



# 1

## Outcome-Informed Practice in Practice

### Two Case Examples



Advancing Core Competencies in This Chapter				
☒ Professional Identity	■ Ethical Practice	☒ Critical Thinking	☒ Diversity in Practice	■ Human Rights & Justice
☒ Research-Based Practice	☒ Human Behavior	■ Policy Practice	☒ Practice Contexts	☒ Engage, Assess, Intervene, Evaluate

In this chapter, we illustrate outcome-informed evidence-based practice using two cases. These two cases illustrate the basic elements of outcome-informed practice. They also provide concrete real-world contexts for formally introducing the concepts of outcome-informed practice in Chapter 2, and we hope that these cases bring these concepts alive.

As you read the following two cases, you might make note of several issues:

- Describe the specific steps taken to enhance the social workers' understanding of their clients' problems and goals. You might recognize steps that you have used in your own work with clients, as well as some you have not used.
- Think about how the social workers' interventions in these cases might be different if they did not take those specific steps. In particular, look at how the social workers monitor their clients' problems during intervention. Do you see specific intervention decisions and actions based on that monitoring that would be possible without this monitoring? Do you think the clients' outcomes would be different, either for better or for worse?

## CASE 1: A FOSTER CHILD'S PROVOCATIVE BEHAVIOR

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Sandra, a 16-year-old who was sexually abused for 7 years until she was placed in foster care 2 years ago, has lived with the Grant family for 6 months. The foster family has consulted an agency social worker because of Sandra's provocative behavior toward her foster father. (She was removed from her first foster home for this reason.) Sandra, her social worker, Gayle, and the foster parents, Diane (age 35) and Greg (age 34), meet in Gayle's office. The couple also has a 2-year-old daughter, Emily. Gayle serves as Sandra's case manager, organizing and managing Sandra's services from various providers, monitoring Sandra's progress in therapy in collaboration with the therapist, and acting as liaison with the court and Sandra's birth parents.

### Session 1

Gayle begins the assessment by asking the foster parents to explain what they mean by *provocative behavior*. Together, Diane and Greg produce this list of problematic behaviors:

- Sandra often walks around the house in just a bath towel or skimpy pajamas, even though she's been asked to wear a robe.
- Sandra kisses Greg on the mouth, sits on his lap, often when scantily dressed, and rubs against him unnecessarily.
- Sandra's tone of voice is often suggestive when she speaks to Greg. (The adults have a hard time describing what they mean by this, so Diane role-plays some examples.)
- Sandra makes racy jokes and comments to Greg.
- Sandra exhibits these behaviors both when Diane is present and when she is not.

When prompted by Gayle, both foster parents agree that Sandra's behavior in other ways is good. She is obedient, is loving and protective of Emily, and does her chores and homework without complaint. Both Diane and Greg have talked to Sandra about these problems before, but she claims not to understand what they mean. "That's just me," she says in the session. "I just sound flirty. I'm not trying to come on to Greg, for heaven's sake! He's my dad now!" She states that, as far as she is concerned, there are no problems between her and her foster parents.

Gayle asks all family members to state their goals. Both Diane and Greg say, "Sandra will just act like a regular member of the family—a daughter, not a sexpot." Sandra's goal is "to make this placement work because I want to stay here."

In the next step, Gayle seeks more details and an estimate of how serious these problems are before discussing intervention: How frequently do these events occur? When and where do they happen? How uncomfortable are Greg and Diane at these times? She asks them and Sandra to help her construct a picture of the previous week. To measure discomfort, she proposes a rating scale from 1 (not at all uncomfortable) to 3 (somewhat uncomfortable) to 5 (uncomfortable) to 7 (extremely uncomfortable) for each event, as shown in Table 1.1. They also define the labels used to describe the numbers on the rating scale according to Greg's

**Table  
1.1****Greg's Discomfort Rating Scale.**

Greg's scale for rating his degree of discomfort						
1	2	3	4	5	6	7
Not at all uncomfortable		Somewhat uncomfortable		Uncomfortable		Extremely uncomfortable

experiences so they will all be in agreement. For example, Greg describes the most uncomfortable he has ever felt in such a situation, and that defines a 7 on the scale.

They then discuss the activities of each day of the previous week using a calendar to prod everyone's memory, noting when and where inappropriate events occurred and how uncomfortable Greg was. Sandra expresses surprise that the specific events described caused such extreme discomfort. She was just being herself—what is the problem?

Sandra's question leads to a discussion of the abuse she experienced in her early life and how it may have affected her attitudes about normal behavior between fathers and daughters. She seems genuinely confused about what is wrong with her behavior. It seems that it will be difficult to get past her confusion to change her behavior until she is able to understand the meaning of these behaviors to Greg and Diane. Therefore, Gayle suggests that the family collect data about the problem in the next week.

Gayle notes that today's discussion may actually change Sandra's (and her foster parents') behavior slightly, but suggests that Greg keep a daily diary of inappropriate behaviors and his level of discomfort in the next week. She explains that the purpose of gathering baseline data before intervention is to determine the extent of the problem, to develop and explore hypotheses that might prove useful for intervention planning, and to monitor how the behaviors change over time as they work on the problem to ensure that sufficient progress is being made. Figure 1.1 on page 4 is an example of a simple form for gathering data that Greg will use.

## Session 2

In the first week of observation (Figures 1.2 and 1.3 on page 4 and 5), Greg's completed chart shows between 1 and 3 uncomfortable interactions with Sandra each day; his highest level of discomfort ranges from 3 to 5 on most occasions and 7 only once (when a male neighbor was in the home with Greg and Sandra came in inappropriately dressed). Greg comments that there were fewer occasions than he expected and says he felt less uncomfortable this week because he realizes now that Sandra's past experiences probably have something to do with what's happening. Diane remains extremely uncomfortable (data not shown).

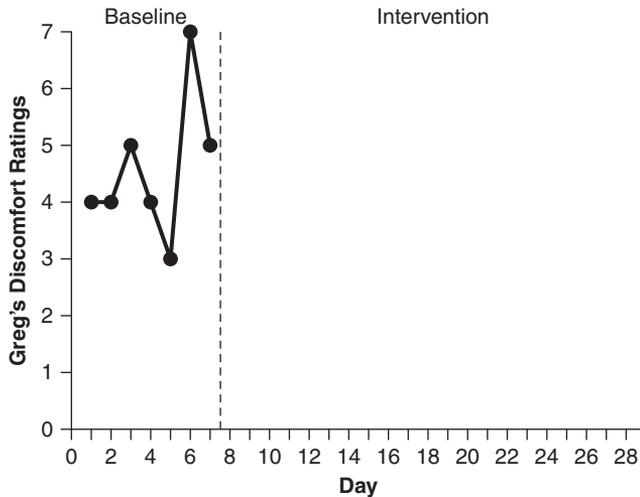


### Engage, Assess, Intervene, Evaluate

**Practice Behavior Example:** Collect, organize, and interpret client data

**Critical Thinking Question:** What are the advantages of carefully measuring the behaviors and feelings selected for intervention in Sandra's case instead of relying on Sandra, Diane, and Greg's informal impressions?



**Figure 1.3** • Greg's Highest Level of Discomfort in Interactions with Sandra (session 1).

Based on the data, the group talks about what Sandra meant to convey on each occasion (affection, gratitude, playfulness), as opposed to Greg's perceptions. Sandra is shocked at Greg's accounts, offering benign explanations for each event. Only the occasion with the neighbor makes sense to her, because she was embarrassed herself. Gayle asks Greg and Diane to describe one other occasion, and as they talk, she writes down a very detailed account of Sandra's behavior (e.g., what Sandra was wearing, what she said and in what tone, how she touched Greg) and what bothered Greg about it (e.g., what he was thinking, how he felt). They spend about 15 minutes going over this event in very specific detail.

Based on this discussion, Gayle offers a tentative conceptualization of the case: As a result of long-standing sexual abuse by her birth-father, Sandra has not learned the kinds of normal behaviors that are typical between fathers and daughters. Although she is not attempting to seduce Greg, her behaviors suggest otherwise and embarrass her foster parents profoundly. Greg and Diane now have a better understanding of Sandra's experiences and sympathize with her, but they are unwilling to allow her to continue to behave this way in their home. Moreover, they fear that her behavior may extend to other males in other settings, and that the behavior could put her in danger. The foster parents' objectives (for this behavior to stop) and Sandra's objectives (to maintain the placement) are compatible, so Greg and Diane readily agree with this conceptualization, and Sandra reluctantly says, "Yea, maybe."

Gayle suggests two possible evidence-based interventions to reach both goals: cognitive behavior therapy (CBT) to help Sandra develop better understanding of what her behavior means to and how it affects other people (delivered by Sandra's therapist in consultation with Gayle) and behavioral skills training with Gayle and the family to teach Sandra how to behave more appropriately. Gayle is unable to find any evidence of uses of these interventions with this type of problem, but both interventions have been shown effective with many other types of problems.

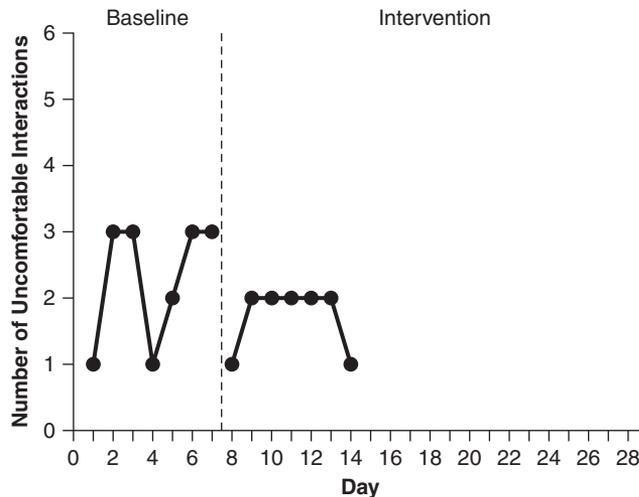
The family agrees to a combination of the two interventions. Greg and Diane feel that Sandra will be better able to change her behavior if she has more insight into her motives and others' perceptions of her behavior, and they are willing to help her learn new behaviors. Sandra reluctantly admits that others might interpret her behavior in ways she doesn't intend and is willing to learn some new skills, even though she doesn't think she is doing anything wrong. She seems sobered by a new realization that Greg and Diane are serious about requiring her to change if she is to remain with them. All three agree to continue to monitor their progress using the approach they used last week. This week Greg also will tell Sandra when she does something inappropriate, and she will record what happened from her perspective, using a form similar to Greg's (Figure 1.1).

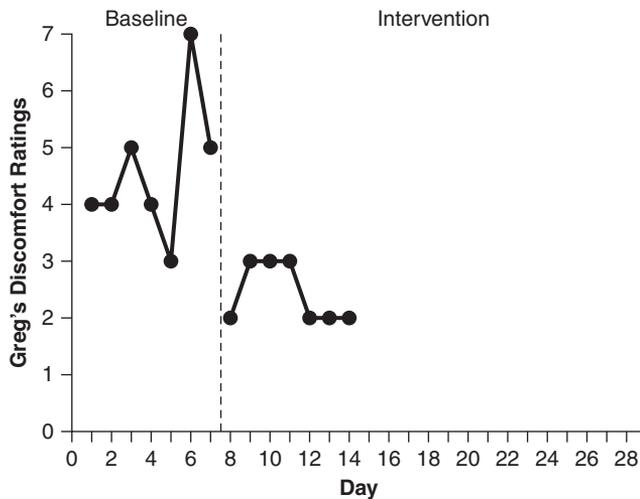
To begin the skills intervention, Gayle asks Diane to model a daughter's appropriate hug and kiss of her father when he comes in at the end of the day. Diane does so, and they describe the specific behaviors they have in mind: Diane kisses Greg on the cheek, hugs him lightly, and avoids pressing her entire body against Greg. Her tone of voice is affectionate but has no hint of sexual overture or flirtation. Sandra rehearses the behavior and the group praises the appropriate parts of her behavior and makes suggestions about other aspects. For the following week, Sandra will practice greeting her foster father appropriately each day. It's important that Greg reinforce Sandra's appropriate behavior by expressing his appreciation and affection in return each time. If Sandra's greeting is inappropriate, he will ignore her, in hopes of extinguishing the behavior.

### Session 3

The graphs shown in Figures 1.4 and 1.5 indicate that Sandra's inappropriate behaviors in the week after beginning the intervention have reduced, and Greg and Diane report feeling more comfortable. They say they have felt closer to Sandra and more spontaneous in interactions with her because they are less worried that she will embarrass them.

**Figure 1.4** • Daily Number of Greg's Uncomfortable Interactions with Sandra (session 2).



**Figure 1.5** • Greg's Highest Level of Discomfort in Interactions with Sandra (session 2).

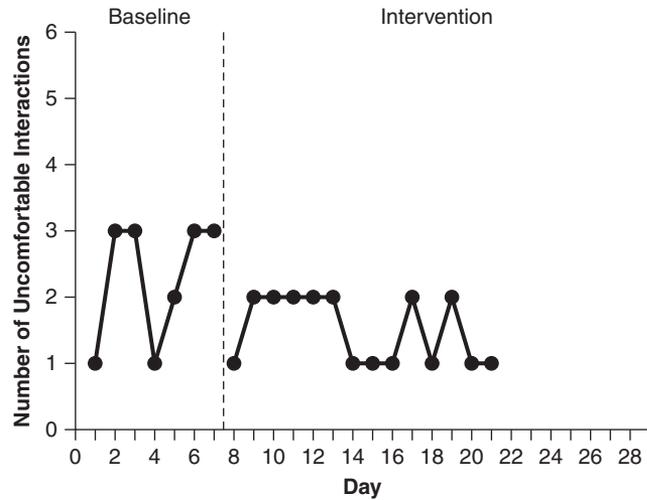
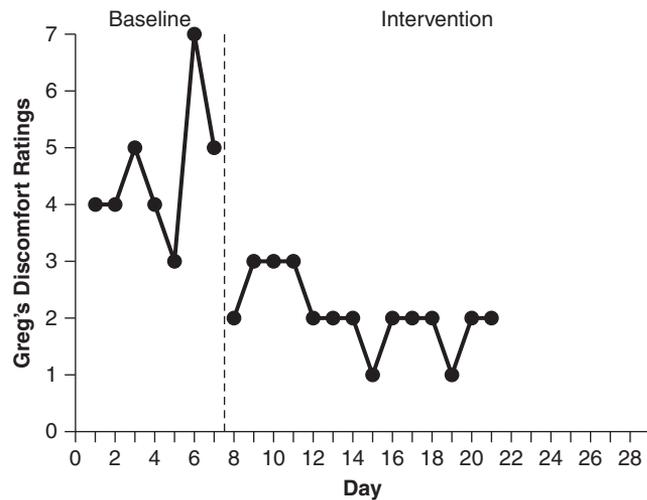
The group discusses several occasions that did make Greg feel uncomfortable in the previous week and how Sandra could have avoided that. Greg admits that maybe he was too touchy on one occasion because he was in a bad mood. They reenact that situation, and Sandra's behavior is perfect. Sandra beams and spontaneously hugs them both appropriately.

Diane asks if Sandra also has made changes in her behavior at school. "I've been thinking," she says. "I think I've been acting all-like-giggly and silly with the boys at school all the time." She reports that she has deliberately toned that down, but now the boys are ignoring her. "They used to tease me a lot and want to be around me, you know like in the halls and at lunch and whatever." She feels ignored now, especially since she doesn't have close female friends. "And if I'm not giggly and flirty, like how should I be? All serious and stuff? I totally don't know how to do that." Diane tentatively adds to her case conceptualization: Perhaps Sandra's past abuse have made it difficult for her to learn appropriate social skills in general? It rings true. The four of them then help Sandra practice friendly behavior to use with both boys and girls at school, including reflective listening and asking interested questions.

The family agrees to another week of monitoring, and Sandra also agrees to monitor her behavior at school and the responses of others. (Sandra will use a form similar to that shown in Figure 1.1, with columns for time and place, her actions, and other kids' responses. For the sake of simplicity and space, we do not show those data here.)

## Session 4

For the third week of observation, Figures 1.6 and 1.7 show continued improvement at home. Sandra says she feels more loved because Greg and Diane are not backing off from her. She also says she is doing better at being friendly at school without being so flirtatious

**Figure 1.6** • Daily Number of Greg's Uncomfortable Interactions with Sandra (session 3).**Figure 1.7** • Greg's Highest Level of Discomfort in Interactions with Sandra (session 3).

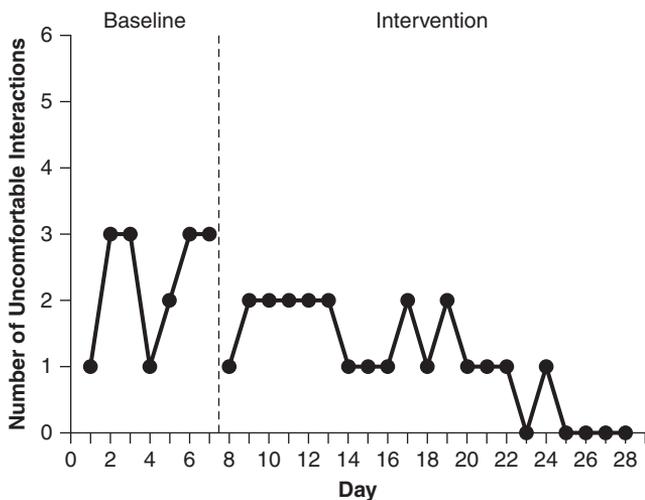
and she likes how people are responding. Now the girls talk to her, too, and she doesn't feel so ridiculous. Some of the boys actually talk to her, rather than just goofing around. She recounts one long conversation with a boy in her English class about a poem they both liked.

The family feels that they will soon be ready to terminate the intervention but would like to monitor for one more week, hoping to see a pattern of stability in their data.

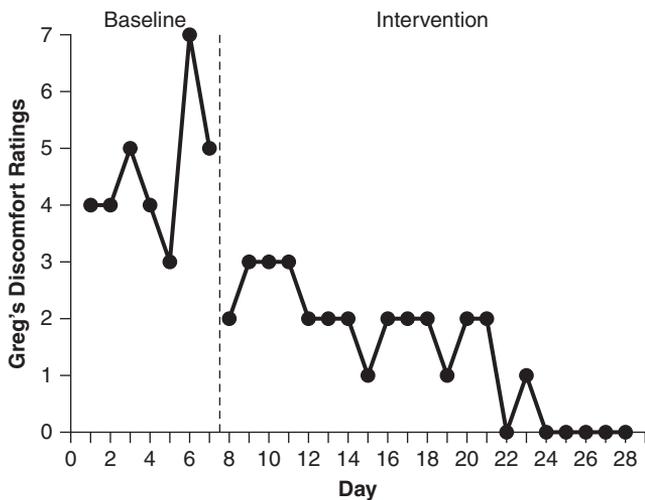
## Session 5

The last week of observation indicates that the family has achieved its objectives, and everyone is satisfied with his or her progress. They review the data in Figures 1.8 and 1.9 and discuss the steps they have taken to make the changes. They agree to terminate, but Gayle will check in with the family monthly, as is customary for the agency, and they will discuss how things are going then.

**Figure 1.8** • Daily Number of Greg’s Uncomfortable Interactions with Sandra (session 4).



**Figure 1.9** • Greg’s Highest Level of Discomfort in Interactions with Sandra (session 4).



## CASE 2: A DEPRESSED UNIVERSITY STUDENT

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### Session 1

Mark is a licensed clinical social worker (LCSW) who works in a university counseling center. His client is Dahlia, a 20-year-old Muslim junior from Saudi Arabia. (It is important to note that Dahlia originally requested a Muslim therapist, but none was available. Mark has some training and experience working with Muslim clients and feels comfortable doing so, so he was assigned and Dahlia agreed.)

Dahlia came to the center complaining of sadness, weepiness, insomnia, and trouble concentrating. Her grades have fallen from nearly all A's to C's this semester. This is of great concern to Dahlia, because she is a premed major, and she may not be accepted to medical school if she isn't able to improve her grades quickly. When asked what she thinks is going on, Dahlia says that she is afraid she has a terrible illness and is dying.

Mark probes for details, and they discuss her problem more concretely:

- Dahlia has had trouble getting to sleep and staying asleep for about 3 months. In the past week, she has experienced this every night, and she estimates she sleeps about 3 hours per night, waking up every hour or so and having trouble going back to sleep. Recently, she has begun napping during the day.
- She experiences difficulty studying every day, partly because she is exhausted and sleepy, and as a result did poorly on an important exam this week.
- She describes herself as “weepy” and reports that she finds herself crying at odd times. She did this every day this past week, including once when she had to leave class. She doesn't know why she was crying.
- She says that she feels worthless and bad, that she is letting down her parents who are sacrificing so much to send her to school, and that poor grades reflect badly on her family as well as the Muslim community.

The assessment process further reveals that Dahlia has few friends, though she is a member of a local mosque that is active on campus. She has always been an introvert and does not enjoy group activities, preferring to study when she is not in class, but she has become friendly with two American girls in her dorm. They eat dinner together nearly every evening and sometimes study together in one of their rooms.

Dahlia's family in Saudi Arabia has urged her by telephone to talk about her problems with her imam, but she is uncomfortable doing that. Her family is very religious and assures her that prayer and religious study will help her, but she is comfortable with Western medicine and feels it is more likely to help her. “My family is more religious than I am,” she says, “and besides, I have a medical problem, not a religious one. Why would I talk to the imam about a medical problem?”

From the beginning, Mark suspects clinical depression, but he resists committing himself to that diagnosis. His research and experience tell him that many Muslims equate mental illness to physical illness, but it is possible that Dahlia does have a physical illness. Dahlia has not used the term *depression*, so he doesn't either. He asks Dahlia if she has had a physical exam lately to rule out possible physical causes. She confirms that she had an exam recently, with no clinical findings; the exam ruled out anemia and thyroid problems, two issues Mark was thinking about. Dahlia cannot recall any specific incident that precipitated her current feelings.

Mark administers the Quick Inventory of Depressive Symptomatology (QIDS; Rush et al., 2003) to Dahlia. This is a standardized scale that is reproduced in Appendix A. He chooses this measure because it is short (16 items, 5–10 minutes), easy to administer and interpret, and has excellent reliability and validity (topics we discuss in Chapter 8). Moreover, the symptom items on the measure seem especially pertinent in Dahlia's case. There are forms for both the client and the practitioner to complete. Mark refers to the website [www.ids-qids.org](http://www.ids-qids.org) for scoring and interpretation information and a copy of the measure, as well as a semistructured interview format. He has some concern about the lack of evidence of use of the measure with Muslims, but he decides to go ahead and use it with caution. Dahlia's English is flawless, and she shows no hesitation that might indicate poor understanding. Nevertheless, he will use the data with caution, as he understands that experiences of symptoms are embedded in culture.

The QIDS asks a series of questions about the respondent's feelings and behavior in the previous 7 days. Dahlia's score of 13 (out of 27) at this first session is categorized as "moderate depression." Mark scores Dahlia at 14 on his version after the session. Table 1.2 provides guidelines for interpreting QIDS scores, and we'll have more to say about this in Chapter 9.

Mark explains that the questionnaire she just completed, as well as her reports and his impressions, indicate that Dahlia is clinically depressed and confirms that she understands what this means. He is careful to refer to depression as an *illness*, since this is the way Dahlia refers to her problem. When asked why she thinks she has become depressed, Dahlia says she does not know, but Mark perceives that she is holding something back. "What has changed? What is different now?" Mark asks. Dahlia just shakes her head. "Nothing, really."

Aware that many Muslims find suicide so repugnant that they are reluctant to admit suicidal ideation, Mark asks Dahlia if she has wished God would let her die. She says yes, she has felt this way for over a month. "Sometimes I think about doing it myself," she says, eyes on her lap and so quietly that Mark almost cannot hear her, "but I would never do that."

Dahlia's treatment goals are to feel well again, to be able to study hard as she always has before, and to "feel at peace." They work to make the goals more specific and concrete so that they will have measurable criteria to define and evaluate Dahlia's progress and ultimate success:

- Dahlia gets a full night's sleep daily and awakens fully rested.
- Dahlia is able to concentrate and study productively for long hours as she did before.

**Table  
1.2**

**Interpreting QIDS Scores.**

QIDS interpretation	QIDS score
No depression	≤5
Mild depression	6–10
Moderate depression	11–15
Severe depression	16–20
Very severe depression	≥21

- Dahlia no longer cries and feels sad every day.
- Dahlia feels good about herself and the work she is doing.
- Dahlia's score on the QIDS remains at 5 or below ("no depression").

Mark offers an early, incomplete case conceptualization: Dahlia's symptoms of sadness, crying, poor sleep, inability to concentrate, and negative self-image indicate that she is clinically depressed, but what is not clear, he tells her, is what is causing her depression. There is no family history, and there have been no recent losses. They will have to think and talk about that. Mark explains that research has shown two interventions to be effective with depression: CBT, a way of changing dysfunctional thoughts that lead to depression, and antidepressant medication. He has read the literature indicating that many Muslims find antidepressants to be the most acceptable option because of their view that depression is a sickness (<http://ssrdqst.rfmh.org/cecc/index.php?q=node/25>, retrieved February 21, 2010), so he wants to offer both options. He adds that some research has found CBT to be effective for depression with Muslims (Hodge, 2006).

Mark suggests that Dahlia might be a candidate for medication and suggests a referral to the psychiatrist in the student health center, as well as a week of baseline data collection about her sleep and study, since these are two major facets of her depression. Dahlia agrees and wants to see a psychiatrist immediately. She is also interested in CBT.

Before ending this first session, Mark and Dahlia sign a contract that she will call him before harming herself in any way, and he gives her his cell phone number. In addition, they make plans to monitor Dahlia's problems; she will record the number of hours she sleeps, aiming for 8 hours nightly, and how many hours she studies daily, aiming for at least 4. In addition, each night she will estimate how sad she feels on a scale from 1 (not at all sad) to 3 (a little sad) to 5 (quite sad) to 7 (as sad as she has ever felt), as shown in Table 1.3. Dahlia's objective is a 2 or below.

## Session 2

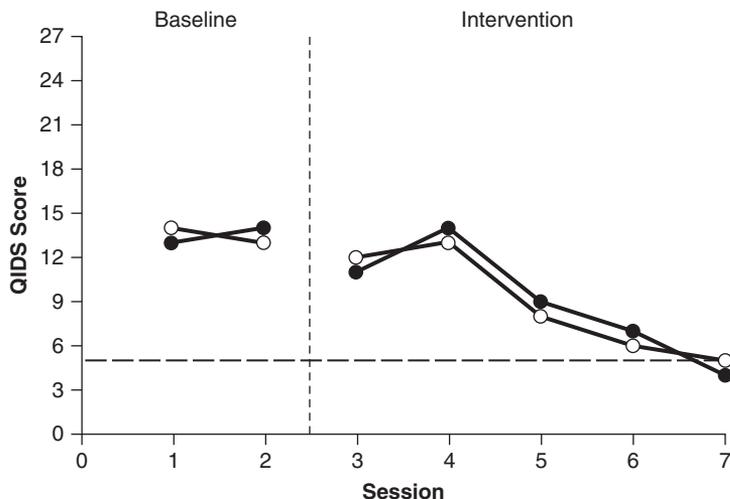
Dahlia completes the QIDS in the lobby before her appointment, and her score is 14, indicating no real change from last week. Mark will complete the QIDS after their session (see Figure 1.10, session 2). They go over her sadness, sleep, and studying data together, and Mark constructs graphs so it will be easy to monitor Dahlia's progress over time. In this case, we present only the completed graphs to conserve space, but remember that in session 2, Dahlia and Mark are working with only the first (baseline) 7 days of sleep and studying data (see Figures 1.11 and 1.12, days 1–7).

**Table  
1.3**

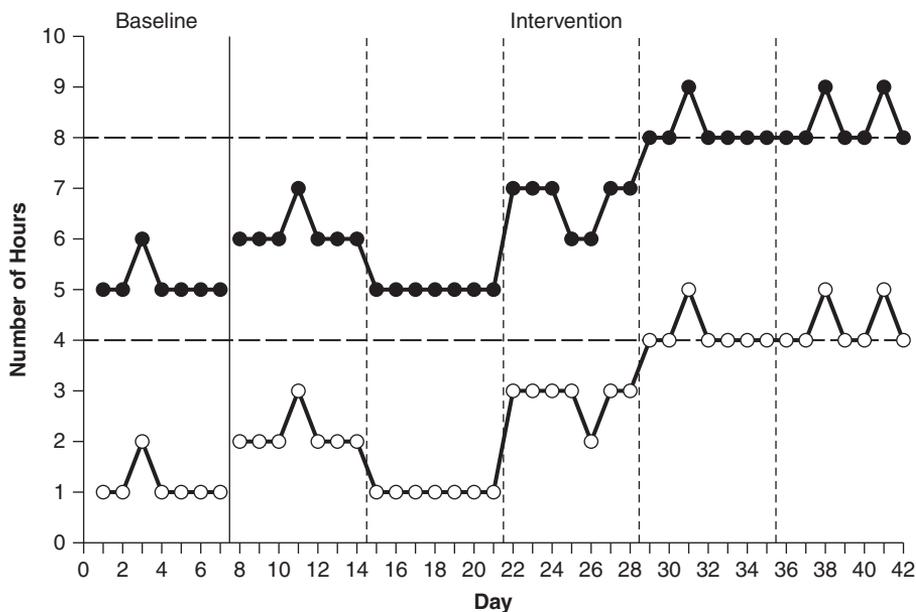
**Dahlia's Sadness Rating Scale.**

Dahlia's scale for rating her degree of sadness						
1	2	3	4	5	6	7
Not at all sad		A little sad		Quite sad		As sad as she has ever felt

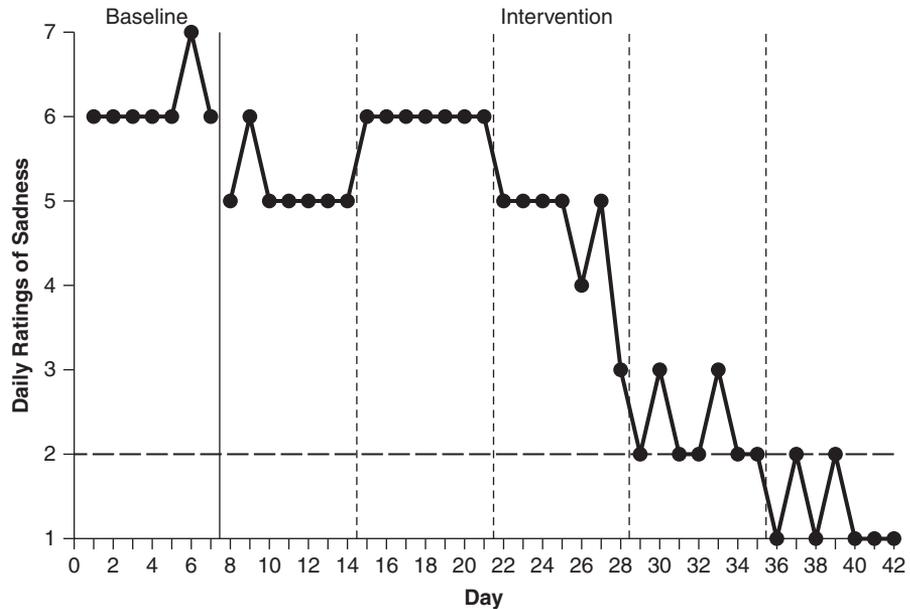
**Figure 1.10** • Dahlia (●) and Mark's (○) QIDS Scores.



**Figure 1.11** • Daily Number of Hours Sleeping (●) and Studying (○).



They discuss each of the items on the graph, beginning with Dahlia’s sadness, which appears to be fairly stable at a high level. Nevertheless, she reports no suicidal urges or feelings in the past week. As for sleep, Mark notes that clearly Dahlia is not sleeping enough to function well. He asks about her sleep routine: what time she goes to bed, what she does right before sleep, and so on. “I usually study after dinner until about 11 or so,

**Figure 1.12 • Daily Ratings of Sadness.**

and then I shower,” she says. “Then, last thing, I talk to my sister in Saudi Arabia on Skype when she is just getting up in the morning. Then I go to sleep—or try to—about midnight.” Mark asks Dahlia to describe her conversations with her sister. What do they talk about? “Well, I always ask about my niece and brother-in-law,” she says, “and the rest of my family. She tells me what they are all doing and what she knows about our friends. And sometimes she asks about my classes, so I tell her about that, and . . .” Dahlia seems hesitant but continues, “and she always asks did I go to mosque and do my prayers and am I reading the Qur’an.”

“You always talk about that?” Mark asks. Dahlia nods and reports that her sister is always preaching to her about going to services and studying the Qur’an. “I am not as religious as my family, and I’ve been having some doubts, and she can tell. It’s terrible of me, but I can’t help it. It really upsets my sister.”

Turning to the discussion of Dahlia’s studying, which is clearly inadequate for her medical school goal, reveals that Dahlia’s best study hours seem to be in the morning, and they speculate about whether the sunlight might improve her concentration. In addition, her insomnia seems to catch up with her in the afternoon, and even when she is able to study she says she can’t concentrate well, so she often naps.

Mark suggests something to think about for conceptualization of the case: Is Dahlia’s depression perhaps related to her conversations with her sister? Dahlia isn’t sure but doesn’t reject the idea. They also question whether the reason for her depression could be broader: Dahlia is changing, as anyone in a new culture and getting an education changes, but these changes contribute to feelings of loneliness and alienation from her family. They discuss her religious doubts a little more and how the doubts contribute to negative self-thoughts. Dahlia describes the negative thoughts and says she has them constantly.

Mark asks Dahlia whether she would like to start CBT or wait until her antidepressant medication begins to work. Dahlia says she would like to start CBT right away. She will continue graphing for another week. Mark suggests adding negative self-thoughts to her monitoring, and Dahlia will use the memo application on her new iPad to record. She will note any negative self-thoughts when she sits down to eat each day. They spend a few moments discussing how to identify and record her negative thoughts. (These data are not included here in the interest of space and simplicity.)

### Session 3

Going over her data (see Figure 1.10, session 3, and Figures 1.11 and 1.12, days 8–14), Mark and Dahlia note some improvements in sleep and studying, though Dahlia is far from her objectives. “I think I have hope now that I can be cured, though,” she says. Mark asks about suicidal thoughts, and Dahlia says there have been none.

Dahlia has had some difficulty charting her negative thoughts (data not shown), because they are so frequent, but she says she realized this week as she was monitoring that they nearly always relate to her sister. Dahlia’s sister always wants to talk about religion and what Dahlia is doing at the mosque and seems to disapprove of any nonreligious activities except classes. Dahlia tries to change the subject to talk about her 3-year-old niece but is not always successful. Mark asks Dahlia, “What do you think it is about talking to your sister that causes you to feel so bad about yourself?”

Reluctantly, Dahlia admits that she is questioning her Muslim beliefs, acculturating and enjoying Western culture, and even feeling more equal to men. She is horrified at her religious doubts, though, and is telling herself that she is terrible for questioning her beliefs, especially after communicating with her sister, who is very devout. “I’ve even been thinking of not wearing the hijab anymore, but I haven’t told anyone. My family and some of the people at the mosque would be horrified.”

Mark has done some research about effective methods for dealing with depression related to religious questions, finding that Islamic beliefs and principles can be effectively integrated with CBT, and that there is some research showing effectiveness for such a modified model (Hodge, 2006). Knowing his own bias against any type of religion and hoping to avoid letting that interfere in his work with Dahlia, Mark is determined to be especially vigilant in monitoring Dahlia’s progress, and he also consults the literature about Arab culture (e.g., Al-Krenawi & Graham, 2000). He is aware that for many Muslims, faith is an integral part of every aspect of life (Graham, Bradshaw, & Trew, 2011) and that effective social work with these clients must include attention to their religious needs. Dahlia will monitor again, this time noting for each negative self-thought whether it is related to religion and how upsetting the thoughts are to her. Next week, they will examine how rational Dahlia’s negative thoughts are and write some corrective thoughts that Dahlia can use to counter the negative ones. Mark and Dahlia also discuss her belief that it is wrong to question her religion and that doing so is dishonoring her family.

Mark asks Dahlia to pay attention to her interactions with her dorm friends this week, too, and to think about her feelings after each occasion. As part of his evolving case conceptualization, Mark wonders if social isolation and loneliness are helping to maintain Dahlia’s depression, as she feels alienated from her family and her culture. He suggests that she has moved away from the interaction and reinforcement of her old life but has not yet replaced those things in her new life. Dahlia agrees to think about that.

## Session 4

Graphs show Dahlia’s depression symptoms to be worse in the past week, especially sadness and difficulty getting to sleep (see Figure 1.10, session 4, and Figures 1.11 and 1.12, days 15–21), and she admits to Mark that she has thought about dying. She has not considered suicide, however. She quit monitoring her negative self-thoughts early in the week because she said they happened “all the time.” She has had no interactions with her dorm friends this past week because school has not been in session and both are out of town. She also did not go to mosque this week. “I had a fight with my sister on the phone about religion—she scolded me for not attending services—and we haven’t talked or emailed since.” In addition, Dahlia has not managed to study enough, although she feels that her concentration might be better. Could it be the medication? Mark agrees that it’s possible.

Mark asks whether she has felt lonely this week, with no conversations with her sister and her friends gone, and she says “yes.” He suggests that they modify her intervention to address her isolation. They discuss ways she can increase her social interactions, including participating in her mosque’s women’s groups and accepting her dorm friends’ invitations to do volunteer work with them at a local homeless shelter. Dahlia admits that she especially likes the latter idea because one religious belief she does not question is the admonition to help others. On the other hand, she says she feels somewhat uncomfortable in the women’s groups at her mosque because most of the women there are very conservative. Dahlia will keep monitoring the other items and try volunteering at least once this week.

## Session 5

Dahlia comes to her session all smiles, reporting major improvements in her symptoms (see Figure 1.10, session 5, and Figures 1.11 and 1.12, days 22–28). She has volunteered twice this week, enjoying the first time so much that she has signed up to do it three times a week. She reports enjoying the interaction there and feeling very in touch with God through the experience. “I am thinking about which parts of my religion are meaningful to me and which are not,” she says. “I have not talked to my sister about this yet, but I will eventually.”

Dahlia also suggests that she quit taking her antidepressants, feeling that she has solved her own problems and doesn’t need them now. Mark cautions that they do not know what role the antidepressants have played in her new feelings of wellness, and

points out that he and Dahlia would work closely with her psychiatrist on this question in any case. He suggests that Dahlia continue the medication until she feels that she has satisfactorily resolved her issues with her sister, allow her mood to stabilize for a while, and then talk with her psychiatrist about gradually discontinuing the medication. She agrees.

Is one reason Dahlia feels better that she is enjoying time with other people? Dahlia thinks Mark might be right. “I look forward to having dinner with my friends at the dorm most evenings, and I really enjoy volunteering



### Professional Identity

**Practice Behavior Example:** Advocate for client access to the services of social work

**Critical Thinking Question:** What are the advantages of monitoring Dahlia’s progress at regular, frequent, predesignated intervals instead of waiting until termination to determine her progress?

with them.” She and her sister are talking a few times a week now, but carefully staying away from the topic of religion.

Mark tells Dahlia about a new support group for students who are struggling with spiritual and religious issues. Several members of the group (including one Jewish boy and one Christian girl) are also questioning their beliefs and having feelings similar to Dahlia’s. Perhaps they can be helpful to one another. Participation in the group also can provide another social outlet for Dahlia. Dahlia is not certain but agrees to think about it and continues monitoring.



## Research-Based Practice

**Practice Behavior Example:** *Use practice experience to inform scientific inquiry*

**Critical Thinking Question:** What are the advantages of modifying the interventions for Sandra and Dahlia based on carefully measuring and monitoring progress in these two cases, instead of just assuming that evidence-based interventions will be effective?

## Session 6

Dahlia arrives for her session without her hijab and smiling broadly. Her graphs show that she is doing well, still volunteering, studying hard, and pulling her grades back up to A’s (see Figure 1.10, session 6, and Figures 1.11 and 1.12, days 29–35). She feels certain that she is “well now,” but has decided she is not ready to discontinue psychotherapy. She also has decided to join the support group Mark mentioned to her.

## Session 7

Dahlia arrives feeling well and happy, as shown by her graphs (see Figure 1.10, session 7, and Figures 1.11 and 1.12, days 36–42). She has joined the support group and attended one meeting. She enjoyed the meeting and feels that it will be a good resource for her in learning to deal with her family. She was surprised to see another young Muslim woman at the group, and they have had lunch together once since that time and seem to have much in common. She takes a deep breath and tells Mark that she thinks she is ready to discontinue therapy, as long as she can call him if she becomes depressed again. “I think I will continue taking the medication for a few months, though.” Together, Mark and Dahlia review Dahlia’s charts, discussing the progress she has made. Dahlia says she might continue monitoring her sleep and studying hours for a while, “just to be sure.”

## CONCLUSIONS

Each of these cases exemplifies outcome-informed evidence-based practice. In both, the practitioners follow the steps of evidence-based practice, but clearly it is the clients’ progress toward their goals and objectives that drive decision-making and actions at each step—not a commitment to the specific intervention or faith that the methods will work. It should be clear that this approach is possible only when you carefully measure and monitor the client’s outcomes consistently, frequently, and systematically. Chapter 2 will refer back to these cases as we explain the terminology and important aspects of outcome-informed practice.



## CHAPTER 1 REVIEW

**PRACTICE TEST** The following questions will test your knowledge of the content found within this chapter and help you prepare for the licensing exam by applying chapter content to practice. For more questions styled like the licensing exam, visit [MySocialWorkLab.com](http://MySocialWorkLab.com)

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1. Which of the following is illustrated by Sandra's case:
  - a. Client problems should be defined after intervention begins
  - b. Qualitative information is not important
  - c. Client progress should be monitored during, but not before intervention
  - d. Measurable criteria should be used to define and evaluate client success
2. It is clear in Dahlia's case that she improved
  - a. Because of antidepressant medication
  - b. Because of CBT
  - c. Over the course of intervention
  - d. Because of participation in a support group
3. Which of the following is the most important reason a social worker should monitor a client's progress:
  - a. Demonstrate the effectiveness of an intervention
  - b. Ensure that the client's goals are achieved
  - c. Provide evidence to funding sources
  - d. Develop knowledge for use with future clients
4. Evidence-based interventions
  - a. Do not guarantee client success
  - b. Guarantee client success when the evidence is strong
  - c. Guarantee client success when implemented properly
  - d. Guarantee client success when implemented by trained social workers
5. A social worker is working with an adult, Adam, who was sexually abused as an adolescent. Adam blames himself for the abuse and is angry at himself. In collaboration with Adam, the social worker selects an evidence-based intervention that he thinks will help Adam. How could you measure and monitor Adam's progress?
6. A social worker is working with Adam, the client described in the previous question. What kind of information would make you change the evidence-based intervention implemented by the social worker?

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