



Mindfulness-Based Cognitive Therapy in individual clinical care for depression*

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Objective: the aim of this multiple case study was to evaluate the applicability of the group protocol of an 8-week Mindfulness-Based Cognitive Therapy program adapted for the individual clinical care of patients with symptoms of depression. **Method:** the method used was to study multiple cases, in which 11 cases of patients with a diagnosis of mild to moderate depression who underwent intervention adapted from this protocol were evaluated in the results of measures of depression, anxiety, stress and mindfulness. **Results:** the results indicated a significant reduction in these symptoms, as well as an increase in mindfulness in everyday life. **Conclusion:** the benefits of the Mindfulness-Based Cognitive Therapy intervention can be presented both in the context of group clinical care, as well as in the individual. In this study, all study participants had significant improvement in the symptoms of depression, as well as in the levels of anxiety and stress, consistent with the data presented in the literature. There is an urgent need for a greater number of studies of this nature. Future research, especially those of an empirical nature, controlled and randomized, will consolidate the external validity of the results found by studies with nature such as this one.

Descriptors: Mindfulness; Meditation; Depression; Anxiety.

* This article refers to the call "Mindfulness and other contemplative practices".

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Terapia cognitiva baseada em mindfulness no atendimento clínico individual de depressão

Objetivo: estudo de casos múltiplos teve objetivo de avaliar a aplicabilidade do protocolo de grupo de um programa de 8 semanas de Terapia Cognitiva Baseada em Mindfulness adaptado para o atendimento clínico individual de pacientes com sintomas de depressão. Método: para o estudo de casos múltiplos, no qual 11 casos de pacientes com diagnóstico de depressão leve à moderada submetidos à intervenção adaptada desse protocolo foram avaliados nos resultados de medidas de depressão, ansiedade, estresse e mindfulness. Resultados: indicaram redução significativa destes sintomas, bem como aumento de mindfulness na vida cotidiana. Conclusão: os benefícios da intervenção de Terapia Cognitiva Baseada em Mindfulness podem se apresentar tanto no contexto de atendimento clínico grupal, bem como no individual. Neste estudo, Todos os participantes do estudo tiveram melhora significativa dos sintomas de depressão, bem como dos níveis de ansiedade e estresse, condizente com a os dados apresentados na literatura. É premente a necessidade de maior número de estudos desta natureza. Pesquisas futuras, especialmente as de natureza empírica, controlados e randomizados, consolidarão a validade externa dos resultados encontrados por estudos com a natureza como o deste.

Descritores: Atenção Plena; Meditação; Depressão; Ansiedade.

Terapia cognitiva basada en la atención plena en la atención clínica individual para la depresión

Objetivo: el objetivo de este estudio de caso múltiple fue evaluar la aplicabilidad del protocolo grupal de un programa de terapia cognitiva basada en la atención plena de 8 semanas adaptado para la atención clínica individual de pacientes con síntomas de depresión. Método: el método utilizado fue estudiar múltiples casos, en el que 11 casos de pacientes con un diagnóstico de depresión leve a moderada que se sometieron a una intervención adaptada de este protocolo fueron evaluados en los resultados de las medidas de depresión, ansiedad, estrés y atención plena. Resultados: los beneficios de la intervención de Terapia Cognitiva Basada en Mindfulness se pueden presentar tanto en el contexto de la atención clínica grupal, como en el individual. En este estudio, todos los participantes del estudio tuvieron una mejoría significativa en los síntomas de la depresión, así como en los niveles de ansiedad y estrés, consistente con los datos presentados en la literatura. Existe una necesidad urgente de un mayor número de estudios de esta naturaleza. Las investigaciones futuras, especialmente las de carácter empírico, controladas y aleatorizadas, consolidarán la validez externa de los resultados encontrados por estudios de naturaleza como este.

Descriptorios: Atención Plena; Meditación; Depresión; Ansiedad.

Introduction

Nowadays, depression is one of the biggest public health problems and risk of premature death⁽¹⁾, with an increase of 18.4% in the period between 2005 and 2015 worldwide, raising it to the level of an alarming condition, with a 4.4% prevalence in the world. In percentage terms, Brazil has the highest index in Latin America and the fifth largest in the world, with a prevalence of 5.8%.

One of the biggest challenges of depression is its recurrence in more than one episode. Several guidelines, for example, from the American Psychiatric Association (APA), the Canadian Network for Mood and Anxiety Treatments (CANMAT), the Cochrane and The National Institute for Health and Care Excellence (NICE), rely on research data from specific interventions for the first episode and for recurrent depression, the treatment being, in the latter case, maintenance. One of these currently widely used and researched interventions is Mindfulness-Based Cognitive Therapy (MBCT), developed in 2002 for recurrent depression⁽²⁾. It is based on the integration of the Cognitive-Behavioral Therapy (CBT) for depression⁽³⁾ with the Mindfulness-Based Stress Reduction (MBSR) Program developed by Kabat-Zinn and colleagues⁽⁴⁾. In this integration, many elements were maintained, but others were changed and added. In the MBCT there is an emphasis on changing consciousness in relation to self and states of thought, emotion, sensations and impulses, but no emphasis on altering the content of thoughts⁽⁵⁾.

A fundamental MBCT assumption is that cultivating a relationship with oneself decentralized from self-deprecating mental states, functioning as prevention in times of potential relapse. In this sense, the main means of developing this decentralization is by teaching people to become more aware of mental states and to relate to them in a broader perspective, recognizing them as mental events only and not identifying with them or recognizing them as necessarily real⁽²⁻⁵⁾. The MBCT includes a variety of mindfulness practices that aim to observe and accept bodily sensations, perceptions, cognitions and emotions without judgment or reaction. These states are seen as the very nature of the mind.

The use of Mindfulness is associated with a 44% reduction in the risk of relapse in patients with a history of three or more relapses of depressive symptoms⁽⁶⁾. The MBCT can be used to reduce residual symptoms of depression regardless of the amount of depressive episodes in the patient, with effects comparable to staying on a maintenance dose of antidepressants⁽⁷⁾. For people looking for a psychosocial approach to staying healthy, Mindfulness appears as an accessible, acceptable and low-cost alternative. Based on this evidence, the National Institute for Health and Clinical Excellence⁽⁸⁾ began to recommend Mindfulness to people

who are currently fine, but have had three or more depression episodes.

A number of studies⁽²⁾ on the results from using Mindfulness in patients with a history of depression point out that the most important finding of their research was that, in the participants with three or more previous episodes of depression (which constituted more than 75% of the studied patients), the MBCT decreased by practically 50% the relapse/recurrence rates during the follow-up period compared to subjects who received usual treatments. As the patients were treated in groups, in terms of cost-effectiveness, this benefit is much greater when compared to patients treated individually, in the conventional individual cognitive therapy format for depression. Indeed, the MBCT was able to assist up to 12 patients almost in the same time as is necessary to treat a single patient in a single conventional session of cognitive therapy for depression.

MBCT programs have undergone meta-analysis studies⁽⁹⁻¹¹⁾ with an effect size comparable to interventions known to be recommended due to the level of evidence of effectiveness for this population, for example, CBT⁽¹²⁾. They have shown significant results in preventing relapses in depression, as well as reducing depressive symptoms in non-clinical populations⁽¹³⁾.

Group protocol studies already used in the individual context⁽¹⁴⁾ conducted a first randomized controlled clinical trial with diabetic patients (types 1 and 2) with depressive symptoms (N=12), obtaining results of significant intervention effectiveness for these symptoms, in addition to improvement in states of anxiety, well-being, mindfulness and self-compassion. The study adapted the classic 8-week MBCT protocol⁽²⁾ for an individual program for people with depression and diabetes. According to the authors, in this adaptation the structure, basic contents and homework of the original group program were maintained. In the following year, the same group of authors carried out another controlled and randomized study⁽¹⁵⁾, comparing the effects of individual CBT and MBCT interventions with a waiting list in a large sample of patients with the same profile (N=91). The results showed the quality and effectiveness of both interventions in the reduction of depressive symptoms. Then, the authors⁽¹⁴⁻¹⁶⁾ carried out a new controlled and randomized study from the previous study, with the objective of evaluating long-term effects of a sample extracted from the same previous sample, in this case, of patients who maintained depressive symptoms. The results in the reduction of depressive symptoms showed effectiveness of the intervention in the long term (9 months).

Most people with depression prefer psychological treatment to medication⁽¹⁷⁾. In addition, some prefer individual interventions over group interventions⁽¹⁸⁻¹⁹⁾.

However, the literature on the MBCT for the individual context is very scarce. It is probable that there are advantages and disadvantages in both approaches. It seems that sharing experiences and encouragement are the main advantages in groups, while privacy and personalization in the individual approach. In addition, there may be cases in which, for the profile of each person, one or the other alternative is indicated, so that if the person submits to one less indicated, they may suffer less or even have no expected beneficial effect. However, these conditions have not been widely verified, which makes studies like this pertinent.

The present study aims to study the applicability of the group protocol of an 8-week program of Mindfulness-Based Cognitive Therapy, adapted from the original model developed for groups⁽²⁾ for the individual clinical care of patients with depression symptoms. The initial hypothesis is that such an intervention can promote the reduction of symptoms of depression, anxiety and stress, as well as an increase in mindfulness in everyday life. In addition, it is expected that the group protocol can be adapted to the context of individual clinical care.

Method

Regarding the research design, this is a multiple case study. Unlike a single case study, it is more concerned with establishing the similarities between situations, establishing a basis for generalization, which often justifies generalization from one case to another, much more than for a population of cases⁽²⁰⁻²¹⁾. The study was carried out in a private practice office of one of the authors, in the city of Foz do Iguaçu.

The sample in this study was for convenience and consisted of 11 patients who sought psychotherapeutic care at the clinic of the first author during 2018 and met the inclusion and exclusion criteria of the study. The mean patient flow at this clinic is 57 per year.

The inclusion criteria for the participants in this study were the following: (a) Age over 18 years old; (b) availability to participate in at least 10 therapy sessions at the specified time and place; (c) depression symptoms greater than normal and this requires, at least, a score of 78 percentile on the DASS-21 instrument. The following exclusion criteria were adopted: (a) severe or extremely severe depression symptoms, that is, a score greater than the percentile over the 95 percentile on the DASS-21 instrument; (b) previous routine meditation practice.

According to specialists in qualitative analysis⁽²²⁾, essential care must be taken in the criterion for choosing the cases, which is to avoid narrowing the universe for choice, when cases that are on the frontier of the phenomenon to be analyzed are not analyzed. For the authors, the borderline cases can show aspects that were

not initially considered, thus offering data to compare discrepancies that force the researcher to clarify the concepts and confirm the limits established for choosing the sample. Thus, following the criteria of the population benefited by the program, the patients were at least in the third depression episode and out of crisis.

The selection was performed by means of a clinical interview based on DSM-5⁽²³⁾ and the use of the DASS-21 instrument, and by the psychotherapist himself who conducted psychotherapy adapted from the intervention of the 8-week MBCT⁽²⁾. The other research authors participated in the subsequent stages.

The participants who completed the intervention and evaluation of this study are 6 females and 5 males, with ages ranging from 19 to 57 years old, all Brazilian and with completed or ongoing higher education level, with no previous experience in meditation. One participant left the group due to time unavailability, as he changed his working hours.

Both for the inclusion and exclusion of participants in this study and for the assessment of improvement in symptoms of depression, anxiety and stress, the Depression Anxiety and Stress Scale - DASS-21 was used, an instrument consisting of a set of three subscales, each one containing 7 *Likert* type 4-point self-responding items. Each subscale is designed to assess emotional states of depression, anxiety and stress. The respondents must indicate how much each item applied to them during the last week. The items on the *Likert* scale refer to severity or frequency and are organized on a scale from 0 to 3 points, the result being obtained by the sum of the answers to the items that make up each of the three subscales. It was adapted to the Brazilian context in 2014⁽²⁴⁾, which verified a good internal consistency: Cronbach's alpha values were 0.90 for depression, 0.86 for anxiety, 0.88 for stress and 0.95 for the total of the three subscales, respectively.

The Mindful Attention Awareness Scale - MAAS, which consists of 15 items, was also used in this study, with the objective of assessing attention to the awareness of the present moment and the attention aspect of mindfulness. The authors conceptualize mindfulness as an attribute of consciousness related to well-being, composed of two factors, consciousness and attention, although they unifactorially operationalize the construct: mindfulness attention. The respondents must indicate how much they have experienced what is described in each statement, using a six-point scale, which ranges from one (almost always) to six (almost never). High scores reflect greater mindfulness capacity. The scale was developed by Brown and Ryan in 2003 and validated by Barros et al.⁽²⁵⁾, who found an internal consistency of Cronbach's alpha = 0.83.

As for the procedures, in the first session, the protocol for patients is proposed and the assessment and FICF instruments are filled out, as well as the MBCT psychoeducation, with an emphasis on mental ways for doing and being. In this session, the importance of daily practices at home is clarified, without which the effectiveness of the intervention is compromised. During a minimum of 8 sessions and, in the case of 11 participants, a maximum of 18 sessions, the 8 sessions adapted from the protocol of the therapist manual *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse*, 2nd ed.⁽²⁾ and in the patient manual *The Mindful Way Workbook An 8-Week Program to Free Yourself from Depression and Emotional Distress* (ibid., 2014) were conducted. The adaptation referred to the number of practices performed in session or the type and quantity of elements of psychoeducation in each session, depending on the patient's need. After the last adapted session of the protocol, the post-intervention evaluation was carried out.

The intervention consists of adapting the original group program to the individual context and presented some distinctions, which refer mainly to the needs and personal characteristics of each patient and to the duration of the session. The sessions lasted 1 hour, while in the group program they last 2 hours. In this way, the adaptation was made by reducing the duration of the practices in session, but maintaining the number of practices and inquiry. In addition, the personal characteristics and needs led to a variation in the distribution of the time for each activity in session. Another aspect that differentiated the individual sessions of this study referred to psychoeducation, which contemplated different aspects of the theme of depression, anxiety and stress, depending on the presence of other clinical aspects such as comorbidities or other health problems, severity of the symptoms, characteristics and personal needs, socio-cultural level, personal interests and lifestyle. It is worth mentioning that the home practices remained faithful to what was proposed in the original group program.

As for the basic contents, structure of the sessions and homework, the adaptation kept the same ones proposed by the original program for groups. They are presented below, session by session.

In the first session of the protocol, whose theme is "Beyond the Autopilot", the "raisin practice", "body scan" and, immediately after, the inquiry, an approach technique of the MBCT instructor, performed immediately after the practices, aiming to stimulate the patient's awareness about their present experiences. The protocol proposes the practice of three exercises during the first week: "body scan", bringing awareness to routine activities and "conscious eating".

In the second session of the protocol, with the theme of "Another Way of Knowledge", the "breathing practice in a seated position" and the inquiry are conducted in session. As activities of the week, the protocol proposes "body scan" and "brief breathing exercise", bringing awareness to routine activities and the calendar of pleasant experiences. Among other issues, it addresses the power of thoughts and feelings, the notion that thoughts are not facts: they are mental events and how mood affects the interpretation of the facts and that interpretation affects mood. The protocol suggests the following regarding home practice: "body scan", bringing awareness to routine activities and an agenda of pleasant experiences.

In the third session of the protocol, with the theme of "Returning to the Present – Reuniting the Scattered Mind", the practices of "stretching" and "3-minute breathing space" are proposed, followed by the inquiry. The protocol suggests, while at home, four activities for the week: combined practice of stretching and breathing interspersed with the practice of conscious movement, a 3-minute breathing space and agenda of unpleasant experiences, with the aim of helping the individual to calm and reorganize the restless and dispersed mind.

In the fourth session of the protocol, with the theme of "Recognizing Aversion", the "breathing in a seated position", "additional 3-minute breathing space" and "conscious walking" practices are performed in the session, followed by the inquiry. One of the main topics covered is learning to see negative feelings with less aversion, by understanding that bad feelings and the changes felt are symptoms of depression, and not a sign of personal failure or inadequacy. The protocol submits the following practices for the week: "sitting breathing", "3-minute breathing space", "additional 3-minute breathing space" and "conscious walking".

In the fifth session of the protocol, with the theme of "Let Things Be As They Are", the "breathing in a sitting position: working through difficulties" and "responsive 3-minute breathing space" practices are performed, followed by the inquiry. The main assumption is that, when changing the attitude towards the experience of "not wanting" to "being open", there is a break in the automatic reactions. For the week, the protocol proposes the "breathing in a sitting position: working with difficulties", "regular 3-minute breathing space", and "responsive 3-minute breathing space" practices with additional instructions.

In the sixth session of the protocol, with the theme of "See Thoughts as Thoughts", the focus is the idea that thoughts are not facts. In the session, the exercise of the "Three ways to practice the perception of practicing thoughts as mental events" is performed. The protocol proposes practically the same activities as in the

previous week, complemented with "Setting up an Early Warning System".

In the seventh session of the protocol, with the theme of "Kindness in Action", a practice of "3-minute breathing space" is carried out, followed by the inquiry. The protocol works with the same three activities as in the sixth week, adding an Action Plan. One of the topics of the week is the relationship between actions and feelings, and that it is possible to change what is felt by changing the actions. As requested during the session, the patient builds an action plan for the moments when they realize they are losing control. First, they describe the signs that precede the disorder: pessimistic thoughts, insecurity, and irritation and then includes mindfulness practices and pleasurable activities.

The eighth session of the protocol, with the theme of "What now?", works on identifying the benefits perceived during the process and how to continue it after the end of the meetings.

Results

Table 1 shows the sociodemographic data of the participants.

Table 1 - Sociodemographic data of the participants, Foz do Iguaçu, PR, Brazil, 2018

	Total	Complete	Withdrawal
N	12	11	1
Mean age (years old)	36.09	31	25
Standard Deviation (SD)	(11.81)	(12.10)	-
Gender			
Female	6	5	1
Male	6	6	0
Schooling			
Incomplete Higher Education	8	7	1
Complete Higher Education	3	3	-
Smokes	2	2	-
Baby	6	5	1
Using medication	5	3	2
Using psychiatric medication	4	3	1
Psychiatric monitoring	2	2	-
Undergoes psychological treatment	1	1	-
Performs physical activity	4	3	1

The comparison between the results of the measures before and after the intervention and the percentage of dedication to the practices in session and at home are presented in Table 2. This last comparison item was established considering the number of studies that demonstrate that the benefits of any mindfulness-based program are directly proportional to the participant's dedication to daily practices outside the session.

Table 2 - Pre-/Post-evaluations of the research participants, Foz do Iguaçu, PR, Brazil, 2018

	Pre-intervention		Post-intervention		Anova* Pre/Post	
	M [†]	SD [‡]	M [†]	SD [‡]	F [§]	p
DASS-21[¶]						
Depression	86.75	0.92	62.67	14.64	29.72	0.0003
Anxiety	83.25	8.82	68.58	9.68	18.71	0.0015
Stress	82.17	7.81	36.17	14.90	199.15	6.27
MAAS^{**}	1.83	0.63	4.00	0.81	58.78	0.000017
Practices			78.17	16.79		

*ANOVA (Double factor without repetition); [†]M = Arithmetic Mean; [‡]SD = Standard Deviation; [§]F = Calculated F; ^{||}p-value; [¶]DASS-21 = Depression, Anxiety and Stress Scale; ^{**}MAAS = Mindful Attention Awareness Scale

The results demonstrate that the 11 participants showed a significant reduction in the depression symptoms, as well as in the levels of anxiety and stress, consistent with the data presented in the literature^(6,14,25,27). This fact can be observed in the data of the depression subscale pre- and post-intervention: $F(4.96) = 29.72$ and $p = 0.0003$; in the data of the anxiety subscale pre- and post-intervention: $F(4.96) = 18.70$ and $p = 0.0015$; and in the data of the stress subscale pre- and post-intervention: $F(4.96) = 29.72$ and $p = 0.0003$ in Table 2.

The rates of greatest remission for symptoms of depression, anxiety and stress are among participants 1, 2, 3, 4 and 11. These were also the patients who performed the most practices outside the session. Scholars⁽¹⁴⁾ stress out that, in adapting the original⁽²⁾ 8-week protocol, it will probably be necessary to maintain the emphasis on carrying out the home tasks and meditative practices. A number of studies indicate that practices at home are more important than the program format itself, for example, if performed in 4 or 8 weeks⁽²⁸⁾.

Discussion

Regarding the results of the MAAS Scale, in the pre-intervention evaluation, all the participants presented scores between 1 and 3, which indicates a low level of attention at the present time, also indicating possible frequent distractions, involvement with concerns about the future, and ruminations about the past. In the post-intervention evaluation, most of the participants increased their attention to level 4 or 5 of the scale. There was a significant effect on the mindfulness state between the pre- and post-intervention, expressed in the data of $F(4.96) = 58.78$ and $p = 0.000017$ in Table 2. The group of researchers of the MBCT in individual format^(6,13,14-16-26,29-30) found in their studies data similar to the increase in attention at the present time. From level 4 of the scale, the respondents have good attention

at the moment, in which most of the activities they perform receive a good degree of their concentration and reflect on affective, social and professional life. At level 5 of the scale, attention to simple and complex activities is very high and the relationship with mental events such as frequent distractions, involvement with concerns about the future, and ruminations about the past are much less frequent, which promotes a state of well-being most of the time. It is worth mentioning again that the participants who stayed below 4 points on the MAAS Scale (participants 9 and 10) were also the ones who least dedicated themselves to practices outside the session.

A data related to the dedication to the practices of the participants which is also important is that those who were more dedicated obtained better levels of improvement of the symptoms of depression, anxiety and stress, as well as attention to the present time, requiring fewer sessions to advance in the program. This reinforces the already pointed out fact that home practices represent, if not the largest responsible, one of the main sources of the benefits of the program⁽²⁸⁾. They are participants 1, 2, 3, 4, 5 and 11. Participant 10 also required fewer sessions, but it is worth mentioning that this participant had limited time for the program, since he was scheduled to travel abroad, which made him dedicate himself to the sessions more hard, even if not to the home practices. This participant works traveling and this was not a factor that could influence positively or negatively, since this type of trip was part of his daily life.

As for comorbidities, it is worth mentioning that participants 1, 2, 3 and 7 met obsessive-compulsive personality disorder criteria and were also submitted to specific evaluations for this disorder, showing significant improvement in the symptoms. In their turn, participants 4, 5 and 10 met generalized anxiety disorder criteria and were also submitted to specific evaluations for this disorder, with participants 4 and 10 presenting a significant improvement of the symptoms and participant 5 with complete remission of the symptoms; while participant 11 met nervous anorexia criteria and was also submitted to specific evaluations for this disorder, showing complete remission of the symptoms. The group of researchers of the MBCT in individual format^(6,13-16,26,30) also mention comorbidities in the studied samples, which deserve further deepening in new research studies.

Taken together, the results suggest that the Mindfulness-Based Cognitive Therapy can be used in the treatment of patients with recurrent episodes of depression, but also for anxiety and stress, corresponding to what is pointed out in the literature^(2,6,13,27). The adaptation of the group protocol

to the context of individual clinical care proved feasible, considering different factors. First, due to the reduction of symptoms, observed in the results of the interventions in the cases of this study, similar to that presented in the literature for the classic group protocol^(2,5,9-10,13). Second, due to increased adherence to the treatment since, in an individual context, the dispersion of contact with the instructor decreases and the bond increases. The patients may feel cared for with greater attention, being treated in a personalized way, conferring with what the literature proposes⁽¹⁸⁻¹⁹⁾. Third, due to the personalization of the intervention, considering the particular aspects of each patient. This advantage is also pointed out in the literature⁽¹⁸⁻¹⁹⁾.

A study of this type has some limitations. First, in terms of external validity, since it included separate experiments and with a sample of only eleven cases, which hinders generalizations. In addition, the participants were selected non-randomly, which also weakens external validity. The external validity of studies with this design can be reinforced with their replication several times, strengthening possibilities of generalizations.

Conclusion

A growing number of therapists have been using Mindfulness-Based Cognitive Therapy adapting the group protocol to the clinical context of the individuals. This study suggests that it is possible to maintain the efficacy potential of this intervention present in the scientific evidence, but it requires adaptations. In addition, it reinforces the literature supporting the effectiveness of the Mindfulness-Based Cognitive Therapy for depression, anxiety and stress.

All the study participants presented a significant improvement in the depression symptoms, as well as in the anxiety and stress levels, a finding which is consistent with the data presented in the literature.

An important fact is that 6 of the 11 participants who had higher rates of remission of symptoms of depression, anxiety and stress were also the patients who performed the most practices outside the session. The literature points out the essential character of home practices.

Studies on the MBCT applied to the individual clinical context are scarce in the literature. Only 04 studies on the theme were found in the search for the writing of the present study; however, there are no review studies that evidence the expressiveness of these studies in the scientific literature. Thus, there is a pressing need for a greater number of studies of this nature.

Future research studies, especially those of an empirical nature, controlled and randomized, will consolidate the external validity of the results found by

studies with a nature similar to that of this research. The increase in this type of studies will allow for statistical analyses that build evidence of the effectiveness of the intervention, allowing them to be applied and stimulated in terms of its use in the individual clinical context.

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Author's Contribution

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