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


Johannsen, M., Sørensen, J., O'Connor, M.,...Zachariae, R. (2017). MBCT is cost-effective compared to a wait-list control for persistent pain in women treated for primary breast cancer-results from a RCT. Psycho-Oncology. [link]


Solati, K. (2017). The efficacy of MBCT on resilience among the wives of patients with schizophrenia. Journal of Clinical & Diagnostic Research. [link]


**Associations**

Articles examining the correlates and mechanisms of mindfulness

performance monitoring in meditators. *Mindfulness.* [link]


mother and infant interaction: A longitudinal study. Infant Mental Health Journal. [link]


Xu, W., An, Y., Ding, X., Goh, P. H. (2017). Dispositional mindfulness, negative posttraumatic beliefs, and academic burnout among adolescents following the 2016 Yancheng tornado. Personality and Individual Differences. [link]


intervention for persons with sickle cell disease: Study protocol for a RCT. Trials. [link]

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**REVIEWS**

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


Chiesa, A., Fazia, T., Bernardinelli, L., Morandi, G. (2017). Citation patterns and trends of systematic reviews about mindfulness. Complementary Therapies in Clinical Practice. [link]


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**TRIALS**

Research studies newly funded by the National Institutes of Health (MAY 2017)

Johns Hopkins University (E. Reider, PI). Mindfulness training with HIV-positive youth and adult family members to improve treatment adherence. NIH/NCCIH project #5K01AT009049-02. [link]
Highlights

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

The social pain associated with rejection or embarrassment activates some of the same brain structures that are activated during the experience of physical pain. These brain structures are also activated when we witness someone else’s embarrassment. Feeling distressed over someone else’s embarrassment can cause us to focus on reducing our own distress rather than on responding compassionately to the other person. In this way, excessive empathic distress paradoxically decreases our ability to relate compassionately.

Can mindfulness reduce the magnitude of empathic distress caused by another’s social pain, thereby facilitating increased compassion? Laneri et al. [Human Brain Mapping] explored how both mindfulness meditation and long-term meditation practice affect the brain mechanisms associated with empathic distress in long-term meditators and matched controls.

The researchers recruited 32 long-term meditators (average age = 51 years, 63% male, average length of meditation practice = 17 years, meditation practice = Zen, Vipassana, or Mindfulness Meditation) and 19 matched meditation-naïve control participants. All of the participants underwent functional magnetic resonance imaging (fMRI) while engaging in a task designed to elicit empathic distress at someone else’s embarrassment.

Half of the long-term meditators were randomly assigned to engage in mindfulness meditation for eight minutes immediately before participating in the fMRI-monitored task, while the other half were instructed to merely rest prior to the task. The meditation-naïve controls also merely rested prior to the task.

The empathy-for-embarrassment task involved viewing a set of embarrassing and neutral social situations presented on a computer screen in the form of drawings accompanied by brief descriptions. As an example, one of the embarrassing situations included the description, “You are at a post-office: you observe a women’s trouser ripping while she bends down to lift a package.” Participants were asked to vividly imagine the situations while undergoing fMRI scanning and rate how embarrassed they thought the person in the drawing might be. Afterwards participants completed self-report measures of their own emotional reactivity to the situations and their level of compassion.

Participants in all groups reported a significantly greater degree of vicarious embarrassment for the embarrassing drawings as compared to the neutral drawings. Long-term meditators reported significantly higher levels of compassion than did controls (Cohen’s d = 1.2). There was significantly greater activation in several brain regions for all groups of participants while viewing the embarrassing pictures including regions involved in the experience of pain (the anterior insula and anterior cingulate cortex) and a region involved in imagining situations from another’s perspective (the medial prefrontal cortex).

Long-term meditators who meditated prior to viewing the drawings showed significantly less activation of the anterior insula than did long-term meditators who rested before viewing the drawings. For long-term meditators, the less their anterior insula activation, the greater their self-rated compassion (r=-.36). For the long-term meditators who engaged in mindfulness before viewing the situations, the longer they meditated in their regular daily practice, the less their anterior insula activation while viewing the drawings (r=-.42).
The study shows that while a history of long-term meditation practice doesn’t alter activity in the brain regions responsible for empathic distress, meditating immediately before viewing another’s embarrassment does. Decreased anterior insula activation was associated with greater self-ratings of compassion in long-term meditators.

These results support the idea that if people can use mindfulness to control their level of empathic distress, they can rely on their ability to see things from another’s perspective to generate increased compassion. This study also replicates earlier research regarding the brain structures involved in processing social embarrassment. The study lacked a comparison group of meditation-naive participants who engaged in mindfulness practice just prior to viewing the embarrassing situations. This makes it harder to disentangle the effects of long-term practice from the short-term effects of meditating during the experiment.

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One in five breast cancer survivors report significant pain that persists years after the conclusion of medical treatment. Persistent post-treatment pain reduces cancer survivors’ quality of life and contributes to greater health care costs due to increased medical visits and medication usage. While mindfulness-based interventions have been shown to reduce pain in cancer survivors, little is known about the overall cost effectiveness of these interventions.

Johannsen et al. [Psycho-Oncology] analyzed data from a previously published randomized, controlled trial of Mindfulness-Based Cognitive Therapy (MBCT) to reduce pain in breast cancer survivors, in order to explore its cost effectiveness.

The researchers randomly assigned 129 Danish female breast cancer patients who had completed treatment and reported persistent pain to either an 8-week trial of MBCT or a wait-list control group. Health care utilization and cost analyses were performed only for a subset of 84 patients for whom there was no missing data. The MBCT intervention followed the standard weekly two-hour group protocol.

Subjective pain ratings were collected from the patients at baseline, immediately at the end of the intervention, and at 3 and 6-month follow-up. The treatment was deemed a success if a patient decreased her pain by at least two points on a 10-point rating scale, which was deemed to be the minimal clinically meaningful difference. A Danish national health registry was the source of information about healthcare utilization and prescription medication usage and costs during the 6-month follow-up period.

As previously reported, 53% of the MBCT patients reduced their pain by at least two points, whereas only 29% of the wait list controls did. MBCT patients made significantly fewer visits to general practitioners, medical specialists, physical therapists and psychologists. They also had fewer hospital visits and shorter hospital stays during the six-month follow-up period than did controls. MBCT patients filled significantly more prescriptions for tricyclic antidepressants (an average of 1.84 vs. 1.03 prescriptions per patient) than controls.

Total average health care utilization costs for the 6-month follow-up period (all medical visits, hospital stays, and medication) came to $1,911 per MBCT patient and $2,728 per control, an average cost saving of $817 for MBCT patients.

The study demonstrates that MBCT resulted in reduced pain, medical utilization, and medical costs compared to a wait-list control for breast cancer survivors with persistent post-treatment pain. Study limitations include the absence of an active control or an analysis to the degree to which greater tricyclic antidepressant use might have contributed to reduced pain and medical utilization.
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KEYNOTE SPEAKERS

Carla Sherrell
Naropa University

Judith Simmer-Brown
Naropa University

Éliane Ubalijoro
McGill University

Additional speakers to be announced

Rhonda Magee
University of San Francisco

Revolutionary Mindfulness
Friday night keynote by Rhonda V. Magee

How do mindfulness and compassion practices support us in the work of educating for not merely radical but revolutionary social change? In this presentation, Prof. Magee identifies research and practices that support the communion of inner work, interpersonal work, and systemic change. She challenges contemplative educators, administrators and leaders to make revolutionary mindfulness the foundation of our work.

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