CHAPTER ONE

Overview: Defining and Linking Assessment, Intervention, and Evaluation

The teaching of basic or essential skills has a long tradition in social work and the allied helping professions. The sources that have influenced the development of the essential-skills curriculum in social work programs over the past century include theory, practice wisdom and tradition, and more recently, empirical research on the processes of psychosocial interventions and their relationships to client outcomes (e.g., Compton & Galaway, 1999; Hill & O’Brien, 2004; O’Hare, 2005; O’Hare & Collins, 1997; Orlinsky, Grawe, & Parks, 1994; Perlman, 1957; Richmond, 1918; Rogers, 1951; Shulman, 1999; Truax & Carkhuff, 1967; Woods & Hollis, 1990). Many other practice scholars, too numerous to name here, have contributed to the vast body of literature on how to help people in serious psychosocial distress. Until recently, however, little work has been done to provide a conceptual model of social work practice that incorporates a broad array of interdisciplinary influences from social work, counseling, clinical psychology, and the other allied helping professions and that emphasizes the skills supported by the preponderance of current process and outcome research.

Building on the prior accomplishments of the previously mentioned practice scholars, the current chapter (1) outlines a conceptual model of social work practice skills that is informed by practice experience and tested through research methods, and provides a foundation for constructing evidence-based practices in contemporary social work, and (2) incorporates essential assessment and evaluation skills into that model.

Practitioners who work with individuals, couples, families, and small groups experiencing psychosocial difficulties and disorders are primarily concerned with three key professional functions: assessment, intervention, and evaluation. Assessment requires that the practitioner have a competent
grasp of the relevant knowledge base pertinent to the client’s presenting problems and a keen understanding of the client’s difficulties and adaptive strengths as conceptualized from each client’s unique point of view. Interventions comprise combinations of essential skills drawn from three major categories: (1) support, which engages the client in a working relationship and facilitates the intervention process; (2) therapeutic coping, which enhances the client’s ability to cope with life’s stressors, reduce symptoms of serious disorders, and solve problems; and (3) case management, which improves social and instrumental supports and coordinates complex services. A practitioner ideally develops an intervention plan by consulting the relevant practice research and then flexibly implementing the approach to fit the client’s needs and circumstances. A practitioner evaluates an intervention by employing key measures of the client’s difficulties at assessment and repeating those measures at key intervals during the intervention, at termination, and if possible, within six months to one year following the termination of services. The measures should include quantitative and qualitative indicators of the client’s problems (e.g., depression) or intervention goals (e.g., improved relationship with parents, reduced alcohol use), so they can be used to monitor client progress and determine (to some degree) whether the intervention was successful.

Figure 1 is a model representing the reciprocal relationships among assessment, intervention, and evaluation. As Figure 1 depicts, assessments are grounded in human behavior research, guide treatment selection, and provide a baseline for evaluation of one’s own practice. A practitioner selects an intervention on the basis of supporting outcome research but flexibly adapts implementation to individual client’s problems, needs, and circumstances. Interventions across all treatment modalities comprise combinations of supportive, therapeutic coping, and case management skills. The practitioner then monitors the client’s progress and evaluates treatment over time with both qualitative and quantitative indicators. Ongoing client change further informs the assessment. This process continues in a cumulative and interactive manner until termination of the case.

The skills combined to conduct assessment, intervention, and evaluation range from the simple to the complex. Becoming an effective advanced practitioner means first learning the essentials and then applying them to more challenging and complex problems over time as one gains additional knowledge and experience. This chapter briefly describes each essential aspect of practice and how all the aspects are interrelated. First, a brief
review of traditional practice theories is in order for two reasons: to understand their contributions to contemporary practice and to understand why each alone does not provide an adequate foundation for effective practice.

A Review of Traditional Practice Theories

Many practice scholars would agree that three or four major theories have guided social work over the second half of the twentieth century: psychodynamic; cognitive behavioral; family systems; and a collection of relatively atheoretical phenomenological approaches known as humanistic, constructivist, narrative, solution focused, existential, and client centered.
Some of these approaches have had important influences on contemporary practice, yet each by itself provides an inadequate foundation for understanding human behavior, conducting a complete assessment, explaining the processes of change, or offering intervention methods that are universally effective. In addition, some of these models have not been adequately tested, and others, when tested, have failed to show substantial benefits to clients.

*Practice theory* (also known as *orientation* or *school of thought*) is a catchall phrase that represents a collection of different types of theories and assumptions associated with a general intervention approach. The term *practice theory* refers to three different practice dimensions: (1) assumptions and theories about human behavior in the social environment (human behavior theory); (2) assumptions and theories about how people change (change-process theory); and (3) a collection of practice skills, techniques, and strategies intended to help people reduce psychosocial distress, reduce symptoms of psychological disorders, and improve coping capabilities (i.e., enhance individual strengths). Collectively, these activities are referred to as an “intervention” (Figure 2).

The first dimension of a practice theory addresses the following questions: Why do people behave as they do? How do human beings develop into happy and productive members of society or become unhappy or troublesome to others? What biological, psychological, social, cultural, and environmental factors affect people over time, and how do these risk and resilience factors interact to result in positive or negative adaptation across different areas of people’s lives? Obviously, such questions are complex, and the research methods for answering them can be complicated as well. Nevertheless, a considerable amount of knowledge has been developed and cataloged that helps us understand some of the factors that contribute to major mental illnesses, addictions, childhood disorders, domestic violence, and so forth. The knowledge base of human behavior in the social environment is derived from the findings of multivariate research and provides a foundation for conducting informed assessments with clients. Human behavior theories are now understood to be complex and multivariate, and they incorporate a range of biopsychosocial influences. Thus, human behavior theories that overemphasize one factor or another (e.g., bad genes, bad mothering, bad learning experiences, dysfunctional thinking, stressful environment) are not considered sufficient to adequately explain the causes of human problems and cannot be relied on exclusively to support adequate assessments.

Human development is influenced by the complex interactions of both risk and resilience factors over time. Risks and resiliencies can originate
from and be expressed as biological, psychological, social, and environmental factors. They can also be conceptualized as two ends of a continuum that represent the influences of both individual psychosocial pathology and adaptive strengths. For example, if a biological predisposition to depression or substance abuse is a risk factor, having parents with no such history or parents who have modeled how to successfully cope with depression can be considered a strength or a form of resilience. The same can be said of positive versus negative psychosocial influences from one’s family (e.g., good vs. negative modeling behavior of parents), quality of education, or other social or socioeconomic influences on one’s life. As these examples imply, both risks and resiliencies can also be categorized as causal factors, change-process factors (i.e., mediating factors), or developmental or treatment outcomes. Biopsychosocial risks and resiliencies can affect human development (e.g., ability to handle stress), affect the process of change in treatment (e.g., ability to handle critical feedback and try new behaviors),
or be the outcome of healthy psychosocial development or the result of an intervention (e.g., the degree to which a client learns to cope with bouts of depression or use social supports). Obviously, any and all of these forms of behavior can be considered either a risk factor or resilience factor depending on how, to what degree, and under what circumstances an individual expresses them.

The second area of knowledge required to support a practice theory derives from research on human-change processes. Change-process theories are human behavior theories that focus on how people change, and like human behavior theories in general, they are likely to include contributions from the biological, psychological, and other social sciences. This category of theory development addresses questions such as the following: What are the psychosocial mechanisms by which people change their behavior or situation for the better? What personal or environmental factors affect how people change? What are the biopsychosocial mechanisms that must be activated for people to achieve lasting change with or without formal psychosocial intervention? Answers to these questions can help us understand how people achieve success over their addictions; reduce impulsive behaviors such as self-mutilation; reduce symptoms of depression or psychosis; gain confidence to conquer anxieties and other fears; or simply become better communicators, problem solvers, more effective parents, or more loving partners.

Depending on the practice theory employed, change has been shown to result from a number of processes, such as increased mastery or self-efficacy; reinforcement from an external source; biological changes brought about by exercise or medication; or situational factors such as finances, improvement in a relationship, spiritual enlightenment, or the removal of some externally oppressive force. The reasons people change are complex and currently poorly understood in the behavioral sciences. Although theories abound, evidence to support specific change-process theories remains inconclusive at best. How these change processes can be activated to help clients overcome problems and enhance their adaptive capabilities is the focus and purpose of psychosocial interventions. However, although it is well known that some psychosocial interventions are effective, and that some are more effective than others for specific problems, much less is currently known about how these approaches help people change.

The third dimension of a practice theory, the intervention methods, are defined by the activities of the practitioner, the client, and the practitioner-client interactions—activities that help a client solve a problem or improve overall psychosocial well-being by activating some or all of the change processes discussed previously. Interventions comprise a collection of
skills, intervention techniques, and overall strategies that help clients move toward their goals. Practice skills, collectively, are the efforts that constitute the intervention, and it is the use of these skills that can be defined, observed, and evaluated.

Although underlying human behavior and change-process theories are critically important matters, it is the actual skill combinations (i.e., the intervention) that can be more readily defined, taught, supervised, tested, and evaluated to determine whether they effectively help clients reduce symptoms, enhance coping abilities, and improve overall life circumstances. Thus, when adopting a practice theory, it is important to clearly distinguish the following separate but related parts: human behavior theory (i.e., the factors that cause the problem), change-process theory (i.e., the factors that explain how people change), and the intervention itself (i.e., the skills the practitioner uses to help the client). Confusion of these parts has often led to erroneous claims and abject confusion in the social work practice literature on the respective roles of theory and practice.

The Current State of Prominent Practice Theories

Although most practice theories and traditions have made positive contributions to effective social work practice, they all have both strengths and limitations. Some of the problems with current practice theories are the following: (1) scientific evidence often does not support the theoretical assumptions; (2) there may be some merit to the underlying theory, but the intervention methods have not been adequately tested or shown to be effective; and (3) the practice theory, in general, is not broad based enough to support a comprehensive approach to treating a wide range of psychosocial problems. Some social work practice theory texts do not use a critical framework to help students judge the relative validity of these theories but rather present practice theories as though they are all, more or less, equal and should be evaluated on their intuitive appeal to the student or the instructor. However, professional practice in all helping professions now demands more critical analysis of evidence in support of theories and practices. Although a thorough critique of each of these theories is not possible here, what follows is a brief overview and summary critique of the more prominent practice theories used in social work practice today.

Psychodynamic Theory

Psychodynamic theory has long been a mainstay for practitioners because of its intuitive appeal and its apparent explanatory power to illuminate
how people develop psychologically (human behavior theory), how they
change (change-process theory), and how practitioners attempt to help
them (intervention techniques). Human behavior theory (according to psy-
choanalytic thought) is somewhat complex and actually represents a col-
llection of somewhat different theories (e.g., Freud, 1938; Kernberg, 1976;
Kohut, 1971). More recently, some psychodynamic social work prac-
titioners have shown interest in relational theory, a reconstituted form of
psychodynamic theory that also borrows from Bowlby’s (1980) and Mahler,
Pine, and Bergman’s (1975) theories on childhood attachment. In brief,
most psychodynamic practitioners work on the assumption that people
develop internal representations of themselves and adaptive capacities
(e.g., ego functioning, defenses) largely as a result of early childhood expe-
riences associated with interactions with their primary caretakers, particu-
larly their mothers. These internal representations and ego functions affect
the way they cope with human relationships and other environmental
stressors over time. Primarily as a result of these early influences, people
develop interpersonal relations that either are generally growth enhancing
or increasingly problematic. Much of the theoretical emphasis in psychody-
nalytic theory and its variants (e.g., ego psychology, object relations theory,
self-psychology, attachment theory, relational theory) is on the way early
childhood experiences establish relationship patterns (internalized models)
that, in large part, determine interpersonal functioning over the life span.
Assuming that clients have difficulties in intrapsychic and interpersonal
functioning, they may seek treatment.

Although psychodynamic theorists and practitioners have rightly
emphasized the importance of early childhood development, the core
assumption that specific disorders can be predicted as a function of the
timing and type of developmental disruption has not survived scientific
scrutiny. Early disruptions in nurturance have not been shown to accu-
rately predict the development of major mental illnesses, substance abuse,
or specific emotional and behavioral disorders. However, cross-sectional
and, more important, longitudinal studies have supported the conclusion
that, to one degree or another, such problems are largely a result of the
combined effects of genetic predisposition; early childhood experiences;
and familial, social, environmental, and cultural influences that interact
and reverberate over time. Thus, the important contributions of psychody-
namic theoreticians and researchers have been greatly modified and incor-
porated into a more multivariate developmental framework.

Regarding intervention methods, psychodynamic practitioners have
made important contributions to effective practice by emphasizing the
importance of developing and maintaining a sound working alliance and
creating a therapeutic environment in which the client can work through psychological injuries incurred in previous relationships. By using therapeutic techniques such as explanation and the interpretation of transference, practitioners attempt to help their clients better understand (through the change processes of insight and corrective emotional experience) how their past experiences affect them in the present. Through explanation and interpretation, practitioners attempt to help clients better understand their difficulties and learn to cope with their current relationships in a more enlightened and fulfilling way. Although some have questioned the specific efficacy of interpretation (Weiss, 1995), a contemporary model of evidence-based practice owes much to the psychodynamic emphasis on the working alliance, which is a cornerstone of effective practice.

**Cognitive-Behavior Therapy**

Cognitive-behavior therapy (CBT) evolved from three sources: scientific approaches to reasoning and cognition, classical and operant behavior theories, and social cognitive theory (Bandura, 1986, 1999; Beck, 1976, 1996). Aaron Beck’s cognitive theory of depression has had a substantial impact on the evolution of CBT. For cognitive therapists, cognition is primary. Thus, for people to change their distressing thoughts about themselves, others, the world about them, and the future, they need to question and refute dysfunctional (i.e., irrational) ways of thinking: “If someone doesn’t like me, then, it must be that I am no good”; “If I don’t get into the school of my choice, I’m never going to be a success”; “I saw some students talking and laughing in the cafeteria; they must be making fun of me”; “If she leaves me, I will have to kill myself”; and so forth. By way of intervention technique, cognitive-behavior therapists guide the client in a critical examination of dysfunctional thinking (see the section “Critical Thinking” in chapter 2). The crux of gentle inquiry is to challenge the client to answer the question: “Where is the evidence to support your view that, for example, you can’t live without her, or that everyone is laughing at you?” However, the goal of CBT is not to simply help clients reason their way out of their dilemma but to set up real-world tests to disconfirm or debunk the irrational belief (i.e., a process known as behavioral disconfirmation). The result of disconfirming dysfunctional beliefs can be highly reinforcing, and with increased self-confidence (i.e., self-efficacy), clients feel that they can continue to make progress with their particular difficulties.

Although cognitive practitioners focus on helping clients challenge irrational beliefs through critical thinking, traditional behaviorists emphasize gradually changing behaviors to positively reinforce change (i.e., increase
the likelihood of change). Although behavioral interventions have shown generally positive results, they are unsatisfactory for some because they tend to downplay the cognitive component, or the client’s view. Theoretically, behavioral models fell short because research has shown that external reinforcement procedures, though facilitative of change, are not always necessary or sufficient to produce change. Neobehaviorists and, later, social cognitive theorists like Albert Bandura began to take a more explicit scientific interest in the role of cognition in relationship to behavior and reinforcement. Social cognitive theory incorporates cognitive and behavioral theories but emphasizes the role of learning without immediate external reinforcement and stresses the importance of increasing self-efficacy, thus bolstering the belief that one can cope with challenging situations. Social cognitive theory provides a somewhat-integrated model for human behavior theories in that it emphasizes the interrelatedness of cognition, physiological responses (e.g., anxiety reduction), behavior change, and their reciprocal relationship in the social environment.

As a result of the combined influences of research in cognition, conditioning theories, and social cognitive theory, change processes in cognitive behavioral interventions now emphasize changing dysfunctional thinking, anxiety reduction methods, and the reduction of dysfunctional thinking through behavioral disconfirmation (i.e., practice in real life), with a resultant increase in one’s belief that one can successfully cope with similar problems in the future (i.e., increased self-efficacy). Intervention methods used by cognitive-behavior therapists are quite eclectic, depending on the problem, and include directly addressing cognitive distortions by critically examining those thoughts (i.e., Socratic questioning); using covert (i.e., in the imagination) and in vivo (i.e., live) rehearsal, role-play, and practice of new behaviors; direct modification of physiological arousal (e.g., exercise, relaxation, and mediation techniques); improved problem-solving and communication skills; and the use of reinforcement techniques to improve one’s own or another’s (e.g., a child’s) behavior.

To illustrate the combined influences of cognitive, behavioral, and social cognitive theory, consider the scenario of the young woman who suffers from severe shyness and general lack of self-confidence. After critically analyzing “the evidence” (or lack thereof) to support her view that no one likes her and everyone laughs at her, the young woman and the practitioner collaboratively plan weekly tasks to initiate brief conversations with some people in her class. The practitioner helps the client reduce her social anxiety through simple breathing techniques and provides guidance
through role modeling and rehearsal to work on improving her conversation skills. After a few in vivo attempts (i.e., actual real-life experiments), she is likely to have had one or two successful conversations, and the expectation that people are always talking about or ridiculing her begins to dissipate. As a result of these reinforcing experiences, she grows in self-confidence, is less concerned about being laughed at, and presents herself as more confident (i.e., greater self-efficacy) and therefore more likable to others. In this way, current approaches to CBT have combined the developments of cognitive, behavioral, and social cognitive theories over the past forty years to result in a flexible and often creative evidence-based approach to practice.

Cognitive-behavior theory has spawned a wide array of effective interventions that have influenced and been combined with other interventions to ameliorate serious problems, including major mental illnesses, depression, anxiety disorders (including panic disorder with agoraphobia, obsessive-compulsive disorder, and posttraumatic stress disorder), eating disorders, substance abuse and addictions, borderline personality disorder, and the full range of childhood emotional and behavioral disorders. No other intervention methods can rival the totality of clinical outcome research that supports cognitive-behavior therapies.

Nevertheless, despite its success, the cognitive-behavioral model has limitations. Until recently, CBT theoreticians and practitioners often gave short shrift to the importance of the therapeutic relationship despite the evidence underscoring its importance as an effective dimension of psychosocial interventions. In addition, change-process research has not clearly supported theoretical assertions regarding how or why people change (e.g., increased self-efficacy, reduced dysfunctional thinking). Other interdisciplinary contributions are needed to enhance CBT approaches: developments in biological sciences regarding the brain and behavior, the addition of family intervention skills to broaden and improve assessments and intervention effectiveness with childhood disorders, an increased focus on processes associated with the therapeutic alliance, and a broader appreciation for environmental factors regarding the impact of cultural and socio-economic influences. Nevertheless, cognitive-behavior therapies have set the benchmark for methodologically sound clinical outcome research, have provided practitioners with well-established effective interventions for a wide array of adult and childhood problems, and have become increasingly eclectic by incorporating multiple methods and modalities in its skill repertoire depending on the client’s disorder or problems-in-living. Needless to
say, empirical developments in cognitive-behavior theory highly influence most evidence-based practices today.

**Phenomenological Therapies**

Since the 1950s, a variety of relatively atheoretical therapies evolved, to some extent, as a counterweight to the dominant approach at the time—psychodynamic therapy—and, more recently, as a reactionary response to empirically supported interventions in general. These include existential (e.g., Frankl, 1963; May, 1969), narrative (e.g., Berg, 1999), humanist (e.g., Goldstein, 1986), solution-focused (e.g., O’Hanlon & Weiner-Davis, 1989), strength-based (e.g., Saleeby, 1996), and other similar phenomenological and experiential approaches. The term *phenomenological* generally refers to an attempt to describe the pure experience of the client, unfiltered and unfettered by psychological theories, research findings, or the practitioner’s perspective. These approaches attempt to engage clients on their own psychological turf and work with their own inner experience (i.e., phenomenology) to define the problem and seek solutions. To varying degrees, phenomenological practitioners generally avoid, diminish, or reject outright theory-driven research on human behavior and feel that practice research somehow distorts or sullies client experience and the creativity and spontaneity of the client’s change experience. This position might be considered a limitation in the current professional environment because practitioners are expected to provide research-based justification for their choice of intervention.

As for practice methods, the approaches generally incorporate a range of counseling techniques and pragmatic problem-solving approaches to help clients express their own unique view of problems and to construct potential solutions for them. Sometimes expressive, creative, or otherwise experiential techniques are employed to aid in this process. These techniques might include drawing, writing poetry, keeping diaries or journals, and using dramatic demonstration or other creative modes of expression. How these methods are arrived at is, perhaps, somewhat spontaneous or intuitive, and clear or testable guidelines for implementation are usually not provided. In fact, such approaches are often difficult to define, and few research-based guidelines are available to either clarify or justify the use of these methods with specific problems. However, a key strength of phenomenological approaches is the emphasis on exploring and understanding clients’ experience from their unique perspective and working with clients’ strengths to develop intervention methods rather than impose interventions on clients.
Client-centered therapy (also called “person-centered therapy”; Raskin & Rogers, 1995; Rogers, 1951) was also developed as a relatively atheoretical approach to interpersonal helping that focused on the client’s inner experience. However, counseling and psychotherapy-process researchers later refined and further developed its key concepts over many years. As a result, client-centered therapy stands apart from other phenomenological approaches in that it has spawned the research foundation of modern psychotherapy process-outcome research. Rogers and his colleagues emphasized the inherent transformational abilities of the client and the practitioner’s abilities to express empathy, authenticity, positive regard, and respect for the client. Developing the working relationship on the basis of these principles remains a cornerstone of the psychosocial helping professions to this day. Client-centered counseling made unique and long-standing contributions to psychosocial practice as a result of the hundreds of studies conducted to define, measure, and test the efficacy of his basic helping concepts. Thus, the evidence for the essential role of the working relationship and the core helping skills of client-centered practice remain quite strong (Hill & O’Brien, 2004; O’Hare, Tran, & Collins, 2002; Orlinsky et al. 1994; Truax & Carkhuff, 1967).

In summary, proponents of narrative, existential, solution-focused, and other atheoretical approaches emphasize understanding clients’ inner experience and helping the client to use their innate abilities, skills, and strengths to find lasting solutions to their difficulties. As such, they provide an important foundation for working with a wide array of clients, but because of the lack of clear treatment guidelines, they must often be complemented with evidence-based approaches especially when working with clients who have moderate to severe psychosocial difficulties and disorders.

Family Therapies

Family therapies are actually a diverse group of practices designed to treat individual, couple, or family problems by including some or all members of the family in the intervention. However, family therapies vary widely in both theoretical foundation and intervention methods. Thus, family therapy is not really a coherent theoretical approach as much as it is a framework within which various theories and practices are applied to understand and deal with families in distress. To be more specific, it makes more sense to stipulate which type of family therapy is the focus of interest: psychodynamic family therapy, behavioral family therapy, humanistic family therapy, and so on.

Nevertheless, there appear to be some broad assumptions common
among family therapies (Becvar & Becvar, 1996; Nichols & Schwartz, 2006). First, working with family members is often a more effective approach because practitioners can see how family members interact as a system and can better understand how those interactions affect the problems of the identified client (i.e., the person, usually a child, who is presented as having or expressing the problem of immediate concern). Second, changes in the behavior of one family member tend to cause changes in other members. Third, the family system is made up of subsystems (e.g., parents, siblings, other alliances) that help maintain problems or can be keys to solving them. Fourth, changing the way the whole family behaves can help maintain changes over time because it is difficult for individuals to change within a family if other members undermine those changes, deliberately or unintentionally. Last, family problems often have a way of being transferred from one generation to the next.

Behaviorally oriented family therapy (including some strategic and structural approaches) has been extensively studied and shown to be effective for a variety of vulnerable clients including families with a member who suffers from schizophrenia, substance use disorders in a parent or adolescent, conduct-disordered children and adolescents, emotional disorders in children, eating disorders, anxiety, and depression, among others. Behavioral family practitioners emphasize the identification of problem behaviors, carry out a functional assessment of how family members interact, track the positive and negative consequences of those behaviors, and help family members change the way they communicate and problem solve to resolve difficulties and reinforce more constructive forms of interaction. These approaches incorporate basic family therapy principles (e.g., interactions, subsystems) but also use core behavioral approaches: cognitive examination of beliefs, practicing new behaviors in the consulting office and at home, promoting mutually reinforcing behaviors among family members, focusing on clear goals, and evaluating outcomes. Behavioral family therapies have also been used to work with families in which one member has a serious disorder such as a major mental illness or addiction to alcohol or other drugs. Evidence to support behaviorally oriented family and couples therapies is substantial, and the approaches are now strongly recommended for work with both emotional and behavioral problems in children and adolescents (Northey, Wells, Silverman, & Bailey, 2003), substance abuse problems (O’Farrell & Fals-Stewart, 2003; Stanton & Shadish, 1997), and mental illness (Dixon, Adams, & Luksted, 2000), among other family-related problems. Beyond working with the immediate family, behavioral family systems approaches have also been applied within a broader ecosystems model whereby the practitioner works with the family...
and other members of the community: law enforcement, schools, and other important collaterals with a vested interest in improving the welfare of the family. Multisystemic therapy (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998) is one exemplary approach.

Change-process theories in family therapies reflect the underlying theoretical assumptions of that particular type of family therapy. So, for example, psychodynamic family therapy relies heavily on relationship development and interpretation; behavioral family therapy emphasizes helping clients interact in ways that are more reinforcing. However, as with individual interventions, theories about how families change remain somewhat speculative. Thus, the only clear guidelines currently available for judging the relative efficacy of various family therapy interventions are drawn from the relevant practice outcome research on working with families. With a few exceptions, the bulk of research has been done on behaviorally oriented family therapies.

An Interdisciplinary Evidence-Based Approach to Social Work Practice

Various schools of practice have made important contributions to contemporary effective social work. The combination of a sound working alliance, respect for the client’s experience and strengths, the use of effective coping skills, and case management strategies provide a coherent framework for effective practice with a wide array of psychosocial challenges. Given that no individual practice theory is sufficiently comprehensive to understand our clients and intervene in their problems, a more systematic interdisciplinary framework is needed to inform social work practice. The approaches applied in this framework, however, must now be supported with guidelines based on practice research. What follows is a brief overview of the essential assessment, intervention, and evaluation skills now required for effective social work practice. These skills will be examined in greater depth in part 2 of this book, and how these skills can be flexibly combined to form evidence-based practices will be addressed in part 3.

Assessment

A Range of Assessment Strategies

In social work practice, assessment is a general term that refers to a range of strategies used to describe, analyze, categorize, measure, and otherwise
help practitioners better understand their client’s difficulties (Bellack & Hersen, 1998; Franklin & Jordan, 2003; O’Hare, 2005; Sadock & Sadock, 2003). There is a wide, varied literature on assessment but little agreement regarding what assessment is. For example, in conducting an assessment with a depressed client (here, Bob), a practitioner may do one or more of the following:

- Qualitatively describe Bob’s difficulties solely on the basis of his own perception and understanding of the problem (Bob might say, “I feel like I’m being crushed by the weight of the world”).
- Apply a psychiatric diagnosis (major depression, 296.00)
- Rate the severity of Bob’s problems in one or more areas of his life (on a four-point scale, where 0 = “none,” 1 = “mild,” 2 = “moderate,” 3 = “serious,” and 4 = “severe”)
- Analyze a sample of Bob’s daily behavior in detail to identify factors that seem to be associated with his depression (e.g., after discussing Bob’s day-to-day struggles at length, the practitioner may try to help him connect the dots by pointing out the following: “It appears that you feel worse after you have consumed a lot of alcohol over the course of a couple of weeks, you’ve missed work, and your wife is angry at you for neglecting her and your children. Your kids don’t sound too happy with you either. Could your depression be, at least in part, a consequence of heavy drinking and the consequences related to drinking?”)
- Observe the interactions of family members to determine how problems are caused or maintained. In a family visit, the family expresses feelings to one another about Bob’s drinking and neglect of his obligations at home and work. The social worker observes the communication patterns, body language, the tone of their expressions, and so on.

All of these methods of assessment have useful qualities to recommend them, and they all have limitations because, as described earlier, the human behavior theories on which they are based have limited explanatory power. Therefore, to apply only one form of assessment is likely to prove inadequate in most cases. Thus, a pragmatic approach to assessment would combine some of the more useful aspects of different methods and capitalize on the guidance of research literature when relevant.

The Critical Role of “Person” Factors

Although practitioners should approach assessment with the understanding that all clients are unique, one should also consider the important roles
of sex, age, race, ethnicity, culture, language, socioeconomic level, sexual orientation, and other client-identifying characteristics that are often grouped as demographics; however, I prefer (for lack of a better phrase) to call them personal identity factors. In the context of human behavior theory and research (in addition to some degree of common sense), these factors often provide important clues to variation in types and severity of problems among both individuals and client groups. For example, on average, men consume more alcohol than women, women are much more likely to meet diagnostic criteria for clinical depression than are men, clients from racial minorities are more likely to feel reluctant to engage in treatment in an agency staffed predominantly by whites, a recent immigrant may have little understanding of what behavioral norms are expected in a therapy clinic, and so on. Although one should avoid stereotyping people by such personal identity factors, they often help guide assessment strategies by pointing out known risk and resilience factors that, on average, may represent some groups of clients more than others. However, the factors should be determined by research findings (e.g., culturally relevant approaches to treating mental illness) and in-depth appreciation for the experience of each client, not by folk wisdom or the practitioner’s personal experience. Clients with similar racial, ethnic, or cultural backgrounds, for example, may have different personal views on the meaning of those characteristics. How to engage clients on these important issues (e.g., cultural competence) will be more thoroughly addressed in chapter 4.

Sources of Assessment Information and Methods for Gathering It

A comprehensive assessment strategy requires gathering salient information, ideally from multiple sources and using multiple information gathering methods. Sources of assessment information are those people or databases that provide information that helps the practitioner better understand clients’ problems, strengths, and other salient facts about their situation. Other people who provide assessment information directly or indirectly (e.g., physician’s record) are referred to as collaterals or collaborators. Such sources include the client, family members or other relatives, school personnel, law enforcement or criminal justice workers, and other medical or human service professionals, among others. Relevant information about the client may be obtained from these parties or from pertinent reports.
Methods of information gathering encompass those techniques employed to obtain information from various sources. The most commonly employed method for gathering assessment information is face-to-face interviews, which are based primarily on the client’s self-report. This method may be relatively unstructured, but most interviewers have some key information that they plan to examine, such as the client’s mental status, quality of relationships with family or others in the community, general health status, use of alcohol or other drugs, and so forth. Given that the interview is somewhat structured, it is referred to as a *semistructured interview*. Because a large amount of essential assessment data can be gathered in the semistructured format, the practitioner wants to hit all the main points but can do so with considerable flexibility to accommodate the client’s pacing, priorities, style of communication, and unexpected disclosures. With practice, a skilled social worker can amass a considerable amount of important qualitative information in a fairly short period of time (for different aspects of interviewing techniques, see chapter 4).

Other information-gathering methods include direct observation of clients (e.g., social worker observing a child with a behavioral problem in school or a treatment facility) and the use of clinical rating scales and similar quantitative instruments (to be discussed subsequently). For a behaviorally troubled child or adolescent, obtaining various points of view from several family members as well as teachers and an attending physician or the child’s tutor or coach is likely to give a more complete assessment picture. In addition, combining large amounts of qualitative information from semistructured interviews and quantitative information from clinical rating scales can provide a rich and useful assessment and basis for ongoing monitoring and evaluation of each case. Above all, practitioners must remember that no client or collateral (collaborator) is interviewed without the informed consent of the client (or guardian), and when the data are collected, every effort is made to protect the client’s confidentiality (for further discussion, see chapter 3).

**Making Sense of Assessment Information**

A practitioner may gather pages of assessment information from the client, family members, and others involved in his or her care. What to make of all this information, however, is another matter. As noted earlier, there are a variety of different theoretical approaches to assessment based on different assumptions about the nature of client’s problems (e.g., a disease, a behavior problem, dysfunctional thinking). Yet, considering all the different models of assessment, there are two overarching themes that encompass them: first, the basic premise that clients’ problems are caused by
multiple biopsychosocial influences, both past and present, and that these problems manifest in multiple areas of a client’s life: psychological, social, physical, and economic, among others. These characteristics of problems (i.e., having multiple causes and manifesting multiple psychosocial effects) constitute multidimensionality.

Second, although clients with similar problems (e.g., addictions, depression) manifest similar characteristics and difficulties, each client experiences those problems differently, which becomes evident when practitioners conduct detailed assessments of the client’s day-to-day life. A detailed analysis of an individual client’s thoughts, feelings, behaviors, and situational factors that influence their behavior will reveal a complex interplay of vulnerabilities and strengths that affect the problem. These factors do not occur randomly but tend to follow a pattern. Even clients with major mental illnesses have good days and bad days, strengths and deficits that appear to coincide with improvements or declines in their condition. Troubled families in which conflict is frequent and intense also experience times of relative tranquility when parents or siblings seem to get along, some affection and cooperation is apparent, and serious problems abate. These patterns revealing both problematic and more adaptive experiences need to be identified so practitioners and their clients can accentuate adaptive behaviors and try to diminish behaviors that seem to maintain problems or precipitate crises. This unique patterning and sequencing of behaviors and related factors addresses the functionality dimension of an assessment. The detailed analysis of factors that seem related to a client’s daily experiences is referred to as functional analysis because the purpose is to tentatively determine and better understand how the problem functions (i.e., how it works). Taken together, contemporary assessment informed by both current research and client experience is referred to as multidimensional-functional (MDF) assessment (O’Hare, 2005; for details on how to conduct an MDF assessment, see chapter 4).

Using Clinical Rating Scales and Other Measurement Tools for Assessment and Evaluation

Evaluation of every case begins during the assessment phase. Although the rationale for evaluation and the use of various evaluation designs will be discussed further on in this chapter, it is important at this point to discuss the use of indexes and scales. What follows is a brief overview of the different types of instruments employed in everyday practice to enhance qualitative assessment and to lay a quantitative foundation for monitoring client progress.
Measurement instrument is, perhaps, the most generic term that encompasses a range of tools for measuring the frequency, intensity, or duration of various client problems. These tools range from the simple (e.g., counting the number of swear words Johnny uses each day) to the complex (e.g., scales that measure quality of life). They may also measure one or more domains of client experience (e.g., thoughts, feelings, behaviors). Measurement tools are not intended to substitute for a comprehensive qualitative assessment, but they serve as a useful adjunct to provide a quantitative baseline of client well-being in one or more areas (e.g., level of depression, anxiety). Scales also are a handy monitoring tool for gauging client progress during and after intervention. Measurement tools have some advantages over qualitative assessment in that the data collected from many clients in the same program can be aggregated and used for program evaluation, something that is much less practical with large volumes of qualitative reports. When used repeatedly on large numbers of clients, scales can provide important tracking information to determine whether a client or group of clients is improving, staying about the same, or getting worse. In addition, most measurement tools can be tested for two critical qualities: the consistency with which they measure some aspect of human behavior (i.e., reliability) and the accuracy with which they measure that behavior (i.e., validity). These matters will be discussed more in-depth in chapter 4.

There are generally four types of measurement tools used in everyday practice: (1) diagnostic categories, (2) simple indexes, (3) unidimensional scales, and (4) multidimensional scales. Although diagnosis is generally not considered a form of measurement, in fact, it is. Categorization is a basic and somewhat useful form of measurement (i.e., nominal measurement), and the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV), also allows for some degree of measuring the severity of the condition. Although diagnosis is an important part of an assessment, especially when dealing with serious mental illnesses, there are considerable limitations to using the DSM-IV, and psychiatric diagnosis is no substitute for a complete assessment.

Simple indexes may be among the most basic and useful tools for quick assessment and continuous monitoring of client progress. Assuming the client’s accurate self-report or others’ observational reports, indexes provide straightforward, useful information and are generally considered reliable and accurate with most clients (unless there is good reason to believe that the client has motive to distort information). Some examples include number of drinks consumed daily, number of good days a conflicted couple reports, number of days a young person attends class (or number of days truant), a student’s overall grade point average, number of times a young
woman with schizophrenia initiates a conversation in the community, level of intensity of panic attacks, intensity of depression on any given day, duration of time-out for an oppositional child, number of days sober for a mom trying to regain custody of her child, and so on. The variety of measures that a practitioner can create to specifically suit a client’s needs or situation is limitless. One needs only to accurately define a problem of concern and decide whether the best way is to measure its frequency (i.e., how often it occurs), intensity (i.e., severity of the problem), or duration (i.e., how long it lasts). Sometimes these indexes are referred to as self-anchored scales when they measure the client’s subjective report (e.g., severely depressed) rather than an observable measure (days absent from work).

Unidimensional scales are instruments that use multiple items to measure the same concept. Valid scales are typically developed by interviewing a representative sample of people that includes those who do and those who do not experience the given problem to one degree or another. For example, a scale for measuring depression may contain twenty items, some of which might include “I feel blue,” “I don’t know if I can go on living,” “I have little interest in things that I used to enjoy,” “I don’t sleep very well,” “I feel guilty,” and so on. Items like these have been shown to correlate statistically with a diagnosis of clinical depression. Depending on the purpose of the scale, the items may be measured by frequency (e.g., all of the time, most of the time, some of the time, seldom, none of the time), intensity (e.g., extremely, moderately, a little), or duration (a day, a week, a month, a year). Most scales measure all the items on the same rating system, though that is not always the case. In addition, some scales contain items that are scored in the opposite direction (e.g., “I feel happy” may be an item in a depression scale). If the client rated that item as “seldom,” then that item would indicate some degree of depression for that client. The benefit of scales is that they use multiple items that enhance reliability (consistency) and validity (accuracy). The client’s level of depression is gauged not on his or her response to one item but on responses to many items. In addition, the use of a scale improves the likelihood that practitioners will not forget to address key items, such as one that measures the frequency or intensity of suicidal thoughts. In this way, the adjunctive use of a scale improves the consistency and accuracy of assessments by indicating client responses to potentially high-risk behaviors.

Multidimensional scales share the same qualities as unidimensional scales but measure multiple aspects of a problem. As are unidimensional scales, they are designed and tested to optimize reliability and validity but are used to measure more complex problems. A scale that measures quality
of life, for example, may use five items to measure each of the following: satisfaction with living situation, health, psychological well-being, relationships, and spirituality. For ten domains of living, a total of fifty items may be used (five for each). Each domain can be scored individually to measure a specific domain (e.g., family satisfaction), and an overall global-life-satisfaction score might be used by combining all subscale measures. In addition to several quality-of-life scales, multidimensional scales have been designed to measure psychiatric symptoms, addiction severity, posttraumatic stress, childhood disorders, and many other areas relevant to social work practice.

Practitioners may decide to use only one type of measurement or a combination of measures. The selection of instruments may vary from client to client, or a program may use one uniform instrument package at client assessment and during intervention and postintervention to evaluate a program. Some instruments are proprietary; that is, they can be used only with the permission of the scale creator (often for a fee), but there is a growing array of scales that are readily available in the public domain for no cost. Practitioners can locate these fairly easily, as they are often compiled in reference books in the library or on various Web sites. Practitioners should also place a high value on a scale’s utility (i.e., practical use). In addition to being reliable and valid, scales should be relatively brief so that they can be incorporated into routine assessment or evaluation without placing undue demand on the client or on agency staff.

Assessment, overall, is both a qualitative and quantitative effort. A competent MDF assessment must be thorough, be grounded in current human behavior research, and describe the unique aspects of the client’s day-to-day experiences. Scales should be used to augment the assessment and lay a foundation for evaluation. Summarizing assessment data succinctly is a challenge, and linking this information to the overall service plan requires further knowledge regarding effective practices, the subject to which we now turn.

**Intervention**

**Defining Effective Interventions**

Interventions are combinations of skills applied by practitioners, their clients, and collateral participants (e.g., family members, teachers) and implemented for the purpose of reducing symptoms, resolving problems, enhancing adaptive capabilities, and improving the overall psychosocial well-being of the client. Interventions include skills and combinations of
skills that help clients achieve important intervention goals (e.g., lower depression, enhance couple’s communication, increase prosocial behavior in behaviorally disordered children, improve school performance, reduce symptoms of psychosis). Later chapters will examine practice skills and their application to specific problems in greater detail.

In brief, hundreds of studies by clinician-researchers have revealed that a wide variety of practice skills provide effective care. However, careful analysis of different practice approaches has revealed that these skills can be categorized under three major headings (Lambert & Bergin, 1994; O’Hare, 2005; Orlinsky & Howard, 1986; Orlinsky et al., 1994):

- **Supportive or facilitative skills**: Efforts to engage clients in a therapeutic relationship and facilitate client change
- **Therapeutic coping skills**: Intervention efforts that engage clients in actively changing the way they think, feel, and behave to solve problems, enhance adaptive strengths, cope better with life’s challenges, and reduce symptoms of serious disorders
- **Case-management skills**: Efforts that help clients deal with social and environmental barriers, gain access to needed resources, enhance social supports, and coordinate efforts of various service providers

As with other professional activities, beginning or basic interventions may comprise one or two key skills to address mild to moderate problems, whereas more complex and advanced interventions are more likely to be combinations of skills that have been shown to be effective in controlled practice research. Thus, the emphasis here is on learning those basic or essential skills that alone or in combination provide the best chance of ameliorating a client’s psychosocial distress and improving the client’s problem-solving and coping abilities over time. Combinations of skills shown in controlled practice research to be effective with moderate to severe psychosocial problems and disorders are now referred to as evidence-based practices (Goodheart, Kazdin, & Sternberg, 2006; Nathan & Gorman, 2007; O’Hare, 2005; Stout & Hayes, 2005; Thyer, 2004). These approaches now define the benchmark for competent social work practice.

Supportive, therapeutic coping, and case management skills are applied in unique ways depending on the client’s problems, challenges, and needs. For example, the application of empathic listening (a supportive skill) with a seriously thought-disordered person is quite different from its application with a person experiencing a normal but difficult grief reaction. Using role-play, problem solving, or graduated exposure (therapeutic coping skills) to
help a young man reduce obsessive-compulsive rituals is quite different from using the same techniques to help a couple improve their communication and parenting skills. Coordinating the efforts of several providers and advocating for client benefits (case management skills) take on a different character whether one is working on a child abuse case or attempting to help a severely disabled elderly person. Essential skills in social work practice share a common research and practice base but take on unique application depending on the client’s problems and needs. The definition of a coherent set of skills that can be used individually and in combination is essential for teaching, implementing, supervising, evaluating, and researching social work interventions.

**Optimally Combining Essential Skills**

Although essential practice skills can be used individually for discrete problems, they are often combined as evidence-based practices. For example, after employing supportive and facilitative skills to engage a troubled couple who have been fighting bitterly and are considering divorce, the practitioner may use both supportive and therapeutic coping skills to help them examine their interactions with each other in a more calm and less reactive manner, to have them take turns listening carefully to each other without interrupting, to ask them to show that they can identify each other’s needs, to communicate their thoughts and feelings in a more sensitive manner, and to work on sharing household and other responsibilities. Case management activities may not be required at all in such a case. In contrast, for a young mentally ill mother who recently had her two children removed from her home under suspicion of neglect, supportive and facilitative skills may be more challenging to implement given the client’s suspicions and other cognitive distortions related to her illness. Therapeutic coping skills might include psychoeducation about her illness, the importance of taking medication to ameliorate her symptoms, coaching her in better parenting skills, and teaching stress-management skills to help her deal better with trauma-related anxiety and depression. Case management skills would likely be required to help the client maintain her benefits and access to mental health care, to coordinate services, to help her manage her money, and to advocate for her with the courts and child welfare department. Most if not all cases will employ some combination of essential supportive, therapeutic coping, and case management skills, but the skills will be applied in different ways depending on the individual challenges facing the client. How these skills are combined and implemented is guided by
both clinical outcome research and the use of the practitioner’s judgment in concert with client input and continuous evaluative feedback.

However, to simply recommend that treatment be tailored to client needs means little if there are no empirical practice guidelines to plan the intervention. (Even the most innovative tailors and designers learned from patterns before they then learn to creatively deviate from them in a thoughtful way.) Although practice typically includes some trial-and-error efforts, exclusive reliance on practice wisdom or one’s presumed creative powers is neither adequate nor necessary in professional social work practice and may even result in substandard interventions. Evidence-based practice guidelines can help practitioners reduce some of the guesswork in treatment planning with clients who struggle with a wide array of problems, from major mental illnesses to addictions, eating disorders, anxiety, traumatic reactions, depression, and emotional and behavioral problems in children. Evidence-based practices are made up of varying configurations of essential skills. These configurations of skills have been packaged to provide practitioners with research-supported intervention guidelines to better serve their clients. However, before practitioners can effectively learn evidence-based practices, they must master the essential supportive, therapeutic coping, and case management skills explained in these chapters. The Psycho-Social Intervention Scale will be described at the end of this chapter to help practitioners evaluate their own use of essential social work practice skills and to consider how to combine them to help different clients.

**Applying Essential Skills to Family Interventions**

The term *treatment modality* refers primarily to the configuration and relationship of clients who participate in the intervention. The traditional service modalities are individual, couple, family, and group work. Other than designating the number and relationship of the participants, these modalities do not refer to any particular practice theory or intervention approach. For example, as noted earlier, the term *family therapy* refers to interventions conducted with some or all members of a family. There are many different forms of family therapy, and the skills applied are likely to vary considerably depending on theoretical assumptions and the specific intervention methods. *Group therapy* refers to working with the members of a group of persons who are generally not related in a familial way to one another. Group therapy can be unstructured or structured, directive or non-directive, psychoeducational or therapeutic, psychodynamic, behavioral, Gestalt, and so on. Regardless of modality, the interventions comprise
some combination of essential skills. Supportive, therapeutic coping, and case management skills are applied across all modalities, and their combination determines whether the intervention will be effective.

Despite the differences across major schools of family therapy, they do share several common assumptions and intervention methods (Becvar & Becvar, 1996; Nichols & Schwartz, 2006). Family therapies are characterized by recognizing family hierarchies, structures and alliances, the importance of interaction and communication patterns, the role of the identified client, and the significance of generational influences. However, these aspects of family therapy apply more to ongoing assessment of family functioning than to the intervention skills used. With regard to intervention, supportive skills apply to family therapies in the following way:

- Joining with the family; that is, engaging and developing a working alliance with some or all family members
- Developing intervention goals and role expectations of both practitioner and family members
- Using accurate and empathic listening to each member in turn
- Demonstrating respect and positive regard for all members
- Using motivational interviewing methods (e.g., not arguing, rolling with the resistance)

Therapeutic coping skills include the following:

- Psychoeducation
- Encouraging and modeling constructive communication
- Exploring dysfunctional beliefs family members have toward one another or other extended family members
- Using stress-management techniques with some or all family members
- Helping family members express intense feelings in more constructive ways
- Role modeling: rehearsing; and practicing better communication, problem solving, or carrying out of specific tasks
- Demonstrating how to apply reinforcement between partners (e.g., increase caring behaviors) and between parents and their children (i.e., improved parenting skills)
- Engaging in self-monitoring so family members can anticipate problems, apply what they have learned to interrupt problems, and evaluate their progress over time.
More specifically, when helping parents deal with emotionally and behaviorally troubled children and adolescents, therapeutic coping skills can be adapted accordingly:

- Teaching of basic behavioral parenting skills (e.g., demonstration of nurturance through caring behaviors and play, positive disciplining skills through clear directives; balancing rewards for prosocial behaviors and mild sanctions for unacceptable behaviors)
- Use of modeling and role play to demonstrate to a child how the parent wants things done (e.g., cleaning up the room, getting settled down to study, playing with siblings)
- Demonstration of how to monitor a child’s progress and shape behavior by stringing together a series of rewards and sanctions to reach long-term goals

Social workers should learn to apply therapeutic coping skills at all levels (e.g., individual, couple, family). Sometimes these skills can be applied one level at a time, and other times concurrently. For example, if a child has a serious behavioral disorder that parental conflict exacerbates, the intervention may have to address each level in turn. First, the couple may have to learn to communicate better and deal with some of their own interpersonal problems as partners (e.g., money concerns, alcohol abuse, infidelity). Second, the social worker may have to focus on helping them collaborate to improve their parenting skills (e.g., setting limits, rewarding and sanctioning behaviors consistently instead of undermining each other). Third, the social worker may then focus on helping the child cope with emotional distress (e.g., learning to accurately identify feelings, finding more constructive ways to cope with anger). Last, the social worker may apply some of these core skills (e.g., communication, psychoeducation) when dealing with the larger social system (e.g., parenting education, classes in local schools). However, these skills are likely to be combined with case management skills as in the following examples:

- Networking and coordinating interventions with the school administration, school psychologist, and classroom teacher to generalize the child’s improvements from home to the school
- Helping parents and teachers work from the same page to help the child maintain behavioral and academic improvements
- Advocating for a parent’s rights in court-ordered cases
- Helping a family bolster social and instrumental supports to reduce isolation and provide for basic financial needs and ensure eligibility
for other benefits if available (e.g., public health insurance for children)

Although essential supportive, therapeutic coping, and case management skills apply as readily to family interventions as to individual cases, their application can be more challenging when working with a seriously troubled family.

Applying Essential Skills to Group Work

Working with groups in social work practice takes different forms. Perhaps the more common approaches include traditional psychotherapeutic interventions (Yalom, 2005) and behaviorally oriented groups for working with clients who experience other specific problems or disorders (e.g., Bieling, McCabe, & Antony, 2006). Groups are also used for early intervention prevention programs, such as youths at risk for substance use or other high-risk behaviors. Traditional psychotherapeutic groups tend to emphasize personal disclosure and expression of feelings, and they address the way group members interact with the practitioner and other group members to engender insight and improved relationships. Although such groups are not well researched, it is reasonable to assume that some clients are likely to benefit from these experiences. The essential skills applied include supportive skills (e.g., empathic listening, encouraging expression of feelings) and therapeutic coping skills (e.g., improving communication skills, examining conflicted thoughts and feelings regarding relationship problems). Although case management skills might be applied (e.g., referral for medication), they are less likely to be emphasized in insight-oriented group therapy.

Psychoeducational groups are commonly used for a wide range of purposes. Some examples include high school students learning to cope effectively with pressures to have sex and use alcohol and other drugs, parents learning to cope more effectively with their mentally ill young adult children, teaching young single moms how to balance the duties of motherhood while pursuing their education, and helping the elderly cope with depression and loneliness. The list of potential uses for psychoeducational groups is long. Although psychoeducational groups rely primarily on didactic methods, the use of supportive skills is critical. Practitioners still need to connect with their audience; listen carefully to their concerns; and communicate positive regard, respect, empathy, and genuineness. They also need to engender motivation in group members to apply what they learn
in their daily lives. Psychoeducation is also a key therapeutic coping skill. Providing information is a rather direct way to alter cognitions (i.e., change beliefs, expectations, and attributions). Young-adult group members attending a psychoeducational group regarding sexual behavior and the use of alcohol and other drugs are often poorly informed about the risks associated with date rape and transmission of infectious diseases, as well as what is required to prevent pregnancy. Although providing information alone is often insufficient to dissuade people from engaging in high-risk behaviors, evidence suggests that it is an essential component.

Behaviorally oriented groups are often used with clients who demonstrate more serious difficulties, such as co-occurring mental illness and substance abuse, substance abuse groups with convicts who have been released from prison, domestic violence (e.g., anger management) groups for offenders, conduct-disordered adolescents, young women diagnosed with eating disorders, or group work with persons diagnosed with borderline personality disorder. Behavioral groups also emphasize the application of essential supportive skills to develop a working relationship with clients, facilitate communication, and enhance motivation. However, behavioral groups are also likely to place a heavy emphasis on a wide array of therapeutic coping skills: challenging dysfunctional cognitions (e.g., regarding substance use, using violence to cope with conflict), practicing self-regulation regarding impulses connected to intense emotions (e.g., self-mutilation, domestic violence, binge-purging by the bulimic client), learning behavioral coping skills through role-play and rehearsal (e.g., saying, “No thanks” to an offer of alcohol or other drugs, seeking social supports when the impulse to strike out in anger is provoked), using communication and problem-solving skills to improve relationships, and learning stress-management skills to enhance an overall healthier lifestyle. In working with clients who experience more serious problems such as these, case management skills are also likely to be used extensively to coordinate services among providers, hospitalize clients in crisis, act as liaison for court-ordered interventions, advocate for a mentally ill client, and enhance social and instrumental supports when needed.

Before becoming proficient at using more advanced family and group interventions, practitioners must first master essential supportive, therapeutic coping, and case management skills. Once these building blocks of effective interventions are mastered, practitioners can learn and effectively implement evidence-based practices with individuals, couples, families, and groups.
A Note on Culturally Competent Practice

Although all practitioners want to provide services that clients consider respectful and congruent with their own cultural background and beliefs, the concept of culturally competent practice remains largely theoretical and untested. For starters, *cultural background* is a heterogeneous term that precludes an easy one-to-one matchup between a client’s race or ethnicity and a specific approach to assessment and treatment. Although culturally informed engagement processes (i.e., working alliance) used early on in the intervention may be critical to successful client engagement, there is currently no body of empirical evidence to guide practitioners in designing or adjusting interventions to fit the client’s cultural background in a way that measurably improves current evidence-based practices. However, practices shown to be effective in controlled research (e.g., many cognitive-behavioral treatments) have been shown to work comparably well across racial, ethnic, and cultural lines (Whaley & Davis, 2007). Although many published treatment studies include people from various racial and cultural backgrounds, there is a pressing need to recruit more people of diverse ethnic backgrounds in practice research.

Despite the lack of controlled research on culturally competent practice, it stands to reason that one can enhance the working relationship with clients and better engage them in treatment if clients feel that the practitioner understands and respects their cultural perspective. Being a culturally competent practitioner is, in part, about educating oneself about the client’s cultural background and using skills in a way that is culturally congruent with client expectations (Sue, 2007). It also refers to possessing a genuine awareness of one’s own cultural background, strengths, limitations, and biases, and learning about client assimilation and acculturation challenges in the host country: how specific policies affect the client’s reference group, what services are available, and what experiences a client has had with racism and discrimination (Lum, 2007). Given the current state of knowledge, practitioners can be culturally competent by engaging clients during the assessment on matters of cultural identity (i.e., what their cultural identity means to them) and by implementing practices that have been shown to be effective in the current outcome research with the understanding that most clients are likely to respond well to these. In a similar way these engagement considerations extend to other personal identity factors: sexual orientation, religious and spiritual beliefs and practices, and other matters. By using the supportive, therapeutic coping, and case management skills in this book in a culturally sensitive and informed way, practitioners can become truly culturally competent.
Evaluation

Evaluating One’s Own Practice

Asserting that one claims to use essential skills or implement them in some combination as an evidence-based practice does not guarantee intervention success. The third major component of social work practice is evaluating one’s own practice (Bloom, Fischer, & Orme, 2006; Siegel, 1984). There are various ways to do this. The most feasible way to evaluate a single case (i.e., individual, couple, or family) is to define and measure one or more key problems during the initial assessment phase, to define the intervention employed, and to monitor changes in the measures periodically over the course of the intervention and again at termination. This approach is sometimes referred to as a passive-observational or naturalistic approach to evaluation because no special controls are employed that might otherwise interfere with the usual delivery of services. No artificial baseline periods are planned, no comparison cases are used, and no treatment conditions are altered in a planned manner. This approach can be implemented by using some indexes discussed earlier in this chapter or by supplementing them with one or more validated scales. In some agencies, scales now are readily incorporated into the routine clinical documentation required of practitioners (e.g., assessments, treatment plans, progress notes). Changes over time (e.g., reduced depression in an elderly man, improved school performance in a child, more loving behavior between partners) indicate positive changes in the client. What this improvement cannot readily deduce is whether the intervention was responsible for the change. For naturalistic single-subject designs, one simply cannot draw such conclusions with a high degree of confidence. Nevertheless, if practitioners implement an evidence-based practice, they know that they have used an intervention with a reasonable likelihood of helping the client because it has previously been shown to be effective in controlled research trials with many clients experiencing similar problems.

Other more complex single-case designs have been discussed at length in the literature on evaluating one’s own practice, but these approaches have little practical application for everyday social work interventions. These designs involve controlling the implementation of the intervention in stages or making other predetermined changes to the intervention at various intervals to see if variations of the intervention affect client outcomes. They are, in fact, single-subject controlled experiments that lend themselves to clinical research, not routine practice (Kazdin, 1978, 1998; O’Hare, 2005). These approaches are called controlled single-case experimental designs and will be discussed in greater depth in chapter 4.
It is also possible to use naturalistic evaluation strategies with large numbers of clients to evaluate a whole program or a smaller program within a larger agency (e.g., a battered women’s group within a mental health agency). In this situation, those participating in the program would record their levels of distress using valid scales during the assessment phase (e.g., to measure depression, anxiety, substance use, self-esteem) and repeat these measures at various intervals during the intervention (e.g., monthly) and at termination. These data can then be used to evaluate the improvement in each client individually and, when data from many clients are aggregated, provide some measure of improvement for the group or program as a whole. Although, as with the single-subject design, one cannot be certain that the improvements were a result of the program, one can place more confidence in the results if large numbers of clients improve and if past research findings indicate strongly that people with similar problems would probably not have improved without intervention. Naturalistic program evaluation will also be discussed in more detail in chapter 4.

Evaluation data from a single client, a group of clients, or a whole program does not prove that the interventions employed are the best or even that they are primarily responsible for client improvement. However, if done consistently well, evaluation can provide a strong indication that practices are implemented effectively at both the individual level and the program level. These data can then be used to identify strong or weaker points in the program, and if analyzed thoughtfully, they can provide a basis for program improvement through purposeful supervision and staff training. Many agencies now have quality-assurance programs that use evaluation methods to improve services to clients.

**Monitoring and Evaluating the Use of Essential Intervention Skills: The Psycho-Social Intervention Scale**

The Psycho-Social Intervention Scale (PSIS) is a self-evaluation practice tool designed to help social workers:

- Become familiar with essential practice skills
- Evaluate the use of these skills on a case-by-case and session-by-session basis
- Examine how to combine various practice skills to form broader intervention strategies
- Monitor how the use of different practice skills changes over time with an individual client, couple, family, or group
Overview

- Examine how practitioners use different combinations of skills depending on the primary problems presented by a client
- Compare the combinations of skills used with existing manualized evidence-based practice guidelines

Used in this manner, the PSIS is a self-teaching and self-evaluation tool designed to help social workers critically examine and better understand how and why they select different combinations of supportive, therapeutic, and case management skills depending on clients’ needs. For example, let’s say a social worker is providing an intervention for a seriously mentally ill person with a co-occurring substance abuse problem. The outcome research suggests that developing a good working alliance, using a motivational approach, enhancing coping skills, and encouraging social supports (e.g., a dual-diagnosis group) would be a promising approach. However, if the practitioner indicates on the PSIS that he or she is focusing primarily on discussing the client’s past relationships and offering interpretations to provide insight into why the client abuses alcohol, these data would indicate an approach that the current outcome research does not support. The social worker’s supervisor might then recommend some readings or additional training for the practitioner to become familiar with state-of-the-art practices.

The PSIS is a modification of the Practice Skills Inventory (PSI) (O’Hare & Collins, 1997; O’Hare, Tran, & Collins, 2002), a tool developed in several research studies to measure supportive, therapeutic coping, and case management skills. To make the PSI more comprehensive and useful for practitioners, new items were added to reflect skills used in recently developed evidence-based practices (see appendix A).

The individual items of the PSIS were designed to be somewhat general so the scale could have broad application to social work service settings and different client problems. For each item, practitioners should specify in their own words (in the lines under each item) what specific skill they are using—the skill that corresponds to that particular item—and then rate the emphasis that they place on the use of that particular skill as one part of the overall intervention plan. For example, under item 20, a practitioner might specify that he or she will help a shy adolescent practice (first, through role play with the therapist) how to start up and maintain a friendly conversation with someone he or she wants to get to know in school. That would be a specific and unique application of that particular skill. Key questions to consider when using the PSIS are as follows: Are the skills that I am using with this client reflecting best practices for this particular problem area? How am I modifying this particular evidence-based practice to suit this specific client? How is the client responding
to the intervention overall? Practitioners and their supervisors can then compare the profile of specific skills used to those recommended in the practice-outcome research.

**Pulling It All Together: Documenting the Comprehensive Service Plan**

Together, documenting the completed assessment, describing the proposed intervention methods to be used, and stipulating the indicators and scales to be used in the evaluation constitute the Comprehensive Service Plan (CSP; see appendix B). Most social workers and agencies are required to document their services to clients. This documentation takes many forms and is far from standardized. The format of assessment and intervention plans vary by program, funding source, accreditation guidelines, and state and federal regulatory requirements. However, some basics are suggested here. First, documentation is required, and is necessary and important for a variety of contractual, legal, risk management, and ethical reasons. Second, although service documentation is often (and sometimes justifiably) considered a time-consuming and expensive nuisance, this author maintains that documentation can enhance social work practice in a number of ways: when conceptually well designed, service-plan documentation can improve the validity (i.e., accuracy, thoroughness) and reliability (i.e., consistency) of assessment, clarify the goals, objectives, and methods used in the intervention, and detail the methods used for monitoring and evaluation. Third, a well-conducted assessment, intervention, and evaluation plan is essential for guiding individual service for clients, and aggregated data from individual service plans can provide a sound basis for evaluation. In general, these processes are sometimes referred to as developing a contract with the client. This contract is closely tied to the important ethical and legal concepts of informed consent and confidentiality (discussed in chapter 3).

The CSP also includes items from the Psycho-Social Wellbeing Scale (PSWS); O’Hare, Sherrer, Connery, Thornton, LaButti, & Emrick, 2003; O’Hare, Sherrer, Cutler, McCall, Dominique, & Garlick, 2002). These items are used to quantitatively rate each area of the multidimensional-functional qualitative assessment. The adjunctive use of quantitative ratings in routine assessment is becoming common practice in human service agencies in response to increasing demands for routine evaluation from both private and public payers. Although qualitative data are critical for evaluating individual client progress, qualitative data cannot be aggregated (summed up and averaged) in any practical way for reporting to payers or to state and
federal agencies. Quantitative ratings can also be used to monitor and evaluate individual client progress across many domains, but data from many clients can be aggregated to provide a database for program evaluation. Beginning practitioners should first make a thoughtful qualitative assessment and then, with all available client information, use the PSWS to rate how well or how impaired the client is in that particular area of well-being. Over time, if the client progresses, improvement will be reflected in higher ratings for individual domains and overall psychosocial well-being. Other scales and indexes should be used to supplement the PSWS according to agency needs and the types of problems for which social workers provide interventions. Many reliable and valid instruments are now available in the public domain and over the Internet (for the PSWS and other useful instruments, see O’Hare, 2005).

After collecting, analyzing, and discussing the information collected from the client, family members, consultants, and others, practitioners often end up with a lot of data. Reducing this information to a concise and useful CSP is an essential social work skill, and becoming proficient at it takes practice. After a full assessment, the practitioner must then collaborate with the client on the development of a formal intervention plan. Under the column “Problems” in the CSP Summary (appendix B), the practitioner should briefly describe those difficulties that the intervention is likely to address. Some efforts should be made to create a problem hierarchy. Under the “Goals” column, practitioners should briefly state what the agreed-on outcomes should be for each problem. Objectives are stepping stones toward each goal. Objectives are the linchpin of interventions: they are often activities that clients carry out as part of the intervention to move closer to their goals. For example, an objective toward a goal of stopping illegal drug use might be “Attend two Narcotics Anonymous meetings this week.” Or an objective for a socially anxious adolescent girl might be “Strike up a conversation with that boy in the cafeteria at least once this coming week.” Accomplishing this objective might bring the young adolescent a step closer to her goal of being more involved socially, but it is also part of a formal intervention (practicing her social skills). Under the “Intervention” section, the practitioner should describe both the formal title of the intervention (e.g., interpersonal psychotherapy) and specifics (e.g., to meet once weekly). Finally, under “Assessment/Evaluation,” practitioners should note any indexes or formal scales they are using to help track client progress and evaluate the effects of the intervention. They should also describe who will collect the data and at what intervals. In chapters 8 through 12, brief case-study illustrations with completed CSPs will help students learn how to develop their own service plans with the outline in appendix B.