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Practicing Meditation to Prevent and Reverse Burnout in Nursing

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The health care system's infrastructure has created a hostile environment for the nursing profession.  Role expectations and the current working conditions place nurses at risk for burnout.  The consequences of burnout affect individual nurses, patients, health care institutions and the health care system.  The writer proposes that practicing meditation, available in various methods, is one strategy that could prevent and reverse burnout in nursing.

In this paper, risk factors to burnout inherent in the nursing profession will be examined and discussed as they relate to the health care infrastructure, the foundation from which nursing has evolved, nursing education and professional socialization of nurses.  In addition, burnout and the psychology that accompanies the syndrome will be presented to further understanding.  Strategies will be developed to support the use of meditation as a strategy to prevent and reverse burnout.  Furthermore, recommendations for nurses, academic and health care institutions to incorporate strategies to foster meditation practice will be provided.

**Nursing**

**Historical/Social/Political**

The nursing profession has been feminized since early inception, which has contributed to social and political implications that are still present today.  Nursing practice was considered in the context of a woman's duty to care for others (Duchscher & Cowin, 2006).  Gender, referring to the societal roles and expectations, influences role expectations, self-concepts, and relationships (MacIntosh, 2002).  In

most cases the socialization of women has led them to tolerate "roles of

subordination, service and compliance" (MacIntosh, 2002, p. 171).

Historically, nursing care generally consisted of the non-scientific delivery of

basic cares rooted within the moral context of Christian values (Duchscher & Cowin,

2006).  "Nurses addressed the individual and collective problems created through

the circumstances of illness by supporting personal resistance to the ravages of

disease, and controlling the environment within which that disease reigned"

(Duchscher & Cowin, 2006, p. 153).  These cares were initially provided in the

homes, but the need for hospitals to be constructed grew as a means to care for the

poor.  Support for these hospitals came from charity and the need to provide a form

of social control of the lower classes.  This included both the patients and the

nursing staff, since nurses in hospital settings were poor women who were unable

to provide for themselves in any other way.

In addition to gender and class influences on the role of nursing, the

subordinate status was strengthened by the budding health care infrastructure.

This organizational structure was and continues to be run by physicians who create

and reinforce the medical model values.  "Male physicians and hospital

administrators controlled the role delineations, decision-making, and clinical

decisions of these institutions, thereby crystallizing the deference and

subordination of nursing to the professional authority of others" (Duchscher &

Cowin, 2006, p. 153).  Nursing professionals and medical professionals have not

acknowledged the organizational foundation of the health care power structure and

its values, and this lack of acknowledgment has contributed to oppressive working conditions in the form of pressures to conform to the values of medical model and disregarding those of nursing.

Although both Florence Nightingale and Edith Cavell were leaders in nursing advancing the nursing profession as a respectable vocation for women, their focus on Christian standards combined with gender roles reinforced expectations of nurse as martyr.  In addition to technical training provided by the medical staff, Nightingale's students had to adhere to her Christian standards (Walker, 2003). "She believed above all else, in hygiene (fresh air, cleanliness, clean water, proper drainage and plenty of light), constant consideration for the patient's feelings and shrewd observations at the sick bed" (Walker, 2003, p. 40).  Similarly, Cavell, as director of the Berkendael Institute of Brussels, demanded the highest standards from her students, stressing "duty and service to others, as well as ethical conduct, cleanliness, dedication to work and punctuality" (Walker, 2003, p. 39).  Self-care to balance the need and duty to care for others is not mentioned or discussed.

As the health care system continues to evolve following a market driven, business model, the status of nursing will likely continue to be subordinate to not only physicians, but to the various other health care professionals.  The focus on increasing monetary gains in this profit-oriented system devalues the altruistic and humanistic intentions that form the basis of nursing's moral imperative to care (Duchscher & Cowin, 2006).  "Caring, in the context of acute-care health care delivery today, has been perversely associated with outcomes that are dependent on

treating illness rather than optimizing health" (Duchscher & Cowin, 2006, p. 154).

Furthermore, this focus on for profit gains reinforces the power dynamic in the

health care system as physicians and other disciplines are revenue generating and

nursing is not.  Nursing work is hidden in with room and board billing.  In this

manner, nursing's contribution and value to the institution is disregarded.  Although

nursing is not acknowledged as revenue generating, the reality is that without the

nurses, the institution is unable to maintain the institutions sources of income.

The main theme surrounding the nurses' role is to care for others.  It is also

noted that the subordinate status of the nursing profession, both gender-based and

medical system-based, impacts the role as well.

**Nursing Education/Professional Socialization**

Expectations, established in a historical and social context, are that nurses

must demonstrate a commitment to humane, selfless service to others (MacIntosh,

2002).  She suggests that this expectation may cause problems with nurses'

perceived professional identity as nursing identifies with their role in caring, which

is not valued, and not on their role in curing and technology, which is.  Nursing

practice includes both caring functions and curing functions, enabling the nursing

profession to practice holistic care.  Having the ability to practice both functions in

one role is the strength of nursing, but the subordinate status and the notion of

selflessness may become problematic in the manner it influences the psychology of

the profession, potentially leading nurses into burnout.  Because nursing practice

exists within a health care system that prioritizes and values the curing and

technology aspects of care, nurses' perceptions and feelings of the meaning of their work as well as their professions worth may be impacted negatively.  By not addressing the source of these feelings, one may not use effective coping strategies and suffer psychological distress that may lead to burnout.

Professional socialization begins in nursing education (MacIntosh, 2003). Shinyashiki, Mendes, Trevizan and Day (2006) note three themes arising amongst various definitions of professional socialization.  These themes include the following: formation of *values and standards*; formation of *behavior*; and the formation of *self-concept* as a professional.  These themes demonstrate the importance of critically examining the values and standards the nursing profession is teaching and reinforcing because these will impact the behavior and self-concept of nurses. In addition, it appears that with the passing of time the nursing profession has acquired more responsibilities resulting in more education in science and the humanities, yet still remains in a subordinate role that is loosely defined.  This lack of clarity challenges the professional socialization process.

Shinyashiki et al. (2006) note that intended and unintended results of an educational curriculum impact professional socialization.  Professional socialization happens through the formal curriculum and hidden curriculum; teaching in the classroom and clinical settings formally and informally; and in the conversations with patients, other students, nurses and other health care providers (Benner, Sutphen, Leonard & Day, 2010).  Moreover, they, using formation to denote professional socialization, suggest that "it is important for nurse educators to

recognize that formation – shaping of the habits and dispositions for use of knowledge and skilled-know how – occurs in every aspect of a nursing student's education" (p.88).

Professional socialization is noted to also take place in the disparities between theory and practice (Benner et al., 2010). These disparities add stress to an already stressful environment. According Duchscher and Cowin (2004) the new nurse with values of caring and high quality care is challenged by institutional values of clinical expediency and unquestioning compliance, which increases stress. If the stress is not managed, they believe it is possible for the new nurse to lose self-esteem, which may affect self-confidence negatively. Furthermore, another potential consequence of unmanaged stress is that the new nurse may form perceptions of failure in realizing his or her professional role. Poorly managed stress has the potential to progress to burnout. Given the added stress the academic and health care institutions have created in their differing value systems, the responsibility to address these issues affecting professional socialization belongs to both of them.

In the meantime nurses themselves have been attempting to reconcile the dissonance between theory and practice. MacIntosh (2003) found that nurses' transition through three phases in a cyclical process to address discrepancies experienced as they develop and maintain their professional identity. The first stage of "assuming adequacy" one focuses on the technical tasks with little to no reflection on nursing practice. The second stage, "realizing practice", consists of two

processes, starting when one develops awareness to the differences between "expectations and experiences, values and practices, and self and others" (p. 732). This may leave one feeling disillusioned and dissatisfied.  In the second process, one uses strategies to reconcile this dissonance by developing protective responses, making connections with others, and seeking opportunities for professional growth. "Developing a reputation", the third stage, includes setting up individual practice styles, selecting standards of care and practice, and participating in activities to advance the nursing profession.

This process of professional socialization is influenced by expectations, and one's interpretation of professional status and level of support (MacIntosh, 2003). The historical and social context forming the foundation of nursing, including gender socialization, may influence nurses' perception of expectations and professional status.  Interpersonal relationships amongst staff and the tone of the work environment influence the level of acceptance one feels, as well as supportiveness in the form of assistance and advocacy (MacIntosh, 2003).  Nurse educators need to be aware of the significance of professional socialization and its process, not only to provide high quality care, but for the mental, emotional and physical health of nursing professionals as well as the profession itself.

## Burnout

**Description**

Burnout is a gradual process where an individual finds oneself with feelings of mental and physical fatigue and lacking energy (Espeland, 2006).  There are psychological components as well.

Denial, a principal feature of burnout, allows one to avoid facing the reality of offensive feelings, perceptions, and experiences (Freudenberger & North, 1985). They state that denial frequently begins with the desire to negate thoughts or feelings related to an overuse of physical, mental or emotional energy, in which over time becomes habitual in the forms of suppression, displacement and projection. Moreover, denial, as a coping strategy, allows one to work harder and longer.  As one begins to consistently deny one's physical, mental and emotional needs and deprives oneself of what sustains them, one's sense of self is undermined.

Freudenberger and North contend that one may progress through the burnout process, which includes twelve stages, but that the stages often have similar aspects that intersect with one another.  (See Appendix A) Furthermore, the level of intensity and duration in a stage varies based on individual circumstances, which include an individual's self-perception and ability to cope with stress.  It is important to note that one is not in the burnout symptom cycle if similar feelings arise during a challenging situation, and return back to baseline after the situation resolves.

Actual or perceived threats activate the sympathetic nervous system to prepare the body to react or respond, which demonstrates the power the brain has over how it perceives and responds to stressful situations (Milliken, Clements & Tillman, 2007). Stress, a key factor of burnout, can be labeled as "good" or "bad" depending on the context and an individual's assessment of the circumstances (Davies, 2008). In addition to stress-producers, Freudenberger and North (1985) report that stress-extenders may lead to burnout. A stress-extender is "any powerful emotion, which is consistently denied or neglected works to extend the day-to-day stress of "normal" living" (Freudenberger & North, 1985, p. 16). Examples of stress-extenders include anger that hasn't been dealt with, unacknowledged hostility, disregarded needs, guilt and low self-esteem.

**Context: Nursing Profession (Healthcare/Academic)**

Studies on burnout in nursing are found from various countries including the United States, Canada, England, Scotland, Germany, Turkey, South Africa, Taiwan and Australia, indicating a global occurrence (Espeland, 2006). According to Duchscher and Cowin (2006) the nursing profession shares a culture of values with fundamental characteristics that are present worldwide. Furthermore, burnout affects nurses at all levels of practice including academia and management (Espeland, 2006).

There are several factors that contribute to job burnout. Potter identified ambiguity, no-win situations, role overload, role conflict, unacknowledged work performance as work conditions contribute to burnout (as cited in Espeland, 2006).

Wu, Zhu, Wang, Wang and Lan (2007) found that role overload, responsibility, role insufficiency and self-care predicted emotional exhaustion, and role insufficiency, role boundary, responsibility, and self-care predicted cynicism, also referred to as depersonalization.  They also found that role insufficiency, social support and cognitive coping predicted professional efficacy, a sense of professional accomplishment.  In addition, the nature of the work itself, including maintaining emotional distance while establishing therapeutic relationships and being a part of the family's experience of illness, may add to the already challenging work environment (Edward & Hercelinskyj, 2007).

The subordinate status of the nursing profession may instill feelings of powerlessness that are not acknowledged in the education and socialization process, and appear to be accepted as the norm in acute care settings.  According to Duchscher and Cowin (2006) some nurses have come to tolerate the oppressive context of acute care, accepting it as the norm by desensitizing themselves as they comply with industry values, at times at the expense of fundamental nursing values.

A lack of awareness and acknowledgment of the subordination of nursing practice places undue psychological distress on nursing professionals, as its presence is often felt.  It is important that the subordinate status of the nursing profession be acknowledged and discussed to be able to begin to own their profession.  Edward and Hercelinskyj (2007) recommend that educators assist nurses to carefully examine and discuss the components and circumstances that impact them professionally encouraging personal reflection of their position.

Having others define and decide what is of value will continue to keep the nursing

profession an oppressed group feeling powerless with high risk for burnout.

According to Duchscher and Cowin (2006) there is evidence that the nursing

profession's subordinate status is still present, but that it has become more covert

and distressing to nurses.  Denying hostility may lead one to displace the

resentment onto someone or something else, or channel it inward in expressions of

self-sacrifice or perfectionism (Freudenberger & North, 1985).  If feelings are

sublimated, one may neglect oneself and one's needs, as well as work harder to meet

unrealistic expectations.  If feelings are displaced, the hostility may manifest in

horizontal violence, which may then decrease feelings of support and cohesion.

Duchscher and Cowin (2004) contend that oppressive circumstances, which

affect one politically or one's economic position, and occur over long periods of time

determine the presence of marginalization.  This concept of marginalization appears

to apply to those in the nursing profession considering its longstanding position in

the health care system.  The "marginalized personality" present in individuals who

are not included within the dominant group, arises from the habitual placement of

individuals into limited subordinate social or economic status within which the

recognition and carrying out of the full sense of self is not only restricted, but from

which they are unable to transcend (Duchscher & Cowin, 2004, p. 290).  This may

lead one into the burnout symptom cycle by instigating a compulsion to prove one's

knowledge, skills, abilities and professional status by working harder, sometimes

under the ideals of performing "perfect" work, and seeking external approval from

those deemed more powerful in terms of knowledge and professional status.

Freudenberger & North (1985) state that potential burnouts are usually dissatisfied

with the existing state of affairs and have a standard in mind that is sought after

with determination, intelligence and resourcefulness.  They warn that without

guiding principles or parameters, it is misperceived with tenacity, which may lead

one onto the path to burnout.

According to Takase, Kershaw and Burt (2002) public opinion may have an

impact on the nurse's self-concept and self-esteem, as well as the collective self-

esteem.  The authors analyzed 80 questionnaires and found direct relationships

between nurses' impressions of public opinion and development of their self-

concept and collective self-esteem, and a weak direct relationship with self-esteem.

This study offers ideas of how nurses' perceive others views of the profession may

negatively influence them from incorporating a positive self-concept and self-

esteem.  In addition, it also draws attention to the significance of professional

socialization, as it was found to be associated with the development of personal self-

esteem.  This indicates that nurse educators must use strategies to facilitate the

development of positive self-concepts and sense of self-esteems of nurses to counter

perceived perceptions of others.  Low self-esteem, a stress-extender, may lead one

to feel that one is not "good enough", which "pressures one into an unrealistic

striving for excellence, recognition, and approval and places an additional burden of

stress on one's life" Freudenberger & North, 1985, p. 17).  This suggests that both

academic institutions and health care institutions need to look into professional

development opportunities to empower nurses, strengthening a healthy sense of

self, and overt ways to acknowledge the professions' contributions in and to health care.

The transition from nursing student to nursing professional has been found to be one of high stress. One of the challenges new nursing graduates face is to develop a professional identity that merges the values and standards of their education with real world practice (Duchscher & Cowin, 2004). In addition, they note that the new graduate's nursing skills and coping abilities are constantly being observed, which may contribute to a wearing away of self-confidence and feelings of competency. The loss of confidence may lead to thoughts and behaviors that place an individual into the burnout symptom cycle by working harder to prove one's competence. This may occur any time a nurse enters a new area of work, whether within the acute care setting, into another context or level of nursing (i.e. management), or within the academic setting.

In nursing education, professional values and ideals are introduced and socialized. As nurses begin their careers, they have expectations that they will be able to meet professional nursing standards including meeting patients' needs and providing optimal care (Espeland, 2006). Duchscher and Cowin (2004) report that the research on professional socialization suggests that new nurses experience moral distress in practice such as lacking autonomy, and feeling guilty and disappointed for not being able to take care of their patients. Furthermore, they suggest that new nurses believed that ethical concession was inevitable when working in acute care.

Duchscher (2001) conducted a qualitative study with five new graduate nurses to gain a deeper understanding of the experiences in their first six months of practice.  Although it was a small sample, it provided useful information, including challenges, surrounding the transition from student to professional. She found new graduates felt conflicted in the following moral dilemmas: *caring effectively or caring efficiently*; *being perceived as independent, capable practitioners by their colleagues or reaching out for needed assistance*; *practicing ideals that had been taught to them in their undergraduate education or assimilating the institutionally modified practice standards of the real world*; *focusing on their own needs or attending to the ever-demanding but unfamiliar needs of their patients*; and *their understanding that while experience was key to their becoming professionals, but they had little control over the nature, intensity or quality of that experience*.  These moral dilemmas may lead to feelings of guilt.  Guilt is a stress-extender that may push one into taking full responsibility and stretching oneself beyond one's endurance (Freudenberger & North, 1985).  Nurse educators in both academic and healthcare institutions need to address these moral dilemmas.  Moreover, the conflict in feeling the need to choose between self and others, the patients, demands a more balanced discussion and reinforcement of the necessity of self-care.

The nursing profession focuses on the needs of others, which involves caring and nurturing.  Anticipation is required in attempts to predict what others will need and what potential emotional responses to situations and events will be to intervene therapeutically.  According to Freudenberger and North (1985), focusing on anticipation may result in one tuned in to the needs and reactions of others while

lacking the skills to recognize one's own needs.  In addition, Bloniasz (2011) asserts

that by routinely neglecting one's needs may result in a lessened ability to

acknowledge them.

Although unintentional, the nursing curriculum may be reinforcing and

exploiting the nurturing tendencies of those who are drawn to the profession by

cultivating values of high quality patient care and meeting the moral imperative that

is central to nursing's identity without the development of personal boundaries.

Nurturers have a tendency to burnout because they tend to deny their own needs

(Freudenberger & North, 1985).

**Consequences of Burnout**

Burnout affects individual nurses emotionally and physically.  Negative

emotions such as frustration, anger, depression, feeling trapped, irritability,

cynicism, bitterness and pessimism towards self, others and the world, come on

gradually and become chronic eventually leading to emotional exhaustion (Espeland,

2006).  Furthermore, loss of meaning and purpose may arise, resulting in a loss of

joy and hope, and affecting self-esteem and self-worth negatively.

Negative emotions affect life and job satisfaction.  On a personal level, the

emotional exhaustion from burnout may pose challenges on how one relates to

others, manifesting in ineffective communication, detachment and a lack of

compassion and empathy for others (Espeland, 2006).  This suggests that burnout

may also affect self-compassion negatively as well.  In addition, the negative

emotions may manifest physically, such as insomnia, fatigue, headaches, muscle

discomfort, gastrointestinal problems, and skin issues (Espeland, 2006).  Individuals

may turn to ineffective coping strategies such as over or under eating, smoking

more, increased caffeine intake, drinking alcohol, using illicit drugs, abusing

prescription drugs, gambling or excessive worrying, and cause more interpersonal

and professional problems.  These unhealthy behaviors may increase risks for

physical illness.

These ineffective lifestyle behaviors and negative physical symptoms that

arise from stress may contribute to higher rates of absenteeism, which adds to

health care institutions costs.  Absenteeism necessitates that the institution have

their staff nurses work overtime or contract agency nurses to fill the missing nurses

hours adding expense.  In addition, when present at work, productivity is affected

negatively as is the quality of care (Espeland, 2006).  When nursing professionals

are in the burnout process, the nurse has less emotional and physical energy to

perform optimally as well as may detach from self and surroundings.

Another serious consequence of burnout for health care institutions is

attrition.  A National Institutes of Health study (2002) found that 43% of nurses who

reported burnout intended to leave that position within the year (as cited in

Espeland, 2006).  Attrition of staff is costly.  Retention of nurses is at stake, and

needs to be of critical importance to health care institutions.  The focus on retention

of experienced nursing staff is crucial to sustain a qualified workforce to care for

patients, and necessitates strategies to prevent and reverse burnout.

**Meditation**

**Description**

Meditation is a cognitive activity that teaches one to become aware of and observe one's thoughts without attaching meaning or reacting to them with the objective of calming the mind (Davies, 2008).  This allows one to develop the skill to focus in the present moment, teaching one to purposefully respond to the current situation rather than react emotionally and physically to it later.  Through the practice of mindfulness meditation, one is able to improve interpersonal and self-management skills, and psychological awareness (Galantino, Baime, Maguire, Szapary & Farrar, 2005).

According to Davies (2008), meditation allows individuals to train their minds to pay attention more closely and more clearly.  There are several methods in which one is able to practice meditation.  He states that the literature identifies three basic elements common to most types including the body scan, sitting meditation, and yoga.

Davies (2008) reports that the body scan involves moving one's mind through different parts of one's body, and using one's breath to feel each area of the body, allowing one to relax and release tension.  Sitting meditation involves observing one's breathing, sensations, emotions, sounds and thoughts in a nonjudgmental manner cultivating self-acceptance while sitting on the floor or in a chair.  Yoga is a series of physical poses that are integrated with the breath to foster awareness of body sensations.  Yoga practice encourages one to move into poses

mindfully, learning to acknowledge physical limitations, sensations, feelings and thoughts; the body is not forced into poses.  This fosters one's awareness of the mind-body connection.

When practicing meditation, one focuses within, limiting the presence of external distractions to facilitate observation of thoughts and feelings (Davies, 2008).   By reducing the flow of thoughts and increasing awareness and understanding, one can start to replace them with positive affirmations.

**Self-care to Prevent and Reverse Burnout**

Changing the circumstances causing or increasing stress is often difficult to do (Prasad, Wahner-Roedler, Cha & Sood, 2011).  The healthcare system and its oppressive work environment, needs significant reform.  The restructuring that is needed, will require significant amounts of time with negotiations and in implementation.  Strategies to reduce stress that contributes to burnout need to be considered immediately.  Considering the current work environment of heavy workloads with high acuity patients and the multifaceted nature of nursing, offering courses to develop skills to manage stress and maintain the health of nurses may be a feasible option for institutions (Raingruber & Robinson, 2007).  In addition, Prasad et al. (2011) suggest increasing personal coping skills to manage stress. Furthermore, Bloniasz (2011) recommends confronting the sources of stress and developing effective responses using the nursing process for stress management. The first step in the nursing process, self-assessment, requires one to increase self-awareness to reconnect with oneself and one's needs.

**Meditation as self-care.**  According to Freudenberger and North (1985), burnout can be reversed when one increases self-awareness to assist altering patterns of thinking, living, and caring for oneself.  Meditation practice looks inward and promotes nonjudgmental observations, developing self-acceptance, instead of looking to external sources to validate and approve.  Cultivating self-compassion and self-acceptance in nurses may be helpful to manage the possible psychological effects of subordination.  The self-awareness that is gained will become the standard by which one will judge their own capacities and limitations, and pressures will be measured against what each individual knows about self rather than the expectations of others (Freudenberger & North, 1985).

Prasad et al. (2011) studied the effect of taking a one session meditation-training program, a stress reducing strategy, into the day-to-day activities of healthy clinic employees.  A two-hour session covered general information about meditation and instruction of a simple breathing program.  The breathing program had participants take slow, deep breaths, and focus attention on "musical chords and moving circles" (Prasad et al., 2011, p.47).  Seventeen participants were asked to practice the meditative program, alternating between the taught breathing pattern and silent meditation, either five, 15 or 30 minutes two times a day for four weeks using the DVD that was given to them.  They found that perceived stress, anxiety and overall quality of life all improved regardless of the length of time taken for meditative practice.  It is important to note that the frequency of practice ranged from 10 to 28 days with median practice 25 days.  Although the study used a small sample of all women, the findings suggest that regularly meditating as little as five

minutes twice a day helps reduce perceived stress and anxiety, and improve overall

quality of life, perhaps preventing and alleviating burnout.  Furthermore, they found

that participation in one-session meditation training was effective for this type of

meditation program.  This finding provides a feasible alternative to longer training

programs.

Raingruber and Robinson (2007) conducted a qualitative study to find the

meaning and significance of practicing one of three mindfulness-based self-care

classes or Reiki healing session for three months to nurses from a university-based

hospital.  Forty-nine nurses agreed to participate in one of the four self-care

strategies: Sivananda Yoga, Tai Chi, guided meditation, or Reiki healing session.

Participants were instructed to reflect on sensations and feelings that arose during

or after self-care, and to describe any differences in practice that were noted in their

self-care journals.

Raingruber and Robinson (2007) found the following three themes: *noticing

sensations of warmth, pulsation, and calm*; *becoming aware of enhanced problem

solving ability*; and *noticing an increased ability to focus on patient needs*.  When they

felt a sense of calm, participants reported having the ability to focus and pay

attention to physical sensations.  In addition, feeling calmer, the participants

observed improved mental clarity facilitating efficient and effective problem solving.

Participants also felt more present with patients, allowing them to be there mentally

and emotionally as well as physically.  Furthermore, they report that nurses who

participated in mindfulness-based self-care classes began to let go of perfectionism.

Perfectionist attitudes link self-worth with achievement, and tend to have high standards.  Therefore, an increase in self-acceptance may prevent and help reverse burnout caused by unrealistic expectations.  These results provide a deeper understanding of the significance and personal impact mindfulness-based self-care may have.

Because ignoring and denying one's needs may lead to a mind-body disconnect and possible disengagement from self, practicing yoga, Tai Chi, meditation and Reiki appear to offer strategies to prevent and reverse burnout by assisting one in reconnecting the mind and body.  In addition, providing opportunities for mindfulness-based self-care classes, healthcare institutions may assist employees in improving their well-being.  The rewards may include a workforce that has gained mental clarity, emotional stability and physical energy to not only withstand current, high stress working conditions and staff retention, but also improve the quality of patient care.

**Meditation-based stress reduction programs.**  Meditation, focusing on mindfulness and the breath, is the foundation for several stress reduction programs. Davies (2008) reports that Jon Kabat-Zinn has developed an effective meditation-based approach to reduce burnout, in which research suggests that emotional exhaustion and depersonalization decrease after one completes a course modeled using this approach. (See Appendix B)

Matchim, Armer and Stewart (2008) conducted a qualitative study with a small sample of nine healthy adults to further understand perceptions of

effectiveness of mindfulness-based stress reduction (MBSR) practice on self-care and well-being.  The following five themes arose from the data: *promote sense of peace and relaxation*; *promote health awareness and self-care concerns*; *promote self-management and responsibility*; *promote sense of giving and sharing*; and *fulfill a basic need for health and well-being*.

Matchim, Armer and Stewart's (2008) findings are promising when looking to prevent and reverse burnout.  The participants in this study reported feeling a sense of calm, kindness, goodness, openness and peace after practicing meditation, which affected their thoughts and perceptions of themselves and others in a positive manner regardless of the situation.  In addition, learning to pay attention on purpose increased clarity and awareness, which allowed them to choose to partake in health promoting activities.  These findings suggest that with a greater sense of self-awareness, nurses may consider their needs and prioritize self-care along with care for others.

The findings from Matchim, Armer and Stewart (2008) are reinforced by a study conducted by Katz et al. (2005a).  Katz et al. and Katz, Wiley, Capuano, Baker and Shapiro (2005b) are parts III and II, respectively of a three-part study that explored the effects of MBSR on nurse stress levels and burnout.

Katz et al. (2005a) analyzed 46 documents and found that participants felt *increased relaxation, feelings of peace* and *being present* as benefits of MBSR during the beginning weeks of the program, and feelings of *self-acceptance, self-awareness* and *self-care* increased during the fifth week lasting through the end of the program.

Benefits that continued or arose after the completion of the program include the

following: *increased patience, calmness or relaxation*; *more confident*; *better sleeping,*

*driving skills, and work prioritization*; *more conscious eating habits*; *enhanced*

*spirituality*; and performance of self-care activities.  Themes surrounding the impact

on relationships included the following: *benefit of the MBSR group setting; difficulty*

*of letting go of worry about others; improved communication in relationships; being*

*fully present in relationships without becoming as reactive or defensive; increased self-*

*confidence; therapeutic presence;* and *increased empathy and appreciation of others.*

Participants also reported experiencing some challenges including feeling restless

and pain, which improved with continued practice.  In addition, difficult emotions

arose, but participants reported that although it was painful, it was also beneficial

enabling them to acknowledge and work through the issues to move on in their lives.

Katz et al. (2005b), part II, analyzed test differences pre and post course

between treatment and wait-list control groups as well as within-treatment groups.

The treatment group consisted of 12 nurses and the wait-list control group had 13.

A second cohort treatment group consisted of seven wait-list control group

participants and four new members.

It was found that emotional exhaustion and feelings of lack of personal

accomplishment significantly decreased, and although not significant, less

depersonalization trended toward significance in the treatment group.  They also

note that the wait-list group also decreased although less than the treatment group.

This may have occurred as a result of unintended effects of attending the initial

information session.  Emotional exhaustion decreased post treatment and three

months after treatment from pre treatment levels within the treatment group.

Regarding personal accomplishment and depersonalization, there was a trend

toward significance.  The second cohort was found to have improved in emotional

exhaustion, and a trend toward significance was found in personal accomplishment.

No improvement was found for depersonalization for this group.  Although the

sample size of this pilot study was small, these findings suggest that the MBSR

course impacts emotional exhaustion, which is thought to be most strongly

associated with burnout.

A study conducted by Galantino et al. (2005) examined the psychological

effects of a mindfulness meditation-based stress reduction program on

administrative and direct patient care health care providers.  The course met once a

week for eight weeks, and included instruction and guided practice of learned

mindfulness-based skills, applicability to health care settings, and discussions.  In

addition, participants had homework assignments of readings and 30 minutes of

daily practice of the skills learned.  The authors analyzed 69 questionnaires and

found improvements in mood and emotional exhaustion upon completion of the

course.  Although this preliminary study had several limitations, including small

sample size and no control group, the findings suggest positive psychological

outcomes after one completes a mindfulness-based program, which is consistent

with available research.

Kravits, McAllister-Black, Grant and Kirk (2010) developed a psycho-educational course for nurses to learn and practice stress management skills, and evaluated its effectiveness.  Although they used Lazarus and Folkman's (1984) Cognitive Model of Stress and Coping as their theoretical framework for the course, there were similarities with MBSR programs.  Instead of an eight-week program, this course was a one-time six-hour class that provided information regarding the importance of self-care, stress, stress response, intentional practice and methods for coping.  In class activities included collage art reflecting patterns of coping, wellness plans, guided deep breathing and imagery practice supporting reflection about self-care, and discussions.

Kravits et al. (2010) looked at the three components of burnout, personal accomplishment, emotional exhaustion and depersonalization, to measure the effectiveness of the course in managing stress.  Although the pre and post test scores for personal accomplishment did not improve, those for emotional exhaustion and depersonalization improved, suggesting course effectiveness in developing coping skills to manage stress.  The rise in feelings of low personal accomplishment after the course may have been the result of a decrease in defenses due to the supportive environment of the course, and more accurately reflect true feelings of personal accomplishment.  In addition, fifty percent of the participants from the cancer center were new-hires on orientation, perhaps still needing opportunities to feel personal accomplishment, which they suggest may account for the difference in personal accomplishment scores between participants from the cancer center and community health care providers. Expectations for what constitutes personal

accomplishment may also be contributing to the level of satisfaction with achievements, which are not noted or discussed.

Kravits et al. (2010) found it challenging to engage the nursing staff to learn and develop new self-care strategies, and recommends looking for ways to draw nurses in to participate in self-care programs. MacGarrigle and Walsh (2011) found that participants' sense of professional accountability towards their clients motivated them to learn and practice mindfulness because they observed themselves providing better service when they used their coping skills as they became aware of their stress. The nursing profession is dedicated to the patient, always in search of ways to enhance the patient experience and provide optimal patient care. Perhaps by defining and establishing self-care as necessary to improve one's patient care abilities and to benefit self, more nurses would be willing to engage in learning and commit to self-care.

Although the study by McGarrigle & Walsh (2011) examined the effects of an eight-week contemplative practice course on self-care, awareness and coping for twelve human service workers, there are commonalities between the nurses and human service workers as both face emotional challenges inherent in their work as well as sharing common stressors of health care. Nurses support people through physically and emotionally challenging situations that may increase stress and lead to burnout. They applied the Cultivating Emotional Resiliency in Education model to human service workers, suggesting that they practice coping skills to manage stress, as they would expect of their clients to do.

The intervention in this study focused on teaching and using contemplative practices to promote one to think, question, discuss, reflect, and concentrate on self to develop deeper understanding and awareness (MacGarrigle & Walsh, 2011).  The two-hour sessions covered information about the history and theological influences on meditation, and various methods of practice.  Instruction and practice included "meditation, body scan, relaxation, yoga, mindful walking and listening exercises," and discussions of concepts and experiences took place at their place of work during working hours (MacGarrigle & Walsh, 2011, p. 217).

MacGarrigle and Walsh (2011) performed a quantitative and qualitative analysis.  The quantitative analysis, looking at pre and post course inventories, demonstrated that mindfulness increased and stress decreased.  The participant's mindfulness may have brought the awareness of stress to the forefront, making it more apparent to the participant that self-care was needed to cope and manage that stress.  The qualitative analysis produced three themes including *accountability, mindfulness and workplace* (MacGarrigle & Walsh, 2011).  Under the theme of accountability, participants felt that it was the practitioner's responsibility to be aware of self and any unmanaged stress.  This suggests that coping with stress and meeting ones needs is imperative in meeting the needs of the client, and at the same time lowers risk for burnout.  In addition, participants felt that both the workplace and the practitioner were accountable for managing practitioner stress.  This balance is also needed in acute care settings where nurses frequently work long hours without breaks, and under high stress conditions.  Employer's need to look at barriers and solutions for self-care at the workplace, and provide professional

development opportunities that include stress management as it affects quality of patient care and retention of staff.

MacGarrigle and Walsh (2011) found several subthemes.  There were two subthemes of mindfulness, which are *mindfulness as a skill* and *interconnections between mindfulness, reflection and self-care*.  It is important to note that instruction and practice are essential for one to become mindful.  Furthermore, the interconnection occurs by first observing the stress, considering the source and possible causes contributing to the stress, and selecting a self-care strategy that best meets needs to effectively cope and maintain well-being.  Meditation develops the ability to observe thoughts and perceptions nonjudgmentally, facilitating a response rather than a reaction to situations.  Three subthemes, *time, permission* and *place*, arose within the workplace theme, and were deemed necessary by the participants to support mindfulness, reflection and self-care (MacGarrigle & Walsh, 2011). Furthermore, participants in this study felt that it was not sufficient to only promote self-care and wellness, the workplace needs to provide time, permission, and a place for staff to learn and practice self-care.

According to MacGarrigle and Walsh (2011), the results suggest that workplace mindfulness education has the potential to assist human service workers manage stress and improve self-care and well-being.  Nurses share similarities with human service workers in their work, and may also benefit from a workplace mindfulness course.

A qualitative study by Schure, Christopher and Christopher (2008) studied the effects of taking an elective course based on MBSR on the personal and professional lives of 33 counseling graduate students.  The course met two times a week for 15 weeks where hatha yoga, sitting meditation qigong and relaxation strategies, and discussions took place.  Homework assignments included readings from various texts and articles, a practice requirement of a minimum of 45 minutes four times a week, and journal writing to reflect on practice and readings.  Although this study includes counseling students, there are similarities with nursing.  Both professions work towards establishing therapeutic relationships and provide emotional support to individuals in stressful situations.

Five themes emerged when analyzing responses to question inquiring about the impact of the course on the participants including: *physical changes*; *emotional changes*; *attitudinal or mental changes*; *spiritual awareness*; and *interpersonal changes* (Schure, Christopher & Christopher, 2008).  Several participants noted that the increase in body awareness and its relationship with the mind empowered them to care for themselves.  In addition, the participants indicated learning effective ways of coping with negative emotions by facing them directly, enabling them to let go of them and foster positive feelings of trust and peace instead.  An increase in self-understanding led to feelings of self-acceptance, and a gain in trust in oneself led to a stronger sense of self-confidence.  Participants also noticed an increased ability to be empathetic towards self and others.

Although the study was a pass/fail elective course, potentially influencing participant responses, the findings suggest that taking the course resulted in positive psychological outcomes. The development of healthy coping strategies is needed in the nursing profession to assist one to reconcile the moral dilemmas of practice and the emotionally and physically challenging aspects of the work itself, instead of avoiding and denying there presence and pushing through it. Meditation may be used as a strategy to work through emotions, and may lead to self-acceptance, deeper understanding and increased awareness (Schure, Christopher & Christopher, 2008).

The aforementioned studies found promising results regarding the practice of meditation and meditation-based stress management programs in potentially decreasing the risk for burnout. Meditation has been found to be an effective stress management strategy by increasing self-awareness, self-acceptance, self-compassion and self-confidence, as well as, increase feelings of peace and relaxation. Furthermore, practicing meditation was also found to have a positive affect on increasing other self-care behaviors. Davies (2008) asserts that reducing an individual's level of stress by practicing meditation does not happen instantaneously because it requires one to learn cognitive and behavioral skills to manage stress. To obtain the benefits of practicing mediation, one must practice routinely. In conclusion, meditation is a skill that needs to be learned and practiced regularly for it be an effective intervention to prevent and reverse burnout.

**Recommendations**

Recommendations are based on the positive findings of meditation and MBSR programs on decreasing levels of stress and anxiety, and the format in which it was provided.  Prasad et al. (2011) found that a one-time session teaching a simple breathing meditation and with a practice time of five minutes twice a day was beneficial in reducing stress and anxiety, and improving overall quality of life.

Raingruber and Robinson (2007) and MacGarrigle and Walsh (2011) both suggest that providing programs and opportunities for self-care at that workplace enabled employee participation to improve wellness and manage stress.  This benefited the institution as well as the individual participant.  In addition, the participants felt that it was both the employee and employer's responsibility to manage the employee's stress, and that the employer needs to provide time, permission and place to facilitate employee participation (MacGarrigle & Walsh, 2011).

In the academic setting, Schure, Christopher and Christopher (2008) provided an elective course using mindfulness-based practices and found positive results including increased self-awareness, self-understanding and self-confidence, and promoting self-care.  This may assist in providing a strong foundation for future nurses to professionally grow upon.

**Academic Institutions**

1.)     Develop and implement a meditation-based stress reduction

pass/fail course to provide more effective stress management

skills, and to cultivate awareness of self-care needs, self-

acceptance, self-compassion and self-confidence thereby

supporting a healthy self-concept and self-esteem.

2.)     Incorporate meditation into clinical practice to encourage a sense

of calm and self-awareness.  For example, practice a five-minute

deep breathing exercise or guided meditation prior to and after

clinical practice.

3.)     Practice mindful psychomotor skills in clinical laboratory,

observing physical sensations to learn to practice paying attention

on purpose and being in the present moment.

4.)     Have guided meditation CDs available at the wellness center for

student use, and a quiet room available for practice.

5.)     Critically examine the nursing curriculum, looking for its hidden

agenda to bring awareness to potential unintended values and

behaviors being fostered and reinforced, influencing professional

socialization.

**Health care Institutions**

1.)     Develop and provide a mandatory eight-week meditation-based

stress reduction course that is offered two times a year.

2.)      Offer a 15-minute guided meditation class at a minimum of once a week at three different times to facilitate practice.

3.)      Have guided meditation CDs available for employee use, and a quiet room available for practice.

4.)      Create a poster board presentation on meditation and five minute guided sitting meditation experience for Nurses Annual Training education.

5.)      Provide a two-hour course covering risks for burnout, necessity of self-care and meditation, including instruction and of a simple breathing meditation practice, to be used during new employee orientation.  Current staff could be invited to these classes.

**Individual Nurses**

1.) Enroll in a course to learn and practice meditation.

2.) Practice meditation on a daily basis.

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Appendix A

Burnout Symptom Cycle

According to Freudenberger and North (1985), there are 12 stages one may

progress through, which they called the burnout symptom cycle.  One is not in the

burnout symptom cycle if feelings resolve after a challenging situation has been

resolved.  The 12 stages are the following:

1. Compulsion to prove: embedded in self-esteem, expectations and worth, and

   is characterized by an uncontrollable determination to achieve.  It is often

   initiated by high expectations of oneself.

2. Intensity: a sense of urgency is added to one's compulsion to achieve and

   prove oneself by taking full responsibility to accomplish one's goal.  The level

   of intensity may be justified when considered in terms of dedication and

   commitment.

3. Subtle Deprivation: characterized by diminished attention to oneself and

   one's needs.  One in this stage tends to postpone personal needs including life

   management duties and leisure time.  This is a significant indicator that one

   is in the burnout process.

4. Dismissal of Conflict and Needs: one becomes aware of internal conflict by

   observing disconnections between feelings and actions, but choose to ignore

   the disconnection to stay on task.

5. Distortion of Values: ignoring the internal conflict, one begins to have

   difficulties separating what is essential and not essential.  With a sense of

urgency, time is only considered in the present.  Furthermore, one's worth is validated by external sources.

6. Heightened Denial: one begins to unconsciously deny human needs and reality that conflicts with one's compulsion.  One's world-view is severely limited.  Feeling intolerant is a key symptom in this stage.  Projection, suppression and displacement may be present.

7. Disengagement: one disengages from self and others.  The reduction of hope and the development of cynicism are symptoms of this stage.  One may begin to conduct oneself in a ritualized manner.

8. Observable Behavior Changes: one cannot differentiate between fears and needs.  Behaviors and feelings become more rigid and inflexible.  There is also a change in language use demonstrating one's change in attitude.  Isolation may result.

9. Depersonalization: a prominent symptom of this stage is self-negation (p. 105).  Self and others do not exist.  One lives on automatic, leaving one feeling less of connected or with less meaning in one's life.

10. Emptiness: one feels a sense of nothingness.  Because this empty space has been created, one may look to fill it with anything gratifying that makes them forget the emptiness (i.e., food, sex, etc.).  This may lead to excessiveness, which is a prominent feature of this stage.

11. Depression: one does not care anymore, and feelings of hopelessness and exhaustion are present.  Wanting to sleep all the time is a key symptom.

12. Total Burnout Exhaustion: one is worn-out to the point that even the original

compulsion has lost its meaning.  One may be at risk for stress-related

illnesses as physical and mental exhaustion has been reached.

Adapted from Freudenberger and North, 1985, p. 88

Appendix B

Mindfulness-Based Stress Reduction (MBSR)

According to Katz et al. (2004), MBSR courses have the following features:

1. Course is taught using a group format.

2. Based on mindfulness meditation, which is defined as the purposeful observation of the present moment, "accepting and acknowledging it", without judgment and emotional reactions (p. 304).

3. Backbone of program includes practice in mindfulness meditation, mindful yoga, and body scan meditation.

4. Content: "core of the curriculum is mindful awareness of physical sensations, thoughts and feelings" (p.304); stress response; behavioral skills; cognitive skills including "communication, identification of one's thoughts, feelings and physiological reactions associated with stressful events" (p. 304); and self-acceptance.

5. Discussions are a significant part of the course.

6. Program originally formatted to meet two and half hours a week for eight weeks with a six-hour retreat to take place after the sixth week, and daily practice of the mindfulness skills as homework.