Chapter 6

Intervention Overview

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Purpose: This chapter describes various resources social workers can access to locate credible information regarding the effectiveness of psychosocial interventions for use with adults.
Rationale: Social workers have many sources of information to help guide their practice. Many of them are outdated, incorrect, and potentially harmful. It is important to be able to locate sources of information that are current and accurate and reflect interventions that have credible evidence to support their application with adults.
How evidence-informed practice is presented: The websites of the Cochrane and Campbell Collaborations contain many systematic reviews that provide credible appraisals of the state of the science pertaining to selected psychosocial interventions.
Overarching question: Which resources can social workers consult to obtain relevant information regarding the effectiveness of various interventions that can be helpful for practice with adult clients?

This chapter reviews contemporary developments and advances regarding the effectiveness of various psychosocial interventions and assessment methods used by social workers who serve adult clients. Clinical social workers comprise the largest professional group providing psychotherapy services to adults in the United States, outnumbering psychologists and psychiatrists combined by a considerable margin. By virtue of our mere numbers, if not our sense of professionalism, it is crucial that members of our discipline keep abreast of the latest information on psychosocial work interventions' effectiveness. The term *psychosocial* treatment or therapy will be used throughout this chapter, because it is more inclusive than psychotherapy, behavior analysis, case management, and other terms for interpersonal helping. Barker (2003) provides the following definition of psychosocial therapy:

> *A relationship that occurs between a professional and an individual, family, group, or community for the purpose of helping the client overcome specific emotional or social problems and achieve specified goals for well-being.*
>
> *—(p. 349)*

It is used here in a much broader sense than that employed by Hollis (1964) in describing a particular theoretically based approach to

social casework. It is juxtaposed to other major methods of intervention, such as medications, surgery, hospitalization, or changes in laws or social policy. It involves both intrapersonal and interpersonal processes as well as changes in a person's physical environment. Although much of this chapter's focus is on psychotherapies, the principles discussed apply to all forms of psychosocial intervention. Occasional reference is made to these other modes of helping—for example, case management, advocacy, behavior analysis, mediation, and so on. In this chapter, persons chronologically older than the teenage years are referred to as *adults*. The purpose of this chapter is to provide the reader with information on how to locate major resources pertaining to the selection of interventions most likely to be of benefit to his or her clients.

Historical Background

In the past two decades, there have been a number of substantive initiatives to identify the evidentiary foundations of various psychosocial interventions. These initiatives are largely independent efforts and have continued on to the present. They are discussed sequentially, but this does not imply any sense of priority or authoritativeness.

Task Force on Promotion and Dissemination of Psychological Interventions

The first one to be addressed was developed at the initiative of Martin Seligman, then president of Division 12, the Division of Clinical Psychology, one of more than 50 divisions within the American Psychological Association. Seligman established a Task Force on Promotion and Dissemination of Psychological Interventions, primarily composed of major players who supported the scientist-practitioner model of psychological training. This group was charged with three distinct tasks. The first was to identify some set of evidentiary standards that could be used to assess the effectiveness of different psychological treatments when applied to help clients with discrete and specific so-called mental disorders. The second assignment was, once these evidentiary guidelines were established, to actually apply them in evaluating the evidence related to the effectiveness of these various interventions and to prepare and publish lists of such well-supported treatments. The third assignment was to prepare a list of treatment manuals for these presumptively well-supported interventions, including information about how these manuals could be obtained and where clinicians could gain supervised experience in learning to use them. A treatment manual was defined as a written document that provided sufficient detail so as to permit a competent clinician to replicate the treatment. As you might imagine, none of these tasks was undertaken without considerable discussion, and, indeed, controversy (see Chambless & Ollendick, 2001), but the original task force continued its work through several successive presidents of Division 12 and was largely successful in completing its assignments.

The first task was perhaps the most contentious, and in the interests of space and time, I will simply refer to the final set of criteria described in Chapter 5 of this volume. On the face of it, these criteria seem relatively modest, but they certainly engendered a storm of controversy, mostly stemming from two overlapping camps. The psychodynamically, phenomenologically, and humanistically inclined psychotherapists were anxious that their preferred treatments may not meet these seemingly (to them) stringent standards and that this could negatively affect the credibility of their services. The second group of opponents were those who advocated postmodernist perspectives and repudiated the idea that certain forms of evidence (e.g., randomized controlled trials) should be given greater credibility than other ways of knowing (e.g., case studies or other forms of qualitative inquiry). The behavior analysts, who rarely employed randomized controlled trials in their evaluations of therapy, successfully insisted that a series of well-controlled single-case studies could also provide convincing evidence related to the effectiveness of psychological treatments.

Acceptance of the evidentiary criteria was helped through a recognition that the task force was clearly committed to identifying genuinely effective psychotherapies, irrespective of theoretical orientations, and also that these standards were modeled after those used by the U.S. Food and Drug Administration in the process to approve the safety, efficacy, and use of new medications. These suggested standards appeared in various publications (Chambless et al., 1998; Task Force, 1995), and the language softened from referring to "empirically validated" to "empirically supported" treatments in order to provide some distance from any implication that research on a given psychotherapy was concluded.

Once the bar had been set, members of the task force began assembling reports on what psychological treatments met these standards and developed lists of them. One such list is partially depicted in Table 6.1. The original list is longer, listing about 25 therapies, and also includes citations to the intervention research justifying the treatment's inclusion. Updates to this list appeared in later publications that collected a list of the treatment manuals describing the well-established interventions and provided information about where they were published or could otherwise be acquired (Chambless et al., 1998; Woody, Weisz, & McLean, 2005). Further publications appeared (Sanderson & Woody, 1995; Van Hasselt & Hersen, 1996; Woody & Sanderson, 1998). Some members of the task force went on to produce books describing these empirically supported treatments, which have proven to greatly enrich the treatment literature (e.g., Nathan & Gorman, 1998, 2007; Weisz, 2004).

A later initiative (Woody et al., 2005) was to conduct a survey of APA-accredited doctoral and internship training programs in clinical psychology in the United States and Canada, assessing the extent to which these programs were providing training in task-force identified, empirically supported treatments and to compare changes in such training opportunities over the past decade (1993–2003). The picture was mixed.

Table 6.1 Examples of Supposedly Empirically Validated Treatments

Well-Established Treatments

Beck's Cognitive Therapy for Depression
Behavioral Marital Therapy
Cognitive Behavior Therapy (CBT) for Panic Disorder With and Without Agoraphobia
CBT for Generalized Anxiety Disorder
Exposure Therapy for Phobias
Exposure Therapy and Response Prevention for Obsessive-Compulsive Disorder
Group CBT for Social Phobia
Interpersonal Psychotherapy for Bulimia
Token Economy Programs for the Chronically Mentally Ill

Probably Efficacious Treatments

Brief Psychodynamic Therapies
Dialectical Behavior Therapy for Borderline Personality Disorder
Lewinsohn's Psychoeducational Treatment for Depression

Adapted from "Training in and Dissemination of Empirically-Validated Psychological Treatments," by the Task Force on Promotion and Dissemination of Psychological Procedures, 1995, *Clinical Psychologist*, *48*(1), pp. 3–23.

In 2003, the modal number of empirically supported treatments that students were trained in during graduate school was 0(!), and the mode for providing supervised training during the internship was also 0(!). The mean numbers of empirically supported treatments (ESTs) taught dropped from 11.5 (1993) to 9.5 (2003), but the responding programs differed from the two surveys, so this is not a reliable index. Only four ESTs were taught by more than 50% of the internship programs. "Most of the treatments that have robust empirical support are not taught (in a supervised way) by the majority of training programs" (Woody et al., 2005, p. 9), a rather embarrassing finding considering the conspicuous manner in which psychology says it is distinguished from other mental-health fields by its rigorous adherence to a scientist-practitioner model of training.

A subsequent national survey of psychotherapy training in psychiatry, psychology, and social work was undertaken by social worker Myrna Weissman et al. (2006). A cross-sectional survey of a probability sample of all accredited training programs in psychiatry ($n = 73$), psychology ($n = 84$), and social work ($n = 64$) responded. The survey asked about required and elective didactic (lectures and reading) classes and supervised clinical practica offering training in one or more empirically supported interventions. Sixty-two percent of the social work programs offered *no* didactic classes combined with clinical supervision in an empirically supported intervention, and only about 10% of the MSW programs offered *both* classes and supervised practice in this area. Overall, the MSW programs fared more poorly in this arena than did those in psychiatry and

clinical psychology. It should be noted that the accreditation standards for both psychiatry and clinical psychology *require* education and training in one or more empirically based treatments, something that current MSW accreditation standards do not require.

The original task force has since been renamed the Committee on Science and Practice, within Division 12 of the APA, and continues its work, although in less striking ways (see http://www.psychology.sunysb.edu/eklonsky-/division12/index.html).

The standards of evidence found in Chapter 5 remain in play, but the list of ESTs is periodically (and appropriately) amended to reflect advances in clinical research (Nathan & Gorman, 1998, 2007). This latter volume is immodestly titled *A Guide to Treatments That Work*, but it really does live up to its name. It was claimed, "This volume emanates from a task force of the board of directors of Division 12 (Clinical Psychology) of the American Psychological Association (APA) established in 1993 during my Presidency of that division" (Seligman, 1998, p. v). Seligman wanted this book to be an interdisciplinary, state-of-the-science summary of what is known to work in terms of psychological (what we social workers would call psychosocial) and pharmacological treatments, disorder by disorder by disorder: "The work was to be a disinterested review of outcome studies, not a lobbying effort: These volumes are intended to be scientific documents of a high order. It is essential that their integrity be unimpeachable" (Seligman, 1998, p. vi). There could be no involvement of researchers who received funding from pharmaceutical companies or who had other financial conflicts of interest, and there was to be no editorial control from either Division 12 or the APA at large. The mandate to the clinician-scholars invited to author various chapters was clear and compelling:

> *The purpose of these chapters is to present the most rigorous, scientifically based evidence for the efficacy of treatments that is available. At the same time, it is clear that for some disorders there are treatments widely recognized by experienced clinicians to be useful that may not have been subjected to rigorous investigation for a variety of reasons. Our aim is to be clear with readers what treatments have been scientifically validated, what treatments are felt by a large number of experts to be valuable but have never been properly scientifically examined, and what treatments are known to be of little value.*
>
> —*(Nathan & Gorman, 1998, p. x)*

This project was carried out as proposed, with the first edition appearing in 1998 and undated editions in 2002 and 2007. It is an invaluable resource for social workers seeking guidance about effective interventions relevant to adult clients who meet the formal diagnostic criteria for a mental disorder. A related book, composed with the same intent, is titled *A Guide to Assessments That Work* (Hunsley & Mash, 2008) and serves as the assessment counterpart to the treatment guides. Chapters are structured around DSM-defined clinical conditions and some other issues that are not themselves formal mental illnesses (e.g., couple distress, pain). Each such

chapter contains a summary of the best (e.g., most scientifically legitimate) assessment methods pertaining to that particular chapter's focal problem.

Keep in mind that Division 12 is but one of more than 50 divisions within the APA, and the APA as the host organization has taken great pains not to officially endorse this initiative of Division 12, due to the sensitivities of the larger community of psychologists, many of whom are decidedly not enamored with efforts such as these. Indeed, the first edition contains a legal disclaimer that lawyers within the APA insisted on including in *A Guide to Treatments That Work*, stating that:

> *This book does not represent an official statement by APA, or any of its divisions, but rather the personal views of the authors based upon their review of the scientific literature relative to therapeutic techniques and drugs for various psychological disorders. The book recites the literature and describes the controlled outcome studies relative to therapies but it is not intended to recommend "treatments of choice," establish standards or guidelines for "care" or provide advice on the efficacy of the therapies listed. . . . [H]ealth care providers and members of the public are advised that this book should not be definitively relied upon in making choices for appropriate care and treatment.*
>
> —*(Seligman, 1998, p. vii)*

So much for Seligman's hope that there would be no outside editorial control! Recently, the APA has begun using the language of evidence-based practice (Kazdin, 2008; Norcross, Beutler, & Levant, 2006), reflecting the more profound influence of this initiative, originating outside psychology and described next, but unfortunately in doing so, the organization has blurred the distinction between the concept of empirically supported treatments (e.g., identifying interventions supported by a certain level of evidence) and the process of evidence-based practice. Nevertheless, these lists of ESTs can be a useful source of information for clinicians seeking credible information regarding psychosocial treatments that have achieved at least some minimal standard of research support.

Evidence-Based Practice

The term *evidence-based medicine* first appeared in print in a 1992 article by Gordon Guyatt, a physician concerned with promoting the greater use of scientifically reliable research findings in the practice of health care. Guyatt, allied with a number of medical doctors with similar views, began publishing a series of papers in the *Journal of the American Medical Association* (*JAMA*), the *British Medical Journal* (*BMJ*), and other leading medical journals, describing the basic tenets of what came to be called *evidence-based practice*, a more broadly based term reflective of the application of these principles to all health-care disciplines, not just medicine. The best-selling textbook *Evidence-Based Medicine: How to Practice and Teach EBM* has gone into its fourth edition (Strauss, Glasziou, Richardson & Haynes, 2011), from which much of the content in this section of this chapter is drawn.

The definition of evidence-based medicine is deceptively simple:

> *Evidence-based medicine (EBM) requires the integration of the best research evidence with our clinical expertise and our patient's unique values and circumstances.*
>
> —(Strauss et al., 2011, p. 1)

This three-component sentence often has casual readers overlooking the second and third elements in favor of an almost exclusive emphasis on the first element, research evidence. In other words, many misconstrue EBP to simply mean locating research evidence (e.g., best-supported interventions) and then applying them to practice. This is clearly a false representation of EBP, because the definition involves three equally important elements: research evidence, clinical expertise, and client's values and circumstances. Anyone who equates EBP solely with applying empirically supported techniques has a gross and fundamental misunderstanding of this process of learning, teaching, and practicing.

EBP arose due to some realizations among its originators:

- Clinicians have a great need for valid information about a client's problem, prognosis, effective ways to assess and diagnosis, how to treat clients, and how to prevent problems.
- The traditional ways of communicating such information are inadequate. Books and journals are frequently out of date, wrong, ineffective, or overwhelming, or they simply convey bogus information.
- There are often growing disparities between our clinical skills, empirically based knowledge, and practice effectiveness.
- There are serious limitations about how much time clinicians can spend in tracking down clinically relevant and valid information.

However, there are some technological developments that make it possible to overcome some of these factors inhibiting genuinely effective practice:

- New ways to track down information efficiently.
- The creation and availability of systematic reviews (of which more will be said later) of the effects of health-care and psychosocial interventions.
- The development of evidence-based journals that reprint summaries of genuinely useful information from recently published journals (e.g., *Evidence-Based Mental Health*; see http://ebmh.bmj.com).
- The development of improved ways to learn about research evidence, clinical skills, and assessment methods.

Evidence-based practice is best viewed as a process of learning or of locating information and acting upon it rather than locating empirically

supported treatments and applying them. Evidence-based practice is seen as having five steps:

1. Converting the need for information (about prevention, diagnosis, prognosis, therapy, causation, etc.) into an answerable question.
2. Tracking down the best evidence with which to answer that question.
3. Critically appraising that evidence for its validity (closeness to the truth), impact (size of the effect), and applicability (usefulness in our clinical practice).
4. Integrating the critical appraisal with our clinical expertise and our patients' unique biology, values, and circumstances.
5. Evaluating our effectiveness and efficiency in executing Steps 1 to 4 and seeking ways to improve them for next time. (Strauss et al., 2011, pp. 2–3)

Strauss et al. (2011) and related primary resources spend a good deal of space on each of these five steps, and the reader interested in learning more about EBP within social work is strongly urged to begin with Strauss et al. and other small books central to the EBP movement (e.g., Guyatt & Rennie, 2002; Moore & McQuay, 2006) *before* delving into the related literatures on EBP to be found in social work (e.g., J. Corcoran, 2000; Cournoyer, 2004; Gibbs, 2003; Gray, Plath, & Webb, 2009; O'Hare, 2005; Roberts & Yeager, 2006; Thyer & Kazi, 2004; Thyer & Wodarski, 2007).

Concurrent with the establishment of the EBP movement within medicine, an international group of health-care professionals established an organization called the Cochrane Collaboration (CC; www.cochrane.org). I strongly urge you to sign on to the Cochrane website and take some time perusing what it has to offer and to become familiar with this highly influential organization. The CC is named after a distinguished British epidemiologist, Archie Cochrane. The CC is both international and not for profit and is

> *dedicated to making up-to-date, accurate information about the effects of health care readily available worldwide. It produces and disseminates systematic reviews of health care interventions and promotes the search for evidence in the form of clinical trials and other studies of interventions. . . . The major product of the Collaboration is the* Cochrane Database of Systematic Reviews *which is published quarterly . . . .Those who prepare the reviews are mostly health professionals who volunteer to work on one of the many Cochrane Review Groups, with editorial teams overseeing the preparation and maintenance of the reviews, as well as application of the rigorous quality standards for which Cochrane Reviews have become known.*
>
> —*(Cochrane website, downloaded March 16, 2007)*

A description of how systematic reviews are defined by the Cochrane Collaboration is presented in Table 6.2.

Table 6.2 What Is a Systematic Review?

A systematic review uses transparent procedures to identify, assess, and synthesize results of research on a particular topic. These procedures are explicit, so that others can replicate the review, and are defined in advance of the review:

Clear inclusion/exclusion criteria specify the study designs, populations, interventions, and outcomes that will be covered in the review.

An explicit search strategy is developed and implemented to identify all published and unpublished studies that meet the inclusion criteria. The search strategy specifies keyword strings and sources (i.e., electronic databases, websites, experts, and journals) that will be included in the search.

Systematic coding and analysis are provided for included studies' methods, intervention and comparison conditions, sample characteristics, outcome measures, and results.

Meta-analysis (when possible) estimates pooled effect sizes (ES) and moderators of ES.

How Are C2 Systematic Reviews Different From Other Systematic Reviews?

C2 reviews must include a systematic search for unpublished reports (to avoid publication bias).

C2 reviews are usually international in scope.

A protocol (proposal) for the review is developed in advance and undergoes careful peer review by international experts in the substantive area, experts in systematic review methods, and a trial search coordinator.

Study inclusion decisions and coding decisions are accomplished by at least two reviewers who work independently and compare results.

C2 reviews undergo peer review and editorial review.

Completed C2 reviews are published in C2-RIPE and may be published elsewhere.

From "What Is a Systematic Review?" by Social Welfare Group, Campbell Collaboration. Retrieved March 16, 2007, from www.campbellcollaboration.org/SWCG/reviews.asp

Health-care professionals from a variety of disciplines (including social work) located around the world volunteer to serve on Cochrane Review Groups (CRGs), of which there are dozens, such as the Childhood Cancer Group; Depression, Anxiety, and Neurosis Group; Drug and Alcohol Group; HIV/AIDS Group; Pain, Palliative, and Supportive Care Group; Pregnancy and Childbirth Group; and the Schizophrenia Group, to list a few of particular relevance to social work. There are also various methods groups and many brick-and-mortar Cochrane Centers located around the world. The CC hosts an annual international conference and many regional or national meetings.

On its website, you can also locate the *Cochrane Manual*, a detailed guide to designing and evaluating systematic reviews (SRs) of high-quality research on health-care interventions and methods of assessment, roughly categorized by the subject matter of the various review groups (see Table 16.2). There are free summaries of these SRs available on the website, and your local university library most likely subscribes to the CC library, allowing you free access to these invaluable resources. In terms of timely, comprehensive, and minimally biased appraisals of the effects of various treatments, the CC reviews represent the state of the art. The CC does admittedly focus on physical-health conditions, which includes mental illnesses; the majority of the reviews deal with medical interventions, not

psychosocial ones, but categorizing issues as either medical and psychosocial problems or as medical treatments versus psychosocial treatments is not always easy. An example is a report appearing in the *British Medical Journal* describing a randomized controlled trial of the effects of providing insulation in homes on the health and well-being of residents (Howden-Chapman et al., 2007). The 4,407 low-income participants lived in 1,350 households, half of which were randomly selected to receive upgraded insulation (to keep the homes warmer). The provision of more insulation produced improved health, fewer days absent from work or school, and fewer visits to the doctor. Is this a medical intervention? Regardless, the implications for social work clinical and community practice seem clear, and studies such as this, which will eventually be incorporated in CC reviews, make it worthwhile for social workers to become familiar with this database of information and reports on treatments for disorders that afflict adult social work clients.

The Campbell Collaboration (C2; see www.campbellcollaboration.org), named after psychologist Donald Campbell, is closely modeled after the work, operation, and products of the Cochrane Collaboration. Unlike CC, the C2, founded in 1999, focuses on preparing SRs in the fields of education, criminal justice, and social welfare. It, too, hosts an annual conference, supports a variety of centers around the world, devises methodological standards, and encourages international social work scholars to propose topics for SRs, develop research protocols related to those titles, and then actually carry out these protocols and publish the SRs. At present, there are more proposed titles and protocols (representing SRs in development) than there are completed SRs (about 70 are available), but the list of published SRs will expand greatly over the next few years. The approach taken by the C2 with respect to systematic reviews is outlined in Table 6.1. Strenuous efforts are made to control for or minimize bias when completing these reviews, and they can be said to represent the most methodologically rigorous and comprehensive evaluations of the literature dealing with EBP-style answerable questions that are available to contemporary social workers. Both the Cochrane and Campbell Collaborations are inclusive organizations, and they are always looking for competent social workers to volunteer to serve on their various review groups or even to undertake SRs in various areas of social welfare. Do not be bashful about contacting them to see if you can help.

The two initiatives covered in this section—EST and EBP—seem to have much in common, although EBP is a more sophisticated and fully developed model. Within psychology, the language of EST and EBP is slowly moving in the direction of the latter, to the detriment of EBP. The reason is that lists of treatments perhaps inevitably take on an aspect of imperativeness—that is, the sense that one *must* use one of these approved therapies and to not do so is somehow ethically and professionally suspect. This is a problem with lists of ESTs. Now, EBP on the other hand, does not endorse particular interventions and clearly leaves open the option to make conscientious decisions to *not* make use of the most scientifically

supported treatments. This is because the EBP model uses additional criteria to help make decisions, with clients, about what course of action to follow. These other factors include client preferences and values, unique features of the client (e.g., those with intellectual disabilities may not be able to benefit from cognitive or insight-oriented treatments), available resources, costs, one's clinical expertise, professional ethics, and so on. All these factors go into making treatment plans in the EBP model, whereas they are virtually ignored in ESTs. Another problem is that clinicians often object to being told what to do, and, if agency administrators dictate that particular treatments be used for clients with particular diagnoses, this is seen as undermining social worker autonomy and professionalism. Some agency administrators and even governmental agencies do exactly that: They select particular treatments and tell providers that this is what they must offer, and this model is erroneously labeled as EBP (when it is really more akin to EST). Thus EBP got tarred with the opprobrium that rightly should be directed to EST and managerialism (see Thyer & Myers, 2011; Thyer & Pignotti, 2011, for more on the distinctions being made here). There *are* ESTs (if you use the APA Division 12 standards for what constitutes enough evidence). There are *no* EBPs, because EBP is a model for arriving at scientifically informed decisions, which is also guided by other important considerations. When people talk about EBPs, they almost always have this term confused with ESTs.

Practice Guidelines

You may have heard of the intriguing term *practice guidelines*, and it may be useful to review what is meant by this phrase:

> *[D]efined as "systematically developed statements to assist practitioner and patient decisions about appropriate care for specific clinical circumstances" (Institute of Medicine, 1990, p. 27), practice guidelines are recommendations for clinical care based on research findings and the consensus of experienced clinicians with expertise in a given practice area. Practice protocols, standards, algorithms, options, parameters, pathways, and preferred practice patterns are nuanced terms broadly synonymous with the concept* clinical practice guidelines.
>
> *—(Howard & Jenson, 1999b, p. 285)*

There has been little discussion of the relevance of practice guidelines within the social work literature. Howard and Jensen (1999b) guest-edited a special issue of the distinguished journal *Research on Social Work Practice* devoted to the topic of practice guidelines and clinical social work, and Rosen and Proctor (2003) edited a book titled *Developing Practice Guidelines for Social Work Interventions: Issues, Methods, and Research Agenda*, based on a conference sponsored by the George Warren Brown School of Social Work at Washington University. To date, I am unaware of any practice guidelines developed by social workers within and for the profession of clinical social work, and our discipline's contributions

to practice guidelines appear to be meager. The National Association of Social Workers (NASW) is a conspicuously absent player on the scene of practice guidelines and is lacking major organizational initiatives; it seems that relatively little will be forthcoming.

There is a very large interdisciplinary and disciplinary literature of practice guidelines, however, for many hundreds of mental illnesses and other psychosocial problems, some of which are obviously potentially applicable to social work intervention with adults. However, these almost always share a glaring problem that you may have overlooked in the definition quoted earlier—namely, that practice guidelines are usually based on an amalgamation of scientific research findings and the consensus of experts. It is this latter feature that contaminates, in the view of many, the credibility of practice guidelines. Those guidelines hammered out behind closed doors, crafted in smoke-filled rooms by the Machiavellian mavens of mental illness, lack the virtues of transparency associated with the APA's Division 12 EST task force or the SR protocols of the CC or C2. You can assign weights to different levels of evidence when crafting an SR, as in so much weight for a randomized controlled trial, so much less weight for a quasi-experimental study, and so on. Also, you can use independent raters to assure the reliability of such judgments. However, you cannot do that when the pristine purity of transparently conducted published research findings are contaminated with the dross of expert consensus. It is like adding a drop of ink to a glass of clear water. The weighty and distinguished voice of senior authority figures, wedded to a given model of practice to which they have devoted their life's work, may overwhelm the timid research-based (but valid) appraisals of the more junior clinical researcher.

Be that as it may, practice guidelines are available for many adult disorders, and those of the American Psychiatric Association have some of the widest currency. The American Psychiatric Association began publishing practice guidelines in 1991. These were initially published in issues of the *American Journal of Psychiatry*, the flagship journal of the American Psychiatric Association, and were later made available for purchase at the website (www.psych.org/psych_pract/treatg/pg/prac_guide.cfm). The guidelines have a notation about when they were initially published, and if your local university subscribes to the *American Journal of Psychiatry*, you will very likely be able to download it directly from the journal at no cost. Also available on this website is the American Psychiatric Association's Guideline Development Process, which describes how its practice guidelines are crafted. In it is noted that

> *[t]he evidence base for practice guidelines is derived from two sources: research studies and clinical consensus. Where gaps exist in the research data, evidence is derived from clinical consensus, obtained through board review of multiple drafts of each guideline. . . . Both research data and clinical consensus vary in their validity and reliability for different clinical situations; guidelines state explicitly the nature of the supporting evidence for specific recommendations,*

so that readers can make their own judgments regarding the utility of the recommendations.

—(Steering Committee on Practice Guidelines, 2006, p. 4)

This approach differs significantly from that used by the APA task force and the CC and C2, each of which largely exclude any role of so-called expert consensus in the crafting of the evaluative reviews. Although the American Psychiatric Association will indeed describe the available research evidence in its practice guidelines, the reader is still left unclear about the extent to which expert opinion was blended with a dispassionate appraisal of empirical research. This renders the American Psychiatric Association's practice guidelines less credible in the view of those who subscribe to more of a science orientation as opposed to an artistic perspective on practice.

One problem that psychologists in particular have noted with respect to the American Psychiatric Association's practice guidelines is that they seemingly overemphasize the use of psychotropic medications at the expense of possibly more efficacious psychosocial treatments (see Persons, Thase, & Crits-Christoph, 1996). This is perhaps understandable, because the psychiatrist's unique contribution to the care of the mentally ill largely resides in his or her ability to provide biological assessments and treatments, whereas the practice of psychotherapy is provided by all the other legally regulated mental-health professions. Does the field of psychiatry's considerable investment (sometimes literal) in psychopharmacological treatments affect the therapy recommendations found in its practice guidelines? Does the field of clinical psychology's investment in psychological treatments bias its appraisals of the research literature so that it favors nonpharmacological interventions? Like *Casablanca's* Inspector Reynaud finding out that gambling is taking place in *Rick's Café Americain*, you, too, might be shocked to discover that pecuniary considerations could influence the crafting of scientific documents—but not so naive as to dismiss the possibility.

Clinical-treatment guidelines are now in the process of being developed by the American Psychological Association (see http://www.apa.org/about/offices/directorates/guidelines/clinical-treatment.aspx), with one of the first being oriented around the problem of obesity. Various writers have suggested that clinical social work should undertake the development of practice guidelines crafted by social workers for use in social work treatment. This strikes me as absurd, and I have said so previously, in more modest language (Thyer, 2003). We have psychiatrists creating practice guidelines for helping people with schizophrenia, psychologists are doing the same thing, as are the nurses, and so on. What seems more legitimate and useful is for social work professional organizations to proactively advocate for having clinical social workers well represented on expert panels that craft *interdisciplinary practice guidelines*, not disciplinary ones. No single field, and certainly not social work, can provide genuinely comprehensive care for adults with mental disorders. Psychiatry, psychology, nursing, and clinical social work all have useful and sometimes admittedly

overlapping roles to play. Creating interdisciplinary practice guidelines for use by *all* the major players and professions, ones that take into proper and judicious account the biological and the psychosocial research literature, would seem far more useful for adults with mental illnesses than having distinct disciplinary practice guidelines for each of the major fields.

Howard and Jensen (1999b) list a wide array of resources that social workers can consult in tracking down clinical practice guidelines, but, to reiterate, the methodological quality of practice guidelines is uneven. Some are based solely on expert consensus and are not the usual resource one would seek out for state-of-the-art-and-science information on helping adults.

Institute of Medicine

The Institute of Medicine (IOM) is a branch of the National Academies, private but federally recognized entities charged with providing the government and public with science-based, independent, and authoritative advice on matters related to biomedical science, medicine, and health (see www.iom.edu). Very few social workers belong to the IOM, including Paula Allen-Meares, former dean of the University of Michigan School of Social Work. The IOM periodically issues reports on various topics, some of which pertain to social work practice with adults, and although these reports lack the transparency and comprehensiveness of SRs, they nevertheless can be a useful source of information that contributes to social care for adults with various problems. A recent one (dated 2012), for example, is titled *Child Maltreatment Research, Policy, and Practice for the Next Decade* and is available for free at http://www.iom.edu/Reports/2012/Child-Maltreatment-Research-Policy-and-Practice-for-the-Next-Decade.aspx. Another report (dated 2011) is titled *Preventing Violence Against Women*, found on the same site. Their relevance to social work practice is obvious.

National Registry of Evidence-Based Programs and Practices

The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) has created a National Registry of Evidence-based Programs and Practices (NREPP) for a wide array of mental disorders and substance problems. This resource is described as follows:

> *The National Registry of Evidence-based Programs and Practices (NREPP) is a searchable online registry of mental health and substance abuse interventions that have been reviewed and rated by independent reviewers. The purpose of this registry is to assist the public in identifying scientifically based approaches to preventing and treating mental and/or substance use disorders that can be readily disseminated to the field. NREPP is one way that SAMHSA is working to improve access to information on tested interventions and thereby reduce the lag time between the creation of scientific knowledge and its practical application in the field.*
>
> *—(downloaded from http://www.nrepp.samhsa.gov/AboutNREPP.aspx on March 30, 2012)*

Although laudable in intent, the evidentiary standards used to qualify an intervention for listing on the NREPP are lamentably low, with more than 20 interventions being supported solely by simple pretest-posttest outcome studies with no control or comparison groups. It does the public little good to lump such minimally supported treatments in among those enjoying considerably higher levels of evidence. Social workers consulting the NREPP need to carefully evaluate the research support behind each listed program, because the overall qualification standards are poor, and simply being listed on this national registry does not automatically imply that the intervention is well supported.

Summary of Useful Resources

The available resources are impressively large relative to what was available only a couple of decades ago, but perhaps discouragingly meager considering the seriousness, complexity, and vastness of needs.

The periodical publications that emerged from the Division 12 Task Force on the Promotion and Dissemination of Psychological Interventions—for example, Chambless et al. (1996, 1998), Sanderson and Woody (1995), Task Force (1995), Woody and Sanderson (1998), and Woody et al. (2005)—are all available for free on the Division 12 website (http://www.psychology.sunysb.edu/eklonsky-/division12/). Frankly, however, a much better resource is Nathan and Gorman's (2007) *A Guide to Treatments That Work*. Each chapter is a comprehensive research synthesis about what is known regarding the psychosocial or pharmacological treatment for clients with a discrete diagnosable mental illness. There is also a summary table at the beginning of the book (some excerpts from this table are reproduced in Table 6.3). In the left column is a specific syndrome, next is a list of empirically supported treatments, the standards of proof used to make this determination, and, last, on the right, some references to research supporting the inclusion of this particular treatment. There are 29 diagnosable mental illnesses for which the authors have provided comprehensive appraisals. The social worker seeking information on effective treatments will find this resource of great value.

Nathan and Gorman's (2007) book is a summary of research and can point social workers in the direction of effective treatments, but Van Hasselt and Hersen (1996) provide actual treatment manuals for 17 adult psychosocial and medical problems. These are listed in Table 6.4. These treatment manuals describe interventions in sufficient detail to enable a skilled clinician (social worker, psychologist, psychiatrist, etc.) to deliver these services to clients. The interventions are all well supported, as defined by the Division 12 task-force criteria, and consulting these manuals would be a great first step for a social worker to begin acquiring clinical skills in delivering these empirically supported psychosocial interventions. The articles by Sanderson and Woody (1995) and Woody and Sanderson (1998)

Table 6.3 Summary of Treatments That Work

Syndromes	Treatments	Standards of Proof	Chapters in Nathan & Gorman
Bulimia Nervosa (BN)	*Several different classes of antidepressant drugs* produce significant, short-term reductions in binge eating and purging.	A large number of Type 1 and Type 2 randomized clinical trials (RCTs), utilizing placebo as comparison.	Wilson and Fairburn, Chapter 22, pp. 559–592
	Manual-based cognitive-behavioral therapy (CBT) is currently the treatment of choice. Roughly half the patients receiving CBT cease binge eating and purging. Long-term maintenance of improvement appears to be reasonably good.	A very substantial number of Type 1 and Type 2 RCTs.	
Schizophrenia	*Behavior therapy and social-learning-token-economy programs* help structure, support, and reinforce prosocial behaviors in persons with schizophrenia.	Many Type 1 and Type 2 RCTs and a very large number of Type 3 studies of behavior therapy and social-learning-token-economy programs.	Kopelowicz, Liberman, and Zarate, Chapter 8, pp. 201–228
	Structured, educational, family interventions help patients with schizophrenia maintain gains achieved with medication and customary case management.	More than 20 Type 1 and Type 2 RCTs of educational family interventions.	
	Social-skills training has enabled persons with schizophrenia to acquire instrumental and affiliative skills to improve functioning in their communities.	More than 40 Type 1 and Type 2 RCTs of social-skills training.	
	Pharmacological treatment has had a profoundly positive impact on the course of schizophrenia. The recent introduction of atypical antipsychotics has been promising because of their reduced side effects and enhanced efficacy in some refractory patients.	A very large number of RCTs over 40 years.	Bradford, Stroup, and Lieberman, Chapter 7, pp. 169–199
Specific phobias	*Exposure-based procedures, especially in-vivo exposure*, reduce or eliminate most or all components of specific phobic disorders.	A very large number of Type 1 RCTs.	Barlow, Raffa, and Cohen, Chapter 13, pp. 301–335
	No pharmacological intervention has been shown to be effective for specific phobias.		Roy-Byrne and Cowley, Chapter 14, pp. 337–365

Table 6.4 Treatment Manuals for Adult Disorders Available in Van Hasselt and Hersen (1996)

Panic Disorder and Agoraphobia
Obsessive-Compulsive Disorder
Cognitive-Behavioral Treatment of Social Phobia
Social-Skills Training for Depression
Cognitive-Behavior Therapy for Treatment of Depressed Inpatients
*Biobehavioral Treatment and Rehabilitation for Persons With Schizophrenia**
Community Reinforcement Training With Concerned Others
Cognitive-Behavioral Treatment of Sex Offenders
Treatment of Sexual Dysfunctions
A Comprehensive Treatment Manual for the Management of Obesity
Lifestyle Change: A Program for Long-Term Weight Management
Managing Marital Therapy: Helping Partners Change
Insomnia
Cognitive-Behavioral Treatment of Body-Image Disturbances
Cognitive-Behavioral Treatment of Postconcussion Syndrome
Trichotillomania Treatment Manual
Anger Management Training With Essential Hypertensive Patients

*This manual was co-authored by a social worker, Stephen E. Wong, PhD.

Source: Sourcebook of Psychological Treatment Manuals for Adult Disorders, by V. B. Van Hasselt and M. Hersen (Eds.), 1996, New York, NY: Plenum Press.

provide another listing of treatment manuals and how to obtain them, but not copies of the actual manuals themselves.

The Campbell and Cochrane Collaborations are another exceedingly useful resource for learning about the evidentiary status of various interventions potentially useful to social workers serving adult clients. If you visit the websites of these two organizations, you will find a long list of proposed topics (to be the subject of future SRs), a shorter list of protocols proposed by various research teams that have been approved by the respective collaborations, and an even shorter list of actual SRs. However, although limited in number, these SRs probably represent the most scientifically credible and up-to-date summaries of the research literature regarding the usefulness of various interventions and assessment methods. Table 6.5 lists a selection of completed SRs that you can locate on these collaborations' websites. The last one listed, *Work Programs for Welfare Recipients*, was completed in August 2006 and is an analysis of randomized controlled studies, quasi-experimental outcome studies, and cluster-randomized controlled trials of welfare-to-work programs for persons receiving public assistance, such as Temporary Assistance for Needy Families (TANF). The analysis of the research literature involved 46 programs encompassing more than 412,000 participants, with outcomes reported for up to 6 years. The free document is 122 pages long. You can see how an SR of this nature is potentially far more informative than reading a single study appearing in a journal; and if you are a social worker

Table 6.5 Examples of Completed Systematic Reviews Addressing Psychosocial Interventions for Adults

From the Cochrane Collaboration (www.cochrane.org)

- Screening and Case Finding Instruments for Depression
- Marital Therapy for Depression
- Short-Term Psychodynamic Psychotherapies for Common Mental Disorders
- Interventions for Helping People Recognize Early Signs of the Recurrence of Bipolar Disorder
- Psychological Debriefing for Prevention of Posttraumatic Stress Disorder (PTSD)
- Psychological Treatment of Posttraumatic Stress Disorder (PTSD)
- Individual Psychotherapy in the Outpatient Treatment of Adults With Anorexia Nervosa
- Interventions for Vaginismus
- Alcoholics Anonymous and Other 12-Step Programs for Alcohol Dependence
- Psychotherapeutic Interventions for Cannabis Abuse and/or Dependence in Outpatient Settings
- Family Intervention for Schizophrenia
- Token Economy for Schizophrenia
- Cognitive-Behavior Therapy for Schizophrenia
- Hypnosis for Schizophrenia
- Life-Skills Programmes for Chronic Mental Illnesses
- Art Therapy for Schizophrenia or Schizophrenia-Like Illnesses
- Supportive Therapy for Schizophrenia
- Individual Behavioural Counseling for Smoking Cessation
- Group-Behaviour-Therapy Programmes for Smoking Cessation
- Strategies for Increasing the Participation of Women in Community Breast-Cancer Screenings
- Reminiscence Therapy for Dementia
- Psychological Treatments for Epilepsy

From the Campbell Collaboration (www.campbellcollaboration.org)

- Cognitive Behavioral Programs for Juvenile and Adult Offenders: A Meta-Analysis of Controlled Intervention Studies
- The Effectiveness of Incarceration-Based Drug Treatment on Criminal Behavior
- Interventions for Learning Disabled Sex Offenders
- Work Programmes for Welfare Recipients
- Advocacy Interventions to Reduce or Eliminate Violence and Promote the Physical and Psychosocial Well-Being of Women Who Experience Intimate Partner Abuse
- Cognitive Behavioural Therapy for Men Who Physically Abuse Their Female Partners
- Court-Mandated Interventions for Individuals Convicted of Domestic Violence
- Cross-Border Trafficking in Human Beings: Prevention and Intervention Strategies for Reducing Sexual Exploitation
- Effects of Drug-Substitution Programs on Offending Among Drug Addicts
- Effects of Second-Responder Programs on Repeat Incidents of Family Abuse
- Mindfulness-Based Stress Reduction (MBSR) for Improving Health, Quality of Life, and Social Functioning in Adults
- Motivational Interviewing for Substance Abuse
- Personal Assistance for Adults (19–64) With Physical Impairments

involved in serving TANF clients, a review of this comprehensive nature could prove enormously useful for you in learning about what aspects of welfare-to-work programs are genuinely helpful versus those that are less beneficial.

Think of the implications of having information of such high quality available, both for social work practice as well as for education. No longer does an individual social worker have to search aimlessly through journals, vainly hoping to locate some potentially useful studies. Other very well-qualified scholars have already culled the literature, separated the credible research from the less useful, and summarized the results for your independent review and analysis of its applicability to your practice situations and clients. Think of the absurdity of teaching social work practice courses using one or more theories as the guiding framework to structure the class when you and students have access to actual outcomes research about various psychosocial treatments readily used by social workers active in various areas of practice, such as schizophrenia, depression, anxiety disorders, and so on. If we are in the business of educating students to practice in these various areas, these systematic reviews published by the Campbell and Cochrane Collaborations could (should?) be a very important component of such instruction. Yet, sadly, many social work students and practitioners have yet to come into contact with these incredibly useful resources.

The IOM is another resource, arguably less comprehensive than the work of the Campbell and Cochrane Collaborations but still potentially valuable in learning about interventions for use with adult clients. A few of its reports with applicability to our field include the following titles, all available at www.iom.edu:

- *Improving the Social Security Disability Decision Process*
- *Posttraumatic Stress Disorder: Diagnosis and Assessment*
- *Improving the Quality of Health Care for Mental and Substance-Use Conditions*
- *WIC Food Packages: Time for a Change*
- *Improving Palliative Care: We Can Take Better Care of People With Cancer*
- *Taking Action to Reduce Tobacco Use*

The American Psychiatric Association has produced a series of practice guidelines for selected mental illnesses, and these are available for purchase as PDF documents at its website (www.psych.org/psych_pract/treatg/pg/prac_guide.cfm) for the following disorders:

- Acute stress disorder and PTSD.
- Alzheimer's disease and other dementias of late life.
- Bipolar disorder.

- Borderline personality disorder.
- Delirium.
- Eating disorders.
- HIV/AIDS.
- Major depressive disorder.
- Obsessive-compulsive disorder.
- Panic disorder.
- Psychiatric evaluation of adults.
- Substance-use disorders.
- Suicidal behaviors.

You may also be able to print them out for free from the applicable issues of the *American Journal of Psychiatry* via your local university library. Keep in mind that these practice guidelines typically overemphasize pharmacological treatments at the expense of psychotherapeutic or psychosocial services, and they involve elements of the consensus clinical opinions of presumptive experts, but even with these caveats, they are still informative.

Limitations of the Evidence

You can view the glass as half full or half empty. Do we know much more now in terms of genuinely effective psychosocial interventions for use with the adult clients of social workers than we did, say, 2 or 3 decades ago? Absolutely! But it is undeniable that large gaps exist, and for many important areas of social work practice, the interventive map remains labeled *terra incognita*. For several dozen of the major mental illnesses, significant strides have been made, and new advances appear in the clinical research literature on a weekly if not daily basis. Keep in mind that the process of evidence-based practice, or the lists of empirically supported treatments, do not exclusively insist on a reliance on an accumulation of pristine RCTs before social work practitioners can decide what to do. We need to decide what to do every day and cannot defer making important decisions about the nature of the services we offer our clients. Evidence-based practice does point out that certain forms of evidence, such as RCTs, meta-analyses, and SRs, can provide us with more credible information about the effectiveness of services, but if that level of evidence is unavailable, then you should act by taking into account the highest quality evidence that is available. This may include quasi-experiments not involving the random assignment of clients to various treatment conditions; time-series studies, case-control investigations, economic analyses, single-subject experiments; or even qualitative research, such as narrative case studies. The point is to make a conscientious effort to seek out the *highest-quality-available* information and integrate this with your own clinical

skills and the clients' values and circumstances in making decisions about potential services to offer. It may be that the highest-quality evidence suggests one course of action (e.g., cognitive therapy for depression), but your own background provides you with insufficient training in this method to be able to offer it. You can opt to provide something else (e.g., nonspecific supportive counseling), but at least you are doing so with the conscious recognition that this is likely to be a less-than-optimal service for your client. Or you may be prompted on the basis of your analysis of the evidence to seek out additional training and supervision of an evidence-based intervention that your client may need or to refer your client to a service provider who can better meet the client's needs.

It is widely recognized that many of the psychosocial interventions that are empirically supported are based on studies in which people of color and other historically oppressed groups are underrepresented. This presents us with the problem of generalizing findings obtained from largely Caucasian client samples to these other groups. There is no need to assume that the treatments will be ineffective with other groups, but it is a far better strategy for findings demonstrated to be valid with one group (Caucasians) to have been successfully replicated in other groups (African Americans, Hispanics, etc.). This is slowly being accomplished.

It is also well known that treatments demonstrated to be useful in tightly controlled studies involving clients who meet the diagnostic criteria for only one disorder, with services provided by atypically well-trained and supervised therapists, may not yield similarly positive benefits when implemented in other practice settings. In the real world, services are likely to involve clients who meet the diagnostic criteria for multiple disorders, who experience impoverished environments, who have additional stressors impacting them, who attend appointments less regularly, and who get services from less-than-stellar clinicians. This problem, too, is being vigorously addressed through translational research studies examining the transportability of empirically supported services into routine care.

There are also significant gaps in the literature related to the disciplinary contributions specific to social work. In the field of psychotherapy, clinical social workers comprise the largest professional group providing such services in the United States, with far more practitioners than clinical psychology or psychiatry; yet social workers are sadly underrepresented in terms of designing, conducting, and publishing high-quality outcome studies. There are many reasons for this. Clinical psychology emerged from an academic discipline that had many decades of an experimentalist tradition in its history, whereas social work came from the Settlement House, the church, and the community organization society, not the laboratory. To be recognized as a psychologist, you must complete a doctorate—in most cases, a research-based doctorate—whereas in social work we made the disciplinary decision to lower the bar, so to speak, back in the mid-1970s by admitting BSWs into our professional ranks (prior to that time, a master's degree was required). We continue to wrestle with defining

what the profession of social work actually is and who a social worker is, and these issues make it difficult to carve out our discipline's unique niche in the human-services and health-care fields (Thyer, 2002). State departments of children and family services rarely have a career ladder specific to BSWs and MSWs and usually open up their child-welfare and other human-services jobs to persons who have completed a wide array of undergraduate or graduate majors. There is actually very little sound evidence, for example, that BSWs make better child-protective-service workers than non-BSWs (Perry, 2006a) or that social workers are better supervisors in the human services than persons without the social work degree (Perry, 2006b). We see life coaches, care coordinators, discharge planners, nurses, philosophical counselors, clinical sociologists, and so on, all undertaking tasks formerly largely conducted by members of our profession. All these issues make it difficult to convincingly assert a unique and specific role for social work and social workers. Those who argue that we somehow possess a value base and ethical system that sets us apart from other fields usually make this argument in ignorance of the considerable attention being given to issues of social justice, the alleviation of poverty, and the provision of services to historically oppressed groups by psychologists, nurses, and psychiatrists. One has only to compare the massive outreach and service efforts of the American Psychological Association to the people of New Orleans following Hurricane Katrina, compared to the minimal responses of the much larger NASW, to see that psychologists were walking the walk, not merely talking the talk.

This is not to conclude that the profession of social work is not incredibly valuable. It is. Indeed there are many aspects of our field that are noble and inspiring. However, the services we provide and the theories we learn about are primarily shared with, if indeed not derived from, other disciplines. If we are to become more than the utility players of the human services, we must take a much more active role as creators and disseminators of the evidence-based knowledge that is increasingly being seen as an important aspect of social care. This leads to the next section.

Implications for Social Work at the Micro-, Mezzo-, and Macrolevels

What should we do with the information presented thus far? Here are a few suggestions.

Micro- and Mezzolevel Practice

The focus of most of the preceding content has been on micro- and mezzolevel social work practice, interventions with individuals, families, small groups, and agencies (Barker, 2003, p. 272), and the implications of this information should be pretty clear. Individual social work students should regularly seek out the evidentiary foundations of what they are

being taught. Politely ask, with a bright smile, the instructors of your direct-practice classes if they can point you to any SRs or randomized controlled studies demonstrating that the interventions you are being taught are really capable of helping clients. Honest instructors should be able to do this right away or do so in a few days, or else they should forthrightly tell you that there is no such evidence. The intellectually corrupt ones will tell you that randomized controlled studies are incapable of measuring the subtle but nonetheless powerful effects of these interventions and that scientific analyses have little place in the evaluation of social work interventions. The morally corrupt ones will angrily inform you that you have no right to ask such questions and that you should accept what they teach without question on the basis of their clinical experience and theoretical knowledge. Reinforce with smiles, attention, and words of encouragement instructor efforts, minimal though they may initially be, to teach about empirically supported treatments and the process of EBP. Use your course evaluations to provide corresponding feedback, organizing your classmates to do the same.

Established practitioners can investigate the intellectual resources described in this chapter to learn more about empirically supported treatments related to the fields of practice you are engaged in. Obtain empirically supported practice guidelines and treatment manuals and attempt to acquire skills in these interventions. Locate sources of qualified supervision in these methods and consider getting formal advanced training via workshops and continuing-education programs. Contact your local NASW chapter and ask it to sponsor Continuing Education Unit (CEU) programs related to EBP and empirically supported treatments. Social work faculty who teach direct-practice classes should begin integrating the principles and resources described in this chapter into their classroom instruction and clinical supervision. Purge your syllabi of outmoded or superceded theory and replace it with readings and texts related to EBP and empirically supported treatments.

Macrolevel Practice

At the macrolevel, meaning political action, community organizing, public education, and the administration of agencies (Barker, 2003, p. 257), there are a number of possible implications for social work practice. Within our major professional organizations, the NASW could amend its code of ethics to include something along the following lines:

> *Clients should be offered as a first choice treatment, interventions with some significant degree of empirical support, where such knowledge exists, and only provided other treatments after such first choice treatments have been given a legitimate trial and shown not to be efficacious.*

and

> *Clinicians should routinely gather empirical data on clients' relevant behavior, affect, and reports of thoughts, using reliable and valid measures, where such measures have been developed. These measures should be repeated throughout*

> *the course of treatment, and used in clinical decision making to supplement professional judgments pertaining to the alteration or termination of treatment.*
>
> *—(Thyer, 1995, p. 95)*

The NASW could also greatly expand on the laudable standard it established as far back as 1992, in its statement on reparative therapies:

> *Proponents of reparative therapies claim—without documentation, many successes. They assert that their processes are supported by conclusive scientific data which are in fact little more than anecdotal. NCOLGI protests these efforts to "convert" people through irresponsible therapies. . . . [E]mpirical research does not demonstrate that . . . sexual orientation (heterosexual or homosexual) can be changed through these so-called reparative therapies.*
>
> *—(National Committee on Lesbian and Gay Issues, 1992, p. 1)*

Similar standards were issued in an updated NASW position paper in 2000 (http://www.socialworkers.org/diversity/lgb/reparative.asp). If one particular therapy is deemed by the NASW as unethical at least in part because it lacks a sufficient empirical foundation, this has the appearance of a precedent-setting standard that could be extended to other, similarly nonempirically supported treatments. It is unclear why gay and lesbian clients should be afforded protection against ineffective and harmful treatments but not other social work clientele.

This series of recommendations would involve a two-pronged approach: promoting the use of the empirically supported treatment and discouraging the use of what has been shown not to be useful. This should be done cautiously. Absence of evidence is not evidence of absence. Many interventions have not yet been adequately tested and may ultimately prove helpful. So an initial focus on treatments that are pretty clearly harmful (e.g., rebirthing therapy, boot camps, primal-scream therapy) or useless (thought-field therapy, neurolinguistic programming, therapeutic touch, hypnosis for chronic mental illness, etc.) would be a good way to shape the field.

Another leverage point the NASW could apply, as could the various state licensure boards, would be to require the providers of continuing education (CE) for social workers to list the evidentiary foundations supporting the assessment and treatment methods they are disseminating. There is much that is useless and bogus being purveyed by the providers of CE, and by declining to endorse these programs in favor of those with a focus on empirically supported treatments, the entire field would be enhanced.

Apart from the NASW, other social work interest groups could provide education to third-party payers, such as insurance companies and managed-care firms, so that they would no longer reimburse social workers who provided interventions known to be bogus or ineffective. Turning off the funding stream that fertilizes the weeds found in private or agency-based practice would be another useful way to improve the discipline.

The CSWE could revise its accreditation standards mandating, as do psychiatry and clinical psychology, that BSW and MSW students be provided training in empirically supported treatments, and it could lessen its emphasis on teaching theoretical content of dubious validity (Thyer, 1994, 2001). Instead, favor more of a problem-focused approach, wherein students take courses in given areas of practice (e.g., child abuse and neglect, domestic violence, chronic mental illness) and are taught about assessment methods and psychosocial interventions that are empirically supported, irrespective of the theoretical orientation they are derived from. If they are helpful to clients, students should be taught about them. Textbooks should be similarly structured around helpful interventions for specific problems (e.g., O'Hare, 2005; Thyer & Wodarski, 2007), not by an overarching theory or collection of theories.

In general, greater attention needs to be given to training in specific methods of clinical intervention (see Thyer, 2007) as opposed to a generalized model of supportive engagement with clients, focusing solely on such skills as empathy, warmth, genuineness, and unconditional positive regard. This traditional model, based on the naive premise that somehow, with the cheerleading of a supportive social worker, clients will be able to dig deep within themselves to solve their own problems, has been incredibly destructive to the effectiveness and credibility of professional social work. These clinical skills are indeed important and need to be taught and mastered by our students, but they are insufficient preparation by themselves for one to be an effective clinician, absent competence in providing one or more empirically supported treatments effective for clients with specific problems.

Another source of change could involve some benevolent patron's underwriting the legal expenses of one or more clients who were seen by licensed social workers and who were provided with a nonempirically supported therapy for the treatment of a condition for which one or more empirically supported treatments have been clearly established. These clients would sue their social worker, alleging malpractice in that the social worker failed to provide them (or at least offer) these empirically supported treatments. The patron would provide sufficient funding to ensure that these cases went to court, where they might be settled in favor of the plaintiff, thus establishing the legal precedent that social work clients should have the right to effective treatment where it is known to exist (see Myers & Thyer, 1997). Oddly, and embarrassingly, this standard does not appear to be established at present (see K. Corcoran, 1998).

Conclusion

There is much to be positive and optimistic about. Our profession has access to powerful tools for effective social work practice with adults. The evidentiary foundations undergirding major areas of practice are rapidly expanding, and the values of transparency and scientific rigor

are assuming an ever-greater importance. These developments are most evident in the fields of mental health and to a lesser extent the general domain of clinical social work. Many long-cherished interventions used within our field are being subjected to rigorous testing. Some are being supported; others are being shown to be of little value; many remain under-researched. These rapidly expanding developments require intellectually nimble social workers committed to a lifetime of professional learning and of keeping abreast with the newest developments. Advances in information technology, such as the computerized searching of journal databases and access via the Internet to international consortia, such as the Campbell and Cochrane Collaborations, make it possible for virtually every social worker to remain current and continually refresh his or her repertoire of effective clinical skills. This is not only a good practice for the individual social worker but essential for the long-term survival of a profession that is being increasingly challenged to demonstrate its capability to prevent and remedy significant interpersonal and societal problems.

At present, faculty in MSW programs reportedly strongly endorse providing students with training in evidence-based practice and in empirically supported treatments (Rubin & Parrish, 2007). Yet, curiously, our MSW programs only rarely provide graduate students with training and clinical supervision in the provision of empirically supported treatments (Bledsoe et al., 2007; Weissman et al., 2006). Training programs in clinical psychology and psychiatry are doing better in this regard. We can and must improve the empirical foundations of what we teach and practice.

Key Terms

Empirical; empirically supported treatments (ESTs)

Evidence-based practice (EBP)

Practice guidelines

Systematic review