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The Experience of Burnout of Inpatient Psychiatric Nurses: Promoting Trauma Informed Care and Examining Mindfulness as a Means for Improved Patient Safety and Nurse Well-Being

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Abstract

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Article #1: *Promoting Trauma Informed Care to Lesson Burnout and Promote Patient Safety among Psychiatric Nurses.*

Article #2: *Exploring the Impact of a Mindfulness-Based Psychoeducational Intervention on Burnout among Inpatient Psychiatric Nurses: A Pilot Study.*

Donna M. Wampole

Chair: Sara Bressi, PhD, LSW

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Intertwined with the focus of patient safety and comfort that Trauma Informed Care lends, exists also a focus on the needs of providers, including nurses. Inpatient psychiatric nurses provide highly interpersonal patient care that requires significant emotional labor. This care is embedded in organizational contexts characterized by numerous workplace stressors including a lack of adequate professional nurse staffing and resources and challenged managerial and inter-nurse support all of which can lead to burnout. Extensive research is present in the literature examining the concept of burnout in the general population, human services, and more specifically, the field of nursing. Despite this existence, little research has been undertaken examining the experience of burnout specific to inpatient-employed psychiatric nurses.

This two-article dissertation addresses the link between the benefits of utilizing Trauma-Informed Care in inpatient psychiatric units in addition to mindfulness skills for the combined purpose of attending to and mitigating the experience of burnout in inpatient-employed psychiatric nurses. The first article addresses the proposed benefits of Trauma-Informed Care and calls to action the expansion of TIC; namely TIC's focus on improved workforce development, as a means to improve nurse burnout and patient safety. The second article reports on a mixed-method research study that examined burnout among nurses employed at a hospital-based inpatient psychiatric unit, and the benefits of participation in a mindfulness skills intervention.

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Andrea Doyle, PhD

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Nancy Hanrahan, PhD, RN FAAN

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and Nurse Well-Being**

Donna M. Wampole

A DISSERTATION

in

Social Work

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School of Social Policy and Practice.

In Partial Fulfillment of the Requirement for the
Degree of Doctorate of Social Work

2018

Sara Bressi, PhD, LSW
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Dissertation Committee

Dedication:

This dissertation is dedicated to three individuals. First and foremost to my mother and father, Glenn and Diane Wampole. Words cannot express my love and gratitude to you and the pride I feel at being your daughter. You have both made tremendous sacrifices so I may have the life I have. You have never given up on me, even during times I've come close to giving up on myself. No matter where life takes me, I will be forever grateful and by your sides until the end. Thank you.

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numerous workplace stressors including a lack of adequate professional nurse staffing and resources and challenged managerial and inter-nurse support all of which can lead to burnout. Extensive research is present in the literature examining the concept of burnout in the general population, human services, and more specifically, the field of nursing. Despite this existence, little research has been undertaken examining the experience of burnout specific to inpatient-employed psychiatric nurses.

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Introduction

Psychiatric nurses employed on inpatient units, commonly have the most direct patient care of all inpatient staff members, and are tasked with a variety of duties from medication management and education to patient progress monitoring, care coordination and at times facilitation of additional treatments including psychoeducational groups. These frontline nurses can face interpersonal challenges with patients suffering from severe and intense patient symptoms. These relational stressors are embedded within and exacerbated by contexts with increasing demands on nursing duties such as expanded communication and documentation requirements dictated by third party payers which compete with time for direct contact and patient care by nurses. (APNA, 2012). Additional concerns including management stressors and intra-nurse tensions further exacerbate stressors of inpatient psychiatric nurses.

An emerging emphasis on the importance of Trauma-Informed Care (TIC) draws attention to the impact of the high levels of distress among particular patient populations on staff, their job satisfaction, and work-related stress (Ford & Courtois, 2014). A significant literature has documented that individuals diagnosed with a mental health disorder are more likely to have a history of trauma (Batelaan, 2016; Li, et al., 2015; Celik & Hocaoglu, 2015; & Zonarini, et al., 1989), and thus experience emotional dysregulation, crisis management difficulties, self harm and other acute symptoms. A Trauma-Informed Care approach cautions against pejorative interpretations of these symptoms and recognizes that these patient presentations occur not out of choice, for attention-seeking or defiance, but out of a developed set of unconscious and conscious

strategies to regain control in response to the patterned invalidation, chaos, and betrayal of complex trauma, (CSWE, 2012). In addition to presenting trauma-related symptoms of mental illness, the constraint of a psychiatric unit- while an attempt to promote safety, may provoke patients to feel trapped, coerced, or in danger and as such, in the context of an acute episode of mental illness, elicit strong affect dysregulation, hyperarousal, or a fight, flight, or freeze response. Survivors of trauma are often challenged with ongoing concerns of disrupted trust and are seeking relations that model a balance of trust and protection (Herman, 1992). Given this search for connection combined with ongoing challenges modulating emotions and correlating behaviors, inpatient nurses are at risk for vicarious traumatization in their work with trauma survivors (Chandler, 2008).

Thus, chronic interaction with traumatized persons and the symptoms of serious mental illnesses intensify the risk for staff burnout. Burnout is defined as adverse behavioral, emotional, and physical symptoms developed in relation to an individual's workplace or work experience (Freudenberger, 1974). Depersonalization and a feeling of emotional exhaustion on the job among staff, two major components of burnout, likely emerge partially in response to these interpersonal challenges with patients, and the embeddedness of these interactions in a work environment that is under resourced (Berzoff & Kita, 2010; Nantsupawat et al., 2017). Burnout is also rooted in organizational contexts that fail to provide structural support for direct care workers for processing daily exposure to victimization and trauma.

Burnout connects to patient care and safety as it places nurses in a position to depersonalize from patients and fail to attune to emotional stressors leading to decreased attunement to issues of patient safety. It is noted that greatest rates of nurse turnover are

in psychiatric nursing (NSI, 2016) and nurse turnover increases the cost of health care in the continual promotion and training of new nurses. In addition, turnover is a source of chronic under staffing and high patient ratios, both known to be factors leading to increased patient mortality which in turn increases nurse burnout (Aiken, Sloane, Clarke, Sochalski, & Siber, 2002).

Despite the unique interpersonal stressors of psychiatric nursing and the risk for burnout, and while evidence exists on its incidence and impact in general nursing (Hannigan et al., 2000; Happell, et al., 2003), examination of burnout among psychiatric nurses is sparse. In turn, interventional strategies aimed at reducing the effects of patient distress on psychiatric nurses have not been examined in the existing literature and thus it remains unclear how to support psychiatric nurses in coping with distress among traumatized persons, thus ameliorating nurse burnout. From a trauma-informed care approach, skills increasing effective communication and attunement to patients with trauma will also maximize nurses' ability to promote trust and safety in their relationships with patients.

Mindfulness skills assist individuals in controlling attention to the present in addition to building skills to let go of distress and work toward the acceptance of what cannot be changed. Contemplative practices involving mindfulness have been present for centuries in a variety of spiritualities and religions with modern research noting its benefits for affect regulation and distress tolerance for individuals in a variety of contexts. In her work developing Dialectical Behavior Therapy, Marsha Linehan focused on the benefits of mindfulness, which she labels Core Mindfulness, as the backbone of the model (Linehan, 1993; Linehan & Wilkes, 2015). The skills of Core Mindfulness

focus on turning one's attention to the here and now and identifying the emotions and thoughts leading to behaviors. The intervention makes direct attempts to impart a strategy for regulating distress and affect for use by patients as well as practitioners of DBT. Mindfulness is now being examined in regards to its benefits to mitigate and prevent stress in a variety of careers including nursing, primary care physicians and general healthcare workers (Goodman & Schorling, 2012; Guillaumie, Boiral, & Champagne, 2017; Penprase, et. al., 2015). Additionally, the mindfulness aspects specific to DBT have been noted to decrease distress and burnout experienced by staff (Persieus, Kaver, Ekdahl, Asberg, & Samuelsson, 2007).

Considering the dearth of literature examining burnout or burnout interventions among psychiatric nurses on an acute-care units, and the documented usefulness of trauma-informed care and mindfulness skills for attending to patient and staff wellbeing, the specific aims of this dissertation are to:

- 1) Call to action the need for inpatient psychiatric units functioning under trauma-informed care with a nursing staff educated in the skills of mindfulness focusing on a reduction of burnout, and increase of patient safety.
- 2) Examine the experience of burnout among inpatient psychiatric nurses; and
- 3) To pilot a mindfulness-based intervention and examine its impact on two components of burnout: depersonalization and emotional exhaustion.

Background and Significance

Definitions of Nurse Burnout and Related Stressors

The term "burn-out" was first coined by psychologist Dr. Herbert Freudenberger, in regards to expressions and symptoms shared by workers in various fields (1974). He described burnout (Burn-Out) as an experience of physical and behavioral symptoms linked to stressors at a job site, beginning at least one year into service. Physical symptoms include fatigue, exhaustion, and chronic medical disruptions such as headaches and gastrointestinal issues, as well as distinct behavioral signs including feelings of being overwhelmed, ease to cry, and even a paranoid ideation against others. Freudenberger noted that those expressing these symptoms shared the commonality of working in environments with ongoing constraint and exposure to stress.

While many researchers conceptualize burnout with different descriptors such as "burned out syndrome," "professional exhaustion syndrome," and "psychological fatigue," (Manzano-Garcia & Ayala-Calvo, 2011), the reported effects experienced by sufferers are typically similar. Individuals report physiological challenges as well as psychological ones (Weber & Jaekel-Reinhard, 2000), and additionally many sufferers report taking increased time off of work or increased utilization of health care benefits to address the above symptoms (Honkonen, et al., 2005).

Christina Maslach and Susan Jackson (1981) expanded upon the concept of burnout redefining it around three conceptual areas, Emotional Exhaustion, Depersonalization, and Reduced Personal Accomplishment. Each concept focused on varying aspects of the burnout experience including feelings of emotional depletion or emptiness (emotional exhaustion), feelings of disconnection and a need to pull back from challenging consumers (depersonalization), and a change in outlook of one's work as "less than" or sub par to prior work (reduced personal accomplishment).

An additional component to examine in the realm of nursing burnout is the concept of Compassion Fatigue (CF). Defined by author and social worker Charles Figley as "a state of tension and preoccupation with traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders, and persistent arousal associated with the patient," (Figley, 2002, p. 1435), compassion fatigue is a phenomena experienced by those who spend regular amounts of time, be they acute or long-term, caring for others. Without balance and self-care, many individuals of the helping professions, be they therapists, shelter workers, social workers, or nurses, are at high risk for compassion fatigue. While Figley's primary professional focus has been social workers, namely those working with individuals with PTSD, War Veterans, and survivors of 9/11, his work and theories have been applied by many to other professions including nursing. Compassion Fatigue, while similar to burnout, focuses on the challenges a caretaker faces in feeling compassion, while burnout's definition focuses on disconnection as well as physical and emotional fatigue. Different from burnout, those experiencing Compassion Fatigue, while noting arousal or a sense of strain from the consumer's experiences, can continue their work without the experience of depersonalizing or othering of the consumer (Slocum-Gori, et al., 2013). An individual can experience Compassion Fatigue, yet still not measure for burnout as the CF may only be experienced in relation to a particular patient's trauma story, and not as an all-encompassing view of the job (Figley, 1995; Slocum-Gori et al., 2013).

Organizational Stressors and Burnout

Burnout in the nursing field is currently a major topic of interest as it effects nurses across multiple specialties and practices (Chatterjee, et al., 2012; Happell, et al.,

2003; & Nantsupawat et al., 2017). Nurses report increased work stress and as a result many opt to change positions between specialties or leave the profession altogether.

Burnout results in part from organizational stressors occurring within the agency or unit itself, along with interpersonal demands of the job itself such as, but not limited to, strains in staffing, high turnover, and insurance-directed care.

The field of healthcare has seen its share of changes in views to manage and protect the bottom line which directly impacts nursing burnout. In many areas, healthcare management's focus has been on decreasing budget lines for medical facilities by increasing the hiring of less educated staff to fill positions previously held by registered nurses. As noted by the American Psychiatric Nursing Association (APNA) in its 2012 Position Statement on Staff of Inpatient Units, movement has been made by healthcare corporations to expand the workforce by using less-skilled and/or educated workers in the form of aids and techs in an effort to expand the treatment provider staff ratio without hiring additional registered nurses. While this may sound fiscally responsible and the intention is to decrease patient to provider ratios, the APNA notes that a staff with higher ratios of registered nurses, not staff in general, results in lower incidences of patient and staff injuries, and lower levels of adverse patient outcomes (2012). In reflecting on the frustration resulting from this situation, many registered nurses are leaving positions as they still feel the pressure and responsibility to manage and provide quality care despite having lower RN staff. The resulting effect is healthcare facilities that are noting the fiscal impact of those turnovers and as Waldman and colleagues (2010) note these agencies must now reinvest in new hires.

Interpersonal Stressors and Burnout

In addition to identifying the top-down organizational pressures placed upon nurses, other studies have shown that often the cause of nurse burnout involves interpersonal challenges experienced between nurses themselves (Happell, et al., 2003; Hannigan et al., 2000; MacKusick & Minick, 2010; Taylor & Barling, 2004; & Watts, et al., 2013). In their study utilizing qualitative analytical interviews with registered nurses who had already chosen to leave their profession, MacKusick and Minick (2010), reported several incidences of hostile work environments including incidences of Horizontal Harassment (as termed by researchers) in which nurses staffed to be working together often engaged in problematic interpersonal communication, blaming, and strained relations including provocation and intra-staff harassment.

In an effort to examine the effects of burnout in psychiatric nursing Happell and colleagues (2003), examined the management of stress and burnout between general psychiatric nurses and those employed on a forensic unit. In looking at the make-up of each unit, the forensic study group was cited as having a strong social support network and correlating lower burnout measurement scores regarding staff distress. This study gives light to the benefits of strong relationships between nurses with supportive work means, and assistance to one another in identifying and addressing perceived stress and burnout. This study may correlate with the latter by MacKusick and Minick (2010), citing evidence that support for nursing stress management as a team may decrease the level of perceived burnout and distress.

Nurses also work in a highly interpersonal stress-related arena with chronic exposure to ongoing trauma and life struggles that require emotional labor (Lee, M,

2016). In addition to stressors relating to the facility psychiatric nurses work in, there is a factor of increased interpersonal contact with patients that can contribute to burnout and stress concerns. In their 2014 study focused on factors keeping mental health nurses in practice, Harrison, Hauck, and Hoffman report that some respondents highlighted a recognition of increased interpersonal interactions with patients when working in mental health versus general nurse care settings. In their 2008 examination of the quality of care for psychiatric patients treated in general care hospitals, Hanrahan, Kumar, and Aiken noted the changes in reported nursing concerns between those employed in surgical care compared to those in psychiatric care. The feedback including an increase in reported verbal abuse against nurses and reports of patient and family dissatisfaction of care. The study notes that 66% of registered nurse participants working in inpatient psychiatric units reported managing complaints from patients and their families and 79% noted incidences of verbal abuse against nurses by patients with both factors being higher than the same reported in the non-psychiatric nursing realm. For some nurses working on inpatient units, judgments can form against the behaviors of patients especially during periods of unit acuity or when patients are acting in aggressive manners (Howard & Holmshaw, 2010). These judgments and perceptions can then lead to challenges in mitigating stressful or even routine interactions with patients.

To best examine burnout in nursing, one must also focus on the relational elements in nursing. Nurses care and attend to patients in the individual's time of need, using both learned skills and as well as the nurse's own experience and being. While the concept of the relationship is of importance in all nursing fields, it is most critical in psychiatric nursing as one is attending not just to a trauma of the body, but of the mind.

Patients seeking treatment on inpatient psychiatric units require a level of care attuned to energy and presence as well as medical knowledge and skills. From this standpoint, nursing is viewed from a relational lens as nurses are in ongoing dyads of interpersonal connection with patients.

Other mental health clinicians are trained in the concept of transference and countertransference which involve the relational reflection between professions, patients, and prior experiences. For patients with trauma histories, distress, anger, anxiety, or sadness expressed toward inpatient staff may in fact be a communication of the patient's internal state, as well as the effects of vicarious trauma from the hospitalization (Berzoff, 2002). Likewise, staff, including nurses, who experience heightened tensions, frustrations and anxieties with patients might be displaying elements of countertransference or an expressive link between the nurse-patient interactions to said nurse's own traumatic or stressful history. Despite being an integral part of a mental health treatment team, most nurses receive limited training on relational dynamic elements like transference, as education is focused on medical modalities (Baca, 2011). Countertransference relates not only to the client but to the shared relationship between client and professional, and can be used as a source for understanding client psychology (Delacour, 2002). It is of great importance for nurses to be educated in the countertransference process and how it can assist in forming negative patient beliefs. Without understanding of countertransference it is possible for inpatient psychiatric nurses to attribute their own emotions to patient personalities, leading to detachment and depersonalization. These factors, coupled with work stress, can decrease nurses' effectiveness to connect with clients (Evans, 2007).

It is here where the concepts of Trauma Informed Care can be applied. A system of care that functions under the lens of Trauma Informed Care (TIC) is one wherein recognition is given to the possibility that every individual expressing pressured and challenging feedback may be doing so from a source of her or his own traumas. TIC embraces the concept of not focusing on how an individual is acting but also what could have happened to her that led to the displayed thoughts or actions. Judith Herman (1992) reflects on trauma's challenge to survivors' ability to regulate affect. "The normal regulation of emotional states is...disrupted by traumatic experiences that repeatedly evoke terror, rage, and grief" (Herman, 1992, pg. 108). By taking into account the prospect of a challenging individual's known or possible history of recent or remote trauma, TIC allows for an understanding that behaviors of this individual may be automatic, born out of defense responses to trauma. As Sandra Bloom and Joseph Foderaro of The Sanctuary Institute both pose, the question becomes not what is wrong with an individual?; but rather what happened to an individual (Bloom 2016a)?

Another element of Trauma Informed Care examines incidences of enactment, or the playing out of prior trauma in current relationships or situations. Sandra Bloom outlines a four-part circle of trauma, beginning with the direct bodily responses to trauma, such as disassociation, flashbacks, and chronic hyperarousal. These elements which the individual chronically experiences lead to an experience of profound loss including a loss of a sense of physical and psychological wholeness, loss of connection to others, and even loss of opportunities in education, employment, and engagement. As a result of this loss, Bloom (2013), posits that trauma survivors often become unknowingly caught in exercises of enactment, wherein traumas are acted out with loved ones,

community members, and treatment personnel. These enactments often result with negative emotions experienced by the trauma survivor who may then seek means of soothing by way of substance abuse, acting out, or self-harming (Bloom, 2016b). The Sanctuary Model, a means of presenting Trauma Informed Care, notes that members of a TIC treatment community need members who exhibit emotional intelligence, are empathetic and patient, and are able to regulate her or his own emotions and be aware of personal affect (Bloom, 2016c). As such, nurses in psychiatric units can benefit by utilizing trauma informed care as this model both focuses on the link between provider well-being and patient well-being. Bloom (2013), writes of the effect of "catching" emotions of another during interpersonal interactions. She writes, "The more our attention is riveted on someone else, the more interrelated we are with someone else" (Bloom, 2013, pg 52). This interaction of emotions and affect can exacerbate negative situations such as shared hysteria over an emergency, yet it can also reflect the sharing of positive, calming emotions, such as when a nurse approaches an agitated or confused patient with patience and kindness.

Mindfulness as an Intervention for Burnout

The prevalence and challenges of general nurse burnout have been studied worldwide, (Duffield, C. et al. 2014), in addition to concerns of distress in nursing students, (Houseman, 2009; Michalec, Difenbeck, & Mahoney, 2013; Ratanasiripong, Park, Ratanasiripong, & Kathalae, 2015; Rees, et al., 2016). Increasing research has additionally focused on the burnout concerns specific to the psychiatric nurse field outside of the United States (Chatterjee, Chaudhury, & Chakraborty, 2012; Hannigan et, al., 2000; Nantsupawat, et al., 2017), yet despite the worldwide focus, a paucity in

research in the United States exists (Hanrahan, Kumar, & Aiken, 2010). Given the plethora of overall burnout-focused research and the knowledge that psychiatric nursing is an interpersonal science focused on intense patient-provider interaction it is imperative that additional research be undertaken to expand the understanding of the prevalence and impact of psychiatric nurse burnout in the United States with additional research focused on mitigating the effects and occurrence of burnout.

Also, as stated above, trauma-informed care requires professionals to develop skills for regulating affect in the midst of intense interpersonal interactions to promote patient safety and ameliorate distress. Mindfulness has been proposed as a vehicle of the promotion of control over affective responses. Mindfulness techniques are skills wherein an individual draws attention to the here and now while also recognizing the ability to let go of distress and situations beyond one's control. As mindfulness practitioner Professor John Kabat-Zinn states, mindfulness is "the awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to the unfolding of experience moment by moment" (2003, pg. 145). While the concept of mindfulness and other forms of contemplative practices predate modern medicine and have been part of several worldwide religions for centuries, recent research during the past two decades has shown it to be of benefit for stress reduction for individuals in a variety of situations. For example, several such studies have been undertaken to examine the benefits of mindfulness training to prevent burnout symptoms in nursing students and nurses working in high-intensity units such as emergency and trauma departments (Zeller & Levin, 2013; Heard, et al., 2013; Ratanasiripong, et al., 2015). Other studies have shown positive outcomes of mindfulness training with general nursing populations (Penprase, et.

al., 2015), but limited research was found that focused specifically on the mindfulness benefits for psychiatric inpatient nurses.

As Guillaumie, Boiral, & Champagne, (2017) note in their review, self-care programs oriented to mindfulness techniques have been shown in numerous studies to be of benefit in lowering stress perceptions and anxiety for nurses working in general medical environments as well as for nursing students. Their mixed-method systematic review of data gathered in 17 studies noted that participants noted an increase of a sense of calmness and wellbeing, increased productive interpersonal communication with patients and peers, and a clearer sense of emotion regulation during periods of acute duress as a result of skills learned in various mindfulness interventions. It is of note that while this study presents as comprehensive addressing a wide variety of nurse populations including trauma care, nursing students, and geriatric nurses, no study members worked specifically in psychiatric care.

In her focus on the treatment of individuals with low emotion regulation and poor distress tolerance skills, Marsha Linehan incorporated mindfulness as the backbone of her model, Dialectical Behavior Therapy (DBT). Developed in response to challenges faced by those clinicians treating individuals with chronic self-harm and suicidal tendencies, DBT later focused to those with the primary diagnosis of Borderline Personality Disorder. Linehan discovered that teaching individuals to embrace the skills of observing and describing an emotion, rather than directly changing it, led to a decrease of patient treatment drop-out and negative patient feedback (Linehan & Wilkes, 2015). Likewise, practitioners of DBT also practice the components of the model in daily life to both hone skills and manage their own emotions, countertransferential experiences, and reactions.

In addition, Linehan made Core Mindfulness a primary focus of DBT to address noted burnout of therapist working with those with Borderline Personality Disorder (Linehan, 1993). Similar to the protocols of psychoanalysis where each practitioner must undergo her own period of psychoanalytic analysis for the purposes of training and self actualization, DBT too focuses on the care and skills practice of the facilitating therapist. Reflecting upon the basis for developing DBT, addressing not only the needs of patients engaging in self-harming behaviors, but also the incidence of treatment provider burnout, mindfulness is a skill which can be utilized to note incidences of judgmental thoughts or feelings a provider may have relating to countertransferential experiences. Without examination, continual experience of the nurse-patient relational experience as negative or stressful could in turn lead to an increase for burnout and compassion fatigue. As noted by Brady and colleagues (2012), nurses trained in skills of mindfulness may improve work skills by being in the moment with a patient and the shared relational experience and be prevented from working in a distracted manner, focused only on a task, rather than person.

This two article conceptual-theoretical dissertation attempts to address the link between the benefits of utilizing Trauma-Informed Care in inpatient psychiatric units in addition to mindfulness skills for the combined purpose of attending to and mitigating the experience of burnout in inpatient-employed psychiatric nurses. The first article addresses the proposed benefits of Trauma-Informed Care and calls to action the expansion of TIC, namely TIC's focus on improved workforce development, as a means to improve nurse burnout and patient safety. Article number two outlines a mixed-method research study examining the experience of burnout of nurses employed at a

hospital-based inpatient psychiatric unit, and the benefits of participation in a mindfulness skills intervention.

**Article One: Promoting Trauma Informed Care to Lessen Burnout and Promote
Patient Safety among Psychiatric Nurses**

INTRODUCTION

Inpatient psychiatric nurses, as part of an interdisciplinary team of clinicians, typically have the most direct contact with patients and are tasked with monitoring patients' progress in treatment, dosing medications, coordinating care with doctors and social workers, and in some contexts facilitating psychoeducational group treatment with patients. As such, these nurses provide highly interpersonal patient care that requires significant emotional labor. This care is embedded in organizational contexts characterized by numerous workplace stressors as outlined by the Association of Psychiatric Nurses including a lack of adequate professional nurse staffing and resources and output pressures from managed care organizations (APNA, 2012).

Perhaps most importantly, the relational quality of treating persons with psychiatric disorders with acute needs is demanding. Persons with psychiatric disorders admitted to inpatient facilities experience the most intense of symptoms including suicidality, affect and mood dysregulation, psychosis, and the psychological and physical effects of dependence on or abuse of psychoactive substances. Relatedly, psychiatric nurses report higher incidences of managing patient and family complaints and elevated rates of verbal abuse when compared to other hospital nurses (Hanrahan, Kumar, & Aiken, 2010).

Adding to the emotional labor required by inpatient psychiatric nursing is a growing recognition that a significant proportion of persons with behavioral health

problems have histories of trauma (Lee, 2016). SAMSHA (2014) defines trauma as “an **event**, series of events, or set of circumstances that is **experienced** by an individual as physically or emotionally harmful or life threatening and that has lasting adverse **effects** on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.” A significant literature has documented that individuals diagnosed with a mental health disorder are more likely to have a history of trauma (Batelaan, 2016,; Li, et al. 2015; Celik & Hocaoglu, 2015; Zanarini et al., 1989), and thus experience emotional dysregulation, crisis management difficulties, self harm, and other acute symptoms. In addition to these presenting trauma-related symptoms, the constraint of a psychiatric unit- while an attempt to promote safety and provide a least restrictive environment- also may provoke patients with trauma histories to feel trapped, coerced, or in danger and as such, in the context of an acute episode of mental illness, elicits strong affect dysregulation, hyperarousal, or a stress-related fight, flight, or freeze response. In other words, while patients are brought to inpatient care to keep them physically safe, they may also feel incredibly emotionally unsafe in this context.

It follows that inpatient units may also feel unsafe for psychiatric nurses. For these frontline staff persons, the severity and intensity of patient symptoms creates a multitude of interpersonal challenges between patients and nurses, between nurses and families, as well as between nurse colleagues. This chronic interpersonal stress related in part to the intensity of patient symptoms in combination with organizational stressors may intensify the risk for nurse burnout.

UNDERSTANDING BURNOUT

The term "burn-out" was first utilized in 1974 by Herbert Freudenberger in reflection of the symptoms displayed by workers in various fields who were placed under ongoing constraint and exposure to stress. He described burnout (Burn-Out) as an experience of physical and behavioral symptoms linked to stressors at a job site, beginning at least one year into service. Physical symptoms of burnout included fatigue, exhaustion, and chronic medical disruptions such as headaches and gastrointestinal issues. Burnout also included behavioral symptoms such as acting out in anger or sadness. Freudenberger (1974) wrote the following about burnout

A staff member's quickness to anger and his instantaneous irritation and frustration responses are the signs. The burn-out candidate finds it just too difficult to hold in feelings. He cries too easily, the slightest pressure makes him feel overburdened and he yells and screams. With the ease of anger may come a suspicious attitude, a kind of suspicion and paranoia. The victim begins to feel that just about everyone is out to screw him, including other staff members. (1974).

In their studies of work-related burnout, Maslach and Jackson (1982) define burnout utilizing three main concepts: Emotional Exhaustion-EE, Depersonalization- DP, and Reduced Personal Accomplishment-PA. They further described each term as referencing experiences of feeling emotionally depleted or empty (emotional exhaustion), feeling withdrawn or emotionally removed from problematic patients (depersonalization) and viewing one's work as "less than" or sub par to prior work (reduced personal accomplishment).

Burnout directly loops back to patient care and safety in placing nurses at risk for diminished efficacy on the job, depersonalization or a negative othering of the patient group, decreased ability to promote safety on the unit, or departure from the workplace-

only to be replaced by less experienced staff (Howard & Holmshaw, 2010). In 2016 (NSI), a survey of 138 hospital facilities reported that behavioral health continues to report the highest registered nurse turnover. These workforce concerns cost the health system in their impact on the efficacy of staff, increased training costs, and poor patient care.

As noted in psychiatric nursing, burnout on the job likely emerges partially in response to interpersonal challenges with patients with significant trauma histories, and the embeddedness of these interactions in a work environment that is under resourced (Bowers & Flood, 2008; Hanrahan, Aiken, McClaine, Hanlon, 2010; Ohnishi, et al., 2010; Berzof, & Kita, 2010; Nantsupawat et al., 2017). Furthermore, burnout is also rooted in organizational contexts that fail to provide structural support for nurses to process the daily exposure to victimization and trauma.

TRUAMA INFORMED CARE

A movement towards offering psychiatric care that is trauma-informed recognizes that patients must feel safe in order to fully benefit from treatment. As defined by SAMSHA, trauma-informed care understands the scope of trauma among vulnerable persons, recognizes the outcomes of trauma, and integrates this knowledge of trauma into direct patient care, policies and systems in an effort to actively resist re-traumatizing the client group (2014). As noted by Judith Herman (1992), survivors of trauma are challenged with modulating intense emotions such as anger or profound sadness, and become severely intolerant of the intense emotions or reactions of others. Additionally, Herman notes that survivors, while experiencing, "profound disruption in basic trust,"

also display an intense need for relationships that foster and ensure trust and protection (pg 56). A trauma-informed care approach cautions against pejorative interpretations of these symptoms and recognizes that these patient presentations occur not out of choice, for attention-seeking or defiance, but out of a developed set of unconscious and conscious strategies to regain control in response to the patterned invalidation, chaos, and betrayal of complex trauma, (CSWE, 2012).

An emerging emphasis on the importance of trauma-informed care draws attention to the impact of the high levels of distress among particular populations on staff, their job satisfaction, and work-related stress (Ford & Courtois, 2014). Trauma-informed care highlights that these behaviors and difficulties in coping with distress developed in the context of survival in abusive environments, will inevitably directly impact the experience of psychiatric nurses and other professionals working with these patients and potentially expose these mental health clinicians to vicarious trauma and subsequent similar problems in regulating distress (Chandler, 2008). In other words, organizations and health systems must “integrate an understanding that the experience of traumatic events impacts all people involved (SAMSHA, 2014). A trauma-informed approach to psychiatric care is notes that clinicians also need to have the emotional labor of the work recognized and processed in order to prevent burnout.

Drawing from the literature, this paper reviews current literature on trauma-informed care and presents four key strategies for promoting trauma-informed care among psychiatric nurses in acute care towards patients, and for reducing the effects of patient distress on psychiatric nurses thus ameliorating nurse burnout. From a patient-safety focused care approach, the first three strategies maximize nurses’ ability to

promote trust and safety in their relationships with patients. In addition reflecting on the literature of the benefits of mindfulness, a fourth strategy proposes the benefits of this practice in trauma-informed care for nurse wellbeing.

Strategy #1: Train and Educate Nurses on the Impact of Trauma

As outlined by the principles of trauma-informed care, it is imperative that psychiatric nurses have education in the nature and impact of trauma. Education may assist nurses in identifying symptoms of trauma (i.e. trauma cueing) as well as aid nurses in promoting healthy decision making which may assist clients to feel safe.

First, education that emphasizes the etiology and effects of trauma is paramount. In a recent meta-analysis, Muskett (2013) reflects that education and promotion of staff competency in the principles of TIC was core to an agency culture valuing trauma-informed care and patient centered recovery. This author further notes that most TIC literature cited by organizations including SAMHSA, NASMHPD, and others all note the importance of reinforcing through continual education the understanding by staff of the effects of childhood trauma on adult mental health pathology. Many studies Muskett (2013) researched utilized trauma-informed care education from the beginning of one's career on an inpatient unit through time focusing on multiple areas including the trauma needs of those with substance abuse disorders, establishment and termination of therapeutic boundaries, and consumer empowerment.

Additionally, education regarding trauma is noted to assist mental health nurses relate to consumers and increase the therapeutic relationship (Wilson, 2017). Compared to units without a trauma-informed lens, those offering trauma-informed care included

education to nurses focused on trauma and how trauma leads to often called maladaptive behaviors which historically have been viewed as simply "bad" patient behavior. By educating nurses on the effects of trauma, patient actions can be assessed as reflective of trauma cues, such as loss of control or loss of patient voice leading to an opportunity for enhance nurse-patient communication for de-escalation.. Wilson and colleagues (2017) do note, that while education is fundamental to TIC, agencies employing TIC care must also embrace it on a system level including managerial and system-wide buy-in. Nurses cannot be educated in TIC if an agency itself has not embraced it. All members of an inpatient unit, preferably the entire facility, needs TIC education to assist one another in understanding patient interactions as well as staff interactions.

Education in trauma-informed care in inpatient psychiatric care is important especially in the use of techniques to assist patients in de-escalation in an effort to eliminate the use of seclusion and restraints which often injure or re-traumatize patients. Seclusion involves the movement of a patient to a solitary environment while restraint involves manual or instrumental maneuvering to obtain physical control of a patient. While these techniques have been used for decades, individuals on whom restraints and seclusion are placed are cued to past periods of abuse or neglect, and thus retraumatized. Thus, use of seclusion and restraint may have a paradoxical effect and lead to a resurgence of the problematic behaviors.

As part of TIC, education needs to include the understanding of the effects of seclusion and restraint as cues to retraumatization as well as training in additional non-traumatizing techniques to improve patient behaviors and make inpatient milieus more manageable for staff (Courtois & Gold, 2009; Isobel & Edwards, 2017; Wisdom, et al.,

2015). This aim was highlighted in 2005 by the National Association of State Mental Health Program Directors (NASMHPD) who established six principles for reducing use of seclusion and restraint. Principle number three, workforce development, highlighted the need for ongoing staff education regarding trauma, restraint, and the prevention of re-traumatization (2005). In their 2011 study which examined the outcomes of implementation of the NASMHPD principles, Azeem and colleagues (2011) noted a markedly downward trend in the use of both seclusion and restraint in a long-term child and adolescent facility. In this facility, education regarding the effects of trauma were implemented as part of the orientation for new hires, continuing education was provided routinely at staff meetings and trainings, and assessment of knowledge was added to regular performance evaluations (Azeem et al., 2011). The study notes that following implementation of the NASMHPD principles, the trend in restraint and seclusion use dropped quickly in the first six months of the study and with the exception of one quarter, maintained reduction for the nearly three-year retrospective study.

Education regarding trauma and its impact, or on skills for patient de-escalation, not only benefit patient safety, and prevent re-traumatization, it also will in reducing patient triggering, it lessens the interpersonal impact on nurses. While limited data currently exists reflecting upon mental health nurse experience with TIC education, what is known cites positive nurse experience (Isobel & Edwards, 2017).

Strategy #2: Build Social Support among Staff

The relationships between and among nurse co-workers is important for managing on the job stress. Prior studies link the experience of nurse burnout to interpersonal challenges experienced between nurse colleagues (Happell, Martin, Pinikahana, 2003;

Hannigan, et al., 2000; MacKusick & Minick, 2010; Taylor & Barling, 2004; Watts J, et al., 2013). In their study utilizing qualitative analytical interviews with registered nurses who had already chosen to leave their profession, MacKusick and Minick (2010), describe several incidences of horizontal harassment (as termed by researchers) in which nurses staffed to be working together often ended at odds, or worse, defending provocation and harassment from one another.

Relatedly, Happell and colleagues (2003), examined the management of stress between general psychiatric nurses and those employed on a forensic psychiatric unit. Originally posited to have higher scores for burnout of the two units, the forensic study group reported stronger positive perceptions of their work environment including stronger involvement in decision making and unit support, which was correlated with lower burnout measurement scores.. This study in particular points to the benefits that nurses who work together in supportive ways assist one another in identifying and addressing perceived stress and burnout. Going beyond the focus of intra-nurse relations, Van Bogaaert (2013) and colleagues focused on nursing care practice environments and their relation to the experience of burnout in mental health nurses, and nurse perceptions on patient quality of care. The study focused on the relational exchange between nurses and physicians, nurses and management systems, and nurses and the overall healthcare organization as correlations to self-reported burnout factors followed by how those relations and ensuing burnout factors affected nurses' perception of patient care. The multivariate analysis noted overall that positive ratings of nurse practice environments, including management and inter-professional relations resulted in positive nursing views of patient outcomes and reduced burnout factors. These studies draw focus on the need

for positive nurse relations and support as a target for improving patient experience and safety.

In examining points of Workforce Development, the NASMHPD asks how facilities addressed staff empowerment issues or how facilities promote employee empowerment at all. They specifically questions if staff members are allowed to swap assignments when needed or flex their schedules. While every unit at all times cannot make such flexibility available, these are needs that feed into nurse self-care to prevent burnout or expression of distress to patients? The combination of healthy communication and flexibility when available can promote healthy nurse relations and team building. Units and hospitals that promote open and constructive communication between nurses, nurses and other staff, and management with nurses can lessen nurse burnout while creating safer, more supportive patient care. Likewise, units that promote flexibility can assist nurses in attending to personal needs to prevent burnout from occurring. Trauma informed Care gives light to the challenges nurses face in relation to patients and staff and acknowledges that the daily interaction on a closed unit can lead to nurse distress. TIC also acknowledges that this exposure may highlight a nurse's own traumatic past experience leading to her/his own retraumatization (Isobel & Edwards, 2017) and so improving nurse experiences with and beyond patient interactions including the use of healthy, open communication, flexibility, and support can assist in nurse wellbeing and reduce burnout.

Strategy #3: Emphasize the Development of Clinical skills for Managing and Processing Patient Distress.

In order to examine the incidence of burnout in the field of nursing, one must also examine the element of 'relationship,' in nursing. While the relationship is of importance in all nursing fields, it is most critical in psychiatric nursing as one is attending not just to a trauma of the body, but of the mind. Patients experiencing mental distress require a level of care attuned to presence, energy, voice inflection, and affect as much as medical knowledge and skills. From this standpoint, nursing can be viewed from a relational lens where nurses are in ongoing dyads of communication and reflection with patients.

Other mental health clinicians are trained in the concept of countertransference and so are aware that distress, anger, anxiety, or sadness experienced by the clinician may in fact be a communication of the patient's internal state or experience (Berzoff, 2002). Countertransference involves thoughts, fantasies, and feelings a professional may experience in interactions with a patient. Countertransference relates not only to the client but to the shared relationship between client and professional. Delacour (2002) states, countertransference one of the most important sources of information for understanding a client's experience. When a professional can tune-in to her own internal perceptions of a client interaction, she can learn where a patient's point of view and importantly, history of expectations or needs of others comes from. Despite being an integral part of a mental health treatment team, most nurses receive limited training on relational dynamic elements like transference or countertransference, as education is focused on medical modalities (Baca, 2011). For nurses, a lack of education and understanding of the countertransferential process may lead to negative conceptualizations of patients and negative relationships. As such, it is possible that when nurses experience these interpersonal stressors at work, they may unwittingly start

to attribute them to the patients being difficult or deficient in some way. Coupled with work stress, this creates depersonalization, and thus decreases the nurses' effectiveness to intervene with clients (Evans, 2007).

Studies focused on patient safety in the psychiatric field have involved examination of how patient safety is defined beyond typical concerns of falls, infection, and medication errors in encompassing the importance of interpersonal safety. Berg and colleagues (2017) learned that psychiatric patients experiencing suicidal emotions while hospitalized report three factors: connection, the knowing someone cares and confirms the patient's feelings; protection, the receipt of support from a caretaker; and control, which includes a the insight a patient gains regarding her/his suicidality as she/he moves toward discharge, as primary features of their perceived safety with staff. One can posit that nurses not attuned to communication and countertransferential experiences can struggle reaching patients in these experiences of safety. Also cited by Berg (2017) from one examined study (Cutcliffe, Stevenson, Jackson, Smith, 2006), suicidal patients receiving inpatient care seek "reconnection with humanity," which is primarily provided through the care and communication with nurses. Nurses attuned to the patient can feel less depersonalization and present as the first step for patients in their reconnection to humanity and experience of interpersonal emotional safety.

Relating to TIC's focus on lessened or extinction of the use of restraint and seclusion, it may be posited that patients experiencing increased connection with a nursing staff that is receptive may present as less distressed with fewer negative behavioral outbursts. As such, fewer incidences of general unit disruption and need for physical interventions, including holds or involuntary injections may keep patients and

staff safer. Additionally, psychiatric nurse units focused on quality intra-staff communication may experience fewer patient safety concerns with shared knowledge of what de-escalation skills work best with which patients and what safety concerns may exist between shifts.

As patients experience an increase in feelings of connections and trust with nurses they are learning recovery skills to use post-hospitalization. Psychiatric units functioning under trauma informed care recognize that inpatient units need to be facilities focused on recovery, not just stabilization from crises and nurses are in the position of educators for long-term care goals. As Wilson and colleagues (2017) note, most non-TIC inpatient facilities limit the topic of ongoing wellbeing in reference to a patient's discharge, not throughout care. By integrating TIC with its focus on staff -patient relationships, nurses can join with their patients in developing and modeling skills of self-regulation, interpersonal effectiveness, and emotion regulation that not only benefit the nurse-patient relationship in the moment but also build the patient's skills for long term recovery. When a patient feels connected to a nurse, trust builds and an opportunity for education on communication and recovery-oriented skill use is born. Additionally, healthy connection with patients decreases depersonalization and therefore can decrease burnout.

**Strategy #4: Promote Mindfulness-Based Interventions for Inpatient
Psychiatric Nurses**

Mindfulness techniques are skills wherein individuals draw attention to the here and now while also recognizing the ability to let go of distress and situations beyond one's control. While the concept of mindfulness and forms of contemplative practices predate modern medicine and have been part of several religious and spiritual traditions

for centuries, recent research from the past two decades have shown it to be of benefit for affect regulation and distress tolerance for individuals in a variety of contexts

(Guendalman, et al., 2017; Lotan, Tanay, & Bernstein, 2013; Luberto & McLeish, 2017).

In her work developing Dialectical Behavior Therapy, Marsha Linehan focused on the benefits of mindfulness, which she labels Core Mindfulness, as the backbone of the model (Linehan, 1993; Linehan & Wilks, 2015). The skills of Core Mindfulness focus on turning one's attention to the here and now and identifying the emotions and thoughts leading to behaviors. The intervention makes direct attempts to impart a strategy for regulating distress and affect. Mindfulness is now being examined in regards to its benefits to preventing and mitigating stress and burnout in multiple careers including nursing (Guillaumie, Boiral, Champagne, 2017), has been shown to reduce depersonalization and emotional exhaustion in general healthcare workers (Goodman, Schorling, 2012), and to positively impact primary care physicians' ability to maintain positive affect relating to patients and work stressors (Montero-Martin et, al., 2015).

Additionally, mindfulness is a skill useful in assisting an individual to note her or his own affect dysregulation, lending to the ability to notice both the distress within the practitioner (the psychiatric nurse) as well as within the patient, leading to a greater ability to engage in effective relational attunement.

Conclusion

Given the plethora of research devoted to general nurse burnout and the primary focus of psychiatric nursing as both a medical and interpersonal science focused on intense patient-provider interaction it is imperative that additional research be undertaken to expand the understanding of the prevalence and impact of psychiatric nurse burnout.

Furthermore, focus needs be placed on studying the impact burnout may have on psychiatric patient safety and what interventions may be of benefit to this concern. By implementing the standards of Trauma Informed Care in inpatient psychiatric settings, nurses can develop a better understanding of the vulnerability of patients to retraumatization which may induce escalated, challenging behaviors. Trauma Informed Care also focuses on the organizational challenges of inpatient units and emphasizes the need for increase staff support of one another to mitigate the experience of burnout. Trauma Informed Care supports nurses in assisting patient in developing self-regulation and communication skills to not only decrease safety risks while in the hospital but also increase recovery outcomes. Finally, the addition of mindfulness skills with Trauma Informed Care can assist nurses employed in an inpatient psychiatric setting to increase their own ability to tune in to both self and patient distress, mitigate incidences of acting on Countertransference, and curb the experience of burnout. By integrating Trauma Informed Care into inpatient psychiatric settings nurses can increase their ability to care for themselves while caring for others, and lead by example how recovery is possible for all.

Article Two: Exploring the Impact of a Mindfulness-Based Psychoeducational Intervention on Burnout among Inpatient Psychiatric Nurses: An Exploratory Study

INTRODUCTION

Acute inpatient mental health units are the frontline critical care settings for youth and adults with behavioral health and substance abuse conditions. Acute-care patients with psychiatric disorders admitted to these facilities experience the most intense of symptoms including suicidality, affect and mood dysregulation, psychosis and the psychological and physical effects of dependence on or abuse of psychoactive substances.

Psychiatric nurses, as part of an interdisciplinary inpatient treatment team, typically have the most direct contact with patients and are tasked with monitoring patients' progress in treatment, dosing medications, coordinating care with doctors and social workers, and in some contexts facilitating psychoeducational groups or milieu-based treatments with patients. For these frontline staff persons, the severity and intensity of patient symptoms may create a multitude of interpersonal stressors between patients and nurses. These stressors are embedded within and exacerbated by contexts with increasing demands on nursing duties. For example, under managed care, third party payers have expanded communication and documentation requirement for nurses which compete directly with time for direct patient care (APNA, 2012).

An emerging emphasis on the importance of trauma-informed care (TIC) draws attention to the impact of the high levels of distress among particular populations on staff, their job satisfaction, and work-related stress (Ford & Courtois, 2014). A major assumption of TIC holds that staff must feel safe in order to create safe environments for

patients. A significant literature has documented that individuals diagnosed with a mental health disorder are more likely to have a history of trauma (Batelaan, 2016; Li, et al., 2015; Celik & Hocaoglu, 2015; Zanarini, et al., 1989), and thus experience emotional dysregulation, crisis management difficulties, self harm, and other acute symptoms. These ongoing symptoms are obvious sources of stress for patients that may also cause disruption and distress to nurses on inpatient psychiatric units. Thus, chronic interaction with traumatized persons and the symptoms of serious mental illnesses intensify the risk for staff to feel unsafe and experience burnout.

Burnout is defined as adverse behavioral, emotional, and physical symptoms developed in relation to an individual's workplace or work experience (Freudenberger, 1974). Depersonalization, an inclination to pull away from patients and other staff, and a feeling of emotional exhaustion on the job among staff, two major components of burnout, likely emerge partially in response to these interpersonal challenges with patients, and the embeddedness of these interactions in a work environment that is under resourced (Berzoff & Kita, 2010; Nantsupawat et al., 2017). Burnout is rooted in organizational contexts that fail to provide structural support for direct care workers for processing daily exposure to victimization and trauma.

Burnout directly loops back to patient care and safety in placing nurses at risk for diminished efficacy on the job, a negative othering of the patient group, decreased ability to promote safety on the unit, or departure from the field. In 2016 (NSI), a survey of 138 hospital facilities reported that behavioral health continues to report the highest registered nurse turnover. These workforce concerns cost the health system in their impact on the efficacy of staff, increased training costs, and poor patient care. Bland-Jones (2004)

noted that the costs of nursing turnover to health systems are multifaceted and include pre-hiring costs of advertising, recruitment, interim overtime payment of currently employed nurses, and the training of new hires.

Despite the unique interpersonal stressors of psychiatric nursing and the risk for burnout, and while evidence exists on its incidence and impact in general nursing (Hannigan et al., 2000; Happell, et al., 2003), examination of burnout among psychiatric nurses is sparse. Comparatively, the prevalence and challenges of general nurse burnout have been studied worldwide. This research has documented the costs of burnout-related nurse turnovers in the United States, Canada, Australia, and New Zealand (Duffield, et al. 2014), the experience of anxiety and stress in Thai nursing students, (Ratanasiripong, Park, Ratanasiripong, & Kathalae, 2015) as well as the experience and efforts to decrease burnout in nurses employed in Chinese emergency departments (Wei, et al. 2017). Research has also focused on the burnout concerns specific to the psychiatric nursing field outside of the United States including India, (Chatterjee, Chaudhury, & Chakraborty, 2012), Wales (Hannigan et al., 2000), Australia (Happell et al., 2008), Thailand, (Nantsupawat, et al., 2017), and Japan (Sugawara, et al., 2017). These studies have focused on a variety of topics including the means to predict psychiatric nurse burnout, how psychiatric nurse burnout compares to that of general nurse practitioners, as well as mitigating factors for forensic psychiatric nurse burnout. Despite these efforts, a paucity in research in the United States exists regarding burnout specific to the field of psychiatric nursing (Hanrahan, Kumar, & Aiken, 2010). Given the plethora of research devoted to general nurse burnout, and the primary focus of psychiatric nursing as both a medical and interpersonal science focused on intense patient-provider interaction it is

imperative that additional research be undertaken to expand the understanding of the prevalence and impact, and subsequently, interventions to reduce psychiatric nurse burnout.

MINDFULNESS FOR ADDRESSING PSYCHIATRIC NURSE BURNOUT

Mindfulness techniques are skills wherein individuals draw attention to the here and now while also developing the ability to let go of distress and situations beyond one's control. While the concept of mindfulness and forms of contemplative practices predate modern medicine and have been part of several religious and spiritual traditions for centuries, recent research from the past two decades have shown it to be of benefit for affect regulation and distress tolerance for individuals in a variety of contexts. In her work developing Dialectical Behavior Therapy, Marsha Linehan focused on the benefits of mindfulness, and identified Core Mindfulness, as the backbone of the model (Linehan, 1993; Linehan & Wilkes, 2015). The skills of Core Mindfulness focus on turning one's attention to the here and now and identifying the emotions and thoughts leading to behaviors and the intervention makes direct attempts to impart a strategy for regulating distress and affect.

Mindfulness is now being examined in regards to its benefits to preventing and mitigating stress and burnout in multiple careers including nursing (Guillaumie, Boiral, & Champagne, 2017), and has been shown to reduce depersonalization and emotional exhaustion in general healthcare workers (Goodman & Schorling, 2012), promote self-care and well being in a variety of healthcare professionals, (Irving, Dobkin, & Park, 2007), and to positively impact primary care physicians' ability to maintain positive affect relating to patients and work stressors (Montero-Martin et al., 2015). Additionally,

mindfulness is a skill set useful in assisting an individual to note her or his own affect dysregulation, lending to the ability to notice both the distress within the practitioner (the psychiatric nurse) as well as within another, leading to a greater ability to engage in effective relational attunement. Thus, being equipped with mindfulness skills for better attunement to emotional and interpersonal experiences it is possible for inpatient psychiatric nurses to manage the affect dysregulation that leads to burnout. These skills may ultimately lead to lessened turnover and an improved patient experience.

PURPOSE OF CURRENT RESEARCH

Given the referenced concerns of nursing burnout, the lack of research specific to inpatient psychiatric nursing burnout, and the proposed benefits of mindfulness-based interventions for addressing burnout, this exploratory study focused on exploring;

- The experiences of burnout among psychiatric nurses, including the elements of emotional exhaustion and depersonalization
- The usefulness and feasibility of a mindfulness-based psychoeducational intervention for impacting depersonalization, emotional exhaustion, and perception of personal accomplishment as elements of burnout among psychiatric nurses.

METHOD

SETTING

The study was based at the WellSpan-Philhaven Inpatient Psychiatric unit located in the York Hospital in York, Pennsylvania. This is a 63-bed inpatient facility, subdivided into four units, each of which focus on the acute care psychiatric stabilization

of individuals aged 18 and over. Patients receiving services are most commonly diagnosed with mood, anxiety, or psychotic disorders, as well as substance abuse disorders. Two units are devoted to individuals with medically-managed needs including comorbid injuries and illnesses as well as dementia disorders. The mindfulness intervention was held on site in a staff accessible activities room. Due to participants working a variety of shifts and shift lengths, the intervention was held at multiple times throughout the week to accommodate work schedules. As a result, session attendance varied from one to five participants per session.

SAMPLE

The sampling frame for this study was registered nurses currently employed at WellSpan-Philhaven York Hospital's inpatient psychiatric unit working in direct-care roles. Individuals working in managerial roles above unit supervisors or in the role of Utilization Reviewers (financial authorization specialists) were not included due to their reduced direct patient contact. At the time of recruitment approximately 50 nurses were included in this frame. Subjects met the following inclusion criteria; completed the probationary period for a new employee of WellSpan-Philhaven (90 days), were able to provide informed consent, and committed to the time of study (not pending extended time off or transfer of position). At the direction of the WellSpan-Philhaven Behavioral Health Research Advisory Committee, subjects with known and actively experiencing uncontrolled symptoms of Bipolar Disorder, Major Depression, Anxiety Disorder, Eating Disorders, Borderline Personality Disorder, Posttraumatic Stress Disorder, and psychotic disorders and subjects disclosing active or recent trigger reactions were ineligible for the

study. The study was approved by both the University of Pennsylvania Institutional Review Board as well as the WellSpan Institutional Review Board.

The investigator met with members of the inpatient unit during staff meetings on three occasions to recruit, presenting materials informing the purpose and format of the study. In addition, the principal investigator (PI, Ms. Donna Wampole) emailed nurse colleagues an informational flyer. A total of 8 nurses entered the study with 5 attending the required 75 percent, or 9 or more sessions of the 12-week intervention. As this was an exploratory study for the purpose of determining a preliminary sense of the usefulness and feasibility of this intervention with this population, a control group was not implemented. In accordance with the study proposal, participants who completed all surveys and the intervention were entered into an incentive drawing to win a \$50.00 gift card to a local convenience store of their choice.

DATA COLLECTION AND STUDY INSTRUMENTS

Upon providing consent, participants were asked to provide socio-demographic information (gender, age, highest education, years in psychiatric nursing, and years employed at the study site) and to complete the Maslach Burnout Inventory- Human Services Survey (MBI-HSS) two-weeks prior to the initiation of the 12-week intervention. Two weeks after completion of the intervention, participants completed a second, identical MBI-HSS.

The Maslach Burnout Inventory- Human Services Survey (MBI-HSS) was utilized to measure burnout in participants. In their studies of work-related burnout, Maslach and Jackson (1981) define burnout utilizing three main constructs: Emotional Exhaustion-EE, Depersonalization- DP, and Personal Accomplishment-PA. They further

described each term as referencing experiences of feeling emotionally depleted or empty (emotional exhaustion), feeling withdrawn or emotionally removed from problematic patients (depersonalization) and viewing one's work as "less than" or sub par to prior work (personal accomplishment). The MBI-HSS is a 22-question Likert-scale survey with seven answers scaled 0 to 6 (0= Never, 1= A few times a year or less, 2= Once a month or less, 3= A few times a month, 4= Once a week, 5= A few times a week, 6= every day). The MBI-HSS was designed for use with members of human services professions including nurses (Maslach & Jackson, 1981). Elevated mean scores in areas of Emotional Exhaustion and Depersonalization and low mean score in Perception of Accomplishment equate to a concern of burnout. Conversely, decreased EE and DP scores with elevated PA scores indicate a participant may not be feeling the effects of burnout. Participants received a digital copy of the MBI-HSS via MindGarden Incorporated (2017), licensed copyright holder of the instrument, with results sent electronically to the investigator.

In addition, participants completed a qualitative written survey of fourteen questions designed from the MBI-HSS highlighting in-depth areas of burnout applicable to inpatient psychiatric nursing. Four questions focused on aspects of relating to emotional exhaustion, five focused on depersonalization, and five on aspects relating to nurse perceptions of personal accomplishment. Participant answers were coded for related themes and themes were then defined.

Table 1. <i>Qualitative Mindfulness Questions</i>

MBI Factor	Qualitative Question
Emotional Exhaustion	<p>Describe how you motivate and prepare yourself before coming to work?</p> <p>Do you feel as though you have enough resources to manage your job? What additional resources would be helpful?</p> <p>How do stressors from work affect your personal life?</p> <p>Describe how you motivate and prepare yourself before coming to work.</p>
Depersonalization	<p>What is the impact of stress on your patients and patient care?</p> <p>How has your view of individuals with mental illness and substance abuse changed since you began working on the unit?</p> <p>Do repeat admissions of patients effect your view of that individual and if so, how?</p> <p>Have you ever felt the need to distance yourself from your patients to reserve your energy?</p> <p>How do you relate to the emotions and concerns of your patients?</p>
Personal Accomplishment	<p>How do you feel you impact and assist the lives of your patients?</p> <p>How do you bring comfort and understanding to your patients?</p> <p>What are some of your best patient-centered achievements working on the unit?</p> <p>How do you bring a sense of relief to your patients, during their stay on the unit?</p> <p>What motivates you in your work with patients?</p>

Additionally, participants completed a qualitative feedback survey after completing the intervention on their experience of the mindfulness-based intervention.

Table 2.

Mindfulness Survey Questions

What in the curriculum of mindfulness was new information to you?

Do you see yourself practicing mindfulness skills in the future as a result of this study and if so, how?

Do you feel that any elements of mindfulness presented in the study have affected or improved your work experience and if so, how?

Do you feel that any elements of mindfulness presented in the study have affected or improved your non-work life and if so, how?

Do you believe this intervention in mindfulness to be of benefits to other nurses in the field and if so, how?

INTERVENTION

The intervention included 12 weekly psychoeducation sessions based on material from Marsha Linehan's Dialectical Behavior Therapy's module Core Mindfulness. The pre-designed Schedule 10 Comprehensive DBT Mindfulness Skills Training (Linehan, 2015) was presented. Each participant was provided handouts in accordance with lessons and practiced mindfulness exercises in sessions.

Table 3.

Schedule of Intervention Topics

<u>Week number</u>	<u>Topic</u>
1	Orientation: Goals of Wise Mind
2	Mindfulness "What" Skills
3	Mindfulness "How" Skills
4	Spiritual Mindfulness
5	Spiritual Mindfulness week #2
6	Mindful Meditation
7	Mindful Meditation week #2
8	Reality Acceptance
9	Willingness
10	Middle Path
11	Mindful Action
12	Review and Wrap-up

Sessions included didactic education of each topic, and additional practices including mindfulness of breath meditation, body scan meditation, mindfulness of an object and recorded or guided meditations.

DATA ANALYSIS

Descriptive statistics including means and ranges were computed via MindGarden.com's Transform program, part of the license purchase for the Maslach Burnout Inventory-Human Services Survey. Content analysis of both qualitative surveys was examined by the PI using open coding of participant answers progressing to recurring themes. Emerging themes were cross checked with those noted in prior peer-reviewed research as a means to check for rigor with similar data emerging in this study compared to others.

RESULTS

Description of Sample

Of the five final participants, all self identified as female and Caucasian. Three held Bachelor's of Nursing Degrees, one had a Bachelor's of Nursing as well as a dual Bachelor's in Psychology and Business Management, and one had an Associates in Nursing. The average age of participants was 42. Participants reported an average of 13 years in psychiatric nursing with a range from 5 to 30 years. With the exception of subject 3, all participants psychiatric nursing experience was entirely at the current study

site. Subject 3 had been employed in psychiatric nursing for 17 years with 2 on the study site.

Table 4.

Subject Demographics and Experience

	<u>Subject 1</u>	<u>Subject 2</u>	<u>Subject 3</u>	<u>Subject 4</u>	<u>Subject 5</u>
Gender	Female	Female	Female	Female	Female
Age	51	33	43	49	34
Highest Nursing Education	BSN	BSN	BSN	BSN	ASN
Years in Nursing	30	9	21	4.8	9
Years in Psych Nursing	30	9	17	4.8	9
Years on Current Unit	30	9	2	4.8	9

BSN- Bachelor's of Science Nursing; ASN- Associates in Nursing

Study participants were required to attend at least 9 of the 12 sessions, with 2 participants attending 9 sessions and all others attending 11. Of the 8 originating participants, 3 failed to complete the study due to missing more than 4 sessions.

Burnout

Table 4.

Pre-Intervention MBI-HSS Scores

	Subject 1	<u>Subject 2</u>	<u>Subject 3</u>	<u>Subject 4</u>	<u>Subject 5</u>
Emotional Exhaustion Total	13	41	33	15	29
<i>EE Score</i>	<i>1.4</i>	<i>4.6</i>	<i>3.7</i>	<i>1.7</i>	<i>3.2</i>
Depersonalization Total	4	10	13	7	17
<i>DP Score</i>	<i>0.8</i>	<i>2.0</i>	<i>2.6</i>	<i>1.4</i>	<i>3.4</i>
Perception of Accomplish. Total	33	34	33	39	28
<i>PA Score</i>	<i>4.1</i>	<i>4.3</i>	<i>4.1</i>	<i>4.9</i>	<i>3.5</i>

* Score is the mean of participant's overall rating per burnout area

Table 5 notes that participants expressed varied experiences of emotional exhaustion (X= 2.92; range = 1.4 to 3.2), limited depersonalization (X= 2.04; range = .08 to 2.6), and in four scenarios notable to high perceptions of accomplishment (X= 4.18; range =3.5-4.9), with the Subject 5 reporting the lowest score (3.5).

	<u>Subject 1</u>	<u>Subject 2</u>	<u>Subject 3</u>	<u>Subject 4</u>	<u>Subject 5</u>
Emotional Exhaustion Total	20	34	35	19	36
<i>EE Score</i>	2.2	3.8	3.9	2.1	4.0
Depersonalization Total	4.0	3.0	15	5.0	16
<i>DP Score</i>	0.8	0.6	3.0	1.0	3.2
Perception of Accomplish. Total	35	40	32	41	20
<i>PA Score</i>	4.4	5.0	4.0	5.1	2.5

* Score is the mean of participant's overall rating per burnout area

Table 6 notes that post intervention, change was noted in MBI-HSS scores with Emotional Exhaustion scores increasing (X= 3.2; range 2.1 to 4.0) and Personal Accomplishment improving, (X=1.72; range .6 to 3.2). Both ranges of change in these areas were slight. Depersonalization scores lessened, a sign of decreased burnout, yet the range of these score did not change. Additionally, scores of Perception of Personal Accomplishment, (X= 4.2; range= 2.5-5.1) showed little change. Due to the small sample size, there is not enough power to inferentially detect a change in scores over time.

Table 7.

	<u>MBI-HSS Pre</u>	<u>MBI-HSS Post</u>	<u>Difference</u>
EE Mean Score	2.9	3.2	+ 0.30
<i>EE Range</i>	3.2	1.9	- 1.30
DP Mean Score	2.04	1.72	- 0.32
<i>DP Range</i>	2.6	2.6	0.00
PA Mean Score	4.18	4.2	+ 0.02
<i>PA Range</i>	1.4	2.6	+1.20

With their completion of the qualitative burnout surveys, participants expanded upon nurse emotional exhaustion, concerns for depersonalization, as well as how nurses view her accomplishments.

Question	Theme	Definition of Theme
Describe what you find most frustrating or tiring about your work.	Patient Challenges	Receiving harsh or abusive language and attitudes from patients or feeling manipulated by patients.
	Lack of Support- Management	Feeling unheard by management or that management does not recognize nurse's perspectives from the floor.
	Lack of Support- Team	Nurses and staff not working together as one.
	Punishment	Feeling pegged by management.
	Open Positions	Open positions in nursing and other inpatient areas.
	Staff Challenges	Nurse behaviors including gossip, back

		stabbing, and placating patients for "easier shifts."
Do you feel as though you have enough resources to manage your job and if not, what additional resources would be helpful?	Open Positions	Open positions in nursing and other inpatient areas
	Need for more patient resources	Lack of resources and items to keep patients occupied on weekends and when not in unit programming.
	Limited Educational Growth	Additional time for education and trainings
How do stressors from work affect your personal life?	Work/Life Separation success	Ability to leave work thoughts and stressors at work and away from home.
	Mood Carryover	Bringing stress from work home.
	Schedule Concerns	Challenges balancing changing work schedule.
	Somatic Issues	Feeling run down or experiencing stress related pain
Describe how you motivate and prepare yourself before coming to work?	Forward planning	Short and long term goals I am working toward
	Positive Attitude	Keeping hopeful
	Spirituality	Use of prayer or meditation and connection to higher power
	Self Care	Getting quality sleep, nutrition, treats, exercise

Regarding emotional exhaustion, participants noted that ongoing challenges of open positions within the nursing department as well as in other staff areas is a primary source of concern and distress. Additionally, nearly all participants cited management

concerns from feeling "undervalued" and "unsupported by management" to beliefs that "management (does) not (make) decisions based on what is best for the unit, staff, patients." Additionally, participants reported concerns of inter-staff challenges from staff, "not working as a team" and nurses having to "pick up the slack of coworkers," as well as stating challenges with other staff "who enable ineffective coping mechanisms with patients because they want an 'easy shift.'"

Participants presented difficulties with balancing work stress and home life with several citing moments in which stress from work spilled over into home and non-work relationships. Despite this concern, participants cited a variety of methods for preparing for work including the use of prayer, focus on self care with balanced eating and quality sleep, as well as keeping a general sense of hope for the day and for the future.

Table 9.

*Qualitative Burnout Survey:
Depersonalization*

<u>Question</u>	<u>Theme</u>	<u>Definition of Theme</u>
What is the impact of stress and burnout on your patients and patient care?	Decreased Attunement	Feeling less compassion and less inclined to connect to patients.
	Short attitude	Finding self frustrated and responding to patients in a clipped manner.
	Lessened Patience	Finding self frustrated and lacking in patience with patients.
	Awareness of Stress	Noticing negative emotions and working to not share in patient interaction
	Lessened Attention	Less available time for patients and patient connection. Less time for in-depth duties.
	Staff hostility	Hostility by staff toward patients

	Staff Turnover	Leave of nurses because of stress and burnout
How has your view of individuals with mental illness and substance abuse changed since you began working the unit?	Consistent Viewpoint	Views have stayed consistent
	Easy to Frustrate	Frustrated with recurrent patient demands.
	Increased awareness of who is affected.	Understanding that disorders can affect anyone,.
	Increased understanding of etiology.	Understanding disease cycle of MH and SA disorders and organic versus environment
	Increased frustration	Building frustration to repeat admissions and lessened empathy
	Diagnostic compassion	Compassion for those with certain symptoms or diagnoses
	Willingness to stand up	Nurse willingness to confront undesired behaviors.
Do repeat admissions of patients effect you view of that individual and if so, how?	Frustration	Expressed frustration by frequently readmitted patients, who continue with challenging behaviors (substance, stop meds, abusive behaviors on the unit)
	Understanding of Disease challenges	Recognition of limits created by symptoms
	Self-check of judgment	Identification of own judgments
	Belief of system abusers	Belief of those who chose to not follow up with recommendations and lean on system
	Hopeful for some	Hope for recovery for some patients

Have you ever felt the need to distance yourself from your to reserve your energy?	Interpersonal conflict	Distance with patients with very differing viewpoint
	Challenging patient	Need for distance with some very challenging patients
	Staff conflict	Need for distance with problematic staff, not patients
How do you relate to the emotions and concerns of your patients?	Shared history or experience Knowledge of experience	Nurses express history of mental illness, substance abuse, or trauma in own or family history
		Nurses express the time spent in psychiatric nursing have made her/him able to draw from past work experiences
	Attunement	Listening to client's concerns and reflecting understanding, care, and patience.
	Attempts at attunement	Nurses share struggle to remain attuned to same patients/same situations

Regarding depersonalization, participants noted a decreased sense of attunement when distressed that at times can lead nurses to "pull back," from some patients to reserve energy. Participants also noted system stressors of new computer technology and reduced staff creating a need for more time to attend to general duty work and paper work and less time for "quality conversation" and joining with patients. Participants also noted efforts to not transfer feelings of burnout or exhaustion onto patients but did admit at times they can "get short" or have limited patience with patients.

Another source of depersonalization was participant responses in regards to beliefs about repeat admissions of certain patients. Some expressed concerns of some patients abusing the mental health care system, "there are individuals abusing the hospital and using it as a hotel until their monthly check comes in." While others shared frustrations with clients not following discharge plans, "sometimes...they don't do what they should have done at discharge." Still others recognized readmission can also be based on a disorder, "Some (patients) are just that sick that they need to return due to meds not working or other factors." Despite these concerns, participants noted that they rarely felt the need to distance themselves from patients with one participant citing a need to instead distance herself from problematic staff, compared to her patients.

Conversely, nearly all participants shared that in ways they relate to patients. Many cited past personal experiences with distress while others noted personal histories touched by mental illness or substance abuse. For those who did not share personal histories, they cited working to, "try to put (myself) in their shoes," as well as recognizing, "We're all humans with emotions and everyone at one time or another has had that moment of being out of control... they just want to feel better somehow."

Table 10.		
<i>Qualitative Survey: Personal Accomplishment</i>		
Question	Theme	Definition of Theme
How do you feel you imp the lives of your patients?	Providing comfort Attunement	Provide needed comfort measures including medications, as well as words of comfort and healing Listening to client's concerns and reflecting

		understanding, care, and patience.
	Sharing resource information	Providing local resource and agency information for discharge
	Unable to tell	Nurse unsure if she is or isn't helping
How do you bring comfort and understanding to your patients?	Attunement	Listening to client's concerns and reflecting understanding, care, and patience
	Listening skills	Listening to client and communicating openly
	Relatability	Nurses have experienced similar challenged and can relate to patients' troubles
	Empowerment	Encourage patients to find own solutions
What are some of your best patient-centered achievements while working on the unit?	De-escalation	Patients decrease agitate behavior and express a feeling of increased calm or safety
	Comfort	Patients describe ease of uncomfortable emotions and feelings of safety
	Receipt of gratitude	When a patient shares her/his gratitude nurse knows she made a difference somehow.
	Knowledge of self practice	Nurse expressed beliefs of providing quality care
How do you bring a sense of relief to your patients during their stay on the unit?	Listening Skills	Listening to client and communicating openly
	Attunement	Listening to client's concerns and reflecting understanding, care, and patience
	Empowerment	Encourage patients to find own solutions
	Follow Through	Nurses follow up with patient concerns and requests as promised
	Medication Management	Provide medications as ordered
What motivates you in your work With patients?	Salary	Getting paid

Knowledge of care	Understanding and seeing the need for and benefits of care to patients
Voice of empowerment	Nurse feels psychiatric clients are often overlooked and need workers to back them
Dedication	Nurse feels committed to work with psychiatric patients
Patient population of choice	Nurses choose to work with psychiatric population over others
Connection	Nurses enjoy the interpersonal connection to patients in psychiatric care.

Personal accomplishment was discussed by participants in a variety of ways. Attunement or the ability to connect with patients is the most prevalent theme in this section with nurses having reported use of “active listening skills,” and offering, “my attention during every interaction,” with patients. Some participants reported the ability to bring comfort, direction, and a listening ear as both their greatest patient centered-achievement as well as the center of their focus on comfort and attuned care. Motivationally, participants reported enjoying a sense of connection with patients and the knowledge they are helping others who are struggling. Additionally, several shared a dedication to patients in the mental health system acknowledging that psychiatric nurses, “have a heart for this population,” and a feeling that “mental health patients need a voice and adequate care that I don't think they always get.”

Qualitative Mindfulness

In addition to the MBI-HSS and Qualitative Burnout Survey, participants completed a brief, five-question qualitative survey regarding the learning experience of the intervention and mindfulness materials.

Table 11.

Qualitative Mindfulness Survey

Question	Theme	Definition
What in the curriculum of mindfulness	Majority-non specific	Participants report the majority of the material to be new to them.
Was new information to you?	Some material	Participants have some prior knowledge or have heard of Mindfulness
	Specifics	Participant cites concepts including Radical Acceptance and States of Mind
Do you see yourself practicing mindfulness skills in the future as a result of this study and if so, how?	Address judgment	Participant wishes to decrease personal judgments with mindfulness skills
	Personal Improvement	Participant wishes to expand skill in general for personal improvement
	Distress Management	Participants wish to use skills in managing stress-inducing situations.
Do you feel that any elements of mindfulness presented in the study have affected or improved your work experience and if so, how?	Distress Management	Participants are using skills in managing stress-inducing situations.
	Patient Education	Participants have shared skills with patients with positive feedback
	Improved Colleague Relations	Participants share skills use with coworkers
Do you feel that any elements of mindfulness presented in the study have affected or improved your non-work life and if so, how?	Meditation	Participants increasing consistency with meditation practice/using new techniques.
	Distress Management	Participants are using skills in managing stress-inducing situations.

Do you believe this intervention in Mindfulness to be of benefit to other nurses and if so, how?	Increased Acceptance	Participants are using skills to practice acceptance of what cannot be changed
	New Viewpoint	Participants are practicing skills of viewing situations from emotion, reasonable, or wise minds
	Skill for others	Participant reports limited non-work stress but shares skills could help a loved one
	Challenging judgment	Skills beneficial for learning to challenge judgment of self and others
	Increase Awareness	Skills beneficial to increase awareness of emotions
	Distress Management	Skills beneficial to management of stress-inducing situations.
	Safe space	Session provide a safe space for nurse bonding and sharing of common goal.
	Increased acceptance	Skills beneficial for learning acceptance of what cannot be changed

Mindfulness and the sub-topics of core mindfulness and Dialectical Behavior Therapy were overall new concepts to members of the intervention group. While some had heard of mindfulness and were familiar with some attributes, most noted the detailed elements of mindfulness as new to them. All participants affirmed that they felt the skills they learned to be of benefit in the future noting, mindfulness can, "help me be more present in situations as well as help me calm down," and helped one participant, "(w)ork through difficult/stressful situations." Two participants cited assistance with judgment with an enhanced ability to, "be aware without judgment.- Observe, Describe, and Participate," and cited, "I know I am judgmental to a degree and would like to continue to work on changing this and a few other areas in my life."

Participants reported improvement on the job citing mindfulness skills benefits such as helping to "'deal' with stressful situations better-also formed a bond with other coworkers that I can discuss with," and help with "replacing willfulness (my reactive mode) with willingness- able to pause and reflect. (Which) will help me stay less stressed!" When asked if mindfulness can help in their non-work roles participants affirmed benefits citing, "Yes, I try to look at situations different such as comparing reasonable mind, emotion mind, and wise mind," and "I am working on improving my tolerance for others in social situations by using some of the skills learned here."

All participants expressed a belief that a curriculum in mindfulness can be of benefit to their profession.

"I feel it can help other nurses see their stress at work and home in a different way. Being Mindful and aware of different aspects of a certain situation helps. Also being aware of the different states of mind help(s) you realize how to look at things differently. Reality acceptance skills is another area that can help when dealing with the things we might not want to deal with. Balancing our doing mind and being mind into our wise mind is another skill that can be helpful. I was not that familiar with all the aspects of mindfulness but this study helped me see things differently."

One participant shared her views on the multiple benefits of the study contents and experience.

"It was great to have a safe place to talk about work stress- And to be (h)heard. I think it also gave myself and several coworkers a unique bond-positive connection. The concepts were easy enough and so applicable to our every day

work flow. I liked having something to look forward to-to keep emotions in check on a near regular basis.”

Another shared her recommendation for mindfulness in assisting all nurses by decreasing judgment, "I feel more need to become more aware of the situations around them and they need to remove the judgmental opinions of others from their work practice. This would help benefit nurses in all fields."

DISCUSSION

The goals of this pilot study were to learn more about the burnout experience among inpatient psychiatric nurses, the factors and experiences of the job that lend to the burnout experience and how, if at all, a psychoeducational intervention may assist in mitigating burnout. Both the Maslach Burnout Inventory-Human Service Survey (MBI-HSS), a quantitative research tool, and a qualitative survey based on the concepts of the MBI-HSS were utilized in addition to a post-intervention qualitative survey regarding nurses' appraisal of the intervention. The results suggest psychiatric nurses experience some emotional exhaustion, depersonalization, and decreased sense of personal accomplishment in their roles on an acute psychiatric unit. As expected, nurses indicated some negative appraisals of the client group and difficulties in interacting with these patients. Most strikingly, participants noted that the predominate feature of workplace stress was not patient relationships or behaviors, but rather challenges in management, intra-nurse relations, and understaffing.

This pilot study shed light on the experience of burnout in inpatient psychiatric nursing. Participants did note elements of Emotional Exhaustion and Depersonalization,

negative factors determining the presence of burnout as well as notations of Personal Accomplishment which counteracts the burnout experience. These reports align with prior research about the burnout experience of nurses and other healthcare workers. The Maslach Burnout Inventory-Human Services Survey (MBI-HSS), a qualitative instrument was of some benefit to noting and measuring burnout factors, however the qualitative burnout survey gave a richer perspective of the factors leading to burnout, enhancing the effectiveness of the MBI-HSS.

The primary cited sources of distress are management challenges, ongoing staffing issues, and frustration with other nurses. Participants shared that while occasional negative interactions with patients may cause acute distress, pervasive understaffing, staffing relationships, and management-line nurse interpersonal ineffectiveness are the chronic sources of nurse stress. These findings relate to previous literature reflecting intra-staff and agency challenges. In their study utilizing qualitative analytical interviews with registered nurses who had already chosen to leave their profession, MacKusick and Minick (2010), reported several incidences of hostile work environments including incidences of Horizontal Harassment (as termed by researchers) in which nurses staffed to be working together often engaged in problematic interpersonal communication, blaming, and strained relations including provocation and intra-staff harassment. Similarly, Happell and colleagues (2003), examined the management of stress and burnout from the lens of comparison between general psychiatric nurses and those employed on a forensic unit serving those with criminal backgrounds. Despite an assumption that forensic clients could present more problematically increasing burnout, it

was found that the make-up of nurses having tighter relations and improved interpersonal, intra-nurse communication led to lessened burnout.

Additionally, research reflects the concerns between staffing ratios, nurse-management and nurse-doctor relationships and safety. In their 2010 study examining adverse patient events and organization factors, Hanrahan and colleagues noted a relationship between the two and cite managerial concerns as a source. Hanrahan and colleagues state that nurse managers "maintain(s) equilibrium amidst complex and unpredictable inpatient psychiatric care environments" (pg. 572), and posit that managerial challenges could lead to patient safety concerns. In the current study, nurses reported concerns with feeling unsupported by management, feeling every mistake to be viewed by management through a punitive lens, and feeling that management follows "higher up" feedback more than that of unit nurses, all of which factor in to emotional exhaustion and concerns for patient and nurse safety.

Nurses in this study focused highly on challenges placed upon them by management, with feelings of being both unsupported, as well as having management follow belief systems and plans laid out by larger hospital systems, or otherwise non-psychiatric focused departments. Nurses expressed concerns that management did not take responsibility for challenging and problematic decisions which in turn gave rise to distrust amongst nurses toward management. Every participant spoke to the need for more staff, namely nurses. That the study site is a unit with multiple open nursing positions speaks to the concern of growing open positions in psychiatric and general nursing (APNA, 2018).

Exploration of the factors that separate the alliance between nursing manager and line-level nurses can be of assistance to the experience of emotional exhaustion. In their 2012 position statement calling for new inpatient staffing models, the American Psychiatric Nurse Association recognizes the need to continually focus on the variables that affect staffing and recurrently evaluate and update all plans formulated by inpatient nurse-management committees to ensure efficacy. As part of such a staffing-focused initiative continued discussion and concentration needs to transpire to build greater cohesion between nurses, organizations, and nurse managers, and attend to setbacks in communication.

In their 2005 examination of Workforce Development, the National Association of State Mental Health Program Directors explored how facilities addressed staff empowerment issues or how facilities promoted employee empowerment at all. They specifically questioned the ability of staff members to exchange assignments when needed or flex their schedules. While such flexibility may not be feasible to each psychiatric unit at all times, these options can assist nurses in both gaining power over their time and contributions to the unit while attuning to self care to prevent burnout. The combination of healthy communication and flexibility when available can promote healthy nurse relations and team building. As exhibited in this study, nurses who feel communication by management is restrictive or in some cases oppressive ("every mistake is punitive") express experiences of emotional exhaustion and feel frustrated by their lack of voice with management. Units and hospitals that promote open and constructive communication between nurses, nurses and other staff, and management with nurses can lessen nurse burnout while creating safer, more supportive patient care. Likewise, units

that promote flexibility can assist nurses in attending to personal needs to prevent burnout from occurring.

Greater focus also needs to be placed on bridging the understanding between general health care units and systems and the specialty function of inpatient psychiatric healthcare. By acknowledging the specialized needs of psychiatric patients including increased history of trauma, substance abuse, and differing limitations to follow-up care, as well as the ensuing specialized needs of psychiatric staff and nurses, general healthcare can better attune to inpatient psychiatric nursing needs. This attunement can create a feeling of being valued and increased interpersonal effectiveness between nurses, management, and the greater organization.

Nurses in this study also cited important components of relational attunement to patients. Some noted challenges in judgments about clients who present on the unit on several occasions. While working to challenge their judgment and remain attuned, some nurse participants shared struggles with the belief that patients need to work harder in recovery or are dependent upon or "abuse" the mental health system. Despite these concerns, nurses shared of ongoing efforts to limit loss of patience with their patients when they feel burned out or frustrated to best care for and remain connected to those they serve.

Nurses in this study shared an ability to reflect upon their own or family experiences with mental health and substance abuse disorders as a means to connect with patients while others focused on viewing how mental health challenges could feel to themselves should they be in a patient role. These reflections show positive connections of nurses to patients which, in addition to lending to the perception of personal

accomplishment can mitigate feelings of depersonalization. Patient relational attunement is of focus in trauma-informed care and recognizes that patients often seek connection with others to obtain emotional safety (Berg, et al., 2007). Nurses who can relate to patients through personal experience, or envisioning themselves in similar situations that invoke fear and distrust, may increase a sense of emotional safety for patients and mitigate trauma-related enactments. As such, this connection can reduce vicarious traumatization in nurses and decrease the potential for burnout. When patients experience safety with nurses, nurses feel the same, and burnout can decrease.

Qualitatively, participants noted enjoyment of skills learned and a belief in its benefits for self-care and psychiatric nursing practice. Participants cited ongoing use of techniques learned to assist in the notation and decrease of judgment as well as redirection of attention to tolerance of stressful situations. Participants shared a belief that learning and practicing mindfulness skills can be of benefit to all nurses, psychiatric or otherwise. Participants shared that these skills are helpful in challenging judgment on and off of the job and lend to an ability to view difficult situations in a multi-faceted way. Others noted the skills helped develop an ability to step back from stressful interactions and, "pause and reflect," before proceeding. These findings present similarly to those of Guillaume, Boiral, and Champagne, (2017) in their examination of the effects of mindfulness with nurses wherein nurses reported improved communication with patients and staff during times of distress, as well as an ability to better regulate mood and emotional changes. Similarly, in their meta-analytical review of studies focused on mindfulness training for healthcare workers, Irving, Dobkin, and Park (2009), noted

benefits of mindfulness by increasing attunement to communication with patients and decreasing personal experiences of anxiety and rumination.

Of challenge to this study was the limited participation and high rate of intervention drop-out. While the author visited and spoke to nurses about the study and disseminated emailed information on several occasions, few retainable participants responded. A plausible concern was the time of said study which, while unplanned, did begin at the same time as WellSpan-Philhaven's "go-live" of a system-wide electronic medical record. Despite this concern, participants reported enjoying having the intervention to attend as a focus beyond the "go-live" stresses. What is unknown are the factors against nurse participation in this study. Adjustments to the study were made allowing for nurse feedback via the MBI-HSS and the qualitative burnout survey (sans intervention participation), with a combined estimated completion time of less than 30 minutes, however no nurses meeting eligibility criteria shared interest. As such, barriers to subject participation presents as a need for examination.

Given the difference in findings, it is apparent that the Maslach Burnout Inventory presents challenges to measuring burnout for this population, as it does not shed light to the factors participants attribute to their stress and burnout. Our qualitative instrument, focusing on the factors of Emotional Exhaustion, Depersonalization, and Perception of Personal Accomplishment as noted by Maslach and Jackson, provide a deeper understanding of the burnout experience of nurses and thus may inform creation of measurement instruments for burnout in psychiatric units and setting, as well as for further examination of the outlines of burnout among psychiatric nurses.

Additionally, research needs be focused on the effect of negatively perceived nurse-management relationships, factors defining the concept of support for psychiatric nurses, and factors attributing to frequent turnover and high patient to nurse ratios. Barriers to on-site interventions and participant motivation need also be examined for the purposes of expanding the examination into this important topic.

LIMITATIONS

Limitations are noted and need to be improved in follow up studies. While multiple attempts were made for recruitment, including a modification to the study of an option for survey completion only, a limited number of nurses were willing to participate. All qualitative surveys were openly then inductively coded yet a challenge to rigor is present as coding was completed only by the primary investigator. Future research should involve independent coding to increase rigor by way of analytic triangulation. As this was a dissertation-based study with limited resources, outside coding assistance was not sought.

Due to the challenges with recruitment and the need for greater research participation, future options for recruitment might include the application and availability of continued educational units for study completion, negotiation with organizational management to offer survey completion and intervention during paid work hours, and greater incentives for study completion. In addition, completion of similar interventions across multiple facilities, either within one community or larger healthcare system, can provide higher recruitment numbers even if each site produces limited participation as with this study.

In light of the challenges of this study, knowledge has been gained that psychiatric nurses experience elements of emotional exhaustion and depersonalization related to organizational and inter-staff stressors. While the current study had limitations, they are balanced by the knowledge learned from study participants which sheds light on these issues and add to the call for further research into the cause, prevention, and experience of burnout and mindfulness.

CONCLUSION

In summation, the literature on human service and nursing-specific occurrences of burnout concludes the presence of this issue, yet limited research is present examining burnout specific to inpatient psychiatric nursing. This pilot study, while small, points to the presence of stress and burnout factors of Emotional Exhaustion and Depersonalization, as well as the countering factor of Perception of Personal Accomplishment in an inpatient psychiatric nurse population. Of note, challenges in nurse-management, decreased staffing, and inter-nurse discord were key sources of emotional exhaustion, frustration and distress. Likewise, participants identified the mindfulness intervention to be of personal benefit and recommended it to their profession.

Trauma-informed care highlights that problematic patient behaviors and difficulties patients display in coping with distress developed in the context of survival in abusive environments. Work with dysregulated patients in addition to work under disconnected management in an understaffed environment, will inevitably impact psychiatric nurses and expose them to vicarious trauma and subsequent emotional exhaustion and depersonalization, and strained intra-nurse relations. A trauma-informed

approach to psychiatric care notes that clinicians need to have the emotional labor of the work recognized and processed in order to prevent burnout. Additional skills provided through mindfulness training can improve nurse perspectives and attunement with patients and with one another, thereby reducing the burnout and trauma experience.

Given the qualitative findings of this research and the paucity of additional research focusing on this topic it is imperative that further research be undertaken regarding the burnout experience, impact and, causal factors of burnout among inpatient psychiatric nurses. With focused research on the needs of this specified population, inpatient psychiatric nurse turnover might be reduced for the betterment of the profession and for the increase of quality patient care. This future research is imperative for building a trauma-informed workforce that engenders nurse and patient safety.

Dissertation Conclusion

This dissertation examines burnout among inpatient psychiatric nurses, as well as the potential for mindfulness to mitigate burnout in these settings. The study was rooted in a trauma-informed approach to psychiatric care. When nurses are cared for, and self-care is promoted for nurse wellbeing, burnout and the related risks to patient safety.

Trauma-Informed Care focuses on the history and understanding of the occurrence of trauma in patients with mental illness, as well as how nurse interactions with said patients can increase trust and recovery from trauma. Mindfulness skills assist individuals hone attention to the here and now without judgment, thereby lending to an objective view of interactions and the environment.

TIC also focuses on the need for increased staff support and effective communication in response to organizational challenges, which can in turn mitigate nurse burnout and turnover. TIC supports nurses in assisting patients in developing self-regulation and communication skills to not only decrease safety risks while in the hospital but also increase recovery outcomes. Mindfulness skills, when presented on an inpatient unit functioning under Trauma Informed Care can assist nurses with increasing their own ability to tune in to both self and patient distress, thereby mitigating negative emotionally charged interactions with patients, and curb the experience of burnout.

Although small, this pilot study shed light on several factors regarding nurse burnout. First, while nurses did report some elements of emotional exhaustion, depersonalization, and perceived personal accomplishment via the Maslach Burnout Inventory-Human Services Survey, further information detailing themes of management-

related distress, inter-staff relational challenges, stress due to staffing needs, and incidences of frustration related to challenging patients, were better gathered with the qualitative burnout study based on the MBI-HSS. In addition, the use of the qualitative survey allowed nurses to share their skills for mitigating depersonalization such as relating to patients during personal times of need, or imagining oneself in the patient role, and sharing how each sees achievements in her daily interactions with patients.

A psycho-educational intervention in mindfulness was reported by inpatient psychiatric nurse participants to be of benefit for monitoring personal judgment, increasing patient attunement, and decreasing attunement to intra-nurse stressors. When incorporated as a skill within a Trauma-Informed Care framework, mindfulness can be beneficial to address patient trauma, nurse self regulation, nurse-patient attunement, and as such, overall patient safety.

The themes of Trauma-Informed Care, mindfulness, and burnout of inpatient psychiatric nurses are critical to the future of psychiatric patient safety. When patient trauma is understood as a precursor to heightened symptoms, nurses can employ skills of mindfulness to attune to patients, decreasing distress, increasing safety, and decreasing the burnout of nurses themselves. By addressing the triad of TIC, burnout and mindfulness, nurses can better care for patients and themselves, thereby experiencing greater personal accomplishment and mitigate exhaustion and depersonalization for an overall improved and safer patient and nurse experience.

Appendix A

DBT Schedule 10: Comprehensive DBT Mindfulness Skills Training.

Topic	Week	Standard Handout	Optional Handouts
Orientation: Goals Wise Mind	1	M1: Goals of Mindfulness Practice M1a: Mindfulness Definitions M2: Overview: Core Mindfulness Skills M3: Wise Mind: States of Mind	
Mindfulness: What Skills	2	M4: Taking Hold of Your Mind: Mindfulness "What Skills"	M4a: Ideas for Practicing Observing M4b: Ideas for Prac: Describing M4c: Ideas..Participating
Mindfulness How Skills	3	M5: Taking Hold of Your Mind "How" Skills	M5a: Ideas... Nonjudgmental M5b: Ideas... One-Mindfulness M5c: Ideas...Effectiveness
Spiritual Mindfulness	4	M7: Goals of Mindfulness Practice: A Spiritual Perspective. M7a: Wise Mind from a Spiritual Perspective M8: Practicing Loving Kindness to Increase Love and Compassion	
Spiritual Mindfulness	5	M7: Goals of Mindfulness Practice: A Spiritual Perspective. M7a: Wise Mind from a Spiritual Perspective M8: Practicing Loving Kindness to Increase Love and Compassion	
Mindful Meditation	6	DT8a: Body Scan Meditation: Step by Step DT9a: Sensory Awareness, Step by Step	
Mindful Meditation	7	ER22: Mindfulness of Current Emotions: Letting Go of Emotional Suffering DT15: Mindfulness of Current Thought DT15a: Practicing Mindfulness of Thoughts	
Reality Acceptance	8	DT 10: Overview: Reality Acceptance Skills D11: Radical Acceptance D11a: Radical Acceptance: Factors that Interfere DT11b: Practicing Radical Acceptance Step by Step (or use DTWS9) DT12: Turning the Mind	DTWS9: Radical Acceptance
Willingness	9	DT13: Willingness DT14: Half-Smile and Willing Hands	DT14: Practicing Half Smile and Willing Hands
Mindful Action	10	M9: Skillful Means: Balancing Doing Mind and Being Mind	M9a: Ideas for Practicing Balancing Doing Mind and Being Mind
Middle Path	11	M10: Walking the Middle Path: Finding the Synthesis between Opposites IE12: Mindfulness of Others	IE12a: Identifying Mindfulness of Others

Adapted from DBT Skills Training Manual, Second Edition. Pg 120 M. Linehan, 2015

Appendix B

MBI-HSS

Construct

Question

Emotional Exhaustion

I feel burnout out from my work.
Working with people all day is really a strain for me.
I feel frustrated by my job.
I feel fatigued when I get up in the morning and have to face another day on the job.
I feel emotionally drained from my work.
Working with people directly puts too much stress on me.
I feel I'm working too hard on my job.
I feel used up at the end of the work day.
I feel like I'm at the end of my rope.

Depersonalization

I worry this job is hardening my emotionally.
I feel recipients blame me for some of their problems.
I don't really care what happens to some recipients.
I've become more callous toward people since I took this job.
I feel I treat some recipients as if they were impersonal objects.

Personal Accomplishment

I deal very effectively with the problems of my recipients.
I feel very energetic.
I can easily create a relaxed environment with my recipients.
I feel exhilarated after working closely with my recipients.
In my work, I deal with emotional problems very calmly.
I can easily understand how my recipients feel about things.
I feel I'm positively influencing other people's lives through my work.
I have accomplished many worthwhile things in this job.

Appendix C

INFORMED CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE OF STUDY: Assessing the Impact of a Mindfulness-Based Psychoeducational
Intervention on Burnout among Inpatient Psychiatric Nurses

Principal Investigator: Jayaram Thimmapuram, MD
Address: 1001 S. George St., York, PA

Telephone 717-851-2753

Co/Sub-Investigator(s): Donna Wampole, LCSW
Address: 1100 Edgar Street Suite A, York, PA 17403

Telephone: 717-324-3436 or 717-851-6378

Sponsor:

WHY AM I BEING ASKED TO TAKE PART IN THIS RESEARCH?

You are being asked to take part in a research study about the experience of burnout occurring in nurses employed in inpatient psychiatric health as well as the benefits of Mindfulness with said burnout. Burnout can involve feelings of being overwhelmed by an environment, feeling detached from patients, or the loss of feeling as though you make a difference in your profession or cause. Mindfulness practice involves skills to help draw attention to the here and now to recognize and let go of distress or situations beyond one's control. Burnout can involve feelings of being overwhelmed by an environment, feeling detached from patients, or the loss of feeling as though you make a difference in your profession or cause. This study is focused on how psychiatric nurses experience burnout and if Mindfulness skills mitigate any reported burnout symptoms. If you volunteer to take part in this study, you will be one of about 20 people at WellSpan Health to do so.

WHO IS DOING THE STUDY?

The person in charge of this study is Jayaram Thimmapuram, MD of WellSpan Health. Dr. Thimmapuram has agreed to the principal investigator on behalf of Donna Wampole, LCSW, doctoral candidate with the University of Pennsylvania. Donna Wampole, is a Licensed Clinical Social Worker employed with WellSpan-Philhaven Behavioral Health, located at the Edgar Square Outpatient Clinic, 1100 Edgar Street, Suite A. She is also the primary recruiter and facilitator of this study. Donna Wampole is a provider of Dialectical Behavior-informed Therapy

with WellSpan Behavioral Health's Edgar Square facility for the past six years, and has been trained in DBT-informed skills by Kevin Harvey, LPC and Michael Farrell, MA. There may be other people on the research team assisting at different times during the study.

WHAT IS THE PURPOSE OF THIS STUDY?

The purpose of the study is to learn more about the experience of burnout reported by registered nurses employed on an inpatient psychiatric unit and to see if a curricula of Mindfulness skills informed by the curricula of Marsha Linehan's Dialectical Behavioral Therapy can mitigate burnout. Dialectical Behavioral Therapy is a model of therapy developed by Marsha Linehan to assist patients with high-risk behaviors such as suicidal actions and self-harming. It was also designed to address and assist with therapist burnout, experienced by those working with this patient population. Dr. Linehan chose to integrate Mindfulness into this model specifically to address concerns of therapist stress linked to the work with this challenging population. Mindfulness includes skills drawing attention to thoughts, emotions, and judgments, as well as methods of practice breathing, walking and moving. In addition, Dr. Linehan has developed a curricula of Mindfulness-based strategies to educate individuals on the basics of Mindfulness skills. It is these skills, informed by Dr. Linehan's text which will be presented in this study. By doing this study, we hope to learn how to better promote self and employer-care for inpatient-employed psychiatric nurses.

ARE THERE REASONS WHY I SHOULD NOT TAKE PART IN THIS STUDY?

If you are only taking part in the survey portion of this study, the surveys involved in this study require approximately 15 minutes of your time and involve confidential disclosure of your experience with burnout. Your personal information will be kept confidential and will be known only to sub-investigator, Donna Wampole.

The skills intervention of this study involves participation in a group activity with your coworkers, which may make you uncomfortable or influence your response to questions. This psycho-educational intervention could also cause you to uncover thoughts, emotions, judgments, or unnoted experiences of the past that may cause distress.

WHERE IS THE STUDY GOING TO TAKE PLACE AND HOW LONG WILL IT LAST?

If only taking part in the survey portion of this study: You will be emailed a brief survey entitled the Maslach Burnout Inventory-Human Services Survey (MBI-HSS). You will also be mailed a brief written survey. Both the MBI-HSS and the written survey will take approximately 10-15 minutes, each to complete. The

total amount of time you will be asked to volunteer for this study is 20-30 minutes.

If you are taking part in the full study: The research procedures will be conducted at the inpatient psychiatric unit activities room located on C Unit, third floor at the York Hospital. You will be asked to attend 12, one-hour weekly sessions of psycho-education about the skills of DBT Mindfulness. You will also be emailed a brief survey entitled the Maslach Burnout Inventory-Human Services Survey (MBI-HSS). You will receive this survey and be asked to complete it on three separate occasions, before and after your DBT class. You will also be given a brief written survey at the end of the study. Both the MBI-HSS and the written survey will take approximately 10-15 minutes to complete. The total amount of time you will be asked to volunteer for this study is 12 weeks for groups and one hour for survey completion over a total of 26 weeks.

WHAT WILL I BE ASKED TO DO?

If participating in surveys only: You will be emailed the Maslach Burnout Inventory survey to be completed in one week. In addition, all participants will receive a multi-question survey in hard-copy form. This survey will be in an envelope with your name, but will be sealed inside another envelope with only a 5-digit code. Your survey, that envelope, and an addressed self-stamped return envelope will all be labeled with this code. Only the sub-investigator, Donna Wampole, will have access to your code number, which will ensure the privacy of your survey. No members of WellSpan-Philhaven will have access to coded information, ensuring the privacy of all employee participants. Once the survey is completed and received by Donna Wampole, your participation is complete.

If participating in the full study: You will be asked to provide your general work hours for the purpose of placing you in a study group. Groups will be held either before noon or after noon during the same 12-week time period.. Upon commencement of the study you will be emailed the first Maslach Burnout Inventory survey to be completed the first week. You will then start your intervention, attending 12, weekly, one-hour DBT-Mindfulness skills groups. You will be provided handouts and writing materials. At the end of 12 weeks, all participants of both groups will be emailed a second Maslach Burnout Inventory survey to be completed that week. In another 12 weeks, participants of both groups will again be emailed a third Maslach Burnout Inventory survey. In addition, all participants will receive a multi-question survey in hard-copy form. This survey will be in an envelope with your name, but will be sealed inside another envelope with only a 5-digit code. Your survey, that envelope, and an addressed self-stamped return envelope will all be labeled with this code. Only the sub-investigator, Donna Wampole, will have access to your code number, which will ensure the privacy of your survey. No members of WellSpan-Philhaven will have access to coded information, ensuring the privacy of all

employee participants. Once the survey is completed and received by Donna Wampole, your participation is complete.

WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?

If participating in surveys only: You will be asked to donate 20-30 minutes of your time to participate in these surveys.

If participating in the full study: Mindfulness skills have been noted to increase practitioners' awareness of emotions and reactions. It is possible that you may note increased emotional awareness of current or past experiences with people or situations. If at any time you feel you are in need of assistance with this awareness, sub-investigator, Donna Wampole, will assist in referrals to local resources such as the Employee Assistance Program. Each skills group will end with the facilitator, Donna Wampole asking all participants to briefly rate her or his level of stress on a scale of 0-10. Any participant noting a high level of discomfort will be invited to meet with investigator Wampole to deescalate if needed. Investigator Wampole will also be available for skills clarification, questions, and support. Any participant who feels she or he may need additional therapeutic support will be guided by Investigator Wampole in finding the best intervention including therapy via Employee Assistance or Crisis Intervention.

WILL I BENEFIT FROM TAKING PART IN THIS STUDY?

There is no guarantee that you will directly get any benefit from taking part in this study. However, some people have experienced an increase in time management and stress reduction with the practice of Mindfulness. Your willingness to take part, however, may, in the future, help expand the knowledge base of nursing burnout and lead to additional studies to help reduce nurse burnout and turnover.

DO I HAVE TO TAKE PART IN THE STUDY?

If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to volunteer. You can stop at any time during the study and still keep the benefits and rights you had before volunteering.

IF I DON'T WANT TO TAKE PART IN THE STUDY, ARE THERE OTHER CHOICES?

If you do not want to be in the study, there are no other choices except not to take part in the study.

WHAT WILL IT COST ME TO PARTICIPATE?

You will not be charged a fee for participation. It is of note that you will not be compensated for your participation in this study and your participation must take part during off-of-the-clock hours. Participants who chose to join will be required to balance her/his time as previously committed to WellSpan-Philhaven, in the form of adding hours (should she/he need to clock-out of a shift to participate). The arrangement of adjusted hours must be negotiated with nurse management.

WHAT IF I GET SICK OR HURT BY PARTICIPATING?

If you believe you are hurt or if you get sick because of something that is due to the study, you should call Jayaram Thimmapuram at 851-2753 immediately. Dr. Thimmapuram will determine what type of treatment, if any, that is best for you at that time.

If you are hurt or get sick because of something that is due to the study, it is important for you to understand:

- In the event that you suffer a research related injury, your medical expenses will be your responsibility or that of your third-party payer, although you are not precluded from seeking to collect compensation for injury related to malpractice, fault, or blame on the part of those involved in the research.
- The sponsor of this study may pay for the medical costs related to your care and treatment.
- WellSpan Health has no plans to pay for any wages you may lose if you are harmed by the study.
- You may need to pay a co-payment or deductible even if your insurer or Medicare/Medicaid has agreed to pay the costs. The amount of the co-payment/deductible may be substantial.
- Medicare or Medicaid may pay medically necessary costs (if you have questions regarding Medicare/Medicaid coverage you should contact them by calling 1-800- Medicare (1-800-633-4227) or Medicaid 1-800-635-2570 before volunteering to participate.)
- You do not give up any of your legal rights by signing this form.

CAN MY TAKING PART IN THE STUDY END EARLY?

If you decide to take part in the study you still have the right to decide at any time that you no longer want to continue. You will not be treated differently if you decide to stop taking part in the study.

The individuals conducting the study may need to withdraw you from the study at any time. This may occur if you are not able to follow the directions they give you, if they find that your being in the study is more risk than benefit to you, or if the agency funding the study decides to stop the study early for a variety of scientific reasons.

HOW DO I STOP PARTICIPATION IN THE STUDY?

You can stop being in the study at any time. If this happens, tell your study physician/nurse that you want withdraw your permission and/or send it in writing to:

Name: Donna Wampole, LCSW
Entity and/or Department: WellSpan BHS
Address: 1100 Edgar St. Suite A
City, State. Zip: York, PA 17403
Email: dwampole@wellspan.org or
travelfar28@comcast.net
Phone: 717-851-6378 or 717-324-3436
FAX: 717-851-1515

S/he will make sure your request to withdraw your permission is correctly processed. You will not be penalized and the care you get from your doctor will not change.

Beginning on the date you withdraw your permission; no new personal health information will be used for research purposes. However, researchers may continue to use the health information that was provided before you withdrew your permission, or if the information is used to follow up on adverse events or has already otherwise been relied upon.

CAN I PARTICIPATE IN ANOTHER RESEARCH STUDY AT THE SAME TIME AS PARTICIPATING IN THIS ONE?

You may take part in this study if you are currently involved in another research study. It is important to let the investigator/your doctor know if you are in another research study. You should also discuss with the investigator before you agree to participate in another research study while you are enrolled in this study.

WILL I RECEIVE ANY REWARDS FOR TAKING PART IN THIS STUDY?

You will not receive any rewards or payment for taking part in the study, however there is an incentive in the form of a random drawing of a \$50.00 gift card to Sheetz or Rutter's for participants from the survey only group and the full study group.

WHAT IF I HAVE QUESTIONS, SUGGESTIONS, CONCERNS, OR COMPLAINTS?

Before you decide whether to accept this invitation to take part in the study, please ask any questions that might come to mind now. Later, if you have questions, suggestions, concerns, or complaints about the study, you can contact the investigator, **Jayaram Thimmapuram, MD at 717-851-2753**. If you have any questions about your rights as a volunteer in this research, contact the IRB Staff in the Emig Research Center of WellSpan Health at 717-851-2223. We will give you a signed copy of this consent form to take with you.

WHAT IF NEW INFORMATION IS LEARNED DURING THE STUDY THAT MIGHT AFFECT MY DECISION TO PARTICIPATE?

If the researcher learns of new information in regards to this study, and it might change your willingness to stay in this study, the information will be provided to you. You may be asked to sign a new informed consent form if the information is provided to you after you have joined the study.

Participant

I have read and understand the information describing this study. All my questions have been answered to my satisfaction. This form is being signed voluntarily to indicate my agreement to be in the study. I will be given a copy of this form for my personal records after all individuals sign and date it. I authorize the release of my research related medical records to the study investigators and their representatives.	
Participant's Name (Print):	
Participant's Name (Signature):	Date:
OR if participant is unable to provide informed consent a Legal Representative (spouse, parent, adult child of parent, legal guardian, power-of-attorney) may provide informed consent on behalf of the participant.	
Legal Representative's Name (Print):	
Legal Representative's Signature:	Date:

Principal Investigator or Designee

I Confirm that the study has been explained to the subject above and that the consent to participate has been given.	
Name of person conducting the consent discussion (Print):	
Signature of person conducting the consent discussion	Date:

Appendix D

UNIVERSITY OF PENNSYLVANIA
INFORMED CONSENT FORM

Title of the Research Study: Assessing the Impact of a Mindfulness-Based Psychoeducational Intervention on Burnout Among Inpatient Psychiatric Nurses

Protocol Number: X

Principal Investigator: Lina Hartocollis, PhD. School of Social Policy and Practice
3701 Locust Walk, Philadelphia, PA
215-746-5486
doylea@sp2.upenn.edu

Sub-investigator: Donna Wampole, LCSW
102 Webster Avenue,
York, PA 17404
(717)-324-3436
dwampole@sp2.upenn.edu

Emergency Contact: sarabressi@brynmawr.edu

You are being asked to take part in a research study. This is not a form of treatment or therapy. It is not supposed to detect a disease or find something wrong. Your participation is voluntary which means you can choose whether or not to participate. If you decide to participate or not to participate there will be no loss of benefits to which you are otherwise entitled. Before you make a decision you will need to know the purpose of the study, the possible risks and benefits of being in the study and what you will have to do if you decide to participate. The research team is going to talk with you about the study and give you this consent document to read. You do not have to make a decision now; you can take the consent document home and share it with friends, family doctor and family. Your doctor may be an investigator in this research study. As an investigator, your doctor is interested both in your clinical welfare and in the conduct of this study. Before entering this study or at any time during the research, you may want to ask for a second opinion about your care from another doctor who is not an investigator in this study. You do not have to participate in any research study offered by your doctor.

If you do not understand what you are reading, do not sign it. Please ask the researcher to explain anything you do not understand, including any language contained in this form. If you decide to participate, you will be asked to sign this form and a copy will be given to you. Keep this form, in it you will find contact information and answers to questions about the study. You may ask to have this form read to you.

What is the purpose of the study?

The purpose of the study is to learn more about

- The incidence of burnout, as defined by the Maslach Burnout Inventory, reported by registered nurses employed on an inpatient psychiatric unit.
- The benefits, if any, of a training course in Dialectical Behavior Therapy informed Mindfulness skills, in the mitigation of burnout symptoms.
- Dialectical Behavioral Therapy is a model of therapy developed by Marsha Linehan to assist patients with high-risk behaviors such as suicidal actions and self-harming as well as address and assist with therapist burnout, experienced by those working with this patient population. Dr. Linehan chose to integrate Mindfulness into this model specifically to address concerns of therapist stress linked to the work with this challenging population. Mindfulness includes skills drawing attention to thoughts, emotions, and judgments, as well as methods of practice breathing, walking and moving.
- This study is being conducted as the dissertation of the Sub Investigator, Donna Wampole, LCSW, for her Doctorate in Clinical Social Work with the University of Pennsylvania.

Why was I asked to participate in the study?

You are being asked to join this study because as a registered nurse employed on an inpatient psychiatric unit, you are an integral part of the behavioral health system, and the clientele it serves. As such, your mental health and wellbeing is equally important for the sake of yourself, you loved ones, and your profession. Furthermore, current available research is very limited regarding the incidence of burnout in inpatient psychiatric nurses and your participation can contribute to the understanding of this topic.

How long will I be in the study?

The study will take place over a period of 5 months.

Where will the study take place?

You will be asked to come to the Activities room located on C Unit of Floor 3-East at the York Hospital.

What will I be asked to do?

If you are participating in the full study and intervention, you will be asked to provide your general work hours for the purpose of placing you in a study group. Groups will be held either before noon or after noon. Upon commencement of the study you will be emailed the first Maslach Burnout Inventory-Human Services Survey to be completed the first week. You will then start your intervention, attending 12, weekly, one-hour DBT-Mindfulness skills groups. You will be provided handouts and writing materials. At the end of the 12 weeks, you will be emailed your second MBI survey to be completed within two weeks. In addition, you will receive a multi-question survey regarding your personal burnout experience, in hard-copy form. This survey will be in an envelope with your

name, but will be sealed inside another envelope with only a 5-digit code. Your survey, that envelope and a return envelope will all have this code. Only the sub-investigator will have access to your code number, which will ensure the privacy of your survey. You will also receive a separate, brief multi-question qualitative survey requesting your personal Mindfulness experience, in hard-copy form. Once the surveys are completed and received by Donna Wampole, your participation is complete.

The DBT-based Mindfulness intervention is a 12 session course designed to teach the skills of mindfulness. Participants will learn about skills to observe, describe and effectively participate with their emotions in a non-judgmental and one-mindful manner. Participants may be taught activities such as body scan meditations, mindful walking, mindful listening, and guided breathing. Discussion will take place on the DBT informed method of finding balance between life and work demands and emotional needs and methods that work the most effectively for participants.

For those participant not taking part in the intervention, you will be emailed the same Maslach Burnout Inventory-Human Services Survey to be completed one week from receipt. In addition, you will be mailed the same multi-question survey in hard-copy form. This survey will be in an envelope with your name, but will be sealed inside another envelope with only a 5-digit code. Your survey, that envelope and a return envelope will all have this code. Only the sub-investigator will have access to your code number, which will ensure the privacy of your survey. Once the survey is completed and received by Donna Wampole, your participation is complete.

What are the risks?

All participants of the study will be expected to use discretion regarding patient and coworker confidentiality. As such, there is a risk of occurrence of a breach of coworker confidentiality in regarding to stress inducing actions or words while in the social support group.

Mindfulness skills have been noted to increase practitioners' awareness of emotions and reactions. It is possible that you may note increased emotional awareness of current or past experiences with people or situations. If at any time you feel you are in need of assistance with this awareness, sub-investigator, Donna Wampole, will assist in referrals to local resources such as the Employee Assistance Program. Each skills group will end with the facilitator, Donna Wampole asking all participants to briefly rate her or his level of stress on a scale of 0-10. Any participant noting a high level of discomfort will be invited to meet with Investigator Wampole to deescalate if needed. Investigator Wampole will also be available for skills clarification, questions, and support. Investigator Wampole will also be available via phone, email or text message for additional clarification outside of the weekly group.

How will I benefit from the study?

There is no assured definite benefit to you however the skills of Mindfulness have been shown to assist some individuals in identifying emotions and thoughts related to external stressors and some studies have shown Mindfulness to be of benefit in mitigating stress. There is no guarantee that you will notice these benefits. Your participation could help us more specifically understand the benefits of DBT Mindfulness on burnout in inpatient psychiatric nurses, which can benefit you indirectly. In the future, this may help other members of your profession to better manage stress and burnout.

What other choices do I have?

Your alternative to being in the study is to not be in the study.

What happens if I do not choose to join the research study?

You may choose to join the study or you may choose not to join the study. Your participation is voluntary. There is no penalty if you choose not to join the research study. You will lose no benefits or advantages that are now coming to you, or would come to you in the future.

When is the study over? Can I leave the study before it ends?

The study is expected to end after all participants have completed all Mindfulness skills sessions and completed the third set of Maslach Burnout Inventories as well as the brief questionnaire. The study may be stopped without your consent for the following reasons:

- The PI feels it is best for your safety and/or health-you will be informed of the reasons why.
- You have not followed the study instructions
- The PI, the sponsor or the Office of Regulatory Affairs at the University of Pennsylvania can stop the study anytime

You have the right to drop out of the research study at any time during your participation. There is no penalty or loss of benefits to which you are otherwise entitled if you decide to do so. Withdrawal will not interfere with your future care.

If you no longer wish to be in the research study, please contact Donna Wampole, LCSW, at 717-324-3436 and take the following steps:

Please speak with or leave a message for Donna on her confidential voice mail stating that you wish to withdraw from the study. A copy of the withdraw survey will be mailed to you confidentially.

How will confidentiality be maintained and my privacy be protected?

We will do our best to make sure that the personal information obtained during the course of this research study will be kept private. However, we cannot guarantee total privacy. Your personal information may be given out if required by law. If information from this study is published or presented at scientific meetings, your name and other personal information will not be used.

Your MBI surveys will be sent to you in an online version as licensed by MindGarden, license holder of the Maslach Burnout Inventory. Your final open-question surveys will be given to you in an envelope with your name, but a code number only will appear on the survey. Donna Wampole and the Institutional Review Board of the University of Pennsylvania are the only entities who will have access to the coding of name to number. Information regarding your perceived level of stress before or after the study is not accessible to WellSpan Health as your employer. It may not be used against you in any way.

What happens if I am injured from being in the study?

We will offer you the care needed to treat injuries directly resulting from taking part in this research. We may bill your insurance company or other third parties, if appropriate, for the costs of the care you get for the injury, but you may also be responsible for some of them.

There are no plans for the University of Pennsylvania to pay you or give you other compensation for the injury. You do not give up your legal rights by signing this form.

If you think you have been injured as a result of taking part in this research study, tell the person in charge of the research study as soon as possible. The researcher's name and phone number are listed in the consent form.

Will I have to pay for anything?

There is no direct cost to you for your participation in this study. You will not receive reimbursement for parking or transportation to and from the study site.

Will I be paid for being in this study?

There is no direct payment for your participation in this study. However, participants who complete the study in full will be entered into a drawing for one of two, \$50.00 Rutter's Farm Store or Sheetz gift cards. The drawing will be held approximately one week after all post-test MBIs and open-ended surveys are received. One winner will be drawn from participants in each of the participant groups (intervention and non-intervention). Only participants who take part in skills groups and complete all surveys will be entered into the drawings.

Please note: In order to be compensated for your participation in this study, you must provide your Social Security Number. Additionally, please note that the University of

Pennsylvania is required to report to the IRS any cumulative payments for participation in research studies that exceed a total of \$600 in a calendar year.

Who can I call with questions, complaints or if I'm concerned about my rights as a research subject?

If you have questions, concerns or complaints regarding your participation in this research study or if you have any questions about your rights as a research subject, you should speak with the Principal Investigator listed on page one of this form. If a member of the research team cannot be reached or you want to talk to someone other than those working on the study, you may contact the Office of Regulatory Affairs with any question, concerns or complaints at the University of Pennsylvania by calling (215) 898-2614.

When you sign this document, you are agreeing to take part in this research study. If you have any questions or there is something you do not understand, please ask. You will receive a copy of this consent document.

Signature of Subject

Print Name of Subject

Date

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