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MINDFULNESS IN PRACTICE

Adapting Mindfulness Meditation for the Older Adult

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Mindfulness meditation has been used to address stress and other issues in a wide array of populations and medical conditions. The reason for this widespread use is that mindfulness meditation is a method for working with the mind—and in particular, the thoughts, emotions, and sensations that arise in the mind—that can be adapted to the particular condition or population being targeted. Generally, the basic meditation method—for example, using the breath as the object of focus—can be taught to just about everyone regardless of their medical condition. Likewise, the attitudes cultivated in mindfulness meditation such as nonjudgment, acceptance, patience, curiosity, and compassion are not linked to any particular population or condition. Because of the universal qualities of mindfulness, once the basic mindfulness meditation method is taught, a program can be developed around it to specifically target a condition or population. We have adapted the program for older adults. Here, we present our experience teaching mindfulness meditation to older adults with chronic pain and adaptations we have made to sitting meditation, the body scan, walking meditation, and mindful yoga to make mindfulness most effective for them. These adaptations can be broadly classified into postural adaptations (which are the majority of the adaptations we have made) and sensory adaptations (specifically for hearing impaired older adults). Since we do not work with patients with dementia, who have their own unique needs and challenges, we do not discuss any cognitive adaptations needed for this population.

There is limited literature on mindfulness meditation in community-dwelling older adults, and it does not delve in-depth into the adaptations made for them. The Eldershine program briefly states that adaptations were made due to physical limitations of older adults and therefore, sitting meditation is done in a chair, no walking meditation is taught, the meditation sessions are kept short, and there is no daylong retreat (Szanton et al. 2011). A notable exception to this is the work of Lucia McBee who describes in-depth her experience teaching mindfulness to frail elders. Because the population she works with is significantly more disabled than the community-dwelling older adults we work with, she does not follow the standard MBSR program and instead has developed "Mindfulness-Based Elder Care" (McBee 2008).

Most of the adaptations we have made to the core mindfulness meditation methods are in response to the physical limitations encountered by adults as they age. Many people have decreased strength, flexibility, and balance as they get older. Additionally, they have stiffer joints and decreased joint mobility. Due to these changes, we have found many adults over the age of 65 cannot sit cross-legged on the floor. We exclusively teach sitting meditation seated on a chair and do not teach sitting meditation seated on a cushion on the floor. We do this because the majority of the older adults consistently cannot sit comfortably on the floor or have the ability to get up from the floor with ease. Instead, they are taught meditation sitting in a chair. The importance of an erect posture is emphasized. This can be achieved by sitting slightly forward on the chair with the hands resting lightly near the knees and the feet firmly planted on the floor—as is taught in standard MBSR—but many prefer to sit with the support of the chair against their back or with a pillow against their back for even more support.

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Sitting in a chair does not limit the novice older meditator from achieving the many benefits that sitting meditation offers. They still lower their blood pressure and heart rate and experience well-being (Morone et al. 2008; Kamprath et al. 2013). One class participant noted "the stillness of the 45 min [meditation] gives a special calm to the activities I do after I meditate." However, we have found an erect spine is important, as an inability to maintain the spine straight inevitably leads to drowsiness. However, some older adults have significant kyphosis (outward curvature of the upper back), preventing them from maintaining a fully erect back. In this case, we have the participant lean back slightly in the chair and maintain their head and/or gaze slightly upward (if their eyes are open) to facilitate wakefulness during sitting meditation. The most important concern of the instructor is to work with the participant so that they achieve a balance between their physical limitations and the optimal posture possible to fully engage in the meditation.

Another major modification we have made is practicing the body scan while sitting in a chair when we are teaching in a class or individually. We have found that older adults can have trouble getting up from the floor without assistance—or getting up from the floor could even cause injury if they have advanced painful knee or hip osteoarthritis or back pain. While arthritis makes it difficult to get up from the floor, decreased flexibility, poor balance, and decreased strength also contribute. We have found that participants in the program can grasp the practice without being in a lying position. Additionally, body awareness while in a seated position also translates to body awareness during mundane daily activities such as sitting in a car or in a doctor's office. Participants will frequently come to class and describe how they have translated the methods taught into their daily lives, without direct instruction on informal mindfulness practice. One participant stated in their weekly diary, "Friday, I had a shot in my right eye. Macular degeneration. Meditated in between drops and seeing the doctor. Felt less stress, less apprehensive."

While the body scan is taught in a chair in the classroom setting, for home practice, the older adult is advised to lie in the bed, couch, or easy chair. While this setting may lead to drowsiness, since it can be a common "side effect" of the meditation practice—whether sitting or lying down—regardless of age—working with and overcoming drowsiness become a springboard for inquiry during class. It is important to note that despite these modifications, the essence of the instructions for sitting meditation and the body scan are not changed. What do we mean by the "essence" of the instructions? We mean the core instructions of mindfulness meditation as taught by Jon Kabat-Zinn (1990). Therefore, for sitting meditation, the instruction is to note the flow of the breath and give full attention to the sensation of breathing. When it is noted that the mind has wandered from attending to the breath, then the instruction is to gently bring it back to awareness of breathing, without judgment or self-blame. Likewise, the instructions for the body scan are not changed, with the participant instructed to notice body sensations in a progressive manner by starting at the feet and moving up to the head and by also picturing the breath moving into and out of these areas. We have found that despite not sitting on the floor or not lying down on the floor, participants still grasp how to meditate and describe the benefits of mindfulness meditation (Morone et al. 2008; Morone et al. 2009). As one participant noted, "When I get to the part of my body that was hurting, the scan exercise made the pain stop bothering me/or else it just went away."

Walking meditation also required modifications because of the loss of balance that occurs with aging. We very quickly discovered that when older adults slow their walking to a pace slower than their usual pace, they were likely to lose their balance. Some even discovered that they never completely lifted one foot off the ground while walking but actually slightly dragged the foot on the floor when swinging it forward. As a result, walking meditation is done at a close to usual walking speed and there is always a wall or other aid available to provide support for a sudden loss of balance. We have found that some participants prefer walking meditation as it facilitates learning mindfulness in a way that was not occurring for them with sitting or the body scan. Some also use it as a means to improve their balance. However, others complain that it bothers their knees and hips. Again, this latter complaint can become a springboard for inquiry in class.

Decreased hearing is another common occurrence as one ages and poses a challenge for class instruction. Instead of excluding their participation in the program, we invite hearing-impaired adults to sit next to the instructor. Or, if they also read lips, they are encouraged to position themselves in such a way that this is possible. The instructor must also increase the volume of their voice. We have not tried microphones to amplify sound as we do not have this technology readily available, but this could be a potential solution. The in-class adaptations we have made are not entirely satisfying; however, because part of the meditation program involves home practice with guided meditations (on compact disc), we have found that hearing-impaired adults are engaging in and learning to meditate through the home practice just as well as older adults who are not hearing impaired.

Cognitive impairment is another challenge for teaching mindfulness meditation. We have not worked with participants with dementia but have worked with participants who have mild cognitive impairment (changes in cognitive function such as memory or language that is noticeable to the person or to the people around them but does not interfere in daily functioning). In our experience, participants with mild cognitive impairment are able to understand the instructions, and we have not had to make changes to the way mindfulness meditation is taught. Actually, mindfulness may benefit cognition for these patients, and we are currently conducting a

large study that is evaluating the effects of mindfulness on cognition in the older adult to help shed light on this area. For those interested in working with patients with dementia, we refer the reader to the work of Lucia McBee, who has worked extensively with frail older adults in the nursing home with and without dementia (McBee 2008).

Mindful movement is taught through yoga in standard MBSR. We have also adapted it for the older adult. Therefore, balancing poses are done near the wall or behind a chair for support and lying postures are adapted to a chair. The intention of mindful movement remains the same as in standard MBSR: mindful and nonjudgmental body awareness during movement while working with the body in the here and now rather than striving to get somewhere or do the postures in a particular way. It is also important to instruct participants that they need to take responsibility for their bodies and that "listening" to their body is equally if not more important than listening to the teacher's instruction. One participant stated, "After our last class, I became aware of how I sit and changed my sitting position."

In conclusion, a few simple adaptations to sitting meditation, the body scan, walking meditation, and mindful yoga allows older adults to fully engage in these mindfulness meditation practices and still receive the full benefits of the program. We have found older adults a particularly delightful population to work with because of the wisdom they bring to class from years of life experiences related to personal relationships, work, illness, and suffering. They also demonstrate a willingness to try something new regardless of their age. When the simple adaptations we describe are incorporated, the older participant can feel comfortable, valued, and included, as they are not being singled out due to inability to get up from the floor or to walk slowly because of the changes that naturally occur in their aging bodies.

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References

Kabat-Zinn, J. (1990). *Full catastrophe living: using the wisdom of your body and mind to face stress, pain, and illness*. New York: Delacorte.

Kamprath, S., Glick, R., & Morone, N. (2013). Physiologic measures of mindfulness meditation in older adults. *Journal of General Internal Medicine, 28*, S145.

McBee, L. (2008). *Mindfulness-based elder care*. New York: Springer.

Morone, N. E., Greco, C. M., & Weiner, D. K. (2008a). Mindfulness meditation for the treatment of chronic low back pain in older adults: a randomized controlled pilot study. *Pain, 134*, 310–319.

Morone, N. E., Lynch, C. S., Greco, C. M., Tindle, H. A., & Weiner, D. K. (2008b). I felt like a new person. The effects of mindfulness meditation on older adults with chronic pain: qualitative narrative analysis of diary entries. *Journal of Pain, 9*, 841–848.

Morone, N. E., Rollman, B. L., Moore, C. G., Li, Q., & Weiner, D. K. (2009). A mind-body program for older adults with chronic low back pain: results of a pilot study. *Pain Medicine, 10*, 1395–1407.

Szanton, S. L., Wenzel, J., Connolly, A. B., & Piferi, R. L. (2011). Examining mindfulness-based stress reduction: perceptions from minority older adults residing in a low-income housing facility. *BMC Complementary & Alternative Medicine, 11*, 44.