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


Ivtzan, I., Young, T., Martman, J.,...Eiroa-Orosa, F. J. (2016). Integrating mindfulness into positive psychology: A randomised controlled trial of an online positive mindfulness program. *Mindfulness*. [link]


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**Randomized controlled trial.** *JMIR Mental Health.* [link]

Lam, K. (2016). **School-Based cognitive mindfulness intervention for internalizing problems: Pilot study with Hong Kong elementary students.** *Journal of Child and Family Studies.* [link]


Sanko, J., Mckay, M., Rogers, S. (2016). **Exploring the impact of mindfulness meditation training in pre-licensure and post graduate nurses.** *Nurse Education Today.* [link]


Thomas, J., Raynor, M., Bakker, M.-C. (2016). **Mindfulness-based stress reduction among Emirati Muslim women.** *Mental Health, Religion & Culture.* [link]


Zemestani, M., Ottaviani, C. (2016). **Effectiveness of mindfulness-based relapse prevention for co-occurring substance use and depression disorders.** *Mindfulness.* [link]


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**Associations**

*Articles examining the correlates and mechanisms of mindfulness*


Cho, S., Lee, H., Oh, K. J., Soto, J. A. (2016). **Mindful attention predicts greater recovery from negative emotions, but not reduced reactivity.** *Cognition and Emotion.* [link]

Daigneault, I., Dion, J., Hébert, M., Bourgeois, C. (2016). **Mindfulness as mediator and moderator of post-traumatic symptomatology in adolescence following childhood sexual abuse or assault.** *Mindfulness.* [link]


Qu, W., Zhang, H., Zhao, W., Ge, Y. (2016). The effect of cognitive errors, mindfulness and personality traits on pedestrian behavior in a Chinese sample. *Transportation Research*. [link]


mindfulness-based cognitive therapy for people with recurrent depression. 
*Psychological Assessment.* [link]


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**REVIEWS**

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


Townshend, K. (2016). *Conceptualizing the key processes of mindful parenting and its application to youth mental health*. Australasian Psychiatry. [link]


TRIALS

Research studies newly funded by the National Institutes of Health (AUG 2016)

University of California at Los Angeles (P. Ganz, PI). *A phase III randomized trial targeting behavioral symptoms in younger breast cancer survivors*. NIH/NCI project #1R01CA200977-01A1. [link]

University of Illinois (J. Davis, PI). *Impact of mindfulness based relapse prevention and mechanisms of change on emerging adult substance use treatment outcomes*. NIH/NIDA project #1R36DA041538-01. [link]

University of Massachusetts (J. Brewer, PI). *Augmenting mindfulness training through experience-driven neurofeedback devices*. NIH/NCCIH project #5R01AT007922-05. [link]

University of New Mexico (K. Witkiewitz, PI). *Mindfulness based intervention and transcranial direct current brain stimulation to reduce heavy drinking: Efficacy and mechanisms of change*. NIH/NIAAA project #1R21AA024926-01. [link]
Highlights

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

Cooperating with others sometimes requires that we set irrelevant negative emotions aside in order to stay focused on achieving common goals. Can mindfulness meditation improve cooperation with others by strengthening our resistance to being distracted by negative emotions? If so, how is the brain involved in this process? Kirk et al. [Neuroimage] studied the effects of mindfulness meditation vs. relaxation training on the decision making and brain functioning of volunteers playing a cooperative economic decision making game.

The researchers randomly assigned 51 healthy adult participants (82% Caucasian, 53% female, average age = 32) who volunteered to participate in a stress reduction program to either an 8-week mindfulness training based on Mindfulness-Based Stress Reduction (MBSR), or an 8-week stress reduction program utilizing progressive muscle relaxation, exercise, stretching, and group discussion of stress-reduction topics. The participants played the computer-based Ultimatum Game before and after training while their brain function was monitored using functional magnetic resonance imaging (fMRI). They also completed the Five Facet Mindfulness Questionnaire (FFMQ) before and after training.

The Ultimatum Game asks participants to consider offers to split $20 between themselves and another player. For example, the computer screen informs participants that someone named “Tom” is offering to split $20 with them 50/50, so that they each would receive $10. Participants then either accept or reject the offer. In reality, the offers weren’t from real people but were computer generated. The offers ranged from equal (50/50) splits to vastly unequal (19/1) splits. While it makes economic sense to accept all offers since rejecting any offer means getting nothing, participants tend to reject offers that are inequitable and seem unfair. Past research shows that the tendency to reject unfair offers is accompanied by increased neural activity in the area of the brain known as the insula, a region that plays a role in bodily and emotional awareness and values-based decision making.

Prior to any mindfulness or relaxation training, fMRI scans showed that the more “unfair” the Ultimatum Game offer, the greater the left anterior insula activation, a finding in accordance with previous research. After training, greater insula activation was associated with rejecting unfair offers for all trainees, but there was a significant difference between the slopes of the correlations for the mindfulness (r=-.42) and relaxation trainees (r=-.52). The difference in slopes suggests that mindfulness trainees were better at regulating their insula activity. This helped them to minimize the impact of feelings of unfairness on their decision making, permitting them to accept offers that were in their overall best economic interest despite their apparent inequity. As a consequence, mindfulness trainees significantly increased their game monetary earnings after training, while control trainees did not.

Further fMRI analyses showed that the trainees who showed the largest increases in accepting “unfair” offers also showed the greatest increases in left septal region activation (r=.61). Previous research shows that the septal region facilitates cooperative social behavior. The mindfulness trainees’ insula and septal regions worked in tandem while they considered “unfair” offers. There was no similar insula-septal region coordination in the relaxation trainees.

While FFMQ total mindfulness scores rose significantly after training in both the mindfulness and relaxation conditions, mindfulness training raised FFMQ scores significantly more than relaxation training. The more mindfulness
meditation that trainees practiced at home, the higher their FFMQ scores (r=.45). After training, mindfulness trainees were significantly more likely to accept “unfair” offers than were relaxation trainees. The higher the mindfulness trainees’ post-training FFMQ scores, the greater the increase in their willingness to accept “unfair” offers (r=.50). There was no similar relationship between the FFMQ and acceptance rates for relaxation trainees.

Findings from this study reveal increases in mindfulness, changes in insula and septal activation and connectivity, and changes in economic decision making as a consequence of mindfulness training. The researchers infer that mindfulness increases social cooperation by improving the regulation of negative emotions. The strength of that inference is weakened by the fact that the “social” nature of the Ultimatum Game involved virtual rather than actual human interaction.

Studies show that older lesbian and bisexual women are more likely to be overweight than their heterosexual peers, but there is a dearth of reported interventions specific to this population. **Ingraham et al. [Women’s Health Issues]** investigated whether mindful eating programs specifically designed for older lesbian and bisexual women can improve their physical and emotional health. The researchers also compared the outcomes of these programs with traditional diet-and-exercise programs that were also tailored for this population.

The U.S. Department of Health and Human Services funded five different interventions at five separate locations to gain information about the how to best reduce overweight status. Two of the sites adopted slightly different mindful eating approaches, while three sites opted for variations on traditional diet-and-exercise approaches. Each site designed its own program curriculum based on the concerns and beliefs of the organizations hosting the programs at each site. All five sites recruited lesbian and bisexual participants 40 years of age or older with a BMI ≥ 25 kg/m². Assignment to groups was based on proximity to sites and was not randomized.

The two different mindful eating interventions were both 12-week group programs employing aspects of Mindfulness-Based Stress Reduction along with the Health At Every Size program’s emphasis on acceptance of body size and shape, and the Intuitive Eating program’s emphasis on attending to hunger and satiety cues. The three traditional diet-and-exercise programs met 12-16 times in weekly support groups and employed techniques such as food logs, recipe handouts, gym memberships, pedometers and personal trainers. There were a total of 160 participants in the mindful eating groups, and 106 in the diet-and-exercise groups.

All participants completed assessments immediately before and after intervention. Self-report measures included a Mindful Eating Questionnaire that measured eating beyond fullness, sensory awareness while eating, and emotionally-triggered eating and a quality of life questionnaire that measured perceptions of physical and mental health. They also completed measures of nutritional intake, physical activity, height, weight, and waist circumference. At baseline, the mindful eating trainees were significantly more likely to be women of color, be more overweight, be older, be less physically active, be disabled, unemployed or retired, and have poorer quality of life than the traditional diet-and-exercise group members.

Mindful eating trainees showed significant, albeit small (6-7%) improvements in mindful eating scores. The women who improved mindful eating scores the most had the largest improvements in physical and mental health quality of life. Women in the upper third of improvement in mindful eating improved their mental health quality of life by 35%, while those in the lower third improved by only 4%. Mindful eating trainees who improved most in mindful eating also showed the largest
increases in physical activity and largest decreases in sweetened beverage consumption.

The women showed significant weight losses (1-5 pounds) and reduced waist-to-hip ratios at all five sites, without significant between-group differences. Only mindful eating trainees significantly improved their mental health quality or increased their fruit and vegetable intake, eating an additional 12 servings a month. Diet-and-exercise trainees reported significantly greater increases in weekly physical activity (117 minutes versus 60 minutes) and physical quality of life compared to mindful eating trainees.

Findings from this study show that mindful eating programs tailored to the needs of older, overweight lesbian and bisexual women can lead to improvements in mindful eating and perceived mental health, as well as increased fruit and vegetable consumption. Traditional diet-and-exercise programs fared better at improving physical activity and perceived physical health. Mindful eating programs provide an alternative for women who are ideologically averse to traditional diet-and-exercise programs. The lack of random assignment limits any inferences about between group differences in outcomes.
Research Presentations:

Two chaired research symposia will be offered during the conference, and submissions under this heading will be considered part of those symposia. Individual presentations will be approximately 25 minutes including time for questions-and-answers, and will be followed by a 10-15 minute wrap-up by the discussant. Submission abstracts must include the following six components: (1) aims and objectives of the study; (2) a brief description of the participants, including age, gender, and (if applicable) targeted clinical population; (3) study design and methodology; (4) mindfulness component of interest or mindfulness intervention used; (5) main findings; and (6) a brief discussion. You are encouraged to include quantitative or mixed methods results and statistical analyses. Maximum 500 words. Submitters whose presentations are not accepted may be invited to submit their research as a poster.

Research Posters:

A poster session will be held on Friday, February 10th and posters will also be displayed all day on February 11th (presenter attendance is not required on the 11th). Submission abstracts must include the following six components: (1) aims and objectives of the study; (2) a brief description of the participants, including age, gender, and (if applicable) targeted clinical population; (3) study design and methodology; (4) mindfulness component of interest or mindfulness intervention used; (5) main findings; and (6) a brief discussion. You are encouraged to include quantitative or mixed methods results and statistical analyses. Maximum 500 words.

Breakout Sessions:

These are 1.5 hour or 3-hour sessions on topics of relevance to the theme of the conference—CREATIVITY, INNOVATIONS, AND CHALLENGES. We would like most sessions to include significant experiential components and interaction among participants, and these are requirements for 3-hour sessions. Our intention is to share the wisdom in the room and foster relationships among participants that will enhance the field. We encourage creativity and innovation in presentation styles and formats. Abstract submission should describe the content and format of the presentation in concise detail, names of presenters and any other relevant information. (Presentations intended largely to describe a single program or curriculum are discouraged unless the content is highly compelling for other reasons.)

SUBMIT NOW. DEADLINE AUGUST 31, 2016.

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