In the words of Jon Kabat-Zinn, who transported the Buddhist concept of mindfulness to Western psychological practice, it is ‘paying attention in a particular way: on purpose, in the present moment and non-judgementally’ (Kabat-Zinn, 1994, p.4). Mindfulness meditation is a means for anyone, whether experiencing acute psychological problems or not, to reduce personal suffering and develop desirable qualities such as awareness, wisdom and compassion (Kabat-Zinn, 2003). It highlights the interconnectedness between the mind and the body; a principle that has been gaining popularity in Western medicine over the last few decades, as illustrated by the growing employment of psychologists in physical health settings.

A number of mindfulness-based therapies have been developed and applied in Western mental health settings, the most well known of which are mindfulness-based stress reduction (MBSR) and mindfulness-based cognitive therapy (MBCT). Evidence for their effectiveness is strong and convincing, particularly regarding coping with psychological aspects of physical health problems. MBSR has been successfully used with patients experiencing chronic pain (Kabat-Zinn, 1982), psoriasis (Kabat-Erikson, 1994) and cancer (Speca et al., 2000). In relation to psychological disorders, MBCT has been shown to significantly reduce relapse rates of major depression compared to a control group (Teasdale et al., 2000).

Yet when we consider the published literature reviews, a worrying gap appears. They only include adults of working age. Older adults, of 65 years of age or above, seem to have been largely exempt from being offered this promising new intervention, and from being included in research trials.

This oversight is all the more concerning when we consider that there are a number of characteristics of the older adult population that make this group very suitable for mindfulness-based interventions. Mindfulness focuses on the interconnectedness of mind and body thus making it relevant to older people who are more likely than their juniors to experience physical health problems and associated psychological issues. For instance, some problems addressed by MBSR, such as chronic pain, are more prevalent in the older adult population (Smith, 2004). Mindfulness also focuses on abilities rather than difficulties, meaning that it is more empowering than some traditional therapeutic approaches. It thus makes mindfulness well suited to older adults who may feel disengaged or uninvolved in decisions relating to their care.

Furthermore, if we consider lifelong developmental stages, Erikson (1959) suggested that the last stage in life is concerned with life review and finding meaning. The focus on reflection and non-judgemental paying attention that are learnt during mindfulness training could help with meaning-finding and acceptance of one’s life and thus be suitable for the older age groups (Smith, 2006). Other factors that make this approach suitable for use with older adults include common over-prescribing of medication that may mean some elderly clients prefer non-pharmacological treatments, as well as the fact that older people tend to be retired and thus may have more time to carry out extensive practice between sessions (Smith, 2004).

Also, the origins of mindfulness in other cultures and contexts – such as Buddhism and meditation practices commonly embraced older adults, so why shouldn’t senior clients in Western mental health settings benefit from these practices?

Given the lack of research underpinning the delivery of mindfulness interventions with older adults, it might not be surprising that commissioners are cautious. Services stick to more traditional therapies with a wider evidence base for that client group. Furthermore, the small number of individual trials published might also explain why researchers conducting literature reviews and meta-analyses have chosen not to include them.

As well as being limited in number, those studies that have made it to academic dissemination suffer from considerable methodological issues. For instance, to my knowledge only one randomised controlled trial (RCT) investigating the usefulness of mindfulness therapies with older adults has been published. The few other papers available, although informative and valuable, include clinical practice reports, case studies and non-controlled studies. This presents difficulties when trying to generalise findings.

Overall, the limited evidence suggests that mindfulness-based therapies can be successfully applied to a number of conditions in the elderly. The only RCT conducted thus far showed that an MBSR course significantly improved physical functioning and pain acceptance in older participants with chronic lower back pain.

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**References**


(Morone, Greco et al., 2008). It also found that nearly half of participants reported taking less medication for pain or sleep following the trial.

A similar study (Morone et al., 2009) showed that although both treatment and control groups improved on measures of pain intensity (thus posing questions on whether merely participating in a group leads to improvements), 88 per cent of participants in the mindfulness group continued practising formal mindfulness techniques following the group. This suggests that nearly all participants felt they had received sufficient benefit from the techniques to warrant continued practice.

A qualitative study using the same sample as the RCT found that analysis of participants’ diaries showed overall positive experiences of older participants and particularly good results in terms of perceived coping with pain (Morone et al., 2008).

Mindfulness-based therapies have also been shown to be promising when applied to psychological disorders in older adults. For instance, Splevins and colleagues (2008) showed that an MBCT course for older adults experiencing functional mental health problems significantly improved participants’ depression, stress and anxiety scores. The fact that increases in mindfulness skills were positively correlated with decreases in depression, stress and anxiety further supports the interventions’ use with older adults.

Equally positive results were reported in an earlier case study (Sun et al., 2003) where depression and anxiety scores improved following intensive mindfulness training. This was further supported by a qualitative study (Smith et al., 2007) that published subjective reports of ‘major improvements in their overall life’ in elderly clients with recurring depression. Interview transcripts highlighted themes such as ‘increased acceptance and enjoyment of self and others’ and ‘greater control over emotional reactions’.

Significantly, only two of the 30 participants had diagnosed relapses in the year following the intervention. There is also evidence from a clinical practice report (McBee, 2003) that aspects of mindfulness practice can be successfully applied to elderly and frail nursing home residents. A group often overlooked in research, and with fewer psychosocial interventions available, mindfulness therapies for nursing home residents, or those with dementia, present a further area where robust research could contribute to our knowledge base and potentially offer new treatment options for these vulnerable groups.

The above evidence could easily lead us to conclude that mindfulness-based therapies within an older adult population are effective and should be offered to this client group. However, trying to generalise findings from such sparse and methodologically questionable evidence is a challenge. Although some studies use sound pre-post intervention designs (e.g. Splevins et al., 2009), others use case studies or exploratory qualitative designs that lack scientific rigour. Small sample sizes as well as high drop-out rates (32 per cent in Morone, Greco et al.’s study) also make it difficult to draw definitive conclusions.

Nonetheless, rather than discrediting mindfulness therapy for older people based on the studies’ weaknesses, the criticisms and yet-to-be-answered questions beg for future research in the field. The existing evidence is promising, and subjective client reports in particular give encouragement for exploring mindfulness-based therapies with older adults further. It is not uncommon for the first studies in a new field to be descriptive in nature rather than being able to provide robust demonstrations of clinical effectiveness, and I have mentioned good reasons why mindfulness-based therapies may be particularly suited for older adults.

Although it is difficult to make clear statements about the clinical implications of the research published to date, the initial and exploratory evidence is positive. The group-based format and short duration of mindfulness-based interventions, and MBCT’s focus on relapse prevention, also mean that such interventions are relatively low-cost. If future studies can confirm clinical effectiveness, it would provide the NHS with some food for thought in terms of considering to commission mindfulness-based therapies in older adult services, which could have the potential to achieve long-lasting improvements in both physical and mental health. And surely the prospect of finding new cost-effective treatments for an ever-growing group in society can only be exciting to all involved!

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