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IN BRIEF REPORT

Relational Mindfulness for Psychiatry Residents: a Pilot Course in Empathy Development and Burnout Prevention

Paige Greason Bentley[1] · Sebastian G. Kaplan[1] · Josephine Mokonogho[1]

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Abstract

Objective Psychiatry residents face challenges daily that test their capacity to be empathic and attuned to their own self-care. This can have a deleterious impact not only on the residents but also on patient-care. Training to manage the challenges of the work and cultivate stronger patient relationships is needed but often missing in medical education. This study aimed to pilot an empathy training course based in relational mindfulness and assess the impact on burnout and empathy.

Methods Seven first-year psychiatry residents (PGY-1) at an academic medical center in a mid-size city in the southeast participated in an eight-week pilot program created by the authors that integrated relational mindfulness and empathy training. Data were gathered from the seven PGY-1s on measures of burnout and empathy and on their experience of the training.

Results The PGY-1s demonstrated a downward trend in means on all three burnout subscales and significant improvement on the measure of empathy ($f = 8.98$; $p = .02$). Overall, the PGY-1s reported an increased awareness of their cognitive and emotional experiences and stated that the skills learned in the program increased their ability to care for themselves, their patients, and their families.

Conclusions Training in intrapersonal and interpersonal attunement is often overlooked in medical training, leading to resident burnout and negative patient outcomes. An empathy course based in relational mindfulness may be a viable strategy for programs looking to attend to their residents' emotional health and bridge the empathy training gap.

Keywords Psychiatry · Residency · Empathy · Mindfulness

Training for psychiatry residents typically focuses on empirically validated treatments. However, evidence suggests that "common factors," specifically qualities of the doctor-patient relationship, are more influential in determining mental health outcomes than any specific treatment model [1]. Additionally, a patient's adherence to recommendations requires a level of trust in their doctor [2].

Unfortunately, sufficient training in the cognitive and affective skills necessary to cultivate stronger working alliances with patients is often missing in medical education [3]. This training gap could lead to negative patient outcomes, increased risk of malpractice suits, and increased burnout [4, 5]. Research suggests that residents who experience burnout in their first year of residency are at increased risk for experiencing decreased empathy, diminished connection to patients, and thus continued burnout [6]. A need exists to develop training programs focused on the mental skills necessary for self-monitoring, self-care, and development of a capacity for healthy empathic responding.

Empathy is a critical skill needed for the development of a trusting doctor-patient relationship [7]. Broadly, empathy refers to the reaction of one person to the experience of another. Empathy is a multidimensional construct involving the cognitive understanding of the experience of the other and an affective emotional response [8]. In the doctor-patient relationship, it also includes communicating an accurate understanding of the patient's experience. Healthy empathy represents a balanced state where the clinician is open to the experience of another, but does not lose him or herself in that experience.

Empathy builds on the capacity for self-monitoring and self-care [9]. One must first be able to hold one's own experiences, thoughts, and feelings in non-judgmental awareness before doing the same for another. Unfortunately, self-

✉ Paige Greason Bentley
pbentley@wakehealth.edu

[1] Wake Forest University School of Medicine, Winston-Salem, NC, USA

monitoring skills are often overlooked in medical training thus potentially stunting empathy throughout medical training [10]. Research suggests this may result from overidentifying with the emotions of others [11], which may be a particular challenge for psychiatry residents given the presenting concerns of many psychiatric patients.

Training in mindfulness could lead to a greater capacity for empathy through teaching of mental habits necessary for empathic attunement to others (e.g., self-monitoring, attentional focus, non-judgment) [12]. Mindfulness training can also reduce stress and burnout among healthcare providers, which may increase their capacity for empathy. Some have proposed that training in "relational mindfulness," which focuses on mindfulness practiced in relationship to others, may deepen and extend those aforementioned positive outcomes [12].

Although research exists on mindfulness training with medical students and healthcare professionals, with positive results on self-compassion and burnout, relational mindfulness and empathy training for psychiatry residents has received little attention [13]. This pilot program aimed to develop, implement, and evaluate a course in relational mindfulness for first-year psychiatry residents (PGY-1).

Methods

The Wake Forest University School of Medicine Institutional Review Board approved this project. The authors developed a course for all seven PGY-1 residents at their institution consisting of 1.5-h sessions for eight consecutive weeks during the spring of their first year (see Table 1 for more details). The course itself was part of the PGY-1s' required didactic training. It was adapted from the literature on mindfulness training in healthcare and from the course directors' trainings in mindfulness-based stress reduction and motivational interviewing. The course leaders were not attending psychiatrists and were not in an evaluative role for the PGY-1s. All PGY-1s consented to participate in the evaluation component, completed measures before and after the course, and received a $5 gift card in appreciation.

The first four sessions focused on mindfulness, and the last four sessions focused on empathy. Each session began with a 10-min meditation. After debriefing the meditation exercise, the group discussed "mindful or empathic moments" throughout the previous week in their personal or professional lives. This was followed by discussion about a predetermined topic (e.g., core mindfulness skills, self-compassion, radical acceptance, reflective listening skills). Mindfulness was introduced as a skill to manage stress and notice internal reactions to clinical experiences with patients without judgment. The larger intention of mindfulness practice was explained as cultivating attunement to self and others and learning to respond with wisdom rather than react from habit to clients and life in general. The core mindfulness skills taught were observing, describing, non-judging, non-reacting, and acting with awareness [14]. PGY-1s were taught to return to these core skills as they practiced more advanced skills such as reflective listening and radical acceptance. Handouts with more details on the mindfulness topics were provided during the four weeks of mindfulness training. The handouts also included recommended "experiments" with mindfulness practices during the week and an "appreciative inquiry" adapted from the work of Krasner and Epstein [15]. The key skill taught during the four weeks focusing on empathy was reflective listening. Practice exercises and brief role plays were used to teach reflections as a means to express a non-judgmental understanding of another's experience. Video demonstration was used to help reinforce course content. The course directors kept the sessions flexible enough so that time was available for discussion on the application of mindfulness and empathy skills to the PGY-1s' current experience.

Measures

Evaluation measures consisted of a demographics questionnaire, a measure of empathy (The Helpful Responses Questionnaire (HRQ) [16]), a measure of burnout (Maslach Burnout Inventory—Human Services Survey (MBI-HSS) [17]), and a Learning Experiences Questionnaire (LEQ) developed by the authors to qualitatively evaluate the course. Questions on the LEQ included a focus on how the course impacted PGY-1s personally, the practices they found most helpful, how they would integrate the concepts and skills into their clinical work, and thoughts about future directions for the course.

Results

Participants

A total of seven PGY-1s (5 men; 2 women) at an academic medical center in a mid-sized city in the southeast completed the HRQ, MBI-HSS, and LEQ before and after the course. None of the PGY-1s reported having any previous mindfulness training. However, two reported having a meditation practice of some sort, specifically yoga and intentional breathing practices.

Quantitative

Due to the small sample size and a pilot nature of this project, the authors present the results of the qualitative assessments as a point of reference only. The seven PGY-1s showed significant positive change in mean scores on the HRQ post-intervention ($N = 7$; pre-intervention mean = 1.21; post-

Table 1 Empathy and mindfulness course outline[a]

Session	Title	Topics covered
1	What is mindfulness?	• Opening meditation: Awareness of thoughts, images, emotions • Discussion Topics: ○ Definition of mindfulness ○ Attitudes necessary for mindfulness ○ Why is mindfulness important for psychiatrists? • Meditation exercise: Raisin • Appreciative inquiry[b]: Note a pleasant or an unpleasant experience during clinical work and its effect on your patient-physician relationship. • Take-home experiment: Attention to breath throughout the day. Mindful eating. Turn five senses "noticing" to any object.
2	Radical Acceptance: Saying Yes to Life	• Opening meditation: Counting breath • Discussion Topics: ○ Definition of radical acceptance ○ Pain vs. Suffering ○ Using the body to explore the moment • Meditation exercise: "Yes" meditation by Tara Brach • Appreciative inquiry: Reflect on a surprising clinical experience (an experience that differed significantly from what you expected). • Take-home experiment: Yes meditation. Body scan. Formal and informal practice of mindfulness of sound, thoughts, body sensations, other objects.
3	Self-compassion	• Opening meditation: Awareness of body sensations • Discussion Topics: ○ Definition of self-compassion ○ Turning the Mind ○ Willingness vs Willfulness ○ Small ways to practice • Meditation exercise: Mountain meditation • Appreciative inquiry: Reflect on an experience of noticing and responding to your own sense of burnout, exhaustion, depersonalization, low sense of personal accomplishment. • Take-home experiment; Self-compassion break. Three-minute breathing space. Continue mindfulness of sounds, thoughts, body sensations, other objects.
4	Relational Mindfulness	• Opening meditation: Awareness of sounds • Discussion Topics: ○ Overview of common factors and dodo bird effect ○ Compassion fatigue • Meditation exercise: Lovingkindness • Appreciative inquiry: Reflect on a clinical encounter involved being present to suffering, sadness, pain, uncertainty, end-of-life, and the awareness of your role as a physician. • Take-home experiment: Hand to heart exercise. Lovingkindness. Insight dialogue mediation prior to entering a conversation. Continue mindfulness of sounds, eating, body sensations.
5	What is empathy?	• Opening meditation: Awareness of the space around you and the people within that space • Discussion Topics: ○ Definition of empathy ○ Why is empathy important for psychiatrists? ○ Facilitators and barriers to empathy • Take-home experiment: Over the next week, notice moments where expressions of empathy are important, either in their presence or absence.
6	How does one *be* empathic?	• Opening meditation: Brief breathing space – snapshot of thoughts, images, body sensations, emotions • Discussion Topics: ○ Verbal and nonverbal expressions of empathy ○ Continued discussion of facilitators and barriers to empathy ○ Introducing reflective listening ○ Reflection practice • Take-home experiment: Practice use of reflections with each other, as well as in clinical situations.
7	Reflective listening and the language of empathy	• Opening meditation: Brief lovingkindness meditation • Discussion Topics: ○ The use of reflections in clinical practice ○ Continued discussion of facilitators and barriers to empathy ○ Reflection practice • Take-home experiment: Continue practice use of reflections with each other, as well as in clinical situations.

Table 1 (continued)

Session	Title	Topics covered
8	Mindful reflections	• Opening meditation: Awareness of body settling meditation • Discussion Topics: ○ How do mindfulness and reflective listening skills fit together? ○ Course wrap-up and feedback from PGY-1s

[a] Reading list available upon request

[b] Appreciative inquiries from Krasner and Epstein [15]

intervention mean = 1.97; $f = 8.98$; $p = .02$). Mean scores on all MBI-HSS subscales among PGY-1s revealed a downward trend after the training (emotional mean change from 27.83 to 25.83, $f = .504$, $p = .509$; depersonalization mean change from 13.5 to 12.83, $f = .260$, $p = .632$; personal accomplishment mean change from 38.33 to 36.83, $f = .918$, $p = .382$).

Qualitative

Overall, the PGY-1s described an increased awareness of their cognitive and/or emotional experiences and described this as helpful in their ability to manage personal and work stressors. For instance, one PGY-1 shared, "I am more aware of the present moment.… In so doing, I'm better able to take of myself, my family, and my patients." The qualitative feedback on the impact of the themes of self-care, patient-care, future clinical work, and areas for program improvement are detailed below.

Self-care The PGY-1s reported that the training helped them become more aware of their thinking processes and gave them permission to be "imperfect." One PGY-1 stated: "I am more grounded and centered. While I have my moments of frustration and stress, I feel that I handle those emotions better." Another shared: "I have been more observant of my heightened emotional states, and think generally I'm more attuned to the shifts in them that are caused by external forces." Three of the seven PGY-1s mentioned the concept of self-compassion as impactful, with statements suggesting that it allowed them to adopt a more forgiving stance toward themselves for perceived imperfections in their work or at home. One shared, "Allowing myself to be imperfect has made me a better wife and mother as I try to just let things be and be more present with my family."

Patient-Care Four out of seven PGY-1s mentioned their patients specifically, describing their improvements in reflective listening, their increased ability to see their patients' perspectives, and an increased awareness of the impact that words have on the care they provide. "I've learned more reflective, patient listening skills, and increased empathic listening in interviews," one PGY-1 stated. Another wrote, "Empathy and mindfulness have allowed my call shifts to be more calm as I try to just take each thing as it comes and give each patient the attention they deserve."

Future Clinical Impact Regarding the expected impact of the learnings on their future clinical work, all PGY-1s described expecting improvements in their work with patients, either through teaching patients about mindfulness or by approaching patients with more empathy and less judgment. They emphasized reflective listening and/or increased empathy as being a priority to integrate into their clinical practice. "I've been able to recognize the way we speak to others and the words we choose can have a large impact on the other person. I need to be cognizant of my own emotions and feelings in situations before I act and speak." Another shared: "The lessons on empathy have reminded me of my own biases I hold toward certain patients and how it affects the care I give them. It's important to enter each encounter with an open mind and listen to what the person has to say and understand the deeper meaning behind their words."

Barriers to Practice The PGY-1s also shared barriers to integrating the skills into practice. They identified time limitations as a significant barrier to being mindful and empathic in their work as psychiatrists. Other barriers identified included documentation requirements that determine a pre-set way of interacting with patients, high patient volumes, burnout, and certain patient populations (e.g., low-functioning patients).

Recommendations One participant recommended that PGY-1s receive the course at the start of the year as opposed to halfway through. Other recommendations included reading lists, a meditation resource list, condensing the mindfulness content, and having more audio/visual content.

In addition to formal qualitative responses from the LEQ, the course directors noted important discussion topics throughout the course. One PGY-1 stated that mindfulness was not helpful because his or her mind was "too distractible." Several PGY-1s stated that they had difficulty applying empathy skills in clinical settings where they felt they could not

provide something that a patient was asking for (e.g., to be discharged from the emergency department). Another area of difficulty the PGY-1s highlighted was how to utilize empathy skills (i.e., reflective listening) flexibly when using question-focused documentation templates.

Discussion

Overall, the 8-session course on empathy and mindfulness was well-received by the PGY-1s. Based on qualitative course feedback, the PGY-1s found the material useful both in their personal lives and in their clinical work. They found the concepts provided a framework for recognizing their own habits and biases. They shared that they hoped to practice more openness and acceptance of patients and themselves based on what they had learned in the program.

As anticipated, the PGY-1s had a significant, though limited, increase in scores on the measure of empathy. Because of the lack of a control group, this could be due to natural learning from residency training in general or due to the curriculum itself. Though not statistically significant, quantitative assessment demonstrated a downward trend in two subscales of the burnout inventory—emotional exhaustion and depersonalization. A downward trend suggests a reduction in overall burnout [17]. An unexpected result was the downward trend in self-reported levels of personal accomplishment. This may be due to the emergency psychiatry rotation the PGY-1s were completing at the time of the program. Dennis et al. sampled psychiatry residents and noted a positive correlation between adverse emergency psychiatry experiences and burnout rates [18]. It is also possible that the training itself increased their awareness of the limitations in helpfulness, resulting in a diminished sense of personal accomplishment if judgment were also present. Baer found that individuals with no meditation experience had a negative correlation between mindfulness skills of observing and non-judging, meaning if they observed their experience they were likely to judge it, as well [14].

Despite this surprising finding, the statements the PGY-1s made about an increased awareness of their cognitive and emotional patterns and a desire to be more present with patients suggests that training may have an impact on residents' ability to respond empathically to others, which ultimately may improve a sense of personal accomplishment. In a study of internists, researchers found that the ability to be present with patients, understanding them as unique and fellow humans (rather than simply objects of care), correlated significantly with finding work meaningful, more so than any diagnostic and therapeutic triumphs [19].

Limitations of this pilot include the small sample size, lack of a control group, and the reliance on self-report measures. There may be some social desirability issues due to the intervention being taught by the researchers, but this potential may be limited because the researchers are not attendings and not in an evaluative role for the PGY-1s.

Based on the findings of this pilot study, recommendations for improving the program's effectiveness include starting at the beginning of the first year and integrating the material throughout residency training to encourage sustained learning. Curricular changes might include helping participants understand how to manage increased awareness of the limitations of effectiveness, developing resource lists, and protecting time for didactic instruction. Future research could explore the "dosage" of training needed to provide a protective function against resident burnout throughout residency and the use of a longitudinal design. Additionally, research could expand the sample size, include a control group, and use a multi-method approach to empathy assessment rather than just self-report.

Given the impact of the doctor-patient relationship on outcomes and the growing awareness of burnout in medicine, it is important that psychiatry residency training programs explore ways of teaching empathy and addressing the self-care needs of residents. This pilot study is an important first step toward developing early interventions to address both.

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Compliance with Ethical Standards

This study was approved by the Institutional Review Board as an exempt protocol and is in adherence with all ethical standards.

Disclosures On behalf of all authors, the corresponding author states that there is no conflict of interest.

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