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CLINICAL USES OF MINDFULNESS TRAINING FOR OLDER PEOPLE

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Abstract. Mindfulness training (MT) is a meditation-based approach that, on its own or in alliance with cognitive therapy, can effectively impact on several therapeutic targets such as recurrent depression, some anxiety problems, and chronic physical pain. This article outlines how mindfulness training complements cognitive-behavioural therapy (CBT), and why it may be particularly useful to older people. The range of potential applications of MT is examined, followed by considerations of the evidence to date and both the advantages and dangers of current developments within the various MT programmes. The author's ongoing research on Mindfulness-based Cognitive Therapy (MBCT) for older people with recurring depression is described, as is the use of Mindfulness-based Stress Reduction (MBSR) in routine clinical practice. Suggestions are provided regarding future research into the range of applications of MT with older people.

Keywords: Mindfulness, stress, anxiety, pain, depression, meditation.

Introduction: The development of mindfulness training

The roots of MT lie in spiritual traditions that are intensely practical. Mindfulness meditation is a central plank of Buddhist approaches to suffering, which is viewed as largely due to mental habits of clinging to what is pleasant and trying to reject what is perceived to be aversive. This can result in difficulty remaining in full contact with present reality and a futile preoccupation with past, future or elsewhere. Few cognitive therapists would have difficulty relating this to their patients' experiences. MT was devised by Kabat-Zinn (1990, 2003) in the form of Mindfulness-based Stress Reduction (MBSR), an eight-session course that teaches participants to become more aware of their mental processes and to develop attentional control. These include: body-focused attention, shifting focus between different kinds of mental content, and mindful walking. Equal emphasis is placed on extending mindfulness to ordinary activities and on bringing gentleness and self-acceptance to the practice.

Most MBSR courses are associated with further optional meetings, often called "graduate classes". This fits with findings that maintenance cognitive therapy is helpful following completion of cognitive therapy for depression (Jarrett et al., 1998). More recently, a different version of MT has married MBSR with cognitive therapy in a cost-effective treatment designed to prevent recurrence of depression. This Mindfulness-based Cognitive Therapy (MBCT)

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(Segal, Williams, & Teasdale, 2002) incorporates some of the principles and techniques of cognitive therapy with mindfulness practice. The choice of which elements of cognitive therapy to include was based on the understanding that at times of lowered mood, people who have experienced multiple depressive episodes experience reactivation of "modes of being" that embrace thoughts, emotions and bodily reactions. It was also based on the understanding that "de-centring" may be a crucial aspect of successful cognitive therapy, particularly effective when combined with an attitude that is self-accepting and open to experience. MBCT is undertaken between depressive episodes, as the work involved may be too demanding for severely depressed people.

Baer (2003) provides a review and meta-analysis of studies of MT, concluding that MBSR and MBCT meet, or are approaching, the American Psychological Association's criteria for "probably efficacious" interventions. However, both need more work to qualify as "well established".

How does mindfulness training fit with CBT?

Superficially, MT may seem to conflict with CBT. Metacognitive theory seems to suggest that because people with emotional disorders self-focus a great deal and this worsens their distress, MT might make matters worse. In fact, many people self-focus in unhelpful ways (self-critically, or persistently trying to solve the insoluble) when emotionally distressed, and MT helps them to become aware of this, helping them to disengage from self-focusing and to alter how they self-focus towards acceptance and kindness rather than self-criticism and rumination.

Another apparent tension between MT and CBT is that in cognitive therapy clients learn how to "fix" things (e.g. to modify "automatic thoughts"). In MT there is no "fixing", rather they are simply taught to become aware of such thoughts, neither trying to change them nor act on them. In truth, the apparent conflict of approaches dissolves during MT, as participants learn mindfully to discriminate between situations requiring acceptance and those where, following mindful consideration, skilful action is needed. Hence, on closer inspection many of the potential conflicts are groundless. Indeed, such inspection would in reality lead to evidence of synergy, especially with the new foci on the therapeutic aspects of "acceptance" and "compassion". For example, "acceptance" is central to MT and is increasingly emphasized in developments in CBT. Thus, this is a core element of Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 1999). It is also vital to Gilbert's developing approach to working with shame, based on what he calls "compassionate mind" (Gilbert, 2003). This convergence between MT and other CBT approaches to self-focusing, self-criticism, shame, and cognitive and behavioural avoidance promises further fruitful research and therapeutic development.

How does mindfulness training help older people?

Mindfulness training fits older people's needs and suits them well

Most benefits of MT apply equally to older and to younger people, and are more important for older people only insofar as the issues they address become more prevalent with increasing age. These include therapeutic factors not specific to mindfulness, such as support from group

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membership, and the de-stigmatizing value of participating in a course with others who have experienced similar difficulties and similar labeling. This may be especially beneficial to older people, some of whose self-esteem has been further battered by our society's pervasive ageism. Finding that one is competent, and being recognized as such, is often healing in itself. Being able to learn and benefit from meditation is surely less stigmatizing than requiring therapy. This benefit is enhanced by the way MT requires participants to work with "what is right with us" and what people have in common, in contrast to more problem-focused approaches. In MBCT, education about depression and relapse is another non-mindfulness-specific benefit. MBSR brings analogous benefits, since such education (e.g. regarding anxiety and stress, or coping with chronic pain) is included in MBSR courses.

In some Eastern traditions, meditation is seen as appropriate to later life, once social, occupational and family responsibilities have been discharged. How far this is congruent with Western culture and psychology is not clear. However, in this author's experience, some older people who struggled to grasp a conventionally structured cognitive therapy approach found MT more intelligible and beneficial. MT may also suit many older people's life style. For example, while some older people lead busy lives, and find adding mindfulness practice to their routine stressful, many have the necessary time to practise the skills.

It is worth noting that this approach is acceptable to people from most religious (or agnostic) backgrounds. This matters as there are more religiously devout older than younger people, at least in the UK. One of the author's recent courses included a Roman Catholic nun, a Methodist lay preacher, a devout Presbyterian and a Jehovah's Witness; their affiliations or beliefs caused no difficulty.

Since many older clients referred for psychological therapy suffer from combinations of depression, chronic pain and anxiety, MT provides therapists with versatile means for addressing combinations of difficulties. Some of the benefits older people derive from MT courses are indicated in Table 1. As will be seen, participants say they find MT beneficial, both in dealing with referred problems and in terms of general wellbeing.

Experience of providing MT for older people

Nature of courses provided and assessment for participation

This author has recently provided six MT courses for people aged over 65: three MBSR courses for clients with anxiety disorders and/or chronic pain; and three MBCT courses for people with histories of three or more major depressive episodes. The MBCT courses formed a research study: data were collected but not fully analysed at the time of writing. Though the research proposal sought to collect both quantitative and qualitative data, the Local Research Ethics Committee did not accept that this could be legitimate. As qualitative data were vital in assessing how the course might suit older people, the proposed quantitative measures were omitted from the study.

Due to resource constraints, all sessions were of two hours, and no "all-day" meetings were possible on these courses. This is congruent with MBCT as provided by Segal et al. (2002), but involves slightly less facilitator contact than does MBSR following Kabat-Zinn's model. Each course provides 16 hours of facilitator contact, plus pre-course assessment. Drop out rates averaged just under 25%.

Considerable facilitator time was involved in assessment and related work, reducing but not outweighing the advantages of group as opposed to individual intervention. This author felt it ethically vital that candidates too depressed or agitated to participate be offered individual CBT. A screening test for cognitive impairment (6CIT: Brooke & Bullock, 1999) was used, because MT would require modification for people with dementia. In the MBCT research protocol, a Beck Depression Inventory (BDI-II) score over 19 triggered exclusion and an offer of individual therapy. Similar screening was used for the MBSR courses.

The MBSR courses were similar to those described in Kabat-Zinn (1990). The MBCT course mirrored that described in Segal et al. (2002). The yoga in both courses, derived from Kabat-Zinn's MBSR, was modified in consultation with a physiotherapist in mental health services for older people. Further modifications were made to accommodate participants who could not lie down in class or could not stand or walk for long. Walking meditation was also adapted as it could not be done as slowly as is conventional without risk of falls.

As the author, like other MT teachers, found it difficult to deliver MBCT in eight 2-hour sessions without considering that the cognitive therapy elements were "shoehorned in", he has re-designed[1] the course to provide the same content in 10 sessions. This was by agreement with the authors of the approach.

Participants' qualitative feedback

Preliminary thematic analyses indicated some important themes in older participants' experiences of MBCT. These themes are outlined in Table 1 and are reported in terms of changes in cognitions, emotions, physiology, behaviour and "general benefits".

The large majority of participants completing the course (95%) said they found MBCT either somewhat or very helpful, as did most participants in MBSR courses (exact percentage not available since the MBSR courses are not currently being researched, but are part of the author's routine clinical practice). Two people did not experience significant benefits: one had difficulties seeing the relevance of the practice and did not engage in it as directed; the other was very sleepy during sessions, but revealed only when the course was nearly over that they had recently been prescribed large doses of morphine.

Physical disability prevented some participants from engaging fully in specific practices, but as in Kabat-Zinn's work, this did not prove a major problem since people were encouraged from the outset to focus on their experience while practising mindfulness, not on what they could achieve.

Range and limits of application of mindfulness training

One of the strengths of MT is its grounding in meditative traditions and disciplines, with the requirement that mindfulness teachers have their own mindfulness practice. Anyone doubting the necessity for this should reflect on the experiences reported by Segal et al. (2002). This does mean that the approach demands much of facilitators. A fully adequate MBCT course facilitator will be a psychological therapist competent to deal with whatever clinical issues the course

[1] Contact author for further details of the contents of the programme.

Table 1. Themes concerning MT derived from older clients' comments

Cognitive changes:

1. Many participants' subjective identities altered in ways that they experienced as positive. (e.g. "I feel more of a whole person").
2. MT enabled participants to pause mentally and observe their experiences, which freed them from having to react in habitual ways.
3. Many participants reported that "being more aware" felt better than operating on "auto-pilot".
4. Other comments indicated that people found MT helped them to let go of attachments to thinking over problems (problem-focused rumination) in favour of accepting the way things were.
5. Learning MT was sometimes puzzling at first.

Emotional changes:

6. With practice, both formal and informal mindfulness became increasingly enjoyable. Several participants also described enjoying other aspects of their lives more during and following MT.

Physiological changes:

7. Many participants reported, and welcomed, feeling calmer and more relaxed.

Behavioural changes:

8. Participants observed themselves acting more assertively.
9. MT freed them from having to react in habitual ways.
10. Some participants said that others saw them as behaving differently (e.g. "They say I smile more"; "He sees I feel better, more relaxed").

General benefits:

11. Many participants came to generally like themselves better.
12. Learning in a group situation was helpful for most (but not all) participants.
13. Many participants linked changes in other domains of life to mindfulness practice. These included: sleeping better; (welcome) weight loss; less susceptibility to seasonal mood variation.

addresses; with group facilitation and teaching skills; maintaining her/his own established mindfulness practice; and having some competence in whichever form of bodywork (e.g. yoga, tai chi or qi gong) his/her MT courses use. MT does not attract all potential clients, nor every therapist!

Just as we need more research to clarify the extent and nature of potential uses of MT, we do not yet know enough of its limitations. However, some pointers can be given. Caution is needed when selecting participants for MT courses, to ensure that no-one is included who has significant post-traumatic issues that they are unready to deal with. For example, people who have experienced sexual abuse may find deliberately sustaining focus on their bodily sensations very distressing; this type of focusing figures right from the first session. This need not be a problem, if people are prepared and guidance given in advance about what to do if distress becomes too intense (this can range from taking a cigarette break, to staying with the exercise but moving on to another area of the body). It does have implications when assessing potential participants. Rarely, meditation may trigger intense distress in ways that suggest the individual should not continue (Lazarus, 1976; Yorston, 2001).

We do not yet know "how depressed" is "too depressed" to participate in MT. However, anyone who cannot concentrate for long may struggle; severe psychomotor slowing is

also probably a contra-indicator. Mindfulness practice in much briefer "chunks" has been found helpful by people with a diagnosis of borderline personality disorder (Linehan, 1993) and may also help people with experiences associated with psychosis (Mills, 2002).

This author began running MT courses with the expectation that psychological-mindedness would correlate positively with ability to benefit from MT. Surprisingly, published work to date does not seem to have addressed this. Though there appears to be some correlation, there have also been strikingly concrete thinkers who have benefited considerably from MT. This has included individuals who found standard cognitive therapy hard to grasp due to limited ability to focus on their thoughts.

Issues for future research on mindfulness training for older people

More work is clearly needed, for example to establish which patterns of anxiety phenomena respond to MT, and to elucidate why MBCT, which benefits those who have experienced several depressive episodes, may not help people who have been depressed only once or twice (Segal et al., 2002). MT is already attracting interest in UK pain management services, and will probably become more widely available. While some may adapt the approach to fit local circumstances, it is to be hoped that enough therapists will offer standard MBSR courses to make multi-centre outcome research feasible.

Because MT has evolved in ways that suggest it may address several clinical issues and deal with co-morbidity in certain circumstances, it is tempting to offer it to people with heterogeneous problems. However, this author fully agrees with Teasdale, Segal and Williams (2003, p. 157) who " . . . caution against assuming that mindfulness can be applied as a generic technique across a range of disorders without formulating how the approach addresses the factors maintaining the disorder in question." Since some benefits described by participants derive from learning with others who are "in the same boat", diluting this aspect of the experience may reduce efficacy. To include participants with many different clinical issues in the same course also risks over-taxing the facilitator's skill in keeping the group working together.

MBCT for recurring depression is a clear, manualized treatment developed for a specific population. Different cognitive therapy content may be required for other mental health issues (e.g. in both the UK and USA MBCT is being developed with cognitive therapy elements specific for people with eating disorders). No-one has yet developed and published such a programme for any anxiety disorder, and though this is likely, it is unclear which anxiety disorder(s) will be targeted first. Because participants in this author's qualitative pilot study reported personally important benefits in areas not predicted nor explicitly focused on in the MT courses (such as, becoming more assertive, losing weight) it may be advisable to record their goals and progress using an individualized change measure such as Goal Attainment Scaling (Kiresuk & Sherman, 1968). This should be done in addition to using standardized measures of both emotional distress and the development of mindfulness skills.

It will be important to remain aware that MT is not for everyone and may in time prove unhelpful for specific disorders. In this author's opinion no fundamental changes will be required for older people, though superficial adaptation of content may be (e.g. body awareness exercises that less able bodies can cope with, or adapting physical stretching exercises in light of the high incidence of posturally induced dizziness in older people). It

may, however, be vital to distinguish outcomes for people with different kinds of anxiety, and perhaps for those older people with depressive episodes of particular aetiology. Some evidence suggests that depression in old age may differ in aetiology as well as in presentation, from depressive experiences of younger people (Kivela, Viramo, & Pahkala, 2000; Heun, Kockler, & Papassotiropoulos, 2000). This is an important issue, not yet studied in relation to MT. It emphasizes the need for separate and careful research into the efficacy of MT with older people. This author's current MBCT research included older people on the basis of having had three or more episodes of depression, commenced before he understood the possible need to exclude (or examine separately) people with first onset in old age. Future research should address this.

There are many unexplored areas where MBSR or MBCT has potential, some relevant to older people's mental health. Formal (paid) and informal carers are numerous, and a large literature examines stress-related emotional distress in carers of people with dementia (e.g. Kneebone & Martin, 2003; Knight, Lutzky, & Macofsky-Urban, 1993). MT may offer some carers ways to cope better with the demands of their roles. Another potentially fruitful area for research is the use of MT by healthcare staff working with older people in various settings (e.g. hospital wards, day units, nursing and residential homes).

Conclusion

No published studies have yet examined MT specifically for older people. Older people's mental health issues are commonly under-detected, under-funded and under-treated (Garrard et al., 1998; Ham & Roberts, 2003). Thus, it matters that clinical researchers working with older people ensure that they are not denied access to this cost-effective therapeutic approach due to lack of evidence. For therapists willing to make the personal commitment involved, MT research and clinical practice offer personal and professional challenges and the chance to help larger numbers of older people. MT offers the possibility of effective intervention for some of the commoner mental health difficulties facing older people. It is heartening that in a large proportion of cases MT may enable us to deal with co-morbid stress, anxiety, pain and depression. However, though the evidence is encouraging, it is not yet robust. MT also has the advantage of being in tune with the growing awareness among psychological therapists and others of the need to provide interventions that are acceptable and de-stigmatizing, and which empower clients to take charge of their own mental health rather than depending on professionals to deal with recurrences of distress. MT is likely to retain the particular flavour derived from connection with established meditative traditions, but is also likely to alter as we come to understand it better within modern psychological conceptual frameworks. Convergence between recent developments in cognitive therapy, particularly those related to "acceptance" and metacognitive theory, suggest that MT is likely to become an abiding part of our dynamic therapeutic landscape. The author looks forward to learning of others working to keep older people on the therapeutic map as MT develops, and to collaborating in research of the quality needed to test and refine increasingly effective mindfulness training.

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