A Qualitative Study of a Compassion, Presence, and Resilience Training for Oncology Interprofessional Teams

Rinat Nissim, PhD
Princess Margaret Cancer Centre
University of Toronto
Carmine Malfitano, MSW
Princess Margaret Cancer Centre
Mark Coleman, MA
The Mindfulness Institute
Gary Rodin, MD
Mary Elliott, MD
Princess Margaret Cancer Centre
University of Toronto

The well-being of health care providers may be challenged by their work, with evidence that oncology health care providers are a high-risk group for burnout. The present qualitative pilot study evaluated a mindfulness-based group intervention, referred to as Compassion, Presence, and Resilience Training (CPR-T), for oncology interprofessional teams. The purpose of this study was to elucidate the subjective experience of oncology health care providers receiving CPR-T and their perceptions of its benefits, risks, or challenges. The CPR-T was delivered to providers from two oncology teams in a large cancer center in Canada. Ten of these providers participated in semistructured interviews 1 to 5 months after completing the CPR-T. The interview transcripts were coded using a thematic analysis strategy. Five benefits of the CPR-T were identified: learning to pause, acquiring a working definition of stress and self-care, becoming fully present, building self-compassion, and receiving organizational acknowledgment and recognition of stress. In addition, two participant-identified challenges were recognized: sharing vulnerability within interprofessional teams and committing to a sitting meditation practice. These findings demonstrate positive transformations as a result of the CPR-T, as well as important challenges, and have important implications for holistic health care practice in oncology. Further research is necessary to validate the findings of this explorative study.

Keywords: cancer/oncology; specific conditions; nurses (basic); group/population; meditation/mindfulness; healing modalities; stress management/relaxation

Introduction

The physical and mental well-being of health care providers is an important challenge in health care (Wallace, Lemaire, & Ghali, 2009). Adverse effects on them have been captured in the construct of burnout, defined as a prolonged sense of emotional exhaustion, depersonalization, and inefficiency in response to chronic job-related stressors (Maslach, Schaufeli, & Leiter, 2001). At the individual level, burnout in health care providers has been associated with mental and physical health problems, including depression, substance abuse,
anxiety, cognitive deficits, and suicidal ideation (West, Dyrbye, Erwin, & Shanafelt, 2016). At the organizational level, burnout has been found to be a strong predictor of absenteeism and turnover intentions (Leiter & Maslach, 2009), and it has been linked to reduction in the quality of patient care, in provider empathy, and in patient safety (Shanafelt et al., 2009). Other far-reaching consequences of burnout were reported by Bakker, van Emmerik, and Euwema (2006), who found that burnout is contagious and that intensive care nurses who experience burnout negatively influence their teams.

Oncology health care providers (OHPs) are a high-risk group for burnout (Eelen et al., 2014). In a Canadian study, oncology nurses and other OHPs identified the following work-related stressors: heavy workload, conflicting demands on their time, poor work–life balance, and the distress of patients (Grunfeld et al., 2005). Other studies demonstrated that the long-term relationships of OHPs with patients are associated with strong emotional reactions to the suffering and death of patients and may trigger experiences such as cumulative grief (Granek, Tozer, Mazzotta, Ramjaun, & Krzyzanowska, 2012), vicarious trauma (Breen, O’Connor, Hewitt, & Lobb, 2014), and compassion fatigue (Brint, 2017; Hooper, Craig, Janvrin, Wetzel, & Reimels, 2010; Houck, 2014; Najjar, Davis, Beck-Coon, & Doebbeling, 2009; Potter et al., 2010).

Although self-care is a foundational element of holistic health care (Frisch, 2001), consistent evidence demonstrates that nurses and other health care providers do not seek help or tend to their mental and physical well-being because of fear of stigma, concerns about confidentiality and a punitive response, and reluctance to be in the role of patient (Siebert & Siebert, 2007; Thacker, Stavarski, Brancato, Flay, & Greenawald, 2016). This tendency to avoid seeking help calls for a preventative approach to protect the health of providers, ensure resiliency, and prevent burnout (Enzman Hines, 2008; Wallace et al., 2009), and interventions to accomplish this are now emerging. Mindfulness-based group interventions are a promising and cost-effective strategy to improve provider wellness. The term mindfulness was defined by Kabat-Zinn (1984) as a skill of focusing attention on one’s experience in the present moment. Epstein (1999) was the first to identify mindfulness as integral to the professional competence of health care providers and to suggest ways to cultivate it in clinical practice. The goals of mindful practice, as defined by Epstein (1999, 2003), are to improve self-awareness, active listening, presence, and compassion. All are qualities that are necessary for the provision of holistic, patient-centered care (Mcevoy & Duffy, 2008).

Quantitative studies investigating mindfulness-based interventions for health care providers from diverse disciplines, such as primary care medicine, nursing, and allied health, have demonstrated improvements in mood, compassion fatigue, burnout, provider empathy, and patient satisfaction (Hevezi, 2016; Smith, 2014; West et al., 2016). However, current mindfulness-based interventions do not address the unique challenges of OHPs (Kearney, Weininger, Vachon, Harrison, & Mount, 2009). Moreover, they emphasize individual strategies for burnout prevention over the relational and organizational factors that contribute to burnout (Maslach et al., 2001; West et al., 2016). Such factors may be best addressed with a multidiscipline, team-based format, particularly in oncology, where care is often provided by interprofessional teams (Jain, Fennell, Chagpar, Connolly, & Nembhard, 2016).

Compassion, Presence, and Resilience Training™

CPR-T is a mindfulness-based and team-based intervention for OHPs, codeveloped by the third and fifth authors (MC and ME). It was informed by the work of Kabat-Zinn (1984); Segal, Williams, and Teasdale (2002); Epstein (1999); and Neff and Germer (2013). Utilizing a range of mindfulness practices and facilitator-led discussions, it is designed to (1) cultivate compassion, responsiveness, and self-care; (2) strengthen presence, focused attention, and calm and nonjudgmental acceptance; and (3) build resilience, stamina, balance, and the ability to face stressful circumstances with equanimity (see Figure 1 for a description of the CPR-T curriculum).

Keeping in mind the heavy workload of OHPs, the CPR-T curriculum includes workplace assignments of “mindfulness micropractices.” These short practices can be utilized on-the-go and on-demand during a busy workday and are intended to become integrated into daily workplace life over the duration of the training. Examples include the following: (1) placing red-dot stickers in the workplace with instructions to pause, take a breath, and observe feelings, thoughts, and body sensations each time
participants notice a dot; (2) transforming mundane daily tasks that are typically automatic and mindless (e.g., hand washing, eating) into mindfulness opportunities by deliberately focusing and using all the senses to be fully immersed in the task at hand; (3) short, mindful breathing and walking practices when arriving at work or when moving from one patient room to the next; and (4) brief compassion strategies for self and others to offset challenging encounters. Also integral to the CPR-T curriculum is education on cultivating presence and experiential instruction on mindful communication skills using in-session dyadic exercises.

CPR-T was designed to be delivered in the workplace, with the understanding that participants may need to resume work immediately after a session. Thus, the agenda of each session is sequenced to sandwich emotionally charged content between grounding exercises at the beginning and resiliency practices (e.g., taking turns naming what brings you a sense of wellness) in the last part of the session.

The first two CPR-T interventions were delivered to two distinct interprofessional oncology teams at a large hospital in Toronto, Ontario, Canada. Enrollment in the two groups consisted of 14 and 16 OHPs, respectively. The participants included nurses, oncologists, and other OHPs. For each group, additional coverage was arranged to ensure that the participants could attend sessions during their regular working hours. The CPR-T curriculum in these two pilot groups unfolded over 8 weeks in sessions that were 1.5 hours per week. Both groups were facilitated by ME, who co-developed the intervention and is a psychiatrist with extensive mindfulness training.

The purpose of the present study was to understand the subjective experiences of the OHPs who participated in the first two CPR-T groups. Utilizing a qualitative evaluation strategy (Patton, 2008), we aimed to gain insight from our pilot participants into how the CPR-T affected them and how it could be optimized. This type of pilot evaluative work is recognized as crucial for the development and evaluation of complex interventions (Craig et al., 2008).

Method

The study received approval from the institution’s research ethics board, and all the participants provided written informed consent. To reduce bias, the CPR-T’s co-developers (ME and MC) were not involved in the recruitment, data collection, and analysis.

Recruitment

All 30 registered participants in the CPR-T pilot groups received an e-mail from the group facilitator
inviting them to take part in the interviews and alerting them that they would be contacted by a research assistant to discuss the research.

Data Collection

We were able to reach 16 of the 30 CPR-T participants, and all were interested in taking part in the interviews. The first and second authors (RN and CM) interviewed the participants within 1 to 5 months of their completing the CPR-T. This time range was selected to gain perspectives on both immediate and longer-term effects. The semistructured interviews ranged from 30 to 90 minutes and explored participants’ experience of the CPR-T. The interview protocol included nine broad questions about perceived benefits or challenges during the CPR-T and afterward. The interviews ceased once data saturation was achieved; hence, we only interviewed 10 of the 16 participants whom we had contacted.

Data Analysis

The interviews were audio recorded and transcribed verbatim. The transcripts were systematically coded using a thematic analysis strategy based on Patton’s (2008) utilization-focused qualitative evaluation approach. The analysis involved an iterative process whereby an initial set of themes related to potential benefits and challenges of the evaluated program were coded based on the first transcripts, and a tentative coding scheme was developed. Then, the tentative codes were applied to new transcripts and revised to adjust for the new information, until no new codes emerged. Coding was conducted by one researcher (RN) and then checked by the other members of the research team.

Results

Our analysis is based on interviews with 10 participants, 4 of whom had participated in the first pilot CPR-T group and 6 in the second group. To maximize confidentiality, potentially identifying characteristics of the participants are not reported.

We identified five benefits and two challenges of the CPR-T. The five categories of benefits are learning to pause, acquiring a working definition of stress and self-care, becoming fully present, building self-compassion, and receiving organizational acknowledgment and recognition of stress. The two categories of challenges are sharing vulnerability within interprofessional teams and committing to a sitting meditation practice. For each category presented, we include direct quotations from different participants from both pilot groups.

Participant-Identified Benefits

Learning to Pause. The brief, on-the-go mindfulness practices taught in the CPR-T resonated with all the participants and provided them a means to pause and reset in the midst of a busy and stressful workday. The micropractices became a part of their daily routine and were described as important “tools that you can go back to when needed” and “to employ when one is spiraling and going in a million different directions.” For example, in the quote below, a participant described the benefits of placing red-dot stickers in the workplace:

I thought that was really good. The red-dot stickers in my department. It was very concrete. It was very simple. But it has an impact; it's about catching up with yourself sometimes. The deep breathing that you do when you see a dot. It's like “Okay, where am I right now?” And thinking more about where you are and where you are acting out of. What is it that's driving you right now? Why is this so important that I have to do it now? And then you take a breath and you sort of think about it. You're like “I can do that tomorrow or I can do that later today or probably have a better way of doing it.” It helps you to get perspective and think about things in a more holistic way.

These brief, easy to utilize, “little tips and tricks” were described as vital during particularly stressful days. They gave participants a way to “stop and calm down,” “block the noise around me,” “take stock of how I am feeling,” and “alleviate the build-up of stress.” As the quote below demonstrates, the participants appreciated being given a repertoire of practices to utilize when they feel caught up in stress:

I find that on a bad day or in a more stressful situation, I'm inclined to think, “Is there some little thing that I can squeeze in to do?” And I don't always do
that those reflective practices were really helpful to kind of help me articulate. I just remember thinking, “Oh, this feels helpful for me to think about these things and reflect upon these things,” because it’s not something I can always just specifically line up like “Okay, what are my specific challenges with this?” . . . So I think that helped me develop a deeper self-awareness as to my overall self and my overall practice.

The guided reflection on work challenges and stressors helped the participants identify and name the impact that stress has on them and to think of it in a more “systematic way.” They experienced relief from acquiring a framework to understand their experiences. One of the participants remarked, “The whole idea of compassion fatigue, just even acknowledging that it exists in itself, helps.” Having a framework for understanding stress helped the participants take action, as another described:

The course brings awareness to you and helps you make that connection between things. You experience stress all the time, but this helps you make the connection to the effect it has on you and how you can do something for yourself to alleviate that.

The recognition of the impact of stress helped the participants understand “that you have to take care of yourself.” This evolving commitment to self-care should not be taken for granted, as one participant explained:

As health care providers, we never put ourselves first. . . . I think it’s engrained, actually, in people that want to go into health care. I just think it’s part of your personality and how you are that you’re a little more selfless. You just give, and you put yourself on the back burner.

Becoming Fully Present. The participants reported a heightened understanding of the value of being fully present in their interactions. One of them noted, “I have realized that part of the gift that I can give is just my presence. So I think [CPR-T] opened that and reaffirmed that a lot more, and it very much made me speak less and hear more.” They described a renewed commitment to being fully in the moment.
with and for the patient, rather than thinking about past or future tasks or attempting to multitask:

The course certainly made me aware of the importance of trying to be more in the moment, trying to be more present. There are so many distractions in this place. So I’m trying to be more present when I’m speaking with someone at work, trying just to focus on the person who is in front of me and not be looking at what’s going on somewhere else, which I sometimes do. I’ll turn my head, to try not to do that, to try just to be with who I’m with.

The participants described acquiring tools to be more present and to sustain presence for longer periods of time. For example, one participant described learning that being fully present involved being attuned to herself in the moment and “acknowledging my own feelings.” Another described realizing how her body posture enabled her to be more present:

I am more mindful about how I am physically. When I sit down or stand to do something with another person, I’ll make sure I’m planted. I’ll take a deep breath, or other little things, which I guess I knew already to a degree, but [the CPR-T] made me more aware.

Similarly, the participants learned strategies for employing more empathy and compassion during challenging interactions, and they described a shift in their interactions as a result; as one reported,

I find myself stopping to think when someone is irritating me. I go, “Okay, well, let that person be safe, let that person be happy.” And it feels good, as opposed to just constantly absorbing more and more. . . . You just somehow calm your own waters.

Building Self-Compassion. The CPR-T helped the participants develop an awareness of tendencies such as perfectionism or self-criticism and to shift gradually toward self-acceptance. One of them remarked, “I think that the theme of acceptance came through . . . that we’re okay wherever we are. . . . [The facilitator] said, ‘We’re not broken,’ and I always think I’m broken. She said, ‘We’re not broken. We’re human.’ And I found that helpful.”

The participants described becoming aware of their tendency to be more compassionate to others than to themselves. They described benefiting from learning about the concept of self-compassion and learning that compassion for self and compassion toward others can be mutually reinforcing:

The self-compassion. That was something new to me. I might have had a rough idea what that meant. But then, sometimes the things I’ve done, I didn’t realize that was not being self-compassionate. So I was able to have more self-talk, like “You shouldn’t be thinking like that because that’s not being kind to yourself.” And I can see that some of the things I have done in the past may have had a negative impact, even if they were meant to be compassionate to others, because I was hard on myself, and how that negative effect sometimes gets transferred to others. Because of the training, I was able to recognize some of that when it happened.

Receiving Organizational Acknowledgment and Recognition of Stress. The fact that the CPR-T was provided in-house and additional coverage was arranged so that participants could attend sessions during work hours was perceived by the participants not only as making it more feasible and convenient for them to attend but also as representing a much-needed organizational acknowledgment of job-related stress. One participant remarked, “I think it’s a validation that what you see every day takes its impact. I think it’s an unspoken validation of the immense suffering that you witness and the anticipatory suffering that you’re going to see.”

The participants highlighted that this was the first time they were offered such formal training and that “it seems almost silly that we can work in cancer care for decades and never address these topics.” They reported that being offered the CPR-T helped them feel supported and “recognized” by the organization and that it symbolized an organizational acknowledgment that self-care is a shared responsibility of the individual and the organization:

I was glad that there was an acknowledgment on behalf of the department that was prioritizing self-care. I think it’s always been the elephant in the room. Nobody ever talks about it, which is fascinating. It’s in a very conversational tone; everyone is
advised to do self-care. Informally, there’s a lot of support. But formally, organizationally, department-wise, I’ve never really noted a financial or time commitment to self-care in that way.

This organizational commitment motivated the participants and increased their engagement. They expressed that they had never considered accessing such a program until it was offered in-house; typically, they explained, “if we’re going to access any kind of course work, it’s usually very related to the clinical practice, not to ourselves as a professional.” They reflected that the CPR-T is a good start in establishing an organizational commitment to self-care and felt that more could be done, such as providing it on a regular basis. One remarked, “I think as a group of hospital staff, this kind of thing really should become part of our continuing competency. We do so many other mandatory courses, but this just seems like something everybody should know something about.”

### Participant-Identified Challenges

**Sharing Vulnerability Within Interprofessional Teams.** The participants’ main challenge was “breaking down the walls, the facade, and being more comfortable with vulnerability.” Vulnerability was associated by the participants with “opening up,” “diving into more personal issues,” being “transparent and fully authentic,” or the risk of “imploding.” One noted,

> I cry very easily, and I didn’t want to cry in front of them. . . . So in an environment where I wanted to be more open and I should be more open, I couldn’t. . . . I was afraid of the emotion that was going to come out as a result.

Our analysis of the theme of vulnerability unpacked three key elements: (1) an organizational culture that upholds having a “stiff upper lip,” (2) managing vulnerability in the sessions, and (3) the paradoxical benefits of sharing vulnerability within the team.

**The culture of a “stiff upper lip.”** The CPR-T invited the participants to reflect on and share difficult experiences. This was challenging as it was an invitation to access “that side of your brain that we almost try not to use during the day. . . . You don’t want to go there; we’d rather just bottle it up.” Or as another participant described it,

> Being at work, you’re working in a different mode, less emotional, more clinical, more go, go, go. You’re in a work mentality. . . . So it was very hard to switch over. It was hard to get into the deeper level of the issues.

The participants were concerned that allowing themselves to “open up” and experience vulnerability in the group would diminish their ability to function effectively when they returned to work. A more pressing concern, however, was that “displaying vulnerability” in the group would be perceived negatively by fellow group members because it would be inconsistent with the expectations of their team and of the organization at large to “keep a stiff upper lip.” These expectations, that “anything less than solid and stellar would not be good,” were engrained and implicit:

> Any expression of emotionality is seen as a weakness. You have to be really careful of that. . . . It’s an unspoken thing. We don’t display vulnerability. It’s not encouraged, not only with our patients, my goodness. We don’t even do it in the department. It’s seen as a negative. . . . These are the threads that wind through any department, the subtleties, the modus operandi; nobody talks about it. . . . It’s subtle. People sometimes can’t even verbalize it because it’s in the fabric, it’s the culture. . . . It sets the tone.

The participants explained that they typically allow themselves to “break down” only in front of close colleagues whom they know well and trust. By contrast, the CPR-T involved self-disclosure in the presence of team members with whom the participants did not necessarily feel safe, and they worried that they would be perceived as incompetent if they disclosed too much or became too emotional. These concerns about stepping outside their comfort zone and their professional role were amplified by the CPR-T’s team-based format. The group was composed of colleagues with whom the participants worked daily, and as one noted, “You can’t open your soul to your colleagues and then be professional an hour later.” The participants were concerned that their “level of integrity and professionalism,” their
“professional relationship,” and “professional trust” will be jeopardized if they share too much. One participant noted, “People are going to remember that. People remember the vulnerabilities expressed. . . . Maybe they would have had an adverse impression and that would impact on their perception of me as a reliable professional.”

Additionally, the participants discussed how power differentials within their team served as a barrier. They were ambivalent about displaying vulnerability in a group composed of team members with different rankings in terms of status or authority. Thus, individuals with leadership roles were uncomfortable about opening up in front of their direct reports, and vice versa:

It really wasn’t the easiest circumstances for people to show or to talk about their challenges, or show their vulnerabilities in front of the person who’s doing their performance appraisal. You really don’t want to say how upset you are about your work to your immediate boss.

A similar tension was noted because of the interprofessionality of the team. For example, one nurse described a sense of “discomfort” related to the presence of physicians in the group:

I think that there is this perception that physicians as a group hold a certain element of power within the health care system. . . . So you want to come across as being all together and perfect because in our minds they have power over certain things and they have authority that we don’t have. . . . They are great doctors and they’re very nice and they’re wonderful, but I still don’t have this feeling that I can just be truly me. So to be in that situation where I would have to share stuff with some of the physicians I work with is uncomfortable.

Managing vulnerability in the sessions. The participants described a gradual shift from holding back to expressing more vulnerability as the CPR-T unfolded; during the first few sessions, the participants felt unprepared and apprehensive about sharing vulnerability, with some considering dropping out:

I think I was a little surprised at how more internally focused the program was. I was going in with the expectation that it would be much like a lot of other learning we do, where you get a checklist or you come out with some sort of tool to fix a problem. This was more sort of internal reflection, and I think I was a little bit surprised by that. It was initially emotional and it’s initially sort of a little uncomfortable or awkward being in front of your colleagues who you don’t necessarily normally relate to on that level.

The participants described being concerned in the first few sessions about what to share and how much to share. They described “not wanting to put the facade down,” “holding back,” “censoring,” “stopping” or “editing” themselves, and providing “a very filtered response” during the initial sessions, opting instead to reflect on the material “off-line”:

I would control myself by just not talking, because as soon as I talked, I knew I would emotionally react. . . . But it was good because the facilitator was asking the questions, so prompting us. I believe it was a step for me, because it prompted me to think about it at least, but I would have to take it off-line and think more about it on my own. The facilitator at least would ask the question to solicit me thinking about it, which is the first step.

As they attended more sessions, however, the participants felt “safer” and more “protected”; they allowed themselves to open up and found it less stressful or “awkward.” They noted that the sessions’ structure helped them become more comfortable with vulnerability because they learned to trust that each session would end with resilience practices that helped them regulate their emotions and have a smooth transition back to work:

There was always a balance between the sadder reflection pieces and then sort of the happier reflection pieces. So I found that balance is definitely necessary, even within the hour and a half, because if you’re just asked to reflect on sad things the whole time, then you’re not even going to be able to function for the rest of the day.

In addition, the participants noted the facilitator’s effort to “carve out an atmosphere and a space of respect and confidentiality” and to respect their
pace. One noted, “It’s not intrusive. You can say or not say as much as you like. The facilitator did a great job trying to make people feel comfortable, and no one felt pressured into divulging when they didn’t want to.” At the same time, some expressed a wish that all dyadic and group exercises could have been prefaced with a statement acknowledging potential uneasiness and explicitly reassuring participants that they can opt out of the exercise.

The paradoxical benefits of sharing vulnerability within the team. The team-based format was perceived by the participants as a predicament. As an alternative to the interprofessional team-based format, the participants suggested that CPR-T groups be more homogeneous, divided by profession or by level of seniority, or composed of individuals who do not normally work together. They argued that these alternative group compositions would have allowed them to be more comfortable with vulnerability from the start:

This was always that at the back of my mind: “I need to see this person every single day. They’re going to see that I was crying.” . . . So I think the best-case scenario would be no one knows each other. . . . I just don’t like publicly crying or being emotional, so that was always a concern, and it became a greater concern with the audience. Being with my peers and being that open was a concern. Doing it with strangers to me would have been more appealing.

However, although the participants were concerned about the potential consequences of demonstrating vulnerability in front of their team members, they could not identify any actual ramifications when specifically asked. In fact, they reported that self-disclosure in the sessions seemed to facilitate mutual trust, empathy, and understanding, and established more authentic and supportive relationships within the team:

I have improved my communication with colleagues. I realized that my colleagues did deal with a lot of different issues. We always have that professional image when we’re working, so at least it brought my awareness to it. They do all have personal things that they deal with or patients that they deal with, that we often may or may not discuss. So even like in-between the sessions we had more of an understanding of the things that we deal with personally, so I guess it brought me closer to some of the colleagues.

The participants commented that the CPR-T helped them recognize the commonalities that they share with their team members, feel more connected to their colleagues, and develop a nonjudgmental attitude toward them. One of them expressed,

I thought it was very eye opening. What I realized is that we all have our own story, and a very significant story to tell. . . . I think that helped build cohesion, and to realize that we have a thing in common that we share among ourselves. For me that was really poignant.

Similarly, the interprofessional format helped challenge assumptions and enhance communication among the different professions. The participants described the benefit of hearing the perspective of other professions in the team. They spoke of their surprise in learning that “they are also vulnerable” and how this awareness helped normalize their own sense of vulnerability and initiate mutual dialogue and learning:

It was great having other professions there really showing their vulnerability, that they are affected as well and they grieve [over] patients. And I think that was so important for the rest of the team to see. . . . We didn’t know that it affected them that deeply. We didn’t know that they remember patients the same way we do.

Although the participants expressed concerns about displaying vulnerability in front of their supervisors, those in management positions noted that they became more understanding and receptive to the needs of their direct reports:

I’m more sensitive to those individuals that attended, because I heard a little bit more. So, for example, now because of the course I know what they are really going through, and I am trying to do my best to accommodate that. I guess a take-away message is the more you get to know someone, the better you can help and be more compassionate towards either
your patients or people who you work with. . . . The way I see individuals has changed a lot.

Committing to a Sitting Meditation Practice. The second participant-identified challenge concerned the difficulty of maintaining a formal sitting meditation practice outside the CPR-T sessions. The participants viewed the in-session practice of sitting meditation positively and appreciated the opportunity to learn it. Those who already had been practicing meditation reported that the CPR-T helped them increase their motivation to meditate and improved their ability to do so:

My skills in meditation are better. I can actually get into my meditation, which is unbelievable, but I can actually get into my meditation faster than I used to. And I see great value in it. Like I’m starting to see more benefit from it than I did before. Still, I find a challenge, in my own life, with home and work demands, it’s still difficult to find that protected time. But even if I can get 10 minutes a week, I’ll do it.

Those who were new to meditation described how the CPR-T “jump started and created a desire to try meditation,” allowing them to experience its benefits. However, despite the fact that the participants were motivated to maintain the meditation practice, they also shared that it was very challenging to meditate outside of the “protected time” of the sessions and to continue meditating once the training ended. Barriers and solutions identified by the participants to maintaining a sitting meditation practice are described below.

Participant-identified barriers to sustaining a sitting meditation practice. The difficulty to “work meditation into my routine” was the main barrier to continuing to practice meditation; the participants indicated that they found it “stressful to carve the dedicated time” for a sitting meditation. One noted, I can’t complete everything on my to-do list at home, and I can’t complete everything on my to-do list at work. So it’s not that I didn’t think I wouldn’t benefit from meditating, but I guess I didn’t prioritize it. The participants often compared the sitting meditation with the brief mindfulness practices to illustrate this difficulty. They explained that it was much easier to engage in the “practical” and “flexible and feasible” micropractices than the “rigid” sitting meditation. Likewise, whereas the formal sitting meditation practice was perceived as “something extra I had to go and do”, the informal practices (e.g., “mindful eating”) merely involved doing “something I naturally do every day” in a more mindful way. As the quote below suggests, it was easier for the participants to integrate the latter into their routine than the formal sitting meditation:

I think that’s too much expectation to set every evening “from this time I’m going to do meditation.” I think that’s too much stress. What I was able to extract was 10 minutes or 15 minutes during my day that I’m doing something but I’m fully aware of what’s happening. I was able to kill a lot of noise around me and focus on the task. To me, this is more meditating [than the sitting meditation].

Another important distinction was that the micropractices, which were utilized “on demand,” were associated with an immediate relief of stress, thus motivating the participants to “stick to” them, “internalize,” and “make them into a habit.” The sitting meditation practice, on the other hand, was associated with a cumulative impact, and those who practiced it tended to discontinue their practice once their overall feeling of stress diminished, as suggested by the quote below:

[Interviewer:] “I wonder if you would have any idea what would make home practice easier to do?” [Participant:] “You just have to make it a routine. I don’t necessarily personally feel like I absolutely need it. It would probably be something nice, but I think you basically just have to almost schedule it in your life and just make it a habit. Of course, some days you are maybe not going to be there at that time and place, or you are just not going to feel like it. That’s okay. But to keep it as a habit most days.” . . . [Interviewer:] “It sounds like doing it with your child was some form of scheduling.” [Participant:] “Yes, because we had a set time. . . . There is no good reason why we kind of just stopped, but we just did. I guess my child has been managing her emotions a bit better, so I haven’t made that connection, but talking about it now probably might help me to dust off that meditation CD and get it going again.”
Participant-identified solutions to sustaining a sitting meditation practice. The participants noted that the help of the facilitator was crucial in maintaining a sitting meditation practice. This help included practical suggestions, such as using a phone app to set reminders or the suggestion of “starting with just 10 minutes a day.” Also, the participants appreciated it when the facilitator shared her personal experience with meditation and described her own challenges with this practice, how these challenges were resolved, and the ways in which she benefited from her practice. Some participants incorporated meditation into their daily routine by involving other family members and making it part of a “family routine.”

The participants advocated for a monthly drop-in group for CPR-T graduates, devoted to group meditation and to debriefing on their home practice, as a way to build a community of practice and sustain and ritualize the meditation:

It would be nice to have something regularly scheduled. Maybe not once a week but once a month. . . . It's like everything else in your life. It's hard to keep something up yourself. You kind of need that scheduled for you. . . . [You need] refreshers, and just creating that space and that time at work to do that “me” moment and that meditation.

Discussion

CPR-T is a mindfulness-based group intervention to enhance compassion, cultivate presence, and promote resilience in OHPs. The current pilot study evaluated qualitatively the CPR-T, conducted for two interprofessional oncology teams, and provided insight into participant experiences. Our findings illuminated positive transformations as a result of the CPR-T, as well as important challenges.

An important participant-identified benefit of the CPR-T was acquiring a repertoire of micropractices, easily woven into daily work activities and brief enough to be feasible with the ever-present time pressures. These practices allowed the participants, faced with a substantial workload and intimate contact with patient suffering, to pause and replenish their internal resources, regulate their emotions, and respond to stressors with greater awareness, creativity, and empathy. Grunfeld et al. (2005) indicated that patient contact becomes a major stressor for OHPs only when they feel that they do not have the time to provide good care. Our findings indicate that OHPs can benefit not only from more objective time but also from developing the skill of “stillness-in-action” (Epstein, 2003). This skill can serve as an alternative to less effective coping strategies in response to stress, common among health care providers, such as denying emotions, operating on “auto-pilot,” or taking time off work (Yoder, 2010).

The participants’ ability to replace some of their habitual reactions to stress with more helpful responses was informed by the new perspective they gained on stress and self-care. Learning ways to recognize stress in the moment, with its associated feelings, cognitions, and bodily sensations, potentialized the control they had over it and helped them develop active attention and accountability to their self-care needs. This finding resonates with previous qualitative findings regarding the impact of mindfulness-based interventions for health care providers, in which the prioritization of self-care was recognized as an important intervention outcome (Beckman et al., 2012; Cohen-Katz et al., 2005; Irving et al., 2014), especially given the tendency of health care providers to minimize their needs or feel guilty for having them (Houck, 2014; Siebert & Siebert, 2007; Yoder, 2010).

The participants described more presence and empathy in their interactions with patients and colleagues. Similar findings were reported by other studies of mindfulness-based interventions for health care providers (Beckman et al., 2012; Morgan, Simpson, & Smith, 2015). Clinician presence involves deep relational contact and a willingness to be affected by suffering (Geller & Greenberg, 2002) and, therefore, is often assumed to be a liability among providers (Kearney et al., 2009). However, presence and empathy are now recognized as protective factors against burnout and compassion fatigue and as contributing to providers’ satisfaction and sense of meaning (Horowitz, Suchman, Branch, & Frankel, 2003). The potential impact of CPR-T and similar mindfulness-based interventions on presence and empathy may also help counteract the documented decline of empathy in health care providers (McFarland, Malone, & Roth, 2016).

The participants became aware of tendencies such as perfectionism and self-criticism and were able to replace them with self-acceptance and self-compassion. Self-compassion is a construct referring to
compassion turned inward at times of failure or suffering, which has been consistently linked to psychological well-being (Neff & Germer, 2013). Cultivating self-compassion may be especially valuable for OHPs because their strong caregiver role identity (Siebert & Siebert, 2007) often prevents them from applying compassion and kindness toward themselves. To offset this, the CPR-T helped the participants realize that compassion for self and compassion toward others are mutually reinforcing rather than opposing each other (Mills, Wand, & Fraser, 2015). Increased self-compassion may serve to break the documented vicious cycle between burnout and poor patient care, in which medical errors or providing suboptimal care lead to a sense of failure and guilt, which further increases burnout risk (West et al., 2006).

Our findings demonstrate the importance of organizational support when delivering CPR-T and of enabling participants to attend sessions during working hours. Indeed, OHP wellness programs offered as a weekend retreat or conducted outside the health care setting have reported dismal attendance (Edmonds, Lockwood, Bezjak, & Nyhof-Young, 2012). Our in-house model not only made it more feasible for potential participants to attend but also symbolized a much-needed organizational acknowledgment of job-related stress (Potter et al., 2010; Wallace et al., 2009).

The participants were uncomfortable initially with displaying vulnerability in the CPR-T sessions. They were concerned that self-disclosure or emotionality may be perceived as lack of professionalism or as weakness or incompetence, and their unease intensified because of the CPR-T team format, especially as the sessions included team members from different disciplines and a range of seniority. However, as their openness and willingness to embrace vulnerability grew, team members were able to meet each other as mutually vulnerable human beings and to form more genuine relationships based on trust and respect. This finding suggests that CPR-T can potentially serve to increase psychological safety within oncology interprofessional teams. Team psychological safety is associated with effective learning and implementation of new clinical practices, organizational commitment, and patient safety (Jain et al., 2016).

A clear distinction was made by the participants between the mindfulness micropractices and the practice of a sitting meditation. Whereas the micropractices were easily integrated into their routine, the formal sitting meditation practice was perceived by participants as difficult to sustain. The health belief model (Glanz & Bishop, 2012) can be useful as an explanatory framework for this difference. Specifically, the model suggests that cues are essential for prompting action. Thus, the successful adoption of the mindfulness micropractices may be associated with their multiple cues to action, including internal cues (stress in the moment) and external cues (linking these practices to daily tasks, e.g., hand washing). Adoption of the formal meditation practice may be enhanced by the establishment of relevant cues for action (e.g., drop-in meditation sessions for CPR-T graduates). Indeed, in a recent metasynthesis of mindfulness-based interventions for health care providers, Morgan et al. (2015) identified formal sitting meditation as a common challenge and concluded that ongoing organizational support for maintaining a formal meditation practice, such as access to monthly drop-in sessions, is essential. Such organizational support is especially valuable given the consistent link between levels of formal meditation practice and participant outcomes in mindfulness-based interventions (Carmody & Baer, 2008).

Limitations of the Present Study

There are a number of limitations to the present study. Given that CPR-T is a bundled complex intervention, it is challenging to determine which component might lead to the specific outcome themes noted. Outcome themes were generated from a small sample and from interviews conducted within 5 months of program completion and, therefore, may not apply over a longer period of time. We utilized a solely qualitative research design and did not collect pre-post quantitative data. Both pilot groups had the same facilitator, and all the participants in the CPR-T and in the qualitative study were self-selected; hence, the applicability of our themes is limited to participants who are similarly motivated. The participants, especially those who were interviewed 5 months after completing the CPR-T, may have been subject to a recall bias. Last, although the interprofessional team format of the pilot groups resulted in unique benefits, it may have served as a deterrent to enrollment. It would be valuable to compare potential outcomes when delivering CPR-T in different formats, for example, as seniority- or profession-specific programs.
Implications of the Present Study

By unpacking participant-identified benefits and challenges, this study informed the CPR-T manual, and some important revisions were made, such as careful attention to the fear associated with vulnerability and self-disclosure, and developing online tools to support and reinforce the formal meditation practice. Our qualitative findings also serve to inform the selection of quantitative outcome measures for future studies evaluating CPR-T; our study suggests that the CPR-T transformed the participants’ relationships with their patients, colleagues, and the health care organization, and therefore, a quantitative study should examine changes in empathy and communication, using both self- and other-reported measures (Lamothe, Rondeau, Malboeuf-Hurtubise, Duval, & Sultan, 2016), as well as other potentially important outcome variables, such as team climate and team effectiveness (Buljac-Samardzic, Dekker-van Doorn, van Wijngaarden, & van Wijk, 2010).

Implications for Holistic Nursing Practice

Our study has several implications for holistic nursing and holistic health care practice in oncology. Importantly, self-care and self-reflection, which are cultivated through the CPR-T, are at the theoretical foundation of holistic nursing practice and are considered fundamentally vital to the ability to provide holistic care (Frisch, 2001). The holistic approach highlights the need for practitioners to view the person as a whole, especially in the case of a complex health issue such as cancer, and to bring authentic presence, empathy, and compassion to interactions (Kinchen, 2015). Our study suggests that these qualities can be supported by CPR-T. Last, CPR-T has the potential to maximize holistic practice in oncology by facilitating interprofessional trust and mutual respect. In oncology, medical, nursing, and allied health professionals provide complex care in an interprofessional context. Ineffective collaboration between nurses and physicians has been related to professional stereotypes, perceived power and status inequalities, and lack of open communication (Engel, Prentice, & Taplay, 2017; Pullon, 2008). The CPR-T, structured as a team-based intervention, allows team members from different disciplines to meet each other in a way that transcends these barriers and to come together to implement holistic, comprehensive, care.

Our findings may inform future studies with similar intervention programs, aiming to resuscitate the intention of health care practitioners to provide humanistic and holistic care. Health care providers who neglect their self-care needs and experience burnout cannot be fully present to others (Enzman Hines, 2008). Given the evidence that burnout and poor self-care practices are experienced by nursing students, as well as students in other health care professions (Turner & McCarthy, 2017), it is important to incorporate these programs as early as possible in the career pathway of those choosing health care as their life work.

ORCID iD

Rinat Nissim https://orcid.org/0000-0002-3624-5806

References


Rinat Nissim PhD, C. Psych is a psychologist in the Department of Supportive Care at the Princess Margaret Cancer Centre and an assistant professor in the Department of Psychiatry, University of Toronto.

Carmine Malfitano MSW, RSW, is a Social Worker in Research at the Princess Margaret Cancer Centre.

Mark Coleman MA is the founder of the Mindfulness Institute and a senior teacher at Spirit Rock Meditation Center, California.

Gary Rodin MD is a psychiatrist and the Joint University of Toronto/University Health Network Harold and Shirley Lederman Chair in Psychosocial Oncology and Palliative Care, Head of the Department of Supportive Care at the Princess Margaret Cancer Centre, Director of the Global Institute of Psychosocial, Palliative and End-of-Life Care (GIPPEC), and a Senior Scientist in the Ontario Cancer Institute.

Mary Elliott MD is a psychiatrist and an assistant professor in the Department of Psychiatry, University of Toronto. She is the developer and lead for the mindfulness program at the Princess Margaret Cancer Centre.