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**INTERVENTIONS**

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

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**Highlights**

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Sakai, A., Terao, T., Kawano, N.,...Ishii, N. (2019). *Existential and mindfulness-based intervention to increase self-compassion in*
apparently healthy subjects (the EXMIND study): A RCT. *Frontiers in Psychiatry.* [link]


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Methods
Articles developing empirical procedures to advance the measurement and methodology of mindfulness

Böge, K., Mouthaan, J., Krause-Utz, A. (2019). Effects of dialogical mindfulness on psychopathology: A pilot study’s results from a seven-day psychosynthesis course about the inner child. The Humanistic Psychologist. [link]


Travis, F. (2019). Temporal and spatial characteristics of meditation EEG. Psychological Trauma. [link]

diabetic peripheral neuropathy. Journal of Behavioral Medicine. [link]

Yoon, Y. B., Bae, D., Kwak, S.,...Kwon, J. S. (2019). Plastic changes in the white matter induced by templestay, a 4-day intensive mindfulness meditation program. Mindfulness. [link]


**REVIEWS**

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


**TRIALS**

*Research studies newly funded by the National Institutes of Health (JUL 2019)*

Brightoutcome Inc. (N. Haas, PI). *Gemini*: Virtual integrative medicine group visits for managing depression and chronic pain. NIH/NCCIH project 1R43MH119985-01. [link]

Pacific University (M. Christopher, PI). *Mindfulness based resilience training for aggression, stress and health in law enforcement officers*. NIH/NCCIH project 1U01AT009841-01. [link]

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

Many women attending residential substance use disorder treatment fail to successfully complete their program. These women often have complex social histories, multiple psychiatric and medical diagnoses, and histories of incarceration. They may also have trouble adjusting to the programs due to conflicts with staff and peers, substance withdrawal and cravings, and difficulty abiding by program rules and structure. Mindfulness may help women negotiate these difficulties by reducing their automatic reactivity to cravings, interpersonal conflicts, and other emotional triggers.

Black et al. [Behaviour Research and Therapy] studied whether a mindfulness-based intervention specifically designed for women in residential substance use disorder treatment settings could reduce the likelihood of prematurely leaving the program in unimproved condition.

The researchers randomly assigned 200 women in residential substance use disorder treatment (average age = 33 years; 58% Hispanic; 62% with incarceration history; 76% with amphetamine/methamphetamine abuse) to either the Moment-by-Moment Women’s Recovery (MMWR) program or a time-matched psycho-educational control. Both were add-on interventions with participants continuing to receive all of the services ordinarily provided by the residential treatment program. In both of the interventions, the participants met twice weekly for 80-minute group sessions over the course of six weeks.

The MMWR program was based on Mindfulness-Based Stress Reduction, but specifically designed for ethnoracially diverse women in residential substance use treatment. The program addressed the role of mindfulness in dealing with cravings and relapse, trauma, parenting, conflicts with staff and peers, and other issues likely to arise in treatment. The psycho-educational control consisted of didactic material regarding brain structure, function, and biochemical changes pertaining to substance abuse. Attendance in both groups averaged 9 out of 12 classes, and participants rated both groups highly in terms of satisfaction.

Upon patient discharge, residential program clinical staff rated participants as to whether they were still in residence, had successfully completed the treatment, had dropped out of treatment but were clinically improved, or had dropped out of treatment and were clinically unimproved. The follow period was 150 days after the start of the study intervention. The researchers were interested in whether MMWR could reduce the likelihood of being in the “non-completing and unimproved” category. They also assessed participants at baseline and post-intervention on measures of mindfulness (using the Five Facet Mindfulness Questionnaire), perceived stress, distress tolerance, emotional regulation, subjective distress, mood, and substance cravings.

The results showed that the risk of non-completion without improvement was lower for the MMWR group than controls (Hazard Ratio=0.46; medium-to-large effect). There were positive trends for both groups to improve on various psychological measures over time, but between-group differences were not significant. Notably, there were significant correlations between class attendance and various psychological measures for the MMWR group but not the control group. In particular, only the MMWR group had large and significant correlations between days of class attendance and mindfulness (r=.61), distress tolerance (r=.55), and positive mood scores (r=.52).

The study shows that MMWR participants are less likely to leave residential treatment without satisfactory improvement. It supports the utility of adjunctive MMWR for residential drug treatment programs that provide services to ethnoracially diverse women. Improvement on a number of psychological variables was dose dependent on MMWR class attendance, meaning the more classes attended the greater the improvement. Study shortcomings include the possibility that the six-week MBSR intervention may have been shorter than optimal length, and the outcome judges were not blind to condition.
Fibromyalgia is a chronic disorder affecting approximately 10,000,000 Americans. The disorder presents with symptoms of widespread musculoskeletal pain, fatigue, and mood, sleep, and cognitive difficulties. The cause of fibromyalgia is unknown, and its treatment is largely palliative, consisting of medication to reduce pain and inflammation, graded physical exercise and/or cognitive-behavioral therapy. The disorder incurs a wide variety of costs including high rates of unemployment, sick leave, disability claims, and direct medical care utilization.

Perez-Aranda et al. [Journal of Clinical Medicine] compared the cost-effectiveness and clinical utility of adjunctive Mindfulness-Based Stress Reduction (MBSR) to a previously validated comparator intervention and treatment-as-usual in the treatment of fibromyalgia.

The researchers randomly assigned 225 fibromyalgia patients recruited from a Spanish hospital to one of three treatment interventions: 1) MBSR + treatment-as-usual, 2) FibroQoL + treatment-as-usual, and 3) treatment-as-usual alone. MBSR was delivered using the standard 8-week group protocol with minimal adaptations. FibroQoL is a fibromyalgia intervention with previously demonstrated superiority to treatment-as-usual. It consists of 8 weekly 2-hour group sessions that include fibromyalgia psycho-education, relaxation, and self-hypnosis to help patients control pain and visualize a future pain-free life. Treatment-as-usual involved prescription medications for pain, inflammation, depression, and anxiety, along with recommendations for daily exercise.

Cost-aware data was only available for a final sample of 204 participants (98% female; average age = 53 years). Analyses were performed separately for the full intention-to-treat sample and for 107 patients who attended at least 6 of the 8 intervention sessions and their 12-month follow-up appointments.

Self-ratings of quality-of-life were obtained at baseline and 12 months using the EuroQol EQ-5D to assess disease impingement on mobility, self-care, and activities of daily living, as well as pain, anxiety, and depression. A EuroQol EQ-5D score of “0” indicates a quality of life “as bad as death” and a score of “1.0” indicates “perfect health.” Direct and indirect costs of fibromyalgia treatment were calculated based on patient medication prescription receipts, patient medication logs, and patient reports of primary care and specialist visits, hospital stays, diagnostic procedures, and sick leave/disability over the past 12 months. MBSR and FibroQoL costs were included in the analyses.

At the 12-month follow-up, average direct and indirect healthcare costs were significantly lower for MBSR ($2,133 USD) than FibroQoL ($2,761 USD) or treatment-as-usual ($3,464 USD) participants. MBSR costs were significantly lower than those of the comparator and control groups primarily due to lower primary care costs and fewer lost workdays. At 12 months, MBSR participants had the best average quality of life scores (0.57), followed by FibroQol participants (0.53) and treatment-as-usual participants (0.45). These group differences achieved overall significance.

A cost-utility analysis showed that MBSR was both significantly cheaper and significantly more effective than treatment-as-usual. MBSR was also cheaper than FibroQoL due to fewer sick days, but there was no significant difference between the two in terms of incremental improvement in quality of life.

The results support the cost-utility of add-on MBSR treatment of fibromyalgia compared to an active comparator or treatment-as-usual alone. MBSR led to a savings of $628 per patient compared to the active comparator, and $1331 per patient compared to treatment-as-usual alone. A significant amount of missing healthcare and follow-up data made the sample size smaller than originally intended. The study's limitations include reduced sample size due to follow-up loss and direct and indirect costs established by retrospective participant recall rather than healthcare records.
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