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A Practitioner's Application and Deconstruction of Evidence-Based Practice

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ABSTRACT

A discussion of the application of evidence-based practice (EBP) in clinical settings is offered from a practitioner's point of view. Questions are raised regarding how the EBP effectiveness client-oriented practical evidence search (COPES) questions and literature review protocol (Gibbs, 2003) guide the operationalization of problems and clients, and suggestions are offered about additional variables to include in this standardized protocol that may enhance the specificity of EBP. An exploration of the EBP collaborative decision-making process is presented from a practice perspective, and a conclusion is drawn about the use of the EBP process in clinical settings.

As a practitioner struggling with meeting the varied needs of my clients, evidence-based practice (EBP) is an alluring concept. The word "evidence" holds power and weight, and inspires confidence in me. This position of sureness feels good, and with evidence supporting me, I envision myself as being more professional, safer somehow in the multidisciplinary world of mental health. But I continue to be nagged by questions regarding whether the process of grouping clients into demographic categories and the classification of client problems is an oversimplification of the therapeutic process. Categorizing my clients and their problems feels very strange, and I am aware that these groupings and generalizations can limit relational possibilities between my clients and me, marginalize my clients' voices, and close conversational doors that would normally have been open in our discussions. But still, the use of modalities that have an evidential seal certainly has the promise of taking some of the ambiguity out of my practice and tremendously simplifying my life as a practitioner. Yet, questions remain about the construction of the term "evidence" and the possibility of standardizing practice to the extent that manualized treatments can be replicated from research studies to day-to-day interactions with clients.

In this article I seek to sort out some of these questions by presenting a discussion of the application of EBP from a practitioner perspective. Specifically, I explore the dynamics of operationalizing clients and problems, suggest including additional variables in the EBP effectiveness literature review protocol (Gambrill, 1999, 2005, 2006; Gibbs, 1990, 2003) to better represent the clinical context, and offer a discussion about the nature of the collaborative relationship in the EBP approach.

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What Is Evidence-Based Practice?

At the outset of this discussion it is important to make a distinction between the core values of EBP and the specific methods by which EBP seeks to find the best approaches to solve client problems. The core values of EBP are of utmost importance and are highly commendable. Seeking the best way to help clients is at the heart of ethical social work. The following exploration of the application of EBP in practice is in no way meant to question these underlying values; rather the purpose is to look at the proposed linking of specific clinical contexts to research studies that may assist with practice decisions.

Evidence-based practice is a clinical decision-making process designed to assist practitioners and clients to jointly choose from the range of researched treatment approaches, preferably those that have been empirically validated through randomized clinical trials (RCT). The EBP process originated in the medical field, was accepted by psychology in the early 1990s, and has served as the mainstay of clinical decision making in social work since the mid-1990s (Gambrill, 2005, 2006; Gibbs & Gambrill, 2002; Myers & Thyer, 1997; Thyer & Myers, 1998a, 1998b, 1999).

In practice, EBP calls for social work practitioners to re-envision themselves as practitioners or scientists who (1) operationalize clients into groups according to demographic variables, (2) operationalize client problems into types, (3) search the literature for the most effective intervention suited for the specific client group and specific problem type, (4) inform clients about interventions that stand out as most effective in the literature, and (5) jointly decide with clients on the best therapeutic approach based on the literature (Gambrill, 2005, 2006; Gambrill & Gibbs, 2002; Gibbs, 1990; Gibbs & Gambrill, 2002). Proponents of EBP cite the adoption of EBP by the field of psychology and the adoption by the National Institutes of Health (NIH) of the RCT as a model to validate treatments to bolster claims that social work should adopt the EBP model on a wide scale.

Opponents of the EBP movement focus on the concern that it may be an adoption of a model-driven linear paradigm into a field dedicated to diversity, relationships, and communities (Irving, 2006; Karger, 1983, 1999; Raw, 1998; Wendt & Slife, 2007; Witkin, 1992, 1996, 1998, 2001a, 2001b; Witkin & Harrison, 2001). Opponents further maintain that decision-making protocols designed to match models of practice to client problems do not capture the complexities of life and are, at worst, oppressive by being model focused rather than client directed, thus not meeting clients in their theories of change (Duncan, Miller, & Sparks, 2004, 2007; Duncan & Miller, 2005; Wampold, 2001). And, from a feminist perspective, categorizing clients by demographic variables and utilizing deficit-based assessments may be isolating clients by ignoring the political context from which the problem(s) may have originated (Hare-Mustin, 1994; Wood & Tully, 2006).

In sum, critics of EBP maintain that (1) problems are not easily categorized and generalized, (2) EBP moves the profession further into a linear-positivist mind-set, thereby simplifying the complexities of human relationships, and (3) EBP invites the reduction of human beings into generalized collections of demographic variables and generalizes problems by using deficit-oriented assessments that do not challenge the contextual and political nature of the problem.

Application of Evidence-Based Practice

The fundamental guiding concept of EBP is that the choice to use a specific treatment modality with a specific client in a specific clinical setting must be guided by research in which the modality has been proven effective with clients of the same demographic characteristics as the specific client, and with clients who present with the same problem as the specific client. To guide practitioners in their search for the most effective treatment, a standardized EBP search protocol has been created known as client-oriented practical evidence search (COPES) (Gambrill, 2005, p. 289; Gibbs, 2003, p. 50). These searches are broken down into seven different types: effectiveness, prevention, assessment, description, prediction/risk, harm, and cost-benefit. For this discussion, the focus will be on the use of the effectiveness COPES protocol as a decision-making aid to select treatment approaches in practice settings. All standardized protocols can be presented in a linear equation. The EBP COPES process to arrive at a searchable question about effectiveness may be represented as (Gibbs, 2003, p. 50):

client + problem + intervention + alternative intervention + hoped-for outcome = effectiveness searchable COPES question

For example, if we wished to determine whether solution-focused therapy is of benefit for reducing stress in White males experiencing work-related stress we would operationalize the variable *client* as "White male," *problem* as "stress," *intervention* as "solution-focused therapy," *alternative* as "none," and *outcome* as "the absence of anxiety disorder," thus arriving at the COPES question: "In White males experiencing work-related stress, would solution-focused therapy or nothing avoid or minimize the likelihood of anxiety disorder?" We could also compare two or more interventions by operationalizing the variable *alternative* with these different interventions instead of "none" in the example.

Utilizing the COPES question as a guide for a literature review requires the use of the same variables and operationalizations used in the COPES question construction. The same terms used to construct the question are used to search for the answer to the question. Therefore, the EBP effectiveness literature search protocol would be:

> *client + problem + intervention + alternative intervention + hoped-for outcome = results to be critically appraised and intervention to be discussed with client*

It is important to note that in EBP the intervention suggested by the literature is not prescriptive but is discussed with the client as an empirically supported treatment option (Gambrill, 2006). The assumed characteristics of this therapist–client discussion will be addressed later in this article. Recall that the EBP practitioner is invited to be a research scientist, and as such must initiate clinical decision making with the EBP standardized protocol. The protocol begins with an operationalization of the presenting client so that the client can be categorized to find a best fit within the researched client groupings.

Operationalization of the Client

Although the appearance of the category *client* seems simple enough, I have found that in practice the operationalization of the client is not always so straightforward. To discuss client operationalization, it may be helpful to move from the clean pages of text and linear logic into the real world of practice, by taking a common case example from my recent clinical work. I should inform the reader that this case, like most cases, is complicated.

I am working with a 7-year-old boy (Johnny) who has been diagnosed by a psychiatrist as having attention-deficit/hyperactivity disorder (ADHD). In my discussions with him, I was surprised to find that he does very well in school. In fact, he has won three awards for attendance and good behavior. But over the summer he has been doing poorly at his mother's house and at the homes of relatives. Upon discussion with the family, I learned that Johnny lives with his aunt, while his two younger sisters live with his mother. Johnny lives apart from them because his mother's new boyfriend (who is the father of his sisters) does not like him. Johnny resembles his father, and this is inflammatory to the new boyfriend. In response to this resemblance, Johnny's mother has chosen to ask Johnny to live with his aunt rather than with her. She made this decision because her boyfriend gets intoxicated most nights and screams at Johnny. Johnny's mother and aunt do not get along well, so Johnny often finds himself caught in the middle. Johnny does not understand the family situation and is very confused and hurt about why his sisters get to stay with his mother while he does not.

The complicated nature of the case (and most cases) throws into question who is to be operationalized as the client in the EBP literature review protocol. Is it Johnny? Does the problem reside in him? Perhaps it should be the mother and the aunt. Perhaps it should be the family as a whole, since all are influenced by the conflict. The new boyfriend and the estranged biological father could also be considered clients. The first question regarding the EBP equation is: Who is to be operationalized as the client? Whose view is privileged to begin the process of decision making via a literature review that will lead to an empirically supported intervention? And, once found, who participates in the discussion to determine whether the empirically supported intervention discovered is appropriate? There is little that is standardized in the scenario just described. The application of the EBP literature review protocol does not help to sort through the complex nature of the case because searches for empirically supported treatments are contingent on the very subjective and dynamic decision regarding the operationalization of the client that begins the literature review process. Matching an empirically supported treatment to a specific clinical context is governed by the operationalization of the client. In the discussed case, if I were to conduct a series of literature reviews and with each literature review operationalize the client variable differently using each person involved I could have a different empirically supported treatment suggestion offered by each literature review. This becomes even more problematic when consideration is given to how the operationalization of the client directly influences the operationalization of the problem.

Operationalization of the Problem

The second operational dilemma involves the operationalization of the problem. The operationalization of any category in a linear equation should be mutually exclusive, and exhaustive. In the scenario described there are three interpretations of the problem: mine, the psychiatrist's, and the diagnosis of conduct disorder found in the boy's file, which was made by Johnny's former psychiatrist. I would have four opinions if I ask Johnny, a fifth if the mother is asked, a sixth if the aunt is asked, a seventh if the boyfriend is asked, eight or more if their neighbors are asked, nine if the community is asked, and so on, depending on how far we would like to extend the conversation. From an EBP collaborative perspective, it has been my experience that it is often impossible for a family to fully agree on a problem interpretation. In fact, this point of conflict about the problem is usually a contributor to the problem and is often displaced on the

family member who has the weakest voice in the negotiation (the child). Thus, I frequently find myself working on many problems at once while aligning myself with each family member individually.

Further, how far the problem definition conversation is extended is very much guided by the theory of assessment that is used *a priori* to the EBP protocol. For example, a biophysical approach would result in the perception that the problem resides in the child. A systems approach would focus on family interaction and would result in the perception that the problem resides in the family system. A postmodern approach, such as narrative, would result in the externalization of the problem as affecting the entire family. A solution-focused approach would focus on goals for both the child and family and emphasize strengths and solutions instead of the problem.

Though it is stated in EBP literature that problems do not have to be operationalized using the biophysical approach via the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV-TR*) (American Psychiatric Association, 2000), the American Psychological Association (APA) Division Twelve's list of empirically validated treatments are categorized by diagnostic types (APA, 2007). Further, the Cochran Library (2007), recognized as the preeminent online search engine for both medical and mental health-based EBP searches, categorizes studies by topic also using *DSM-IV-TR* categories. This would seem to suggest that to use the EBP linear protocol in a productive way to find empirically supported clinical approaches a practitioner may need to privilege a biophysical approach. This privileging is illustrated further by the APA Division Twelve clinical guide for clients, which suggests that the first question to ask prospective clinicians when beginning the therapeutic process is: "What diagnosis best describes my problem?" followed by the question "What therapies have scientific support showing that they are beneficial for treatment of my problem?" (APA, 2007, p. 1).

If the usefulness of EBP lies in the operationalization of the problem in searchable ways, and the most searchable way is via biophysical constructions, it may appear that in this regard EBP may not be completely client directed, meaning clients may have little voice in how the problem is to be understood. This point will be discussed further when addressing the nature of the EBP collaborative relationship.

Problem operationalization raises another question about the EBP linear protocol: In the given scenario to whom is authority given to operationalize the problem? In addition, how do we choose which problem to privilege? And yet another question: How are any of these problem perceptions mutually exclusive and exhaustive? In our scenario we could view this as ADHD, as the first psychiatrist diagnosed, or as a family dynamics problem, or as an economic problem placing stress on the family, or as an alcohol problem of the boyfriend influencing family members, or as many individual problems operating together. And this brings us to another question: Why does there have to be only one problem? Why can we not view all of these problems as working in combination? And, ultimately, does the problem chosen to be operationalized in the EBP linear protocol match the problem treated in the research studies used to choose the intervention?

Problem Dynamics

If, for the sake of discussion, we make the assumption that client problems can be operationalized in one valid and reliably searchable way a new question arises regarding the static nature of the problem category in the EBP linear protocol. What happens to the protocol if the problem changes, as it so often does in the real world of practice? Again, I turn to a clinical example from my practice. I was working with a female client who was concerned about depression. We worked together for 3 weeks, and on the fourth week she shared with me that she had been sexually molested by her father from the age of 4 until 16. From an EBP approach, what should the standardized response be when the problem changes? From a biophysical perspective, the *DSM-IV-TR* could be used to label the problem as shifting from major depressive disorder to post-traumatic stress disorder.

To progress with the EBP process it appears that the operationalization of the problem must change. But we must now consider the effects of using the manualized empirically supported treatment suggested for major depressive disorder from the first literature review. A quick trip to both the Cochran Library and the APA Division Twelve Web sites inform me that cognitive behavioral therapy (CBT) is the best choice for depression. Several questions are now raised. If I had been using manualized CBT, which places the problem in the client's thinking and constructs noncompliance to treatment as resistance (Beck, 1995), would the relationship have developed in such a way that she would have felt comfortable to have shared with me that she was abused? EBP supports an open collaborative relationship with clients, but it is unclear how far I can move away from the empirically validated manual without watering down the treatment deemed effective by random clinical trials. As mentioned previously this is especially tricky when the modality being used is one that constructs client negativity with treatment as resistance that stems from a dysfunctional belief. Beck (1995) stated that a "common difficulty involves the patient's unwillingness to conform to the prescribed structure because of her perceptions of and dysfunctional beliefs about herself, the therapist, and/or therapy" (p. 63). If a client expresses negative feedback about the treatment and the

treatment itself defines how to interpret a negative client comment (dysfunctional belief), it becomes unclear as to how much a practitioner can adapt the manualized treatment suggested by the literature. The practitioner may be split between remaining true to the empirically validated manualized treatment (by viewing a negative client comment as resistance) or remaining true to a collaborative relationship (by viewing the client comment as an indicator that change is needed in the therapeutic context). For example, my client explained to me that when growing up she was hospitalized eight times for suicide attempts and never felt comfortable enough to disclose that she had been abused because, as she put it, "I never felt like they listened to me because they were too busy trying to teach me what I was supposed to think and do" (personal communication, January 21, 2006).

Variables That Should Be Included in the Literature Search

Up to this point I presented a discussion regarding questions that have arisen from my use of the EBP model that, while based on good values, have proven challenging. I will now offer a further discussion about the variables that should be included in the literature review to better capture the dynamics of therapy if EBP it is to be adopted in social work as a standardized process for clinical decision making.

Why Are Practitioner Variables Not Considered?

The EBP protocol recommends the client be operationalized, the problem operationalized, and a literature review be conducted based on:

> *client + problem + intervention + alternative intervention + hoped-for outcome = results to be critically appraised and intervention to be discussed with client*

Absent from this equation is the practitioner. Should practitioner variables be added to the literature review search? Good scientific procedure requires that all variables be considered regardless of whether they are independent, dependent, or latent variables. Accounting for these variables is especially important if a match is sought between the research literature and the client–social worker context. This becomes particularly important if research is considered that reports that therapist effects account for 6–7% of client outcomes (Wampold, 2001). In addition, the *Code of Ethics of the National Association of Social Workers* (National Association of Social Workers [NASW], 1999) requires that social workers practice in nonoppressive and culturally sensitive ways. Practice from this ethical base must include a recognition of the influence of how a social worker's race, culture, clinical training, family of origin, present relational status, and so forth could be influential to his or her worldview and how the practitioner could be interpreted by the client. To appropriately reflect the control of these variables in EBP and to meet NASW *Code of Ethics* requirements, it seems that the literature review equation should be modified to:

> *practitioner + client + problem + intervention + alternative intervention + hoped-for outcome = results to be critically appraised and intervention to be discussed with client*

The range of practitioner variables is great, and based on questions clients typically ask me in practice that matter to them the list could include such things as age, ethnicity, marital status, number of children, time in practice, methodological practice preferences, life satisfaction, job satisfaction, and career satisfaction, along with more obvious variables such as gender and race.

Why Are Context Variables Not Considered?

EBP should also account for the influence of variables related to context. These considerations may seem trivial but they are variables that should be considered and controlled if a clinical modality match is sought between the research literature and client–social worker context. This becomes particularly important if research is considered that attributes between 40%, (Asay & Lambert, 2002) and 87% (Wampold, 2001) of client change to extratherapeutic, context-related factors. Whether these context variables are obvious, like outpatient and inpatient, or less obvious, like the location of the office, the building, the part of town, distance clients drive, use of public or private transportation, ease of arrival, cultural composition of the neighborhood in which the office is located, client comfort level in being in the neighborhood and office, day and time of the week services are provided (Mondays and Fridays in particular should be considered), and time of year services are provided (winter, fall, summer, spring), these variables must be controlled and accounted. To enhance the effectiveness of the EBP linear protocol when attempting to match effective treatment to specific contexts these context variables should be included. Therefore, to appropriately control for variables the equation could be changed to:

> *practitioner + client + problem + context + intervention + alternative intervention + hoped-for outcome = results to be critically appraised and intervention to be discussed with client*

Why Are Client–Practitioner Relationship Variables Not Considered?

From an EBP approach, consideration should be given to the type and quality of the relationship between practitioner and client and how this relationship will influence the effectiveness of any intervention. Randomized clinical trials used to empirically validate treatments are based on manuals that specifically address how therapists should interact with clients in an effort to reduce therapist effects. If therapist effects are important to control, it would seem wise to consider them when seeking a match between a research study and a specific clinical context. This point is furthered by research that demonstrates the link between the therapist–client relationship and positive clinical outcome. More than 1,000 research findings demonstrate that a positive alliance is one of the best predictors of outcome (Orlinsky, Grawe, & Parks, 1994; Orlinsky, Ronnestad, & Willutzki, 2003) and far more influential than the clinical model being used (Asay & Lambert, 2002; Duncan & Miller, 2005; Wampold, 2001).

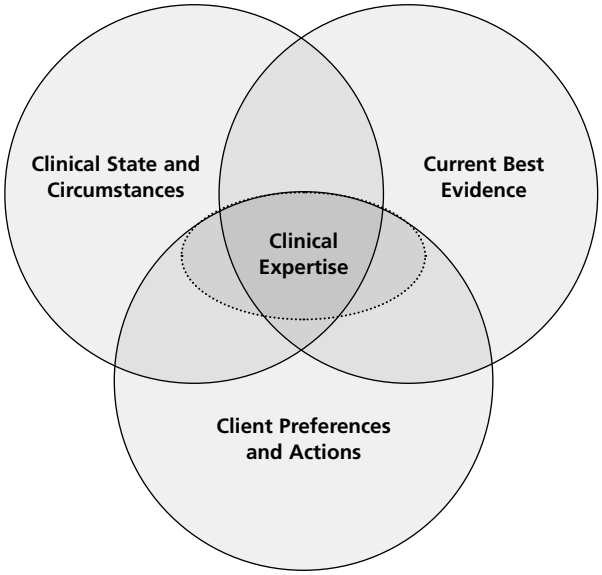
Additional questions that should be considered regarding the relationship include the following: If others (family members, friends) are brought into the therapeutic context, how does the relationship change? How does the practitioner change? And how does this influence the application of the intervention? It may be beneficial to include relational variables in the EBP protocol if a clinical modality match is to be made between specific context and researched treatments. These variables are endless and would include the reflexive interaction between variables for both practitioner and client such as their races, nationalities, economic statuses, family backgrounds, biases and beliefs, marital statuses, and life experiences, as well as whether family members attend sessions or if they don't show up for sessions. All of these variables will influence the relationship between client and practitioner. The relationship will influence the intervention itself. To control for these relational variables, perhaps they should be included in the literature review equation:

> *practitioner + client + context + relationship with client + problem + intervention + alternative intervention + hoped-for outcome = results to be critically appraised and intervention to be discussed with client*

Questioning Evidence-Based Practice Collaboration

To ensure that the client has a voice in the EBP process, the EBP protocol requires that the empirically supported treatment discovered through the literature review and informed by the EBP protocol be discussed with the client. To illustrate the collaborative nature of the EBP approach, Haynes, Devereaux, and Guyatt (2002) developed an oft-cited EBP model that considers a divide between three variables to arrive at the clinical approach to be used with a client: (1) 33.3% practitioner judgment, presented as clinical state and circumstance; (2) 33.3% client preference, presented as client preferences and actions; and (3) 33.3% research, presented as current best evidence (Figure 1). While this figure looks very clear on paper, in application questions have surfaced regarding its simplicity and accuracy.

Figure 1. *An evidence-based practice collaborative model.*

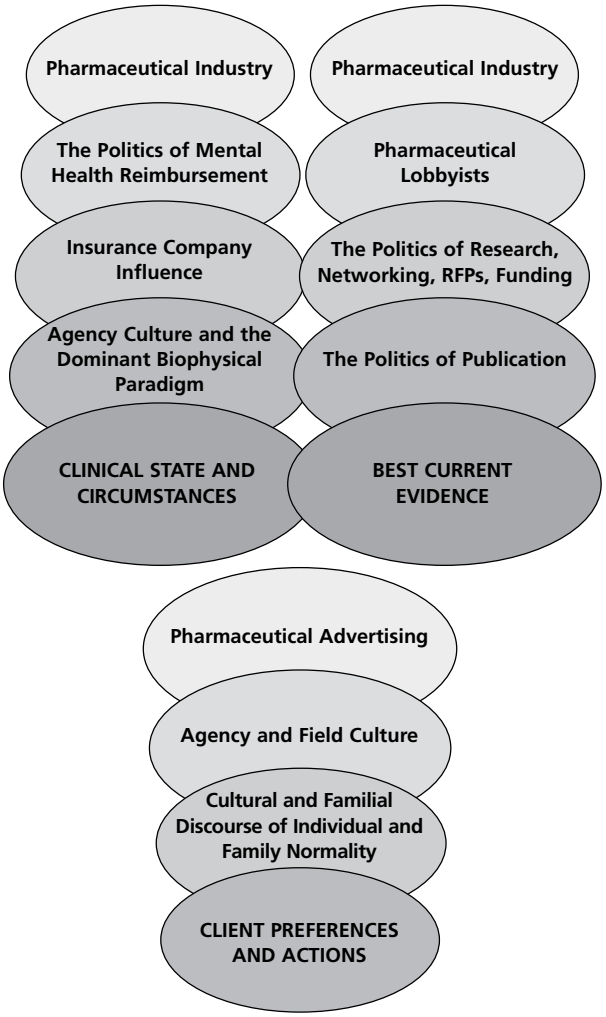


Note. Rendered from Haynes, Devereaux, & Guyatt (2002).

The consideration of the client's voice in the EBP model is certainly in line with the NASW *Code of Ethics* (NASW, 1999) but it may simplify the client–social worker interaction by ignoring power dynamics of which they are both a part. Power dynamics are especially important to recognize in social work because so many of our clients are in underprivileged and oppressed situations. To ignore the dynamics of power is to ignore the cultural influence of the mental health profession, the politics of research, and the effects of cultural and familial discourses that operate in the client–social worker relationship and on the client and social worker before the client–social worker relationship is formed. These forces obscure possibilities for the client, and for the relationship, that in many cases may have contributed to the development of the problem.

In an effort to better explain the power dynamics that have been experienced in clinical practice the one-dimensional model presented by Haynes et al. (2002) has been shifted to a two-dimensional model (Figure 2). This shift exposes the political nature of the therapeutic relationship. In opening these categories, we see that what

Figure 2. *A visual relationship of power dynamics in evidence-based practice collaboration.*



appears to be a simple, level playing field of collaboration may be more complex in application, especially when working with clients who are oppressed in varied ways. We see that discussions that occur in the therapy room about problems and treatment options are more complex, hierarchical, and political than they may first appear.

In the new model, hierarchical problem perceptions are recognized. It is possible to see that in some situations generalized research knowledge may take precedence over practitioner and client perceptions because the practitioner is operating within the "professional" culture of the mental health industry and under the influence of the politics of knowledge creation. The mental health industry may be seen as a culture with a language that privileges certain understandings and obscures others. Practitioners are trained in, operate within, and must survive inside the cultural hierarchy of mental health. Clients must enter the culture of mental health when seeking services. Within this culture clients may have little voice to define their problems when faced with more dominant ways of understanding as represented by *DSM-IV-TR* categories, constructed evidence, and privileged "professional" knowledge. To illustrate this point, recall the APA Division Twelve suggestion to clients that the first question to ask prospective clinicians when beginning the therapeutic process is: "What diagnosis best describes my problem?" followed by the question "What therapies have scientific support showing that they are beneficial for treatment of my problem?" (APA, 2007, p. 1). This marginalization of the client voice may occur because in EBP the client and therapist are not invited to rise above the influence of the dominant discourse of pathology and internalization of problems within individuals. The pathology discourse invites client and practitioner to self-subjugate around constructions of cultural normality.

Adjustments to the Haynes et al. (2002) model help to illustrate that best current "evidence" may be put in a privileged position by EBP. The logic of the protocol begins and ends here. With "evidence" at the axial point, decisions are made within the EBP collaborative conversation that either go with or against the constructed literature review findings. This may place clients in a power disadvantage as they choose whether to follow the privileged knowledge constructed as "evidence" or choose to go against it. The construction of this binary privileges knowledge that has been given the constructed evidential seal. What may be masked is the subjective operationalization of the EBP linear protocol that leads to the discussed empirically supported treatment, the political and cultural creation of this evidential seal, and the political and cultural creation of the knowledge that displays its label. This process is Foucault's (1965, 1975, 1979) concept of power or knowledge in action. In addition to the power differential in the therapeutic context, the EBP collaborative model may leave little room to discuss research counter to the effectiveness literature that maintains that all modalities are equally effective regardless of problem type (Asay & Lambert, 2002; Wampold 2001).

Client Preferences and Actions

Clients are bombarded with discourses concerning health and normality that operate on them in personally devaluing and segmenting ways. Advertising from drug companies, among others, invites the public to compare their lives to the lives they "should be" leading. The yardstick of normality is constructed and marketed to people during strategically researched times for capturing targeted audiences.

Peppered between sitcoms showing beautiful people from a mostly White culture humorously solving problems in 30 minutes are commercials asking questions as to why viewers are not happy enough, sexual enough, relaxed enough, focused enough. These commercials increase during peak marketing hours: Friday and Saturday nights, daytime, and late nights. Many clients in my office have been bombarded by discourses of normality to which they are to measure up and with pathological label suggestions. Often they seek help after viewing commercials or reading print ads marketed to coincide with the latest drug release.

In sum, the conclusion that when operating within the EBP paradigm the client is making his or her own unbiased, uninfluenced choice concerning treatment may be shortsighted because many factors contributing to the construction of the decision are not addressed. Specifically, these factors are representative of the power differential that exists between expert knowledge and indigenous client knowledge within the discourse of mental health, in which researchers receive funding, and by which pharmaceutical companies prosper.

Evidence-Based Practice Questions Considered

A discussion of EBP and the challenges of its application in clinical practice have been presented. The core values of EBP are commendable, and it is of utmost importance to find the best way to assist clients in achieving their goals. The application of the EBP effectiveness literature review protocol in practice raises questions about its feasibility to test or match a researched modality to a specific clinical context. Specifically, questions were raised concerning (1) the difficulty of operationalizing clients and problems; (2) the fact that problems are very rarely singular and very rarely static; (3) consideration of additional variables such as practitioner, context, and client–social worker relationship; and (4) the possibility that the EBP model may underestimate a power imbalance between client and social worker.

With recognition of the subjective nature of operationalizing the client and the problem variables in the EBP effectiveness protocol and the addition of the variables of the practitioner, context, and relationship, it may be more difficult to conduct an EBP literature review that will return valid and useful results regarding researched modalities. To test this hypothesis a search was conducted using the modified EBP COPES protocol constructed in this article with the search engines EBSCOhost and ProQuest. The EBP protocol was operationalized based on a client diagnosed with depression, and practitioner, context, and relationship variables were drawn from my demographics and practice with the client. No results were returned from either search engine based on these characteristics.

From a client-directed perspective, the space liberated by this lack of literature results is ripe with possibilities and may serve to emphasize the client voice in the therapeutic process. Lacking an outside source detailed sufficiently to capture the complexities of the specific therapeutic context perhaps emphasis could be placed on listening to clients and moving in relation to their theories of change, and the dynamic understandings of the problem(s) they are experiencing. Void of generalized knowledge, the space may be recognized as being filled with client knowledge, and knowledge in context, which could lead to client and relational possibilities. A client-directed approach may honor the therapeutic space by placing clients in focus and exploring their understandings, honoring the diversity of context, individual, relational, and cultural ways of understanding through the privileging of the indigenous knowledge of the client. With this understanding of practice, outcomes need not be cast aside as irrelevant but sought from the specific client, and created and reflected upon in collaborative ways. Evidence of effectiveness stems from the specific clinical context, and collaborative shifting is guided by client feedback within that context.

Clients are bombarded with discourses concerning health and normality that operate on them in personally devaluing and segmenting ways.

In conclusion, EBP is an approach to practice decision making that is steeped in excellent values. These values are based on assisting clients and social workers to find the best and most efficient ways to solve and manage problems. In application, the use of EBP as a clinical decision-making model has been challenging in its present state due to a lack of flexibility and specificity in the literature review protocol. The present infeasibility of its use leads me to client-directed forms of clinical decision making, informed by collaboration with clients and centered on their understanding of the problem(s) they are experiencing and their theories of how change can occur. Practice is guided by the evidence of effectiveness gathered in this shared therapeutic context and adapted based on progression toward client goals.

References

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

American Psychological Association. *A guide to beneficial psychotherapy*. Retrieved October 10, 2007, from http://www.apa.org/divisions/div12/cppi.html

Asay, T. P., & Lambert, M. J. (2002). The empirical case for the common factors in therapy: Quantitative findings. In M. A. Hubble & B. L. Duncan (Eds.), *Heart and soul of change: What works in therapy* (pp. 23–55). Washington, DC: American Psychological Association.

Beck, J. S. (1995). *Cognitive therapy: Basics and beyond*. New York: Guilford.

Cochran Library. (2007). Retrieved on October 10, 2007, from http://www.mrw.interscience.wiley.com/cochrane/cochrane_clsysrev_subjects_fs.html

Duncan, B., & Miller, S. (2005). The manual is not the territory. In J. Norcross, R. Levant, & L. Beutler (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 329-337). Washington, DC: American Psychological Association.

Duncan, B., Miller, S., & Sparks, J. (2004). *The heroic client*. San Francisco: Jossey-Bass.

Duncan, B., Miller, S., & Sparks, J. (2007). Common factors and the uncommon heroism of youth. *Psychotherapy in Australia, 13*(2), 34–43.

Foucault, M. (1965). *Madness and civilization: A history of insanity in the age of reason*. New York: Vintage.

Foucault, M. (1975). *The birth of a clinic: An archaeology of medical perception*. New York: Vintage.

Foucault, M. (1979). *Discipline and punish: The birth of the prison*. New York: Pantheon.

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

Gambrill, E. (2005). *Critical thinking in clinical practice: Improving the quality of judgments and decisions*, (2nd ed.). New York: Wiley.

Gambrill, E. (2006). *Social work practice: A critical thinkers guide*. London: Oxford.

Gambrill, E., & Gibbs, L. (2002). Making practice decisions: Is what's good for the goose good for the gander? *Ethical Human Sciences & Services, 4*(1), 31–46.

Gibbs, L. (1990). Using online databases to guide practice and research. *Computers in Human Services, 6*(1–3), 97–116.

Gibbs, L. (2003). *Evidence-based practice for the helping professions*. Pacific Grove, CA: Brooks/Cole.

Gibbs, L., & Gambrill, E. (2002). Evidence-based practice: Counterarguments to objections. *Research on Social Work Practice, 12*(3), 452–476.

Hare-Mustin, R. (1994). Discourse in the mirrored room: A postmodern analysis of therapy. *Family Process, 33*, 19–35.

Haynes, R. B., Devereaux, P. J., & Guyatt, G. H. (2002, March–April). Clinical expertise in the era of evidence-based medicine and patient choice. [Editorial]. *ACP Journal Club, 136*(A11), 1–2.

Irving, A. (2006). Being is not syntactical: Ethics as intensities. *Canadian Social Work Review, 23*(1-2), 131–137.

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

Karger, H. J. (1999). The politics of social work research. *Research on Social Work Practice, 9*(1), 96–99.

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

National Association of Social Workers. (1999). *Code of ethics of the National Association of Social Workers*. Washington, DC: Author.

Orlinsky, D. E., Grawe, K., & Parks, B. K. (1994). Process and outcome in psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 270–378). New York: Wiley.

Orlinsky, D. E., Ronnestad, M. H., & Willutzki, U. (2003). 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.

Raw, S. D. (1998). Who is to define effective treatment for social work clients? *Social Work, 43*(1), 81–86.

Thyer, B. A., & Myers, L. L. (1998a). Response to Raw letter: More on the empirical practice movement. *Social Work, 43*(5), 478–480.

Thyer, B. A., & Myers, L. L. (1998b). Supporting the client's right to effective treatment: Touching a Raw nerve? *Social Work, 43*(1), 87–91.

Thyer, B. A., & Myers, L. L. (1999). On science, antiscience, and the client's right to effective treatment. *Social Work, 44*(5), 501–504.

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

Wendt, D. C., & Slife, B. D. (2007). Is evidence-based practice diverse enough? Philosophy of science considerations. *American Psychologist, 62*, 613–614.

Witkin, S. L. (1992). Should empirically-based practice be taught in BSW and MSW programs? No! *Journal of Social Work Education, 28*, 265–269.

Witkin, S. L. (1996). If empirical practice is the answer, then what is the question? *Social Work Research, 20*(2), 69–75.

Witkin, S. L. (1998). The right to effective treatment and the effective treatment of rights: Rhetorical empiricism and the politics of research. *Social Work, 43*(1), 75–80.

Witkin, S. L. (2001a). Complicating causes. *Social Work, 46*(3), 197–201.

Witkin, S. L. (2001b). The measure of things. *Social Work, 46*(2), 101–104.

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

Wood, G., & Tully, C. (2006). *The structural approach to direct practice in social work: A social constructionist perspective*. New York: Columbia.

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Manuscript received: March 13, 2007
Revised: October 24, 2007
Accepted: November 30, 2007

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