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ORIGINAL PAPER

Mindful Living in Older Age: a Pilot Study of a Brief, Community-Based, Positive Aging Intervention

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Abstract Although mindfulness-based interventions have been successfully used with older adults, there have been few interventions that (a) are created specifically for older adults, (b) are delivered in the community, and (c) aim to promote successful aging (rather than treating dysfunction/disorder). To this end, the current study piloted a brief 'positive aging' intervention, comprising two 150-minute sessions, with six female older adults living in the community. Data were gathered through focus groups that were interwoven throughout the intervention. Using thematic analysis, four main themes were identified: (a) aging as a mixed blessing, (b) understanding mindfulness, (c) the challenges of mindfulness, and (d) the benefits of mindfulness. Overall, the intervention was successful in introducing participants to mindfulness and potentially forming the basis of a longer-term practice. However, the study also highlighted important points regarding the challenges of practising mindfulness, in relation to which the paper makes recommendations pertaining to the teaching of mindfulness with older adults.

Keywords Mindfulness · Intervention · Positive aging · Older adults · Community · Wellbeing

One of the great public health challenges faced by Western societies in the years ahead is managing the demands posed by an aging population. Due to demographic changes, such as marked increases in life expectancy over recent decades, it is estimated that the proportion of people aged over 65 in the UK will increase from 16 % currently to around 25 % in 2050 (Crackness 2010). These challenges are exacerbated by recent economic and political trends, which have seen austerity policies imposed across the Western world, leading to reduced public spending; e.g. in the UK, it is calculated that local council spending will have dropped by almost 30 % by 2015 (Johnstone 2014). As a result, Age UK suggest that care is 'in crisis' (Abrahams et al. 2014): on the one hand, there is rising demand for care, with the number of people aged over 85 increasing by 30 % between 2005 and 2014; however, despite such increases, funding for care of the elderly has been reduced, by as much as 10 % in real terms from 2010 to 2014. Consequently, there is great need for cost-effective ways of meeting the needs of an aging population.

Among the priorities in this regard will be promoting health and wellbeing in older age. Physical and mental health burdens associated with aging mean older adults are liable to a marked reduction in quality of life, particularly those aged over 75 (Department of Health 2014). The health burdens of older age are manifold. There is increased morbidity, with greater susceptibility to illness such as cancer (Turner et al. 1999). There are degenerative issues, from osteoporosis (Kanis et al. 1994) to diseases such as Alzheimer's (Ferri et al. 2006). Furthermore, these issues intersect in complex ways with mental health; although there is not a greater prevalence of mental disorder among older adults per se (Kessler et al. 2005), disorders like depression are associated with aspects of older age, such as social isolation (Alpass and Neville 2003) and loss of mobility (Strawbridge et al. 2002). Taken together, the issues above show that wellbeing in older age is *multidimensional*, involving a complex lattice of interlocking aspects (Lomas et al. 2015a); it is not simply about physical decline, but complex psychological and social challenges too. This idea of multidimensionality is reflected in the

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WHO's (1948, p.1) definition of health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.

Addressing the multidimensional burdens of older age is not only of importance to older adults themselves, and as such a moral issue for society—as Gandhi purportedly said, 'A nation's greatness is measured by how it treats its weakest members'—but also an economic one. For example, with mobility, falls are the most common cause of death from injury in the UK in the over 65s, and cost the NHS over £2 billion each year (Fenton 2014), with each hip fracture costing around £12,000 (Department of Health 2009). With cognitive decline, dementia costs the UK around £26 billion per year and is the biggest single economic illness burden per sufferer (£32,250) (Prince et al. 2014). Indeed, the King's Fund estimates that by 2026, dementia care will constitute 73 % of all mental health service costs, up from 66 % today (McCrone et al. 2008). Thus, any effects to mitigate the burdens of aging should also be a priority for society, even if purely considered from an economic perspective.

Given the importance of promoting health and wellbeing in older age, and moreover doing so in a multidimensional way, a key question is, *how* can we do so? Efforts have been made to develop interventions—specifically designed or tailored for older adults—to cultivate or protect the various wellbeing factors affected by age (Fernández-Ballesteros et al. 2007). These include physical activity initiatives (see Falck et al. 2015, for a review): Tai-Chi-based programmes to improve strength and balance (Gryffin et al. 2015), reminiscence therapies to encourage positive memory recall (Elias, Neville, and Scott 2015), education interventions to facilitate ongoing learning (Yamashita et al. 2015), and nutrition programmes to promote healthy eating (Silva-Smith, Fleury, and Belyea 2013).

In light of the discussion above, it is vital for interventions to be of good cost-benefit value, and multidimensional in their outcomes (affecting multiple aspects of wellbeing). One particularly promising intervention in this regard is mindfulness. Although ostensibly 'just' an awareness-training technique (Kabat-Zinn 1982), studies suggest mindfulness can impact on multiple dimensions of wellbeing in older adults, including: ameliorating age-related cognitive decline, thus lowering the risk of developing Alzheimer's disease (see Gard et al. (2014) for a review); helping pain management (Morone et al. 2008) and mobility (Adler and Roberts 2006); and reducing loneliness (Creswell et al. 2012). As such, mindfulness may function like a 'master key', affecting multiple components of wellbeing; in theoretical terms, this is because mindfulness is thought to enhance, among other capacities, executive cognitive function, which plays a pivotal role in diverse physical and mental behaviours, from emotional management to goal planning and implementation (Heeren et al. 2009; Lomas et al. 2014c).

However, most studies with older adults have simply used conventional mindfulness-based interventions (MBIs) with this particular population, most prominently Kabat-Zinn's (1982) mindfulness-based stress reduction (MBSR) (e.g. Creswell et al. 2012), as well as Segal et al.'s (2002) mindfulness-based cognitive therapy (e.g. Foulk et al. 2014). As such, there are very few MBIs created *specifically* for older adults. An exception is Zellner Keller et al. (2014), but theirs is an 8-month ongoing programme, rather than a structured intervention. Moreover, most MBIs with older adults involve clinical populations, with either mental disorders like depression (Lynch and Bronner 2006) or physical issues like back pain (Morone et al. 2008). There are exceptions that focus on community populations, but these generally still utilise interventions developed for clinical groups (e.g. MBSR) and are focused on correcting deficits, such as reducing emotional distress (Young and Baime 2010) or blood pressure (Palta et al. 2012). Morone et al.'s (2009) mind-body intervention does appear to be designed specifically for older community-dwelling adults, but again, is still somewhat 'deficit focused'.

Thus, there is considerable scope for creating MBIs that (a) are specifically designed to address the needs of older adults (rather than generic MBIs), (b) are delivered in the community (rather than in clinical settings), and (c) aim to promote 'successful aging' (rather than just treating dysfunction/disorder). This latter point is in keeping with the ethos of positive psychology (Seligman and Csikszentmihalyi 2000), defined as the 'science and practice of improving wellbeing' (Lomas et al. 2014a, p.ix). In this relatively new field, efforts are made to develop asset-based therapeutic interventions to enhance wellbeing. Rather than treating people who are physically/mentally ill (who are well taken care of by clinical fields), preventative 'prophylactic' efforts are made to enhance wellbeing among those who are currently well but are at risk of developing physical and mental health issues. One such group is healthy older adults aged 65–75. Such adults are liable to the health risks associated with aging above, but may not currently suffer from these. Any efforts to stall or slow down the onset of such issues in this age group will therefore be of value. Moreover, beyond just stalling decline, the new subfield of 'positive aging' (Tornstam 2005) aims to understand and promote 'successful' (i.e. 'flourishing') aging, with the aim of adding 'more life to years, not just more years to life' (Vaillant 2004, p.561).

As such, a brief 'positive aging' MBI was created specifically for older adults, entitled Mindful Living in Older Age (MLOA), and was piloted with a group of six older adults, as outlined below. There were four interlinked research questions: (a) does MLOA enhance wellbeing in 'well' older adults in the community?; (b) does MLOA affect multiple and/or specific aspects of wellbeing, including pain, mobility, happiness, and relationships?; (c) what conclusions from the

findings can be drawn relating to challenges to wellbeing in older age?; and (d) what strategies/recommendations can be extrapolated from the findings pertaining to the use of mindfulness to promote positive aging (not limited specifically to the MLOA intervention)?

Methods

Participants

Six older adults were recruited from an educational/social group for older adults in London, the University of the Third Age (U3A). Inclusion criteria were that participants be aged 65–75 and able to understand English, while the exclusion criteria were previous experiences of practising mindfulness and/or being diagnosed with dementia or other mental incapacitation. The administrator of U3A sent an email to all members containing a brief description of the research, advising them to contact the researchers if interested. Ten people did so and were emailed an invitation letter containing further details. Six were able to attend the two sessions; these were all female, university-educated, in good health, and with professional backgrounds. The research was approved by the University ethics committee, and protocols were in place to ensure the wellbeing of participants (e.g. offering to spend time with participants after sessions in case of distress).

Procedure and Measures

The intervention and data collection will be outlined together, since these were interwoven, i.e. data collection occurred throughout the intervention sessions. The intervention involved two 150-minute sessions, one week apart, at a residence in London. Data collection consisted of focus groups (FGs), comprising the participants and the first and second authors (who were also the instructors for the intervention). Rather than just capturing the 'before' and 'after' effects of the intervention through pre and post focus groups (as per Hefferon et al. 2012), group discussions during the intervention itself were also audio recorded. These discussions essentially served as a 'peri-intervention' FG, meaning that participants' responses to activities were recorded in real time. ('Peri' is a Greek term for around/about.) As such, the analysis was able to capture participants' 'journey' through the intervention. Moreover, the FGs were not simply methodological devices, but integral elements of the intervention itself. That is, like most MBIs, MLOA featured discussion segments, in which participants could share experiences, develop understandings, and ask questions of the instructors; the difference here is that such discussions were also recorded and harnessed as data. Gathering qualitative data in this way, i.e. during the MBI itself, is relatively novel, having been recently pioneered by Shonin et al. (2014)

Session 1 unfolded as follows. The first 45 minutes technically served as the 'pre-intervention' FG, in which participants engaged in discussion around topics such as wellbeing. However, in effect, this pre-intervention FG can actually be seen as an important part of the intervention *itself*, as it helped create a group bond and introduced participants to mindfulness. This featured four main questions: what does happiness or wellbeing mean to you?, are there particular challenges or benefits associated with this time of life?, what does mindfulness mean to you?, and why were you drawn to participate in the intervention?. The intervention proper then involved three practices, each of which were immediately followed by a 15-minute FG discussing the activity. The first was a 15-minute guided mindfulness of breathing, featuring four stages: counting to ten at the end of the out-breath, focusing on the nostrils, focusing on the diaphragm, and open mindfulness. The second practice was a 15-minute guided body scan.

In addition to these standard mindfulness practices, the third practice was a 15-minute reminiscence activity—adapted from Goldstein's (2007) 'Sacred moments' MBI—in which participants were invited to recall a 'precious' memory and to feel where it manifested in their body. Now, it is recognised that 'ruminative reminiscing' can not only be potentially detrimental to wellbeing (Brinker 2013), but conflicts with the kind of receptive openness to the present that characterises mindfulness. However, rather than using mindfulness to help older adults refrain from reminiscing, it was felt that there may be a benefit from enabling them to bring a degree of mindfulness *to* this activity. The rationale here is that while 'ruminative reminiscing' may be problematic, reminiscence itself can be a valued activity, e.g. as a way to experience and construct a sense of meaning in life (Bohlmeijer et al. 2007). Thus, it was hypothesised that facilitating a *mindful* reminiscence might prevent the activity from becoming ruminative, therefore enabling it to remain potentially beneficial. Moreover, it was not necessarily the case that the activity conflicted with the ethos of mindfulness: although the cognitive object (i.e. the memory) was 'in the past', participants were encouraged to be mindful of how they were experiencing this object in the *present*. The inspiration and precedent for the practice was Goldstein's (2007) MBI, which included a similar activity, in which participants were encouraged to contemplate a 'sacred object'—which could include a memory—and to attend mindfully to it. In the present study, participants were likewise encouraged to bring to mind a 'precious' memory. The instructor advised that this should not be too 'poignant or highly emotionally charged', but simply a memory that was positive and that they were 'fond of'. Following this guidance, as per more conventional mindfulness practices, the instructor invited participants to explore the way this memory was manifesting in the body, i.e. attending with mindful curiosity to

any visceral sensations that were present in relation to the memory.

Finally, the closing FG of the first session ended by participants being invited to commit to practising mindfulness for 10 minutes every day (choosing from any of the three practices they had learned in the session).

The second session began with a 15-minute FG, in which participants reflected on their experiences of practising mindfulness during the week. The session then involved four mindfulness practices, each immediately followed by a 15-minute FG discussing the activity. The first two were the mindfulness of breathing and the body scan, as per week 1 (in order to reinforce participants' understanding of these two key practices). The third was a 15-minute 'mindful eating' exercise. Instead of simply using a raisin as per the MBSR protocol, attempts were made to make the activity veridical by approximating a small meal, thereby suggesting to participants that all meals could be eaten mindfully (cf. Dalen et al. 2010). Thus, participants helped themselves from a buffet featuring cheese, bread, grapes and cake, and were guided through eating some of each of the elements mindfully (and noticing the differences between them). The fourth practice was a 15-minute guided 'mindful walking' exercise (cf. Mills and Allen 2000), undertaken at varying speeds in the garden of the residence. The session ended with a 40-minute 'post-intervention' FG, which again though, was also an integral debriefing component of the intervention itself. This featured three main questions: what did you find most useful about the sessions, what did you find less useful, and are you likely to continue practising mindfulness (and if so, which practices)?

Data Analysis

Analysis was conducted using inductive thematic analysis (Braun and Clarke 2006), a useful method for qualitative analysis of FGs conducted in relation to wellbeing interventions (e.g. Hefferon et al. 2012). More specifically, the analysis followed most of the key steps of grounded theory (GT), including close reading of the transcripts, followed by open and then axial coding (Strauss and Corbin 1998). However, other elements that would make it a 'full' GT analysis were missing, including a larger sample of participants, and the end-point development of new theory. As such, out of respect for the fact that we did not undertake a full GT analysis, but rather a form of GT 'lite', following Pidgeon and Henwood (1997), we are simply referring to our analysis using the more generic label of thematic analysis. After all, as Braun and Clarke (2006) argue, most forms of qualitative analysis are essentially thematic analysis, in that their main unit of analysis is the theme. Labels such as GT thus just arguably serve to delineate particular and specific forms of thematic analysis. That said, as Pidgeon and Henwood point out, many empirical studies that ostensibly use GT are actually similarly 'lite', so our analysis could likewise perhaps simply be regarded as a version of GT.

In terms of the analysis itself, as indicated above, rather than a simple 'before' versus 'after' analysis, FG data from throughout both sessions were combined and analysed together. The analysis began with a close reading of FG transcripts (across both sessions). These were examined for emergent themes—as per the GT stage of open coding—a process which generated over 100. Then, as per the GT stage of axial coding, themes were compared with one another in a process of constant comparison and aggregated into meta-themes based on conceptual similarity, generating around 20 meta-themes. These meta-themes were then also compared with each other and again aggregated into categories. This created four categories, which are the four main subsections of the 'Results' section below. Unlike 'full' GT, we let the analysis rest at this point—without choosing one core category through a process of selective coding, or generating a new substantive theory—as we did not feel that the data were sufficient to generate a new theory per se.

Results

Across the two sessions, one overarching theme emerged: the dialectical nature of wellbeing. The data were suffused with the sense that everything—mindfulness, wellbeing, aging, and life itself—was a complicated blend of positive and negative elements (cf. Lomas and Ivtzan 2015). Within this overarching theme, four key themes were identified as follows: (a) aging as a mixed blessing, (b) understanding mindfulness, (c) challenges of mindfulness, and (d) benefits of mindfulness. These will be discussed in turn, illustrated with FG excerpts; all names are pseudonyms.

Aging as a Mixed Blessing

Our first category pertains to the process of aging. All participants articulated its 'dialectical' nature, portraying it as a complex mix of light and dark elements. There were five subthemes here: feeling blessed, liberation, embracing opportunity, concern for society, and fear of the 'horrors'.

Near the start of the first session, perhaps cognizant of the common stigmatisation of aging as a process of terminal decline, participants were keen to stress the benefits of aging. This was initially prompted by a question posed at the start of the session, which asked 'what does happiness or wellbeing mean to you?' This prompted insightful reflections on the nature of wellbeing and happiness, and on their relative merits as labels. Among the first to reflect was Ruth, who began by saying, 'I prefer the term wellbeing, because I don't think the aim in life is to be happy. Wellbeing comes about from some

kind of acceptance of what is'. This was followed by her depiction of the aging process.

> As I get older, the word that comes to mind is blessed. It's actually quite nice getting older, I'm quite enjoying it. I'm waiting for the horrid bits to really start, and they're just beginning to now. But I just feel very grateful for the time that I've lived through, and as you get older, things that used to matter don't matter so much… So I just feel grateful really about this stage of my life, because it's more comfortable than it has been sometimes in the past.

This excerpt encapsulates the idea of aging as a mixed blessing. On the darker side, there is fear of the onset of 'horrid' aspects of aging, of which more will be said below. And yet, there is a strong and genuine sense of it being a valued time. At this comment, all participants assented and chimed in with examples of why they were enjoying this phase of life. (Indeed, the potential for participants to spark contributions from each other—whether agreements or disagreements—is a key strength of the FG paradigm.) The two dominant interlinked themes here were liberation and embracing opportunity. With the former, essentially, participants were freed from the burden of having to work, while still enjoying a degree of financial security through their pension. As Heather exclaimed, 'Not going to work, but the money comes in! It makes me feel very relaxed and pleased'. Ruth described this as liberating:

> There's freedom. You don't have to turn up to work. You can wear what you like and do what you want. It's a very nice feeling.

This liberation was the platform for the pursuit of diverse activities—often newly adopted (i.e. post-retirement)—that were conducive to wellbeing. For instance, two participants spoke about the exhilaration and social bonding they got from being part of group that regularly went walking in the mountains. As Heather put it, 'It's like flying an aeroplane without having to be in a control, you can see everything… It's a wonderful experience'. Annabel spoke of her enthusiasm for playing the piano, a hobby she had just taken up.

> Nobody has to tell me how to practice, I just do! It's my way of relaxing. It's just wonderful to have a new thing, at my age!

However, as positive as such narratives were, participants also touched upon the negatives of aging. There was a concern with the state of society generally, and that the social safety net that participants had previously benefited from was being withdrawn. For instance, Lillian worried about increased use of foodbanks, saying that 'You have an awful conscience about people who don't have enough'. However, the weightiest negative was fear about the onset of the aging process, as alluded to in Ruth's excerpt above. As these participants were relatively young older adults (65–75), these were mainly worries about physical issues that were yet to come; however, participants were alert to ominous signs that such issues were encroaching. For instance, Josie worried that she was 'developing a hip'. As such, participants were very interested in the potential for mindfulness to help them address physical issues, as discussed in the fourth category below.

Understanding Mindfulness

This second category concerns participants' journies towards a greater understanding of mindfulness, from initial preconceptions through to arriving at an understanding that worked for them. This comprised five themes: (a) misconceptions, (b) intelligent questioning, (c) valuing science, (d) discursive sensitivity, and (e) appreciating contextualisation.

First, participants came to the intervention with various perspectives on mindfulness which could—from both a conventional Buddhist and a scientific stance—be viewed as misconceptions. Participants were aware of mindfulness prior to receiving the invitation to participate, with two referring to it as a 'buzzword' in society (an appraisal that had led both to harbour an element of cynicism towards it, e.g. as simply a trendy activity). Evidently, this had not deterred them from joining the intervention. However, their views were problematic vis-à-vis their potential involvement in the intervention, as they had both come to believe that mindfulness was prohibitively difficult and inaccessible.

> Something I read on mindfulness give me the idea that it involved emptying the mind… That's quite hard to do! (Ruth)

That said, participants were very keen to learn more about mindfulness and were likewise open to changing their perspective. Thus, a continual thread throughout both sessions was a process of intelligent questioning. Some of this was procedural, e.g. when, where, and for how long they should practice. Alongside this, participants asked the instructors thoughtful questions about the emotional dynamics of mindfulness. For instance, Annabel queried what 'you would do with a feeling like anger', worrying whether anger might not be useful in some circumstances (e.g. in motivating one to change an iniquitous situation), and thus whether making the mind unduly calm through mindfulness might be problematic. As part of this questioning, participants were particularly drawn to, and convinced by, scientific evidence and discourse as a validation of mindfulness. As Rita said,

> I think that therapists have discovered in their work with neuroscientists that… I don't know if I am using the right words, but there is a new kind of little neural pathway can be opened up, so therapy [involving mindfulness] is much more efficacious than drugs.

In their journey towards understanding mindfulness, participants appeared very attuned to the nuances of language, and alert to how this affected their appraisal and experience of mindfulness. For instance, after the body scan, Sarah said she found the guidance unhelpful, and that the notion of taking one's breath 'to' particular parts of the body prohibited her from engaging: 'The logic of my mind thought, 'but your brain doesn't go down to the bottom of your spine, so how on earth am I going to take my awareness down there''. Conversely, Ruth reflected on how a phrase in the mindfulness of breathing (about the breath as a 'river') really opened up her experience of the practice, after having initially struggled to engage.

> I'm not very comfortable on this chair, so that was on my mind. But then when you used the word 'river', that really opened things up, like a string between [my chest] and [my core].

Finally, it helped participants when they could relate mindfulness to activities or experiences they were already familiar with. Indeed, participants were very able and willing to draw parallels in this regard. For instance, Annabel related mindfulness to the 'creative listening' she had practised in her work as a psychotherapist. In being absorbed in the moment, Heather felt mindfulness was 'just like going back to childhood'. Ruth related it to her enjoyment of sitting in her 'beautiful garden' and appreciating the flowers. Stella imaginatively compared observing the breath to going into the countryside, and noticing that, despite initial appearances, it was actually full of life.

> At first you think it's all quiet, and then you become aware that there are a million and one little noises.

The Challenges of Mindfulness

In participants' journey of engaging with mindfulness through the two sessions (and the intervening week), there were some difficulties along the way. Four main ones emerged: procedural issues, 'anaesthesia', discomfort, and 'dark encounters'.

First, all participants struggled with the 'how' of practice. They were often concerned that they had got the instructions wrong. As Ruth said after the body scan, 'I was worried if I was doing it right. Sometimes I couldn't feel anything'. At times, some practices felt over-complicated; for instance, during the mindful movement, Josie found that trying to pay attention to walking *and* breathing was tricky: 'When you said 'don't forget your breathing', I thought 'Oh dear', and I couldn't do both things at once'. As such, there was an ongoing balancing act for the intervention instructor between giving sufficient guidance and being intrusively prescriptive. On one hand, it was common for participants to be unsure about what they were 'supposed to be doing' (Stella). As such, in the mindfulness of breathing, it was universally reported by participants that the counting phases were far easier to engage with than the more open stages (Ruth: 'It's much easier to focus on the breath with the number'). Conversely, participants were resistant to guidance being overly intrusive, and appreciated having the quietude to engage with the exercise. Heather light-heartedly chastised the instructors after the reminiscence exercise:

> Don't talk too much! I got annoyed I'm afraid that you kept on interrupting my memory… I was thinking 'just shut up'!

A second theme might be termed 'anaesthesia'. This refers to participants not feeling any particular emotion or sensation during the practice. This was particularly the case during the body scan. While participants did appreciate this practice, as elucidated below, it was not uncommon for them to fail to notice sensations in certain areas. This could be problematic when participants felt they 'ought' to experience such sensations (as some of instructions appeared to imply). As Stella put it, 'I didn't feel anything in my heart particularly, and I didn't know what I was supposed to feel'! A related issue was that participants could fail to engage with a practice and/or found it boring, leaving them generally nonplussed and underwhelmed by the experience. As Rita put it after the first mindfulness of breathing session, 'I don't feel as if it's been a hugely exciting experience'!

Conversely, participants were also perturbed to encounter uncomfortable experiences during mindfulness. Some of these were physical pains or annoyances. As Heather said, 'The mind was quiet, but the body was complaining'. Explaining further, Heather found it 'hard to sit still, and not annoy other people. I develop itches, all over the body, and I want to scratch out each of them'. Participants also complained about intrusive thoughts: describing her efforts to do the reminiscence practice, Josie complained that 'as soon as you start to try and think of a positive memory, all this other stuff comes in and says 'naff off''! More seriously, participants reported what might be called 'dark encounters', i.e. troubling or discomforting qualia. These were not especially common; for instance, discussing her experience of practising during the intervening week (approximately 10 minutes per day), Heather said that '90 % of it was very good'. However, the remaining 10 % was very disquieting to her:

> Sometimes it's very difficult to keep out some very frightening thoughts that really upset you… As soon

> as you close your eyes you can start visualising things you don't like… it can be extremely horrid… You can get these the thoughts coming in, which if you're busy you don't get, because you're doing things…

Participants therefore harboured some concerns about mindfulness opening them up to these kinds of experiences. However, such concerns did not deter participants from practising mindfulness, nor intending to in the future. This was because (a) the benefits (see below) outweighed the negatives; (b) with the benefit of their wisdom and experience, participants reported feeling adequate and able to deal with these negatives; and (c) mindfulness was perceived as a relatively 'mild' practice. On this latter point, two participants had previously tried other forms of meditation, e.g. transcendental meditation, 'many many years ago', and discussed how such practices could be much more 'intense'. Annabel (who had been a psychotherapist) spoke about the dangers of intensive Buddhist retreats producing a 'psychotic breakdown' since people 'don't know what they are pursuing' [i.e. don't appreciate how challenging notions such as ego-transcendence can be]. Compared to such intensities then, Josie felt that mindfulness was both relatively harmless and more convenient and 'user-friendly'.

> In term of 10 minutes [just] thinking about breathing, it seems the opposite of having anxious, intense experiences, it's just about calming down and relaxing… I wouldn't say a quick fix, but it's much easier to fit into my daily life.

The Benefits of Mindfulness

As the previous excerpt indicated, despite presenting some challenges, participants generally experienced mindfulness as a beneficial activity. There were four main themes here: (a) calming, (b) coping, (c) exploring, and (d) savouring.

As per Josie's statement above, participants concurred that mindfulness was generally calming. At the end of session 1, participants were asked if they would commit to practising 10 minutes of mindfulness per day during the following week. At the second session, all said they had kept to this arrangement (except for a day or two), generally preferring to do the mindfulness of breathing (as opposed to the body scan or the reminiscence practice) in the morning. In their reports of the week, apart from some challenging instances (as noted above), participants tended to find that brief periods of mindfulness allowed them to tap into a restorative sense of calm (even if thoughts could still be intrusive). As Stella said,

> It's relaxing, it's a nice thing to do, to make time for, it's calming. It sort of centers you, despite the fact that, you know, all kinds of thoughts keep happening.

Moreover, even though participants had only been practising for a week, they suggested that it could be useful in coping with stress in their daily life. In session 1, participants were encouraged to try to be mindful at select points during the day. Subsequently, two reported that they had engaged mindfully with their breathing while using public transport—which they usually found stressful—and that this had helped them feel calmer (Josie: 'It slows me down a bit, calms me down'). Participants thus appreciated the value of mindfulness as an in situ coping strategy and suggested they would use it as such in future.

> I would certainly be inclined to use it at, you know, at a time of stress… let's go shut down and just breathe (Stella)

Mindfulness also enabled participants to explore a different relationship with their embodied experience. Some of this exploration links to the theme of coping. As noted above, participants were concerned about the onset of physical issues; some had thus been drawn to the intervention on the recommendations of friends, who had reported that mindfulness was able to ameliorate pain. During the week, some participants were then pleased to note that practice, particularly the body scan, seemed able to do this. Josie, who worried about her hip, focused her attention on this during meditation and found it 'quite useful', saying it was 'cathartic' for the joint to be 'covered in attention' in this way. Ruth, who also had hip trouble, reported that 'the day after our first session I walked along the road and I didn't feel it at all, which was lovely, and I thought, 'Maybe it's done the trick, I'll come back again"! Annabel had a nice image for why mindfulness could be helpful for pain.

> I feel it's a bit like a kind parent saying to a child who's fallen over, something reassuring like, 'Oh dear, you've grazed your knee, it hurts a bit but it will get better'. The pain is obviously still there but the child has been reassured.

Beyond simply coping with pain, some embodied explorations were more overtly positive in nature. After trying the body scan, for instance, Stella reported that 'when we got up to the top of the head, I felt quite weightless. I could float up like a balloon'. Similarly, in the reminiscence practice, Annabel felt a sensation of 'warmth' around her heart which she described as an 'experience of pure love'. Such reflections intersect with the final theme, that of savouring. Participants described particularly enjoying the mindfulness of eating and movement sessions. For instance, with eating, Ruth reported that 'I do love the sensation of eating', and that in doing this mindfully she was 'much more conscious of the taste'. With walking, Rita was intrigued by 'all the insects on the leaves, which I hadn't noticed before'. while Annabel commented on 'what lovely light there was in the garden'. She continued by

saying that she could envisage trying to extend this mindful savouring to walking around more generally.

> If you go to a beautiful garden, you're walking differently aren't you? Taking it all in, in a different sort of way. I suppose the point is though, even if you're just doing a trip to the shops, you can do it in a certain way, you can still notice the gardens and things around you.

Discussion

The results here provide a unique window onto the potential benefits of mindfulness in older age. At the same time though, the findings also shed a valuable light onto the challenges of introducing mindfulness to such a population. In terms of the specific intervention being piloted here, MLOA appears to be a useful vehicle for helping older adults begin to engage with mindfulness; the findings suggested it offered a brief, focused programme that was sufficient for initiating basic practices, such as the mindfulness of breathing, and for 'planting a seed' for their ongoing practice. Furthermore, beyond the MLOA specifically, the richness of the qualitative data provides a valuable insight into how mindfulness is received and experienced by older adults, which offers pertinent lessons for all clinicians/researchers seeking to offer MBIs to such a population.

Before considering the impact of the intervention per se, let us contextualise the discussion by exploring the findings on aging more generally. Although some cultures afford respect and even reverence to old age (e.g. associating it with wisdom), Western societies tend to depict aging as a period of decline and decay (Löckenhoff et al. 2009). However, the emergent 'positive aging' paradigm holds that perceptions of aging are often misplaced: for instance, while recognising that aging is attended by manifold hardships, Tornstam (2005, p.2) suggests there are 'severe mismatches between the nuisances and miseries we tend to project on old age and what those who have reached advanced age tell themselves'. For instance, longitudinal studies appear to show that subjective wellbeing is 'U-shaped' through the lifespan: analysing data from around 500,000 Americans and Europeans, Blanchflower and Oswald (2008) found that although wellbeing declined from youth into middle age, it rose again as people entered older ages.

The data here support such findings, with many participants finding benefits to aging, particularly increased freedom from burdens such as needing to work and social obligations around appearance (see Simmons and Betschild (2001) for analysis of the complex benefits and problems linked to retirement). However, this positive view of aging must be qualified with two important caveats. First, participants here constituted a relatively 'privileged' group of older adults, fulfilling many of the predictive criteria for 'successful aging', such as a high level of education, active engagement in social groups/programmes (such as U3A), and a decent level of health (Vaillant 2004). Second, even for these relatively 'successful' agers, aging was portrayed as a mixed blessing, with a tangible fear of the onset of aging-related issues such as musculoskeletal complaints, e.g. painful and/or weak hip joints, which are one of the most significant physical burdens of aging (Department of Health 2009).

In this context, participants were keen to harness any benefits that mindfulness might offer in enabling them to deal with such aging-related issues. The MLOA was promising in this regard: even after just two sessions and one week of practice, it was reported that mindfulness had appeared to ameliorate subjective experiences of pain. Indeed, Kabat-Zinn's (1982) MBSR, the prototypical MBI, was created for this very purpose and was able to successfully treat chronic pain. At this point though, it is worth raising a critical point regarding the validity of qualitative data in assessing the efficacy of MBIs like MLOA. It has been suggested by critical health theorists that positive narratives of undertaking MBIs do not *necessarily* mean that participants 'genuinely' experience psychophysical benefits, but could be constructing a positive portrayal for other reasons, such as simply 'buying into' discourses of mindfulness or wanting to convey a desirable impression to researchers (Ridge et al. 2008; Lomas et al. 2014b). However, there is no need to adopt such a critical stance here, as participants were by no means reluctant to critique mindfulness or to admit to negative experiences in relation to it. Thus, we might avail ourselves of Ricoeur's (1981) differentiation between a hermeneutics of 'faith' and of 'suspicion'. The former involves an empathic-interpretative perspective in which we trust respondents' accounts as being relatively accurate and faithful to their actual experiences. The latter recognises the performative functions of discourse, and that people construct narratives for various reasons, such as the creation of positive self-identities. Ideally, Ricoeur recommends a 'double hermeneutics', in which both perspectives are taken into account to provide a 'more complete understanding of the participant's lived experience' (Frost et al. 2010, p.15). Thus, while we recognise an element of performativity to the data, there is no reason we must 'disbelieve' it; as such, participants' reports about the effect of mindfulness practices should be taken as credible and reliable.

This credibility status applies not only to the amelioration of pain, but to the other beneficial outcomes. Principle among such findings were that mindfulness could (a) induce a feeling of calm (corroborating the use of MBIs to help deal with anxiety, e.g. Goodman et al. 2014); (b) provide an in situ coping technique to help defuse feelings of anger or stress (cf. the use of MBIs as a tool to help manage aggression, e.g. Singh et al. 2011); (c) provide participants with

opportunities to engage with pleasant embodied sensations (cf. Caldwell's (2014) notion of 'bodyfulness'); and (d) enhance savouring of daily activities like eating and walking (reflecting the findings of Quoidbach et al. 2010). Moreover, most studies reporting these positive effects tend to be extensive programmes (e.g. 8 weeks) in clinical settings; as such, it is notable to also find these here in a brief, community-based intervention.

However, this credibility status also applies to the negative findings pertaining to mindfulness uncovered in the research. Until recently, it was suggested that amidst the widespread enthusiasm for mindfulness, relatively little attention had been paid to possible risks and downsides (Lustyk et al. 2009), with the exception of isolated studies such as Shapiro (1992). However, researchers have begun to shine a spotlight on experiential challenges associated with mindfulness in both clinical (Dobkin et al. 2012) and community settings (Lomas et al. 2015b). For instance, Lomas et al. found that meditation was a difficult skill to learn and practise, and that participants often encountered troubling thoughts and feelings which were hard to manage. Similar themes were uncovered here, and even if, according to one participant, mindfulness was '90 % positive', it is important to remain cognizant of the risks in the remaining 10 %. It should be noted that much of the original Buddhist literature on mindfulness does emphasise its challenging nature (Engler 2003). However, there is a danger of these pitfalls being insufficiently addressed in contemporary conceptualisations of mindfulness. In correcting this lacuna, this should not only mean being careful with the use of meditation in clinical populations such as people with a history of psychosis (Lustyk et al. 2009). It is also important to advise community practitioners of potential challenges they may encounter, and to put appropriate precautions and protocols in place; indeed, drawing on Lomas et al., the current study sought to do just this, with the ethics protocols including provisions such as instructors setting aside time after the sessions to talk with participants who may have been troubled by their experiences.

Nevertheless, in the event, participants were not *unduly* troubled by their negative experiences, and on the whole were positive about the intervention. That said, they offered many insightful comments and questions throughout, providing valuable data on how to enhance the teaching of mindfulness for older adults. (In obtaining this data, the innovative 'pre-peri-post' design of the research really came to the fore.) First, in terms of participants being able to understand what mindfulness is, and how it might be used in real life, it helps to relate it conceptually to activities they are already familiar with, such as sitting in a garden appreciating the flowers. Drawing such analogies serves to de-mystify mindfulness and to clear up common misunderstandings (e.g. that it involves 'emptying the mind'). Second, it is also helpful if participants are able to incorporate mindfulness into their existing patterns of behaviour. While it is true that participants seemed very open to trying out new behaviours—countering the stereotype that older adults are ingrained in their habits (cf. Ludwig 1998)—they appeared disinclined to adopt any radical changes to their overall lifestyle. Thus, the fact that mindfulness could be slotted into their existing routines, e.g. as a daily practice that did not need to last more than 10 minutes, and could be practised in the comfort of their home, was certainly in its favour.

Participants also gave useful advice regarding the instruction of mindfulness. For a start, participants were sensitive to the nuances of language, which influenced the extent to which they were able to engage with the practices. For instance, they appreciated the skilful use of similes (e.g. breath being like a river), but resisted crude metaphors that contradicted their understanding of how the mind works (e.g. the implied notion that they could literally take their awareness to different parts of the body). While the pedagogical effectiveness of different forms of language has been well studied in educational settings (Cameron 2003), the teaching of mindfulness appears not to have been analysed with the same level of linguistic attention, which future research could ideally remedy. Participants also had useful views on the extensiveness of the instruction, wanting specific and detailed guidance (e.g. appreciating the structured nature of counting breaths), but resisting intrusive ongoing instruction that disrupted their experience. Finally, in terms of attempting to ensure 'compliance' in homework activities—often an issue in mindfulness research (Vettese et al. 2009)—and increase the likelihood of participants adopting a sustainable practice post-intervention, it would appear better to 'under-promise and over-deliver'. Participants felt that being asked to commit to just 10 minutes per day was very realistic and 'doable', whereas a longer session would have been onerous and likely to deter engagement. In any case, it was reported by many that these 10-minute sessions frequently stretched to 20 or even 30 minutes once participants were engaged in the practice.

Taking the above points together, the following recommendations for encouraging mindfulness in older adults can be offered to researchers and instructors. First, make efforts to relate mindfulness conceptually to existing activities. Second, enable practice to easily fit into existing patterns of behaviour. Third, pay attention to language and use similes/metaphors with care. Fourth, give precise and structured guidance. Fifth, the counting of breaths is a particularly good introductory practice. Sixth, avoid intrusive instruction during the intervention itself. Finally, seventh, avoid onerous demands; 10-minute home practice daily is a good length of time to recommend.

Further work is of course needed, both to further corroborate the value of the MLOA intervention, and in relation to using mindfulness with older adults more generally. As ever, the current study has its limitations. First, as noted above,

there are limits to the claims one can make on the basis of qualitative data, since such data is to an extent a performative construction (Ricoeur 1981). As such, any follow-up trial of the efficacy of MLOA should ideally avail itself of an experimental design and quantitative methodologies. Second, as also addressed above, participants here could be deemed relatively privileged, being people who benefited from factors that predisposed them to successful aging (e.g. high levels of education), and indeed by most metrics *were* already aging successfully (Vaillant 2004). While mindfulness can certainly be of benefit to all people, there is arguably a more urgent need to bring it to more vulnerable populations—such as people of low socio-economic status, as exemplified in the work of Kerrigan et al. (2011)—which future work on the MLOA will endeavour to do. Also noteworthy is the fact that no men expressed an interest in participating, despite males making up around one quarter of the membership of U3A (from where participants were recruited). Such patterns align with observations that men are less likely to engage with health-promoting activities, partly due to masculinity norms which encourage toughness and invulnerability (Courtenay 2000; Lomas 2013). As such, future trials of the MLOA might endeavour to reach out to men specifically, as these are a relatively vulnerable population health-wise (Mansfield et al. 2003).

Nevertheless, this study has shown that the MLOA intervention can potentially play a useful role in facilitating 'positive aging'. The aim was to 'plant a seed' in participants regarding the possibility of 'mindful living' in older age, and it seemed successful in this regard. In follow-up correspondence two months after the sessions, four of the six participants said they were still practising some mindfulness nearly every day at home, while one other participant practised occasionally when she saw opportunities to do so in a group (she valued the social dimensions of practice more than the meditation per se). As such, MLOA seemed successful in introducing participants to mindfulness and encouraging its ongoing use, thus hopefully, in the words of Vaillant (2004, p.561), helping to add 'more life to years, not just more years to life'. Moreover, the brief nature of MLOA means it may potentially be more cost-effective than lengthier MBIs, which is an important consideration given the widespread reductions in healthcare spending (Abrahams et al. 2014), although more extensive systematic trials and analyses in future will be required to assess this possibility.

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