Evaluation of the Mantram Repetition Program for Health Care Providers

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An easy-to-learn meditative intervention program for health care providers addresses workplace stress and burnout without a significant investment of time.

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According to the National Institute for Occupational Safety and Health (NIOSH), stress is a major problem for more than 18 million US health care workers (HCWs).[1] Increases in technology, high patient acuity, and new demands for meeting institutional benchmarks create stressful clinical work environments. HCWs at the US Department of Veterans Affairs (VA) are perhaps at particular risk of experiencing burnout due to the unique needs of VA patients and bureaucratic demands.[2] Stress may lead to depression, decreased job satisfaction, and other psychological distress among HCWs.[3] This, in turn, affects the delivery of care. High levels of burnout have been associated with increased medication errors, lower quality of care, and lower patient satisfaction scores.[4-10]

A *Cochrane Review* found that mental and physical relaxation reduce stress in HCWs.[11] Among these, meditative interventions (eg, mindfulness, meditation, yoga) have demonstrated promise.[12-14] Results from a systematic meta-analysis of meditative interventions for HCWs indicated small-to-moderate improvements in emotional exhaustion, sense of personal accomplishment, and life satisfaction. Additional research is needed to determine effects of meditative interventions on burnout and caregiver burden.[15]

Unfortunately, many meditative intervention programs are lengthy and require a significant investment of time. They also require some form of sitting meditation every day, placing additional demands on busy HCWs. There remains a need for practical strategies to reduce HCW stress that are easier to master and practice.

BACKGROUND

We developed, implemented, evaluated, and modified an evidence-based meditative intervention called the Mantram Repetition Program (MRP) to address workplace stress and burnout. The MRP is a mind-body, spiritually enhanced intervention that offers benefits similar to other types of meditative interventions.[16] MRP is composed of 3 primary components: (1) silently repeating a self-selected, meaningful word or phrase (here called a mantram); (2) intentionally slowing down thoughts and behaviors; and (3) developing the ability to focus on a single task at a time (ie, one-pointed attention). The MRP does not require participants to set aside a specific place to practice, and mantram repetition can be initiated intermittently and privately throughout the day (eg, between tasks, while walking or waiting). Examples of 4 sessions (eg, Mantram 1, 2, 3, and 4) can be found on the PsychArmor Institute website (www.psycharmor.org; San Diego, CA).

Initially, the MRP was offered in a group format, in 6 or 8 weekly, 90-minute face-to-face sessions to both patient and nonpatient populations. Studies in veterans with chronic diseases demonstrated improvements in perceived stress, anxiety, and anger, and increased levels of spiritual well-being and quality of life (QOL).[17-19] Veterans with posttraumatic stress disorder (PTSD) reported improvements in PTSD symptoms, QOL, and spiritual well-being.[20-23] Family caregivers of veterans with dementia reported significant reductions in caregiver burden, depression, and anxiety after participating in the MRP.[24]

Similar results have substantiated the effects of the MRP among HCWs, including reductions in perceived stress, stress of conscience (ie, the conflict that results from competing values and behaviors in the workplace), and burnout.[25-27] HCWs also reported improvements in mindfulness and spiritual well-being.[28] In a randomized controlled trial,

South Korean nurse managers who completed the MRP demonstrated significant improvements in psychosocial and spiritual well-being and leadership practice and experienced reductions in burnout compared with that of the control group.[27] In a qualitative study, the most frequently reported benefits of the MRP were improvements in managing symptoms of stress, anxiety, and feeling out of control.[18]

HCWs reported they found it difficult to attend the 8-week MRP face-to-face group classes. Therefore, we developed a shorter online version of the MRP consisting of six 1-hour educational sessions: 4 online self-learning modules, and 2 live meeting webinars with the course facilitator.[28] VA employees were invited to enroll in the program from June 2013 through 2016 through group e-mails and announcements in the VA Employee Education Service newsletters. Those eligible to participate could earn up to 6 hours of continuing education.

Although the program was generally well accepted, feedback from HCWs indicated that providers still lacked enough time to participate fully. We therefore condensed the MRP into one 90-minute, videotaped webinar entitled "Mind-Body-Spiritual Strategies for a Healthy Workforce: The Mantram Repetition Program." The webinar was delivered in real time in June 2013 and archived for viewing later. This condensed course provided an overview of the development, theory, and practice of MRP core components. Specific instructions included how to choose and use a mantram; the importance of acting slowly with intention to avoid mistakes; and ways of developing single-pointed attention. Participants were invited to complete a standard course evaluation using an online survey.

This article presents results from qualitative analyses of participant feedback for the condensed MRP in a nationwide sample of more than 1,700 HCWs within the VA. We used template summary analysis to identify themes in participants' responses to 2 open-ended questions: "What about this learning activity was most useful to you?" and "What about this learning activity was least useful to you?" These results have implications for reducing HCW stress and developing training programs for HCWs.

ANALYSIS

Responses to the what was most useful question were downloaded to a spreadsheet file for analyses. Investigators chose summary template analysis, a rapid qualitative analytic technique, as the best strategy for analyzing these textual data. This technique is often used in health services research when it is unrealistic to use more time-consuming qualitative methods, such as coding.[29]

To begin, the analyst, a PhD-level anthropologist, read through the feedback to identify similar words, phrases, and/or concepts (ie, themes). Once the analyst gained a sense of general themes, she developed category labels using verbatim words and/or phrases in the feedback (similar to developing in vivo codes.[30] She listed these categories at the top of a summary template document, providing a definition for each to ensure analytic rigor.

Next, each category was listed down the left side of the template. Participant feedback was copied and pasted from the spreadsheet form into the appropriate category for each of 200 responses. The investigator identified subthemes within each category. After analysis was completed for the first 200 course participants, the analyst grouped similar categories together into broader domains to further organize the data. She then read through the feedback from the remaining 917 course participants to identify negative cases (ie, dissimilarities in feedback). An additional researcher familiar with the condensed MRP training then examined the categories and domains. Together, they discussed and resolved any inconsistencies in interpretation of the data.

To get a better sense of the full range of perspectives about the training, the analyst then read through the written feedback for the what was least useful question. She scanned the feedback for negative cases that contradicted template findings and noted these in a document. A more balanced evaluation of the course emerged through this secondary analysis.

RESULTS

Online surveys were completed by 1,117 participants, of which three-quarters (841) were female. Two hundred eleven (19%) viewed the condensed MRP in real time. The remaining participants viewed an online video of the

course. Anonymous course evaluations captured only gender and professional classification of participants. Participants represented a wide range of professional roles. The majority (63%) held clinical positions with direct patient care. The next largest category included administrative or health information personnel (21%). There were also students and trainees among these categories.

Qualitative Findings

Feedback about the course was organized into categories during analysis: (1) instructional format; (2) mode of delivery; (3) course content; (4) professional and personal empowerment; (5) religion and spirituality; and (6) ease of mantram practice. These categories represented 2 broad domains: feedback about the course and feedback about the intervention.

Instructional Format

HCWs often reported that the most useful aspect of the course was the instructional format. Most cited the ease with which they could understand the materials and helpfulness of the examples of mantram practice. The option to download course materials for later reference was also useful. Some HCWs indicated that the course could have been improved by incorporating an experiential component in which participants paused to practice a mantram.

Mode of Delivery

Delivery mode including the convenience of the training and the flexibility of having the course available at both work and home was mentioned in the feedback. Some HCWs reported that the most useful aspect of the training was the on-demand feature, which allowed them to stop and restart the program as needed. A few, however, referenced technical difficulties with the webinar.

Content

HCWs also indicated that general information about mantram repetition and information regarding the benefits of the intervention (eg, stress reduction) were useful. The scientific basis of mantram was described as useful by some, though others reported it as least useful. Practical guidance regarding the appropriate time and place to practice a mantram as well as concrete information regarding how to select a mantram was mentioned as the most useful by other participants.

Professional and Personal Empowerment

Professional and personal empowerment was referenced in evaluations. Professional development, such as learning a strategy for enhancing work performance, was reported as positive. HCWs also reported that learning a new strategy for self-care and coping with stress was useful. Some described having experienced a sense of validation by participating in the course that was empowering. Finally, some HCWs indicated the personal growth experienced as the most useful.

Religion and Spirituality

General statements regarding the utility of having learned a spiritually-based practice that crossed religious boundaries as well as general references to the power of prayer were listed in the feedback. Other HCWs indicated the usefulness of having learned that a mantram could be secular.

Ease of Mantram

HCWs referenced the ease with which a mantram can be learned and/or practiced. Course participants described the simplicity of mantram repetition and referenced its portability (ie, it can be practiced in many different settings). Finally, the overall flexibility of mantram practice of where and when it can be performed was also described as useful.

DISCUSSION

Qualitative feedback from participant evaluations of a 90-minute, virtual online MRP course suggests that HCWs representing all areas of care are interested in learning practical strategies for managing workplace stress. Participants overwhelmingly perceived mantram practice as feasible to implement, with the portability of mantram repetition described as particularly useful. This aspect of mantram repetition represents a distinct advantage over meditative interventions that require a dedicated space and time in which to practice (eg, yoga postures, sitting meditation).

These preliminary findings also suggest that mantram practice is acceptable to HCWs representing a variety of roles.

Participants indicated that they valued learning a meditative practice that can be interpreted as spiritual or secular, depending on the word or phrase chosen. Only 1 participant reported that the practice of mantram conflicted with his/her personal beliefs. A small minority of participants who found the discussion of spirituality disconcerting nevertheless indicated that the intervention was acceptable to them.

The finding that even a 90-minute course was challenging for some HCWs to accommodate speaks to the importance of developing short-duration stress-reduction programs. The standardized Mindfulness Based Stress Reduction (MBSR) program consists of 8 weekly 2.5-hour sessions and a full-day retreat for an overall commitment of 29 to 33 hours.[31] Additionally, a systematic review of meditative interventions for informal and professional caregivers found that programs ranged from 4 to 8 weeks.[15] These lengthier programs are likely more challenging than the condensed MRP.

These results also suggest the importance of general guidelines for meditative intervention courses for reducing HCW stress. The mode of delivery should be as flexible as possible, allowing course participants to start, stop, and restart the program as needed and to participate from a location most convenient to them. Although presenting evidence for clinical effectiveness is critical for establishing credibility, statistical data should be briefly summarized. An experiential component in which participants are encouraged to practice the intervention will enhance learning and ensure the translation of knowledge into practice. Finally, framing meditative practices as compatible with many different faiths and/or secular will enhance their acceptability.

Three recommended components of an overall strategy for reducing occupational burnout in health care settings include modifying the organizational structure and work processes, improving the fit between the organization and HCWs, and promoting and allowing time for individuals to learn strategies for coping with work-related stress.[32] This 90-minute online MRP course represents an aspect of an overall strategy to reduce HCW stress and burnout. Providing opportunities for HCWs to learn strategies for managing stress could enhance the quality of care and improve patient outcomes. Future pragmatic trials could determine whether mantram practice impacts clinical care at the VA and elsewhere.

Limitations

All participants were self-selected; therefore, the findings may be biased favorably toward the intervention. These qualitative analyses are not generalizable. HCWs in other, non-VA settings might have different needs and/or stressors that should be considered in future program development. If this intervention is offered to a wider audience, then other formats ought to be offered, such as print, at-home recordings, live meeting, and face-to-face.

CONCLUSION

Course participants reported that the condensed 90-minute virtual MRP was convenient to complete. They described the intervention as flexible and easy to learn. Participants indicated that they intended to implement what they learned in the course to reduce work-related stress. This feedback can be used to recommend guidelines for developing meditative interventions aimed at reducing stress in HCWs.

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Disclaimer

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