Developing Competence with Mindfulness-Based Interventions: Guidelines for Clinical Social Workers

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Abstract

Mindfulness practices are now a common part of several contemporary clinical social work interventions for a multitude of issues and populations. While the use of mindfulness in clinical practice has proliferated, there continues to be concerns about training standards and ensuring competency when utilizing mindfulness skills. This article reviews emerging guidelines for developing competency with mindfulness practices in clinical social work. It examines adherence scales developed to promote training and treatment fidelity and recommendations for clinical supervision. Finally, it explores criticisms regarding the use of mindfulness in therapy.

Keywords: Mindfulness; competency; clinical supervision; clinical social work practice

1. Introduction

Mindfulness-based interventions are now a common and established aspect of clinical social work practice. Mindfulness skills are an integral component of several contemporary psychotherapeutic systems and treatment interventions, especially ones described as third-wave or contextual cognitive-behavior therapy (CBT). These include Mindfulness-Based Stress Reduction (MBSR), Mindfulness-Based Cognitive Therapy (MBCT) and its derivatives, Dialectical Behavior Therapy (DBT), Acceptance and Commitment Therapy (ACT), and Compassion-Focused Therapy (CFT) (Holt & Cottone, 2014; Sears, Tirch & Denton, 2011). Mindfulness has been widely utilized for a multitude of physical and psychological conditions across a variety of settings and populations. These interventions have proven to be a generally effective for treating and addressing numerous issues (Dimidjian et al., 2016; Gotink et al., 2015; Keng, Smoski, & Robins, 2011).

Social work education is also increasingly addressing and including mindfulness practices (Gockel & Deng, 2016; Lynn, 2010). Socials work educators are using mindfulness practices, especially in direct practice and field education courses, both as a form of self-care for students (Gockel, Burton, James & Bryer, 2013; Lee & Himmelheber, 2016) and to enhance direct practice skills of attending, therapeutic presence and fostering an accepting and non-judgmental stance towards clients (Gockel, 2015; Thomas, 2017). Recent studies have shown that mindfulness practices can help social work students and interns to reduce compassion fatigue and improve their perspective and outlook on their life despite experiencing the stress associated with completing rigorous and demanding coursework and field education expectations (Bonifas & Napoli, 2014; Decker, Brown, Ong, & Stiney-Ziskind, 2015).With the increased presence of mindfulness in social work education and practice, it is important to identify training and competency guidelines for the effective use of these practices.

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2. Guidelines for Developing Competence with Mindfulness-Based Interventions

Several authors (Bradsma, 2017; McCown, Reibel & Micozzi, 2010; Piet, Fjorback & Santorelli, 2016; Sears, 2015; Wolf & Serpa, 2015) have begun to address the issue of developing competency with mindfulness-based interventions. This article does not provide an exhaustive review of this issue, but rather seeks to provide clinical social work practitioners and educators with an overview of six emerging general guidelines related to developing competence with mindfulness-based interventions, summarized in Table 1.

Table 1: General Guidelines of Developing Competency with Mindfulness-Based Interventions

1. Baseline general clinical competency
2. Functional understanding of mindfulness
3. Training in the delivery of mindfulness skills
4. On-going supervision and education related to mindfulness
5. Sensitivity to diversity issues and client preference
6. The clinician maintaining their own personal mindfulness practice

2.1 Baseline general clinical competency

The foundation for competence with mindfulness-based interventions relies upon general clinical competence. Clinical social workers need to have baseline competency in and experience with general clinical skills prior to pursuing more specific and advanced training in mindfulness (Crane et al., 2012). They also need education and training in specific intervention strategies for particular conditions and with using various therapeutic modalities (individual, group, etc.), as well as a strong foundation in the theoretical orientation from which they are working (Sears, 2015).

2.2 Functional understanding of mindfulness

Clinicians utilizing mindfulness-based interventions need to have a strong working understanding of mindfulness. They need to be able to generally define and describe mindfulness; including explaining what mindfulness is, providing a rationale for its benefits, and how mindfulness applies to the client's experiences and circumstances (Piet, Fjorback & Santorelli, 2016; Sears 2015). Clinicians also need to be able to educate clients on the planned treatment approach, the role mindfulness will play in their therapy, and how mindfulness skills specifically apply to their condition. This includes being familiar with and informing clients about the evidence base for mindfulness and mindfulness-based interventions, especially their use with the condition for which the client is being treated (Crane et al., 2012; Wolf & Serpa, 2015).

2.3 Training in the delivery of mindfulness skills

It is important for therapists to know how to successfully introduce, lead and teach mindfulness practices. This is true for both teaching particular mindfulness skills and practices and for delivering multiple skills across a multi-week program, such as MBSR or MBCT, which requires familiarity with the structure and curriculum of the given program (Piet, Fjorback & Santorelli, 2016; Sears 2015). There are a variety of scripts and recordings to help support effective delivery, but ultimately the therapist needs to develop their own working understanding of how to deliver these skills to clients and their own voice in leading practices (Evans et al, 2015; Sears, 2015).

An additional recommendation for training in the delivery of mindfulness skills is for clinicians themselves to participate in one of the before mentioned multi-week curricula. The suggestion is for the clinician ideally to go through the program on three separate occasions-once as a participant, once as a trainee observing the facilitator, and finally a third time as a co-facilitator (Sears, 2015). Part of teaching mindfulness practices also includes a particular style of reflecting on experiences while practicing. At the conclusion of practice sessions therapists often ask clients what they experienced during practice, but these experiences are not then deeply explored or processed as they might be typically during therapy. Instead, the therapist encourages being open to present-moment experiences and gently noticing them without contention and judgment (Piet, Fjorback & Santorelli, 2016; Sears 2015).

2.4 On-going supervision and education related to mindfulness

On-going supervision and continuing education is essential for the successful application of mindfulness practices in therapy. This supervision needs to focus on both the therapist's personal practice with these skills and with how they are utilizing them in therapy with clients for particular conditions.

When developing their foundational mindfulness practices, therapists might receive training from non-clinicians with expertise in mindfulness skills and practices, such as community meditation instructors or yoga teachers (Evans et al, 2015; Sears, 2015). Continuing education can take the form of reviewing literature on the topic (journal articles, instructional guidebooks, etc.), attending shorter workshops or receiving training from mindfulness-specific programs or institutes (Piet, Fjorback & Santorelli, 2016).

Ideally, a clinical social worker utilizing mindfulness-based interventions would then also meet with a clinical supervisor who is personally and professionally familiar with mindfulness practices and trained in the therapeutic application of mindfulness. This allows clinical social work supervisees to process their own personal experiences with the practices while also receiving feedback on the utilization of the practices in therapy. Clinical supervisors could then also model mindfulness for supervisees and integrate mindfulness practice into supervision sessions (Evans et al, 2015; Sears, 2015). Some common strategies for reviewing and assessing a supervisee's application of mindfulness with clients include supervisee self-reflection and assessment, direct observation or reviewing recordings of the supervisee leading practices (Crane et al., 2012).

2.5 Sensitivity to diversity issues and client preference

While research on mindfulness over the past several decades provides a strong scientific rationale for the use and effectiveness of these practices regardless of their socio-historical origins, it is important to acknowledge that mindfulness and related practices come from the Buddhist tradition. While there is no need to identify as a Buddhist in order to engage in or benefit from the practices, certain clients might believe mindfulness practices are incompatible with their own faith commitments and might see them as conflicting with their identified religious tradition. Other clients generally opposed to spiritual and religious practices may also hesitate to engage in a practice such as mindfulness (Sears, 2015).

In such circumstances, it is important for the clinical social worker to be sensitive to diversity issues and client preferences and respect their right to choose their own values while not imposing the values of the social worker on the client (NASW, 2017). As DBT therapist and trainer Lane Pederson (2015) states:"If (the planned intervention) cannot be brought into accord with the client's preferences, the second option is finding a preferable treatment for the client. A client who does not subscribe to (the planned intervention) and its methods will have a chance at succeeding with therapy…fitting therapies to clients, and not the other way around, is the best practice (p. 48)".It is best for the clinical social worker in these instances to pursue other courses of treatment for the client (Evans et al, 2015; Sears, 2015).

2.6 The clinician maintaining their own personal mindfulness practice

The most vital attribute for developing competence with mindfulness-based interventions is for the clinical social worker to establish and maintain their own consistent personal mindfulness practice. This includes an on-going commitment to study and deepening one's practice through periods of extended retreats (Piet, Fjorback & Santorelli, 2016). Unlike other therapeutic interventions, clinical social workers need consistently to use mindfulness skills in their own lives, just as they ask clients to do. Maintaining a personal practice allows the clinical social worker to speak from the wisdom of their own direct experience and to serve as a behavioral role model for the practices. It also helps the clinical social worker to appreciate common struggles inherent in the practices and to better address questions and challenges that clients will experience while trying to practice (Evans et al, 2015; Sears, 2015; Wolf & Serpa, 2015).

3. Adherence Scales

There are now several adherence scales to support training and treatment fidelity with mindfulness-based interventions. Such scales assist clinical social workers with strengthening their competency in delivering mindfulness skills while also providing them with feedback on their use of the skills for clinical supervision. Receiving training in the delivery of mindfulness skills and on-going supervision helps to ensure that clinical social workers are meeting their ethical responsibility to practice within the scope of their competency (NASW, 2017).

Most of these scales focus on MBCT and adaptations of this curriculum, such as mindfulness-based relapse prevention (MBRP) for addiction (Bowen, Chawla, & Marlatt, 2011), that introduce a variety of mindfulness practices over the course of several weeks. In most instances, evaluators either directly observe or view video recordings of clinicians delivering these programs and rate their performance.

The Mindfulness-Based Cognitive Therapy Adherence Scale (MBCT-AS) (Segal, Teasdale, Williams, & Gemar, 2002) allows evaluators to score a clinician's performance implementing MBCT on nine core mindfulness competencies and eight general clinical competencies. The Mindfulness-Based Relapse Prevention Adherence and Competence Scale (MBRP-AC) (Chawla et al., 2010) allows evaluators to rate a clinician's adherence to and competence with delivering MBRP. The MBCT-AS and MBRP-AC both demonstrate good internal consistency, inter-rater reliability and validity (Chawla et al., 2010; Segal, Teasdale, Williams, & Gemar, 2002). The Bangor, Exeter, & Oxford Mindfulness-Based Interventions Teaching Assessment Criteria (MBI-TAC) (Crane, Soulsby, Kuyken, Williams, & Eames, 2012) is another instrument designed more broadly to encompass general core qualities associated with a variety of mindfulness-based interventions, including MBSR and MBCT. The MBI-TAC also has good reported internal consistency, inter-rater reliability, and validity (Crane et al, 2013).

4. Limitations

While mindfulness has gained acceptance and popularity in both the broader culture and within scientific and healthcare communities, there have also been significant criticisms raised about mindfulness and concerns expressed over the consequences of its rapid dissemination. These include issues surrounding turning mindfulness into a technique removed from its original Buddhist context and whether this dilutes the practice, as well as concerns that some researchers and practitioners are misrepresenting, exaggerating and over stating the benefits of mindfulness (Rosenbaum & Magid, 2016). Given the vast number of workbooks, audio recordings of practices, and brief workshops on the topic, there is also concern that therapists will too quickly seek to implement mindfulness practices without truly having knowledge of the skills or competency in their delivery, thus reducing the clinical effectiveness of these techniques (Piet, Fjorback & Santorelli, 2016).

Researchers have raised notable concerns abouta lack of consensus over operationally defining mindfulness. This has led to multiple differing definitions of mindfulness and the assertion that what different therapeutic approaches incorporating mindfulness into their interventions refer to as mindfulness in actuality might not be the same (Hartelius, 2015; Van Dam et al., 2017). They also highlight frequent methodological issues with mindfulness research and believe there has been too little attention given to potential risks of mindfulness practices and contraindications for using mindfulness in therapy, especially with certain diagnoses or types of conditions (Van Dam et al, 2017).

5. Conclusion

Mindfulness practices now have a well-established presence in clinical social work. They are also now frequently included in social work courses, especially ones focused on direct practice skills or field experience. The inclusion of mindfulness in social work education is an important step towards developing competence with these approaches. Through coursework, students gain exposure to the mindfulness research literature and begin to develop and practice skills they will later apply in clinical social work practice (Gockel, 2015; Gockel & Deng, 2016; Thomas, 2017). With the expanding use of mindfulness skills in clinical social work practice, it is important to establish guidelines for developing competency with these skills. Clinical social workers planning to utilize these approaches in their practice first need to ensure that they possess competency with general clinical skills. They then need to have a good understanding of mindfulness and know how effectively to deliver mindfulness practices in therapy. This includes using mindfulness in a way that is sensitive to diversity issues and client preferences. Ongoing clinical supervision specific to mindfulness is important, and one of the many adherence scales developed for ensuring competence and fidelity, can be utilized in training and supervision. Most important, however, is the clinical social worker's commitment to their own personal practice, allowing them to embody these skills with and for their clients.

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