Why Are Researchers Not Interested in Studying Individual Mindfulness-Based Interventions?

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Abstract:	In the past two decades, there has been an exponential increase in clinical and research interests in mindfulness-based interventions. As it strikes us how little research has been done on an individual application of mindfulness-based interventions, despite the fact that more and more therapists are offering mindfulness in individual sessions, we summarize our work with individual Mindfulness-Based Cognitive Therapy (iMBCT) in the past 10 years, as a means to inspire researchers and clinicians to become more aware of and curious about the opportunities that iMBCT offers.

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Keywords:

Mindfulness, individual, RCT, depressive symptoms.

In the last 15 years, there has been an exponential increase in societal and clinical interests in mindfulness-based interventions and research on the beneficial effects of these interventions. It strikes us that there is still relatively little research on the application and efficacy of mindfulness in an individual setting, despite the fact that more and more therapists are offering mindfulness to their clients in individual sessions. From mindful group trainers, we understand that they think that mindfulness training without the group sharing cannot be very effective. Yet, how does this align with a growing application of and research on the effectiveness of online mindfulness-based interventions in which there is no or only some online contact with other participants (Spijkerman et al., 2016). Such online interventions not only lack face-to-face contact with other group members, but also with a trainer embodying mindfulness. With this letter, we summarize our work with *individual Mindfulness-Based Cognitive Therapy* (iMBCT). We hope to make researchers and clinicians more aware of and curious about the opportunities that iMBCT offers and stimulate more carefully controlled research to examine its effects across target populations and problems.

Our research into iMBCT started in 2008, when we received a grant from the Dutch Diabetes Foundation for developing and testing a new intervention in people with diabetes to reduce psychological distress. Based on the increased number of studies suggesting that mindfulness-based interventions are effective for reducing distress and depressed feelings, also in people with a somatic condition, we reasoned that for people with diabetes who face serious health risks and often need to follow a strict regimen of a healthy lifestyle and medication for the rest of their lives, mindfulness may be a useful intervention given its focus on increasing an open and accepting awareness of current reality.

However, the standard mode of delivery of mindfulness-based interventions was in a group setting at this time, while a requirement for our funding was that the intervention had to be individually. The main reason for this was that psychological care in hospitals in the Netherlands is characterized by an individual treatment approach. Given this setting, in which it is not always easy or possible to offer a group training and assuming that not everyone may benefit from group participation and group sharing and instead prefer an individual training, we decided to take the challenge and develop an individual MBCT protocol. We set a ground rule: the new protocol had to follow the structure and set-up of group MBCT as much as possible, including the training (rather than therapy) character; so at least half of each session should be dedicated to doing mindfulness exercises. We came up with a detailed structured 8-week intervention protocol, following the themes and exercises as done in the group training, only shorter (see for details, Schroevers et al., 2015).

First, we tested the acceptability and feasibility of the iMBCT protocol in a pilot study randomized controlled trial (RCT) in 24 people with diabetes (Schroevers et al., 2015). Results showed that it was feasible for trainers to adhere to the protocol (e.g. clear resemblance to the group MBCT protocol, feasible in one hour, clearly written protocol). Challenges were to stay out of the content and to teach 'common humanity' (i.e. that many problems are universal and part of being human). Most participants were very satisfied with iMBCT and preliminary findings suggested that iMBCT was related to reductions in depressive symptoms and diabetes-related distress and improvements in mindfulness. When we presented these results at a mindfulness conference in 2011, we noticed that there was quite some resistance, with trainers reporting such a strong faith in the power of the group that they could not see any reason for offering the training individually. At the same time, we also spoke to some trainers that were applying mindfulness training in individual sessions and who thanked us for bringing up this application of MBCT.

The promising results of the pilot study led us to conduct a larger multicenter RCT in 94 patients, including not only a wait-group control condition, but also an active intervention as comparison to iMBCT, namely the gold standard to treating depressive symptoms: Cognitive Behavioral Therapy (iCBT) (Tovote et al., 2013). The study was set up according to strict methodological recommendations for a high quality RCT, including a blinded outcome measure in addition to questionnaires, a manualized protocol with clear session-to-session descriptions, monitoring of therapists' adherence to the protocol and patients' adherence to homework, specifying our primary outcome (i.e. depressive symptoms), and reporting on loss of patients at follow-up. Results showed significant and clinically relevant reductions in depressive symptoms in individual who had received MBCT or CBT, with no significant differences between these two types of interventions (Tovote et al., 2014; Tovote et al., 2017). These positive effects of both interventions were sustained up till 9-month follow-up (Tovote et al., 2015).

In a next step, we investigated whether our individual approach was as acceptable and effective as the group MBCT training. In this RCT, we included 56 people with a chronic somatic illness (Schroevers et al.,

2016). Intriguingly, about one-third of people allocated to the group training preferred iMBCT before being randomized, whereas post-intervention all participants were satisfied with the type of intervention (i.e. group or individual) they received. Both types of interventions were found to be equally effective in reducing depressive symptoms and increasing mindfulness until 3-month follow-up.

After having received the training, participants having received individual MBCT reported the following advantages: personal and full attention of the trainer, less distractions, difficulty to remain silent and passive, easier to fully be oneself, less shame, and the fact that the training schedule was more feasible and flexible; a downside was the lack of stories from others. Participants having received group MBCT reported the following advantages: peer contact, being able to share experiences with others, recognition and support from the group, allowing to putting things in perspective; a downside was the intensity of hearing stories from others.

These positive findings motivated us to share our evidence-based protocol with other trainers in the Netherlands. In 2014, we started to offer a two-day course for mindfulness trainers to learn to deliver iMBCT at the Center for Mindfulness in Amsterdam. So far, we have taught nine groups, with in total about 130 trainers. Trainers are generally very positive, as it gives them a clear and evidence-based tool to offer MBCT individually. Many trainers had before this two-day course struggled with developing an own developed individual protocol and felt uncertain about what they were teaching.

Besides our research, there is still hardly any research on individual mindfulness training, with a few recent non-randomized pilot studies in people hearing voices or people with an autism spectrum disorder (Conner & White, 2018; Louise et al., 2019). Some have investigated the added value of a single mindfulness session or integration of one or two mindfulness exercises in routine individual therapy (Dimidjian and Segal, 2015; Mander et al., 2019). There is also literature about the value of being a mindful therapist and cultivating mindfulness in therapeutic relationships (Siegel, 2010). These approaches differ from our iMBCT, as our aim is to teach mindfulness as an individual 8-week training program

To conclude, we want to bring forward the question to you, fellow mindfulness researchers and trainers: why is it that most researchers exclusively focus on the effects of the group training, what is it that keeps them from examining iMBCT? We hope that the promising evidence for the feasibility, acceptability, and effectiveness of individual Mindfulness-Based Cognitive Therapy (iMBCT) and the increased use of individualized MBCT/MBSR protocols in practice motivates researchers to conduct future research on iMBCT in other countries, cultures, health care settings, and health care systems. Not only to examine the replication of our findings, but also to examine for which types of problems iMBCT is (less) effective, for whom it is (less) acceptable and effective, and which factors explain the benefits of iMBCT on outcomes (i.e. mechanisms of change). We look forward to such future research, as more evidence is needed to show to what extent it is empirically sound to offer people a choice for doing a mindfulness-based training, either individually or in a group.

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