

Mindfulness: Reconnecting the Body and Mind in Geriatric Medicine and Gerontology

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Derived from Buddhism, mindfulness is a unique approach for understanding human suffering and happiness that has attracted rapidly growing interest among health care professionals. In this article I describe current thinking about the concept of mindfulness and elaborate on why and how mindfulness-based interventions have potential within the context of geriatric medicine and gerontology. Upon reviewing definitions and models of the concept, I give attention to the unique role that the body plays in cultivating mindfulness and the advantages that this focus has for older adults because they have aging biological systems and may experience chronic disease, pain, and disability. In the final section I discuss why mindfulness may be particularly useful in promoting physical activity among older adults and how physical activity may be used as a vehicle to promote mindfulness.

Key Words: Disability, Interventions in aging, Pain, Physical activity

Psychology has taken a growing interest in the intersection of Eastern and Western thought, as evident from recent publications by Wallace and Shapiro (2006) and Leary, Adams, and Tate (2006).

Support for this article was provided under Grant HL076441-01A1 from the National Heart, Lung, and Blood Institute, Grant 5P60 AG10484 from the National Institutes for Aging, and Grant M01-RR007122 from the General Clinical Research Center.

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More specifically, references to *mindfulness* have appeared with increasing frequency in behavioral medicine (Baer, 2006), psychiatry (Schwartz & Begley, 2002), counseling psychology (Strosahl, Hayes, Wilson, & Gifford, 2004), and neuroscience (Lutz, Greischar, Rawlings, Ricard, & Davidson, 2004). This paradigm evolved from rich Eastern traditions that have sought to develop a path to reducing suffering and promoting happiness. Understandably, because suffering and unhappiness are commonplace in Western society and the typical "strive harder" motto of our culture has not provided adequate solutions to this trance of distress, the appeal of a new approach is compelling (Leary et al.).

Between now and 2030, North America will experience a dramatic demographic shift as a consequence of an aging baby boom generation. The projected economic, social, and psychological toll will be staggering. Anyone who has spent time in the field of gerontology or geriatric medicine can attest to the incredible suffering that many people experience as they age. The burden of chronic disease is inevitable; multiple biological systems become impaired; caregiving and watching significant others suffer takes a daily toll, even on the healthy; and the mind tends to wander into the past and to ask repeatedly, "How did I come to this?"

The purpose of this article is to review the conceptual underpinnings of a mindfulness perspective as a new and useful approach to understanding the profound connections that exist between mind and body, a relationship that takes on added significance with aging. In discussing how the mind and body interrelate in mindfulness, I give attention to the topic of pain, because this symptom is central to psychological and physical disability in aging. In

the final section I examine how mindfulness can be used in promoting physical activity in aging and how physical activity can be used as a vehicle to cultivate a mindfulness perspective in the daily lives of older adults.

Understanding the Mindfulness Perspective

The term *mindfulness* originates in Eastern contemplative traditions, most notably Buddhism. It is best viewed as a framework or perspective for understanding human growth and suffering, rather than as a distinct construct common to theory building in Western psychology. This point is evident in mindfulness-based therapeutic models such as dialectic behavior therapy (Linehan, 1993) and acceptance and commitment therapy (ACT; Hayes & Strosahl, 2004).

A main point of contention among Western psychologists concerns the process of becoming more mindful. On the one hand, therapeutic approaches such as ACT adapt the concept of mindfulness to the paradigm of mainstream Western psychology, arguing that *meditation practice is not necessary* (Hayes & Feldman, 2004). On the other hand, meditation is the backbone of such therapeutic approaches as mindfulness-based stress reduction (MBSR; Kabat-Zinn, 1990); it is a *necessary* practice to develop for living mindfully.

Evolving approaches are now blending these two extremes. For example, Segal and his colleagues (Segal, Williams, & Teasdale, 2002) have developed and formally evaluated the benefits of mindfulness-based cognitive therapy (MBCT) on the prevention of relapse for depression. MBCT is strongly rooted in meditation yet integrates well-tested cognitive behavioral methods into its treatment protocol. Epstein, a Buddhist-oriented psychoanalyst, advocates meditation with psychoanalysis in his clinical practice (Epstein, 2005), and there are a growing number of psychotherapists who are now convinced that meditation has a natural role in the therapeutic process (Germer, Siegel, & Fulton, 2005). Cross-sectional research has shown that long-term meditation users experience adaptive changes in both short- and long-term neural mechanisms as compared with beginners, an effect that is dose dependent (Lutz et al., 2004). Moreover, Davidson and his colleagues (Davidson et al., 2003) found that in young and middle-aged adults, just 8 weeks of MBSR training lead to significant, positive changes in left-sided anterior activation of the brain, changes that are associated with reductions in anxiety and negative affect and increases in positive affect.

A recent meta-analysis concluded that both uncontrolled and controlled studies of MBSR have produced consistent and relatively strong effect sizes in support of mindfulness training for coping with pain, distress, and disability (Grossman, Niemann,

Schmidt, & Walach, 2004); MBCT has been found to be effective in treating depressed patients who have a history of relapse (Segal et al., 2002). However, whereas the meta-analysis by Grossman and colleagues suggests that the effects of MBSR on these outcomes are robust, there are no existing randomized controlled trials that have specifically targeted older adults; nor have there been subgroup analyses in existing trials based on age. To date, no attention has been given to potential limitations imposed by cognitive impairment or the dose of training that might be tolerated by older adults. Similar limitations exist for MBCT, and dismantling research is warranted to understand how important the cognitive behavior components of this program are to its success.

So what is meant by the concept of mindfulness? Kabat-Zinn (1994), the founder of MBSR, defined the concept of mindfulness as “paying attention in a particular way; that is, on purpose, in the present moment, and nonjudgmentally” (p. 4). Recently, Western psychologists have attempted (a) to develop a definition of mindfulness for purposes of research, and (b) to identify core dimensions of the concept. For example, at a series of scientific meetings in Toronto, Bishop and colleagues (2004) developed a two-component operational definition of mindfulness. “The first component involves the self-regulation of attention so that it is maintained on immediate experience, thereby allowing for increasing recognition of mental events in the present moment. The second component involves adopting a particular orientation or attitude toward one’s experience in the present moment, an orientation that is characterized by curiosity, openness and acceptance” (p. 232).

It has been well established in both cognitive psychology and cognitive neuroscience that attention is essential to self-regulation (Posner & Rothbart, 2007). Although there has been less systemic study on training the mind to develop focused attention, cross-sectional research suggests that attention can be developed and lead to observable changes in the structure of the brain (Lutz et al., 2004). Schwartz and Begley (2002), using mindfulness-based methods, have shown that patients with obsessive-compulsive disorders can actually alter the metabolic activity of their caudate nucleus and experience relief of symptoms by changing what thoughts are given conscious attention. In treating older adults who present with various anxiety and depressive disorders with MBSR, Smith (2006) notes that training in how to really attend to experience was described by one patient as “waking up from a dream.”

Within the mindfulness literature, no one has explicitly studied the second component of the definition by Bishop and colleagues (2004) concerning curiosity, openness, and acceptance, with the exception of research on measurement (see Lau et al., 2006). However, as I show later in this article, there

is a growing interest in the concept of acceptance as an important facet of coping with pain (McCracken, Vowles, & Eccleston, 2004), and there are well-controlled studies that illustrate the value of acceptance in coping with anxiety (Eifert & Heffner, 2003; Levitt, Brown, Orsillo, & Barlow, 2004). It is also important to point out that the measurement research by Lau and associates produced a single factor, termed *decentering*, which captures the orientation of curiosity, openness, and acceptance to experience.

A 2006 article on mechanisms of mindfulness by Shapiro and colleagues (Shapiro, Carlson, Astin, & Freedman, 2006) identified *three axioms of mindfulness*: (a) intention, (b) attention, and (c) attitude. Whereas the concepts of attention and attitude parallel the two-component model of Bishop and colleagues (2004), the axiom of intent expands on this definition, suggesting that the goals or values that participants bring to practice “[set] the stage for what is possible” (Kabat-Zinn, 1990; p. 32). Although to my knowledge no research has directly addressed the axiom of intent within the context of mindfulness, nor is this axiom a central, consistent component of either MBSR or MBCT, Sheldon and colleagues (Sheldon, Ryan, Deci, & Kasser, 2007), using the framework of self-determination theory, have provided evidence that well-being is codetermined by both what people pursue as well as *why they pursue it*. That is, a life oriented around personal growth, emotional intimacy, and community involvement has positive effects on well-being, whereas pursuing goals in an effort to enhance one’s image, fame, or financial success negatively influences well-being. Because older adults often do take a hard look at “the meaning of life,” this is a potential important component of mindfulness that deserves empirical study in gerontology.

What is also relevant to this discussion is the fact that establishing *commitment in life* is a key feature of ACT, as is the concept of *acceptance*, according to Hayes and Feldman (2004). However, as indicated previously, these authors dismiss the need for attention training as a key facet of the therapeutic process. Thus, yet another interesting hypothesis would be to contrast meditative and cognitive-behavioral approaches to acceptance of either pain or functional limitations in aging.

Most recently, Wallace and Shapiro (2006) published an article in the *American Psychologist*, entitled “Mental Balance and Well-Being: Building Bridges Between Buddhism and Western Psychology.” They propose that well-being achieved through mindful meditation has four dimensions: conative balance, attentional balance, cognitive balance, and affective balance. Conative balance captures the axiom of intent by Shapiro and colleagues (2006). It concerns aspirations that are “oriented toward one’s own and other’s happiness” (p. 694; Wallace & Shapiro) and is impossible if people are caught on

the hedonic treadmill of seeking pleasant and avoiding unpleasant events. It requires an appreciation of the fact that we do not exist independently of others and, thus, our well-being arises from concern for others. This perspective is very similar to Adler’s (1998) contention that life becomes meaningful when human behavior is motivated by social interest and to research on self-determination theory, mentioned previously (Sheldon et al., 2007).

Attentional balance is the ability to develop sustained, voluntary attention on a focal object or sensation. This skill creates a feeling of tranquility and was the basis of Benson’s (1975) work on the relaxation response. It is important to note, however, that the primary focus of relaxation training is letting go of tension in the body, whereas in mindfulness there is dual focus on a tranquil body and an alert mind that is in a state of focused attention. Although no data support the position that sustained attention on the breath has advantages over sustained attention on any other sensation or object, it has been demonstrated that slow breathing enhances activation of the parasympathetic nervous system (Jerath, Edry, Barnes & Jerath, 2006). One recent experimental study contrasted the effects of a month of relaxation training versus mindfulness meditation on a variety of psychological outcomes (Jain et al., 2007). Of interest is that fact that the meditation group showed larger effect sizes for positive affect than did the relaxation group. Furthermore, only the meditation group had significantly greater decreases in ruminative and distractive thoughts as compared with a waitlist control group.

Cognitive balance implies experiencing the world with pure attention, without allowing preexisting concepts or notions to distort perception. This concept is reflected in the second component of the definition of mindfulness by Bishop and colleagues (2004), described earlier, that involves the adoption of a particular orientation toward one’s experience in the present moment (in which the orientation is characterized by curiosity, openness, and acceptance). The challenge is to relate to thoughts as self-constructed entities, not as real or necessarily accurate ones, because in Buddhism the reification of thoughts is believed to be a major cause of suffering. Cognitive balance is radically different from the cognitive restructuring that is popular in cognitive behavioral therapy (Greenberger & Padesky, 1995). Specifically, thoughts are accepted as opposed to being restructured; they are observed for what they are—transient phenomena that are impermanent and do not define the self. On the surface, a mindfulness approach to well-being may seem to conflict with the assumptions of cognitive behavioral therapy, which hold that encouraging self-focused attention in people who are self-critical to begin with might intensify their negative affect. However, as Smith (2004) has argued, mindfulness training helps older adults to become aware of how the mind’s

propensity to be self-critical perpetuates suffering, “helping them to disengage from self-focusing and to alter how they self-focus towards acceptance and kindness rather than self-criticism and rumination” (p. 423). Explicit tests of this distinction are warranted in older adults given that there is no shortage of rumination (Einstein & McDaniel, 1997) and self-criticism (Martin, Leary & Rejeski, 2000) with aging.

Affective balance implies freedom from excessive emotional volatility. Wallace and Shapiro’s model sees it as a natural outcome of achieving conative, attentional, and cognitive balance. Central to achieving affective balance are the qualities of loving-kindness, compassion, empathetic joy, and equanimity (Salzberg, 1995). Loving-kindness seeks to befriend ourselves and others, whereas compassion is sensing from “within what it must be like to experience someone else’s experience” (Salzberg, p. 109). Empathetic joy asks of us, “Can we allow the lives of others to be different from ours and feel happy for them? Can we rejoice for them as their happiness grows, in whatever way that is happening?” (Salzberg, p. 121). Finally, equanimity means deeply learning what it means to let go of concepts and preconceptions that bias our interpretations of life experiences; to really live moment to moment with focused attention. The astute reader will recognize the overlap of this concept with cognitive balance, underscoring Wallace and Shapiro’s (2006) position that affective balance is a natural outcome of conative, attentional, and cognitive balance. Although various features of Wallace and Shapiro’s model of well-being are intriguing and have support from related literature (see Wallace & Shapiro, 2006), formal tests of the concepts and propositions are lacking.

As research on mindfulness in older adults moves forward, it will be important to understand the physiological and neurological sequelae that occur in response to acute episodes of training with older adults who have varying levels of experience with the practice and how training might influence persistent changes in the brain and in other biological systems. In addition, it should be clear that mindfulness involves more than simple relaxation. A discussion of progressions in training and forms of meditative practice is beyond the scope of this article; however, interested readers should consult Alan Wallace’s (2005) book, entitled *Genuine Happiness: Meditation as a Path to Fulfillment*.

The Body, Aging, and Mindfulness

Western society actively lives out a dualism of mind and body that has plagued science for centuries. Only recently has medicine considered cognition and emotions relevant topics in the study of physical health (Sternberg, 2000). Moreover,

although medicine has a long history of research into the biology of emotional pathologies, such as depression, rarely do scientific theories or people in the context of their daily lives acknowledge how important bodily sensations are to the way they think and feel. In contrast, from the Buddhist perspective, the first foundation of mindfulness is attention to the body. As Brach (2003) so aptly puts it, “Sensations in the body are ground zero, the place where we directly experience the entire play of life” (p. 95). Just how does this alliance occur?

As we move through the day, we are either consciously or unconsciously processing sensory input. The brain then interprets the data from these sensory inputs for our experience. People grasp at those moments that the mind interprets as pleasant and seek to avoid those perceived as unpleasant. This approach-avoidance pattern is a well known, empirically validated law in psychology, and, in many instances, the body is a partner in or enabler of these tendencies. However, the ultimate irony from a Buddhist perspective is that all of life’s possessions and moments of pleasure such as those brought on through the satisfaction of cravings are impermanent. Although difficult to accept, according to quantum physics, the concept of impermanence is a basic law of nature (Stapp, 2007). After conducting years of research on happiness, both nationally and internationally, Diener (Myers & Diener, 1995) concluded that satisfaction with life “is less a matter of getting what you want than wanting what you have” (p. 13). The Buddhist view takes this position a step further, suggesting that happiness, a trait, has less to do with transient external satisfaction than it does with “the propensity toward compassion, reduced vulnerability to outer circumstances, and the interconnectedness with people and other living beings in one’s environment” (Ekman, Davidson, Ricard, & Wallace, 2005; p. 65). It would seem that this perspective on happiness deserves empirical study in aging, given the interest in quality of life in gerontology.

Interestingly, the mind orchestrates what we see and how we react and suffer; reality is in the eye of the beholder. This fact was supported in a classic experiment conducted more than 30 years ago (Speisman, Lazarus, Mordkoff, & Davidson, 1964). In this study, college students watched a film on the rite of passage for young boys in a primitive society. The procedure involved making a deep incision on the underside of the penis from the tip to the scrotum. Before viewing the film, students were randomly assigned to one of four treatment conditions: (a) viewing the film with no sound track, (b) viewing the film with a sound track accompanied by a narrative that underscored the “physical trauma,” (c) a “denial” narration that put aside the pain and harm, emphasizing the joyful nature of the occasion in this primitive society, or (d) a scientific narration that encouraged the viewers to watch the film in

a detached and objective manner. The results clearly showed that students' stress responses were most acute in the trauma condition; suffering was a construction of the mind. What this experiment and many others since have told us is that thoughts, feelings, and images related to the past, present, and future trigger reactions in various systems of the body that can lead to disease and disability (Krantz & McCeney, 2002; Kiecolt-Glaser, McGuire, Robles, & Glaser, 2002), offering support to the deleterious physical effects of cognitive imbalance (see Wallace & Shapiro, 2006).

What is particularly important from the perspective of mindfulness is that the richness of present-moment experience is channeled to us through the sensory systems of the body. In mindfulness, specifically for mental balance, one trains the mind to pay strict attention to sensory experience in the absence of distortions that are created by mental concepts and images (Wallace & Shapiro, 2006). As Brown and Ryan (2003) cogently argue, mindfulness in the present moment is a perceptual experience, not an act of metacognition, or thinking about thinking. Therefore, and perhaps a bit ironically, *the body is where mindfulness is experienced*. Brach (2003), in reflecting on suffering in her own life, argued that by opening mindfully to the play of her body's sensations during a stressful encounter, the grip of her own anger, the drama that she had created, naturally loosened. She concludes that in doing so, "we free ourselves at the ground level from the reactivity that perpetuates our suffering" (p. 97).

A very similar perspective has been developing around the concept of pain, perhaps the single most important symptom in medicine and in the lives of many older adults. As soon as pain arises, the mind becomes preoccupied with how to get relief, how to move away from it, as from other unpleasant events. Accumulating evidence suggests that acceptance of pain results in lower physical and psychological disability and to lower pain intensity than avoidance-oriented coping (McCracken et al., 2004). Furthermore, it is known that cognitive and affective distortions of painful stimuli—imbalances in the Wallace and Shapiro (2006) model—intensify the experience of pain. For example, in one prospective study of patients with rheumatoid arthritis, catastrophizing thoughts significantly predicted the severity of pain, self-reported functional limitations, and depression 6 months downstream (Keefe, Brown, Wallston, & Caldwell, 1989). Alternatively, among patients with knee osteoarthritis (Keefe et al., 1987), low catastrophizing thoughts in combination with strong perceptions of control were inversely related to knee pain, disability, and psychological distress.

What, then, does mindfulness offer as an alternative way of coping with pain? As Brach (2003) and Young (2004) have suggested, rather than looking for relief or trying to avoid pain by building resistance in both the mind and body, it is best to break the trap of mind-body dualism and train the mind to develop

a different relationship with the sensations—to be with them. As Leventhal and Everhart (1979) suggest, if pain sensations are accepted, and the subject attempts to isolate their size, specific location, and shape—informational attributes—neither the body nor the mind resists the experience, and the sensations are tolerated with less emotional, cognitive, and behavioral reactivity. We have observed similar outcomes in people processing fatigue and other cues of discomfort during physical work (Rejeski, 1985).

One clear lesson from this discussion is that the body is important to the experience of suffering and learning how to pay attention to shifting sensations moment by moment. The equanimity that applies to letting go of concepts and preconceptions (Wallace & Shapiro, 2006) is perhaps most important in relation to bodily sensations that evolve from psychological or physical discomfort. Furthermore, because of the body's profound place in cultivating mindfulness, movement should be central to mindfulness-based therapies, as is true in MBSR (Kabat-Zinn, 1990). Within this context, the final section of this article examines the potential relationship between physical activity and mindfulness in aging.

Mindfulness, Physical Activity, and Aging

A mindfulness perspective can benefit the promotion of physical activities and a new relationship with the body in aging. Likewise, physical activities in the context of aging provide an ideal means of developing mindfulness in day-to-day life. For more than 20 years, my colleagues and I have conducted randomized clinical trials of physical activity with older adults who have a range of comorbidities, including cardiovascular disease, arthritis, chronic obstructive pulmonary disease, obesity, and mobility disability (Rejeski & Brawley, 2006). As we described in a recent supplement of the *American Journal of Preventive Medicine*, good evidence supports the conclusion that physical activity has positive effects on many health outcomes and can improve physical function even in late life (Rejeski, Brawley, & Haskell, 2003).

As the observed effects of physical activity on various health outcomes for older adults have been so impressive, I have become increasingly committed to using cognitive behavior methods to promote it. Keeping in mind the fact that there may be some older adults who lack either the physical or mental resources to effectively engage in self-management, our research suggests (Rejeski et al., 2003) that many older adults simply lack the self-regulation skills, the knowledge about physical activity, and the motivation to make long-term behavior changes that could enhance their quality of life. Whereas cognitive behavior methods used in this context have been shown to improve adherence over traditional

exercise programs (Rejeski et al.), I believe this approach for promoting physical activity also has limitations if we are really concerned about older adults' self-managing and developing a different relationship to their health.

In general, good clinical trial researchers will do whatever it takes to get people to adopt and to achieve study goals. After all, how can you evaluate the efficacy of a drug or a behavioral intervention if the frequency and dosage of treatment varies widely? Yet our lifestyle-behavior trials ask a significant percentage of older adults to make major changes in their day-to-day practices while suffering chronic pain, deteriorating health, and the burden of caregiving. Naturally, some will wonder, "What is the point of all of this?" Is it any surprise that nearly half who begin the ambitious trek drop out before studies have been completed (Martin & Sinden, 2001)? Are our lifestyle interventions really helping older adults to get more out of life? As one older woman put it, "This is just more of what I am already tired of doing!" *Doing* is the key word here. A shift in paradigm may more effectively achieve the goal of getting older adults to be physically active and think consciously about health behaviors.

First, I believe that physical activity should be promoted in a manner that diminishes the focus on social comparison, self-relevant thoughts, abstract thinking, and past or future mind traps. In line with Leary and colleagues (2006), we should seek to promote hypoegeic moment-to-moment self-regulation, that is, diminishing thoughts about the self. For example, we want to decrease the extent to which older adults (a) worry about how they are doing in comparison with others, (b) are self-critical of what they do, (c) think about abstract concepts, such as what they will look like 3 to 6 months from now if they just "do what we suggest," and (d) allow the mind to cling to past memories or to future plans disconnected from the activity of the body in the present moment. These goals are in fact the target of mindfulness-based therapies such as MBSR (Kabat-Zinn, 1990) and MBCT (Segal et al., 2002) and are deserving of study in promoting active lifestyles in aging.

Second, negative emotions and physical symptoms are major inhibiting factors in behavior change and commonly faced complaints in geriatric medicine and gerontology. In a mindfulness-based movement program, emotions and physical symptoms are core experiences for learning. As older adults begin to tune into the sensations of movement, they can be encouraged to notice how negative thoughts, emotions, and physical symptoms express themselves in the body. Identifying the physical reality of an experience, such as anxiety, and feeling the body resist pain are first steps in being able to let go or to relax the body and, concurrently, to let go and to relax the mind (Brach, 2003; Young, 2004). Physical activity can become a laboratory for acquiring wisdom about the self. It can provide valuable

lessons about the nature of suffering, the impermanence of sensations and experience, and how the mind functions in the construction of self.

Finally, physical activity can provide repeated mindfulness opportunities in the daily lives of older adults. As Thich Nhat Hanh and other authors have emphasized (Kabat-Zinn, 1994; Goldstein & Kornfield, 1987; Wallace, 2005), the true practice of mindfulness is not limited to the quiet, serene confines of a meditation chamber. On the contrary, it is a way of living, a commitment to just simply *be* with moment-to-moment sensory experience as opposed to being obsessed with doing things and going places, often finding ourselves trapped in a "trance of unworthiness" (Brach, 2003) if we cannot keep up. In the process of integrating mindful physical activity into the daily lives of older adults, we also hope to compress disability and morbidity into the final weeks or months of life. If we can accomplish this goal, geriatric medicine would help to fulfill a commitment of the Gerontological Society of America: "Adding life to years, not just more years to life."

Summary

As Kabat-Zinn (1994) so eloquently stated, mindfulness is "paying attention in a particular way; that is, on purpose, in the present moment, and nonjudgmentally" (p. 4). In this article, I underscore the body's central role in cultivating mindfulness; indeed, the body is ground zero for both suffering and happiness (Brach, 2003). Furthermore, mindfulness-based interventions that focus on reconnecting the mind and body around the theme of acceptance have particular therapeutic value for older adults, because physical symptoms, deteriorating biological systems, chronic disease, caregiving, and suffering are inevitable. Smith (2004) agrees that mindfulness is particularly important for older adults because the problems that this training addresses are more prevalent with increasing age.

In recent years, several authors have sought to identify key dimensions of mindfulness training. The most elaborate framework is offered by Wallace and Shapiro (2006). Particularly relevant for older adults is the concept of conative balance, in short, re-evaluating priorities and making certain that their daily behavior is consistent with how they want to be remembered. In Western society, many people step on a conveyor belt of striving early in life, and as Salzberg (1995) warns, "After that first step, we often don't pay much attention until we've gone a long way down the road. We might then look back and exclaim, 'This isn't the road I mean to come down!'" (p. 192). Mindfulness challenges people at any age to look back, not to stir the pot of suffering, but as a means of increasing wisdom. It challenges us to focus our attention on this moment and each successive moment of our lives so that we can gain

insight into the purpose of our existence and create a path in life that fosters well-being.

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Received February 27, 2007

Accepted June 21, 2007

Decision Editor: William J. McAuley, PhD