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A pilot test of a mindfulness-based communication training to enhance resilience in palliative care professionals

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ABSTRACT

Although many providers enter palliative medicine with the intention of helping others, working in this practice also entails that providers will be repeatedly exposed to the pain, trauma, and the death of their patients. These experiences may threaten the values of providers and evoke a range of avoidant coping behaviors that potentiate distress and erode the quality of care provided. This manuscript reports pilot findings from Aware Compassionate Communication: An Experiential Provider Training Series (ACCEPTS) for Palliative Care Providers that is informed by Mindfulness-Based Interventions and principles of Psychological Flexibility Theory. Providers participated in a group-based 8-week, 10-session training series that emphasized mindfulness and acceptance-based interventions as applied to the needs of those working with the chronically ill and dying. The program included formal meditation practice, communication role plays, and value clarification exercises. Participants completed measures of distress (i.e. Depression, PTSD, and Burnout), and potential mechanisms of change (i.e. cognitive fusion and experiential avoidance) at pre-training, mid-training and post-training. Significant reductions were observed in cognitive fusion (posttreatment $d = -.54$, $p < .05$), depressive symptoms (posttreatment $d = -.64$, $p < .01$), depersonalization (posttreatment $d = -.83$, $p < .01$), PTSD Re-experiencing (posttreatment $d = -.34$, $p < .01$). Results indicated that ACCEPTS is an acceptable and feasible intervention for providers that may enhance well-being. More research is needed to assess cognitive fusion as a potential mechanism of change in the program

1. Introduction

Medicine offers many opportunities for personal and professional growth. While the decision to enter medical training is informed by diverse values, many individuals desire to care for others, gain respect, and engage in the scientific study of health and healing (McManus, Livingston, & Katona, 2006). However, providers who care for the chronically ill and dying in the specialties of palliative care and hospice repeatedly encounter the pain, trauma and death of their patients (Levy, 2000). As providers empathize with these patients, their own traumatic stress symptoms, burnout, and avoidant coping styles may detract from their own well-being and may interfere with their provision of patient-centered care. This manuscript reports the outcomes of a pilot study of *Aware Compassionate Communication: An Experiential Provider Training Series (ACCEPTS) for Palliative Care Providers*. ACCEPTS is informed by principles of mindfulness and is tailored to the needs of providers who work with patients receiving palliative and hospice care with the aims of enhancing psychological flexibility and communication.

Patient interactions provide the nexus at which patient and provider well-being converges. Beneficence tends to be the prevailing ethic and value in medicine (Taylor, 2013), and providers are strongly motivated to care for their patients (McManus et al., 2006). Just as patients look to their palliative care providers for support and comfort in the midst of pain (Gerhart, Sanchez Varela, Burns, Hobfoll, & Fung, 2015), palliative care professionals can find a sense of satisfaction as they attend to their patients' needs, provide comfort and alleviate distress (Stamm, 2002). When providers are skilled in communication and patient care they identify underlying concerns, provide effective care, receive gratitude from patients and families, and are buffered from distress (Stamm, 2002).

When patients are in pain, physical decline or facing decisions

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about ending life sustaining care, providers also experience levels of emotional distress (Figley, 2002; Jenkins, & Baird, 2002; Najjar, Davis, Beck-Coon, & Doebbeling, 2009) including burnout (i.e. emotional and physical exhaustion), and secondary traumatic stress (IsHak et al., 2009; Deary, Watson, & Hogston, 2003). Burnout may affect 62 percent of palliative care clinicians (Kamal et al., 2014). Up to 78 percent of Hospice nurses in one sample reported compassion fatigue, a form of vicarious trauma akin to Posttraumatic Stress Disorder (PTSD) (Abendroth, & Flannery, 2006; Figley, 2002). Similar symptom profiles of burnout, depression, and traumatic stress symptoms have been discussed in social workers, physicians, and psychotherapists (Adams, Boscarino, & Figley, 2006; Figley, 2002; Huggard, 2003).

Psychological Flexibility theory suggests that efforts to pursue deeper values of beneficence and compassion may be constrained or eroded if individuals habitually avoid their subjective experiences, or adopt inflexible beliefs (Hayes, Strosahl, & Wilson, 2012). Experiential avoidance, the process of negatively evaluating thoughts and emotions and attempting to avoid, escape or suppress them may paradoxically increase distress (Hayes et al., 2012). Many poor communication behaviors observed in medicine—including changing the topic of conversation (Baranowsky, 2002) or simply spending less time with patients (Najjar et al., 2009)—could potentially serve experientially avoidant functions because they reduce contact with distressing events. Following stressful encounters, providers may also continue to relive difficult aspects of the communication (Baranowsky, 2002; Ptacek, Fries, Eberhardt, & Ptacek, 1999). Providers who have difficulty shifting their attention from difficult encounters or negative beliefs about their performance may be said to be engaging in cognitive fusion, or the tendency to take thoughts to be literally true. Ultimately, the routine stress and trauma of palliative care coupled with these processes may lead to a downward spiral of distress, disrupted communication and general detachment from values of compassion and beneficence (Gysels, Richardson, & Higginson, 2004; McManus et al., 2006).

2. Intervening on provider distress

An array of strategies has been recommended to help medical providers cope with trauma and stress. These strategies have included meaning-centered interventions (Fillion et al., 2009), music therapy (Hilliard, 2005) and arts-based approaches, along with workflow, communication, and quality improvement interventions (Linzer et al., 2015). Huggard (2003) points to personal and professional strategies such as awareness, psychotherapy, self-care, and work-life balance along with organizational interventions aimed at reducing workplace stressors and promoting support and respect in the workplace. A review of the relevant literature concluded that communication training and mindfulness would be critical components to future research and intervention (Kearney, Weininger, Vachon, Harrison, & Mount, 2009). Providers may also benefit from experiences that help them clarify their value systems as medical providers, in particular the inherent value of connecting with their patients at a humanistic level (Horowitz, Suchman, Branch, & Frankel, 2003).

Mindfulness-based interventions offer promising avenues for enhancing the well-being of medical providers (Cohen-Katz, 2004; Krasner et al., 2009). Mindfulness refers to a nonjudgmental awareness of momentary experiences including sensation, emotion and cognition (Kabat-Zinn, 1994; Roemer & Orsillo, 2009). A mindful approach to observing momentary experience may help to normalize both pleasant and uncomfortable experiences that are commonly evoked by professional caregiving, and may also reduce judgmental reactions to those events. As such, mindfulness-based communication interventions are promising in the context of palliative care as they may enable providers to be more aware and accepting of their personal experiences with patients, and to develop the capacity to engage in effective care and communication even in the presence of their own distress (Anthony, & Vidal, 2010; Hayes et al., 2012; Krasner et al., 2009). Krasner et al. (2009) found that mindfulness-based communication training for primary care physicians was associated with significant improvements in well-being, burnout and mood. Similar improvements in burnout have been observed in a number of pre-to-post tests of mindfulness for medical providers (Fortney, Luchterhand, Zakletskaia, Zgierska, & Rakel, 2013; Goodman & Shorling, 2012). Although the emerging literature is promising, less is known about the use of mindfulness-based interventions for palliative care professionals who routinely encounter patient death and trauma.

Enhancing mindfulness may also support communication and the provision of patient care. Mindful communication refers to the process of actively and attentively engaging with patients (Anthony and Vidal, 2010). Whereas many patient interactions may become routine, mindfulness encourages providers to listen attentively, and consider the unique needs of the patient as they unfold in the context of the present moment. Targeted communication training provides professionals with flexible skill sets to address common patient concerns. As providers learn to communicate effectively with patients they develop a sense of control and mastery for being present with patients in suffering. The experience of approaching and reducing patient suffering, activating family systems and exploring patient values be directly and deeply rewarding to providers, sufficiently so to counteract their competing urges to avoid, silence or shutdown. To reinforce these caring behaviors in the midst of adversity provides may also benefit from clarifying their values and finding deeper meaning in the provision of care.

3. The ACCEPTS intervention

The ACCEPTS intervention was developed as a multimodal program with an emphasis on using mindfulness and communication training to reduce distress among palliative care professionals while simultaneously enhancing communication and engagement with provision of care. The program was primarily informed by principles of mindfulness-based interventions, and augmented with value clarification exercises consistent with broader Psychological Flexibility Theory to help providers to clarify, re-engage and commit to values. A group format was used to harness opportunities to improve communication among providers. This included directed exercises to engage with peers, express common reactions to patient trauma, and listen to the reactions shared by others. Sitting meditation was the primary mindfulness exercise emphasized during the group. These exercises were also augmented by contemplations of events with the intention of cultivating nonjudgmental awareness of thoughts, emotions, and sensations commonly elicited in the course of medical practice. Finally, brief didactics and role plays were utilized to strengthen skills in commonly used communication strategies such as reflective listening. The primary study hypothesis was that participation in the group would be associated with reduction in provider mental health symptoms as evidenced by measures of depression, burnout and PTSD symptoms.