PART I

OVERVIEW OF EVIDENCE-BASED PRACTICE

Chapter 1

INTRODUCTION TO EVIDENCE-BASED PRACTICE

You've started reading a book about research so you must have some free time. But aren't there other things you could do right now that are less onerous than reading about research? You could dust your office. You could make that overdue visit to your dentist. Or maybe listen to a Barry Manilow CD. Okay, okay, not Barry Manilow! But read about research? What compelled you to do that?

Actually, that's a rhetorical question because I think I know the answer, and I'm just trying to connect with you. Start where the reader (i.e., the client) is at, as it were—sort of like building a therapeutic alliance. My hunch is that you're reading this book because there is significant pressure these days on practitioners to engage in **evidence-based practice (EBP),** which implies (in part) using research findings to guide their practice decisions. If you are like most of the practitioners I know, you probably resent that pressure. But it's a reality you must deal with, and perhaps by reading this book you'll be better prepared to deal with it on your terms. That is, by learning more about how to utilize and appraise EBP research, you'll be better equipped to understand, question, or negotiate with others—like managed care companies—who cite EBP as the

reason they think they know better than you do what you should do in your practice.

Although the term *evidence-based practice* has become fashionable only recently, the main ideas behind it are really quite old. As early as 1917, for example, in her classic text on social casework, Mary Richmond discussed the use of research-generated facts to guide the provision of direct clinical services as well as social reform efforts.

Also quite old is the skepticism implicit in EBP about the notion that your practice experience and expertise—that is, your practice wisdom—are a sufficient foundation for effective practice. That skepticism does not imply that your practice experience and expertise are irrelevant and unnecessary—just that they *alone* are not enough.

Perhaps you don't share that skepticism. In fact, it's understandable if you even resent it. Many decades ago, when I first began learning about clinical practice, I was taught that to be an effective practitioner I had to believe in my own effectiveness as well as the effectiveness of the interventions I employed. Chances are that you have learned this, too, either in your training or through your own practice experience. It stands to reason that clients will react differently depending on whether they are being served by practitioners who are skeptical about the effectiveness of the interventions they provide versus practitioners who believe in the effectiveness of the interventions and are enthusiastic about them.

But it's hard to maintain optimism about your effectiveness if influential sources—like research-oriented scholars or managed care companies—express skepticism about the services you provide. I first encountered such skepticism long ago when my professors discussed a notorious research study by Eysenck (1952), which concluded that psychotherapy was not effective (at least not in those days). Although I later encountered various critiques of Eysenck's analysis that supported the effectiveness of psychotherapy, maintaining optimism was not easy in the face of various subsequent research reviews that shared Eysenck's conclusions about different forms of human services (Fischer, 1973; Mullen & Dumpson, 1972). Those reviews in part helped usher in what was then called an *age of accountability*—a precursor of the current EBP era.

The main idea behind this so-called *age* was the need to evaluate the effectiveness of all human services. It was believed that doing so would help the public learn "what bang it was getting for its buck" and in turn lead to discontinued funding for ineffective programs and continued funding for effective ones. Thus, this era was also known as the *program evaluation movement.* It eventually became apparent, however, that many of the ensuing evaluations lacked credibility due to fatal flaws in their research designs and methods—flaws that often stemmed from biases connected to the vested interests of program stakeholders. Nevertheless, many scientif-

ically rigorous evaluations were conducted, and many had encouraging re-
sults supporting the effectiveness of certain types of interventions.

In addition to studies supporting the effectiveness of particular inter-
vention modalities, perhaps most encouraging to clinicians were studies
that found that one of the most important factors influencing service ef-
fectiveness is the quality of the practitioner-client relationship. Some
studies even concluded that the quality of practitioners' clinical relation-
ship skills has more influence on treatment outcome than the choices
practitioners make about what particular interventions to employ. Al-
though that conclusion continues to be debated, as the twenty-first cen-
tury dawned, mounting scientific evidence showed that practitioner
effectiveness is influenced by both the type of intervention employed
and relationship factors (Nathan, 2004).

EMERGENCE OF EVIDENCE-BASED PRACTICE

The accumulation of scientifically rigorous studies showing that some
interventions appear to be more effective than others helped spawn the
EBP movement. In simple terms, the EBP movement encourages and
expects practitioners to make practice decisions—especially about the
interventions they provide—in light of the best scientific evidence avail-
able. In other words, practitioners might be expected to provide inter-
ventions whose effectiveness has been most supported by rigorous
research and to eschew interventions that lack such support—even if the
latter interventions are the ones with which they have the most experi-
ence and skills.

In the preceding paragraph, I used the words *in light of* the best scien-
tific evidence, instead of implying that the decisions had to be dictated by
that evidence. That distinction is noteworthy because some mistakenly
view EBP in an overly simplistic cookbook fashion that seems to disre-
gard practitioner expertise and practitioner understanding of client values
and preferences. For example, EBP is commonly misconstrued to be a
cost-cutting tool used by third-party payers that uses a rigid decision-tree
approach to making intervention choices irrespective of practitioner
judgment. Perhaps you have encountered that view of EBP in your own
practice when dealing with managed care companies that have rigid rules
about what interventions you must employ as well as the maximum num-
ber of sessions that will be reimbursed. If so, you might fervently resent
the EBP concept, and who could blame you! Many practitioners share
that resentment.

Managed care companies that interpret EBP in such overly simplistic
terms can pressure you to do things that your professional expertise leads
you to believe are not in your clients' best interests. Moreover, in a seeming

disregard for the scientific evidence about the importance of relationship factors, managed care companies can foster self-doubt about your own practice effectiveness when you do not mechanically provide the interventions on their list of what they might call "evidence-based practices." Such doubt can hinder your belief in what you are doing and in turn hinder the more generic relationship factors that can influence client progress as much as the interventions you employ.

DEFINING EVIDENCE-BASED PRACTICE

The foregoing, overly simplistic view of EBP probably emanated from the way it was defined originally in medicine in the 1980s (Barber, in press; Rosenthal, 2006). Fortunately, the revised definition of EBP now prominent in the professional medical literature (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000) as well as the human service professions literature (Rubin & Babbie, 2008) incorporates practitioner judgment and client values and preferences. The more current and widely accepted definition shows that managed care companies or other influential sources are distorting EBP when they define it as merely a list of what intervention to use automatically for what diagnosis, regardless of your professional expertise and special understanding of idiosyncratic client characteristics and circumstances.

The current definition of EBP incorporates two overarching perspectives:

1. EBP is a *process* that includes locating and appraising credible evidence as a part of practice decisions.
2. EBP is a way to designate certain *interventions* as empirically supported under certain conditions.

Although a comprehensive definition of EBP combines these two perspectives, various influential sources define EBP in terms of only one of the two perspectives. For example, as noted previously, some managed care companies or government agencies define EBP solely in terms of the intervention perspective—that is, they will call your practice *evidence based* only if you are providing a specific intervention that appears on their list of interventions whose effectiveness has been supported by a sufficient number of rigorous experimental outcome evaluations to merit their "seal of approval" as an evidence-based intervention. In addition, a recent survey found a great deal of disparity among faculty members as to whether they define EBP solely in terms of the process perspective, solely in terms of the intervention perspective, or (more correctly) in terms of a combination of the two perspectives (Rubin & Parrish, 2007).

Incorporating practitioner expertise and patient values in the revised definition signifies that EBP is more than a static list of interventions that have a "seal of approval" and thus should be provided by clinicians even when clinician knowledge about client idiosyncrasies suggests that an approved intervention appears to be contraindicated. The revised definition also is more consistent with the scientific method, which holds that all knowledge is provisional and subject to refutation. The older, more mechanistic view of EBP solely in terms of a list of approved interventions conflicts with the view that, in science, knowledge is constantly evolving. Indeed, at any moment a new study might appear that debunks current perceptions that a particular intervention has the best empirical support. Rather than feel compelled to adhere to a list of approved interventions that predates such a new study, practitioners should be free to engage in an EBP *process* that enables them to critically appraise and be guided by *emerging* scientific evidence.

A comprehensive definition of EBP—one that is more consistent with definitions that are prominent in the current human service professions literature—is:

> EBP is a process for making practice decisions in which practitioners integrate the best research evidence available with their practice expertise and with client attributes, values, preferences, and circumstances. When those decisions involve selecting an intervention to provide, practitioners will attempt to maximize the likelihood that their clients will receive the most effective intervention possible in light of the following:
>
> - The most rigorous scientific evidence available;
> - Practitioner expertise;
> - Client attributes, values, preferences, and circumstances;
> - Assessing for each case whether the chosen intervention is achieving the desired outcome; and
> - If the intervention is not achieving the desired outcome, repeating the process of choosing and evaluating alternative interventions.

Figure 1.1 shows the original EBP model, illustrating the integration of current best evidence, practitioner expertise, and client values and expectations. Unlike misconceptions of EBP that characterize it as requiring practitioners to mechanically apply interventions that have the best research evidence, Figure 1.1 shows EBP residing in the shaded area, where practice decisions are made based on the intersection of the best evidence, practitioner expertise, and client values and expectations. In discussing this diagram, Shlonsky and Gibbs (2004) observe:

> None of the three core elements can stand alone; they work in concert by using practitioner skills to develop a client-sensitive case plan that utilizes

Figure 1.1   Original EBP Model
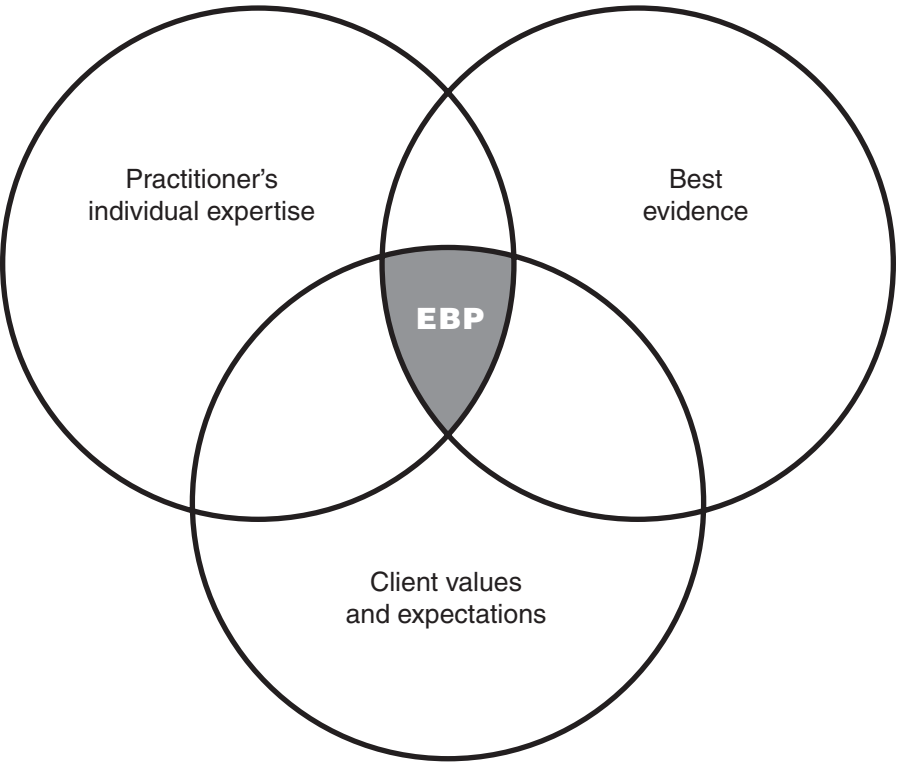
interventions with a history of effectiveness. In the absence of relevant evidence, the other two elements are weighted more heavily, whereas in the presence of overwhelming evidence the best-evidence component might be weighted more heavily. (p. 138)

Figure 1.2 represents a newer, more sophisticated diagram of the EBP model (Haynes, Devereaux, & Guyatt, 2002). In this diagram, practitioner expertise is shown not to exist as a separate entity. Instead, it is based on and combines knowledge of the client's clinical state and circumstances, the client's preferences and actions, and the research evidence applicable to the client. As in the original model, the practitioner skillfully blends all of the elements at the intersection of all the circles, and practice decisions are made in collaboration with the client based on that intersection.

Figure 1.3 illustrates how the diagram in Figure 1.2 is implemented sequentially as a cyclical process with an individual client, not as a one-time application of an "approved" intervention (Mullen, Shlonsky, Bledsoe, & Bellamy, 2005). The practitioner's knowledge of current best evidence is
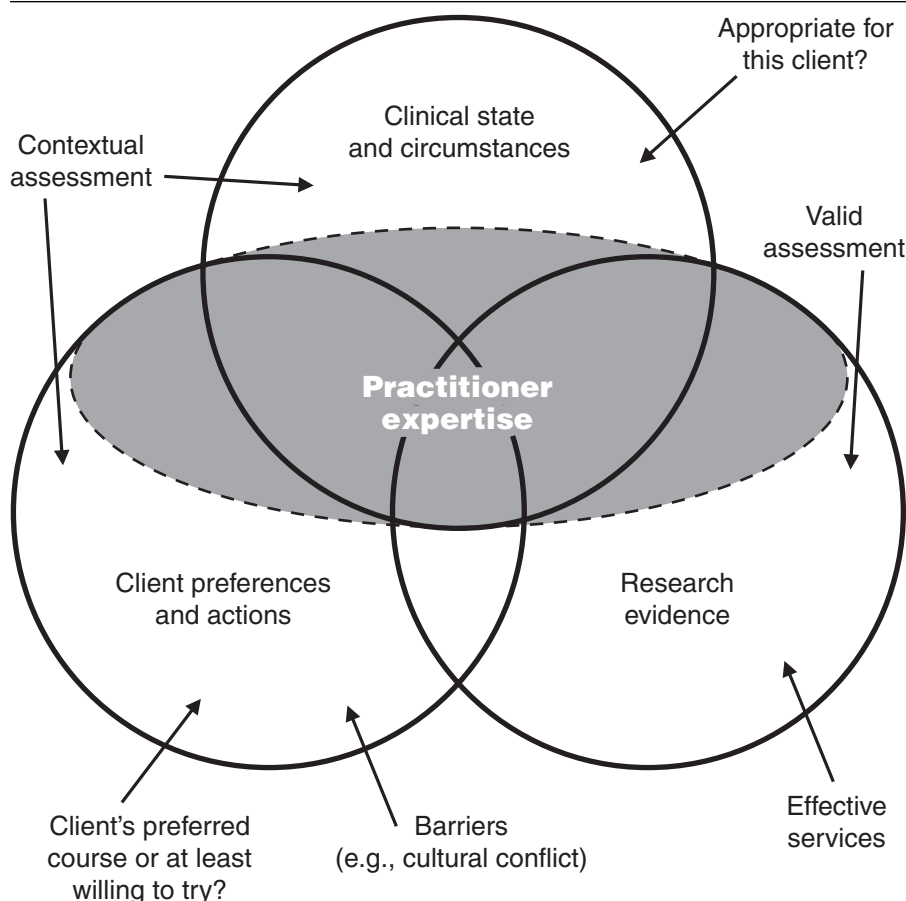
Figure 1.2   Newer EBP Model
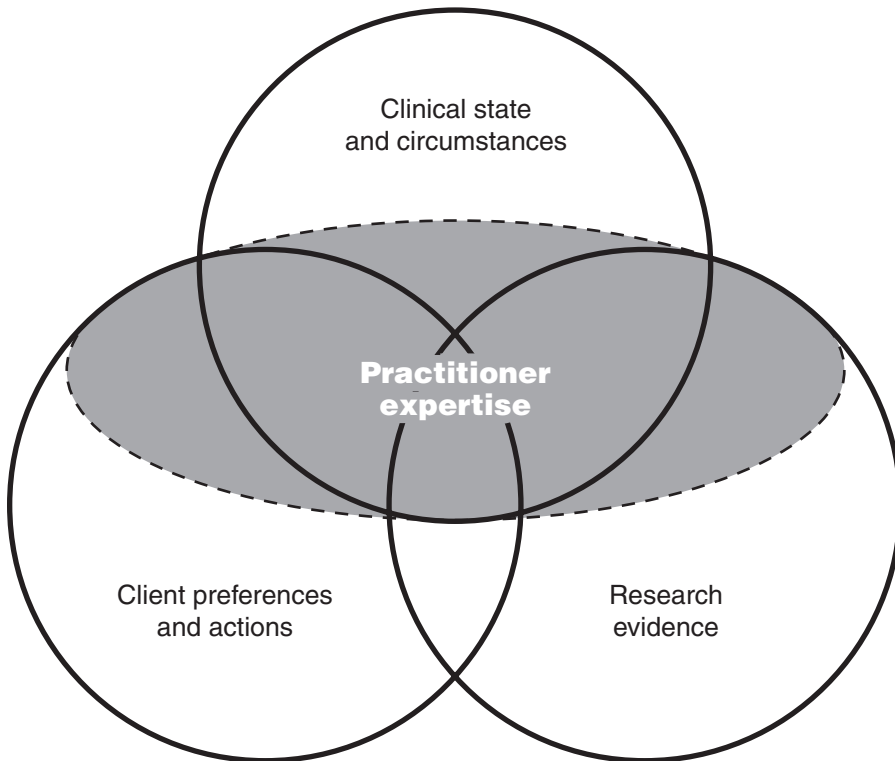
Source: "Physicians' and Patients' Choice in Evidence-Based Practice," by R. Haynes, P. Devereaux, and G. Guyatt, 2002, *British Medical Journal, 324,* p. 1350. Reprinted with permission.

the start of the cycle. Two types of evidence are relevant: (1) evidence about the best (most valid) tools for assessing client problems and needs, and (2) evidence about the most effective services pertaining to those problems and needs. The practitioner then draws on his or her practice expertise in integrating that evidence with information from the other two circles. Moving clockwise, the practitioner decides whether a particular course of action would be appropriate for the particular client, and if not, the cycle begins anew.

The cyclical process of EBP can be conceptualized as involving the following five steps: (1) question formulation, (2) searching for the best evidence to answer the question, (3) critically appraising the evidence, (4) selecting an intervention based on a critical appraisal of the evidence and integrating that appraisal with practitioner expertise and awareness of the client's preferences and clinical state and circumstances, and (5) monitoring client progress. Depending on the outcome observed in the fifth step, the cycle may need to go back to an earlier step to seek an intervention that

Figure 1.3   The Cycle of EBP

Appropriate for
this client?

Clinical state
and circumstances

Contextual
assessment

Valid
assessment

**Practitioner
expertise**

Client preferences
and actions

Research
evidence

Client's preferred
course or at least
willing to try?

Barriers
(e.g., cultural conflict)

Effective
services

Adapted from "From Concept to Implementation: Challenges Facing Evidence-Based Social Work," by E. J. Mullen and A. Shlonsky, 2004, Setember, Paper presented at Faculty Research and Insights: A Series Featuring CUSSW Faculty Research, New York, NY. Retrieved December 15, 2006, from www.columbia.edu/cu/musher/EBP%20Resources.htm.

might work better for the particular client, perhaps one that has less evidence to support it but which might nevertheless prove to be more effective for the particular client in light of the client's needs, strengths, values, and circumstances. Chapter 2 examines each of these five steps in more detail.

As is implicit in the previous definition and model, EBP decisions are not necessarily limited to questions about the effectiveness of specific interventions. Practitioners might want to seek evidence to answer many other types of practice questions. For example, they might seek evidence about client needs, what measures to use in assessment and diagnosis, when inpatient treatment or discharge is appropriate, understanding cultural influences on clients, determining whether a child should be placed in foster care, and so on.

EVIDENCE-BASED PRACTICE IS NOT RESTRICTED TO CLINICAL DECISIONS

Much of the literature on EBP focuses on the clinical level of practice. However, EBP pertains to decisions made at other levels of practice, as well, such as decisions about community interventions, administrative matters, and policy. Much of the EBP literature focuses on health care policy. An excellent book on that topic, by Muir Gray (2001), is *Evidence-Based Healthcare: How to Make Health Policy and Management Decisions.*

For example, one common area of inquiry regarding evidence-based health care policy pertains to the impact of *managed care*—a term referring to various approaches that try to control the costs of health care. The main idea is for a large organization (such as a health insurance company or a health maintenance organization) to contract with service providers who agree to provide health care at reduced costs. Health care providers are willing to meet the reduced cost demands so that more clients covered under the managed care plan will use their services.

Managed care companies also attempt to reduce costs by agreeing to pay only for the type and amount of services that they consider necessary and effective. Consequently, health care providers may feel pressured to provide briefer and less costly forms of treatment. Trujillo (2004, p. 116), for example, reviewed research on the EBP question: "Do for-profit health plans restrict access to high-cost procedures?" He found no evidence to indicate that patients covered by for-profit managed care plans are less likely to be treated with high-cost procedures than patients covered by nonprofit managed care plans.

Countless hours could be spent trying to list every possible EBP-related question. For now, however, let's focus primarily on EBP decisions about selecting and evaluating interventions in our efforts to maximize treatment effectiveness. Those decisions are most prominent in the EBP literature and in dealing with managed care companies. In later chapters, we examine how to utilize research to answer some of the other types of practice questions.

DEVELOPING AN EVIDENCE-BASED PRACTICE PROCESS OUTLOOK

Becoming an evidence-based practitioner does not begin just by implementing the phases of the EBP process, phases that we examine more thoroughly in Chapter 2. To implement the process successfully, practitioners might have to change the way they have been influenced to think about practice knowledge. For example, relatively inexperienced practitioners typically work in settings where more experienced practitioners

and supervisors generally do not value research evidence as a basis for making practice decisions. In their own practice as well as in their influences on newer practitioners, older and more experienced practitioners are likely to resist notions that they should be influenced by such evidence to change the way they intervene (Sanderson, 2002). These practitioners—including many who provide practicum training in professional education—may have been trained and feel proficient in only a small number of treatment approaches—approaches that may not be supported by the best evidence. Not only might they be dogmatically wedded to those approaches, research evidence might have little credibility in influencing them to reconsider what they do. Instead, they might be much more predisposed to value the testimonials of esteemed practitioner colleagues or luminaries renowned for their practice expertise (Bilsker & Goldner, 2004; Chwalisz, 2003; Dulcan, 2005; Sanderson, 2002).

Critical Thinking

Gambrill (1999), for example, contrasts EBP with *authority-based practice.* Rather than rely on testimonials from esteemed practitioner authorities, EBP requires *critical thinking.* Doing so means being vigilant in trying to recognize testimonials and traditions that are based on unfounded beliefs and assumptions—no matter how prestigious the source of such testimonials and no matter how long the traditions have been in vogue in a practice setting. Although it is advisable for practitioners—especially inexperienced ones—to respect the "practice wisdom" of their superiors, if they are critical thinkers engaged in EBP, they will not just blindly accept and blindly conform to what esteemed others tell them about practice and how to intervene—solely on the basis of authority or tradition.

In addition to questioning the logic and evidentiary grounds for what luminaries might promulgate as practice wisdom, critical thinkers engaged in EBP will want to be guided in their practice decisions by the best scientific evidence available. If that evidence supports the wisdom of authorities, then the critical thinkers will be more predisposed to be guided by that wisdom. Otherwise, they will be more skeptical about that wisdom and more likely to be guided by the best evidence. By emphasizing the importance of evidence in guiding practice, practitioners are thus being more scientific and less authority based in their practice.

A couple of critical thinking experiences in my practice career illustrate these points. When I was first trained in family therapy many decades ago, I was instructed to treat all individual mental health problems as symptomatic of dysfunctional family dynamics and to try to help families see the problems as a reflection of sick families, not sick individuals. This instruction came from several esteemed psychiatrists in a prestigious psychiatric training institute and from the readings and films they provided—readings

and films depicting the ideas and practice of other notable family therapists. When I asked one prestigious trainer what evidence existed as to the effectiveness of the intervention approaches being espoused, he had none to offer. Instead, he just rubbed his beard and wondered aloud about what personal dynamics might be prompting me to need such certainty.

As a green trainee, his reaction intimidated me, and I said no more. However, shortly after concluding my training, various scientifically rigorous studies emerged showing that taking the approach espoused in my training is actually harmful to people suffering from schizophrenia, as well as to their families. Telling families that schizophrenia is not an individual (and largely biological) illness, but rather a reflection of dysfunctional family dynamics, makes things worse. It makes family members feel culpable for causing their loved one's illness. In addition to the emotional pain induced in family members, this sense of culpability exacerbates the negatively charged emotional intensity expressed in the family. People suffering from schizophrenia have difficulty tolerating this increased negative emotional intensity and are more likely to experience a relapse as a result of it. Thus, the authorities guiding my training were wrong in their generalizations about treating *all* mental health problems as a reflection of sick families.

Much later in my career, after many years of teaching research, I decided to try my hand at practice again by volunteering in my spare time as a therapist at a child guidance center, working with traumatized children. The long-standing tradition at the center was to emphasize nondirective play therapy. Being new to play therapy, I began reading about it and learned that there were directive approaches to it as well. I then asked one of the center's psychologists about her perspective on directive play therapy. She responded as if I had asked for her opinion on the merits of spanking clients. "We never take a directive approach here!" she said with an admonishing tone in her voice and rather snobby facial expression. Once again, I was intimidated. But I kept searching the literature for studies on play therapy and found several studies supporting the superior effectiveness of directive approaches for traumatized children. Although more research in this area is needed, what I found showed me that there was no basis for the psychologist's intimidating reaction to my question. Instead, there was a good scientific basis for the center to question its long-standing tradition, at least in regard to treating traumatized clients.

Evidence-Based Practice as a Client-Centered, Compassionate Means, Not an End unto Itself

My experiences illustrated that being scientific is not an end unto itself in EBP. More importantly, it is a means. That is, proponents of EBP don't urge practitioners to engage in the EBP process just because they want

them to be scientific. They want them to be more scientifically oriented and less authority based because they believe that being evidence based is the best way to help clients. In that sense, EBP is seen as both a client-centered and compassionate endeavor.

Imagine, for example, that you have developed some pain from over-doing your exercising. You've stopped exercising for several weeks, but the pain does not subside. So you ask a few of your exercise companions if they know of any health professionals who are good at treating the pain you are experiencing. One friend recommends an acupuncturist who will stick needles in you near various nerve endings. The other recommends a chiropractor who will manipulate your bones and zap you with a laser device. On what grounds will you choose to see either or neither of these professionals? My guess is that before you subject yourself to either treatment you'll inquire as to the scientific evidence about its potential to cure you or perhaps harm you. You'll do so not because you worship science as an end unto itself, but because you want to get better and not be harmed.

Needless to say, you have some self-compassion. What about the compassion of the two professionals? Suppose you make a preliminary visit to each one to discuss what they do before you decide on a treatment. Suppose you ask them about the research evidence regarding the likelihood that their treatment will help you or harm you. Suppose one pooh-poohs the need for research studies and instead says he is too busy to pay attention to such studies—too busy providing a treatment that he has been trained in and that he believes in. Suppose the other responds in a manner showing that she has taken the time to keep up on all the latest studies. I suspect that because the latter professional took the time and effort to be evidence based you would perceive her to be more compassionate.

But human service interventions, such as alternative forms of psychotherapy, don't involve poking people with needles, manipulating their bones, or zapping them with lasers. At least not yet! If you are familiar with such controversial treatments as touch field therapy or rebirthing therapy, you might wonder what's next. You might also have read about a child's death that resulted from rebirthing therapy (Crowder & Lowe, 2000). But human service interventions can be harmful without causing physical damage. For example, the studies I alluded to in discussing my family therapy training found that certain intervention approaches for schizophrenia had unintended harmful effects. Instead of increasing the amount of time between relapses of schizophrenia, they decreased it (Anderson, Reiss, & Hogarty, 1986; Simon, McNeil, Franklin, & Cooperman, 1991).

Moreover, providing an ineffective intervention to people who are suffering—even if that intervention does not make matters worse—is harmful if we miss the opportunity to have alleviated their suffering with an available intervention that has been scientifically shown to be more effective.

Evidence-Based Practice and Professional Ethics

Thus, developing an EBP outlook is not just about science; it is about being more client centered, more compassionate, and even more ethical. Why ethical? Because, as you probably already have observed in your profession's code of ethics, ethical practice involves keeping up on the scientific evidence as part of trying to provide your clients with the most effective treatment possible. For example, the "Code of ethics" of the National Association of Social Workers (1999) specifically requires social workers to include evidence-based knowledge in guiding their practice. It further states that practitioners have an ethical obligation to "fully utilize evaluation and research evidence in their professional practice" (5.02).

EASIER SAID THAN DONE

Being scientific and evidence based is a lot easier said than done. In Chapter 2, we examine various feasibility constraints practitioners face in trying to engage in the EBP process. For now, let's just note two problems. One problem is that searching for and finding the best scientific evidence to guide practice decisions can be difficult and time consuming. Another problem is that even when you find the best evidence, it may not easily guide your practice decisions. Perhaps, for example, equally strong studies reach conflicting conclusions. In the vast literature evaluating the effectiveness of exposure therapy versus eye movement desensitization and reprocessing (EMDR) therapy in treating posttraumatic stress disorder (PTSD), for example, there are approximately equal numbers of rigorous clinical outcome experiments favoring the effectiveness of exposure therapy over EMDR and favoring EMDR over exposure therapy (Rubin, 2003).

Some searches will fail to find any rigorous studies that clearly supply strong evidence supporting the effectiveness of a particular intervention approach. Perhaps, instead, you find many seriously flawed studies, each of which supports the effectiveness of a different intervention approach. Some searches might just find what interventions are ineffective. (At least those searches might help guide you in deciding what *not* to do.)

Some searches might find the best scientific evidence supports an intervention approach that doesn't fit some aspect of your practice situation. Although exposure therapy and EMDR both have strong evidence for their effectiveness in treating PTSD, for example, some clients refuse to participate in them because they fear that the treatment process will be too painful in requiring them to recall and discuss the details of the trauma or perhaps visit places in vivo that resemble the site of the trauma. (Clinicians often succeed in helping clients surmount their fears of these therapies, but this is not always the case.)

Likewise, some interventions with the best evidence might never have been evaluated with a population of clients like yours, and your clients

might have attributes that in some important ways are not like the attributes of those clients who participated in the evaluations. Suppose, for example, you reside in Alaska and want to start a program to treat Native Alaskan girls who have been victims of physical or sexual abuse and who suffer from PTSD. If you search the literature for effective treatments for PTSD, you are likely to find the best evidence supports the effectiveness of interventions such as exposure therapy, EMDR, or cognitive restructuring. I say the "best" evidence because those interventions are likely to have been supported by the most scientifically rigorous outcome evaluations. However, in a search that I recently completed in preparing for a talk on EBP that I presented in Anchorage, Alaska, I found no rigorous evaluations of the foregoing evaluations in which Native Alaskans participated.

I did, however, find numerous articles discussing the high prevalence of comorbidity with substance abuse among physically or sexually abused Native Alaskan girls. That illustrates another difficulty. Most of the evaluations offering the best evidence regarding the effectiveness of these treatments have excluded participants whose PTSD was comorbid with substance abuse. Thus, you would face a double whammy in trying to develop your treatment program based on the best evaluations. You would have serious doubts as to whether the findings of those studies can be generalized to Native Alaskan girls or girls with comorbidity. Even if the ethnicity issue didn't matter, the comorbidity issue might matter a great deal.

Even if you can't find the best sorts of evidence supporting the effectiveness of an intervention with clients just like yours, you still can operate from an EBP framework. One option would be to look for less rigorous evaluations that have involved clients like yours and which—while not offering the best evidence from a scientific standpoint—are not fatally flawed and thus offer some credible evidence supporting a particular intervention. If that option doesn't pan out, an alternative would be to use your practice judgment in deciding whether an intervention supported by the best evidence with clients unlike yours seems to be worth proposing to your client. If you monitor client progress (or lack thereof) during your client's treatment, you can change course if the intervention is not achieving the desired result. In the next chapter, as we examine the steps in the EBP process, you will continue to see the importance of your practice expertise and idiosyncratic client circumstances and preferences in that process.

KEY CHAPTER CONCEPTS

- Although the term *evidence-based practice* is new, its underlying ideas are quite old.
- One of the most important factors influencing service effectiveness is the quality of the practitioner-client relationship.

- EBP is a process for making practice decisions in which practitioners integrate the best research evidence available with their practice expertise and with client attributes, values, preferences, and circumstances.
- Some misconstrue EBP in an overly simplistic cookbook fashion that seems to disregard practitioner expertise and practitioner understanding of client values and preferences.
- EBP is more than a static list of approved interventions that should be provided by practitioners even when practitioner knowledge about client idiosyncrasies suggests that an approved intervention appears to be contraindicated.
- Unlike authority-based practice that relies on testimonials from esteemed practitioner authorities, EBP requires critical thinking.
- Critical thinking involves the ability to spot unfounded beliefs and assumptions and to inquire about the logic and evidence supporting them.
- Developing an EBP outlook is not just about science; it is about being more client centered, more compassionate, and more ethical.

Review Exercises

1. *Before reading Chapter 1, had you encountered colleagues using the term* evidence-based practice? *If yes, how did they characterize it? Did they portray it in a manner that is consistent with the way it is defined in Chapter 1? If not, what would you tell them to improve their perception of, and perhaps their attitude about, evidence-based practice?*
2. *Try to recall a situation in your education, in-service training, or interactions with colleagues when someone espoused a particular intervention or practice idea based on authority or tradition. How did you react? Why did you react that way? To what extent was your reaction based on critical thinking? In light of what you have read in Chapter 1, how would you react now in a similar situation. Why would you react that way?*
3. *Think of a client you have worked with. Using the shaded area in Figure 1.1, identify elements of each of the three circles that would fit the shaded area with respect to that client, your expertise, and any evidence you are aware of regarding an intervention that fits that client.*

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