*Brief Report*

# Building Resiliency in a Palliative Care Team: A Pilot Study

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## Abstract

**Context.** Palliative care clinicians (PCCs) are vulnerable to burnout as a result of chronic stress related to working with seriously ill patients. Burnout can lead to absenteeism, ineffective communication, medical errors, and job turnover. Interventions that promote better coping with stress are needed in this population.

**Objectives.** This pilot study tested the feasibility of the Relaxation Response Resiliency Program for Palliative Care Clinicians, a program targeted to decrease stress and increase resiliency, in a multidisciplinary cohort of PCCs ($N = 16$) at a major academic medical center.

**Methods.** A physician delivered the intervention over two months in five sessions (12 hours total). Data were collected the week before the program start and two months after completion. The main outcome was feasibility of the program. Changes in perceived stress, positive and negative affect, perspective taking, optimism, satisfaction with life, and self-efficacy were examined using nonparametric statistical tests. Effect size was quantified using Cohen's d.

**Results.** The intervention was feasible; all participants attended at least four of the five sessions, and there was no attrition. After the intervention, participants showed reductions in perceived stress and improvements in perspective taking.

**Conclusion.** Our findings suggest that a novel team-based resiliency intervention based on elicitation of the relaxation response was feasible and may help promote resiliency and protect against the negative consequences of stress for PCCs. J Pain Symptom Manage 2016;51:604–608. 

***Key Words***

*Palliative care providers, health care provider wellness, stress, group intervention, relaxation response, resiliency, mind-body therapies*

## Introduction

Health care providers are susceptible to the deleterious effects of stress,[1,2] resulting in consequences such as decreased productivity because of absenteeism and increased medical errors.[3,4] In addition, stress may play a role in quality of care, as elevated stress may lead to poor communication and teamwork in health care settings.[2,4,5] These negative consequences of stress have been demonstrated in palliative care clinicians (PCCs) as well.[6] Not only do palliative care providers experience these stressors but also constant exposure to death and loss, time pressures and unpredictable schedules, increasing workloads, and competing role demands.[7–9]

Given these findings, there has been increased interest in the development of treatments aimed at promoting provider wellness and resiliency in palliative care. Resiliency is the capacity of a dynamic, malleable system to withstand challenges to its stability, viability, or development. Studies of group interventions to enhance resiliency in health care providers have found improvements in various domains of provider well-being.[10,11]

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*Accepted for publication: October 28, 2015.*



0885-3924/$ - see front matter
http://dx.doi.org/10.1016/j.jpainsymman.2015.10.013

Although these interventions have focused primarily on providers within a single discipline, palliative care services often are unique in their organizational structure in that they consist of an interdisciplinary team, which often includes physicians, nurses, chaplains, psychologists, and social workers. Success of the palliative care service is contingent on the cohesion and well-being of the team members, especially as caseloads and job demands have increased. However, to our knowledge, no intervention to date has explored the feasibility of mind-body resiliency programs among an interdisciplinary palliative care team.

The Relaxation Response Resiliency Program (3RP) is a mind-body program designed to promote resiliency[12] and has been shown to decrease stress and increase resiliency in a broad range of populations.[13–17] For the purposes of this study, we adapted the existing program based on our previous qualitative work to meet the specific stressors, challenges, and training needs of PCCs.[8] We sought to test the feasibility of this adapted 3RP,[12] among a team of palliative care providers. Additionally, we explored PCC characteristics that could be associated with higher levels of stress.

## Methods

### *Participants*

Our pilot study intervened with a multidisciplinary team of PCCs (physicians, nurse practitioners, nurses, and social workers) at a major academic medical center. PCCs were informed about the 3RP program through e-mails and informal presentations. Informed consent was obtained from each participant. There were no specific financial incentives provided to participants, except that their time was protected by the Division Chief. Staff members were expected to participate in the resiliency training sessions as part of job responsibilities but were not required to participate in the research component and could opt out of the self-report questionnaires at their discretion. The primary inclusion criterion was full-time employment as a clinician in the Palliative Care Division. There were no exclusion criteria, and the Partners Human Research Committee approved the project.

### *Assessment*

Study data were collected and managed using REDCap (Research Electronic Data Capture) tools hosted at Massachusetts General Hospital (MGH) and were deidentified. REDCap is a secure, web-based application designed to support data capture for research studies. Study data were collected at two time points: the week before the start of the program, and two months after completion of the program. Research assistants performed the data collection and analysis. Members of the Palliative Care Division leadership did not participate in data collection or analysis. Data were confidential and not reviewed by the PC leadership at any time.

### *Intervention*

The 3RP for PCCs (3RP-PCC) was adapted from the MGH Benson-Henry Institute for Mind-Body Medicine (BHI) manualized 3RP program through an iterative process, taking into account the PC needs assessment[9] and discussions with PC leadership. The intervention consisted of an initial four-hour introductory session followed by four two-hour education sessions delivered in a group format by a physician from the MGH (BHI). The sessions were held every other week over a period of two months. Based on principles of cognitive behavioral therapy and positive psychology, the goals of the program included 1) eliciting the relaxation response, 2) reducing overall stress reactivity, 3) increasing connectedness to oneself and others. The 3RP for PCCs incorporated a multimodal approach to introduce and reinforce new skills, including didactics, in-session activities, discussions, and weekly practice assignments. Each education session began with the practice of a new exercise to elicit the relaxation response (e.g., breath awareness), followed by didactics and in-class exercises.

### *Outcome Measures*

We assessed feasibility as the proportion of full-time MGH PCCs who enrolled in the pilot trial, attended the intervention sessions, and completed the assessments. In addition, six constructs were selected to explore the three core components of the 3RP relaxation response: stress awareness, adaptive strategies, and resiliency. Each construct was assessed at preintervention and postintervention.

*Relaxation Response.* We evaluated perceived stress using the well-validated Perceived Stress Scale (10 items, score range 0–40).[18] The Perceived Stress Scale assesses the extent to which life has been stressful, uncontrollable, or unmanageable during the past week, with higher scores indicating greater stress.

*Stress Awareness.* Participants' affect during the past week was assessed with the Positive and Negative Affect Schedule.[19] The Positive and Negative Affect Schedule comprises two 10-item subscales (positive affect and negative affect, score ranges 10–50), with higher scores indicating more affect.

*Adaptive Strategies.* We administered the perspective-taking subscale of the Interpersonal Reactivity Index (IRI).[20] The 28-item IRI was developed to assess cognitive and affective dimensions of empathy. The IRI