Mindfulness in Hospice Care: Practicing Meditation-in-Action

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In this interpretive study, the authors explore the experience of mindfulness among hospice caregivers who regularly practice mindfulness meditation at a Zen hospice. They explore meditative awareness constituted within themes of meditation-in-action, abiding in liminal spaces, seeing differently, and resting in groundlessness. By opening into nonconceptual, paradoxical, and uncertain dimensions of experience, hospice caregivers cultivate internal and external environments in which direct experience is increasingly held without judgment. This inquiry points to in-between spaces of human experience wherein mindfulness fosters openness and supports letting go, and creating spaces for whatever is happening in attending the living-and-dying process.

Keywords: *mindfulness; meditation; Buddhism; end-of-life; palliative care; presence*

Mindfulness meditation is currently being adopted by health practitioners, including nurses, in a variety of settings. Increasingly, empirical evidence shows positive health outcomes of mindfulness-based clinical interventions in response to a range of conditions, including depression, anxiety, chronic pain, and stress-related symptoms. Although a review of medical and social science literature shows promising results concerning the effectiveness of mindfulness-based clinical interventions (see Baer, 2003; Bishop, 2002), there is little research that examines the lived experience of mindfulness and its meaning for those who practice it. The purpose of this study is to explore the experience of those who regularly practice mindfulness meditation and who are either living with their own dying or caring for persons at the end of life. Although we examine experiences of both caregivers and those diagnosed with life-limiting illness (Bruce, 2002), the findings reported here focus on hospice caregivers who engaged in mindful end-of-life care.

MINDFULNESS

Although meditation in some form is practiced in most cultures, Buddhist traditions of mindfulness meditation are the primary source of mind-body approaches

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currently incorporated into biomedical health care. The interest in Buddhist forms of meditation might stem, in part, from its nontheistic nature, which is seemingly compatible with the secular perspectives of science. Both science and Buddhism examine human experience through observation, analysis, and empirical experience. Unlike theistic traditions such as Christianity, Islam, or Judaism, which are rooted in faith and particular belief systems, Buddhism does not posit an Ultimate Being or divine source. Consequently, according to Bash's (2004) categorization of theistic and nontheistic traditions, Buddhism would fall within a category of nontheistic traditions, wherein the emphasis is direct experience in the here-and-now rather than particular beliefs. Some scholars have also argued that without a sense of creator or divine source, Buddhism is more accurately understood as psychology or philosophy rather than religion. As such, perhaps the prominence of mind-body experience rather than metaphysical beliefs allows Buddhist meditation practices to be incorporated both as spiritual and as secular practice into biomedical health care.

In a similar vein, Salzberg and Kabat-Zinn (1997) have suggested that mindfulness meditation is devoid of religious context and can be practiced by people holding diverse religious or spiritual beliefs. According to these authors, mindfulness is simply learning to pay attention with an open and accepting attitude to whatever arises in the mind while watching the movement of the mind. In the study findings reported here, mindfulness is understood as

> a state in which one is highly aware and focused on the reality of the present moment, accepting and acknowledging it, without getting caught up in thoughts that are about the situation or in emotional reactions to the situation. (Bishop, 2002, p. 71)

Although there is overlap, mindfulness meditation as a therapeutic intervention is distinguished from mindfulness as a spiritual practice in this study. The hospice staff and volunteers participating in the inquiry engaged in mindfulness as a spiritual practice, and their intentions, therefore, differed from those who practice meditation with the aim of health improvement. Used as a health intervention, there is an undercurrent of self-fulfillment or hope of achieving a particular outcome, whether that is reduced stress, decreased anxiety, or relief from some form of suffering. In a health context, meditation is used to achieve a goal or buffer oneself from discomfort. In contrast, the participants in this study practiced working with awareness not to remove suffering but to open more fully into their own experience, which includes suffering. As Buddhist spiritual practice, realization of impermanence, suffering, and dying were the starting places in learning to accept and acknowledge without getting caught up in thoughts or emotional reactions to situations (Sogyal, 1993).

MINDFULNESS MEDITATION AND HOSPICE CARE

As a spiritual practice, mindfulness has its roots in Theravada Buddhism, where it is known as *sattipatana vipassana* (Gunaratana, 2002). Three major traditions of Buddhism are often identified: Theravada (practiced in Sri Lanka, Thailand, Burma), Mahayana (Japanese Zen, Chinese Chan, and Indo-Tibetan), and Vajrayana

(Tibetan Buddhism). Study participants came from all three traditions. Although these traditions differ somewhat in their doctrines, they share the basic tenets and practices of mindfulness. Mindfulness meditation is neither mystical nor complex and in its simplest expression is the practice of paying attention, without judgment, to mind-body process as it arises and passes moment to moment (Sogyal, 1993). Study participants used some version of mindfulness practice regularly.

Instructions for mindfulness meditation include sitting in a comfortable upright position in a chair or cross-legged on a cushion. Using breath as an object of awareness, the practice is simply to place one's awareness on the experience of breathing and notice as thoughts, emotions, and sensations arise and pass away. When one becomes aware of being lost in the content of mind—thoughts, emotions, and internal mental chatter—then attention is gently returned to the object of attention (breath) until awareness is stabilized.

Through practicing paying close attention to experience, meditators are said to gain insight into the nature of impermanence as everything moves and changes (Gunaratana, 2002). In particular, Sogyal (1993) has suggested that through repeated observations of the arising and passing of our identity, one begins to experience its impermanence: Birth and death are evoked at a very deep level. From a Buddhist perspective, meditators can use their lives to prepare for death and assist others in this process. Sharpe (cited in Coberly, 1997) has suggested that caring for those who are dying is like looking into a living mirror in which our emotional experiences of fear, guilt, anger, and attachment rise to the surface.

> When we are called upon to help other people, we will be more trusted if we are not just passing on advice but can speak from our own experience. But since everyone is different, no two people will have exactly the same experience. So the point is . . . not to come up with the correct understanding of death but to have the courage to look at how we deal with it personally. (Lief, 2001, p. 67)

LITERATURE REVIEW

Academic, professional, and lay literature that integrates Buddhist ideas and practices into end-of-life care is increasingly available (Collett, 1999; Kapleau, 1998; Lief, 2001; Nairn, 2004). Although McGrath (1998) has explored the connections between discourses of Buddhist philosophy and its parallels in hospice ideology at a community-based Buddhist hospice organization, in-depth explorations of Buddhist philosophy vis-à-vis hospice care are just beginning. McGrath examined the practical notions of compassion and wisdom, service, tolerance, acceptance of death, and a duty to do no harm found in the everyday of Buddhist philosophy and their compatibility within the philosophy of hospice care.

In addition to Buddhist perspectives in end-of-life care, scientific investigation of meditation has been prolific in the past decade. Most research has conceptualized meditation as a self-care practice suggesting positive health outcomes across a variety of illnesses, including anxiety, depression, chronic pain, psoriasis, and fibromyalgia (Baer, 2003; Bonadonna, 2003; Carlson, Ursuliak, Goodey, Angen, & Speca, 2001; Kaplan, Goldenberg, & Galvin-Nadeau, 1993; Relman, Kabat-Zinn, Hosmer, & Riley, 2001; Teasdale, Pope, Moore, Hayhurst, & Williams, 2002). The benefits of being present and the role of mindfulness therein have also been explored as clinical

interventions with cancer patients (Brennan & Stevens, 1998; Brown & Ryan, 2003). The degree of scientific scrutiny underway into mindfulness is also indicated by recent psychometric developments for measuring mindful awareness (Brown & Ryan, 2003). Although a few studies address the contemplative components of meditation and its role in fostering spiritual growth and understanding (Astin, 1997; Tart & Deikman, 1991), the spiritual aspect of mindfulness remains underexplored.

In the domain of meditation and health care providers, a growing body of research includes studies of mindful practice with medical clinicians (Epstein, 1998, 1999) medical students (Shapiro, Schwartz, & Bonner, 1998), nursing students (Bruce, Young, Turner, Van der Wal, & Linden, 2002), and nurse practitioners (Hayes & Alexander, 2000). In a survey of 202 Connecticut nurse practitioners, Hayes and Alexander reported that meditation is the second most highly recommended alternative therapy by nurse practitioners.

However, empirical investigation into mindfulness meditation is dominated almost exclusively by quantitative research designs using Western theoretical frameworks. Little research addresses the lived experience of mindfulness as a spiritual practice or mindfulness in end-of-life care using Buddhist interpretive perspectives.

METHOD

In the broadest sense, this inquiry is viewed as a form of narrative inquiry. However, what began as an empirical narrative analysis became more akin to a philosophical exploration or rhetorical project inspired by the data and ongoing experience of Buddhist ontology. The nature of language and the challenges of "thinking about" prereflective or nonconceptual experience became an integral aspect of the study; as one participant shared, "It [awareness] is hard to talk about with language that is so subject and object oriented." This aspect of the method will be explored in depth in a future article. Given that the participants and interviewing researcher (A.B.) were long-time practitioners of Buddhist meditation, with an average of 16 years of study and practice, the way of "speaking the world of experience" was permeated with terms and phrases that assumed a shared understanding and approach to articulating reality. For example, when participants spoke of "mind," there was a shared understanding that mind is not located in the brain or in cognition alone but includes a heart quality of feeling. Consequently, the conversations and language contain an emic perspective (Emerson, Fritz, & Shaw, 1995), wherein learned vocabulary and ways of labeling experience within a particular framework are apparent. Even so, the transcribed texts and generated data were understood not as carriers of fixed meaning that can be recounted but as sites of ongoing negotiation of meaning and possibility. Explicating and interpreting the textuality of the transcripts and field notes rendered an inextricable weaving of researchers' and participants' voices.

Generating Data

A unique hospice setting in which Western palliative care and Zen Buddhist philosophy are integrated was identified. Although historically, residents of the hospice

might not practice meditation or necessarily be interested in this domain, the foundation of care at the hospice is described as mindfulness practice. The site was ideal for several reasons. First, mindfulness meditation is an established practice, with the beginning and end of workdays marked by short meditation sessions. The opportunity to participate in day-to-day hospice activities afforded an understanding of how Buddhist perceptions of death, dying, and meditation were embodied in end-of-life care. Second, the hospice staff and volunteers practiced meditation as part of their everyday lives.

As a registered nurse and meditation practitioner, A.B. negotiated access to the hospice as a researcher and volunteer caregiver with relative ease. University ethical review was obtained, and authorization to proceed with the study was granted from the hospice administration. The fieldwork was conducted in a 5-month period in 2000 and 2001, with two overlapping phases. The first phase focused on immersion in the practice of mindfulness and developing relationships with hospice staff. Approximately 10 weeks of full-time residency at a monastery were completed by one researcher (A.B.) during this phase. The residency emphasized mindfulness practice and ensured that with the study "intellectual understanding of the meditative processes is dependant on an adequate base of personal experience" (Walsh, 1982, p. 82). A Guest Student program at the monastery provided an opportunity to establish meditation as an integral part of everyday life. Although one researcher (A.B.) had previous experience with Tibetan Buddhist practices, Zen was a new tradition. The daily monastic schedule was rigorous and included sitting meditation practice beginning at 5:25 a.m., study, and work. Study included attending semiweekly lectures, individual meetings with teachers, and participating in two courses, Zen and Psychotherapy and Contemporary American Koans, offered onsite. Volunteer work at hospice began during this phase with office and administrative duties.

The second phase included a 40-hour hospice volunteer training and approximately 250 hours of caregiving 3 to 4 days per week. Hospice volunteers worked in pairs with a salaried care attendant, along with a nurse and physician who visited weekly as needed. All basic care for hospice residents, including bathing, feeding, meal preparations, laundry, errands, and attending to needs and wishes, was accomplished by volunteers. A journal and field notes were kept throughout both phases.

Data were generated through reflexive participation (mindfully attending to experiences), field writings, and open-ended unstructured conversations with 9 participants. Field writing took the forms of free-association writing, stories, and poetry. Initially, A.B. carried a small notebook and pencil to take notes during hospice shifts, but this practice was soon abandoned. There was little time to write during shifts; memos were jotted in a local café afterward, with more extensive contemplations written later in the day. A.B. conducted in-depth unstructured conversations with 9 participants after 3 months, when the researcher and participants knew each other. Participants volunteered directly during informal discussions during hospice shifts, were identified through snowball sampling, or were approached by one researcher (A.B.). All participants provided informed consent and were reassured that involvement was voluntary. Open-ended conversations were conducted at the hospice or in participants' homes according to their wish; they were 1½ to 2 hours long and explored participants' experiences of mindfulness awareness and its

impact on providing hospice care. Conversations were audiotaped and transcribed verbatim.

Nine meditation practitioners participated: 4 volunteer caregivers, 3 staff caregivers, and 2 community members living with HIV/AIDS. Their average age was 49 years; they averaged 5 years of hospice experience. Participants (6 men and 3 women) averaged 16 years of meditation practice. They practiced within different traditions of Buddhism, including 5 Zen practitioners, 3 Tibetan Vajrayana practitioners, and 1 Theravadin practitioner.

Criteria for participation were (a) willingness and ability to talk about experiences of mindfulness and its relationship to caring for adults who were dying, and (b) a regular meditation practice for at least 6 months. Based on Kabat-Zinn's (1982, 1996) studies, regular practice was defined as formal or informal meditation, three or more times per week for 15 minutes or longer. Formal meditation involved mindfulness practice sitting in a chair or on a meditation cushion; informal meditation involved intentional application of mindfulness to any activity such as walking, washing residents, or listening.

The rationale for requesting 6 months of meditation practice was twofold. For most beginners, meditation is often approached as a skill that is applied in developing some degree of mental stability, whereby the mind is able to stay with an object of meditation for increasing lengths of time. After regular practice, the technique is surpassed, and one develops "an approach to reality through the technique, a kind of feeling in relation to the present moment" (Trungpa, 1969, p. 74). The assumption here was that 6 months of practice would provide a deeper experience and understanding of mindfulness. Although meditation is a highly individual path, and there is no projected timeline for progression, 6 months of regular practice provided a baseline. Second, current research on meditation often recruits participants with only a few months of experience (Astin, 1997). Therefore, this study offers an understanding of meditation from more established practitioners in this setting.

Data Analysis

Analysis was inspired by an iterative interpretive process rather than a direct application of any particular method. The following approaches were used: (a) We read each transcript and field-writing segment in its entirety to gain a sense of the whole; images, visuals, and feelings arising while reading were recorded in efforts to attend to nonconceptual interpretive processes; (b) regular meditation was an aspect of analysis to cultivate spaces of perceiving where what was said and unsaid could be appreciated; (c) themes were constituted with slow readings of the data; eventually, themes were collapsed into four main themes; and (d) procedures for ensuring trustworthiness were established and included mindful reflexivity, peer debriefing and review with five university faculty members, prolonged engagement with the data, and discussions with selected caregivers. Evaluating the "goodness" of these interpretive findings also included what Emden and Sandelowski (1999) have called a criterion of uncertainty, which assumes a constructivist position of openly acknowledging that claims about research findings are tentative at best and might be impossible to show otherwise. This contingent view is congruent both with the emic nature of this study and its interpretive framework.

TABLE 1: Themes

Meditation-in-action
Anchoring awareness in ordinary activities
An approach to being present
Relaxing into the immediacy of what is happening
Setting an intention and being aware of intention
Abiding in liminal spaces
Sense of separation dissolves
An in-between space
Appreciating opposing tensions
Sense of in/separability between caregivers and residents
Integral to empathy and compassion
Seeing differently
Perceptions shifting
Vivid sense of appreciation and beauty
Seeing what needs to be done
Leaning into stillness of activities
Cultivating openness without agendas
Resting with groundlessness
Recognizing we are change
Letting go of wishing things were otherwise and fearing what might be
Becoming intimate with fear
Practicing abiding in the midst of emotions
Practicing continuously opening to experience

THEMES

Four themes were generated: meditation-in-action,[1] abiding in liminal spaces, seeing differently, and resting with groundlessness. These themes constitute an interpretation of the experience of repeatedly bringing one's awareness partially or fully to the moment in end-of-life care (Table 1).

Hospice Care as Meditation-in-Action

Inquiry participants considered caregiving a significant aspect of their meditation practice. Mindfulness was described as "an ordinary process of focusing my mind and letting go of thoughts," "training myself to bring awareness without judgment to whatever arises," and "practicing being in the moment." Participants described how, over time, they could more easily bring their attention back to the moment. One participant took opportunities for paying attention by anchoring his awareness on ordinary activities such as the sensations of giving a massage, bathing a resident, or the experience of walking.

Practicing mindfulness was a way of being present. Attending to what one was doing and why, seeing the shifting and incessant nature of being present were aspects of meditation-in-action. Mindfulness was experienced as not holding onto the past, the future, or "nowness" but relaxing into the immediacy of whatever was happening. As a way of training the mind, mindfulness was applied to paying attention to the everyday activities of service: cooking for, washing, feeding, sitting with, and listening to residents.

Bringing awareness to whatever was happening included setting an intention to be mindfully open and present. The emphasis was not on what caregivers did but on how they did it. As one participant stated, the practice is not only examining one's mind but also cultivating motivation to benefit others:

> How I work with my mind in relation to my work definitely has a path quality. I set my motivation in the morning and my intention is very strong. . . . I mean, I'm a neurotic person like everybody else, I have aggression and ignorance and all that stuff. But when I go to work may whatever I do, first of all, may it not be harmful and then may it somehow serve the people around me. And . . . I think that's the most important part.

Therefore, both setting an intention and being aware of one's intention were paramount.

Abiding in Liminal Spaces

The practice of mindfulness also included an intention of opening into spaces where a sense of separation dissolved; dualities of self-other, of work life–spiritual life faded, and solid binaries of living and dying vanished. Such spaces of dissolution are conceptualized as liminal spaces:

> In the best of all worlds that is what it [experience in hospice] is . . . it's an in-between space . . . there is a time when people are moving into their dying . . . helping people actively explore this phase . . . which is their dying . . . and it is a different phase. And there is a need to know and to experience this phase of life . . . and if we pretend that it isn't happening or that it's just like every other phase, then I think we are really coming up short. So it is an in-between phase . . . a liminal space.

Liminality points to an in-between space both beyond and within dualities, that is, a space in the hyphen within living-dying or presence-absence. In this space, opposites meet in-between, where one is both living yet dying, or present yet absent. Liminality in this context provides spaces where self-and-other are in/separable, and binaries exist yet dissolve at the same time. An appreciation that opposing tensions of living while dying or being joyful while saddened can be held simultaneously without contradiction.

Synchronizing mind and body through mindfulness provided insights into the in/separability between caregivers and residents and the in-between spaces of living-dying. Some participants experienced liminal spaces of self-other as integral to empathy and compassion. One participant shared how her realization that we are not separate from but interdependent with others resulted in a natural tenderness toward others. She reasoned that because harshness to others means being harsh toward oneself, then aggression tended to wane. This attitude was thought to evolve naturally through practicing mindfulness and was supported in experiences with caregivers at the hospice who embodied relaxed kindness. Of note, this kindness was not sweet but had an edge of directness based in the sort of logic that because we are interdependent, working for the benefit of others also benefits oneself. In this way, meditation practice served caregiving, whereas caregiving served meditation in a doubling or mutuality:

> We go to the bedside . . . in an interesting way . . . to be supported. I go with generosity and kindness—but there is mutuality. Our lives are interconnected . . . your suffering is my suffering . . . you're dying and I'm going to die. I don't assume that I am independent from the person in the bed. Or in a peculiar way, I don't assume that I am better off.

The capacity to realize fully a view of interdependence was seen as an ongoing challenge. Without seeing an in/separabiltiy of all beings or an intention to work for the benefit of others, one risked becoming self-focused and self-absorbed—the antithesis of mindfulness meditation practice. One participant described this self-absorption as "getting stuck at the personal-growth level." The possibility of co-opting meditation or spiritual practices primarily for personal benefit was an obstacle participants acknowledged and has been conceptualized by Buddhist scholar Trungpa (1973) as spiritual materialism.

Seeing Differently

When mind-and-body were synchronized, participants observed how their perception shifted, and they saw things differently.

> You start to appreciate beauty in places you never saw it before. A flower can be just amazing . . . and you see things differently.

Participants noticed things that they had not seen before, or simply saw the familiar as if for the first time. As perceptions changed, a sense of vivid appreciation and beauty arose.

One participant described this as "noticing the beauty of life." He also equated the elegance of a Japanese rock garden and meditation hall (*Zendo*) with a particular kind of spacious aesthetic where letting go can happen. Creating a physical and mental environment that supported "noticing" and "letting go" seemed integral to mindful care. Simplicity and attention to details created opportunities to "see" and "feel" the flower-ness of a flower in space or the easing inward and fading of a resident who was dying. Preparing elegant, simple meals; having bright, clean rooms, fresh flowers, and incense; paying attention to the vital, immaterial space; and catering to the wishes and whims of residents as much as it was possible contributed to an expansive environment that could accommodate suffering and peace.

Meditation appeared to cultivate the ability to both see what needed to get done and do what was called for in supporting residents.

> Mindfulness makes me alert to what is happening . . . I see things that I didn't see before; I begin to notice. For example, when there is a lot of chaos in the room . . . or, if the commode is sitting in the middle of the room in the eye-line of the person lying in bed—is that what she is seeing all day? Maybe it's a convenient location for the caregiver but maybe it's a terrible location for the person in the bed.

As residents began to deteriorate and withdraw, there were fewer needs, whereas "doing" became more invisible as the lines between doing-nondoing began to blur. Learning how not to fill the gaps with busyness while leaning into the stillness of whatever activity they were doing became a meditative aspect of doing.

> Sometimes when I give someone a massage, I can be completely there. And there is nothing else going on except that massage and that person. I'm serving that person and I'm completely there . . . and I think that gets across to the person.

Cultivating Un/knowing

Another aspect of seeing differently was recognizing predetermined expectations about people or situations. Cultivating an open attitude seemed to soften hard opinions about how things are or are expected to be. When caregivers were open—without fixed judgments and expectations—they experienced kindness and availability with residents and one another:

> Sometimes not knowing is the most intimate. There is something about trusting *that* . . . and recognizing that it is pretty demanding.

Living from that place was said to communicate to people on various levels, even though such communication was usually not verbal. This capacity to engage and to be engaged without an agenda was described as "presence." Being without a predetermined agenda is conceptualized as the un/knowing caregivers attributed to their capacity to connect authentically with others. For example, one participant shared her response to entering a situation of uncertainty:

> And if I feel intimately connected I can just sit there all choked up . . . and maybe start to cry . . . and hold your hand . . . and both of us just sit there and cry . . . and neither of us has a clue about what to do. And I think that's very powerful . . . and I think that can be very helpful too.

The paradox of engaging in situations without a script was seen as acting wholeheartedly based not on convictions of certainty but in trusting in the moment, trusting their direct experience. Being fully present and trusting the authenticity of their intention and skills allowed new possibilities for responding to residents' needs.

Resting in Groundlessness

Through the formal meditation practice of placing attention on the experience of breathing, a sense of unceasing movement with shifting thoughts and feelings arises:

> By turning the lens of mindfulness on ourselves we start to see the truth of change . . . we all understand that everything is changing, you know, we can intellectually grasp this . . . however when we turn the lens of mindfulness on ourselves we begin to understand that we are change . . . then I can't hold so tightly to this notion of solidity… then my whole relationship to death changes . . . it dramatically shifts . . . and death becomes less of a tragedy.

Such realization emerged slowly, however, and brought fear with it. Participants described how fear manifested itself on many levels, including subtle ways of closing down or turning away from situations and residents:

> Two weeks ago Jean mentioned something about her death which shocked me completely because I'd never heard that word come out of her mouth before . . . especially in relation to herself. I just left it—just let her say what she said. I didn't reply or take it as an invitation to have a conversation about her death, though it may have been—but I wasn't ready for it . . . she may have been but I wasn't . . . so I just let it go. And then today, she said, "I don't think I'm going to be here much longer" and I said, "Oh, you notice a big difference?" She said, "Yeah," and then, "Can I count on you being here?" . . . I said, "I'll be here with you, for you . . . even if it's not my [work] day." And it was like a big piece of armour just fell . . . just crashed to the floor.

Other aspects of this realization included holding onto hopes, often subconsciously, that residents would get better and carrying this attitude into the room. Some caregivers felt that hope was linked with fear and created a veil between them and residents. To be without hope, in this sense, was to let go of wishing things were otherwise and fearing what might be; entering a space mindful of hope-fear allowed caregivers to open more fully to whatever was happening at this moment. Participants wondered if caregivers are really able to stay engaged in groundlessness if they are wishing the situation were otherwise. Can caregivers be open to and witness the suffering of another when there is fear, struggle, and resistance within? They saw the "work" of meditation-caregiving as subtly exploring these questions to recognize resistance, separation, fear, and practice abiding t/here with another:

> I was thinking of Aretha[2] this morning; she was kind of scared. And I really think creating an atmosphere where we are not scared when she is scared [is important] where we are just there with her. And we don't necessarily do anything with the fear. We don't say, "no, no, no" but we don't say, "YES, you're dying, oh how horrible" but we just kind of embrace that—then, it's much easier for people, you know? And I think that in itself, to be mindful that somebody is afraid and not to reject it, not to sugar it over with something but also not to be freaked out. But to really be with that feeling and to embrace it and to feel from our heart . . . Then, it seems the person can usually . . . can relax.

Through mindfully being present, participants created atmospheres where they were able to just rest in the situation with a resident who was fearful, not doing anything with the/ir fear. The practice was in being able to rest, opening to the experience and noticing when one turned away and the resultant impact of turning away on others in the situation. The therapeutic use of mindfulness was in becoming intimate with fear through direct experience that could provide meeting places for others who were afraid. The emphasis was not on perfecting fearlessness but, rather, on practicing to open to one's experience continuously and be willing to shift, and be changed in the process. Ordinary actions like resistance to walking into a new resident's room were considered a practice of staying present in a space of mutual vulnerability; staying open in the face of not knowing what to do or of turning away.

DISCUSSION

The capacity to bring one's awareness fully to patients and families is a vital ability that has not been studied extensively in nursing literature. Although presence is an

important aspect of caregiving that is increasingly recognized in nursing texts (Gardner, 1992; Gilje, 1992; Osterman & Schwartz-Barcott, 1996), in this study, we explore awareness configured through a lens of mindfulness that both resonates and disrupts current notions of presence in nursing.

Paterson and Zderad (1976) catalyzed interest in the importance of presence and "existential awareness of self and of the other" (p. 3) in nursing care. They saw nursing as a living dialogue that involves "doing with" and "being with" the patient. Paterson and Zderad introduced a mutual and transactional aspect of human existence wherein transaction inferred an "aware knowing" (p. 122) of one's effect in situations between persons. Although "self" was described as relationally constituted, they maintained, as do many Western theorists, an emphasis on individuality rather than relationality. Even so, Paterson and Zderad also pointed to a liminal space and doubling of sorts:

> Existential experience . . . calls for a recognition of each man as existing singularly in-his-situation and struggling and striving with his fellows for survival and becoming, for confirmation of his existence and understanding of its meaning.
>
> So, "all-at-once," while each man is unique; paradoxically, he is also like his fellows. His very uniqueness is a characteristic of his commonality with all other men. (p. 4)

Despite its dated and gendered language, *Humanistic Nursing* (Paterson & Zderad, 1976) was a prescient theory that is coming of age. Paterson and Zderad proposed that nurses consciously and intentionally approach nursing as an existential experience, suggesting existentialism as an "awareness of self and otherness" (p. 4) that recognizes human capacity for sameness-and-difference simultaneously. Although awareness of oneself and others is accentuated, the authors do not explore the phenomenon of awareness per se or how it is cultivated.

This inquiry lends support to many of the perspectives in Paterson and Zderad's (1976) work, yet there is also dissonance. For example, in humanistic nursing, "presence" involves knowing patients phenomenologically and coexperiencing their worlds in the context of their health care (Minicucci, 1998). The findings of this inquiry differ from such perspectives in both degree and kind.

For example, in Minicucci's (1998) interpretation, the focus is on knowing and having a shared sense of experience. Moreover, nursing theories using holistic approaches see the nurse's role as learning about the meanings patients attach to certain experiences and how to facilitate, through dialogue, a re-construction of meaning as the patient's life circumstances change (Parse, 1987; Paterson & Zderad, 1976). Although creating meaning and finding ways to understand chaotic, groundless experiences are known to be beneficial, they also align with the dominance of epistemic knowledge and knowing in Western traditions. The privileging of knowing and meaning often ignores the role and importance of groundless unknowing—that is, resting directly in prereflective experience. Frank (2001) recognized the dominance of meaning, even in situations that are unable to be spoken. He described his fears of health care professionals who would seek to explain (away) his suffering rather than encounter directly its groundless incomprehensibility. Frank shared how some human suffering must simply be lived. Attempts to assuage such suffering become subtle acts of refusal: refusal to see and fully respect another's experience. Learning to recognize and rest mindfully in groundless

incomprehensibility necessitates a way of being that rests in between the sayable and the unsayable.

Similarly, mindfulness awareness moves beyond hegemony of knowing into spaces that equally acknowledge un/knowing, self/lessness, and no/thingness. This leads to liminal sites of self-other, or I-Thou, which include our inseparability while maintaining the ability to continue questioning. Although humanistic nursing points in these directions, this study lingers longer in these sites of in-between. This lingering, or difference in degree, is one significant way in which presence is constituted differently in experiences shaped by mindfulness.

Other resonances and disjunctures are found in the work of Benner (1984), who identified presence, or being with, as one of eight competencies held by expert nurses. Based on interviews with experienced, expert nurses, presence was considered therapeutic and healing for patients. Noteworthy, however, is how presence was seen to occur once patients were stabilized, and nurses' attention could expand from the narrower physiological domain to the whole person. In this way, presence was constructed as an intervention analogous to the therapeutic use of self (Fuller, 1991; Minicucci, 1998) that could be engaged when a patient was no longer critically unstable and physiological concerns no longer took precedence.

Benner (1984) did not emphasize a mutuality or interdependence between nurse and patients. Although not her intention, this omission minimizes the context of a relational space and can lead to an instrumentalist view of presence as embodied in one's self as a therapeutic tool to be applied in nurse-patient encounters. Moch and Schaefer (1998), for example, cautioned nurses to attend carefully to cues from patients to avoid "forcing a presence encounter" (p. 165). Such remarks infer presence as something that can be forced on another. In contrast, participants in this inquiry engaged presence not as something brought to a situation but, rather, as a letting go into [a] presence that is always t/here.

In contrast, a reification of presence is also noted in the typologies of Osterman and Schwartz-Barcott (1996) and Easter (2000), whereby mind and body are separated into body-to-body (physical presence), mind-to-mind (therapeutic presence), and body-mind-spirit (holistic presence). Easter's holistic presence resonates most with mindfulness in its integration of mind-body-spirit and reciprocity between nurse and patient. Easter also identified meditation as a technique for fostering holistic presence. Although holistic presence, as such, is not described extensively in the literature, Easter moved toward a more Eastern view in her notion of transpersonal space in nurse-patient encounters.

That said, findings from this inquiry caution against an instrumentalist view of mindfulness meditation. Without a context of mindfulness as both a method and not a method (Trungpa, 1981), meditation might be used for reifying rather than letting go. As mentioned earlier, according to the Buddhist view from which mindfulness stems, the practice of directing attention is intended not to avoid suffering but to open into it. In constructing mindfulness as a tool for self-help, health care professionals might unwittingly decontextualize the practice and circumvent many of its potential benefits. In addition, as a technique alone, self-awareness practices might foster self-absorption and be limiting to personal growth.

The co-option of spiritual practices primarily for personal benefit has been discussed by Trungpa (1973) and, more recently, by Taylor (2002), a philosopher. Taylor recounted that during the past 50 years, there has been a shift away from organized

religion toward spirituality and what he called expressive individualism; that is, individualism aimed at pursuing happiness through the consumption of goods and services, including spiritual practices. One might ask whether meditation is at risk of becoming another "tool" for relieving personal health concerns divorced from its roots as a practice requiring a larger view of interdependence of self and others.

Finally, although further research is needed, enhanced awareness of patterns of avoidance, discomfort, and fear might, paradoxically, provide avenues to engage existential fears of patients, families, and care providers. The practice of mindfulness by caregivers is embedded in awareness and existential curiosity through everyday hospice care. Where is living-dying happening? How does presence-absence arise? Who dies? Such curiosity is not idle intellectualism but cuts to the heart of the tension within living-dying and accompanying another in their dying. Such noticing is not merely cognitive questioning; it is paying attention to the conundrums of life that open the possibility for caregivers to know without ever knowing fully. Such openness might contribute further to environments where patients and families can venture into what previously might have been unspeakable. Entering ambiguous spaces through paying attention to what is happening within and beyond conceptual knowing potentially cultivates recognition and caregivers' capacities to rest within groundless experience. Engaging the mystery of dying and accompanying those during such experiences call nurses who are willing continuously to open and wander into the questions themselves.

Further research into nonconceptual, mindful experience and its relevance in different cultural understandings of death and dying and caregiving is needed. Also, the suggestion that regular meditation practice influences death anxiety among caregivers warrants further inquiry. Finally, establishing further empirical evidence of a relationship between quality of life and meditation practice for hospice caregivers and those living with chronic or terminal conditions would enhance these interpretations.

CONCLUSIONS

Creating environments that support patients' natural healing capacities has been a nursing function since Florence Nightingale (Macrae, 2001). Mindfulness meditation was practiced by hospice caregivers and fostered internal and external environments wherein ambiguous, nondual, and paradoxical human experiences were supported. Through opening into these dimensions with another, caregivers helped create environments in which uncertainty could be held. In many ways, this inquiry points to an appreciation of sites of tension as vital spaces of human connection and an indivisibility between self-other. Through sensitivity to in-between spaces of human experience, care providers can foster environments of spaciousness that support whatever is required in a person's dying process.

Mindfulness is only one way of cultivating embodied awareness. This study signifies the importance of attending to nonconceptual experiences located in alternative discourses, finding ways to disrupt privileged views of presence while recognizing other possibilities. Although Western nursing practices are returning to the relational aspects of spirituality in nursing care, this study points to ways of understanding awareness from nontheistic and non-Western locations.

NOTES

1. The term *meditation-in-action* was first used by Trungpa (1969). Although the themes identified in this study address meditation with the activity of daily routines, the notion presented by Trungpa is much broader and more inclusive.

2. All names are pseudonyms.

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