

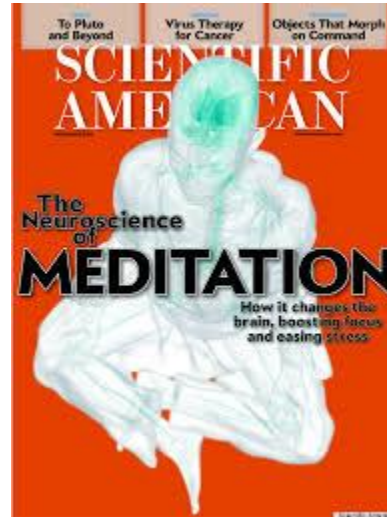
Introduzione alla meditazione orientata alla mindfulness: dalle evidenze scientifiche, alla pratica

Cristiano Crescentini

cristiano.crescentini@uniud.it

DIPARTIMENTO DI LINGUE E LETTERATURE,
COMUNICAZIONE, FORMAZIONE E SOCIETA',
UNIVERSITA' DI UDINE

Il termine **Mindfulness** si riferisce all'esperienza di uno stato mentale: «la consapevolezza che emerge attraverso il prestare attenzione in un particolare modo: intenzionalmente, nel momento presente e in modo non giudicante» (Kabat-Zinn, 1994)



Che cosa significa “meditazione”

- La parola “meditazione” deriva dal latino ‘*mederi*’ che significa: risanare, curare, guarire, aiutare.
- Il termine sanscrito che si riferisce alla meditazione è ‘*bhāvanā*’, che significa ‘crescita spirituale’ oppure ‘coltivare il ricordo di sé’.

Mind the Hype: A Critical Evaluation and Prescriptive Agenda for Research on Mindfulness and Meditation

Nicholas T. Van Dam¹, Marieke K. van Vugt^{2†}, David R. Vago^{3†},
Laura Schmalzl^{4†}, Clifford D. Saron^{5†}, Andrew Olendzki^{6†},
Ted Meissner^{7†}, Sara W. Lazar^{8†}, Catherine E. Kerr^{9†*},
Jolie Gorchov^{10†}, Kieran C. R. Fox^{11†}, Brent A. Field^{12†},
Willoughby B. Britton^{13†}, Julie A. Brefczynski-Lewis^{14†}, and
David E. Meyer¹⁵

Perspectives on Psychological Science
1–26

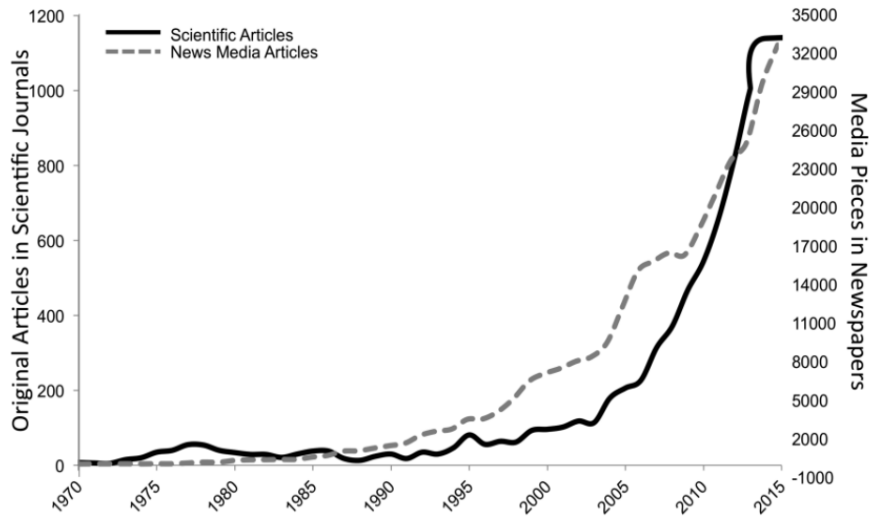
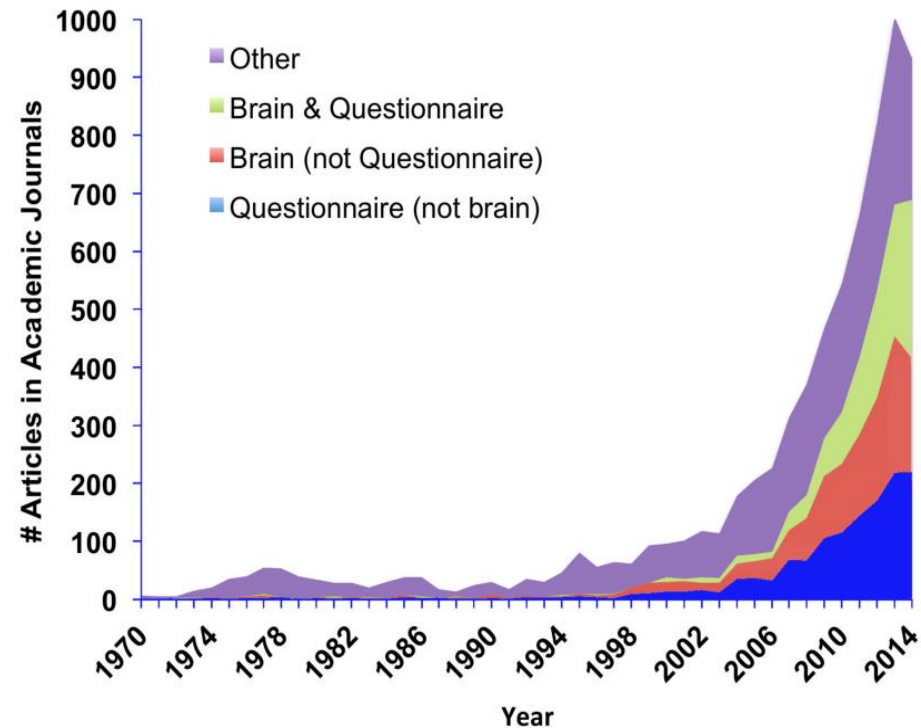
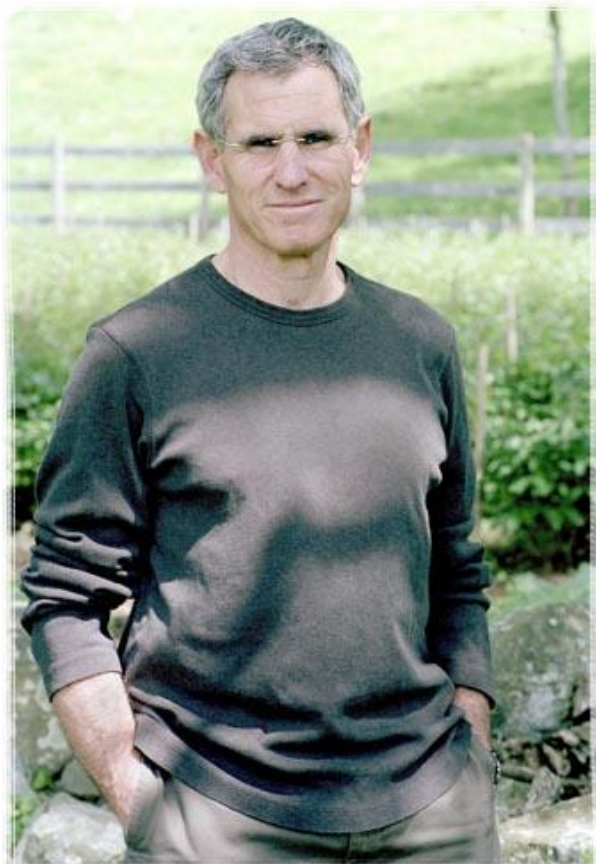


Fig. 1. Scientific and news media articles on mindfulness and/or meditation by year from 1970 to 2015. Empirical scientific articles (black line) with the term *mindfulness* or *meditation* in the abstract, title, or keywords, published between 1970 and 2015 were searched using Scopus. Media pieces (dashed gray line) with the term *mindfulness* or *meditation*, published between 1970 and 2015 were searched using LexisNexis.



Mindfulness Based Stress Reduction: MBSR

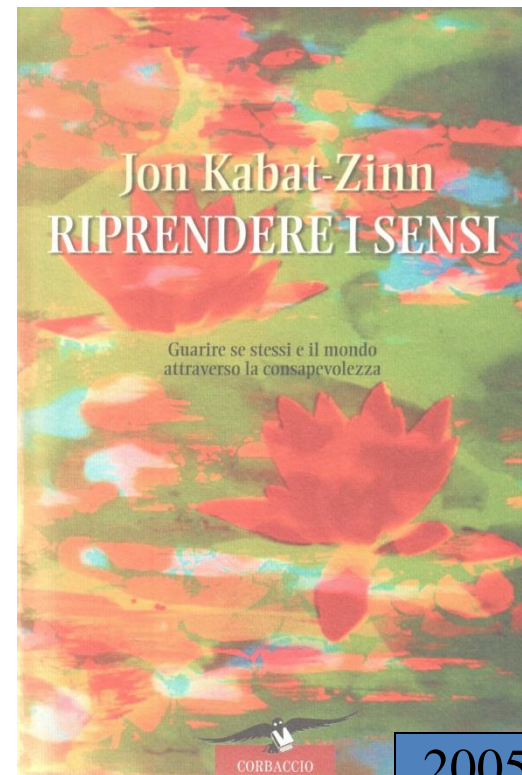
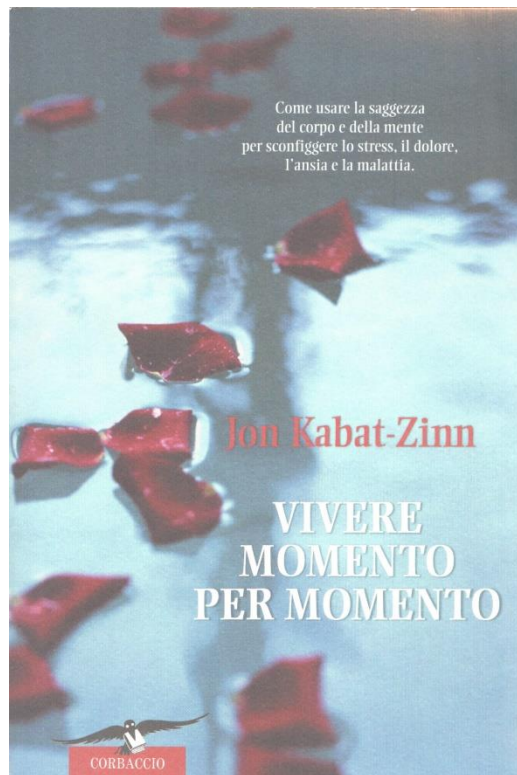


1944

2004 e 2016

La MBSR è stata ideata nel 1979 dal Kabat Zinn (Massachusetts Medical School)

Egli ha integrato la meditazione buddista di consapevolezza (*mindfulness*) con la clinica psicologica contemporanea



2005

Early research into MBSR

Chronic pain

(See Kabat-Zinn, Lipworth & Burney, 1985, The clinical use of mindfulness meditation for the self-regulation of chronic pain, *J. of Behavioural Medicine*, 8, 163-190; Kabat-Zinn, Lipworth, Burney & Sellers, 1987, Four-year follow up of a meditation program for the self-regulation of chronic pain: Treatment outcomes and compliance, *Clinical J. of Pain*, 2, 159-173)

Anxiety

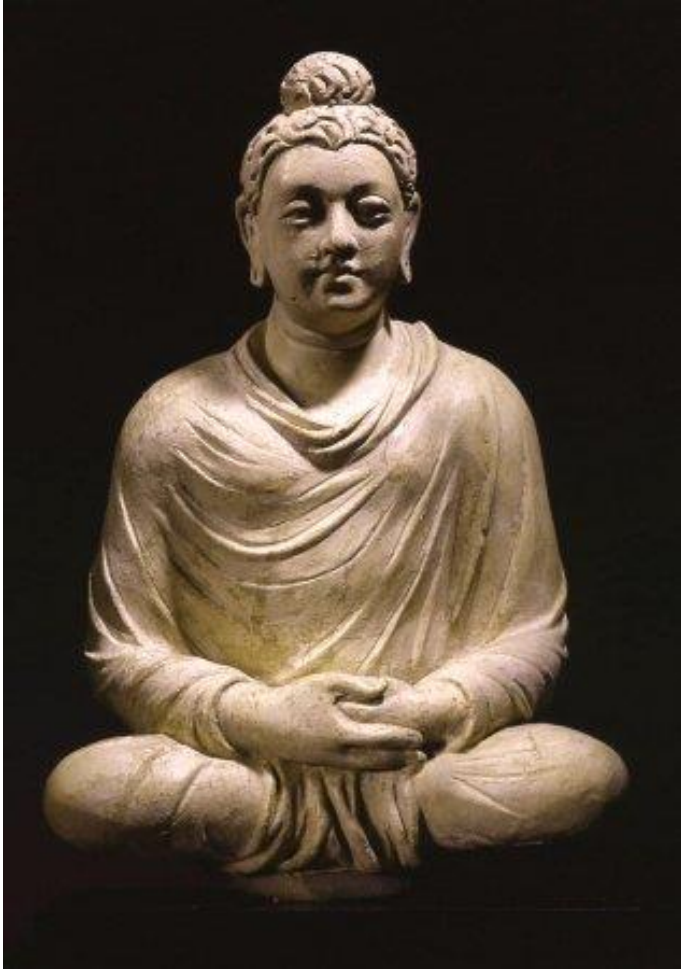
(See Kabat-Zinn, Massion, Kristeller et al., 1992, Effectiveness of a meditation-based stress reduction program in the treatment of anxiety disorders, *American J. of Psychiatry*, 149, 936-943)

Psoriasis

(See Kabat-Zinn, Wheeler, Light et al., 1998, Influence of a mindfulness meditation-based stress reduction program on rates of skin clearing in patients with moderate to severe psoriasis undergoing phototherapy. *Psychosomatic Medicine*, 50, 625-632)

Mindfulness = Sati

Si riferisce alla pedagogia della liberazione insegnata del Buddha, che si articola:



Siddharta Gotama il Buddha (566-486 aC)

Quattro nobili verità:

- I) Esistenza del malessere (*dukkha*)
- II) Origine del malessere
- III) Cessazione del malessere
- IV) Ottuplice sentiero per la liberazione

Ottuplice sentiero:

- 1) *Samma ditti* (precisa comprensione)
- 2) *Samma sankappo* (precisa intenzione)
- 3) *Samma vacco* (preciso pensiero)
- 4) *Samma kammanto* (precisa azione)
- 5) *Samma ajivo* (precisi mezzi di sussistenza)
- 6) *Samma vayano* (preciso sforzo)
- 7) **SAMMA SATI** (precisa presenza mentale)
- 8) *Samma samadhi* (preciso assorbimento)

Modello a due componenti di Bishop e colleghi, 2004

La mindfulness è un modo particolare di prestare attenzione contraddistinto dall'autoregolazione dell'attenzione e da un particolare orientamento verso l'esperienza presente

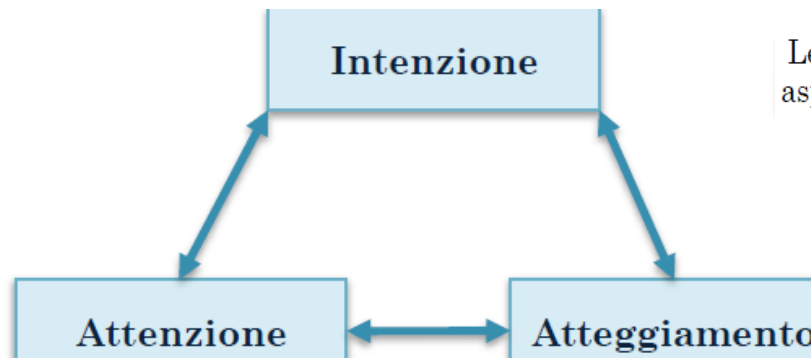
Autoregolazione dell'attenzione:

- ✓ Capacità di dirigere la propria consapevolezza sull'esperienza immediata tramite la regolazione del proprio focus attentivo
- ✓ Capacità di divenire pienamente presenti e consapevoli del momento attuale

Particolare orientamento verso l'esperienza presente:

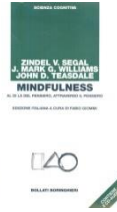
- ✓ *Curiosità*: avere un atteggiamento curioso verso la mente, ogniqualvolta questa si allontana dal momento presente
- ✓ *Accettazione e apertura mentale*: è un processo attivo in base al quale si sceglie di accettare ciò che compare nel campo della consapevolezza con un atteggiamento di apertura mentale e recettività

Modello a tre componenti di Shapiro e colleghi, 2006



Le tre componenti non sono separate ma sono aspetti intrecciati di un singolo processo ciclico ed esistono simultaneamente

Protocolli Terapeutici basati sulla mindfulness



Mindfulness Based Cognitive Therapy: MBCT

- Mindfulness-Based Stress Reduction (Kabat-Zinn, 1990)
- Mindfulness-Based Cognitive Therapy (Segal, Williams, Teasdale, 2001)
- Dialectical Behavior Therapy - DBT (Linehan, 1993)
- Acceptance and Commitment Therapy - ACT (Hayes, 1994)
- Compassion Focused Therapy (Gilbert, 2009)
- Mindfulness Based Relapse Prevention (substance abuse) – MBRP (Marlatt & Gordon, 1985)
- Mindfulness-Based CBT for OCD and Anxiety (Hershfield & Corboy, 2013; Didonna, 2014)
- Mindfulness Oriented Meditation (MOM; Fabbro e Muratori, 2012; Fabbro e Crescentini, 2014; Crescentini et al., 2014, 2015, 2016, 2017)

Applicazioni cliniche dei protocolli mindfulness

- **Depressione Maggiore** (Teasdale, Williams, Segal, 1995)
- **Disturbi d'Ansia (GAD, Panico, Fobia Sociale)** (Kabat-Zinn, 1992; Borkovec e Sharpless, 2004; Miller et al., 1995; Roemer & Orsillo, 2002)
- **Disturbo da Stress Post-traumatico e Trauma** (Follette et al., 2008; Foa et al. 2000)
- **Disturbo Borderline di Personalità** (Linehan, 1993)
- **Disturbi Alimentari** (Baer et al., 2007; Kristeller et al., 1999; Telch, Agras, & Linehan, 2001; Quillian-Wolever, 2008)
- **Disturbo da Deficit di Attenzione con Iperattività** (Smalley et. al., 2007; Zilowska et al., 2008)
- **Disturbo Ossessivo-Compulsivo** (Schwartz,1997; Gorbis, 2004; Didonna, 2008)
- **Abuso di Sostanze- Dipendenze** (Marlatt et al., 2004, Breslin et al., 2002; Bien, 2008)
- **Psicosi** (Chadwick, 2005, Pinto, 2008)
- **Terapia di coppia** (Christensen et al., 2004; Jacobson et al., 2000)
- **Dolore Cronico** (Kabat-Zinn et al., 1982, 1986, 1987; Randolph et al., 1999)
- **Cancro** (Carlson et al., 2008; Specca et al., 2000)
- **Fibromialgia** (Kaplan et al., 1993; Goldemberg et al., 1994)
- **Psoriasi** (Kabat-Zinn et al., 1998)
- **Riduzione dello Stress** (Carceri, Ospedali, personale infermieristico, etc)

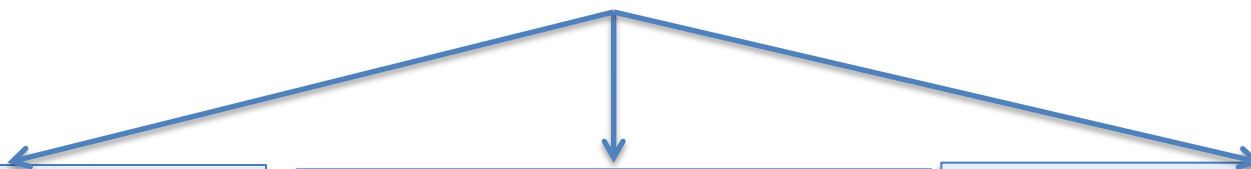
Mindfulness Oriented Meditation (MOM) (Fabbro & Muratori, 2012; Fabbro & Crescentini, 2014a; 2014b; 2016; Crescentini et al., 2014, 2015, 2016, 2017, 2018)

- 8 settimane di training
- un incontro alla settimana;
- incontri: ½ h teoria; ½ pratica; ½ discussione;
- ½ h di meditazione a casa per 2 mesi (anche frazionata in tre o più momenti);
- a casa a giorni alterni meditazione guidata (file audio) e meditazione “autoguidata” a giorni alterni;
- Struttura della meditazione:
 - *anapanasati* (focalizzazione dell'attenzione sul respiro)
 - contemplazione del corpo (*body scan*)
 - *vipassana* (osservazione del fluire dei processi mentali)

> 30 Corsi MOM offerti presso: Ospedale SMM Udine, SERT Udine, Carcere Udine, Istituti comprensivi Udine e provincia, Università (Scienze della Formazione), AISM Udine, Giunti OS, ENAIP FVG, Federsanità, CRO Aviano, A.A.S. FVG

La pratica della consapevolezza ci aiuta a modificare quei comportamenti automatici, reattivi e distruttivi che spesso vengono adottati nella vita quotidiana, con scelte consapevoli e maggiormente appropriate al contesto.

Ciò si realizza attraverso tre abilità:



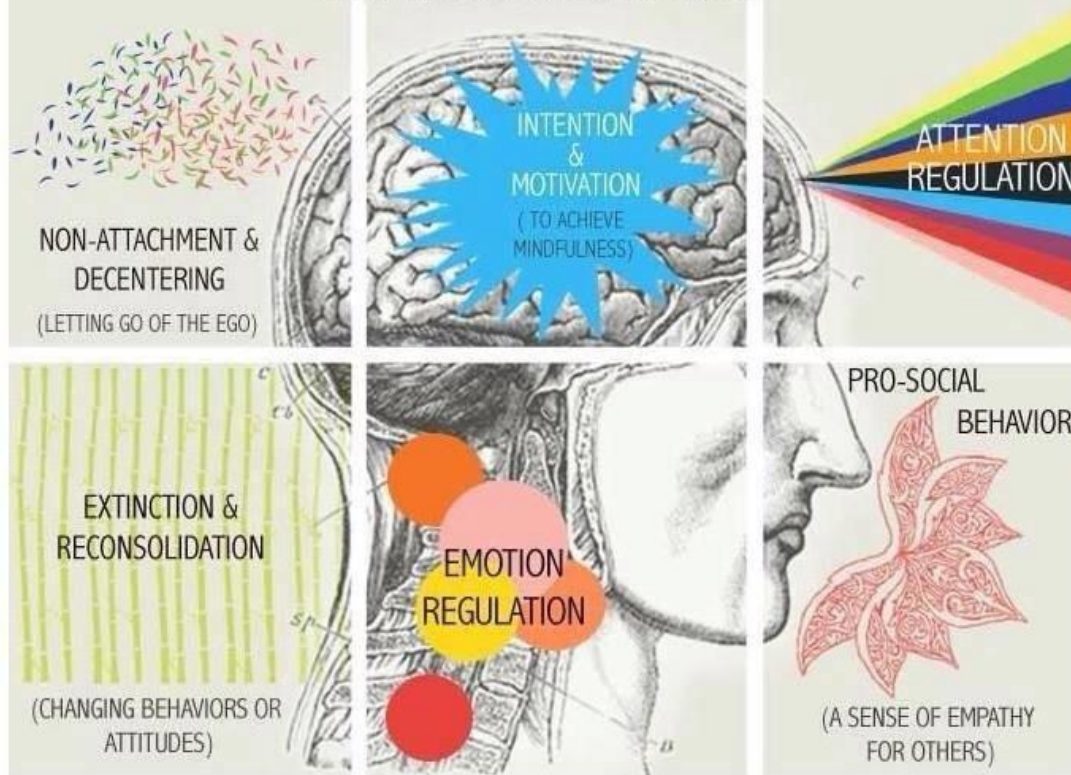
Apprendere ad ancorarsi al momento presente, invece di essere coinvolti dalle emozioni catastrofiche. L'attenzione al momento presente è una componente fondamentale dei protocolli basati sulla mindfulness adottati a fini terapeutici (e.g., Kabat-Zinn, 1990).

Apprendere a riconoscere i pensieri in quanto tali, e a non considerarli dati di fatto. Con la pratica della mindfulness si cerca di perseguire il “decentramento” o “defusione” o “de-identificazione” dai propri pensieri (Kabat-Zinn, 1999; Segal et al., 2005; Hayes, 1999)

Superare la tendenza all'evitamento esperenziale, caratterizzato da atteggiamenti di fuga e di rifiuto nei confronti dei propri pensieri, emozioni e sensazioni fisiche. Questo obiettivo è correlato alla consapevolezza di poter scegliere le proprie azioni.

HOW IT WORKS: THE SCIENCE OF MEDITATION

MINDFULNESS INVOLVES SIX NEUROPSYCHOLOGICAL PROCESSES THAT LEAD TO A PERSON'S MEDITATIVE STATE OF SELF-AWARENESS.

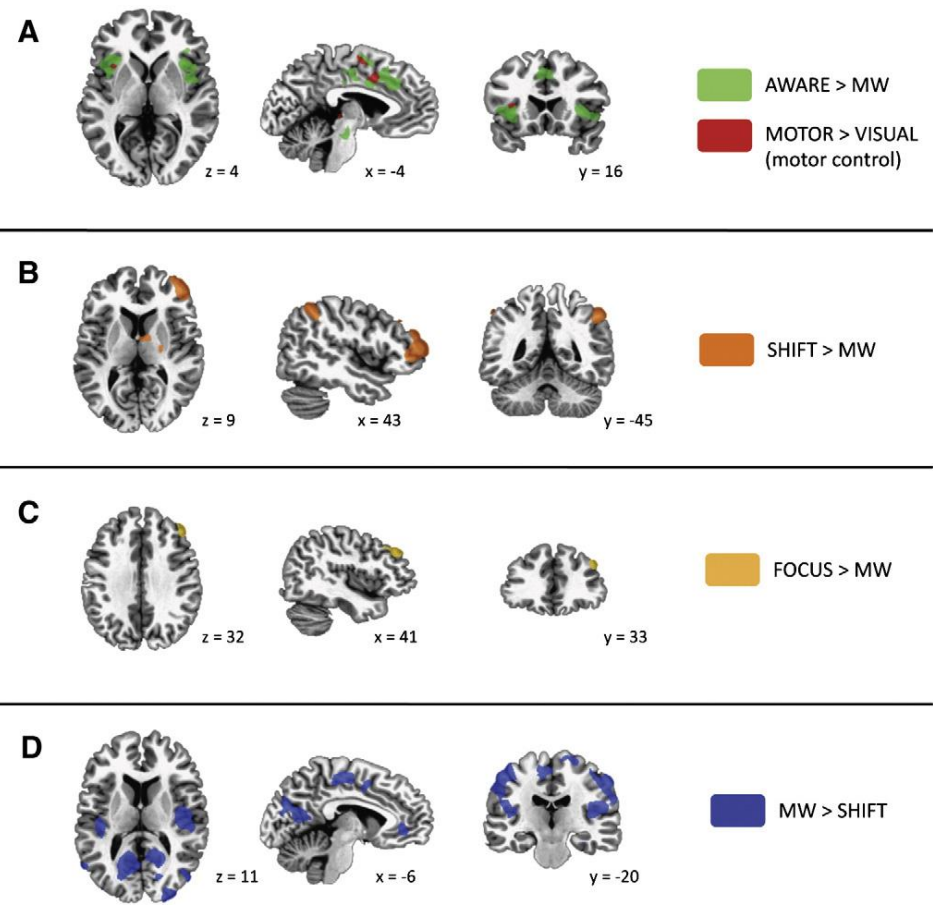
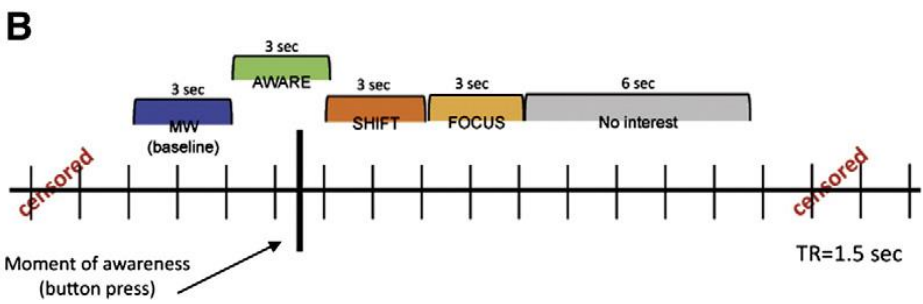
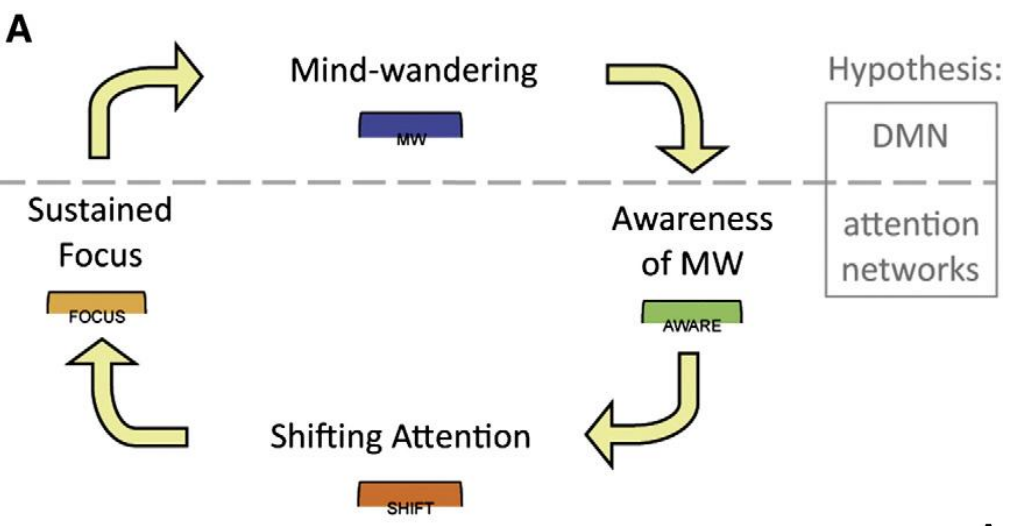


La scienza della meditazione di consapevolezza mindfulness mostra che il cervello cambia in maniera positiva con la pratica

La pratica della mindfulness lavora:

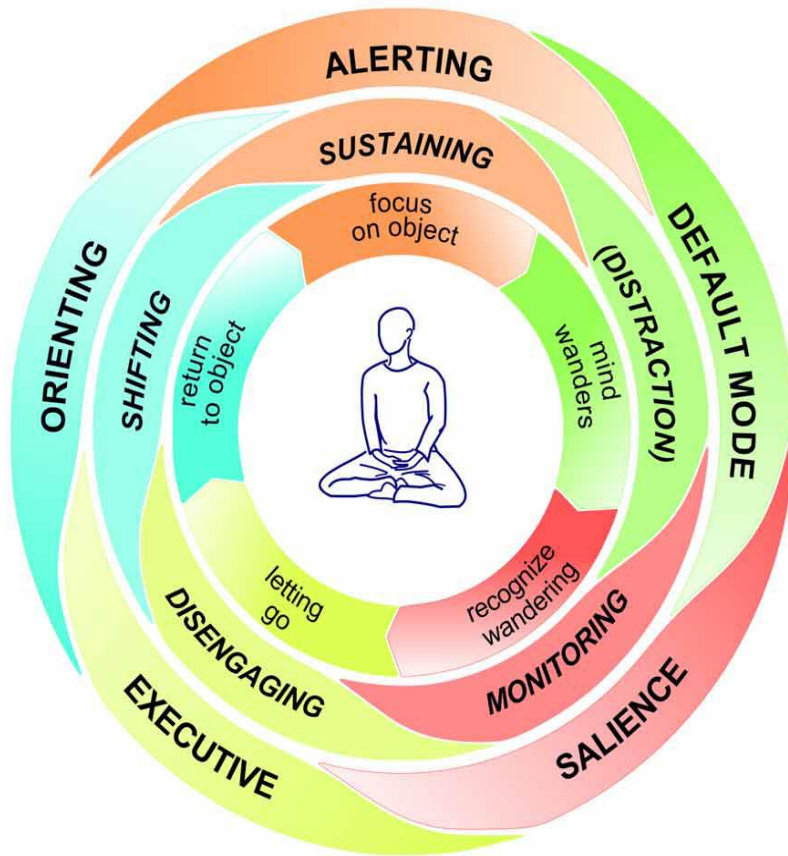
Table 2. Components Proposed to Describe the Mechanisms Through Which Mindfulness Works

Mechanism	Exemplary instructions	Self-reported and experimental behavioral findings	Associated brain areas
1. Attention regulation	Sustaining attention on the chosen object; whenever distracted, returning attention to the object	Enhanced performance: executive attention (Attention Network Test and Stroop interference), orienting, alerting, diminished attentional blink effect	Anterior cingulate cortex
2. Body awareness	Focus is usually an object of internal experience: sensory experiences of breathing, emotions, or other body sensations	Increased scores on the Observe subscale of the Five Facet Mindfulness Questionnaire; narrative self-reports of enhanced body awareness	Insula, temporo-parietal junction
3.1 Emotion regulation: reappraisal	Approaching ongoing emotional reactions in a different way (nonjudgmentally, with acceptance)	Increases in positive reappraisal (Cognitive Emotion Regulation Questionnaire)	(Dorsal) prefrontal cortex (PFC)
3.2 Emotion regulation: exposure, extinction, and reconsolidation	Exposing oneself to whatever is present in the field of awareness; letting oneself be affected by it; refraining from internal reactivity	Increases in nonreactivity to inner experiences (Five Facet Mindfulness Questionnaire)	Ventro-medial PFC, hippocampus, amygdala
4. Change in perspective on the self	Detachment from identification with a static sense of self	Self-reported changes in self-concept (Tennessee Self-Concept Scale, Temperament and Character Inventory)	Medial PFC, posterior cingulate cortex, insula, temporo-parietal junction

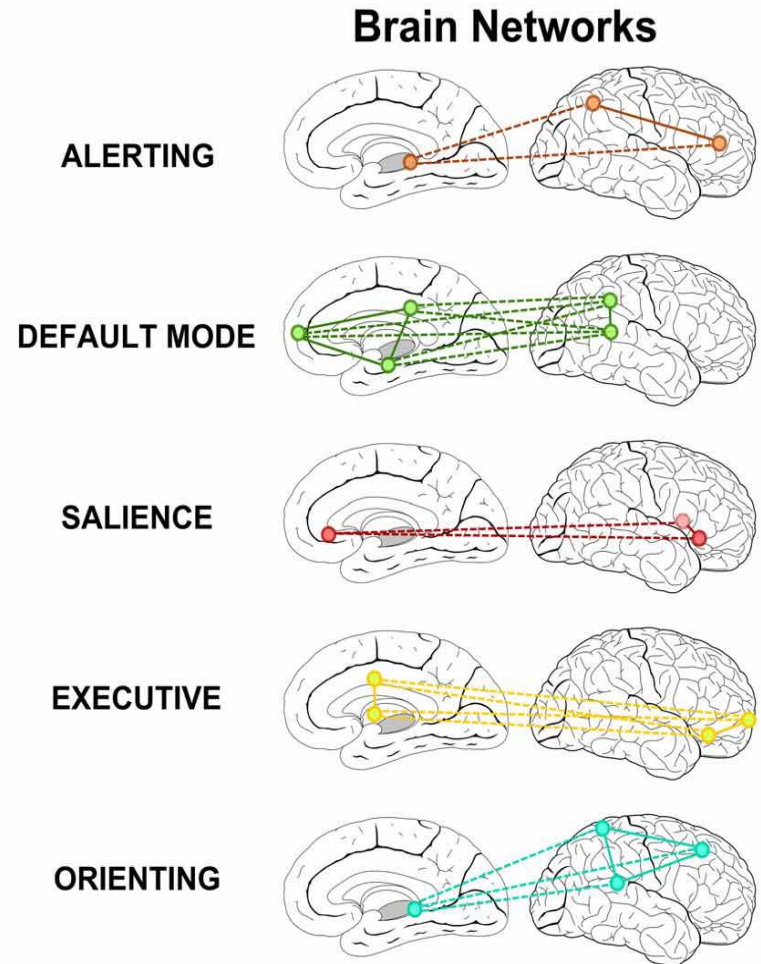


Hasenkamp et al., 2012

A Meditation Process



B Brain Networks



La mindfulness è una pratica per “fermare” il sistema default (dialogo interno) e l’ abitudine di “viaggiare” nel tempo per tornare nel “qui e ora”

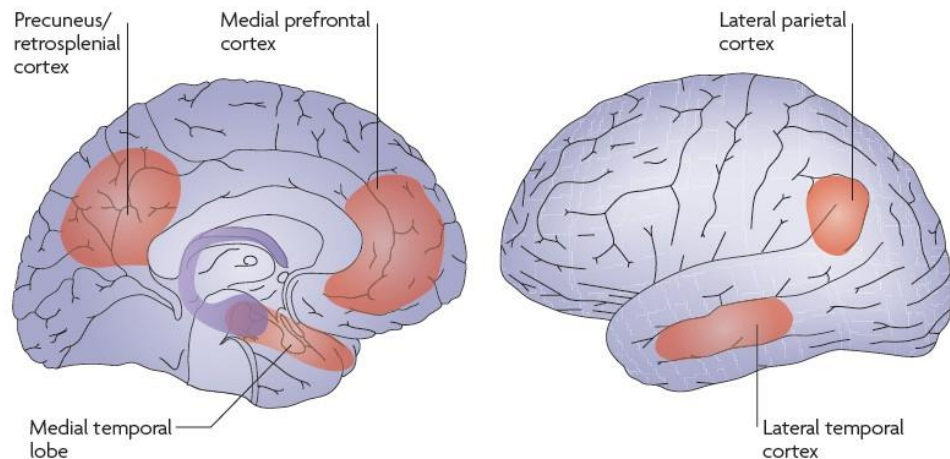
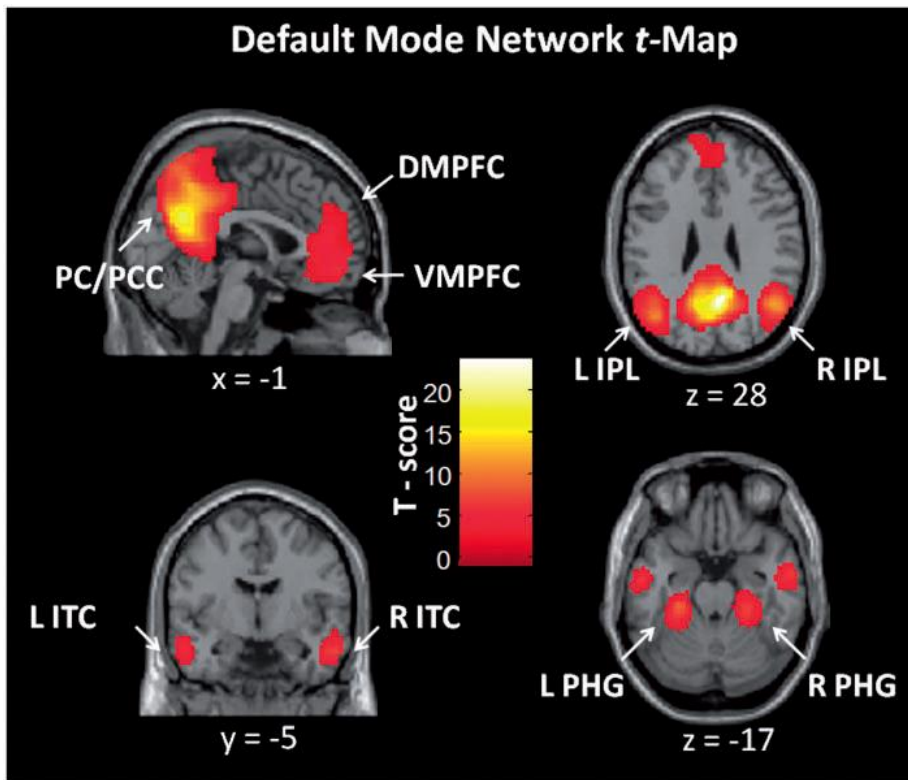


Figure 1 | **The core brain system that mediates past and future thinking.** The core brain system that is consistently activated while remembering the past^{30,31,33}, envisioning the future²⁶⁻²⁸ and during related forms of mental simulation³² is illustrated schematically. Prominent components of this network include medial prefrontal regions, posterior regions in the medial and lateral parietal cortex (extending into the precuneus and the retrosplenial cortex), the lateral temporal cortex and the medial temporal lobe. Moreover, regions within this core brain system are functionally correlated with each other and, prominently, with the hippocampal formation^{34,35}. We suggest that this core brain system functions adaptively to integrate information about relationships and associations from past experiences, in order to construct mental simulations about possible future events.

A Randomized Controlled Trial of Mindfulness Meditation Versus Relaxation Training: Effects on Distress, Positive States of Mind, Rumination, and Distraction

Jain et al., 2007 (*Ann Behav Med* 2007, 33(1):11–21)

Background: Although mindfulness meditation interventions have recently shown benefits for reducing stress in various populations, little is known about their relative efficacy compared with relaxation interventions. **Purpose:** This randomized controlled trial examines the effects of a 1-month mindfulness meditation versus somatic relaxation training as compared to a control group in 83 students (M age = 25; 16 men and 67 women) reporting distress. **Method:** Psychological distress, positive states of mind, distractive and ruminative thoughts and behaviors, and spiritual experience were measured, while controlling for social desirability. **Results:** Hierarchical linear modeling reveals that both meditation and relaxation groups experienced significant decreases in distress as well as increases in positive mood states over time, compared with the control group ($p < .05$ in all cases). There were no significant differences between meditation and relaxation on distress and positive mood states over time. Effect sizes for distress were large for both meditation and relaxation (Cohen's $d = 1.36$ and $.91$, respectively), whereas the meditation group showed a larger effect size for positive states of mind than relaxation (Cohen's $d = .71$ and $.25$, respectively). The meditation group also demonstrated significant pre-post decreases in both distractive and ruminative thoughts/behaviors compared with the control group ($p < .04$ in all cases; Cohen's $d = .57$ for rumination and $.25$ for distraction for the meditation group), with mediation models suggesting that mindfulness meditation's effects on reducing distress were partially mediated by reducing rumination. No significant effects were found for spiritual experience. **Conclusions:** The data suggest that compared with a no-treatment control, brief training in mindfulness meditation or somatic relaxation reduces distress and improves positive mood states. However, mindfulness meditation may be specific in its ability to reduce distractive and ruminative thoughts and behaviors, and this ability may provide a unique mechanism by which mindfulness meditation reduces distress.

Bodily maps of emotions

Lauri Nummenmaa^{a,b,c,1}, Enrico Glerean^a, Riitta Hari^{b,1}, and Jari K. Hietanen^d

Emotions are often felt in the body, and somatosensory feedback has been proposed to trigger conscious emotional experiences. Here we reveal maps of bodily sensations associated with different emotions using a unique topographical self-report method. In five experiments, participants ($n = 701$) were shown two silhouettes of bodies alongside emotional words, stories, movies, or facial expressions. They were asked to color the bodily regions whose activity they felt increasing or decreasing while viewing each stimulus. Different emotions were consistently associated with statistically separable bodily sensation maps across experiments. These maps were concordant across West European and East Asian samples. Statistical classifiers distinguished emotion-specific activation maps accurately, confirming independence of topographies across emotions. We propose that emotions are represented in the somatosensory system as culturally universal categorical somatotopic maps. Perception of these emotion-triggered bodily changes may play a key role in generating consciously felt emotions.

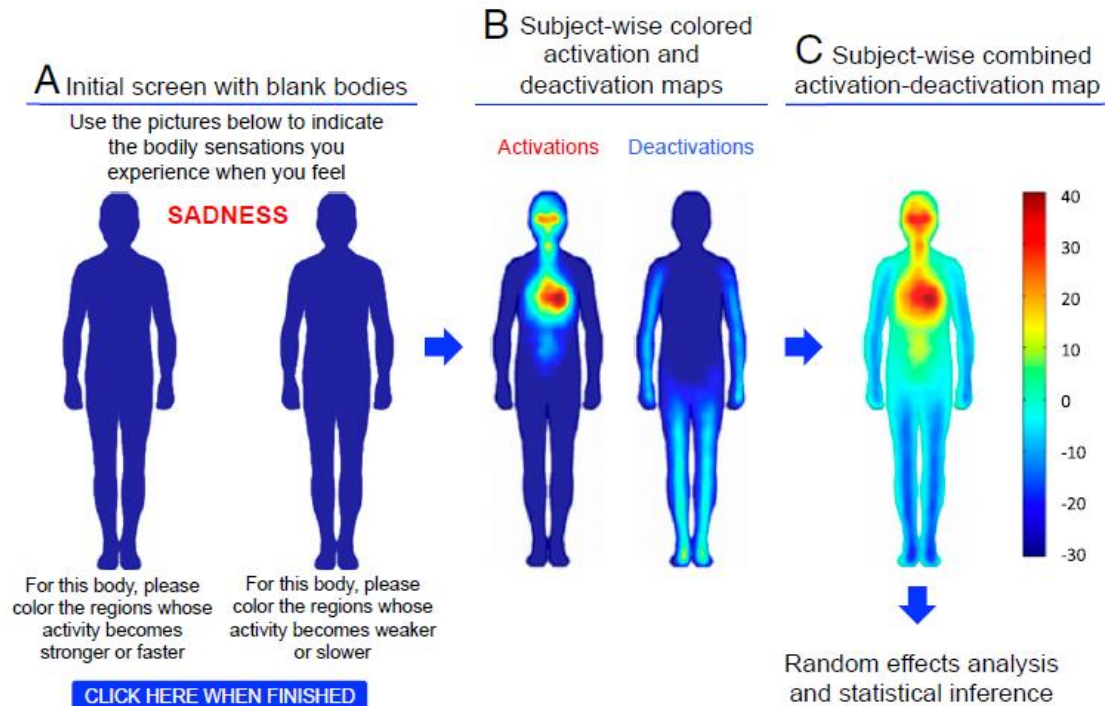


Fig. 1. The *emBODY* tool. Participants colored the initially blank body regions (A) whose activity they felt increasing (left body) and decreasing (right body) during emotions. Subjectwise activation-deactivation data (B) were stored as integers, with the whole body being represented by 50,364 data points. Activation and deactivation maps were subsequently combined (C) for statistical analysis.

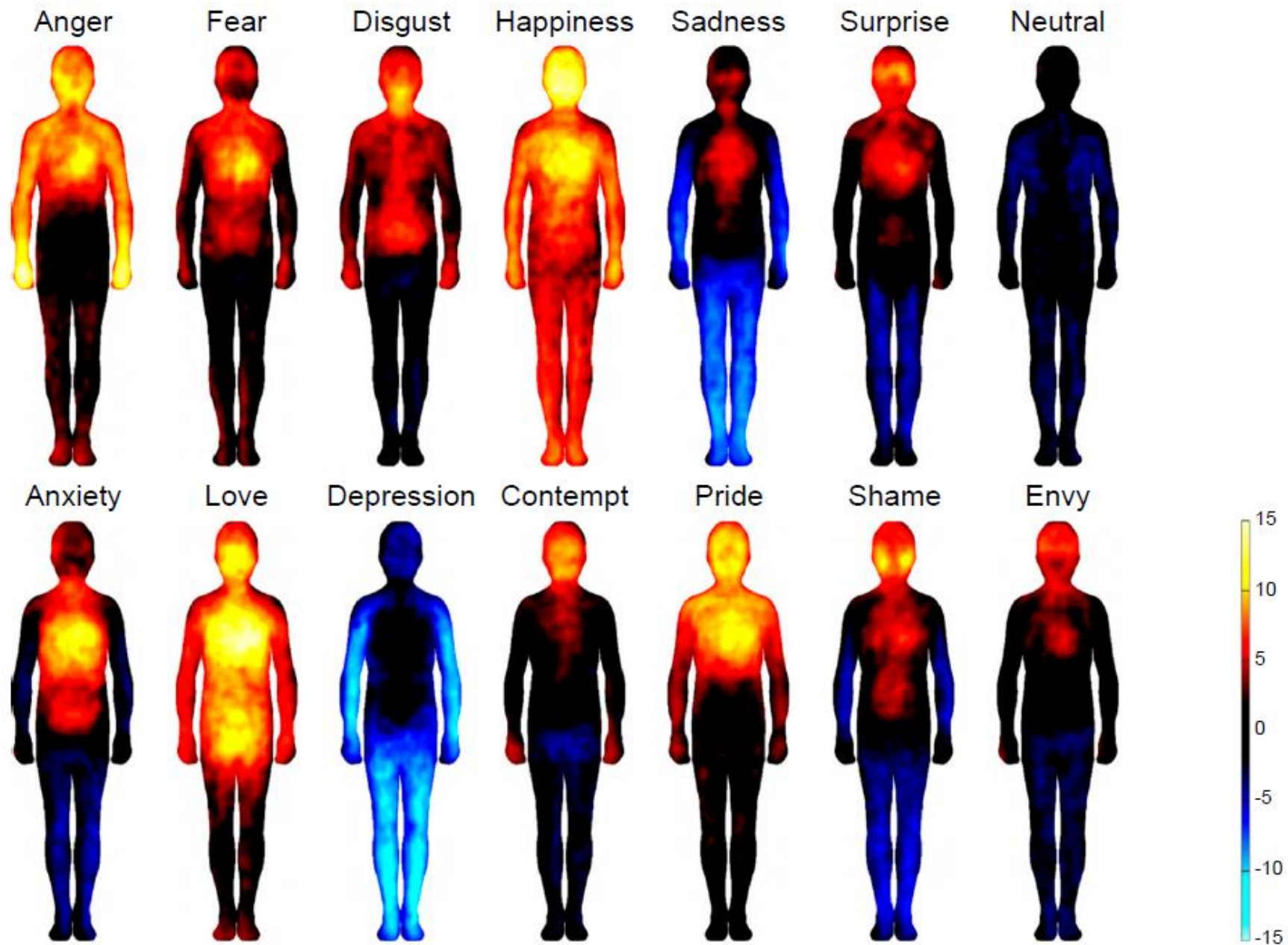


Fig. 2. Bodily topography of basic (*Upper*) and nonbasic (*Lower*) emotions associated with words. The body maps show regions whose activation increased (warm colors) or decreased (cool colors) when feeling each emotion. ($P < 0.05$ FDR corrected; $t > 1.94$). The colorbar indicates the t-statistic range.

The neuroscience of mindfulness meditation

Yi-Yuan Tang^{1,2}, Britta K. Hölzel^{3,4*} and Michael I. Posner²*

Box 3 | Mindfulness meditation as exposure therapy

Exposure therapy aims for patients to extinguish a fear response and instead to acquire a sense of safety in the presence of a formerly feared stimulus by exposing them to that stimulus and preventing the usual response¹⁶⁴. Mindfulness meditation resembles an exposure situation because practitioners 'turn towards their emotional experience', bring acceptance to bodily and affective responses, and refrain from engaging in internal reactivity towards it. Research on fear conditioning has helped to identify a network of brain regions that are crucial for the extinction of conditioned fear responses and the retention of extinction¹⁶⁵. This network includes the ventromedial prefrontal cortex (vmPFC), which is important for a successful recall of the extinction; the hippocampus¹⁶⁶, which is related to signalling the extinguished context (contextual safety); and the amygdala, which has a crucial role during the acquisition and expression of conditioned fear¹⁶⁷ and is thought to be downregulated by the vmPFC and the hippocampus^{105,168}. Activation in the vmPFC (subgenual anterior cingulate cortex) is primarily linked to the expression of fear learning during a delayed test of extinction and is critical for the retention of extinction¹⁶⁹.

There is emerging evidence from MRI studies that the aforementioned brain regions show structural and functional changes following mindfulness meditation training (see main text). This overlap of involved brain regions, as well as the conceptual similarity between mindfulness and an exposure situation, suggest that mindfulness training might enhance the ability to extinguish conditioned fear by structurally and functionally affecting the brain network that supports safety signalling. The capacity for successful extinction memories reliably differentiates healthy from pathological conditions^{170,171}, and is crucial in order to overcome maladaptive states. It helps individuals to learn to have no fear response to neutral stimuli when there is no adaptive function for a fear response. Instead, individuals can experience a sense of safety and can flexibly elicit other emotions and behaviours.



Full length article

Psychological and physiological responses to stressful situations in immersive virtual reality: Differences between users who practice mindfulness meditation and controls



Cristiano Crescentini ^{a,*}, Luca Chittaro ^b, Viviana Capurso ^{a,c}, Riccardo Sioni ^b, Franco Fabbro ^{d,e}

^a Department of Human Sciences, University of Udine, Udine, Italy



Effects of an 8-week meditation program on the implicit and explicit attitudes toward religious/spiritual self-representations



Cristiano Crescentini ^{a,b,*}, Cosimo Urgesi ^a, Fabio Campanella ^c, Roberto Eleopra ^d, Franco Fabbro ^{a,e}

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IMPROVING PERSONALITY/CHARACTER TRAITS IN INDIVIDUALS WITH ALCOHOL DEPENDENCE: THE INFLUENCE OF MINDFULNESS-ORIENTED MEDITATION

Cristiano Crescentini, PhD¹, Alessio Matiz, MSc², Franco Fabbro, MD^{1,2}

¹Department of Human Sciences, University of Udine, Udine, Italy

²Perceptual Robotics (PERCRO) Laboratory, Scuola Superiore Sant'Anna, Pisa, Italy



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Mindfulness meditation and explicit and implicit indicators of personality and self-concept changes

Cristiano Crescentini^{1*} and Viviana Capurso^{1,2}

¹ Department of Human Sciences, University of Udine, Udine, Italy

² Department of Psychology, University of Rome La Sapienza, Rome, Italy



ORIGINAL RESEARCH
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Mindfulness-Oriented Meditation for Primary School Children: Effects on Attention and Psychological Well-Being

Cristiano Crescentini^{1*}, Viviana Capurso^{1,2†}, Samantha Furlan³ and Franco Fabbro^{1,4}

¹ Department of Human Sciences, University of Udine, Udine, Italy; ² Department of Psychology, Sapienza University of Rome, Rome, Italy; ³ Degree Course in Education Sciences, University of Udine, Udine, Italy; ⁴ PERCRO Perceptual Robotics Laboratory, Scuola Superiore Sant'Anna, Pisa, Italy



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Mindfulness-oriented meditation improves self-related character scales in healthy individuals

Fabio Campanella ^{a,*}, Cristiano Crescentini ^{a,b}, Cosimo Urgesi ^a, Franco Fabbro ^{a,c}

^a Department of Human Sciences, University of Udine, Udine, Italy

^b Department of Psychology, University of Rome, "La Sapienza", Rome, Italy

^c Perceptual Robotics (PERCRO) Laboratory, Scuola Superiore Sant'Anna, Pisa, Italy

Applicazioni della meditazione di consapevolezza in età evolutiva

Mindfulness nel contesto educativo

La *mindfulness* è fondamentale per imparare a prestare attenzione al momento presente, a essere gentili, curiosi e non giudicanti verso di sé e gli altri



La *mindfulness* è fondamentale in adolescenza per l'importanza dell'apprendimento della capacità di regolazione emozionale e comportamentale



La capacità di autoregolazione attentiva ed emotiva correlano positivamente alle abilità socio-emotive e al rendimento scolastico

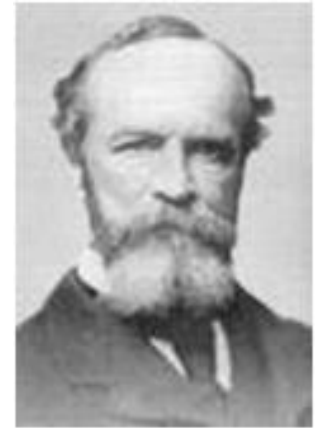


Il legame tra *mindfulness* ed educazione è fondamentale

Amy Saltzman (2012) sottolinea il paradosso del sistema educativo: nonostante agli studenti venga chiesto continuamente di prestare attenzione, nessuno insegna loro come farlo

"The faculty of voluntarily bringing back a wandering attention, over and over again, is the very root of judgment, character, and will... An education which should improve this faculty would be the education par excellence"

-William James 1890



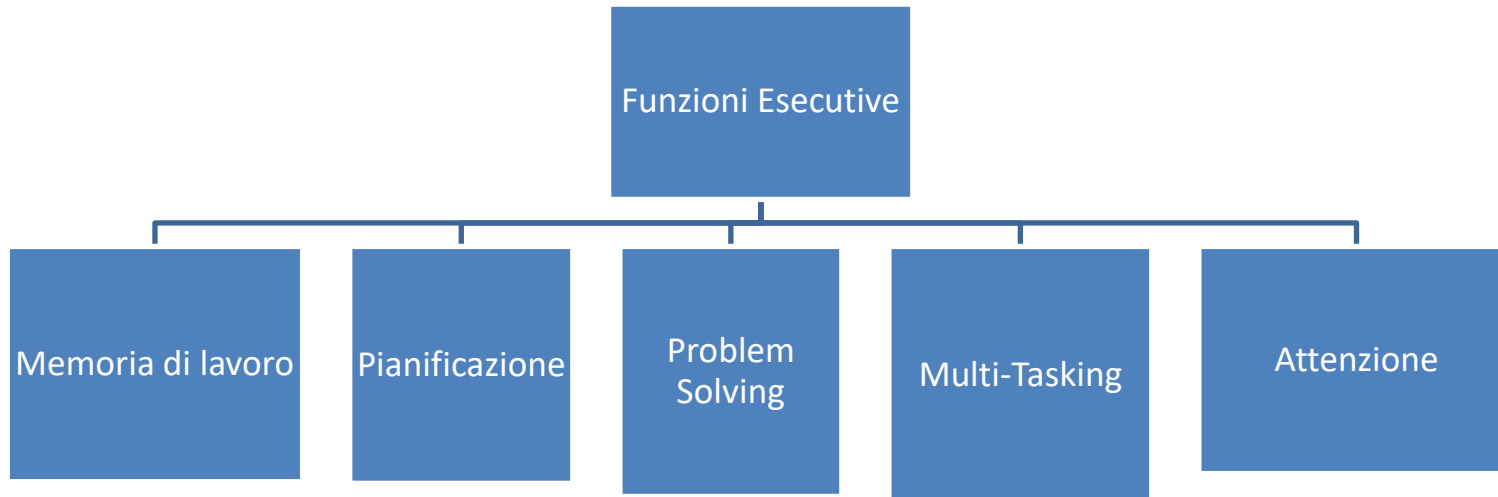
La facoltà di riportare costantemente indietro l'attenzione vagante, è la vera radice della saggezza, del carattere, della volontà....Un'educazione che favorisse lo sviluppo di questa facoltà sarebbe l'educazione per eccellenza. Ma è più facile definire questo ideale che fornire delle istruzioni pratiche per crearla

-William James,
Principi di psicologia (1890)

L'impatto della mindfulness in adolescenza

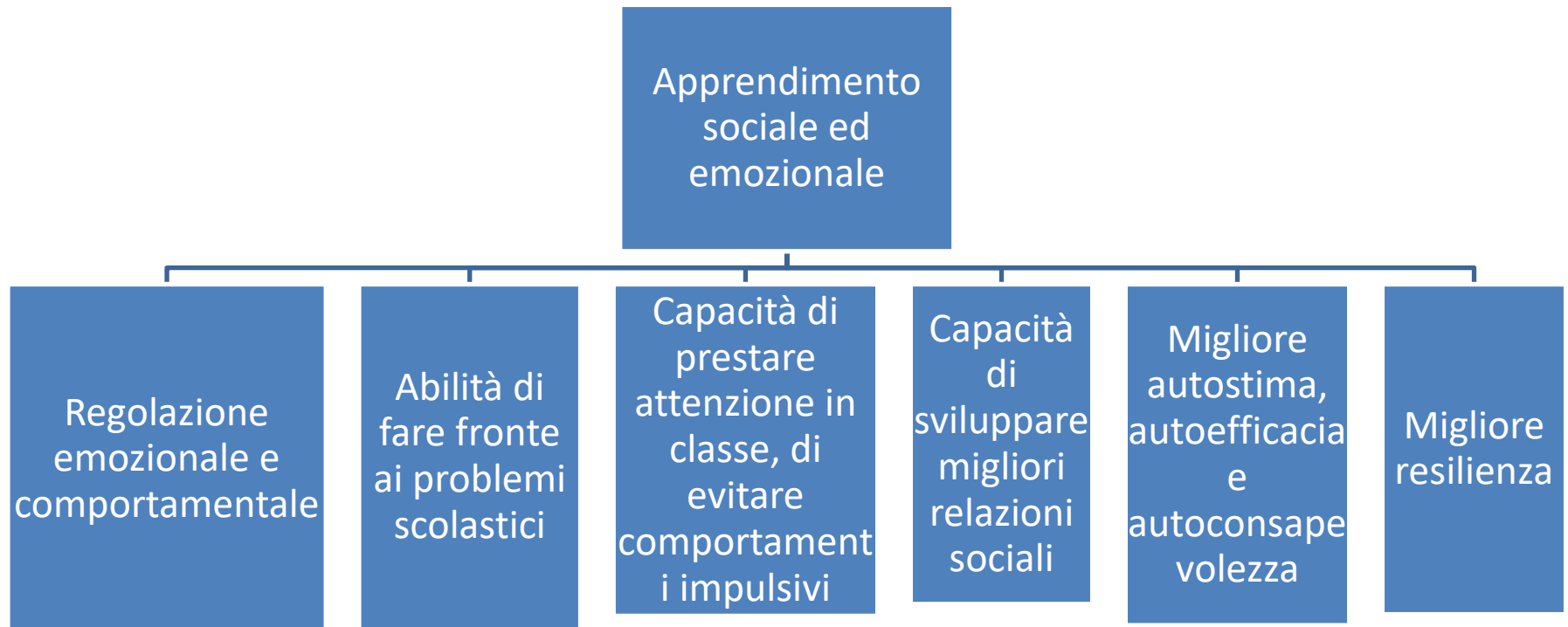


L'impatto della mindfulness in adolescenza



La mindfulness incide sulle performance accademiche, sui risultati scolastici, sull'apprendimento, sulla concentrazione e sulla memoria

L'impatto della mindfulness in adolescenza



Mindfulness-Based Approaches with Children and Adolescents: A Preliminary Review of Current Research in an Emergent Field

Christine A. Burke

Table 2 Mindfulness-based interventions with elementary school children

Study	N	Participant type	Age/grade	Intervention location	Research design	Treatment group	Control group	Random assignment	Dependent variables	Effect size/data reported
Ott (2002)	1	Clinical, outpatient, gastroesophageal reflux	9 years	Outpatient clinic	Single case study	Mindfulness meditation intervention	No	No	Reflux symptoms, medication, sleep quality	No data reported
Semple et al. (2005)	5	Clinical, anxiety symptoms	7–8 years	School	Within participant pre-post	MBCT-C, 6 wks, wkly	No	No	Anxiety, internalizing and externalizing behavior	Trends in results, clinical observation
Singh, et al. (2009)	2	Clinical, ADHD	10–12 years	Not stated	Multiple baseline across participants	Mindfulness training, 12 wks parent, 12 wks chd	No	No	Children's compliance	Percentage data reported
Napoli, et al. (2005)	228	Non-clinical school students	Grades 1–3	School	RCT between groups pre-post	AAP fortnightly 24 wks	Yes quiet activities/reading	Yes	Attention; social skills; behavior	Cohen's $d = .39-.60$
Saltzman and Goldin (2008)	74 (39 chn, 35 parents)	Non-clinical self referred	Grades 4–6	Community setting	Between groups pre-post, wait list control	Modified MBSR, 8 wks, wkly	Yes, waitlist	Not stated	Attention, self compassion, depression, anxiety, mindfulness	Data analysis incomplete
Lee et al. (2008)	25	Non-clinical reading class	9–12 years	Community based reading clinic	Pre-post intent to treat, 2 phase open trial	MBTC-C, 8 wks, wkly	No	No	Internalizing, externalizing behavior, anxiety, depression	Cohen's $d = .11-.40$

MBSR Mindfulness-based stress reduction, *MBCT-C* Mindfulness-based cognitive therapy-children, *AAP* Attention academy program, *ADHD* Attention deficit hyperactivity disorder, *chd* Child, *chn* Children, *wkly* Weekly, *wks* Weeks, *develop. disabilities* Developmental disabilities

Burke, 2010 (2)

Table 3 Mindfulness-based interventions with high school adolescents

Study	<i>N</i>	Participant type	Age/grade	Intervention location	Research design	Treatment group	Control group	Random assignment	Dependent variables	Effect size/data reported
Bootzin and Stevens (2005)	55	Clinical, adolescents substance use, sleep disorders	13–19 years	Clinic	Pre-post within participant	MBSR, 5/6 wks, 6 wk cog th, light th, educ., stimulus control inst.	No	No	Sleep data, substance use, mental health, worry	$p < .05$ for some sleep indices, $p > .05$ all other measures
Zylowska et al. (2007)	32; 8 adol, 24 adults	Clinical, ADHD or probable ADHD	Adol mean 15.6 years; adult mean 48.5 years	Not stated	Pre-post within participant	MAPs, 8 wks, wkly	No	No	Attention, anxiety, depression	Pooled results, $p < .01$ some attn meas., all others non-signif
Singh, et al. (2007)	3	Clinical, conduct disorder	13–14 years	Not stated	Multiple base line across participants	Mindfulness meditation, 4 wks, 3 × wkly, 25 wk mindfulness practice	No	No	Aggressive and non-compliant incidents	Percentage data reported
Singh et al. (2008)	1	Clinical, Prader-Willi syndrome	17 years	Home-based	Within participant multiple baseline-changing criterion design	Multiple components: mindfulness meditation × 24 months, exercise, food awareness program	No	No	Body weight	Weight change in lbs, BMI reported
Bogels et al. (2008)	14 adol and parents	Clinical, externalizing disorders, mixed	11–18 years	Community mental health clinic	Within participant pre-post, intent to treat, f/up	MBCT, 8 wks, wkly	Non-random waitlist	Not stated	Goals, behavior, happiness, mindfulness	Cohen's $d = -0.1-1.4$; f/up: $d = -.02-1.5$, (at 8 wks)
Biegel et al. (2009)	102	Clinical, psychiatric disorders, mixed	14–18 years	Outpatient psychiatric clinic	RCT, pre-post, f/up within group	MBSR, 8 wks, wkly and TAU	Yes, TAU, waitlist	Yes	Mental health, GAF, stress, psych symp, self-esteem	Cohen's $d = .14-1.11$ ($d = \text{pre-test}-f/up$)
Wall (2005)	Not reported	Non-clinical school students	11–13 years	School	Nil	Elements of MBSR and Tai Chi	No	No	Nil	Informal observation, comments
Beauchemin et al. (2008)	34	Non-clinical volunteers	13–18 years	School	Pre-post within participant	Mindfulness meditation	No	No	Anxiety, social skills, academic performance	All $ps < .05$



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Research in Developmental Disabilities
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Research
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Soles of the Feet: a mindfulness-based self-control intervention for aggression by an individual with mild mental retardation and mental illness

Nirbhay N. Singh^{a,*}, Robert G. Wahler^b,
Angela D. Adkins^c, Rachel E. Myers^d

The Mindfulness Research Group¹

2.1. Participant

James was a 27-year-old man who, because of uncontrolled aggression, had been institutionalized several times in a facility for developmental disabilities beginning at the age of 7. At the age of 15 years, he was placed in foster care but was admitted a year later to an adolescent psychiatric hospital to control his aggression. He was given an Axis I diagnosis of Conduct Disorder and an Axis II diagnosis of mild mental retardation. He was discharged after 4 months on a combined behavioral and psychopharmacological treatment. During the next 10 years, he was admitted and discharged several times from adolescent and later adult inpatient psychiatric hospitals. By this time he had experienced several group home placements and had developed a reputation among community providers as being “difficult” to deal with. All community providers had mandated that they would not accept him back into a group home or assisted living until he was free of aggression for 6 months in an inpatient psychiatric hospital.

His last admission prior to involvement with the current treatment was at the age of 26 when he seriously hurt one of his peers in a group home. He was admitted with an Axis I diagnosis of Psychotic Disorder, NOS and an Axis II diagnosis of mild mental retardation and treated with psychotropic medications (Seroquel and Zyprexa) and behavior therapy. His behavior treatment plan was developed initially on a trial-and-error basis until, after 4 months of implementation, it was found to be ineffective. A new behavior plan was developed based on a functional analysis and was implemented in the fifth month. His psychotropic medication was rationalized and by the eighth month he was on monotherapy of Risperdal. After 12 months as an inpatient without achieving much control of his verbal and physical aggression, James, at his request, was referred for alternative treatment because he was highly motivated to live in the community.

Table 1
Soles of the Feet training

Skill
Controlling the urge to be physically or verbally aggressive

Rationale
When an incident occurs or a situation arises that typically makes you angry and you feel like either verbally threatening or hitting someone, it is important to control these feelings. We try not to threaten or hurt people when we disagree with them. There is a simple way of quickly calming yourself

Steps of the Skill

1. If you are standing, stand in a natural rather than an aggressive posture, with the soles of your feet flat on the floor
2. If you are sitting, sit comfortably with the soles of your feet flat on the floor
3. Breathe naturally, and do nothing
4. Cast your mind back to an incident that made you very angry. Stay with the anger
5. You are feeling angry, and angry thoughts are flowing through your mind. Let them flow naturally, without restriction. Stay with the anger. Your body may show signs of anger (e.g., rapid breathing)
6. Now, shift all your attention to the soles of your feet
7. Slowly, move your toes, feel your shoes covering your feet, feel the texture of your socks or hose, the curve of your arch, and the heels of your feet against the back of your shoes. If you do not have shoes on, feel the floor or carpet with the soles of your feet
8. Keep breathing naturally and focus on the soles of your feet until you feel calm
9. Practice this mindfulness exercise until you can use it wherever you are and whenever an incident occurs that may lead to you being verbally or physically aggressive
10. Remember that once you are calm, you can walk away from the incident or situation with a smile on your face because you controlled your anger. Alternatively, if you need to, you can respond to the incident or situation with a calm and clear mind without verbal threats or physical aggression

Scenes to use in role-plays

1. Responding to someone who is saying something that offends you
2. Responding to a peer who threatens to hit you
3. Responding to a staff member or co-worker who is not nice to you
4. Responding to someone who pushes you around

Special considerations when teaching this Skill

1. Angry thoughts occur to all of us but not all of us act on all of them. In addition, anger can be justifiable and necessary depending on the context. Therefore, we do not want to eliminate anger entirely
2. Anger is a strength because it provides us with information about the situation we are in, and alerts us to do something positive to change the situation
3. Do not ask the individual to actively stop angry thoughts. The thoughts stop by themselves when the focus of attention shifts fully to the soles of the feet
4. Remind the individual to breathe naturally. It is not necessary to take deep breaths
5. This type of meditation can be done while standing, sitting, or walking slowly. Of course, with some modifications, it can be done while lying down but may not be convenient in the rush of daily activities

Table 2
Mean number of occurrences of target variables across phases

	History	Baseline	Intervention	Follow-up
Staff-reported behaviors				
Incidents		25.4	9.5	4.5
Self-control		0.0	5.4	4.5
Physical aggression	18.8	15.4	2.0	0.0
Verbal aggression	16.2	10.0	2.1	0.0
PRN medication	14.2	12.2	0.8	0.0
Physical restraints	11.8	10.4	0.0	0.0
Staff injuries	9.7	9.2	0.0	0.0
Resident injuries	9.1	8.6	0.6	0.0
Socially integrated activities	3.2	3.6	44.0	100+
Physically integrated activities	0.0	0.0	43.0	100+
Self-reported behaviors				
Incidents		30.8	11.5	6.3
Self-control		5.4	7.4	6.3

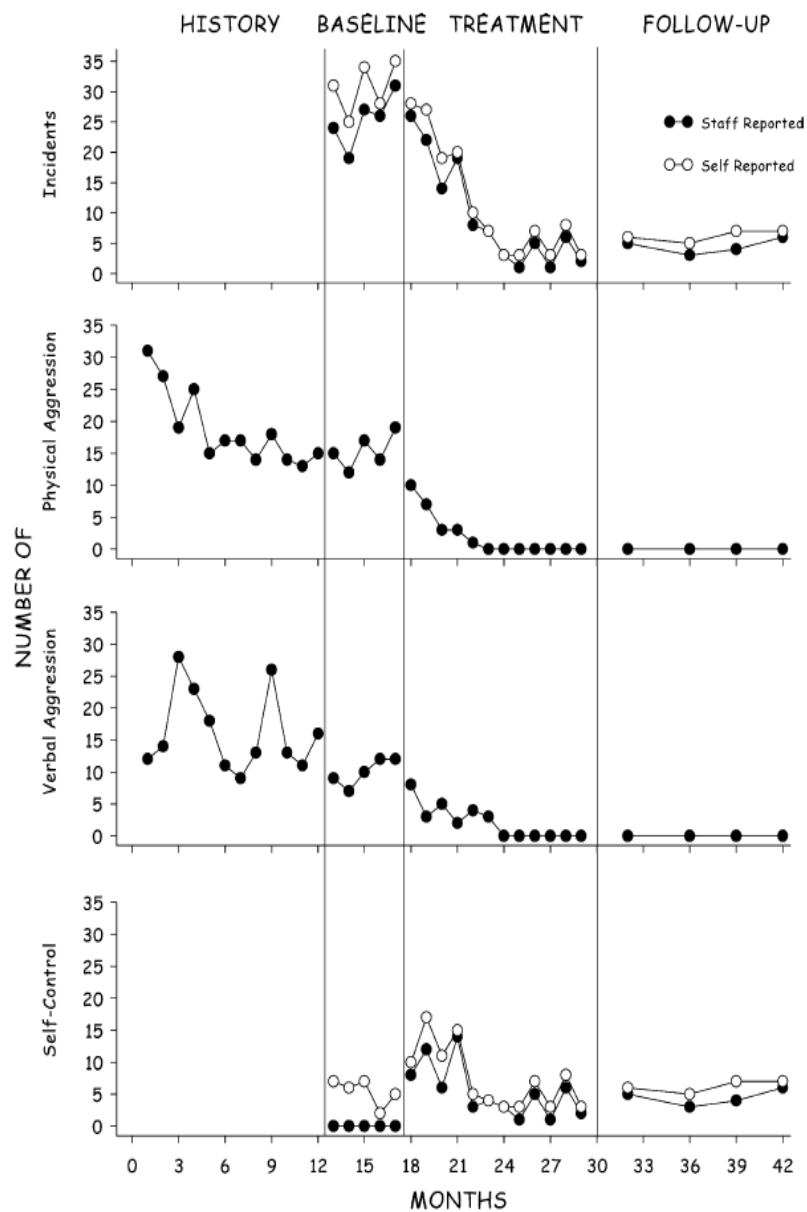


Fig. 1. Number of staff- and self-reported incidents and self-control responses, physical aggression and verbal aggression across phases.

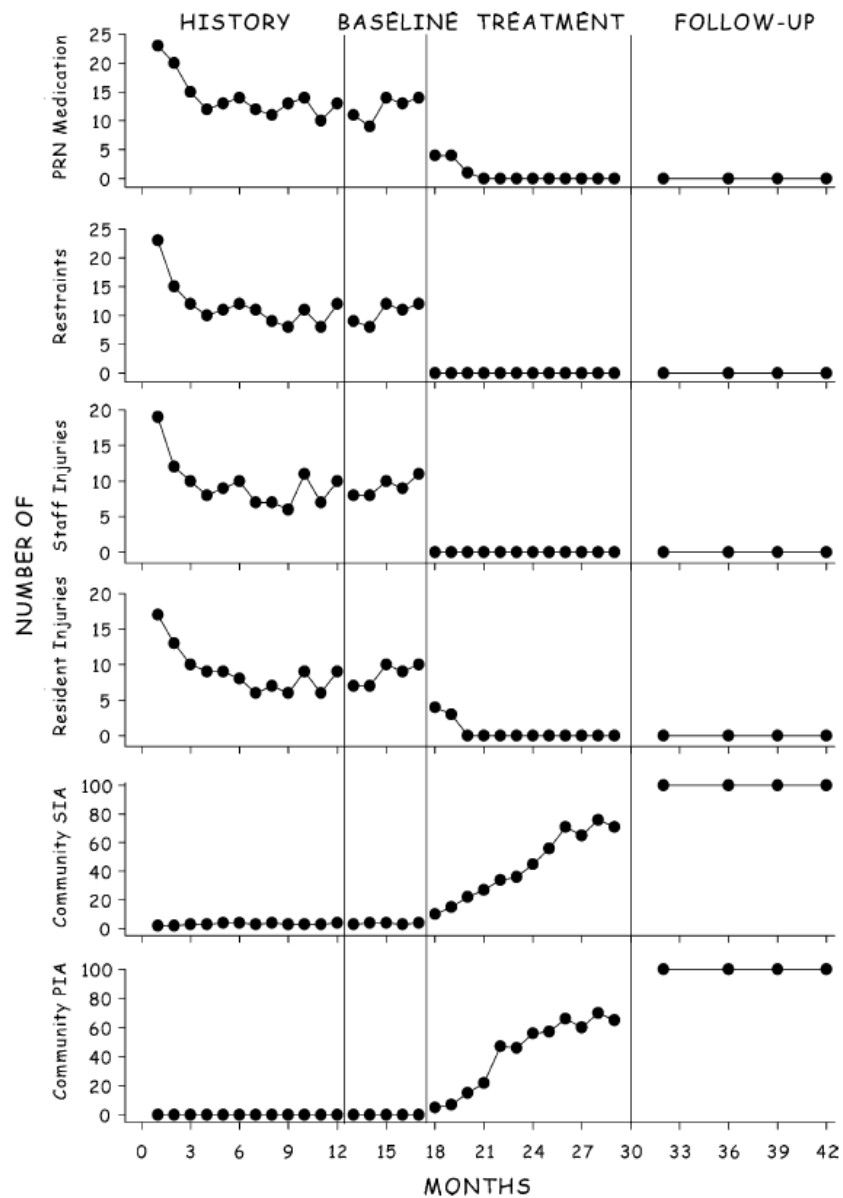


Fig. 2. Number of PRN medications, physical restraints, staff and resident injuries, and socially and physically integrated activities in the community.

Mindfulness Interventions with Youth: A Meta-Analysis**Table 1** Effect sizes aggregated across all dependent variable types and study characteristics for included studies

Study	Outcome types	<i>del</i>	CI	<i>N</i>	Design type	Sample origin	Outside practice	Instructor experience	Tx length (wks)	Intervention type
Barnes et al. (2004)	Obj, Psych	0.20	[-0.17, 0.56]	73	RCT	Non-clinical	Yes	Trained	12	Part of MBSR
Barnes et al. (2008)	Obj	0.13	[-0.47, 0.72]	66	RCT	Non-clinical	Yes	Trained	12	Part of MBSR
Beauchemin et al. (2008)	Psych	0.62	[0.08, 1.16]	34	Tx only	Clinical	No	Trained	5	Other
Biegel et al. (2009)	Psych	0.56	[0.23, 0.89]	102	RCT	Clinical	Yes	Experienced	8	MBSR
Bogels et al. (2008)	Obj, Psych, Mind	0.24	[-0.57, 1.06]	14	Tx only	Clinical	Yes	Experienced	8	MBCT
Broderick and Metz (2009)	Psych	0.28	[-0.01, 0.56]	120	OCT	Non-clinical	No	Experienced	5	Other
Flook et al. (2010)	Mind	0.11	[-0.29, 0.51]	64	RCT	Non-clinical	No	Experienced	8	Other
Gregoski et al. (2010)	Obj	0.23	[-0.01, 0.47]	166	RCT	Non-clinical	Yes	Trained	12	Part of MBSR
Huppert and Johnson (2010)	Mind	0.00	[-0.29, 0.29]	155	RCT	Non-clinical	Yes	Experienced	4	MBSR
Joyce et al. (2010)	Psych	0.11	[-0.18, 0.41]	175	Tx only	Non-clinical	No	Trained	10	Other
Lee et al. (2008)	Psych	0.21	[-0.56, 0.99]	25	Tx only	Non-clinical	Yes	Experienced	12	MBCT
Liehr and Diaz (2010)	Psych	1.14	[0.20, 2.09]	18	RCT	Non-clinical	No	Experienced	2	Other
Mendelson et al. (2010)	Psych	0.22	[-0.13, 0.56]	97	RCT	Non-clinical	No	Experienced	12	Other
Napoli et al. (2005)	Obj, Psych, Mind	0.28	[0.05, 0.51]	228	RCT	Non-clinical	No	Experienced	24	Other
Schonert-Reichl et al. (2010)	Psych, Mind	0.21	[0.01, 0.41]	246	RCT	Non-clinical	Yes	Trained	10	Other
Semple et al. (2005)	Psych	0.16	[-0.58, 0.91]	4	Tx only	Clinical	Yes	Trained	6	Other
Semple et al. (2010) ^a	Psych, Mind	0.16	[-0.50, 0.81]	25	RCT	Non-clinical	Yes	Experienced	12	MBCT
Sibinga et al. (2011)	Psych	0.23	[-0.57, 1.03]	26	Tx only	Non-clinical	Yes	Experienced	9	MBSR
White (2011) ^a	Mind	0.01	[-0.39, 0.40]	155	RCT	Non-clinical	Yes	Experienced	8	Part of MBSR
Wright et al. (2011)	Obj, Psych	0.26	[-0.04, 0.56]	121	RCT	Non-clinical	Yes	Trained	12	Part of MBSR

Note: *Obj* = objective measures, *Psych* = measures of psychological symptoms, *Mind* = mindfulness-related measures (e.g., attention), *RCT* = randomized controlled trial, *OCT* = open-controlled trial (no randomization), *Tx* = treatment, *Tx only* = treatment only design, *del* = effect size (Becker 1988), *CI* = 95 % confidence interval, *N* = study sample size, *MBSR* = mindfulness-based stress reduction, *MBCT* = mindfulness-based cognitive therapy, *Tx length (wks)* = length of treatment in weeks; ^a = Included non-active control group, imputed control group *g* used in effect size computations



Mindfulness-based interventions in schools – a systematic review and meta-analysis

Charlotte Zenner, Solveig Hemleben-Kurz and Harald Walach *

Table 1 | Empirical studies on MBI's in a school-setting.

Study	N	Age range, mean (SD), grade and gender	School/ participant description (country)	Study design	Measures and domain		<i>g</i> Hedges Baseline equivalence	<i>g</i> Hedges Within-group	<i>g</i> Hedge Differences in change scores	Reported findings according to authors
RANDOMIZED CONTROLLED TRIALS										
1. Desmond and Hanich, 2010	40	11–12, 6th grade 41% female	Urban, public middle school, low income (USA)	M-group (<i>n</i> = 15) vs. C (<i>n</i> = 25)	BRIEF (teacher)	T	0.26	0.04	0.31	MANOVAs: No sig. time by group interaction (all <i>ps</i> > 0.05). Multiple regression analysis: Sig. interaction between pre-test score and group membership for predicting differences in one of eight subscales, indicating that M-group showed greater improvement in ability to shift (<i>p</i> < 0.05). In general, M-group maintained or improved executive function skills, while C shows a decline.
2. Flook et al., 2010	64	7–9 8.23 (0.66) 2nd + 3rd grade 55% female	On-campus university elementary school, diverse ethical backgrounds (USA)	M-group (<i>n</i> = 32) vs. C (<i>n</i> = 32)	BRIEF (teacher) BRIEF (parent)	T T	0.31 0.27	0.20 0.39	0.08 0.12	MANCOVAs with post-test scores as outcome variables: No sig. group main effect, indicating no group differences for pre- to post-test (<i>p</i> < 0.05). Sig. interaction between baseline levels and group in teacher report (<i>p</i> = 0.005) as well as in parent report (<i>p</i> = 0.020). In M-group, children with poorer initial executive function showed greater improvement at Time 2 compared to C.
3. Franco Justo, 2009	60	15–18 17.3 1st + 2nd year high school 72% female	3 public secondary schools (Spain)	M-group (<i>n</i> = 30) vs. waitlist c (<i>n</i> = 30), follow-up after 3 months	TTCT (verbal) -Fluency -Flexibility -Originality	C	-0.11 0.05 -0.05	1.50 1.53 1.61	1.48 1.87 1.67	Independent and dependent <i>t</i> -Tests: Sig. improvement from pre- to post-test in M-group in all subscales (Fluency, Flexibility, Originality; all <i>ps</i> < 0.01) and no improvement in C (all <i>ps</i> > 0.05). At post-test M-group shows significantly higher scores in all subscales compared to C (all <i>ps</i> < 0.01). Effects sustained at follow up compared to pre-test (all <i>ps</i> = 0.001), but not compared to post-test (all <i>ps</i> > 0.05).
4. Franco Justo et al., 2011a	61	16–18 16.75 (0.83) 1st year high school 48% female	3 compulsory secondary schools, public (Spain)	M-group (<i>n</i> = 31) vs. waitlist c (<i>n</i> = 30) Schools were allocated at random	Grades Self-concept STAI	C R E	-0.27 0.59 0.35	1.52 1.55 0.62	1.43 1.84 0.11	Dependent and independent <i>t</i> -Tests: Sig. improvement from pre- to post-test in M-group in all measures (all <i>ps</i> = 0.001) and no improvement in C (all <i>ps</i> > 0.05). Sig. difference between groups in post-tests (all <i>ps</i> > 0.01). Detailed analysis: students with middle range academic performance show the most improvement in Grades (Cohen's <i>d</i> = 3.05), Students with low self-concept show most improvement in self-concept (<i>d</i> = 5.12), students with high state anxiety benefited the most on state anxiety (<i>d</i> = 1.95) and students with medium trait anxiety benefited the most on trait anxiety (<i>d</i> = 1.44).

(Continued)

REVIEW ARTICLE

Autism and Mind–Body Therapies: A Systematic Review

Sarah Hourston, ND, MS,^{1,2} and Rachel Atchley, PhD¹

Abstract

Background: Mind–body therapies are often used by people with autism spectrum disorders (ASD). However, there has been little examination into which types of mind–body therapies have been investigated for people with ASD and for what purposes. A systematic review was conducted to evaluate the existing evidence for mind–body therapies for people with ASD, particularly to determine the types of mind–body therapies used and the outcomes that are targeted.


Methods: PubMed, PsychInfo, and Scopus were searched using terms for ASD and mind–body therapies. Sixteen studies were selected for review; these studies tested interventions using mindfulness, meditation, yoga, Nei Yang Gong, and acceptance commitment therapy. Most study outcomes targeted behavior, psychological symptoms, and quality of life for children and adults with ASD as well as their parents.

Results: There was little overlap between studies on the types of mind–body therapies used and associated outcomes, and only three of the studies were randomized controlled trials. Most studies were small and uncontrolled. Some studies modified the mind–body therapies to increase accessibility for people with ASD.

Conclusion: The evidence for mind–body therapies for people with ASD is limited and would benefit from larger randomized controlled trials.

Keywords: autism, Asperger syndrome, mind-body, yoga, mindfulness

The Effectiveness of Mindfulness-Based Therapies for ADHD: A Meta-Analytic Review

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Molly Cairncross¹ and Carlin J. Miller¹

Abstract

Objective: Mindfulness-based therapies (MBTs) have been shown to be efficacious in treating internally focused psychological disorders (e.g., depression); however, it is still unclear whether MBTs provide improved functioning and symptom relief for individuals with externalizing disorders, including ADHD. To clarify the literature on the effectiveness of MBTs in treating ADHD and to guide future research, an effect-size analysis was conducted. **Method:** A systematic review of studies published in PsycINFO, PubMed, and Google Scholar was completed from the earliest available date until December 2014. **Results:** A total of 10 studies were included in the analysis of inattention and the overall effect size was $d = -.66$. A total of nine studies were included in the analysis of hyperactivity/impulsivity and the overall effect was calculated at $d = -.53$. **Conclusion:** Results of this study highlight the possible benefits of MBTs in reducing symptoms of ADHD. (*J. of Att. Dis.* XXXX; XX(X) XX-XX)



Mindfulness-Oriented Meditation for Primary School Children: Effects on Attention and Psychological Well-Being

Cristiano Crescentini^{1*}, Viviana Capurso^{1,2†}, Samantha Furlan³ and Franco Fabbro^{1,4}

¹ Department of Human Sciences, University of Udine, Udine, Italy, ² Department of Psychology, Sapienza University of Rome, Rome, Italy, ³ Degree Course in Education Science, University of Udine, Udine, Italy, ⁴ PEF-CRO Perceptual Robotics Laboratory, Scuola Superiore Sant'Anna, Pisa, Italy

Mindfulness-based interventions are increasingly being used as methods to promote psychological well-being of clinical and non-clinical adult populations. Much less is known, however, on the feasibility of these forms of mental training on healthy primary school students. Here, we tested the effects of a mindfulness-meditation training on a group of 16 healthy children within 7–8 years of age from an Italian primary school. An active control condition focused on emotion awareness was employed on a group of 15 age-matched healthy children from the same school. Both programs were delivered by the same instructors three times per week, for 8 total weeks. The same main teacher of the two classes did not participate in the trainings but she completed questionnaires aimed at giving comprehensive pre-post training evaluations of behavior, social, emotion, and attention regulation skills in the children. A children's self-report measure of mood and depressive symptoms was also used. From the teacher's reports we found a specific positive effect of the mindfulness-meditation training in reducing attention problems and also positive effects of both trainings in reducing children's internalizing problems. However, subjectively, no child in either group reported less depressive symptoms after the trainings. The findings were interpreted as suggestive of a positive effect of mindfulness-meditation on several children's psychological well-being dimensions and were also discussed in light of the discrepancy between teacher and children's reports. More generally, the results were held to speak in favor of the effectiveness of mindfulness-based interventions for healthy primary school children.

Keywords: primary school children, mindfulness-meditation, teachers' report, attention, psychological well-being

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*Correspondence:

Cristiano Crescentini
cristiano.crescentini@uniud.it

[†] These authors have contributed
equally to this work.

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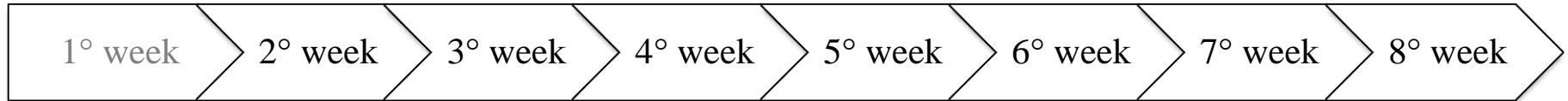
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TABLE 3 | Mean T-scores and standard deviations (in parentheses) obtained by children in the MOM and control groups in the two testing sessions (i.e., before and after the trainings).

CTRS – R	Pre-training MOM group M T-score (SD)	Post-training MOM group M T-score (SD)	Pre-training control group M T-score (SD)	Post-training control group M T-score (SD)
Oppositional	49 (6.76)	48.81 (7.12)	49.46 (5.99)	48.8 (5.11)
Cognitive Problems/Inattention*	49.81 (8.63)	47.75 (5.49)	45.73 (3.01)	45.6 (2.84)
Hyperactivity	48.37 (6.84)	47.87 (6.39)	47.2 (5.33)	47.13 (5.71)
Anxious-Shy	48.56 (9.23)	47.12 (8.13)	44.06 (4.23)	43.26 (3.89)
Perfectionism	45.81 (7.79)	45.12 (7.01)	44.26 (5.67)	43.46 (4.47)
Social Problems	53.12 (9.72)	52 (8.54)	51.06 (5.75)	50 (6.30)
ADHD Index*	48.06 (6.60)	46.37 (4.93)	46.33 (5.15)	46.46 (5.22)
DSM-IV: Inattention**	50.68 (10.16)	48.75 (6.64)	46.73 (5.02)	46.53 (5.04)
DSM-IV: Hyperactivity	47.50 (4.85)	47.31 (4.46)	46.93 (5.25)	47 (5.81)
CGI: Restless-Impulsive*	48.25 (6.90)	46.62 (6.14)	45.86 (5.26)	45.73 (5.11)
CGI: Emotional Lability	49.87 (7.75)	48.06 (6.58)	46.13 (5.19)	46 (5.19)
CGI: Total	48.5 (7.08)	46.81 (6.36)	45.66 (5.17)	45.46 (4.88)

CTRS-R stands for Conners Teacher Rating Scale-Revised; ADHD stands for Attention deficit/hyperactivity disorder; CGI stands for Conners Global Index; DSM-IV stands for Diagnostic and Statistical Manual of Mental Disorders 4th Edition. * Indicates the scales for which significant effects were found in the MANOVA analysis after the application of a Bonferroni correction for multiple comparisons; ** Indicates the scales for which marginally significant effects were found in the MANOVA analysis after the application of the Bonferroni correction (see main text for further details). The anxious-shy, perfectionism, social problems, CGI: Emotional Lability, and CGI: Total scores were not individually analyzed but the data are still reported in the table.

MOM vs CNT



MOM

3 DAYS	3 DAYS	3 DAYS	3 DAYS	3 DAYS	3 DAYS	3 DAYS	3 DAYS
3' breath	4' breath	5' breath	6' breath	7' breath	8' breath	9' breath	10' breath
3' body	4' body	5' body	6' body	7' body	8' body	9' body	10' body
3' thoughts	4' thoughts	5' thoughts	6' thoughts	7' thoughts	8' thoughts	9' thoughts	10' thoughts

CNT

3 DAYS	3 DAYS	3 DAYS	3 DAYS	3 DAYS	3 DAYS	3 DAYS	3 DAYS
4' reading	6' reading	7' reading	9' reading	10' reading	12' reading	13' reading	14' reading
5' comments	6' comments	8' comments	9' comments	11' comments	12' comments	14' comments	16' comments

30 min

45 min

1 h

1 h e 30 min

Aspetti del training MOM

Componenti chiave:

1. Calmare la mente e focalizzare l'attenzione sul respiro
2. Essere presenti alle sensazioni provenienti dal corpo (comprese pratiche di Yoga consapevole)
3. Osservazione dei pensieri e emozioni
4. Gentilezza verso se stessi e gli altri

Conclusioni

I dati hanno mostrato specifici effetti positivi del training MOM nel ridurre problemi di tipo cognitivo e comportamentale dei bambini, e in particolar modo problemi di tipo attentivo. Tuttavia, soggettivamente, i bambini nei gruppi MOM o di controllo non hanno segnalato un migliore stato d'animo o meno sintomi depressivi dopo i training.

Nel complesso, i risultati suggeriscono la fattibilità e l'utilità degli interventi basati sulla mindfulness nei contesti educativi che coinvolgono studenti delle scuole primarie, mostrando effetti positivi in diverse dimensioni del benessere psicologico dei bambini.



Cristiano Crescentini e Deny Menghini
(a cura di)

La mindfulness per l'ADHD e i disturbi del neurosviluppo

*Applicazione clinica della Meditazione
Orientata alla Mindfulness – MOM*

Neuropsicologia in età evolutiva

Teorie, modelli, strumenti di diagnosi e intervento

Direttore *Stefano Vicari*



Erickson

Il Progetto "Mindfulness, Educazione Alla Consapevolezza"

(Università di Udine)

(Fabbro, Crescentini, Paschetto, Matiz)

Studio, ricerca, diffusione del metodo MOM in ambito scolastico – educativo

Insegnanti e adolescenti

- 8 settimane di training 1 volta la settimana.
- Esercitazioni da fare a casa giornalmente.
- ½ ora ogni giorno

Bambini

- 8 settimane di training 3 volta la settimana.
- 1 volta con istruttore MOM, 2 con insegnante.
- 9 min → 30 min

Mindfulness per insegnanti

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Mind Brain Educ. 2013 September ; 7(3): . doi:10.1111/mbe.12026.

Mindfulness for teachers: A pilot study to assess effects on stress, burnout and teaching efficacy

Lisa Flook^{*}, Simon B. Goldberg, Laura Pinger, Katherine Bonus, and Richard J. Davidson
University of Wisconsin-Madison

Journal of Educational Psychology

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Mindfulness Training and Reductions in Teacher Stress and Burnout: Results From Two Randomized, Waitlist-Control Field Trials

Robert W. Roeser
Portland State University

Kimberly A. Schonert-Reichl
University of British Columbia

J Child Fam Stud (2010) 19:184–189
DOI 10.1007/s10826-009-9344-0

ORIGINAL PAPER

Mindfulness-Based Stress Reduction (MBSR) for Primary School Teachers

Eluned Gold · Alistair Smith · Ieuan Hopper ·
David Herne · Glenis Tansey · Christine Hulland

Mindfulness
DOI 10.1007/s12671-012-0094-5

REVIEW

Integrating Mindfulness Training into K-12 Education: Fostering the Resilience of Teachers and Students

John Meiklejohn · Catherine Phillips ·
M. Lee Freedman · Mary Lee Griffin · Gina Biegel ·
Andy Roach · Jenny Frank · Christine Burke ·
Laura Pinger · Geoff Soloway · Roberta Isberg ·
Erica Sibinga · Laurie Grossman · Amy Saltzman

Mindfulness Training and Reductions in Teacher Stress and Burnout: Results From Two Randomized, Waitlist-Control Field Trials

Robert W. Roeser
Portland State University

Kimberly A. Schonert-Reichl
University of British Columbia

Amishi Jha
University of Miami

Margaret Cullen
Berkeley, California

Linda Wallace and Rona Wilensky
Boulder, Colorado

Eva Oberle and Kimberly Thomson
University of British Columbia

Cynthia Taylor and Jessica Harrison
Portland State University

The effects of randomization to mindfulness training (MT) or to a waitlist-control condition on psychological and physiological indicators of teachers' occupational stress and burnout were examined in 2 field trials. The sample included 113 elementary and secondary school teachers (89% female) from Canada and the United States. Measures were collected at baseline, post-program, and 3-month follow-up; teachers were randomly assigned to condition after baseline assessment. Results showed that 87% of teachers completed the program and found it beneficial. Teachers randomized to MT showed greater mindfulness, focused attention and working memory capacity, and occupational self-compassion, as well as lower levels of occupational stress and burnout at post-program and follow-up, than did those in the control condition. No statistically significant differences due to MT were found for physiological measures of stress. Mediation analyses showed that group differences in mindfulness and self-compassion at post-program mediated reductions in stress and burnout as well as symptoms of anxiety and depression at follow-up. Implications for teaching and learning are discussed.

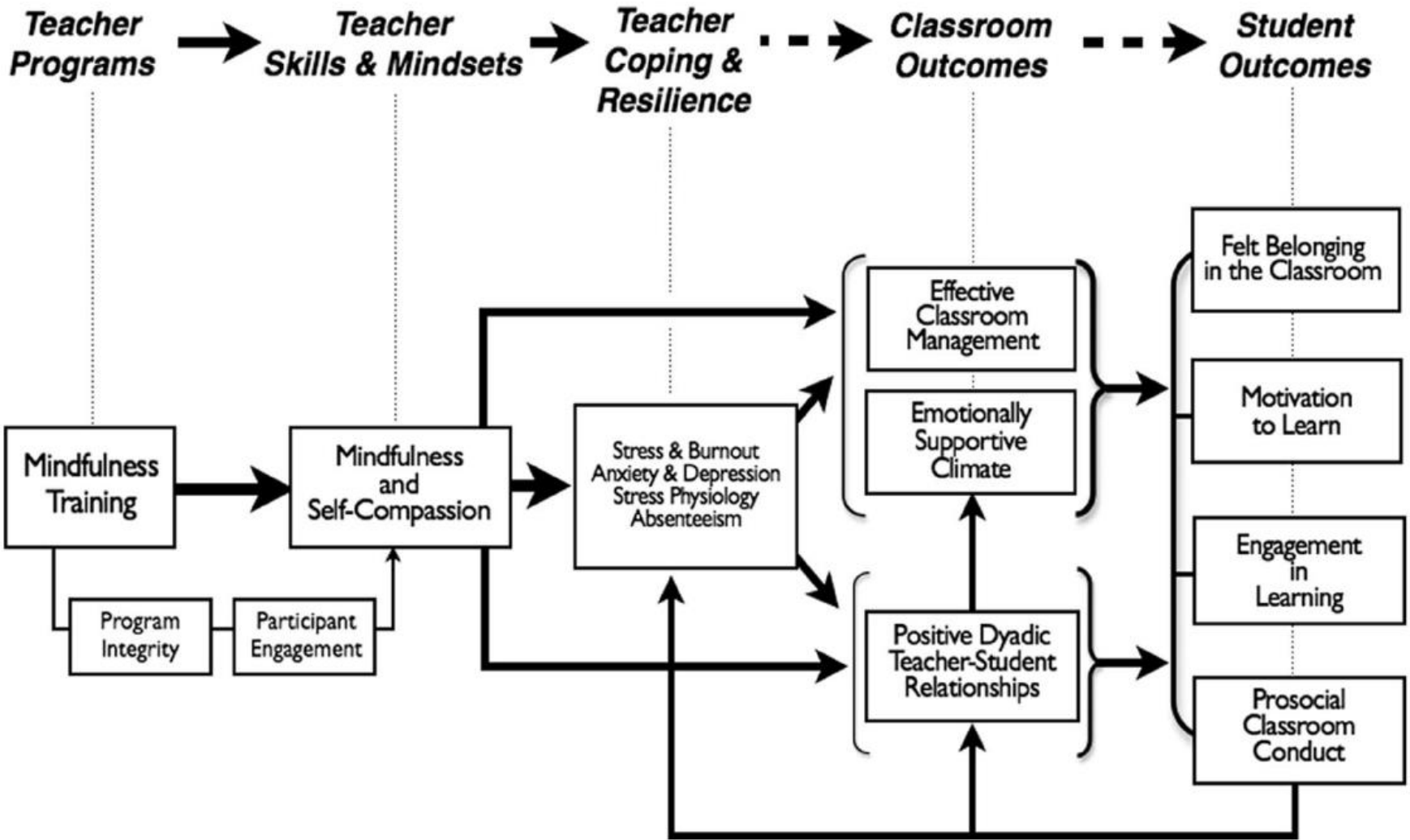


Figure 1. Teacher mindfulness training logic model and theory of change.

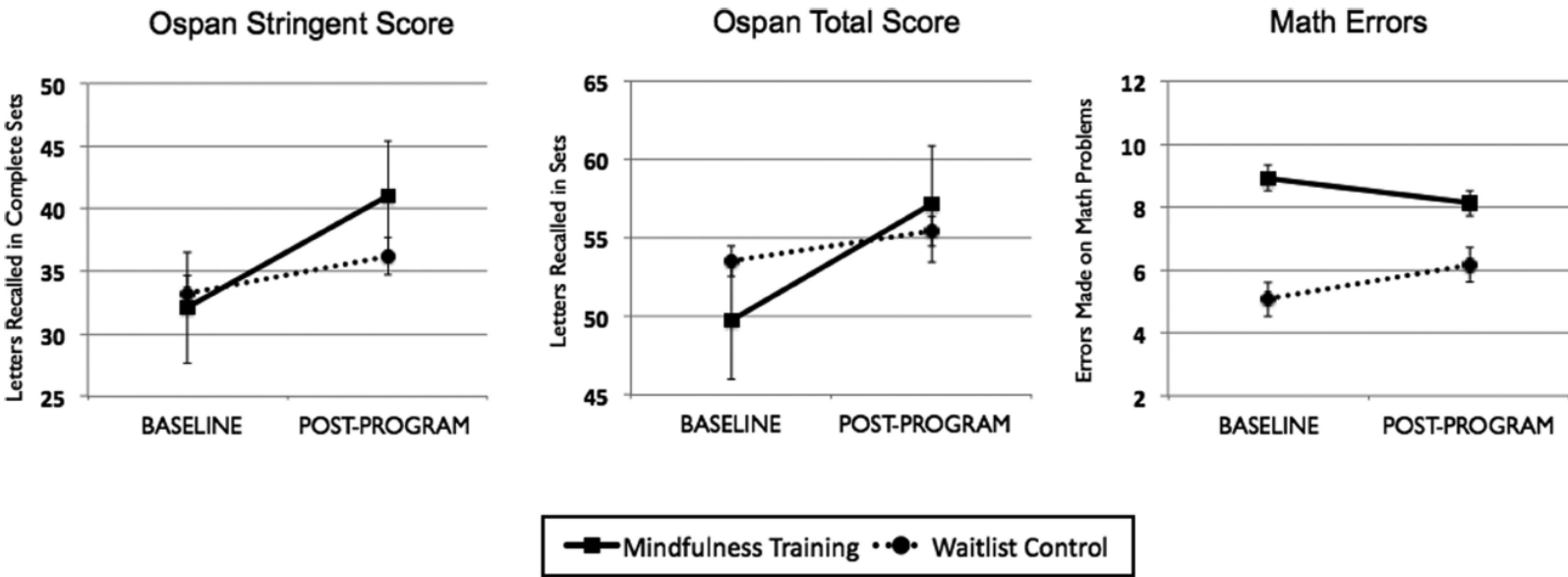
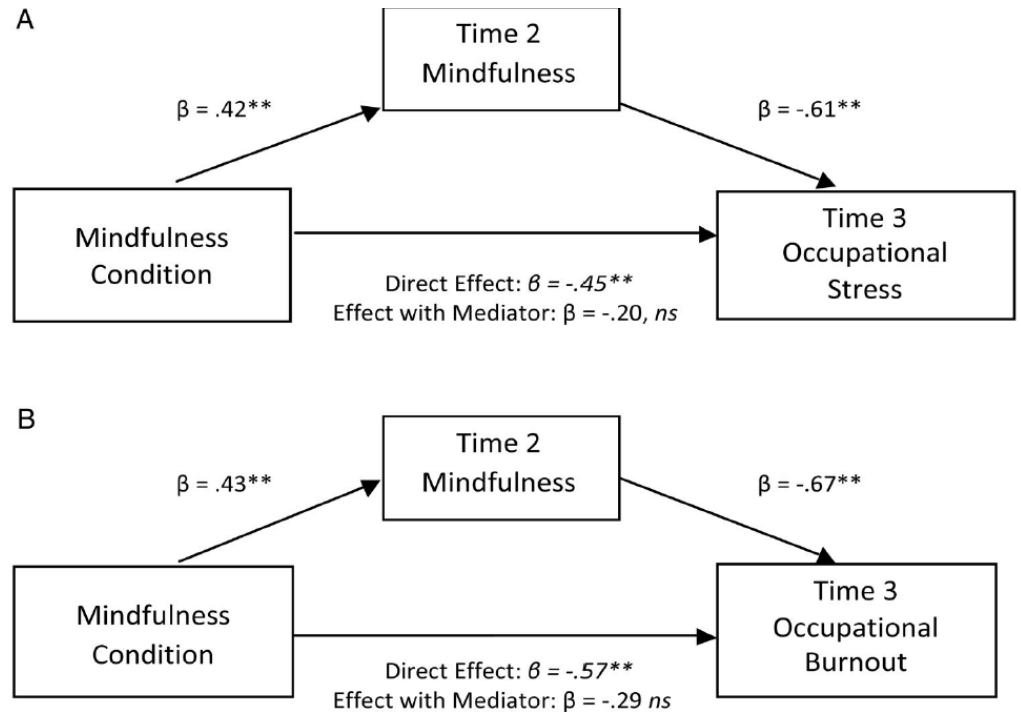


Figure 2. Teachers' focused attention and working memory capacity by study condition (Canadian sample only). Error bars = ± 1 standard error.



Roeser et al., 2013



The effects of mindfulness-oriented meditation on school teachers' stress and personality traits

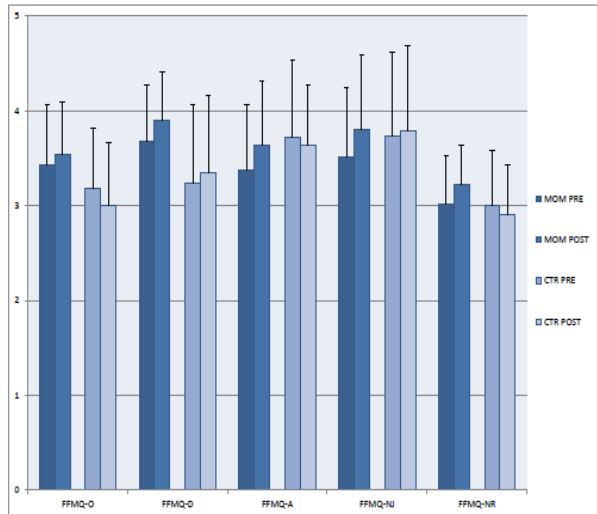


Viviana Capurso^{a,b}, Franco Fabbro^b, Cristiano Crescentini^b

^aDepartment of Psychology, University of Rome "La Sapienza", Rome, Italy

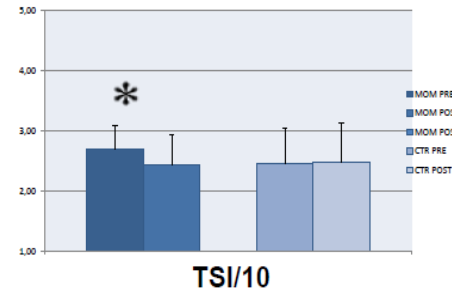
^bDepartment of Medical and Biological Sciences, University of Udine, Udine, Italy

Main Results



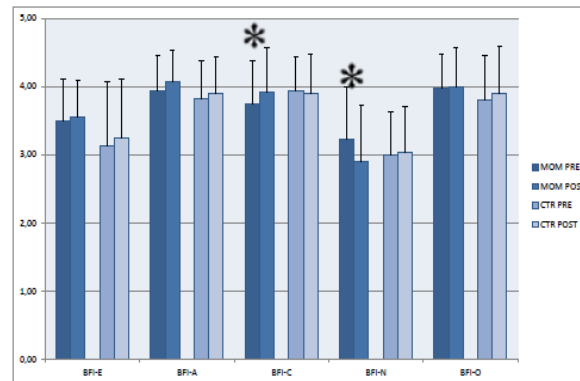
FFMQ

2 (Group: MOM, CNT) x 2 (Time, pre-test, post-test) x 5 (FFMQ scales) ANOVA showed a significant Group X Time interaction indicating increased FFMQ scores after MOM for MOM participants



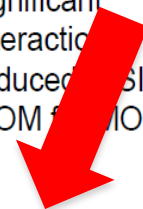
Teacher Stress Inventory (Global Index)

2 (Group: MOM, CNT) x 2 (Time, pre-test, post-test) ANOVA showed a significant two-way interaction indicating reduced TSI scores after MOM for MOM participants



Big Five Inventory

2 (Group: MOM, CNT) x 2 (Time, pre-test, post-test) x 5 (BFI scales) ANOVA showed a significant three-way interaction indicating increased Conscientiousness scores and decreased Neuroticism scores after MOM for MOM participants



Observe
Describe
Awareness
Non-Judge
Non-React

Extraversion
Agreeableness
Conscientiousness
Neuroticism
Openness