

Engagement in a Community-Based
Integral Practice Program Enhances Well-Being

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Abstract

This project examined associations between engagement in a community-based integral practice program and measures of health and well-being. In this prospective within-subjects uncontrolled cohort study, 53 participants of Integral Transformative Practice (ITP), a program that incorporates movement, nutritional and exercise recommendations, affirmations, contemplative introspection, theory and philosophy, and group discussions and activities, were followed over one year. Participants completed online questionnaires upon enrollment, at six months, and one year later. Repeated measures analyses showed that participants reported improved overall health and reduced symptoms of ill health, as well as increased psychological well-being, vitality, and quality of life over the course of the year. Greater involvement in the practice community predicted better psychological well-being, increased quality of life, and greater self-transcendence. Self-transcendence mediated the relationship between level of ITP involvement and psychological well-being outcomes, and predicted physical health outcomes, suggesting that this construct may be important to the effectiveness of participating in wellness interventions.

Key Words: psychological well-being, health, transformative practice, integral, spirituality, self-transcendence

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How do people make positive changes in their lives? When confronted with stress, emotional difficulties, physical ailments, or life transitions, many people seek the help a medical or psychological professional, or a clergy person. They may engage in religious or spiritual practices, diet and exercise regimens, or educational programs. They might join a gym, seek psychotherapy, join a church or a secular group, take up a hobby, or begin a meditation or yoga practice, all with the goal of increased well-being.

The way that people care for various aspects of their well-being is often fragmented: in general, the physical body is attended to by diet, exercise, and the health care system, the mental/emotional aspects of the self are attended to by friends and family, formal education, or by mental health professionals - the vast majority of the latter employing “talk” therapy. Spiritual or existential needs may be addressed by involvement in organized religion or a spiritual practice.

However, there is a growing awareness among health and healing professionals that attending simultaneously to multiple dimensions of being may hold greater potential for health, healing, and quality of life than attending separately to single aspects (Ferrer, 2003; Schlitz, Amorok, & Micozzi, 2005). In a growing paradigm described as *integral*, spiritual teachers, psychologists, health care providers, and theorists have noted that attending to physical, mental, emotional, *and* spiritual aspects of being in an integrated fashion, particularly in the context of community, may be optimal for achieving psychological well-being (Aurobindo, 1993; Engel, 1977; Farias, Underwood, & Claridge, 2013; Ferrer, 2003; Ginting, Naring, Kwakkenbos, &

Becker, 2014; H. G. Koenig et al., 2014; Leonard & Murphy, 2005; Schlitz et al., 2005; Short, 2006; Wilber, Patten, Leonard, & Morelli, 2008).

A number of community-based programs (that is, programs that are not part of the conventional healthcare system or of formal organized institutions such as a workplace, church or school) have been developed that attempt to integrate physical, psychological, emotional, and spiritual practices for well-being into a cohesive program (Luskin, 2004). Whether short-term (such as a weekend workshop), or longer lasting (months or years), these integrated practice programs offer participants a community of like-minded people, a set of individual and group activities, a narrative about the nature of reality, and a theoretical pathway to personal growth. Oftentimes, programs request that participants make a commitment to a prescribed set of practices, as well as out-of-pocket fees to support the program. People may select a program because they encounter a book or website describing the program, or receive a recommendation from a professional or a trusted friend.

Comprehensive programs for health promotion that incorporate health care, nutrition, exercise, and stress management in the workplace have shown benefit and cost-effectiveness (Pelletier, 2001). Very little research exists on community-based programs however. Most of the existing literature on community-based self-improvement programs focuses on those that address a specific ailment or issue. Twelve-step programs, such as Alcoholics Anonymous, may represent the best known and largest community-based program, with an estimated 2.1 million people attending AA meetings in 115,000 locations worldwide. Empirical research on AA indicates modest positive effects on alcohol dependence, but few studies have examined the effects of participation in AA on overall health and quality of life, and many studies have been of inadequate methodological quality (Tonigan, Connors, & Miller, 2003). In another example of

an issue-specific transformative practice program, the Dean Ornish lifestyle program, which integrates stress-management, diet, exercise, and group support for people experiencing coronary artery disease, was shown to have beneficial outcomes that were sustained through a five-year follow-up (Koertge et al., 2003; Ornish et al., 1998).

In general, religious/spiritual involvement has been linked to greater physical and mental health, (Ellison & Levin, 1998; Goyal et al., 2014; Gu, Strauss, Bond, & Cavanagh, 2015; Harold G. Koenig, 2004; Levin & Chatters, 1998; Strauss, Cavanagh, Oliver, & Pettman, 2014) and health-related physiological processes (Galante, Galante, Bekkers, & Gallacher, 2014; Seeman, Dubin, & Seeman, 2003). For example, there is a large body of literature on the health and well-being effects of Transcendental Meditation (Rainforth et al., 2007; Travis et al., 2010), mindfulness-based programs (Baer, 2003; Grossman, 2004) and other forms of meditation (Cahn & Polich, 2006; Galante et al., 2014; Murphy & Donovan, 1999) and some empirical studies on outcomes of various types of yoga and martial arts (Bushell, 2009; J. Fuller, 1988; Kirkwood, 2005; Pilkington, Kirkwood, Rampes, & Richardson, 2005). However, few empirical studies have focused on community-based programs that integrate mind-body practices from different wisdom traditions, have multiple teachers, and provide health recommendations combined with other psychological, emotional, or spiritual methods for improving well-being.

There is some evidence that these multi-component community-based self-improvement programs hold promise for improving health and well-being. A study of a ten-day “emotional education program,” called the Hoffman Process, which includes mind, body, and spiritual aspects, showed that participation in the program was associated with declines in negative affect and depressive symptoms, and increases in positive outcomes such as life satisfaction, empathy, mastery, and emotional intelligence, and that these changes were sustained at a one-year follow-

up (Levenson, Aldwin, & Yancura, 2006). Furthermore, the study showed that increases in forgiveness and spirituality mediated the effect of program participation on depressive symptoms. Very few other empirical studies of such programs exist.

Our previous research indicated that subjective retrospective reports of spiritual transformation identified less identification with ego, increased sense of meaning and purpose, and feeling part of a greater whole were essential to increasing well-being. The current study sought to examine prospectively how participation in Integral Transformative Practice (ITP), a community-based integral practice program (see Appendices A and B for a description of the ITP Program) was associated with health and well-being, and if so to investigate to what extent self-transcendence mediated such effects. Rather than determining efficacy in comparison to an active control, this pilot project sought to establish the promise of the program, and to develop appropriate measures, sample size estimates, and meditational hypotheses for a future randomized-controlled trial. Our objectives were to explore 1) whether participation in the program would be associated with measurable improvements in health and well-being over the course of a year; 2) whether amount or type of practice and involvement would be positively associated with greater improvements; and 3) to examine if variables related to spirituality, such as self-transcendence, would mediate the relationship between engagement in the program and measures of health and well-being.

Methods

Participants

Participants were 62 adults recruited from nine different ITP groups in the United States who were asked to complete a battery of measures three times over the course of one-year: upon

enrollment, six-months later, and one-year later. Using several approaches to enhance retention, such as small gifts, thank you notes, and birthday greetings, 86% of the sample was retained at the one-year measurement point. Of 9 people who dropped out, seven dropped out of the ITP program, and two did not wish to complete the survey. The locations included Berkeley, CA, Columbus, OH, Crystal Lake, IL, Houston, TX, Mill Valley, CA, Palo Alto, CA, Seattle, WA, Tulsa, OK, and Walnut Creek, CA.

Participants (see Table 1) who completed the study were 65% female, had a mean age of 55 ($SD = 10.2$), and 45% were married or had a long-term live-in partner (35% separated or divorced). Ninety-six percent of the sample was White/Caucasian, most had completed college and some graduate education, and the mean gross family income was \$167,244 ($SD = \$54,789$). Fifty percent of the participants were professionals, 15% were business owners or entrepreneurs, and 7% were in management/sales or administration, with the remainder in other occupations or retired. One-third of the sample lived in urban areas, two-thirds in suburban areas, and one person in a rural area.

Over half (59%) of the participants were in their first or second year of participating in the ITP program. Fifteen people reported being new to ITP, and another 22 were in their second year. Thirteen percent had been practicing ITP for three years, 10% for four years, 5% each for between five to seven and seven to ten years, and 4% for over ten years. Forty-seven percent reported an upbringing that was deeply religious or spiritual, and another 43% reported a moderately spiritual or religious upbringing, whereas the remaining ten percent rated the extent of their religious or spiritual upbringing as little or very little.

Measures

Demographics and history. Demographics including age, ethnicity, income, education, marital status, and region were collected at baseline. Historical engagement in ITP and other spiritual or transformative practices was measured with questions such as, “have you engaged in a meditation practice prior to ITP? If so, how often did you meditate? For how many months or years did you engage regularly in this practice?”

Level of engagement. Involvement in ITP and other self-improvement practices were measured using investigator-developed scales that asked participants to report on the quantity, frequency, and type of practices they used during the 90 days prior to each measurement point. Quantity of Practice was operationalized as the number of days in the 90 days prior to completing the survey that participants engaged in ITP activities. Because quantity and frequency may not necessarily reflect participants’ subjective involvement of the practice, we also asked participants to rate their overall perceived level of involvement (e.g. “Over the last 90 days, to what extent do you consider yourself involved in your transformative practice?”).

General physical health. Self-reported overall health was measured using one-item “Thinking back over the past month, how would you say your general health has been?” This global self-rating of general health has been shown to be reliably associated with mortality and survival in large samples, with predictive power over and above other methods of assessing health, such as physicians’ ratings (Idler & Benyamini, 1997).

Health symptoms. Physical symptoms were assessed using a thirteen-item health symptom checklist asking participants to report how often they had any of the following in the past month: headaches, faintness/dizziness, stomachache/pain, shortness of breath, chest pain, acne/skin irritation, runny/congested nose, stiff or sore muscles, stomach upset/nausea, irritable bowels, hot or cold spells, poor appetite, coughing/sore throat, or other. This measure is a

reliable and valid index of self-perceived health status that has been used in previous research (Elliot & Sheldon, 1998; Emmons, 1992; Emmons & McCullough, 2003; Pennebaker, 1982).

Psychological well-being. The Psychological General Well-Being Index (PGWBI) (Dupuy, 1984) is a 22-item questionnaire assessing subjective psychological well-being or distress. It contains validated subscales for Anxiety, Depressed Mood, Positive Well-Being, Self-Control, General Health, and Vitality. Internal consistencies for the subscales ranged from 0.72 - 0.88, and for the overall index, 0.94. The scale was validated in large public health samples, demonstrating high concurrent validity with longer scales. Test-retest reliabilities ranged from .50 - .86 depending on length between tests, demonstrating both stability and sensitivity to change over time (Dupuy, 1984).

Stress. The 10-item Perceived Stress Scale (PSS) (S. Cohen & Williamson, 1988) was used to measure stress. It is the most widely used measure to assess the degree to which life circumstances are appraised as stressful, and demonstrates excellent reliability, and concurrent, predictive, and discriminant validity (S. Cohen & Janicki-Deverts, In press).

Quality of life. The Quality of Life Scale (QOLS) (Burckhardt & Anderson, 2003; Burckhardt, Woods, Schultz, & Ziebarth, 1989) is a 16-item instrument that requests that respondents rate their satisfaction with five conceptual domains of quality of life: material and physical well-being, relationships with other people, social, community and civic activities, personal development and fulfillment, and recreation, as delighted, pleased, mostly satisfied, mixed, mostly dissatisfied, unhappy, or terrible. It demonstrates high convergent and discriminant validity, and high internal consistency (0.82 – 0.92), and three-week test re-test reliability (0.78 – 0.84) while still being sensitive to change over time (Burckhardt & Anderson, 2003).

Self-transcendence. The Adult Self-Transcendence Inventory (ASTI) (Levenson, Jennings, Aldwin, & Shiraishi, 2005) was used to measure “self-transcendence,” a term used to describe (a) a desire to discover meaning in human life (Frankl, 2000), (b) a growing spirituality involving both an expansion of boundaries and an increased appreciation of the present (Reed, 1991), or (c) a developmental process that forms a pathway to wisdom (Levenson, Aldwin, & Cupertino, 2001). Representative items are “I often engage in quiet contemplation,” or “I feel that my individual life is a part of a greater whole,” and “Different parts of me are often at cross purposes” (reverse-scored). The ASTI demonstrates good internal consistency ($\alpha = 0.64 - 0.75$), and is correlated with personality in expected directions, but only modestly, supporting its validity as an independent construct. Scores on the ASTI are positively correlated to experience with meditation practice ($r = .30, p < .001$) (Levenson et al., 2005).

Daily Spiritual Experiences/Religiosity/Spirituality. Spiritual variables were measured using a modified version of the Brief Multidimensional Measure of Religiousness/Spirituality (BMMRS) (*Multidimensional Measurement of Religiousness/Spirituality for Use in Health Research. A Report of the Fetzer Institute/National Institute on Aging Working Group, 1999; Traphagan, 2005*), which includes questions about Daily Spiritual Experiences, Meaning, Values/Beliefs, Forgiveness, Private Religious Practices, Religious and Spiritual Coping, Religious Support, Religious/Spiritual History, and Commitment. This instrument measures multiple aspects of religiousness and spirituality including religious and spiritual activities, beliefs, and identities, as opposed to previous measures that had focused primarily on religious affiliation and church attendance. In this study, we particularly focused on scores from the BMMRS 6-item Daily Spiritual Experiences subscale (Underwood & Teresi, 2002) to measure the inner spiritual feelings and awareness that one experiences from day to day. In table 3, we

also report Meaning and Value subscale although data for this scale was not collected after 6-month practice. Since the DSE uses religious language that the participants in our study do not themselves use, we modified the scale to include relevant terms. Modifications were made in collaboration with representatives from the ITP program. Sample items with modifications in brackets are: “I feel comfort in my religion, spiritual tradition, [or transformative practice].” “I feel God’s [or a spiritual force’s] presence.” Participants were asked to rate the frequency of these and other experiences as occurring many times a day, every day, most days, some days, once in a while, or never or almost never.

Other measures not included in this paper that are the subject of a manuscript in preparation included an in-depth narrative of one past transformative experience (A. B. Cohen, Gruber, & Keltner, 2010; Shaver, Schwartz, Kirson, & O’Conner, 1987) cognitive appraisals related to the transformative experience (Smith & Ellsworth, 1985), positive and negative emotions experienced during the transformative experience (Watson, Clark, & Tellegen, 1988), and a number of qualitative, open-ended questions. One open-ended item “How have you changed in the past year?” assessed if participants reported positive changes in 1) mood, 2) awareness, 3) confidence, 4) alignment with values, 5) compassion for self and others, and 6) communication/relationships. .

Procedure

In this prospective, within-subjects design, participants were asked to complete online questionnaires upon enrollment in the study (baseline), six-months later (mid-year), and one year after enrollment (year-end). Prior to data collection, the survey items were reviewed with representatives from the ITP program to determine linguistic and programmatic relevance, and revised where appropriate. There was no comparison or control group.

Enrollment in this study coincided with the beginning of a year-long session in September 2006. People enrolling in the ITP program in their area were notified about the opportunity to participate in the study via emails from their local community group leaders and from the ITP central office. In addition, some ITP groups presented the opportunity to participate at their in-person local meetings. Interested participants enrolled in the project by phone or email and if interested in participating, were directed to an online survey link. Consent was obtained online. Participants were contacted by email or by phone six-months and one-year later to complete the same measures, with the exception of the historical information and demographics. At the end of the study, all questionnaire data were downloaded from the online survey software, processed, scored according to instructions for each scale, and analyzed using SPSS and Matlab Statistical Software. In all cases, we used test (Mauchly's sphericity for ANOVA; Kolmogorov Smirnov for t-test) implemented in the SPSS software to assess if it was appropriate to use a given test.

Results

Preliminary Analysis

Before testing the main hypotheses, we explored whether there were any baseline demographic differences between those who dropped out of the longitudinal survey and those who did not. We used a student t-test for continuous variables (age, height, weight) and sign test (also known as Wilcoxon test) for binary ones (gender; marital status). For other categorical variables, because of the small sample size – only 9 participants dropped out - we used a Fisher's exact test. All tests were performed two-tailed. No significant differences at the threshold $p < 0.05$

were identified between completers and drop-outs, including age, gender, height/weight, marital status, employment, ethnicity, education, income, or geographic region.

Repeated Measure Linear Trend Analysis

Repeated measures analyses of variance were performed to assess trends from baseline to 6-month and 12-month outcome measures. For each measure, data collection time was used a categorical predictor in the ANOVA. Results showed that participants experienced a significant reduction in health symptoms, improved general health, quality of life, and general psychological well-being. Three subscales of the General Psychological Well-Being Index improved significantly: vitality, positive well-being, and self-control. Table 2 provides the mean scores and repeated measures outcomes for each variable.

Relationship of Quantity and Involvement in Practice to Outcomes

Was the level of engagement in ITP activities in the period preceding the measurement points predictive of health and well-being outcomes? As Table 3 shows, the Number of Days of Practice prior to the measurement point was not significantly correlated with physical health outcomes, but it was positively associated with psychological well-being at the 12-month measurement point, quality of life at the 6 and 12-month measurement points, and was negatively correlated with perceived stress at the 6-month measurement point.

Furthermore, Perceived Level of Involvement with ITP was associated with higher quality of life, lower levels of perceived stress, higher self-transcendence, and more daily spiritual experiences at the 6-month measurement point, and with psychological well-being and self-transcendence at the 12-month measurement point. Reported engagement in ITP activities (e.g. actual activity in the last 90 days) appears to be an overlapping but distinct construct from perceived involvement (e.g. subjective level of involvement or importance of the practice in

one's life), with correlations ranging from 0.414 at the 6-month time point to 0.500 at the 12-month time point, so both measures of involvement were utilized in subsequent analyses.

Self-Transcendence Predicts Physical Health

A mediation analysis revealed that self-transcendence partially mediated the relationship between ITP involvement at 6 months and psychological well-being at 12 months (see Figure 1.A). In other words, increases in self-transcendence (See Appendix C for the items that make up the self-transcendence scale) in large part explain the improvements in psychological well-being. Furthermore, self-transcendence was a strong predictor of general physical health at all time points ($r = .286, p < .05$ at Time 1, $r = .409, p < .01$ at Time 2, $r = .302, p < .05$ at Time 3). A subsequent mediation analysis revealed that psychological well-being mediated the relationship between self-transcendence and general physical health, all at 12 months (see Figure 1.B).

Qualitative Outcomes

As indicated in the method section, we used open-ended questions to assess changes that might not have been captured by the questionnaire data. Answers to the open-ended question "How have you changed in the past year?" were qualitatively analyzed by two independent coders using a thematic analysis process in which they read through the responses, categorized similar or synonymous responses into themes, and then compared their themes for consensus. This resulted in six themes with at least three responses each including positive changes in: 1) mood, 2) awareness, 3) confidence, 4) alignment with values, 5) compassion for self and others, and 6) communication/relationships.

Discussion and Conclusion

These results indicate that overall health, psychological well-being, and quality of life improved over the course of a year among the ITP participants in this study. Quantity/frequency

of ITP activities and subjective level of engagement in ITP were correlated with psychological, but not with physical, health outcomes. Self-transcendence mediated the relationship between ITP involvement and psychological well-being, suggesting that finding greater peace, meaning, belonging, and connection to a greater whole may have accounted for improvements in overall psychological well-being.

We anticipated that higher level of engagement in ITP activities would directly predict increased physical health. This hypothesis was not supported. Though health did improve in the overall sample over the course of the year, it was not significantly related to the reported amount of practice. However, ITP involvement did directly predict increases in self-transcendence, which in turn predicted physical health. Furthermore, psychological well-being mediated the relationship between self-transcendence and physical health. Our qualitative results are notable because while many participants reported joining the program to enhance physical health, their reported salient outcomes lay more in the arena of positive psychological and social well-being. Our results indicate that these changes may have in fact facilitated the improvements observed in quantitative measures of physical health. Many neuroscientists believe in the somatic marker hypothesis (Damasio, 1994) in which psychological elements (memories, thoughts, and feelings) are rooted in the body. Therefore working with the mind, body, and spirit simultaneously could potentially alter physical health.

Our results support a hypothetical model in which involvement in integral practices leads to greater self-transcendence, which results in greater psychological well-being, and then leads to enhanced physical health. This leads us to speculate that perhaps the common notion that physical health should be attained first, and then psychological health, and then existential well-

being as a sort of “icing on the cake,” might be turned on its head. Perhaps existential well-being should be considered fundamental, leading to increased psychological health, and then increased physical health.

This notion is not without empirical and theoretical support. There is growing evidence that psychological well-being and happiness predict longer life expectancy (Yang, 2008). Cloninger et al. (1993), a pioneering researcher in neurobiology and genetics of personality and psychopathology, identified self-transcendence as one of seven dimensions of temperament and character. His model has demonstrated concurrent, discriminant, and predictive validity in multiple experiments, and genetic and neurobiological underpinnings have been identified for the temperament and character dimensions (Cloninger, 2004). After decades of research, Cloninger (2004) has concluded that “Prior approaches to feeling good have small or brief benefits because they separate the biological, psychological, social, and spiritual processes of living that must be in harmony for a happy life. (p. v)” He identifies self-transcendence as a developmentally advanced character trait that leads to greater personality coherence and well-being (Cloninger, Svrakic, & Svrakic, 1997).

Self-transcendence has been described by Levenson et al. (2005) as “a decreasing reliance on externals for definition of the self, increasing interiority and spirituality, and a greater sense of connectedness with past and future generations” (p. 127), and the authors identify this shift in self-identity as an essential component of wisdom. Interestingly, Kohls, Walach & Wirtz (2009) conclude from their research that spiritual *practices* may buffer one against the distress that can be caused by potentially stress-inducing spiritual *experiences* like ego loss or cognitive deconstruction (Conrada & Ashmore, 1999; Metzinger, 2010). It is possible that involvement in

a spiritual practice may support the process of self-transcendence, some aspects of which might otherwise be destabilizing.

An emerging field of research is showing that health behavior and emotional well-being cluster in social networks, and that health interventions can have a “contagious” effect in communities (Fowler JH & Christakis, 2008). The fact that this population showed increases in physical health at a mean age of 55 (sd 10.5) is promising. Previous work studying ITP participants showed significant improvements in cognitive abilities in seniors over 55 over the course of one year (Brassington, Luskin, DiNucci, & Haskell, 2003). Future research should explore whether engaging in an integrated program of mind-body practices in a supportive community holds the potential to buffer against declining mental and physical health with age, perhaps in comparison to involvement in secular communities or engagement in single practices.

The phenomenon of people participating in community-based self-improvement programs that incorporate spiritual practices and contemplative introspection, along with study and readings, discussions and activities, and nutrition and exercise recommendations, may reflect a societal movement toward an increasing number of people self-identifying as “spiritual but not religious.” (R. C. Fuller, 2001; Phillips, 2009). It is possible that such participation is taking the place of activities that used to be a part of involvement in one’s organized religion. It may also reflect a growing movement among individuals who are finding ways to improve their health and well-being outside of the conventional healthcare system.

Limitations of this study include a small sample size, lack of a comparison/control group, reliance on self-report and retrospective recall measures, and analyses that were primarily correlational. In addition, this was a relatively homogeneous, high-income sample, which may limit generalizability to other populations. While there was adequate retention over the course of

the year, with a 16% drop-out rate and no significant differences between drop-outs and study-completers on baseline variables, it may be that people who did not complete the year-long ITP program experienced fewer benefits than those who remained in the program. Future research utilizing a randomized controlled design and intent-to-treat analysis is warranted.

Learning more about how effective community-based integral practice programs are in promoting health and personal development in their participants, what specific elements of the programs account for the outcomes observed, by what mechanisms these changes occur, and how background and inherent characteristics of participants affect the outcomes, may provide useful information for developing new community-based health and well-being programs. Through engagement in integral practice communities, perhaps there are greater potentials for health, well-being, and quality of life as people age than was previously thought possible.

Conflicts of Interest

The authors declare no competing interests.

Authors Contributions

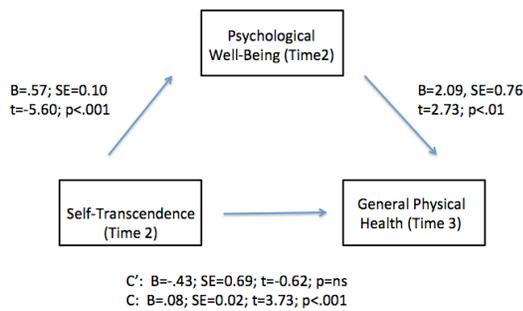
CV was responsible for the overall design and implementation of the study, ME conducted the bulk of the statistical analysis, AC participated in the selection of measures and interpretation and reporting of results, AD and DR assisted with manuscript preparation, statistical analysis and interpretation of results, and MMS participated in the design of the study.

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A



B

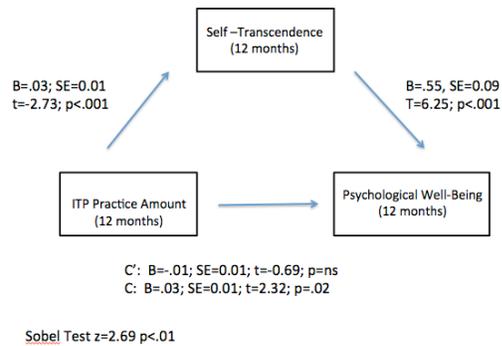


Figure 1: Mediation analyses. A. Self-Transcendence mediates the relationship between ITP Practice Amount and Psychological Well-Being. All analyses were performed at Time 3 (12-months). B. Psychological Well-Being mediates the relationship between Self-Transcendence and General Physical Health. Self-Transcendence was assessed using the ASTI questionnaire and Psychological Well-Being was assessed using the PGWBI, both at Time 2 (6-months). Physical Health was assessed using General Health questionnaire at time 3 (12-months).

Appendix A. Integral Transformative Practice

When Michael Murphy, author and co-founder of the Esalen Institute, and George Leonard, a journalist/writer, fifth-degree black belt in Aikido, led personal growth workshops at Esalen and elsewhere, they observed that participants often experienced insights that resulted in temporary gains in health, well-being, and quality of life (Leonard & Murphy, 2005). However, these gains often rapidly faded as they returned to their ‘regular lives.’ To address this, they developed Integral Transformative Practice™ (ITP), a community-based integral practice program, and co-wrote “The Life We Are Given” (Leonard & Murphy, 2005) with the intention of providing a set of coherent practices in a supportive community environment for ongoing personal and social development.

ITP is *integral* in that the various aspects of the self are seen as complementary attributes of an underlying wholeness. It is *transformative* in that it aims at positive change in body, being or performance, or the manifestation of unrealized potentialities. And it is a *practice* in that it involves long-term, positive activities which, above and beyond any specific external rewards, are of value in and of themselves. The essence of ITP’s theoretical underpinnings is the philosophy of “evolutionary panentheism,” that of the divine being both immanent and transcendent to our world.

While ITP can be done on one’s own or with another person, it is customarily practiced in a group or community that meets weekly. At the core of the practice are nine commitments which include a 1) 40 minute series of physical exercises called the “kata”, which involves movement, rhythmic breathing, deep relaxation techniques, imagery, focused surrender, affirmations and meditation, 2) contemplative practice, 3) physical fitness training, 4) cognitive

development, and 5) a service component, (all of which are detailed in Appendix B), and 6) participation in Leonard Energy Training (LET) exercises, a set of practices derived from Aikido, for centering mind, body, and spirit through the exploration of one's subtle energy. ITP stands on four legs: theory & philosophy, practice, community, and research, and also distinguishes itself through the concept of multiple practices, multiple teachers, and multiple leaders.

Appendix B. The Nine Integral Transformative Practice Commitments

1. I take full responsibility for my practice and for all transformations of my body and being that flow from it. While respecting my teachers and fellow practitioners, I fully understand that I am the final authority.
 2. I seek to join in commitments with other ITP practitioners. While maintaining my individual autonomy and authority, I commit myself to my ITP community in vision and practice. I understand that just two people can make a community. I also know that I can create a community through electronic networks, or even practice alone, bolstered by the greater ITP community.
 3. I do the ITP Kata at least five times a week. I understand that, time permitting, I can lengthen any part of the Kata, and that extended periods of meditation at the end of the Kata and at other times of the day are recommended.
 4. I accomplish at least three hours of aerobic exercise every week in increments of no less than twenty minutes. Three sessions of strength training a week are also recommended, but there is no commitment on this.
 5. I am conscious of everything I eat.
 6. I develop my intellectual powers by reading, writing, and discussion. I thoughtfully consider the visions and the readings set forth in chapter 12 and, commensurate with my own best judgment, seek to integrate cognitive understanding into my practice.
 7. I open my heart to others in love and service. I stay current in expressing my feelings to those close to me and take care of my emotional needs in appropriate and healthy ways, seeking counsel when needed.
 8. For each six- to twelve-month period, I make at least one affirmation having to do with significant positive change in my own being. I also make the following affirmation: “My entire being is balanced, vital, and healthy.” I include my affirmations during transformative imaging in my Kata and seek in appropriate and healthy ways to realize those affirmations.
 9. I am dedicated to finding ways of reaching out and offering help to those in need. I understand that an important part of Integral Transformative Practice is to help ameliorate the unnecessary waste and suffering in the world and advance the evolution of our species and society to a more balanced, more peaceful, more joyful condition.
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Table 1.
Participant Characteristics

Variable	Percentage of Participants (N=53)
<i>Gender</i>	
Male	35%
Female	65%
<i>Age (M/sd)</i>	
	55 (10.2)
<i>Marital Status</i>	
Never Married	18%
Married or Long term live in partner	45%
Separated or divorced	35%
Widowed	2%
<i>Occupation/Profession</i>	
Homemaker	3%
Professional	50%
Tradesperson	0%
Management/Sales	7%
Administration	5%
Business Owner/ Entrepreneur	15%
Service Profession	3%
Unemployed or Unable to Work	2%
Other	16%
<i>Ethnicity</i>	
White	96%
Latino/Hispanic	4%
<i>Formal Education (yrs) (M/sd)</i>	
	17 (2.2)
<i>Gross Annual Income (M/sd)</i>	
	\$167,244 (\$54,789)
<i>Geographical Location</i>	
Urban	31%
Suburban	67%
Rural	2%
<i>Years in ITP (M/sd)</i>	
	13.6 (12.8)
First Year	24%
Second Year	35%
Third Year	13%
Fourth Year	10%
Five – Seven Years	5%
Seven to Ten Years	5%
Over Ten Years	8%
<i>Religious Upbringing</i>	
0 Not at all	0%
1	4%
2	6%
3	24%
4	19%
5 Deeply	47%

Table 2. Repeated measure linear trend analysis of self-reported health, well-being, and transformative experience.

Dependent Variables	Means			F	df	Sig.
	Baseline	6-months	12-months			
Health Symptoms	206.00	219.00	234.00	8.99	(1, 46)	p< .01
General Health	10.75	11.10	11.69	7.65	(1, 47)	p<.001
Psychological Well-Being	80.19	81.43	85.83	15.17	(1,47)	p<.001
Vitality (Subscale)	13.59	13.90	14.56	11.43	(1, 47)	P<.001
Positive Well-Being (Subscale)	13.98	13.90	14.77	4.59	(1,47)	p<.05
Self Control (Subscale)	12.27	12.43	13.01	13.71	(1,47)	p<.001
Quality of Life	88.06	89.82	91.20	4.59	(1,46)	p<.05
Perceived Stress	13.71	13.13	13.98	--	(1,47)	ns
Self Transcendence	134.9	134.7	137.5	3.11	(1,46)	p<0.08
Daily Spiritual Experiences	15.51	16.44	16.07	--	(1,47)	ns

Table 3. Pearson correlations between reported frequency/quantity and subjective level of engagement in ITP practice over 30 days prior to measurement point with health, well-being, and spiritual outcomes.

	Health Symptoms	General Health	Psych Well-Being	Quality of Life	Perceived Stress	Self Transcendence	Daily Spiritual Experiences	Meaning and Value
Six-Months								
Total Activity Days in Past 3 Months	.174	.085	.252	.307*	-.298*	.434**	.338*	not assessed
Subjective Level of Engagement	.226	.041	.172	.430**	-.284*	.430**	.447**	not assessed
Twelve Months								
Total Activity Days in Past 3 Months	-.019	.002	.315*	.307*	-.220	.363*	.564**	.395**
Subjective Level of Engagement	.122	.130	.285*	.223	-.212	.313*	.257	.373**

Note: * $p < .05$ (two-tailed); ** $p < .01$ (two-tailed).

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