Mindfulness (2019) 10:799–811
https://doi.org/10.1007/s12671-019-01142-6

COMMENTARY

# Principles for a Responsible Integration of Mindfulness in Individual Therapy

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Published online: 29 April 2019
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## Abstract

**Objectives** Mindfulness-based interventions (MBIs) like mindfulness-based stress reduction (MBSR) and mindfulness-based cognitive therapy (MBCT) teach mindfulness in a group-based format. Empirical research has shown that many therapists working in individual therapy integrate mindfulness practices (e.g., body scan, sitting meditation) into their treatments. However, research on this topic is in its infancy. The purpose of this paper is to present recommendations for a responsible use of mindfulness in individual therapy.

**Methods** Informed by a literature review, an expert group developed guidelines for a responsible use of mindfulness in individual therapy.

**Results** Recommendations for the following issues were developed: (a) different types of integration; (b) diagnoses/clinical problems for which integration of mindfulness in individual therapy could be useful; (c) qualification of therapists; (d) case formulation; (e) the inquiry process; (f) types and optimal duration of mindfulness practices in individual therapy; (g) managing difficult experiences; (h) integration of mindfulness into individual therapy training programs. Finally, we formulate important topics for research on the integration of mindfulness into individual therapy.

**Conclusions** By formulating recommendations for the most important issues of the integration of mindfulness into individual therapy, we want to stimulate the discussion on a responsible use of mindfulness in this setting. Since research on this topic is scarce, our recommendations can only be tentative.

**Keywords** Mindfulness · Implementation · Individual therapy

Over the past two decades, mindfulness has gained a great deal of attention in the therapeutic community. Much of this momentum was driven by the development and empirical investigation of mindfulness-based interventions (MBIs) like mindfulness-based stress reduction (MBSR, Kabat-Zinn 2013) and mindfulness-based cognitive therapy (MBCT, Segal et al. 2013). MBSR and MBCT teach mindfulness in a group-based format and their developers have stressed several advantages of teaching in this format. In addition to the favorable cost-effectiveness of group-based programs, non-specific factors characteristic of group psychotherapy (Yalom 1995) such as the demonstration of universality (seeing suffering as part of a shared human experience) and the availability of peer support are likely to play a role. Also, patients can profit from observing the way in which other group members deal with challenges and develop new modes to relate to their experience in a mindful way. Indeed, qualitative studies have shown that patients consistently stress the importance of peer support as one of the key components of the healing process

The original version of this article was revised due to a retrospective Open Access order.

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during mindfulness-based programs (e.g., Allen et al. 2009; Mason and Hargreaves 2001).

The accumulating evidence on the efficacy of mindfulness-based group programs (e.g., Khoury et al. 2013; Kuyken et al. 2016) has led to a call for 'top-down' dissemination of these programs in some countries. One example from the United Kingdom is the Mindful Nation UK initiative of the Mindfulness All-Party Parliamentary Group (2015), which formulated concrete goals to make MBCT available to adults, at risk of recurrent depression. For example, they recommended that funding should be made available to train 100 MBCT teachers per year in the UK to supply a total of 1200 MBCT teachers in the UK National Health Service by 2020. Moreover, some countries, such as the UK and Germany, have included mindfulness-based interventions in their clinical guidelines: e.g., the UK's NICE guidelines and the German „Nationale Versorgungsleitlinie Unipolare Depression "(DGPPN et al. 2015) both mention MBCT as an approach to prevent depressive episodes in recurrently depressed patients.

However, in addition to this type of 'top-down' dissemination, the growing interest in mindfulness in the psychotherapy community also has the quality of a grassroots movement carried forward by the practitioners in the field (e.g., Rycroft-Malone et al. 2017). Inspired by the accumulating evidence on the therapeutic potential of mindfulness-based interventions and often grounded in personal experience with practicing meditation and mindfulness, many therapists have started to experiment with different forms of integration of mindfulness into their therapeutic work (for a discussion of possible reasons for the strong interest in mindfulness within the Western health system see Michalak and Heidenreich 2018). This is, for example, indicated by a growing number of books on mindfulness in psychotherapy that do not focus on group-based mindfulness-based programs, but instead describe the integration of mindfulness into individual therapy (e.g., Fleck 2015; Lohmann and Annies 2018). One of the earliest publications with this focus was the book edited by Germer, Siegel, and Fulton (Germer et al. 2005) covering a broad range of ideas and approaches to integrating mindfulness into psychotherapy.

Moreover, empirical data show that many therapists use mindfulness practices stemming from MBSR in an individual therapy setting. Michalak et al. (2019) conducted a survey on the use of mindfulness by German psychotherapists in private practice. In this study, over 80% of psychotherapists reported that they use mindfulness practices at least sometimes with their patients in individual psychotherapy. Most therapists in this study reported that they do not deliver mindfulness in a group format (i.e., MBSR or MBCT), but instead used mindfulness in a much more eclectic way by incorporating isolated practices from MBSR or MBCT (e.g., body scan) with practice times that are usually much shorter than in MBSR/MBCT. Typically, mindfulness practices of 11 to 20 min duration were used, and with up to 30% of outpatients. Integration rates were high among cognitive behavioral as well as in psychodynamic-oriented therapists. Although these numbers have to be interpreted with some caution considering the low response rate in this study (16%), the results show that a considerable number of patients have contact with mindfulness in individual therapy settings and not in the established structured group formats.

A similar pattern of integration has been reported by Librowicz (2017) for Austria. In this study, using a representative sample of psychosocial counselors, over 60% reported that they integrated elements of MBSR to medium to high degree in their work, whereas only around 20% used the complete MBSR program. Of note, less than 1% of the counselors reported a daily personal meditation practice and less than 10% meditated at least several times a week. Again, this result shows that a common way for clients to get in contact with mindfulness is through individual treatments integrating mindfulness in an eclectic way.

## Empirical Studies on the Efficacy of Mindfulness in the Context of Individual Therapy

In contrast to the flourishing literature on group-based mindfulness programs, there are only a few empirical studies on the efficacy of mindfulness practice in the context of individual therapy. A study by Tovote et al. (2014) investigated the efficacy of MBCT in individual treatment. They randomized 94 outpatients with diabetes with comorbid depressive symptoms to individual MBCT, Cognitive Behavior Therapy (CBT), or waiting list. MBCT was adapted in several ways: session duration was shortened (45–60 min), practices were shortened and psychoeducational content was adapted to individuals with diabetes. Participants in the MBCT and CBT conditions showed significantly greater reductions in depressive symptoms compared to the control condition. Both active treatments also had effects on anxiety, well-being, and diabetes-related distress. Follow-up analyses after 9 months indicated that both MBCT and CBT had sustained beneficial effects on depressive symptoms and other outcome measures (Tovote et al. 2015).

In a pilot randomized controlled trial with 56 people with somatic conditions and comorbid depressive symptoms, Schroevers et al. (2016) compared group and individual MBCT directly. They found significant improvements in depressive symptoms, anxiety and well-being outcomes in those receiving group or individual MBCT, with no significant differences between the two conditions.

Moreover, in a small pilot study Conner and White (2017) showed evidence for the efficacy of mindfulness training in an individual treatment format for patients with autism spectrum disorder and a case study by Luberto, Magidson, and Blashill

(2017) reported significant improvements for a patient with health anxiety treated with an intervention largely based on MBCT and supplemented by traditional cognitive-behavioral techniques.

However, a study comparing a 5-min session-introducing intervention with mindfulness elements with a 5-min session-introducing relaxation intervention and treatment as usual in individual therapy found no advantage of add-on mindfulness exercises related to therapeutic alliance and symptom reduction in 162 patients with anxiety and depression (Mander et al. 2019).

In contrast to studies that investigate mindfulness practices for patients, the study by Grepmair et al. (2007) had a different focus: they investigated the role of mindfulness *of therapists.* In their study, they could show that meditation before individual therapy positively affected session outcome. The authors speculated that meditation enhanced self-awareness and self-regulation skills of therapists and might have made them more attuned to their patients. This view was supported by a qualitative study by Cigolla and Brown (2011) that explored the experiences of therapists who have a mindfulness practice, investigating how this is brought into individual therapy.

Although these studies show that mindfulness in an individual therapy format might have promise, data are very preliminary. In particular, both the above studies on I-MBCT are focused on patients with somatic conditions. Data directly targeting the efficacy of I-MBCT in psychological disorders is currently missing. Moreover, in many contexts, it is not possible to apply a full I-MBCT package in individual therapy because of specific restraints related to the way individual therapy has to be applied. Moreover, the sample size of most studies on the use of mindfulness in individual therapy was small and for this reason firm evidence-based conclusions are difficult to draw. Therefore, it is not possible to refer to the existing data alone to derive recommendations for the integration on mindfulness in individual therapy.

## Challenges of Integrating Mindfulness in Individual Therapy

Although the existing data on mindfulness in individual therapy is limited, it is possible to anticipate a few challenges that may face therapists, particularly those with limited mindfulness training who wish to use mindfulness within individual therapy. First, as discussed above, much of the scientific evidence for mindfulness-based interventions relates to the use of manualized group formats such as MBSR and MBCT. Dimidjian and Segal (2015) have pointed out that there is the danger of an "implementation cliff" (Weisz et al. 2014), where interventions with established efficacy in research settings do not progress to evaluation of real-word effectiveness. Some interventions stall at the efficacy stage, and some move into real-world practice without formal evaluation and sometimes with significant modifications to format and content which may have unexpected effects on their clinical impact. In particular, a "voltage drop" (lessening of effect size) may occur as interventions move to routine clinical practice, which may be attributed in part to an "implementation limbo" in which resource constraints set the "bar" for training providers at progressively lower levels. Therefore, in contrast to the solid evidence base for the manualized 8-week group format of MBSR or MBCT, the combination of divergence from evidence-based programs and reduced training of deliverers that are observed in studies on the implementation of mindfulness in individual therapy (Librowicz 2017; Michalak et al. 2019) may result in the use of unskillful ways of integrating mindfulness in individual therapy.

One challenge facing practitioners without in-depth training in mindfulness-oriented skills is the difficulty of integrating mindfulness practices and attitudes with core non-mindfulness-components of their treatment as well as difficulties in mastering the challenging task of integrating mindfulness practices into coherent case conceptualizations. In the absence of such skillful integration, there is likely to be a greater tendency for mindfulness practices to be used in a disintegrated way. For example, therapists might use mindfulness practices in an attempt to produce short-term improvements in mood or as a strategy for downregulating states of anxiety without 'coming in contact' with feared content. While not necessarily inherently problematic, such approaches to the use of mindfulness techniques depart substantially from their intended use within evidence-based programs.

Moreover, practitioners without in-depth training might find it difficult to explore the experiences of patients in a skillful inquiry process or to sufficiently assist patients to deal with inevitable challenges that arise during mindfulness practice (for a broader perspective on critical aspects of the growing momentum in mindfulness intervention and research see Davidson and Kaszniak 2015). It is important to note that trainee therapists already use mindfulness exercises in their training therapies (Hopkins and Proeve 2013). As trainees are per definition in their earliest stages of delivering psychotherapy, and have yet to learn basic therapeutic skills, using mindfulness exercises without a broader perspective and background knowledge might be especially difficult. In order to limit difficulties, it is it likely to be of particular importance to deliver basic background information on mindfulness during the training of psychotherapists to avoid potential misuse, and specific idea of how this could be done is described later in this manuscript. Uncritically implementing mindfulness elements in psychotherapy could lead to the patient having less access to empirically established or evidence-based interventions.

In the face of the potentials and challenges we presented, the purpose of this paper is to discuss principles for a responsible use of mindfulness in individual therapy. The rationale for developing these principles is the fact that many therapists already use or want to use mindfulness in individual treatment setting, but there is currently a lack of consensus around many of the important parameters that might influence successful integration. In response to this need for guiding principles and standards, we formed a group of experts in research on and training in mindfulness-based interventions to discuss important facets of the integration of mindfulness in individual therapy. Where possible the discussion was informed by the body of empirical findings from the following fields: (a) basic research on meditation and research on mindfulness-based group interventions, (b) research on training of psychotherapists, (c) research on case conceptualization, and (d) general research on psychotherapy outcome and process. However, since for many aspects of integration, empirical findings are missing, the consensus was often based on clinical experience. This paper presents the consensus of the expert group on principles of a responsible integration of mindfulness into individual therapy.

## Relevant Issues for the Integration of Mindfulness into Individual Therapy

It is important to recognize that mindfulness can be integrated into individual therapy in a variety of forms. Germer et al. (2005) distinguished three ways of integrating mindfulness into therapy: (1) therapist embodiment of mindfulness (i.e., therapists' own practice of meditation); (2) mindful relating (i.e., teaching mindfulness through a mindful therapeutic relationship), and (3) teaching mindfulness practices. Furthermore, mindfulness can be brought into therapy in varying intensities. For example, a therapist might (a) recommend books or other resources on mindfulness to help patients to get a "taste" of mindfulness, (b) suggest that patients participate in an MBSR or MBCT course, (c) teach mindfulness exercises in individual therapy, or (d) adapt mindfulness-based group therapy, like MBCT, to an individual format. The different forms and intensities of integration should be kept in mind when considering the recommendations contained in this article.

**Therapists Personal Mindfulness Practice and Mindful Relating** The most basic form of integration is that therapists may personally practice mindfulness meditation (either formally, or through the use of informal mindfulness practices) themselves to cultivate a more mindful presence in psychotherapy. For example, as the study of Grepmair et al. (2007) showed, from the perspective of therapists, personal mindfulness practice changes their way of being, and thus might potentially affect the therapeutic relationship (Cigolla and Brown 2011). This view is supported by research showing that mindfulness may have beneficial effects on therapists' qualities such as empathy and counseling skills (for a review see Davis and Hayes 2011; for a more critical review on the effects of mindfulness on prosocial behaviors like empathy see Kreplin et al. 2018). Furthermore, trait mindfulness of therapists has been shown to relate positively to alliance ratings and some dimensions of treatment outcome (Ryan et al. 2012). According to the two-stage model by Kristeller and Johnson (2005) therapists' practice of mindfulness exercises improves self-acceptance and self-compassion (stage 1), which leads to the development of stronger empathy and acceptance towards patients (stage 2). Consequently, therapists' mindfulness practice might directly strengthen the therapeutic alliance (Mander et al. 2015) a factor which has been identified as relevant for symptom reduction, with an $r = .27$ (Horvath et al. 2011). Hence, potential effects of mindfulness on the therapeutic alliance are of clinical relevance. Preliminary empirical evidence from small studies supports the theoretical assumptions of this model and shows that therapists' mindfulness practice strengthens the therapeutic alliances with their patients (Dunn et al. 2013; Horst et al. 2013).

A therapist's personal mindfulness practices might also have an important role in self-care. Mindfulness practice has consistently shown to have positive effects on mental health (Khoury et al. 2013) and has been shown to be beneficial for working adults (Virgili 2015). Moreover, it has specifically been shown that MBCT improves therapists' self-care (Hopkins and Proeve 2013). This highlights the possible role that mindfulness practice might play for therapists in developing a more balanced and healthy way of living.

**Recommendation** Based on the evidence presented and based on our personal and professional experience, we recommend personal mindfulness practice for therapists. In addition to the positive effects on the therapists' well-being, mindfulness practice may also support therapists' relationship building skills to form a solid basis for the next stage of more explicitly applying mindfulness to clinical work.

**Conducting Mindfulness Exercises with Patients** On a very basic level, one could ask whether teaching mindfulness practices to patients is necessary at all. The few studies directly comparing (group-based) mindfulness interventions with more traditional treatment models (i.e., CBT) have never reported superior outcome in the mindfulness interventions (e.g., Farb et al. 2018; Manicavasgar et al. 2011; Michalak et al. 2015), and a single study that compared the full MBCT protocol to a treatment protocol in which the mindfulness practice was removed, showed no difference in outcomes (Williams et al. 2014). While data from studies exploring the

additive benefits of including mindfulness components in existing non-mindfulness treatment protocols is lacking, the data that does exist suggests that there is no empirically derived 'must' to integrate mindfulness and that therapists can deliver effective therapy without including mindfulness-based treatment elements. Therefore, practicing mindfulness with patients is a therapeutic *option* that should be considered if the following prerequisites are met (all discussed in more detail below).

One issue that needs consideration especially because of the growing public interest in mindfulness is that increasingly patients themselves are asking to be introduced to mindfulness as part of their therapy. Some of them might have misconceptions of mindfulness as a relaxation technique or a shortcut to happiness. It is important for therapists to use mindfulness practices only when indicated and not to feel pressured to use mindfulness when conditions for a responsible integration into therapy are not met (e.g., other therapeutic approaches are more indicated, therapists qualifications are not met).

**Recommendation** Therapists should consider integration of mindfulness practice into therapy if (a) the therapist has personal mindfulness practice, which allows a 'teaching from the inside' perspective; (b) the empirical literature suggests that patients' diagnoses or clinical problem makes it likely that mindfulness is a promising treatment option; (c) the rationale for mindfulness practice is embedded in a coherent case conceptualization that takes into account processes such as rumination, differential activation etc.

**Self-Compassion** Over the past decade, there has been a growing recognition of the importance of self-compassion in mindfulness-based therapy. Like mindfulness, self-compassion is rooted in Buddhist psychology and practice and has been picked up as a focus of Western psychological research. Neff (2003) described self-compassion as extending compassion to one's self in instances of perceived inadequacy, failure, or general suffering. It encompasses three components: (1) self-kindness (i.e., being warm towards oneself when encountering pain and personal shortcomings in contrast to being self-critical) (2) common humanity (i.e., recognizing that suffering and personal failure is part of the shared human experience in contrast to feelings of isolation when confronted with suffering), and (3) mindfulness (i.e., feelings are neither suppressed nor exaggerated).

It has been shown that levels of self-compassion are associated with psychopathology (MacBeth and Gumley 2012) and there is preliminary empirical evidence that the development of self-compassion is a mediator of the effects of mindfulness-based interventions (Kuyken et al. 2010). Moreover, studies have shown that brief priming of self-compassion can increase the willingness to continue with mindfulness following an initial introductory mindfulness exercise (Rowe et al. 2016) and that compassion practices may facilitate a stronger commitment to meditation practice and more lasting effects (May et al. 2014; for an overview of the intimate relationship between mindfulness and compassion, see Germer 2019, Germer and Barnhofer 2017). There is consensus among most mindfulness experts that self-compassion adds an important "warming up" quality to the present moment awareness that is essential for the healing effects of mindfulness. However, there is some discussion in the field on the most appropriate way to support vulnerable patients to develop self-compassionate ways of relating to suffering. On the one hand, several programs were developed that *explicitly* teach self-compassion such as Compassion Focused Therapy (CFT, Gilbert 2010) and Mindful Self-Compassion (MSC, Germer and Neff 2013). On the other hand, some authors favor indirect routes to cultivating self-compassion. In MBCT, Segal, Williams, and Teasdale (Segal et al. 2013, p. 137–143) argued that for patients with psychological disorders, there is a risk that explicit compassion practices may trigger vulnerabilities. Highly ruminative patients, for example, might misunderstand the instructions in compassion practices as a call to *strive* to achieve these qualities, which is likely to lead to failure and self-recrimination. Compassion can also activate seemingly opposite emotions, such as sadness or shame (*backdraft*; Germer 2009). Therefore, therapists are encouraged to embody a kind and compassionate attitude rather than explicitly teaching self-compassion.

**Recommendations** Therapists should be aware of the importance of bringing the warm and kind quality of compassion into mindfulness practices. This quality can be best brought into therapy when therapists have learned how to relate compassionately to themselves (by their own meditation practice). When explicitly integrating compassion practices from compassion training programs like CFT or MSC, therapists should receive special training in these approaches to recognize and safely address the clinical challenges that can arise during practice.

## Diagnoses/Clinical Problems for Which Integration of Mindfulness in Individual Therapy Could Be Useful

The current evidence of mindfulness in individual therapy is too limited to derive practical recommendations. The studies by Tovote et al. (2015) and Schroevers et al. (2016) suggest that I-MBCT is useful for patients with somatic conditions and comorbid clinical conditions. Beyond that, we suggest that adaptation of mindfulness interventions for individual therapy seems most promising for diagnoses and clinical problems where the efficacy of group-based versions has been

consistently shown. However, it should be noted that even in these cases the legitimacy of generalizing from evidence of group MBIs to individual settings might be questioned, because mechanisms of change of MBIs are not fully established (e.g., how much of the effect is carried by group processes of various kinds?) and it is unclear how much is tied up in the particular contextualization of the practice within the psychoeducational structure of the programs. Correspondingly, the following recommendations have to be interpreted with caution.

The strongest evidence base for MBSR or MBCT is found in adaptation to cancer and recurrent depression (Dimidjian and Segal 2015), and therefore, it seems most likely that individual format applications might be useful for these conditions. The relatively broad efficacy of group-based MBIs for various psychological and physical conditions suggests, that a transdiagnostic process might be addressed with these interventions. One of the core transdiagnostic processes discussed in literature on MBIs is discrepancy-based processing resulting in repetitive negative thinking like rumination or worry (Ehring and Watkins 2008; Williams 2008). Therefore, integration of mindfulness practices into therapies for patients with heightened levels of rumination or worry might be useful. However, it should be noted that mindfulness practice might also be especially challenging for these patients because of the strong tendency of their minds to fall into habitual and maladaptive thought patterns. Informing patients about these challenges in advance and carefully and compassionately addressing these difficulties in the inquiry process might be a useful antidote to demoralization. And this can best be done on the basis of the therapist's own experiences of how to deal mindfully with difficult thoughts or repeatedly emerging thought patterns which we all can experience from time to time although we do not suffer from a mental disease.

Furthermore, mindfulness is suitable for patients who are looking for a more intensive and vivid contact with the here-and-now. The wish to be in contact with the here-and-now might often be a characteristic of patients with high levels of worry or rumination, but might also be present in patients independent of it. In these cases, mindfulness practices can be used to strengthen a present-oriented being-mode as a valuable resource to get in contact with the richness of every moment (Geschwind et al. 2011).

Indeed, mindfulness practice often initially enables people to feel more vivid and alive, to be in more authentic contact with themselves and their lives and to regain trust in life and in themselves. These beneficial effects of practice can foster the motivation to keep on practicing. However, as people continue and go deeper with the mindfulness practices, they might also experience unwanted and difficult feelings and thoughts more intensely. If the person is able to confront their difficulties in a mindful way this might be a benefit for the therapeutic process. However, it can also trigger patterns of avoidance accompanied by the feeling that mindfulness does not work for them because they have been unable to stay with the "good feelings" and the "nice contact with the here-and-now." This is the point where the therapist has to be able to guide the person through this process in a mindful way. This means creating a mindful space of contact in the therapeutic relationship so that the practice of being mindful with the here-and-now in all its facets—the pleasant and the unpleasant—can be beneficial for the patient, through a change in the way they relate to their difficulties. In this way, mindfulness, offered during individual therapy, may enhance patients' resilience to the stress of therapy and to stressful life events occurring during therapy. However, it requires considerable skill on the part of the therapist to offer this balance approach of mindfulness.

**Recommendation** Because current research on mindfulness in individual therapy is too limited to allow strong suggestions, we recommend considering integrating mindfulness practices for disorders/clinical problems that are shown to be responsive to group-based mindfulness interventions. Currently, the evidence base is most robust for recurrent depression and cancer. Moreover, we recommend using mindfulness practices with patients showing heightened levels of rumination or worry and/or those who are looking for a more intensive and vivid contact with the here-and-now, and as a skill to manage stressful events and thoughts.

## Qualification of Therapists

In the following sections, we will address the appropriate clinical qualification of mindfulness instructors as well as the question of how much personal mindfulness experience and current practice a therapist needs to have in order to adequately deliver mindfulness in individual therapy. However, it should be noted that empirical data on adequate qualifications for mindfulness instructors for individual therapy settings are still scarce (Crane et al. 2016). Moreover, the empirical findings on the effect of instruction competence on outcome in MBIs are partly sobering. One preliminary study investigated the association of MBCT teacher competence and its relation to treatment outcome in patients with depression (Huijbers et al. 2017). The study showed in a sample of 241 patients treated with MBCT by 15 teachers that teacher competence had no significant association to treatment outcome or relevant therapeutic change mechanisms. Possible explanations for this null effect suggested by the authors are the standardized delivery of MBCT and the strong emphasis on self-reliance within the MBCT learning process. Having these findings in mind, our recommendations for qualification of therapists can only be tentative.

**Clinical Qualifications** Therapists delivering mindfulness in individual therapy, as in delivering therapy generally, should have adequate clinical knowledge and therapeutic skills (relationship building skills, skills to develop detailed case conceptualization and to adequately deliver therapeutic interventions). Therefore, an accredited training in counseling or psychotherapy is a prerequisite. Moreover, they should have in-depth knowledge of the clinical population they are dealing with. This is because it is essential to integrate mindfulness into a stringent case conceptualization that takes into account the relevant maintaining conditions of the disorder/clinical problem. If this is not done adequately there is a danger that mindfulness practices, rather than being used effectively to target key maintaining mechanisms, may instead intensify dysfunctional processes. For example, in panic disorders, therapists should be alert to the fact that mindfulness is not to be used as a subtle avoidance strategy to down-regulate distressing bodily sensations.

**Recommendation** Therapists integrating mindfulness practices should have adequate clinical qualifications (i.e., accredited training) and in-depth knowledge of the disorder/clinical condition treated. When they want to teach mindfulness practices to patients (and not just want to recommend books/recourse on mindfulness or mindfulness courses by other teachers), they should have attended workshops on the clinical application of mindfulness.

**Personal Mindfulness Practice as Qualification** The study by Grepmeier et al. (Grepmair et al. 2007) we presented above has shown that therapists' mindfulness practice before treatment sessions might have positive effects on outcome. Moreover, several (mostly qualitative) studies that investigated (trainee) therapists participating in structured mindfulness programs (i.e., MBSR or MBCT) have indicated positive effects on therapist variables like empathy and compassion (for a review see Hemanth and Fisher 2015). Nevertheless, to the best of our knowledge, there is no specific data on the relationship between the amount/quality of therapists personal mindfulness practice and treatment outcome. However, experts in the mindfulness field agree that a prerequisite for the skillful teaching of *mindfulness practices* is firsthand and ongoing personal mindfulness experience of the therapist. This allows the therapist to embody "from the inside" the attitudes he or she wants to convey and to more skillfully react to patients' difficulties and challenges during the mindfulness process. Moreover, the deeper a therapist's personal experience of mindfulness, the more likely they are to choose skillfully the type and intensity of the mindfulness practice to offer the patient, drawing on a mixture of clinical experience and mindfulness practice.

If therapists want to integrate formal mindfulness practices into individual therapy, they should have a daily formal personal mindfulness practice for at least 1 year before they want to teach mindfulness to their patients (see Segal et al. 2013, p. 79). Moreover, they should have extensive experience in the specific type of practice they want to teach (e.g., the body scan). This could also enable them to anticipate different challenges in different clients. Attending several MBSR or MBCT 8-week courses as a participant, trainee and co-therapist is an excellent training for delivering mindfulness in individual therapy, this will give the therapist a basic understanding of the ways in which individuals learn mindfulness. Moreover, we recommend ongoing peer supervision with an experienced mindfulness therapist including feedback based on audio- or video-recordings. Ideally, therapists would also regularly participate in residential, teacher-led mindfulness mediation retreats to deepen and expand their experience.

**Recommendation** The recommended mindfulness practice depends on the intended level and intensity of integration. When recommending books/recourses on mindfulness or mindfulness courses led by other teachers, it is beneficial to have some inside experience with mindfulness. When therapists intend to integrate mindfulness practices into their clinical work, they should have an ongoing personal mindfulness practice for at least 1 year before they teach practices to patients, also an understanding of how individuals learn mindfulness and should have ongoing peer supervision,

## Appropriate Case Formulation

Including mindfulness elements and practices into therapy requires a case formulation that clearly identifies the processes assumed to play a major role in the maintenance of a certain psychological problem and a theoretical explanation as well as the presence of empirical data concerning why mindfulness should be an intervention of choice. As an example, relapse in recurrent depression is characterized by cognitive processes that Teasdale (1988) described as "differential activation": negative mood states activate dysfunctional cognitive processes, usually without the patient being aware of this. The result is that negative information processing, activated by negative mood, triggers a number of other dysfunctional processes such as social withdrawal which in turn may lead to full-blown depressive episode. The role of mindfulness (in this conceptualization central to MBCT) is to enable patients to observe these processes from a decentered perspective and respond in a wise way rather than react automatically and thus enable them to "step out" of these vicious circles.

Similar case formulations (although with fewer empirical data to back them) can be found for anxiety disorders such as panic disorder and generalized anxiety disorder: establishing a

mindful stance rather than reacting automatically may help the patient to disidentify with their respective beliefs and thus help them to see their catastrophic thoughts as thoughts rather than reality. Similarly, from a psychodynamic perspective, mindfulness can be included in psychodynamic hypotheses. For example, in their alliance ruptures approach, Safran and Muran (2000) highlight the role of mindfulness in assisting the patients to become aware of and de-automate their unconscious self-defeating patterns in relationships with other people.

**Recommendation** Including a mindfulness rationale and mindfulness exercises requires a case conceptualization backed by research evidence which indicates the usefulness of mindfulness to target central processes that play a role in maintaining the psychological problem. Examples may include activation of dysfunctional modes of mind by low mood ("differential activation", Teasdale 1988) or excessive negative patterns of thought such as worry or rumination.

## Dealing with Experiences During Mindfulness Exercises: the Inquiry Process

Introducing mindfulness (practices) into therapy can be done in a number of different ways: for example, therapists can hand the patient a recording of audiotaped mindfulness exercises and ask them to "listen to it once in a while". Although this may be of some benefit, it may be difficult for many patients to make appropriate connections to their presenting problems. There is some evidence that mindfulness exercises have an effect as stand-alone interventions (Blanck et al. 2018). However, we assume that providing patients with a clear conceptual framework regarding the potential benefits of mindfulness practices is a basic prerequisite for their use.

Additionally, when mindfulness practices are used within therapy following them with an inquiry process that starts with physical experiences ("did you notice anything during this exercise?") and then continues to frame these experiences in the light of the case conceptualization mentioned above is likely to increase their efficacy. To start the process with an extensive inquiry of physical sensations is important because the body is a source of information (e.g., emotion, warning signs of distress/mood change) and *through body-mind loops* body states or posture influences mood state and judgment, even without awareness (Michalak, Burg and Heidenreich Michalak et al. 2012). Bringing awareness to the body might interrupt these processes. Moreover, bringing awareness to the body helps to "get patients out of their heads" into a more direct *experience* of the here-and-now.

An example of inquiry could be a therapist guides a short practice like breathing meditation and asks the patient: "What did you experience in this meditation?". Patient: "It was good, I liked it". Therapist: "Could you tell a bit more about the experience that made you say, it was good?" Patient: "I felt calm and focused". Therapist: "How did you know that you were calm and focused?" Patient: "My body was calm and my mind didn't wander as much as in other meditations". Therapist: "And how did that feel?" Patient: "It felt good. I felt successful and there were thoughts like oh, this is a good meditation today". Therapist: "And how is it for you, when your mind wanders?". Patient: "Then I feel like a failure and I am concerned that I will never be able to meditate". Therapist: "And how does that feel?" Patient: "That feels bad. I don't want to be so restless". Therapist: "And what is happening now?" Patient: "I feel sad to see how unfriendly I am with myself when I am not functioning in the way I expect myself to do. This is a pattern that I know very well".

This could be the point to expand the conversation about this pattern and the themes around it in the context of the case conceptualization.

It should be noted that patients often want to please their therapists by reporting positive experiences after mindfulness exercises. However, mindfulness is a practice of meeting *all* experiences with spacious, friendly awareness. Therefore, as the example above illustrates, therapists should remember to ask about difficulties that may have arisen during a mindfulness exercise, or may be lingering after the exercise, and explore together how to meet those experiences with mindful awareness.

Since in individual therapy the exchange with other group members is not possible, the patients cannot profit from their experience and their discovery of alternative ways relate to themselves and to act. Therefore, therapists may need to connect the patient with experiences of other mindfulness practitioners in more indirect ways. For example, they can, when appropriate, explicitly talk about their own personal mindfulness experience or about other patients´ experience. When the therapist has experienced mindfulness in a group, either as a participant or facilitator, he or she will be able to report examples from group-based learning (e.g., 'if we were in a group now, you would probably hear others say similar things').

However, they should be careful to do so in a disciplined way, so as not to 'overwhelm' patients with the narrative of other people's experiences. Moreover, they can recommend books (e.g., Meibert 2014, Williams et al. 2007) or videos (e.g., "Healing from Within" the documentary of an MBSR course lead by Kabat-Zinn which is available on youtube: https://www.youtube.com/watch?v=D09HI_WFl5U) that contain reports of other patients´ experiences. In addition, there is a web-based MBCT course that contains videos with patients' reports of their experiences and tools to cope with challenges during mindfulness practice (Dimidjian et al. 2014).

**Recommendation** After conducting mindfulness exercises in sessions or as homework, therapists and patients should

engage in an inquiry process that takes into account physical experiences as well as mental events and their potential role in the maintenance of a psychological problem. Moreover, they should use different media to connect patients' experience with mindfulness experiences of other patients/people.

## Types and Optimal Duration of Mindfulness Practices in Individual Therapy Settings

There are different intensities or styles of integrating mindfulness into individual therapy. On the most basic level, therapists might recommend books or internet pages on mindfulness, if they just want the patient to get a first idea of the principle of mindfulness or to motivate them to start mindfulness practice. A responsible way to integrate mindfulness is to refer patients to MBCT or MBSR courses of qualified instructors and to speak about their MBSR/MBCT-experiences in individual treatment sessions and to interweave these experiences with the session content.

If therapists want to teach mindfulness practice in treatment, they face the fact that individual therapy sessions typically last for 50 min. Hence, it is difficult to repeatedly integrate long mindfulness exercises like body scan or sitting meditation together with a detailed inquiry in the regular sessions. This especially applies as individual therapy is based on a case conception to work on individual problems of the patients. Thus, regularly integrating long mindfulness exercises into individual therapy might conflict with the time required to work on individual problems based on the case conception.

Possible solutions for these issues could be as follows: In the first step, it is important to include a detailed plan of time required for mindfulness exercises in the individualized cases conceptualizations and therapy planning to balance time used for mindfulness and traditional therapeutic interventions. Then, mindfulness should be introduced in an experience-based mode by reserving one whole session (or even better: organize a double session) where a long mindfulness exercise (typically the body scan) is introduced and practiced followed by a detailed inquiry. Later in therapy, brief mindfulness exercises, like the breathing space, could be regularly practiced in therapy sessions, e.g., as session-introducing interventions: Coming into a state of present moment awareness at the start of therapy sessions could help to more effectively work on problem-solving strategies during the therapy sessions. Additionally, long mindfulness exercises should be practiced by the patient as homework exercises and experiences during this homework should be regularly reflected in the therapy sessions.

Another question is the type of presentation of mindfulness exercises during the therapy sessions: should audiotape presentations or instructions by therapist be used? We generally think that a direct instruction by the therapist might be more dynamic and flexible, as the therapist could directly adapt the instruction as it is best for the individual patient.

**Recommendation** Therapists could start the introduction of mindfulness with a long exercise together with detailed inquiry. Then, long exercises could be practiced at home and brief mindfulness exercises could be directly integrated into therapy sessions.

**Managing Difficult Experiences** Research suggests that across a range of psychological treatments a small proportion of individuals experience sustained deteriorations in clinical symptoms, or report that they have been harmed. For example, in a study of nearly 15,000 patients receiving psychological treatment in the UK National Health Service (Crawford et al. 2016), around 5% of patients agreed slightly to strongly that they had experienced "lasting bad effects from treatment". There is increasingly recognition that people following mindfulness-based programs may also sometimes experience difficulties. At present there is only very limited data concerning the nature and extent of these difficulties, because such data has not often been routinely collected (Dobkin et al. 2012), and much of the commentary is based on anecdotal reports or studies focusing on individuals practicing meditation in Buddhist contexts (e.g., Britton et al. 2017). Where data has been collected on serious adverse events and reactions in trials of MBCT, these events appeared to be rare with rates not exceeding those in comparison conditions (e.g., Kuyken et al. 2016). However, since mindfulness practice encourages patients to come into direct and sustained contact with experience, including negative experience, temporary discomfort is likely to be quite common. Recognizing and differentiating between temporary discomfort, which is likely to be a typical part of the learning process in MBIs, and more intense or sustained discomfort which may be indicative of harm, is crucial to the safe delivery of MBIs.

The integration of mindfulness into individual therapy may hold some advantages as well as challenges in terms of the management of difficult experiences. For example, individual therapists are likely to have a more detailed knowledge of the clinical history and presenting difficulties of their patient/client than a typical MBI instructor might have, and this is likely to provide the therapist with a more nuanced understanding of potential areas of challenge in the use of mindfulness practice. Individual therapists also have the opportunity to tailor the pattern of mindfulness practice to the needs of the individual patient/client and tailor the inquiry and the contextualizing dialog to the client/patient's specific experiences and concerns, increasing the likelihood that guidance provided will be relevant and supportive. Finally, because the therapeutic relationship is likely to be stronger in individual therapy than a group-based MBI, it is perhaps more likely that patients will acknowledge difficulties so that they can be addressed.

Despite these potential advantages of individual therapy, there are also potential challenges. The first is that, as discussed above, some therapists may lack the in-depth personal experience and training in mindfulness that enables them to understand difficult experiences from the inside and recognize boundaries between typical discomfort and atypical experiences. Second, where therapists are integrating mindfulness in a more ad hoc way, they may simply have observed fewer people going through mindfulness programs and so may accrue less experience of the typical difficulties that arise for people with different presenting problems. Finally, when mindfulness is being integrated with other therapy components, it may be more difficult to identify which elements are contributing to any difficulties experienced.

**Recommendations** As discussed above, therapists using mindfulness practice in individual therapy should be appropriately trained, and should prepare individuals for the potential difficulties of mindfulness practice. Clients should be encouraged to share any difficulties encountered through the inquiry process so that these can be addressed. Therapists with less extensive experience of mindfulness practice should consider accessing specific training in the management of difficult experiences in MBIs.

## Integration of Mindfulness into Individual Therapy Training Routine

Although MBIs are recommended by several clinical guidelines (for an overview see Crane et al. 2010), there are only a limited number of mindfulness teachers who received in-depth training, resulting in difficulties in providing MBIs on a large scale in the health care system (Crane et al. 2012). According to the NIH stage model, it is of importance to develop therapeutic interventions that can be easily transferred into real-world settings (Onken et al. 2014). Hence, the question arises whether MBIs could be directly integrated into the regular workshop training of psychotherapy training centers as a cost-effective solution to this dissemination issue (Shallcross et al. 2015). More specifically, MBIs could be introduced in workshop programs offered to a large group of trainee therapists by one mindfulness expert with several years of experience. This idea of one mindfulness expert teaching several trainee therapists could have strong and economic dissemination effects. Further, it could help trainee therapists to have a basic knowledge about mindfulness and thus could also help prevent misuse of mindfulness (e.g., if a trainee therapists with zero mindfulness training inappropriately applies mindfulness exercises from treatment manuals) (Mander et al. 2017).

However, this method has the risk of being too superficial a training in mindfulness (Crane et al. 2016). We think that mindfulness workshops in routine training (which, because of time restraints, might typically comprise one or two weekends) have more of an educational character and cannot deliver in-depth experience-based mindfulness training. Hence, if trainees intend to use mindfulness in their individual therapies, it would be of importance to additionally participate in in-depth training in centers specialized in (group) mindfulness programs. This would guarantee that the trainees could participate in MBCT or MBSR courses as well as mindfulness retreats and thus would provide the experience of more intense mindfulness practice as proposed by guidelines (Crane et al. 2010). Then, the trainees could use mindfulness in their own treatments while receiving regular supervision.

A specific process to deliver mindfulness individual therapy training could be as follows: (1) Mindfulness training should be delivered by an experienced therapist with long standing mindfulness practice as well as a high level of clinical experience. (2) Mindfulness training should include an understanding of the effects of personal mindfulness practice on the therapeutic process. (3) A cautious use of mindfulness and relevant contraindications of mindfulness interventions (e.g., during acute psychosis) should be intensively elaborated. (4) It is of importance to be as practice-oriented as possible. Specifically, clinical case examples should be presented by the experienced mindfulness teacher. Using these case examples, specific skills in decision making for the integration of mindfulness interventions should be explicitly delivered. (5) The trainees should develop a high level of mindfulness self-experience during their own daily life to be more authentic when using mindfulness in their individual therapies. (6) Regular supervision by an experienced mindfulness teacher is of high importance. (7) Good practice guidelines should explicitly be taught to the trainees to guarantee that mindfulness exercises are used with caution and according to the current scientific standards.

**Recommendation** We think that it is important to offer basic mindfulness workshops in regular training centers to deliver information about mindfulness, its background, and applications and limitations. This could help prevent misuse of mindfulness exercises without appropriate personal experience. Further, we recommend that trainees should participate in MBCT and MBSR courses as well as mindfulness retreats in specialized training centers, if trainees want to apply mindfulness in their individual therapies.

## How Should Research on Mindfulness in Individual Therapy Proceed?

Many therapists integrate mindfulness exercises (like body scan, sitting meditation or breathing space) into their individual therapies (e.g., Michalak et al. 2019). However, there is scarce empirical evidence on the effectiveness of such use of mindfulness in individual therapy settings. Empirical evidence would be helpful

to better understand whether and under what conditions this practice has positive or even negative effects on treatment outcome. The principles we described in this manuscript are more expert recommendations and are not empirically based. Hence, in order to enhance our understanding of how mindfulness should be integrated into individual therapy, we need empirical evidence. Studies investigating mindfulness in individual therapy should focus on two major issues.

First, it is of importance to investigate the intensity of mindfulness training delivered to the therapists and its relationship to therapist and client variables. Research should aim to identify the optimal dose of mindfulness training in terms of effectiveness and cost-effectiveness in delivering desired outcomes. Broadly, the research could address questions such as: Is it important for therapists to have participated in several MBCT / MBSR courses and have daily mindfulness practice or could lower doses of mindfulness self-experience be sufficient? Are therapists who have participated in MBCT/MBSR workshops more skillful and effective in delivering mindfulness in individual therapy than therapists who deliver mindfulness without formal training? Does supervision increase skills and efficacy of therapists?

Additionally, randomized controlled trials that compare mindfulness exercises as add-on component in individual therapy with control groups that do not include such add-ons should be investigated. These studies should focus on disorders where group-based MBIs have shown efficacy (e.g., recurrent depression or cancer) or on patients showing transdiagnostic process most like addressed by mindfulness like rumination or worry.

In these studies, mindfulness could be integrated in individual therapy according to the above-mentioned procedure: Therapists could first introduce mindfulness with longer exercises (like body scan) together with a detailed inquiry. Then, brief exercises like the breathing space could be applied as a session-introduction in every therapy session while patients practice longer exercises (e.g., body scan) regularly at home. Routine treatment without mindfulness exercise could serve as control condition. It could also be of interest to compare mindfulness with active control groups like progressive muscle relaxation to better understand whether mindfulness training per se is the relevant factor accounting for potential improvements.

Research questions could be as follows: Is individual therapy with additional mindfulness practices more effective than routine therapy and/or active control groups in improving specified clinical outcomes? Does mindfulness in individual therapy have beneficial effects on the therapeutic process (e. g. effects on therapeutic alliance)? Are there patient subgroups that specifically benefit from mindfulness in individual therapy? Moreover, these studies could assess therapists' competence in delivering mindfulness interventions and investigate associations with therapeutic process and outcome measures.

To conclude, during the past decades, a growing number of therapists have integrated mindfulness into individual therapy. This trend reflects a genuine interest in mindfulness and the confidence of therapists that mindfulness is a principle with specific therapeutic potential. On the other hand, a mindfulness 'hype' (van Dam et al. 2017) with unreflective und unskillful use of mindfulness interventions might also have the potential to harm patients and to damage the integrity of the mindfulness training itself. Therefore, the present manuscript aims to start a discussion on principles for a responsible integration of mindfulness in individual therapy. Since research on this topic is in its infancy, we are aware that our recommendations are tentative and only one of several possible perspectives on the question what a responsible integration of mindfulness in individual therapy should look like. Moreover, the expansion of mindfulness into different therapeutic fields has the quality of a grassroots movement that is carried forward by the practitioners. Therefore, the principles we propose will certainly need modification and expansion in the future.

**Acknowledgements** C.C. is funded by the Wellcome Trust, GR104908/Z/14/Z and GR107496/Z/15/Z.

**Author Contributions** J. Mi., J. Ma., and T. H. prepared the first draft of the paper; C. C., C. G, E. G., P. M., and Z. S. provided feedback to the manuscript, extensively discussed the topic (in writing as well as in an extensive online meeting) and wrote additional paragraphs in later versions of the manuscript. All co-authors agreed on the final manuscript.

## Compliance with Ethical Standards

**Conflict of Interest** C. C. is research lead at the Oxford Mindfulness Centre, and conducts research on mindfulness-based programs but receives no additional remuneration for training, teaching, or publications related to mindfulness or mindfulness-based program. C.G. is a co-developer of the Mindful Self-Compassion program and he receives royalties from books and stipends from workshops on mindfulness and self-compassion. P. M. and J. Mi. are Directors of the Achtsamkeitsinstitut Ruhr (an institute offering mindfulness training). J. Mi. is Principal Investigator of several DFG (German Science Foundation) research projects. T. H., P. M., and J. Mi. receive royalties from mindfulness books they have authored and receive stipends from workshops on mindfulness. Z. S. is one of the developers of Mindfulness Based Cognitive Therapy and receives royalties from books and stipends from clinical workshops on MBCT. E. G. and J. Ma. declare that they have no conflict of interest.

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