# Secular Meditation & Mindfulness for general health and well being in people with long term conditions: A pilot study

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## Background

Secular meditation and mindfulness practises include the ability to non-judgementally observe and become aware of emotions, sensations, bodily states, consciousness, and the environment, while encouraging openness and acceptance. As well as reducing stress in healthy adults (Chisea & Serretti, 2009), meditation and mindfulness based meditation approaches (such as mindfulness based stress reduction) are known to reduce worry and rumination, which contribute to the maintenance of mood disorders (Hayes, 2004). However the benefits of meditation and mindfulness in adults with long term conditions (LTCs) such as diabetes and coronary heart disease are less certain. The acceptability of using meditation and mindfulness based approaches in the context of LTCs is currently unknown.

## Aims

1) To qualitatively evaluate acceptability and feasibility of the Meditation Foundation's health & wellbeing programme, in terms of delivering meditation and mindfulness teaching for general health and well being, for people with diabetes and/or coronary heart disease (CHD)

2) To evaluate change in worry, rumination and intrusive thoughts using self-report questionnaires

## Methods

- Participants (n=38) with diabetes/CHD recruited from voluntary self-help organisations
- 6 week, manualised course in mindfulness-based meditation, consisted of weekly group sessions and home practice
- Mixed methods – questionnaires to assess worry and intrusive thoughts (Penn State Worry Questionnaire and White Bear Suppression Inventory)
- Focus group and 16 in-depth qualitative interviews
- Framework.

**Table 1: Characteristics of participants (N = 38)**

| Characteristic | Number (%) |
|---|---|
| Age (mean, range) | 68.9, 54 – 85 |
| Gender | |
| Male | 17 (45.9) |
| Female | 20 (54.1) |
| Marital status | |
| Married | 19 (51.4) |
| Widowed | 7 (18.9) |
| Divorced | 5 (13.5) |
| Single | 4 (10.8) |
| Civil partnership | 1 (2.7) |
| Not specified | 1 (2.7) |
| Ethnicity | |
| White/Caucasian | 31 (83.8) |
| Other | 5 (13.5) |
| Not specified | 1 (2.7) |
| Self-reported diagnosis | |
| Diabetes | 12 (32.4) |
| Heart condition | 19 (51.4) |
| Both | 3 (8.1) |
| Not specified | 3 (8.1) |
| Mean number of self-reported co morbidities (s.d.)[a] | 6.89 (3.6) |
| Mean disease burden (s.d.) | 14.2 (10.3) |
| Worry pre-intervention | 48.55 (14.1) |
| Worry post-intervention | 42.84 (12.0) |
| Mean change | -5.71 (8.0) |
| Thought suppression pre-intervention | 49.53 (12.4) |
| Thought suppression post-intervention | 46.34 (11.5) |
| Change in thought suppression | -3.18 (7.7) |

[a] From a list of 21 conditions, plus (up to 4) conditions added by the respondent. Range 1-15

## Results

Results of statistical analyses are presented in table 1. Emergent themes from the qualitative analysis, common to all participants, are presented below.

### 1.Profile needs and benefits of support groups

Participants reported difficulties in managing their LTC, especially after diagnosis. They recalled receiving mixed messages from health professionals about **lifestyle management**, and felt frustrated about being **uninformed** about their condition.

*'In the early days when you don't know very much, because they don't tell you very much… they give you a pile of booklets and send you home'.* (p2004, HD)

*'The first month that I'd been diagnosed I think I lost nearly a stone of my weight because every time I picked anything up to eat it I thought; oh, I'm not sure whether I should be eating that, and put it down again.'* (p1008, DM)

This led to emotional consequences, such as fear associated with living with a LTC. Local support groups, conceptualised as providing support for physical health, were seen as important in providing **emotional support** for people with LTCs, that was otherwise not provided through routine health care.

*'They don't tell you the physical, the psychological side of having that bypass and it's frightening… some people are frightened, which I must admit I was. I was frightened of being on my own. Only because I was frightened of having a 'do' you know.'* (p2002, HD)

*'You realise that you're not on your own, that their experiences are pretty similar to yours and everybody has their own little bit of input, you know, it's a meeting every fortnight and you can go and have a bit of a chat and a laugh.'* (p1008, DM)

### 2. Benefits of meditation

Participants reported **psychological benefits** (e.g. reduction in worry and stress) and **physical benefits** (e.g. reduction in blood pressure, greater control of angina symptoms) which helped them manage their LTC.

*'It relieved the angina without me using my spray. I do it upstairs and I was upstairs when it started and I thought I'll go and sit in my room with the tape on and I'll do my exercises and did and when I got up it had gone.'* (P2020, HD)

*'I don't worry the same, and I never realised how rushy everything is and how you haven't got that time for yourself.'* (P2020, HD)

Participants reported they were now able to 'think more clearly' and 'take control' of their thoughts, specifically reporting they were able to deal with worry and stress in more retrospective ways. They went on to describe ways in which a new 'focused approach' to their lifestyle helped them **self-manage** their condition.

*'Chronic conditions always leave at the back of your mind a level of anxiety, you're always concerned in case you've not taken your medication or the medication's not been enough, or your diet's got out of kilter, you're going to go hyperglycaemic…there's always this level of, "Am I dealing with it correctly?" …after a little while you can become quite dismissive, a bit blasé. I think the meditation allows you to take a more balanced view of it, you can look at yourself and see that in relationship to yourself.'* (P2005, HD)

Participants welcomed meditation as an **alternative to other self-management practices**, such as medication, and exercise. They felt that participating in a group was beneficial, much like their experiences with self-help groups.

*'Doing it collectively, with a voice leading you through it…it was a collective thing, we were all taking part in it, learning from it.'* (P2039, DM)

### 3.Challenges of implementation in clinical practice

Whilst the benefits of practicing meditation and mindfulness were reported, participants suggested that opportunities to take part in meditation classes are very limited in the NHS.

Participants suggested it may be difficult to access meditation programmes beyond the research setting. Reasons for this were due to the **negative perceptions of service users** and **service providers** regarding its effectiveness for **physical health conditions**, and negative attitudes towards meditation.

*'I didn't sign up for myself because I was so sceptical. I mean I had visions, meditation, we'd be sat there trying to get cross legged. Not for me.'* (P1019, HD & DM)

*'But I think primarily it's convincing the GPs that it's a good idea… it's the GP that's going to diagnose the problem, therefore, they would need to be aware that this was available.'* (P2001, DM)

However, participants suggested that if meditation was to form a part of routine health care, it should be offered as part of an early intervention package, for example, following diagnosis or an acute event, such as a heart attack.

## Conclusions

Short, manualised meditation and mindfulness sessions can reduce worry and intrusive thoughts and potentially play a key role in self-management practices for people with long-term conditions.

Further research should aim to deepen our understanding of the extent to which meditation and mindfulness practices can enhance both psychological and physical states, which can ultimately lead to better health outcomes.

## References

Chisea & Serretti. (2009). Mindfulness-based stress reduction for stress management in healthy people: a review and meta-analysis. *Journal of Alternative and Complementary Medicine, 15,* 593-600.

Hayes (2004). Acceptance and commitment therapy, relational frame theory, and the third wave of behavior therapy. *Behavior Therapy, 35,* 639–665.

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