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Interventions

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

Chen, S., Gao, X., Shi, T., ...& He, Y. (2023).

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Benefits of Modified MBSR Training for
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pandemic—A RCT with 3-month follow-up. *Internet Interventions.* [link]

Zhu, Q., Wang, Q., & Yang, S. (2023). Does mindfulness matter in the development of character strengths? A RCT study comparing mindfulness-based strengths practice and character strengths-based intervention. The Journal of Positive Psychology. [link]

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Cloonan, S., Fowers, R., Huberty, J., & Stecher, C. (2023). Meditation App Habits and Mental Health: A Longitudinal Study of Meditation App Users During the COVID-19 Pandemic. *Mindfulness*. [link]

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Reviews

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

Chambers, R., Stoliker, D., & Simonsson, O. (2023). Psychedelic-Assisted Psychotherapy and Mindfulness-Based Cognitive Therapy: Potential Synergies. *Mindfulness*. [link]

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University of Rhode Island (J. Bosse, PI). **Evaluating the Feasibility and Acceptability of Mindful Self-Compassion Among Gender Minority Young Adults**. NIH/NCCIH project #1K01AT012495-01. [link]

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Highlights

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

A child's ability to self-regulate emotions and attention is the foundation for later social and emotional development. Programs that foster these abilities can have beneficial effects on later academic, work, family, social, and civic functioning. Many primary schools already employ social-emotional learning curricula around the globe, but could those curricula be improved by adding a mindfulness-based component?

Haines et al. [Mindfulness] conducted a randomized controlled study to test the effects of a Mindfulness-Based Kindness Curriculum (MBKC) on early childhood social-emotional, executive, and academic functioning.

The researchers randomly assigned 16 preschool and 4 kindergarten classrooms, comprising 245 children(mean age = 4 years; 77% lower income; 54% male; 42% Caucasian, 24% Hispanic, 13% Black, 12% Asian, 8% mixed ethnicity), to a classroom curriculum-as-usual or the classroom curriculum with the addition of MBKC. Fourteen of the 16 classrooms (including all the control classrooms) already had established social-emotional learning programs as part of their regular curricula.

The 12-week MBKC program consisted of 24 lessons, each lasting 15-20 minutes, and these lessons taught by the children's regular classroom teachers, each of whom received 26 hours of training. The MBKC lessons incorporated children's literature, music, and movement, and they were organized into 8 thematic categories: mindful bodies, inside emotions, emotional expression, emotional caretaking, self-calming, gratitude, caring for others, and caring for the world. The overarching focus of the program was on teaching non-judgmental acceptance, presentmoment awareness, and kindness.

To assess the impact of the intervention, students were evaluated 6 weeks before the program's initiation and 4 weeks after its completion. The assessments included a set of social and cognitive tasks, which were scored by blinded raters. Additionally, self-assessments, teacher evaluations, and parent ratings were used to measure social-emotional, academic, and developmental competencies.

The results showed that the MBKC group outperformed controls on a generosity task in which they could keep stickers for themselves or dole them out to various others, including a sick child (partial η^2 = .02). According to teacher reports, the MBKC group was rated as more prosocial (.07) and empathic (.08) and as showing greater social emotional intelligence (.08), cognitive development (.19), physical development (.41), language ability (.10), math ability (.20), and literacy (.43). According to parent reports, the MBKC group showed higher levels of cognitive empathy (.05) and socialemotional functioning (.02).

On many of the measures, children who initially performed poorly on pre-intervention measures benefitted the least from MBKC, while those who initially performed the best on the baseline showed the greatest improvements. For example, when it came to a task measuring the ability to remain undistracted by extraneous cues (known as the Flanker task), children who initially scored the lowest on the pretest benefitted more from the routine curriculum, while those who initially scored the highest on the pretest benefitted more from MBKC (.07).

The study demonstrates that MBKC has the potential to enhance generosity, empathy, and social-emotional functioning in young children, particularly in those who already possess baseline social-emotional and cognitive competencies. The study suffers some limitations. Ratings provided by teachers and parents who were not blinded to the study group yielded results that were more pronounced than those provided by objective measures that were scored by blind raters. Also, the significant improvements in teacher ratings

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for children's physical, language, and math competencies were unexpected.

Respiration rate, which denotes the number of times we breathe each minute, holds promise as a potential biomarker for subjective well-being. Respiration rate tends to increase during periods of stress, anxiety, or pain, while it tends to decrease during periods of calm and relaxation. Rates are potentially modifiable: the more meditation hours long-term meditators have cumulatively, the slower their baseline respiration rates. Perhaps it is respiration rate that improves subjective well-being in meditators.

Kral et al. [Scientific Reports] tested the effect of Mindfulness-Based Stress Reduction (MBSR) on the respiration rates and wellbeing of people who were naïve to meditation. They also conducted a cross-sectional analysis to test for a possible association between respiration rate and well-being in more experienced meditators not involved in the MBSR trial.

The researchers randomized 203 meditationnaïve adults (average age = 42 years; 61% female; 90% Caucasian) to MBSR, a Health Enhancement Program (HEP), or a waitlist control. This secondary analysis is part of a larger study of MBSR and asthma. Out of the 203 participants, 70 had been diagnosed with asthma. Participants with asthma were assigned to either MBSR or HEP, while those without asthma were assigned to MBSR, HEP, or the waitlist control.

The MBSR intervention followed standard protocol. HEP matched MBSR in terms of the length and frequency of group sessions and homework. HEP sessions did not teach mindfulness but instead focused on nutrition, music therapy, balance and agility, and aerobic exercise. Participants completed assessments at pre-randomization, post-intervention, and 6-month follow-up, which included baseline respiration rate and self-report measures of physical and subjective well-being and distress. Respiration rates

were measured using an abdominally-placed pneumatic belt while participants underwent fMRI scans (fMRI data were not reported in this article).

The researchers also recruited a cohort of 42 long-term meditators (mean age = 44 years; 62% male; 88% Caucasian) with a minimum of 5 years of daily meditation practice and at least 5 weeks of meditation retreat experience. Long-term meditators were not assigned to interventions and were evaluated once.



The results for the long-term meditators showed a significant association between slower respiration rates and lower distress and greater well-being scores. The meditation-naïve MBSR group showed significantly lowered respiration rates compared to waitlist controls, but this difference was no longer significant at six months. The MBSR group had decreased distress symptoms at post-intervention compared to both HEP and control groups, but scores on well-being showed no group differences after the intervention.

The study suggests that slower respiration rates are associated with greater subjective wellbeing in long-term meditators. MBSR can lower respiration rates and reduce distress in meditation-naïve participants, but slowed respiration rates do not persist over time, and there is no significant improvement in wellbeing beyond some stress and anxiety reduction.

The study has limitations, including the differential enrollment and assignment to groups of asthmatic and non-asthmatic samples, as well as by its reliance on a single measure of respiration rate captured only in a controlled laboratory setting. Additionally, the measure of subjective well-being used in this study may not be sensitive to short-term interventions but may primarily reflect long-term shifts in other factors such as relationships and achievements.