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ORIGINAL PAPER

The Art of Practicing with Evidence

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Abstract This article reviews the definition of evidence-based practice and promotes an expansive view of the kinds of evidence available to the practitioner. It suggests that art and science are intertwined in practice, and describes the process of balancing and incorporating evidence derived from multiple sources, including the findings of research, the cumulative experience and wisdom of the practitioner, and the values and preferences of clients.

Keywords Evidence-based practice · The art of practice · Effective clinical practice

Introduction

After graduating with an MSW I went to work at a private psychiatric hospital, where I stayed for 6 years, starting my doctoral studies a couple of years after. I then moved into private practice while working on my Ph.D. I was told as I entered my doctoral program that it would not improve my clinical practice. I discovered, however that this statement was inaccurate. It was through the course of those studies that I first fully appreciated and confirmed my commitment to the scientific method, not only in my professional practice, but as part of my perspective on the world. It was something of a revelation to me, though it may be obvious to others, that there is one idea that undergirds the scientific method that is more important than any other; that all knowledge is provisional (Kerlinger 1973).

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The concept of evidence-based practice (EBP) emerges from a diverse range of sources and perspectives, but with a common intent to insure that practice is ethical and effective, and that outcomes are optimal. It is sometimes presented and/or perceived in reductionist ways, and thus appropriately invites concern and criticism (Adams et al. 2009). In particular, when EBP is construed simply as a process by which the practitioner integrates findings from published research into clinical decisions, it quickly feels remote and unwieldy to any experienced social work practitioner. This is further complicated when the knowledge itself is embedded in flawed assumptions: "The evidence-based treatment movement places emphasis on *treatments* when it has been found that the type of treatment accounts for very little of the variability in outcome" (Wampold and Bhati 2004, 568). Furman notes that EBP privileges many things, including that which is measurable, methods over individuals and knowledge over values, and cautions that EBP must be considered within an ethical framework (Furman 2009). Gray and McDonald go further, and suggest that: "the ethical intent ascribed to EBP is social work can be pursued just as readily (and without the limiting and disabling rigidities) by the use of well-developed moral reasoning" (Gray and McDonald 2006, 9).

Gambrill addresses this by offering a more nuanced description: "EBP is a process for handling the uncertainty surrounding decisions that must be made in real life, in real time. It is a way of dealing honestly with uncertainty" (Gambrill 2007, 450). Thus EBP attempts to deal directly with provisional knowledge, through a process designed to continually update, or perhaps more accurately, *revise* our understanding. Nevertheless, how to practice in this way is the real challenge, as the quest for certainty can lead to constraints on the definition of what counts as evidence. But that's a forgivable transgression—working with people

is complex, confusing, challenging, invigorating, stimulating, overwhelming, and rewarding; sometimes all on the same day. "Any good clinician is aware that therapy is anything but linear in nature" (Pollio 2006, 225.) The complexity of practice is what evokes a sense that "evidence" or "science" are inadequate terms, and that there are alternative ways of knowing and being that are integral to practice. These are variously described as art (Pollio 2006; Graybeal 2007), values-guided (Rosen 2003), craft (Cnaan and Dichter 2008), and naturalistic, intuitive, or transrational (Hudson 2009). The art of practice, notes Pollio, lies in the ability of the practitioner to "connect the EBP to the client's experience, understanding his or her reluctance or enthusiasm and being willing to respond to this effectively" (2006, 230). This article will describe some of the challenges and opportunities inherent in that process.

Integrating Art and Evidence

As scientific practitioners in any field of inquiry, we must stand ready to incorporate discoveries born of evidence that unsettle and provoke our thinking and our practice. Depending on the day, and the situation before us, this can be experienced either as an affirmation or a threat. The art of practicing with evidence is based in a combination of trust in what we *know* alongside the skills and capacity to embrace those things that poke holes in our certainty. Nowhere does this occur with greater complexity and diversity than in the negotiation of human relationships.

There is without question an art to clinical practice. But it is an informed art, grounded in the knowledge, values, and skills of the profession. Great art rarely emerges spontaneously, but is the outcome of years of practice. The art of clinical social work practice is not sudden or random; it is rather the culmination of a lengthy process of training and development, study and practice, and multiple starts both dismal and promising. But practice alone does not result in mastery; it must be meaningful practice, informed by systematic feedback and grounded in good critical reasoning (Rosen 2003). There is also the intriguing question of talent; for example, no amount of practice alone will create another Barbara Streisand or Michael Jordan—and in a similar fashion, there are some individuals who seem to have a knack for establishing relationships. This is one reason why in certain circumstances a neophyte social work student in her first contact with a client may prove to be more effective than her supervisor with 20 years of experience.

Social work is somewhat unique among the professions in that the primary instrument is the use of self. We don't have the medicines of psychiatry, the tools of surgery or dentistry, the testing of psychology, the direct contact of nursing or physical therapy, or the physical devices of occupational therapy, though all of those professions do share with social work the use of self. Social workers by definition work on social concerns, or more specifically, the relationship and impact between individuals and families and the social environment. That is why our understanding of what constitutes evidence is essential to the development of our art. Evidence is available in every instant of every human encounter, and our task is to attend to that fact, and to make ourselves available to it. Nelle Morton once said that "the furthest journey on earth is the journey into the presence of the person nearest to you" (Gallagher 1989). This reminds us that the first goal for practice at any level is to quiet the distractions that take one out of the present—the classifications, diagnoses, similar situations encountered before, what to have for lunch, and so on, and to be as attentive as possible to the unique circumstances, behavior, and feedback that are present in this moment.

There is an inherent risk to our art when what we "see" is defined and organized around the holy trinity of assessment, diagnosis, and intervention. Seeing through categories increases the potential for a process by which the path becomes clearer, but the destination less interesting. The key to the art of practicing with evidence lies in the capacity to take a wide view, one that encompasses the richness and diversity of evidence available. As Sherlock Holmes once said to Dr. Watson: "You see, but you do not observe. The distinction is clear" (Conan Doyle 1892, 162). For a social worker, to be observant is to widen the scope of inquiry to an understanding of the greater context, the person-in-environment frame so central to social work understanding. This is not an argument to eliminate the process of assessment, diagnosis, and treatment, but to respectfully relegate it to its proper place, as a subset to the greater aim of clinical social work (Pollio 2006). That aim is something significantly more meaningful and substantive than the amelioration of symptoms, or the application of a treatment to a problem. The art of practicing with evidence is to expand the scope of observation, discover the inherent range of possibilities, and to partner with another in the exploration the available options.

In the pages that follow, I will start with a definition of EBP, describe the elements of that definition, and then describe a process by which those elements combine to create the art of practice. First, I offer the following case example from my own practice, shortly after entering the profession.

Case Example #1

> The first example comes from my first year out of graduate school. I was an avid reader and an

enthusiastic consumer of practice literature and research. I was meeting with a couple, a man and woman who'd been married 20 years or so, and seemed to argue about everything. They were from New York City, and they talked simultaneously in loud and expressive voices and many hand gestures and dramatic facial expressions. I was having little success, and found it nearly impossible to sort out what they were saying, as I found it difficult to hear either one. Luckily, I thought, I had just attended a workshop on marital therapy. The instructor had suggested a series of techniques for difficult situations, and I had the inspiration to apply one of them with this couple. I asked for their attention and then said:
"Okay, let's have a rule that just one person speaks at a time."
The wife looked at me, and slowly turned to her husband with a smile on her face. She lifted her forearm up beside her and then lowered her wrist and pointed at me as she continued to look at him:
"Oh, he's a Protestant!"

I had made an earnest attempt to incorporate what I thought was an evidence-based, or perhaps more accurately termed "authority-based" (Gambrill 1999) intervention to a specific clinical presentation. I did not anticipate the client's response, but it provided a lesson in at least two things: understanding the cultural context, and understanding that our clients have their own capacity to diagnose or label, sometimes with discomfiting accuracy!

Gambrill describes EBP as a process that "involves integrating individual practice expertise with the best available external evidence from systematic research as well as considering the values and expectations of clients" (Gambrill 1999, p. 346). Drisko observes that EBP has been further delineated into four parts: "(1) the client's needs and situation, (2) relevant and locatable high-quality research evidence, (3) the client's views and preferences all integrated by the clinician's (4) professional expertise" (Drisko 2011, 335). EBP should be distinguished from the more restricted concept of empirically supported treatments (EST), that "promote the use of standardized procedures (treatment manuals) for specific disorders" (Hagemoser, 2009, 601). The conflation of these two terms has occasionally led to considerable confusion and frustration on the part of front-line practitioners. "Whereas EST implies a collection of tools that a practitioner has, EBP may be better conceptualized as what the professional does" (Hagemoser 2009, 611).

I don't think that we need to find a new name for this process, such as "evidence-guided" (Gitterman and Knight 2013; Thyer 2013), but I do think that our concept of and appreciation for evidence should continue to evolve (Bohart 2005). Evidence is generally defined as "the data on which a judgment or conclusion may be based" (Morris 1973). If we think of EBP as a three-legged stool, then there are three main sources of support, and the body that connects them to one another. Some of our attention to evidence should be directed at staying current with the literature and thinking about how to apply it. Another place of focus is the evidence accumulated from our life and work experience, critical thought and reflection, and systematic feedback from supervisors, peers, and clients. To this we add the stated preferences and unique life experiences of the individuals we work with, who ultimately have control over anything and everything that happens. Finally, it is the relationship between these sources of evidence that helps to establish a coherent whole. Something as subtle as a client's facial expression may in the end prove to be the most powerful piece of evidence available, and what we do with it the greatest predictor of outcome. The art of practicing with evidence is ultimately embedded in the capacity to balance the various sources and forms of evidence in a process that leads to meaningful outcomes.

Evidence from Formal Research

This category includes ESTs but it also derives more broadly from the history and methods of social science inquiry. It includes data derived from observations of individuals, groups, and populations, classified by characteristics, exposed to differential experiences, and evaluated for outcomes. The foundation for practice models sometimes draws on literature from diverse professions including sociology, psychology, biology and anatomy, neurobiology, cultural anthropology, psychiatry, medicine, and public health, among others. It draws as well from the past 100 years of research into diagnosis and treatment in health and mental health; the attempt to design and match one to the other, comparative studies of effectiveness, and long term outcomes.

The process of clinical practice has been studied in various ways for more than 50 years, resulting in thousands of studies on its effectiveness. This has resulted in the emergence of meta-analysis, or the grouping of multiple single studies in order to enhance reliability and to reduce random error (Smith and Glass 1977, Lambert and Ogles 2004). This is an important development, and preferable to any reliance on the findings from a single study. Ideally, assertions about the superiority of any single technique or model should be supported by a number of studies, primarily due to the considerable difficulty in controlling independent, intervening, and dependent variables. The

diagnosis of most mental disorders is somewhat unreliable (Kutchins and Kirk 1997), and their presentation rarely encompasses all or even most of the range of concerns expressed by clients. The application of a method or technique can sometimes be standardized, but the personality, mood, energy level, empathy, intelligence, and so on of the individual delivering it cannot. We can measure the specific change in one or more symptoms or problems, but global functioning must be generalized. All of these factors make it difficult to match a single intervention or technique with the needs of an individual client or family.

Nevertheless, whether you call it counseling, psychotherapy, or social work, and whether you apply any one of a dozen or more recognized theoretical approaches, "it" helps, and a foundation in the common factors of helping will increase the potential for success (Wampold 2001). This is not and never has been an argument for an eclectic free-for-all, or a reason not to be an avid consumer of practice research. Starting with this foundation in common factors, and the overwhelming evidence that relationship matters, the artful practitioner sets about establishing a positive working relationship and then explores the application of specific strategies in unique situations. What makes social work interesting is that each new study provides potential insights and adds to the practitioner's toolbox. Thus the goal is to collaborate with clients to ensure a good match. "The defining characteristic of a scientist-practitioner is not claiming to have been given the right answers; it is being willing and able to ask the right questions" (Hagemoser, 611). A number of years ago I had a colleague who was very well versed in treatment models, and the way he approached this with clients was to describe three distinct approaches; family systems, cognitive-behavioral, and supportive/Rogerian. He would then ask the individual which one seemed the best fit to them at that time. His clients responded very favorably to this approach, and during the course of their work together would sometimes ask to transition from one approach to another, adjusting to the changing needs and process of their work together.

Practice Wisdom

The second source of evidence is that which resides in the cumulative experience and knowledge of the practitioner, or practice wisdom. Experience alone does not result in wisdom; it must be accompanied by a strong theoretical and conceptual foundation, along with common sense, reasoning, and good judgment. This is perhaps the most highly variable of the three sources, as we are all susceptible to self-delusion to one degree or another. But for the practitioner who is self-reflective, and imbued with a sensibility toward cultural anthropology, each and every human encounter provides an additional opportunity for discovery and the potential for collaboration. In this context, social work theories, building on the broad foundation of knowledge described earlier, help to guide choices of intervention through the lens of values and ethics (Gray and McDonald 2006).

Practice wisdom is also a form of scientific knowledge, accumulated through trial and error, or what Popper described as conjecture and refutation (Popper 1965). Each interaction with a client begins with an exploration, a conjecture, based on the social worker's experience and theoretical perspective. Through language and behavior the client either affirms or refutes that conjecture, and through this process, understanding grows. In some ways, it is the errors and refutations that seem to resonate even longer than the successes. Like the earlier example of the couple from New York, there are other vivid memories, particularly from early in my career, when something I did or said was clearly not helpful to a client. Groopman describes a similar process among physicians:

> "Different doctors…achieve competency in remarkably similar ways, despite working in disparate fields. Primarily, they recognize and remember their mistakes and misjudgments, and incorporate those memories into their thinking. Studies show that expertise is largely acquired not only by sustained practice but by receiving feedback that helps you understand your technical errors and misguided decisions" (Groopman 2007, 21).

Systematic feedback is critically important to the accumulation of expertise and wisdom. An expert supervisor, as anyone who has experienced this process will attest, knows how to ask just the right question at the right time, and how to provide feedback in a way that is constructive and can be heard.

Interpersonal effectiveness also requires emotional intelligence on the part of the practitioner, as a strong intellect does not itself ensure the capacity to read emotional states. The two basic elements of emotional intelligence are self-awareness and the awareness of emotions in others (Goleman 1995). Effective practitioners tend to be calm, non-reactive, considered, and attentive. Their choice of words and specific interventions is usually delivered with a mixture of confidence and flexibility, and the awareness that what works for some or for many does not necessarily work for all.

Values and Preferences of the Client

The third primary source of evidence is found in the values, preferences, language, and behavior of the client or patient. Despite our profession's emphasis on client-centeredness as a principle, there is an inexorable impulse at times to

assert one's expertise and for it to take precedence. This is neither bad nor evil; it is simply a fact of life. But it is something that to guard against, and to regularly assess through self-reflection, exploration of options, and discussion with other professionals. Most importantly, we need to be assiduous in our attention to the unique details of our clients' perception and experience.

Adjectives such as resistant, non-compliant, uncooperative, and so on are far too often used by practitioners to summarize behavior they find unattractive or cumbersome to work with. This is not to deny that such qualities exist, but rather to suggest that identifying clients in those terms rarely leads to useful strategies for helping. It's useful to imagine oneself as a cultural anthropologist in a foreign land. I find it helps me to step back and carefully consider the questions I might ask that will help me to fully appreciate this person's experience.

The relationship between social worker and client is often perceived as something that develops over hours, days, weeks, or months. While it is true that relationships can deepen over time, it takes just a few minutes or even seconds for client and provider to form an initial assessment of one another. And it probably takes just three to 5 min to establish the basic parameters of a working alliance. In those opening moments, it is critical to observe and adapt to clients' individual styles of interaction; how they move, the quality of interaction, their language, their sense of ease or discomfort, where they sit, and what they look at. The immediacy of practice is reflected in parallels to improvisational theater (Walter 2003). The core elements of improvisation can be reduced to three principles: attend, accept, and advance. To attend is to listen and observe carefully. To accept is to suspend disbelief or judgment and fully appreciate what is being presented. And to advance is to take what is offered and move it forward. Clients are always providing feedback; it's up to us to be sensitive enough to notice, and to check in with them on a regular basis to insure that we understand their concerns, perceptions, and needs.

Case Example #2

> I was working with a couple in an outpatient setting. I had seen them three times before and they were starting to work on some difficult issues in their relationship. When they arrived at my office, I said "Hello" and they walked over and settled into two chairs at right angles to one another. He looked at me and then turned to her and asked her a question. It was a good question, and she answered, initiating a lengthy conversation about their perceptions. Periodically there would be a brief pause, and then one or the other would pick things up with another question or observation. I noted my watch a few times: twenty-minutes; thirty-three minutes; forty-seven minutes. I had a habit of starting to wrap things up at fifty minutes in order to leave time to transition to the next appointment, so at fifty minutes, I waited for a short pause, and then spoke for the second time:
> "It looks like we're about out of time," I said.
> They looked at me, and then one another, then stood up, and started for the door. But then they both turned back and looked at me again:
> "This was the most helpful session yet," she said.
> "Yes, thanks," he added, "See you next week."
> I smiled and nodded, not wishing to spoil the moment with words.

I call this my "Zen" session. For one fleeting hour, I felt I had mastered the art of practice. During that session, I watched and listened diligently. I nodded a few times, but that was it. This couple was doing all the work—my only role at that point was to serve as witness. I had many tools and techniques, theories and perspective, life experience and practice wisdom, all at the ready should the need arise. It never did, other than to restrain any impulse to intervene. The next week I commented on it, and they seemed genuinely surprised that I hadn't said anything the week before. But they did say that for the first time in years they felt safe to talk about the difficult things. While there were still issues to work on, we were able to wrap up just a couple of weeks later. That was some time ago and nothing like my "Zen" session has ever happened to me again.

Conclusion and Summary

The art of practicing with evidence is discovered and learned through achieving a balance between the primary sources described above—the findings of research; accumulated experience, or practice wisdom; and the evidence supplied directly from clients and patients as they describe their experience, values, and preferences. Sometimes the path is obvious, the concern or symptom well defined, and the treatment options clear. When that occurs, you can proceed with increased confidence. Interestingly, there is considerable evidence that confidence in one's approach can substantially increase its effectiveness (Wampold 2001). Other times the path is less clear, the treatment less obvious. In that instance, attention should shift from the focus on intervention to further exploration of the client's values, preferences, and experience. This can lead to clues that suggest a new direction. For example, if the first foray was action-oriented, but the client seems stuck

or uncomfortable, something as simple as "perhaps I'm moving too fast". Consider the parallels with a singer and accompanist, working through a new piece of music. The transcription, like our theories and methods, provides a roadmap. The singer is the client, reading the music, but endeavoring to find a unique interpretation and expression. The social worker plays accompanist, supporting but not leading, adjusting volume and intensity so that it never obscures the singer's voice.

Such metaphors do have limits. In social work practice, there are times when we do need to take the lead. For example, when a client lacks confidence or is just feeling overwhelmed, it is often helpful to encourage exploration and experimentation. The social worker may share information about research or a specific technique, perhaps adding information that will normalize the client's experience: "A lot of people in your situation have found that (insert technique or activity) helps with the situation you are facing." This suggests they aren't alone, and also offers hope. If there is any concern, the client should be enlisted as a co-researcher: "I can understand your hesitancy. Let's treat this as an experiment. Try this for 1 week, then come back and report to me what happened. Then together we can determine whether it was useful to you, and if so, in what way. If it's not useful, that will provide helpful information as well, and lead us in another direction." Thus, success or failure is not assigned to the client, but rather to the technique or activity. This approach is exemplified in the Partners for Change Outcome Management System, an evidence-based model developed by Duncan to incorporate immediate client feedback into the process of treatment (Duncan, 2012). No matter the outcome, there will be useful information. Thus the worker and client are seeking evidence together, and actively integrating all the elements of EBP in a shared decision making process. "Conceived in this manner, EBP can avoid becoming a technology and instead become a kind of dynamic art or dance that is informed by and grounded in multiple sources of evidence and in the reflective use of self" (Hudson 2009, 172).

Sometimes a practitioner will experience an intuitive hunch—a "sense" that something would be helpful. Such hunches are not really mysterious; they're the result of years of experience, tempered by ongoing learning, and seasoned by the observed responses of clients in both diverse and similar circumstances. Hunches are also evidence of a sort. The only risk is in following them blindly. Alternatively, as long as they are integrated into the process, as conjectures, subject to affirmation or refutation, they can lead to very meaningful insights and outcomes.

The social worker seeks a balance between these sources of evidence, exploring their relationship with one another, and the thoughtful and creative negotiation of ideas and insights through discovery and collaboration. Each new interaction provides an opportunity for an entirely original combination. We can never be experts in the unique circumstances of our clients' lives, but we can achieve artistry in the integration of evidence and its application to their desires and goals.

In closing, I'd like to offer one final story. It illustrates one of those times when I trusted an intuitive hunch in the moment, and the response I received suggested it was in fact just the right thing to say at that moment.

Case Example #3

> A few years ago, I had a student who would always read every single reference on the syllabus of every course. But that was not enough. Next he would check the bibliographies of each article, and go on to read many of the original sources. Sometimes he would ask me for additional recommendations, and then read those. Then to my amazement, following the commencement ceremony at graduation, and still dressed in cap and gown, he approached me and asked if I had any additional recommendations for things he should read. I looked at him and considered the question for a moment, and then it came to me: "Yes." I said, "The collected works of William Shakespeare."
> He looked at me, an "ah hah" moment crossing his face. He smiled, nodded, and said nothing.

Ultimately, it is our humanity that helps us to make the connections between our knowledge and expertise, the available evidence and the specific life situation and needs of the client. The broader our perspective, the more diverse our knowledge, the more inclusive our understanding of the nature and sources of evidence: the richer our art. Of course, Shakespeare is just a start, but it's a great one as we ponder the vagaries and varieties of individual needs and desires, and the options for our response.

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