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Evidence for the Art of Social Work

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ABSTRACT

Social work depends on relationship building to achieve its goals. This requires knowledge derived from research, as well as the intuitive understanding and interpretive abilities that are refined through experience with clients. The evidence-based practice movement and its forebears have for decades attempted to determine which theory or method of practice is most effective when applied to specific problems or diagnoses. However, extensive meta-analyses have determined that other variables—in particular, the quality of alliance formed between worker and client—matter most in predicting outcomes. This article summarizes the research and concludes that the evidence supports an improvisatory conception of practice, and that improved outcomes will result when there is increased attention to those variables that enhance the working alliance.

Introduction: Art and Science in Social Work

Knowledge vanquishes ignorance, but mystery abides.
—Chet Raymo

Every day, social workers listen to the unique and surprising stories of diverse, complex, and unpredictable human beings. Chances are that the very next person one encounters will present some entirely unanticipated and unique constellation of concerns, confounding the diagnosticians and challenging policy protocols. The stage is set for an improvised scene. The social worker enters, armed with theory and technique, experience and intuition, and a desire to be helpful. The client enters the stage as if from another play, having none of the same assumptions or training, but with a lifetime of individual experience, and an expectation of being helped, or at the very least to not be harmed. There is no script. The two players must find a way to interact, to establish a meaningful and productive relationship. This collaboration, to be successful, will ultimately emerge from a synthesis of science and art, or a "third space" of social work practice (Walter, 2003) that builds on a broad base of knowledge and experience, and is highly improvisatory in nature.

Science centers on a quest for truth and bases this quest on its confidence in the scientific method. It requires, in one sense, a juxtaposition of belief and faith. One puts forward a belief, an idea, or a conjecture, and willingly subjects it to testing. This requires having confidence and placing trust in the scientific method, because it is likely that what one believes will have to be modified as a consequence of what one finds. Consider Copernicus, whose observations moved the Earth from the center of the universe to its periphery, or Darwin, who suggested that the origins of humankind were linked to those of all other life-forms. For each, it was a long time between their observations and the dissemination of their conclusions, in part due to the struggle between faith in the scientific

method and the prevailing beliefs of the time. The pursuit of understanding must find a balance between that which is commonly understood and accepted knowledge, and the continual questioning and challenging that is the hallmark of the scientific method. One can't question everything, or nothing would get done. On the other hand, acting on beliefs alone leads inevitably to incompetence and injustice. The evidence-based practice (EBP) movement in social work and other related professions is heavily invested in the belief that the most important question to be explored is which theory or method is most effective with which particular problem or diagnostic category. But that belief is being challenged by the cumulative findings of over a half century of research.

Art also seeks truth, and the artist endeavors to express a truth about experience. Art emerges from the dynamic interaction between structure and improvisation. Consider the jazz trumpeter Miles Davis, whose unique voice was expressed in the tension between the constraints of form—of scales, beat, and melody—and his capacity to transcend them, to float above and around them while never deserting them altogether. Think of Picasso, whose revolutionary sense of perspective allowed one to see both sides of a person's face at the same time. Or look at Robin Williams, who by himself on a stage is capable of creating multiple characters and realities in a matter of moments. In each case the structure, whether musical form, canvas and paint, or voice and movement, provides an anchor and a discipline for the creative impulse. Great art finds a balance between structure and improvisation. Too much structure will inhibit creativity. Too little, and one runs the risk of disorder and irrelevance.

There is an art to social work practice, but it is an informed art, born of a balance between the structured, general knowledge that prepares the practitioner for categories of concern, and the intuitive, improvisatory understanding that is expressed in the immeasurable details of being fully present to another human being:

> Competence in social work therefore will be found not by seeking to avoid intuition, but by its recognition and development, by the creation of uncommon common sense. Social work is a matter of intuitive understanding, but it must be intuition which is unusually sound, unusually fluent and accessible, and subject to unusually careful evaluation. The absence of a framework for such evaluation in social work is the biggest single expression of the confusion about social work's character, and also one of the biggest obstacles to social work's wider plausibility. Social work can achieve no effective evaluation if it denies its essentially intuitive character. (England, 1986, p. 39)

Social work practitioners have historically relied more on experiential understanding than on the knowledge derived from large-scale studies or the incorporation of methods of practice evaluation. As this article will demonstrate, however, meta-analytic studies of outcome research have produced a mass of evidence in support of "uncommon common sense," as described by England. We can say now with confidence that in general, social work is effective, and that most models or methods appear to work reasonably well. What is most intriguing, however, is that while there are some differences among these various models, there are other variables that account for much greater differences within models or from case to case. These other variables include factors such as the practitioner's capacity to listen, understand, support, and work with the inherent wisdom of clients; to identify and incorporate their strengths; and to foster their hopes and expectations. In other words, the profession's long-standing emphasis on the relationship between worker and client is at the heart of change. This is not, it should be emphasized, an affirmation of a "go with your gut" approach. And it does not mean that method or theoretical perspective are irrelevant, but rather that they must be understood as but one dimension of effective practice. The cumulative evidence supports a comprehensive, artistic, improvisatory, and relational conception of practice, informed by structured feedback and evaluation. To return to an earlier analogy, a jazz musician must study scales, rhythm, chord structure, and melody for years in preparation for improvisation. The methods, models, and techniques of social work are similarly essential, providing the base for social work skills. But it is the capacity to form collaborative relationships, based on interpersonal improvisation and feedback derived in the moment, that leads to the most significant and lasting changes.

It should be noted that this article focuses on research into primary helping relationships, as exemplified by activities such as counseling, psychotherapy (individual, family, and group), and casework. Therefore, it is not possible to draw conclusions about other forms or levels of practice, such as supervision, administration, and community development. Nevertheless, because so much of social work practice, at all levels of intervention, is based in the primacy of collaborative relationships, there may be some universal themes that will merit further exploration in the future.

Ideology and Science: An Enduring Dilemma

Scientific knowledge is inherently provisional, that is, subject to disproval by the data. Yet within the social work research establishment, there appears to be some reluctance to let go of, or to hold up to the light, a fundamental assumption of what has come to be known as the

evidence-based practice "movement" (Reid, 1994). This guiding assumption essentially holds that the theory or method one applies to a particular problem situation is the most important variable in predicting outcome. This assumption has persisted, despite overwhelming evidence that other factors are more important in this equation. It is hard to know for sure why this is so, but it may be related to any number of enduring historical influences, including career identification and investment in particular models of practice, an overconfidence in the medical model analogy as applied to social concerns, a restricted definition of what counts as evidence, or a disconnect with the general complexity and irreducibility of everyday practice. This section will review some of the history of the effort to evaluate practice and some of the related dilemmas.

Questions regarding the effectiveness of social work and psychotherapy have been around for a long time. Arguments have focused on both the generic process of knowledge development as well as the evaluation of specific interventions. In the early 1950s, Eysenck (1952), a psychologist, famously suggested that the outcome of psychotherapy was roughly equivalent to the rate of spontaneous remission, and championed the principles of behaviorism. His analysis was challenged by others, (Luborsky, 1954; Rosenszweig, 1954), though these responses were not afforded the same level of attention as his original condemnation. In social work, Kadushin (1959) suggested that the knowledge base for social work was inadequately conceptualized, and therefore, hard to measure and hard to accumulate. Austin (1978) observed that the process of knowledge building appeared to be more competitive than cumulative, as the proponents of various practice models vied to assert superiority or uniqueness. Model building, according to some, was and is primarily the province of an academic elite who control not only research but also the process of knowledge building (Berger, 1986; Karger, 1983).

Starting in the 1970s, serious questions were raised about the effectiveness of social work interventions. Fischer (1973) issued a challenge to the profession, suggesting that the evidence of effectiveness was weak. He later called for a "revolution" in the direction of more empirically supported practice methods (Fischer,1981). Fischer and others were concerned that without a strong scientific foundation, social work would lose credibility. Psychology and psychiatry were emphasizing the measurable and quantifiable aspects of treatment, and policymakers and funding sources were increasing the focus on accountability. Wood (1978) concluded that there was some evidence that casework was effective, but called for improved research methods more suitable to the subject at hand. Hudson asserted, "The validity of any theory (including theories of social work practice) cannot be established if it is not capable of refutation through experience" (Hudson, 1982, p. 256). There was a growing emphasis, at least within the academic community, to transform social work into an empirically grounded profession, as described by Goldstein:

> The profession has consistently upheld the idea that, by the use of proper scientific methods, these realities can be converted into a dependable foundation of knowledge, and that this foundation yields a proper set of procedures that can be applied to real-life problems. (Goldstein, 1986, p. 354)

Goldstein (1986) described the difficulties inherent in attempting to derive universal methods that were applicable to particular situations. Schon (1983) suggested that knowledge for practice emerges in a variety of professions as a consequence of "reflection-in-action," and suggested that practitioners were actively engaged in developing a "theory of the unique case." The abstract generalities of formal theory, he asserted, were limited in application to individual situations. And England noted that the practice of social work is simply too complex an activity, and one embedded with particular meanings, to be described only as a science:

> An assessment of the nature of social work must necessarily include an examination of social work as art as well as social work as science; both are clearly integral and essential parts of the whole. (England, 1986, p. 115)

Understanding and evaluating the question of whether and in what ways social work is effective seemed to be more complex than simply a question of whether a specific method worked with a specific problem. Tyson (1992) suggested that the positivist paradigm for social work research was not adequate or appropriate to the task, and recommended an alternative heuristic paradigm. In response, however, 42 prominent social work authors (Grinnell et al., 1994) wrote a brief but scathing attack, arguing that Tyson had falsely dichotomized research into positivist and heuristic camps, and thereby done a disservice to the profession. This response did little to advance integration or understanding, though, and calls to expand both the scope of inquiry and the definition of evidence for practice have continued up to the present (Glasby & Beresford, 2006; Webb, 2001).

The term "evidence-based medicine" first appeared in the medical literature in the early 1990s, (Evidence-Based Working Group, 1992). The concept has achieved widespread acceptance, with a proliferation of journals, articles, and books dedicated to this topic (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000). Social work adopted this terminology soon after, and the evidence-based social work practice movement was born (Gambrill,

1999; Reid, 1994). Evidence-based practice has been described as "the planned use of empirically supported assessment and intervention methods combined with the judicious use of monitoring and evaluation strategies for the purpose of improving the psychosocial well-being of clients " (O'Hare, 2005, p. 6). The rationale for EBP clearly emanates from a commitment to core values of the profession: "social work practice must be responsive to client needs and ethical; goal-directed and outcome oriented; subject to scrutiny and accountability (hence systematic and explicit); guided by scientifically tested knowledge; and evaluated for its effectiveness" (Rosen, 2003, p. 199).

The primary thrust of evidence-based practice movement has been the attempt to create a specific set of empirically validated treatments (EVTs) or empirically supported treatments (ESTs). This is the logical outcome of an assumption that it is the differences between methods that provide the largest differences in outcomes, which, as we shall see, is a flawed assumption. The American Psychological Association's Task Force on Promotion and Dissemination of Psychological Procedures (1995) recommended developing such a list to be used to determine best practice methods. An empirically validated treatment was defined as one that had been supported by two studies showing it to be superior to a control group and that was guided by a treatment manual. Soon after, Myers and Thyer (1997) recommended that the *Code of Ethics of the National Association of Social Workers* (NASW, 1996) be modified to include the client's right to effective treatment. Following the lead of the American Psychiatric Association, they suggested that, "social workers should … be bound to provide empirically validated treatments to their clients when such are available"(Myers & Thyer, 1997, p. 296). There is a certain inexorable logic to this reasoning. After all, as the authors point out, would a patient seeing a medical doctor want to receive the treatment that has been proven to be most effective? The problem facing social work, and related professions, is not with the logic behind this position, but rather with the analogy, which turns out to be of limited use, particularly when dealing with thoughts, feelings, and behavior, or the essence of social work practice.

According to Wampold (2001), the medical model, as applied to social and psychological problems, comprises the following components:

1. The client has a disorder, problem, or complaint.
2. There is a proposed psychological explanation for the disorder, problem, or complaint.
3. There is a posited mechanism of change (related to therapeutic approach).
4. There are specific therapeutic ingredients, or techniques.
5. Specificity: The techniques are specific to the disorder, problem, or complaint.

It is the last three items that are most important when considering how research into the effectiveness of social work has been primarily conducted. There is a posited mechanism of change, and specific therapeutic techniques that are applied in specific ways. These characteristics strongly favor certain models, particularly highly structured ones, such as cognitive and behavioral approaches, that are more amenable to standardization and measurement. But the limitations of a medical model in social work have been noted over the years. One consistent criticism has been that it tends to promote mechanistic and reductionistic thinking: "Individuals were seen in isolation from the rich patterns of their environment and with other individuals" (Miller, 1980, p. 284). Social and psychological concerns, Miller noted, are embedded in a context, and solving problems is not a matter of external expertise, but rather the result of expanding clients' options. Weick (1983) suggested that the emphasis on disease and dysfunction was inherently limiting to clients' potential, because it places the responsibility for healing primarily in the hands of the professional. She advocated a shift from a disease-oriented to a health-oriented model. "In essence, this view is based on the belief that human beings have the innate capacity to be the source of their own change and that the process of self-healing is one expression of that capacity" (p. 469). It has proven difficult, however, to emphasize health in a context that reinforces the medicalization of social concerns and minimizes the impact of social variables.

Perhaps no other single factor has contributed to this as much as the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV-TR*; American Psychiatric Association, 2000). Though it strongly identifies with and claims an empirical philosophy and basis, much of its content is the result not so much of empirical testing as the consensus of committees. The significant philosophical and practical dilemmas created by social work's reliance on the *DSM* have been chronicled in detail (Kutchins & Kirk, 1997). These include problems of reliability and validity; inconsistent application; ethical and moral factors influencing diagnostic patterns; the role of social, economic, and political factors in the development and maintenance of diagnostic categories; and reimbursement guidelines that require the application of medical diagnoses to essentially social problems.

Concerns about the current medical model are not limited to mental health and social work The Institute of Medicine (2001) recommended a major shift in the principles of medical practice. Currently, they note, medical care emphasizes individual office visits, professional autonomy and control, and decision making based on training and experience. In the future, they suggest that care should be based on "continuous healing relationships," designed around patient needs and values, controlled by the patient, and informed by evidence (p. 67).

Ethical principles, as well as the evidence, they argue, support such a paradigm shift.

The limitations of the medical model become apparent when applied to human behavior that comprises psychological, social, physical, and spiritual dimensions. There must be a broader conceptualization that guides both research and practice. To begin to develop such an understanding, it is critical to recognize and understand what contributes to making a difference in client outcomes.

What Contributes to Making a Difference?

There have been literally thousands of studies of psychotherapy and other forms of social work practice. Most of this research is designed to find evidence that a particular model or method is effective. The most common research design compares two methods with a similar client population, or compares one or more treatment groups with a control group. There are, in fact, so many such studies that a second major type of study has emerged: the meta-analysis. In this process, large numbers of smaller studies are examined together in order to explore common variables, themes, and trends, and to combine findings when feasible. Meta-analyses have become increasingly popular, and the methods of analysis and statistical interpretation have continually evolved. The most important finding from these studies over the last 30 years is that clients who receive either psychotherapy or other related social work interventions are generally better off than roughly 75–80% of those individuals in similar situations who do not receive services (Gorey, 1996; Gorey, Thyer, & Pawluck, 1998; Lambert & Ogles, 2004; Lambert, Shapiro, & Bergin, 1986; MacDonald, Sheldon, & Gillespie, 1992; Orlinsky, Ronnestad, & Willutzki, 2004; Reid & Fortune, 2003; Reid, Kenaley, & Colvin, 2004; Smith & Glass, 1977; Smith, Glass, & Miller, 1980; Wampold, 2001; Wood, 1978). Effectiveness has been established across diverse treatment modalities and theoretical perspectives, as well as a wide spectrum of client problems and diagnoses. Benefits from intervention have generally been found to be statistically significant, clinically meaningful, and long-lasting (Lambert & Ogles, 2004).

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One of the most significant, and in some ways, troubling findings from this body of research, however, is that amount of variability accounted for by the particular intervention method is quite small. Lambert and his colleagues have been studying the process and outcome of psychotherapy for 20 years, and they calculate the differential effect of theoretical model or technique to account for about 15% of the variability in outcome (Asay & Lambert, 1999; Lambert, 1986; Lambert, 2004; Lambert & Ogles, 2004; Lambert et al., 1986; Maione, & Chenail, 1999). This is no longer news, but it seems to have had little impact on those model builders who have built careers on claims of uniqueness and superiority, and to those who insist that the road to better outcomes will be established through a list of empirically validated treatments. On the other hand, it should comfort those practitioners who have been chided in the past for believing that various models are roughly equivalent in effectiveness (Persons, 1995).

The discovery that the model or technique accounted for just 15% of change led to the development of *the common factors model*, (Drisko, 2004; Lambert et al., 1986) which posits that there are factors common to all the various helping theories and models. Lambert et al. (1986) calculated that placebo effects, or the expectancy of change, account for another 15%. This includes factors such as clients' expectations of help, the generation of hope, and therapist confidence in the approach. Characteristics of the therapist, such as empathy, warmth, acceptance, and encouragement, contribute 30%. And finally, extratherapeutic change, or all those things that go on in clients' lives outside of their role as a client accounts for the largest portion, or 40%. These factors include spontaneous remission of the problem, personal strengths and resources, social supports and context, and the role of chance circumstances and fortuitous events.

Wampold (2001) noted that Lambert had described and offered these percentages as rough calculations. His own comprehensive meta-analysis, which is exemplary for its conceptual, methodological, and statistical sophistication, led him to conclude that if anything, the common factors model overestimates the power of specific effects. Using more advanced statistical methods, he calculated the actual variance attributable to theoretical orientation or model to be closer to 8% (Wampold, 2001). He summarized his findings under the following categories: absolute efficacy, relative efficacy, specific effects, general effects, and therapist effects. Each is reviewed briefly here.

Absolute efficacy refers to the effects of a treatment or intervention versus no treatment at all. As noted earlier, a series of studies have concluded with great certainty that

psychotherapy and social work are generally effective, and this holds true across all of the major accepted theoretical orientations to practice.

Relative efficacy refers to whether one model is more effective than another. Wampold et al. (1997) conducted a comprehensive meta-analysis of prior meta-analytic studies, exploring the question of whether the increasing specificity of treatment protocols has led to greater outcome differences between models. Surprisingly, their findings did not support this conclusion: "The preponderance of effects were near zero, and the frequency of the larger effects was consistent with what would be produced by chance, given the sampling distribution of effect sizes" (Wampold et al., 1997, p. 94). Furthermore, when differences were noted, the aggregate effect size was just 0.20. (Essentially, an effect size of 1.0 represents a change of one full standard deviation from the mean of the population being studied. The effect sizes found in the meta-analyses of psychotherapy and social work tend to lie in the 0.80 to 1.20 range.) In other words, even when differences were noted between models, they were relatively small, and this includes cognitive-behavioral methods, often promoted as more effective than others. Wampold (2001) noted that when studies that suggest one method is superior to another are controlled for factors such as instrument reactivity, researcher bias, and subject selection, most or all of the differences disappear. Gorey et al. (1998), in their meta-analysis of 45 studies of social work practice, reached a similar conclusion: "In exploring main interventive effects, the present review did not find evidence in support of their differential effectiveness" (p. 274). However, they did find that when the focus of change was the individual client, personal orientations were more effective, and when the focus of change was systemic, structural models were more effective.

Specific effects refers to the application of specific techniques or methods within a model of psychotherapy. Research in this area is conducted by adding or subtracting a specific technique from a treatment protocol, and then measuring the difference in outcome. Ahn and Wampold (2001) conducted a meta-analysis of 27 studies that attempted to isolate and measure the effect of specific components. The aggregate effect size from these studies was –0.20, which is both the opposite of what was predicted and not statistically significant. The authors concluded that there is little evidence that specific ingredients are primary factors in producing psychotherapeutic change.

General effects include many of the common factors identified earlier. Those factors that appear to be particularly important include the therapeutic alliance and the therapist's allegiance to a particular treatment model. A number of studies (Blatt, Zuroff, Quinlan, & Pilkonis, 1996; Burns & Nolen-Hoeksema, 1992; Horvath & Symonds, 1991; Krupnick et al., 1996; Martin, Garske, & Davis, 2000) have found a fairly robust relationship between the therapeutic alliance and the eventual outcome. Therapeutic allegiance is defined as "the degree to which the therapist delivering the treatment believes that the therapy is efficacious" (Wampold, 2001, p. 159). Several meta-analytic studies of the therapist allegiance have identified an effect size of approximately 0.65, which is quite remarkable in contrast to the findings for relative efficacy and specific effects (Berman, Miller, & Massman, 1985; Dush, Hirt, & Schroeder, 1983; Robinson, Berman, & Neimeyer, 1990; Smith et al., 1980). In fact, these studies suggest that the general affects account for *many times* the amount of variance that is due to the differences between models. Lambert et al. (1986) concluded that:

> Interpersonal, social, and affective factors common across all therapies still loom large as stimulators of patient improvement. It should come as no surprise that helping others deal with depression, inadequacy, anxiety, and inner conflicts, as well as helping them form viable relationships and meaningful directions for their lives, can be greatly facilitated in a therapeutic relationship that is characterized by trust, warmth, understanding, acceptance, kindness, and human wisdom. These relationship factors are probably crucial even in the more technical therapies that generally ignore relationship factors and emphasize the importance of technique in their theory of change. *This is not to say that techniques are irrelevant but that their power for change is limited when compared with personal influence* [emphasis added]. (pp. 180–181)

Therapist effects have to do with the impact of specific characteristics of a particular therapist on therapeutic outcome. These characteristics include things such as age, gender, culture, experience, style, personality, values, expectations, and philosophy of treatment (Beutler, Machado, & Neufield , 1994). Several researchers have conducted meta-analyses of published studies to identify the influence of therapist effects (Blatt, Sanislow, Zuroff, & Pilkonis, 1996; Crits-Christoph et al., 1991; Crits-Christoph & Mintz, 1991; Wampold & Serlin, 2000). In Wampold's review of these studies, he noted effect sizes due to therapist effects in the 0.60 range, and concluded that "a preponderance of the evidence indicates that there are large therapist effects and that these effects greatly exceed treatment effects" (Wampold, 2001, p. 200). One attempt to control differential therapist effects has been the creation of manuals and training designed to standardize treatment protocols and techniques. But interestingly, while this appears to improve adherence to a particular model, it does not appear to have much of an impact on client outcomes (Wampold, 2001). In fact, this regimentation runs the risk of adversely affecting the

working alliance and alienating clients. It appears that even when treatment regimens have been standardized, there are very substantial effects due to the individual characteristics of the therapist and the quality of the alliance formed.

Drisko (2004) noted that the research into common factors has a number of implications for social work practice and research. These include a need for social workers to be better informed about this material, and a call for more research into how and why therapy works. He noted in particular the consistency between the common factors model and social work's emphasis on extratherapeutic factors. But he also described the challenges of promoting common factors: "In the current economic and academic marketplace, competition among different therapies is emphasized, and efforts at identifying common factors across therapies are not actively supported" (p. 89).

Reid et al. (2004) asserted a challenge to the common factors model. They reviewed 39 studies of social work programs published between 1990 and 2001 and found that 77% of these studies demonstrated differential effects between interventions. Many of these studies focused on group and family interventions, instructional methods, and environmental modification, and the authors concluded that the common factors may not play as large a role in many social work interventions as they do in psychotherapy. However, the absence of common factors was posited in just 7 of the 39 studies, and how this absence was defined or determined was not explained. While the majority of these studies found differential effects, it is also curious that the authors did not discuss the size of those effects, whether they were greater than those found in comparative studies of psychotherapy, or whether they approached the effect size attributable to common factors. They also did not discuss the extent to which any of the studies attempted to control for common factors, or even acknowledge them. Finally, they noted: "In all but a few of the programs, it was evident that the authors were responsible for program development or direction" (Reid et al., 2004, p. 73).

This raises a potential concern. Controlling for investigator bias tends to reduce or even eliminate differential effects in many studies, and it appears that in a number of these subject studies, the researchers had a potential investment in the outcome (Wampold, 2001). If the empirical base of social work is to be strengthened through comparative experimental design, as advocated by Reid et al. (2004), these factors need to be addressed. In the meantime, there is no logic in privileging such research over potentially more fruitful directions.

In sum, the prevalence and significance of differential effects between models or for specific techniques within models is relatively small, with model and technique accounting for approximately 8% of variability in outcome; whereas general effects, including the alliance and the individual therapist, account for as much as 70%, leaving an unexplained variance of about 22% (Wampold, 2001, p. 209). Wampold concluded that the EST movement as presently conceptualized should be abolished, and that "designated empirically supported treatments should not be used to mandate services, reimburse service providers, or restrict or guide the training of therapists" (p. 225).

This is a powerful statement, but one that is supported by the most rigorous analysis of the evidence to date. It also forms the basis for a collective call to seek out the "third space" (Walter, 2003) in social work, the place where art and evidence comingle in a coherent whole. Wampold, a consummate research scientist, concluded: "Therapy practice is both a science and an art … the master therapist, informed by psychological knowledge and theory, and guided by experience, produces an artistry that assists clients to move ahead in their lives with meaning and health" (Wampold, 2001, p. 225).

The Client's Voice and the Art of Collaboration

Success in social work is not a matter of doing for, or doing to, but rather of doing with. "A good relationship is necessary not only for the perfection, but also the essence, of the casework service in every setting" (Biestek, 1957, 19). Duncan, Miller, and Sparks (2004) suggested that all clients have some idea about how change occurs in general and a wealth of experience about how it occurs for themselves as individuals. These authors described this body of knowledge as the client's theory of change. The art of collaboration depends on finding ways to acknowledge, understand, and incorporate the client's worldview into every aspect of practice.

Nevertheless, it would be hard to deny that the formal theories of practitioners have held a privileged position over the informal theories of their clients. And this is certainly true within the evidence-based practice movement, which emphasizes best outcomes as defined by professionals, with only limited attention to role and contribution of clients (Witkin & Harrison, 2001). A careful reading of some recent articles extolling the potential of the evidence-based movement finds them to be nearly oblivious to the role of client strengths, desires, and theories of change (Gellis & Reid, 2004; Rosen, 2003). This is disturbing, given the proliferation of evidence that suggests that the client's experience and evaluation of the working alliance with a practitioner is significantly more important than the model being employed. Respect for the client's worldview is more than morally and ethically appropriate, it also has a direct connection to outcome and is affected by the extent to which the client senses that the practitioner honors and will work with his or her theory of change.

> Rather than recasting the client's personal views into the therapist's formal theory, we calibrate applicable

> theories to the client's beliefs. Each client, therefore, presents the therapist with a new theory to discover and a different solution path to follow. (Duncan et al., 2004, p. 122)

Incorporating the client's perspective or theory of change is an integral part of knowledge development in social work. But this requires alternatives to the medical or problem-based model of understanding, which still tends to pervade most practice settings. Weick (1986) described the ongoing struggle within social work to find a balance between its commitment to scientific inquiry and its commitment to humanistic beliefs and democratic principles. The *health model*, she asserts, provides a way to begin to achieve such a balance:

> The overall goal of intervention in a health model is to elicit the participation of individuals in a process that they are to direct. The enhancement of their knowledge and skill in support of their own health enables them to recognize their capacity for positive growth and change. (Weick, 1986, p. 556)

Wampold (2001) asserted emphatically that the evidence for practice effectiveness consistently contradicts the medical model as a metaphor for interpersonal helping. In contrast, he suggests a *contextual model*, developed by Frank and Frank (1991), as a more accurate metaphor, based on the following components: an emotionally charged, confiding relationship with a helping person; a healing setting, in which the client entrusts a professional to work on his or her behalf; a plausible explanation for the client's symptoms that is consistent with the client's perceptions, attitudes, and values; and a process or procedure in which both client and therapist have an active role to play.

These factors set the stage for a different emphasis in research and practice, and for a more effective combination of the two. A perfect example of this union can be found in the work of Duncan et al. (2004), who found that practice effectiveness is greatly enhanced when practitioners become client-directed and outcome-informed. This is based on their *relational model*, based on the following equation:

> Client resources and resilience + client theories of change + client feedback about the fit and benefit of services = Client perception of preferred outcomes. (Duncan et al., 2004, p. 48)

This model is derived from a combination of the research into common factors, as well as their own emphasis on evidence derived from measures of both process and outcome. Several studies have found that clients' evaluation of the therapeutic alliance is a more powerful predictor of outcome than either the method of treatment or the severity of the problem (Blatt, Zuroff, et al., 1996; Krupnick et al., 1996). And most interestingly, clients' ratings also are more predictive of both short- and long-term improvement than are ratings by therapists (Bachelor & Horvath, 1999). The client's "subjective" perceptions appear to be more reliable than the "objective" observations of therapists. As Duncan et al. (2004) argued, client feedback about the fit and benefit of services is at the heart of change.

Duncan et al. (2004) developed two instruments, the Session Rating Scale (SRS), and the Outcome Rating Scale (ORS), each derived through extensive testing of lengthier instruments, and each designed to be filled out by the client at the end of a session in less than a minute. The SRS provides feedback on the current session and is composed of four subscales: relationship, goals and topics, approach or method, and overall. Extensive research and practice application with the SRS demonstrates that it is highly sensitive to the client's perception of the alliance, and that discussing the client's perceptions can help the social worker to reorient the process so that it more closely aligns with the client's theory of change. The ORS measures progress toward the client's desired outcome on the following four dimensions: individual well-being, family and close relationships, work and school, and overall. Monitoring this measure helps client and worker to evaluate progress and to readjust accordingly.

Miller, Duncan, Sorrell, and Brown (2005) concluded that "access to client's experience of progress and alliance as measured by the ORS and SRS can as much as double the effect size of treatment and simultaneously improve client retention and cost-effectiveness" (Miller et al., 2005, p. 207). These instruments are free and easily accessible and have now been used in over 100,000 clinical cases (Miller & Duncan, 2006). These authors emphasized that the SRS and ORS are but one method to monitor those factors that have been proven to be of critical importance for creating change, and they recommended further experimentation with alternatives. The critical point is that there needs to be an increased emphasis on the voices of clients, who have the best vantage point to determine what works for them. Incorporating this knowledge and methodology will enhance reflection in action (Schon, 1983), providing immediate critical feedback that can be used in the moment, as well as in the education, training, and supervision of social work practitioners.

Implications for Other Levels of Practice

This article has focused on social work practice at the level of direct intervention, but there is increasing evidence that suggests a similar process is at work in other arenas. For example, one major study of competencies in organizations concluded that relational factors were more highly correlated to outcome than specific methods employed: "Compared to IQ and expertise, emotional competence

mattered twice as much. This held true across all categories of jobs, and in all kinds of organizations" (Goleman, 1998, p. 31). The author noted that effective leaders are strong in five areas of emotional intelligence: self-awareness, self-regulation, motivation, empathy, and social skills; whereas leaders who tend to fail are characterized by poor relationships with others in the organization and a rigid style that makes them unresponsive to feedback. Collins (2001) found that highly successful leaders are fearless when confronting the facts of the situation. They invite critical feedback, credit successes to others, and take full responsibility for failures. And Quinn (2004) described the process of organizational change as a process of continual feedback and modification in the moment: "What we know from past experience is an asset, but what leads to successful transformation is our capacity to learn in real time. While knowledge is useful, learning is essential" (p. 65). These findings warrant further exploration and development in social work settings, given that they suggest that success at the organizational level is, as in clinical practice, based on the capacity to develop collaborative relationships and incorporate the feedback of clients and others into the process of change.

Summary

The essence of social work lies in facilitating human relationships in ways that support and increase potential, enhance choice, and contribute to the empowerment of individuals and groups. This is a remarkably diverse and complex undertaking, subject to ever-changing details that inevitably arise in the challenges of unique and individual lives. As with any such human endeavor, there is no endpoint on the road toward knowledge and understanding. It unfolds before us, just as the horizon inexorably recedes as we travel forward:

> It is in the nature of the social worker's task that he will encounter diversity greater than that for which he can be specifically prepared, not least because each situation will be specifically distinct. Social workers can be prepared in general terms for situations which they will probably encounter, but they must be clear—and not apologetic—that such knowledge only serves to sketch in the likely dominant characteristics of experience. (England, 1986, p. 35)

When a question remains unanswered for any length of time, it is always worth exploring whether it is being asked in the correct way. Usually, the solution is to step back and to look at the phenomenon under consideration from a fresh perspective. Such a move can be a bit scary, but it is likely to be liberating at the same time. Throughout the history of the profession, social workers have endeavored to develop helping relationships that are grounded in a core set of values and derived from a strong empirical foundation. Much of the quest for evidence of effectiveness has focused on determining which theory, model, or technique will be most effective with which particular problem situation or diagnosis. However, considering the full scope of the evidence for what works in social work practice and psychotherapy, we now know that it is not enough to simply evaluate one model or technique versus another. Although that remains a viable and important aspect of research into practice effectiveness, a much wider scope of inquiry is now called for, including a consideration of the unique characteristics of the client, the unique characteristics of the practitioner, and the unique characteristics of their collaboration. We need to know why some practitioners are more effective than others, why clients with the same problems recover in different ways, what factors contribute to effective working alliances, and what factors detract. Most important, we need to emphasize criteria for success that are developed by clients themselves.

The art of practice is embedded in the capacity of the individual practitioner to form working alliances with clients, and to abstract from the generalities of accumulated knowledge to the particulars and the exigencies of a moment in time. For those practitioners who have long incorporated methods derived from a wide range of models and theories, there is validation in the knowledge that their particular synthesis may be supported by the research into the common factors of change. But there is also an opportunity to use client and supervisory feedback to examine factors that could be impediments to progress. When it is more widely understood that client perceptions have substantial predictive ability as well as practical utility for making within-session adjustments, practitioners are likely to become more sensitive to and interested in incorporating structured evaluative tools.

In this article, I have argued that there is now substantial evidence that supports the art of social work practice. But science and art in social work must do more than coexist in order for the profession to reap the full benefits of either. They are rather two dimensions of a coherent and integrated whole. Acknowledging the artistic dimension of practice should not be seen as a refutation of science, but rather as an opportunity to enrich and expand the scope of inquiry, and thereby the potential contribution of science. And acknowledging the scientific dimension of practice should not be seen as an imposition on the uniqueness of the practitioner's style, but rather as an opportunity to both legitimate and enhance the structures and tools of improvisation.

References

Ahn, H., & Wampold, B. (2001). Where oh where are the specific ingredients? A meta-analysis of component studies in counseling and psychology. *Journal of Counseling Psychology, 48*(3), 251–157.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders.* (4th ed., text rev.). Washington, DC: Author.

Asay, T. P., & Lambert, M. J. (1999). The empirical case for the common factors in therapy: Quantitative findings. In M. A. Hubble, B. L. Duncan, & S. D. Miller, (Eds.), *The heart and soul of change: What works in therapy* (pp. 33–56). Washington, DC: American Psychological Association.

Austin, D. (1978). Research and social work: Educational paradoxes and possibilities. *Journal of Social Service Research, 2*(2), 159–176.

Bachelor, A., & Horvath, A. (1999). The therapeutic relationship. In M. A. Hubble, B. L. Duncan, & S. D. Miller, (Eds.), *The heart and soul of change: What works in therapy* (pp. 133–178). Washington, DC: American Psychological Association.

Berger, R. (1986). Social work practice models: A better recipe. *Social Casework, 67*(1), 45–54.

Berman, J. S., Miller, C., & Massman, P. J. (1985). Cognitive therapy versus systematic desensitization: Is one treatment superior? *Psychological Bulletin, 97*(3), 451–461.

Beutler, L. E., Machado, P., & Neufield, S. (1994). Therapist variables. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed.). New York: Wiley.

Biestek, F. (1957). *The casework relationship.* Chicago: Loyola University Press.

Blatt, S. J., Sanislow, C. A., Zuroff, D. C., & Pilkonis, P. A. (1996). Characteristics of effective therapists: Further analysis of the National Institute of Mental Health treatment of depression collaborative research program. *Journal of Consulting and Clinical Psychology, 64*(6), 1276–1284.

Blatt, S. J., Zuroff, D. C., Quinlan, D. M., & Pilkonis, P. A. (1996). Interpersonal factors in brief treatment of depression: Further analysis of the National Institute of Mental Health treatment of depression collaborative research program. *Journal of Consulting and Clinical Psychology, 64*(1), 162–171.

Burns, D. D., & Nolen-Hoeksema, S. (1992). Therapeutic empathy and recovery from depression in cognitive-behavioral therapy: A structural equation model. *Journal of Consulting and Clinical Psychology, 60*(3), 441–449.

Collins, J. (2001). *Good to great: Why some companies make the leap, and others don't.* New York: HarperCollins.

Crits-Christoph, P., Baranackie, K., Kurcias, J. S., Carroll, K., Luborsky, L., McLellan, T., Woody, G., Thompson, L., Gallagier, D., & Zitrin, C. (1991). Meta-analysis of therapist effects in psychotherapy outcome studies. *Psychotherapy Research, 1,* 81–91.

Crits-Christoph, P., & Mintz, J. (1991). Implications of therapist effects for the design and analysis of comparative studies of psychotherapies. *Journal of Consulting and Clinical Psychology, 59*(1), 20–26.

Drisko, J. W. (2004). Common factors in psychotherapy outcome: Meta-analytic findings and their implications for practice and research. *Families in Society, 85*(1), 81–90.

Duncan, B. L., Miller, S. D., & Sparks, J. A. (2004). *The heroic client: A revolutionary way to improve effectiveness through client-directed, outcome-informed therapy.* San Francisco: Jossey-Bass.

Dush, D. M., Hirt, M. L., & Schroeder, H. (1983). Self-statement modification with adults: A meta-analysis. *Psychological Bulletin, 94*(3), 408–422.

England, H. (1986). *Social work as art.* London: Allen and Unwin.

Evidence-Based Working Group. (1992). Evidence-based medicine: A new approach to teaching the practice of medicine. *Journal of the American Medical Association, 268,* 2420–2425.

Eysenck, H. J. (1952). The effects of psychotherapy: An evaluation. *Journal of Consulting Psychology, 16,* 319–324.

Fischer, J. (1973). Is casework effective? A review. *Social Work, 18*(1), 5–20.

Fischer, J. (1981). The social work revolution. *Social Work, 26*(3), 199–207.

Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore: Johns Hopkins University Press.

Gambrill, E. (1999). Evidence-based practice: An alternative to authority-based practice. *Families in Society, 80*(4), 341–350.

Gellis, Z., & Reid, W. J. (2004). Strengthening evidence-based practice. *Brief Treatment and Crisis Intervention, Psychology Module, 4*(2), 155–165.

Glasby, J., & Beresford, P. (2006). Who knows best? Evidence-based practice and the service user contribution. *Critical Social Policy, 26*(1), 268–284.

Goldstein, H. (1986). Toward the integration of theory and practice: A humanistic approach. *Social Work, 31*(5), 352–357.

Goleman, D. (1998). *Working with emotional intelligence.* New York: Bantam.

Gorey, K. M. (1996). Effectiveness of social work intervention research: Internal versus external evaluations. *Social Work Research, 20*(2), 119–128.

Gorey, K. M., Thyer, B. A., & Pawluck, D. E. (1998). Differential effectiveness of prevalent social work practice models: A meta-analysis. *Social Work, 43*(3), 269–278.

Grinnell, R. M., et al. [41 coauthors] (1994). Social work researchers' quest for respectability. *Social Work, 39*(4), 469–470.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38,* 139–149.

Hudson, W. (1982). Scientific imperatives in social work research. *Social Service Review, 56,* 246–258.

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century.* Washington, DC: National Academy Press.

Kadushin, A. (1959). The knowledge base of social work. In A. Kahn (Ed.), *Issues in American social work.* New York: Columbia University Press.

Karger, H. (1983). Science, research, and social work: Who controls the profession? *Social Work, 28*(3), 200–205.

Krupnick, J. L., Simmens, S., Moyer, J., Elkin, I., Watkins, J. T., & Pilkonis, P. A. (1996). The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: Findings in the National Institute of Mental Health treatment of depression collaborative research program. *Journal of Consulting and Clinical Psychology, 64*(3), 532–539.

Kutchins, H., & Kirk, S. A. (1997). *Making us crazy: DSM: The psychiatric bible and the creation of mental disorders.* New York: Free Press.

Lambert, M. J. (1986). Implications of psychotherapy outcome research for eclectic psychotherapy. In J. C. Norcross (Ed.), *Handbook of eclectic psychotherapy* (pp. 436–462*).* New York: Brunner/Mazel.

Lambert, M. J. (Ed.). (2004). *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed.). New York: Wiley.

Lambert, M. J., Shapiro, D. A., & Bergin, A. E. (1986). The effectiveness of psychotherapy. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed., pp. 157–187). New York: Wiley.

Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 139–193). New York: Wiley.

Luborsky, L. (1954). A note on Eysenck's article "The effect of psychotherapy: An evaluation." *British Journal of Psychology, 45,* 129–131.

MacDonald, G., Sheldon, B., & Gillespie, J. (1992). Contemporary studies of the effectiveness of social work. *British Journal of Social Work, 22*(6), 615–643.

Maione, P. V., & Chenail, R. J. (1999). Qualitative inquiry in psychotherapy: Research on the common factors. In M. A. Hubble, B. L. Duncan, & S. D. Miller, (Eds.), *The heart and soul of change: What works in therapy* (pp. 57–90). Washington, DC: American Psychological Association.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68,* 438–450.

Miller, W. L. (1980). Casework and the medical metaphor. *Social Work, 25*(4), 281–285.

Miller, S. D.; Duncan, B. L.; Sorrell, R.; & Brown, G. S. (2005). The partners for change outcome management system. *Journal of Clinical Psychology, 61*(2), 199–208.

Miller, S. D., & Duncan, B. L. (2006). How to improve your effectiveness by 65% without hardly trying. Conference presentation: *The Heart and Soul of Change*, Bar Harbor, ME, June 23.

Myers, L, & Thyer, B. (1997). Should social work clients have the right to effective treatment? *Social Work, 42*(3), 288–298.

National Association of Social Workers. (1996). *Code of Ethics of the National Association of Social Workers.* Washington, DC: Author.

O'Hare, T. (2005). *Evidence-based practices for social workers: An interdisciplinary approach.* Chicago: Lyceum.

Orlinsky, D. E., Ronnestad, M. H., & Willutzki, U. (2004). Fifty years of process-outcome research: Continuity and change. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change,* (5th ed., pp. 307–390). New York: Wiley.

Persons, J. B. (1995). Why practicing psychologists are slow to adopt empirically validated treatments. In S. C. Hayes, V. M. Follette, R. M. Dawes, & K. E. Grady (Eds.), *Scientific standards of psychological practice: Issues and recommendations* (pp. 141–157). Reno, NV: Context Press.

Quinn, R. (2004). *Building the bridge as you walk on it: A guide for leading change.* New York: Jossey-Bass.

Reid, W. J. (1994). The empirical practice movement. *Social Service Review, 68*(2), 165–184.

Reid, W. J., & Fortune, A. E. (2003). Empirical foundations for practice guidelines in current social work knowledge. In A. Rosen & E. Proctor (Eds.), *Developing practice guidelines for social work intervention: Issues, methods, and research agenda* (pp. 59–79). New York: Columbia University Press.

Reid, W. J., Kenaley, B. D., & Colvin, J. (2004). Do some interventions work better than others? A review of comparative social work experiments. *Social Work Research, 28*(2), 71–81.

Robinson, L. A., Berman, J. S., & Neimeyer, R. A. (1990). Psychotherapy for the treatment of depression: A comprehensive review of the controlled outcome research. *Psychological Bulletin, 108*(1), 30–49.

Rosen, A. (2003). Evidence-based social work practice: Challenges and promise. *Social Work Research, 27*(4), 197–208.

Rosenzweig, S. (1954). A transvaluation of psychotherapy: A reply to Hans Eysenck. *Journal of Abnormal and Social Psychology, 49,* 298–304.

Sackett, D. L., Straus, S. E., Richardson, W. S., Rosenberg, W., & Haynes, R. B. (2000). *Evidence-based medicine: How to practice and teach EBM* (2nd ed.). New York: Churchill Livingstone.

Schon, D. (1983). *The reflective practitioner.* New York: BasicBooks.

Smith, M. L., & Glass, G. V. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist, 32*(9), 752–760.

Smith, M. L., Glass, G. V., & Miller, T. I. (1980). *The benefits of psychotherapy.* Baltimore: Johns Hopkins University Press.

Task Force on Promotion and Dissemination of Psychological Procedures. (1995). Training in and dissemination of empirically-validated psychological treatment: Report and recommendations. *The Clinical Psychologist, 48*(1), 2–23.

Tyson, K. (1992). A new approach to relevant and scientific research for practitioners: The heuristic paradigm. *Social Work, 37*(6), 541–556.

Walter, U. (2003). Toward a third space: Improvisation and professionalism in social work. *Families in Society, 84*(3), 317–322.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings.* Mahwah, NJ: Erlbaum.

Wampold, B. E., Mondin, G. W., Moody, M., Stich, F., Benson, K., & Ahn, H. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, "All must have prizes." *Psychological Bulletin*, *122*(3), 203–215.

Wampold, B. E., & Serlin, R. C. (2000). The consequences of ignoring a nested factor on measures of effect size in analysis of variance designs. *Psychological Methods, 5*(4), 425–433.

Webb, S. (2001). Some considerations on the validity of evidence-based practice in social work. *British Journal of Social Work, 31*(1), 57–79.

Weick, A. (1983). Issues in overturning a medical model of social work practice. *Social Work, 28*(6), 467–471.

Weick, A. (1986). The philosophical context of a health model of social work. *Social Casework, 67*(9), 551–559.

Witkin, S. L., & Harrison, W. D. (2001). Editorial: Whose evidence and for what purpose? *Social Work, 46*(4), 293–296.

Wood, K. (1978). Casework effectiveness: A new look at the research evidence. *Social Work, 23*(6), 437–457.

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