

EXPERIENCE AS EDUCATOR: THE JOURNEY FROM CLINICIAN TO PRACTICE-BASED RESEARCHER

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This narrative reconstructs the author's experiences as project director of the Women's Wellness Initiative. The benefits and challenges of community-based research in the "real world" are illustrated through the story of her experience from the first conceptualization of the project through its implementation and pending closure. At the same time, her own professional growth is challenged both by roots in clinical social work practice and education in social work research during her doctoral program. Through reflection, this narrative provides the opportunity to see inside project leadership as well as inside the development of a practice-based researcher. Ultimately, it contains lessons designed to increase the fluency of both researchers and practitioners in the language of community collaboration and empowerment.

"Experiences in order to be educative must lead out into an expanding world of subject matter, a subject matter of facts or information and of ideas. This condition is satisfied only as the educator views teaching and learning as a continuous process of reconstruction of experience."

—John Dewey (1938)

By the time this article reaches the eyes of its readers, a four-year project under my direction will terminate and the formal outcome evaluation will delineate the successes and challenges of the Women's Wellness Initiative. A more subjective story hides behind those formal numbers, one that perhaps provides a deeper understanding of program process as an integral partner with program outcome. I am a doctoral student and a self-declared "newbie" researcher. However, I do have years of experience as a social work practitioner that inform my decisions and, at times, create challenging role conflicts. Putting aside my data tables and statistical models for the moment, I will embrace my roots as clinician and allow my own story to unfold. The narrative behind the numbers conveys valuable lessons from which I still learn, from both my triumphs and my frustrations. Time will tell whether objectivity

or subjectivity provides the more meaningful evaluation of this experience.

The Newbie Researcher Goes Forth

The transformational process began for me as I sat in front of the RFP for the first federally funded grant I had ever considered writing. A mix of enthusiasm and uncertainty occupied my thoughts. Six months into a social work doctoral program that had transplanted me from New York to the Midwest, I was also working part-time as an MSW with a community-based organization. With my clinical eyes newly trained to focus through the lens of research, I began to uncover the health disparities present in many local communities we served in our region of the state. One community, a rural area about two hours south of where I lived, was unlike any other I had encountered in terms of unmet need, gaps in service, and high rates of infant mortality. It seemed as if the federal government could read my thoughts when a seemingly perfect funding opportunity presented itself. My mind reeled with possibilities and potential benefits of this project in spite of the enormity of the undertaking. Looking back, I smile at my own naïveté; I had no idea how the next four years

would unfold either for the project or for my own professional growth.

My foray as project director began long before my funding. I was already familiar with the staff and programs of the Healthy Start project that would serve as the site for this proposed mental health initiative. I was also anxious to employ my newly acquired knowledge of applied social research in a real-world setting. So, engaging their staff and consumers, we initiated a "taking stock" activity by using snowball sampling to identify community organizations that might interact with women of reproductive age in this rural community. The needs assessment I completed revealed a poignant picture: 100% of community-based clinicians identified depression in this population as a serious issue, and no one routinely screened for depression in any formal way. Buy-in to the idea of a project addressing maternal depression from professionals in the region was tremendous and letters of support flowed freely. I was assured that there were services available in my project region to treat women with depression, but that stigma and geographic isolation prevented full service utilization. During long days and nights of proposal writing, I was fueled by the overwhelming sense that this was a necessary project for this community and my research knowledge could truly be used for productive community action. The objective data supported my initial clinical assessment based on the individual women with whom I had worked. Exhausted, but confident, I submitted my grant proposal to the funding agency and awaited their decision.

The Eyes of Practitioner Illuminate the Researcher

During the weeks that followed, I decided to become as familiar as possible with daily life in the rural community that would house my project. In hindsight, this would be my most important decision. I traveled on my own

time, visited with local people, met with professionals, sampled the regional favorites at local restaurants and shopped for produce at farm stands while chatting with the community at large about what I hoped to accomplish if and when we were funded. As the reality of everyday life in the community expanded my awareness, my optimistic views began to falter. People were receptive to me, but began to say things like, "Yeah, someone else came down here and did something like that... never heard what happened, though. I guess we're kind of like bugs under a microscope down here" or "People like you come here and talk and talk about our problems... but that's the end of it and we never see them again." I was floored. I doubted that whatever researchers were being referred to knew of the community's angst. More likely, good intentions had somehow met up with real-world limitations of funding, time, and management of multiple projects and deadlines.

Confronted with the community's skepticism, I began to question to what degree the community was actively involved in many of the published research studies I had read. Community participation in research is an emerging "buzzword" in the academic community, but community involvement and engagement at all levels of the research process have not been well established. Literature promoting evidence-based practices describes community-level impact but is less clear about how often the participants actually sit at the same table as researchers throughout the process of designing and implementing these practices. Even less clear to me was how the outcomes of published studies are received by the community (assuming outcomes are shared) since that is rarely addressed in the contents of most empirical articles. What did the community think about the outcomes the study chose to measure? Did participants in the study ever have access to the findings in

language that was culturally sensitive to their knowledge and education? Were they given a voice in implementing the study's findings in their own communities? As a practitioner turned researcher, I knew these questions demanded answers in order to insure ethical and fair treatment of individuals and communities involved in research.

As I began to work more intensely with this rural area my project called home, research skepticism emerged as a dominant theme in those with whom I spoke and echoed my own internal dialogue. One memorable time, I was speaking with a nurse at a local hospital about my intentions to address the problem of depression in rural communities. Immediately, she demanded, "Who says we're depressed...and how do they know any better than we know?!" Citations about clinical screening and community epidemiology of rural areas were reeling in my mind, but I relegated them to silence while I listened to the words that were being shared with me. People felt objectified, at times even patronized, by well-meaning researchers like me who wanted to fly in with a new concept and "save" their community. I felt ashamed. And, I hate to admit it, but I honestly had second thoughts about whether I really wanted the funding to come through. What if I added to their negative feelings about researchers? What if my project *failed* in the attempt to improve services? What if I built a project and no one came? Amid my building sense of doubt, I received the news that forced me into reality: the Women's Wellness Initiative had been funded.

As a newbie researcher, I found comfort in the familiarity of looking at my start-up tasks through the foundation of my clinical experience: I had to start with trust building and assessment and then engage in mutual goal setting with my new "client," this community. I made an important decision early on in this project as I began to really listen to the community's skepticism towards research. In

order to fully respect this community and break down barriers of past negativity regarding research, the community's need would have to take precedence over my research agenda. Client-centered and solution-focused practice was the foundation of my experience, so community-centered research was a natural extension. Every engagement with the community was an education for me; I learned to listen to the intrinsic wisdom and experience each person had to offer. Each job interview with prospective staff, every meeting with a sub-contractor, and all initial contacts with local consumers started the same way. I briefly introduced myself and the Women's Wellness concept; then I asked what I will refer to as my own version of a "miracle question" (deShazer, 1988, p. 5) to my community representatives: "If I were to walk into this community four years from now and this project was miraculously successful, how would you know? Tell me what would be different."

Women in the community began to tell me stories about being able to talk with other women in similar situations without having to drive to another community, about not having to feel humiliated that they had no insurance and could not afford counseling even if they wanted to go, about being able to be strong enough to prioritize taking care of their own mental health instead of feeling as if it was their burden to bear, about being able to even consider putting their own mental health on the long list of daily struggles for survival in an economically deprived area. Summarizing their responses, they were telling me time after time: we can take care of ourselves, but we need someone to invest in us and help us create realistic opportunities for self-care.

I began to realize I had written the wrong grant...or at least, taken the wrong approach in my original grant writing. My skepticism began to dissolve into a new understanding regarding the importance of designing

interventions that balance evidence-based approaches with continual community input at all steps of the process. Whether or not the literature addressed the role of the community, my own values and ethics dictated that this project must actively engage the community as a mutual partner in order to be both successful in its stated objectives and successful in providing lasting impact to participants after funding ended.

At this point in my professional growth, I engaged in a reflective process about my role as administrator and researcher. I realized that I was not the expert who would bring an empirically supported intervention to the real world and somehow "save" this community. Previously published literature was informative but in itself was not the expert. My perspective changed to recognize that this community was the expert in its own identification of needs and the authority on how to make meaningful and lasting changes happen. My role in engaging with this community through this project was to provide information, structure, and education to the community in the areas of my own expertise. If this project were to succeed, the community needed to have ownership of its own progress and we would need to be equal partners in the research and project-management process. Since I will always be a practitioner at heart, this approach made intrinsic sense to me. For years, I began every counseling session visualizing with my clients what it would take to accomplish their goals and "graduate" from therapy to fully empowered, self-directed action. Now, I needed to make sure that after our work together was completed, this community would be empowered to go on without this project and without me.

So, with the lofty pedestal of "Principal Investigator" pulled out from under me, I landed squarely on the roots of social work and community organization. With a more humble leader and a shared vision, this community and I set out on our journey

together. Looking back on this process, I realize that my own professional growth had taken a very natural course. While I had added social-science research-methods skills to my professional knowledge base and had changed my title and job description slightly, I still (proudly) remained a Social Worker. This valuable lesson kept me centered and focused on a daily basis in my budding academic career.

A Second Chance to Get it Right

Meanwhile, in Washington, D.C., the federal government was no longer engaging in telepathic harmony with my project. Six months after first funding, we were instructed to shift our focus from identification of depression and building community linkages to a case-management model. In other words, our destination changed from a commuter flight to a transatlantic expedition immediately after take-off. Of course, this presented a significant challenge. I realized that it also offered me a second chance to actively engage the community in meeting this demand. Having learned from the community about their own internal strengths, I could more effectively serve in my role of facilitator. My contribution was to scour the existing literature for possible approaches to integrating case management into community settings and translate these studies into models I could describe to professionals and consumers. The community's contribution was to think through the information I presented and thoughtfully collaborate regarding the best way to develop a meaningful program (and program evaluation) that would succeed given the unique features of this community.

The community made one thing clear: to be successful, this project had to place the power of treatment in the hands of the women we worked with. They decided that a community survey could inform us about the attitudes, beliefs, and help-seeking preferences of our target population. These

findings were echoed by the qualitative interviews they recognized were essential to understanding the voice of our consumers. Together, a new direction was forged that bridged identified gaps in services. We formalized our panel of community providers and consumers and established an empowerment evaluation model (Fetterman, Kaftarian, & Wandersman, 1996) to guide our project development and monitor our ongoing progress. This cemented into place our mutual collaboration. We took stock, created a mission, set goals, and decided on our intervention plan and evaluative approaches with my primary goal to share the knowledge I possessed with the community in order to allow them to evaluate their own efforts in the future.

While there are many illustrations of the way this empowerment approach of engaged collaboration unfolded, the most memorable to me was our struggle surrounding the concept of case management. We had a true impasse: our funding agency demanded case management, but no one in the community wanted anything to do with such a medical model approach. Heated discussions highlighted how the community wished to avoid viewing women experiencing depressive symptoms as needy recipients of enforced treatment. Some argued that we should fight against the funder's requirement. Some argued that we should develop a sort of sub-contract as a way to distance ourselves from case-managed services. But, what we worked through in our discussions together was a vision that case management could be redefined as a way to support women's right to access treatment they desired across multiple sectors while partnering with them to address the tangible and intangible barriers to receiving those services. We worked as a team to develop an approach that was desirable to the community, met the requirements of funders, and addressed key concerns raised in the empirical literature.

What the community had told me initially was now taking shape: if we partner together, we can put in place a better system to help the people in this community help themselves.

What I realize now is that a dual process occurred during this second chance at project start-up: the community had built its trust with me, but I had also built my trust with the community. We had faith in each other; we had a shared vision, a set of mutual goals and objectives, and, most importantly, a shared desire to allow the community to take responsibility for its own success. I realized very profoundly that this project had moved from a newbie-researcher's first attempt to get funding and instead had become a way to help a community empower itself. While I entrusted the community to collaborate in what had at first been "my" research, the community entrusted me as someone who would work jointly with them to help develop, monitor, and evaluate their efforts to improve the lives of women. This mutual respect is the core element of a community-research partnership, where both researchers and the community have joint ownership of their project.

Project Accomplishments

Momentarily, I must pause to put on my evaluator's hat to share a bit of objective data. The Women's Wellness Initiative has had tremendous success since our start-up in many ways. We have experienced unprecedented community participation and buy-in with the project. While I felt this every time a staff member told me she was getting flooded with calls and every time I held a training session for a room packed full of attendees, the objective researcher in me was finally satisfied that this new approach was working when we met our four-year service objectives by the end of our first year. Over 100 women had willingly been screened for depression, and over 50 had self-referred for our supportive case-management program as a

bridge to treatment in the specialty mental health, primary care, or self-help service sector. So, we increased our goal for the remaining three years to triple our original expectations. We met those revised objectives before the beginning of the fourth year and had to double our staffing and write a supplemental grant to meet the needs of all the women who were seeking services from our project. This success is attributable to the community's participation in planning, designing, and evaluating the project as it has progressed, and in our adaptability to making changes along the way when we encountered obstacles. My realization from our objective success: if you work with a community to build a project together, have no doubt about it, they will come.

Another success for this community-research partnership has been finding out information about this community that was not previously known or articulated. During year two, a large-scale community survey was conducted with the intention of finding out what stigmas surrounded depression and what the community's help-seeking preferences were. We found that stigmatized beliefs about the origins of depression were very prevalent in the local community, and many (even those who considered themselves depressed) felt that depression was indicative of personal weakness. The community team's response was to infuse esteem-building and empowerment-oriented language into a wide array of materials to which the general population had access; we measured the results of this response two years later by repeating our community survey and comparing stigmatized beliefs. A statistically significant change in community perception of depression as caused by individual weakness was found from baseline to follow-up. We also learned through anonymous, open-ended questionnaires about the stresses, accomplishments, and regrets of women in this community. We heard stories about

chemical dependency, institutionalized patterns of mental and physical abuse, low self-esteem, and deep regrets of children who had been removed from the homes and lives of women in desperate situations. We gained insight regarding resilience in obtaining education against all obstacles, going through recovery, and finding inner strength in a drained community through social bonds and faith. These rich, honest responses tell a story of a hurting community with profound strength and courage.

One noteworthy outcome is from literal investment in the community. We were able to fund a small line item of "collaborative community funds" to offer as seed money to community-driven initiatives designed to improve the self-esteem of women and encourage healthy decisions about their own lives. Five thousand dollars per year has funded over 25 community-driven initiatives in volunteer groups, churches, community coalitions, and professional organizations stepping outside their usual service parameters. From this investment emerged self-help groups run by community volunteers, youth-empowerment seminars, motivational and informational community conferences, and other innovative women-helping-women projects that the community had hoped for years to bring into being.

One important realization that shaped our intervention was that people were not inclined to utilize specialty mental health care and turned mostly to their friends, family, and primary care doctors for information about depression. So, in addition to promoting specialty mental health treatment when needed, we also educated the friends, families, and health care providers. Since we couldn't get many health care providers to come to the office, we made office manuals and delivered them to the physicians. Evaluation of the effectiveness of this intervention has proven a challenge because physicians have not been willing participants

in follow-up surveys. What our consumer surveys tell us, though, is that more women report satisfaction with the information and support they are receiving from their physicians than before our project, and increasingly more women are choosing to involve primary care providers in their mental health. Not surprisingly, once there was improved response by family and friends to talking about mental health, even our referral rates to specialty mental health services began to grow. Communities change with action from individuals; individual behavior also changes in response to an enhanced awareness and acceptance level in the community.

Embracing Challenges

By the mid-point of our project together, I felt confident engaging with the community as director of the details of our core project and facilitator of their own empowered community action team. This allowed for introduction of evidenced-based practice and evaluation methods into our project while still encouraging the autonomy and fluidity of community project ownership. My leadership style is one that embraces facilitation and collaboration, so empowerment evaluation and facilitation were also natural fits. As the evaluation plan began to unfold with active participation from community professionals and consumers about what *they* wanted to know, I realized the absolute benefit of community-driven evaluation and research. The project would use our mutual talents and strengths to develop, expand, and plan for project sustainability based on the findings we generated and the way the community engaged in discussion of the findings and implications for service delivery and future action.

Interestingly, our community panel didn't shy away from evaluation but embraced the utility of evaluation for their community and sustainability efforts. Participants genuinely

looked forward to the findings we would discuss at each meeting. It is with their encouragement that I have now been willing to put our project "on paper," presenting outcomes and sharing the story of our progress together for publication and benefit to other communities facing similar challenges. Unfortunately, there have also been dismissive remarks from some aspects of academia: "What about fidelity to a research plan...?" "Well, since it's *only* program evaluation..." I have learned that the practice community and the academic community do not always speak the same language, even if we are both contributing to the same profession. I, however, am putting myself up for appointment as an official translator.

There are other very real, significant challenges and frustrations that this project continues to encounter. First, there are the ever-changing social policies and domestic funding cuts that impact our project and our community. When we began, it was safe to say that women with serious mental health problems could receive services, regardless of their socioeconomic status. Community mental health centers had discretionary funds to support provision of necessary services not funded through Medicaid, and Medicaid dollars that were available to reimburse services directly for those with serious mental health problems. With budget cuts at state and federal levels sharply increasing during years two and three of the project, Medicaid dollars are no longer available to the same extent as when we began. The reimbursable definition of what constitutes a serious mental health problem has relegated Major Depression to a non-serious category in most cases. More women are falling through the cracks in our region than ever before; as a result, demand for our project's support services has dramatically increased. Our community mental health center refers women to us who otherwise would have to be denied treatment due to funding cuts. This is a systemic issue

that is reflective of lack of parity in reimbursement for mental health vs. physical health services, as well as general domestic spending trends in the United States. Here we are, preparing to close our project having met our objectives to enhance service utilization and now, the services relied upon by our consumers are eroding away. The challenge of growing needs amid shrinking resources is a continual source of frustration that impacts full implementation of research findings back into community action.

Then, there are the very real challenges of rural practice and research. There is often a distribution of scarce funds to urban areas with higher populations, while rural communities suffer many of the same problems with an ever-shrinking availability of resources. In rural regions, cost per person appears much higher due to geographic constraints, distance traveled to services, and the high cost of attracting qualified practitioners. Then, there is the perpetual problem of a lack of skilled providers willing to work in our project area. Funding for a preventative project such as ours seems to be at the bottom of every funding priority list, although the merit of our project is quickly acknowledged. This year, we learned that there would be no continuing RFP issued for our maternal depression project from the federal agency that originally created it. We are meeting this challenge by again turning to our community members. Our partnering prenatal care project will continue to offer the core depression services to all women enrolled, and other community partners in other social service settings are committed to continuity with or without designated funding. Our collaborative partnership has been beneficial to this inter-agency collaboration. Agencies in our community cannot afford to compete with each other, so we are joining forces to attract funding to our rural area to keep alive as many pieces of this project as possible.

While the sustainability of programs still hangs in the balance, this story does have a happy ending. This week, I convened a meeting of our community and professional stakeholders on the eve of our transition. We have successfully worked together on a proposal that will provide interim funding for an additional year, and two individual agencies have written grants to utilize the same programmatic model within their own host settings to perpetuate the services initially provided by the Women's Wellness project. This amazing group of women from diverse backgrounds and interests brainstormed ideas for ongoing sustainability that ranged from federal research opportunities to approaching Oprah Winfrey's foundation for continuity of their community initiatives. The community participants in this project have found a higher calling than that of bugs under a microscope: they are now committed change agents who are working together to continue to support women in their community. That, in my subjective opinion, is success.

Personal Challenges, Accommodations, and Growth

In spite of these accomplishments, our project also had numerous challenges. One personal challenge I encountered was an identity crisis: Is this a research project? Or, is it a community-driven intervention project? Although I would like to flippantly say that it is both, the fact is that my descriptive word choice would create an identity to the target population. I re-read DeShazer's *Words Were Originally Magic* (1994) as I wrestled with decisions about whether we had "clients," "participants," or "respondents," and what descriptors I would use to frame our discussion about evaluative models. When I listened to the community, however, I could feel the depth of residual hurt from past years as a target of research without any benefit. I began to understand that years of projects conducted without any harm, but also without

providing direct benefit, had made many residents of this rural community wary of the word "research." And, flouting a lofty title after my name or referring to myself as an investigator or researcher would be the kiss of death. The meanings that had been attributed to those words were more powerful than one project could eliminate.

As for me, this meant one more huge change. I personally wrestled with decisions surrounding how my doctoral education interfaced with this project. I became increasingly uncomfortable with the concept of basing my dissertation research on my project findings. In conducting dissertation research, I needed to be accountable to my own needs, not to mention those of my advisor and committee members. I realized that I could not prioritize the desires of the community with a formal research agenda that had intense academic oversight. Thankfully for me, my dissertation chair was supportive of my rationale and understood the dilemma facing me in my dual role. So, I chose to pursue my dissertation research apart from this project, using a national data set with the potential to inform my area of expertise in other ways—more humility and frustration, but the right approach for what was needed in this community. These challenges are not unique to my role as student; doing research on the ground means having to make difficult choices balancing our roles as researchers with the needs and demands of our community partners. The trust-building process also means that everyone has compromises to thoughtfully consider.

Although I am confident that my decision to pursue this project apart from my dissertation was the right one in order to maximize community autonomy, I am less certain about the implications of this decision to the future development of our field. While striving for rigor in social work research, we have adopted the medical model's "gold standard" of the randomized-controlled trial

as the hallmark of the scientific method. I have learned that the science of research is grounded in empirical validity, parsimony, and pragmatism. I am also driven to enhancing the credibility of the social work profession within the field of applied science. But, there is also a heart and soul to engaging individuals, families, and communities in an empowered, participatory research process that stands apart from these scientific principles based in the laboratory. The "real world" is imperfect; human beings are complex; and community empowerment necessitates a fluid approach to intervention development to meet the ever-changing needs of real people in the real world as they themselves define their challenges and solutions. Rather than apologize for these deviations, our profession has the capacity to embrace them. However, there is both an art and a science to this practice that I am not convinced that the mysterious "they" who set standards for research (including dissertation research) are ready to embrace. Perhaps social work, as a progressive discipline, may find a future role as change agent within the institution of academia as well.

The concept of evaluation itself also posed a challenge to my understanding of my role as community-based researcher. While the collaborative efforts between professionals and consumers have been particularly exciting to watch, they are difficult to formally evaluate. In a small community where social isolation is profound, watching women find the desire, energy, and time to create self-help groups, sponsor peer-mentoring initiatives, and invest in future generations of young women brings a feeling of success. At the same time, grassroots activities undertaken by volunteers with tiny amounts of seed money do not have the resources to formally evaluate service outcomes. When meeting with the community, narrative experiences illustrated the value of newly formed collaborative services to their participants, while the thought that one would administer a pre- and post-test during these

events was seen as ridiculous by members of the community. The balance struck between research and community action was to teach those involved in projects we funded how to self-evaluate their own efforts through qualitative interviews and participation in our larger community quantitative surveys and outcome studies. I learned there is a role for both approaches and a need to honestly acknowledge that the community has valid ways of identifying success in its grassroots endeavors. What is important to learn as researchers is that there is a place for self-evaluation within the community that may be separate from the findings we report or generalize. Developing that balance is part of the collaborative process.

In my own professional growth, I have considered a personal metaphor for distinguishing between the need for objective and subjective evaluation. Using stress as an example (something we can all relate to), what defines the difference between an "intervention" and "those things you do to stay sane?" When I vent my frustrations and share mutual support with a group of social work colleagues that meets about once a month for lunch, we don't gather together our list of formal objectives and rate the perceived benefit of our mutual support group on a Likert-type scale. But, if asked, we could recount personal narratives where we shared stories, humor, and social support and afterwards felt better and less stressed. Consider our community members striving to do the same thing. If we feel an intrinsic desire to impose objective accountability on those in a community in order to simply satisfy our funders, or publish our findings, then we negate the value of their own need for self-accountability. Perhaps this is where research distrust begins, with our inability to allow the community to be accountable for its own successes and aware of its own limitations. To those in the community, it may feel as if we are reaping the rewards of their efforts by

giving ourselves a pat on the back for "interventions" that prove successful or dismissing those with questionable results. In the end, we have to believe that when provided with the tools to self-monitor, community members will be able to identify when objective evaluation is needed.

Personal Reflections

As for my own story, I am awestruck at the changes in my own professional identity through this experience. Through the process of engaging in this community-research partnership, I have become the self-appointed "broken record" to speak to the value of practice-based research as a core of social work's contribution to the social science field. As a result of my work with this project and this community, I experienced a personal transformation in my own view of the interrelatedness of social work practice and social work research. Intrinsic to doing research in the real world is an inherent opportunity for social change, which is the core of our profession. What is more controversial, however, is that my experiences working with the community have made me believe that social work research *must* find a way to advance goals of social change at some level through our research. What else separates our profession from any other? Social work is founded on principles of social justice; self-determination requires us to consider the relevance of our research activities through the perspective of our participants. Through the eyes of this community, I have learned that there is a heavy price for disregarding the direct benefit of research to our participants. The price we pay will be institutional distrust not only of research but also of our profession, which is something we cannot afford.

I now find myself questioning every piece of research that I encounter for a direct link between science and community-based implementation. I question whether our

profession is equally balancing “society” and “science” in application of social science to social work practice and continually infuse my lectures with examples of “real world” lessons that illustrate both the application and limitations of theory and empirical research. I listen to researchers blame clinicians for not using empirically supported practices and listen to clinicians blame researchers for creating studies that cannot be replicated in the constraints of the real world. As I strive to create my own identity as a practice-based researcher, I realize that we can all too quickly place the blame on each other instead of really listening to the power contained in the words we speak and the actions we take towards the individuals, families, and social systems with whom and with which we interact. Our choice to collaborate must be rooted in mutual respect.

Every day, social work practitioners work with individuals, families, and communities to empower real changes; every day, social work researchers strive to quantify those changes and demonstrate the effectiveness of our professional standards of practice. Uniting these intentions will certainly make an impact that reaches beyond our profession and speaks to lasting social change. Opening up my project to objective evaluation and subjective inquiry is my first step at uniting these powerful forces in my own professional research career. Through my process of helping, I have received a deep and lasting education that could not have come any other way than through first-hand experience in a community setting and ongoing critical reflection on the integration of practice and research that is essential to the survival of our profession.

References

- Dewey, J. (1938). *Experience and Education*, as quoted in *The Columbia World of Quotations* (1996). Columbia University Press.
- deShazer, S. (1988). *Clues: Investigating Solutions in Brief Therapy*. New York: W.W. Norton.
- deShazer, S. (1994). *Words Were Originally Magic*. New York: W.W. Norton.
- Fetterman, D.M. (2001). *Foundations of Empowerment Evaluation*. Thousand Oaks, CA: Sage Publications.
- Fetterman, D., Kaftarian, A., & Wandersman, S. (Eds.). (1996). *Empowerment Evaluation: Knowledge and Tools for Self-Assessment and Accountability*. Thousand Oaks, CA: Sage.

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