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#### **Interventions**

Articles testing the applied science and implementation of mindfulness-based interventions

Abbott, D., Lack, C. W., Anderson, P. (2023). **Does Using a Mindfulness App Reduce Anxiety and Worry? A Randomized Controlled Trial**. *Journal of Cognitive Psychotherapy*. [link]

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#### **Reviews**

Articles reviewing content areas of mindfulness or conducting meta-analyses of published research

Cavanna, A. E., Purpura, G., Riva, A., ...& Seri, S. (2023). **The Western origins of mindfulness therapy in ancient Rome**. *Neurological Sciences*. [link]

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#### **Trials**

Research studies newly funded by the National Institutes of Health (FEB 2023)

Duke University (T. Lentz, PI). **Feasibility trial** of a novel integrated mindfulness and acupuncture program to improve outcomes after spine surgery. NIH/NCCIH project # 1R34AT012082-01A1. [link]

West Virginia University (K. Jochimsen, PI). **Development and feasibility of a mind-body intervention to improve physical activity for patients with chronic hip pain**. NIH/NCCIH project #1K23AT011922-01A1. [link]

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## **Highlights**

A summary of select studies from the issue, providing a snapshot of some of the latest research

Moral decision making sometimes involves weighing trade-offs between self-serving interests and causing harm to others. Social psychology experiments reveal a moral "slippery slope." That is, once experimental participants begin making decisions that serve their own interests but harm others, they progressively become more self-serving and less concerned about harm to others as time goes on. Moral decision-making includes decisions about what actions to take as well as judgments about how ethical those decisions are.

Mindfulness training might affect how moral decisions are made and judged by cultivating a present-moment focus that reduces goal-oriented behavior (seeking future gain) or by increasing empathy for others. **Du et al.**[Scientific Reports] tested the effect of Mindfulness-Based Stress Reduction (MBSR) on moral decision-making involving tradeoffs between benefits to self and harm to self and others.

The researchers randomly assigned 68 meditation-naïve Chinese participants (75% female; Average age = 30 years) to either an 8-week MBSR course or a wait-list control. The MBSR protocol was the standard MBSR protocol delivered in a Chinese-language format. All participants engaged in moral decision making and judgment tasks and completed Chinese-language versions of mindfulness (the Five Factor Mindfulness Questionnaire), emotional regulation, and failures in executive control (problems in planning, impulsivity, and motivation) questionnaires one week prior to and after intervention.

In the moral decision-making task, participant pain thresholds were assessed to determine the level of electric shock needed to evoke a pain of "8" on a 10-point pain scale.

Participants then engaged in a series of 96 decision making trials in which they chose between receiving various amounts of money while receiving painful shocks or giving them to another "person" in the next room. There was, in fact, no other person in the next room. Participants then rated the other "person's" choices on the same task in terms of how moral their decisions were.



Results from the study showed that mindfulness and executive control scores were significantly higher in the MBSR group as compared to controls after the intervention. While the control group showed an increased willingness to inflict harm on another as compared to oneself from pre- to post-testing (the "slippery slope" effect), the MBSR group did not (partial  $\eta^2$ = 0.08).

Using Bayesian hierarchical drift diffusion modeling, the researchers established that the amount of money participants received for each decision had less of an effect on MBSR decision-makers than controls. In other words, MBSR suppressed the influence of increases in money on moral decision-making, whereas controls were more likely to morally justify causing harm to others when the amount of monetary compensation was sufficiently high. MBSR did not make participants more moral compared to their own baseline but reduced the magnitude of the slippery slope compared to controls.

In terms of moral judgment, participants became less judgmental of other's choices from pretesting to post-testing. Participants weighted the importance of money more and the importance of pain less during post-testing than pretesting. There was a difference between groups in this effect, however. For controls, the same amount of money justified more harm in post-testing than pretesting, whereas the amount of money had less of an effect on the mindfulness group's judgment.

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The study shows MBSR can shift the relative value of monetary gain in moral decision making and judgment involving harm compared to a wait-list control. The study is limited by the lack of an active control and the possibility that group differences in moral performance may owe more to the demand characteristics of having been in a mindfulness condition than to cognitive changes due to mindfulness per se.

Treatments for excessive alcohol use are often only moderately successful, and clinicians are always on the lookout for more effective interventions. Mindfulness-Based Relapse Prevention (MBRP) is a promising intervention that combines standard cognitive-behavioral relapse prevention with teaching substance users to mindfully resist acting impulsively on urges.

Most existing MBRP research with persons with alcohol use disorders does not compare MBRP to other empirically validated treatments. **Skrzynski et al.** [Journal of Studies on Alcohol and Drugs] tested the relative efficacy of MBRP to standard relapse prevention alone in reducing alcohol use in heavy alcohol users.

The researchers randomly assigned 182 heavy alcohol users (52% male; 92% Caucasian; average age = 44 years) who volunteered because they wished to reduce their drinking to MBRP or relapse prevention alone. At baseline, participants drank an average of 5 drinks per day, and had 12 heavy drinking days per month when they consumed more than 4 drinks per day. Forty-two percent also used cannabis at least once the past month.

Both treatments were delivered in eight weekly individual therapy sessions delivered over the course of 2 months, with follow-up appointments at weeks 20 and 32. Therapy was delivered by doctoral and post-doctoral psychology students with 3 days of specialized training in motivational

interviewing, MBRP, and relapse prevention. Assessments at baseline, 4, 8, 20, and 32 weeks included an alcohol use questionnaire and timeline follow-back measures of alcohol use based on self-report.



The results showed that both groups significantly reduced their scores on an alcohol use questionnaire, and their average number of drinks per day and total number of heavy drinking days significantly declined from baseline to posttreatment. While reduction in heavy drinking days was equal for both groups at posttreatment, MBRP participants maintained their improvement in heavy drinking days in subsequent follow-up, whereas the relapse prevention group did not. By the end of the study, the MBRP participants had significantly fewer heavy drinking days than controls.

The efficacy of the treatment was equal for males and females. High levels of cannabis use led to continued decreases in the MBRP group in drinks per day and heavy drinking days in the follow-up period, but to increases in heavy drinking days in controls.

The study showed that MBRP and relapse prevention alone were equally effective in reducing drinks per day and heavy drinking days in alcohol users who wished to reduce their drinking, but only MBRP helped participants maintain their reduction in heavy drinking days out to 32 weeks.

The study is limited by potential participants being aware that the study treatment included mindfulness, and 18% of the sample had a history of experience with mindfulness. It is unclear whether the same results would obtain in a meditation-naïve cohort or one less favorable to the idea of mindfulness. The study is also limited by the relative inexperience of the students delivering the interventions.