

Quantitative Research

The Effects of the *Relaxation Response* on Nurses' Level of Anxiety, Depression, Well-Being, Work-Related Stress, and Confidence to Teach Patients

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Journal of Holistic Nursing
American Holistic Nurses Association
Volume XX Number X
XXXX 201X 1–10
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10.1177/0898010117719207
journals.sagepub.com/home/jhn



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Purpose: The purpose of this pilot study was threefold: to teach nurses the *Relaxation Response* (RR), a relaxation technique created by Benson; to measure the effects of the RR on nurses' levels of anxiety, depression, well-being, and work-related stress; and to explore nurses' confidence in teaching their patients the RR. **Design:** A wait-list, randomized-control quantitative study design was used. **Method:** Nurses in the intervention group were trained on the benefits and the technique of the RR and were then asked to practice the RR over an 8-week period. **Findings:** No statistical significance was found in nurses' reported level of anxiety, depression, well-being, and work-related stress. However, the nurses reported greater confidence in teaching this technique to patients ($p < .001$). **Conclusion:** As a strategy for self-care in the workplace, nurses were receptive to learning the RR and reported confidence in using this strategy for their patients. Larger studies may reveal more significant reductions in workplace stress and anxiety for nurses.

Keywords: nurses (basic); stress and coping; caring; expanding consciousness; holistic; coping; caregivers; holistic nursing; meditation; mind-body techniques

Introduction

Research confirms that nurses frequently leave the profession due to secondary stressors experienced in their work and work settings (Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Duvall & Andrews, 2010). One in five new nurses leave their job within 1 year because of job stress. More concerning is that 27% to 54% of nurses under the age of 30—the future of the nursing profession—plan on leaving their position within 1 year (Hong Lu, Barriball, Zhang, & While, 2012). Increased nursing turnover is related to decreased job satisfaction commonly linked to a poor working environment including stress associated with staffing, leadership, teamwork, and relationship issues (Hayes, Doulas, & Bonner, 2014). Nurses are leaving the bedside due to the physical demands, job stress, and the “failure to nurture nurses” (Duvall & Andrews, 2010).

Offering nurses self-nurturing opportunities in the workplace may combat overall stress. The American Holistic Nurses Association (AHNA; 2013) has delineated the Scope of Practice for holistic nurses. Holistic nursing focuses on practices of

Author's Note: The author would like to acknowledge Dr. Jane Flanagan, PhD, RN, Massachusetts General Hospital, Dr. Joseph Greer, PhD, Statistician, Massachusetts General Hospital, and Jake Starmer, Starmer Communications, for their efforts in reviewing and assisting in the early development of this article. The author would like to acknowledge Kimberly McGuigan for her recent efforts in reviewing the article. The author would also like to acknowledge the nursing administration, nursing directors, and nursing staff at Massachusetts General Hospital who allowed this study to take place and for their participation in this project. The funding source was from the Make a Difference Grant at Massachusetts General Hospital. Please address correspondence to Catherine Calder Calisi, MS, RN, GNP-BC, 36 Arrowwood Street, Methuen, MA 01844; e-mail: ccalder1@partners.org.

self-care, intentionality, presence, mindfulness, and therapeutic use of self for facilitating one's healing and wellness. Holistic nursing requires nurses to integrate self-care practices into one's life. Self-compassion, personal responsibility, spirituality, and reflection of one's life can foster stress relief while promoting self-healing. According to *Holistic Nursing: Scope and Standards of Practice* (AHNA, 2013), one of the core values delineated as an integral component of holistic nursing includes self-care. Many are familiar with basic healthy rituals such as proper sleep, exercise, nutrition, and mindfulness (Murphy, 2014). However, self-care and self-compassion are also necessary to make improvements in health and well-being. It requires self-kindness, mindfulness, and wisdom toward oneself (Reyes, 2012). As nurses, we must have self-care and compassion for ourselves, so that we can care compassionately for our patients (Watson, 1985).

Dr. Herbert Benson's work (Benson, 2000; Benson & Proctor, 2010) recognizing the toxicity of the *stress response* provoked the development of the *relaxation response* (RR). Benson clearly identified several stress-related physical and emotional conditions that can be improved by such techniques. This study describes the potential effect of one self-care method, the RR, on decreasing nurses' level of overall stress while improving their well-being. It also describes the nurses' overall confidence to teach this technique to patients.

Background

Defining Burnout Versus Compassion Fatigue

On busy inpatient units, nurses typically use highly technical equipment and experience unpredictable workloads, with ever-changing sets of circumstances that often need reprioritizing; essentially there is not enough time to complete the tasks of caring for a patient with multidimensional needs. These conditions reduce opportunities for the nurses to take breaks for rest or nourishment. In the short term, this stress may lead to physical and mental fatigue, and often hinders productivity and job performance. Long-term effects of the persistent stress can lead to depression, which may contribute to many other unhealthy or "non-wellness" conditions (Benson, 2000). Ill effects including decreased job

satisfaction, poor relationships, reduced concentration, and a limited ability to connect with the patients are also symptomatic of "non-wellness" (Arcari, 2008). Nurses with high work-related stress have lower job performance, lower morale, higher absenteeism, and tend to make more frequent medication errors and poor judgment calls (Aiken et al., 2008). The demands of the current system are taking their toll on the mental, emotional, and physical health of nurses, leading to decreased well-being and an increased level of nursing stress called "burn-out" and/or "compassion fatigue" (Chesak et al., 2014; Murphy, 2014).

Despite a stressful work environment, nurses are expected to be compassionate to all patients and families, including those who are in pain, disabled, disfigured, emotionally stressed, or dealing with end-of-life issues (Repar & Patton, 2007). Providing compassionate care to patients requires an emotional engagement between the patient and the nurse, which nurses cannot provide if they are burnt out. This constant attention on their patients without an opportunity to be self-nurtured places nurses at risk of experiencing "compassion fatigue" (Murphy, 2014; Repar & Patton, 2007). Compassion fatigue results when relational heart energy is not renewed (Boyle, 2011). Compassion fatigue has a more abrupt onset, rather than the insidiousness of burnout. If not addressed, burnout can ensue and has been correlated with poor patient outcomes: increased mortality, increased infections, and decreased patient satisfaction (Romano, Trotta, & Rich, 2013). Burnout and compassion fatigue can be prevented when nurses are given tools and time to nurture themselves in the workplace environment.

On a continuum of energy levels, "burnout" is at one end of the continuum with "vitality" at the other (Hover-Kramer, Mabbett, & Shames, 1996). Vitality is described as a sense of aliveness, optimism, and wellness. On the other hand, burnout represents fatigue, negativity, and diminished health. Nurses with high vitality experience meaningfulness and motivation in their relationships and their daily work. This is compared with nurses with low vitality, who often experience feelings of hopelessness, demoralization, and depleted energies. Individuals who function at high levels of vitality often have a sense of purpose and commitment and are able to be present in the moment with their patients (Hover-Kramer et al., 1996). These characteristics of vitality

can be taught to staff, thus improving the workplace environment (Aiken et al., 2008; Arcari, 2008; Lachman, 1996).

Wellness Strategies to Reduce Nursing Stress

“Wellness practice” is a general term for any one of several techniques such as meditation (*Relaxation Response*), yoga, tai chi, reflection, guided imagery, and so on. The common denominator is mindfulness, a mental state of focusing one’s awareness on the present moment. Practicing mindfulness is about being in the moment, slowing down the mind, practicing loving kindness, or compassion to self and others in whatever modality you choose. The purpose is to slow the mind and invoke the body and spirit to flow.

Teaching nurses how to reduce their stress and how to be aware of their potential for personal growth with mindfulness practices can facilitate resilience (Arcari, 2008). Nurses who have enhanced resilience are more adaptable and better able to cope within their ever-challenging work environment. Nurses can build resilience using techniques such as reflection, emotional insight, positivity, spirituality, and maintaining balance (Jackson, Firtko, & Edenborough, 2007). Nurses who are more cognizant of their perceptions, attitudes, outlooks, and surroundings are generally more connected to their patients’ needs and less apt to be concerned with negative judgments. Nurses who are more resilient are better able to communicate and are less judgmental, thus promoting a healthier work environment (McGee, 2006). Staff retention issues can be improved by creating an empowering work environment (Hayes et al., 2014). Efforts have been made in hospitals to improve patients’ low satisfaction scores and by addressing compassion fatigue of caregivers (Potter, Deshields, & Rodriguez, 2013). Nurses can be taught self-care strategies reducing the detrimental effects of burnout affecting nurses, patients, and health care organizations (Henry, 2014).

Mindfulness-based, stress-reduction education can decrease levels of perceived stress (Monson, 2010; Olivio, Dodson-Lavelle, Wren, Yang, & Oz, 2009). In order to maintain a balanced homeostatic state of being, nurses can alter their *perceptions* of stress, which can ultimately help them adapt and

cope with the “stressful” environment. Katz, Wiley, Capuano, Baker, and Shapiro (2004, 2005) describe the positive effects of the mindfulness-based stress-reduction programs as an effective means to lower nurse burnout and enhance well-being. Qualitative data revealed that those nurses in the intervention group had significant reductions in emotional exhaustion and depersonalization. There also was a trend toward significant improvement in their sense of personal accomplishment. These assessments are very reflective of positive nurse vitality indicators.

The National Institute of Health expert panel reported that pervasive evidence exists that meditation interventions are associated with better health outcomes among clinical populations (Oman, Hedburg, & Thoreson, 2006; Seeman, Dubin, & Seeman, 2003). Kabat-Zinn (2005) found that meditative practices not only decrease stress but also help individuals to see other perspectives on life events and recognize ways to cope. One study of 22 hospice and VNA nurses who participated in a day-long workshop, “Wellness for Nurses,” reported findings of stress reduction, increased morale, and improved team building. The exercises included personal goal setting for the day, positive affirmation exercises, yoga class, music for healing, nutrition discussion, guided imagery, storytelling with humor and imagination, and individual coping strategies for dealing with the demands of the job. After the nurses completed the day, they were able to recognize each other’s strengths and developed a new closeness through renewed respect for their colleagues (Repar & Patton, 2007).

One study offered nurses in the corporate setting mindfulness-based stress-reduction programs. Most programs were offered while the nurse was off duty, at home, and over the phone (i.e., meditation groups). They found improvements in general health ($p < .01$), decreased stress ($p < .001$), and decrease in work burnout ($p < .001$). The findings revealed mindfulness-based stress-reduction programs can be a low-cost, feasible, and a measurable intervention that shows positive impact in health and well-being (Bazarko, Cate, Azocar, & Kreitzer, 2013).

In a study by Brown (2006), nurse managers who were introduced to various self-care techniques revealed several positive effects on their personal and work interactions. This program included 10 one-hour classes about caring for oneself in the workplace. The courses focused on themes such as

making the environment more organized and efficient, as well as practicing stress-reduction and positive psychology techniques. One nurse manager reported, "Even in tense, hectic, noisy surroundings, you can take steps to improve your peace of mind, soothe your body, and renew your spirit" (Brown, 2006, p. 54). Nurses who participated in the classes saw an improved staff morale. Aiken, Clarke, Sloane, Sochalski, and Silber (2002) saw a trickle-down effect from the improved staff morale of the nurses to the patients, who in turn may have improved satisfaction, improved adherence to medical regimes, decreased mortality, and decreased morbidity.

A qualitative study of pediatric intensive care unit nurses measured the effects of an 8-week mind/body course. In it nurses reported that starting their shift with meditation reduced stress, improved inner peace, more compassion and joy, increased ability to focus, and increased self-awareness. Their conclusions were that they had less burnout (Moody et al., 2013). A study by Foureur, Besley, Burton, Yu, and Crisp (2013) measured 20 nurses who attended a 1-day workshop and were asked to meditate daily for 8 weeks. They found that those who meditated over the course of 8 weeks had an improved overall general health and an improved sense of coherence in their life, less anxiety, less depression, and less stress.

For nurses to have compassion for others, they first must possess *self-compassion*. Gauthier, Meyer, Grefe, and Gold (2015) identified this potential problem and offered nurses opportunities for meditation with guided imagery for 5 minutes at the beginning of every shift. The nurses felt appreciative of this time to become more balanced at the beginning of their shift. Mackenzie, Poulin, and Seidman-Carlson (2006) found that even brief interventions in practicing mindfulness for both nurses and nurse's aides found improvements in life satisfaction, stress, and burnout scores. Other researchers also found similar improvements in satisfaction and well-being scores (Chesak et al., 2014; Horner, Piercy, Eure, & Woodard, 2014).

Another study by Erstein and McCaffrey (2007) demonstrated that workplace support and various interventions can decrease some of the stress. Strategies on both an individual and group basis can significantly decrease stress and burnout (Lachman, 1996). Bedside nurses can better handle stress by viewing the wholeness of oneself (the mind, the body, and the spirit) by rechanneling stress through

various dimensions of an individual (cognitive, spiritual, and emotional) and then incorporating new views or behaviors to effectually cope with the stressor.

In summary of the literature to date, fewer studies attempt to discuss a potential solution for this high stress environment associated with nursing. Most of the nursing literature speaks of the burnout conditions associated with the stress of nursing and fewer of these research studies have demonstrated the effectiveness of nurturing nurses *in* the workplace environment, at the bedside. The bulk of studies measure the stress level of student nurses, graduate nurses, or nurse executives and not the bedside nurse (Song & Lindquist, 2015). Currently, there exists a gap in the data between identifying the problem of burnout and addressing potential solutions.

The Relaxation Response

Dr. Herbert Benson developed a relaxation technique, *The Relaxation Response* (RR), which consists of a diaphragmatic breathing pattern and a repetitive mental focus that breaks the train of everyday thought. Research suggests that when the RR is performed twice a day for approximately 10 to 20 minutes, it improves a variety of stress-related conditions including hypertension, cardiac arrhythmias, anxiety, depression, insomnia, premenstrual syndrome, phobias, infertility, general well-being, and pain (Benson, 2000). The RR is one complementary therapy that supports holistic self-care, including the physical, emotional, mental, and spiritual aspects of the individual. Several decades of this research have identified the power of one's expectation and belief of wellness, when one makes the mind-body connection toward one's own healing (Benson & Proctor, 2010).

In 2008, Arcari completed a pilot study of approximately 50 nurses of varying specialties. The nurses took part in a course titled "Mind Body Strategies for Healing," which included RR, mindfulness, and cognitive strategies. The study showed that the nurses who practiced these interventions on a regular basis reported increased competence and confidence in areas of stress management, resiliency, and coping. Regardless of the approach practiced, the result can be the transformative movement of the individual toward balance and healing

(Benson, 2000). Arcari (2008), Benson (2000), and others have been able to translate this body of knowledge into an improved practice of offering stress-reduction programs to nurses (McElligott, Siemers, Thomas, & Kohn, 2009; White, 2013).

Aims of Research

This pilot study is designed to measure the effects of the *RR* on levels of anxiety, depression, well-being, and work-related stress among cardiac nurses. The hypothesis is that nurses who care for themselves using the *RR* might experience less anxiety, depression, and work-related stress, which could lead to an improved sense of well-being. A second hypothesis is that nurses may have enhanced confidence in teaching this technique to their patients in order to help them better cope with the stress of their illness.

Theoretical Framework: Watson's Theory on Human Caring

Jean Watson's (1979) Theory on Human Caring speaks about the effects of the human component of caring, with the moment-to-moment interactions between the one giving the care and the one receiving the care. She describes the value of "transpersonal caring" or the interaction between the caregiver and the care receiver through various interventions to induce positive change in patients' lives. This care is reciprocal in that the caregiver also can receive care from the patient as such human connection is formed. Watson has identified 10 curative factors that are part of the interventions necessary to obtain the rewards of the transpersonal caring. These include practice lovingkindness to self and others; nurturing self and others; instilling faith/hope; develop caring relationships; accepting expressions of positive or negative feelings; assist with mental, physical, or spiritual needs; creating healing environments; creative problem solving; teaching and learning to meet individual's styles; and being open to the mystery of miracles. Watson's theory states that in order to care for others, you must have the ability to care for yourself in your own environment. The nurse can then be most effective to others at that time. A new vision of self-care must be promoted to all nurses; both seasoned and novice nurses need to better understand that caring for

oneself leads to more effective and efficient care for others.

Method

Design

This pilot study used a randomized, wait-list control, quantitative study design to measure the pre and post effects of an intervention of the *RR* over an 8-week period.

Sample

Participation was voluntary. Subjects were registered nurses from three of the cardiac units at Massachusetts General Hospital. Forty-six nurses (all female) completed the study (24 nurses in the intervention group and 22 nurses in the control group) of the 53 registered nurses who enrolled in the study. However, 7 participants (13.2%) discontinued the study without providing reasons for withdrawal. The participants' ages ranged from 27 to 60 years. The participants' years of nursing practice ranged from 6 to 38 years.

Procedures

The hospital institutional review board approved this study prior to initiation. The institutional review board felt that due to the nature of this study, the consent form was waived, as there was minimal risk to the participants. All data were kept completely confidential.

Intervention

During the recruitment phase of the study, the principal investigator met with the nurse managers, from the respective cardiac units (Cardiac Step Down Unit, Coronary Care Unit, Cardiac Access Unit) and reviewed the study goals and the proposed interventions to be presented to the staff. Once the nurse manager agreed to offer participation to her staff, the principal investigator met with the staff to explain the study. The nurses who agreed to voluntary participation were randomized into either the wait-list control group or the intervention group. The nurses randomized to the intervention group received a 45-minute in-service regarding the *RR*. In this session, nurses learned about the benefits and utilization of

the RR in their personal lives and practiced the actual technique in the class. They were encouraged to do the breathing exercises for 10 to 20 minutes, twice per day, for 8 weeks and were asked to keep a journal of their relaxation breathing sessions. The nurses in both groups completed the pre and post self-report assessments. The nurses that were in the control group were eligible to receive the class at the termination of the study, if they so desired.

Measures

All participants completed the following self-report instruments at enrollment (pre) and at the end of the 8-week period (post):

- 1. State Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, & Lushene, 1970): The STAI is a 40-item, well-validated and reliable tool widely used in research that includes two separate subscales for measuring state (current) and trait (as overall) anxiety levels.
- 2. Semantic differential scales (Friborg, Martinussen, & Rosenvinge, 2006): Participants completed semantic differential scales and were asked to draw a line to rate each degree of measure: the degree of anxiety (“0” no anxiety/“7” the most anxiety), the degree of depression (“0” no depression/“7” the most depression), the degree of well-being (“0” well-being/“7” ill-being), the degree of work-related stress (“0” no work-related stress/“7” the most work-related stress), and the degree of confidence in teaching the relaxation response to their patients (“0” confidence in teaching/“7” no confidence in teaching). Raters indicated the extent to which they experienced each psychological variable, with higher scores indicating greater distress and less confidence. Semantic differential scales are reliable and well validated for measures of resiliency.

Statistical Analyses

SPSS (v. 17.0) was used to perform all statistical tests. Analyses began with descriptive summaries, including means and standard deviations, of the

Table 1. Descriptive Statistics for Study Variables at Baseline

Study Variable	Wait-List Control Group (N = 22), M (SD)	Intervention Group (N = 24), M (SD)	p Value
STAI-State	38.14 (7.56)	38.40 (6.65)	.90
STAI-Trait	38.50 (7.41)	39.32 (7.05)	.70
Visual Analog Scale			
Anxiety	3.59 (1.26)	3.92 (1.44)	.41
Depression	2.86 (1.58)	2.68 (1.49)	.68
Work-related Stress	4.55 (1.30)	4.80 (1.29)	.51
Well-being	2.64 (1.18)	2.32 (0.95)	.31
Confidence to teach	5.23 (1.80)	5.32 (1.84)	.86

Note: STAI = State Trait Anxiety Inventory. Higher scores on the STAI indicate worse state-trait anxiety symptoms; higher scores on the Visual Analog Scales indicate worse anxiety, depression, and stress, as well as decreased well-being and less confidence to teach the relaxation response. P values derived from independent sample t tests.

study variables. Independent-sample t tests were used to compare study variables at baseline. Paired-sample t tests and repeated-measures analysis of variance were used to assess the effect of the intervention on the main outcome measures over time, both within and between study groups.

Findings

There was an 86.8% response rate of nurses who enrolled and completed the study. As shown in Table 1, the two study groups were well balanced at baseline with respect to state-trait anxiety as well as the semantic differential scale measures of anxiety, depression, well-being, work-related stress, and confidence teaching the RR. A comparison of the postintervention scores revealed that the outcome measures did not differ between groups, except for ratings of participant confidence in teaching the RR. At the postassessment, participants in the intervention group reported greater confidence to teach the RR (M = 3.58, SD = 1.70) compared with the control group (M = 5.76, SD = 1.34, t[43] = 4.74, SE = 0.46, p < .001).

We also examined the change in participants’ scores within each group from baseline to post-assessment. Using paired-sample t tests to examine the intervention group outcomes, we observed on

Table 2. Comparisons of Mean Change in Outcome Measures From Baseline to Postassessment Between Study Groups

Study Variable	Wait-List Control Group (N = 22), Mean Change (SD)	Intervention Group (N = 24), Mean Change (SD)	Group × Time F-Ratio	p Value
STAI-State	-.73 (7.92)	-1.71 (9.47)	0.14	.71
STAI-Trait	-1.09 (4.99)	-2.79 (7.98)	0.74	.40
Visual Analog Scales				
Anxiety	-0.05 (1.32)	-0.75 (1.45)	2.85	.10
Depression	-0.38 (1.47)	-0.38 (1.58)	<0.001	.99
Work-related Stress	-0.38 (1.53)	-1.25 (1.90)	2.85	.10
Well-being	-0.05 (1.32)	0.08 (1.25)	0.12	.73
Confidence to Teach	0.43 (1.66)	-1.67 (2.24)	12.40	.001

Note: STAI = State Trait Anxiety Inventory. *P* values derived from the repeated-measures analysis of variance. The boldface *p* value represents statistical significance.

the semantic differential scales that nurses who received training in the *RR* reported feeling less anxious (mean change = -0.75 , $SD = 1.45$, $t[23] = -2.53$, $SE = 0.30$, $p = .02$), less stressed at work (mean change = -1.25 , $SD = 1.90$, $t[23] = -3.27$, $SE = 0.38$, $p = .003$), and more confident to teach the *RR* (mean change = -1.67 , $SD = 2.24$, $t[23] = -3.65$, $SE = 0.46$, $p = .001$) over the course of the study. However, repeated-measures analysis of variance showed that the mean change in these scores from baseline to postassessment did not differ significantly between groups except for ratings of confidence to teach the *RR* (see Table 2).

Finally, the nurses who participated in this study requested future opportunities for such wellness, stress-reducing breaks while at work. The nurses found great benefit in learning this technique. They expressed desire for additional opportunities of taking a mindfulness break when they need it most, *during* their busy shifts.

Discussion

This pilot study was designed to measure the effects of the *RR* on levels of anxiety, depression, well-being, and work-related stress among cardiac nurses using a randomized control study design. The nurses in the intervention group were trained in the *RR* and were asked to practice two times per day for 8 weeks. The pre-post testing measures were the STAI and semantic differential scales measuring anxiety, depression, well-being, work-related stress, and confidence to teach patients. The primary hypothesis, that nurses would have improvements in lower stress levels and less work-related stress levels, was not statistically significant.

The second hypothesis, that nurses may have enhanced confidence in teaching this technique to their patients, once they learned and practiced this type of relaxation, was supported with statistical significance ($p < .001$). This finding *alone* demonstrates favorable results of the study. However, this finding *in combination* with the first hypothesis, which was not statistically significant, may demonstrate a compelling, unexpected finding. Nurses typically reach out to care for others *before* they will care for themselves. Here, the results revealed that nurses are more comfortable teaching this to patients than they are to possibly receive this technique favorably for themselves. Ultimately, the goal of caring for the patient begins with the nurse caring for himself/herself. As the oxygen mask theory states, you must put the oxygen mask on yourself before you place the mask on someone else. This is a strength to this study, and an unexpected result, that nurses need to learn to care for themselves.

Nurses can be excellent role models for stress-reduction techniques and wellness strategies if their belief systems include personal wellness. Conversely, not having the knowledge and skill of practicing personal wellness decreases the nurse's ability to teach patients stress-reduction strategies. Holistic nurses who practice compassionate self-care may be more capable of providing their patients with compassion and loving kindness. These nurses can connect well with their patients and provide them with the necessary tools to enable healthy lifestyle changes; teaching the *RR* can educate patients of the importance, and the means, to decrease their stress.

Hospitalized patients are usually dealing with some degree of anxiety related to their condition and

the overall stress of the hospitalization. It is crucial that they learn to deal with the anxiety related to both the acute and chronic aspects of their illness. Nurses can teach stress-reduction and wellness practices to their patients who are dealing with pain, anxiety, or other ailments by teaching them to actively care for themselves, also known as *self-care*. Nurses can assist and guide patients to be more aware of themselves in their environment and their mind-body connections (Mandell, 1996). They can help patients create new ways of thinking and behaving, to replace older non-serving behaviors. For patients, an illness can be the time for personal transformation. Patients are seeking better understanding of themselves and better connection to others, such as the nurse (Rosa, 2012).

Limitations

Some of the limitations of this pilot study include the small sample size, not allowing for a large enough change between the two groups pre- and postintervention. Additionally, since it was a pilot study, we accepted all data. The nurses who were assigned to the intervention may have completed fewer than the suggested number of relaxation sessions. These factors may account for why the between-group differences were not statistically significant. Another limitation is that this study was restricted to only one type of nurse specialty (cardiac).

Future studies would validate additional ways to potentially improve nurse satisfaction by lowering anxiety and decreasing levels of work-related stress. Future studies looking at patient satisfaction may reveal that less stressed nurses lead to more satisfied patients with better patient outcomes. A larger sample size might reveal positive effects of practicing the *RR* on work-life balance. A larger dose of intervention might reveal statistical significance for nurses having less anxiety, less depression, and less work-related stress. Other areas of study include looking at measures such as job satisfaction, morale, and patient outcome data.

Implications

This pilot study revealed that it is feasible and acceptable to bring nurses together to teach relaxation techniques and other forms of stress reduction while at work. Although the small sample size did

not enable us to find decreased anxiety or work-related stress levels, nurses might have benefited from learning stress-reducing strategies, as the demands of caring for patients at the bedside are constant and exhausting. The gap in the data surrounding nursing burnout and compassion fatigue must motivate nursing administrators to proactively support nurses holistically. As in accordance with the *Holistic Nursing: Scope and Standards of Practice* (AHNA, 2013), one of the core values and integral components of holistic nursing includes self-care.

One way nursing leaders can thwart such high levels of nursing stress is through an enhanced commitment to educating nurses about stress reduction, wellness strategies, and techniques that they can use both at work and at home. The data show that nurses who are supported by the administration and who practice holistic nursing have more vitality, optimism, commitment, and are more empowered in their work (Tarantino, Earley, Audia, D'Aamo, & Berman, 2013). Holistic nurses generally practice loving kindness to all and take the appropriate measures to prioritize these critical issues of compassionate *caring* for the patient.

Many questions remain: Are nurses who practice mindfulness stress-reduction techniques better able to cope with the demands of nursing? Do nurses who practice these techniques have improved morale, improved satisfaction, healthier relationships, fewer tendencies to make harsh judgments of others, have less work-related stress, make less errors, and have less absenteeism? How beneficial is it to educate student nurses on the importance of caring for oneself by demonstrating and practicing these techniques in undergraduate nursing programs? Would offering such programs for all nurses, both novice and seasoned, demonstrate less turnover and less attrition? Similar studies incorporating the financial aspects of improved nurse satisfaction and improved quality care indicators may reveal compelling data for nurses, hospital administrators, and insurance companies.

Conclusion

The results from this small pilot study are promising and would support future research in this area. Nurses demonstrated confidence to teach this technique of self-care to their patients. Stress, a leading cause of disease and a reason for increased nursing

burnout, should be prevented whatever the cost; patients and nurses alike must be less stressed to function and perform optimally. Teaching nurses the RR and similar strategies may accomplish the needs of patients and health care providers alike. The quality of the work-life environment has not been a priority for most organizations as they struggle with their fiscal affairs. However, administrators and nursing leaders must now reconsider and prioritize offering holistic nursing support. The economic factors, now on the forefront of health care survival, might just be the stimulus necessary to redirect the focus from “the patient” to “the patient *via* the nurse.” As Nightingale envisioned, we need to reveal nursing’s full potential for growth and resiliency by delivering *care* for the nurses. Moreover, a new direction toward wellness may provide both financial strength and holistic well-being for all.

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