MINDFULNESS-BASED PRACTICE FOR ELDERLY VETERANS: A PROJECT TO EVALUATE THE INTEREST AND APPLICABILITY OF A MINDFULNESS-BASED PROGRAM FOR RESIDENTS AT A VETERANS HOME

By

Bernd Peter Hansen

A Project Presented to

The Faculty of Humboldt State University

In Partial Fulfillment of the Requirements for the Degree

Master of Social Work

Yvonne Doble, MSW, Advisor
Julie Angeloni, LCSW, Committee Partner
Yatiel Owens, MSW, Second Reader
Geneva Shaw, MSW, Program Graduate Coordinator

May 2016
Abstract

MINDFULNESS-BASED PRACTICE FOR ELDERLY VETERANS: A PROJECT TO EVALUATE THE INTEREST AND APPLICABILITY OF A MINDFULNESS-BASED PROGRAM FOR RESIDENTS AT A VETERANS HOME

Bernd Peter Hansen

This project aimed to evaluate the interest in mindfulness-based practices in a Veterans Home. Mindfulness-based practices have proven effective as an evidence-based treatment method for depressive disorder allowing individuals to regain a sense of hope, purpose, and meaning. With the use of semi-structured interviews of the clients and staff, their perspectives were collected and evaluated which afforded them with the opportunity to provide input and empowerment to assess and make recommendations regarding the interest, applicability, process of implementation, and sustainability of a program. Findings were used to make system wide recommendations.

Keywords: veterans, depression, mindfulness
Acknowledgements

I would like to thank Julie Angeloni, Chief Social Worker of the California Veterans Home, Yountville, for offering access and support during the development of this project. For the staff and residents at the Veteran’s Home that participated in the interviews, and shared with me their expertise and wisdom, thank you. A special thanks to the faculty and staff in the Department of Social Work at Humboldt State University, who changed my life and allowed me to fulfill my dream. I am grateful to my Committee for their work and support, especially Committee Chair Yvonne Doble for being present, persistent, and whose faith never faltered and Committee Member Yatiel Owens for her never ending support. To my fellow students, the cohort that I began with, I could have never done this without you. Thank you for all your support and being the wonderful caring people that you are. Finally, I want to thank my family for their continued love, support, and sacrifices, without which this endeavor would not have been possible.
# Table of Contents

Abstract ........................................................................................................................................ ii

Acknowledgements ................................................................................................................... iii

List of Tables ............................................................................................................................ vi

List of Figures ........................................................................................................................ vii

Introduction ............................................................................................................................... 1

Elderly Veteran Population .................................................................................................... 3

Physical and Mental Health in Elderly Veterans ..................................................................... 6

Mindfulness-based Practice ..................................................................................................... 11

Methodology ............................................................................................................................ 15

Theoretical Framework ........................................................................................................... 15

Sample ...................................................................................................................................... 16

Design ....................................................................................................................................... 16

Interviews ................................................................................................................................. 17

Interview questions ................................................................................................................ 17

Data Analysis ........................................................................................................................... 18

Quantitative data analysis ....................................................................................................... 19

Qualitative data analysis ......................................................................................................... 19

Data Collection and Storage .................................................................................................. 19

Risks Management Procedure ............................................................................................... 20

Potential risks ........................................................................................................................ 20

Risk management .................................................................................................................. 20

Outcome Evaluation ............................................................................................................... 20

iv
Results ........................................................................................................................................................................ 22

Data Analysis ...................................................................................................................................................................... 22

Quantitative data analysis .................................................................................................................................................... 22

Quantitative data analysis for residents ............................................................................................................................. 22

Quantitative data analysis for social work staff .................................................................................................................. 22

Qualitative data analysis ....................................................................................................................................................... 23

Qualitative data analysis for residents ................................................................................................................................. 24

Qualitative data analysis for social worker staff .................................................................................................................. 24

Conclusion ............................................................................................................................................................................. 26

Alternative Hypotheses ......................................................................................................................................................... 26

Importance to Social Work .................................................................................................................................................... 28

Implementation Suggestions at this Site ............................................................................................................................... 28

Future Program Implementation and Research .................................................................................................................... 29

References ............................................................................................................................................................................. 31
List of Tables

Table 1. Percentage of yes answers by residents and staff........................................... 23
List of Figures

Figure 1. Percentage of yes answers .......................................................... 23
Figure 2. Word cloud of themes ................................................................. 25
Introduction

The purpose of the project is to evaluate the interest and applicability of mindfulness-based practice to address depression in elderly Veterans living in a Veterans Home. Emerging research indicates that 11\% of Veterans ages 65 years and older have a diagnosis of major depressive disorder, a rate more than twice found in the general population (Veterans Health Administration, 2015). Some of the Veterans are fortunate enough to find shelter in a Veterans Home where they receive rehabilitative, residential, medical care and services in a home-like environment.

At first glance the Veterans Home appears more like a resort than a permanent home for Veterans. Veterans, who have been honorably discharged from active military duty and are over the age of 55 years, are eligible to apply for admission. The age requirement might be waived for disabled or homeless Veterans that are in need of long-term care. Also, if so desired, the Veterans can bring their spouses to join them so that they can continue to live together. The Home offers various recreational services for residents including a theater, golf course, baseball stadium, bowling lanes, and swimming pool. Health care needs of residents are met by on-grounds facilities including Residential Care for the Elderly, Intermediate Care, Skilled Nursing Care, and a “Memory Care Center” for residents with various forms of dementia.

Regrettably, not everything is as idyllic as it appears at a first glance. Many of the residents who find themselves at the Home were homeless or otherwise not financially able to support themselves independently and the Home provides them with the
opportunity to a life that supports their basic needs. Others arrived at the Veterans Home because they themselves, or family members, realized a need for assisted care. In the end, residents seek out the Veterans Home because they no longer can support themselves independently, lack needed support, or possibly find themselves alone after their significant others have passed.

The move to the Veterans Home solidifies their realization of aging and mortality, often leaving residents prideful and resentful. In addition, many of the residents bring with them unresolved challenges, such as Post Traumatic Stress Disorder (PTSD), depression, or substance use disorders. While the Home provides outstanding health care services for its residents, including readily available social workers, the overarching sense of isolation, depression, and fear of aging remains. All of this comes together to create complex living conditions that can foster depression among residents.

This situation is further exacerbated by the lack of community empowerment available to the residents. According to the World Health Organization (WHO), “Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities - their ownership and control of their own endeavors and destinies” (WHO, 1986). This project aims to empower residents by allowing the community rather than “experts” to identify matters of importance, giving the residents decision-making powers over the program including design, strategy, and implementation, and by measuring success via residents’ perceived control over decisions affecting their lives and health (Braunack-Mayer & Louise, 2008).
This project was requested because staff perceived a high degree of depression among residents of the Veterans Home. Julie Angeloni, LCSW and Chief of Social Work Services at the Veterans Home was recruited as a Community Member for this project in order to provide expert advice on agency and resident information and background.

Semi-structured interview questions were used to capture both client and staff input and to allow for the empowerment of the researched. The methods used in this project were designed to collect both quantitative and qualitative information to discover interest, applicability, process of implementation, and sustainability of a mindfulness-based program. The goal behind this project is to encourage the further development and implementation of a program that has been constructed in a true collaboration between staff and clients. With the data collected clients will have the opportunity to have their voices heard and staff will have the opportunity to support, educate, and assist, providing the necessary synergy to meet the needs of all the stakeholders.

The following supplemental details about elderly Veterans and mindfulness-based practice will provide more context and background information for this project.

**Elderly Veteran Population**

Current and upcoming elderly Veterans are facing unprecedented challenges related to an increase in aging population (a.k.a. Silver Tsunami) and consequently limited resources to address their needs. Unfortunately, the prospect of future limited resources will have a direct impact on the services that will be available for the elderly including prescription drugs and mental health services.
The US population is aging at an alarming rate. Based on the Administration on Aging (AoA), the population aged 65 and over has increased from 35.9 million in 2003 to 44.7 million in 2013 (a 24.7% increase) and is projected to more than double to 98 million in 2060. The 85+ population is projected to triple from 6 million in 2013 to 14.6 million in 2040 (AoA, 2014). At the same time the Veteran population is shrinking. Based on the Department of Veterans Affairs (VA), in 2013 there where over 22 million Veterans. By 2043 this number is estimated to shrink to 14.5 million while the rate of female Veterans is going to increase from 9% to 16%. This trend is also reflected with an increase in minority Veterans (Department of Veterans Affairs, 2015). But just as the nation’s population is aging, so is the Veterans’ population.

While the overall Veteran population is declining, the age group of Veterans over 65 is expected to increase over time. This points to a need for future services addressing health care concerns of an older Veteran population that is bringing new challenges to health-care service providers. Elderly Veterans have comparatively higher prevalence of certain chronic conditions such as, arthritis, heart condition, and high blood pressure. Hence, health care providers serving older Veterans need to become skilled at both the management of chronic diseases and providing education concerning health risks and prevention methods (Villa, Harada, Washington, & Damon-Rodriguez, 2003).

The increase in elderly population could potentially have very negative consequences for the aging Veteran population. While the Veteran population over the age of 65 year accounts for less than 30% of the overall Veteran population, they are the largest consumers of services and resources provided by the Department of Veterans
Affairs. In addition, Veterans and their families still account for 35% of the Social Security beneficiary population (Villa et al., 2003). According to the Department of Health & Human Services report, “The rapid growth of the elderly, particularly the oldest old, represents in part a triumph of the efforts to extend human life, but these age groups also require a disproportionately large share of special services and public support. There will be large increases by 2030 in the numbers requiring special services in housing, transportation, recreation, and education as well as in health and nutrition” (as cited in Wilson, 2012).

Unfortunately, programs benefiting the elderly such as provided by the VA, Social Security, and Medicare are in danger of becoming overwhelmed by the aging population and running out of resources (Olsen & O’Leary, 2011). For example, as per the latest economic and demographic projections by the trustees of the Social Security system, the combined trust funds that pay for old age and disability benefits are predicted to run out by 2034. This will not eliminate benefits since the system is by and large a pay-as-you-go structure where younger people in the workforce will still pay taxes. But, it will deplete any and all savings reducing the possible funding to about 79% of scheduled benefits (Regnier, 2015).

All of this information points to the fact that our population demographic will shift towards an older population including more elderly Veterans. Those Veterans will have unique long-term health care challenges and the funding to meet those challenges will become an important factor in the future, in particular for Veterans who strongly rely on public retirement funds. Consequently, alternative, low-cost, evidence-based options
that focus on physical and psychological treatment opportunities of an increased older population are desirable and needed.

**Physical and Mental Health in Elderly Veterans**

It has been shown that negative physical and mental health effects experienced by Veterans depend on factors such as the type of service, the severity of experiences (strongest with Veterans who have seen heavy conflict or captivity), the timing and duration of service, characteristics and resources of individuals, and treatment strategies. For example, military service during World War II (WWII) has been associated with a variety of long-term physical health disparities including, tuberculosis, chronic bronchitis and emphysema, cardiovascular disorders, arteriosclerosis, digestive disorders, chronic rheumatism, arthritis, skin diseases, and premature aging. In addition, military service has been linked to an increase in mortality rate particularly during the years following deployment. Similarly, it was found that individuals entering the service at a later age seem to experience an increase in negative health consequences when compared to those mobilized at a younger age (Settersten, 2006).

When considering the physical health of aging Veterans one cannot underestimate the effects of psychological states. In particular, the relationship between psychological repression and physical health. As Veterans return from the services try to integrate into civilian life they often suppress their experiences deep into their minds in order to forget about the war and past. During WWII this was even encouraged by the government that
handed out leaflets and advertised in women’s magazines, encouraging Veterans, and their spouses, to shoulder and assume the emotional stresses resulting from the war.

Unfortunately, repression of emotional responses, even in low levels, will, over time, have negative physical and psychological consequences that may surface later in life (Settersten, 2006). Results from a study that focuses on life-span effects of military service by Spiro, Schnurr and Aldwin, (1997) show that not only do the effects of any traumatic experience have immediate affects; they also continue to have important influences on current behavior. Sometimes psychiatric symptoms can occur among previously asymptomatic Veterans, even 50 years after the initial experience (Spiro, Schnurr, & Aldwin, 1997).

One hypothesis to explain this phenomenon is that the Veterans suffer from a delayed onset of PTSD triggered by stressful events associated with aging such as retirement or bereavement (Spiro et al., 1997). To complicate matters further, stigma over particular illnesses, especially mental illnesses, may affect the generations of Veterans who served during WWII and Korea who may be less willing to share their experiences and seek medical attention compared to Veterans of more recent conflicts (Settersten, 2006).

Undoubtedly, one of the greatest psychological burdens that Veterans have to carry are the affects from exposure to the traumatic events related to war and active combat. According to Parrish (2001), during the early 1800s, military doctors first began diagnosing soldiers with something referred to as “exhaustion” following the stress of combat. Exhaustion was characterized by mental shutdown due to trauma. At the same
time in England, the diagnosis of “railway spine” or “railway hysteria” appeared bearing similarities to the modern PTSD. This diagnosis was created based on the response to a catastrophic railway accident. Throughout World War I, the condition was labeled as “soldier’s heart” and “the effort syndrome.” During WW II, the labels “shell shock” and “combat fatigue” emerged. All these terms were utilized to describe Veterans suffering from anxiety, stress, and depression due to experiences with traumatic combat events. The first official description of PTSD was written and published in 1980 as part of the American Psychiatric Association’s third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) (Parrish, 2001).

Based on findings collected by the National Center for PTSD, there are multiple studies that have tried to quantify the scale of PTSD among Veterans. First, based on the National Vietnam Veterans Readjustment Study (NVVRS), conducted between November 1986 and February 1988, the estimated lifetime prevalence of PTSD among these Veterans was 30.9% for men and 26.9% for women. Second, of Vietnam conflict Veterans, 15.2% of males and 8.1% of females were diagnosed with PTSD. Third, Kang and others found that the prevalence of current PTSD in a sample of Gulf War Veterans was 12.1%. Finally, based on a 2008 population-based study by the RAND Corporation, Center for Military Health Policy Research, previously deployed Operation Enduring Freedom and Operation Iraqi Freedom (Afghanistan and Iraq) service members, the prevalence of PTSD was 13.8% (as cited in Gradus, 2015).

Equally important is the interrelated diagnosis of Depressive Disorder among Veterans. Emerging research indicates that 11% of Veterans ages 65 years and older have
a diagnosis of major depressive disorder, a rate more than twice found in the general population. A large national survey found that depression is nearly 3 to 5 times more likely in those with PTSD than those without PTSD. For example, a survey of survivors from the Oklahoma City bombing found that 23% had depression after the bombing compared to 13% that had been diagnosed with a depression disorder before the bombing (National Center for PTSD, 2015).

Based on the DSM-5, all depressive disorders have in common the presence of sad, empty, or irritable mood, that are accompanied by somatic and cognitive changes that significantly effect the individual's capacity to function. The typically major depressive disorder is depicted by distinct occurrences of at least 2 weeks' duration (often lasting substantially longer) including unambiguous changes in effect, cognition, and neurovegetative functions and inter-episode remissions. It is interesting to note that bereavement during an episode tends to be more severe compared with bereavement that is not accompanied by major depressive disorder. Bereavement-related depression tends to befall persons with other susceptibilities to depressive disorders and that management may be aided with antidepressant treatment. Also relevant to the project is that a more chronic form of depression, persistent depressive disorder (dysthymia), is being diagnosed in individuals when the mood disturbance continues for at least 2 years in adults (American Psychiatric Association, 2013).

Based on the information provided by Julie Angeloni, Chief Social Worker at the Veterans Home, residents asked for the assistance with their depression and hence depression among the residents at the Veterans Home is a major concern. Since physical,
mental, and cognitive health are closely connected in the elderly the diagnosis of depression late in life is challenging. Typical depressive symptoms such as sadness, problems with memory, unexplained pain or fatigue, anxiety, hopelessness, helplessness, and irritability can all be found among the residents. The consequences of depression include an increase in a risk for medical problems, cognitive decline, dementia, and even suicide. The researcher found that many of the residents are subject to triggers that may cause depressive episodes such as the death of a spouse, family member, or pet, medical problems, physical and mental disabilities, retirement, financial strain, and individual isolation.

Traditionally, treatment for depressive symptoms in elderly includes the use of antidepressant medication, as suggested in the DSM-5, such as selective serotonin reuptake inhibitors, serotonin and norepinephrine reuptake inhibitors, and Tricyclic antidepressants. In addition, psychotherapy has been found to be an effective treatment modality. (American Psychiatric Association, 2013). Unfortunately, finding an effective medication for Veterans with a comorbidity of cognitive impairment has proven challenging. Dr. Crabb from the Geriatric Research Education and Clinical Center (GRECC) in Palo Alto suggests focusing on hope, purpose, and meaning. Veterans should be supported to solve problems and re-engage in meaningful activities, such as volunteering, physical exercise, or spending time with loved ones. Her team uses life review exercises to encourage the recollecting of life experiences in order to discover how they managed past challenges and tap into their life-long strengths. She states that, “Older Veterans are used to solving their own problems and can find it hard to accept
help. It’s important for them to feel that their health care provider respects their life experience” (National Center for PTSD, 2015).

In order to overcome depressive symptoms and to prevent the relapses of depressive episodes the researcher suggests the supplemental use of an alternative healing method that is focusing on the elderly Veterans own abilities to take control of their lives.

**Mindfulness-based Practice**

The origin of mindfulness can be traced back to ancient Hindu teachings. It rose in popularity 2500 years ago with the experiences and schoolings of the Buddha in India. At the center of the Buddha’s teachings are the effects of practicing mindfulness and associated philosophy. Over the next 2000 years, Buddhism spread through India and the Far East. While extending, it incorporated aspects of various local, cultures and indigenous religions creating a diverse variety of Buddhists schools of thoughts. For example, Tibetan Buddhism is deeply influenced by the previously existing Shamanistic Bon religion, Chan Buddhism in China is infused with Confucian and Taoist thought, and the Japanese Zen is permeated with Japanese culture (Gilbert, 2015).

Eventually Buddhism found its way to the west. With the decline of the established Christian churches in the West, there has been a growing rise of alternative religions and culture. First, during the early 20th century, theosophists and spiritualists started to appear. Next, followed the beatnik insurgency of the late 1950’s and hippies of the late 1960’s. During the 1970’s a flurry of exchanges occurred as young Americans and Europeans traveled to India, Burma, and Thailand to train under Buddhist meditation
masters and returned back home where they began teaching themselves. As a result, Buddhist monasteries, communities and centers began to emerge in Europe and the US. (Gilbert, 2015).

Notable in this process of learning and exchange is one man often identified as the father of modern Western-based meditation practice and the founder of Mindfulness-Based Stress Reduction (MBSR), Jon Kabat-Zinn. MBSR came into existence in 1979 at the University of Massachusetts Medical School where it has since grown into a Center for Mindfulness that has treated thousands of patients (Cullen, 2011). Also significant is cognitive psychologist Zindel Segal who, in 2002 with his colleagues, combined mindfulness-based practice with traditional Cognitive Behavior Therapy to create Mindfulness-Based Cognitive Therapy (MBCT) in order to treat depression and depressive self-images (Segal, 2015).

Now the question arises, what exactly constitutes mindfulness-based practice? According to Jon Kabat-Zinn (1994), mindfulness is “paying attention in a particular way: on purpose, in the present moment, and non-judgmentally” (p. 4). He considers mindfulness as a “way of being,” not static but rather a dynamic process, embedded within all of life, both intra- and inter-personal.

MBSR accomplishes this by using various formal practices to address the four foundations of mindfulness. The first practice is gentle Hatha Yoga to emphasize mindful awareness of movement and the body. Second, the practice of the body scan to cultivate body awareness. Finally, sitting meditation to promote awareness of the breath and to widen the field of awareness. All three practices lead to the four foundations of
mindfulness: awareness of the body, feeling tone, mental states and mental contents. The MBSR program systematically introduces the four foundations and their applicability to daily life through an eight-week program that many participants claim provides them with a taste of freedom that intensely impacts their lives (Cullen, 2011).

Hundreds of studies have found that mindfulness-based practices help Veterans with both PTSD and depression related symptoms. For example, Omidi, Mohammadi, Zargar, and Akbari found in a 2013 study that MBSR helped Veterans diagnosed with PTSD with their symptoms of depression, dizziness, fatigue, and tension (Omidi, Mohammadi, Zarga, & Akbari, 2013). David, McDermott, Malte, Martinez, and Simpson, found in their 2012 study that Veterans who participated in a MBSR program experienced significant improvements in measures of mental health, including measures of PTSD, depression, experiential avoidance, and behavioral activation as well as mental and physical health-related quality of life over a 6-month period (David, McDermott, Malte, Martinez, & Simpson, 2012). Important to note is that the participants in the MBSR program continued to improve with extended participation in mindfulness-based practice (David et al., 2012). Further research encourages the use of mindfulness-based programs to supplement or even eliminate the use of anti-depressants pharmacology treatment models to address the reoccurrences of depressive episodes. Piet and Hougaard used meta-analyses in 2011 to find that in two studies MBCT was at least as effective as maintenance of anti-depressive medication to prevent the relapse in recurrent major depressive disorder (Piet & Hougaard, 2011).
Mindfulness-based practices clearly can be used to address the health concerns of Veterans. However, it also empowers them to take charge of their own well-being while potentially reducing the cost of healthcare. Ruff and Mackenzie (2009) make a very strong case for mindfulness interventions reducing the cost of healthcare. They noted, “Regardless of who pays for healthcare in the United States, the cost must come down. Without a reduction in healthcare expenditures, the system will not be sustainable for long. Applying what we know about the potential for mindfulness-based interventions to prevent disease, promote health, treat chronic conditions and improve the quality of care may well turn out to be a cornerstone of a more humane, equitable and effective approach to health and healthcare that can actually reduce costs in a meaningful way. Leveraging the body’s innate capacity to heal itself may be the key to creating a sustainable healthcare system for the 21st century” (Ruff & Mackenzie, 2009).
Methodology

The methodology section will cover the theoretical framework that informs this research. It will provide a detailed description of the sample used and the design, including interview questions, to obtain the needed information. Next, it will focus on the data that was collected incorporating data analysis, data collection and storage. The section will conclude with a focus on risk management procedures that were in place and an outcome evaluation of the study.

Theoretical Framework

The framework that informs this research is that of empowerment. In order for Veterans to move into the Home they have to agree to limiting rules and regulations. This results in a loss of power relative to their previous independent lives. Fortunately, since power does not exist in isolation and is created in relationships, power and power relationships with others can change. There are different ways that power can be seen and understood, but in order for empowerment to occur the viewpoint that power can be shared is essential.

A broader definition of the construct of empowerment by Page and Czuba suggests that “empowerment is a multi-dimensional social process that helps people gain control over their own lives. It is a process that fosters power (that is, the capacity to implement) in people, for use in their own lives, their communities, and in their society, by acting on issues that they define as important” (Page & Czuba, 1999).
Understandably, the Veterans at the Home facing a loss of control over their daily lives are seeking ways to resist this loss. To that end, this research is attempting to create a collaborative effort, based on mutual respect, and diverse perspectives for residents and staff to work together towards the creation of a creative and realistic solution. In other words, the sharing of power that results in a partnership and empowerment to both the residents and staff.

**Sample**

The sample consists of residents who lived at the Veterans Home and had a medical diagnosis of a depressive disorder. Residents were randomly selected by the responsible social worker and verbally solicited to voluntarily participate in the research. In addition, all social worker staff employed during the time of the research were solicited via email to voluntarily participate in their part of the project.

A total of 15 residents contacted participated at least in part in the interview. A total of seven social workers contacted participated at least in part in the interview.

**Design**

The semi-structured interviews were conducted in person at the Veterans Home. Each question contained both quantitative and qualitative parts with the goal to gather the interviewees’ perspective on the subject. The sample population was comprised of two groups. First, volunteer Veterans with a diagnosis of a depressive disorder who were randomly selected and solicited by the responsible social worker. Second, all the social
work staff, who were solicited via email to voluntarily participate in their part of the project.

**Interviews.** The researcher interviewed selected Veterans Home residents and staff face-to-face at the Veterans Home during scheduled meeting times. Interviews took an average of 25 minutes and notes were taken during and after each interview. Prior to asking any questions a short description of mindfulness-based practice was given to the participant in order to ensure a basic understanding of the therapeutic principles. The theoretical framework of empowerment significantly shaped the design of the semi-structured interview questions for both the residents and social workers. The questions for both residents and social workers were almost identical allowing for a shared power base without any group having any inherent power advantage. Each question was designed so that the first part asked quantifiable yes/no questions while the later part asked qualitative related follow-up questions.

**Interview questions.** The semi-structured client interview questions were as follows:

1. Do you understand the principles and ideas behind mindfulness-based practice? Yes/No? Any questions?
2. Did you ever try mindfulness-based practice to address your depression? Yes/No? When and where did you try? What parts were helpful? What parts did you dislike?
3. Does mindfulness-based practice appeal to you? Yes/No? What parts?
4. Do you think that mindfulness-based practice could be helpful with depression in elderly Veterans? Yes/No? Why?

5. Do you like the idea of a mindfulness-based program at the Veterans Home? Yes/No? Where and how would you like to see it implemented?

The semi-structured social work staff interview questions were as follows:

1. Do you understand the principles and ideas behind mindfulness-based practice? Yes/No? Any questions?

2. Did you ever try mindfulness-based practice personally or with your clients? Yes/No? When and where did you try? What parts were helpful? What parts did you dislike?

3. Do you think that mindfulness-based practice could be helpful for residents that have been diagnosed with depression? Yes/No? Why?

4. Do you like the idea of a mindfulness-based practice program at the Veterans Home? Yes/No? Where and how would you like to see it implemented?

5. What would it take for you to implement a mindfulness-based practice program? What would be foreseeable barriers?

**Data Analysis**

This project used a mixed method approach using both quantitative and qualitative data to form conclusions. The benefit to this approach was that it provided reliable objective data via the quantifiable yes/no questions that focused on the breadth of
the subject. Quantifiable questions are in general independent of the researcher and should always provide the same results stipulated that the methodologies used are the same. At the same time, the quantifiable part put attention on homogenous exploration and provided understanding of behaviors of values, beliefs and assumptions (Choy, 2014).

**Quantitative data analysis.** The quantitative portions of the data collected were analyzed using the simple percentage approach. This approach provided the opportunity to identify and graphically display how many of the interviewees had previous experience with mindfulness-based practice, if they believed that it could be beneficial, and if a program is desirable.

**Qualitative data analysis.** Qualitative analysis was undertaken using inductive analysis. Inductive analysis is a simple and nontechnical way to perform qualitative analysis. It provided a simple, straightforward approach for deriving findings linked to focused evaluation questions (Thomas, 2006). The result is a report that includes the most important categories in the main findings of the inductive analysis.

**Data Collection and Storage**

Interview notes were transcribed after each interview and shredded after transcription. All information obtained was kept on a password-protected computer in a locked room throughout the duration of the project. Upon project completion in May of 2016, all information collected will be destroyed.
Informed consent forms were kept in a locked drawer throughout the duration of the project. Upon project completion all informed consent forms have been retained and will be housed with the Committee Chair for three years. After three years the documents will be destroyed.

**Risks Management Procedure**

**Potential risks.** The semi-structured interview could potentially have resulted in emotional discomfort for the participants if they have had negative experiences with practices related to mindfulness. The project was positive in its approach and stressed empowerment so it was not anticipated that the tone of the interview would be a cause of discomfort.

**Risk management.** Compassionate efforts of a well-trained and supported graduate student from the Department of Social Work were used to make the process as comfortable as possible. Furthermore, in case of need, the participants had access to their assigned social worker staff who had been notified of the project. Finally, participants were advised that any or all questions could be skipped and the interview process stopped at any time.

**Outcome Evaluation**

The benefit of this research project to the participant is having the opportunity to contribute their knowledge and perspective on the interest and applicability of a
mindfulness-based program at the Veterans Home. In addition, participant’s input could become instrumental in the development of a future program.
Results

The project used semi-structured interviews to collect data. In total 15 residents and seven social work staff were interviewed. The data collected were both qualitative and quantitative in nature and thus have been analyzed separately.

Data Analysis

Quantitative data analysis. Per Choy, quantitative data analysis has two significant advantages. First, surveys can be administered and evaluated rather quickly allowing for responses to be calculated within a short timeframe. Second, the numerical data obtained lends itself to easy comparisons between groups, as well as clarifying the extent of agreement or disagreement among the surveyed (Choy, 2014). Table 1 shows percentage of yes answers to the interview questions by both residents and social work staff.

Quantitative data analysis for residents. The results for the residents indicate that 93% understand the principles and ideas behind mindfulness and like the idea of a mindfulness-based program at the Veterans Home. Mindfulness-based practice appeals to 80% of the residents and 80% believe that it could be helpful with depression in elderly Veterans. Of the residents interviewed, 47% tried mindfulness in the past to address their depression.

Quantitative data analysis for social work staff. The results for the social work staff indicates that 100% understand the principles and ideas behind mindfulness, tried it
personally or with clients, think that it would be helpful for residents that have been diagnosed with depression, and like the idea of a mindfulness-based practice program at the Veterans Home.

Table 1. Percentage of yes answers by residents and staff

<table>
<thead>
<tr>
<th>Interview Participants</th>
<th>Question 1</th>
<th>Question 2</th>
<th>Question 3</th>
<th>Question 4</th>
<th>Question 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents</td>
<td>93%</td>
<td>47%</td>
<td>80%</td>
<td>80%</td>
<td>93%</td>
</tr>
<tr>
<td>Social Worker Staff</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

Figure 1. Percentage of yes answers

Qualitative data analysis. Per Thomas, “The primary purpose of the inductive approach is to allow research findings to emerge from the frequent, dominant, or significant themes inherent in raw data, without the restraints imposed by structured
methodologies” (Thomas, 2006). As suggested by the approach, the researcher developed and categorized themes by studying the transcripts to evaluate probable meanings until no new themes arose. Each question or category resulted in relational key themes found during the interviews.

**Qualitative data analysis for residents.** Question one did not result in any follow up questions or themes. Question two, the inquiry where they experienced mindfulness-based practice in the past, if it was and helpful, and parts that were disliked resulted in the themes of Veterans Home, therapy sessions, individual therapy, meditation, calming, and objective insights. There were no reported dislikes. Question three focused on the appeal of meditation and found the reoccurring themes of meditation (relaxation, calmness, and focus on breathing) and Buddhist origin. The inquiry to ascertain if mindfulness-based practice would be helpful with depression in elderly Veterans, as asked in question four, found it beneficial as a tool for Veterans to become centered and to avoid being overwhelmed by life challenges. Question five inquired if there is interest in a mindfulness-based program at the Veterans Home and where/how it could be implemented. Most residents prefer individual settings followed by group settings at each section, and finally via the local TV broadcast station.

**Qualitative data analysis for social worker staff.** Question one did not result in any follow up questions or themes. Themes based on question two, experience with mindfulness-based practice, resulted in personal/client practice, calming the mind, body-mind connection, and reframing of thoughts. Question three, helpfulness of mindfulness to address depression in residents, resulted in the themes of cognitive reframing, sense of
reality, and security. Where and how to implement a program, as asked in question four, resulted in the themes of group practice, activities center, and one-on-one. Finally, question five, what would it take to implement a mindfulness-based program and foreseeable barriers, provided the themes of interest by residents and staff, time constrains, training/workshops, and lack of interest/support.

Figure 2. Word cloud of themes
Conclusion

Based on the research findings, there appears to be great interest in a mindfulness-based program at the Veterans Home. Most of the Veterans and social workers interviewed understood the idea behind mindfulness-based practice and many have even tried it in the past. Overall, participants believe that it would be a helpful approach to address depression in elderly Veterans. Results point to a pattern of interest and a notable degree of motivation to implement a mindfulness-based practice for Veterans diagnosed with a depressive disorder living at the Veterans Home.

Additional data provided by Veterans during the interviews indicate that most of them don’t care if the practice is led by their assigned social worker, somebody else who is proficient in the practice, or even via television broadcast on the local channel. Also, negative feedback was usually associated with older Veterans who showed little interest in any programs. Social workers, in general, lean towards a group approach while residents prefer individual therapy. All social workers voiced some concerns about the actual implementation of a program. Their most common concerns mentioned were related to availability of time, resources, and adequate training to provide a meaningful program.

Alternative Hypotheses

Since there is an overwhelming positive response to the questions one might wonder why there is not a program in place at this time. Consequently, there could be
alternative explanations or hypothesis for the responses given. First, residents might be interested in any assistance that is offered. Life at the Veterans Home can be very lonely and unexciting. It is possible that the residents responded favorably since an interview is novel and attention to their opinion is welcomed. Also, the data might be inaccurate due to confirmation bias by the researcher. Since the researcher also functioned as interviewer he might inadvertently have influenced the interviewees. Some of the interviewees could have responded positively to show interest in the unusual topic or appreciation for the interviewer’s enthusiasm. Lastly, the volunteer Veterans were randomly selected and solicited by the responsible social workers. This could have caused selection bias by the social workers who chose the participating residents. Besides having being diagnosed with a depressive disorder there might have been other factors, such as prior exposure to mindfulness or unusual agreeableness, that might have been influential in the selection of the resident and consequently resulted in biased interview responses.

Additional limitations to the project could be the small sample size of participants who were solicited and interviewed and also time constrains throughout the project design and implementation phase. Expanding the study to allow for more time and the inclusion of clients without a depressive disorder diagnosis would allow for more comprehensive results that more accurately reflect a range of Veterans’ perspectives and reduce some of the identified biases.
Importance to Social Work

This project and associated findings are important to social work for several reasons. First, it confirms the acceptance and interest of a mindfulness-based program at the Veterans Home by both resident elderly Veterans and social worker staff. As previously mentioned, mindfulness is becoming increasingly accepted and utilized by mental health professionals including social workers. This study also shows that elderly Veterans living in a retirement community are interested in mindfulness-based practices.

Considering that three generations of Veterans reside at the Veterans Home it is uplifting to learn of the overwhelming support and interest in a mindfulness-based program. In addition, this study empowers the residents at the Veterans Home by offering them with the opportunity to provide input into their treatment choice and therapeutic design. Future programs should include elements identified by Veterans as part of this study in order to ensure its success. It is the researcher’s hope that perhaps a seed has been planted through the project to allow for the implementation of a mindfulness-based program and further community empowerment for the residents.

Implementation Suggestions at this Site

There are two aspects surrounding the project that are important to note for future implementation at the Veterans Home.

First, as part of a monthly social worker staff meeting at the Veterans Home the researcher presented his findings to the community partner and social worker staff. The
overwhelming positive results were greeted with great interest and enthusiasm. The following round table discussion focused on the usefulness and sustainability of a future program but also on the currently available limited resources. Staff was very receptive for future implementation efforts by Master of Social Work graduate students.

Second, as previously mentioned in the methodology section of the paper, prior to asking any of the interview questions a short description of mindfulness-based practice was given to the participant in order to ensure a basic understanding of the therapeutic principles. Just verbally explaining the concept was difficult and often times a practical short meditation exercise were necessary to facilitate understanding. The researcher found that this process required the skills to convey the meanings and to discover the resident’s level of comprehension on the topic of mindfulness-based practice. Since residents will have different ideas on what mindfulness-based practice entails it is important for future implementation efforts to be aware these different anticipations and solutions should be found that bring every participant on the same level of expectation and understanding. A possible approach to accomplish this would be to practice individual meditation session with the residents before moving towards a group approach.

**Future Program Implementation and Research**

This study only covers a small part in the quest for understanding how mindfulness-based practice can assist elderly Veterans that are suffering from depressive disorders. In the spirit of advancing the research on mindfulness-based programs and elderly Veterans more work is required to gain a greater understanding on the challenges
to program implementation, outcomes, and sustainability. Pending questions include: How in detail would a mindfulness-based program be structured and administered in order to provide the best benefit and desirability for elderly Veterans? What are some of the foreseeable challenges to implementation? And, how can future programs be promoted and expand to provide help to elderly and Veterans in general? Finding answers to these question will further the knowledge in the field of social work, advance mindfulness-based programs, but perhaps most importantly, will strengthen the empowerment of elderly Veterans.

A particularly inspiring part of the study is the acceptance and interest in alternative non-Western based healing methods by older Veterans. There is an increased validation of usefulness related to non-Western based approaches at the Veterans Home such as acupuncture, yoga, and tai-chi. While a mindfulness-based program is a good start, it is the researcher’s hope that perhaps other non-traditional healing practices will find their way to the Veterans Home community. Future areas of study at the Veterans Home should include complementary and alternative therapeutic methodologies including interests in Native American healing methods such as sweat lodges and drum-circles.
References


