Mindfulness in Elder Care
- A Perspective for Professionals

Pia-Christine Hyppönen

Degree Thesis

Human Ageing and Elderly Services 2010

2013

DEGREE THESIS	
Arcada	
Degree Programme:	Human Ageing and Elderly Services 2010
Identification number:	12865
Author:	Pia-Christine Hyppönen
Title:	Mindfulness in Elder Care – A Perspective for Professionals
Supervisor (Arcada):	Gun-Britt Leijonqusist
Commissioned by:	Kustaankartano

Abstract:

The approach to eldercare will have to be modified. Amongst the reasons for this are demographic change and a more demanding generation of baby-boomers. Another cause is the combination of high work load and staff shortage leading to stress and burnout in caregivers. As a result, services to elder clients are reduced and suffer.

The aim of this paper, which was commissioned by Kustaankartano, is to find out how mindfulness affects the caring/work situation and how it can be applied in elder care.

A deductive content analysis of ten articles was carried out, using Carper's (1978) Four Fundamental Patterns of Knowing as the theoretical framework.

It was found that mindfulness affected all four patterns (empirics, esthetics, personal and ethical knowledge). Effects showed in an increase of open-mindedness, presence and compassion, self-awareness, and an awareness of ethical issues as well as an overall change of perception. Salutogenic outcomes, such as decrease in stress and fatigue and increase in physical and psychological health were observed.

The findings suggest that mindfulness practice is recommendable for caregivers, to allow for better work conditions resulting in client-centered care. It is recommended to integrate mindfulness training in colleges as part of the professional training as well as in organisations.

Limitations:

There are more approaches to mindfulness than those that have been studied here, which were mostly Mindfulness Based Interventions on the basis of Mindfulness Based Stress Reduction (MBSR). Cultural differences were not taken into account due to English-language studies only. Using the four patterns of knowing, the search brackets were defined narrowly which may have resulted in restricted findings. The same is true for the defining of categories and their subsequent evaluation and interpretation.

Keywords:	Mindfulness, Eldercare, Mindfulness Based Interventions, Carper's Four Fundamental Patterns of Knowing, Kustaankartano
Number of pages:	48
Language:	English
Date of acceptance:	28.10.2013

OPINNÄYTE	
Arcada	
Koulutusohjelma:	Human Ageing and Elderly Services 2010
Tunnistenumero:	12865
Tekijä:	Pia-Christine Hyppönen
Työn nimi:	Mindfulness in Elder Care – A Perspective for Professionals
Työn ohjaaja (Arcada):	Gun-Britt Leijonqusist
Toimeksiantaja:	Kustaankartano

Tiivistelmä:

Lähestymistapaa vanhustenhoidossa on muutettava. Syitä tähän ovat esimerkiksi väestörakenteen muutos eli suuret ikäluokat, sekä siitä johtuva palvelutarpeen kasvu. Toinen syy on rasituksen ja ylikuormittavuuden lisääntyminen yhdistettynä henkilöstöpulaan. Tämän seurauksena ikäihmisten palvelut vähenevät ja kärsivät. Tämän tutkimuksen on tilannut Kustaankartano, ja sen tavoitteena on selvittää, miten mindfulness vaikuttaa hoivaan ja työtilanteisiin sekä miten sitä voidaan soveltaa vanhustyössä. Deduktiivinen sisällön analyysi suoritettiin kymmenen artikkelin pohjalta käyttäen Carperin (1978) Four Fundamental Patterns of Knowing-teoriaa viitekehyksenä. On todettu, että mindfulness vaikuttaa jokaiseen neljästä osa-alueesta (empiriaan, estetiikkaan, henkilökohtaiseen ja eettiseen tietoon). Vaikutukset osoittivat lisääntynyttä ennakkoluulottomuutta, läsnäoloa, myötätuntoa, itsetuntemusta ja tietoisuutta eettisiin kysymyksiin liittyen sekä kokonaisvaltaisten havaintojen muuttumista. Terveydellisiä tuloksia, kuten stressin ja väsymyksen vähenemistä, sekä fyysisen ja psyykkisen terveyden kohentumista havaittiin. Havainnot viittaavat siihen, että mindfulness käytäntö on suositeltava hoitajille, jotta pystytään saavuttamaan paremmat työolosuhteet, sekä sitä kautta keskittymään olennaisemmin asiakaslähtöiseen työskentelyyn. On suositeltavaa integroida mindfulness käytäntöä hoitoalan koulutukseen oppilaitoksissa, sekä myös osaksi koulutusta työelämän puolella. Rajoitteita: Mindfulnessiin liittyviä lähestymistapoja on useampia kuin tässä tutkimuksessa esille nostetut, mitkä ovat lähinnä tarkkaavaisuuteen liittyviä interventioita (MBI), jotka perustuvat Mindfulness Based Stress Reduction-viitekehykseen (MBSR). Kulttuurivaikutuksia ei otettu huomioon tämän tutkimuksen aikana, koska tutkimuksen käyttökieli oli ainoastaan englanti. Koska teoreettisena viitekehyksenä käytettiin Four Fundamental Patterns of Knowing-kehystä, hakukriteerit määriteltiin suppeasti, mikä voi aiheuttaa rajoitettuihin päätelmiin päätymistä. Sama pätee kategorioiden määrittelyyn ja niiden arviointiin sekä tulkintaan.

Avainsanat:	Mindfulness, Eldercare, Mindfulness Based Interventions, Carper's Four Fundamental Patterns of Knowing, Kustaankartano
Sivumäärä:	48
Kieli:	englanti
Hyväksymispäivämäärä:	28.10.2013

Acknowledgments

First of all I would like to thank Kustaankartano for commissioning this thesis, which would not have been written if it hadn't been for the help and support from friends and family. Many, many thanks to HP, Bill and Bob, Lois and all our friends - what would I do without you?? Thank you, Marie, Bill and Tony for reading through drafts and for your valuable feedback. I am very grateful to Raimo, Juhani, Tomi, Rosita and the kids, for keeping me afloat. Thank you, Mom for your help and for taking me out to pick berries. Thank you to my teachers Christel and Solveig for long chats on the phone and face to face. Thank you Gun-Britt for supervising this work. Thank you to all at Arcada, especially Library and IT-helpdesk! Thanks to Touko for the help with the Finnish abstract. I am very grateful to all the professionals and clients I have met over the years and who have taught me a lot. A big thank you to Esa my wonderful husband, for all your support and for washing the dishes. Last, but by no means least: Thank you to Amaretto our old cat, who taught me a thing or two about relaxing and taking a break throughout the day.

This work is dedicated to 'Tante Else', the first significant 'old' person in my life, who taught me through living her life that age is a question of attitude.

CONTENTS

Tables

1 FOREWORD

"How we treat our elders matters. Ageing is a part of life. And if you don't like that certainty that your body will wear out – consider the alternative." (McBee 2008 p.3)

The reason for choosing this topic lies in my observations during practical trainings and work in elder care facilities. I felt that as a visiting student I had no right to interfere and decided to watch. I saw that many caregivers seemed to have the best in mind for their clients and do all in their power to care and help but they seemed to be stressed, overwhelmed and dissatisfied. This in turn, I believe, had a direct effect on their clients.

I also witnessed clients being yanked out of bed, patronized and made fun of. I saw caregivers rushing the work with their clients in order to spend time in the staff room with their colleagues or browsing the web. Clients' calls were answered but not always responded to straight away. Diapers were partly used to ease the workload. Instead of taking time to be with an anxious client, anxieties were calmed with medications.

I heard often that there just was no time. Staff shortage is a current reality but I do not believe that there is no time. I am convinced that there is always enough time for the things we really want to do.

If what I saw is the common reality and not just a bad example, the professional standards in elder care have to be raised. It is necessary to create a work ethic that has the individual client in mind, acknowledges differences and yet is able to serve the whole. I think this change can only start on an individual basis, with the caregiver. I strongly feel that continuous education of caregivers is the only way to better the circumstances for older people.

As a professional in elder care, I need to be conscious of the reality and the consequences of my actions and I need to ask myself: Would I like my parents to be cared for like this? Would I like my children to be treated like this? Along with these questions and in view of the likelihood of a long life, and therefore purely selfish reasons, I may ask myself 'How would I like to be cared for?'

2 INTRODUCTION

The approach to elder care will have to be modified. One reason is the global demographic change and the cohort of baby-boomers starting to retire. According to the United Nations (UN 2009) the proportion of older people worldwide is expected to more than double over the next 50 years. This means that an increasing number of over 65-year-olds will have to be supported by a relatively small number of people in working age, which will put higher demands on the younger groups. (UN 2009)

In the year 2011, 42 % of the population in Finland lived alone, with one third being 65 years and older (Official Statistics of Finland/ OSF 2011). In 2009 almost 50% of those who died over the age of 80, had suffered from ischaemic heart disease or memory disorders, which were the cause of death. 'The number of deaths caused by dementia has more than doubled in two decades' (OSF 2009). Once individuals are not able to move freely and independently for physical or cognitive reasons, they will become dependent on formal and informal caregivers.

The overall aim of The Finnish National Framework is for people to live in their own homes for as long as possible (Ministry of Social Affairs and Health 2008, 2012). However, Böckerman et al. (2012 p.1188) report that individuals living in "old age homes actually report higher levels of SWB [subjective wellbeing] than those who are living at home." Whether they are taken care of by close relatives, friends, or practical nurses, many older people end up, or will end up, spending a lot of time by themselves. Their basic physical needs might be met, but humans also have mental, spiritual and social needs.

There is evidence that social interaction is important for the maintenance of a good quality of life. Abu-Rayya (2006) suggests that social activities can prevent depression in older people. Ayalon and Shiovitz-Ezra (2011) found a correlation between loneliness and passive death wishes in people over 50 and propose that interventions should address "the subjective sense of loneliness' rather than 'objective indicators of social interaction" (Ayalon & Shiovitz-Ezra 2011 Abstract).

Another motivation for change in elder care is the Baby Boomers generation. Baby Boomers are not as silent and easily satisfied as their forefathers and mothers. “It is anticipated that this group will expect, perhaps demand, changes in the ways health care is provided” (McBee 2008 p 6). This is mirrored in the opinion of 80% of Europeans that “committees of older people [would be] useful to deal with issues they face in their local communities” (Eurobarometer 2012 p 122).

In Finland, older people who cannot care for themselves are cared for at home, in hospitals and assisted living facilities. (Eurohealth 2010) At present, the main role of professional caregivers, mainly practical nurses who are supervised by registered nurses, is to aid with activities of daily living (ADLs) such as washing, dressing or eating, that cannot be carried out by the client themselves. In addition, and depending on the facility, staff members belonging to different professions are available to the clients, including physiotherapists, occupational therapists and social workers. Sometimes they are supported by volunteers.

Older people who live at home receive homecare depending on their physical needs but caregivers do play an important role in the social life of clients who are unable to leave their homes. (Dale et al. 2010) The contact with the client is restricted to a minimum, yet, social contact is one important aspect of human well-being and quality of life. Studies suggest that social contact, next to physical exercise have shown to slow down the progression of Alzheimer's Disease (Alzheimer's Association 2013) and there is evidence that the feeling of loneliness and the feeling of physical pain are correlated and activate the same regions of the brain (Kross et al. 2011) .

A third reason for the need for change in the approach to elder care is the current work-dissatisfaction and the resulting high staff turn-over, sick leave and early retirement due to work related illness. “A main cause of people leaving working life early is work disability due to depression”(Masto /Hyssälä 2009 p 2). This is not restricted to care work and has been addressed in the Masto Project on a country wide level between 2007 and 2011 (Masto 2009).

Although social activities are considered important (Eurohealth 2010), caregivers often do not have the capacity to listen and to engage with their clients on a deeper level. This might be due to lack of professional training (Engström et al. 2011) or to reasons of

time pressure due to schedules that need adhering to, which in turn can result in automated, hurried interactions.

Working and relating with older people who suffer, can put a strain on caregivers, who might feel overwhelmed by the demands they are facing. Especially working with people who have dementia "can lead to frustration for both the nurse and patient and may result in avoidance of interactions" (Jootun & McGhee 2011 p 44). This affects formal as well as informal caregivers. Not being able to meet the old persons' needs can lead to feelings of guilt and incompetence (Spillers et al. 2008) which can result in more stress and burnout, putting more strain on the caregiver and as a result impact the caring and social relationship with the client (de Rooij et al. 2012).

Policies and directives change over the years and, in Finland, are different from one municipality to another. This can give caregivers a feeling of powerlessness, which results in more stress. "Common to this job situation are complaints of too much responsibility and too little authority" (APA 2013). The amount of demands and the lack of time and resources to carry them out, lead to dissatisfaction in the caregivers, which affects their relationship with their clients, and vice versa (Häggström et al. 2004).

Humans are holistic beings, with a body, mind and spirit. It is important to see and relate to the whole being as Buber claimed in 1923. This being said, Bullington & Fagerberg (2013) call for a scientific concept and clear philosophical definitions for the terms 'holistic care' and 'person-centered care', as they are often "fuzzy", "with an air of new age movement" (Bullington & Fagerberg 2013 p. 493) and therefore lack credibility. However, it is suggested that in the future it will be necessary for caregivers to address all aspects of care, in order to provide person-centered service. This does not demand perfection or knowing-it-all by the caregiver, but it does ask for a more holistic approach, to get away from the 'achieving to get rid of symptoms' to a 'being with and enabling/empowering'.

One cannot give what one does not have, therefore it is suggested that it is necessary to find out about oneself, to become self-aware and meet the client from that center. It is important to remember why care work was chosen as a career, what one's individual needs are to carry it out, according to the inner work ethic. It is important to remember

or to find out, what that ethic entails. “True morality consists not in following the beaten track, but in finding the true path for ourselves, and fearlessly following it” (Mahatma Gandhi). This is a tall order for mere mortals. It might not possible for one caregiver to change national policies, but it is possible to change the personal approach and attitude towards care and work and to make a little difference on a daily basis. Knowing how to measure blood pressure, give insulin, wash a client or make food, is important.

However, knowing how to let go of stress, how to interact with clients in a meaningful way, knowing ones limits and being aware of one’s attitudes, are going to be as important skills in the work life in general and in the contact with older people in particular. One aspect that is needed in all situations is presence and awareness. Mindfulness could be one way of achieving this and its effects have been studied a lot over the years.

2.1 Aim & Research Questions

The aim of this paper is to find out how mindfulness might affect the caring/work situation and how it could be applied in elder care. This led to the following two questions:

- What are the effects of Mindfulness?
- How can mindfulness be applied by the caregiver in the work with older people?

2.2 Theoretical Frame

Despite saving policies and work stress, caregivers give a lot of themselves, they apply knowledge based in professional education but also in personal experience and a work ethic. Carper (1978) proposed four patterns of knowing, that are necessary for nurses to provide good care. Her theory was chosen as a frame because nursing is a significant part in the work with older people, albeit not the only one. It is suggested that Carper’s theory can effortlessly be applied to care and professional work in the widest sense. The four patterns of knowing are “(1) empirics, the science of nursing; (2) esthetics, the art of nursing; (3) the component of a personal knowledge in nursing; and (4) ethics, the component of moral knowledge in nursing.” (Carper 1978 p 23)

According to Carper, all those ways of knowing are related to each other and cannot stand by themselves. She proposes that nursing (caring) should be a mixture of scientific knowledge, creativity, empathy, self-knowledge and taking responsibility for moral choices. Although 'psychic' detachment is necessary in order to relate and engage with the individual patient/client on a personal basis rather than a case amongst many, Carper's idea of relationship between nurse and patient asks for "a risk of total commitment" (Carper 1978 p 28). Amongst others she refers to Buber's *I-Though* and its application of an "authentic, personal relationship between two persons." (Carper 1978 p 28)

2.2.1 Mindfulness

In the English language, being 'mindful' is synonymous to being "full of care; heedful, thoughtful; full of memories' and 'taking thought or care, being conscious or aware." (Oxford English Dictionary Online 2013)

The concept of mindfulness has its origin in Buddhism, a philosophy based on the teachings by Siddhārtha Gautama, known as Buddha about 2500 years ago. Its aim is the cessation of suffering, which can be achieved through the cultivation of mindfulness, which leads to the awareness that the only constant in life is change and that attachment of any sort, mental or material, creates suffering. Mindfulness is an (innate) state as well as meditative practice. Mindfulness is something we all have when focussed in the moment, instead of "being lost in fantasy" (Mann & Youd 1998 p 32). One could say that practicing state mindfulness enhances trait-mindfulness, which is expressed in higher levels of focus, empathy and detachment.

Dane (2011) defines and relates Mindfulness to other ways of consciousness, such as 'absorption' and 'flow' and shows the varying levels of 'present moment orientation' and 'breadth of attention'. He also states, that mindfulness is not a cure-all but one way of performing tasks. By definition, mindfulness is a state of consciousness where the individual is aware of what is going on within themselves and the environment surrounding them.

Dane (2011) argues that the task at hand, the environment (static or dynamic) and the performer's skill (novice or expert) are decisive for the form of consciousness to use. In

other words, a novice is not able to focus on more than one task at a time and the ability to take in the surroundings simultaneously comes with experience. Dane (2011) also suggests that mindfulness possibly enhances ethical behavior. If an individual has a wider view on a situation, he or she might be able to anticipate consequences and act accordingly. By the same token, mindfulness might make a person aware of ethical issues.

Chiesa and Malinowski (2011) remind their readers that Mindfulness can be achieved in different ways, that meditation, although the basis for many forms of Mindfulness Based Interventions (MBIs) is not absolutely necessary. Terminology and definitions vary between and also within different philosophical traditions pertaining to mindfulness. Therefore the question whether the term 'mindfulness' should be used as an "umbrella term" for the many varying concepts, states and ways to achieve mindfulness is worth asking (Chiesa & Malinowski 2011 p. 420). This is contrary to Kabat-Zinn's initial intention to keep the whole concept of Mindfulness Based Stress Reduction (MBSR) as simple as possible by using the umbrella term 'mindfulness', trusting that "the details concerning the use of the word mindfulness in the various contexts in which we were deploying it could be worked out later by scholars and researchers who were knowledgeable in this area" (Kabat-Zinn 2011 p. 290).

According to Malinowski (2008), measuring mindfulness and the effects of meditation is ambiguous. Due to different conceptualizations of Mindfulness, a range of measuring scales have been developed, for instance the FMI, KIMS, CAMS, MAAS, FFMQ and TMS, which all have varying measuring factors. (For full names of scales and their authors, see glossary in appendix.) Further, statements on self-report scales might have different meanings to the participants of a study, depending on their prior exposure to the concept and practice of Mindfulness. These facts make "clarifying the underlying construct […of Mindfulness…] a challenging one" (Malinowski 2008).

2.2.2 Meditation

Chiesa and Malinowski (2011 p. 407) inform their reader that "the word 'meditation' derives from Latin 'meditari', which means 'to engage in contemplation or reflection' and can be defined as both a process and a state." In The Encyclopedia Britannica

Merkur (2013) defines meditation as “private devotion or mental exercise encompassing various techniques of concentration, contemplation, and abstraction, regarded as conducive to heightened spiritual awareness or somatic calm.”

Meditation has been part of the world religions for thousands of years. Depending on the religion or philosophy of the person meditating, the aim might be detachment from the ego, understanding of a spiritual text, enlightenment, purification or simply calming down (Merkur 2013). However, one can meditate without any spiritual or religious notion. Gauding (2005 p.12ff) described meditation as “the choice to focus your mind on something” and divides the forms of meditation into four groups: ‘Focusing’, ‘Thinking’, ‘Visualizing’ and ‘Experiencing’. She points out that reading a book can be a form of meditation and that different meditations work for different people (Gauding 2005 p. 12ff). Depending on the discipline, for instance mindfulness - vs. transcendental - meditation, a practitioner can expand or concentrate their awareness respectively (Malinowski 2008).

A meditative state of mind can be attained by listening to music or looking at an object or picture. One can concentrate on ones heartbeat or breath. One can say a mantra, that is, repeat a word or words continuously, or be silent. One can sit in a chair with both feet on the ground or cross-legged on the floor. One can ‘experience’ movement or sensations such as in yoga or tai-chi, walk, dance or wash the dishes. One can ‘think’, of a particular problem or a concept. Whereas mindfulness meditation is to observe one’s fleeting thoughts or feelings, visualization meditation is generating a specific image in the mind and thus creating a different reality. As part of their training routine it is used by athletes who suffer from competition anxiety. Visualizing their actions in a competition can be one tool to help overcome anxiety and create better outcomes. (Newmark 2012)

As part of self-care, a meditator can lie in bed and do a body-scan, which is focusing on the body and look out for tension, pain or “subtle changes that could signal imbalance and the beginning of more serious problems” (Gauding 2005 p.152ff). ‘Body scan’ is one feature of Mindfulness Based Stress Reduction.

2.2.3 Mindfulness Based Stress Reduction

In 1979, Jon Kabat-Zinn, a molecular biologist at the University of Massachusetts Medical Center, developed a program he called Mindfulness Based Stress Reduction (MBSR). A practicing Buddhist himself, his aim was and is to bring more compassion and healing to the world by joining the worlds of Buddhist philosophy and western science. Original MBSR courses last eight weeks and consist of weekly group sessions where participants are instructed in yoga and mindfulness meditation practices. Home assignments are meant to deepen the gained knowledge on a daily basis. (Center for Mindfulness, 2013)

Kabat-Zinn (2011) describes MBSR as 'Buddhist Meditation without the Buddhism […] and yoga'. He defined mindfulness as "paying attention in a particular way: on purpose, in the present moment, and non-judgmentally." (see Cullen 2011 p. 187). Mindfulness is not only a skill that can be trained but a way of life. Taking the whole person into account, his stress-clinic's approach emphasizes the importance of the patient's involvement in the healing process which is achieved by the patient's focusing on what's right "and let the healthcare team take care of what is 'wrong'" (Kabat-Zinn 2011 p. 293).

MBSR has served as a basis for other Mindfulness-Based Interventions (MBIs). Mindfulness-Based Cognitive Therapy (MBCT), is a combination of MBSR and Cognitive Based Therapy methods and is used successfully in the treatment of depression. (MBCT 2007). Mindfulness-Based Elder Care (MBEC), as introduced by McBee (2008), adds aromatherapy, hand massage, creative therapy and humour to MBSR methods. The program is adapted to the ability of older and frail people and also addresses their caregivers. The basic "marrow" (Kabat-Zinn 2011 p. 300) of mindfulness - based intervention is, that just being in this very moment is enough.

> We might say that if mindfulness does not in some sense become our default mode, then its opposite, mindlessness or unawareness, will certainly retain that role. The inevitable result is to be caught up in a great many of our moments in a reactive, robotic, automatic pilot mode that has the potential to easily consume and colour our entire life and virtually all our relationships. (Kabat-Zinn 2011 p. 293)

In this author's view any form of mindfulness or mediation has its purpose. In an ideal world, all levels of interactions would be carried out 'full of care; heedful and thoughtful. Caregivers would have time to listen to elders "full of memories" and would

be “conscious or aware” (OED 2013). How this is achieved varies from person to person. Different situations ask for different forms of presence, often it is necessary to be multi-tasking (being aware of many things at the same time), sometimes being ‘in the flow’ is possible and even desirable. Contrary to other forms of Mindfulness practices, MBIs are scientifically researched the most and therefore presented here.

2.3 Limitations

This paper has several limitations. The concept of ‘Mindfulness’ is an expansive subject matter on which the views are divided. The studies used here are mostly MBI – methods. This can easily form the false impression that they are the only way of achieving mindfulness. It could be argued that, by using the four patterns of knowing, the search brackets were defined too narrowly which resulted in restricted findings. The same is true for the defining of categories and their subsequent evaluation and interpretation. The studies examined were all written in English with a predominantly Anglo-American background. Therefore they do not take into account cultural differences. To show quantitative features of the findings, the number of occurrences of a statement could have been counted.

3 METHOD AND MATERIAL

A deductive content analysis was carried out. The deductive approach was chosen in order to find out how the concept of mindfulness could be related to Carper’s Four Patterns of Knowing. Content analysis is an approach that helps to summarize and analyze the knowledge gained from the many studies carried out in nursing and social work and is applicable to qualitative and quantitative data. (Elo & Kyngäs 2007) Rather than choosing one approach over the other, a mixture of qualitative and quantitative research is useful, depending on the questions asked and data needed. (Ercikan & Roth 2006) Although humans are all individuals, they still share and have certain traits in common which can be classified. Yet, the classification does not take away from the individual experience and vice versa.

Findings from qualitative research are not countable, but personal values, impressions, expressions and feelings are being considered and looked at within a social context

(Bryman 2004 p. 266). The way to summarize this data is to label and to group the subjective findings into meaning units, which in turn are clustered into themes and subthemes. "[…] events, persons, and processes are grouped according to similarity" (Leininger 1985 p. 62). One of their main characteristics, "A common feature of all Qualitative methods [,] is the use of interpretation" (da Silva 2002 p.40) and "Qualitative Data […] do not speak for themselves […] they need to be analysed" (Abott & Sapsford 1998 p.132).

The measurements of quantitative research produce clear values and validity and reliability are clearly defined. Reliability looks for patterns and themes (or lack thereof) of subjective experiences and points of views in various situations (Leininger 1985 p. 69). Reliability is also measured in terms of how well an experiment or study can be replicated, which is easier in quantitative research than qualitative research (Bryman 2004 p. 273). By relating the process and the findings as detailed as possible, others can follow, understand and replicate it (Elo & Kyngäs 2007). Graneheim & Lundman (2003 p. 110) proposed that "Trustworthiness will increase if the findings are presented in a way that allows the reader to look for alternative interpretations."

Trustworthiness in the context of this paper can be achieved through the variety of articles from different fields, and the variety of subjects who took part in mindfulness courses or who practice mindfulness. Another way to gain trustworthiness would be to include studies that are not particularly in favour, or even negatively inclined towards mindfulness. By presenting these findings, the reader is enabled to make their own decision in regards to the application of mindfulness.

According to Elo & Kyngäs (2007) there is no right or wrong way of doing a content analysis. The interpretation of text is subjective as the researcher's view on everything is marked by his or her environment and society "and the researcher's interpretation is influenced by his or her personal history" (Graneheim & Lundmann 2003 p.111). The perception and objectivity of the researcher plays an important part in the analysis of any text.

Often the studies analysed here do not have enough participants to allow for quantitative trustworthiness. However, the aim of this paper, to find out about the effects of mindfulness, is not something that can be measured in numbers, as the experience of

meditation, the resulting well-being or lack thereof, is a subjective one. In qualitative research, “Measurement is not the goal, rather knowing and understanding the phenomenon is the goal” (Leininger, 1985 p.68).

3.1 Search

The Arcada Nelli Portal was accessed directly through computers at ARCADA or through remote access from home. An advanced Meta search was conducted. The category ‘Social services’ with the sub category ‘Human ageing’ contains twenty databases. Search terms were not limited to subject but filtered through ‘all fields’.

Because of existing extensive research on mindfulness, it was decided to conduct a deductive qualitative content analysis using Carper's four patterns of knowing as categories. Carper's Fundamental patterns of knowing are made up of four components: empirics, esthetics, personal knowledge and ethics. Search was conducted by combining those words with ‘mindfulness’. Since the topic of this paper is Mindfulness in elder care, the term ‘mindfulness’ was also combined with the terms ‘AND older people’ and ‘AND elder care’. The term ‘mindfulness’ was combined with the terms ‘AND empathy’, ‘AND empirical studies’, ‘AND ethics’, ‘AND transactions/communication’ and ‘AND quality of personal contacts’.

Due to the inquiry of effects of mindfulness on the caring situation, another search was carried out, combining ‘Effects of mindfulness’ with ‘AND stress’, ‘AND stress AND empathy fatigue’, ‘AND subjective wellbeing’, ‘AND social support’, ‘AND social support AND older people’ and ‘AND social support AND formal caregiver’

To be initially included, articles had to be ‘peer reviewed’, could be qualitative or quantitative in nature, and be published in or after 2008. EBRARY results were excluded at all times, as this database does not contain articles. Based on the abstracts, articles were accepted preliminary and exported from their database into RefWorks. They were collected into a folder named ‘Mindfulness Thesis’ for later reading and final inclusion.

The ten chosen articles (see Table 1) were numbered and read with the question in mind: “What are the effects of mindfulness?” Any statement that expressed an effect

was highlighted. The information gathered from each article was recorded into an Excel-file (Appendix 2). The categories for deduction were the four patterns of knowledge as proposed by Carper (1978), empirical knowledge, personal knowledge, esthetic knowledge and ethical knowledge. A preliminary categorization showed that some statements would have fit into all four categories. The aim of one category per statement made it necessary to divide longer testimonies into shorter meaning - units to avoid overlapping of categories. Carper's article was read several times to find the main themes of each pattern in order to categorize statements accordingly. The meaning units were created according to the emerging themes. (Appendix 2)

4 FINDINGS

Categories and sub-categories have been chosen in line with Carper's article from 1978 where she described the four different patterns, and what they entail. The classification that followed is by no means categorical. The statements chosen to represent the findings are taken from the studies analyzed. They are not absolute but represent the essence of similar statements from the categories. The categorization of meaning units was challenging at times. This is due to the fact that the four patterns themselves are overlapping and feeding into each other. Rather than a linear chain of events, the four patterns of knowing could be described as a moving, braided circle. According to Carper (1978) none of them can stand by itself and none would be the same without the others.

There were few negative side effects reported as results of practising mindfulness. Irving et al. (2009 p. 65) state: "Potentially negative side effects of mindfulness found (albeit rarely) exacerbation of psychiatric symptoms as well as altered reality testing, grandiosity, unusual behaviour, euphoria, and even psychosis." However, the authors draw attention to the role of the instructor's training and experience in regards to the outcome of mindfulness interventions.

The findings for each pattern have been entered into tables which can be found in each section. The quotes for all subcategories were taken from the texts analysed. The numbers in brackets behind quotes refer to the articles' numbers as shown in the table below.

Table 1: Articles used for Content Analysis

No.	Year	Author	n	Design	Intervention/ Method	Article's Results
1	2010	Christopher, Chrisman, Trotter-Mathison, Schure, Dahlen & Christopher	16	Qualitative	2-6 year follow up after Participation in Mindfulness training/ semi-structured phone interviews; inductive content analysis	Mindfulness and self-care practices found to have positive influence on mental, physical, emotional wellbeing and interpersonal relationships.
2	2010	Ruedy & Schweitzer	S 1: 97 S 2: 125/135	Quantitative	Study 1: Surveys (MAAS,MMS,SINS,SMI), Study 2: experiment (CAM)	strong correlation between mindfulness and ethical behavior and formalism
3	2010	Richards, Campenni & Muse-Burke	148	Quantitative	Survey, Questionnaires (MAAS, SOS-10, SRIS)	mindfulness increases self-awareness, well-being, and self-care importance
4	2009	Chiesa &Serretti	10	Quantitative	Review and Meta - Analysis	increase in mindfulness leads to decrease in stress, anxiety, depressive symptoms; increase in empathy, self-compassion, self-control, self confidence
5	2009	Carmody, Baer, Lykins & Olendzki	320	Quantitative	Questionnaires (FFMQ,SRS,..)	increase in mindfulness related to reduction of stress and increase in well-being
6	2009	Irving, Dobkin & Park	10		Review	MBSR benefits physical and mental health; promotes wellbeing
7	2010	Oken, Fonareva, Haas, Wahbeh, Lane, Zajdel & Amen	31	Quantitative	Participation in Mindfulness training, control activities /Pilot randomized trial	"mindfulness positively affected caregiver self efficacy and cognitive measures" , "significant correlations between mindfulness and self-rated stress sores", stress and depression scales relating to mindfulness
8	2008	Schure, Christopher & Christopher	33	Qualitative	Participation in Mindfulness training/ Open ended questions; inductive content analysis	overall positive effects on physical, cognitive, emotional and spiritual level; positive effects on personal and professional relationships
9	2009	Krasner, Epstein, Beckman, Suchman, Chapman, Mooney &Quill	70	Quantitative	Participation in CME course/Self-administered Surveys at 5 time points (Maslach Burnout Inventory, Jefferson Scale of Physician Empathy…)	improvements in mindfulness lead to decrease in burnout; increase in empathy, emotional stability,
10	2010	Valentine, Godkin & Varca	781	Quantitative	Self-report Surveys measuring role conflict, mindfulness and organizational ethics	increased mindfulness leads to decrease in role conflict

4.1 The Pattern of Empirical Knowledge

For the purpose of this work, 'Empirical knowledge' has been divided into two subcategories, 'Health' and 'Changed Perspective'. They were chosen as part of Carper's central idea of "health to be [...] a dynamic state or process [...] rather than a static either/or entity" as a result of changed paradigms (p. 24). 'Health' has been further divided into the themes 'Physical' and 'Psychological'. The sub-categories for 'Changed perspective' are 'Care' and 'Life'.

Table 2: Effects of Mindfulness Practice and Empirical Knowledge

Empirical Knowledge	**Health**	Physical	"increase in electrical activity on the left sided anterior of the brain which controls immunity and positive affect" (1), reduced "mental disorders" (4) and "suffering" (5), "Salutogenic outcomes" (5), MBSR efficient with various populations for stress reduction (1, 2, 3, 4, 5, 6, 9, 10), Mindfulness training to "decrease stress" (3) , "its somatic symptoms" (1), "physical pain" (1,2,6), medical illness (3, 4)
		Psychological	decrease "burnout" (6,9). "Fatigue" (9) , "tension and distress lessened" (9, 5). "reduced depression and anxiety" (1, 2, 4, 8, 9, 10) and increased relaxation (11). It was found that "self-care importance increased" (3). Wellbeing (2, 3, 5, 9), circulation (1) and sleep quality (4, 8) increased
	Changed Perspective	Care	"Changes in conceptual framework" (1), "an ability to categorize familiar stimuli in novel ways"(2), conceptual framework of profession changed: "Seeking new ways of approaching a familiar task" (2) new "holistic view on healing and well-being" (1), "realizing to which extent reactivity can contribute to suffering and stress" (1), understanding of "personal reaction to stress" (7) and "seemed to influence their clinical skill" (1)
		Life	"a fundamental shift in perspective" (5) and practice had a "significant impact on worldview" (1), "changes in their thinking" (8), "mental clarity" (8) as well as "greater clarity and objectivity" (5), "ruminative thinking decreased" (4).

4.1.1 Health of Practioners of Mindfulness

All studies reported that practising mindfulness has an overall positive effect on physical and psychological health, or "Salutogenic outcomes" (5). An "increase in electrical activity on the left sided anterior of the brain which controls immunity and positive affect" (1) has been reported. Compliance with MBSR treatment reduced "mental disorders" (4) and "suffering" (5) and as a program for stress reduction, MBSR has been found to be efficient with various populations (1, 2, 3, 4, 5, 6, 9, 10). Different kinds of mindfulness training have been observed to "decrease stress" (3) and "its somatic symptoms" (1), "physical pain" (1, 2, 6), medical illness (3, 4) and "burnout"

(6, 9). “Fatigue” (9) as well as “tension and distress lessened” (9, 5). Practice of mindfulness “reduced depression and anxiety” (1, 2, 4, 8, 9, 10) and increased relaxation (11). It was found that “self-care importance increased” (3). Wellbeing (2, 3, 5, 9), circulation (1) and sleep quality (4, 8) were found to improve with heightened mindfulness. Following yoga and chi-gong practice, participants experienced “more physical flexibility and balance” (8)

4.1.2 Changed Perspective

“Changed perspective”, the second sub-category of “Empirical knowledge” reports the findings relating to changed views on care /professional life as well as on life on the whole. Some practitioners of mindfulness experienced a “fundamental shift in perspective” (5) and practice had a “significant impact on worldview” (1). Others reported “changes in their thinking” (8) and “mental clarity” (8) as well as “greater clarity and objectivity” (5), “ruminative thinking decreased” (4). For others, “Changes in conceptual framework” (1) took place and “an ability to categorize familiar stimuli in novel ways” (2) was stated. “Seeking new ways of approaching a familiar task” (2) and a new “holistic view on healing and well-being” (1) was noticed, “realizing to which extent reactivity can contribute to suffering and stress” (1). On the whole mindfulness training appeared to develop an understanding of their “personal reaction to stress” (7) and “seemed to influence their clinical skill” (1).

4.1.3 Discussion

As part of the pattern of Empirical knowledge, ‘Health’ and ‘Changed Perspective’ have been chosen because the main aim of nursing and caring is to generate health and well-being. Changed perspectives and raised standards of living over the centuries have defined what it means to be healthy and what constitutes good care. According to Carper (1978 p. 24) “The representation of health as more than the absence of disease is a crucial change.” The growing amount of scientific research into Mindfulness is possibly an indicator for this change.

A caregiver’s empirical knowledge includes fact-based, observable phenomena that can be counted, measured and validated. It consists of evidence based knowledge gained at

schools and in training, founded in peer reviewed literature and textbooks which are read by students with a more or less open mind. Empirical knowledge is what students are supposed to take out into practice and it enables them to draw conclusions and to research further. Whether and how gained empirical knowledge is applied in practice depends on the individual receiving it and on the environment they enter.

The articles analyzed here, mostly describe studies that have applied statistical scales and measurements and have shown effect sizes of all sizes after mindfulness interventions with different populations. Although mindfulness cannot be measured in centimeters or litres, the findings of those studies are relevant for 'Empirical Knowledge' because they show patterns and correlations. The scales applied to measure mindfulness have been developed based on scientific research. Any results, qualitative and quantitative, always depend on the measures used and the person analyzing the results. Therefore, no result is ever absolute. Over the centuries it has been seen, that "all knowledge is subject to change and revision" (Carper 1978 p.32). Mindfulness has entered the mainstream which is probably due to the extensive research carried out. This could be considered a paradigm shift in itself.

The cultivation of mindfulness has shown to enhance mental clarity (8) and objectivity (5) which in turn allows for an open mind and enables to think outside the box. Looking at a problem from another viewpoint is a prerequisite for continuing and developing research and practical work. This change of perspective also involves the inclusion of qualitative studies which gather knowledge from a subjective perspective as well as describing patterns. Their numbers of participants are smaller than those of quantitative studies, but their focus is on patterns and phenomena (Leininger 1985). Many small studies with similar results indicate a pattern.

People grow old and older because of the successes of empirical knowledge. Every day we find out more about Diabetes, Parkinson's, and the importance of a healthy diet and physical activity. The knowledge would not be available if it weren't for the many professionals who become aware of correlations and researchers who carry out empirical research, measuring and counting in the name of science. We want to have longer lives. But is longer always better? Is there any sense in quantity if there is no quality?

Throughout individual lifetimes, people learn and modify their ideas and attitudes. Over the centuries, scientific paradigms, morals, and the definition of beauty have changed repeatedly. Many were perceived as the final word, yet, they did not escape change. Heraclitus was right, change is the only constant. All that remains is the present moment (1). The concepts of 'well-being' and 'quality of life' have found their way into elder care as a result of changed paradigms which is "a fundamental shift in perspective" (5) on a large level. One example for open mindedness shows in the research into music and its influence on well-being and quality of life (Weeks & Nilson 2011; Creech et al. 2013) Another example are the findings on the importance of social contact to counteract the development of dementia (Walach & Loef 2012). Music and social contact do not appear to be common subjects of empirical research, they cannot be measured, yet their effect on people can be observed. Someone, at some point had an open mind and looked at a situation from a different point of view.

4.2 The Pattern of Personal Knowledge

Carper (1978) perceived the pattern of Personal Knoweldge as "the most problematic, the most difficult to master and to teach [yet] perhaps the pattern most essential to understanding the meaning of health in terms of individual well-being" (p. 27). The sub-categories for this Pattern of Knowing are 'Self-awareness' and 'I-thou'. 'Self-awareness' was devided into 'Physical-', 'Emotional-' and 'Intellectual Self-awareness' because these aspects all play into each other and are seen as part of the wholeness that Carper promoted. The sub-category 'Physical' was divided into 'Physical well-being' and 'Self-care'. On the intellectual level, the sub-categories 'Cognition' and 'Meta-Cognition' were created. 'Emotional self-awareness' was divided into the sub-categories of 'Self-compassion' and 'Self-confidence'. I-Thou describes the Quality of interactions and relationships and has been divided into 'Therapeutic use of self', 'Promoting wholeness' and 'Commitment and Reciprocity'.

Table 3: Effects of Mindfulness Practice on Personal Knowledge

Personal Knowledge	**Self-awareness**	Physical	*Physical well-being*	"increased bodily awareness" (8), "I noticed more balance, leg strength, overall flexibility and a slight weight loss. I have more aerobic capacity" (8), "notice, observe, experience, bodily sensations, thoughts and feelings" (9)
			Self -care	physical self-care practices were valued more and increased (1, 3, 6, 8), "consciousness of one's body and its capabilities" (8), "trust their bodies" (8), "encouraged them to listen for clues in their bodies", "body connectedness with the mind" (8)
		Emotional	*Self-compassion*	"Self-acceptance" (1, 8) , "tolerate uncomfortable emotions and sensations (2), "increase of emotional acceptance" (2), "self-compassion"(4), "Willingness to remain in contact with unpleasant internal experiences"(5) "allowed some to feel more centered" (8), "dealing with powerful emotions." (8)
			Self-confidence	"less fear of failure"(1), "increased vulnerability" (8), "decreased anxiety" (8), "efficacy increased", "more assertive"
		Intellectual	*Cognition*	Overall changes in awareness (1), specifically "self-awareness" (1, 2, 3, 8, 9), "insight" (3) and "awareness of one's experiences" (3), "understanding of self" (3), "negative thought patterns decreased" (8), "more attentive to presence of stress" (9)
			Meta-Cognition	"deeper insights into own thought processes" (2), "awareness of biases and self-serving cognition" (2), "self-evaluation process became more conscious and salient" (2), "ability to observe ones thoughts as temporary" (5), recognition of "cognitive and behavioural patterns" (10) , The knowledge of "what is known about what is noticed" (10)
	I-thou	Quality of interactions and relationships	*Therapeutic use of self*	Overall improvements of interpersonal relationships (1, 2, 4, 5, 6, 8, 9), "Positive changes in therapeutic relationship" (1), "disinclination towards automatic behavior" (2) "Higher client evaluations of therapeutic relationship" (6)
			Promoting wholeness	"increased emphasis on the being aware of non-verbal cues" (1) and "new ways of intimacy" (1), "helping people to be present to themselves"(1)
			Commitment & Reciprocity	"different mode of relating" (1), "the only thing we have is this moment" (1) , "improvements in personal relationships" (4) , "friendly presence" (6) , "practicing patience" (8),"focusing on moment-to-moment" (10)

4.2.1 Self-Awareness

Physical

Overall it was found that practitioners of mindfulness reported to "notice, observe, experience, bodily sensations, thoughts and feelings" (9). Practitioners felt "increased bodily awareness" (8), were more able to "trust their bodies" (8) and developed a "consciousness of one's body and its capabilities" (8)."I noticed more balance, leg strength, overall flexibility and a slight weight loss. I have more aerobic capacity" (8). A "body connectedness with the mind" (8) was experienced and physical self-care practices were valued more and increased (1, 3, 6, 8)

Intellectual

Overall changes in awareness (1), specifically "self-awareness" (1, 2, 3, 8, 9), "insight" (3) and awareness of one's experiences (3) were reported. They led to an "understanding of self" (3), "deeper insights into own thought processes" (2) and an "awareness of biases and self-serving cognition" (2). Recognition of "cognitive and behavioural patterns" (10) and an "ability to observe ones thoughts as temporary" (5) were also effects of practising mindfulness. The knowledge of "what is known about what is noticed" was elevated (10). Practitioners were "more attentive to presence of stress" (9).The "self-evaluation process became more conscious and salient" (2) and "negative thought patterns decreased" (8).

Emotional

Self-compassion and confidence were expressed in "Self-acceptance" (1, 8), "less fear of failure" (1), "increased vulnerability" (8) and "decreased anxiety" (8). "Willingness to remain in contact with unpleasant internal experiences" (5) and to "tolerate uncomfortable emotions and sensations (2) was reported. An "increase of emotional acceptance" (2) and "self-compassion" (4) were observed. Mindfulness practice "allowed some to feel more centered" (8) and for "acceptance of inner issues" and "dealing with powerful emotions." (8)

4.2.2 I- Thou

The I-Though aspect defines the 'Quality of Relations and Interactions with others'. The sub-themes, derived from Carper's article (1978, p. 28), 'Therapeutic use of self', the concept of 'Promoting wholeness' and "Commitment [and] Reciprocity" were found to be enhanced with the practice of mindfulness. Overall, studies reported improvements in interpersonal relationships (1, 2, 4, 5, 6, 8, 9). "Positive changes in therapeutic relationship" (1) and "improvements in personal relationships" (4) were observed. Mindfulness enabled therapists to "help people to be present to themselves" (1), becoming aware that "the only thing we have is this moment" (1) as well as "focusing on moment-to-moment" (10). Mindfulness training resulted in "disinclination towards automatic behavior" (2) and led to a "different mode of relating" (1) which was noticed, as "practicing patience" (8) and having a "friendly presence" (6). An "increased

emphasis on the being aware of non-verbal cues" (1) and "new ways of intimacy" (1) were experienced. "Higher client evaluations of therapeutic relationship" (6) were further results of mindfulness practice.

4.2.3 Discussion

Stress and burnout at work often are due to role conflict, ambiguity, time pressure and work overload as experienced by the individual. Stress is a normal part of life but in its extreme form it can lead to burnout, which Sandberg (2005) described as a process of five phases with excitement turning into dissatisfaction, leading into hopelessness, doubt, frustration and irritability. As a result "caring becomes a routine" (Sandberg 2005 p.12) and psychosomatic problems arise, such as headaches, back-aches and a growing proneness to infections, which in turn lead to absenteeism. Finally the individual is at the risk of substance abuse (Sandberg 2005). Self-awareness, the knowledge of one's physical, emotional and intellectual strengths and limitations and self monitoring could be a key factor in the prevention of burnout (Gupta et al. 2012). In their study on the influence of personality traits on burnout, Gustaffson et al. (2009 p. 345) concluded, that

> In order to prevent burnout, it is important to be aware of one's own temperament, characteristic style of thinking, perception, and behaviour so that one can beware of situations in which one's personality traits may determine whether there are opportunities or risks in dealing with one's circumstances.

Self-knowledge is also necessary in the interaction with clients. In order to take care of others, it is essential to know how to take care of oneself, when to take a rest, when to eat. A stressful situation can become easier to handle if the caregiver is aware of their rising stress levels, bad mood or an emotional trigger (9, 8). Mindfulness practice enhanced importance of self-care and physical well-being in practitioners. The awareness of being tired or hungry is as important as sleeping or eating. It seems that mindfulness raises the awareness and enables people to follow up on it (1, 3, 6, 8). Self-care leads to physical well-being. If we eat, sleep, enjoy life, we feel better about ourselves and life on the whole. If we cannot eat because of stress, if we wake up during the night and cannot get back to sleep because we cannot switch off, our body responds with illness in all sorts of ways. Illness is a sign to stop as hunger is a sign to eat and caregivers do not need to beat themselves to the very end.

The relationship with oneself affects the relationships with others. There is strong evidence that practicing mindfulness enhances all forms of self-awareness as well as self-care and self-compassion (4). Practitioners report the awareness of their physical as well as mental experience and are able to observe without judging themselves harshly (2, 4, 8). Knowledge of self has an impact on our lives. Knowing what interests us and what our strength are, can make us choose a profession. A combination of self-acceptance and intellectual knowledge is beneficial because it shows us our limits.

Intellectual knowledge is not only the empirical knowledge we have gained at schools and trainings which we apply sometimes consciously, sometimes unconsciously. It is important to be able to say, 'Sorry, I don't know, I have to ask someone' or 'Sorry, I can't give you this medication because I am not trained to do it.' Intellectual knowledge also gives us the confidence to interact with other professionals and to act professionally based on evidence based research. However, it is also the 'thinking about thinking', meta-cognition, being aware of our own thought processes and biases (2), to realize when we slip into non-constructive thoughts realizing them as "temporary" (5), before we continue to act on them. This in turn affects our presence, which is part of Ethical Knowledge and illustrates how the patterns affect each other.

Cognition and Meta-cognition were found to be influenced by mindfulness training. Cognition, the way information is processed, plays an important part in problem solving and how we generally relate to life. There is nothing wrong with not liking a certain situation, but what happens next? Are we aware of this? Are we 'in a bad mood' or are we avoiding the entire situation? Practice of mindfulness can help to recognize "cognitive and behavioural patterns" (10). With the practice of mindfulness, negative thought patterns have been found to decrease (8) and 'thinking about the thinking', Meta-cognition, has been found to be enhanced. Being aware of our own thought process, observing ourselves, and to realize that thoughts come and go and that we have a possibility to change them at any given time is a very likely result of mindfulness practice (5). Our awareness and perception is the key to our well-being. Our happiness is our choice and our responsibility. The quality of interactions and relationships with clients depend partly on the self-knowledge of the caregiver who needs to find a balance between professional caring and serving and the involvement of oneself.

Dane (2011) suggested that there are different levels of consciousness and that experience is needed to be able to be mindful in the sense of being able to focus on one task and still be open to one's surroundings. Anybody who has learned a new skill will have gone through the experience that multi-tasking is not possible when one is not familiar with a specific task. Considering that mindfulness practice affects Meta-Cognition, its practice might help a novice caregiver to be more aware of what they need to pay attention to, to know "what is known about what is noticed" (10) and to be aware of their abilities and room for improvement. More experienced caregivers, who pride themselves in their ability to multi - task might realize through mindfulness practice that sometimes just listening to the client is all that is needed.

Emotional self-awareness is an essential part of self-knowledge. The themes that emerged from the articles are 'self-compassion' and 'self-confidence'. "Although people typically value being kind and compassionate to others, they are often harsh and uncaring toward themselves." (Neff & Vonk 2009 p.26) To have self-compassion means to be gentle to self, to forgive oneself for not being perfect and to accept oneself fully. "A growing body of research suggests that self-compassion is associated with psychological health." (Neff & Vonk 2009 p.26) Mindfulness practice makes us sit with ourselves, to "tolerate uncomfortable feelings, emotions, sensations" (2) and at the same time raises self-compassion (1, 4, 8), the ability to tolerate those feelings and to be gentle with ourselves. This raises the question: Is it possible that a lack of self-compassion makes us rush from A to B? Is rushing a form of avoidance to sit with ourselves? Are we too uncomfortable to feel the 'ugly' feelings?

Mindfulness training seemed to enhance the levels of self-compassion as well as self-confidence. Persons who practiced mindfulness reported to feel 'more assertive and less of a failure' (1). Self-confidence is one of the features needed to be who we really are and to be able to meet others on the level of humanness, rather than having to hide behind the roles of our professions. Self-confidence allows for more vulnerability (8), the ability to say 'I don't know' or 'Sorry' and through this improve our relationships with others (1, 2, 4, 5, 6, 8, 9). The ability to be humble and to acknowledge our imperfections as well as our strength enables us to meet others. This is the chance for the *I-Thou* quality of 'Personal Knowledge' to emerge. "I-Thou relationships, characterized by spontaneity, subjectivity, reciprocity, and recognition and acceptance

of the unique other, are essential for humanhood" (Cohn 2001 p.171). If the professional is accepting of their own strengths and limitations, the client can be met on the level of reciprocity rather than hierarchy.

> The life of dialogue is no privilege of intellectual activity like dialectic. It does not begin in the upper story of humanity. It begins no higher than where humanity begins. There are no gifted and ungifted here, only those that give themselves and those who withhold themselves (Buber, 1969)

The tools of actors and dancers are their bodies. Singers use their voice, craftsmen their hands. Professionals in elder care use all of those tools to a more or lesser degree, depending on their field of expertise. The overall aim of caring is to make the other feel better. In order to achieve this, according to Carper (1978), caregivers should use all of themselves, with the aim to promote wholeness. How can we apply 'Therapeutic use of (our) selves' if we do not know ourselves? By being friendly and patient, a caregiver can make older people feel better about themselves. Seeing and being with the whole person, not just a case or a name on the work-list is promotion of wholeness.

Many older people have learned to be modest which results in the tendency of not expressing their needs. Many do not want to bother the caregiver. Promoting wholeness can be achieved by paying attention to and being aware of non-verbal cues (1), reading between the lines. Sometimes asking is not enough, and the caregiver needs to show through commitment and reciprocity that they are interested in the client. This commitment can be shown by "practicing patience" (8) and by "being in the moment" (10), listening to them without the hope or thought of getting away soon. Being present for the client and being with the client as a human being makes it possible to create relationships and interactions that may give the client hope and something to look forward to.

Walach and Loef (2012) point out the importance of social interaction and healthy, supportive relationships. They refer to studies (by Bauer, Qualmann et al. 1998; Bauer 2002), which found correlations between the lack of "healthy participation, shared decision making and supportive relationships" (Walach and Loef 2012 p. 13) and the development of Alzheimer's disease. They suggest to make "social inclusion part of a comprehensive prevention program for AD" and for overall well-being (Walach and Loef, 2012 p. 13).

Many older people lack those relationships and for many, caregivers are their only social contact. High staff-turnover stands in the way of these relationships. The reality for many older persons is to have a stranger coming into their home, having them undress and wash them, no time to sit and talk and getting to know them. Even if they had the time to talk, chances are, tomorrow there will be another one. Carper asked for "a risk of total commitment" (1978 p. 28) from the caregiver. The prerequisite for this is a commitment to oneself by taking care of oneself through knowing oneself. This could be one way of facing the challenge of high staff turnover.

4.3 The Pattern of Esthetic Knowledge

The chosen sub-categories for 'Esthetic Knowledge' are 'Presence' and 'Empathy'. Carper described 'Empathy' as an "important mode in the esthetic pattern of knowing" (Carper 1978 p. 27) and she pointed out that for nursing to have an esthetic quality, it "must be controlled by the perception of the balance, rhythm, proportion, and unity of what is done in relation to the dynamic integration and articulation of the whole" (p. 27). 'Presence' is expressed through 'Perception' with its sub-themes of 'Environment' and 'Non-Verbal Communication' and 'Flexibility', which was further divided into 'reflection in action' and 'open-mindedness'. The Sub-categories for 'Empathy' are 'Detachment' and 'Individual Experience'.

Table 4: Effects of Mindfulness Practice on Esthetic Knoweldge

Esthetic knowledge	**Presence**	Flexibility	*'reflection in action'*	"more effectively respond to environmental demands"(10) , "more present and centered" (8), "increased responsiveness" (8), "reactivity improvements and efficiacy increased (7), "presence is healing" (1)
			open mindedness	"emotional flexibility" (5) , "open to all thoughts, actions, sensations" (6) , "more forgiving"(1), "openness to experience" (3)
		Perception	*environment*	"more open, in a broader way"(1), "attention to ones' surroundings" (3), "sense of being in the present moment" (1), "make sense of their work-settings" (10), "not being on autopilot" (9)
			non-verbal communication	"increased awareness of client's reactions." (1), "aware of what's taking place in the present" (2), "Qualities of attending experience" (5)
	Empathy	Detachment		"separate their own emotions from those of their clients"(1), "Clearer boundaries"(1), "ability to view thoughts and feelings with a certain distance."(2)
		Individual experience		"empathy increased (4, 6, 8, 9) "Standing in the patient's shoes and perspective taking", "patient centered qualities increased"(9), "enhanced listening abilities (8), "be with client" (1), "compassionate quality" (9), "kindness", "openness, curiosity and patience"

4.3.1 Presence

The sub-themes of ‘Presence’, ‘Flexibility’ and ‘Perception’ were expressed in findings that conveyed practitioners of mindfulness to be “more open, in a broader way” (1) with an “increased awareness of client’s reactions” (1) and, “attention to ones’ surroundings” (3). An “openness to experience” (3) as well as being “open to all thoughts, actions, sensations”, a form of “heightened awareness of inner and outer experience” (6) was reported.

A “sense of being in the present moment” (1), being “aware of what’s taking place in the present” (2), “not [being] on autopilot” (9) was reported. Practitioners of mindfulness were found to “more effectively respond to environmental demands” (10) and experience “emotional flexibility” (5). Participants were found to be “more present and centered” (8) with an “increased responsiveness” (8) and the ability to “make sense of their work-settings” (10). “reactivity improvements and efficacy increased (7) and practitioners found that “presence is healing” (1)

4.3.2 Empathy

A general “increase of empathy” (4, 6, 8, 9) was found with “enhanced listening abilities (8) and a “compassionate quality” (9) that allowed to “be with client” (1). At the same time the ability to “separate their own emotions from those of their clients” (1), “Clearer boundaries” (1), and the “ability to view thoughts and feelings with a certain distance.” (2) was enhanced. An increase of “patient-centered qualities” (9) and an ability to be “more forgiving” were reported.

4.3.3 Discussion

The esthetic pattern of knowledge is the ‘How’ of care. The chosen main characteristics of esthetical knowledge are presence and empathy. Presence is denoted by flexibility and perception, both found to be enhanced by mindfulness training. Carper’s defintion could be termed “Reflection in action” and is expressed by practitioners of mindfulness

who felt more “present and centered” (8) and were able to “more effectively respond to the environmental demands” (10) by “not being on autopilot” (9).

As mentioned earlier, perception of the environment and of non-verbal communication is a useful aptitude in the field of elder care. Many older people do not want to be a bother and therefore will not express their needs verbally. Apart from a smile, kindness, as part of empathy, can be expressed by being open to those unexpressed needs. A caregiver, who senses an inhibition or embarrassment in the client, can encourage them to talk about it, stay with them for a little longer, and try to find out, whether the client might need a hug or someone to listen to. By investing time and by being present, the caregiver can communicate to the client that they are being heard and seen. This can be likened to what Halldorsdottir (1996 Abstract) called ‘building a bridge’, which results in “an increased sense of well-being and health, [and] can be summarized as empowerment […] of the recipients of care.”

Knowledge of self is necessary to keep a “psychic distance” (Carper 1978 p. 27) and to still be able to support the other in their pain. In Carper’s patterns, empathy is part of the esthetical knowledge which asks for creativity and flexibility in combining the other patterns in any given situation and to be in the moment, with the client. We can never truly understand what another person feels and experiences. Empathy is the ability to understand on a feeling level what another person might go through. The findings suggest that detachment is improved and raised through the practicing of mindfulness (1, 2). Detachment is the ability to separate one's own feelings from those of another, and not to get overwhelmed by them. The practice of observing through meditation, to detach from one's own feelings and see them as fleeting, has been shown to encourage detachment, without a decrease in kindness (1, 4). It has been seen that mindfulness practice has a positive effect on the ability to acknowledge and sit with one's own feelings. (2, 5) The ability to remember what it feels like to be sad or angry or disappointed makes it easier to understand the other person.

Mindfulness practice has been shown to have an effect on “separating their own emotions from those of the client” (1) and at the same time “increase the awareness of client’s reactions” (1). This can enable the caregiver to see the situation through the eyes of the client. Looking at a situation through the eyes of the other is an advantage

for two reasons. Firstly we might understand better what the other person might feel, secondly we might catch a glimpse of ourselves in the situation, the way our client sees us, and realize that we might need to correct our behaviour or activity. This could be on an emotional, intellectual or physical and practical level.

A bedridden client has a different visual perspective on the room than the caregivers who walk in and out. For esthetic knowledge to be put into practice, we need to be aware of the environment in terms of safety, while at the same time, take into consideration the client's wishes regarding the environment they live in. The way the furniture is laid out might be practical for the caregivers, but what does it look like from the client's point of view? What is practical or beautiful for the caregiver might not be practical or beautiful in the eye of the client. The need for flexibility and communication and time to find a compromise becomes apparent.

An anxious client might ask for reassurance again and again. Where do caregivers find the time to respond with kindness and patience when a tight schedule and a large number of clients are reminding them constantly that there is no time? Mindfulness-practice seemed to raise "patient-centered qualities" (9). Practitioners were "more centered" (8) and at the same time "emotionally more flexible" (5). It might be necessary to develop this inner flexibility more consciously in order to respond to the external conditions of the work environment. This is true for both, the demands of time-tables and the demands of clients. Mindfulness practice can help to develop an awareness of the moment (12), to be present now, having the time-table in mind, but detaching from it and focusing on the client (1, 10)

Can eldercare be client-centered if adhering to time-tables is the priority? After all, the one thing most older people have more than enough to share is time. Client–centered work means giving it to them according to their individual needs. The adherence to time tables is needed for certain activities, such as the administration of medication and doctor's appointments. Waking, sleeping, eating and other activities might well be built around the client's needs.

4.4 The Pattern of Ethical Knowledge

According to Carper (1978 p. 29), "the moral code that guides ethical conduct of nurses is based on the primary principle of obligation embodied in the concepts of service to people and respect for human life". However, "morality goes beyond simply knowing norms or ethical codes of the discipline. It includes all voluntary actions that are deliberate and subject to the judgement of right and wrong" (p. 29). The awareness of moral dilemmas and what constitutes right and wrong and to take responsibility for actions and decisions are aspects of Ethical Knowledge (Carper p.30). 'Ethical Knowledge' was divided into 'Moral' and 'Responsibility'. The chosen sub-categories for 'Moral' are 'Ambiguity', 'Judgement' and 'Reactions'. 'Intentions' and 'Actions' were selected as sub-categories for 'Responsibility'.

Table 5: Effects of Mindfulness Practice on Ethical Knowledge

Ethical Knowledge	**Moral**	Ambiguity	"decrease in role-conflict"(10), "tolerating ambiguity, ambivalence and difficult feelings is healing" (1), "A positive sense of control" (6), "acceptance" (1, 3, 5), "appreciate conflict of interest" (2)
		Judgement	"raised levels of tolerance", "less judgemental" (1, 2, 6, 9), "raised awareness of a moral aspect of an issue" (2), "tolerance increase" (8), "ability to realistically and accurately evaluate circumstances" (10)
		Reactions	"learned to experience events without unconsciously reacting to them", "less controlled by particular thoughts and emotions" (5), "self-control", "self-regulation" (2, 3, 5, 10), "own reactivity to stressful events decreased" (9), increase in "emotional stability and conscientiousness"(9), increase in "self-control" (4)
	Responsibility	Intentions	"cultivating intentional compassion"(1), "skills and means to modify stress reactions" (7), "awareness of one's motives"(3), a sense of "purpose and direction"(8), "evaluate beliefs and values"(8), "internal moral focus"(2), "valued upholding ethical standards"(2), "purposeful state" (3)
		Actions	"having more choices", "more willingness to seek help and consultation"(1) , "high in mindfulness cheated less"(2), "taking responsibility" (10) and "responsibility for own feelings"(8), "act more reflectively than impulsively"(4), "conscientiousness increased" (9), "self-confidence increased"(4), "self-actualization" and "autonomy"(6), "feeling of competence and mastery" (7), "more assertive" (4)

4.4.1 Moral

It was observed that practitioners of mindfulness were “less controlled by particular thoughts and emotions” (5) and had higher levels of “self-control” (4) and “self-regulation” (2, 3, 5, 10). Their “own reactivity to stressful events decreased” (9) with an observed increase in “emotional stability and conscientiousness” (9), an “ability to realistically and accurately evaluate circumstances” (10) and to “appreciate conflict of interest” (2). A “raised awareness of a moral aspect of an issue” (2), “a positive sense of control” (6) and a “decrease in role-conflict” (10) were noticed. An increase in “tolerance” (8), “acceptance” (1, 3, 5) and being “less judgemental” (1, 2, 6, 9) were further effects of mindfulness practice. Practitioners found that “tolerating ambiguity, ambivalence and difficult feelings is healing” (1)

4.4.2 Responsibility

Responsibility was divided into ‘Intentions’ and ‘Actions’. “Taking responsibility” (10) and “responsibility for own feelings” (8), an “awareness of one’s motives” (3), as well as a sense of “purpose and direction” (8) were results of practicing mindfulness. Exercising mindfulness provided practitioners with “skills and means to modify stress reactions” (7), “evaluate beliefs and values” (8) and have means of “cultivating intentional compassion” (1). There was “more willingness to seek help and consultation” (1) and to “act more reflectively than impulsively” (4). Persons “high in mindfulness cheated less” (2), had an “internal moral focus” (2) and “valued upholding ethical standards” (2). A general “purposeful state” (3) was expressed. Practitioners of mindfulness became “more assertive” (4) and realized they had “more choices” (1). As a result of practicing mindfulness “conscientiousness” (9), “self-confidence” (4), “self-actualization [and] autonomy” (6) and a “feeling of competence and mastery” (7) increased.

4.4.3 Discussion

In Carper’s theory (1978 p. 29) “service to people and respect for human life” are the center of nursing ethics, which in turn influence personal, esthetical and empirical knowledge. ‘Moral’ and ‘Responsibility’ have been chosen as the subthemes for ethical

knowledge. Ethical knowledge enables caregivers to make decisions in the face of ambiguity. It is about making judgments without being judgmental, as it is necessary to be able to see other points of view and to keep an open mind in order to make a decision based on any information given. Ethical knowledge allows the professional to be more tolerant and non-judging of what they see, traits which seemed to be enhanced through Mindfulness practice. (1, 2, 6, 8, 9)

A personal idea of what is right or wrong is essential to acting with integrity. However, when caring for others, a personal ethic needs to be combined with the professional ethic. The professional will have to be called upon making decisions. Mindfulness allows for the realistic and accurate evaluation of a situation (10). At times this might be taxing, as it also means having to take responsibility for the actions that follow. Clashes between personal and professional ethics and policies can create conflict or ambiguity, which can be appreciated (2) rather than seen as another obstacle. These do not have to be 'big' issues. A caregiver might be aware of the importance of the client to choose their clothes for themselves, but the client is slow and the caregiver under time pressure and has no time to wait for a decision. Is it right to choose the clothes for the client when they are perfectly capable of deciding for themselves? Many small issues can sum up to a big problem. Here it might be important to detach and to remember that the client is the true expert of their life. It is the caregiver's responsibility to respect and acknowledge the client's needs and at the same time apply their empirical knowledge. Mindfulness was found to increase intentional compassion (10) and raised self-control in stressful situations (4, 9). Intention and motive are at the chore of any decision and the factors that make a decision and action ethical. Schmidt (2004) suggests to continuously ask oneself: "Why do I want to work in this profession?" And what is the aim of my engagement in this profession?"

Ethical knowledge also includes the awareness that there are many ways of looking at the world and the resulting "complexities of moral judgement" (Carper 1978 p. 30). This becomes more important with the field of eldercare being increasingly multi-cultural. Caregivers and clients from different cultures might experience extra challenges due to language difficulties and cultural differences. Team work can become unnecessarily demanding and result in negative consequences for the client, if those differences are not perceived and addressed. In times of conflict it is an advantage if

colleagues are able to take responsibility for their reactions to stress (8) without taking things too personally and talk openly about their difficulties and act "more reflectively than impulsively" (4).

The way we perceive life depends on our attitude, which is the only thing we can control. Instead of trying to change the status quo from the outside by complaining about the employer or the policy makers, caregivers can change their perception of the situation. "Role conflict is based on perception in other words it is a state of mind" (Valentine p.457). This does not mean that caregivers should accept bad working conditions and low pay, to the contrary. In order for elder care to change direction, it is this author's opinion that caregivers need to be empowered to act ethically and responsibly. This also includes acting ethically towards oneself. Through practicing mindfulness, caregivers can learn to take responsibility for themselves and their working conditions (10), and to realise their choices (1). To act ethically, it is necessary to be aware that there is an ethical issue at hand. If caregivers listen to themselves, look out for discrepancies between their own ethic and their company policy, they have a possibility to change their current reality.

Mindfulness training was shown to raise awareness of ethical issues. New ways of doing often meet resistance, old patterns are as comfortable as old slippers, but they are not always the best to walk in. Creating an organizational environment of mindfulness, doing things differently, not getting stuck in routine but to be open and flexible, creating an openness to change and client-centeredness, takes time, but it needs to start at some point. Mindfulness was found to raise 'self-actualization and autonomy" (6). It might be necessary for all members of organizations to re-think their approach to elder care and staff-welfare. One way of approaching change could be through the process of 'Appreciative Inquiry' (AI), which "is a way to create organizational change by building on its most important asset, its people." (Richer, Ritchie & Marchionni 2009 p.953) They report innovative ideas by nurses but point out that support from the management was considered important by staff-members.

Making decisions requires responsibility, the ability to respond, rather than react. It is based in our intention and motivation and the resulting actions. If our decisions and actions match our internal idea of right and wrong, we act with integrity, and can take

responsibility for our actions. As professionals in elder care we have more responsibility than we might think.

> "It is concluded that nurses and other health professionals can, by their professional caring or lack of it, be powerful sources of empowerment or discouragement to those whom they are pledged to serve." (Halldorsdottir 1996 Abstract)

In the light of the Finnish National Framework (Ministry of Social Affairs and Health 2008, 2012) which has the aim to keep people in their own homes for as long as possible, our visit and moment of presence might literally mean the world to an older person who is living alone and unable to get out of the house. "Be the change you want to see in the world." Gandhi said. Mindfulness practice makes it possible to become aware of what kind of change we want to see. It might even alter our idea of what this change should look like and make us focus on changing ourselves, which in the end is the only variable we can change.

4.5 Spirituality

A 'side-effect' found was an awareness of and a raise in spirituality (1, 4, 6, 8). Humans are holistic beings, and their physical, emotional, intellectual and spiritual dimensions need to be considered. Narayanasami et al. (2004) mention the possibility of despair and depression in older people due to unaddressed spiritual needs. Some of the studies analysed here found a rise in spiritual awareness following mindfulness meditation. The caregiver's openness to this topic is necessary to give clients the opportunity to express themselves fully without being judged by the caregiver, regardless of what either one believes. Spirituality was not considered as a part of the four patterns, since it was not mentioned as such in Carper's article but it is this author's opinion, that spirituality is an important aspect that needs to be addressed.

Scientists who research the effects of mindfulness agree on "the involvement of sustained attention to the present moment" (Chiesa & Malinowski 2011 p.407) but a precise and explicit definition of mindfulness and meditation that is all-encompassing has not been found, and according to Chiesa and Malinowski, "may be impossible". This is reflected in the many different forms of MBIs, which have developed over the years.

Findings confirm that practitioners of mindfulness seem to show improvements and overall benefits but it is not possible to find out what exactly happens, the specific and non-specific effects remain unclear. Scientists wreck their brains, but the question remains: What is the 'magic' ingredient, why does it work? This bears the next question: If it seems to work on a level that science cannot grasp, is it because it is the spiritual aspect that science has tried to avoid like the devil avoids the holy water? Kabat-Zinn called it "Buddhist meditation without the Buddhism […] and yoga" (2011 p. 294). His reason to take the somewhat spiritual aspect out of the equation was based in what he considered the "serious risk that would have undermined our attempts to present it as commonsensical, evidence-based, and ordinary, and ultimately a legitimate element of mainstream medical care." (Kabat-Zinn, 2011 p. 282) Yoga and meditation at the time were strongly related to 'New Age' and therefore not perceived as scientifically sound.

In their hospice study, Egan et al. (2011), found that spirituality was important to many and that it is not religion. However, religion can be one way of expressing spirituality.

> Spirituality means different things to different people. It may include (a search for): one's ultimate beliefs and values; a sense of meaning and purpose in life; a sense of connectedness; identity and awareness; and for some people, religion. It may be understood at an individual or population level. (Egan et al. , 2011 p. 321)

Their study found that for some, Mindfulness was connected to spirituality through expressed mindful actions and they quote two hospice workers:

> 'if they take particular trouble about the way the meal tray is set up or make sure that there are flowers in the room for somebody who hasn't had any brought by visitors. I think that's spirituality too' (Melissa, 51, chaplain). Ida, a hospice nurse, talked often about 'awareness and mindfulness' (Ida, 45, hospice nurse) within spirituality and spiritual care. (Egan et al. 2011 p. 316.)

A part of spirituality is the trust or belief in something despite there being no guarantee. Flowers on a table can make a patient feel good. The action of putting them on the table could be understood as an expression of Carper's esthetic pattern or as plainly considerate. It could be based on empirical knowledge gained about flowers and well-being or it could be perceived as a spiritual act. From a non-scientific view it does not matter why the flowers make the patient happy. What matters is that they do.

Where science is looking for proof by dissecting and analyzing, spirituality is all encompassing and believing. Just as qualitative and quantitative research, science and

spirituality can accomplish each other. Both are needed and valid in their own right. Every single person is capable of some form of mindfulness, rather than looking for THE way, would it not be more helpful to accept that every person could find their own? 'All ways lead to Rome' and 'It's the travel, not the destiny that matters' are platitudes but on some, maybe not a scientific level, they are true, especially for heterogenic cohorts of older people.

Egan and al. (2011) suggest that a growing understanding of the breadth of spirituality, and a growing number of caregivers who become more knowledgeable of its importance and effects, can be a way to improve end of life care. Elder care is end of life care. Is it time to bring the spirit back?

4.6 Implications

The implications of the findings lead to the second research question, 'How can mindfulness be applied in Eldercare?' To answer it, one might ask: What is the purpose of elder care? What is the philosophy of individual retirement homes and wards? What is the aim of the individual professional? Do they match? Is the whole organization working and acting according to their ethical principles? Do they *have* ethical principles? Do staff members get sufficient training? In "Listening as embracing the other: Martin Buber's philosophy of dialogue", Gordon (2011) proposes that to Buber a dialogue meant having a connection here and now with an open mind and without any agendas. This means just to be there and to listen without preconceived answers. He proposes that good listening skills "can only be ''learned'' when one is aroused to pay closer attention to oneself, to others, and to one's relation to the world." (Gordon 2011 p. 219) This is the case for caregivers as well as their clients. "Research suggests that mindfulness training can serve as a viable tool for the promotion of self-care and well-being." (Irving, Dobkin & Park p. 65)

Considering the findings and based on recommendations by other authors (Walach & Loef 2012 ; Healy & Sharry 2011; Richards et al. 2010; Irving et. al 2009) it is suggested to integrate mindfulness training into curricula of schools, high-schools and colleges. Caregivers could use mindfulness techniques (Orken et al. 2010; Krasner et al.

2009) and integrate their experience in the work with their clients (Christopher et al. 2010; Schure et al. 2008)

> Taking all of these points into consideration, we would consider a comprehensive culture of consciousness, involving a set of practices, the prime tool of which would be a meditation practice, as an important component in a preventive program. (Walach & Loef 2012 p. 12)

Organizations have a strong influence on how nurses can cope with and reduce stress. (Sandberg 2005; Richer et al. 2009) Of course nobody can be forced to become mindful, but based on the findings it is suggested to organizations to provide an environment conducive to the development of mindfulness and for their employees to be encouraged to practice some sort of mindfulness and self-care. (Ruedy & Schweitzer 2011; Valentine et al. 2010; Krasner et al. 2009)

As part of an organizational ethic, managers should meet their staff and clients on the 'human' level and be open to new ideas. This can be achieved by asking students in practical training for ideas and honest feed-back, have open and honest exchange with staff on team and individual level. If necessary, the aim and policies of the organization might have to be (re)-defined, made visible and remembered. Inclusion and empowering of staff in decision making through processes such as Appreciative Inquiry (AI), allow for creating a work environment where everybody feels responsible and appreciated.

To reduce stress and burnout mindfulness practice could be provided as part of organizational training. Becoming more aware of ourselves can help us realize why we are stressed, annoyed or anxious. Sometimes a glass of water, sitting down and focusing on one's breathing might be all that is needed. A moment of silence as part of the handover at the change of work-shift might be a possibility to start the day together as a team and to leave the outside world behind, to focus on the work ahead.

As part of the caregiver's empowerment and growing responsibility, it is suggested that caregivers are made aware that every single caregiver is responsible for the overall well-being of themselves, their clients and their work-environment. Any conflicts that arise throughout the day have their root in our perception of things. Not eating or drinking enough because of 'no time' has stressful effects on the body and mind. Suggestions for self-reflective questions can be found in Appendix 3.

The multi-professional approach in elder care aims to take into account the different needs of clients. This author believes that it is necessary for every professional to consider the whole person, not only in regards to their own field of expertise. Rather than objectifying the client and working through the routine of the day, the professional needs to be open to the client. Carper (1978 p.28) suggested considering "The individual […] as an integrated, open system incorporating movement toward growth and fulfillment of human potential."

"Growth and fulfillment of human potential" are words of hope. How can an old, fragile person grow? How can someone who has lived ninety years further fulfill their potential? They have lived a long life and they are the experts of their own lives. They know their answers. Maybe all we need to do is to be present to them, listen to and respect them. Schmidt (2004) depicts the role of mindfulness in a healing environment and argues that the inner attitude of the carer is helping in creating an optimal healing environment for the client. Maybe an old person can no longer be healed physically but by meeting them mindfully, and thus creating hope, they may have a possibility to heal emotionally. (Schmidt 2004)

As part of the morality Carper advocated, which "includes all voluntary actions that are deliberate and subject to the judgment of right and wrong" (1978 p.29), caregivers are invited to consciously give time and to be kind and patient in dealing with their clients. Keeping an open mind, applying the four patterns of knowing to work, remembering to be gentle to oneself and others , and to take responsibility for one's environment and actions **are** ways to apply mindfulness. A little stop there and then to breathe and to detach from a situation can do wonders in avoiding more serious physical and mental conditions.

5 CRITICISM

> Selling mindfulness as a commodity implies there is a desirable result that can be bought, and this underlying assumption of gaining results goes against an important feature of most Buddhist meditational training: that of learning to let go of aspirations or expectations. (Plank 2010 p. 53)

This "underlying assumption" is an aspect of this paper that needs to be looked at critically. By looking at the effects and aims of mindfulness practice, it is assumed to be means to an end. By focusing on what can be achieved through mindfulness, it can be

easily overlooked that mindfulness, not its effects, is the original purpose of mindfulness.

Malinowski (2008 p. 161) argues that in order to justify the label 'mindfulness-based', "major theoretical and conceptual developments are required, before the efficacy of such measures can clearly be established." Overall, there is strong scientific evidence, that the cultivation of mindfulness has various positive effects on practitioners and their relationships with themselves, others and their environment. This author's preference for qualitative research shows in the lack of quantitative features of the findings, such as more detail of correlations, or the number of occurrences of a statement.

This author's personal experience with different forms of meditation and the subjective understanding of its benefits prior to writing this paper, can confirm the findings. However, as a result of gained self-knowledge and its effects over the years, a possible bias towards the pattern of 'Personal Knowledge', resulting in a higher frequency of findings for this pattern, cannot be excluded.

It was found that the main focus of empirical enquiry in regards to mindfulness is on MBSR and MBCT. Those and other MBIs are one way of approaching a mindful attitude. However, there are many different ways to achieve a mindful state of consciousness (Dane 2011). Plank (2010 p.53) raises the issue of "a colonisation of the mind", whereby focusing research on particular aspects of mindfulness, other avenues are not explored. This author believes that a central theme of mindfulness is to be open-minded, present and detached. An exclusive focus on one particular way of achieving mindfulness seems to be a contradiction in terms.

Evidence based MBIs have their root in the Buddhist tradition and they have been found to be helpful for all kinds of physical and psychological problems. However, the western medical approach to this eastern philosophy has removed the spiritual aspect. Whereas in Buddhist communities, as part of Buddhist tradition, teachings are given freely, MBSR courses are usually expensive and therefore only easily available to those who have the financial means (Plank 2010). It is useful to keep in mind that "Without a clear understanding of mindfulness, secular interventions using the name "mindfulness" can easily degenerate into mere stress reduction." (Cullen 2011 p. 192). No matter what the path chosen, the disciplines that are to change our long-held perceptions and

opinions are not of the instant variety and need the commitment to self as it is proposed by Carper as part of self-knowledge.

Skills need to be exercised to be developed. For mindfulness, it seems that that the most important factor is the continuity of practice, as it is for any competence if the aim is to integrate it into one's life. A Meta search on Nelly combing search terms 'mindfulness' AND 'long-term effect' (20.8.2013) yielded 3486 results. However, in this work, only one study (1) reported long-term evidence for the effects of mindfulness. This is probably due to the narrow search window, which used the four patterns of knowing and did not look for long-term effects.

Overall, it could be argued that the search brackets were defined too narrowly which resulted in restricted findings. The same is true for the defining of categories and their subsequent evaluation and interpretation. On the other hand, it could be argued that the frame of reference was not narrow enough, that it was not possible to get into the subject matter.

The studies examined were all written in English with a predominantly Anglo-American background. North American findings need to be adapted to different European cultural settings. A growing culturally diverse workforce makes acknowledgment of cultural differences imperative in the field of elder care. The same is true for cultural differences between age cohorts of the same country and culture. However, it is this author's opinion that a combination of today's rapid information exchange and mindfulness practice could be an opportunity to narrow the gap between cultures and generations.

6 FINAL DISCUSSION AND CONCLUSION

The aim of this paper was to look at the effects of mindfulness and how it could be applied in eldercare. Three main reasons were suggested as motivations for change in elder care: Demographic change, resulting in a low caregiver ratio, the generation of baby boomers being more demanding than earlier generations and work-related stress leading to illness and high staff turn-over.

Carper's (1978) four patterns of Knowing (Empirical, Personal, Esthetical, Ethical) were applied as the theoretical framework. The findings show that all four patterns of

knowing were enhanced through the training and application of mindfulness. Empirical knowledge tells us that our life-style affects the way we are ageing. This is not only true for physical exercise and diet, but also for mindfulness. Walach & Loef (2012) hypothesize that education in mindfulness and meditation might affect and even prevent the development of Alzheimer's disease. They argue that today's information overload, the constant activation of certain parts of the brain and the resulting lack of capacity result in stress, burnout and memory-loss.

The empirical knowledge we have about mindfulness is worthy of introducing further into elder care for two reasons: The first motive for inclusion of mindfulness practice in the workplace is for the sake of the caregivers' health. The findings showed that mindfulness practices alleviate many symptoms related to stress (1, 2, 3, 4, 5, 6, 9, 10) and burnout (6, 9) and lead to increased well-being (2, 3, 5, 9). Secondly, open minds are needed in the wards of hospitals, elder care homes and assisted living facilities, to stay receptive to new knowledge, instead of becoming complacent, saying, 'We have always done it like that.' This in itself is not a problem, but as it was seen in the introduction, the field of elder care has a problem. As long as we keep on doing what we have always done, we will be getting what we have always gotten. Making use of the pattern of empirical knowledge also includes applying it where it is needed.

Personal knowledge was considered "essential" by Carper (p. 27) but she pointed out that "One does not know about the self; one strives simply to know the self" (Carper 1978 p. 28). The findings presented here suggest that mindfulness and mediation can be considered forms of striving towards knowing the self, as self-awareness and the relationships with others were enhanced through practice of Mindfulness.

Personal Knoweldge feeds into ethical knowledge because it "includes all voluntary actions that are deliberate and subject to the judgement of right and wrong." (Carper 179 p. 29). It was found that Mindfulness practice enabled practioners to detach from challenging situations, to appreciate conflicts and to be able to judge situations with an open mind. Based on the detachment, reactivity lessened which had an effect on intentions and actions. Whatever we do, our thoughts and actions have a rippling effect on our environment and in turn we will benefit from it in the future. The idea of

accepting and appreciating differences and acting accordingly is expressed in the univeral golden rule "Do unto others as you would have them do unto you".

> Normally we interpret the golden rule as telling us how to *act.* But in practice its greater role may be psychological, alerting us to everyday self-absorption, and the failure to consider our impacts on others. The rule reminds us also that we are peers to others who deserve comparable consideration. It suggests a general orientation toward others, an outlook for seeing our relations with them. At the least, we should not impact others negatively, treating their interests as secondary. (Puka 2010, Common Observations and Tradition)

Work with older people requires all four fundamental patterns of knowing: self-knowledge, empirical knowledge, a professional ethic and a sense for esthetics. Esthetic knowledge could be considered the glue that joins the other patterns together. It is expressed in presence and flexibility. Presence enables to see beyond the obvious and flexibility makes it possible to respond accordingly. Findings suggest that esthetic knowledge was enhanced through mindfulness practice and makes it possible for caregivers to respond to individual situations, to give what is needed at this moment in time and to express empathy. As needs vary from person to person, a multi-professional approach is currently practiced and it is proposed that the application of the patterns does not need to be confined to nurses but can be expanded to all professional groups dealing with older people.

It was found that practioners of mindfulness had a raised awareness in regards to their own spirituality. Spirituality is an aspect of human life that does not seem to fit into scientific paradigms. In this author's view science is one way of making sense of life. Spiriutality is another way. Rather than creating a dichotomy of either/or, it is suggested to allow them to stand next to each other and to accept that both have a purpose in their own right.

Even though studies and findings relating to mindfulness based interventions do not always report statistically significant data, the overall self-reported increase of well-being and reduction of stress is worthy of consideration. Demographic change and a growing assertiveness amongst the older generations are facts that need to be accepted. The question, whether continuous saving and low-staff policies in elder care should be accepted or challenged by professionals and clients, is worth asking. Considering the lack of staff and time and the importance of social interaction to well-being, one must ask: Is it really wise to aim for older people to stay at home for as long as possible? Is it

time for new models of ageing? Maybe practice of mindfulness could bring innovative answers to these questions.

Work-related stress as a consequence of the current reality is the only factor that can be controlled by individual caregivers and managers. The findings have shown that cultivating mindfulness in some form or another gives practitioners tools to deal with all kinds of stressors, mainly by slowly learning to detach and to look at life and work from a different perspective. Mindfulness is not a quick-fix and it is not a wonder weapon but it can enable caregivers to learn to listen to themselves, and to be present for their clients in a way that is respectful and satisfying to both. Even if we do not think of the clients today, we can think of the personal benefits and effects on our own lives today and in the future.

7 REFERENCES

Abott, P. and Sapsford R. 1998, *Research Methods for nurses and caring professions*. 2nd edition, ISBN 0-335-19697-7(pb), Open University Press, Buckingham, UK

Abu-Rayya, H.M. 2006. Depression And Social Involvement Among Elders in: *The Internet Journal of Health*, Vol 5 No 1. DOI: 10.5580/1df2 on [http://www.share-project.org/publications/journalarticles0.html] last accessed 18.1.2013

Alzheimer's Association, 2013 [internet] [http://www.alz.org/research/science/alzheimers_prevention_and_risk.asp] last accessed 15.4.2013

APA 2013, Stress in the workplace.[internet] Adapted from *The Stress Solution by Lyle H. Miller, and Alma Dell Smith,* American Psychological Association [http://www.apa.org/helpcenter/workplace-stress.aspx] last accessed 16.4.2013

Ayalon, L. and Shiovitz-Ezra, S. 2011, The relationship between loneliness and passive death wishes in the second half of life, in: *International Psychogeriatrics*, Vol 23/ Issue 10, pp 1677-1685 DOI: http://dx.doi.org/10.1017/S1041610211001384; [http://www.share-project.org/publications/journalarticles0.html]last accessed 15.8.2013

Baer, R. A., Smith, G. T., & Allen, K. B. 2004, Assessment of mindfulness by self-report: The kentucky inventory of mindfulness skills. *Assessment,* 11(3), 191-206. accessed on [http://www.mindfulexperience.org/measurement.php] last accessed 12.8.2013

Baer, R. A., Smith, G. T., Hopkins, J., et al. 2006, Using self-report assessment methods to explore facets of mindfulness. *Assessment*, 13(1), 27-45. accessed on [http://www.mindfulexperience.org/measurement.php] last accessed 12.8.2013

Böckerman, P., Johansson, E. and Saarni, S. I. 2012, Institutionalisation and subjective wellbeing for old-age individuals: is life really miserable in care homes? in: *Ageing & Society*, 32, 1176-1192

Brown, K. W., & Ryan, R. M. 2003, The benefits of being present: Mindfulness and its role in psychological well-being, in: *Journal of Personality and Social Psychology*, 84(4), 822-48. accessed on [http://www.mindfulexperience.org/measurement.php] last accessed 12.8.2013

Bryman, A. 2004, *Social Research Methods*. Oxford University Press, ISBN 10: 019-926446-5

Buber, M. 1969 *"Between Man and Man", trans. Roger Gregor Smith (New York: Macmillan, 1969)* in: Gordon, M. 2011 "Listening as Embracing the other: Martin Buber's philosophy of dialogue." *Educational Theory,* Vol 61 No, 2011 Board of Trustees University of Illinois

Buchheld, N., Grossman, P., & Walach, H. 2001, Measuring mindfulness in insight meditation (vipassana) and meditation-based psychotherapy: The development of the freiburg mindfulness inventory (FMI), in: *Journal for Meditation and Meditation Research*, 1(1), 11-34.[http://www.mindfulexperience.org/measurement.php] last accessed 12.8.2013

Bullington, J. and Fagerberg, I. 2013, The fuzzy concept of 'holistic care': a critical examination, in: *Scandinavian Journal of Caring Sciences* Sep, Vol. 27 Issue 3, p493-494.

Carper, B. 1978, Fundamental Patterns of Knowing in Nursing, in: *Advances in Nursing Science* 1(1): 13-24, Reprinted with permission from and Copyright ©1978 Aspen Publishers, Inc.

Carmody, J., Baer, R.A., Lykins, E. L.B. & Olendzki, N. 2009, An empirical study of the mechanisms of mindfulness in a mindfulness-based stress reduction program, in: *Journal of Clinical Psychology,* vol. 65, no. 6, pp. 613-626.

Center for Mindfulness 2013, Stress Reduction Program. [internet]University of Massachusetts, Center for Mindfulness, Department of Medicine, Division of Preventative and Behavioural Medicine. [http://www.umassmed.edu/cfm/stress/index.aspx] last accessed 12.8.2013

Chiesa, A. & Serretti, A. 2009, Mindfulness-based stress reduction for stress management in healthy people: a review and meta-analysis, in: *Journal of Alternative & Complementary Medicine,* vol. 15, no. 5, pp. 593-600.

Chiesa, A. and Malinowski, P. 2011, Mindfulness-Based Approaches: Are They All the Same?, in: *Journal of Clinical Psychology*, Vol 67, Issue 4, April pp 404–424, Wiley Periodicals, Inc.

Christopher, J.C., Chrisman, J.A., Trotter-Mathison, M.J., Schure, M.B., Dahlen, P. & Christopher, S.B. 2011, Perceptions of the Long-Term Influence of Mindfulness Training on Counselors and Psychotherapists: A Qualitative Inquiry, in: *Journal of Humanistic Psychology,* vol. 51, no. 3, pp. 318-349.

Cohn, F. 2001, Existential Medicine: Martin Buber and Physician-Patient Relationships, in: *Journal of Continuing Education in the Health Professions,* Vol 21, Issue 3, pp 170–181, Article first published online: 26 Apr.2005, DOI: 10.1002/chp.1340210308

Creech, A., Hallam, S., Varvarigou, M., McQueen, H. and Gaunt, H. 2013, Active music making: a route to enhanced subjective well-being among older people, in: *Perspectives in Public Health*, Jan 133 (1), pp. 36-43 London: SAGE Publications, Cinahl/EBSCO

Cullen, M. 2011, Mindfulness-Based Interventions: An Emerging Phenomenon, in: *Mindfulness*, Vol 2, Issue 3, September, pp 186-193, DOI 10.1007/s12671-011-0058-1 Springer Science+Business Media, LLC 2011

Dale, B. Sævareid, H., Kirkevold, M., Söderhamn, O. 2010, Older home nursing patients' perception of social provisions and received care in: *Scandinavian Journal of Caring Sciences*; Vol 24 Issue 3 pp 523-532

Dane, E. 2011, Paying Attention to Mindfulness and Its Effects on Task Performance in the Workplace in: *Journal of Management,* vol. 37, no. 4, pp. 997-1018.

da Silva, A. 2002, Analysis of the Uniqueness and Theoretical Foundations of Qualitative Methods, in: *Qualitative Methods in Public Health Reasearch-Theoretical Foudations and Practical examples*. Lillemor R-M Hallberg (ed.) Studentlitteratur, Lund, ISBN: 91-44-02179-8

de Rooij, A., Luijkx, K., Declercq, A., Emmerink, P., Schols, J. 2012, Professional Caregivers' Mental Health Problems and Burnout in Small-Scale and Traditional Long Term Care Settings for Elderly People With Dementia in The Netherlands and Belgium, in: *Journal of the American Medical Directors Association,* 13 (5) Jun pp 486.e7-486.e11

Egan, R.; MacLeod, R.; Jaye, C.; McGee, R.; Baxter, J. and Herbison, P. 2011, What is spirituality? Evidence from a New Zealand hospice study, in: *Mortality*, Vol. 16, No. 4, November pp 307-324, DOI: 10.1080/13576275.2011.613267, Academic Search Elite

Elo, S. & Kyngäs, H. 2008, The Qualitative content analysis process, in: *Journal of Advanced Nursing* 62(1), 107-115. doi: 10.1111/j.1365-2648.2007.04569x

Engström, M. Skytt, B. & Nilsson, A. 2011, Working life and stress symptoms among caregivers in elderly care with formal and no formal competence, in: *Journal of Nursing Management*, Vol 19, Issue 6, September, pp 732–741,

Ercikan, K. & Roth, M. 2006, What Good is Polarizing Research into Qualitative and Quantitative?, in: *Educational Researcher, Vol 35, No 5, June pp 14-23* DOI: 10.3102/0013189X035005014

Eurobarometer 2012/Active Ageing [http://ec.europa.eu/public_opinion/archives/ebs/ebs_378_en.pdf] last accessed 12.4.2013

Eurohealth 2010, Finne-Soveri, H., Hammar, T. & Noro A. 2010, Measuring the quality of longterm institutional care in Finland, in: *Eurohealth*, Volume 16 Number 2, 2010, [http://www.euro.who.int/en/who-we-are/partners/observatory/eurohealth] last accessed 15.8.2013

Feldman, G., Hayes, A., Kumar, S., Greeson, J. and Laurenceau J.-P. 2007, Mindfulness and emotion regulation: The development and initial validation of the cognitive and affective mindfulness scale-revised (CAMS-R), in: *Journal of Psychopathology and Behavioral Assessment*, 29(3), 177-190. accessed on [http://www.mindfulexperience.org/measurement.php] last accessed 12.8.2013

Gauding, M. 2005, *The Meditation Bible. A definitive guide to meditations for every purpose*. Godsfield Press, Octopus Publishing Group Ltd, London, 2005

Gordon, M. 2011, Listening as Embracing the other: Martin Buber's philosophy of dialogue, in: *Educational Theory*, Vol. 61 No. 2 pp 207–219, April, Board of Trustees University of Illinois

Graneheim, U.H. and Lundman, B. 2004, Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness, in: *Nurse Education Today*, Vol 24 pp 105-112

Gupta, S.; Paterson, M.; Lysaght, R.; and von Zweck, C. 2012, Experiences of Burnout and Coping Strategies Utilized by Occupational Therapists, in: *Canadian Journal of Occupational Therapy*, Vol 79, Issue 2, pp86 [http://cjo.sagepub.com/content/79/2/86; DOI: 10.2182/cjot.2012.79.2.4]

Gustafsson, G.; Persson, B.; Eriksson, S.; Norberg, A. and Strandberg, G., 2009, Personality traits among burnt out and non-burnt out health-care personnel at the same workplaces: A pilot study, in: *International Journal of Mental Health Nursing*, 18, 336–348. EBSCO

Halldorsdottir, S.1996, Caring and uncaring encounters in nursing and health care: Developing a theory. (Doctoral dissertation). Linköping: Linköpings universitet. [http://liu.diva-portal.org/smash/record.jsf?pid=diva2:248040] last accessed 2.8.2013

Häggström E, Skovdahl K, Fläckman B, Kihlgren AL, Kihlgren M. 2004, To feel betrayed and to feel that you are betraying the older residents: caregivers' experiences at a newly opened nursing home, in: *Journal of Clinical Nursing.* Sep;13(6):687-96.

Healy, D. & Mc Sharry, P. 2011, Promoting self-awareness in undergraduate nursing students in relation to their health status and personal behaviours, in: *Nurse Education in Practice*, vol. 11, no. 4, pp. 228-233.

Hyssälä, L. 2009 in: "Masto Project" Ministry of Social Affairs and Health, [http://www.stm.fi/en/publications/publication/-/_julkaisu/1381393#en] last accessed 16.4.2013

Irving, J.A., Dobkin, P.L. & Park, J. 2009, Cultivating mindfulness in health care professionals: a review of empirical studies of mindfulness-based stress reduction (MBSR), in: *Complementary Therapies in Clinical Practice,* vol. 15, no. 2, pp. 61-66.

Jootun, D. & McGhee, G. 2011, Effective communication with people who have dementia. (Cover story), in: *Nursing Standard*, vol. 25, no. 25, pp. 40-46.

Kabat-Zinn, J, 1982, An outpatient program in behavioral medicine for chronic pain patients based on the practice of mindfulness meditation: theoretical considerations and preliminary results, in: *General Hopsital Psychiatry*, 1982 Apr;4(1):33-47.

Kabat-Zinn, J. 2011, Some reflections on the origins of MBSR, skillful means, and the trouble with maps, in: *Contemporary Buddhism,* vol. 12, no. 1, pp. 281-306.

Krasner, M.S., Epstein, R.M., Beckman, H., Suchman, A.L., Chapman, B., Mooney, C.J. & Quill, T.E. 2009, Association of an Educational Program in Mindful Communication With Burnout, Empathy, and Attitudes Among Primary Care Physicians, in: *JAMA: Journal of the American Medical Association,* vol. 302, no. 12, pp. 1284-1293.

Kross, E., Berman, MG, Mischel W, Smith EE, Wager TD. 2011, Social rejection shares somatosensory representations with physical pain, in: *Proceedings of the National Academy of Sciences of the United States of America,* on PubMed Apr 12, 108(15):6270-5. doi: 10.1073/pnas.1102693108. Epub 2011 Mar 28.

Lau, M. A., Bishop, S. R., Segal, Z. V., Buis, T., Anderson, ND., Carlson, L., Shapiro, S., Carmody, J., Abbey, S., Devins, G. 2006, The Toronto Mindfulness Scale: Development and validation, in: *Journal of Clinical Psychology,* 62(12), 1445. accessed on [http://www.mindfulexperience.org/measurement.php] last accessed 12.8.2013

Leininger, M. 1985, Ethnography and Ethnonursing: Models and Modes of Qualitative Data Analysis in: *Qualitative Research Methods in Nursing.* Editor: Madeleine M. Leininger, Grune & Stratton, Inc. Orlando, FL 32887, ISBN 0-8089-1676-9

Malinowski, P. 2008, Mindfulness as psychological dimension: Concepts and applications, in: *The Irish Journal of Psychology,*Vol 29 No.1 pp 155-166 Copyright by The Psychological Society of Ireland, ISSN 0303-3910

Mann, R. & Youd, R., 1998, *Buddhism: The plain facts.* Aukana Trust, Bradford on Avon, Great Britain

MBCT 2007, Mindfulness Based Cognitive Therapy. [internet] About MBCT [http://www.mbct.com/index.htm] last accessed 12.08.2013

McBee, L. 2008, *Mindfulness-Based Elder Care: a CAM model for frail elders and their caregivers*, Springer Publishing Company, LLC, New York, NY.

Merkur, D. 2013, meditation, in: *Encyclopædia Britannica Online*, from [http://www.britannica.com/EBchecked/topic/372609/meditation] through Arcada Nelly Portal, last accessed 15.8.2013

Ministry of Social Affairs and Health 2008, National Framework for High-Quality Services for Older People, MSAH publications. [http://pre20090115.stm.fi/ka1212393066110/passthru.pdf] last accessed 15.8.2013

Ministry of Social Affairs and Health 2012, Act on Care Services for Older People to ensure a high standard of quality nationwide. Press release 235/2012, [http://www.stm.fi/en/pressreleases/pressrelease/-/view/1847332#en] last accessed 15.8.2013

Narayanasamy, A.; Clissett, P.; Parumal, L.; Thompson, D.; Annasamy, S.; Edge, R., 2004, Responses to the spiritual needs of older people, in: Journal of Advanced Nursing, Oct, Vol. 48 Issue 1, p6-16, Academic Search Elite (EBSCO), Cinahl (EBSCO)

Neff, K. and Vonk, R. 2009, Self-Compassion Versus Global Self-Esteem: Two Different Ways of Relating to Oneself, in: *Journal of Personality*, Vol. 77 Issue 1, p23-50, EBSCO

Newmark, T. 2012, Cases in Visualization for Improved Athletic Performance, in: *Psychiatric Annals*, Vol 42, Issue 10, October, pp 385-387. DOI: 10.3928/00485713-20121003-07 [http://www.healio.com/psychiatry/journals/psycann/%7Bb39a71aa-2e68-49c7-9367-dd3eed3f4f52%7D/cases-in-visualization-for-improved-athletic-performance#] last accessed 15.8.2013

Oken, B.S., Fonareva, I., Haas, M., Wahbeh, H., Lane, J.B., Zajdel, D. & Amen, A. 2010, Pilot Controlled Trial of Mindfulness Meditation and Education for Dementia Caregivers, in: *Journal of Alternative & Complementary Medicine*, vol. 16, no. 10, pp. 1031-1038.

OSF 2009, *Official Statistics of Finland: Causes of death* [e-publication]. ISSN=1799-5078. Helsinki: Statistics Finland [http://www.stat.fi/til/ksyyt/2009/ksyyt_2009_2010-12-17_tie_001_en.html.] last accessed 22.1.2013

OSF 2011, *Official Statistics of Finland: Dwellings and housing conditions* [e-publication]. ISSN=1798-6761. Helsinki: Statistics Finland. [http://www.stat.fi/til/asas/2011/asas_2011_2012-05-22_tie_001_en.html.] last accessed 22.1.2013

Oxford English Dictionary Online 2013, *mindful*, [internet] [http://www.oed.com/view/Entry/118742?redirectedFrom=mindfulness&] last accessed 10.1.2013

Plank, K. 2010, Mindful Medicine: The Growing Trend of Mindfulness-Based Therapies in the Swedish Health Care System, in: *Finnish Journal of Ethnicity and Migration*, Vol. 5, No.2, January, pp 47-55

Puka, B. 2010, The Golden Rule. Published on: *Internet Encyclopedia of Philosophy*, *IEP*, last updated: September 16, 2010 | Originally published: September 16, 2010 [http://www.iep.utm.edu/goldrule/] last accessed 2.8.2012

Richards, K.C., Campenni, C.E. & Muse-Burke, J. 2010, Self-care and Well-being in Mental Health Professionals: The Mediating Effects of Self-awareness and Mindfulness, in: *Journal of Mental Health Counseling*, vol. 32, no. 3, pp. 247-264

Richer, M., Ritchie, J. & Marchionni, C. 2009, 'If we can't do more, let's do it differently!': using appreciative inquiry to promote innovative ideas for better health care work environments, in: *Journal of Nursing Management*, 2009, 17 , 947–955, Wiley-Blackwell, (EBSCO)

Ruedy, N.E. & Schweitzer, M. E. 2010, In the Moment: The Effect of Mindfulness on Ethical Decision Making, in: *Journal of Business Ethics*, vol. 95, pp. 73-87

Sandberg, A. 2005, Comparative Study of Stress and Coping Between Nurses Working with Children and Nurses Working with Elderly, CD Extended Essay, Luleå University of Technology, 17, ISSN: 1402 – 1781 [http://epubl.ltu.se/1402-1781/2005/17/index-en.html] pdf: [LTU - C/DUPP - -05/17 - SE] last accessed 26.8.2013

Schmidt, S. 2004, Mindfulness and Healing Intention: Concepts, Practice, and Research Evaluation, in: *Journal of Alternative & Complementary Medicine*, vol. 10, pp. S-7; S-14

Schure, M.B, Christopher, J. & Christopher, S. 2008, Mind-Body Medicine and the Art of Self-Care: Teaching Mindfulness to Counseling Students Through Yoga, Meditation, and Qigong", in: *Journal of Counseling and Development : JCD*, vol. 86, no. 1, pp. 47-56

Spillers, R., Wellisch,D., Kim, Y., Matthews, A. & Baker, F. *2008*, Family Caregivers and Guilt in the Context of Cancer Care, in: *Psychosomatics*, Vol. 49, Issue 6, November–December, pp 511–519, [http://www.sciencedirect.com/science/article/pii/S003331820870882X] last accessed 12.4.2013

Teasdale, J.D., Segal, Z.V., Williams, J.M.G., Ridgeway, V., Soulsby, J., & Lau, M. 2000, Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy, in: Journal of Consulting and Clinical Psychology, 68, 615-623

UN 2009 [http://www.un.org/esa/population/publications/WPA2009/WPA2009_WorkingPaper.pdf]last accessed 12.4.2013

Valentine, S., Godkin, L. & Varca, P. E. 2010, Role Conflict, Mindfulness, and Organizational Ethics in an Education-Based Healthcare Institution, in: *Journal of Business Ethics*, vol. 94, no. 3, pp. 455-469

Walach, H. and Loef, M. 2012, Towards Primary Prevention of Alzheimer's Disease, in: *American Journal of Alzheimer's Disease,* Vol. 1 pp 1-28, doi:10.7726/ajad.2012.1001; Pu Ruedy, N.E. & Schweitzer, M. E. 2010, In the Moment: The Effect of Mindfulness on Ethical Decision Making, in: *Journal of Business Ethics*, vol. 95, pp. 73-87, Published online 29 September 2012; Published with open access at uscip.org

Weeks, B and Nilson, U. 2011, Music interventions in patients during coronary angiographic procedures: A randomized controlled study of the effect on patients' anxiety and well-being, in: *European Journal of Cardiovascular Nursing*, Vol. 10 Issue 2 pp 88-93, Cinahl (EBSCO

8 APPENDICES

Glossary

MBI – Mindfulness Based Intervention

MBSR – Mindfulness Based Stress Reduction (Kabat-Zinn 1982)

MBCT – Mindfulness Based Cognitive Therapy (Teasdale et al. 2000).

MBEC – Mindfulness Based Elder Care (McBee 2008)

FMI - Freiburg Mindfulness Inventory (Buchheld, Grossman & Walach 2001)

KIMS - Kentucky Inventory of Mindfulness Skills (Baer, Smith and Allen 2004)

CAMS - Cognitive and Affective Mindfulness Scale (Feldman, G., Hayes, A., Kumar, S., et al. 2007)

MAAS - Mindful Attention Awareness Scale (Brown & Ryan, 2003)

FFMQ - Five Facet Mindfulness Questionnaire (Baer et al. 2006)

TMS - Toronto Mindfulness Scale (Lau et al. 2006)

Appendix 1

Search Terms	Database	Number of Hits on Meta search	Hits with limiters (peer reviewed & 2008-2013)	Hits after other limiters (see Appendix)	Number of Accepted Abstracts	Number of Accepted Articles for reading
Mindfulness AND Ethics	AB/Inform Pro Quest	554	306	155	1	5
	EBSCO	893	43		5	
	Cinahl	6				
	ERIC	9				
Mindfulness AND Empathy	AB/Inform Pro Quest	273	85		12	8
	EBSCO	633/(79 in DB)	60			
	Cinahl	20				
	ERIC	5				
Mindfulness AND Empirical evidence	AB/Inform Pro Quest	623	250		20	10
	EBSCO	995 (25 in DB)	25			
	Cinahl	18				
	ERIC					
Mindfulness AND Transactions	AB/Inform Pro Quest	332	101		1	1
	EBSCO	112	2		0	
	Cinahl	2				

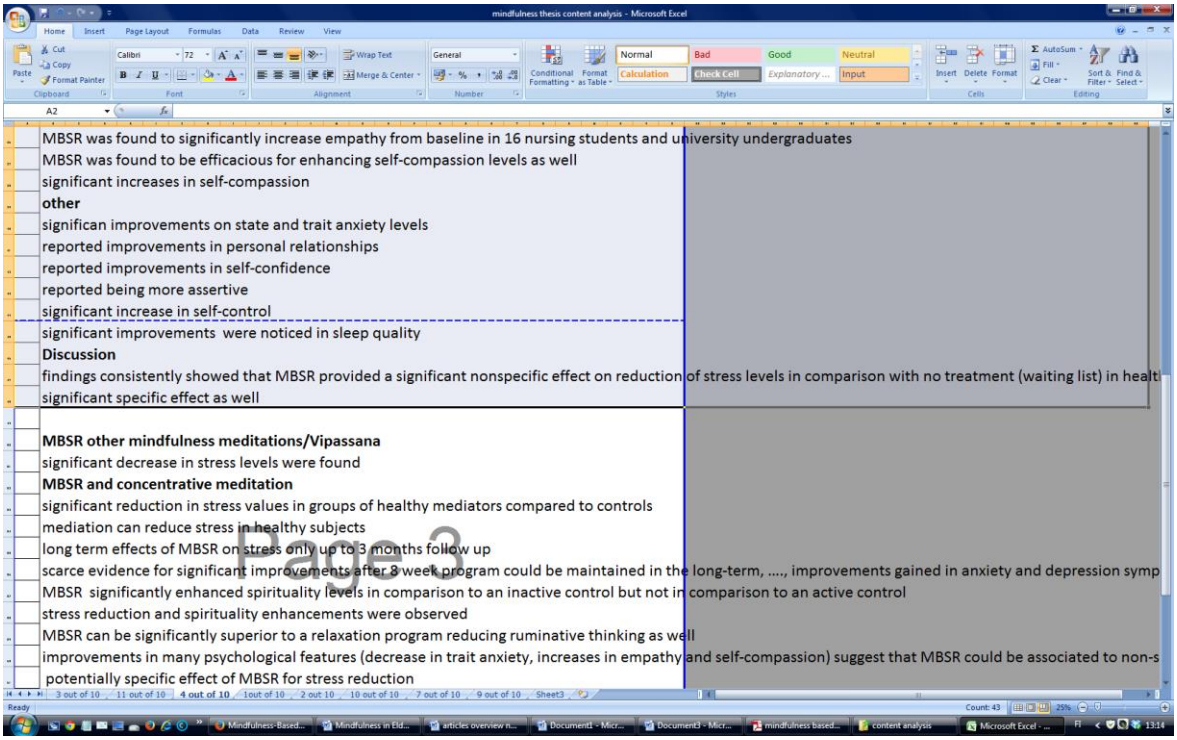
	ERIC	3			0	
Mindfulness AND Quality of Interpersonal Contacts	AB/Inform Pro Quest	185				
	EBSCO	46				
	Cinahl					
	ERIC					
SEARCH TERM	DATA BASE	HITS/ METASEARCH	REFINED SEARCH 'AND'	HITS	REFINED SEARCH 'AND'	
Effects of Mindfulness	AB/Inform Pro Quest	1256	stress	645	empathy fatigue	27
	EBSCO	2416		1455		72
	Cinahl	141		93		1
	ERIC	57		22		
Effects of Mindfulness	AB/Inform Pro Quest	1256	subjective wellbeing	61		
	EBSCO	2416		81		
	Cinahl	141		2		
	ERIC	57		0		
SEARCH TERM	DATA BASE	HITS/ METASEARCH	REFINED SEARCH 'AND'	HITS	REFINED SEARCH 'AND'	
Effects of Mindfulness AND social support	AB/Inform	921	older people	544		

	Pro Quest					
	EBSCO	1431		453		
	Cinahl	15		5		
	ERIC	5		0		
Effects of Mindfulness AND social support	AB/Inform Pro Quest	921	formal caregiver	23		
	EBSCO	1431		37		
	Cinahl	15		2		
	ERIC	5		0		
SEARCH TERM	DATA BASE	HITS/ METASEARCH	REFINED SEARCH 'AND'	HITS	REFINED SEARCH 'AND'	
Mindfulness	AB/Inform Pro Quest	2059	Older people	887		
	EBSCO	5748		812		
	CINAHL	731		11		
	ERIC	333		0		
	ARTO	14		0		
Mindfulness	AB/Inform Pro Quest	2059	AND elder care	530		
	EBSCO	5748		94		
	CINAHL	731		4		
	ERIC	333				
	ARTO	14				

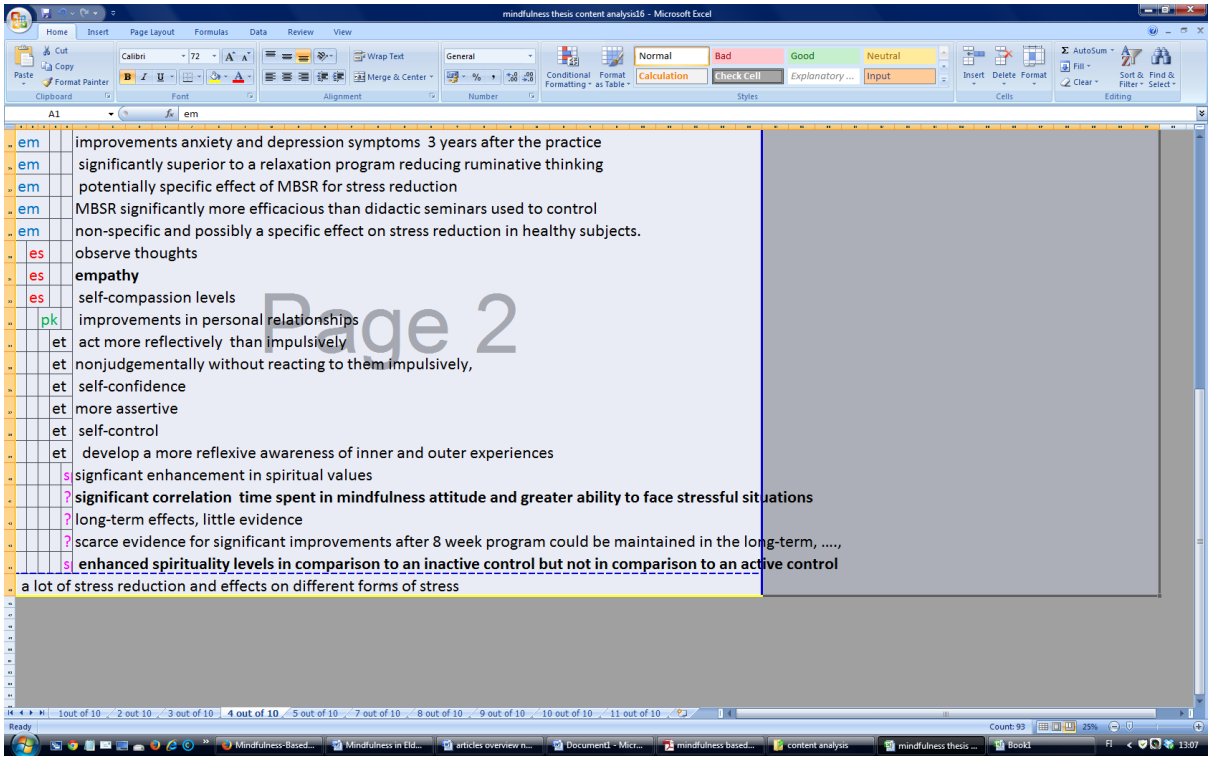
Appendix 2

Example of Elimination process on Article ‘4’ drafts ‘1’ and ‘16’

Draft 1



Draft 16



Appendix 3

Suggestions

Additional to physical mindfulness - exercises and mediations, caregivers, managers and other employees may ask themselves following, by no means exhaustive, self-reflective questions as part of a group exercise or yearly appraisals:

Empirical Knowledge:

Questions:

Do I need more training? / Is there a specific topic relating to elder care that interests me? / Am I informed about latest research? / Do I know how to deal with clients who have dementia, Parkinson's, Diabetes? Where do I have my knowledge from? Am I open to new findings? / Do I ever say: 'This is how we have always done it.'?

Suggestions:

- Someone in the team could find out about the latest research and bring their findings into the next team-meeting.
- In-house training possibilities for staff members

Self-knowledge

Questions:

Do I know my physical, mental and emotional limits? / What are they? / Where do I draw the line? / Am I generally patient or do I easily lose my temper? / What do I like about my job? / What don't I like? / Why is this person getting on my nerves? / Why don't I like to care for a particular client? / Why do I prefer this client? / Considering that other people are my mirror, can I see something in them, that I cannot see in myself? / Do I have compassion for myself? / Do I judge myself harshly? / Is the glass half full or half empty? / How do I relate to others, to my environment? / 'What do I think about my colleagues, clients, and superiors?' /'How do I talk about them? How do I relate to them? / Why do I want to care for older people? / What are my motives? / Is

this really what I am good at and what I want to do, or is this the only job available? Do these questions annoy me? / What could the reason for my annoyance be?

Ethical knowledge:

Questions:

Is my way of working with clients 'right'? /Do I ever feel a conflict? / In which situations do I feel a conflict between my actions and my idea of what is right or wrong? / How could the conflict be overcome? / What could I do to feel better about my work situation? / What could I do to overcome the conflict?

Since it seems necessary to make elder care more client-centered, it might also be required to detach from strict timetables. The question is:

Whose timetable is it?/ What is important?/ Is it possible that priorities need to be reconsidered?/ Who dictates timetables in our center or home for the elderly?/ Has anybody asked the client whether they want to get up early or sleep in late?/ What about meals? Am I sure the client likes porridge for breakfast today? / Do I eat the same breakfast every day? / Can I imagine eating it for the rest of my life? / Do I remember to ask the client each time or do I make assumptions?

Estethical knowledge

Questions:

How do I greet the client in the morning/the first time I meet them?/ Do I smile?/ Do I ask them how they have slept?/ How they are?/ Do I listen to their answer? / Do I care?/ Do I feel empathy? / Can I relate to their feeling?/ Do I take time to be present?/ Can I be present? Is it difficult for me to stay present? Can I listen to the client? / Do I ask the client for what they need?/ Do I let the client choose their clothes?/ Do I move in a hurried way?/ Do I tidy up any clutter?/ Water flowers? / Wash the dishes? / Am I patient and kind?