



Exploring the impact of mindfulness meditation training in pre-licensure and post graduate nurses



Jill Sanko PhD, MS, ARNP, CHSE-A^{a,*}, Mary McKay DNP, ARNP, CNE^a, Scott Rogers MS, JD^b

^a University of Miami, School of Nursing and Health Studies, PO Box 258153, Coral Gables, FL 33124, United States

^b University of Miami School of Law 1311 Miller Drive, Coral Gables, FL 33146

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ABSTRACT

The complex, high stress, technologically laden healthcare environment compromises providers' ability to be fully present in the moment; especially during patient interactions. This "pulling away" of attention (mindlessness) from the present moment creates an environment where decision making can take place in the absence of thoughtful, deliberate engagement in the task at hand. Mindfulness, can be cultivated through a variety of mindfulness practices. Few schools of nursing or hospitals offer mindfulness training, despite study findings supporting its effectiveness in improving levels of mindfulness, and perceived connections with patients and families.

Methods: A mindfulness program developed for this study and tailored to nursing was used to provide the mindfulness training. Pre and post training assessments were completed and included administration of the Freiburg Mindfulness Inventory (FMI) and the Defining Issues Test (DIT) of moral judgment version 2.

Results: A statistically significant improvement in the FMI scores $p = 0.003$ was found. The pre-licensure group did not show a statistically significant improvement in their FMI scores pre to post training ($p = 0.281$), however the post graduate group did ($p = 0.004$). Statistically significant pre - post scores were found in two schemas of the DIT-2 (P [Post conventional] score, $p = 0.039$ and N2 [Maintaining norms] score, $p = 0.032$).

Conclusions: Mindfulness training improves mindfulness and some aspects of ethical decision making in the groups studied as part of this project. The findings of this study are promising and further demonstrate the merits of a mindfulness practice, however aspects of mindfulness training would need to be addressed prior to launching a full scale attempt to incorporate this into a work life or some other quality improvement program.

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1. Introduction

The current healthcare environment is demanding of the attention of nurses. Studies have demonstrated that distracted, partially attentive people tend to engage in more unethical behaviors, which can negatively affect patient outcomes (Ruedy & Schweitzer, 2010; Shapiro et al., 2012; Riskin, 2009). The complex, stressful, and technologically encumbered healthcare environment compromises healthcare providers' ability to be fully present in the moment; especially during patient interactions. This "pulling away" of attention from the present moment creates an environment where decision making can take place in the absence of thoughtful, deliberate engagement, a state known as mindlessness (Langer, 1989a, b; Ruedy & Schweitzer, 2010). Because awareness is a critical component of ethical decision making, this state of mind can contribute to unethical decision making (Ruedy & Schweitzer, 2010). The experience of many

nursing students and nursing professionals is one of high stress that can lead to anxiety and depression (Kliszcz et al., 2004; Letvak et al., 2012).

The current healthcare atmosphere is juxtaposed to the expectation that nurses provide focused patient centered care within the framework of a "culture of caring" (Fox et al., 1990). Building a more mindful nursing workforce may assist in returning nurses and their attention to the bedside; enabling them to provide more mindful, ethical, patient centered care.

Mindfulness, regarded as paying attention to the moment-to-moment experience in an engaged and unassuming way (Rogers and Jacobowitz, 2015; Rogers, 2014) can be cultivated through mindfulness practices. Jon Kabat-Zinn, a leading researcher and teacher of mindfulness speaks of mindfulness as paying attention in an intentional and non-judgmental way, with focus, on the present moment, and non-judgmentally (Kabat-Zinn, 1991). In contrast to mindlessness, mindfulness fosters clearer thinking, encourages openheartedness, and assists in maintaining awareness across time (Ludwig and Kabat-Zinn, 2008). Mindfulness promotes compliance with applications of the Golden Rule also known as the ethic of reciprocity ("do unto others as you would have others do unto you") and can foster a sense of interconnection,

* Corresponding author.

E-mail addresses: J.Sanko@miami.edu (J. Sanko), mmckay@miami.edu (M. McKay), s.rogers1@miami.edu (S. Rogers).

and a deeper understanding of others (Flickstein, 2001; Riskin, 2009). Professor Leonard Riskin (2009) notes in the context of law and ethical behavior, mindfulness can help bring about a “wedge of awareness” that assists in noticing intentions and developing the habit of pausing prior to acting in a way that would benefit themselves at the detriment of another (Riskin, 2009).

Mindfulness has been shown in studies to enrich the lives of those who regularly practice it, including improving feelings of well-being, mood, overall health, and sleep quality (Carlson et al., 2003; Chiesa and Serretti, 2010; Galantino et al., 2005; Grossman et al., 2004; Kreitzer et al., 2005). It is associated with reducing emotional reactivity to stress, and promoting recovery following stressful events (Arch and Craske, 2006; Britton et al., 2012; Erisman & Roemer, 2012; Jha et al., 2013; Keng et al., 2011; Moynihan et al., 2013). Mindfulness improves executive functioning, attention, and emotional interference in cognitive tasks (Jha et al., 2007; Ortner et al., 2007; Semple, 2010; Morrison et al., 2014).

While the majority of studies exploring the effects of mindfulness meditation demonstrate positive effects, there has been some interest in the safety of mindfulness related to reports of negative effects (Lustyk et al., 2009). There have been reports of people experiencing auditory hallucinations (Sethi and Bhargava, 2003) and worsening of depression (Shapiro, 1992) therefore it may be important to screen participants susceptible to experiencing untoward effects especially if the practice will include long periods of sensory deprivation and decreased episodes of sleep ((Lustyk et al., 2009). Further, the validity of the practice should be considered. New courses should be guided by an expert, and it should be noted that variability in practices, and techniques may affect experiences and outcomes both negative and positive.

Mindfulness in healthcare is not novel; organized activities teaching mindfulness are already part of physician residency programs and have been incorporated into medical school curriculums (Epstein, 1999; Ludwig and Kabat-Zinn, 2008; Krasner, 2009). Mindfulness training has been found to enhance self-compassion among healthcare professionals (Shapiro et al., 2005), as well as levels of self-reported empathy (Shapiro et al., 1998). A 2013 multicenter trial findings showed that providers with high levels of mindfulness had a more patient-centered pattern of communication, and displayed more positive emotional tone with patients (Beach et al., 2013). Mindfulness practice has also demonstrated an approach helpful in combating physician burnout (Cohen-Katz et al., 2004; Moon, 2009; Krasner, 2009).

Clinically, mindfulness has many successes as a treatment intervention. A well-known mindfulness training program, Mindfulness Based Stress Reduction (MBSR), has been used successfully to assist patients in alleviating suffering associated with physical, psychosomatic, and psychiatric disorders (Grossman et al., 2004). In patients with Irritable Bowel Disease, mindfulness has improved gastrointestinal symptoms and quality of life associated with anxiety (Kearney et al., 2011). In patients with Multiple Sclerosis, mindfulness has helped to reduce fatigue, anxiety, and depression (Sherman, 2011). In diabetics it has demonstrated promise in controlling blood glucose levels (Zoler, 2013). Finally, its use in the treatment of hypertension, myocardial ischemia, human immunodeficiency virus, substance abuse, attention deficit hyperactivity disorder, and bulimia has shown promising results (Ludwig and Kabat-Zinn, 2008).

Few schools of nursing or hospitals offer mindfulness training (Beddoe and Murphy, 2004) even though studies have demonstrated its effectiveness in improving levels of mindfulness, depression, and anxiety in nursing students (Green and Prunier, 2013; Shields, 2011; Song and Lindquist, 2015) and decreases in stress and increases in perceived connections with patients and families in practicing nurses (Ponte and Koppel, 2015). It was hypothesized that a similar positive impact on mindfulness would be found, but the exploration of mindfulness training on mindfulness and ethical decision making in pre-licensure and post graduate nurses was sought as there were no studies found in the literature exploring this relationship.

2. Methods

A time series, two group interventional design was used. Following IRB approval, participants were recruited to participate in the study consisting of an 8-week mindfulness training program. Potential participants were informed during the consent process of the requirements of participation in the study. It was explained during the consent process that the intent of the study was to explore the relationship of mindfulness training on mindfulness and decision making. The Internal Review Board approved the de-emphasis of participants' knowledge of the fact that the intent was to specifically measure ethical decision making; it was felt that this knowledge would skew results.

A mindfulness program was developed specifically to be used to provide the mindfulness training. A decision was made early in the planning to pre-record live audience mindfulness training sessions rather than deliver the content in real time. This was decided for several reasons; (1) to be able to accommodate a variety of participant schedules, (2) to be able to offer each session multiple times within the study time frame, (3) preservation of the fidelity of each session and (4) to meet a secondary aim of the study to develop a mindfulness program that would remain beyond the completion of the study. The program was tailored to the nursing context and developed over the course of many weeks in collaboration with a mindfulness training expert, the PIs, nurses, and two instructional designers.

2.1. Phase I – Pre-planning

The PIs met with the mindfulness training expert to discuss the goals of the training, the population that would take part in the training, and the most efficient and effective method for delivery. During these initial meetings, session content, scheduling, delivery method, and goals were planned. It was decided that no session would exceed 60 min to prevent participant fatigue. Although, traditional mindfulness training sessions (e.g., MBSR, MBST) exceed 60 min per session, shortening the length of the sessions allowed for the study of shortened training intervals. The expert suggested that the shortened sessions represented a length of time adequate for training, while minimizing participant fatigue. It was further decided that of the eight planned sessions, six would include a mix of education and mindfulness meditation practice, and two would consist exclusively of mindfulness meditation practice.

2.2. Phase II – Recording of Sessions

First participants were recruited to participate in the recorded sessions. In this way, study participants watching the videos would have the benefit of hearing a dialogue around learning and practicing mindfulness, much as they would in live training sessions. Those who participated in the recorded sessions were ineligible to participate in the study. Each recorded session had at least three people in the audience, their voices were heard, but not their faces to decrease participant bias related to the fact that some the study participants may be students of the participants of the recorded sessions. Both Principal Investigators (PIs) participated in all of the recorded sessions.

2.3. Phase III – Production of Final Recorded Sessions

During this phase the PIs and the mindfulness expert worked with instructional designers to create the final recorded sessions. Introductions and closing remarks for each session were captured in studio. These segments were then added to the recorded live audience content that had been previously recorded. Each rough-cut recording was reviewed by the PIs and the mindfulness expert to determine what should be retained for use, what required re-recording, and what should be excluded. Any material that needed to be re-recorded was completed during this phase. Audio recordings for various mindfulness exercises that were taught during the sessions were also recorded at this time.

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