, p. 1). The prayer serves as a poignant reminder of the cultural competence required to offer compassionate care to patients in a multicultural and multi-faith society. Considering the needs of the whole person —body, mind, and spirit — is also a requirement of the Joint Commission, a regulatory body setting standards for safe, quality patient care in the United States (Swihart et al., 2023). The integration of trauma-informed care, particularly when introducing mindfulness interventions, further contributes to patient safety. Healthcare professionals collaborate with patients, drawing on their clinical judgment to customize care to address individual needs, enhancing quality of life and health outcomes. Mindfulness-based interventions can be designed to offer trauma-informed, whole person care to hospitalized patients experiencing physical health challenges to ease distress.

Whole Person Care, Patient Distress, and the Impact of Mindfulness

After a diving accident on July 30, 1967, left a 17-year-old girl with quadriplegia, Joni Eareckson Tada could never have foreseen the profound meaning she would discover in the aftermath of her suffering. Joni's journey through physical, emotional, and spiritual distress ultimately led her to author multiple books and establish a ministry providing hope, assistance, and encouragement to people with disabilities worldwide (Joni and Friends, 2023). During the year and a half she spent frozen in her hospital bed, Eareckson-Tada (1976) describes her deep depression, anger at God, and overwhelming grief. Joni's spiritual and psychological distress led to her begging her friends to help her end her life. Over 45 years later, Eareckson's strong faith has helped her fight breast cancer multiple times and cope with the deep suffering of chronic pain (Joni and Friends, 2023).

In her book *A Place of Healing*, Joni writes, "He has chosen not to heal me, but to hold me. The more intense the pain, the closer His embrace" (Eareckson-Tada, 2010, p. 36). Her poignant words serve as a testament to the potential for health and well-being beyond medical interventions and prescriptions. Joni's inspirational life emphasizes the need for whole person care and sensitivity for the traumatic events patients may endure. While physical suffering remains the primary focus of research and patient care in hospitals, addressing psychological and spiritual distress impacts health outcomes, and mindfulness-based interventions have emerged to help meet the needs of the whole person. This literature review will explore the history of mindfulness, potential mechanisms contributing to the efficacy of MBIs, and the spiritual and psychological dimensions of whole-person care in relation to suffering and mindfulness.

The History of Mindfulness

The term mindfulness originated in the English translation of the French word *pensée*, meaning 'to think,' as noted by John Palsgrave in 1530 (p. 245) and later defined by Samuel Johnson in 1850 (p. 754). In *A Dictionary of the English Language*, Johnson (1850) defined mindfulness as "attention" or "regard" (p. 754), aligning with the existing English word mindful, which has been in use since the mid-fourteenth century (Sun, 2014). Early usage of mindfulness was rooted in a Christian context, emphasizing continual mindfulness of God's presence and consideration for others through love and kindness (Sun, 2014). Practiced to grow spiritually and live in accordance with God's will and commands, being mindful of God's presence fostered a sense of closeness to Him (Sun, 2014).

Mindfulness was initially defined in a Buddhist context in 1881 when Professor and Pali language scholar T.W. Rhys Davids reshaped its meaning to describe *sati* in his translation of the *Mahāparinibbāna Sutta* (Sun, 2014). Defining *sati* proved challenging due to the Sanskrit equivalent, *smrti*, meaning memory, falling short of encompassing the multifaceted descriptions provided by Siddhartha Gautama (563 BCE), also known as the Buddha, in his discourses (Bodhi, 2013). Instead of a singular definition, mindfulness was conveyed through operational demonstrations, memorized, and transmitted orally for four centuries before being written down (Bodhi, 2013).

Sati appears in the *Mahāparinibbāna Sutta* as *sammā-sati* (right mindfulness), described as "the watchful, active mind" and "that concentration of thought." Right mindfulness is an integral part of the Eightfold Path leading to *nirvana* and liberation from the cycle of suffering (*samsara*) (Davids, 1910, pp. 167, 250). Davids (1910) further illuminates the meaning of *sati* by characterizing it as the awareness of "bodily and mental" phenomena, with a particular focus on

impermanence and ethics (p. 322). The *Satipaṭṭhāna Sutta* emphasizes the central role of mindfulness practice, presenting it as a path of purification to transcend suffering, pain, and displeasure (Sun, 2014). The *Sutta* also introduces the four foundations of mindfulness: contemplation of the body, feelings, states of mind, and the *dhammā*—the teachings of the Buddha (Bodhi, 2023).

Bodhi (2013) defines *sati* as "the lucid awareness of each event that presents itself on the successive occasions of experience," strengthened through practice to comprehend the true nature of things and relate insights to the Buddha's teachings (p. 21). Seeing into the true nature of reality is referred to as direct insight (*vipassanā*). His definition considers how mindfulness is defined in the *Patisambhidāmagga*, a text of the Pali canon, as an act of establishing presence (*upatthāna*) (Bodhi, 2013). Bodhi unifies various descriptions of *sati* in the Buddha's teachings, explaining that mindfulness brings an object into focus, whether it be a memory from the past or lucid awareness of the present (Bodhi, 2013).

German monk and scholar Nyanaponika Thera (1969) introduced the term 'bare attention' in his book *The Heart of Buddhist Meditation*, defining it as "the clear single-minded awareness of what actually happens to us and in us, at the successive moments of perception" (p. 16). Nyanaponika (1969) explains that "attention or mindfulness is kept to a bare registering of facts observed, without reacting to them by deed, speech, or by mental comment, which may be one of self-reference (like, dislike, etc.), judgment, or reflection" (p. 17). By defining mindfulness as bare attention, Nyanaponika helped pave the way for its secular applications.

In *Wherever You Go, There You Are*, Jon Kabat-Zinn (2009) refines the definition of mindfulness, describing it as "paying attention in a particular way: on purpose, in the present moment, non-judgmentally" (p. 4). Kabat-Zinn's conceptualization of mindfulness as present-

centered bare attention, coupled with the development of the Mindfulness-Based Stress Reduction (MBSR) program at the UMass Memorial Health Center in 1979, brought mindfulness to the mainstream by secularizing the Buddhist concept of *sati* (Kabat-Zinn, 2003; King, 2016). As a result, secular mindfulness programs, designed for both staff and patients, have continued to be developed in healthcare settings, aiming to enhance patient care (LeVasseur et al., 2019).

While Kabat-Zinn's contributions have played a pivotal role in providing holistic mindfulness interventions to alleviate patient suffering, his definition is not without its critics (King, 2014). Dreyfus (2013) contends that mindfulness "is not always present-centered non-judgmental awareness of an object, but the paying close attention to an object," leading to the retention of information and integration of "meaningful patterns used for goal-directed activities" (p. 47). Both the Christian and Buddhist concepts of mindfulness include paying attention, yet secular mindfulness omits explicit forms of meaning-making and ethical considerations, which may not be supportive or acceptable for some individuals (King, 2016; Sun, 2014).

Mechanisms of Mindfulness

As research into the efficacy of mindfulness continues to expand, understanding the mechanisms of mindfulness has become increasingly important for the development of MBIs. An overall review of the literature on MBIs emphasizes the need for a greater comprehension of the underlying mechanisms responsible for their effectiveness (Zhang et al., 2021). While no consensus exists on the definition of mindfulness or the mechanisms involved, attention and acceptance consistently emerge as fundamental components within definitions, scientific conceptualizations, and the skill outcomes of training programs (Lindsay & Creswell, 2017). Attention and acceptance, the mechanisms identified in Monitor and Acceptance Theory (MAT),

to be discussed below, have historically played central roles in religious, philosophical, and psychological inquiries for centuries, helping to shape the understanding of contemporary mindfulness interventions.

Attention

In his book *Outlines of Psychology*, Wundt (1902) defines the focus of attention as "the fixation point of consciousness" in "the present moment" (p. 230). In Buddhism, attention (*manasikāra*) is literally translated as "making in the mind". It is the mental factor responsible for turning one's mind toward an object when it is made present to consciousness (Bodhi, 2000, p. 150). The term one-pointedness (*ekaggatā*), denoting "the unification of the mind on its object," frequently appears in the *jhānas*, altered states of consciousness brought on by concentration, and has the characteristic of non-distraction (Bodhi, 2000, p. 150; Brasington, 2017). The word *jhanā* is derived from the verb *jhāyati*, "to meditate," and the Buddha would often conclude dhamma talks with the instruction to go meditate (*jhayatha!*) under a tree or in any empty hut (Brasington, 2017, para. 2). The practice of focusing attention on a single object, especially the breath, during mindfulness meditation is beneficial for beginners, and was suggested by the Buddha.

The term mind-wandering is often used in mindfulness interventions when distraction occurs. Psychologist William James (1890) referred to this as the "wandering of our attention" in his famed work *The Principles of Psychology* (p. 126). While it is difficult to pinpoint when the phrase was first used in the context of mindfulness, 17th-century Carmelite monk Brother Lawrence offers guidance on managing a wandering mind in his book *The Practice of the Presence of God*. "If your mind wanders at times, do not be upset, because being upset will only distract you more. Allow your will to recall your attention gently to God. Such perseverance will

please Him" (Lawrence, 1982, p. 314). This approach mirrors contemporary mindfulness interventions, encouraging practitioners to simply notice distractions and redirect attention to an anchor like the breath to stay grounded in the present moment.

Acceptance

Heraclitus of Ephesus (500 BCE), a Greek Pre-Socratic philosopher, depicted life as a river in a constant state of motion, expressed in his phrase "life is flux" (*Panta Rhei*) (Mark, 2010, para. 4). Heraclitus believed that resisting change was, in essence, resisting life itself (Mark, 2020). Similarly, Siddhartha Gautama recognized the constant state of change in life, referring to it as impermanence (*aniccatā*) or the passing away of material phenomena (Bodhi, 2000). In Buddhist teachings, acceptance of whatever is arising and passing away is achieved by cultivating equanimity (*upekkhāsahagata*) or impartiality. Equanimity is a mental state that "cannot be swayed by biases and preference" and denotes a neutral feeling, whether an experience is pleasant or unpleasant (Bodhi, 2000, p. 82). Within mindfulness interventions, an attitude of acceptance extends to a neutral response to mind-wandering. Fénélon (1853), in *The Inner Life*, encourages the acceptance of distractions rather than resistance, stating, "Let us only turn our thoughts, whenever we can, towards the face of the Well-beloved without being troubled at our wanderings. When He shall see fit to enable us to preserve a more constant sense of His presence with us, He will do so" (p. 494). His guidance exemplifies how acceptance has been integrated into spiritual practices that foster mindfulness.

Adopting a curious and receptive approach to pleasant and unpleasant thoughts, feelings, memories, and impulses increases acceptance, quality of life, patient functioning, and health-related behaviors (Stockton et al., 2019). Shapiro et al. (2018) define acceptance as "allowing things to be as they are," offering a temporary refuge from challenges to better engage with them

skillfully (p. 1695). This approach to acceptance and embracing the present moment does not justify or support unjust actions or unnecessary distress. Instead, it eliminates resistance, reducing overall suffering (Shapiro et al., 2018). According to Goldstein (2013), labeling difficult emotions creates space to be with and let go of temporary visitors, allowing one to accept what arises in the present moment. "Direct insight—that is, seeing into their passing away—brings about the space to be with mind states and emotions without fear, without identification, and without reaction" (Goldstein, 2013, p. 116). Emotions and mind states are always changing, and removing any sense of ownership of thoughts and emotions that arise frees their hold on the mind.

While acceptance has roots in various philosophical and religious traditions, research in this area is often associated with the development of Acceptance and Commitment Therapy (ACT) by Steven Hayes in 1982 (Stockton et al., 2019). ACT, classified as a third-wave cognitive-behavioral therapy, promotes the acceptance of unwanted, distressing physiological and emotional experiences while living in accordance with personal values (Stockton et al., 2019, p. 333). Rather than focusing on symptom reduction, ACT encourages clients to pursue a meaningful life. Accepting painful experiences and aligning actions with values and beliefs lead to symptom relief as a natural outcome (Harris, 2006). Clients learn to mindfully observe internal phenomena without attempting to evaluate or change thoughts, feelings, or sensations (Hofmann & Gomez, 2017). ACT interventions have demonstrated effectiveness in treating anxiety, depression, addictions, and somatic health conditions (Stockton et al., 2019).

Monitor and Acceptance Theory

Monitor and Acceptance Theory (MAT) offers "a testable and theoretical account to help explain mindfulness effects on cognition, affect, stress, and health outcomes" grounded on

"conceptual, clinical, and empirical work" (Lindsay & Creswell, 2017, p. 48). Attention and acceptance, the mechanisms identified in MAT, are thought to be responsible for the improved mental and physical health outcomes of mindfulness interventions. Within the MAT theoretical framework, attention monitoring is "an ongoing awareness of present-moment sensory and perceptual experiences" (Lindsay & Creswell, 2017, p. 4). Acceptance is an attitude of openness and equanimity to all inner and outer experiences that arise moment to moment (Lindsay & Creswell, 2017). Cultivating this attitude helps improve emotional regulation and prevent attention monitoring from intensifying distressing stimuli, leading to negative affective states. Lindsay & Creswell's theory holds the promise of inspiring additional research into the underlying mechanisms, potentially facilitating the development of mindfulness interventions that can more effectively address the diverse needs of patients.

While additional research is needed, studies have shown that attention monitoring and acceptance contribute to the efficacy of MBIs. Acceptance has been demonstrated to alter stress reactivity and influence the subsequent health-related effects of stress reduction (Lindsay & Creswell, 2017). In a three-arm parallel trial examining the underlying components of mindfulness, a brief 15-lesson smartphone intervention was utilized to examine the effectiveness of Monitor + Accept (MA) training (Lindsay et al., 2018). The results provided the first evidence that acceptance training is integral to improving stress reduction and health outcomes of mindfulness interventions. Compared to the Monitor-only and coping control training, which found negligible reductions in biological stress, Monitor + Acceptance training reduced neuroendocrine and sympathetic nervous system stress reactivity biomarkers. The study also showed that a brief intervention could effectively reduce biological stress and lower study attrition rates, which are higher in longer mindfulness training programs (Lindsay et al., 2018).

While attention monitoring did not reduce stress in the study without acceptance, a randomized control trial found that present-focused monitoring skills training improves momentary attentional control (Chin et al., 2021). The results also noted increased trait attentional control, which may facilitate increased engagement with mindfulness-based interventions, potentially enhancing their overall efficacy (Chin et al., 2021).

Physical Illness, Distress, and Mindfulness

Cassel (1998) explains that patients are often unaware of the internal processes of their bodies or their daily behaviors in good health and only notice when illness leads to discomfort and alters their daily routine. The experience of physical illness for patients may be an alienating process, leaving a person feeling vulnerable and no longer at home in their body (Svenaeus, 2009). Disease can create fear and uncertainty about the future, and bodily discomfort may create challenges and obstructions to completing daily tasks (Svenaeus, 2009). Patients may experience loss and feel diminished by physical conditions that change functional ability and impact their roles as professionals, spouses, parents, and members of their community (Cassel, 1998). Attitudes and behaviors toward illness may also leave patients feeling isolated, pitied, or censured by others (Cassel, 1998).

Physical illness often creates suffering from the disease's symptoms and the treatments to address it (Cassel, 1998). While pain is most often associated with physical distress, failure to get air, feeling too hot or cold, nausea, thirst, hunger, and inability to move are potential sources of discomfort or suffering (Svenaeus, 2014). Invisible symptoms like pain and fatigue may accompany chronic illnesses and lead to physical changes in appearance (*Chronic Illness*, n.d.) Patients may also experience physical distress from decreased range of motion, morning stiffness, and other forms of disability (*Chronic Illness*, n.d.). Perceptions of physical illness and

distress may also be impacted by a patient's personal relationships and level of social support (Cassel, 1998).

In addressing the impact of physical illness and distress on patients, mindfulness emerges as a leading stress reduction intervention. Proven effective in mitigating physiological and subjective reactivity to acute stress within eight-week programs, mindfulness-based interventions (MBIs) bring about significant reductions in heart rate, respiratory rates, blood pressure, skin conductance, and pain levels (Lindsay et al., 2018; Zhang et al., 2021). Mindfulness-based interventions consistently demonstrate efficacy across a range of health conditions, offering relief for both chronic and acute issues such as pain, hypertension, weight management, and symptoms associated with cancer (Hofmann & Gomez, 2017; Zhang et al., 2020). A meta-analysis of 10 randomized controlled trials on eight-week Mindfulness-Based Stress Reduction (MBSR) courses for cancer patients revealed marked improvements, including reduced disease-related stressors, anxiety, fatigue, and mood and sleep disturbances (Ledesma & Kumano, 2008). Mindfulness interventions have also shown efficacy in managing chronic conditions like type 2 diabetes, fibromyalgia, and rheumatoid arthritis (Merkes, 2010).

Whole Person Care

Daniel Sulmasy's (2002) Biopsychosocial-Spiritual Model builds upon Engel's Biopsychosocial Model by incorporating a spiritual dimension (Sulmasy, 2002). In contrast to the Biomedical Model, which solely considers measurable biological variables, Engel expanded his model to include psychological and social factors (Engel, 1977). The interconnected biological, psychological, social, and spiritual dimensions within the Biopsychosocial-Spiritual Model are integral to patient health and well-being. The model also considers the ethical obligation of healthcare professionals to offer whole person care and the importance of

understanding the various levels of expertise of a healthcare team in each of the dimensions (Balboni et al., 2014). Whole person care supports the Biopsychosocial-Spiritual Model, delving into the internal milieu of the patient beyond physical healing (Sulmasy, 2002). Cassell (1998) refers to the whole person and emphasizes the complexities of a patient beyond human biology when addressing suffering, grief, and loss. This approach is particularly impactful for terminally ill patients, allowing them to confront spiritual and psychosocial distress and find meaning in their lives, suffering, and death (Sulmasy, 2002).

Treating the whole person also impacts how suffering is viewed, defined, and treated in healthcare. According to Cassell (1998), suffering arises when an imminent threat to the whole person is recognized and persists until the threat subsides and restoration occurs. Recognizing spiritual and psychosocial distress, in addition to physical pain, is needed to address patient suffering. Suffering-based medicine (SBM) expands the view of a patient's disease, acknowledging the multidimensional nature of suffering following physical illness (Del Giglio, 2019). As a form of whole person care, SBM goes beyond treating physical complaints to understand a patient's suffering within their cultural, psychological, and spiritual context, ultimately improving health and well-being (Del Giglio, 2019).

The Spiritual Dimension of Care

While focusing on the spiritual dimension is more commonly associated with palliative and end-of-life care, recognizing and addressing spiritual needs is essential across the healthcare continuum, reflecting a commitment to high-quality, compassionate care (Puchalski et al., 2014). Supporting patients in meeting their spiritual needs enhances their inner resources for coping with the burdens of illness and contributes to overall well-being (Puchalski et al., 2014). Nursing was one of the first healthcare professions to acknowledge the significance of patients' spiritual

needs, introducing spiritual distress as a nursing diagnosis in 1978 (Galek et al., 2005; Eshghi et al., 2023). An extensive review of the literature on patient spiritual needs has identified seven major constructs: belonging, meaning, peace, the sacred, morality, beauty, and acceptance of dying (Galek et al., 2005). A multidimensional instrument was developed based on the constructs to assess the spiritual needs of patients and provide direction for healthcare professionals providing spiritual care (Galek et al., 2005).

In addition to understanding patients' spiritual needs, defining spirituality is important for comprehending the spiritual dimension. The 2013 International Conference on Improving the Spiritual Dimension of Whole Person Care devised a definition of spirituality in a healthcare context emphasizing cultural competence.

> Spirituality is the dynamic dimension of human life that relates to the way persons (individual and community) experience, express, and/or seek meaning, purpose, and transcendence, and the way they connect to the moment, to self, to others, to nature, to the significant and/or the sacred. (Puchalski et al., 2014)

This definition focuses on meaning-making, identified as a major construct of patient spiritual needs in the literature. It serves as a guide to support religious and spiritual coping, offering potential relief for the spiritual distress experienced by hospitalized patients (Roberts & Whall, 1996; Schmidt et al., 2012).

While progress has been made in defining spirituality and spiritual needs, barriers to providing spiritual care remain. Time constraints, which often prioritize biomedical needs over spiritual ones, present challenges to considering the spiritual health and well-being of the patient. Another hurdle for healthcare professionals is discomfort with offering spiritual care in a multifaith society. Although the ideal solution would involve increasing staff and training on the

spiritual dimension, staff shortages, and limited resources may necessitate cost-effective and easily implementable solutions (Alch et al., 2021; Balboni et al., 2014).

Spiritual Distress

While patients often turn to family and caregivers for spiritual support, healthcare professionals must address spiritual needs and recognize signs of spiritual distress (Galek et al., 2005). According to Bahraini et al. (2020), spiritual suffering arises when an individual's need for meaning and purpose in life, through connections with self, others, nature, or the sacred, remains unfulfilled. Spiritual suffering is also referred to as a negative form of religious coping and may be expressed through terms such as distress, struggle, pain, or crises. A systematic review revealed that a range of 10-63% of seriously ill patients experienced moderate spiritual distress (Roze des Ordons et al., 2018). Such distress is associated with adverse physical and psychological effects, increased mortality risk, and decreased quality of life (Bahraini et al., 2020). Life-altering events, such as chronic diseases, palliative care, or sudden physical crises like amputations or quadriplegia, may trigger spiritual distress (Bahraini et al., 2020).

A two-year longitudinal study involving 268 elderly hospitalized patients indicated that spiritual suffering or negative religious coping predicted long-term health decline (Pargament et al., 2004). Initial baseline assessments included patient information on religious coping methods, physical and mental health, and spiritual data obtained through interviews and medical records. Two years later, follow-up interviews included measures of religious coping, depression, quality of life, stress, spiritual changes, physical and cognitive functioning, and medical illness. Spiritual distress correlated with decreased independence in daily living, poorer cognitive functioning, depressed mood, and diminished quality of life (Pargament et al., 2004). Healthcare providers are advised to conduct spiritual screening for all patients in both inpatient and outpatient settings

to identify those experiencing spiritual suffering and requiring spiritual care (Bahraini et al., 2020).

Religious Coping

Pargament (2001) defines religious coping as "methods to understand and handle negative life events in relation to the sacred" (p. 32). The sacred refers to divine beings, higher powers, God, transcendent reality, or any other aspect of life with spiritual meaning through its association with the divine (Pargament, 2007). The Religious Coping Scales (RCOPE) was developed to assess religious coping, focusing on how individuals utilize religion to navigate life stressors (Pargament et al., 2000). Religion is conceptualized as the search for the significant in relation to the sacred (Pargament, 2007). In contrast to previous measures that concentrated on the frequency of prayer and church attendance, RCOPE is grounded in five functions of religion identified by theorists in psychology and religion (Pargament et al., 2000). These functions—meaning, control, comfort, intimacy, and life transformation—shape the religious coping methods measured by the scale.

Religion provides a framework for finding meaning in suffering and can lead to a reappraisal of a stressor as an opportunity for spiritual growth. Pargament et al. (2000) state that closeness to God offers comfort and a reminder of His love and care. Religious coping is multidimensional, with individuals utilizing various methods simultaneously to cope with a stressor (Pargament et al., 1998). Each method may result in positive or negative forms of religious coping. Positive religious coping includes a secure relationship with God, finding meaning in life, and fostering connectedness with others. In contrast, negative forms of religious coping may manifest as an insecure relationship with God, a sense of meaninglessness in life, and a negative worldview (Pargament et al., 1998).

Meaning-making

In his book *Man's Search for Meaning*, Victor Frankl, a Jewish psychiatrist and Holocaust survivor, describes the experiences of prisoners in Nazi concentration camps who, devoid of hope for the future and unable to see opportunities for spiritual growth, struggled to find meaning in their existence (Frankl, 1992). Frankl (1992) writes, "They did not take their life seriously and despised it as something of no consequence. They preferred to close their eyes and to live in the past. Life for such people became meaningless" (p. 71). Amidst unthinkable atrocities, Frankl saw firsthand the pivotal role of discovering meaning in life to endure profound suffering.

Park's meaning-making model follows a body of research on meaning that developed around Frankl's contributions to the field of psychology, providing a framework for understanding the role of religion and spirituality in meaning-making (Lewis Hall & Hill, 2019). Meaning-making is a coping strategy utilized during times of suffering that requires an understanding of spiritual and religious contexts (Hall, 2015; Bock et al., 2023). According to Park's model, the distress experienced after events such as the loss of a loved one is influenced by the gap between the appraised meaning of the event and the sufferer's global orienting systems or worldview. The term worldview, derived from the German word *weltanschauung*, meaning a view of the world or universe, encompasses an individual's values, beliefs, and outlook on life, influencing motivation, affect, behavior, cognition, and culture (Koltko-Rivera, 2004). Park's model suggests that the reduction of this discrepancy and distress occurs through either altering the appraised meaning (assimilation) or a change in worldview (Lewis Hall & Hill, 2019).

Spiritual Care. Addressing spiritual needs through meaning-making is a crucial aspect of healthcare, particularly in end-of-life care, where healthcare providers strive to help patients maintain a sense of meaning, peace, and hope as they navigate the progression of their illness (Breitbart, 2002). Religious and spiritual meaning-making spans the entire lifespan, addressing existential questions about the purpose of life and suffering while instilling hope (Lewis Hall & Hill, 2019). An example of assimilation in the meaning-making model for a patient who believes in God may be the reappraisal of a life-threatening diagnosis as an opportunity for spiritual growth. Using the same example, a patient might alter their worldview, accepting that a loving God would allow them to face serious illness. Trusting in God's plan could lead to a shift in worldview, alleviating suffering by easing fears and concerns about the future (Bock et al., 2023; Hall, 2015). In both instances, the goal is to reduce additional distress stemming from challenges to their belief in God's love and finding meaning in their suffering. While some studies suggest that all forms of meaning-making are beneficial, Park's model emphasizes the content of meaning (Lewis Hall & Hill, 2019). The varying levels of distress experienced by a sufferer depend on the congruency between the appraised meaning and worldview, underscoring the significance of considering the content of meaning-making (Lewis Hall & Hill, 2019).

Connection. According to author and researcher Dr. Brené Brown (2022), connection is "the energy that exists between people when they feel seen, heard, and valued; when they can give and receive without judgment; and when they derive sustenance and strength from the relationship" (p. 28). In her book *The Gifts of Imperfection*, Brown (2022) describes spirituality, drawing from her own experience, as a connection with God through nature, music, and community. Research on meaning-making reveals that individuals may find spiritual support by connecting with oneself, other people, the sacred, or the world (Park, 2010). Human brains are

also naturally wired for connection, and nurturing relationships contribute to improved mental and physical health (Fishbane, 2007). For some patients, cultural and religious beliefs are integral to their worldview, with religion serving as the most comprehensive, complex, and accessible meaning system available (Bock et al., 2023; Lewis Hall & Hill, 2019). Relational processes may be as important as emotional and cognitive processes in meaning-making, and purposeful connections may help meet spiritual needs, supporting patient health and well-being during times of suffering (Bock et al., 2023).

Relational Spirituality. Relational Spirituality is an attachment-based model developed by psychologists Dr. Todd Hall and Dr. Elizabeth Hall for spiritual and religious development, providing a psychological perspective on spiritual transformation and meaning-making (Augustyn et al., 2017). Grounded in Bowlby's attachment theory, attachment-based models propose that implicit relational processes or working models are formed during childhood in response to the presence or absence of support from parents or caregivers when a child is distressed (Hall, 2015; Bosmans & Borelli, 2022). According to the Relational Spirituality model, early childhood attachments shape emotional appraisals of meaning (Hall, 2015). Attachment plays an important role in emotional regulation and the use of meaning-making as a coping strategy during times of suffering (Bock et al., 2023). Bowlby suggests that suffering activates emotional meaning structures related to attachment to regulate emotions in response to distress (Bock et al., 2023). The Relational Spirituality model posits that relational processes impact all aspects of spiritual functioning, including one's relationship with God (Hall, 2015). Implicit meaning structures of securely attached adults support a consistent, fulfilling, and purposeful experience of life and their relationship with God (Bock et al., 2023). In contrast, individuals with an insecure attachment style may struggle to view the world as safe, God and

people as reliable, and themselves as lovable and valuable (Bock et al., 2023). This model, applicable across various religious traditions and spiritual beliefs, emphasizes the enduring impact of early attachments on spiritual development (Augustyn et al., 2017).

Connection with God. With 81% of Americans reporting a belief in God in a 2022 Gallup poll, the impact of relational spirituality on meaning-making and health outcomes is worth considering (Saad & Hrynowski, 2022). According to a Pew Research survey, 75% of Americans reportedly speak to God (of their understanding), suggesting a relational quality to their personal beliefs (Americans' Beliefs About the Nature of God, 2022). In a study on the construct of God in the 12-step process of Narcotics Anonymous, 91% of 450 participants talk to 'God as we understand Him,' and 72% feel the presence of God (Galanter et al., 2020). Twelve-step programs are spiritual, not religious, allowing each person to determine what God means to them and their recovery (Galanter et al., 2020). Neuroimaging studies suggest that individuals with strong religious beliefs engage similar brain regions when connecting with God as they do in other interpersonal relationships (Schjoedt et al., 2009; Neubauer, 2014). A functional magnetic resonance imaging (fMRI) study found that highly religious participants recruit areas of social cognition in personal prayer (Schjoedt et al., 2009). These results highlight the importance of supporting the religious and spiritual beliefs of patients who rely on faith for spiritual and social support during a health crisis.

One study of cancer survivors found that meaning-based coping strategies, consisting of positive reframing and religion, were used more often by participants with a secure attachment than those with insecure attachment styles (Schmidt et al., 2012). Research also suggests that older adults over the age of 65 desire proximity to an attachment figure, and for many, their primary attachment is God (Kent et al., 2018). When secure attachment to God is coupled with

feeling forgiven by a higher power, older adults experience greater life satisfaction and mental health. Forgiveness and secure attachment are associated with optimism and self-esteem, both crucial for older adults in a reflective stage of life prone to experiencing guilt and unresolved internal conflicts (Kent et al., 2018). Secure attachment to God may also impact appraisals of suffering for those experiencing grief, life-threatening diagnoses, and chronic pain. In a study of 300 Iranian older adults with chronic lower back pain, greater pain acceptance and lower pain intensity were correlated with secure attachment to God and religious coping (Hatefi et al., 2019). While the studies do not specify how each participant defines God, the research highlights the importance of considering the impact of relational spirituality in meaning-making and its influence on suffering in patients from diverse cultural, spiritual, and religious backgrounds.

Nature-connectedness. Pargament (2007) suggests that immersing oneself in the natural world provides an opportunity to delve into life's sacred or spiritual dimensions, exploring the mysterious and ultimate meaning of existence. Evidence indicates that spending time in nature fosters an enhanced sense of connectedness to the world, contributing to feeling part of something greater than oneself. As a result, this connection improves personal identity and purpose (Choe et al., 2020). Numerous studies have demonstrated that exposure to natural environments and green spaces correlates with improved well-being, mood, cognition, and overall health (Capaldi et al., 2014; Jimenez, 2021).

In a qualitative study on nature-connectedness and self-healing, diverse perspectives on spirituality and the natural world emerged (Hegarty, 2010). For one participant, spirituality meant "seeing God in creation" and using nature to "connect with God and the inner life" (Hegarty, 2010, p. 70). Others in the study did not perceive God in nature; instead, they viewed spirituality and nature-connectedness as "being in the presence of our own, i.e., what was made

with us" (Hegarty, 2010, p. 70). Participants highlighted an increased connection with oneself, the natural world, or Mother Earth. They reported feelings of peace, relaxation, and appreciation for the preciousness and beauty of nature. For some, nature-connectedness addressed psychological needs, offering relief from stress, anxiety, and depression (Hegarty, 2010). While research in this area is limited, the study illustrates the complexity of understanding how spirituality is expressed and defined within the context of nature-connectedness. Additionally, interventions incorporating nature may prove beneficial in meeting the psychological needs of patients who do not perceive nature as inherently spiritual.

Joy. Cultivating joy through faith and appreciation of beauty encourages meaning-making and supports spiritual well-being. King and Defoy (2020) define joy as "a virtue that involves one's capacity for positive emotions and abilities to identify and reflect on one's system of meaning and act accordingly" (p.19). Joy is a positive affect associated with feelings of safety, ease, and freedom that may lead to changes in visual perceptions like colors appearing brighter, involuntary movements such as a smile, and cognitive changes like creativity (Johnson, 2020). For patients facing serious illness, "suffering carves out valleys that then can be filled with joy" (Underwood, 2020, p. 55). Experiences of suffering may enhance moments of joy by offering a greater contrast and relief for distress. Joy can also be found in ordinary moments of life by delighting in small things like a smile from a stranger or a compassionate act that makes a person feel cared for and adds meaning to life.

Regardless of the circumstances, faith can serve as a profound source of joy for patients, enabling them to perceive moments of suffering in a new light. Faith, as defined by a concept analysis related to health and nursing, offers present meaning and support for authentic living (Dyess, 2011). For patients who believe in God, momentary afflictions may be viewed as

ultimately redeemable by a power greater than themselves (Johnson, 2020). Worship and connection with the divine provide potential avenues for ordinary joy in everyday life (Underwood, 2020). For some, joy possesses a transcendent quality, eliciting a feeling of moving beyond ordinary existence to a place detached from space, time, or a sense of self (Johnson, 2020). Research indicates that spirituality can amplify delightful sensations accompanying joy, framing the experience as a divine blessing. The spiritual facet of joy may also instill a yearning for the transcendent (Watkins et al., 2018).

Appreciation contributes to joy, fostering positive qualities and virtues through gratitude (Peterson & Seligman, 2004). According to Peterson and Seligman (2004), appreciation is a character strength that connects an individual to excellence and goodness through gratitude. Patients cultivating gratitude amid suffering can enhance their ability to engage with the present moment and cope spiritually (Feldman & Cullen, 2020). Gratitude, encompassing inner qualities, connections, life circumstances, spiritual resources within, forgiveness, and future possibilities, offers nourishment to the heart and energy to practice kindness and compassion (Feldman & Cullen, 2020; Watkins et al., 2017).

For patients experiencing spiritual distress, appreciating beauty may offer a meaningful connection to something greater than themselves. The joy found in gratitude for the beauty in the world is fulfilling and may be a transcendent experience for individuals (Peterson & Seligman, 2004). The majesty of nature, art, music, athletics, or the moral brilliance of another person may be sources of beauty and appreciation (Peterson & Seligman, 2004). In his book, *The Varieties of Religious Experience*, William James (1902) writes about appreciating the beauty of the natural world found in mountains, valleys, a lush forest, and gentle rain, describing it as a source of great joy and spiritual well-being. Appreciation of beauty creates more opportunities to experience

moments of joy and may offer spiritual support to patients who struggle to understand or find meaning in a crisis. For patients with dementia, joy may be found in theatrical performances incorporating music, humor, and dance to help access memories and encourage engagement and meaningful interactions (Dun et al., 2019). Engaging the senses by examining treasured items from their past, a freshly picked flower or an impressionist painting may also spark joy (Parsons, 2015). While challenges remain, simple joys are accessible to patients regardless of circumstance and may help meet spiritual needs.

Serenity. Serenity plays an important role in meaning-making and spirituality, particularly for individuals navigating health crises. When faced with the challenges of severe health conditions, the ability to cultivate peace under any circumstance becomes a powerful factor in enhancing the quality of life and accommodating diverse belief systems (Roberts & Aspy, 1993). In the exploration of serenity, Roberts and Fitzgerald (1991) define it as "a spiritual experience of inner peace, trust, and connectedness that exists independently of external events" (p.133), capturing common attributes found in serenity literature. Among these attributes is the capacity to let go of expectations and desires for different circumstances (Roberts & Fitzgerald, 1991). Co-founder of Alcoholics Anonymous, William Wilson, or "Bill" (1967), describes this aspect through the Serenity Prayer, emphasizing the release of the need for overpowering adversity: "God grant us the serenity to accept the things we cannot change, the courage to change the things we can, and the wisdom to know the difference" (p. 20). This prayer, a staple in 12-step programs, proves particularly beneficial for patients not engaging in appropriate problem-based coping, offering an avenue for spiritual coping and acceptance of the present moment (Slattery & Park, 2011). Rather than arising from resignation or resistance, serenity arises through acceptance and being present with whatever is happening in the present moment.

For those in 12-step programs, acceptance involves surrendering their lives and will to the care of God (of their understanding) (Galanter et al., 2020). Serene persons may lean on their faith, trusting in a power greater than themselves, to guide them through challenging circumstances and bring purpose to their lives (Roberts & Fitzgerald, 1991).

Additionally, serene individuals often establish an inner haven of security amid serious illness and hospitalization, described as inner strength, spirit, self, center, or a detached observer (Roberts & Fitzgerald, 1991). This inner sanctuary is fortified by acts of love, compassion, and forgiveness extended to others. Offering love and compassion without expecting anything in return and forgiving oneself and others can contribute to inner peace and alleviate suffering in those experiencing spiritual distress (Roberts & Fitzgerald, 1991; Bodley, 1955). Activities like journaling, known for helping release fears and anxieties, can be therapeutic, promoting a sense of calm and well-being (Krentzman et al., 2023). Prayer, solitude, and meditation are also used to nurture a feeling of inner security regardless of life's difficulties (Roberts & Fitzgerald, 1991). Wilson (1967) describes prayer and meditation as vital for his health and "as important as air, food, or sunshine to nourish his soul and prevent spiritual suffering" (p. 93). In addition to prayer, patients may find peace of mind in their faith through worship, sacred reading, and experiencing the presence of God (Timmins et al., 2015).

Mindfulness and the Spiritual Dimension

Mindfulness has emerged as a transformative practice, demonstrating its potential to elevate spirituality while positively influencing physical and mental health outcomes (Carmody et al., 2008). In adapting mindfulness-based interventions (MBIs) to address religious and spiritual needs, a promising avenue unfolds for nurturing the spiritual dimension of whole-person care within hospital settings. Adaptive mindfulness is based on secular practices, supported by

empirical research, and has been modified to align with diverse worldviews (Ford & Garzon, 2017). This inclusivity extends to religiously accommodative treatments designed to enhance therapeutic effectiveness by integrating the client's unique worldview. In clinical settings, multicultural sensitivity becomes paramount, emphasizing the consideration of individual values and beliefs (Ford & Garzon, 2017). Person-centered mindfulness, a culturally and spiritually sensitive approach, is grounded in the patient's faith tradition (Koenig, 2023). This clinical approach encourages healthcare professionals to be transparent about secular interventions' Buddhist roots and focus on the patient's values, beliefs, and worldview (Koenig, 2023). The interconnectedness of mindfulness with meaning-making, serenity, and the appreciation of beauty further reinforces its role in supporting the spiritual dimension of care (Labelle et al., 2014; Harrison & Clark, 2021).

Meaning-making. Mindfulness may improve the spiritual well-being of patients experiencing physical illness by increasing the meaning and purpose found in connection, serenity, and joy. A study exploring the impact of Mindfulness-Based Stress Reduction (MBSR) on post-traumatic growth and spirituality found increased spirituality among cancer patients, with mindfulness facilitating a sense of meaning, peacefulness, connection, and growth (Labelle et al., 2014). In a comparative study examining the effectiveness of Mindfulness-Based Stress Reduction (MBSR) versus a healing in the creative arts program, the findings suggested that MBSR may offer greater effectiveness in enhancing spirituality and reducing stress and anger among patients diagnosed with breast cancer (Garland et al., 2007). The results indicated that heightened spirituality, influenced by MBSR, contributed to an increased sense of meaning and purpose in life (Garland et al., 2007). Mindfulness-based cognitive therapy (MBCT), incorporating cognitive behavioral therapy into MBSR, has also been shown to impact

spirituality (Park et al., 2020). A study examining the effect of MBCT on psychological distress and spirituality in breast cancer patients discovered that mindfulness enhanced spiritual well-being measured by a sense of meaning and faith (Park et al., 2020). Engaging in mindfulness practice to enhance spirituality may also be a protective factor promoting abstinence for individuals with substance use disorder (Temme & Kopak, 2016).

Research indicates that a connection with God and nature enhances the effectiveness of mindfulness-based interventions (MBIs), contributing to improved patient health and well-being (Freeze et al., 2020; Choe et al., 2020). Dr. Herbert Benson, a Harvard-trained Cardiologist, developed a mindfulness intervention known as the Relaxation Response to counteract the toxic effects of chronic stress. The simple steps of his method to elicit this response included the option to focus on a sacred word, phrase, or prayer, incorporating a patient's faith. In his research, patients who integrated their faith into the intervention reported heightened mental and physical health benefits, a phenomenon Dr. Benson termed the "faith factor" (Benson, 1974, p. 21). A study on God attachment and mindfulness revealed that higher levels of anxious and avoidant attachment to God predicted lower levels across the five facets of mindfulness: observing, describing, acting with awareness, non-judgmental inner experience, and non-reactivity (Freeze et al., 2020). The results indicate that fostering a closer relationship with God may increase mindfulness and lead to subsequent health benefits for patients who wish to connect with God as a form of spiritual coping.

Nature connectedness enhanced the benefits of an MBSR course by offering greater mindful awareness and psychological well-being, extending past the course's end (Choe et al., 2020). Choe et al. (2020) examined whether exposure to nature during an MBSR course would lead to greater long-term well-being and increased mindfulness during practice. The findings

showed that a natural environment offered increased stress relief and reflection while reducing levels of rumination in comparison to settings without green space (Choe et al., 2020). Beginning meditators who struggle with attentional control and distractions may also benefit from introducing a natural environment to increase mindful awareness (Lymeus et al., 2016). In one study on the impact of nature on participants who were new to meditating, images of nature were incorporated into the practice. The results showed that overcoming the initial self-regulatory efforts required for beginning meditators may be improved by including nature in practice (Lymeus et al., 2016). Due to the lack of research on mindfulness, spirituality, and nature-connectedness, the psychological benefits noted may or may not be influenced by a participant's spirituality. However, the studies show that nature may be important in holistic interventions, whether the patient views it as a psychological or spiritual need.

Thich Nhat Hanh (2008) writes that mindfulness nurtures peace and joy, helping people become conduits of both in the world. When a patient encounters a joyful moment, mindfulness of joy is practiced, supporting their spirituality (Hanh, 2008). In a study examining trait mindfulness and its connection to appreciation of natural beauty, participants with heightened mindful awareness exhibited increased engagement with the beauty of the natural world, thereby enhancing their overall well-being (Harrison & Clark, 2021). These findings highlight how mindfulness can elevate appreciation of beauty, create joyful moments, and potentially aid patients in meeting their spiritual needs (Harrison & Clark, 2021). Mindfulness can also foster serenity in patients with elevated stress levels. A study on dispositional mindfulness and serenity revealed that serene persons, possessing an inner haven and an accepting attitude, experienced significantly reduced stress levels and heightened mental well-being (Soysa et al., 2021). These

results suggest that mindfulness may serve as a tool for patients to cultivate greater joy and peace, ultimately contributing to improved health outcomes.

The Psychological Dimension of Care

The COVID-19 pandemic, an extraordinary global health crisis impacting over 100 million people worldwide, not only increased awareness of the intricate relationship between psychological distress, physical illness, and mental health outcomes but also laid bare the vulnerabilities and resilience of healthcare systems (Dong, 2021; Greenberg, 2021). Beyond the unprecedented scale of infections, individuals faced the profound impact of isolation from family and friends, unable to share the support and comfort that close connections provide. The strict infection control and prevention protocols implemented to curb the spread of the virus restricted the ability to visit loved ones in the hospital, amplifying feelings of anxiety, depression, and PTSD for patients already struggling to cope, especially for individuals with pre-existing health conditions (Dong, 2021).

Beyond the recent crisis, it is essential to acknowledge that psychological distress continues to be a frequently neglected yet significant concern for individuals hospitalized with physical illnesses. According to the World Health Organization (2022), health includes a person's "physical, mental, and social well-being" and not just the absence of disease. Aligning with this perspective, the American Psychological Association (APA) defines mental health as a state characterized by emotional well-being, adaptive behavior, freedom from debilitating symptoms like anxiety, and the capacity to establish and sustain positive relationships while effectively coping with life's normal stressors (Mental Health, n.d.). In the aftermath of the pandemic, an increased understanding of the profound impact of psychological suffering presents an opportunity for advancements in patient care and support.

Psychological Distress

Richard S. Lazarus (2013), an American psychologist known for his contributions to the understanding of emotion and stress, undertook the important task of validating the psychological distress experienced by patients with physical illnesses. He shed light on the prevalent issues of toxic positivity and superficial professionalism within the medical community, which, unintentionally, could trivialize or pathologize legitimate emotions like anger, pain, and grief in response to the potential loss of roles, relationships, dignity, and life itself (Lazarus, 2013). For patients recovering from traumatic near-death experiences in the ICU or those processing the shock and despair of a stage IV cancer diagnosis while awaiting surgery, psychological suffering can be acute, debilitating, and significantly impact health outcomes. Psychological distress is an emotional state experienced by a patient in response to a stressor, resulting in temporary or permanent harm (Ridner, 2004). It is characterized by a perceived inability to cope, a change in baseline emotional state, mental discomfort, verbal or non-verbal expressions of discomfort, and harm ranging from altered social relations to poor health outcomes (Ridner, 2004). A change in a patient's baseline emotional state may result in depression, anxiety, irritability, aggressiveness, low self-esteem, social disengagement, a loss of meaning and agency, and somatic symptoms such as fatigue (Massé, 2000).

Physical Health Outcomes. A systematic review examining the connection between psychological distress and health outcomes revealed a consistent negative impact on health across various patient populations. The risks associated with psychological distress include reduced immunity, medication adherence, self-care, and increased mortality (Barry et al., 2020). Distress caused by chronic stressors such as job-related stress, caregiving responsibilities, and marital discord were identified as contributors to the development of physical illnesses like

cardiovascular disease and cancer, exacerbating suffering for affected patients (Dimsdale, 2008; Shin et al., 2016). The influence of psychological distress on specific patient populations, particularly cancer patients, is well-documented. Psychological suffering significantly heightens mortality risks across various cancer types, such as lung, bladder, breast, colorectal, hematopoietic system, kidney, and prostate cancers (Wang et al., 2020).

Loneliness emerged as another significant source of psychological distress with adverse effects on health outcomes. Studies linked loneliness to conditions such as high blood pressure, cardiovascular disease, disability, cognitive decline, and depression (Gerst-Emerson & Jayawardhana, 2015). Depression, a comorbidity often noted in patients with physical illness and higher levels of psychological distress, is associated with increased physical symptoms, functional disability, and decreased quality of life and is often undetected and left untreated (Walker et al., 2018). A study focused on heart failure patients demonstrated that poor perceptions of illness and coping challenges, indicative of psychological suffering, contributed to heightened depression in response to physical symptoms. This, in turn, impacted patients' ability to self-monitor and engage in rehabilitation, influencing overall health outcomes (Chen et al., 2020).

The impact of pre-operative psychological distress on health outcomes following surgical procedures was evident in various studies. Pre-operative distress correlated with increased post-operative pain, poor functional outcomes, and comorbidities such as anxiety and depression (Lingard et al., 2007; Skeppholm et al., 2017; Sorel et al., 2019). A study investigating the influence of pre-operative psychological distress on cervical radiculopathy patients reported a higher incidence of secondary surgery within a two-year follow-up for those experiencing elevated pre-surgical distress (Skeppholm et al., 2017). The study suggested addressing mental

distress as an adjunct to surgical treatment (Skeppholm et al., 2017). Additionally, a separate study involving 952 patients across 13 surgical centers revealed that psychologically distressed patients reported increased post-operative pain for up to two years following knee arthroplasty (Lingard et al., 2007).

Mental Health Outcomes. In addition to negative physical health outcomes, psychological distress may contribute to the onset of mental health conditions in hospitalized patients. Life-altering events experienced during hospitalization may result in posttraumatic stress, challenges in emotional regulation, and comorbidities such as anxiety and depression, leading to a loss of meaning (Greenberg & Rafferty, 2021; Vlake et al., 2020; Alzahrani, 2021; Massé, 2000). A systematic review examining the impact of hospitalization on emotional and psychological well-being found that it negatively affected how patients cope and adjust, leading to increased symptoms of anxiety and depression (Alzahrani, 2021). Patients with critical life-threatening illnesses are more likely to suffer from psychological distress, which may have long-lasting mental health consequences.

Patients hospitalized in the Intensive Care Unit (ICU) due to life-threatening illnesses may develop Post Intensive Care Syndrome (PICS), resulting in physical and mental impairment, including mental illnesses such as depression and post-traumatic stress disorder (PTSD) (Sivanathan et al., 2019; Vlake et al., 2020). These conditions are identified as the primary contributors to psychological distress in such patients. In a Dutch study focusing on survivors of critical illness, it was revealed that 59% experienced psychological Post Intensive Care Syndrome (PICS), exhibiting notably more symptoms of PTSD and depression compared to survivors without PICS for up to 2.5 years after their discharge from the ICU (Vlake et al., 2020). The study also found that 77% of patients desired additional information about PICS prior

to discharge, leaving them with unmet psychological needs and a lack of follow-up care (Vlake et al., 2020). These findings align with a decade-long study (2005-2015) encompassing nearly two million patients with critical and life-threatening illnesses who survived ICU hospitalization, indicating a heightened risk of mental illness. Excluding patients with conditions known to elevate the risk of mental illness diagnoses, such as stroke, traumatic brain injury, cardiac arrest, cardiac surgery, and pregnancy, the study identified an increased risk of mental illness associated with more extended ICU stays (> 48 hours) and the requirement for mechanical ventilation (Sivanathan et al., 2019).

Pain Perception. In the book *The Body in Pain: The Making and Unmaking of the World*, pain is equated to torture, transforming mundane household items like beds, chairs, and bathtubs into potential instruments of torment, rendering the home a hostile and alien place for the sufferer (Scarry, 1985). In states of health, the body typically remains in the background of one's field of attention (Svenaeus, 2014). According to Svenaeus (2014), the experience of pain can narrow a patient's focus of attention to the point that physical discomfort becomes all-consuming. Perception of pain plays an important role in the experience and intensity of physical distress. A patient's discovery that the source of their pain is life-threatening may cause the pain to be perceived as more acute in response to a changing view of the seriousness of their condition (Cassell, 1998). When pain is chronic or the source is unknown, patients may feel out of control and struggle to manage their pain. In contrast, the belief that pain can be managed has been shown to decrease the intensity of pain experienced. Patients with terminal illnesses often experience relief from the discovery that their physical pain can be controlled and may be able to tolerate the same pain intensity without analgesics (Cassell, 1998).

Nevertheless, physicians may sometimes dismiss a patient's physical pain, categorizing it as psychological, which can erode the patient's trust in their perceptions of reality (Cassell, 1998). Despite the validity of self-report measures in assessing pain, healthcare providers frequently underestimate the level of pain reported by patients (Boring et al., 2021). Current motivations, contexts, and experiences can influence patient perceptions of pain and reporting. Factors such as beliefs about pain being a normal part of aging, cultural stigma, racial bias, discrimination, and concerns about social judgment may contribute to the underreporting of pain and result in disparities in pain treatment (Boring et al., 2021).

Trauma. Psychologist Peter Levine (2005), known for his work in the study of trauma and stress, views trauma as the most ignored, misunderstood, and untreated cause of suffering. While trauma is commonly linked to extreme violence and disasters, its origins are far more nuanced, diverse, and individualized. Various factors, including genetics, family dynamics, and early childhood experiences, also contribute to the complexity of each person's experience of trauma (Levine, 2005). Trauma occurs when a person's ability to respond to a perceived threat is overwhelmed, and they are unable to move through the fight or flight response and let go of the fear amidst helplessness. The impact of trauma may be severely debilitating, limiting an individual's ability to cope and be present. It may be met with harsh judgments from others, leading to shame and self-hatred. According to Levine (2005), symptoms such as nervousness, panic, or any response to something in a person's internal or external environment related to past trauma are an arousal or activation of the energy experienced during the original event that has not been released. Common symptoms of trauma include anxiety, panic attacks, disassociation, avoidance behaviors, addictive tendencies, somatic complaints, and challenges with memory and attachment. The frequency of symptoms may be ongoing, triggered by stress, or reappear later in

life (Levine, 2005). Common causes of trauma are war, extreme violence, natural disasters, severe abuse (emotional, physical, or sexual), and childhood (neglect, betrayal, or abandonment).

The experience of life-threatening diagnoses, recurrent hospitalizations, continuous treatments and procedures, pain, feelings of powerlessness, and disorientation within the hospital environment can contribute to the development of medical trauma (Hall & Hall, 2013). The causes of trauma also vary across the lifespan, with children facing potential trauma from routine medical procedures and older adults experiencing trauma through falls, particularly when contending with challenges related to balance, decreased bone density, and mobility (Levine, 2005; Flood & Buckwalter, 2009). Patients may have a history of trauma related to discrimination based on age, race, sexual orientation, religion, or disability and fear re-exposure in a healthcare setting (Chen & McNamara, 2020; Comas-Díaz et al., 2019). While trauma-informed care is crucial for all patients, its importance is especially evident in the context of caring for veterans. Combat trauma inflicts profound psychological wounds, often resulting in a diagnosis of posttraumatic stress disorder (PTSD) for veterans, accompanied by debilitating symptoms and mental and physical health morbidities (Benedict et al., 2020).

Mindfulness and the Psychological Dimension

Research suggests that mindfulness can help alleviate psychological distress, improving mental and physical health outcomes and overall quality of life (Merkes, 2010). Mindfulness-based interventions (MBIs) have demonstrated efficacy in alleviating anxiety and depression and fostering increased prosocial behaviors that impact mental health (Hofmann & Gomez, 2017). A comprehensive analysis of mindfulness interventions by Zhang et al. (2021) highlights the impact of mindfulness on behavioral regulation, positive affect, and the alleviation of anxiety,

negative emotions, and depressive symptoms (Zhang et al., 2021). Studies also indicate that MBIs help alleviate symptoms of post-traumatic stress (Hopwood & Schutte, 2017).

Pain Perception and Mindfulness. Mindfulness assists patients in changing their perceptions of pain, alleviating physical distress for acute and chronic conditions. By bringing attention to painful sensations and releasing resistance to physical discomfort, patients effectively lower the intensity of their pain (Penman, 2015). In contrast, prolonged focus on sources of physical discomfort amplifies pain. Mindfulness-based interventions for pain management teach patients to broaden their focus within the body, counteracting the tendency to concentrate narrowly and thus alleviate suffering. Hospital pain clinics prescribe mindfulness for treating various conditions such as migraines, fibromyalgia, multiple sclerosis, the side effects of chemotherapy, and numerous other diseases (Penman, 2015).

A systematic review evaluating the effectiveness of brief mindfulness-based interventions (MBIs) in the nonpharmacologic treatment of acute and chronic pain found that provider-led MBIs, surpassing five minutes of instruction, significantly contributed to pain management (McClintock et al., 2019). Furthermore, an fMRI study investigating the impact of mindfulness meditation on pain-related brain processes reported a notable reduction in pain unpleasantness ratings and pain-related activation (Zeidan et al., 2011). Decentering, a mindfulness technique encouraging participants to observe their thoughts, feelings, and sensations with detachment, also appears beneficial for chronic pain management. A study exploring the relationship between decentering, mindfulness, and chronic pain revealed that participants experienced heightened pain acceptance, improved functioning, and reduced distress when they did not identify with their pain (McCracken, 2013).

Trauma and Mindfulness. Many problem behaviors arising from trauma are linked to experiential avoidance, where individuals resist engaging with internal experiences such as thoughts, emotions, memories, and body sensations (Roche et al., 2019). This resistance, attempting to change or suppress upsetting experiences, often leads to poorer outcomes and increased distress. Mindfulness, in contrast, stands as the antithesis to experiential avoidance, emphasizing awareness of present-moment experiences with openness and acceptance. A study conducted at Midwestern University revealed a connection between experiential avoidance and problem behaviors in college students who had experienced childhood trauma (Roche et al., 2019). The study suggested that mindfulness components, such as awareness and non-judgment of inner experiences, played a pivotal role in influencing the association between trauma and problem behaviors (Roche et al., 2019). Repeating a mantra (a sacred word or phrase) like "shalom" or "Jesus loves me" has demonstrated positive effects for veterans dealing with PTSD. This practice not only enhances mindful attention but also reduces trauma-related symptoms and depression, contributing to an overall improvement in psychological well-being (Bormann et al., 2014). This approach is particularly beneficial for individuals who lack access to quiet environments and aligns with the unique values and beliefs of the patient.

While mindfulness-based interventions (MBIs) have shown effectiveness in reducing trauma symptoms, there is limited research on the efficacy of interventions specifically designed to address the unique needs of trauma survivors. Further investigation into the effectiveness of trauma-informed mindfulness is crucial, as unmodified mindfulness interventions have been found to exacerbate symptoms of PTSD in some patients (Hopwood & Schutte, 2017). Trauma-informed mindfulness aims to teach a survivor how to be present in one's life and to notice whatever is arising in a healing way instead of triggering and possibly re-traumatizing (McCown

et al., 2016). The full curriculum for mindfulness-based interventions is available to patients with trauma histories by incorporating trauma-sensitive modifications. While there are exceptions, patients who have experienced trauma should not be discounted or discouraged from practicing mindfulness. Contradictions to engaging in MBIs include suicidal thoughts, active addiction, and active psychosis (McCown et al., 2016).

Teaching trauma-informed mindfulness emphasizes choice, grounding, and compassion. Prioritizing patient agency, healthcare providers empower patients by presenting choices during practice and seeking permission rather than making demands (McCown et al., 2016). Providing options for present-moment anchors fosters emotional regulation, helps prevent triggering past trauma, and recognizes the varying comfort levels with specific anchors like the breath or body. This modified approach to mindfulness practices accommodates individual needs, creating a healing and supportive environment for those with a history of trauma (McCown et al., 2016). Grounding techniques, such as focusing on the body against a chair or bed, may be introduced at the beginning of mindfulness interventions to regulate the nervous system. Compassion is woven into instructions and patient interactions, as providers exemplify mindful responses to reactivity, promoting kindness to oneself and normalizing challenging emotions. Patients are also encouraged to practice self-compassion by pausing or stopping at any time to prevent becoming overwhelmed and causing additional psychological distress (McCown et al., 2016).

One pilot study evaluating a trauma-informed model of MBSR (TI-MBSR) found that female survivors of interpersonal violence exhibited significantly decreased levels of post-traumatic stress symptoms, anxious attachment, and depressive symptoms compared to the wait-list control group (Kelly & Garland, 2016). The program incorporates psychoeducation on trauma in addition to the same exercises and practices that are included in MBSR programs.

Trauma-sensitive Mindfulness and Compassion (TMC) is another treatment approach modifying mindfulness for trauma survivors. Grounding, mindfulness, and compassion practices are offered along with trauma-related psychoeducation to create safer interventions for people with trauma-related symptoms (Wästlund et al., 2023). In a qualitative study exploring the effects of introducing TMC to therapy clients with a history of trauma, participants expressed a transformed relationship with themselves and their bodies. They reported experiencing increased freedom in their relationships and overall lives (Wästlund et al., 2023). The promising outcomes of both studies highlight the need for further research on effective modifications, ensuring that mindfulness remains a supportive and accessible tool for individuals with trauma histories.

Introduction of the Be Still Method

Sometimes, we need to interject meaning into our deepest places of suffering to find hope when there appears to be none. I am reminded of a patient I will refer to as Grace. I will never forget the look in her eyes when I found her curled up in a ball on the bathroom floor in total agony. It was as if her entire being was simultaneously screaming, breaking, fighting, and wanting to disappear. I remember us singing together after I applied “sun tan lotion” and described the gentle waves and warm breeze of the beach that had replaced the cold, stark hospital room. I was used to describing places like this to my mom when she experienced chronic pain. It was a song her grandmother would sing to her as a child to comfort her. Even though she struggled to sing the words, her voice was hauntingly beautiful and brave, and every so often, I could see a hint of a smile forming on her battle-worn face.

Her grandmother would sing her a children’s song about a sleeping monk who has not heard the ringing of the morning bell. The beauty and irony of remembering and reconnecting with a moment of love and innocence amidst the brutalities of life was not lost on me then or

now. Her meaning-making became mine. I shared this story with someone who has helped me find purpose in my suffering right after they had listened to the third movement of Mahler's Symphony No. 1. The deeply moving and thought-provoking piece transforms the same nursery rhyme we sang together into a dark, ironic funeral march. As I looked more into the meaning behind Mahler's symphony, I saw a man trying to understand the complexities of life, death, and suffering just like the rest of us. The meaning we find in the various movements, all the innocent, dark, lovely, mournful, joyful, exhilarating, and crushing notes, form the symphony of our lives. It is uniquely ours, and the melodies of our hearts and minds join together with others and, for some, with God. My experience with Grace woke me up and opened my eyes to the profound impact meaning-making has on suffering.

The Be Still Method is an intervention that adds meaning to mindfulness to help ease distress and meet the needs of the whole person —body, mind, and spirit. Meaning-making has shaped my experience of suffering and has influenced how I practice mindfulness. Psalm 46:10 says, "Be still, and know that I am God; I will be exalted among the nations, I will be exalted in the earth (NIV, 2002, p. 3981). "Be still" comes from the Hebrew root word *raphah*, which means "to release" or "relax" (Strong's Number 7503, n.d.). The psalm contains three parts: relaxation, release, and meaning-making. Being still encourages me to relax by focusing on His presence in the present moment. Knowing God allows me to accept whatever is arising and release everything into His care, trusting that He will work it out for good. Being still and surrendering everything to Him allows me to glorify God and experience His love, bringing meaning to my life.

Mindfulness and meaning-making have a synergistic relationship and can enhance and support one another in a mutually beneficial way. While current definitions of mindfulness do

not include meaning-making, mindfulness was originally defined in Christian and Buddhist contexts with meaning in mind. For this intervention, I define mindfulness as the choice we make in any given moment to focus our attention on something present or remembered, to be with our experience as it is right now, and to release it while making meaning. Meaning-making is unique to each individual and adds depth and purpose to the practice of mindfulness. Meaning provides a "why" for living in the present and influences a person's focus of attention and acceptance of present moment experience. Making sense of suffering may also help patients ease distress, potentially enhancing the efficacy of MBIs.

The Be Still Method (BSM) was developed to help patients ease stress and distress by quieting the mind to listen, remember, and find meaning. The three phases of the method— "Be Still," "Set Free," and "Make Meaning" —are designed to relax the mind and body while establishing present-moment awareness, free the mind, body, and spirit by being with and releasing whatever arises, and provide resources for individuals to engage with complex problems by making meaning. Just as a stream naturally knows where it is going, people need only be still and reminded of what they already know. The meaning they possess helps people trust the natural flow of life amidst uncertainty and constant change. This is especially helpful for patients facing serious health challenges, providing psychospiritual support to promote health and well-being. The incorporation of focused attention and acceptance, recognized as potential mechanisms contributing to the efficacy of MBIs, is also woven into the method. For an in-depth explanation of each phase of the BSM and guidance on introducing it to hospitalized patients, please refer to Appendix A and B.

The Be Still Method utilizes neutral language to express the core concepts of MBIs, aiming to support patients in discovering their own meaning in mindfulness. The wording is

simple, easy to understand, and free of any jargon to support patients from diverse cultural, religious, and spiritual backgrounds and different ages and abilities. The BSM considers the needs of patients with memory impairments and intellectual disabilities, helping them to be present and find meaning by engaging their senses and focusing on moments of joy. Sensitivity is also given to working with patients who may have a history of trauma by fostering compassion and choice to create a safer space to engage with mindfulness-based interventions.

Discussion

Suffering impacts patients in multiple dimensions, encompassing the biological, psychological, social, and spiritual aspects of the person. The Biopsychosocial-Spiritual Model provides a comprehensive framework to address patient distress, recognizing the interconnected nature of these dimensions and understanding their substantial influence on health outcomes, overall well-being, and quality of life. The Be Still Method helps address the needs of the whole person, providing additional support to patients finding it difficult to cope. The BSM is highly adaptable, making it suitable for addressing patients' diverse and changing needs. The method's simplicity and flexibility make it easy for healthcare staff to use, especially when time is limited.

While research has explored the impact of mindfulness on spirituality, the BSM incorporates meaning-making to support the spiritual dimension. For healthcare professionals uncomfortable providing spiritual care, the method integrates suggestions for spiritual coping, reminding patients of their resources during a crisis. Surrender, serenity, prayer, and acceptance are forms of meaning-making included in the method that may offer support to patients in recovery who attend 12-step programs. The BSM also follows best practices for offering religiously accommodative and culturally sensitive mindfulness interventions.

Programs such as Trauma-informed MBSR and Trauma-sensitive Mindfulness and Compassion incorporate trauma-informed psychoeducation, but they require significant time and are led by trained instructors. The Be Still Method incorporates trauma-informed instructions directly into the method, offering a short-term intervention accessible to patients at any time. Hospitalized patients can rarely commit to extended mindfulness programs or attend in person, providing a tool for immediate use during moments of distress. While the effectiveness of the BSM has not been studied, it incorporates focused attention and acceptance, mindfulness mechanisms that have been proven effective in brief MBIs.

Research is necessary to explore the BSM's diverse applications in various healthcare settings and populations. Future studies could explore its impact on mindfulness, attention, and acceptance, utilizing validated scales to clarify the mechanisms contributing to its effectiveness. Researching its effectiveness in addressing distress among hospitalized patients experiencing various forms of suffering can contribute significantly to the growing knowledge of whole person care. Additionally, investigating physiological responses, such as blood pressure and stress biomarkers, could offer valuable insights into the holistic effects of the Be Still Method on patients' health. Studying potential adverse effects or challenges when applying the BSM to individuals with a history of trauma is also crucial.

Limitations include the lack of research to determine potential adverse effects or challenges, especially when applying the BSM to individuals with a trauma history. Establishing the necessary modifications to ensure patient safety and comfort is crucial for ethical and effective care. The Be Still Method must also be further developed to be more accessible to healthcare professionals and patients.

The potential application of the BSM extends to diverse settings, including nursing homes, homeless populations, and prisons. Considering the reliance on technology in healthcare, the method could be further developed into an app, incorporating visual and auditory elements to make it more user-friendly. This could enhance its accessibility, especially for individuals with hearing or vision impairments.

Conclusion

Continued development of mindfulness-based interventions is essential for delivering culturally sensitive, whole person care to hospitalized patients, aiming to alleviate distress and promote health and well-being. Within this context, The Be Still Method provides a framework to address the multidimensional needs of the whole person. While further research is required to validate its efficacy, explore different applications, and ensure ethical considerations, the BSM can potentially enhance whole-person care. This method can assist patients in easing suffering and cultivating meaningful moments, irrespective of their circumstances.

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Appendix A

Introducing the Be Still Method to Hospitalized Patients

The Be Still method begins and ends with making meaning. Meaning begins with the person making it, and in a hospital setting, that's staff and patients. Everyone has a story, and depending on their age, they may have a lifetime of moments that have shaped their experience. If patients find their lives purposeful, they have a vault of meaningful moments to call upon to offer hope and purpose. For others, making meaning may feel out of reach and pointless. There may be very few memories patients want to remember, and they may have experienced unthinkable tragedy and trauma. Still, there are opportunities to find meaning in the present. Many patients have simply forgotten about the deep repository of meaning that lies within them in the middle of a health crisis, leading to feelings of hopelessness and overwhelm as they try to solve seemingly impossible problems that may threaten their very existence.

Hospitalized patients experiencing physical, psychological, or spiritual distress may feel disconnected from their experience, making it difficult to think clearly or draw upon much-needed resources like meaning-making. Connection shapes our experience and is at the heart of meaning-making. Our brains are wired for connection, and we long to be loved, known, and truly seen. As we travel through this life, facing the unknown and countless difficulties that can bring us to our knees, connection helps ground us in the present and brings meaning to our lives no matter our circumstances. When we feel disconnected from ourselves, others, and the world around us, we also feel disconnected from our present-moment experience, and it's more challenging to cultivate meaningful moments or remember sources of meaning that offer support when we need it most.

Before introducing the BSM, it's important for healthcare professionals to understand their needs and the patient's need to make meaning and feel connected. Doctors, nurses, nursing assistants, physical therapists, and countless other members of the healthcare team provide the main source of connection for hospitalized patients, helping them adjust to an environment that can be disorienting and distressing. While working in healthcare can also be incredibly stressful and draining, it's important to remember that patients want to be seen as more than a diagnosis, representing a list of tasks there's scarcely time to complete. Healthcare professionals are also much more than the care and tasks they provide. Meaning and connection shape the milieu of the hospital environment, providing countless opportunities to make meaning amidst deep suffering. Patients and staff make meaning together or find purpose in what's meaningful to one another. Meaning abounds in every moment if we're looking for it, and mindfulness helps us do just that.

For someone intending to introduce the Be Still Method in a hospital setting, it may be beneficial to recall a patient who has brought meaning to their lives. Inspiration may arise from a patient's meaning-making, helping them face incredibly difficult circumstances. Alternatively, meaning and purpose may be discovered in having the resilience to confront ridiculously challenging situations without the help or resources needed to do the job effectively. For example, a nurse may have unearthed unknown sources of inner strength that kept their patients alive. Even if they went home afterward feeling completely overwhelmed, crashing under the weight of their responsibilities, meaning was made through the realization that they could withstand and overcome a tremendous amount while keeping their heads about them—at least when it counts—and in the end that's all that matters.

Finding a "Why"

Before delving into an explanation of the Be Still Method with a patient, it's essential to establish an initial connection and offer compassion by acknowledging the stress or distress the patient is experiencing. This can be achieved through an informal check-in by simply asking how the patient is doing. Some patients may welcome the question and provide more details about their struggles than necessary. Others may convey their feelings and state of mind through facial expressions and tone of voice. Every patient is different, so it may take a slightly different approach to discover any unmet needs or struggles the patient may be experiencing. Whatever the situation may be, it's possible to acknowledge that they are experiencing a challenging time in their lives to offer support, validation, and compassion.

Next, patients are asked a simple question, which will most likely be a huge relief as they try to solve complex problems. While it may lead to a cynical laugh or a side glance, it's a very important question. It can also be very cathartic for someone to express any frustration or disillusionment they may be experiencing. The patient is asked if they would like to help ease their stress or distress. This may seem like a ridiculous question because who wouldn't? But it's a valid question because patients may prioritize their distress over seeking out relief, and it brings attention to this internal fight to either wallow in physical, psychological, or spiritual pain or move towards living a meaningful life no matter the circumstance.

Connecting with our present-moment experience is about living life more fully, and patients may not think they have a good reason for doing this. If all they can see is pain, why would they want to be present? Mindfulness is also a practice that takes some effort, especially in the beginning, and may prove to be even more challenging when coupled with fatigue, pain, and countless other worries related to physical illness. Patients need a "why" that's compelling

enough to engage in the first place. Even if their reason is to reduce stress or experience more calm, there is a wealth of meaning beneath the surface that has influenced their seemingly simple, straightforward answer. They want relief because they still have a purpose and a reason for wanting to be alive. Even if they struggle at first to access rich sources of meaning, especially in a moment of distress, there is a recognition that they want to feel better, which means they want to live full lives and live them well.

There are different ways that the purpose of the Be Still Method can be conveyed, but it needs to explain its meaning, relating it to the patient's experience. Using neutral language works best by describing it as a relaxation exercise to quiet the mind, experience more calm, and ease stress or distress. It's also important to explain that it provides the opportunity to focus on something purposeful or find new sources of meaning, helping them cope with challenges.

Be Still

Once the patient understands the purpose of the BSM and agrees to try it, the "Be Still" phase is introduced. First, we explain to patients what it means to be still because the phrase may cause some initial confusion. Stillness isn't about becoming our own personal statue; it's about quieting the mind and allowing our present moment experience to flow freely, helping us relax and experience some much-needed relief. Being still may be the last thing a hospitalized patient wants to do when they feel forced to slow down, even though their minds haven't gotten the memo. When patients are used to never taking a moment to pause and be fully present amidst the busyness of life, it can feel jolting to go from one extreme to another. Patients may try to keep that momentum going by busying their minds with an inordinate number of thoughts or distracting themselves with devices.

If patients are resistant to being still, it may be helpful to explain the problem and costs involved with refusing to slow down and quiet the mind. The problem is that their minds may be moving too fast, even though their body is sitting still, adding stress to their lives. Chronic stress limits the resources available to cope with the stressors that come along with the serious medical conditions or injuries that landed them in the hospital in the first place, which may have been caused, in part, by all the other stressors in their lives. This may help someone introducing the BSM to get buy-in.

Pain and Attention

Next, we pose another question to patients. What can you bring your attention to in this moment that isn't a source of pain, stress, or distress? While a patient may not have an immediate answer, this question helps them identify sources of discomfort, even those they may not be aware of initially. We make it clear that this isn't an attempt to suppress or avoid anything. Instead, we explain to patients that prolonged focus on a source of pain amplifies it. It's also a good time to educate patients on the impact of the stress response, highlighting how it hinders clear thinking and promotes reactive behavior.

Often, we refuse to pay attention to what's happening in the present when our pain or distress refuses to give up being the center of attention. It's repeating ad nauseam, "Look at me, look at me!" Our brains are designed to be excellent problem solvers, and we imagine that intense focus on the source of our discomfort will help us work it out until it doesn't, and the hyper-focus on our pain only worsens it. We may ignore the help right in front of us because we believe our brains know better, and it may feel impossible to notice anything else.

Who else knows our internal experience as well as we do? We may be overly confident in our abilities to see things clearly, especially when our pre-frontal cortex, responsible for our

ability to think rationally, has gone offline because of our heightened stress. Our past experiences and conditioning are also coloring our experience. Instead of responding to a situation, we get triggered, react, and experience our least mindful state. We aren't being; we're doing, and what we're doing is completely futile because we're ramming our heads up against a proverbial concrete wall. Concrete, not brick, it's easier to chip away at mortar. It's reinforced with steel and is more impossible and immovable than your next-door neighbor. You get the picture.

Choosing a focus of attention that's neutral or comfortable helps ease distress, offers greater clarity of mind, and broadens our awareness to notice other aspects of life. This broadened focus leads to experiencing more meaningful moments, providing the resources patients need to deal with dialysis, dressing changes, and respiratory care. We also provide crucial insight into what's not working by explaining that right out of the gate. The patient can see for themselves when their minds begin to clear and life starts to feel more manageable, that it may be wise to consider another strategy going forward. As healthcare professionals, we also benefit from having more reasonable patients who aren't fighting us or resisting treatment. So, we end up being less stressed and reactive, and around and around it goes. This is also why we need to practice what we intend to teach.

Pause, Relax, Now

The Be Still Method offers three steps to guide a patient into focusing on the present moment: pause, relax, and now. The first two steps—pause and relax—help ease a person into the present by preparing the mind and body. First, the patient is asked to pause whatever they are doing by removing distractions and getting into a comfortable position. The eyes may be open or closed, and this should be mentioned as the first instruction is given because patients may be familiar with guided mediations that encourage the eyes to be closed, which may not be

comfortable or neutral for those with a history of trauma. Next, the patient is offered the choice to take a couple of deep breaths into the diaphragm and relax any tension in the body. Deep diaphragmatic breaths help regulate the nervous system, making it easier to think clearly and be present. Releasing tension in the body reassures the mind that all is well and offers a sense of greater ease. Relaxing the body through deep breathing and softening any tightness in the body are both optional because they may trigger a trauma response.

Finally, we ask patients to select a single focus of attention (anchor) to ground them in the present, directing their focus to the here and now instead of dwelling on the past or future. Three categories of anchors are offered to provide trauma-informed choices: the breath, a still object, and meaning. Additional options are necessary because focusing on the breath or body is not neutral or comfortable for everyone. Patients can focus on their breath or, as an alternative, carry the words “be” and “still” on the breath. The latter choice may be particularly helpful for patients in a noisy environment. Selecting a still object as an anchor enables the patient to either ground themselves by noticing their body against a bed or chair or to focus on an object in the room or outdoors. There’s also the choice to bring attention to a source of joy or spiritual meaning, such as appreciating nature or focusing on a sacred word or phrase. For patients with dementia, focusing on a treasured keepsake may bring back memories and offer comfort. Fully engaging with the senses may also provide moments of joy even when they cannot remember. By offering the option to focus on something meaningful, patients who struggle to follow the instructions of the BSM can still find relief, providing compassionate care to those who need it most.

Where is My Mind?

It's a bird! It's a plane! It's a distraction! For anyone who doesn't know, that's an outdated Superman reference for your reading pleasure. I'm willing to use cheesy jokes to keep your attention, which is already a challenge because our attention span is shorter than a goldfish. This has actually been debunked, but it feels true. Mind-wandering occurs when our mind drifts from our chosen focus of attention. It's that simple, and it happens just as often to experienced meditators. The difference is that long-time meditators understand this and have normalized their experience. So, it's our job to normalize a patient's experience and to explain what mind-wandering is and what to do when it occurs. What do you do? Simply notice it without judgment and return to the present moment. That's all, folks!

Set Free

What are we holding too tightly or resisting with all of the mental and emotional energy we have available to us? "I'm right, you're wrong, and there's nothing you can do about it." These are the words of Harry Wormwood, in the movie Matilda, when he reacts to his daughter's innocent plea for her dad to sell good cars as her brother can be seen in the background dutifully using a drill to force down the mileage on a junk heap of a car that barely runs. The message Mr. Wormwood tries to drill into Matilda's head is that he sells cheap, unreliable cars to make the money he needs to support his family, and she doesn't know what she's talking about. Somewhere deep inside all of us is a critical voice telling us that we are wrong to simply be with our present moment experience as it is, and we need to keep engaging with life in a way that makes it hard for us to function because it's for our own good. This is the voice of fear and limitation telling us that we have to hold on to what is pleasant and push away what is unpleasant to keep us safe and satisfied, even though it runs us down and leaves us stranded at the worst

possible moments. What I have just described is the opposite of a Buddhist concept called equanimity, which is practiced when we view all our experiences equally and impartially, and in the famous words of the Beatles, we let it be so that we can let it go and make room for what's coming next. This is acceptance.

When patients understand that trying to hold on to what's pleasant is just as detrimental as pushing away what's unpleasant, they may be more willing to free their minds and hearts by releasing the clutter and returning to the present. It's all the same. It's just debris, nothing more and nothing less. Getting in touch with our thoughts and emotions is important, but we need to learn to sit with what's arising and release it so that it doesn't become a source of suffering. In the second phase of the BSM, the first step is understanding the meaning of "Set Free." This means releasing whatever arises in the present without clinging or pushing it away. Whether pleasant or unpleasant, letting go frees the body, mind, and spirit, easing stress and distress.

Equanimity also applies to many different faith traditions. Surrender is one of the optional tools provided to patients in the "Set Free" phase of the BSM. Through the act of surrender, patients release everything into the care of God, believing that whether an experience is pleasant or unpleasant, God will use all of it for their good and for a greater purpose. Unpleasant experiences may also be viewed as opportunities for spiritual growth, helping to remove resistance. Instead of clinging to and living for their own desires, the focus is on doing the will of God and accepting whatever arises. This view of equanimity may be an important source of meaning-making for patients experiencing distress.

It's hard to be with and let go of what's arising when we lack understanding. Thoughts and emotions can be very complex and difficult to distinguish from one another. Often, we say we feel a certain way, but we're describing a thought. Our repetitive thoughts may result from

avoiding emotions we're too afraid to feel or don't know how to get in touch with. Our thoughts and emotions also lack a tangible quality, unlike something we can see or measure. Patients may also have grown up in families where the only things that mattered were practical and visible, and we may have, too.

Experiencing feelings of hopelessness, a sense of abandonment by God, or trauma symptoms may give rise to shame and denial. It may not be considered real pain to a patient unless it's physical, but psychological and spiritual distress impact health outcomes. Psychospiritual distress can steal our hope and ability to see the sources of meaning in our lives, which helps us cope with the incredible toll physical illness can have on a person. Moreover, our perceptions, thoughts, and emotions can intensify physical pain, and experiences of grief and loss may manifest as sensations of physical distress.

We can support patients in discerning between thoughts and emotions by inviting them to place a hand on their head and heart, helping them connect with how they are experienced in the body and grounding them in the present. Tension in the temples, tightness in the chest, or an uneasy feeling in the stomach are various ways patients may experience difficult thoughts and emotions in the body. We can encourage patients to simply notice, be with, and release these sensations without focusing on detailed descriptions or an in-depth understanding of psychological distress. To help facilitate this release, we can guide the patient in identifying areas of tension and discomfort as they breathe in and releasing them as they breathe out.

Labeling emotions with "this is" statements may also help create much-needed space to be with fear, anger, or sadness without overly identifying with them. For example, instead of saying, "I'm afraid," adopting a more detached perspective involves stating, "This is fear." When a patient keeps experiencing persistent thoughts, we may encourage them to imagine being at a

train station. The patient has the choice not to board a train of thought that would take them far away from their present moment experience. Using visualizations to help patients better connect with their inner experience while creating some much-needed space to work with them is a valuable tool when straightforward instructions don't seem to resonate.

Pain perception can also be a challenging subject to discuss with patients. While perceptions of pain can intensify physical discomfort, we don't want to discourage patients from effectively managing their pain because, no matter the cause, it's very real to them. Patients may benefit from noticing any thoughts or emotions related to their pain and exploring the possibility of holding onto them less tightly. Since it may feel like pain has them in a death grip, it's helpful to begin releasing its hold on the mind. Additionally, patients can be guided to widen their focus in the body, redirecting attention from the primary source of their physical discomfort.

Make Meaning

What brings meaning and purpose to your life, no matter the circumstance? This can be an incredibly loaded question for patients. As I mentioned earlier, expanding our focus to perceive anything beyond our distress can sometimes seem insurmountable. It may be challenging to remember what makes us want to get up every morning and draw another breath. For some patients, breathing may be a small feat in and of itself. Physical impairments may feel like a thief stealing away what it means to feel alive—being able to run, dance, walk, or move freely without discomfort. It can feel soul-destroying when we don't have any meaning to fortify our losses, giving us a reason to be with our present moment experience and to live our lives to the fullest no matter what we face.

At this point in the intervention, patients have some practice being present and letting go. Now, it's time to notice and remember what's meaningful during challenging moments. But why

shift the focus to meaning-making if mindfulness can be meaningful in and of itself? Consider the times when you naturally slowed down and were fully present. What were they? I'm willing to bet that you weren't fighting traffic, getting your teeth cleaned at the dentist, or lying in a hospital bed. It was the awe and wonder of looking up into the dark expanse of sky and stars as you stood in a field of white or the salty smell of the ocean breeze that you could almost taste as you watched a shaggy dog race into the water with full abandon. Or maybe it was a moment of pure joy and connection etched into your memory, much like the lines on your grandmother's face that all seemed to smile when she did.

These are the moments that define us and give us purpose. They help patients look beyond their hospital room and remember why they want to live in the present. Their memories cannot be taken from them, like a foot, an organ, or their ability to move their arms and legs. Meaning allows us to focus on the moments when we felt free and most alive, living on forever in the minds and hearts of others. We can sit with someone we love dearly and lost, drawing comfort from the touch of their hand, the warmth of their presence, or their gentle words of encouragement that live on with us. These memories carry us through the darkest moments of our lives and give us hope that says "keep going" when there seems to be no place left to go. Meaning lights our path and offers an outreached arm to steady us as we make our long trek up the mountain.

In stark contrast to this are the moments that violently pick us up without warning and spin us around like a ragdoll, uprooting us from any feeling of safety or home. We are left reeling, trying to make sense of it all so that the pain in our chest, the queasiness in our stomach, and the lump in our throat—that horrible seasickness—will depart from us. There are countless sources of deep suffering that bitterly squeeze the life right out of us or loudly toss us around in a

tumble dryer like a pair of worn-out shoes. The excruciating pain of it all. Where is the meaning in that? There's no inherent good in it. Even when Jesus was in the Garden of Gethsemane awaiting His crucifixion, He cried out to God in anguish, saying, "Father, if you are willing, please take this cup of suffering away from me. Yet I want your will to be done, not mine (Luke 22:42, NIV)." For some patients, meaning is made out of suffering, and God is accomplishing something far greater, using the deep wounds and crushing blows to the body, mind, and spirit.

I'm also reminded of the words of Dr. Martin Luther King: "Darkness cannot drive out darkness; only light can do that. Hate cannot drive out hate; only love can do that." Suffering is a kind of darkness that makes it difficult to find meaning, leaving a destructive path in its wake. But amidst the wreckage, love is waiting to be found. It's the most defiant and liberating thing you can do when you come face to face with suffering. Fearlessly look it straight in the eyes and say, "I choose love." The words may be difficult to muster, but opportunities for closer connection and meaning-making hide in plain sight amidst our brokenness.

Patients may view their illness as a way to deepen their relationship with God, drawing new strength from their faith as their body weakens. Appreciation may grow for friends and family who lift us up and step in to help when we feel completely overwhelmed and overtaken by fear. There are also opportunities to help fellow sufferers, using the insight we've gained to ease the pain of another. Sometimes, the most loving gift we can give someone is forgiveness. In these moments, we want the best for another person, expecting nothing in return. That's love, and whether suffering is viewed as meaningless or filled with purpose, it's worth considering what it can teach our hearts.

While accepting difficulties, change, or loss is challenging, it's a part of living and brings meaning to each moment. We become more aware of the preciousness of life and the people in

it. The purpose we find in being alive also provides a powerful reason to make our home in the present, and meaning becomes a beautiful canvas we can hang on our walls, reminding us of why we want to experience every moment of our lives to the fullest.

The “Make Meaning” phase of the Be Still Method encourages patients to focus on one source of meaning, whether from the past or in the present, to help alleviate distress and navigate health challenges. Examples are provided to guide the patient in discovering meaningful practices that nurture the well-being of the mind, body, and spirit. Patients are encouraged to foster closer connections, whether in person, over the phone, or through their memory and imagination. Those experiencing loneliness can connect with God through prayer or reflect on the love, care, and meaningful interactions they’ve shared with others, supporting psychospiritual coping.

Even within the confines of a hospital room, patients can use their bodies to participate in activities that foster creativity, movement, and self-care—things many of us take for granted. For those experiencing mobility issues, there’s the option to virtually engage in activities, whether it’s watching Julia Child make Beef Bourguignon or observing a prima ballerina pirouette across the stage. Patients are also encouraged to use their memories and imagination to recall special moments or create new ones vividly. Reflecting on personal growth and accomplishments is another source of inspiration, and exploring gratitude helps cultivate a positive mindset amid health challenges. For spiritual well-being, engaging in practices that evoke joy and peace, such as reading sacred texts or immersing oneself in faith-based messages, are other ways to make meaning. By finding purpose in their suffering and connecting with their spiritual beliefs, patients can also discover newfound strength to cope with serious illnesses, knowing that they are not alone or forgotten.

Appendix B

Be Still Method Overview

Purpose of the BSM: *The Be Still Method is a relaxation exercise that promotes physical, psychological, and spiritual well-being. Additionally, it provides an opportunity to focus on something purposeful or find new sources of meaning, helping patients cope with challenges.*

Getting Started:

1) Spend time familiarizing yourself with the BSM by practicing the method.
2) Acknowledge the importance of connection and making meaning amidst distress.
3) Recall a patient who has brought meaning to your life. How can this experience be used to support patients being introduced to the BSM?

Finding a Why:

1) Establish an initial connection with the patient by doing a quick check-in.
2) Listen to uncover potential unmet psychological, spiritual, or physical needs.
3) Offer compassion by acknowledging that the patient is experiencing a difficult time.
4) Get buy-in by asking the patient if they would like to ease their stress or distress.
5) Explain the purpose of the BSM using neutral language.

Be Still: *Relax by quieting the mind and focusing on the present moment.*

1) Explain the meaning of "Be Still."
2) Recognize the challenge of calming the mind amid the busyness of life.
3) Address any resistance to practicing being still.
   - Discuss the impact of chronic stress on health outcomes.
   - Explain the impact of heightened stress on reactivity and decision-making.
4) Ask the patient, "What can you focus on right now that isn't causing pain, stress, or distress?"
   - Emphasize that prolonged focus on the source of pain or distress can intensify it.
   - Clarify that the goal is not to suppress or avoid anything unpleasant.
5) Guide the patient into focusing on the present using three steps: pause, relax, and now.
   - Pause: Remove distractions and find a comfortable position (with eyes open or closed).
   - Relax: Offer the patient the choice to take a few deep belly breaths and/or to notice and release any tension in the body (only if neutral or comfortable).
   - Now: Explain to the patient that being still in the present involves using an anchor—a single focus of attention that grounds us in the here and now.
6) Assist the patient in choosing an anchor to stay grounded in the present moment.
   - Help the patient choose an anchor that's neutral or comfortable (see options below).
   - Encourage pausing or stopping if overwhelm occurs.
7) Explain what mind-wandering is and how to address it.
   - When your mind wanders, you shift away from your anchor and the present moment.

- Simply notice it, know it happens to everyone, and gently return your focus to your anchor and the present.

BSM Anchors:

Breath:

- Regular or deep breathing.
- Carry the words "be" while breathing in and "still" while breathing out.

Still Object:

- Notice your body against a bed or chair.
- Focus on an object inside or outside.

Meaning: Focus on a source of joy or spiritual meaning.

***Moments of Joy*:**

- Appreciating nature or beauty.
- Enjoying one of the five senses **(**sight, sound, touch, taste, or smell).

***Spirituality*:**

- Any source with spiritual meaning to you.
- Sacred word, phrase, text, prayer, object, or image.
- Presence of God (of your understanding).

Set Free: *Release whatever arises in the present moment without clinging or pushing it away. Whether a feeling, thought, or sensation is pleasant or unpleasant, let it go to free the body, mind, and spirit, easing stress and distress.*

1) Explain the meaning of "Set Free."
2) Emphasize that clinging or pushing away whatever arises leads to stress and distress.
3) Encourage the patient to seek a temporary respite from challenges, revisiting them later to engage with them more effectively.
4) Help patients identify sources of physical, psychological, or spiritual distress.
   - What may be difficult to release?
   - Provide examples to help the patient identify sources of distress (see below).
5) Provide tools for being with and releasing sources of distress.
   - Use "this is" statements to create space to be with and let go of difficult thoughts, emotions, and sensations (e.g., this is pain, fear, or unforgiveness).
   - Distinguish between thoughts and emotions by placing a hand on the head and the heart, focusing on the body's sensations, and letting them go.
   - Notice sources of distress on the in-breath, release any resistance on the out-breath and relax the body.
   - Expand focus on the body beyond the source of physical pain.
   - Surrender everything into the care of God (of your understanding).

Sources of Distress:

Body: pain, fatigue, nausea, immobility, thirst, hunger, temperature, and difficulties breathing.

Mind: difficult or repetitive thoughts, cravings, worry, panic, confusion, anger, sadness, fear, guilt, shame, and self-hatred.

Spirit: hopelessness, uncertainty, distrust, disillusionment, anger, guilt, fear, unforgiveness, hatred, judgment, and abandonment related to personal or spiritual beliefs.

Make Meaning: *Find or remember sources of meaning and purpose to better cope with challenging circumstances and distress.*

1) Explain the purpose of "Make Meaning."
2) Pose the question, "What brings meaning to your life, no matter the circumstance?
3) Ask the patient to focus on one source of meaning in the present or remembered.
4) Normalize any difficulties identifying a source of meaning or purpose.
5) Provide examples of meaning-making that support physical, psychological, and spiritual wellbeing (see below).

Meaningful Practices:

Body:

- Engage in physical activities encouraging creativity, movement, and personal care (e.g., knitting, stretching, or painting nails).
- Remember or virtually engage in physical activities (e.g., cooking shows, virtual nature walks, or sports).

Mind:

- Imagine yourself doing something you love to do and savor every moment.
- Remember a specific moment in detail when you were naturally present.
- Recall accomplishments, personal growth, and challenges you've overcome.
- Reflect on what you are grateful for and genuinely value in life.

Personal Connection:

- Remember the love, care, and service you have given or received.
- Offer kindness and support to yourself as you would a close friend.
- Spend time with loved ones in person, over the phone, or through your memories/imagination.

Spirit:

- Spend time engaging in any spiritual practice that brings you joy or peace.
- Read sacred texts, listen to sacred music, or watch faith-based messages.
- Find purpose in suffering based on your beliefs.

Spiritual Connection:

- Find joy or peace in God through prayer, praise, thanksgiving, and worship.
- Focus on the love and care you have given to or received from God.
- Remember how God has provided for you and trust God's plan.