PROLOGUE
The Whole Story—Briefly

PART I. STARTING SCIENTIFIC PRACTICE

Establishing the Practice, Ethical, and Evaluation Contexts (I.A.1., I.B.1, and I.C.1)

Welcome to what may be for you a new way of looking at the world, as a scientific practitioner. We assume that you are (or want to become) a practitioner first and foremost, but also that you want to be as effective and sensitive a practitioner as possible. What we offer in this book is a step toward those goals, but an unusual step in that we want to present an integrated experience that involves all of the major components of scientific practice. (The numbers and letters following the heading correspond to those in Exhibit P.1. on pages 4–5.) There are five components, as follows.

The *practice component* is touched on briefly, as, we hope, your professional school will provide or has provided many classes in this area. Here, we emphasize that practice is a problem-solving process in which the practitioner makes contact with the client so as to understand what

problems and strengths are present in the situation, uses theory and its empirically supported evidence to guide practice, gets into and out of ethical problems involved in practice, and ultimately makes sense of all this through a carefully planned evaluation.

The *practice theory or approach and its research-based evidence* is a vital component that involves using the best available information to determine what guiding models you choose to direct your practice. There is a considerable body of empirically informed practice theory. We present some guidelines for connecting abstract theory/research to concrete practice as part of the ongoing search for new and more effective ways to serve consumers. This involves the skills, attitudes, and the commitment to keep learning from others as well as from our own experience.

Every human interaction involves *ethical choices,* and the helping professional has to negotiate these choices with great care, for all of the people directly and indirectly involved in the case situation. The helping professions have a commitment in words and deeds to the values of a democratic society where there is

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care and concern for the well-being, rights, and dignity of clients and consumers. We will raise these issues in this Prologue and offer a specific code of ethics for evaluators near the end of the book (Chapter 25).

Evaluation of one's own practice is the focus of this book, and in this Prologue we want to illustrate why evaluation is such a critically important feature of scientific practice. Evaluation, and especially its systematic monitoring, essentially tells us where the client starts, how the client is doing during the helping process, and whether the client gets to where he or she wants to go. We believe that if practitioners can answer at least these questions, then they will be doing the task society has set for professional helping practice. If not, then we all are going to be in trouble—the consumers, the profession, and society.

There is one more ingredient in scientific practice: *you, the person who is providing the professional help*. By including you in the equation, we want to recognize how much the helping person brings to scientific practice. It is your motivation to help, your intelligence to make sense of challenging information, your sensitivity to the cultural and value nuances of the situation, and your energy to bring all of the pieces together that in fact make scientific practice a reality. One reason we have introduced portions of this evaluation text on CD-ROM and refer to numerous Internet sites is to encourage you to interact with this material and to feel comfortable using it in field situations.

Now the question is how to present an integrated perspective on practice methods, theories and research studies, ethics, and evaluation of your own practice. It is difficult to do all of these at the same time, and most textbooks (let alone classes) focus on one or another, and essentially leave it up to the student to make the integration. We believe this is a major mistake, and so we have tried to avoid it by integrating these components in this Prologue, although the rest of this book will focus mainly on the evaluation component. Here is a preview of coming attractions.

Imagine yourself in a three-dimensional space. In front of you is your client (or client-system, like fam-

ilies, neighborhood associations, etc.; we'll use the word *client* to refer to any client/system). Keep your eye steadily on the client.

On your left hand is a body of theoretical information and a smaller portion of it that is supported by empirical research. You will use this general information to make sense of the specific problems your individual client is facing.

On your right hand is a body of ethical information, useful in keeping clearly on the professional path toward helping the client if you can, but if you can't, then doing no harm (a brief restatement of the Hippocratic code of ethics).

And backing you up are the ideas and processes for evaluating your own practice.

There you are, moving through this space and time with your client, but always in contact with evidence-based theory, professional ethical principles, and reasonably objective evaluation of your own practice so you know where your client started, where the client wants to go, where the client is currently headed, and when the client reaches the goal. As you are close enough to shake hands with your client, so too, you are close enough to lay your hands on theoretical ideas and empirical evidence, on guiding ethical principles, and on the relatively simple tools to evaluate your practice. All within your hands' reach, all at the same time. This is the space of scientific practice (see Figure P.1).
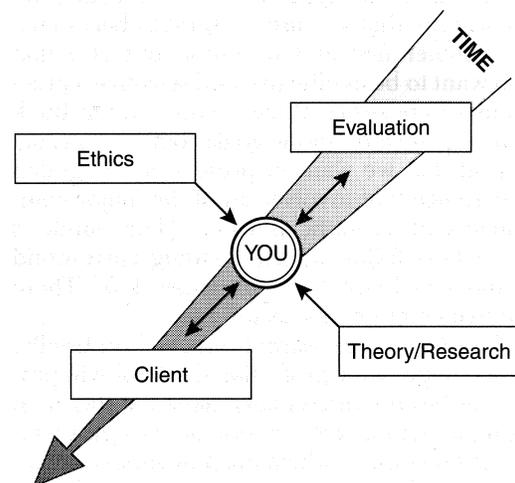

FIGURE P.1 The space of scientific practice.

Why is it that programs that teach various forms of social and human services expect the students to put everything together from the 15 to 20 classes and field experiences they might have? We'll tell you why: because many teachers have trouble teaching it. Each student practitioner has to struggle to complete this multidimensional puzzle for himself or herself. Most teachers are more comfortable teaching one piece of the whole, but that is not how reality is. What is real is that there is a client or a client/system in front of you, with some problems and some resources, and you have to help that client/system solve a problem or achieve some desired goal. Any human action is automatically a system of moral relationships, so that you and the clients have to consider what the ethical issues are in taking or not taking some particular course of action. The clients probably have exhausted other sources of advice and, finding them lacking, have turned to you. This often is true even when clients are legally mandated.

Why? The clients don't know you from Adam or Eve, but they do know that you have some professional training that sets you apart from their buddies, or parents, or the local bartender. And they believe—or hope—that you literally will reach into your professional bag and pull out some theory and research that will let you facilitate their solving the challenges facing them. They also believe that you will do this with all due confidentiality for their private affairs. Fortunately, you do have some behavioral science theory and research as part of your training, and you have considered how to use your profession's code of ethics, so you can in fact do something like what they fantasize. More than that, you are now about to learn how to evaluate your professional actions as they influence the client and his or her environment, a bonus for the client and for the society that is ultimately paying the bill.

Now, the task of this Prologue is to see if we can put all these elements together in a way that will help you put similar ingredients together as you begin your scientific practice. To do this, we can't present a linear progression of facts and instructions. We have to tell a story. Granted, storytelling is a bit fuzzy, but

so is life. Now sit back and enjoy a holistic experience about scientific practice in which you can imagine that you are one of the principal actors. Of course, this is just a brief sketch; more of the evaluation details will be found in this book, and other details in your other textbooks on practice, theory, research, and ethics. The flowchart on pages 4–5 (Exhibit P.1) is your road map, and the numbers and letters in the text that follows refer to that chart. Keep one thing in mind throughout this Prologue—you are moving through that scientific practice space, and the client, theory and research, ethical guidelines, and the evaluation of your ongoing practice are all within your reach.

PART II. DEVELOPING A GOOD SOCIAL RELATIONSHIP, IDENTIFYING CLIENT PROBLEMS AND STRENGTHS, IDENTIFYING CLIENT GOALS AND OBJECTIVES, AND ASSESSMENT

Rapport-Building for a Trusting Relationship: Getting a Feeling for the Presenting Situation (II.A.2.)

Come meet Mrs. Abbott, a widow in her early 90s, who lives at the Wintergreen Senior Citizens' Residence. I'll tell you about her as we go in. It's a fairly nice building, set back a ways from a major boulevard and located about three miles from the heart of downtown. This is the main entrance. I will nod to the receptionist (who will recognize me as a social work student intern, and I introduce you to her as a student in community psychology who is looking into some group projects among the elderly), and then we head for the rear second floor suite of Mrs. Abbott. You notice the public calendar of activities at the Residence and seem amazed at how many activities a person might engage in this month (October). "That's pretty typical," I observe, having seen a notebook of prior calendars. We pass the dining area, which looks quite gracious, with tables seating six, comfortable chairs with arms, and large windows facing the terrace and lawn.

Exhibit P.1 Flow Diagram for Evaluating Practice

*Read down one step, then read across for concurrent activities.

The Flow of Scientific Practice	A — The Practice Context	B — Contexts of Theory and Ethical Concerns	C — The Evaluation Context
Part I, Starting Scientific Practice	A.1. Establishing the Practice Context	B.1. Establishing Ethical and Conceptual Contexts	C.1. Establishing the Evaluation Context (Ch. 1)
Part II, Developing a Good Relationship, Assessment	A.2. Rapport-Building	B.2. Developing a Working Theory through Conceptualization	C.2. Rapport-Building for Evaluation
	A.3. Presenting Problems and Strengths	B.3. Exercising the Working Theory: Finding Unrecognized Events	C.3. Conceptualization: Basis for Measurement (Ch. 2)
	A.4. Presenting Goals and Objectives	B.4. Ethical Review: "Help, if you can, but . . . do no harm"	C.4. Redefining Problems and Strengths (Ch. 3)
	A.5. Assessment: Matching Client and Practitioner Perceptions of the Whole Situation; Connections with Intervention	B.5. Ethical Assessment: Matching Client and Practitioner Ethical Perceptions of the Whole Situation	C.5. Reconceptualization and Measurement: Planning for Evaluation (Ch. 4)
			C.6. Measurement a. Behavioral Observations (Ch. 5) b. Individualized Rating Scales (Ch. 6) c. Standardized Questionnaires (Ch. 7) d. Logs (Ch. 8) e. Reactivity and Nonreactive Measures (Ch. 9) f. Selecting a Measure (Ch. 10)
Part III, Designs for Informed and Ethical Practice and Evaluation	A.6. Selecting and Implementing Interventions: Practice Designs a. Primary Prevention b. Treatment c. Rehabilitation d. Palliative Care	B.6. Ethical Designs: Review and Modification of Practice Plans	C.7. Single-System Evaluation: Basic Principles of Design (Chs. 11 and 12)
	A.7. Contracting: Who Does What with Whom under What Circumstances?	B.7. Practice Hypotheses: What Specific Ways Will the Client and/or Situations Change for the Better? What Are the Risks the Situation Will Change for the Worse?	C.8. Baselining (Ch. 12)
			C.9. Evaluation Designs a. Case Study to A-B (Ch. 13) b. Experimental Designs (Ch. 14) c. Multiple Designs (Ch. 15) d. Changing Intensity and Successive Intervention Designs (Ch. 16) e. Complex and Combined Designs (Ch. 17) f. Selecting a Design (Ch. 18)

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Exhibit P.1 Flow Diagram for Evaluating Practice (*continued*)

The Flow of Scientific Practice	A The Practice Context	B Contexts of Theory and Ethical Concerns	C The Evaluation Context
Part IV, Analysis of Data, Monitoring Change, Decision Making, Maintenance Planning, and Termination and Follow-Up	A.8. Monitoring the Data: Modifying the Intervention as Needed A.9. Comparing Goals and Outcomes: Using Your Results to Test Your Practice Hypotheses A.10. Decision Making: Combining Evaluation with Values and Practice Wisdom 　a. Acting on the Basis of Empirically Supported Evidence 　b. Planning to Maintain Positive Results after Intervention 　c. Termination 　d. Follow-up (with possible need for "booster shots")	B.8. The Ethics of Changing Events B.9. Client Bill of Rights (Ch. 25) B.10. Informed Consent (Ch. 25)	C.10. Analysis (Ch. 19) 　a. Visual Analysis (Ch. 20) 　b. Descriptive Statistics (Ch. 21) 　c. Tests of Statistical Significance (Ch. 22) 　d. Computer Analysis (Ch. 23) 　e. Selecting a Procedure (Ch. 24)
Part V, Scientific Practice in the Community: The Challenge	A.11. Report to the Agency: 　a. Adding to Practice Wisdom and Personal Practice Repertoire	B.11. Report to the Community 　a. Innovations for Managed Care (Ch. 25) 　b. Innovations for Primary Prevention (Ch. 25) 　c. Ethical Accountability and Cost-Benefit Analyses	C.11. Report to the Profession 　a. Critical Issues in Single-System Design (Ch. 25)

"They serve three meals a day, seven days a week," I mention. We go by some game rooms, a craft hall, a medical area where a visiting physician sees residents several times a week. "There are also several nurses here, around the clock," I report. And we noticed something new, a computer room–an addition to the old library.

On the way up, I tell you a bit about Mrs. Abbott. She's a former school teacher and later principal, a widow, no children, and some family who live all over the country but not here. The pictures on the wall are from her many favorite pupils over the years. The Residence Administrator (RA) called my agency and indicated that Mrs. Abbott was acting in a moody and unsettled way–which was unusual for her–and she didn't seem to be coming down to meals regularly, which also was unusual. The RA asked her whether she had any health problems, and she said no, nothing to speak of. But something is going on. Could we do something, please? That happened just as my practicum instructor was looking for cases for me. And so, here I am.

I ring the bell, and in a few moments an attractive, gray-haired woman comes to the door, smiles in recognition, but then sighs, and motions us in. We walk past a tiny alcove that houses the kitchenette, and go into the living room, which is quite cheery with a big picture window overlooking an expanse of lawn and trees in the distance, and several pieces of comfortable, if worn, furniture, a TV, a desk, lots of pictures of children in a cluster of frames on the wall and a patterned Indian rug that covers a bit of the institutional red tile throughout the apartment. On the other side of the room is a short hallway leading to the bedroom, a walk-in closet, and the bathroom.

I introduce you and we sit down to talk. "How have you been, Mrs. Abbott?" I ask. "Oh, about the same, not so good. I just don't seem to have energy to do anything, and the worst thing is, I don't seem to care," she says in a rather weak voice.

I summarize the events to date, partly for your sake, but mainly to put things into perspective for Mrs. Abbott. "Mr. Johnston, the Residence Administrator, was concerned about you and asked our family agency to see if there was something we might do to help. The first time we met, you were telling me about your friends, many of whom seem to have had problems that occurred about the same time. I think they were all members of your card group, what was the name? Oh, yes, the "Roaring Nineties" Club.

"Yes, that's right," Mrs. Abbott replies. "We were just going into our 90s and were pretty feisty when we started our club four years ago. Oh, everyone had a few aches and pains, but we were all bright-eyed and bushy-tailed. But now, Mrs. Bennet is back at the Residence after a fall that broke her hip, and she's having trouble getting up and around. She's afraid she might have to go to a nursing home. And about a year ago, Miss Carol had a stroke that left her paralyzed on her left side, and she's getting lots of medical rehabilitation. But she thinks it is only a matter of time before all the other things catch up with her and overwhelm her, and she'll have to go live with her daughter and son-in-law somewhere out west. She's a wonderful friend and I'd hate to see her go. Poor David Dunn died; he was such a cheerful man; made us all laugh. His wife, Dorothy, is doing quite well physically, but she is still in mourning and doesn't seem to want to come out of her shell. Say, is there something you can do for her?"

"I'll check on that with my supervisor; thanks for mentioning it," I say. Mrs. Abbott goes on about a few of her other friends at the Wintergreen who were having problems, and how she feels about the situation. (I'll say more about this part of the conversation later.) When she finishes I ask, "Are you and your friends still playing cards together?"

"No, we hardly get together nowadays." She pulls out her desk calendar and points to the few occasions when her card group met. Then she continues: "We used to meet a lot, maybe several times a week when we could reserve one of the card rooms downstairs. But now, when we do meet, we don't even pick up the cards. We just talk and commiserate. But that's important for some of them," she notes, with a bit of defensiveness in her voice. I say that I

agree with her about that. We talk about her other friends at the Wintergreen who played cards with the Roaring Nineties group on occasion, but it seems that everyone had her or his own problems, and not much was happening among residents, even with all the movies, crafts, outings to local stores, exercise classes, and such that were part of life at this well-run residence.

You summarize the conversation quite well when you say to Mrs. Abbott, "It sounds to me as if these past few months have been very hard on all of you, for different reasons, but that you are still trying to maintain what goal you and your friends all share in common: being here at the Wintergreen and enjoying each other's company in the best way you can. And it's distressing because there's no good solution that's apparent."

"Yes," she says, "yes, that's it in a nutshell."

As we say our goodbyes for this session, Mrs. Abbott insists on taking us over to the photo gallery and telling us about her favorite pupils of long ago. She laughs, in spite of herself, at memories of some of the jokes they shared. She clearly enjoys laughing when there is something to laugh about.

Identifying the Presenting Problems and Strengths of the Client (II.A.3.)

We sit down in the staff cafeteria and think about this case. You get out a legal sized notepad and begin to make some jottings, including both the presenting risks or limitations *and* the presenting strengths, for both Mrs. Abbott and this supportive setting. Then you pause, pencil in midair, "I suddenly realize," you say, "that I never actually talked with someone over 90 before, and I was amazed at her vocabulary and her physical energy, even though you said she had slowed down lately. Yet I feel uneasy. Maybe I am just afraid of introducing any change in her fragile life."

"I had a similar reaction when I first met Mrs. Abbott," I reply, "but she seems quite resilient and was able to set limits on what I was suggesting at first. Maybe some of the other residents are more fragile, so it is good to keep

sensitive to working with the very old. My field instructor suggested I read some books about older persons, and maybe this would be helpful for you too. I liked Betty Friedan's *The Fountains of Age* (1993), but there are lots of good books out there in gerontology, especially Alchley and Barusch's (2004) new work.

"Mrs. Abbott is what they call the *new old,* an older person with a good education, pretty good health, and an adequate income. She's also a great example of the strengths perspective," I add, "and a great antidote to all of the focus on pathology in the literature and at school. (See Cowger, 1994; Saleebey, 1997.) Let's see now: what do we have?"

With regard to personal limitations or circumstances that posed risks for her, we both agree that Mrs. Abbott looked weak, had low levels of energy, and seemed to be dwelling on problems among her friends; she spent most of our time together talking about her friends' problems. We recall that we weren't able to get her to articulate any specific happy objectives in her immediate future. Her apartment seemed much less tidy than I recalled from my earlier visits. In addition, she didn't have any nearby relatives and most of her friends were either in residences like hers, or living with family. You are especially concerned about that, but I point out that she has a lot of friends among the other residents and staff of this residence.

On the strengths side, we realize that we have to distinguish factors more carefully. Even though she had low energy, she was doing all of her own housework—slowly—and that was fine. It seemed to give her a sense of accomplishment. We also recognize that Mrs. Abbott herself seemed to be free of any illness or chronic condition, and that while she was much involved with the ills of her friends, this could be viewed positively as reflecting her care and concern for her friends. She is clearly mentally alert, has a good sense of humor, and commands a lot of respect among staff and friends at the Wintergreen. The Residence itself should be counted among her resources because, in fact, it has a lot to offer, including a new computer room where residents can e-mail their friends and relatives. "I can't

believe that these ninety-year-olds are going to start using computers," you mutter. "But we passed the computer center on the way down here, and it was filled with residents. So I guess I had better believe it." (I see your stereotypes about the elderly collapsing, one by one, just as mine did a few weeks earlier.)

Identifying the Presenting Goals and Objectives (II.A.4.)

"What has Mrs. Abbott said about her needs and goals?" you ask, after we had gone through the inventory of her strengths and limitations.

"About the first thing she said to me, after we met, was that she wanted to stay here at the Wintergreen, that it was truly a home for her that provided all of the basic supports that she ever wanted–good friends, comfort, stimulation, and a good deal of security now that she was getting older," I report. "It is sort of like Maslow's (1968) discussion of the hierarchy of needs. Let's see. First, there are physiological needs like food and such. Then, safety needs, like a safe shelter in a safe environment. Then there are the needs to belong to a loving group, and this is one of the critical points in her life at this time. She gets plenty of esteem (the next hierarchical need), but that means nothing if she doesn't belong to a loving group. I think the self-actualization needs are next."

"What are they?" you ask.

"It means, at least in my terms, being all you can be and being happy about it," I reply, smiling as I realize that I inadvertently quoted the U.S. Army recruiting slogan. "I think each person formulates his or her own version of being self-actualized or fulfilled. For Mrs. Abbott, this has meant service to others. She was a dedicated teacher and administrator, and that photographic display shows her success in that endeavor."

"So you're saying that our job is to help her achieve her goal to belong to and maintain a loving group," you summarize. "And she has pretty well worked through the other goals, but she needs to reaffirm that belongingness goal. This makes sense as a guide for our working on keeping her support group together at the Wintergreen as long as feasible,

and not let irrelevant issues break up the old gang."

"You've got it!" I exclaim. "And of course there are a lot of intervening tasks to accomplish before we can hope to reach any one person's long-term goal, let alone goals common to the group. From the way Mrs. Abbott was speaking, each of the others had quite different problems, from physical to emotional, and yet I got the sense that all of them relished their Roaring Nineties group. So, all we have to do is to add the sum of individual goals and get a group goal. Right?"

"Well," you say, "not exactly. Some group goals, like morale or satisfaction with the group, are dependent on the interaction of the whole group, and aren't just the sum of individual ideas or feelings on that topic. It is like something new emerges when people continually interact together. No one person has group morale; rather, it is something that floats in their collective atmosphere, so to speak, and is shared by each of them. Group morale is something apart from the specific feelings of any member. We know it exists because we can measure its effects on members, keeping them attracted to the group, like Mrs. Abbott is, for example."

Establishing an Ethical Context (II.B.1.)

Developing a Working Theory through Conceptualization (II.B.2.)

After we had listed all of the problems or limitations with Mrs. Abbott and her living situation, plus all of the strengths and resources she had available, we just sit there thinking about these points. How are we to go about helping Mrs. Abbott and do it well? It is hard to describe what happened, but for me, it seems that, as I think about those key words over and over, certain general ideas come up that seem to summarize the whole lot of them. Ah, so these particular human events are instances of the abstract and general concepts–just what my instructor was saying in that theory class last semester. I realize that I just generalized

Mrs. Abbott's comments and my observations of her into an abstract and summarizing term, a concept. I am rather pleased with myself for having made this conceptual connection, until you ask me to explain how I did it.

I try to retrace my steps. I had many observations that came to me about the same time, but I especially noticed the affective tone in Mrs. Abbott's conversations and movements. She seemed unhappy and unsettled. It was as if she was thinking about and grappling with a lot of things and was not able to come to any resolution. It was easy to see the sources of her distress, the various states of ill health of her friends who constituted her closest friendship group. And she, who had been so good at organizing events to help people, didn't see any solution to these existential issues. It got her down. She walked more slowly, had less energy for doing other things, and it showed up in how she was fulfilling her own basic needs, including having no appetite to eat regularly, or to plan for pleasant future objectives. In a word, or rather, a concept, I thought Mrs. Abbott was depressed. *This seems to be a major dimension in the ethical context for our work with Mrs. Abbott: Can we help? Or, at least, can we make sure we do no harm?*

You think about that for a moment, nod your head in agreement, and say, "I think you may have a good idea, even though depression could be either a strictly personal concept (like when you say 'the individual feels very unhappy') or it could be a person:environment (P:E) concept (Germain & Bloom, 1999); that is, the individual is inseparable from her environment; both must be considered in any assessment—like saying that in this depressing context, the person's unhappy feelings get magnified."

"Why does it matter whether it is a personal, or a P:E concept?" I ask, and you say it influences how we are supposed to direct our energies to make suitable changes, to the person alone, or necessarily to both the person and the context. "Ah ha!" I say. "Then I would definitely go with the P:E interpretation. We have more options on how to direct our energies. For example, this P:E interpretation would lead us to check out things we didn't

currently know about, like the medications she is taking (a personal factor) in interaction with the social atmosphere of the dining hall (an environmental factor). Both factors might influence her level of nutrition. We'll have to check into those things. Anyway, that concept (P:E depression) was quite an eye-opener. But I guess that is what concepts are supposed to do."

You must have been doing the same abstracting because you are sort of muttering to yourself, "strong, a real survivor, a person with lots of strengths." As we talk about these observations, we both arrive at another concept at about the same time. This concept (strengths) seems to summarize a lot of the other traits we had observed in Mrs. Abbott. So now we have two concepts to work with, depression and strength. It also seems that as we define our concepts, we are also clarifying the ethical context within which we have to work—to try to decrease the former, while increasing the latter, without damaging any other ethical relationships.

"Concepts don't stand alone," I pontificate. "Where there's smoke, there's fire. Where there are concepts, there must be a theory." You look a bit glazed and comment that I must have been studying too hard, but yes, you agree that we ought to consider theories because they not only describe situations and offer explanations for what's going on, but also they predict future events and thus allow us to interrupt those events so as to attain a better outcome, one that the client prefers. We first start to think about the concept, depression. What theories would be useful here that have the concept *depression* as a key term or that analyze the condition?

There is a moment of silence, and I offer several possibilities. "I think psychoanalytic theory says something about depression, and the cognitive-behavioral model does too. I believe there is some biological thinking about depression as genetic or inherited. And I was reading something about the existential position and dread; maybe that's like depression."

"So, what evidence do we know about any of these theories?" you ask. Neither of us can think of any supporting evidence for the

psychoanalytic model (Ford & Urban, 2000), and besides, we can't hope to use techniques involving the unconscious to produce changes in people with our level of training. I mention the cognitive-behavioral theory and say I had read some books that presented a lot of evidence supporting that idea (Beck, 1976; Clark, Beck, & Alford, 1999). You mention the existentialist notion of dread (Frankl, 1962). Maybe Mrs. Abbott was fearing death, which she was seeing in bits and pieces in all her friends. We can't disregard that idea, but there doesn't seem to be any research evidence that we know. As for biological models, or maybe basic physiological development in very elderly people, we realize that we don't have much information. Maybe there was something about Mrs. Abbott's health or nutrition that was involved. We would have to check with her records at the Residence, and we agree to check out the other theories at the university library information retrieval center. But, for the moment, we think the cognitive-behavioral approach has the most to offer in this situation. We'll call this our working theory—to see whether it works for guiding us to see the whole picture, including some new ideas we may have overlooked.

I don't want to brag, but I studied so hard for that theory exam last year that I even remember some of what I learned. As I recall, the main concepts and propositions of the cognitive-behavioral model are these:

People are complex cognitive/affective/behavioral beings. A significant proportion of our mental distress (and delight) comes from how we understand the world around us. Some of these areas of mental distress are well justified (friends do die, senseless discrimination does exist), but others are distress that we create for ourselves. We may, for example, expect or desire the impossible—to be perfect in every way on all occasions before all people. And when we inevitably recognize that we are not perfect, this may become distressing. However, it is possible to dispute this senseless belief and reframe our thoughts to view the world in more adaptive terms—we would prefer to be well liked, but in reality, not everyone is going to like us, no matter what we do. It may take learning new skills to restructure our thinking in less harmful ways, and to actively work on performing them. This might include re-

laxation exercises, problem-solving training, self-instructional skills, among others (Clark et al., 1999; Meichenbaum, 1985). Moreover, the model also examines the relationship between environmental events and how they affect peoples' perceptions and other cognitions. Thus, interventions also could be targeted to changing those environmental events so that changes in cognitions will follow.

Exercising the Working Theory: Finding Unrecognized Events to Give a More Complete Understanding of the Client/Situation (II.B.3.)

You get up to get another glass of orange juice. "This thinking requires more energy," you announce. And while you are gone, I am thinking about cognitive-behavioral theory in relationship to Mrs. Abbott, and wonder, did we forget anything? Does the theory tell us to look for something we haven't considered yet? The people who publish well-constructed theories probably had a lot of experience with the topic, and may have considered events that we hadn't. I am thinking about this when you bring back two glasses. "Here," you order. "You need it too." This prompts me to think that maybe Mrs. Abbott might need more food for her energy, but I decide to hold that idea and check it out later. You can't do everything at once.

We sit there silently, staring at the notepad and thinking. Suddenly, you say, "Wait a minute. If Mrs. Abbott is really depressed, why isn't she thoroughly and consistently depressed? She seems to go in and out of acting like she's depressed, and yet there is nothing specifically about her personal health that should make her depressed. At times, she looks and acts spritely; other times, she looks really down. Shouldn't people be consistently depressed, if they are really depressed?"

"Good question," I observe, "and I don't know the answer. But thinking about Beck's cognitive theory itself, I would say that people can look at some situations as depressing and respond to those with their own depressed behaviors. And at other times, they can look at pleasant or neutral situations, and see the world as relatively pleasant or neutral."

"So, it depends on how a person views the situation that in effect contributes to his or her depression?" you ask. "Then, all we have to do is to change how they view those situations, which also means trying to change those situations?"

"I guess so," I say, and immediately add (since I know you would say it anyway), "but guessing isn't the best way to run a practice. So we had better find out. But at least this insight gives us something to think about and something for which to use the information retrieval services to find a specific answer." Silence.

Ethical Review: "Help, if you can, but . . . do no harm" (II.B.4.)

You frown. "What's the matter?" I ask.

"It's just that this theory is leading us to do things *to* Mrs. Abbott, like change her cognitive frame of reference, and I wonder if that is ethical to do? Are we such great experts that we can impose our solution on her? I mean, how do we know it wouldn't do more harm than good?" you lament.

I reply, "I don't know if anyone is an expert with someone else's life. All we can do is offer hopefully enlightened suggestions relevant to client goals. Remember that the Hippocratic Oath says first to help if you can, and then it says to do no harm. I think that the least harmful and least intrusive way to help should give us the greatest helping effect. Yet, we better check our plans of action to see if they fulfill ethical guidelines while also meeting client goals." Warming to this topic, I go on: "At minimum, I think we have to believe that we have something to offer in this situation, namely, our theories and the practice suggestions based on them. We have to begin with Mrs. Abbott and discuss these ideas and the direction in which they are leading us. She might have some other ideas that would change the direction, as she knows her own feelings and the context a lot better than we do.

"Sharing our ideas on practice between the client and the practitioner is like informed consent applied to the practice situation, rather than informed consent in research terms. The client knows exactly what the plans are and in fact has contributed her ideas and directions to them. And she would likely be more motivated to participate if she had a full part in the discussion and decisions."

Just then, Mrs. Hill and Mike Breen come up to our table—she's a practicum instructor at the Residence and some other places where students are placed, and he's my classmate and a real nag. I'll tell you about him in a minute, but we do get into an interesting discussion with Mrs. Hill that I want to note. This is why I think having a practicum in the field is such a great idea—one gets some very important practice wisdom conveyed immediately and in the context of one's own clients. We exchange greetings and invite them to join us at the table. Then we talk about our field placement and our idea for a group and individual intervention project. Our excitement must have sparked an interest in Mrs. Hill because she asks us to give her more details. Happily we reconstruct our ideas of the goals and objectives, and some of our other ideas. When we stop, we look at Mrs. Hill and wait for a response. There is a long silence, and then she says, "Interesting."

We are not going to take that lying down, and so we ask her to give us some early warning feedback, and this is what she says:

"I don't know Mrs. Abbott personally, but I wonder if there is more going on in her life than what you have said—or even what you know. After all, you have only been with her two or three times, and you can't expect a client to give you the whole story of her situation in that amount of time. She may be depressed, but it may also be that she is exhibiting some depressed feelings for good reasons as you were saying. Either idea is a reasonable hypothesis to explore. But she also has some unique strengths that you aren't employing directly, and if you look at the whole person in the whole context, then you probably should consider her 'adopted family,' her friends at this residence, and even the children she taught and their children. It seems to me that she has some real leadership skills and personal skills. How can you use that part of

her strength in your overall planning? She belongs to several domains in her life here, and you might want to consider all or most of them in your planning, since they are all tied together. Your intervention plan has to account for all of these."

We listen attentively to Mrs. Hill, and nod in agreement that we should explore other aspects of Mrs. Abbott's life situation. In fact, we were discussing strengths just as Mrs. Hill and Mike came to our table. Maybe the pieces would come together in a larger plan. But I am fascinated at the way Mrs. Hill brought pieces of information together and created new ways of looking at the situation. You and I had those pieces of information at hand too, but we didn't see the connections. This is perhaps a matter of experience in developing practice wisdom. In class, our teacher had pointed out that practice wisdom involves the balanced interactions among theory and its supporting research, direct contact with clients, and our generalizations from this practice. These generalizations become concepts made about the client situation, but they also link us with concepts from theories that provide additional options on further aspects of practice (Klein & Bloom, 1995).

Another observation I make on Mrs. Hill's comments was the intrinsic connection between any action we might take with regard to Mrs. Abbott and the ethical stances we were necessarily taking. To interact professionally is to take an ethical stance. When these ethical positions are pointed out, we realize that taking professional action automatically involves operating within our codes of ethics.

Mrs. Hill looks at her watch and says she has to be moving to another agency to talk with students in practicum. We all say goodbye.

Building Rapport with the Client for Evaluating the Practice Situation (II.C.2.)

As we are talking about ethics and practice, we are both surprised to realize how much vocabulary we are using from theory and research classes we had taken—informed consent, client participation with the process of helping, our own critiques of theories and concepts. It all seems to flow together when we begin to think about what we are doing. But we get stuck on one thing: How do we know whether the interventions we want to do with Mrs. Abbott, even with her full understanding and participation, will be effective?

"Won't this be obvious?" you ask eagerly.

"Maybe so or maybe not," I reply. "I'm just as eager as you and she would be to have a successful outcome, and that may be the problem—a little bit too much bias in our own favor. The real proof of the pudding in terms of effective outcomes will come in how others (who don't share our biases that stem from working toward these goals) see Mrs. Abbott and her friends behaving in the ordinary world. Somehow, we have to tap into their opinions and observations to see if what we are planning to do has the desired effects we all eagerly (too eagerly?) want to happen."

"Okay. I can go along with that," you say. "Now, how should we get this evaluation started? Is it something different from all the other things we will have to do in the practice procedures? I'm not sure I can handle a whole lot more things to do as an intern."

"I hear you," I say, nodding in agreement, "but do we intend to think clearly about what the targets are in this case situation? Do we intend to be careful in observing what is happening as we continue our interventions? Do we expect to be sensitive to the feedback from our observations that will lead us to make corrections in the way we are proceeding with our work? What my practice teacher said about all this is that if we want to have this kind of practice, then inevitably how we conduct our practice actions will constitute a good part of how we evaluate. We define terms clearly. We observe the ongoing process carefully. And we consider honestly what these data tell us about how the intervention is going and whether we might need to make some adjustments to get to where we all want to go."

"I'd like to see that in action," you say. "How do we begin?"

"According to this point of view, we have begun evaluation in the very process of being clear about practice. The one point we have to

consider is helping the client to see that evaluation is an intrinsic part of practice. It is like a social thermometer that takes readings on the major components of the client's problems and goals. Even a social thermometer can be intrusive, so we have to be careful to emphasize the positive. For example, we might not want to have the client help in measuring how many depressive thoughts he or she was having—because it emphasizes thinking about being depressed. However, we would want to get equivalent but opposite information, such as how much of the time this person was involved in pleasant and socially useful activities. You ordinarily can't be thinking about the former (how depressed you are) while doing the latter (being involved in fun activities)."

"Let's talk specifically about Mrs. Abbott," you suggest. "She probably will be a cooperative participant in evaluation because she will be able to see the value of taking readings, as you said. In fact, being as sharp as she is, she might positively enjoy participating in the evaluation as well as the practice. But how should we introduce this topic to her?"

"Let's see. First, we have to be sure she trusts us, and that she knows we really care about helping her. We also want her to know that we are doing our best to understand her and her feelings. Once we've accomplished that, I think we might begin discussing evaluation, but only after we agreed on our plans for the intervention. We might start by talking about the need for accurate information, as feedback to fine-tune our intervention, but also because we need to have clear evidence of the effectiveness of our work for the agency."

"And for the taxpayers and charity contributors who underwrite a large portion of our agency's activities," you add. "I think that is a reasonable beginning plan."

Conceptualization: Basis for Measurement (Chapter 2) (II.C.3.)

"Let me be clear about what we've been saying," you start anew. "I need to put some substantive content in our abstract thinking so far. Let's start with the concept of depression from a cognitive-behavioral perspective. This im-

plies that we should look at the social situation at the Residence and how Mrs. Abbott views this as affecting her unhappy feelings and her decreased energy level. Once we understand how she views this complex situation, then we can plan with her some possible interventions and observe, or actually measure, the changes that occur, both in the environment and in her views of these changes.

"As I see it," you go on, "these possible interventions have to include working with Mrs. Abbott's strengths and the other positive resources in her environment. After all, it is these strengths and resources that we want to focus on; they are the substance of our intervention."

"Good points," I respond. "Let's get specific. At least four of the mainstays of her card club have gotten sick or lost a spouse in the past year, and they all need help of one sort or another in order to function on their own at the Residence. If they go, they all lose out on what was a wonderful support group. What do they need to stay here? None of them seems to have figured out an answer, and they are all in mourning for their dying friendship (or at least their immediate proximity friendship). They are all sort of depressed about this."

"But I still come back to the fact that these seem to be basically bright and mentally healthy individuals who have one kind or another of some physical problem," you add.

"Don't forget Mrs. Dunn, a widow who has not been able to get back her functioning since the death of her spouse," I remark. "She needs someone who can be there more to get her involved with other activities than those associated with caring for a sick spouse."

Part 1. Assessment: Matching Practitioner and Client Perceptions of the Whole Situation; Connections with Interventions (II.A.5.)

Ethical Assessment (II.B.5.)

I see Mrs. Abbott coming back from lunch, one day, and I walk back with her to her apartment. We talk about nothing in particular, but when we get to her door, she raises the point about

the still gloomy atmosphere hanging over her group of friends. "What do you mean?" I ask.

"I can't express it exactly, but it is as if we're spinning our wheels and getting nowhere, while inevitably things are occurring that are going to drive us apart and drive some people away from the Wintergreen. It's like we are in mourning for the old gang, even though we are still the old gang.

"So, you're saying that you and your friends haven't been able to solve this tough problem that seems to have so many ramifications, and you're all feeling rather blue," I say.

"Yes," she replies. "It really does have a lot of ramifications, and each one adds something depressing to the others. It seems like there would be some kinds of solutions, but I think our brain power is being used up with daily crises, and we're not seeing the bigger picture. And I am especially frustrated with myself because I can't seem to step away to see the larger picture." Mrs. Abbott then enumerates all the problems she sees in her friends' situations, first one point, then another, then another in regard to one friend. Then, again, with another friend . . . . She really does see many particulars in their situations, and they are quite varied, from ill health to psychological depression, from family pressures to leave, to doubts about where they might go.

"I know that it's hard to step outside yourself when you are so close to this situation," I console. "Maybe I can be of some help, as I come to understand what you and your friends are facing. I think I understand everything that you've been saying about these matters, so far. I'd like to think about them and then meet with you; maybe I could suggest some new possibilities."

She looks at me a minute, and then says, "Maybe so." We make plans to meet early next week.

The next day, you and I are talking by telephone: You begin to speculate, "How can the people in the Roaring Nineties group attain their individual objectives, and thereby increase chances of obtaining their overall common goal? They can't afford full-time help, you said, right?"

"Yes."

"And yet they all have some part-time help now, I assume."

"Yes," I answer, "but they are not always pleased with their helpers. When someone calls in sick, their own planned schedules are shot, since there aren't any substitutes, apparently. Or, Mrs. Abbott hasn't mentioned any. But she did mention that she wished they had full-time, well-trained aides, but no one could afford such a person."

"What if they went in together and hired one, no, maybe two well-trained aides full-time, since they all live in the same residence? Then the aides could move among apartments as needed, and with two aides, there would be some safety in case one couldn't make it sometime," you suggest. "There are an increasing number of home aide agencies in the community and good standards of training and service are being developed."

"That sounds interesting," I reply, brightening up at this good suggestion. "And you know what, Mrs. Abbott might play some part in arranging for these aides, and sort of managing the situation. That would give her some role in all this, and she might reframe her view of the situation now that she was contributing to and promoting the general health and welfare of all of her friends. I think that is what cognitive-behavioral theory might suggest—getting some new ideas about the situation, helping the residents to see things in a new way, and then facilitating their growth by assisting in whatever ways we can to make an environmental change in this situation."

Several days later, I meet with Mrs. Abbott myself. She greets me with her usual warmth and a bit more energy than previously, and so I decide to continue explorations of her feelings and ideas about her situation. Her small friendship group had gotten together over meals several days in a row, and they even played a game of cards.

"I'm glad to hear that everyone is getting along well," I say. "Maybe it is the beautiful weather we have been having."

"No," says Mrs. Abbott, "it's not that. I think it is just a chance event where everyone's helpers were on the job. Shows what can hap

pen when that occurs. If we could only make it happen more often," she muses.

Sensing an opening, I say, "It certainly would be a good thing to have a more consistent group of helpers. Have you and your friends given any thought to the idea that if you all went in together, you all could probably afford to hire maybe two full-time aides, and you could take turns employing them? Emergencies would come first, but everyone would have the satisfaction of having a well-trained aide who would be backed up by the agency in case one of them got sick. This one action might help deal with a lot of different ramifications that we were talking about the other day."

Mrs. Abbott listens without saying anything, but it is clear that gears were whirring in her mind. "Say," she says. "That reminds me. I was talking with a guest speaker the other day—I think she was the director of a social agency—and she was talking about just the kind of aides you were describing. And all I did was to say to myself, 'too bad my friends couldn't get an aide like that.' But I think you're right; if we all chipped in, we might just make a go of such an arrangement."

"Oh?" I said. "So what are you going to do next?"

"Why, I am going to call my friends, as soon as we are finished talking, and suggest the idea. If they agree, I'll call that speaker and see if we can work something out. I'll probably have to handle the details. That is something I was pretty good at when I was working. So I think I just might be able to handle this new project. And if it works, why, my old gang can hang around the Wintergreen until they have to carry us out feet first. I'd love that, sticking around the Wintergreen, that is. Why, thank you, my dear. That was a great idea. It's like Popeye and a can of spinach. Do you know Popeye, the sailor?" she asks.

"I've heard of Popeye, but I don't think I ever saw any comic strips," I reply.

"Too bad," she says. "You're a wee bit too young, but this cartoon character was popular when I was your age, and just when Popeye was getting into some terrible situation, he would pop open a can of spinach, swallow it down, and energy would surge into his body

and he would carry the day. That's how I felt just now. My dear, if you wouldn't mind calling it a day, I have some work to do."

Part 2. Reassessing the Situation: Change Is Inevitable (II.A.5.)

I call on Mrs. Abbott several days later after I was finished with another client, and Mrs. Abbott sounds decidedly unhappy. "What happened?" I ask. "You were so happy the other day with the idea of organizing home aides for you and your friends."

"It's my dear friend, Joanne Carol," Mrs. Abbott said. "She had another stroke two days ago, and I think she is still in intensive care. It does not look good, and we are all sick to death about it. Her daughter flew into town and has been making plans to have her put into a nursing home. Joanne's roommate, Amanda, has been keeping us informed, and we all cry together. It is so sad."

"I'm very sorry to hear this; it must be very distressing for you all."

"Yes," replies Mrs. Abbott, "but it also is interesting. As soon as Joanne went to the hospital, a number of other residents came forward and comforted us. And now, through this sad experience, we seem to have gained more friends than we had before. I guess every cloud has a silver lining."

"I think times of crisis bring out the best in many people, and this is one of those special times when everyone shares the same hopes and fears, and it does pull people together. Do you see these new people as becoming a part of the Roaring Nineties group?" I ask as lightly as possible.

"Maybe," she replies. "We haven't talked about that, but I think it is inevitable that new folks will come in as . . . as other folks leave." We are both silent for a moment. I take her hand and she looks so grateful. There is a sisterhood, even across ages, I think. Maybe she thinks the same thing, because we both give each other a big hug.

I call Mrs. Abbott after the weekend, and she matter of factly tells me that Miss Carol has died. The old gang does not appear to be greatly distressed at this news; they did their

mourning as best they could when she had her stroke. But there is a somber air about the Wintergreen, as original members of the Roaring Nineties plan a commemorative at the Residence. They discuss music and short readings and such, and make arrangements with the management. (Mrs. Abbott made the arrangements.) And I am able to be there for the service. It has a quiet dignity, but it is poignant to watch the original Nineties and the new Nineties (who were hardly into their eighties) working together.

Redefining Problems and Strengths (Chapter 3) (II.C.4.)

Matters were changing, and we had to change our thinking about them, too. Miss Carol's death had put a new urgency in our work, but the way the residents responded to the death showed greater sources of strength than we had previously recognized. I observe little clusters of residents talking in earnest around the building, as if they are trying to process these events and connect them with their own lives. I believe that the death actually was bringing the residents closer together, as though people were helping each other deal with this shared experience. I can see that we might tap into this reservoir of shared feeling in order to introduce the idea of shared helpers. The question is how?

Reconceptualization and Measurement: Planning for Evaluating through the Many Ways of Collecting Data (Chapter 4) (II.C.5.)

"I was trying to reconstruct what we were talking about the other day," you say as we walk into the lunch room of the Wintergreen early one morning. "I think we had better write down these brainstorms before the weather clears up. As a general goal, we are thinking about helping the club members to stay at the Residence as long as they want and are able to do so. For specific intermediary objectives (or short-term goals), the members' states of health have to be at least at some minimum level to stay at this residence, since it doesn't provide ongoing nursing care. Also, they have to be able to manage their apartments up to some level of acceptability. Then there is the question of bringing new members into the Roaring Nineties group."

"Let's focus on two objectives: health and managing their apartments," I suggest, "as being essential steps toward the general goal of staying at the Wintergreen. How would we measure levels of health and managing apartments? This is what researchers call *operationalizing* objectives. I know there are some simple measures of the activities of daily living that probably represent the lower levels of functioning, such as the ability to get up from a chair, dress oneself, feed oneself, and the like. These are easily observed and yet provide important danger signals to deteriorating levels of functioning. With managing apartments, I suppose a weekly visit to apartments would enable us to estimate orderliness and cleanliness."

You agree, but add, "We better connect our project with each participant's physician to get clear directions if something special is needed."

Then Mike comes bounding up. I have a feeling about what he is going to say, and he says it. "So, how's your client doing? Making any progress?" Mike is our local expert in research, and for him everything needs to be evaluated. At first, I resented these questions, but I finally got used to them—especially when I started asking these same questions myself—and Mike was a great resource. He is interning at a Head Start program and is involved in a project to link people at the Wintergreen with preschoolers, for their mutual benefit. But he wanted to hear about us. "We're just starting out, so nothing to report," I say, and immediately regret saying that.

"What do you mean, 'nothing to report'? What about your baseline?" he asks.

You look a bit perplexed until I explain that a baseline is a starting point in any case situation, a kind of point of reference in order to know if what you instigated in the case had any effect.

Measurement (Chapters 5–10) (II.C.6.)

"So, tell me what your plans are for measuring your baseline," he repeats.

"Well, look, Mike, we really are just starting, and we have a hunch that there is some depression in our client. We've both noticed some behaviors that seem to indicate depression. Yeah, yeah, I know. Behaviors are behaviors and what we make of them by imposing a concept like depression goes beyond sheer behavioral observation. But we really do see concrete behaviors, like low energy, flat expression in her voice, disinterest in ordinary daily activities, and from what we remember from the literature, these and others may be related to depression," I state with a bit more firmness than I feel. "And I think we can reliably measure how often these behaviors occur."

"Okay, I hear you," Mike says, but then he goes on. "You ought to consider the wide array of ways you can measure what is happening in your clients. Behavioral observations that you just spoke of are fine (see Chapter 5), but do you remember those discussions of the other ways of evaluating, such as creating individualized rating scales (see Chapter 6), or using standardized questionnaires (see Chapter 7)? And don't forget client logs about what is happening in their lives (see Chapter 8). And above all, don't forget about reactivity—how the act of measurement itself can change client behaviors; to overcome that, we try to use unobtrusive (nonreactive) measures (see Chapter 9)."

"What is he talking about?" you ask, and I try to explain briefly about each of those ways of measuring. They're not particularly difficult, one by one when you study them in class, but presented this way, you just have to take my word for it that we will be able to look at all of the situations we've talked about and use some appropriate ways to get the data we need to see how well our intervention is working.

You look at Mike; then you look at me, and say, "Okay, I'll suspend judgment for the time being, until I study those methods of measuring."

PART III. DESIGNS FOR INFORMED AND ETHICAL PRACTICE AND EVALUATION

Selecting Interventions and Practice Designs (III.A.6.)

We decide that we have enough information at this point to identify what our interventions will be. We all agree that our ongoing meetings with Mrs. Abbott will be one intervention, and that the home aide plan will be the second one. However, as the three of us talk together over the course of this semester, we realize that we each have different practice preferences, for primary prevention, treatment, or rehabilitation. And, in the course of our conversations, we each try to persuade the others of the centrality of his or her favorite practice. What actually happens is that we all become better informed about these three modes of practice, whatever we think about our favorite. Mrs. Hill, the practicum instructor, also meets with us from time to time and argues for a better understanding of palliative care.

"I don't understand why you want to go into treatment when you can prevent some problems from occurring in the first place," you argue. "Help people stay healthy and also try to enhance their desired objectives, isn't that what professional practice is all about?"

"But there are so many people needing treatment," I argue. "We have to take care of them here and now. Some problems just don't cure themselves. That is where real practice takes place."

"I don't know about that," says Mike. "After all, you have to rehabilitate people back into their ordinary world after any treatment. It would be inexcusable to stop before the real job was finished."

Mrs. Hill says, "You're all correct. Professional helping has many aspects and they are all equally important, especially to the clients involved." Then she excuses herself, as she has to give a talk to a community group on the provision of palliative care to the terminally ill. "This is where professional practice is greatly needed, and sadly neglected," she says as she leaves. Mike has the audacity to ask, after she

is out of earshot, what she meant by "where professional practice" really was—in trying to make changes in the community, or in the lives of individual ill clients, or in impressionable students?

So you say, "They're all correct, Mike."

"I recall one of my practice teachers saying that 'what we do in practice *is* our practice design,'" I said.

"What does that mean?" Mike asks.

"I think it means that the whole package of our thoughts and actions over time constitutes whatever it is we do in practice," I respond. "We may intend to be ever so subtle and brilliant, but there are some times we say and do things that don't quite match our plans. So, we may say we are using a cognitive-behavioral model in practice, but if we do things that are more than, or less than, the model calls for, then it is what we *do,* not what we say we are planning to do, that is our practice design."

"I have another take on that," you say. "I think practice designs are the larger structures of our actions. So, if we act before some problem emerges, we are doing preventive practice. If we act after a problem surfaces, we are doing treatment. And if we act after treatment has gone as far as it can, then we are following a rehabilitative model."

"But I can see a situation where we might be doing all three of these at once," Mike says. "For example, say you have a delinquent teenager who has been sent back to his home. The father is steaming mad at his son, and that is going to require some judicious rehabilitation work for the whole family to get reconciled. And the son himself is getting counseling for his substance use problems. That would be treatment of an existing problem. But say there is also a younger brother in the family; the very fact that the counselor is there (doing rehabilitation and treatment) may mean that the younger brother may be diverted from starting on the same path as his older sibling. That would be prevention" (Alexander, Robbins, & Sexton, 2000).

"I don't see any contradiction between what you both just said," you say. "I mean the whole package of our specific actions within a preventive or treatment or rehabilitative context are just the opposite sides of the same three-sided coin. Together they make up a practice design, especially when it is all *planned,* because, after all, *planning is what makes it a design.*"

Mike mutters something about three-sided coins, but I nod in agreement. "Yeah, I like that," I say.

"But once you have a practice design that you use with evaluation, doesn't this lead to some ethical problems?" you ask. "For example, I would imagine that doing evaluation takes time away from the actual helping practice. Doesn't it?"

"Yes and no," I remark with all the wisdom of one research course under my belt. "Yes, it takes time to learn in the first place, but remember that evaluation is an intrinsic part of practice. All practice methods take time to learn. And with evaluation, you get important feedback about how practice itself is going. If you don't take the time to evaluate as you go along, it will catch up with you when something goes wrong that you weren't expecting. Maybe ongoing monitoring would have given you some advanced warning."

"I see what you are saying," you reply, "but really aren't we just doing all this to pass our research requirements? I mean, isn't evaluation nothing more than disguised research?"

I can see Mike turning three shades of red, but fortunately, he is quite restrained as he says, "Not exactly. Research has an entirely different purpose—the creation of new knowledge or the validation of old knowledge—whereas evaluation seeks to provide feedback for practice situations, so as to make that practice more helpful to the client. Evaluation is more practice oriented, whereas research is more science oriented."

"Well," you go on, "all this talk of objective measures of subtle human problems leaves me a bit cold. I mean, if the social construction theorists are correct, then there is no hard reality out there; everything we see or do is influenced by our own way of viewing the world, including what researchers—I mean evaluators, sorry—do with their clients. Talk about self-fulfilling prophecies, just look at what we are doing."

Mike and I look at each other and are speechless.

"Sorry, guys, I was just kidding," you go on. "I just had a philosophy class the other day, and this is one of those paradigmatic situations that lead to questions about everything. I know this point of view is no way to run a scientific practice, but it certainly gives one pause on how strongly to believe in the objectivity of everything we do."

Contracting: Who Does What with Whom under What Circumstances? (III.A.7.)

You continue, "Something else is bothering me. There seems to be a lot of work not only in conducting but also in evaluating practice. Who's going to do all this work? We've got lots of people involved in this project, and potentially we will be doing a million things all at the same time. I'm dedicating my life to human services, but I didn't think that meant every minute in every twenty-four hours."

"Calm down," Mike says. "We don't have to do it all ourselves. It's sort of like conducting an orchestra. You contract with different people to perform as part of a team, and you wave your arms and make beautiful music."

"What Mike means," I say, "is that we do the planning and then figure out who is the natural person to do the various aspects of the project. The Residence nutritionist ordinarily keeps tabs on who is or is not coming to meals, and we just collect that information from time to time. Same thing with the ordinary records on use of the lounge for group activities. Mrs. Abbott could be asked to keep a log book of her state of contentment at the end of each day, for example. And again we would collect this information once a week and plot the data, along with all the other data, to see if we could make sense of the patterns. That's essentially our evaluation task, which we would integrate with our practice activities, like asking Mrs. Abbott how it has been going for the past week. Contracting means figuring out who is to do what with whom under what conditions, both for practice and evaluation activities."

"What she means," Mike says, "is that many hands make light work."

It is getting late, and we agree to get together at the library next Saturday morning to do some of the information retrieval searches, and to talk some more about this case situation. In the meantime, I will be seeing Mrs. Abbott to assess some of the basic ideas we had considered.

Ethical Designs: Review of Practice Plans (III.B.6.)

It is you who, once again, brings us back to the recognition that we are working with ninety-year-old people, and that we had better be extremely careful in making plans that might cause harm, even as we intend them to cause good. "What are the risks involved in our intervention plan?" you ask. "For example, is there any downside of having agency-based home aides on a regular basis? The costs per person should be about the same as they are currently paying for irregular nonagency services, and if anything, the risk of theft is probably smaller among trained workers. Certainly, the level of personal service (and resident–employee relationships) should be higher because of their training in sensitivity, although the cleaning services might be at about the same level."

We can't think of any ethical downside, which doesn't mean there won't be any. We have to be attentive to the comments of our clients about their home aides. We also speculate about the effects of maintaining the Roaring Nineties group longer. Maybe it will become the Roaring Centenarians? But eventually we all will die. Are we setting them up for a more difficult reaction because they have been together longer? We realize we haven't a clue about how the very old reacted to death among their own, except for the quiet and somber period that occurred at the death of Miss Carol. Perhaps we have more to learn about dying and our reactions to death than did the Roaring Nineties group.

We realize that we aren't very successful in this ethical review. We agree to talk about it with our practicum supervisors on a personal basis. Maybe we can get a better handle on

these difficult matters, especially when our practice gets too close for comfort to our lives. And maybe that is the essence of an ethical design for practice—realizing how much what we do affects not only clients but also ourselves. That is why ethical clarity is needed—to keep the focus of helping on the client (see Loewenberg & Dolgoff, 1996; Reamer, 1995).

Practice Hypotheses (II.B.7.)

You and Mike and I are sitting in the staff lounge again, on an orange juice break. We have been talking about our work at the Wintergreen, especially on those cases where our work overlapped. Mike says that since Mrs. Abbott is my direct client, I should call the shots on what specific practice hypotheses we make. What exactly do we intend to happen as a result of our intervention involving the home aide arrangement as organized by Mrs. Abbott? So, as team leader, I construct the following practice hypotheses, first for the group as a whole, and later, for my individual clients. You and Mike construct your own for your own clients.

First, for the Roaring Nineties group:

Hypothesis I: The presence of a dependable, well-trained, and economical home aide service would increase the probability of group members staying at the Wintergreen Residence and maintaining their friendship and support group, compared to the time before the arrival of this service. Specifically, we would observe a significant improvement in sign-ups for group get-togethers in the Wintergreen card rooms, representing one important way this group of people supplies mutual support for one another.

Second, for my individual client:

Hypothesis II-A (Abbott/Nutrition): Mrs. Abbott would participate in regularly planned residence meals at a higher level after the introduction of the home aide service than before. Specifically, we would examine the Residence dietician's records of attendance at meals during the time before and after the introduction of the home aide service, attendance being a prerequisite indicator for obtaining proper nutrition defined as the average daily caloric intake for a person her age.

Hypothesis II-B (Abbott/Level of Energy): Mrs. Abbott would demonstrate a higher level of energy in engaging in social activities of everyday life after she maintained regular eating patterns than before. Specifically, we would examine nursing records that originally identified lower energy levels and compare that period of time before with the time during her regular meal-partaking behavior.

Hypothesis II-C (Abbott/Depression): Mrs. Abbott would demonstrate a more contented and less depressed emotional pattern, comparing the time before the introduction of the home aide service and her regular attendance at meals with the time during. Specifically, (1) we would introduce at least one standardized measure of depression to be used once a week with the goal of reducing depression to below the clinical cutoff score; (2) we would also simultaneously collect practitioner observations of her behavior, including a standard probe, "How are you feeling today?" to be used at each regularly scheduled meeting; (3) we would ask permission to use the nursing staff summary evaluations of all residents on affective states. (This was the original source of concern over Mrs. Abbott's affective state.)

We also identify different objectives for the other clients, but we won't go into them here. Mike does note that what we are driving at, with these various hypotheses, is to attain a kind of *practical significance,* something that makes a practical difference in the world that the clients experience. Our statistical tests would tell us about *statistical significance,* whether the changes we observed could have happened by chance or not. Both are important, but they are different, as is the idea of *theoretical significance,* regardless of whether what we observe happening is what our guiding theory led us to believe would happen. These three kinds of significance are the three dimensions of scientific efficacy (see Chapter 19).

Single-System Evaluation: Basic Principles of Design (Chapter 11) (III.C.7.)

But one day, Mike comes into the staff cafeteria where we are meeting, and he has his hands

on his hips and is glaring at us. "What's up, Mike?" I venture.

"If the three of us are going to cooperate on working with the Roaring Nineties group, then we really had better start collecting our baseline data," he declares. "There's a lot at stake in this, you know."

"You're feeling a little anxious, are you Mike?" you ask.

"Do you believe that you are going to flunk out of school because of your two lazy colleagues?" I ask, and we both snicker.

"Now, cut that out, you two. This is serious." Mike looks a bit redder than usual. "Do you know how late it is in the semester?"

"Actually, yes, we do. We were looking at the calendar in the Resident Administrator's office just before you got here, and we recorded some interesting data. Look here." I show him the rough sketch of the data on sign-ups for card rooms by Mrs. Abbott or any of the group of 'Roaring Nineties' over the last several months. Mike's mouth dropped open and then he smiled.

Baselining (Chapter 12) (III.C.8.)

"Ah, baselining! Now you're talking my language," he responds.

"We talked about these ideas before, that when the group met in the card room after dinner, it could be a simple but nonreactive indicator that the group was getting together and enjoying each other's company," you say. "Even when they didn't play cards much, just about the time we were called in, there is still a rough indication that they are getting together and providing whatever mutual support they can. It isn't a perfect indicator by any means, but it's simple to collect and it goes right to the heart of the matter. So, we recorded the number of weekly sign-ups by Mrs. Abbott or any of the group. We were plotting these numbers on some graph paper just as you (Mike) came charging up.

"Moreover, I also went to the dietician and got some other records of Mrs. Abbott's meal-eating pattern. I was just in time; she was going to toss out some old records, so I have data for about three months before I started interning

here. I'll plot these data on nutrition as soon as I can."

"What about those several measures of depression you were thinking about?" Mike asks.

"We're making some progress on these too. But it took a bit of persuasion from my practicum instructor to get to use records from the Residence, since I needed some reliability checks as part of my research class project," you add.

Evaluation Designs (Chapters 13–18) (III.C.9.)

It was several days after the memorial service for Miss Carol that I asked Mrs. Abbott how the home aide arrangement was working, and she said all of the details had been ironed out among the various residents, herself, and the agency. And the home aides were set to come in Mondays. More residents were involved than Mrs. Abbott had expected, and some were on a waiting list, to see if there would be enough home aides to help them. But Mrs. Abbott seemed to rise to the occasion and got all the agreements in place. I asked to see what the plans looked like and how the residents were going to decide whether the program was a success. Mrs. Abbott said she had given a lot of thought to that, since there were so many people involved. First, she was going to circulate a little survey every so often to see if people were satisfied with their agency home aide services, compared to what help they were getting before. Then, she was going to find out what her close friends needed (she herself had put in some extra money in order to get the home aide to do some housework for her) and whether they thought that particular work was being done adequately. She paused and said that she should probably check in with her friends on these points reasonably often because things change so suddenly around the Residence.

"Brilliant, Mrs. Abbott," I thought. "You just passed the first exam in my research class with flying colors. An attitude survey and an impressionistic behavioral study, using a kind of *A-B* design (that is, a before and during intervention design) with multiple data collection

points" (see Chapter 13). I volunteered to assist her in designing the questionnaire and in being a bit more systematic in the behavioral study, and she readily agreed.

I am musing this over in the cafeteria when you and Mike come in. I proudly tell you about Mrs. Abbott's evaluation plans being the basic evaluation design we had studied last semester, and Mike frowns.

"Something wrong, Mike?" you ask.

"No, not really," he replies. "It's just that the *A-B* design tells us only part of the story, whether or not there is change in the target events. But it takes a stronger design to help us infer that what we did had a part in causing those changes. So long as we are doing the evaluation, we should probably try to use the strongest design that is suitable to this setting, and get both change information and causal information on whether we influenced that change."

Unfortunately, you ask Mike what those stronger designs are, but I glance at my watch. Mike takes the cue and says that it's too long a story to tell now, but that he is sure you would enjoy the various evaluation designs (see Chapters 14–18) when you got to them. "To set up the most powerful and yet least intrusive design is really the artistic part of the whole evaluation process," Mike muses.

"And the most ethical as well," I add. "We have to be very careful about being intrusive, but let's face it, to serve people can be somewhat intrusive. So, let's make the most of the time we have available with clients to get the best possible information to help them reach their goals and objectives."

PART IV. ANALYZING AND USING YOUR RESULTS: MAKING PRACTICE DECISIONS BASED ON EVALUATED PRACTICE IN THE CONTEXT OF THEORY AND ETHICS

Monitoring Progress, Annotating Graphs, and Modifying the Intervention (IV.A.8.)

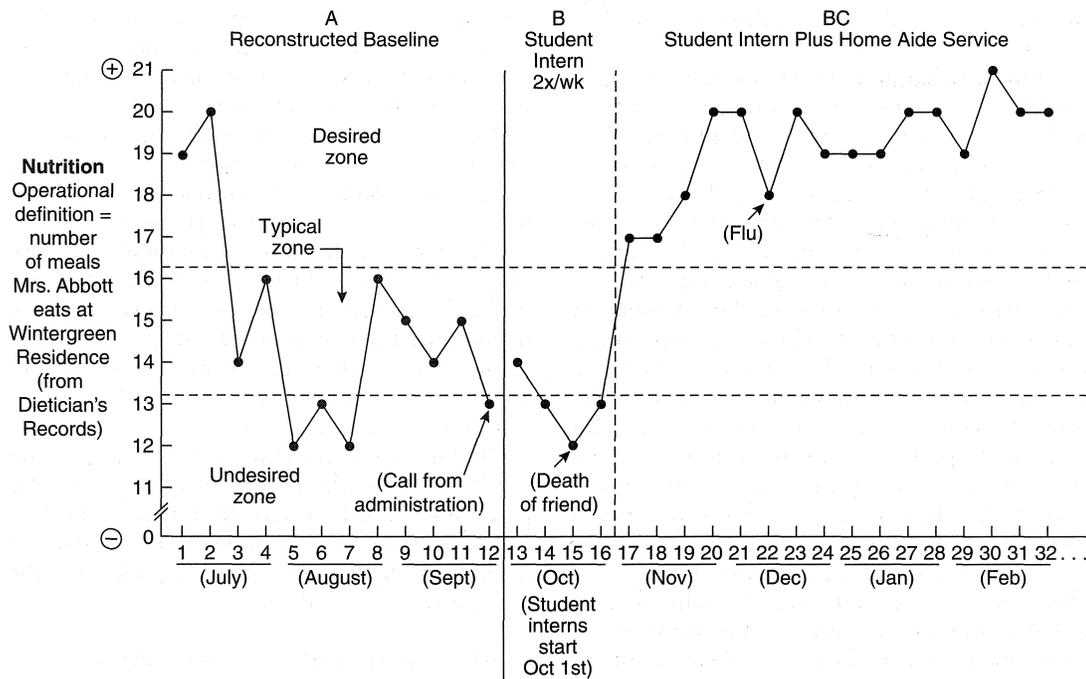One of the big surprises for me was watching the data as they came in, and trying to make sense of the patterns that were emerging. Our theories told us what to expect; this was, of course, the basis for our particular practice decisions. But nothing quite prepared us for monitoring progress. It must be a little like watching the stock market go up and down each day, which must be nerve-racking for compulsive investors. We learned to be a little patient and watch for patterns over time. We had the luxury of being patient because there were no life-threatening conditions that we were addressing. And when anything unusual appeared on the charts, we annotated those data. That is, we made notes on the graph paper of events that may account for the observed changes (e.g., see Figure P.2). So we continued our work and carefully watched the data for a number of weeks.

The point is, numbers tell a story—if we will listen. How does one become sensitive to these numbers that keep coming in, week after week? This was a new experience for us, and we spend some time discussing this. Mike, as usual, has some ideas:

"Let's look at the nutrition data," Mike says (see Figure P.2). "We have reconstructed the baseline from the dietician's records of the number of meals Mrs. Abbott had for the past three months before we arrived. We could have had more, but the dietician said that Mrs. Abbott's pattern of eating was very constant, as were the patterns of most residents—a very high level of coming to every meal. But that began to change about three months ago, and we transcribed those data onto our graphs as reconstructed baseline data."

"What does reconstructed data mean?" you ask.

I pipe in that most baseline data are collected concurrently with the targeted event we are studying, but sometimes that is impossible—for example, when no one ever thought about using standardized measures of depression when Mrs. Abbott wasn't having any problems. Fortunately for us, the nurses routinely collect information about all of the residents at Wintergreen, one portion of which is close to our understanding of depressed behavior. Because of this, we decide to use this nursing information as a rough indicator of depression to

Proportion of events in desired zone in baseline = .167 or 1/6 (2 out of 12; Table 19.3)

Number of events in desired zone observed in (the combined B and BC) intervention period = 16 out of 20

Number of events in desired zone needed in intervention period to constitute
statistical significance at the $P < .05$ level = 7
$P < .01$ level = 9

•• Graph shows significant change at the $P < .05$ level and $P < .01$ level; this analysis uses
the proportion/frequency approach (Ch. 22)

FIGURE P.2   Change in nutrition over several months.

give us a ballpark picture of what Mrs. Abbott was like during that time. That is, we reconstruct information collected for one purpose for use in another (our) purpose. It was the best we had at the time.

"Okay," you say. "Now what? I see that you have combined the two interventions: B is our regular two times a week meeting with our clients, and C is the home aide service. I presume you did that since they mostly occurred concurrently. Right?"

"Yes," Mike says.

"And looking at the data," you go on, "it looks like things continued to get worse in the first four weeks we were here—so much for our impact. Then, after the home aide service was

set up, Mrs. Abbott seems to have had a major turnaround. Just look at those data!"

"Yes, very encouraging," Mike says, "until week 22 when all of a sudden Mrs. Abbott's attendence at meals went down sharply. I began to wonder if something had gone wrong with the home aide service. I looked again at the data and then I noticed that you had annotated the graph that she got the flu that week and I interpreted this to mean that she didn't feel much like eating in the dining hall."

"More than that, Mike," I say. "I saw those data too, and I alerted the nurses, who then tried to persuade her to eat as much as she could, even in her room. Monitoring data

points" (see Chapter 13). I volunteered to assist her in designing the questionnaire and in being a bit more systematic in the behavioral study, and she readily agreed.

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"Something wrong, Mike?" you ask.

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Unfortunately, you ask Mike what those stronger designs are, but I glance at my watch. Mike takes the cue and says that it's too long a story to tell now, but that he is sure you would enjoy the various evaluation designs (see Chapters 14–18) when you got to them. "To set up the most powerful and yet least intrusive design is really the artistic part of the whole evaluation process," Mike muses.

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PART IV. ANALYZING AND USING YOUR RESULTS: MAKING PRACTICE DECISIONS BASED ON EVALUATED PRACTICE IN THE CONTEXT OF THEORY AND ETHICS

Monitoring Progress, Annotating Graphs, and Modifying the Intervention (IV.A.8.)

One of the big surprises for me was watching the data as they came in, and trying to make sense of the patterns that were emerging. Our theories told us what to expect; this was, of course, the basis for our particular practice decisions. But nothing quite prepared us for monitoring progress. It must be a little like watching the stock market go up and down each day, which must be nerve-racking for compulsive investors. We learned to be a little patient and watch for patterns over time. We had the luxury of being patient because there were no life-threatening conditions that we were addressing. And when anything unusual appeared on the charts, we annotated those data. That is, we made notes on the graph paper of events that may account for the observed changes (e.g., see Figure P.2). So we continued our work and carefully watched the data for a number of weeks.

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We know that isn't the whole story, but life is too short to spend collecting every possible relevant fact. So be happy for these simple graphs."

"Yes, but only if we selected the right simple graphs to use," I add. "You know, it may be that we are way off on one or another of these indicators and that we are not getting useful information at all."

"That's bad," you say. "So how do you protect yourself against choosing the wrong indicator?"

"I can think of one way," Mike says. "Remember, we have a whole set of factors, and they are expected to react with each other in predictable ways, according to our theory. One is supposed to go up, another down, and so forth. If one of these factors doesn't respond as expected, then we should examine it carefully to see if it is measuring the wrong thing."

"Is this what you mean by analysis of the data?" you ask.

"Essentially, yes," I say. "Analysis means looking at the pattern the data take and comparing it to something. Either standard norms, if we have any; or against some idealized goal; or just comparing the patterns of change from before to during or after intervention."

"That doesn't sound hard," you say.

"Well, no one can guarantee that," Mike confesses. "We can go in stages of analysis. Whatever else we do, we should just start by looking at the pattern of data as they appear on the graph. Here, look at Figure P.2. What do you see?"

"Wiggly lines," you report, too honestly.

"Yeah, yeah, but beyond that. What patterns?" Mike asks.

"Looks like things are getting worse during baseline," you observe.

"Right!" Mike says. "That's exactly so. And that is the reason that we became involved in the first place. Things were getting worse and there was no easy explanation or solution."

"Then things continue to get worse after we started working here," you observe.

"Let's not dwell on that," I request uncomfortably. "Let's say this is a kind of training period. We were trying to get Mrs. Abbott and the others used to the fact that we were here

and that we would be offering some ideas to them to facilitate changes."

"Moreover, you can see this is also the time when Miss Carol died, and Mrs. Abbott was quite upset about that, which may also account for why she didn't go to meals as often as she had before," Mike notes.

"Then, in the fourth week Mrs. Abbott starts to improve," you suggest.

"Maybe," Mike says. "That improvement could have been due to chance factors in the fourth week, but look at the data after that. Big changes and relatively steady improvement. That's what we like to see. That is also when the home aide service started, taking a big burden off Mrs. Abbott's mind."

"It is sort of like you guys are reading a sheet of notes and making beautiful music from it," you say.

"Sometimes the music isn't as harmonious as it is here," Mike comments. "In fact, it is sometimes hard to tell what is really an important change and what isn't. Statistical analysis may help us find the answers."

Descriptive Statistics (Chapter 21) (IV.C.10.b.)

Mike says, "Notice that we are going to need some basic arithmetic in order to analyze these data. Can you calculate means? Or proportions? We'll need proportions when it comes time to do one kind of analysis; it's called the proportion/frequency approach. Like, how many times did the behaviors appear in the desired behavior zone, as compared with the total number of observation times during that period? To get a proportion, you just divide the big number into the little number, like 9 divided by 12 is, ah, ..."

".75," you say. "I went as far as calculus in college."

"Sorry," Mike blushes. "I was just asking."

Tests of Statistical Significance (Chapter 22) (IV.C.10.c.)

"The real payoff of analysis," Mike quickly goes on, "is to find out how likely a given set of outcomes could have happened by chance

alone. When some outcome is very unlikely to occur by chance alone, and when we try to make that kind of outcome occur, we can test for statistical significance—that is, how common or how rare a given finding is. After that, we can make some interpretations about what that significance level means."

"That sounds hard," you admit.

"Not really," I say. "Once you get into a few good habits, it is quite easy to do. Mike is a computer buff, and he says he can do the same things much faster and more accurately using a computer analysis program in our textbook (Chapter 23). But it may be useful to learn the basics by hand, and then try your hand at the computer."

"Okay," you say, somewhat doubtfully. "Let's do the analysis on the nutrition data and see if the interventions caused Mrs. Abbott to eat more regular meals."

Mike and I look at each other. "Well, not so fast," I say gently. "This simple before and during evaluation design (*A-B*) is not strong enough to tell us whether the intervention *caused* the outcomes, or whether other factors that we didn't measure in fact caused the outcomes. All we can tell from this design is whether the problem really has changed. That's why we talked some time ago about different kinds of evaluation designs; some were more limited and others were stronger and thus able to provide causal information—whether what we did through the intervention in fact is the likely cause of some perceived outcome."

Mike takes it from there. "Look at the data on nutrition again." Mike then explains briefly the proportion/frequency approach to analysis. He describes the approach as if one were superimposing a normal curve over the data on the vertical line, and finding the middle two-thirds of the data points as representing the "typical" pattern of problematic behavior during the baseline period of 12 weeks. Then, by projecting those typical lines into the future (the intervention period), in effect we predict what will happen if nothing is changed. But of course, something is changed, namely, we intervened, and so we can look for patterns of change and see whether there is statistically significant improvement, including the chance

that matters may grow significantly worse. Mike shows you some models in the text (Chapter 13), and you seem to get the idea that if the pattern of data during intervention is "better" than the typical pattern of problem behavior in baseline, then we can claim real improvement. However, the simple *A-B* design that we are using can't permit us to infer causality—that we caused the positive results.

You look a bit puzzled when Mike starts pointing to the tables that he says tell us about statistical significance, but I suggest that you wait until you come to that chapter in the text to understand what Mike is saying. "It seems so easy when you do it," you say, and we agree. It really is easy once you get the hang of it.

Computer Analysis (Chapter 23) (IV.C.10.d.)

You and I wander back through the halls on the way out, and happen past the computer room. No one is there. "Say," you mention, "how about if we do some data analysis here with the various tables?"

I respond, "We can't do them here, because we would have to enter the program into a computer, and I don't know if there is enough capacity with these computers. They are primarily dedicated to e-mail and writing. But we could stop off at the university computer center and run some of these data."

Later, at the computer center, I bring up the program. "Then, all you do," I explain, "is follow the instructions on the screen, and the computer does all the work for you. Here, let me enter some data and then get a printout of the computer analysis."

"That looks like fun," you observe. "Where did you say I could read more about this?"

"In several chapters in the textbook," I reply. "And this same program can generate the graphs we drew by hand, and it can also construct the trend lines that we'll need as we analyze our data."

"Then, I'll bet I could use my laptop to do all of this at the Wintergreen on an ongoing basis," you suggest.

"Absolutely," I reply.

Selecting a Procedure for Analyzing Data (Chapter 24) (IV.C.10.e.)

Later, at school, we are looking at some printouts and begin to compare them with the work involved in visual analysis and the use of the tables of significance. "When you are all set up and have the data in the computer, the computer analysis makes a lot of sense," you say, "especially if you need to be formal about results for your instructor or for publication. But if you don't have that program available, especially on the spot at the Wintergreen, then it is useful just to do a quick visual analysis for clues on whether it is worth going further. The hand analysis using the tables seems reasonable, once you get used to the procedures. I am glad that the instructions are specified in the titles of those tables. So, I guess each method of analysis has its uses in certain places."

"Awesome," I exclaim. "You are a fast learner."

Comparing Goals and Objectives: Using Results to Test Practice Hypotheses (IV.A.9.)

The weeks went by with incredible speed; we were busy every moment and often exhilarated with field work and its outcomes. But the semester was coming to an end, and we had to pull all of our work together for the final evaluation/practice joint project.

You say, "I sure wish I had some models of how evaluation reports should be written." And Mike replies that there are hundreds of references to reports in the text. I happen to have some photocopies of a couple that I loaned you, including Jason & Brackshaw (1999); Staat, van Leeuwen, & Wit (2000); Kastner, Tingstrom, & Edwards (2000); and Austin, Alvero, & Olson (1998).

I'll tell you what I did, as an example. First, I went back to the practice hypotheses, which described in advance what we expected to happen. Our group hypothesis stated that the home aide service would increase the probability that the group could stay together at the Wintergreen, and thus maintain their friend-

ship and support of one another. We chose to use a simple, nonobtrusive indicator of the mutual support group being together, the sign-up sheets for the card room.

Looking at Figure P.3, which uses a proportion/frequency approach with the mutual support meetings, we observe that there was a statistically significant change in the attendance during the intervention period, compared with the projected pattern stemming from the baseline pattern. In statistical language, we can say, based on these data, that the improved attendance we observed could not have happened by chance alone, except 5 times in 100 occasions ($p < .05$).

I had two hypotheses specifically for Mrs. Abbott. The first was that her nutrition would improve, as indicated by her attendance at regularly scheduled meals in the dining room of the Wintergreen. We analyzed those data using the proportion/frequency model, and found a sharp improvement as compared with the baseline condition, enough to claim there was a statistically significant difference at the $p < .05$ level (see Figure P.2). But again, because of the limited logical properties of the design, we cannot assert that we caused this strong positive change with the intervention, and, of course, we really cannot distinguish the effects of the two interventions that we combined—the home aide service and our direct work as interns.

The second hypothesis for Mrs. Abbott concerned her signs of depression, as indicated in three ways. First, we used a standardized depression scale, which we could obtain only after we started interning at the Wintergreen. So we had no baseline, but we did have the norms of the scale in general, compared to the scores Mrs. Abbott got. There we observed positive change, comparing her scores with the norms for people who had scores indicating clinical depression.

Then, we also continued to use the monthly nursing rating of all residents, which included one indicator item that we used as our operational definition of depression, namely, level of social functioning, as interpreted on a five-point scale, with 1 meaning very poor, and 5 meaning very good. These were the only baseline data we had, and since we adapted them
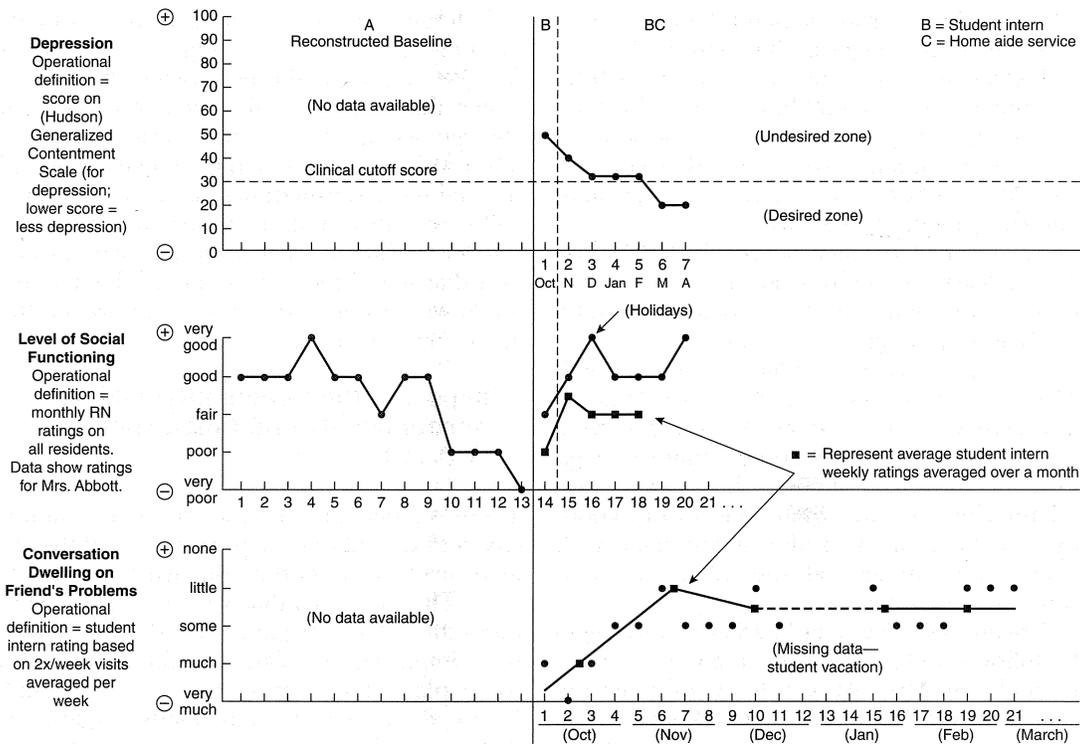
Mutual Support Operational definition = *M* number of sign-ups for card room per month (From Residence records)

Proportion of events in desired zone in the baseline = .06 or .05 using "conservative rule" (1 out of 15; Table 19.2)

Number of positive events in intervention period = 3 (3 out of 6)

Number of events needed in desired zone in the intervention period to constitute statistical significance at the $P < .05 = 2$
$P < .01 = 3$

•• Graph shows significant change at the $P < .05$ level and $P < .01$ level (Proportion/frequency approach; Ch. 22)

■ = Monthly intern data

FIGURE P.3   Mutual support.

from other original uses, we took them as a rough reconstructed baseline on Mrs. Abbott's state of mind. It showed reasonably high levels of functioning until a few months before we started at the Wintergreen, when she began to exhibit the behaviors that eventually led to a call to our agency for help. After the joint intervention of both of us (the interns, B, on the chart) and home aide services, C, we observe some improvements.

Finally, we also made some observational ratings twice each week as part of our regular meetings with clients (bottom graph in Figure P.4). These ratings were averaged weekly. The weekly ratings showed some improvements, but since no other data were collected weekly, we had to average these weekly data over a month-long period to be able to compare them with other depression data. Look at the middle graph in Figure P.4 where we added (with small boxes) the constructed monthly intern

data to compare those data with the monthly nursing data. We can see some closely correlated findings, but we always saw the client as lower in social functioning, that is, as more nearly depressed, than did the nurses. We don't know how to interpret such a discrepancy; it may be that we are simply less experienced than the nurses in the ranges of functioning of very old persons.

When we compare all three sets of depression data in Figure P.4, we find a general common pattern of improvement after the home aide services began. This is a useful finding as it suggests that as long as these basic needs are met, then the group probably can continue to function as a mutual support group. However because of the advanced ages of its members, we encouraged them to admit a few more members to their ranks as insurance against the inevitable

Overall, especially when we look at the pattern of positive changes across all three charts

FIGURE P.4   Charts of different perspectives on depression.

we can show evidence of some real improvements in outcomes over the baseline period (including reconstructed baselines). Not perfect, but we speculated that nothing would be perfect in an imperfect world. We are pretty pleased with ourselves, I must admit.

Decision Making: Combining Evaluation with Values and Practice Wisdom (IV.A.10.)

In the second semester, we were assigned other cases, including Mrs. Dunn, who continued to be morose after the death of her husband; our field instructor urged us to look at the data on Mrs. Abbott and our practice goals, and decide when we should terminate services. We recognized that the home aide service, especially with Mrs. Abbott monitoring it from the Wintergreen, was an ongoing service.

From the records, Mrs. Abbott was eating regularly; the dietician told us this was the norm for her, from her memory of Mrs. Abbott before the records we had gotten from her. And the Roaring Nineties (now with a number of younger 80-year-olds included) met almost every night, even if not all members met that regularly. It proved to be a self-sustaining group as well.

What we realized in this review of the cases was that we were acting on the basis of some empirical information. It may not have been the strongest empirical information, but it was reasonable, given the time and energy we had to put into it. "That's what single-system designs are all about," Mike almost shouted.

"Okay, so what's next?" you ask. "Are we going to drop Mrs. Abbott and the others just like that? According to my instructors, we should be planning some maintenance phase

where we help her to maintain these successes after we are no longer in the picture."

I agree, except in this situation, we will be working in the same building and can check on how things are going in a variety of ways. If need be, we might have some other contacts with Mrs. Abbott and the others to offer them encouragement or new ideas.

"That's like booster sessions," Mike says. "But at least we should make clear to Mrs. Abbott that we—or others at our agency—would be ready to step in again, if need be."

So, regretfully, we terminated service with Mrs. Abbott and her friends, as we took up new tasks with others at the Wintergreen. Mrs. Abbott had seen practitioners come and go over the years, and while we had a very good relationship, she was quite able to say good-bye. In fact, she was almost too busy with events and services at the Wintergreen to squeeze in time for me.

I realized too late that I hadn't made a regular follow-up plan, so I made it a point to drop in and see Mrs. Abbott frequently on my rounds at the Wintergreen. I did look at the nurse's reports on her and the others and was pleased to see that their progress was sustained.

PART V. SCIENTIFIC PRACTICE IN THE COMMUNITY: THE CHALLENGE (CHAPTER 25)

Report to the Agency: Adding to Practice Wisdom and to Our Personal Practice Repertoire (V.A.11.)

As part of our intern service, we were required to write up a report of our services to Mrs. Abbott and the group. This turned out to be quite easy because we had our field progress notes and also the graphs of the several variables we were following, especially with the annotations we had made that added flesh to the skeleton of events. We included the graphs and explanations, and received positive affirmation from agency personnel.

Whether or not we changed the world—or even the world at the Wintergreen—we cannot say. We did show the empirically based evidence that it appears that people's lives can change; we hope that our services and the home aides contributed to it. People we served seemed more satisfied; maybe we should have collected satisfaction measures to document this point. But we noted with our own satisfaction that many more residents of the Wintergreen were using home aides when we left the agency in the spring.

Report to the Community: Ethical Accountability and Cost-Benefits (V.B.11.)

There is a network of senior residences in our city, and we did make a presentation at the annual meeting, describing our work and its effects. The questions that we were asked were interesting. They began as accusations that we were imposing our plan onto the group, until we explained our process in greater detail. Funny, these were the same kinds of questions that you had raised in our team long before. Fortunately we had some reasonable answers.

However, the network seemed more interested in the cost figures we were able to present. Briefly, these involved the costs for supporting interns in general, plus the extra money needed to purchase home aide services when particular residents were not able to do so. These costs were to be compared with the benefits, tangible and intangible, from the project. First, more long-term residents were enabled to stay longer periods of time, which was very important to them and to the reputation of the Residence. They appeared to be healthier (until late in their lives) and much happier. This contentment with life at the Wintergreen became a prized possession in advertising for future residents, and a long waiting list was generated. We came away from this experience recognizing how applicable the single-system evaluation process was for a variety of concerns, as well as how alive and well were the many critical issues raised about this form of evaluation.

Report to the Profession: Adding to Applied Social Science Knowledge (V.C.11.)

The three of us did get our act together long enough to submit a proposal at the state National Association of Social Workers chapter conference to present a poster session, and it was accepted. So, about a year later, we three went to the conference and presented what we had done to a small group of interested people (mainly from nursing homes and senior residences). That was very stimulating. I am sure that we learned far more in constructing our presentation than most of the audience got in that short period of time. But it gave us a taste of what contributing to our professions could be like.

ADIOS, MRS. ABBOTT: TILL WE MEET AGAIN

I must tell you that when I was about to terminate with Mrs. Abbott, she was about to terminate with me. She was so busy with new projects. A Mrs. Alvarez was coming to the Residence, and she spoke almost no English. Mrs. Abbott met her when she came for an exploratory visit, and they got along very well—in hand signs. So, naturally, Mrs. Abbott started to learn Spanish. Adios, Mrs. Abbott. You have taught me much about human nature and have made me proud to be a helping professional.