Care-giver perspectives

Perspectives of healthcare professionals and patients on the application of mindfulness in individuals with chronic obstructive pulmonary disease

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\textbf{A B S T R A C T}

\textbf{Objective:} To explore the views of healthcare professionals (HCPs) and patients towards mindfulness for individuals with COPD.

\textbf{Methods:} A qualitative study design informed by and analyzed using deductive thematic analysis. Twenty HCPs, with at least one year’s clinical experience in COPD management and 19 individuals with moderate to severe COPD participated in semi-structured interviews.

\textbf{Results:} Analysis revealed seven themes. 1. Mindfulness is difficult to articulate and separate from relaxation. 2. Mindfulness has a role in disease management. 3. Mindfulness therapy should be optional. 4. Preferred techniques include; breathing meditation, music and body scan. 5. Mindfulness should be delivered by knowledgeable, enthusiastic and compassionate trainers. 6. Preferred mode of delivery is shorter sessions delivered alongside pulmonary rehabilitation, with refresher courses. 7. Efficacy should be assessed using psychological outcome measures and qualitative methodologies.

\textbf{Conclusions:} Mindfulness appears to be an attractive therapy for individuals with COPD. An understanding of the perspectives of HCPs and patients should inform the delivery of such programs.

\textbf{Practical implication:} Individuals with COPD were comfortable using breathing to reduce anxiety. Stigma and negative preconceptions were considered barriers to participation. Short sessions delivered by experienced trainers were preferred. A combination of methodologies should be used to examine effectiveness.

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\textbf{1. Introduction}

Mindfulness is a therapeutic modality which may be well suited to the needs of individuals with Chronic Obstructive Pulmonary Disease (COPD), given their high prevalence of anxiety and depression \cite{1,2}. Using breath as a focus, mindfulness promotes a moment-by-moment non-judgmental awareness of thoughts, feelings, body sensations and environment \cite{3}.

Mindfulness reduces stress, anxiety and depression in individuals with chronic physical or mental health conditions \cite{4}. Its positive impact on fatigue, self-efficacy and quality of life has been reported in; heart failure, arthritis and asthma \cite{5–7}. The lack of effect of mindfulness in individuals with COPD has been ascribed to poor adherence \cite{8}, with improvements in emotional function being observed in those who completed six or more sessions \cite{9}.

The success of any intervention is helped by the knowledge, skills and beliefs of the persons who deliver it. Although the lack of specialist training in the delivery of any self-management intervention in COPD has been noted, the views of health care professionals (HCPs) or patients towards mindfulness have not been reported \cite{10}.

In this qualitative study we report the views of HCPs and patients towards the application of mindfulness for individuals with COPD. Such information will inform the development of successful mindfulness interventions.

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2. Methods

A qualitative study design was employed. Approval was obtained from the local hospital research ethics board and all participants provided written informed consent.

A purposeful sampling strategy was used to identify HCPs with at least one year’s clinical experience managing individuals with COPD. Participants were identified via personal contacts, posters, emails, advertisements and hospital announcements as well as through interviewees suggesting other peers. All HCPs who volunteered to take part in the study completed.

Purposeful sampling was used to gain a wide diversity of attitudes from patients with COPD currently enrolled in pulmonary rehabilitation (PR). Eligible individuals had; COPD confirmed by spirometry [11] and a smoking history greater than 20 pack years. Individuals were excluded if they were unable to communicate because of language skills, hearing or cognitive impairment. Twenty-nine patients were approached, nine refused to take part in the study due to time commitments (n = 8) and not wishing to return to the hospital (n = 1), one patient was excluded due to limited language skills.

Recruitment was considered to be complete once data saturation was reached; following 17 interviews with HCPs and 15 interviews with patients and confirmed by three more HCPs interviews and four more in individuals with COPD.

Demographic data including gender, age and any involvement in mindfulness, yoga or meditation was recorded. Profession and experience working in COPD was recorded for HCPs. Spirometry, smoking history and years diagnosed were recorded for individuals with COPD.

Face-to-face semi-structured interviews with HCPs and patients were conducted by a post-doctoral trainee (SH). SH is a registered physiotherapist in the UK with experience managing patients with COPD. The interviews lasted approximately 30 min and took place in a quiet private, room with only the interviewer and interviewee present. The content of the interview schedules were informed by a systematic review exploring the effect of mindfulness for individuals with a respiratory diagnosis [12] and were revised throughout data collection to encompass any additional topics which arose and to improve clarity and flow (Supplements 1 and 2). The first question asked participants to describe what they understood about mindfulness. They were then shown a five-minute you-tube video (https://www.youtube.com/watch?v=HmEo6RI4Wvs) on mindfulness.

All interviews were recorded and transcribed verbatim by a professional transcriber. The data was stored and organized using a computer software programme (QSR NVivo version 9; QSR International, Doncaster, Australia) and analyzed using Deductive Thematic Analysis (DTA) which adopts a framework approach where there are pre-identified issues but new themes are uncovered.

The analysis followed the six step procedure of Braun and Clark [13]. Two researchers familiarized themselves with the data before developing a preliminary list of codes. SH organized units of text under each code, creating additional codes if new issues were identified. AL verified the coding in two transcripts before the two researchers organized the codes into overarching ‘candidate themes’. The candidate themes were presented and discussed with a third researcher (DB). SH and AL read all the data extracts coded under each theme to consider if the themes were coherent and the data extracts appropriate. The researchers (SH, AL) used thematic mapping to consider the validity of the themes in the context of the entire data set. They provided a description of each theme and discussed the definitions with a third researcher (DB). SH selected data extracts to support each theme before writing up the final report.

3. Results

Demographics of the HCPs and patients interviewed can be found in Tables 1 and 2 respectively.

Seven overarching themes on the delivery of a mindfulness programme were identified.

3.1. Mindfulness is difficult to articulate and separate from relaxation

Difficulties articulating a definition of mindfulness were described by both groups “it’s a weird thing to describe” HCP ID. 6. “It’s hard to explain” patient ID. 2. Understanding of mindfulness varied with some communicating detailed knowledge and others expressing total naivety “It’s a way of sort of centering your attention back onto yourself without there being a particular

Table 1
Demographics of the health care professionals.

<table>
<thead>
<tr>
<th>Participant ID</th>
<th>Gender</th>
<th>Age</th>
<th>Profession</th>
<th>Number of years working in COPD</th>
<th>Any involvement in mindfulness/yoga/meditation</th>
<th>Years spent practicing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>M</td>
<td>37</td>
<td>Physician</td>
<td>10</td>
<td>None</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>30</td>
<td>Physiotherapist</td>
<td>6</td>
<td>Current-yoga</td>
<td>6</td>
</tr>
<tr>
<td>3</td>
<td>F</td>
<td>47</td>
<td>Physiotherapist</td>
<td>15</td>
<td>Previous-mindfulness</td>
<td>0.5</td>
</tr>
<tr>
<td>4</td>
<td>M</td>
<td>45</td>
<td>Nurse</td>
<td>4</td>
<td>Current-yoga</td>
<td>7</td>
</tr>
<tr>
<td>5</td>
<td>F</td>
<td>61</td>
<td>Respiratory Therapist</td>
<td>37</td>
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<td>0</td>
</tr>
<tr>
<td>6</td>
<td>F</td>
<td>27</td>
<td>Occupational Therapist</td>
<td>2.5</td>
<td>Previous-mindfulness</td>
<td>2.5</td>
</tr>
<tr>
<td>7</td>
<td>F</td>
<td>40</td>
<td>Occupational Therapist</td>
<td>11</td>
<td>Previous-yoga</td>
<td>1</td>
</tr>
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<td>8</td>
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<td>0</td>
</tr>
<tr>
<td>9</td>
<td>F</td>
<td>47</td>
<td>Nurse</td>
<td>5</td>
<td>Current-Yoga</td>
<td>2</td>
</tr>
<tr>
<td>10</td>
<td>M</td>
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<td>Exercise Physiologist</td>
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<tr>
<td>11</td>
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<td>PT/OT assistant</td>
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<td>0</td>
</tr>
<tr>
<td>12</td>
<td>M</td>
<td>42</td>
<td>Respiratory Therapist</td>
<td>17</td>
<td>Previous-Yoga</td>
<td>2</td>
</tr>
<tr>
<td>13</td>
<td>F</td>
<td>28</td>
<td>Recreational therapy Assistant</td>
<td>3.5</td>
<td>Current-mindfulness and yoga</td>
<td>2</td>
</tr>
<tr>
<td>14</td>
<td>F</td>
<td>29</td>
<td>Recreational therapist</td>
<td>6</td>
<td>None</td>
<td>0</td>
</tr>
<tr>
<td>15</td>
<td>M</td>
<td>39</td>
<td>Physiotherapist</td>
<td>2</td>
<td>Current-mindfulness</td>
<td>1</td>
</tr>
<tr>
<td>16</td>
<td>M</td>
<td>65</td>
<td>Physician</td>
<td>35</td>
<td>Previous-meditation retreat</td>
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</tr>
<tr>
<td>17</td>
<td>F</td>
<td>65</td>
<td>Physiotherapist</td>
<td>30</td>
<td>Current-meditation</td>
<td>40</td>
</tr>
<tr>
<td>18</td>
<td>F</td>
<td>51</td>
<td>Occupational therapists</td>
<td>5</td>
<td>Current-Yoga and mindfulness</td>
<td>3</td>
</tr>
<tr>
<td>19</td>
<td>M</td>
<td>44</td>
<td>Recreational therapists</td>
<td>6</td>
<td>None</td>
<td>0</td>
</tr>
<tr>
<td>20</td>
<td>F</td>
<td>47</td>
<td>Social worker</td>
<td>5</td>
<td>None</td>
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</tr>
</tbody>
</table>

COPD; Chronic Obstructive Pulmonary Disease.

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