Reducing burnout among mental health providers using a mindfulness intervention.

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REDUCING BURNOUT AMONG MENTAL HEALTH PROVIDERS USING
A MINDFULNESS INTERVENTION

by

Joy Lindsey-Buckler

Paper submitted in partial fulfillment of the
requirements for the degree of

Doctor of Nursing Practice

University of Louisville
School of Nursing

Date Finalized

Signature DNP Project Chair

Date

Signature DNP Project Committee Member

Date

Signature Program Director

Date

Signature Associate Dean for Academic Affairs

Date
Acknowledgments

I would like to thank all the DNP faculty at the University of Louisville, especially my project chairperson, Dr. Ruth Robinson Staten and my committee member, Dr. Whitney Nash.

Dr. Staten’s tireless efforts in this process, has gone over and above for my success. A special thanks to the clinicians and staff at St. Jude’s Women’s’ Recovery Center for their participation. Particularly, Pam Scott, CADC Director of Clinical Services, she was instrumental in making this intervention a reality. Dr. Holly Rogers for allowing me to utilize her KORU© Mindfulness Practice. Karen Newton, MPH, RD, certified KORU© instructor, who is a gifted teacher. A sincere Thank you to you all.
Dedication

I dedicate this work to my family, each of you sacrificed greatly for this dream to become reality. My beloved family, whose love, support and belief in me, who urged me on, to create something that would otherwise have never come to fruition. I love each of you more than words. Always and forever.
Abstract

Burnout has been recognized as a barrier to quality care and expected patient outcomes for nearly 50 years (Freudenberg, 1974). Burnout, an “occupational phenomenon”, a syndrome of untreated chronic work-place stress, (WHO, 2019). Burnout has three factors: emotional exhaustion described as depletion of energy, depersonalization characterized by, increased levels of detachment; finally, reduced feelings of personal accomplishment with reduced feelings of professional efficacy. Health care providers (HCPs), Mental Health Providers (MHPs) and staff providing care in substance use disorder programs, experience high levels of burnout. Mindfulness practices have demonstrated efficacy in reducing burnout among HCPs.

Purpose: The purpose of this quality improvement project was to provide a four-week, 75-minute mindfulness program (© 2019 The Center for Koru Mindfulness®) for staff (N = 8) working in a non-profit women’s residential treatment program to increase mindfulness and reduce burnout.

Results: The Completer’s (N=5) reflected belief in burnout and belief mindfulness may be beneficial to reduce burnout. In comparison, on the pretest, both completers (N=5), and non completers (N=3) had high levels of burnout demonstrated by a lowered sense of personal accomplishment and moderate levels of emotional exhaustion. Non-Completers scored twice the level of depersonalization, on the pretest. The KIMS scale, the original (N=8) scored moderate to low knowledge of mindfulness. Final comparison of pre and post test of Completers, (n=5), improved scores in: HPBA, MBI, and KIMS scale’s decreased burnout on the MBI, increased levels of mindfulness on the KIMS.
Key words: health provider/mental health/physician/nurse burnout; mindfulness; KORU®; MBI, KIMS, HBM
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Reducing Burnout Among Mental Health Providers Using a Mindfulness Intervention

Since the mid-1970’s (Freudenberg, 1974), burnout has been recognized as a barrier to quality care and expected patient outcomes (Freudenberg, 1974). Burnout is an occupational risk that is defined by emotional exhaustion, depersonalization, and decreased sense of personal accomplishment (Maslach & Jackson, 1981). All health care providers (HCPs), including Mental Health Providers (MHPs) and staff providing care in substance use disorder treatment programs, experience high levels of burnout. According to the World Health Organization (2019), burnout is an epidemic affecting all types of health care providers worldwide. In May 2019, burnout was added to the ICD-11 (WHO, 2019). Evidence of higher patient-provider ratios, ever changing governmental guidelines, increased demands of patient populations with chronic and recurrent illnesses, the advent of electronic health records, and decreased resources found in organizational environments have been attributed to the rise in burnout. Effects of burnout include are in no way limited to, higher patient mortality rates; increased cost of healthcare; lower patient satisfaction scores; increased staff turnover; and increased negative health risks to providers (West, Dyrbye, Shanafelt, 2018; Arrendondo et al., 2017; Shanafelt et al., 2015; Williams, Manwell, Konrad, Linzer, et al 2007).

**Background and Significance**

Up to 50% of physicians report experiencing elements of burnout (Arredondo et al, 2017). Additionally, other healthcare professionals have been found to experience similar rates and effects of burnout to physicians. MHPs are reported to have increased risk of burnout, as the impact of the growing need for providers creates strain and fatigue in the MHP. The rate of MHP burnout is as high as 56% (Acker, G., 2011). The effects of burnout negatively affect the MHPs’ health and well-being, patient outcomes and healthcare costs (Acker, G. 2011).
is linked to a threefold increase risk of medical errors, including medication errors by providers experiencing burnout, as compared to those providers’ not experiencing burnout (Asuero, et al 2014).

While much of the research on provider burnout has been conducted on physicians, mental health providers working with persons with mental health and substance use disorders have experienced similar problems (Vitor et al, 2017; Asuero, et al 2014). Burnout has caused medical errors, poorer patient outcomes, lower patient satisfaction and challenges related to reimbursement (Dyrbye, et al, p. 2, 2017). HCPs experiencing burnout were three times more likely to make a patient-related medical error (Dyrbye et al, 2017). Burnout has severe effects on the health of providers and can be debilitating. The evidence suggested that HCPs who experienced burnout have higher rates of depression, lower sense of personal accomplishment, greater difficulties with personal relationships, higher incidence of illness, suicidality, and suicide ideation, than the general public. In fact, suicide ideation, suicide attempts, both non-lethal and lethal, were shown to be higher in HCPs than any other profession globally (Dyrbye, et al 2017; WHO 1992; Shapiro, Astin, Bishop, Cordova, 2005). There have been multiple efforts to strategize a way to decrease burnout and lower the negative impact that burnout has on HCP’s and patient outcomes (Arredondo et al, 2017, Asuero et al, 2014).

This project presented the background related to burnout among mental health providers and described an evidence-based strategy, mindfulness, that has demonstrated effectiveness in the reduction of burnout (Matthew & John, 2012). The purpose of this project was to determine if an evidence-based mindfulness intervention could reduce burnout and increase mindfulness among MHP’s and staff working in a non-profit women’s residential substance use disorder treatment facility.
Physician and Nurse Burnout

The urgency of burnout among physicians was highlighted in recent years with the addition of self-care as the fourth aim of the Institute for Health Care Improvement Triple Aim (cost, quality, and patient satisfaction) in optimizing healthcare systems (IHI, 2017). Burnout in studies of physicians and physician students, have been linked to adverse patient outcomes, increased healthcare costs and poorer physician well-being (West, Dyrbye, Shanafelt, 2018; Arrendondo et al., 2017; Shanafelt et al., 2015; Williams, Manwell, Konrad, Linzer, et al 2007). The evidence of physician burnout is clear. Burnout is a significant phenomenon in healthcare and its negative impact is well-documented in both provider’s and patients. Further, there are more studies implicating other specialty areas of clinical professionals.

Prevalence and impact of burnout among nurses was first reported in early 2000’s. Among 10,000 nurses surveyed from four states, Aiken et al (2002) found that staffing shortages contributed to nurse burnout, job dissatisfaction and more importantly, patient mortality rates. McHugh et al (2011) studied over 65,000 nurses, 51% indicated effects of burnout. This study compared those nurses working in direct patient roles with those nurses working in administrative, educational, and managerial positions in either hospitals, nursing homes or mixed facilities. The study found that nurses providing direct patient care were significantly more likely to experience burnout and have lower patient satisfaction and job satisfaction scores overall when compared to nurses working in non-direct care areas (McHugh, et al 2011).

While burnout is high among nurses in general, those nurses that spend most of their time with patients are particularly at-risk for burnout, including emotional exhaustion, depersonalization, and lowered senses of personal accomplishment (McHugh, et al 2011).
Mental Health Providers

Mental health providers (MHP) have been a rapidly growing and globally at-risk profession for experiencing burnout (WHO, 2018). Vilardaga et al (2017) suggest that for decades there has been increasing awareness that a MHPs are at a higher risk of burnout and psychological distress than many other professions. This chronic stress can increase burnout experienced by, MHP’s providing care in substance use disorder treatment programs. These MHP’s are reportedly experiencing high levels of burnout (WHO, 2019).

In a study with MHPs working with patients with severe and persistent mental illness, 73% of these providers were found to have role stress and 56% burnout (Acker, G. 2011). Burnout has been shown to be a mediator variable to role stress (Acker, G. 2011). Burnout among MHPs has been linked to budget cuts, changes in required licensure and certification, and the addition of court-mandated clients. These conditions of burnout for the MHP’s create additional barriers to overcome in order for their population to receive services (Vilardaga et al 2011). Further, MPHs list low salaries, high rates of staff turnover, and high rates of population recidivism, and overdose deaths of clients as causes for burnout (Vilardaga, et al 2011).

Problem Statement

Mental health providers (MHPs) have been experiencing high levels of burnout that can negatively impact their health and patient/client outcomes. This trend has increased for years and is not expected to change soon, as growing issues of substance use and mental health disorders have continued to increase, so has the frequency and severity of burnout in MHPs (Acker, G. 2011). Evidenced-based strategies that have been shown to be effective in reducing burnout have not routinely been implemented and/or evaluated in mental health care settings or by individual Mental Health providers. However, there have been multiple evidenced–based
interventions implemented with other healthcare professionals, that have shown to have decreased burnout in those providers.

**Clinical Question**

Do mental health providers who participate in a mindfulness intervention experience reduced self-rated burnout and an increased mindfulness?

**Literature Review**

Mindfulness can be defined as paying attention in the present moment, purposefully, and without judgment attached (Baldwin-White, 2016). Mindfulness interventions have been demonstrated to reduce the components of burnout which include emotional exhaustion, depersonalization, and lowered sense of personal accomplishment (Maslach & Jackson, 1981).

Mindfulness has been achieved through many different teachings and practices (WHO, 2019). Several interventions including yoga, Thai chi, meditation, and Mindfulness-based Stress Reduction have been used to reduce stress and burnout (Kabot-Zinn, 1996). Mindfulness has proved to have most evidence and expert support for helping individual HCPs and MHPs reduce burnout and its effects on personal and patient outcome (Kabot-Zinn, 1996). Mindfulness-based stress reduction introduced by Joh Kabot-Zinn in 1996, has been study widely. Variations on mindfulness practices have evidence that support this approach and have reduced burnout among providers.

CINAHL, Medline, PubMed were searched using the following key terms: provider burnout; mental health provider burnout; resiliency; burnout; nurse burnout; physician burnout, Maslach Burnout Inventory, Kentucky Mindfulness scale; Health Belief Model Conceptual Theory; Statistics of burnout and providers; methods to reduce burnout; mindfulness, stress reduction.
The search resulted 36 articles that were possible for inclusion. Of those articles, eleven were reviewed for matching criteria. There were five randomized controlled trials (Arredondo et al., 2017; Asuero; Asuero Andrés Martín, 2014; Greeson, 2017; L. Shapiro, Astin, John A., Bishop, Scott R., Cordova, Matthew, 2005; S. L. Shapiro, Brown, Thoresen, & Plante, 2011), three cross-sectional studies (Harker, Pidgeon, Klaassen, & King, 2016; Matthew & John, 2012; Yang, Meredith, & Khan, 2017), and three cohort studies (Baldwin-White, 2016; Dobkin, 2017; Suyi, Meredith, & Khan, 2017). Inclusion criteria was limited to reduction of burnout of healthcare professionals and exclusion criteria were studies older than 2005, those targeting only physicians’, and studies with measurements that did not include, emotional exhaustion, depersonalization, and lowered personal accomplishment in relation to and or descriptive of burnout, or variable’s that were not descriptive of some or all components of burnout.

**Interventions to Reduce Burnout**

In recent years, many intervention studies have been conducted to address burnout among providers. These interventions overall have shown to be beneficial. The data suggested that the phenomenon of burnout is receptive to various interventions. One environmental study compared levels of burnout in employees who took scheduled breaks in hospital breakrooms to those who used an employee outside garden area for break time. Employees who visited the garden experienced a significant decrease in level of depersonalization (1.8 vs. 0.0; P =.02) and decreased levels of emotional exhaustion (4.5 vs. -0.2; P < 0.01) when compared to employees whose breaks were in the hospital breakroom. There was no significant difference between the employees in personal accomplishment (-0.6 vs. 0.0; P =.55). Additionally, the Present Functioning Visual Analog Scale, VAS, was used to measure six emotional states, anxiety, sadness, worry, anger, fatigue, and pain that were expressed/exhibited as six faces. This measure
rated the severity of symptoms immediately before the breaks and immediately after breaks were taken. The employees who took breaks in the garden demonstrated significant difference in emotional states before and after break (Cordoza, et al 2018).

Vilardaga, et al 2011 demonstrated a reduction in burnout among addiction counselors who participated in a two-day workshop that utilized mindfulness interventions. The average emotional exhaustion (EE) scores and average personal accomplishment scores in this sample were within one standard deviation above the mean provided by Maslach (Maslach, 1974). EE scores (M = 16.89; SD = 8.90), aligned with other data that showed increased mindfulness practices, and average depersonalization scores were within one standard deviation below the mean reported by Maslach (1974) (M = 7.72; SD = 4.62).

In a wait-list control-group study conducted using KORU© Mindfulness, a 4-week program developed for students at Duke University, to decrease stress, increase self-compassion and gratitude among graduate students (Greeson, 2017). When compared to the wait list group, the intervention group reported a statistically significant reduction in stress, and an increase in self-compassion and gratitude. The data showed (F=4.50, df [1, 76.40], p=.037, d=.45) with a decrease in sleep problems (F= 4.71, df [1,79.49], p=.033, d=.52) increase in mindfulness (F=26.80, df [1, 79.09], p<.001, d=.95), and self-compassion (F=18.08, df [1, 74.77], p<.001, d=.75). All significant effects were repeated in the waitlist group.

Similar results and measurements of decreased burnout and increased mindfulness spanned all the literature reviewed for this project which included cross-sectional and cohort studies previously listed. All were in varying degrees and there were differences noted in the number of factors that were evaluated as compared with the tools and variables of burnout and mindfulness that were measured in this project. Additionally, each intervention delivered in these
eleven studies, including KORU© Mindfulness, were a variation of the MBSR (Kabot-Zin, 1990). Traditionally, mindfulness training has been based on Mindfulness-Based Stress Reduction introduced in (1990) by Jon Kabot-Zin. MBSR, is an eight-week, course that is 2.5 hours in length, per week with 45 min per day required practice outside of the MBSR sessions (Kabat-Zin, 1990). Mindfulness interventions have been successfully used to combat provider burnout. However, like MBSR, some interventions that were reviewed required a daily commitment of 30-45 minutes outside of class plus the 2.5 hr. meetings per week, in an already over-extended schedule.

KORU© Mindfulness, consists of four weekly 75-minutes sessions with weekly practice, KORU© came to the University of Louisville in 2015. KORU© is used extensively at the University, with more than fifteen trained faculty members on site between the two campuses, the Health Science Center and the Belknap campus. The University offers KORU© sessions each semester to faculty, staff, and students. The recommended size for the KORU© curriculum is 8-10 participants (Rogers & Mayten, 2010). Thus, this KORU© Mindfulness was chosen because of its completion rate and practical application strategy for reduced burnout and increased mindfulness among mental health providers working in a non-profit agency serving persons with substance use and mental health disorders.

**Theoretical Framework**

The Health Belief Model (HBM) developed to assess knowledge of negative health behaviors, readiness of participants to transition to an alternative, healthier behavior that may improve patient/participant outcomes. (Becker, 1974). HBM identifies barriers to healthier behaviors, such as financial concerns, transportation, and other feasibility of participation. This
model promotes change of perceived burnout (a problematic health behavior), by increased awareness of the risk of negative health conditions from the effects of burnout.

Four factors were assessed (Becker, 1974); 1) what value is placed by an individual on a preferred health outcome; 2) the belief of an individual that the chosen action will create the reality of their preferred health outcome; 3) identified barriers to obtain; and 4) sustain an alternative health behavior (Becker, 1974).

The HBM was founded on the expectation of value for effort, even if the choices are uncertain (Becker, 1974). The HBM asks, “Will I gain benefit for my efforts, and what will I gain?” The potential health benefits considered, the potential costs are subtracted ex., (efforts, inconvenience, monetary expense) or barriers ex., (transportation, scheduling conflicts, childcare, financial) (Becker, 1974). HBM identifies barriers to achieving alternative health behaviors and is unique as it assesses the subject’s point of view, ascertaining the choices presented, perceived, and combined with their readiness to act on a known or at-risk health condition (Becker, 1974). Assessing a subject’s feelings of their susceptibility and vulnerability to a health condition is vital to the HBM.

Based upon the HBM, an alternative health behavior, (mindfulness) was provided, the degree of belief was assessed, did the participants believe effects from burnout were harmful and did they believe that mindfulness practice could have a positive effect? The HBM also assessed for the readiness of the participants to act: Were the participants motivated to act based on the risks vs. benefits of sustained burnout?

**Purpose of Project**

The purpose of this project is to determine if a mindfulness intervention program delivered by a certified mindfulness professional reduced and increased mindfulness among
mental health providers in a community non-profit agency serving clients with substance use and mental health disorders.

**Methods**

**Setting and Organizational Assessment**

A non-profit 50-bed women’s residential substance use treatment program that is part of a larger religiously support community services organization hosted the mindfulness intervention. This facility is one of few in this region that accept clients that are actively taking prescribed medications for their mental health, substance use treatment and offers treatment for dual-diagnosis. The participants, MHP and staff of the agency attend a 75-minute session each week, four weeks consecutively. The meeting room is secluded from any interruptions, and suitable for mindfulness practice. The participants were accommodated with any requirement to facilitate focus of mindfulness and comfort to convey mindful practices. The intervention was provided at no cost to the participants or the agency.

**Participants**

Participants were recruited for this program through a flyer (See Appendix A) for an informational session. All participants were 18 years or older, fluent in English language and work individually or as a group with the clients. The flyer was emailed to the facility administrator and distributed to staff. Inclusion criteria: Those MHPs and staff who provided direct care to clients, committed to attend all four sessions, completion of the weekly mindfulness activity logs and had an adequate understanding of the English language were included.
Intervention

KORU© Mindfulness Intervention had four 75-minutes sessions (Rogers & Mayten, 2010) (Schedule and description of the four session of the course Appendix D). A certified KORU© Mindfulness instructor conducted all four sessions. In each session, principles and practices of mindfulness were introduced and reinforced. Participants were given a practice log that includes what their mindfulness skill or practice was for that week. Session One introduced the concepts mindfulness and its tenets of acceptance and non-judgment of mindfulness practice. Two practices, were taught at each session, practiced and logged each week. If a participant could not attend one of the sessions, the KORU© protocol was followed, for reproducible outcomes (Rogers & Mayten, 2010). The protocol states that there are only four sessions and if a participant must miss they were directed to the KORU© website for that week's practice and join the following week having had gone through that week's practice ready to pick up with the remainder of the group (K. Newton, personal communication, July 16, 2018).

The training focuses on increasing the calm from within and the potential ability to utilize mindfulness tools in any situation. Participants were encouraged to practice at home the skills introduced at each session and keep a log to be brought to the following session. The staff were informed of the intervention start date and given a brief overview of the planned intervention, after IRB approval was received.

Ethical Considerations and Institutional Review Board

This QI projects were reviewed by the University of Louisville Institutional Review Board and determined not to be Human Subjects Research. All participant and client health information were protected with HIPAA regulations. Due to the potential rate of self – harm,
depression, and suicides among HCP who experienced burnout, a crisis referral plan (Appendix F) was created and provided to each of the participants at the start of the project intervention. Participants were provided with resources for accessing support services which included the suicide lifeline and instructions to contact community-based services and or their own current provider or employee assistance. No participants experience distress that required support, intervention or referral by the project staff.

An agreement letter from the agency and permission from Holly Rogers, M.D. (2019) was sought and procured prior to implantation of the project. MBI was purchased for use in this project, (© 2019 Mind Garden, Inc.)

**Project Design**

This Quality Improvement project used an impact evaluation pretest- posttest design to evaluate the objective of this project.

**Measures**

The demographic questions include age, background/education, experience, and role and time in current position, previous mindfulness training and current mindful practices.

Three measures were included in the pre and post test (See Table x). Health Perceived Belief Assessment (HPBA). Health beliefs of participants regarding burnout and strategies to alleviate burnout were measured by HPBA. (Appendix B), developed for this project. The HPBA is a four-item questionnaire using a Likert scale with 1 being strongly do not believe, and 10 being strongly believe.

The Maslach Burnout Inventory (MBI) (Maslach, 1974) measured burnout. The MBI is the gold standard for measuring burnout (Eckleberry-Hunt, Kirkpatrick, & Barbera, p. 369, 2018). The MBI (Maslach & Jackson, 1981) is a 22- item questionnaire that assesses the degree
of burnout, with a 7-point scale with responses ranging from Never to Every Day (see Appendix C). The MBI has three subscales 1) emotion exhaustion with Cronbach’s Alpha of 0.90; 2) depersonalization with Cronbach’s Alpha of 0.76; and 3) personal accomplishment with Cronbach’s Alpha 0.76 (Iwanicki & Swab, 1981; Gold, 1984). Levels of Emotional Exhaustion are: score of 17 or less indicates a low-level burnout, scores from 18 and 29 indicates a moderate level of burnout, and scores of 30 or greater indicates high level burnout. Levels of Depersonalization are: scores of 5 or less indicate low level burnout, scores between 6 and 11 indicates moderate level burnout, and scores of 12 or greater indicates high level burnout. Levels of Personal Accomplishment are: scores of 33 or less indicate high level burnout, scores between 34 and 39 indicate moderate level burnout, and scores 40 or greater indicate low level burnout. A high score in the first two sections and a low score in the last section may indicate burnout.

The Kentucky Mindfulness Scale (KIMS) (Baer, 2004) was used to measure mindfulness (KIMS, Appendix D). The KIMS scale is a 39-question survey focused on the growth and adaptation of mindfulness in a given individual. The questions assessed the participants’ feelings of breathing pattern, heart rate, descriptive verbiage of the participants’ own thoughts, feelings, and actions related to mindfulness. The subscales of the KIMS scale, subscales were reported as having (> .70) to very good (> .80) internal reliability with a Cronbach’s alpha ranges from .76 to .87). Instructions for scoring the KIMS Scale have each question tallied and then sum the scores for each subscale is equated with the mindfulness of the participant as it related to the intervention. The higher the score of each subscale, the more inference of mindfulness properties of the participant is likely present.
Data Collection

The three measurements, the MBI, KIMS and HPBA, and the demographic questionnaire were given to all participants prior to the beginning of the course. The MBI, KIMS and HPBA, were administered at the close of the last session. All project surveys were stored in a locked file cabinet in a secure location.

Data Analysis.

Data were analyzed using SPSS, Version 26. Pallant (2016). Due to the low number of participants, percentages and means were used to describe the variables and compare differences between completers and non-completers and for pre and post test comparisons of measures of the completers.

Results

Participants were mental health providers and staff at a women’s residential substance abuse treatment facility. There were eight participants who completed the pretest measurements and attended the initial group session. Five participants completed all four sessions. However, the number of the participants at each session varied, with a consistent 5 participants at all four sessions.

The participants were female, 75% (n = 6) were white and the majority (n = 5) were 35 years or younger. The majority were in the peer support role (62%, n = 5) and 50% (n = 4) had been in the mental health field for six years or less with 62% (n=5) in their current role two years or less. The majority 62.5% (n=5) had a bachelor’s or master’s degree. None of the participants had previous mindfulness training or practices. (See Table 1).
Table 1 Percentage of Participants’ Age, Ethnicity, Experience and Education (N = 8).

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<tr>
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<tr>
<td><strong>Race/. Ethnicity</strong></td>
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<tr>
<td>White</td>
<td>75% (n = 6)</td>
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<tr>
<td>Black</td>
<td>25% (n = 2)</td>
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<tr>
<td><strong>Age</strong></td>
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<tr>
<td>25-30 years</td>
<td>25.5% (n = 2)</td>
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<td>31-36 years</td>
<td>37.5% (n = 3)</td>
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<td>36-40 years</td>
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<tr>
<td>50+ years</td>
<td>37.5% (n = 3)</td>
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<tr>
<td><strong>Years in mental health field</strong></td>
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<tr>
<td>1-2</td>
<td>50% (n = 4)</td>
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<tr>
<td>3-6 years</td>
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<td>11-15 years</td>
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<tr>
<td>16 + years</td>
<td>25% (n = 2)</td>
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<tr>
<td><strong>Years in current position</strong></td>
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<tr>
<td>1-2</td>
<td>62.5% (n = 5)</td>
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<td>10 +</td>
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Table 1 (continued)

Percentage of Participants’ Age, Ethnicity, Experience and Education (N = 8).

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<tr>
<th>Demographic Characteristic</th>
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<td>Highest grade completed</td>
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<tr>
<td>Bachelor’s</td>
<td>37.5% (n=3)</td>
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<tr>
<td>Master’s</td>
<td>25% (n=2)</td>
</tr>
<tr>
<td>Other</td>
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</tbody>
</table>

HBPA, MBI, KIMS

Due to the small sample size (N= 8) and the high number of non-completers (n= 3), only means for the measures were calculated. Pretest for all eight participants and pre and post test for five completers were analyzed.

Initial Pretest Health Beliefs, Burnout and Mindfulness for All Participants

HPBA

Given that higher scores indicate agreement with the statements, in general, on the initial HPBA, those who completed the sessions in comparison to those who did not complete, had greater belief that they were experiencing burnout (6.8 and 3, respectively), that they would benefit from mindfulness (7 and 2.7, respectively) and burnout could put them at-risk for negative physical and mental outcomes (5.9 and 2, respectively). Although those who completed the sessions were higher (4.2) than those who did not (2.3), the mean score on the belief that mindfulness could improve well-being was lower than the other variables in the HPBA and there was less difference between the two groups.
Table 2 Comparison of Pre-test Scores only for the HPBA of those who Completers and Non-Completers

<table>
<thead>
<tr>
<th>Variable</th>
<th>Completers (n=5)</th>
<th>Non-Completers (n = 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPBA Perceived belief burnout may be present</td>
<td>6.8</td>
<td>3</td>
</tr>
<tr>
<td>HPBA Perceived belief benefit from mindfulness</td>
<td>7</td>
<td>2.7</td>
</tr>
<tr>
<td>HPBA Perceived belief risk for negative outcomes</td>
<td>5.9</td>
<td>2.0</td>
</tr>
<tr>
<td>HPBA Perceived mindfulness may improve well-being</td>
<td>4.2</td>
<td>2.3</td>
</tr>
</tbody>
</table>

MBI

On the MBI, scores on the Emotional Exhaustion subscale indicated that all participants were experiencing a moderate level of exhaustion and low levels of personal accomplishment. These levels indicate moderate to high levels of burnout (see Table 3). The level of depersonalization for those who did not complete the sessions scored almost twice as high as those who did complete the sessions.
Table 3 Comparison of Pre-test Scores only for the MBI of those who Completers and Non-Completers

<table>
<thead>
<tr>
<th>Variable</th>
<th>Completers (n=5)</th>
<th>Non-Completers (n = 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean Scores</td>
<td>Means Scores</td>
</tr>
<tr>
<td>MBI-Emotional Exhaustion</td>
<td>23.4</td>
<td>23</td>
</tr>
<tr>
<td>MBI-Depersonalization</td>
<td>13.8</td>
<td>21</td>
</tr>
<tr>
<td>MBI- Personal Accomplishment</td>
<td>29.4</td>
<td>32.66</td>
</tr>
</tbody>
</table>

KIMS

On the initial KIMS, both those who completed the sessions and those who did not had similar scores on the subscales related to the acting with awareness (29.4 and 32, respectively) and accepting without judgment (30 and 29.3, respectively) (see Table 4). Those who completed the sessions scored higher than those who did not complete on subscales of observes (33.6 and 13.6, respectively) and describes (33 and 23.3, respectively).

Table 4 Comparison of Pre-test Scores only for the KIMS of those who Completers and Non-Completers

<table>
<thead>
<tr>
<th>Variable</th>
<th>Completers (n=5)</th>
<th>Non-Completers (n = 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean Scores</td>
<td>Means Scores</td>
</tr>
<tr>
<td>KIMS-Observes</td>
<td>33.6</td>
<td>13.6</td>
</tr>
<tr>
<td>KIMS-Describes</td>
<td>33</td>
<td>23.3</td>
</tr>
<tr>
<td>KIMS-Acts w/Awareness</td>
<td>29.4</td>
<td>32</td>
</tr>
<tr>
<td>KIMS-Accepts w/o Judgment</td>
<td>30</td>
<td>29.3</td>
</tr>
</tbody>
</table>
Comparison of Pre-test and Post-test Scores on the HPBA, of those who completed all four sessions

For those who completed the four sessions, there were changes in the expected directions on all three measures.

HPBA

The score of perceived belief of burnout decreased from (6.8 to 3.8, respectively). The belief in benefit of mindfulness increased from (7 to 8.6, respectively). The greatest increase in scores were found in the final two subscales: Belief in the risk of negative physical and mental outcomes (5.9 to 8.6, respectively), and belief that mindfulness may improve their well-being, (4.2 to 9.6, respectively) (See Figure 1).

MBI

The MBI subscales reported by those who completed all four sessions were consistent with the reduction of self-reported levels of burnout. Emotional Exhaustion scores from the pre to the post test were decreased from 23.4 to 3.6, respectively. Depersonalization scores decreased from 13.8 to 6.6, respectively. A sense of Personal Accomplishment increased from 33 to 39, respectively (see Figure 1).

KIMS

Increased levels of mindfulness for those who completed all four sessions had were demonstrated by the changes in the KIMS subscale scores from pretest to post test: Observed (38.6 to 42, respectively); Describe (29.4 to 33.2, respectively); Act with Awareness (30 35.6, respectively); and Accept without Judgement (30 to 40.2, respectively) showed the greatest change. (see Figure 1).
Figure 1 Comparison of Pre-test and Post test for HPBA, MBI, and KIMS

<table>
<thead>
<tr>
<th>Scale</th>
<th>HPBA1</th>
<th>HPBA2</th>
<th>HPBA3</th>
<th>HPBA4</th>
<th>MBIA</th>
<th>MBIB</th>
<th>MBIC</th>
<th>KIMSAWOJ</th>
<th>KIMSAWA</th>
<th>KIMSDes</th>
<th>KIMSObs</th>
<th>Pre-test</th>
<th>Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3.8</td>
<td>6.8</td>
<td>8.6</td>
<td>8.6</td>
<td>5.9</td>
<td>3.6</td>
<td>6.6</td>
<td>30</td>
<td>30</td>
<td>29.4</td>
<td>33.2</td>
<td>39</td>
<td>42</td>
</tr>
</tbody>
</table>

Discussion

Consistent with previous research on burnout among Mental Health Providers (Maslach & Jackson, 1981; Eckleberry-Hunt, J. & Kirkpatrick B., p. 369, 2018), each participant in this project demonstrated high levels of burnout, reported in the pre-test. The theoretical framework, The Health Belief Model was supported in that those who perceived higher levels of belief in perceived burnout and increased belief that a mindfulness intervention could be beneficial were more likely to complete all four sessions. Those who completed showed increased strength in their belief that mindfulness would decrease burnout and improve well-being. The KIMS Scale also showed that those who completed all four sessions had increased observation, description, awareness, and acceptance without judgment. It could be hypothesized that those who did not perceive a belief of burnout, the harm of burnout, the benefit of burnout, or the increased potential well-being from managing burnout that those participants were unaware they perceived...
burnout or its effects. Those who did not complete the sessions were in the youngest age range, had worked the least years at their positions, and in the mental health field.

Participants who completed all four sessions consistently improved on each subscale and reflected post test results that indicated mindfulness increased and was helpful in reducing burnout. It is of interest to note that those who did not complete the sessions indicated a high level of depersonalization. Those who did burnout not complete were in the peer support role. The results of this project are consistent with the results reported by Greeson et al (2014) in the randomized control trial conducted with college students. As with the results of this current project with MHP, college students in the Greeson et al, (2014), reported decreased levels of burnout after completing four weeks of KORU© mindfulness.

Clinically significance has been established as the MHP’s have incorporated some of the mindfulness they learned into some class sessions with their clients, (Personal communication with lead Program Clinician Pam Scott, CADC.) One of the clinicians stated since completing the mindfulness sessions, they were no longer dreading coming to work everyday, (Personal communication with participant who choose to remain anonymous).

**Limitations**

Limitations included a small sample size of those within the agency with eight starting the sessions and five completing. The small sample size limited the type of statistical analysis that could be examined. The post test was completed immediately after the final sessions, thus limiting the ability to evaluate the impact of the intervention over time, both for individual outcomes and those of the agency.
**Conclusion**

This intervention appeared to decrease burnout in participants who completed the sessions and strengthened the belief that mindfulness can help them reduce burnout. The program has an on-line free version of the mindfulness practices that the participants can use for sustainability.

Further exploration of KORU© and provider burnout is necessary to develop tools needed to manage chronic workplace stress. Mindfulness intervention seemed successful in decreasing burnout and increasing mindfulness in those that completed the sessions indicating the potential to lessen burnout for providers in other settings.
References

AHRQ. 2019 https://www.ahrq.gov/professionals/clinicians-providers/

AHRQ-works/burnout/index.html.


Appendix A Invitation Flyer

KORU MINDFULNESS

Learn Tools to Manage Stress

Mindfulness training course:

Mindfulness can reduce stress and increase well-being

INFORMATION SESSION

Karen Newton, MPH, RD, Certified KORU Mindfulness Instructor

Dates of Sessions: Thursdays June 20, June 27, July 11, July 18

(You must be able to attend all four sessions)

Location: St. Jude’s Women’s Recovery Center

(This free offering is part of a Doctorate of Nursing Practice Project)
Appendix B Perceived Health-Belief Assessment (PHBA)

Please circle the corresponding number that reflects your current response to the question.

Burnout is commonly described as having emotional exhaustion, increased sense of depersonalization and a decreased sense of personal accomplishment.

Mindfulness is defined by paying attention, on purpose and realizing the moment as you are encountering each moment.

Please circle the corresponding number as it pertains to your belief that burnout is present, could be present and how strongly present you believe it may be in your life. As well, please circle the corresponding number as it pertains that your belief in a mindfulness practice, could be present, is not present and how strongly or not you may feel about belief that a mindfulness intervention may affect the rated burnout in your life or not.

1.) On a scale of 1 – 10, what is your perceived level of burnout?

1 2 3 4 5 6 7 8 9 10

1= Strongly do not believe I am experiencing burnout

10= Strongly believe I am experiencing burnout

2.) On a scale of 1 –10, do you believe that mindfulness could be helpful reduce your perceived level of burnout?

1 2 3 4 5 6 7 8 9 10

1= Strongly do not believe mindfulness will be helpful

10= Strongly believe mindfulness will be helpful
3.) On a scale of 1 – 10, do you believe burnout is a risk factor for developing negative physical and mental health outcomes over time?

1 2 3 4 5 6 7 8 9 10

1= Strongly do not believe
burnout has negative outcomes

10=Strongly believe
burnout has negative outcomes

4.) On a scale of 1 -10, do you believe that by developing successful strategies to manage perceived levels of burnout that this will improve your mental and physical well-being and decrease negative health outcomes over time?

1 2 3 4 5 6 7 8 9 10

1=Strongly do not believe
strategies to manage burnout will improve health

10=Strongly believe
strategies to manage burnout will improve health
Appendix C Maslach Burnout Inventory (MBI) Burnout Self-Test

The Maslach Burnout Inventory is the most frequently used to measure. This tool can be helpful as a self-assessment of burnout; however, this tool does in no way diagnose the conditions of burnout. The MBI is not a diagnostic tool and is simply used to bring awareness to the phenomenon of burnout.

Answer each question with the correlating score that reflects your response. At the bottom of each section the scores will be tallied and compare to the scoring interpretation at the end of the survey.

<table>
<thead>
<tr>
<th>Questions</th>
<th>Never</th>
<th>A Few Times a Year</th>
<th>Once a Month</th>
<th>A few Times per Month</th>
<th>Once a Week</th>
<th>A Few Times per Week</th>
<th>Every Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I feel emotionally drained by my work.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Working with people all day long requires a great deal of effort.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I feel frustrated by my work.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I feel I work too hard at my job.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>It stresses me too much to work in direct contact with people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>
### Section A

<table>
<thead>
<tr>
<th>Questions</th>
<th>Never</th>
<th>A Few Times a Year</th>
<th>Once a Month</th>
<th>A Few Times per Month</th>
<th>Once a Week</th>
<th>A Few Times per Week</th>
<th>Every Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel like I’s at the end of my rope.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Total Score</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Section B

<table>
<thead>
<tr>
<th>Questions</th>
<th>Never</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel like I look after certain patients/clients impersonally, as if they are objects.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I feel tired when I get up in the morning and must face another day at work.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I have the impression that my patients/clients make me responsible for some of their problems.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I really don’t care about what happens to some of my patients/clients.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I have become more insensitive to people since I’ve been working.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>
I’m afraid that this job is making me uncaring.  

<table>
<thead>
<tr>
<th>Section B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questions</td>
</tr>
<tr>
<td>I accomplish many worthwhile things in this job.</td>
</tr>
<tr>
<td>I feel full of energy.</td>
</tr>
<tr>
<td>I am easily able to understand what my patients/clients feel.</td>
</tr>
<tr>
<td>I look after my patients’/clients’ problems very effectively.</td>
</tr>
<tr>
<td>In my work, I handle emotional problems very calmly.</td>
</tr>
</tbody>
</table>
I am easily able to create a relaxed atmosphere with my patients/clients at work.
0 1 2 3 4 5 6

I feel refreshed when I have been close to my patients/clients at work.
0 1 2 3 4 5 6

Total score - Section C


Scoring Results – Interpretation

Section A: Burnout
Total 17 or less: Low level burnout
Total between 18 and 29 inclusive: Moderate burnout
Total greater than 30: High burnout

Section B: Depersonalization
Total 5 or less: Low level burnout
Total between 6 and 11 inclusive: Moderate burnout
Total of 12 and greater: High level burnout

Section C: Personal Accomplishment
Total 33 or less: High level burnout
Total between 34 and 39 inclusive: Moderate level burnout
Total greater than 40: Low level burnout

A high score in the first two sections and a low score in the last section may indicate burnout.
Appendix D Kentucky Inventory of Mindfulness Skills (KIMS)

Ruth A. Baer Ph.D.
University of Kentucky

Rate the following statements using the scale provided.

Place the number in the blank from the scale provided that best describes your own opinion and what is generally true for you.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never or very rarely true</td>
<td>Rarely true</td>
<td>Sometimes true</td>
<td>Often true</td>
<td>Very often, or always true</td>
<td></td>
</tr>
</tbody>
</table>

1. I notice changes in my body, such as whether my breathing slows down or speeds up.
2. I’m good at finding words that describe my feelings.
3. When I do things, my mind wanders off and I am easily distracted.
4. I criticize myself for having irrational or inappropriate emotions.
5. I pay attention to whether my muscles are tense or relaxed.
6. I can easily put my beliefs, emotions and expectations into words.
7. When I’m doing something, I’m only focused on what I am doing and nothing else.
8. I tend to evaluate whether my perceptions are right or wrong.
9. When I’m walking, I deliberately notice the sensation of my body moving.
10. I’m good at thinking of words to express my perceptions, such as how things taste, smell, or sound.
11. I drive on “automatic pilot” without paying attention to what I’m doing.
12. I tell myself that I shouldn’t be feeling the way I’m feeling.

13. When I take a shower or bath, I stay alert to the sensations of water on my body.

14. It’s hard for me to find the words to what I’m thinking.

15. When I’m reading, I focus all my attention on what I’m reading.

16. I believe some of my thoughts are abnormal or bad and I shouldn’t think that way.

17. I notice how foods and drinks affect my thoughts, affect my thoughts, bodily sensations, and emotions.

18. I have trouble thinking of the right words to express how I feel about things.

19. When I do things, I get totally wrapped up in them and don’t think about anything else.

20. I make judgement about whether my thoughts are good or bad.

21. I pay attention to sensations, such as the wind in my hair or sun on my face.

22. When I have sensation in my body, it’s difficult for me to describe it because I can’t find the right words.

23. I don’t pay attention to what I’m doing because I’m daydreaming, worrying, or otherwise distracted.

24. I tend to make judgements about how worthwhile or worthless my experiences are.

25. I pay attention to sounds, such as clocks ticking, birds chirping, or cars passing.

26. Even when feeling terribly upset, I can find a way to put it into words.

27. When I’m doing chores, as cleaning or laundry, I tend to daydream or think of other things.

28. I tell myself that I shouldn’t be thinking the way I’m thinking.

29. I notice the smells and aromas of things.
30. I intentionally stay aware of my feelings.
31. I tend to do several things at once rather focusing on one thing at a time.
32. I think some of my emotions are bad and inappropriate and I shouldn't feel them.
33. I notice visual elements in art or nature, such as colors, shapes, textures, or patterns of light and shadows.
34. My natural tendency is to put my experiences into words.
35. When I'm working on something, part of my mind is occupied with other topics, such as what I'll be doing later, or things I'd rather be doing.
36. I disapprove of myself when I have irrational ideas.
37. I pay attention to how my emotions affect my thoughts and behavior.
38. I get completely absorbed in what I'm doing, so that all my attention is focused on it.
39. I notice when my moods begin to change.

KIMS Scoring instructions- For investigators only

For all items marked “R” the scoring must be reversed.

Change 1 to 5, 2 to 4, 4 to 2, and 5 to 1 (3 stays unchanged).

Then sum the scores for each subscale.

Observe, 5, 9, 13, 17, 21, 25, 29, 30, 33, 37, 39
Describe, 6, 10, 14R, 14R, 22R, 26, 34

For more information, see Baer, R. A., Smith G. T., & Allen, K. B. (2004).
Assessment of mindfulness by self-report: The Kentucky Inventory of Mindfulness Skills.
Assessment, 11, 191-206.
Appendix E KORU© Mindfulness Curriculum

Week 1

Introduction

A simple introduction of mindfulness will be given. Goals of KORU© explained.

No expectation of becoming an expert of Mindfulness. However, to find what stands out and practice those and build upon them after this course is complete.

Practice

Introduce two skills:

- Diaphragmatic breathing – Belly breathing very calming and great for anxiety, also can help with sleep and
- Dynamic breathing: An active breathing that helps with focus, and restlessness. This is used for worry, and when there is work to be done and finish. Meditation practice: will be

The Body Scan--Learn to check in with the body- helps ground the participant with their Awareness.

Homework

The Homework will consist of the mindfulness log. Using one of the practices/ meditations learned this week pick an activity that you will do each day utilizing the skill that was learned until the next class meeting. Bring it to the next class for discussion.

Week 2

Introduction

The first part of the class will be a mindfulness check in a 1-minute meditation.

Discuss the mindfulness logs, what did you like about it? How did you feel? Did you sleep better,

feel more rested?
Practice

Practice Walking Meditation for this week’s skill. Walking slowly across the floor, feeling anchored through your feet, bringing awareness to the sensations as your walk. This can be used when you are too sleepy or restless to sit still to meditate.

The meditation: Gatha, a series of words that sometimes is referred to a meditation poem, used to help bring focus to your mind during meditation. This is used when very distracted.

Homework

The Homework will consist of the mindfulness log. Using one of the practices/meditations learned this week pick an activity that you will do each day utilizing the skill that was learned, until the next class meeting. Bring it to the next class for discussion.

Readings

Read chapter 2, in the Dr. Holly Rogers book, *Mindful Twenty-Something*

Week 3

Introduction

The first part of the class will be a mindfulness check in a 1-minute meditation. Discuss the mindfulness logs, what did you like about it? How did you feel? Did you sleep better and feel more rested?

Practice

Skill – Guided Imagery – this is a good way to self soothe if feeling anxiety or stress over something. Used for high levels of stress and worry.

Meditation: Labeling thoughts: This is vital in mindful practices. Realizing that thoughts are there when you are meditating, noticing them, without judging and then letting them go.

Homework
The Homework will consist of the mindfulness log. Using one of the practices/meditations learned this week pick an activity that you will do each day utilizing the skill that was learned, until the next class meeting. Bring it to the next class for discussion.

Readings
Read chapter 3 in the Dr. Holly Rogers book, *Mindful Twenty-Something*

Week 4

Introduction

Practice

Skill: Eating meditation, allows you to eat noticing the sensations while using a very careful approach to eating. Realizing the feelings when you eat. Allows a more health way of eating.

Meditation:
Labeling Feelings: Persistent recurring strong feeling that may arise along with labeling meditation from last week this skill helps you set free those sometimes very strong emotions.

Readings
Read chapter 4 in the Dr. Holly Rogers book, *Mindful Twenty-Something*

Rogers, H. & Mayten (2016)
Appendix F Demographics

Please circle the appropriate response:

Age: 20-24  25-30  31-35  36-40  40-45  45-50  50+

Race/ethnicity: Caucasian  Hispanic/Latino  Black/African-American  Native American  Asian/Pacific Islander  Other  Prefer not to answer

Gender: Male  Female  Other  Prefer not to answer

Current Position: Give some choices—otherwise, it will be all over the place

Clinician, Peer support, Clerical, Other staff positions

Years in current position: <1-2  3-6  7-10  10 or more

Years in mental health related field: <1-2  3-6  7-10  11-15  16 or more

Highest degree completed: Bachelor’s Degree  Master’s Degree  Other

Previous experience with mindfulness practice

___no formal mindfulness training

___previous training  ___type

___currently practice mindfulness ______usual times per week

Current practice of strategy that supports mindfulness

meditation, yoga, tai chi, etc.

___no previous practice

___previously practiced, but not currently

___currently practice
Appendix G Crisis protocol for participants:

If at any time you become distressed during these sessions, please let the instructor know. The instructor Karen Newton will direct you to the crisis lifeline and other potential services that are listed below, if you are in crisis of any kind. Please, you are urged to utilize the numbers provided below if you do not want to share with the instructor that you are feeling distressed or are in crisis of any kind. Please know that any and all communication through these sessions are strictly confidential and will not be communicated to the investigator(s) of this project. The only data collected is provided in the pretests and posttests and will be de-identified.

**National Suicide Prevention Lifeline**

Call 1-800-273-8255

University of Louisville Counseling Center

If a crisis occurs, please call:

502-852-6585

In cases of imminent danger to self or others, please call 911 or ULPD.

Emergency Psychiatry at University of Louisville Hospital:

502-562-3120

**Centerstone Adult Crisis Line:**

502-589-4313 or 800-221-0446

This 24/7 hotline is a resource offered by a local Louisville agency, formerly Seven 7Counties Services.

Individuals who are deaf or hard of hearing can call using KY Relay at 711.