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The role of healthcare chaplaincy in restoring the spiritual dimension of clinical mindfulness: A conceptual framework

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Abstract

Background: Mindfulness-based interventions are embedded across mental health, primary care, oncology, pain management, and supportive care. Their clinical translation has produced therapeutic benefits but has also encouraged a predominantly technique-oriented model in which attention regulation and symptom reduction may become separated from questions of meaning, moral orientation, worldview, suffering, transcendence, and relationship. These dimensions are not universally religious, yet they often constitute the spiritual context through which patients interpret illness and contemplative practice.
Aim: This paper develops a conceptual framework for the chaplain's role in recovering the spiritual dimension of clinical mindfulness while preserving clinical evidence, patient autonomy, cultural humility, and professional boundaries.
Methods: A theory-informed conceptual synthesis was undertaken using recent literature published from 2019 onward concerning mindfulness-based interventions, meditation-related adverse effects, spirituality in healthcare, spiritual care, chaplaincy outcomes, interdisciplinary practice, and culturally responsive mindfulness. Concepts were integrated through iterative comparison of mindfulness mechanisms, spiritual-care functions, chaplain competencies, and clinical safety requirements.
Results: The proposed Chaplain-Integrated Spiritual Mindfulness (CISM) Framework contains seven interdependent constructs: spiritual receptivity, worldview congruence, meaning coherence, ethical congruence, relational-transcendent connection, spiritual struggle, and integrative safety. The chaplain contributes through spiritual assessment, interpretive dialogue, meaning reconstruction, tradition-sensitive translation, ethical discernment, compassionate presence, and interdisciplinary referral. A staged clinical pathway and seven testable propositions link chaplain involvement to engagement, spiritual well-being, coping, treatment congruence, and safety.
Conclusions: Chaplaincy can enrich clinical mindfulness without re-religionizing healthcare or replacing mindfulness clinicians. Its distinctive contribution is contextual: helping patients determine what mindfulness means within their own worldview, values, relationships, suffering, and sources of transcendence. The framework provides a basis for interdisciplinary implementation and empirical testing of spiritually responsive mindfulness care.
Keywords: mindfulness; chaplaincy; spiritual care; spirituality; contemplative practice; meaning; whole-person care; conceptual framework

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1. INTRODUCTION

Mindfulness-based interventions have been adopted from relatively niche contemplative programmes to become a part of the mainstream of clinical practice. Beneficial effects have been found in several psychological outcomes with varying effect sizes, comparative efficacy, methodological quality and clinical indications [1,2]. For instance, in anxiety disorders, mindfulness-based stress reduction has been shown to have clinically significant effects in randomized comparison with pharmacotherapy, so that mindfulness can be regarded as a therapeutic intervention and not only as a wellness movement [3].

Despite its clinical efficacy, however, there has been a conceptual tension from the success of mindfulness. In health, the usual mindfulness traits are: attention regulation, non-reactivity, and present-moment awareness, self-regulation, stress management and symptom reduction. This type of translation has a great practical value but can fail to consider meaning, purpose, responsibility, vulnerability, interconnectedness, hope, sacredness, or transcendence as lived by the patient. Increasingly, modern health care literature has come to see the spiritual aspects of life as encompassing precisely these issues, and more, rather than only institutional religion [4,5].

This tension is not meant to be resolved by anyone claiming that all patients have a spiritual component to their experience of mindfulness, that mindfulness is a purely spiritual aspect of a single faith and religion, or that spiritual framing always enhances treatment. Patient preference is the number one priority. However, person-centred approaches would focus on the need for different language, interpretation and goals for contemplative practices depending on individual cultural and spiritual orientation [6]. Recent studies also reveal that even when meditation is claimed to be secular, there are prevalent and variegated ideas regarding spirituality, religion, science, selfhood, and the goals of contemplative practice [7].

Another motivation to restore contextual depth is safety. In recent years, the modern science of mindfulness has gradually broken from the assumption that meditation is all wholesome. The importance of carefully defining adverse events, understanding the difference between uncomfortable events

and events of clinical importance, identifying the vulnerable individuals, and subsequent tracking has been called for [8-13]. These results do not invalidate the therapeutic benefits of mindfulness but call for a more nuanced approach, based on clinically-supervised methods and person-sensitive approaches.

Chaplains are uniquely positioned to address this issue, both because of their professional sphere of competence which involves meaning, existential and spiritual distress, worldview, values, relationships, hope, loss, transcendence and the impact of illness on a person's interpretive world. Modern models of spiritual-care define spiritual care as a relationship and a process rather than a ritual or denomination [14]. Systematic reviews of the inpatient chaplains also demonstrate that the chaplains are involved in clinically relevant outcomes, communication, coping, spiritual well-being, and interdisciplinary care [15].

The purpose of this article is then to state a concept for the recovery of the spiritual aspect of clinical mindfulness that does not compromise its evidence-based clinical form. The proposed Chaplain-Integrated Spiritual Mindfulness Framework does not state that psychologists, physicians or nurses, or certified mindfulness teachers, should be replaced. Rather, it suggests contexts, in which the chaplain is an interpretive and relational specialist who helps clinicians and patients integrate contemplative practice with meaning, worldview, ethics, spiritual resources, and spiritual struggle.

This paper makes four principal contributions. First, it conceptualizes “spiritual thinning” as a clinically relevant limitation of technique-centred mindfulness and identifies the dimensions of meaning, worldview, values, relationality, transcendence, and spiritual struggle that may become insufficiently addressed in secular clinical delivery. Second, it introduces the Chaplain-Integrated Spiritual Mindfulness (CISM) Framework, specifying seven constructs through which spiritual and existential dimensions can be integrated without compromising patient autonomy, pluralism, professional boundaries, or evidence-based mindfulness practice. Third, it translates these constructs into an interdisciplinary clinical pathway that clarifies the respective responsibilities of mindfulness clinicians, chaplains, and the wider healthcare team. Fourth, it generates testable propositions, implementation priorities, and measurable outcomes that move the relationship between chaplaincy and clinical mindfulness from conceptual discussion toward prospective empirical evaluation.

2. METHODS

2.1 Conceptual approach

This paper was not a systematic review or meta-analysis but, instead, adopted a theory-informed conceptual synthesis. The aim was to construct a framework, i.e., to find and combine other constructs from the literature relating to recent mindfulness, spirituality and chaplaincy research that could be incorporated into an explanatory model appropriate to empirical testing.

The literature search was bounded to publications from January 2019 through December 2025 and focused on five intersecting areas: clinical effectiveness and mechanisms of mindfulness-based interventions, harms and safety of mindfulness, spirituality and spiritual care in healthcare, chaplaincy, and culturally or spiritually responsive mindfulness. Targeted searches were conducted in PubMed/MEDLINE, Scopus, Web of Science Core Collection, and PsycINFO. The primary search strategy combined the concepts ("mindfulness" OR "mindfulness-based intervention*" OR "meditation") AND ("chaplain*" OR "spiritual care" OR "spirituality" OR "religio*" OR "existential" OR "worldview" OR "meaning"), with supplementary terms including "adverse effect*", "harm*", "safety", "culturally responsive", and "person-centred". Because the purpose was theory-informed conceptual synthesis rather than an exhaustive systematic review, records were screened for direct conceptual relevance to the framework, including evidence on mechanisms, clinical boundaries, chaplain functions, patient-centred integration, and safety.

Four steps in conceptual analysis were followed. Recurrent functions attributed to the contemporary mindfulness were correlated with the dimensions of spirituality that are recognized in healthcare. Second, elements that may have been lost in a mindfulness that is too often only used as a therapeutic tool were identified. Third, these gaps were contrasted with contemporary descriptions of competence for chaplains and of spiritual-care processes. Fourth, the relationship between the constructs is presented in a clinical pathway and set of empirically testable propositions.

2.2 Conceptual boundaries

There were three boundaries that formed the structure. Spiritual care is patient-led, there should be no religious or transcendent interpretation. Second, the chaplain is not a psychiatrist and does not alter evidence-based treatment or treatments beyond their abilities. Thirdly, spirituality is not taken for granted to be good in all its aspects. Distress may be caused by religious conflict, spiritual struggle, guilt, abandonment, coercive belief systems, or destabilizing contemplative experiences. These limits are similar to those found in modern practice where spiritual care, rather than religious care, is directed towards the individual and is an interdisciplinary process [5,14-16].

3. RESULTS: THE CHAPLAIN-INTEGRATED SPIRITUAL MINDFULNESS FRAMEWORK

3.1 The problem of spiritual thinning

Clinical mindfulness does not necessarily become problematic by being secular. Secular presentation can make it more accessible, less coercive and allow to be implemented in pluralistic healthcare systems. The concern is more limited-spiritual thinning when mindfulness is only seen as an attentional technology and the patient's bigger interpretive context is clinically invisible.

A patient can be taught to watch for signs of pain without immediately responding, and at the same time asking what being chronically sick entails for his/her identity, justice, hope, family obligations, or relationship to God. Another patient might be able to participate well with breath and not hold the language of "non-attachment" to be compatible with their cherished relationship and/or theological commitments. In practice, a third might experience a sense of grief, dissociation, guilt or existential fear. Sometimes these phenomena cannot be solved by simply fine-tuning attentional instructions as the difficulty is not just a technical one but an interpretive one as well.

The chaplain's role is consequently neither to "put religion back into mindfulness" nor to claim ownership of contemplative practice. It is to prevent the patient's spiritual or existential world from disappearing merely because mindfulness has entered a clinical setting.

3.2 Construct 1: Spiritual receptivity

Spiritual receptivity is the degree and willingness of a patient to integrate spiritual, existential, religious, or transcendent issues into mindfulness practice. It precedes intervention. There will be some patients who explicitly state they want “faith-congruent” meditation, while others prefer to have the meditation in philosophical or existential terms, and others who want none at all.

This variability is respected, which is a sign of respecting autonomy. If spiritual receptivity is a factor then it should be measured and not assumed by religion. The involvement of a chaplain is not just suggested when a patient identifies with a religion, but when the patient wants to know about meaning, worldview, existential issues, or spiritual resources.

3.3 Construct 2: Worldview congruence

Worldview congruence is the degree to which patients feel synchronized with the language of mindfulness and their personal understanding of self, suffering, agency, reality, and transcendence.

What can sound like a useful practice in the clinical context can fall flat if it is perceived as foreign to the experience. Patients might, for instance, comprehend mindful attention as a presence, a feeling, connectedness, human awareness, finitude, or psychological self-regulation. It is not the role of the chaplain to make these interpretations equal. Instead, it is to decide on the valid and viable interpretations for the patient. It is vital to mindful practices that are person-centred, including a cultural and spiritual sensitivity [6]. Thus, a positive correlation is hypothesized between high congruence and perceptions of increased trust and continued participation, while incongruence will lead to resistance even if the attentional exercise is not aversive.

3.4 Construct 3: Meaning coherence

Meaning coherence refers to the patient's ability to bring together the contemplative experience and a coherent story of illness, identity, values, relationships and future orientation.

Raising awareness of experience through mindfulness does not mean that you are offering an interpretation of experience. The patient may be very conscious of fear and yet cannot answer the question, "What is this illness doing to the life I believed I was living? The chaplain also adds a hermeneutic dimension: assisting the patients to integrate observations that come up during mindfulness into their bigger story. The function is reflective of modern perspectives of spiritual care as a journey of connection, interpretation, presence and concern for the existential [14].

3.5 Construct 4: Ethical congruence

Ethical congruence is about the congruence between the conscious awareness and the values on which the patient wishes to act.

There is a conceptual stopping place for clinical mindfulness, at awareness or at non-reactivity. In addition to the question of what does awareness mean, there is another question in the integrated mindfulness, which is, what kind of response should awareness provide? The response continues to be patient determined. Awareness might serve as a means to forgiveness for one, a way to establish a healthy boundary setting for another, a way to compassionately care for the other person, or to reconcile, to be courageous, to accept, etc. for another. The goal is NOT to give moral advice from the chaplain. Instead, a patient's own stated values and responsibilities are linked to the awareness of mind.

3.6 Construct 5: Relational-transcendent connection

In healthcare, spirituality is often manifested in relationships with self, family, community, nature, the sacred, God or an entity that is greater than the individual [4,5]. Relational-transcendent connection then is the degree to which mindfulness promotes, not constrains, these connections.

The domain of chaplaincy is particularly well suited to this domain, as often spiritual care is found in the domain of presence. Mindfulness can become a relationally supported practice when listening, being silent, ritual when called upon, compassionate witnessing and recognition of suffering are involved.

3.7 Construct 6: Spiritual struggle

Spiritual distress involves some type of faith or meaning distress, guilt, sacred values, perceived abandonment, loss of purpose, moral distress, or conflict with what the patient considers sacred.

Spirituality is excluded deliberately from the construct as a resource. Spirituality must not be romanticised. Patients can experience previously suppressed questions or conflicts during meditation, and they can experience difficult inner experiences in theological, existential or moral terms. A chaplain can tell the difference, for instance, between frustration at meditating and a crisis in which the sufferer feels that the experience of pain is the result of God's judgment or his own sin.

3.8 Construct 7: Integrative safety

Integrative Safety is continuous assessment of the psychological, spiritual, cultural and clinical appropriateness of mindfulness.

There have been several reported adverse experiences related to meditation in clinical and community settings [9-13]. The observed phenomena are: anxiety, affective disturbance, changes in the sense of self, intrusive experiences, and functional impairment, but prevalence and causal interpretation depend on definitions and study design. The correct implication is not that mindfulness is unsafe per se, but that monitoring should be directed beyond symptom scores towards the meaning that the patient gives to the experience that emerges.

3.9 The distinctive functions of the chaplain

The proposed framework outlines five roles. Assessment role is to identify spiritual resources, struggles, beliefs, meaning systems and preferences. Interpretive is the role that facilitates the translation of contemplative experiences to a language that is compatible to the patient's worldview. The integrative role relates values, relationships, purpose and illness narratives to present-moment awareness. The relational role may be a response to the compassionate presence needed to process difficult contemplative experiences interpersonally. Lastly, the liaison function links spiritual observations to the multidisciplinary team, if appropriate and clinically relevant. There are already examples of collaborative models in place that integrate chaplains into multidisciplinary care instead of at its edge [16]. There are also some randomized and quasi-experimental studies that are starting to assess structured spiritual-care interventions and chaplain involvement with outcomes at the patient- and family-level [17-19]. These functions differentiate the practice of chaplain-integrated mindfulness from a mindfulness clinician discussing spirituality. Education for spiritual care among healthcare professionals is beneficial [20] and spiritual assessment and intervention are specialist skills and competencies that could be referred for if concerns are considered complex [15,20,21].

3.10 A clinical pathway for Chaplain-Integrated Spiritual Mindfulness

The CISM pathway begins with clinical indication rather than spirituality. Mindfulness should first have a plausible therapeutic purpose. Spiritual assessment then determines whether contextual integration is wanted or necessary.

The pathway produces three broad routes. Patients who do not desire spiritual framing continue standard clinical mindfulness. Patients with supportive spiritual resources may receive worldview-congruent adaptation. Patients experiencing spiritual conflict require deeper assessment and potentially modified, paused, or alternative practice.

3.11 Proposed mechanisms

The framework anticipates that the presence of a chaplain is not enough to lead to improvement. The effects should manifest themselves via mediation of certain variables: increased worldview congruence (coherence); increased therapeutic trust; increased compassionate intentions; decreased spiritual conflict; increased integration of practice and daily values. There is a growing body of evidence looking at the impact of chaplaincy in patient-centred outcome studies and evidence for likely mechanisms [19,22]. Research on structured chaplaincy and spiritual-health interventions also indicates that spiritual care is

not so much a ritual to be reduced to as an experimental field of study [17,18,23-25].

4. Discussion

4.1 Recovering context rather than re-religionizing mindfulness

The main thesis of this scheme is intentionally limited as a call to "restore religion" to mindfulness. Clinical mindfulness is practiced with many populations, and it is accessible, and has been made secular, as a factor in its spread. The issue arises when the access to secularism becomes confused with a neutrality in existence.

Contemplative experiences will always be understood within the patient's preconceptions about mind, identity, suffering, morality, death, relationship, hope and transcendence. Recent evidence that meditators themselves have a variety of religious, spiritual, scientific and secular understandings also undermines the notion of clinical instruction being independent of worldview [7].

The chaplain can thus serve as a context specialist. This re-framing also preserves the boundaries of the disciplines. Psychologists and mindfulness teachers continue to work in their competence in therapeutic formulation and evidence-based technique; chaplains bring their competence of meaning, spiritual assessment, belief system, existential distress, ritual (as appropriate), relational presence, and spiritual resources. This is supported by research carried out by chaplains today which indicates that patients receive spiritual care through the dimensions of connection, comfort, meaning, relationship and being understood, and by the presence of chaplains within rather than apart from clinical teams in models that are interdisciplinary [15,16,19].

4.2 Why chaplaincy may matter clinically

The proposed model suggests that contextual recovery has the potential to impact clinical outcomes in four ways. Engagement can be improved by worldview congruence, first of all. Patients are more likely to do business with a practice that they can align with their highest values and convictions. Second, coherence promotes integration by allowing the contemplative experience to be kept psychologically connected to illness narratives. Third, focusing explicitly on spiritual struggle could increase safety, especially if meditation invites guilt, existential dread, loss of identity or religious tension. Fourth, chaplain involvement can help to provide whole-person care, particularly in times of serious illness when spiritual needs often overlap with issues of treatment, hope, family, and death [5].

The framework therefore generates a clear empirical question: does patient-selected chaplain integration into mindfulness programmes improve clinically meaningful outcomes compared with standard mindfulness care? The model does not presume benefit; instead, it specifies mechanisms and outcomes that can be tested prospectively. Outcome research has highlighted the importance of finding meaningful outcomes of chaplaincy and yet maintaining the integrity of spiritual care [22]. Recent controlled and quasi-experimental studies have also demonstrated that patient-centred outcomes can be measured for chaplain-delivered and multidisciplinary spiritual-care interventions, which can be operationalized [17,18,23-25].

4.3 Ethical safeguards

The framework relies upon protection from spiritual manipulation. The first is permission: Spiritual integration can only happen when it is wanted or when the patient chooses to investigate the spiritual issues. The second is pluralism, which is atheistic, agnostic, humanistic, religious, indigenous, philosophical and doubt-filled worldviews must be treated without hierarchy. The third is role clarity: chaplains should not diagnose psychiatric illness or take over the clinical treatment, and clinicians should be aware of when spiritual conflict is complex and requires specialist assessment.

The fourth protection is the non-instrumentalization. Spirituality cannot be employed simply as another technology to reduce symptoms. A patient's beliefs are valid and should be engaged—whether or not they make treatment more difficult. Competence is the fifth one. Spiritual-care training has measurable relevance for professional practice, but there needs to be a focus on communication, self-awareness, cultural humility, interdisciplinary referral, and boundaries in education [20,26,27].

4.4 Implications for Implementation

Implementation should begin in services where mindfulness and professional chaplaincy are already established, such as oncology, palliative care, behavioural health, chronic pain, rehabilitation, and serious-illness programmes. At the health-system level, leaders should establish governance before scale-up: define eligible clinical settings, preserve a fully secular pathway, specify consent and confidentiality expectations, set referral and escalation criteria, and confirm minimum competencies for chaplains and mindfulness clinicians. A small pilot within one or two services can test feasibility, role clarity, and workflow before wider adoption.

At the clinical-management level, managers should translate the CISM pathway into an operational protocol. Mindfulness intake can include brief spiritual-receptivity questions, with referral triggers for an explicit wish for spiritual integration, conflict between mindfulness instructions and worldview, spiritual or existential distress, moral injury, grief or loss of meaning during practice, requests for tradition-sensitive interpretation, or uncertainty about the significance of a meditation-related experience. The protocol should identify who leads the clinical intervention, when chaplain consultation is optional or indicated, how co-formulation is documented, and when practice should be adapted, paused, discontinued, or escalated for medical or psychiatric review.

At the interdisciplinary-team level, clinicians and chaplains should use shared language and brief case review to monitor worldview congruence, meaning, values, spiritual struggle, therapeutic benefit, and safety while maintaining professional boundaries. Evaluation should combine conventional clinical endpoints—such as anxiety, depression, pain interference, functional status, adherence, and treatment satisfaction—with engagement and retention, meaning and peace, spiritual distress, hope, values congruence, therapeutic alliance, referral or escalation events, and meditation-related adverse effects. Implementation success should not be defined as increasing spirituality; it should be defined as better patient-practice fit, informed choice, coordinated care, and safer whole-person mindfulness delivery.

4.5 Research Agenda

The CISM Framework is not just a philosophical proposition, but a research generator producing falsifiable research. Before embarking on a program of chaplain consultations, feasibility studies should establish if patients in mindfulness programs are willing to accept chaplain consultation and define meaningful need by referral requirements.

Future trials should compare the delivery of standard mindfulness with patient selected chaplain-integrated mindfulness. Some benefit may be due to change in congruence of the worldviews (coherence), or to change in the level of spiritual struggle: mediation analysis could test this. Religious/ Spiritual orientation, secular preference, diagnosis, culture, trauma exposure, prior meditation experience, and serious-illness status should be considered when conducting moderator analyses.

Safety research takes special importance. Previous mindfulness research has shown that there needs to be more clarity and systematic measurement of adverse effects [8-13]. Interdisciplinary review of spiritual assessment and to adjust or

discontinue contemplative practice could be tested in chaplain integrated programs to determine if there are spiritual aspects of distress not captured by symptom monitoring and if interdisciplinary review enhances decisions to adjust or discontinue contemplative practice.

4.6 Limitations

There are a number of restrictions to this framework. It is conceptual and so cannot determine causal benefit of chaplain involvement in mindfulness programs. There is also a lack of uniformity in the types of evidence bases: For example, evidence-based research in mindfulness is relatively well developed, while research on the outcomes of controlled chaplaincy is still relatively small and inconsistent in methodology [15,22].

Secondly the terms "spirituality", "mindfulness" and "chaplaincy" contain a great deal of variation between countries, with traditions, within the institutions and within the professional systems. This framework may not be easily applicable across a denominational or under-integrated clinical team environment. Thirdly, for certain patients, spiritual adaptation can actually lead to a decrease in their acceptability. The CISM model thus assumes that receptivity is a moderator in therapy, rather than an assumed therapeutic ingredient.

Lastly, the framework does not seek to adjudicate on historical or theological issues regarding the "authentic" meaning of "mindfulness. Its concern is clinical: Does the contemporary provision of mindfulness care sufficiently take account of the meaning system of the patient, and can chaplaincy offer a disciplined approach to this dimension?

5. CONCLUSION

Clinical mindfulness has achieved broad accessibility in part through secular delivery across religious and cultural contexts, and that accessibility should be preserved. However, secular delivery does not require the clinical encounter to become spiritually or existentially thin.

The Chaplain-Integrated Spiritual Mindfulness Framework proposes that chaplains can help recover dimensions often overlooked in technique-centred mindfulness - meaning, worldview, values, relationality, transcendence, spiritual struggle, and discernment - without re-religionizing mindfulness or replacing evidence-based clinical care. The role is to support patient-defined interpretation and integration within clear professional, ethical, and safety boundaries.

As a patient-centred, interdisciplinary, pluralistic, and empirically testable model, CISM provides a basis for implementation and prospective evaluation. Future research should determine for whom, under what conditions, and through which mechanisms chaplain integration improves engagement, spiritual well-being, coping, safety, and whole-person care.

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Consent for publication

Not applicable.

Availability of data and materials

No primary dataset was generated or analysed.

Competing interests

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Tables and Figures

Table 1. Dimensions potentially thinned in technique-centred mindfulness and corresponding chaplain functions

Dimension	Technique-centred reduction	Potential clinical consequence	Chaplain contribution
Telos or purpose	Mindfulness framed principally as stress or symptom reduction	Patient may lack a personally meaningful reason for practice	Clarifies what the practice serves in the patient's life
Worldview	Practice presented as metaphysically neutral	Hidden conflict with religious, humanistic, cultural, or philosophical beliefs	Explores worldview and develops congruent language
Meaning	Distress treated primarily as internal experience to observe	Existential questions may remain unresolved	Facilitates meaning-making and narrative integration
Ethics and values	Attention taught separately from moral orientation	Mindfulness may become detached from how the patient wishes to live	Connects awareness with values, responsibility, compassion, and action
Relationality	Emphasis placed on individual self-regulation	Illness may be experienced primarily through relationships and community	Restores interpersonal, communal, and caregiving dimensions
Transcendence or sacredness	Excluded to preserve secular accessibility	Spiritually oriented patients may perceive practice as incomplete	Permits patient-defined sacred or transcendent interpretation
Suffering	Discomfort conceptualized principally as an object of awareness	Moral injury, grief, spiritual struggle, or perceived abandonment may be missed	Discerns the existential/spiritual meaning of suffering
Safety and discernment	Persistence in practice presumed desirable	Destabilizing experiences may be overlooked	Supports meaning-sensitive monitoring and interdisciplinary referral

Table 2. Core constructs of the Chaplain-Integrated Spiritual Mindfulness Framework

Construct	Definition	Clinical question	Primary chaplain function	Boundary condition
Spiritual receptivity	Desire for spiritual/existential integration	Do you want these dimensions included?	Elicit preference without assumption	No spiritual framing if declined
Worldview congruence	Compatibility of practice with patient's beliefs	Does this practice make sense within how you understand life?	Translate and clarify	Do not alter clinical mechanisms deceptively
Meaning coherence	Integration of experience into life narrative	What does this experience mean to you?	Meaning-oriented dialogue	Avoid supplying predetermined meaning
Ethical congruence	Alignment with values and intended action	What does awareness invite you to do or become?	Values discernment	Avoid moral coercion
Relational-transcendent connection	Connection with others, community, nature, sacredness, or transcendence	What helps you feel connected beyond yourself?	Facilitate patient-defined connection	Transcendence is optional
Spiritual struggle	Conflict involving faith, purpose, guilt, sacred values, or existential meaning	Has practice intensified any spiritual conflict?	Assess, accompany, interpret, refer	Do not pathologize legitimate belief
Integrative safety	Multidimensional appropriateness of continued practice	Is this helping, overwhelming, or changing you in concerning ways?	Monitor meaning and spiritual effects	Clinical deterioration requires clinician involvement

Table 3. Proposed CISM clinical workflow and interdisciplinary responsibilities

Stage	Primary task	Mindfulness clinician/clinical team	Chaplain	Expected output
1. Clinical indication	Determine why mindfulness is being considered	Assess diagnosis, symptoms, treatment goals, contraindications	Consult if relevant	Clear clinical rationale
2. Spiritual screening	Identify preference or possible spiritual concern	Ask brief preference-based questions	Available for referral	Spiritual integration: desired, neutral, or declined
3. Spiritual assessment	Explore meaning, worldview, resources, struggle	Share clinically relevant context	Conduct deeper assessment	Spiritual formulation
4. Co-formulation	Determine how mindfulness should be framed	Protect intervention fidelity and safety	Advise culturally/spiritually congruent language	Shared plan
5. Practice delivery	Implement mindfulness	Lead evidence-based technique	Participate when meaning/spiritual support is relevant	Adapted but clinically coherent practice
6. Monitoring	Track benefit and harm	Monitor symptoms and functioning	Monitor spiritual response and interpretation	Continue, adapt, pause, or refer
7. Integration	Connect practice with daily life	Reinforce therapeutic skills	Explore values, purpose, relationships, hope	Broader life integration
8. Escalation/referral	Respond to significant deterioration or conflict	Manage psychiatric/medical risk	Address spiritual crisis within scope	Coordinated care

Note. CISM = Chaplain-Integrated Spiritual Mindfulness.

Table 4. Testable propositions generated by the CISM Framework

Proposition	Hypothesized mechanism	Predicted outcome	Suitable empirical design
P1	Worldview-congruent framing increases perceived relevance	Greater mindfulness engagement and retention	Pragmatic randomized trial
P2	Meaning-oriented chaplain dialogue integrates contemplative experiences into illness narratives	Greater meaning coherence and spiritual well-being	Longitudinal mediation study
P3	Values integration connects awareness to personally important action	Improved treatment congruence and coping	Mixed-methods cohort study
P4	Chaplain presence reduces unaddressed spiritual conflict	Lower spiritual distress and higher acceptability	Controlled comparative study
P5	Spiritual assessment identifies contraindicating or destabilizing interpretations earlier	Earlier adaptation or referral and fewer severe adverse consequences	Prospective safety registry
P6	Interdisciplinary co-formulation integrates psychological and spiritual knowledge	Higher patient-centredness and therapeutic alliance	Cluster-randomized implementation trial
P7	Benefits depend on patient receptivity rather than religious affiliation alone	Stronger effects among patients who desire spiritual integration	Moderator analysis

Note. CISM = Chaplain-Integrated Spiritual Mindfulness; P = proposition.

Table 5. Risks, safeguards, and professional boundaries in chaplain-integrated mindfulness

Risk	Example	Required safeguard
Spiritual coercion	Assuming a patient should interpret mindfulness religiously	Obtain explicit permission and preserve a fully secular option
Tradition mismatch	Using concepts incompatible with the patient's faith or worldview	Patient-led language and chaplain cultural humility

Risk	Example	Required safeguard
Scope confusion	Chaplain interpreting panic, psychosis, or dissociation solely as spiritual phenomena	Immediate interdisciplinary clinical assessment
Spiritual bypassing	Using acceptance language to avoid grief, injustice, anger, or relational problems	Differentiate acceptance of experience from passive acceptance of harmful circumstances
Technique distortion	Alteration makes the intervention unrecognizable or therapeutically incoherent	Co-design adaptations with the mindfulness clinician
Meditation-related harm	Practice intensifies distress or functional impairment	Monitor, reduce intensity, pause, discontinue, or refer
Confidentiality ambiguity	Spiritual disclosures automatically transmitted to team	Explain confidentiality and share only appropriately
Overgeneralization	Treating religious affiliation as evidence of spiritual need	Assess individual preference and meaning

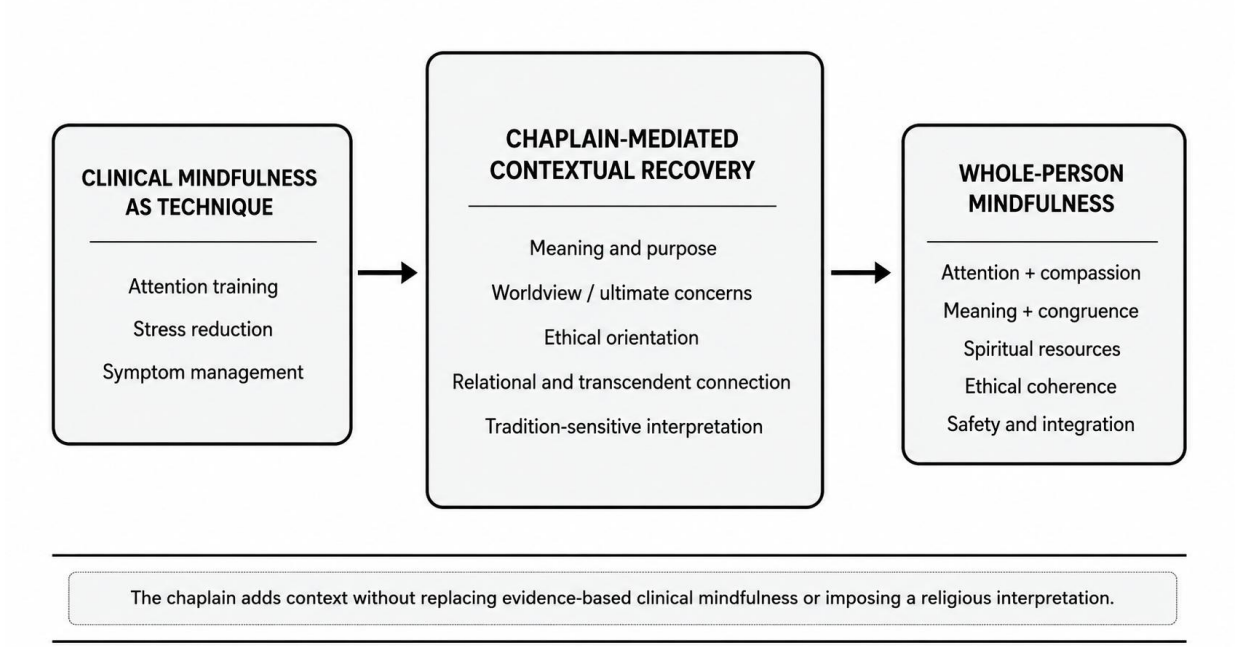

Figure 1. Recovering the spiritual dimension of clinical mindfulness.

Note. The chaplain provides contextual recovery through meaning, worldview, ethical orientation, relational and transcendent connection, and tradition-sensitive interpretation without replacing evidence-based clinical mindfulness or imposing religious interpretation.

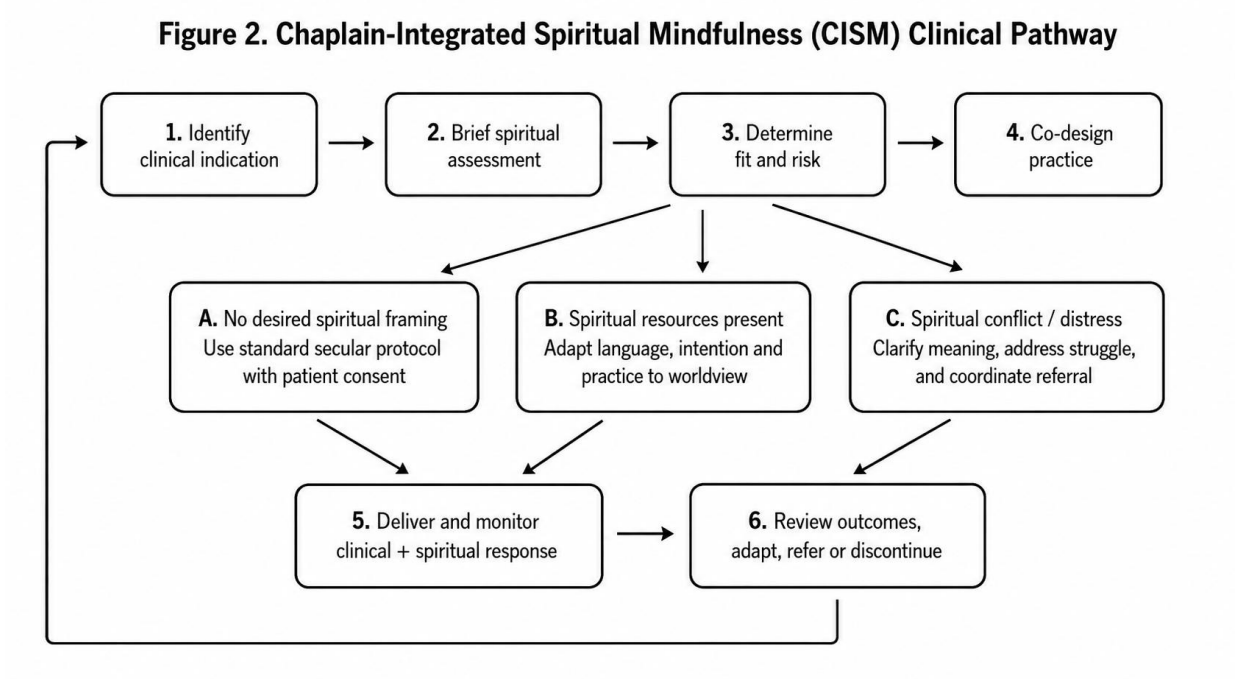

Figure 2. Chaplain-Integrated Spiritual Mindfulness (CISM) clinical pathway.

Clinical indication is followed by spiritual assessment, determination of fit and risk, patient-centred co-design, delivery, monitoring, and iterative review. Spiritual integration is optional rather than assumed.

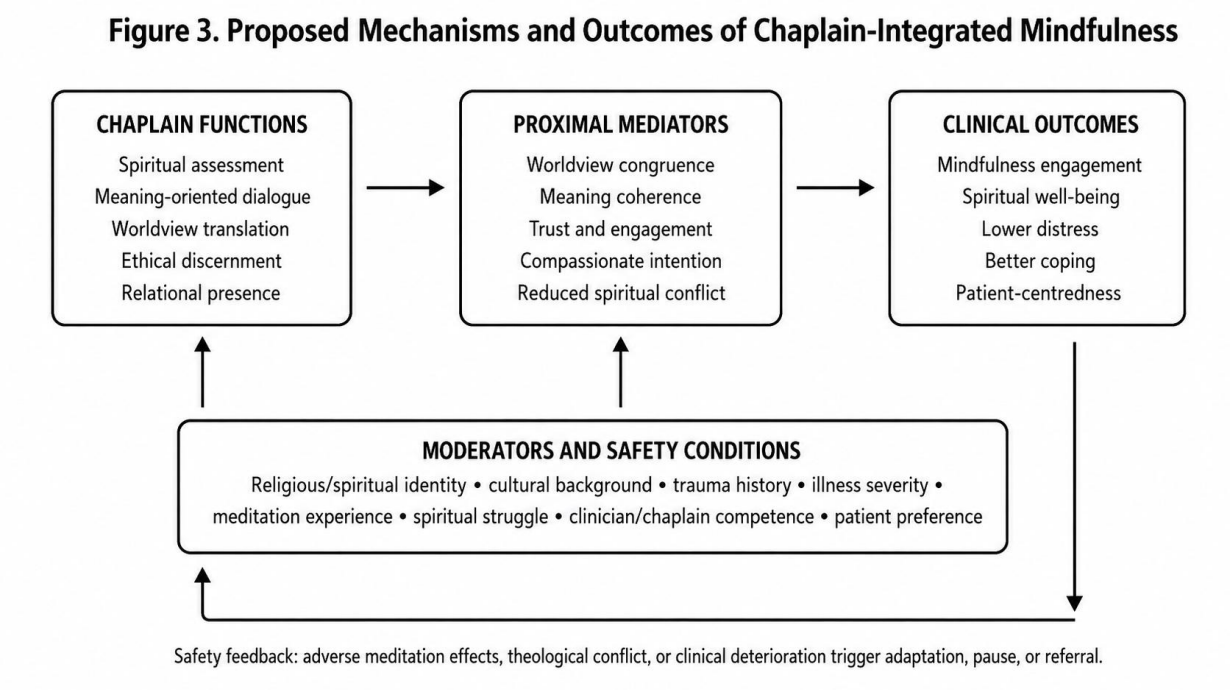

Figure 3. Proposed mechanisms and outcomes of chaplain-integrated mindfulness.
Note. Chaplain functions are hypothesized to affect outcomes through proximal mediators including worldview congruence, meaning coherence, trust, compassionate intention, and reduced spiritual conflict. Patient characteristics and safety conditions moderate these relationships.