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Using meditation for less stress and better wellbeing

A seminar for GPs

Background

General practitioner stress is a recognised problem for which meditation is a potential intervention. The aim of this project was to evaluate the feasibility, acceptability and effectiveness of an initiative to train GPs in a set of evidence based meditation skills.

Method

General practitioners attended a seminar comprising a 1 hour lecture on GP wellbeing, a 45 minute session on meditation, meditation skills practise in groups with an experienced instructor, a larger group review and the provision of take home kits. At the seminar's conclusion, GPs were offered the option of meditating at home twice daily. Measures were taken before and after the seminar and after 2 weeks home practise. The measures included the Kessler Psychological Distress Scale – 10 (K10), personal experience rating by visual analogue scale, and diary card.

Results

A total of 299 GPs attended the seminar, from which 293 provided visual analogue scale on the day. Pre- and post-K10 data was provided by 111 GPs. The mean pre-K10 score for these GPs was 17.2 (SD: 5.67); the post-K10 score was 14.7 (SD: 3.92), with 25.1% of the 'at risk' participants moving to the 'low risk' category. Mean compliance with meditation was 79.5%.

Discussion

A meditation workshop for GP wellbeing is practical, feasible and appealing to GPs. Quantitative feedback from the workshop indicates its potential as an effective mental health promotion and prevention strategy.

■ **A recent survey found that 60% of general practitioners wanted educational material to help in the management of stress, and that 28% of those seeking education were experiencing significant levels of stress.¹**

A national survey of Australian GPs found that work was the major stressor in GPs' lives. One in eight (12.8%) GPs surveyed had scores indicative of severe psychiatric disturbance. Fifty percent of respondents had considered leaving their current workplace and 53% had considered abandoning general practice because of occupational stress. Those who had considered leaving their current workplace or careers were also more likely to be moderately or severely stressed.²

Concerning the issue of stress in the medical profession, Riley states: 'The issues of health and wellbeing of doctors – self care, stress management and so on – should be... kept on the agenda in continuing professional development programs'. He goes on: 'We must be better prepared as individuals and as organisations to respond to the early signs of distress... accordingly, relevant professional organisations need to devise and become familiar with pathways for responding'.³

Stress management interventions such as meditation have been identified as simple yet potentially effective health promotional strategies that can make a significant contribution to improving general health, beyond that of simply addressing the immediate impact of work stress.⁴ Meditation is a particularly important stress management skill because, once taught, it can be practised independently, and at will, to both reduce acute stress and serve as a buffer against ongoing and chronic stress.⁵

Meditation is widely perceived as an effective method of reducing stress and enhancing wellbeing. In Australia, a survey of the general community (n=1033) found that 11% of respondents had practised meditation at least once.⁶ The Australian community survey found that 29% of Australians found prayer to be a source of peace and wellbeing, while 24% used meditation for the same



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purpose.^{7,8} Interestingly, Kaldor reports some psychophysiological differences between prayer and meditation,⁶ while Benson has suggested that meditation can be practised without need for change in religious affiliation.⁹

Health professionals are also enthusiastic about meditation, despite a lack of formal education about it. A survey of Australian GPs in 2000 found that almost 80% of respondents had recommended meditation to patients at some time in the course of their practice, despite the fact that only approximately 30% had had any type of education about it.¹⁰ A more recent formal survey by Cohen et al¹¹ in 2005 found that 56% of GPs would like to receive some form of training in meditation skills.¹¹

It is unclear however, whether or not such a meditation based resource, when implemented in the 'real world', would be feasible or effective for GPs as a stress reducing, wellbeing enhancing strategy.

The aim of this project was to evaluate the feasibility, acceptability and effectiveness of an initiative to train GPs in a set of evidence based meditation skills. The project was based on the findings of the Meditation Research Programme (MRP) at the Natural Therapies Unit of the Royal Hospital for Women in Sydney.¹² The MRP has been involved in the systematic evaluation of a 'mental silence' orientated form of meditation and subsequent development of delivery strategies for consumers, patients and professionals since 1998. A rigorous randomised trial of this approach, when compared to an active control, demonstrated significant effects on measures of work related stress, anxiety and depression.¹³ Other trials of the same approach have demonstrated promising effects in depression/anxiety,¹⁴ asthma¹⁵ and epilepsy.^{16,17} The technique evaluated by the MRP is called 'Sahaja yoga' and it is typified by the experience of mental silence.¹²

Method

The seminar was advertised broadly to the GP community through a brochure distributed via medical newspapers and direct mail. It comprised a 1 hour lecture on GP wellbeing issues followed by a 45 minute lecture on meditation and its potential benefits. This was followed by a guided meditation session for the entire group. Delegates then broke up into smaller groups of approximately 25–30 to revise and expand the skills they had learnt, with the aim of enhancing the mental silence experience. Each group was facilitated by an experienced meditation instructor. After the workshops, participants reassembled in the auditorium for a further meditation session, which was followed by concluding comments and questions. Each participant was given a home practise kit which included a

meditation CD (developed as part of the MRP's clinical trials), an instruction card, a diary, the K10 questionnaire and a candle.

Participants had the option of undertaking further structured home practise consisting of twice daily meditation for 2 weeks, which they would record on the diary card. Participation in the seminar alone qualified GPs for Category 2 CPD points; the 2 week home practise tasks (based on diary card and post-task questionnaires) were considered an active learning module (ALM) and qualified participants for Category 1 CPD points.

Measures

Kessler 10 Psychological Distress Scale

The Kessler Psychological Distress Scale – 10 (K10) questionnaire was completed at the beginning of the seminar (the 'before' assessment) and at the end of the 2 week home practise session (the 'after' assessment). Consisting of 10 questions that appraise psychological distress, the K10 questionnaire has been used in a number of population health surveys in Australia.^{18,19} The National Health and Wellbeing survey in 2001 used the K10 as a measurement tool to identify segments of the population at risk of developing mental illness. The categories are based on work by Andrews and Slade¹⁹ and comprise 'low', 'moderate', 'high' and 'very high'. The last category represents the portion of the population previously found to meet diagnostic criteria for clinical depression and anxiety requiring professional help.

Personal experience rating by visual analogue scale

At the end of the seminar, participants rated the degree to which their experience of 'mental activity', 'calm and peacefulness' and 'stress tension' had changed compared to usual, using a specifically developed visual analogue scale (VAS).

The RACGP learning objectives survey

A compulsory part of the continuing professional development (CPD) process, The Royal Australian College of General Practitioners (RACGP) learning objectives survey provides feedback on participant perceptions of the educational effectiveness of the initiative.

Diary card

Using a diary card, participants indicated how often they were meditating. They also rated their experience of mental silence on a scale where 0 represented their usual level of thinking and 10 complete inner silence.

Results

Participation and response rates are summarised in *Table 1*.

K10 scores

Using the same standardised risk categories described above, 46.2% of the GP sample was in the low risk (ie. normal) category. Australian population norms show 64.3% of people in this category²⁰ – a statistically significant difference ($p < 0.01$).

Of the GPs who attended the seminar, 111 completed the home based meditation tasks and provided pre- and post-K10 data. Analysis showed that the mean pre-program K10 score was 17.2 (SD: 5.67), and the post-program score 14.7 (SD: 3.92). Using the Australian Bureau of Statistics risk categories, 46.3% of this sample was in the low risk category at the beginning of the skilling program. At the end of the 2 week home based program, 71.4% of the sample was in the low risk category, meaning that one-quarter (25.1%) of the at risk participants had improved sufficiently to shift into the low risk category. This difference was significant using McNemar's test ($p < 0.001$). The mean improvement of the at risk group's K10 score was 20%.

Personal experience ratings

At the end of the seminar, 293 of the total 299 GP participants (98%) provided VASs that were suitable for inclusion in analysis. The results are summarised in *Table 2*.

Diary cards

Participants returned 163 diary cards, which showed day 1 compliance was 84.4% and day 14 compliance 77.4% (mean 79.5%).

The mean mental silence rating on day 1 was 4.5 (SD: 2.3); on day 14 it was 6.3 (SD: 2.3), an improvement of 40%. A paired t-test indicated that this was significant ($t=12.9$, $df=160$, $p < 0.001$).

Learning objectives survey

Feedback was very positive, with 98.8% of the 151 respondents indicating that their learning needs had been fully (54%) or partially (45%) met, and 97.5% indicating that the event was fully (56.0%) or partially (41.5%) relevant to their medical practice.

Relationship between mental silence experience and workshop outcomes

The relationship between participants' self reported experience of 'mental activity/silence' in the VAS and their self reported experience of 'calm/peaceful' and 'tension/anxiety/stress' VASs was strong and highly significant, such that the more that participants' mental activity moved toward the silent state, the more calm/peaceful (Spearman's rank correlation test $r=0.78$, $p < 0.001$) and the less tense/anxious/stressed they felt ($r=0.70$, $p < 0.001$).

In the diary card data, a significant relationship between self rated mental silence and K10 score at day 1, the day of the seminar (Spearman's $r=-0.36$, $p < 0.001$) and at day 14 (Spearman's $r=-0.25$, $p < 0.01$) was evident, such that a higher level (a higher self rated score) of mental silence was associated with a lower level of psychological distress (a lower K10 score). Among those GPs who rated the event highly there was a significant positive relationship between the change in mental silence rating and change in K10 score ($r=0.26$, $p < 0.05$).

Discussion

Kessler 10 scores indicate that the GPs who attended the event were experiencing high levels of psychological distress and that

Table 1. Participation and response rates

Category of participants	Response rates (n)
Total medical practitioners participating (GPs, specialists, junior medical officers)	318
GPs	299
GPs who provided VAS data at the beginning of the workshop	293
GPs who completed baseline K10 questionnaire at the beginning of the workshop	283
GPs who completed both 'before' and 'after' K10 questionnaires	111
GPs who claimed CPD points	214
GPs who did the take home tasks (ALM) and earned Category 1 CPD points	163

Table 2. Change in qualitative experience as measured by visual analogue scores

Experiential factor	Any improvement	More than 50% improvement	More than 75% improvement
Mental silence	93%	40%	12%
Calm and peacefulness	96%	53%	23%
Stress, tension, anxiety	93%	46%	22%

the intervention was successful in targeting those GPs who needed assistance. The substantial change in the number of GPs in the at risk categories at the end of the initiative is clinically significant, suggesting that the intervention has practical potential.

The correlations between K10 scores and self rated mental silence provide some support for the notion that mental silence is of specific importance to the beneficial effects of the seminar.

Both the personal experience ratings and the learning objectives survey indicate that the experience was constructive and perceived as successful in upskilling and educating GPs on how meditation may be useful. This study, along with the other published studies, demonstrates that regular meditation can empower participants to pursue and maintain higher levels of wellbeing. Therefore, meditation has considerable potential both as a mental health promotion strategy and as a primary prevention strategy for those identified as suffering from mild to moderate psychological distress and who are therefore at risk of further deterioration. Logically, the potential benefits of this type of initiative are relevant to all health professionals.

In fact, GPs' patients may well be a reasonable target for interventions such as this. Overseas studies estimate that up to 40% of patients presenting to GPs are psychologically distressed.²¹⁻²³ The majority (50-70%) of general practice consultations feature stress related issues,²⁴ which makes medical practitioners, and especially GPs, the first point of contact for most people who are psychologically distressed.²⁵⁻²⁸ Cohen's 2005 survey¹¹ reported that if the topic of meditation is raised by a patient, 65% of GPs would actively encourage them to pursue it. The survey also reported that 9% of

GPs suggested this course of action in their practice at least once per week, with 56% suggesting it at least once per month. Given this evidence, publicly accessible workshops, based on the model evaluated above, are a potentially useful referral pathway for primary health professionals.

Implications for general practice

- A low cost, nonprofit meditation workshop for GP wellbeing is practically feasible and appealing to GPs.
- A meditation workshop for GPs has potential as an effective mental health promotion and prevention strategy.
- Given the increasing attention on the issue of GP stress and wellbeing, meditation represents an important addition to GPs' self care resources.

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References

- Holt J, Mar CD. Psychological distress among GPs. *Aust Fam Physician* 2005;34:599–602.
- Schattner P, Coman G. The stress of metropolitan general practice. *Med J Aust* 1998;169:133–7.
- Riley G. Understanding the stresses and strains of being a doctor. *Med J Aust* 2004;181:350.
- Cryer B, McCraty R, Childre D. Pull the plug on stress. *Harvard Business Review* 2003;81:118.
- Smith J. *Relaxation, meditation, and mindfulness: A mental health practitioner's guide to new and traditional approaches*. New York: Springer, 2005.
- Kaldor P, Francis L, Fisher J. Personality and spirituality: Christian prayer and Eastern meditation are not the same. *Pastoral Psychol* 2002;50:165–72.
- Bellamy J, Castle K. 2001 Church attendance estimates. NCLS occasional papers. Sydney: National Church Life Survey, 2004.
- Kaldor P, Bellamy J, Powell R. 1998 Australian community survey. *Build my church: Trends and possibilities for Australian churches*. Adelaide: Openbook, 1999.
- Benson H. The relaxation response: its subjective and objective historical precedents and physiology. *Trends Neurosci* 1983;6:281–4.
- Pirotta M, Cohen M, Kotsirilos V, Farish S. Complementary therapies: Have they become accepted in general practice? *Med J Aust* 2000;172:105–9.
- Cohen M, Penman S, Pirotta M, Costa CD. The integration of complementary therapies in Australian general practice: Results of a national survey. *J Altern Complement Med* 2005;11:995–1004.
- Manocha R. Why Meditation? *Aust Fam Physician* 2000;29:1135–8.
- Manocha R. A randomised controlled trial of mental silence meditation for work stress. 10th International Congress of Behavioural Medicine. Tokyo: International Society of Behavioural Medicine and Japanese Society of Behavioural Medicine, 2008.
- Morgan D. Sahaja yoga: An ancient path to modern mental health? *Transpersonal Psychology Review* 2000;4:41–9.
- Manocha R, Marks G, Kenchington P, Peters D, Salome C. Sahaja yoga in the management of moderate to severe asthma: a randomised controlled trial. *Thorax* 2002;57:110–5.
- Panjwani U, Gupta H, Singh S, Selvamurthy W, Rai U. Effect of Sahaja yoga practice on stress management in patients of epilepsy. *Indian J Physiol Pharmacol* 1995;39:111–6.
- Panjwani U, Selvanurthy W, Singh S, Gupta H, Thakur L, Rai U. Effect of Sahaja yoga practice on seizure control and EEG changes in patients of epilepsy. *Indian J Med Res* 1996;103:165–72.
- Grande ED, Taylor A, Wilson D et al. Mental health status of the South Australian population. *Aust N Z J Public Health* 2000;24:29–34.
- Andrews G, Slade T. Interpreting scores on the Kessler Psychological Distress Scale (K10). *Aust N Z J Public Health* 2001;25:494–7.
- Australian Bureau of Statistics: Mental health and wellbeing: Profile of adults, Australia 1997, cat no. 4326.0. Canberra: ABS, 1998.
- Marks J, Goldberg D, Hillier V. Determinants of the ability of general practitioners to detect psychiatric illness. *Psychol Med* 1979;9:337–53.
- Boardman A. The general health questionnaire and the detection of emotional disorder by GPs: A replicated study. *Br J Psychiatry* 1987;151:373–87.
- Howe A. Detecting psychological distress: Can general practitioners improve their own performance. *Br J Gen Pract* 1996;46:407–10.
- Manuso. Testimony to the president's commission on mental health. Washington: US Government Printing Office, 1978.
- Corney R. A survey of professional help sought by patients for psychosocial problems. *Br J Gen Pract* 1990;40:365–8.
- Bindman A, Forrest C, Britt H, Crampton P, Majeed A. Diagnostic scope of and exposure to primary care physicians in Australia, New Zealand and the United States: cross sectional analysis of results from three national surveys. *BMJ* 2007;334:1261.
- Britt H, Miller G, Henderson J, Bayram C. Patient-based substudies from BEACH: Abstracts and research tools 1999–2006. Canberra: Australian Institute of Health and Welfare, 2007.
- Cohen S, Kamarck T, Mermelstein R. A global measure of perceived stress. *J Health Soc Behav* 1983;24:385–96.



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