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**RESEARCH ARTICLE**

# ABCD MODEL AND RELATIONAL-CULTURAL THEORY AS THE FOUNDATION FOR CLINICAL-COMMUNITY PRACTICE

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**ABSTRACT**

The Asset Based Community Development (ABCD) model has been used across the globe to engage communities in proactive action however the interpersonal dimensions of this process have not been explored in great detail. The ABCD model often focuses solely on the macro environment with little attention being given to the micro environment. However Relational-cultural Theory, most often used in interpersonal relationships, can be utilized to create growth fostering relationships which bridge the gap between community changes and interpersonal changes. Through a meta-analysis of Academic Search Complete, ERIC, psych ARTICLES, psych INFO, Social Work Abstracts, Soc INDEX with Full Text, and Women's Studies International, the authors hope to elucidate the nature of this model and theory as it applies to practice and how these theories can best be used to complement each other in clinical and community practice. Often social workers have their feet in both of these fields without a sturdy bridge between them. By combining these concepts, practitioners may be able to confidently serve their communities by helping to promote client growth by building trusting relationships and developing community partnerships in a positive manner.

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## INTRODUCTION

Practitioners often have a difficult time bridging the gap between clinical practice and community engagement. Several schools across the country have adopted a perspective of clinical-community practice to engage students so that this bridge will be easier to cross. However this change in academia needs to be followed with the development and application of theories and models of practice that extend across both of these fields. Asset-Based Community Development and Relational-Cultural theory hold the potential to be influential in this process since both of these concepts hold relationships as a core construct. This potential was found through a meta-analysis of recent literature. Through this meta-analysis, the authors hope to achieve an integration and synthesis of different kinds of practice and certain theories.

### Meta-analysis of Peer-Reviewed Literature

A meta-analysis was conducted through seven different databases to collect a total of sixty-six articles. The databases used were Academic Search Complete, ERIC, psych ARTICLES, psych INFO, Social Work Abstracts, Soc INDEX with Full Text, and Women's Studies International. For the search, two separate search phrases were used. These phrases are asset-based community development model and relational-cultural theory & community. For the first phrase, a total of forty articles were found that corresponded with the researchers' need. For the second phrase, a total of twenty six articles were found that corresponded with the researchers' need. The research was then separated into qualitative, quantitative, and mixed methods design for each search phrase. For the first search phrase, a total of thirty four articles were found for qualitative, three were quantitative, and three were mixed methods designs. For the second search phrase, fourteen articles were found that were qualitative, four were quantitative, and eight were mixed methods designs. From this certain conclusions can be made. The meta-analysis can show that research done for either of these terms is largely qualitative. In relational-cultural theory and community though, a sizable amount of the research found comes from mixed methods. Also by reading through the research, certain common variables can be found between the two categories of search terms that may assist in integrating the asset-based community development model and relational-cultural theory. Before addressing this combined model of practice and theory,

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clinical practice, community engagement, clinical-community practice, and the model and theories roles need to be elucidated so that there is a strong foundation for these concepts to be synthesized. Since clinical practice is the most familiar to most practitioners, this can be used as a starting ground to elucidate more complex concepts.

**What is Clinical Practice?**

Mental health professionals work in many different areas of client's lives. The most direct method of service delivery is within the realm of clinical practice. The definition of this term can be explained through a wide variety of perspectives and is ambiguous for this reason. However, clinical social work practice can be summed up to state it involves the, "treatment and prevention of psychosocial dysfunction, disability, or impairment," through the usage of social work theories and methods in order to affect the person-in-environment (Barker, 2003). That has been described as simply face-to-face interactions by practitioners and scholars (Folgheraiter & Raineri, 2012). These interactions are guided by the relationship between client and clinician. As such, relational-cultural theory seems to be a good fit to describe the nature of interactions not only in real world environments but also within the context of clinical practice.

**Role of Relational-Cultural Theory in Clinical Practice**

Relationships are at the core of relational-cultural theory. These relationships are enhanced, changed, or diminished, according to relational-cultural theory, through relational contexts, images, trauma, and violations (Comstock *et al*., 2008). Similarly, the sign of a healthy individual according to this theory is someone that grows their capacity for relationships, authenticity, empowerment, empathy, ability to handle conflict, and their ability to foster growth with other individuals (Comstock *et al*., 2008; Liang, Tracy, Kenny, Brogan & Gatha, 2010). The idea that relationships are central to a person's development is not a new concept. Rather, the creators of relational-cultural theory wanted to show what good comes from mutually empathetic, growth fostering relationships. According to relational-cultural theory, "five good things" come from these kinds of relationships (West, 2005). Specifically relationships foster the characteristics of zest, the want to act for good, a sense of worth, knowledge of how others perceive them and how they perceive themselves, and the desire to be more connected (West, 2005).These different capacities can be altered negatively though through relational traumas and violations. Language also plays an important role in this theory and in people's lives.

Before continuing onwards, the language being used to describe this theory needs to be placed in context. The language used here such as relational images, trauma, and central relational paradox are not specific to relational-cultural theory. Rather this theory works to create a more common language; away from jargon so that both clinician and client can understand each other better and create a more authentic relationship (West, 2005). The language of relational images, self, and trauma are utilized in order to create a piece of the picture that relational-cultural theory can fit into just as people use their own language to express their feelings or thoughts. Often time's relational traumas and violations experienced by an individual are cultural in nature and deal heavily with language. Culture can be defined as a circumscribed set of beliefs, behaviors, norms, rituals and taboos that are centered on a certain age group, gender, ethnicity, or social class (Barker, 2003; Falkheimer & Heide, 2006). Commonly people fromdifferent cultures have opposing views on some of the most basic aspects of life and have difficulty translating their beliefs to other cultures due to various barriers such as language and core norms or beliefs of the cultures (Falkheimer & Heide, 2006) Often times, these sorts of impasses in communication lead to relational traumas and violations. (Comstock *et al*. 2008). According to Birrell and Freyd (2006), these relational traumas tend to leave individuals with more emotional symptoms than traumas that are not relational in nature such as a car being broken into by a stranger. As such, these traumas should be looked at in the relational context of the situation and the relational images that it creates for the individual suffering the relational trauma.

The kinds of relationships that people engage in can not only create social supports and networks but also can define a person's identity throughout the life span through the fostering of the "five good things". Koerner (2006) describes this concept as a model of relating or as relational-cultural theory would deem it, relational images. These images consist of the relationship, the self in the relationship, and the other in the relationship. Each relational image is based upon the individual's beliefs about that relationship and the individual will utilize the best relational image to match the current relationship (Koerner, 2006). Usually, the images created can foster mutually empathetic and growing relationships that will help to create the "five good things" in the individuals involved. The difficulty occurs when these images become maladaptive and start to cause behaviors which isolate the individual, also known as the central relational paradox. The central relational paradox occurs when an individual has been violated or traumatized by past relationships and readily uses those relational images to guide further relationships (Comstock *et al*. 2008). This leads the individual to either experience the trauma over or to isolate themselves and halting their relational development. Regardless of whether or not the relational images match the way the world actually is, they affect the individual in the way that it exists to them (Ornsetein & Ganzer, 1997). Either way, the individual affected by the central relational paradox can seek therapy or a clinical practitioner to help them with these issues.

Therapy in a relational context emphasizes the role of the relationship between client and clinician as one of the main devices for moving forward proactive change with the client. Many different approaches utilize this concept in collaboration with others such as Rogerian and Positive Psychology (Joseph & Murphy, 2013; Comstock *et al*., 2008).According to Relational-Cultural Theory, the role of the clinician within the context of the therapeutic relationship is to not only to help the individual with their relational images but by their interaction create and redefine the client's relational images (Birrell & Freyd, 2006).

This sort of relational helping and reframing should challenge the client's notions of old ways of relating in order to create new ways of relating that can assist the client in their relational world (Ornstein & Ganzer, 1997). Therapy from the perspective of relational-cultural theory can assist in the creation of mutually empathetic, growth fostering relationships which can help foster the development of the "five good things"(Comstock *et al*. 2008; West, 2005). These relationships occur within the context of culture, the person's environment, and community. Therefore in order to create a more complete picture of the helping relationship, another perspective needs to be taken. Clinical practice and clinical theories can be better utilized when viewed from within the perspective of a community and through engaging communities, more clients may be helped.

**What is Community Engagement?**

Practitioners in the helping professions are not always involved with clients or citizens in one on one helping or working relationships. This set of practitioners is involved in what may be called, indirect service delivery. The Social Work Dictionary (Barker, 2011) prescribes that community organizers are "facilitators of planned efforts to achieve specified goals in the development of a group, neighborhood, constituency, or other community." Community organizers and other community practitioners can engage communities to achieve those goals through many different methods, many of which are based upon theories and models of practice. A dichotomy of practice has formed though in community engagement with relation to how the community is engaged. The usual model for community engagement until several years ago has been a needs-based model.

The needs-based model works from the framework that a community needs an outside expert to identify the needs of the citizens of the community and then provide services to fit that need. This sort of model is necessary for many reasons and consists of examples such as food stamps and public housing. Those types of services are in place because of a need that the community has. However Kretzmann and McKnight (1996) believe that this model may turn citizens into clients with long lists of problems that become synonymous with the community. They further elaborate how the needs-based model only gives part of the picture of a community. The other part of the picture may be found through the Asset-Based Community Development (ABCD) model. The ABCD model is the antithesis to the needs-based model and seeks to engage people from an egalitarian standpoint instead of from a hierarchal standpoint.

**Role of the ABCD Model in Community Engagement**

The ABCD model focuses on what the community already has at hand. Specifically, practitioners utilizing the ABCD model find out the passions, skills or assets, fears, and relationships that a community has stored but are often overlooked. This is accomplished through a qualitative interview method called learning conversations (Kretzmann & McKnight, 1996). These learning conversations find out those variables or assets and passions of different members of a community.

The job of the practitioner then, in order to engage the community, is to link people with similar passions together so that they may start building relationships and creating groups which the citizens lead. These groups are called connector-leader groups (Kretzmann & McKnight, 1996). Another step in this process is to map out the assets of a community based upon passions and/or location. Eventually, with enough relationships, social capital, and linked assets, these groups form into community partnerships and take on initiatives to better the lives of the people in their community (Green, Moore, & O'Brien, 2009). All of this is accomplished through the ABCD model's focus on three concepts.

The ABCD model focuses on three separate but related concepts. These concepts are asset-based, internally focused, and relationship driven. Asset-based initiatives first look at a community will gather the strengths and skills of the community not the needs and problems (Mathie & Cunningham, 2003). The concept of internally-focused means that most everything a community needs can be found within the community as opposed to relying on outside experts in a given field(Green, Moore, & O'Brien, 2009). Finally, the concept of being relationship driven can show that the relationships between citizens in a community are the driving components of any community initiative (Green, Moore, & O'Brien, 2009).The concepts of working from a strengths based or asset-based perspective, working with what the client has or being internally focused, and utilizing relationships as the main fuel for change are not new concepts to the field of social work. Sometimes the field of community engagement overlaps with the field of clinical practice to create a special kind of opportunity for both community practitioners and clinicians to utilize skills from both the macro and micro perspectives in unison. To set the stage for the ABCD model and Relational-cultural theory, a kind of practice needs to be elucidated which combines the settings for each of these concepts.

**What is Clinical-Community Practice?**

Clinical-Community practice is a fairly new term and style to the field of mental health. This sort of practice combines the aspects of clinical practice and community engagement in order to serve citizens or clients on multiple levels of systems. This new style of practice has come from clinicians that have become aware of the political, social, and economic issues that come alongside purely clinical work (Llorens, 2009). By working through communities as well as through clinical practice, more levels of systems can be addressed and worked on. The actual approach to working from both a clinical and community perspective has to be developed by the individual or group of practitioners since this is such a new concept. Many different theoretical perspectives can be taken and utilized but the main purpose of clinical-community practice is to change the internal and external lives of citizens and clients as one in the same from a person-in-environment perspective (Austin, Coombs, Barr, 2005). Clinical-Community practice can also be better understood by taking a closer look at relationships and their contexts in both clinical and community practices.

## Why Focus on Relationships?

Relationships can be seen as the main driving factor, not only in community engagement but also throughout clinical practice and normal every day interactions. In the person-centered approach to therapy, Rogers claimed that relationships need to be mutual, empathetic, and authentic in order for the relationship to make an impact on all of the parties involved (Joseph & Murphy, 2013). These factors are often called the common factors model. Much research done on the common factors model shows that the main vehicle for change in the therapeutic relationship is not the clinician's techniques but rather it is how the clinician interacts with the client (Reisner, 2005). This idea lends credence for Relational-Cultural theory in the sense that this theory shows how relationships are the key to change an individual. This same message can be explained through the field of community engagement as well.
In community engagement, relationships have come into the forefront of recent literature but have taken a distinctively different name. Relationships and the byproducts of relationship building can be coined social capital (Sarker & Uddin, 2011). The Social Work Dictionary, 5th Edition, cites social capital as "economic value that is derived from the existence of relevant social networks that foster trust and promote cooperative exchange and collective action and the skills of the workforce within those networks." To take this further, Mathie and Cunnigham (2003) describe social capital as being either bonded or bridged social capital. Bonded social capital can be described as social capital which can be depleted over time, such as doing a favor for someone. Bridged social capital however is not depleted over time and its use strengthens the amount of social capital available. Butterfield, Kebede, and Gessesse (2009) give a demonstration of bridged social capital by sharing research with their participant community in order to build relationships. This sharing of information built trust within the community, an important part of relationships, in order to start other community initiatives. This sort of focus on relationship building or social capital acquiring seems almost synonymous for clinical practice and community engagement.

This sort of synonymy applies as well to clinical-community practice. A study done by Chen and Liao (2005) shows how relational factors are instrumental to the implementation of a community based HIV prevention program. In this study, the authors implement a western intervention program with eastern ethics to guide it. The eastern ethics dictate that "trustful and supportive relationships" are key to the "delivery of health promotion services" in the sense that new information is often mistrusted if it is not backed by a source which can be trusted (Chen & Liao, 2005). By utilizing trust through relationship building in the delivery of indirect and direct services, the authors show statistically significant results in how often Chinese women use contraceptives which prevent the spread of HIV. This pilot study can show the usefulness of relationships and relational interventions on not only a micro level but also a macro level, the foundation for clinical-community practice. Since clinical-community practice is a fairly new idea, the "so-what" factor may be a little cloudy for practitioners utilizing these concepts to create with value.

## What is the value of Relational-cultural Theory in Clinical-Community Practice?

The value of relational-cultural theory within the context of clinical-community practice is its emphasis on mutually empathetic, growth fostering relationships. By growing relationships, people can realize the "five good things" that come from them (Comstock *et al*., 2008). Not only through that but by achieving a common ground through language, the ideas of people, clinician to client, and vice versa can be used to help foster these relationships (West, 2005). As the commonalities grow, differences tend to shrink away. For instance in group work, people tend towards mutuality and equity after an emotional experience, such as sharing visual arts, which members of the group can identify with (Skudrzyk *et al*., 2009).This is an important aspect to take in clinical-community practice since clinicians and community workers engage a variety of individuals with whom major differences may be found between them. Especially in the field of social work, diversity is commonly found in almost every case and it is important to recognize those differences and to build bridges across them in order to foster relationship building.

By building relationships through relational-cultural theory in clinical-community practice, clients can access more support and resources through their social networks. Along with these invaluable, tangible things, the relationships formed through the relational-cultural theory framework will also create characteristics in the individuals that will help them to overcome traumas and other difficulties in life (Birrell & Freyd, 2006).This sort of relationship building can help conquer social injustice by providing people with the tools they need to act, with others, against social injustices. For example in ethnic identity theory, the ethnic identity of a person is not created in isolation but rather through the interdependence of all members of the ethnicity through the relationships and perceptions they share (Yeh & Hwang, 2000). In order to further such identity creation and any sort of crisis resolution thereafter, mutually empathetic, growth fostering relationships should serve a key role in the creation of the self.This, however, is only one perspective into how relationships can be valued by clinical and community practitioners. The ABCD model may create new value for the place of relationships in both clinical and community practice.

## What is the Value of the ABCD Model in Clinical-Community Practice?

Just as in relational-cultural theory, relationships take a primary stance in the asset-based community development model for clinical-community practice. In this sort of practice, the mental health professionals' role would be to link together individuals with shared passions in order to create relationships (Mathie & Cunningham, 2003). Despite the value of relationships being similar in the asset-based community development model as they are to relational-cultural theory in clinical-community practice, the role of relationships is different. Relationships serve as paths for assets to come together and passions to be linked together in order for change to occur in citizens' lives(Mathie & Cunningham, 2003).

Without relationships being built, there is no chance to engage the community from either an agency to community link or a person to person link. In the Gedam Sefer community, building trust and relationships with the female heads of household was instrumental to engaging and facilitating growth in the community through research and projects (Yeneabat & Butterfield, 2012). These relationships allow the citizens to take collective ownership of projects that they will lead and take accountability for their communities (Nowell & Boyd, 2010). The projects, since they are strengths-based in nature, can instill hope, wellbeing, and act as methods for positive changes to occur (Rapp, Saleebey, &Sullivan, 2005).These characteristics or variables can be seen as the products or outcomes of the asset-based community development model but quantifying these may serve to be problematic.

Outcomes are necessary parts of successful community projects since outcomes are how they are measured in relation to other programs and for funding. The outcomes for the asset-based community development model are largely intangible and difficult for the participants or facilitators of the projects to articulate. Creative, innovative, and sometimes expensive means such as Photovoice, asset inventories, or other asset-based measures must be used to elicit the data-based outcomes from members of the community in order to show growth.(Williams, Bray, Shapiro-Mendoza, Reisz, & Peranteau, 2009). While the participants may end up bettering their lives and overcoming issues during the course of the initiative, the individual results that come from it may vary from participant to participant and each participant may feel like the initiative has helped a community in different but similar ways(Yeneabat & Butterfield, 2012). These differences in outcomes, difficulty attaining data-based outcomes, or difficulty in conceptualizing how a macro model may fit into a micro model of case work may cause the asset-based community development model to not be readily used in clinical practice. However, there may be ways to find common variables between theories and models in order to make these sorts of initiatives more grounded in empiricism and with unified results. Integrating these concepts can provide for a way towards grounding both in empirical results and practical applications.

**Integrating a Model and Theory for Clinical-Community Practice**

By looking at a model and theory as separate parts, integration becomes monumental task. However if the model and theory are taken as different but interconnected parts of the same system, integration can be achieved more easily and a practice modality can be created. Specifically, the asset-based community development model places relationships into a macro context as to how relationships can affect communities and relational-cultural theory places relationships into a micro context as to how relationships can affect individuals. By utilizing relationships as the key connection between the model and theory, the work comes not in integrating the two but rather the difficulty comes in developing strategies for practice which utilize the two. For this kind of integration to work, two additional steps need to be applied.

The first is finding the other linking factors between the model and theory while the second is creating real world frameworks for practitioners. Techniques that show aspects of both concepts can serve as a useful tool in linking them together. For instance, asset-based community development utilizes learning conversations as a means for relationship building. These conversations help to build relationships through authentic questions that relate to a person's strengths, connections, and passion (Mathie & Cunningham, 2003). This could potentially be used as a self-awareness tool alongside a relationship/data gathering tool (Wilson, Mott, & Batman, 2004). By building relationships through this sort of technique, an individual may gain a sense of worth, a better understanding of how they are connected to others, a purpose and willingness to act, and a greater desire to connect to others (Comstock *et al*., 2008). By following this line of thinking an individual could see portions of the "good five things" from relational-cultural theory being fostered by conducting these kinds of conversations (West, 2005). This is not the only kind of connecting factor these concepts share though.

Perspectives can be used as an umbrella to hold the frameworks of many different theories and models. For instance asset-based community development and relational-cultural theory both can fall under the strengths-based perspective by the concept's focus on well being, strengths, and the positive influences of relationships (Joseph & Murphy, 2013; Rapp, Saleebey, & Sullivan, 2005). Furthermore the model and theory may also fall under the relational perspective for their emphasis on relationships and may also apply to the person-in-environment perspective since in each of these concepts the external circumstances of an individual can be explained to heavily influence an individual's behavior, thoughts, and feelings (Rapp, Saleebey, & Sullivan, 2005; Gilgun, 1996a; Gilgun, 1996b). Even though common techniques and common perspectives can be found, a solution to a paradox may be able to further explain how these concepts can be blended.

A problem or paradox in a person's life can serve as a useful thought experiment to see how concepts may apply and may work in real life without causing harm. The central relational paradox sits at the center of many different relational theories. When a person is hurt relationally, they may tend to isolate themselves to cause further pain from being caused but this may also cause undesired consequences to the individual (Comstock *et al*., 2008). This sort of problem occurs in many marginalized populations because of attitudes and perceptions of culture (Birrell & Freyd, 2006). In relational-cultural theory, a clinician may help a person in the midst of this paradox by providing a mutually empathetic, growth fostering relationships to help foster the "five good things" in the person (West, 2005). In asset-based community development, a community worker may help a person in the midst of this paradox by introducing them to, slowly, other community members that may share similar passions and conduct learning conversations to bridge relationships (Butterfield, Kebede, Gessesse, 2009). Both of these concepts may take different but ideologically similar roads to solve the paradox. What serves as the ideology is relationship building. This now can serve as a foundation for creating frameworks for practice.

**Implications of this Practice Modality**

**For Clinical Practice**

For those practitioners involved in clinical practice, this integration can serve several purposes. The integration of the ABCD model and relational-cultural theory can help to effectively engage multiple clients at once, help them to regain control over an aspect of their lives, help to empower them, and help to build mutually empathetic, growth fostering relationships. An example of how this may be done can be shown through group therapy. In group therapy, one of the challenges may be how to effectively engage several clients in meaningful discussion at the same time. By conducting learning conversations in addition to regular therapy, connections of strengths and/or passions may be uncovered and facilitated, which can increase a client's sense of worth (Green, Moore, & O'Brien, 2009). Furthermore, this model targets the educational health interventions. These connections may be applied to a project, such as an art project if that is what they decide upon, that can help convey and express the clients' feelings and thoughts (Skudrzyrk *et al*., 2009). The project, under the nature of the ABCD model, should be run by the clients in order to give them control over an aspect of their life (Yeneabat & Butterfield, 2012). Through the course of the project, meaningful change can occur with the clients by the development of the relationships in order to accomplish a successful completion. While this is a bare bones demonstration, other possibilities are entirely possible and should be implemented but this is only from a clinical perspective.

**Implications of this Practice Modality for Community Engagement**

For community practitioners that have found difficulty finding outcomes utilizing the asset-based community development model, the integration of these two concepts may serve an instrumental purpose. The asset-based community development model, being a relatively new model utilized by community practitioners, has had difficulty establishing data-based outcomes. Through the focus on relationships though, data-based outcomes may be achieved more easily. For instance, the relational health indices can be used to demonstrate the appearance and realization of mutually empathetic, growth fostering relationships (Liang *et al*., 2010). Furthermore by utilizing relationships as the key for outcome creation, community development can be measured by more than the perceived needs of a community but rather by the assets, relationships, cultural development, and other scales which have already been tested to be valid and reliable which focus on these areas (Liang *et al*., 2010; Sandage& Harden, 2011). Combining clinical practice and community engagement though needs a different kind of framework to elucidate the possibilities effectively.

**Implications of this Practice Modality for Clinical-Community Practice**

In clinical-community settings, practitioners need to be innovative in their design in order to accomplish the goals of clinical practice, health education and community engagement simultaneously. This can be done in such a manner through participatory action research or research where the participants are the researchers. An example of this would be photovoice. Photovoice is a unique participatory action research design which utilizes photography and critical discussions to capture citizen's perspectives of their lives and communities (Powers, Freedman, &Pitner, 2012). By engaging, for instance,multiple at-risk youth utilizing photovoice, they may benefit through creating mutually empathetic, growth fostering relationships through the group discussions. This sort of change can be quantified through using a valid and reliable scale that focuses on relationships such as the relational health indices for youth (Liang *et al*., 2010). The change accomplished individually is only a piece of the community picture. After the project is completed, steps can be taken to allow the asset-based community development model to connect resources uncovered through the project and the participants may be interested at the end of it to continue connecting people together for another project. That is the essence of the asset-based community development model. It can tend to spiral out affecting more individuals after the completion of a project or initiative (Green, Moore, & O'Brien, 2009). Through this combination of concepts, a multitude of possibilities can be found to implement this new practice modality to effectively change populations of citizens and clients through successful engagement and relationship building.

**Summary**

The effect of combining the asset-based community development model with relational-cultural theory can change the field of mental health from the inside out. By utilizing multiple perspectives and techniques through the power of relationships, change can be made for individuals, groups, and entire communities. Asset-based community development sets the stage for macro change to occur within the micro picture of relationships and their effects that comes from relational-cultural theory. The important *take-home* message though is that in order to be an effective practitioner in any field of mental health, the practitioner needs to be innovative in their practice, keep current with research, and utilize the results of their practice to guide new empirically based methods for future practitioners.

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