Developing a Resiliency Program For Palliative Care Clinicians (PCC)

Giselle K. Perez, PhD, Vivian Haime, BS, Vicki Jackson, MD, Darshan Mehta, MD, Elyse R. Park, PhD, MPH

The Benson-Henry Institute for Mind Body Medicine

Massachusetts General Hospital
Background

- Palliative Care Clinicians (PCCs) are susceptible to experiencing chronic stress and burnout\(^1,2\)

- Burnout is associated with adverse outcomes for both provider and patient\(^2-4\)
  - Providers → impaired decision-making, adverse events, physical and psychological morbidity, work dissatisfaction
  - Patients → decreased treatment compliance, satisfaction and trust in providers

- There are no studies on interventions that reduce burnout and promote resiliency among PCCs

---

Methods

- **Objective**: Develop and evaluate effects of the Relaxation Response Resiliency Program for PCCs (3RP-PCCs)

- 2 Phase study
  - Phase 1: Intervention development
    - Qualitative, in-depth individual interviews (n=15)
    - Explore stressors, coping strategies and training needs
  - Phase 2: Single-arm Pilot (n=15)
    - 5 sessions over 2 months
    - Pre and post assessment
## Sample Characteristics

<table>
<thead>
<tr>
<th>Demographic Characteristics</th>
<th>N (%)</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, yrs</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>Gender: female</td>
<td>12 (80)</td>
<td></td>
</tr>
<tr>
<td>Race: White</td>
<td>13 (87)</td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never married</td>
<td>7 (47)</td>
<td></td>
</tr>
<tr>
<td>Married/living as if married</td>
<td>7 (47)</td>
<td></td>
</tr>
<tr>
<td>Divorced/separated</td>
<td>1 (7)</td>
<td></td>
</tr>
<tr>
<td>Role in Palliative care service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>6 (40)</td>
<td></td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>6 (40)</td>
<td></td>
</tr>
<tr>
<td>Clinical Social Worker</td>
<td>2 (13)</td>
<td></td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>1 (7)</td>
<td></td>
</tr>
<tr>
<td>How long in palliative care service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;1 year</td>
<td>1 (7)</td>
<td></td>
</tr>
<tr>
<td>1-5 years</td>
<td>7 (47)</td>
<td></td>
</tr>
<tr>
<td>6-10 years</td>
<td>7 (47)</td>
<td></td>
</tr>
</tbody>
</table>
Phase 1: Qualitative Results

Perceived Stressors

Coping Strategies

Training Needs
Phase 1: Qualitative Results

Perceived Stressors

Coping Strategies

Training Needs
Individual Challenges

System Level Stressors

Patient-Centered Stressors
Phase 1: Qualitative Results

Perceived Stressors: System-level
- Limited time and resources
- Competing demands
- Unpredictable schedules

‘...You think [it’ll be] a 15-minute patient and you walk through the door and there’s five family members there and they have a million questions ...before you know it your 15-minute turns into an impromptu two-hour family meeting.’
Phase 1: Qualitative Results

**Perceived Stressors:** Patient-centered stressors
- Managing patient and familial expectations
- Intensity of cases

“You see this kind of loss and illness and suffering and you realize how vulnerable all of us are and how little control we have. It causes me to be aware of the fragility and even in my moments of extreme happiness, that at any moment this could change. It’s hard to live without any barrier to that knowledge.”
Phase 1: Qualitative Results

**Perceived Stressors:** Personal Challenges

- Setting boundaries
- Recognizing and accepting limitations

“We’re so used to listening to others and taking on their suffering …I think figuring out where that boundary should be is often a little bit challenging. I don’t want to set it so far that people don’t feel they can open up to me, but I also don’t want to be at the point where I can’t stop thinking about the patients when I come home at night.”
Phase 1: Qualitative Results

Perceived Stressors

Coping Strategies

Training Needs
Phase 1: Qualitative Results

Coping strategies

- Physical self-care (i.e., diet, exercise, sleep)
- Social and emotional support
- Emotional and physical distancing

“I need to take a certain amount of downtime, just kind of quiet time, and so sometimes it’s just cooking a meal in my house… I just need to observe some quiet time.”
Phase 1: Qualitative Results

Perceived Stressors

Coping Strategies

Training Needs
Phase 1: Qualitative Results

Training needs

- Mind-body skills training
- Cognitive skills
- Stress education
- Brief strategies for real time implementation

“I think it would be interesting to learn how other folks find ways to deal with the stress while they’re in it...how it is to incorporate exercise or some kind of relaxation or mindfulness practice that can be practiced when you have limited time...”
Intervention Adaptation

What they said they needed:

- Brief treatment
- Strategies that can be implemented in workplace
- Combined mind-body and cognitive tools
- Group support
Treatment adaptation

- Decreasing the Stress Response
- Promoting Growth Enhancement
- Promoting the Relaxation Response
- Growth Enhancement
- Resiliency

Mini, brief RR practice

Identifying burnout symptoms

5 vs. 8 sessions

Emphasize self-awareness, reappraisal of “limitations,” meaning making
Outcome Measures

- **Feasibility**: Proportion enrolled, attended sessions & completed assessments

- Promoting Relaxation Response
  - Decreasing the stress response
  - Promoting growth enhancement

- Resiliency
  - General Self-Efficacy Scale

- Interpersonal Reactivity Index; Life Orientation Test-Revised; Brief Satisfaction with Life Scale

Results: Feasibility and Acceptability

- 93.8% (15 out of 16 providers) participated and enrolled

- **All** completed 80% of sessions (4 out of 5)

- 100% completed pre and post-assessments

- **Specific Likes**
  - Group experiences/validation
  - Activities and MINIs helpful
## Results: Preliminary Efficacy

<table>
<thead>
<tr>
<th>Variable</th>
<th>Pre-Mean (SD)</th>
<th>Post-Mean (SD)</th>
<th>Cohen’s D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceived Stress Scale</td>
<td>17.87 (5.21)</td>
<td>14.20 (5.17)</td>
<td>0.65*</td>
</tr>
<tr>
<td>PANAS – positive affect</td>
<td>31.86 (6.56)</td>
<td>34.27 (6.97)</td>
<td>0.42</td>
</tr>
<tr>
<td>PANAS- negative affect</td>
<td>19.29 (5.18)</td>
<td>18.11 (3.68)</td>
<td>0.19</td>
</tr>
<tr>
<td>IRI (empathy)</td>
<td>19.86 (4.54)</td>
<td>21.73 (5.16)</td>
<td>0.67</td>
</tr>
<tr>
<td>LOT-R (optimism)</td>
<td>14.47 (4.05)</td>
<td>16.33 (2.94)</td>
<td>0.36</td>
</tr>
<tr>
<td>Global Life Satisfaction</td>
<td>23.85 (6.66)</td>
<td>25.07 (7.15)</td>
<td>0.29</td>
</tr>
<tr>
<td>General Self-Efficacy</td>
<td>30.43 (2.79)</td>
<td>31.33± 3.20</td>
<td>0.30</td>
</tr>
</tbody>
</table>

*p<.05
Discussion

- 3RP was feasible for this population of PCCs

- Preliminary data demonstrates improvements in perceived stress, little movement in other model constructs
  - Sample size and time!

- PCCs want skills that can be used in the workplace to mitigate stressors and promote sustainability; desired skills provided by program are consistent with existing life practices and identified work needs