Transcendental Meditation was found to be valuable in the treatment of a variety of psychiatric and addictive disorders in a vocational rehabilitation unit. At follow-up after discharge from the unit, patients who had learned Transcendental Meditation were found to be more often employed and more frequently maintained on outpatient care alone than non-meditating patients.

The following is the text of the original paper which was presented at the Annual Convention of the American Psychological Association, Los Angeles, California, U.S.A., August 24, 1981.

The value of the Transcendental Meditation (TM) technique as a self-help support system in a vocational rehabilitation unit was assessed. Approximately half of all patients in the unit were psychiatric, while the remainder were addicts (drug, alcohol, and gambling). The TM technique had been offered to patients in the unit on an optional basis for several years, and a proportion of patients had learnt the technique. The clinical impression was that patients who practiced TM improved in a global sense more rapidly than those who did not.
In a follow-up study of patients who had been discharged from the unit for at least two months, it was found that patients who had learned the TM technique were more often employed or between jobs \((p < .01)\) and were more often receiving only outpatient care \((p < .01)\) as compared to those patients who had not learned the technique. The TM group showed a zero incidence of imprisonment compared to a 10% incidence in the non-TM group.

These findings are in agreement with previous studies on the benefits of the TM technique in rehabilitation, and can be explained on the basis of the reductions in anxiety and stress, and the improvements in creativity, personal integration, and self-actualization known to occur with the practice of TM.

It is concluded that Transcendental Meditation is not just a self-help support system but is a meta-support system which allows better use to be made of various existing support systems through the reduction of stress and the increasing ability to self-actualize as a human being.

**INTRODUCTION**

Much of what applied psychologists do is related to the attempt to eliminate symptoms or at least reduce symptoms to a manageable level. Development of constructive support systems where deficient or nonexistent, seems at least as important as symptom reduction in maintaining or establishing long-term mental health. Employment is probably the largest single support system available to the majority of people suffering from mental or emotional disorders. At Cleveland VA Hospital it was noted prior to 1972 that patients who were discharged with a job in hand had a lower recidivism rate than those who were discharged with no job to go to. After the Vocational Rehabilitation Unit was established, it quickly became apparent that many patients were able to work in the community but were totally or partially dependent on the Medical Center to maintain the rest of their lives.

About half our patients on the Vocational Rehabilitation Unit are addicts (drug, alcohol, gambling) and the other half psychiatric. Large proportions of these patients, especially the addicts, had burned their bridges (support systems) behind them. We very quickly began to cast about for additional support systems to allow patients to more comfortably make the transition from living in a hospital to living in the community. All the traditional support systems like Alcoholics Anonymous, Gamblers Anonymous, Recovery Inc., singles groups, churches, activities groups (bowling, bridge, chess clubs, etc.) were tried and proven useful to a greater or lesser extent.

I would like to focus on one of the not so traditional support systems that we experimented with, namely, Transcendental Meditation. TM was used both as a support system and as an adjunct to other therapies. It may be useful to go over the way patients were instructed in TM. The author originally presented reasons why a patient might be interested in starting TM. This included some of the research documenting benefits of TM. Initially this was done in ward government meetings. Interested patients were told where and when introductory TM lectures could be attended in the community. Occasionally a TM teacher would come out to the hospital to give one or two lectures. Payment of course fees might have been a problem since the majority of patients on the Vocational Rehabilitation Unit were indigent. Resolution of lack of funds came in several forms. The International Meditation Society charged a reduced rate, the college student rate, mainly, because the author would do most of the follow-up after instruction in the form of checking meditation regularly. The local office of the Ohio Bureau of Vocational Rehabilitation, located physically on the Vocational Rehabilitation Unit, offered to pay for a portion of the instruction fee if TM were made part of the patients vocational plan. The author insisted that the veteran pay for a portion of the instruction fee out of his own resources. This amount was typically about a fourth of the instruction fee. This amount could be earned at the Medical Center while participating in work-for-pay therapies. Next, patients had to arrange to get to the TM center for lectures and instruction. This was not always easy as the center is located 20 miles from the Medical Center.

TM purports to mentally and physically remove stress from the practitioner's system. If true, this would naturally lead to increasing levels of integration for the individual regularly practicing the TM technique. In contrast, psychiatric medication allows one to tolerate the amount of stress he already has.
in his system and for many patients, psychiatric medication increases stress by causing unwanted side effects. In addition many forms of psychotherapy are oriented toward coping with stress or avoiding incurring further stress. Perhaps only some cathartic therapies actually relieve or reduce stress while others (biofeedback and stress management techniques) only regulate or manage stress much like chemotherapy.

The question then became, “Was TM really helping the veterans who added it to their other therapies?” The author’s clinical impression was that patients who did TM improved in a global sense more rapidly than those who didn’t. However, there was always the nagging doubt that perhaps his own involvement with the practice of the TM technique may have led to that bias. In addition, BVR supervisors and management wanted to know if their investment of state money into clients’ practice of TM was warranted.

**METHOD**

During the summer of 1979 it was decided to do a general evaluation of the effectiveness of the Vocational Rehabilitation Unit by attempting to contact all inpatients who had participated in the program since its inception in October of 1972. It was decided to contact all patients who had been discharged at least two months and to ask additional questions of those who had learned TM. On the basis of a few simple questions both the patients who had learned TM and those who had not were classified into one of five rough categories of descending order of social integration. In the first category were those who at the time of follow-up were employed or engaged in vocational training (including college). The second category included those who had worked, or since discharge, but who at the time of follow-up were not employed and were actively looking for work. This category was termed, “Between Jobs”. The third category entitled, “No Job”, included those who had never worked since discharge and who considered themselves, “too sick to work”. These patients were, nevertheless outpatients at the time of the follow-up. The fourth category included patients who were still inpatients in our Medical Center (though on a different ward), those who had been readmitted to our Medical Center or another hospital and those who had earned the privilege of living in prison at the time of follow-up. This group was labeled “Incarcerated”. The final category was labeled simply “Deceased”.

**RESULTS**

In table I, within each cell, the first number is the actual number of patients classified in that cell while the second number represents the percentage along each row. It is readily apparent that those patients who learned the TM technique were relatively more often employed or between jobs as compared to those who had not learned the TM technique and less often incarcerated or deceased. The \( x^2 \) for the five by two table was significant at the .05 level. Collapsing across rows from table I, in such a way that those patients who had worked from one group while those who had not from the other, we get table II. Clearly, those who learned TM were vocationally more productive than those who did not. Collapsing across rows from table I into outpatients and non-outpatients we get table III. It can be seen that those who learn TM are proportionally more often outpatients compared to those who do not learn TM. Finally, comparing patients who were alive versus deceased at the time of follow-up we get table IV. There is a tendency (short of .05 significance) for those instructed in TM to be relatively more frequently alive at the time of follow-up.

A few comments about the incarcerated and deceased cells in table I. Among the TM group, of the four patients incarcerated at the time of follow-up, all were in a psychiatric hospital and none in jail or prison. On the other hand, of those who did not learn the TM technique, fully half of the 48 incarcerated at the time of follow-up were in jail or prison. Presumably, those who violate society’s rules

<table>
<thead>
<tr>
<th></th>
<th>JOB</th>
<th>BETWEEN JOBS</th>
<th>NO JOB</th>
<th>INCARCERATED</th>
<th>DECEASED</th>
<th>TOTAL</th>
<th>SAMPLE SIZE</th>
</tr>
</thead>
<tbody>
<tr>
<td>TM</td>
<td>20 (48)</td>
<td>9 (21)</td>
<td>6 (14)</td>
<td>4 (10)</td>
<td>3 (07)</td>
<td>42</td>
<td>92</td>
</tr>
<tr>
<td>No TM</td>
<td>81 (35)</td>
<td>24 (10)</td>
<td>40 (17)</td>
<td>48 (21)</td>
<td>40 (17)</td>
<td>233</td>
<td>667</td>
</tr>
<tr>
<td>Total</td>
<td>101</td>
<td>33</td>
<td>46</td>
<td>52</td>
<td>43</td>
<td>275</td>
<td>759</td>
</tr>
</tbody>
</table>

\( x^2 = 10.0, 4 \text{ df}, p<.05 \)
enough to wind up in jail or prison are more socially disruptive than those who present themselves for psychiatric treatment. All three patients who had started TM but died prior to the time of follow-up were employed at the time of their death. By comparison, only a dozen of the 40 patients who had not learned TM and were deceased at the time of follow-up could have been classified in either the Job or Between Jobs categories had they not died. Frequencies in these last two cells are too low, especially in the TM group to draw hard conclusions, nonetheless, close examination of these patients has been suggestive.

**DISCUSSION**

There are two obvious interpretations to this data: 1. Patients who learn TM become better integrated and on the average function at a higher level because of their practice of the TM technique. 2. Patients who are initially better integrated are more likely to become motivated to start TM. TM was used as a treatment modality on the Vocational Rehabilitation Unit. The research on which this paper is based was part of ongoing institutional research which tends to come after the fact as opposed to being planned. Therefore the question of whether those trained in the TM technique were better integrated initially on the average, is difficult to assess at this late date. The author's clinical impression was that those who started TM were a representative sample of patients who had been on the Vocational Rehabilitation Unit over the seven years it had been open. During that time the VRU patient population was composed of roughly half psychiatric patients and half addicts. Of the addicts, approximately 55% have been alcoholics, 35% drug addicts, and about 10% compulsive gamblers. Of the psychiatric patients, about 55 – 60% were diagnosed schizophrenic and the rest other psychiatric disorders. In the follow-up sample of those who learned TM, 26 of 42 were psychiatric patients, 15 of whose primary diagnosis was schizophrenia. Of the addicts, 10 were alcoholic and 3 each drug addicts and compulsive gamblers. If anything, there was an overrepresentation of psychiatric and schizophrenic patients in the sample. Seven of the schizophrenic patients had spent half or more of their adult lives in psychiatric hospitals.

The findings of this study generally agree with the findings of Glueck and Stroebel (1975). They found patients adding TM to their treatment programs were significantly more improved and displayed less pathology on discharge than a matched comparison group. The present study shows that such improvements hold up over time after discharge when follow-up is done in the community. Reasons for higher proportion of patients who learned TM holding jobs on follow-up may be provided by Frew (1974):

TM would appear to be positively related to productivity—Meditators report that they experience more job satisfaction, improved performance, less desire to change job (turnover), better interpersonal relationships, and a decreased climbing orientation.

In general, the practice of TM appears to reduce stress, particularly in the form of anxiety (Nidich, Seeman, and Siebert, 1973; Davies, 1974; Stern, 1974) and to increase self-actualization (Seeman, Nidich, and Banta, 1972; Shapiro, 1974). Fehr (1974) found that the regular practice of TM led to, "... a reduction in neuroticism ... followed by the growth of creativity and integration throughout the rest of the first year of practice." Most of these pieces of research were paper and pencil test measures. The research under consideration today indicates the
gains in self-actualization and personal integration also carry over into real world activities.

To summarize, we can conclude that the regular practice of TM is not just a self-help support system but is a meta-support system. Its practice allows patients to make better use of support systems like a vocation, and various helping or interest groups by reducing stress (particularly anxiety) and increasing the ability to self-actualize as a human being.

REFERENCES


