EXERCISE 30 *How Do We Know We're Helping?*

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Purpose

1. To help you understand the reasons for evaluating practice effectiveness.
2. To examine some of the shortcomings in subjective appraisals of effectiveness.
3. To examine alternative ways of assessing progress.

Background

Increasingly, the people who pay for social work services (whether insurance companies, government agencies, or the clients themselves) demand to see evidence that the intervention is making a difference. Some social workers feel these demands intrude on their practice and reject the use of evaluation instruments. Others acknowledge that evaluation is important, but prefer to use their instincts to tell them that their work is having an impact. Others believe that such methods are unreliable and suggest that tools such as goal attainment scaling, assessment instruments, and other methods should be used to more carefully track and document progress.

This exercise introduces you to two brief readings that offer different perspectives on evaluating effectiveness and asks you to critically examine the two viewpoints and develop your own position about how you'll "know that you're making a difference."

Instructions

1. On the following page, list all reasons for and against practice evaluation—Why is it important to do? Why is it not important? Your instructor may assign you to groups for brainstorming.
2. After a discussion of your results, read the following articles and address the questions at the end of the exercise.
3. Consider cases from your field placement. List some methods that are or could be used to evaluate the outcomes in cases and the effectiveness of the social workers in bringing about those outcomes. If you don't have access to field cases, address the question as it might apply to cases presented elsewhere in the workbook, for example, the Carr family in Exercise 8.

EXERCISE 30

Evaluating Practice Effectiveness

Why?

Why not?

Evaluating Effectiveness From the Practitioner Perspective
by Martin A. Elks and Karen E. Kirkhart

Although systematic evaluation has been conceptualized as a tool for improving human services programs, relatively little evidence exists that shows how evaluative information is used to enhance direct clinical practice. Quantitative studies of clinical use of evaluation have shed little light on the research-practice linkage. The authors report the results of a qualitative study of 17 social workers designed to develop a more complete understanding of how practitioners evaluate themselves in their day-to-day practice. Three main findings emerged from the interviews: (1) an acknowledged difficulty in really knowing one's effectiveness; (2) a perceived incompatibility between evaluation and practice; and (3) the presence of an implicit model of self-evaluation comprising five components: intuition and experience, personal and professional issues, client change, business aspects, and the therapist-client relationship. Several social work implications for the teaching of self-evaluation in schools of social work and for clinical practice are discussed.

Key Words: *effectiveness; evaluation; practice; self-evaluation model*

Systematic evaluation has been conceptualized as a tool for improving the quality and effectiveness of human services programs. Much systematic evaluation is conducted within the service system and for primarily formative reasons. Ideally, such self-evaluation provides growth and renewal for those who work within the service system. Yet even though evaluators are committed to this ideal, relatively little evidence exists that evaluative information is used to actually improve service.

The difficulty in identifying connections between empirical evidence and clinical practice is neither new nor unique to evaluation. The integration of research and practice has been a long-standing concern of the helping professions (Mullen, 1978; Thomlison, 1984). Historically, much has been written on the two communities of research and practice, citing differences in values, purpose, and methods (Andreozzi, 1985; Rodman & Kolodny, 1964). In the early 1970s, evaluation was heralded as a logical bridge between research and practice, and the development of new methodologies flourished. However, it soon became apparent that evaluation and practice were also difficult to link effectively. Many evaluative methods did little to facilitate practice integration. For example, single-system designs that focus on the clinical perspective address many of the practical and methodological limitations of group designs, but they fail to address many other requisites to evaluation-practice integration (Barlow & Hersen, 1984). Most evaluation methods that do address themselves to direct practice (Barlow, Hayes, & Nelson, 1984; Bloom & Fischer, 1982; Jayaratne & Levy, 1979) are still only a theoretical ideal, and the debate continues regarding the fit between the methods of empirical evaluation and the exigencies of actual clinical practice (Blythe, 1992; Witkin, 1992).

Evaluation from clinical and administrative perspectives has developed out of different research traditions with relatively little exchange, and research on use has followed suit (Kirkhart, 1986). Empirical research on the use of evaluative information has focused primarily on administrative or program levels (Cousins & Leithwood, 1986). Use of evaluative information by clinicians or direct practitioners is less understood. Typically, studies with clinicians have approached evaluation with a theoretical model of use clearly in mind and have found that the clinician's view of evaluation did not conform to the model being tested (Eldridge, 1983). This research tradition has contributed to an understanding of what the evaluation-practice linkage is not, but it has yielded little insight into what it is. An alternative research model is needed, one that is exploratory rather than confirmatory, building a model of evaluation from the practitioner's own accounts rather than superimposing an ideal model and testing for conformity (Scott, 1990).

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The overall goal of the authors' research was to develop a more complete understanding of the clinical use of evaluative data and its relationship to direct practice. Objectives include describing the use of evaluation by the practicing clinician, examining evaluative decisions made by clinicians regarding their own practice in a context relatively free from formal systems of accountability, and examining the relationship of evaluation use to improved clinical practice. The research questions included the following: How do clinicians evaluate their performance and practice? How do they know they are doing a good job with each client? What information is used and how?

Methods

Sample

Private practitioners were selected for this study for the following reasons:

- Private practitioners represent a significant section of social work practice.
- Self-evaluation is important to private practitioners because they are not formally responsible to agencies or supervisors for the quality of their work.
- Direct clinical practice may be examined relatively free from contextual influences such as agency policy and procedures.
- Private practice is seen as an ideal by many students and agency practitioners and therefore an important area for research.

The sample comprised 17 clinicians in private practice (11 women and 6 men). All were located in a metropolitan setting in the northeastern United States. Data were collected using semistructured interviews. Interviews were conducted in person, by appointment, at the home or office of the private practitioner and lasted 45 to 90 minutes. Interview topics corresponded to the research objectives and questions identified earlier. All interviews began with the following questions: How do you evaluate what you are doing? How do you know you are doing a good job? How do you know you are not doing a good job? The interviewer then asked open-ended questions to elicit the roles, if any, evaluation plays in the practitioners' work, the types and sources of information they use in their practice, and the manner in which they use the information.

Toward the end of the interview, and only if not already covered by the practitioners themselves, the interviewer asked about sources of evaluative information such as scales and questionnaires, reading, use of colleagues, and systematic notetaking tools that are seen in the current research literature as important for practice evaluation (e.g., Barlow et al., 1984; Bloom & Fischer, 1982).

Data Analysis

The interviews were tape-recorded and transcribed. The transcripts were then coded and analyzed for themes and patterns (Bogdan & Biklen, 1982; Corbin & Strauss, 1990). The aim of the analysis was to use a grounded theory approach (Glaser & Strauss, 1967) to develop an accurate description of how practitioners evaluate their practice using the words and concepts that they regard as important and significant (Blumer, 1969).

The authors used a grounded theory approach to inductively derive themes that are based ("grounded") in the data. In this study the data are transcripts of interviews of social work practitioners in private practice. Each concept or issue mentioned by the interviewee in regard to self-evaluation was given an identifying code. The codes were then sorted or grouped by hand and referenced by transcript page number. Gradually and over repeated interviews, key or frequently used codes began to emerge from the data. The codes were then grouped to represent higher-order themes or patterns. For example, the theme "client change" comprises four codes: symptom and problem alleviation, improved appearance and mood, decreased

resistance, and increased skills. The final task of the analysis was to discern the relationships between the themes and codes and to describe an overall model of how practitioners use them in their actual practice evaluation.

Findings

Two findings emerged from the interviews: Practitioners acknowledged difficulty in really knowing their effectiveness, and they perceived incompatibility between the roles of evaluator and practitioner. Also, an implicit model of self-evaluation was found. (Numbers next to each extract refer to interviewee identification number and page of interview transcript.)

Difficulty in Really Knowing One's Effectiveness

Interviewees were keenly aware of the limitations they face in demonstrating that they are helpful to clients and that clients would not necessarily get better by themselves without the practitioner and his or her interventions.

> *17-4 It's hard to take credit in this sort of work for really helping people, because you don't really know how much what you're doing in your office is really helping to bring about the change in someone's life . . . so you are always questioning, Is it really something you are doing here, or might this have happened anyway? . . . So it's really complex.*

> *9-7 See, I'm not even sure that anybody knows why psychotherapy works. One of my secret suspicions is that mostly people get better by themselves, and we're privileged to see it here and be with the people and collect the money.*

> *6-6 I almost feel like I never really have any way of knowing. I'm sitting here and I'm telling you these parameters, but to really know . . . I'm not sure that I do.*

However, the presence of doubts about knowing one's effectiveness appears to be more a philosophical concern than one that directly impinges on practice. As shown later, practitioners made many statements that they believed were very effective and indeed had a coherent model for evaluating their practice effectiveness.

Practitioner Role Versus Evaluator Role

Throughout the interview process, it was very clear that evaluation was equated by the practitioners with science, measurement, and research methodology and was not for them. Evaluation was seen as something researchers do involving measurement, follow-up studies, formal studies, questionnaires, and research methodology designed to prove effectiveness. As such, evaluation is alien to private practice, because few practitioners feel competent at research or with formal procedures.

Evaluation and judgments of effectiveness were regarded as not being a personal strength or not part of the job. Practitioners readily admitted they could not prove effectiveness to evaluators because "the people who write evaluation articles would not accept their methods of measuring themselves." Nevertheless, the practitioners appeared confident about their effectiveness and saw no need to change as long as they were achieving acceptable results.

> *15-11 It's not my job to evaluate somebody—it's my job to help them move on with their lives. . . . Don't ask me to evaluate people—that just clutters my mind . . . so I just stay away from it.*

16-3 Well, I try not to focus [on my effectiveness]. . . . I feel like people give me money and for that they should get something useful to them, but I try not to obsess over [my effectiveness] because I could drive myself crazy worrying about it. I can't dismiss it, but it's not real important.

9-9 Other things . . . are more urgent. My system is that I have a rotating pile of papers, and whenever it's time for paperwork, I take the one on top and I either do something with it or put it on the bottom, and evaluation has been circulating for a while. Every time it comes up maybe I write a sentence or two . . . so I feel something's happening . . . .

Perhaps the incompatibility between the needs of practitioners and the requirements of formal evaluation can best be seen in their consistent attitudes toward research instruments and scales.

14-7 Instruments are not a part of the way I operate. I feel from myself and the feedback that I get from my patients that I am doing a very [emphatically] good job that I find to be very gratifying and therefore I don't feel the need for a lot else.

13-5 I don't hear evaluation as anything like how I quantify in any sense. On a practical level I wouldn't consider them [scales and instruments] to be quite honest. I'm really moving from one thing to the next and really I don't have the time. Seems to me to do something like that [administer instruments] would be an extreme luxury—and in some way a nice luxury if I had the time. . . .

Private practitioners seem to have little use for formal, quantifiable evaluation instruments. Such instruments are seen as luxuries, requiring too much time, and possibly more relevant to other helping professionals such as psychologists.

Ignorance may be another reason for role incompatibility.

12-3 The reason I don't use [evaluation measurements] is because I don't know of them—that is, in terms of keeping up with lots of other things, that's an area that I've not kept up with or learned about as it evolved, so ignorance is probably the reason.

11-1 I received a questionnaire once from a group therapy association but never used it because I was afraid it might show me to be no good. [The respondent freely admitted she was not very good with groups.]

However, several interviewees admitted to a willingness to use formal instruments, albeit rather ambivalently and not confidently.

Research instruments were used by two interviewees (both male) in specialized areas such as behavior modification with children, formal professional peer reviews, and smoking cessation and pain control. These are areas where behavior research has been prominent or where standardization and objectivity are important (as in peer reviews).

Specific criteria were spelled out by one interviewee who used a "pain questionnaire" as to why it (and presumably any other potential instrument) was chosen:

9-5 It was simple, it was quick, it appeared as if the client could do it in his own time, or if I had to do it, it would only take five minutes. . . . I was thinking that I could use it not only as an evaluation instrument, but [also] as a treatment tool.

Such criteria epitomize a pragmatic professionals' approach to research instruments: They are not central to practice, have doubtful utility, and are to be used only if they require little time and effort and are potentially beneficial to the client in themselves.

Pragmatic-Professional Model

No practitioner offered an explicit, well-articulated model for self-evaluation. It was nevertheless possible to perceive the existence of an underlying or implicit model of practice evaluation and to classify into a coherent framework the concepts and issues that practitioners as a whole thought were important to their practice and its evaluation. The authors have termed this model of self-evaluation the "pragmatic-professional model" to contrast it with others such as the "scientist-practitioner model" (Barlow et al., 1984; Jayaratne & Levy, 1979) or the "reflective-practitioner model" (Schon, 1983).

The pragmatic-professional model is characterized by its down-to-earthness, immediacy, and practical relevance. Practitioners needed no statistics, computers, or elaborate theory to use the model. These practitioners were comfortable with the way they were operating; saw themselves as at the peak, or approaching the peak, of their effectiveness and expertise; and regarded formal evaluation procedures as being irrelevant at best and intrusive at worst.

The model consists of five main components or sources of evaluative information: the intuition and experience of the social workers themselves, professional and personal values, client change, business aspects, and the practitioner-client relationship. All are used intuitively and refined with experience.

Intuition and Experience

When the practitioners were asked how they evaluated their practice, the response was overwhelmingly by intuition.

> *15-6 I've got to tell you it comes down to a great feeling.*
>
> *14-2 I would say that in part it come simply from being sensitive to whether people are feeling good or bad. I evaluate what I do emotionally.*
>
> *13-1 Some of it is thought out and some of it probably is intuitive. . . . I hate to admit this but it's a very intuitive process—I was going to say subjective, but I think intuitive is better because intuition is the blending of the thinking and the feeling. I know I'm not being very clear . . . what I'm trying to get at is that there is this whole thing in my head that tends to screen and evaluate all the time, but when you ask me how I do it it's hard for me to break it down and put it into words.*

However, this intuition is not naive but is refined by years (up to 30) of experience. Practitioners were highly confident in their ability as therapists, counselors, and so forth. Their confidence has come from surviving and even flourishing in private practice and not from books on research.

> *17-9 I've done this for a long time. . . . I've done everything, I think I can do much of everything. . . . .*
>
> *15-1 I think that when you do this year after year you notice these things. . . . Your experience with these things is the only teacher, there's no prescription for it. . . . Someone said to me, "You know, it takes about 10 years before you think you have some idea about what's going on."*

11-1 After 30 years one has a sense of confidence that one is doing a good job.

4-4 I've been around this community for 30 years. . . . I've spent a lot of time and energy . . . developing what I do.

Statements about confidence in one's effectiveness appear to contradict earlier statements about not really knowing if one is effective. However, the issue seems to be that of not being absolutely certain of one's effectiveness and being unable to prove it to evaluators, while at the same time knowing enough to be confident one is doing something worthwhile for clients. Pragmatic professionals seem to be able to live with this ambiguity and uncertainty.

Professional and Personal Values

There are four sources of evaluative information that the social worker brings to the situation, has internalized, or is primarily responsible for: an internalized model of the ideal practitioner, personal life and circumstances, notetaking, and reading.

The Ideal Practitioner

Practitioners have internalized a series of rules of practice by which they measure their performance as therapists.

8-2 I have a set of internal standards that I've never articulated, so this will be a first, but I have some internal standards . . . fairly strict parameters . . . about my own behavior and how I will engage with a client that I think are probably a more reliable gauge of how I am doing than what the client says.

4-1 I use these standards as barometers, as ways to monitor myself and my ongoing practice.

The practitioners assume that the better they match their performance standards or rules, the more effective they will be. This assumption frees the practitioner from worrying too much about positive outcomes, because these are assumed to follow from the good practice of the ideal practitioner. Also, it is much easier to monitor one's own behavior than to engage in measuring outcomes or monitor the behavior of the client (especially outside the therapy situation).

These ideals also serve as a safeguard to relying entirely on client statements of change. For example, a practitioner's internal rules and orientation may lead him or her to distrust a particular client's statements. Ethically, too, practitioners regard these standards as the bottom line of practice—whatever else may happen, he or she should adhere to these standards.

What are these ideal rules of practice? The following general list is take from the interviews: maintaining a professional stance; not taking sides; maintaining distance between the client and his or her problems; keeping in touch with one's own physiological reactions (e.g., anxiety, fatigue, boredom, concentration); and working through one's own personal problems. Any indication that a practitioner is failing in any of these dimensions is a sign that something is wrong.

Personal Life and Circumstances

Practitioners evaluate themselves from the feedback of their spouse, friends, family, and colleagues (and in one instance, his golf game). Using friends and family for consultation is not surprising, because often practitioners are married to other helping professionals, have other members of the family in the

same professions, and often have colleagues who are also personal and family friends. Thus, the distinction between a practitioner's professional and private life may be very blurred.

> *6-7 I don't really see that much separation between—and maybe some might think I'm crazy—my professional life and my personal life.*

Of the 11 interviewees who were married, nine (82 percent) were married to another clinical social worker, physician, psychologist, psychiatrist, or psychiatric nurse-hypnotherapist. A majority reported that they often used their spouses as a source of consultation and feedback for cases. This interrelatedness extends into the larger family as well. For example, one practitioner is one of three sisters, all of whom are social workers, and another, who is married to a psychiatrist, receives referrals from her father (a physician) and sees clients in a room in his office.

Private practitioners overwhelmingly relied on colleagues for support, feedback, and advice. Typically the use of colleagues for evaluative feedback is in the form of a peer group or reading group that meets regularly (e.g., biweekly or monthly). Similarly, practitioners reported a large overlap between their colleagues and their personal friends. One interviewee is a member of a sports team composed entirely of mental health professionals.

One result of the connectedness among mental health professionals on both levels is the presence of an informal network where professionals "get to know what's going on in town," which is another source of evaluative information.

Notetaking and Reading

Whether practitioners take minimal or copious notes, little use is made of them. Practitioners rarely read more than the notes of the last session with a client, and systematic review of notes is usually only done if the practitioner has a persistent problem with a client or if an insurance company requests a report on treatment progress. For some practitioners, the move to private practice carried with it the benefit of being free from the burden and requirements of paperwork in an agency setting.

The content of notes varies from significant events to the general topic of the session and whether the client paid the fee. Not surprisingly, notetaking is not seen as being of great relevance to practitioner effectiveness. Practitioners often remark that they have an excellent memory, especially for affective material, and hence do not need notes.

> *5-9 My practice has very, very little paperwork. I'm trying not to take notes after every session. I feel like a free woman. What I have decided to do is that if something significant happens I would note it.*

As with notetaking, reading was never volunteered as a source of self-evaluation. Once prompted, however, interviewees commented about the role of reading in their practice. For example, practitioners read from a very little (some acknowledged an aversion to it) to a considerable amount.

> *13-4 I read very little when it comes to the field as such. What I tend to do is scan.*

> *6-4 I read quite a bit. I go through periods of reading a lot and then not reading very much. . . . I just bought ten books, and [now] I'm in a period of reading quite a bit.*

> *15-8 The journals seem to pile up at the end of my desk, and I may read three articles a year, but I get all the journals. I will read the cover of what's in them, and even if I did see one I might like I might not read it, but I make a note of it.*

Practice literature is overwhelmingly preferred to "research" literature, the latter being seen to be limited to teaching and not practice. Pragmatic professionals read not to evaluate themselves but to be of use to clients and to further improve their already considerable skills.

11-1 I don't read research because I'm not interested in it, and I don't feel I know how to read it anyway. . . . I read a lot of practice books.

7-7 I try to read journals, books . . . that are useful for my client.

Reading groups seem to be a popular way of keeping up with the literature, and those who belong to such groups seem to value them greatly.

8-5 I'm in two peer supervision and reading groups. Reading is crucial, it keeps me alive. Reading is what I do to keep me stimulated and attuned.

6-4 I think [reading groups] can be a big help, just in terms of the use of certain metaphors that one reads about and then uses in therapy that make sense to people.

Client Change

Practitioners gauge their effectiveness in relation to client change. For some practitioners, any change is assumed to be good, the assumption being that clients seek help because they are "stuck." Any movement from a stuck position is assumed by definition to be a positive change.

15-1 I assume that they come to me because they've got difficulty, so I'm looking to see change . . . usually in contrast from when I first met them.

10-2 A client who is changing will usually talk about experiencing a shift . . . they will either use the work "shift" or something equivalent to it.

3-6 I don't always look for resolution or closure, but [rather] for movement or satisfaction with where the person is at.

Six areas of change for the better include (1) symptom or problem alleviation; (2) improved quality of life; (3) development of an "internal orientation," or taking control of one's life; (4) increased skills, even to the point of imitation of the therapist; (5) decreased resistance to therapy and increased insight into problems; and (6) improved personal appearance and mood. The following excerpts from interviews illustrate each area of change:

Symptom or Problem Alleviation.

17-1 What conflicts, what symptoms brought them in initially, whether they feel that there has been a decrease in their level of depression, whether they are sleeping better, whether they are not battling as much with their husband or with their wife, or whether Johnny's academic performance is improved or not, whether he's gotten fewer in-school suspensions this semester than last semester.

15-1 When people get better and don't come back anymore. Someone might deal with a spouse in a totally new way and they'll recognize that, and that's a behavior that I'd never seen before or heard them talk about before. Or things change in their job scene, or they decide to move, or you see a change in patterns of behavior.

Improved Quality of Life.

13-2 How they report how things are going in their lives, which is a little bit beyond symptoms. They're beginning to talk about the quality of their life; for example, "I was able to take the risk to get out of this marriage and to get into a new one, or be single and feel OK about that." So if I begin to see them come alive, it makes me feel very good and gives me some sense that I'll be able to help them in the process.

8-3 I have one client who said, "I've had a lot of therapists but you're the only one who got me married"—I know exactly what we did together so that she was able to go for what she wanted in her life.

Development of an "Interior Orientation."

16-1 I guess the primary thing is an interior orientation—if the person can shift from making decisions about life in terms of external kinds of situations. . . . When people stop projecting onto others, when they stop blaming other people.

8-2 If a client really begins to get a grip and begins to take steps toward getting his life under his own control, then I think somehow we're doing a good job.

Increased Skills.

5-10 I'll tell you another way [I evaluate therapy]. I'm thinking of another person, a person who's been very, very depressed for a number of years due to loss, and she—and many of my people are doing this—adopted my technique. . . . So in a sense I have modeled for them, demonstrated, taught them a way of dealing with life's problems.

3-1 "You've helped us to talk, communicate"—it sounds so basic, but that's the kind of feedback that I get from clients. . . . They've found their old coping mechanisms or they've developed some new ones. . . . They come back and say, "I had a couple of days when I really felt down this week, but I handled it differently."

Decreased Resistance to Therapy and Increased Insight Into Problems.

17-1 Basically another tool is how much resistance I am getting in therapy. As I move close and identify underlying issues, is there more of a tendency to withhold, to cancel, to avoid, to move more to small talk?

5-1 Now after many months she's really willing to talk about [her problem]. When I confront her with some of his behavior [that] seems negative, she's able to hear it where before she would either get upset or would change the subject.

Improved Personal Appearance and Mood.

> *15-1 Also you can see a countenance change . . . it's vibes, it's a look in the eye, maybe even new hairstyle or new clothing, an aura or reflections.*

> *7-1 The way they look, how they present themselves, their mood, their affect, their thoughts, their general rapport.*

The Ideal Client

Thus, not only does the practitioner have a model of an ideal practitioner, he or she also appears to have a model of an ideal client in mind. An ideal client is growing and changing, has few problems that require counseling, reports a good quality of life, looks good, takes control of his or her life, and has good communication skills. Such an ideal allows for the evaluation of progress to the degree that the client moves toward the qualities of that ideal.

Lack of Change

Relatedly, lack of change is universally recognized as a negative indicator of treatment—unless the client is happy with no change.

> *15-5 I get very uncomfortable when therapy goes on for a long period of time, beyond three years, and I don't see any change . . . especially if it's a younger person . . . between 23 and 35.*

> *8-3 We feel stuck, there's no movement, and the client [and I] feel discouraged . . . the client will say "nothing seems to be changing."*

> *6-2 When I hear the same thing over and over every week, [it seems that] not much effort [has been] made to do anything to change their behavior or the things that they are complaining about.*

Business Aspects

Private practice forces practitioners to consider financial aspects of their work. Thus, two sources of self-evaluation are the same as for any business: Are the clients satisfied with the service, and is the business making a profit? Some practitioners refer to business concepts directly, such as referring to clients as "buyers" and considering whether they are getting their "money's worth." Others use concepts that have clear business overtones:

> *17-2 Well, if one considers or admits that part of being a therapist, or an aspect of being a therapist in private practice, is that you are also wearing a businessman's hat, then paying the rent and putting some money in the bank is an indication that I'm doing well.*

> *15-7 In other fields you consider yourself successful if the business works and earns you an income. I'm not so sure that should be overlooked.*

Thus, if the practitioner is making money, has a waiting list of clients, and has clients who express satisfaction with the services they have received, then the practitioner concludes that he or she is doing a good job. Should any of these indicators decline, then the practitioner can assume that he or she is not effective.

Furthermore, these business concepts are not antagonistic to the other sources of self-evaluation in the model. For example, a good relationship with the client may also be seen as good public relations with

the consumer and is likely, through word of mouth, to generate new clients. Clients who make positive changes in their lives are also likely to be satisfied and pay their fees. Clients who wait to see a popular practitioner who charges a high fee may be more likely to expect positive outcomes and a good relationship with the practitioner.

Practitioner-Client Relationship

Therapy is seen as a two-way relationship between the client and practitioner. This relationship, referred to in terms of a "match," "alliance," "bond," and as that of "cosleuths," can be very close.

> *15-10 My treatment of my client is so much a part of me. . . . There's a piece of me that gets intermingled in [clients'] lives, and they become real. . . . I think that's an important part of the therapy. . . . This is a real relationship, . . . a very unique phenomenon.*

> *14-2 When you see someone over an extended period of time you become as acquainted with the facial expression of the patient as you do with the facial expression of your own family members.*

It is not surprising, then, that the relationship that exists between the therapist and client is an indicator of how well the therapy is going or is likely to proceed. It is assumed that a good relationship will facilitate positive change for the client and that a good relationship in the counseling situation will generalize to other settings outside counseling. It is also assumed that the counseling relationship mirrors relationships the client is having with people outside of counseling and, hence, that the benefits of the therapeutic relationship will transfer to other relationships.

> *1-4 I would look at how the person relates to me in the interview and assume that . . . whatever they do with me they do with other significant people in their lives.*

Indicators of a good relationship include keeping the next appointment, cooperating, and being honest.

> *17-1 If they [clients] keep their next appointment, if they continue to maintain the therapy contact, that at least tells me that I'm doing something right, that they are at least finding it comfortable to come in and continue to talk and continue to explore what brought them in.*

> *9-4 I think what's necessary in therapy is to have a therapeutic alliance, so that it's me and the client joined against the disorder, . . . if there's harmony and cooperation and treatment compliance.*

> *6-3 There's a sense of straight talk between me and the client—the communication is direct and straightforward, it's not obstructed. That's when I feel I'm doing a good job.*

Indicators of a poor relationship include disharmony, anger, and dislike of the client.

> *9-4 There's disharmony, argumentativeness, little honest inquiry or honestly asking questions with an open mind, defensiveness, even outright anger.*

> *4-5 I decided I wouldn't be good for her because I was too reactive to her. . . . She wasn't really willing to hear anything else, and I really didn't want to be a part of that.*

> *3-2 There are other times where I think my button gets pushed and I'm not really able to help them.*

Discussion and Conclusions

Practitioners evaluate themselves using a number of indicators of both broad and narrow focus, and it is possible to construct an implicit model of self-evaluation used by social work practitioners that reflects their concerns. Such a model appears to be far removed from the textbook prescriptions of objective scientific and systematic methods of evaluating practice, but it is a valid and useful model from the perspective of the practitioners and seems to service their requirements well.

This research is nevertheless limited in that we used practitioner self-report as the only source of data. Further research that uses observational data or data of actual therapy sessions with comments by practitioners and clients would enable researchers to study specific instances of evaluative judgments as they occur. Such data could further elaborate the model and suggest new areas to pursue.

A number of questions may be asked about the pragmatic-professional approach to self-evaluation. For example, is the model valid from the client's perspective? Should the model be taught to students and recommended within the profession? Should the nature of private practice change to incorporate more scientific methods of evaluation, or should evaluation research do more to reflect actual practice?

The social work profession would be enhanced by further research using qualitative methods. Such research could help bring the roles of evaluator and practitioner close together and explore areas for their mutual enrichment. For example, the seeming contradiction between practitioners' doubts about really knowing if they are being effective and other statements about their confidence in their effectiveness needs to be explored. Perhaps some practitioner-oriented evaluation researcher could help devise ways in which some of these doubts could be alleviated.

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The View From the Other Chair
by Eric E. McCollum and Jim Beer

It was a hot August morning when Jim Beer picked me up at the office and we began the hour-long drive through Midwestern cornfields. The back of Jim's car was packed with equipment—video camera, tripod, tape recorder, extra tapes—and I felt like a *National Geographic* explorer heading out into the unknown. There was only one difference: *National Geographic* explorers aim their cameras at other people, and today, I was to be the object of study—at least one of them.

Jim turned off the main road, wound through elm-shaded streets, and finally stopped the car in front of Jerry and Cathy's house. While he unpacked his equipment, I stood for a moment, looking around. Kids' voices from a basketball game drifted across the vacant lot next door. Somewhere down the block, a screen door slammed, accompanied by a shout of, "I'm leaving, Mom." Neither the town nor the house were as I had imagined them from listening to Jerry and Cathy talk during our sessions. Their conflicts and concerns didn't seem to fit the neat corner house in this serene neighborhood. I'd imagined something less wholesome, I guess a house that mirrored the struggles going on within it—an unkempt lawn perhaps, or peeling paint. What strange images of our clients' lives we build based on 50-minute sessions, once a week.

I gave Jim a hand with the camera and tripod as he led the way to the front porch. He'd been here before, but this was my first visit. Cathy met us at the door, dressed in shorts and a sleeveless blouse, her fair hair pulled back with a headband. Although casually dressed, she still had a stylish flair, and I could see how she'd make a success out of her home cosmetics business. She directed Jim to the front room while Jerry took me to the kitchen to show me the new drywall and window frames they'd put up—a remodeling job that had been a contentious issue between them in past sessions. Tall and with crew-cut hair, his hands showed the ravages of his job as a mechanic. After the tour, they offered us iced tea and cake and then, like teenagers on a first date, we sat for a moment wondering how to begin. Jim broke the ice.

"Shall we look at the tape?" he asked. We all nodded, and Jim pushed the play button on the VCR. An image of our most recent therapy session flashed on the screen.

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"I'm curious to know what you all think of the session as we go along," Jim said, fast-forwarding the tape past the getting-settled stage, "and what question you'd like to ask each other about the work you've been doing together."

We all took a deep breath at that point, wondering what we'd gotten ourselves into.

That morning with Jerry and Cathy was a unique opportunity in my nearly 20 years as a therapist. While I'd occasionally looked at tapes of sessions with clients before, the focus had always been on *them*—their problems, what they were doing that got them in trouble, what they might do to change. Never before had I sat down with my clients to view a tape of a session and talk about the process—what was helpful, what wasn't, how they felt about what we'd done, how I felt about it. Never before had I made such a direct effort to cross the border that separated my clients' world and mine.

This journey started when Jim approached me about helping him with his Ph.D. dissertation. I assumed he wanted me to be on his committee and assured him that I would be. But that wasn't what he wanted. He was looking for a therapist to study, someone to help him examine a single case of marital therapy in depth to see how clients and therapists learn to work together. I was his candidate. He wanted to find a willing couple for me to see, observe each of our sessions, talk to us separately afterward to hear what we thought about what had happened, and then go over the videotapes with us, asking us to comment on what was going on. Jim called it an ethnographic study, but I saw it as a chance to finally hear what my clients thought of being in therapy with me. Although I hadn't any idea what they would say, I was curious to know.

Jim observed the first 10 of my sessions with Jerry and Cathy before he left for an internship. After the 10th session, we all met together to look at the tape. When Jim was gone, Jerry, Cathy and I met 11 more times. We continued to tape our meetings and sent the videos on to Jim, sometimes recording an addendum of our thoughts about the session. "Research without the researcher," we called it. The whole project was, by turns, exhilarating and sobering, and it brought me face-to-face with fundamental questions about our field: What does it really mean to collaborate with clients? What can be learned from the study of just one couple working with one therapist? What do I really think is important in therapy? One of Jim's questions proved consistently hard to answer: "What do you think Jerry and Cathy would say about the session today?" he asked after each therapy meeting. "How do you think they saw what happened?"

Most days, I was damned if I knew.

In the history of our profession, the views of clients have had little influence on the development of what we do. Psychoanalysis interpreted clients' criticisms of therapy as an expression of what was wrong with the client. Analyzing this phenomenon—resistance was the heart of treatment—and accepting clients' suggestions or complaints about therapy at face value didn't make sense when the conventional wisdom said those dissatisfactions reflected the clients' inner conflicts, not the shortcomings of psychoanalysis. While we've come a long way from traditional psychoanalysis, I think some vestiges of that approach remain. Even now, when we pride ourselves on being client-focused, co-constructive and conversational, in important ways we're not. Therapists still set the rules and rarely consult clients about how to make therapy more helpful to them. Is it always good to steer away from "problem talk" and ask about solutions? Does interrupting a sequence always help? Are there times when compliments annoy clients? Had Freud asked his clients what they thought would help them or what they wanted from therapy, we might have a very different profession today.

Jerry and Cathy came to see me after 14 years of marriage. They were struggling with a slow-growing marital malaise that had no specific focus. While they didn't like where they found themselves as a couple, they weren't sure where they wanted to be, either. And the stakes were high. Cathy was clear from the beginning that if therapy didn't help, divorce was the only other option. In our fourth session, I tried a technique I'd learned about from Australian therapist Michael White's work and externalized the disquiet they felt. If they joined forces to fight their dissatisfaction, I thought, maybe they could pull closer together.

"Are there ever times when you conquer this Pressure between the two of you?" I asked. "Are there times when you tell Pressure to back off and let you enjoy your marriage?"

When Jerry and Cathy could recount only a few recent good times, I suggested that they go home and try for a week to observe instances when they could keep Pressure from driving a wedge between them.

I left feeling it had been a good session, meeting many of my criteria for competent therapy—coherent, organized around a theme, using a theoretical model consistently. I found out months later, when therapy was done and I read their reactions in Jim's dissertation, that the couple felt the session was a flop. In a postsession interview with Jim, Cathy said the focus on exceptions was "corny" and was worried that I misunderstood her grave doubts about whether or not the marriage could survive. She felt it was fine to talk about good things, but not at the expense of discussing the "real problems." Jerry felt the session had had a "surface" feel to it.

I was chagrined when I read their comments. I'd been trying so hard to help them and had been so convinced of my success, that hearing their criticisms hurt. It helped to know that therapy was over and that Jerry and Cathy were satisfied with the outcome. My "Michael White session," Jim and I came to call it, hadn't been a fatal flaw, but we'd seen things so differently! Jerry and Cathy clearly didn't share my standards for "good therapy," and wanted something very different. Cathy told Jim, "To me, positive is not what we need to fix. It's the negative. What's the use of having wonderful bonding time if the night before was terrible? To me, Eric clearly didn't see the depth of the problem at that point."

"What's Eric thinking? What does he think of us?" Cathy and Jerry asked Jim time after time in their postsession interviews. The issue came up again when we all met together.

"It kills me sometimes to not know what you're thinking," Cathy said to me in her living room. "I'd give anything to know." Jerry nodded his agreement.

Their wish to know what I thought challenged what I'd been taught early in my career—that we must protect our clients from what we think of them, doling out our opinions only in scrupulously constructed interventions. There's a reason for this injunction, of course. The therapist's power in the therapeutic relationship may give an offhand remark more impact than we would ever guess. We need to be careful, but how careful? Jerry and Cathy said they would sacrifice a little caution for a better sense of my reactions.

"I respect your opinion," Cathy told me. "You've talked to lots of people about problems and have a lot of experience that I don't have."

What about the fear that I would unduly influence them?

"I may not agree with you," Cathy continued. "I'll still make up my own mind."

Cathy told me how dismayed she had been in the first session when Jerry brought up their two earlier experiences in therapy. My reassurance that I would try not to repeat what they had found unhelpful before (the counselors told Cathy she needed to accept that Jerry wouldn't change and "quit whining about it"), was, in fact, not reassuring at all. When we all met together, Cathy told me, "I don't want you to be afraid to say 'You're doing *this* wrong,' or 'You're looking at *this* out of perspective.' " Unfortunately, there was some accuracy in what she feared. I had found myself being careful with her, knowing how she'd been treated in therapy before. When I saw her ambivalence about Jerry—asking him to change something but still being dissatisfied when he did—I was reluctant to point it out, fearing it would sound like what she'd been told before. I saw my restraint as helpful. Cathy didn't. My efforts to protect her without knowing what protection, if any, she felt she needed, had backfired. And without Jim's research, I'd never have known about it.

As important to Cathy and Jerry as knowing what I thought about them was being sure that I understood them. Both rated our third session a "10" on the 1 to 10 scale Jim used with all of us. "One" meant the session had not been helpful, while "10" meant it had been extremely helpful. What made the third session a "10?" Cathy explained it to Jim this way: "I really felt Eric knows where I am today . . . I don't think he ever heard me before to where I really feel I am . . . until today." What had been so helpful to Cathy and Jerry that day wasn't some clever intervention. The difference was my ability to let them know I understood that their lives were on the line here, that their problems had tied them in knots they weren't sure could ever be untied. It wasn't so important that I help them do something about it just then, only that I grasp how serious it was.

To get away from the endless search for understanding that can stretch traditional therapy into a years-long venture, family therapists have taken the path of problem solving and action. We acknowledge the importance of empathy and the client-therapist relationship, but often relegate them to the murky land of "joining"—something to be gotten out of the way before real therapy can begin. For Cathy and Jerry, at least, this wasn't so. Feeling understood as they told their story was powerful. And healing.

"Were you embarrassed the day we brought up our sex problems?" Jerry asked me that morning in August. I thought for a moment, remembering the session several weeks before, trying to reconstruct what I'd been thinking.

"I wasn't embarrassed," I said, "but I felt pretty cautious, because I could tell it was a painful thing for both of you."

"I could see on your face that you were nervous," Jerry said.

Cathy chimed in, "I told Jerry in the car on the way home that I thought we'd embarrassed you. I could see you didn't know exactly what to say."

Her comment brought me up short. I *hadn't* known what to say, but should I tell them that? Talking about my indecision and uncertainty felt dangerous. Would it hurt them to know I sometimes didn't know what to do? Would it shake their confidence in our work together? And who would my silence protect—them or me? Despite the fear that I was breaking another therapy taboo, I struggled to match their candor with my own.

"I guess I really didn't know what to say. Would it have been better if I'd just told you that I felt like we were into something deep here, and that I needed your help in knowing exactly how far we could go?"

"It might have," Jerry said. "I felt bad about it later. I wondered if we'd done something wrong."

Cathy had a different view.

"I like it better when you're in charge," she said to me, "especially when it comes to the hard things. We're the ones who made a mess of our marriage, after all."

It was the kind of talk I've often wanted to have with my clients, the chance to step out of character and ask, "What is it you want from me, *really*? I know you're scared. Sometimes, so am I. Now, how can I help?" Later, Jim asked Jerry and Cathy why they hadn't shared some of their ideas with me during our sessions. "Eric's the professional," Jerry replied. "It just doesn't seem right. It's kind of like I wouldn't go to my doctor and tell him that I sure like those X-rays he took of me. I don't know anything about X-rays, so it isn't my place."

Hearing that comment, it dawned on me what different people Cathy and Jerry were in their own home. They responded to Jim's questions, offered their own views, and asked questions of me. In therapy, they were nothing like this. Many of our sessions had a tension and desperation you could feel. I'd picture them at home as a dispirited, humorless couple. Instead, I saw Cathy fondly needle Jim about his "famous 10-point scales," Jerry work to put this thoughts into words, and the two of them discuss easily and clearly their ongoing evaluation of therapy. The discrepancy left my head spinning. Had I been wrong about these two? Had I misjudged them and seen them defective when clearly they weren't?

The answer is more complicated than a simple personal failing. Jerry's comment about "his place" offered a clue. I hadn't misjudged them. I'd only seen what the therapy room let me see and had missed the parts of Cathy and Jerry that weren't in "therapy character." That's not to say that there was something duplicitous about what they said or did in our sessions. Rather, it is a testament to how limiting the therapy room is, how what happens there is organized to allow only a slim and circumscribed part of both the client and the therapist to appear. Clients' trouble and therapists' expertise come through the door easily, while clients' strengths, successes and playfulness, and therapists' doubts, confusion and uncertainty are rarely seen. That really doesn't diminish therapy or its usefulness. But we will always know only one small part of our clients. They are infinitely more complex than what emerges in therapy. For that matter, so are we.

Throughout therapy, my efforts to compliment Jerry and Cathy on the progress they made often left Cathy feeling unsettled.

"It scares me when you say we're doing a good job," she told me in our 10th session, as I once again tried to highlight progress. "I don't trust it. We've been here before and then slid back."

After watching herself say that again on tape in her living room, Cathy stopped the VCR.

"Right there, I just pushed Eric all the way back." She laughed. "He tried to say something nice and I just went 'Whooaa! Don't say that nice thing.' "

She got more serious and she turned to me.

"How did you feel, Eric, when I said that to you?"

It was a startling moment. Rarely had one of my clients asked me so straightforwardly how I felt about working with them. If they had, I'd turned the focus back to them, wondering if their curiosity indicated some insecurity about how they were coming across. Cathy's earnest question, however, and the openness of our conversation that morning, nudged me out of the protective shell of "therapist" by inviting a more personal response. I told her that I hadn't felt put off, that I realized she was scared. I didn't want to push her, but I didn't want to ignore good things, either. I reminded her that we'd made a little joke of it in the session as I changed from saying they'd made progress to saying, "You two are talking about some tiny, little differences in how you get along."

"It felt nice that I could joke with you about it," I said, "because when I first met you, I don't think I could have done that. I don't think you'd have known me well enough to know that when I was joking, I wasn't making fun of you."

Cathy agreed. "I was in a different place emotionally back then," she said.

Then Jim offered another thought: "I wonder if Eric can joke with you now, Cathy, because you've had enough interaction with him to know he understands."

"I do now," she replied.

It was a sweet moment, full of understanding and a kind of connection I'd never felt with a client before. We'd peeked through the scrim of "therapy" and caught a glimpse of each other as people.

In the three years since I last saw Jerry and Cathy, I've taken them with me, in my mind at least, to several professional meetings and workshops and as I read professional journals and articles I've been sent for review. They've followed along as I supervised, taught, and met with clients. Their presence has given me a new vantage point from which to access the work I do. Much of what I've noticed had been disturbing.

Amid all the talk of collaboration, equalizing professional hierarchies, and creating space for our clients' voices, I've yet to find an actual client participating in the debate. At conferences, presenters and panels opine about what clients need and want, but no client is there to speak for him- or herself. Our codes of ethics are formulated to protect clients. Have we ever asked them what kind of protections they need or want? As we move toward shorter, more focused therapy to "better serve our clients," why don't we ask if briefer approaches are helpful, or if they serve clients' needs? How many of our outcome studies include measures of client satisfaction with treatment? How many of our training programs use client input as part of students' evaluations? As we educate ourselves about gender, race, and class differences, does it occur to us to ask our clients if they find our knowledge of these things helpful?

Hearing our clients' voices doesn't mean we must blindly do anything they say. I honestly don't know, for example, if it's better for a couple to stay together or divorce, nor do I know who's right or who's wrong in most situations. When clients ask me to make such judgments, I have to decline. When I suggest that we listen to our clients' voices, what I have in mind is that we enter them into the larger conversations about therapy we are currently having as a field. We need such talk not to change *them* but to change *us,* to reshape our ideas of what therapy is, how it can help, what place it should occupy in society. And it's only fair, after all. Our clients hold a major stake in the outcome.

Cathy and Jerry left therapy after 21 sessions. Like so many therapy experiences, we ended not with a bang but with a gradual realization that they didn't need to come back. The time between sessions lengthened. We sometimes found ourselves with little to talk about. They'd made many changes during the months of our work together and were more settled than they had been in a long time. Cathy had come

out from behind her emotional wall and felt the marriage would be livable for her, now. Jerry had learned to turn the TV off and listen to his wife.

We said goodbye in the same waiting room where we'd met. I found myself lingering with them, wondering if I had the courage to ask the questions I hadn't asked. They were the hardest ones, the most personal—Did I really help you? Do you think I'm a good therapist? Do you like me as much as I've come to like you? Crossing that last barrier, however, and acknowledging some of my own needs as a therapist, was more than I could do that day. Instead, I tried to put some closure to all that we'd done.

"You two have really given me something special," I said. "Therapists and clients don't usually get together and talk about therapy the way we did. You've taught me a lot."

It sounded lame to me, pale against the excitement of our experiment. But it was the best I could do.

What Cathy and Jerry taught me has woven its way into my life as a therapist, lying quietly below the surface for weeks at a time before emerging when I need it. Just last week, I watched one of my students try to compliment a single mother on what a good job she was doing with her son.

"But you don't understand," the client said plaintively. "I don't feel like I'm doing a good job. I don't feel like I'm doing anything right."

As the student was about to try again, I called in and interrupted, remembering Cathy's admonition that problems had to be understood before strengths would seem relevant.

"Listen to her," I said to my student over the phone. "Slow down. Explore it a little more. She knows what she needs to be talking about."

Discussion Questions—Readings on Evaluation

1. What are your initial reactions to the articles? What key points did you take away from them?

   Elks and Kirkhart article

McCollum and Beer article

2. How would your list of pros and cons for evaluation change as a result of what you've read?

3. Elks and Kirkhart offer five categories that practitioners use in self-evaluation. Describe the strengths and weaknesses of using each approach to evaluate effectiveness.

Intuition and experience

Personal and professional values

Client change

Business aspects

Practitioner-client relationship

4. In what way(s) does the experience described by McCollum and Beer contrast with the techniques used by the therapists whom Elks and Kirkhart interviewed?

5. Based on what you have read, what strategies do you recommend for evaluating our effectiveness as social workers?

6. How does your answer to Question 5 change if the "client" is a group, organization, or community?

7. What responsibilities for assessing practice effectiveness do the Code of Ethics, licensure boards, and funders place on social workers? Do any of those bodies offer guidelines for selecting measures for evaluating effectiveness?

List of Methods to Evaluate Outcomes