



Certified nursing assistants' experiences with self-compassion training in the nursing home setting

Christine Lathren, MD, MSPH^{a,*}, Karen Sheffield-Abdullah, PhD, RN, CNM^a, Philip D. Sloane, MD, MPH^{b,c}, Karen Bluth, PhD^{d,e}, Johanna V.T.S. Hickey, MSW^b, Christopher J. Wretman, PhD^{b,f}, Laura Prochnow Phillips, MA^b, Sheryl Zimmerman, PhD^{b,f}

^a Department of Physical Medicine and Rehabilitation, Program on Integrative Medicine, University of North Carolina at Chapel Hill, Box 7200, Chapel Hill, NC 27514, United States

^b The Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, Chapel Hill, NC, United States

^c Department of Family Medicine, School of Medicine, University of North Carolina at Chapel Hill, Chapel Hill, NC, United States

^d Department of Psychiatry, University of North Carolina at Chapel Hill, Chapel Hill, NC, United States

^e Frank Porter Graham Child Development Institute, University of North Carolina at Chapel Hill, Chapel Hill, NC, United States

^f School of Social Work, University of North Carolina at Chapel Hill, Chapel Hill, NC, United States

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ABSTRACT

Certified nursing assistants (CNAs) in nursing home (NH) settings experience considerable work-related and personal stress. Self-compassion is a personal resource linked to improved stress coping and may be particularly relevant to health care workers. In this study, we explored NH CNA's experiences with self-compassion training based on their narrative replies. Twenty-two CNAs (100% female, mean age 48 years, 82% Black/African American) from 3 mid-sized, non-profit NHs in the Southeast US completed either a standard 8-week, 20 h self-compassion training or a 6-week, 6 h modified version designed for health care providers. Qualitative data analyses from post-training focus group discussions identified four themes pertaining to changes in: (1) stress management, (2) appreciation and support, (3) caregiver role, and (4) connection to others. Findings suggested self-compassion training is feasible and beneficial for the stressors that CNAs experience. In the era of COVID-19 and beyond, self-compassion training is a promising method to improve CNAs' well-being.

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Introduction

Certified nursing assistants (CNAs) are responsible for the daily direct care of approximately 1.35 million residents in U.S. nursing home (NH) settings.¹ Despite the essential role of CNAs in promoting residents' health, safety, and quality of life, job retention has been a long-standing challenge.² Physically and emotionally demanding workloads and low workplace support are commonly cited sources of CNA stress, burnout, and job dissatisfaction,^{3,4} which may contribute to job turnover and subsequent decreased care quality.⁵

For many CNAs, occupational stressors are compounded by life stressors rooted in the intersections of gender, race, and socio-economic disparities. In the U.S., CNAs are predominantly female, with approximately 60% identifying as Black/African American, Latino/a, or Asian/Pacific Islander and one-fifth having been born outside of the U.S.⁶ CNAs receive low compensation and work benefits, which contributes to the fact that an estimated 44% of CNAs are living in low-income

households (defined as below 200 percent of the federal poverty level), 15% report income below federal poverty levels, and nearly half receive public assistance.⁶ CNAs also report experiencing high rates of traumatizing life events,⁷ including experiences of racism⁸ and workplace discrimination.⁹ COVID-related challenges have posed additional strain for long-term care communities and compounded stress and risk for direct care workers.¹⁰ Now more than ever, these factors underscore the need for systemic change to adequately compensate CNAs and to address racial and gender discrimination. Additionally, strategies that can help alleviate CNAs personal and work-related stress and contribute to their well-being are needed.

One potential strategy to support CNA well-being is through self-compassion training. Self-compassion is a way of relating to oneself that has been linked to a host of psychological benefits, including lower perceived stress, depression and anxiety¹¹ and greater well-being.¹² Self-compassion as defined by Neff¹³ entails six interrelated components: increased mindfulness, common humanity and self-kindness, and corresponding reduced overidentification, isolation and self-judgment. Mindfulness is defined as balanced awareness and acceptance of difficult thoughts and emotions, as opposed to overidentifying with and

* Corresponding author.

E-mail address: lathren@email.unc.edu (C. Lathren).

becoming overwhelmed by them. Common humanity is the recognition that difficult emotions are part of the human experience as opposed to feeling isolated by these experiences. Self-kindness means taking an active role to protect oneself under the threat of harm or treating oneself with kindness when encountering challenges as opposed to being harshly judgmental or self-critical. These components are hypothesized to work together to facilitate emotional regulation¹⁴ and adaptive stress coping responses.¹⁵

Over the past decade, self-compassion trainings have demonstrated efficacy in improving psychosocial outcomes in a wide variety of community and clinical populations.¹⁶ A growing body of literature suggests that self-compassion may be particularly beneficial to health care providers, whose demanding occupational duties may lead to forgone self-care, secondary trauma (i.e., through repeated exposure to others' physical and emotional pain), burnout, and empathetic distress.^{17,18} As a case in point, a recent pilot study found that a standardized 8-week, 20 h group training in Mindful Self-Compassion (MSC) for nurses was associated with increased resilience and decreased burnout and secondary trauma.¹⁹ Acknowledging that health care providers often have limited time to participate in programs, the developers of MSC adapted the program to a 6-week, 6 h program, called Self-Compassion for Health Care Communities (SCHC). When provided to interdisciplinary health-care teams (e.g., physicians, nurses, allied health, office staff), SCHC was associated with increased participant well-being and compassion for others and decreased burnout and secondary traumatic stress with medium to large effects.²⁰

Prior to our work, however, self-compassion trainings have not been explored exclusively for NH CNAs. To address this gap, our team recently examined feasibility, acceptability and preliminary outcomes of self-compassion training for CNAs within 3 NH settings; we implemented the 20 h format in NH1 and the 6 h adapted format in NHs 2 and 3. We found both training formats were feasible, acceptable, and associated with significantly decreased stress and depressive symptoms and increased self-compassion post-training.²¹

To understand the experiences of CNA participants more deeply, this article provides an analysis of participants' post-training focus group discussions. The primary aim of this work is to explore CNA perceptions regarding whether and, if so, how self-compassion training was relevant to and facilitated change in their lives. The results provide additional evidence regarding the potential usefulness of self-compassion training in promoting CNA well-being. Further, although relevance to one's culture or racial/ethnic identity was not specifically addressed within the intervention or focus group discussions, this study also provides novel qualitative data regarding the experiences of Black/African American women with a self-compassion intervention.

Methods

Participants and Setting

CNAs who worked at three NHs in the southeast U.S. participated in self-compassion training that was advertised as a "CNA Wellbeing Program". The NHs were of similar size (licensed for 80–120 beds), profit status (all non-profit), overall quality (4 or 5 stars), and location. Study staff directly approached the NH administrators at each site to describe the project, and then met with both the administrator and the director of nursing to discuss site-specific recruitment and training details. CNAs at each site were recruited via informational sessions during shift change, announcements at staff meetings, and posted flyers. Inclusion criteria included being at least 18 years old, speaking English, working onsite at least 20 h/week, being able to attend at least 75% of the classes, and having the expectation to remain employed at that NH throughout the program. For safety reasons, CNAs with a history of hospitalization for a psychotic disorder

were ineligible. Overall, 39 CNAs were screened, 34 provided informed consent and baseline data, and 30 CNAs completed the intervention at the three NH sites.

Intervention and study design

We chose one NH to receive the standard 20 h MSC training. At this site, once weekly 2.5 h group sessions were offered in a private room in the NH. Two session times were offered, one prior to second shift and the other following first shift. CNAs who worked overnight shifts generally could not participate given that these times were during their sleeping hours. CNAs received up to \$180 compensation for participation in the training and evaluation of the program, which included \$10 per session and \$25 per data collection timepoint. Food and drink were offered at the start of each session.

Two certified MSC instructors led experiential exercises, skill-building practices, didactics and discussions designed to increase participants' capacity to respond with self-compassion to difficulties at work and in their personal lives. Participants learned formal practices (e.g., guided meditations) as well as informal ('in the moment') practices to be used in daily life. Instructors encouraged home practice and gave each participant the MSC workbook,²² authored by the co-creators of the program, to review as desired. (See Supplementary Appendix 1 for an overview of the weekly curriculum). An additional four-hour off-site weekend retreat, which is part of the standard curriculum, was offered but not conducted because the CNAs' work schedules and home obligations precluded participation.

Based on recruitment challenges for the standard MSC training format, feedback from program participants, and preliminary data from another study showing validity of the newly developed and abbreviated SCHC program,²⁰ the SCHC training was offered in the other two NHs. This format provides similar content (see Supplementary Appendix 2), modified to fit in 6 weekly 1 h group sessions. Aside from duration, the SCHC was similar in timing (i.e., two session times one offered before second shift and one after first shift), location (i.e., private room within the NH), and structure (e.g., led by the same two instructors, food offered) as the standard format. Participants in the 6 h format received up to \$140 for participation, which included \$10 per session and \$20 per data collection timepoint. This increased hourly compensation was based on feedback from NH1 participants, some of whom travelled to the NH on their day off from work to participate.

Data collection

Using a semi-structured interview guide, focus groups were conducted with each cohort following the last training session. Author CL, a white female MD post-doctoral fellow studying self-compassion in caregivers and with qualitative methods training, conducted 2 focus groups with participants who received the 20 h MSC format. Participants were invited to a 'post-training feedback session' during typical training hours (before and after work shifts) in a private room in the NH. To minimize participants feeling uncomfortable sharing negative feedback, participants had not met the facilitator previously and were told the main purpose of the group was to understand their experiences so that the training could be tailored for CNA participants. Of the 10 total participants in the MSC training, 7 participated in the focus group sessions (some reported not having the time). Focus group questions included: What stands out to you about this program? What are the aspects of the program that you liked most/least? (See Supplementary Appendix 3 for questions). These questions have been used in other post-training focus group settings.

The focus groups for participants in the 6 h SCHC training format were co-conducted by authors CL and KSA, a Black female PhD post-doctoral fellow studying mindfulness in African American women and with qualitative methods training. They conducted 4 focus

groups with participants in the two NHs. In NH 2, of the 7 people who finished the training, 5 participated in focus groups; in NH 3, 13 CNAs completed the training, and of these, 10 participated in focus groups (some reported not having time to participate). These 4 groups were asked questions similar to those posed to MSC participants, as well as experiences with stress, mindfulness and self-compassion prior to and after their participation. See Supplementary Appendix 4 for questions. In each group, facilitators made field notes during and after the one-hour session.

Data analysis

Focus group sessions were audio-recorded and then transcribed verbatim, and the data were de-identified for analysis. Author CL listened to all recordings to verify that transcription process was accurate. Then, the co-authors who facilitated the focus groups read all transcripts multiple times to become familiar with the content.

Data were analyzed following six steps suggested by Braun and Clarke²³ for thematic analysis, which includes familiarization, initial coding, searching for themes, reviewing themes, defining and naming themes, and report writing. Thematic analysis was conducted because it allows researchers to “see and make sense of collective or shared meanings or experiences”,²³ which is a primary aim of this work. An iterative team-based approach was used for code generation and application as a means to account for individual bias, incorporate multiple perspectives and multidisciplinary expertise, and create a final product that is a valuable and novel contribution to the field.²⁴ Each member of the full 8-person team generated initial codes for two transcripts, such that multiple team members overlapped on each transcript, using a mix of both inductive (content-driven) and deductive (researcher-derived) coding.²⁵ After the initial round of coding, the full team met to discuss and refine codes and draft a codebook. Two rounds of sub-team meetings were held to discuss areas of differing code application, reach consensus and refine the codebook. The codebook included 43 codes, which were the following code groups (individual codes not listed): program implementation, experiences during the training, changes related to training participation, stress, work life, personal life, and understanding of mindful self-compassion principles.

Using ATLAS.ti 8 for data management, the co-authors who facilitated the focus groups applied final codes to all transcripts. In a heuristic process, coders examined agreement, reached consensus as needed, and assigned codes. Separately and then together, authors CL and KSA reviewed the coded data and grouped into 4 broad themes. The final themes were reviewed and agreed upon by the full research team. To assist with confirmability, the research team maintained an audit trail that included notes on iterative changes to codes, code definitions and groupings, and themes.

This study was approved by the university's Institutional Review Board (IRB # 18-2012) and was registered with ClinicalTrials.gov (#NCT03720652).

Results

All 22 CNA participants were female, with average age of 48.2 years. They were 81.8% African American, 4.5% White, 4.5% Asian, 4.5% American Indian/Alaskan Native, and 4.5% Native Hawaiian, with 1 person who identified as Hispanic/Latina; 18% had completed high school or equivalent, 55% had completed some college, and 27% had an associate degree or higher. Fifty five percent were married, 23% were never married, and 23% were divorced, separated or widowed. Overall, the CNAs had an average of 14.8 years (range 2–38) working as a CNA.

Quantitative findings regarding training feasibility, acceptability, and psychosocial outcomes are reported elsewhere.²¹ Most participants noted that, although not perfect, trainings held in the NH prior to or post-shift were the most convenient and feasible time and place. Regarding recruitment, several CNAs noted that having a brief introduction to the training content prior to enrollment and hearing about positive endorsements from other CNAs would motivate interest. Others described the benefit of making the training an “in-service”, so that all could participate during work hours and receive their usual wages. There were differing opinions about training length. In general, the shorter SCHC training was easiest to commit to, however some felt the length was too short (e.g., several desired ongoing support after the 6 weeks ended), while others preferred meeting twice a week (as opposed to weekly) in order to practice the skills. Finally, regarding changes to the curriculum, one group discussed the benefit of tailoring the content for CNAs by adding role-playing of job scenarios.

Thematic analysis

Analyses identified four themes describing CNA's experiences with and response to the self-compassion training content: changes in (1) stress management, (2) support and appreciation, (3) caregiver role, and (4) connection to others.

Changes in stress management

Many CNAs described incorporating new stress management behaviors in response to or in anticipation of stressful encounters with the NH residents in their care, including use of breathing practices and ‘soothing touch’ (i.e., a supportive physical gesture towards oneself). For example, participants described doing brief ‘in the moment’ practices prior to entering residents’ rooms or taking short breaks during challenging interpersonal encounters. Some participants described that these moments of practice improved the care they provided:

“I need a moment when I go into that room, but I'm better equipped to do that now and to take care of me. If I'm good, then I can give good patient care. I think I give better patient care because I'm a better person in handling stress.”

Several participants described lowering their stress by working to better understand and to develop empathy for residents who they found to be challenging. For one participant, the training helped her relate more empathetically to a resident:

“I have this one particular patient that no one wants to come on the floor to work with. . . .When I get to that door, I just take a deep breath and love me and think. . . it could be me in that position, and I just take care of her.”

Another described being better able to recognize “mood swings” in the residents she cares for, and to respond in a compassionate and patient way to these difficulties (e.g., using soothing touch, recognizing that residents have experienced life hardships). Yet another described having increased patience with a resident who typically gets aggressive during care.

Others described getting along better with colleagues, being less self-critical in response to difficult encounters with residents and becoming less overwhelmed when the NH was short-staffed. For example, one participant said that while she typically would be very harsh with herself after shifts when she felt she did not meet all the residents’ needs, now she “doesn’t stay stuck.” She learned to give herself support and encouragement that motivated her to come to

work the following day without feeling defeated, referring to the next day as a new opportunity to “be a super CNA”. This shift in attitude came with the realization that tending to herself did not mean she was neglecting her duties as she previously would have thought; rather, she could support herself and “still care” about the residents.

Participants also described using emotional awareness to process and cope with difficult situations. One participant discussed how the practice of pausing and naming her emotions helped her realize that grief was underlying her sense of aggravation:

“And the other thing I really loved is the “naming it”. Because sometimes I have a feeling like I’m really aggravated. Then I’ll take a moment and take a deep breath and I realize, ‘you know what, I’m not mad, I’m discouraged.’ And it just changed the whole outlook of what was happening to me, within myself. . . Because this has been a hard two months for me on my hall. I’ve had a lot, a lot of people pass away. And because I’ve been here so long, I’ve known some a really long, long time. So, it’s okay, I’m not really mad. I’m just sad.”

Another participant explained the training helped her realize that she often dealt with a difficult emotion by “pushing it aside”. After receiving the training, she felt she was better able to recognize these emotions and address problems more directly.

For others, the training led to an expansion of their existing spiritual practice as a way of managing stressors. One said she was “more of a praying person now”, and because of this she was able to cope better when the residents were in bad situations, whereas previously she had felt powerless to help. Several others echoed turning to prayer more often after taking the training, particularly in situations where they felt they lacked control, including difficulties with family members and CNAs’ own personal health problems.

Changes in support and appreciation

For some CNAs, participation in the training led to a shift in the ability to be self-supportive and increased their self-appreciation. This shift appeared to stem both from training content and from the warm, supportive nature of the group, which contrasted with the lack of support and appreciation they perceived at times from their work environments.

The self-compassion training content centers on growing the skills to become aware of one’s own feelings and needs, and to meet these needs in a warm and supportive manner. For many, this skill was met with resistance at first, describing it as “weird” or “self-centered,” or explaining that the process made them feel “guilty.” After training, some participants realized “there’s nothing wrong with taking time for yourself.” Some also noted that self-compassion was deeper than typical self-care behaviors, such as the “artificial stuff like getting your nails done.” The training helped participants, who are often *care providers*, realize that they were “important, too” and that they could offer that same level of emotional support to themselves. One person described this shift as learning to do for herself what she naturally does for others in her life:

“It was funny. . . it was like somebody was paying attention to me, or telling me it was okay, or seeing about me. Giving me tools or something to take care of me, you know, versus ‘cause I’m a CNA and I’m trained all day to do for everybody else.’ I’m a caregiver, so this program helped me to just say, hey, just like I am actually standing outside of my body and doing the same thing I do for you. . . for me.”

Another CNA described that her increased self-appreciation could be summed up in the new way she would be celebrating her birthday:

“For me, I never thought about my birthday. I do not care, it comes and goes. . . but tomorrow is my birthday and since this class, I’m not

even working tomorrow. . . Today I was talking about it in the dining room and telling everybody that it’s my birthday, it’s like I’m looking forward to it. . . Indirectly it’s having an impact on me and on my life. There was so many years I didn’t care about my birthday, so for the first day in my life I’m not working on my birthday!”

Moreover, the skill of learning to be one’s own source of care and support appeared novel to most participants. Some said they “didn’t know” they could do this for themselves, and that it was both beneficial and needed:

“What this class has done for us is put a coping mechanism in place that we can go to. . . On a regular workday who’s going to think about giving themselves compassion? We would have never thought about it. You know, I would not have, and you come to this class and wonder where has this been all the time?... I’m sorry I didn’t come a long time ago. That’s something CNAs really need in the field.”

Aside from learning how to be self-supportive, many participants experienced caring interpersonal interactions with the training instructors, and a warm supportive group atmosphere. Some noted that the instructors modeled compassion towards them; they were “non-judgmental” and “flexible” and made them feel “comfortable.” Another gave the example that when she had to leave a session early, the instructors were “not nasty” about it. Others noted they felt the instructors demonstrated true care and concern for them and listened to them. Participants also enjoyed feeling “cared for” when they were asked about their food preferences.

In contrast to feelings of support within the group, some participants expressed feeling “overlooked” at times within their work role. Participants in multiple groups described expectations to endure high workloads while their own needs were often ignored: “You know, we’re more than just caregivers, we’re people, we experience things too.” Several others described a general lack of appreciation for CNAs’ contributions: “We have all heard ‘you are just a CNA.’ Well, CNAs are the backbone of the building!” Another described how nurses, at times, “seem oblivious” to the stress CNAs experience. This sentiment was echoed by others, who felt there was a general lack of supportiveness and teamwork in the workplace from both fellow CNAs and nursing staff.

Given this background, discussion emerged in one group about how validating it was to have a training for CNAs rather than the typical “patient care” focused in-service:

“This is the first time they gave us something for us, the CNAs. Finally, somebody thought about the CNAs. Because everybody goes ‘oh, the CNAs do this, oh let the girls do that,’ and they think we’re magic, and we can do everything. So, this was like something that like. . . Somebody thought about us, our feelings, thought about our strengths, about the load we carry every day. So, I enjoyed the course.”

The impact of feeling supported and valued through participation also had a downside once the training came to an end. For a number of participants in the SCHC training, the end of the training felt abrupt, especially considering the time it took to develop group trust and connection: “I heard a couple of people say ‘as soon as we got used to them, they’re gone.’ As one participant verbalized:

“I wish they [instructors] could have stayed. It’s so different to open up to a set of people and they’re not in my life anymore. It feels like a man done came by, and I feel sad. I’m still trying to get over them. So, it’s like I’m not going to see them no more and they’re now a part of my life, so it’s just like I opened up and that was like short-lived.”

Thus, while some participants experienced validation and support from participation in the training, for some, this was coupled with a sense of loss when the sessions ended.

Changes in the caregiver role

Participants experienced changes in their tendencies, within their personal and occupational caregiver roles, to self-sacrifice and over-extend themselves. In general, participation in self-compassion training helped CNAs gain better balance between meeting their own needs and the needs of those for whom they provided care.

Many participants were caregivers both at work and within their homes. This role appeared to be a core part of their identities and instilled a sense of pride; however, for some, the training helped them recognize that their self-imposed expectations to provide care were unrealistic:

"I was more so a people pleaser, making sure that those around me are taken care of and they have what they want and need and being able to provide for them. It really wasn't about me. I have a tendency of putting others before myself... [but now] I had to come to realize I'm one person. I cannot solve everybody's problems."

Another participant described how she was "always doing something for somebody," whether it be at work or with family and friends. Another described herself as the person everyone comes to for advice, but she rarely took her own advice. Another described how, prior to the training, she would work her shift and then come home to "go, run, run" doing household chores late into the evening. The training appeared to temper some of the drive to support others "all the time" which often happened at the expense of their own well-being:

"Before I would just extend myself even though I'm tired or fatigued and I didn't feel like doing it at all. I'll still find that low energy within me and extend myself and do it anyway. But since the class I no longer feel that way, I no longer see things that way. It kind of opened up my eyes to... You know what? There's water in the fridge, there's food in the freezer, and if you want to eat, go cook it."

This shift was noticed and appreciated by others in the CNAs' personal lives. One person said her child saw "changes" in her and remarked that she was "so kind now"; another said her family "finally realized she needs her 'me' time" as she takes time to meditate at home; yet another said her husband noticed she was taking better care of herself now.

Finally, caregiver fatigue is a training topic that seemed to resonate with participants. Near the end of the training, participants learned about equanimity, an attitude that promotes mental balance and perspective during challenging situations where one has little control. During this session, participants practiced equanimity through phrases designed to highlight that, while a caregiver might wish to alleviate the pain of others, it is not entirely in their power to do so, as each person is on his or her own "journey." This practice, which is designed to help caregivers bring a more balanced emotional response to their role and responsibilities as they experience others' hardships, appeared beneficial:

"One thing that I really liked towards the end of the course was when we started talking about the path, the journey. That we were on a journey with the residents and we were here to help them, to be with them on their journey. That helps you not to take it so personal, to me. It relieves some of the stress that you have. For me, it relieved my

stress, that I'm here on their journey, so whatever this holds today, right now as I walk in the patient's room, is what's going to happen."

Changes in connection to others

There were two types of connections to others that became evident during focus group discussions: broad social connection and interpersonal connection. Regarding broad social connection, one of the core components of self-compassion training is "common humanity," which entails the recognition that difficult emotions are a normal and expected part of the human experience. From this perspective, emotional pain is not unique or isolating; rather, it highlights our connection to one another. Related to this concept, some participants spontaneously described the recognition that difficult feelings are experiences that tie us together. For example, in explaining how her self-talk in response to making mistakes had changed since taking the training, one participant said she tells herself, "Everyone messes up, you're not alone." Another recognized that she came to relate to residents who were having a difficult time because "we all have our crosses to carry." Another, in response to a tough day at work, said that she had learned to give herself a break, because "this would be hard for anybody, not just me". Thus, recalling that difficult emotions and imperfections are part of the human experience was a useful coping skill for some participants. "I think to myself that I'm not the only one that is going through it... and that gives me comfort," one said. For others, recognizing this shared experience helped them feel "normal" or "empowered" because "other people have survived it."

At the same time, at the individual level, some participants described feeling disconnected from their support networks. For example, one participant described feeling misunderstood by others in the context of her own specific difficult circumstances: "There are some things you think, 'ok, nobody is going to get this. This is mine.' Even with explaining it... Nobody is getting what I'm saying." Similarly, a participant who was facing a serious medical problem expressed she felt that others who were not in her situation could not fully understand her experience, and this kept her from engaging with others.

For others, it appeared that the prevalence of hardship and challenge among people they knew deterred them from leaning on others during their times of need. For example, one participant noted: "Nobody has time to hear mine, because everybody else has their own problems." Another explained that recognizing that "everybody has it tough" led her to refrain from reaching out for support, because she did not want to further burden others who are also struggling.

Thus, for some, the training appeared to facilitate increases in broad feelings of connection to others; this experience was described as supportive and beneficial. On the other hand, in specific interpersonal contexts, some described the preference to remain disconnected from others when facing challenging circumstances. For varying reasons, these participants expressed the desire to cope independently.

Discussion and implications

The results of this study suggested that self-compassion training for CNAs within NH settings is feasible and leads to self-perceived beneficial changes in stress management, emotional self-care and coping. Regarding implementation, feasibility would be enhanced if administrators offered the training as a paid in-service during regular working hours. This opportunity would increase accessibility to the training for CNAs with out-of-work obligations and those who work night shifts, two groups that were difficult to recruit. Moreover, the training would convey workplace support for CNAs. While the optimal training length is unclear, it seems offering the SCHC format combined with opportunities for ongoing support (e.g., regular

'booster' sessions) would be the most accommodating. This approach balances time commitment barriers with the time necessary to build relationships and trust. Other worksite wellness initiatives engaging long-term care CNAs have suggested that offering both paid time for wellness activities and 'booster' sessions improve training reach and adherence.²⁶ However, regardless of the chosen option, there are cost implications to providing the training and boosters, unless a trained volunteer were available.

CNAs described using self-compassion skills to cope with common NH stressors, including challenging resident behaviors, difficulties related to high workload and understaffing, lack of coworker support, and feelings of being undervalued members of the NH team. In other literature, these types of stressors have been linked to burnout, job dissatisfaction, and turnover,^{27,28} suggesting self-compassion skills may be particularly relevant to CNAs' work experiences and may have impact on job retention. While participants spontaneously applied self-compassion skills in response to challenging interactions with residents, future work may consider incorporating role play to further hone these skills. CNAs also described using skills in personal circumstances, suggesting these skills are broadly relevant to CNAs' lives.

Some participants described pre-training tendencies to over-extend themselves in the service of others, forgo self-care, and suppress emotions in personal and professional caregiving contexts. Given that nearly 50% of NH direct care workers are either double-duty or triple-duty caregivers (i.e., provide care both at work and within their families for parents and/or children),²⁹ these attributes may be common contributors to the experiences of the CNA workforce. In addition, similar characteristics—including an obligation to prioritize the needs of others to the detriment of one's own health and emotional suppression—have been described in frameworks for understanding socialization and stress experiences of African American women, who represented over 80% of study participants. For example, participants' described tendencies to be selfless and self-reliant are in line with both Superwoman Schema³⁰ and strong Black woman³¹ conceptualizations. Thus, future research regarding how social determinants of health, including race, culture, gender, and personal caregiving roles, influence CNAs' stress and experiences with self-compassion training, are warranted.

Importantly, self-compassion training appeared to modify self-sacrificing and emotion suppressing tendencies, as participants developed skills for emotional awareness and a more balanced view of their caregiving roles. Participants discussed being more accepting of their limitations as caregivers, recognizing that they cannot 'do it all' and developing less rigid and more realistic expectations of themselves. They also described instances where they valued and appreciated themselves, actively supporting themselves in times where they might previously neglect needs, judge themselves harshly, or feel guilty about tending to themselves. These new responses represent important boundary-setting and self-support strategies that may attenuate symptoms related to the stress of chronic caregiving. Thus, further examination of the health impact of CNAs' improved responsiveness to *their own* care needs while continuing to *provide* care in multiple settings may be fruitful.

Increased boundaries and self-directed support did not, however, appear to detract from the quality-of-care CNA participants provided. Rather, CNAs described *increased* empathetic and understanding responses towards residents in their care, particularly during situations where residents were distressed or exhibiting challenging behavior. For nurses, self-compassion protects against compassion fatigue and reduced empathy due to chronic caregiving stress,³² and is associated with increased compassion for others and feelings of fulfillment in the caregiving role.²⁰ Our findings suggest NH CNAs may reap similar benefits from training, although more objective measures of care provision will confirm these benefits.

CNAs' increased capacity to see things from residents' perspective and to respond compassionately to residents' distress align well with person-centered care principles. This approach seeks to honor residents' preferences and perspectives and has been linked to improved resident and caregiver outcomes.³³ Moreover, although person-centered principles in dementia care emphasize *resident* quality of life, the more comprehensive approach includes "valuing and respecting persons with dementia *and those that care for them*" and emphasizes the importance of the caregiver-resident relationship.³³ Future studies might incorporate CNA self-compassion training with other person-centered care initiatives as a way to holistically support the CNA-resident dyad while also improving CNAs capacity to recognize the needs and preferences for residents with a reduced capacity to express these needs.

Some participants described a lack of social support personally and professionally, and the preference to persevere through challenges alone. Given that self-compassion has been described as an "inner caregiver" response,³⁴ it is plausible that training benefits are compounded for individuals with low external support. In support of this hypothesis, self-compassion has been shown to mediate the relationship between perceived social support and psychological well-being,³⁵ suggesting self-compassion may be an important mechanism by which to improve well-being in those lacking external support. Further exploration of the role of social support in self-compassion training will add to our understanding of how and for whom trainings are most effective.

Relatedly, some participants noted changes in interpersonal workplace relationships in response to the training. For example, some described handling difficult co-worker encounters with greater ease. In the context of the NH environment, the development of positive interpersonal connections with residents, colleagues and supervisors are important sources of workplace well-being, satisfaction and job retention.^{36,37} Although predominantly cross-sectional in nature, evidence supports a link between healthy interpersonal functioning and self-compassion.³⁸ For example, self-compassion may help individuals resolve conflicts constructively by considering one's own needs simultaneously with the needs of others,³⁹ while also enhancing tolerance of other's faults and imperfections.⁴⁰ Thus, future studies could explore training impact on workplace relationships and culture. Offering separate self-compassion trainings to NH nursing staff and administrators may accentuate positive outcomes by improving relational skills more broadly and creating a more supportive and compassionate workplace culture.

Finally, findings revealed that the provision of ongoing self-compassion training support is an important ethical consideration for SCHC participants, several of whom described feeling somewhat distressed once the weekly training ended. Typically, online and written resources are available to self-compassion training graduates, including virtual practice sessions with other graduates across the country. Given the unique experience of learning self-compassion within the NH setting and the high rates of NH turnover, customizable and flexible options for sustained practice and support may be valuable. This support might include intervention booster sessions, online support specific to CNAs, training opportunities for other NH staff members such as nursing supervisors and administrators to encourage a "self-compassionate" work environment, and other protocols that incorporate brief opportunities for CNAs to practice self-compassion during daily work routines.

There are several important limitations to this work. Methodologically, participants were limited to a small group of predominantly Black/African American, female, and experienced CNAs from 3 highly rated NHs in the southeastern U.S. These results may not be generalizable to CNAs of other race or gender identities, levels of experience, or in other geographic regions and NH contexts. Given that participants' opinions may be different than those who could not or chose not to participate, it is unknown if findings would be similar if these

groups were included. In addition, focus groups included fewer participants than those typically recommended, which may have limited the richness of the discussion; similarly, the limited number of groups suggests that saturation may not have been achieved.⁴¹ Transcripts and findings were not returned to participants for review, which may have implications for the validity of the findings. Finally, it is unknown if self-compassion training ultimately improves care quality and decreases job turnover, two key issues that might motivate necessary policy change and resource investment for successful dissemination and sustainability.

In conclusion, self-compassion training is a feasible and beneficial method to improve stress management and emotional self-care for critical members of the health care system. While the trainings described in this study were delivered *prior* to the onset of the COVID-19 pandemic, the current situation highlights the acute importance of accessible ways to support the well-being of direct care workers who are often excluded from receiving the resources and accolades given to front-line nurses and physicians.¹⁰ Importantly, self-compassion training will *not* substitute for the widespread structural changes needed to improve CNAs' working conditions (e.g., fair compensation and job benefits, adequate job training). Rather, self-compassion training could be one aspect of a multi-faceted strategy to support the direct care workforce, with the potential to accentuate improvements in care quality and job stability garnered through additional approaches such as increased compensation and work benefits. Finally, given that CNAs are a racially, ethnically and culturally diverse group, future work should examine the training through this lens, thereby adding to the growing literature on culturally-responsive mindfulness-based interventions^{42,43} and expanding the relevance and reach of these interventions to under-represented communities.

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Declaration of Competing Interest

Dr. Bluth and Ms. Prochnow Phillips are certified Mindful Self-Compassion instructors and receive salary support from teaching these trainings. All other authors have no conflicts to declare.

Supplementary materials

Supplementary material associated with this article can be found in the online version at doi:10.1016/j.gerinurse.2021.08.013.

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