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AUTHOR Grubb, Henry Jefferson
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ABSTRACT

Barlow (1981) lists nine reasons why clinical psychologists do not undertake research and why traditional research does not influence clinicians. These reasons focus on: (1) lack of access to a large subject pool; (2) manpower costs of conducting research; (3) financial costs of conducting research; (4) ethics; (5) research's overreliance on statistical significance; (6) difficulty in predicting a treatment's effectiveness with an individual from nomothetic research; (7) the practitioner's awareness that each client is different; (8) the practitioner's resistance to using factorial designs; and (9) the view that research may thwart clinician's effort to get clients better as quickly as possible. Intensive local observation, a series of single case studies using each patient seen by a therapist as a self-contained experiment, may be one solution to closing the researcher-practitioner gap. A more basic underlying reason that clinicians do not engage in research, are not trusted by the public, and are ineffective is that graduate schools are training the wrong people to be clinical psychologists. Too much emphasis is placed on psychometric and standardized intelligence tests. Students in experimental psychology perform well because experimentation and statistics can be taught and learned. Psychotherapy is more difficult to teach and learn. If clinical psychology is to improve its effectiveness, it must put less emphasis on abilities like memorization and social conformity and must attract students who are emotionally mature, have lived less sheltered lives, and have some knowledge of the world. (NB)

The Relation of Clinical Research to Practice and the Apparent Crisis of Confidence

Henry Jefferson Grubb

Virginia Polytechnic Institute & State University[1]

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[1]Paper begun while author was a graduate student at Virginia Polytechnic Institute & State University. The author can now be reached at the Department of Psychology, P. O. Box 21970A, East Tennessee State University, Johnson City, TN 37614

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Crisis of Confidence

(Abstract)

Barlow's appeal for the use of Cronbach's method of intensive local observation by clinicians is discussed. It is agreed that this technique will overcome all of the objections and reasons given by practicing psychologists for not being involved in research. Strupp's assessment of the experimenter-clinician rift as a pseudo-problem is also addressed. Strupp's conclusion that our training institutions are not properly teaching the skills needed by the clinician is extended. Strupp argues that the call for research clinncians is really a call for accountability by the law, second party service provides, and the public. It is herein added that those being trained by our graduate schools are not being screened properly prior to training: we are training the wrong future providers.

Henry Jefferson Grubb received his Ph.D. in Clinical Psychology in November 1985 from Virginia Polytechnic Institute & State University. He completed an APA-approved clinical internship at Western Psychiatric Institute & Clinic (pittsburgh) and is now Assistant Professor of Psychology and Psychiatry at East Tennessee State University, Johnson City, Tennessee. Dr. Grubb is married and the father of four children.

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Barlow's (1981) rendering of Cronbach's (1975) "intensive local observation" approach to clinical investigation and his (Barlow's) suggestion that adoption of this approach will lead to a narrowing of the scientist-practitioner gap is basically sound. Barlow discusses why the scientist-practitioner gap is now in existence and then persuavsively argues how "intensive local observation" is the answer to the problems causing the gap. I will therefore attempt to follow his format.

Barlow gives nine major reasons why clinicians do not undertake research and why traditional research does not influence clinicians. One reason is that for most clinicians, gaining access to a large enough subject pool to do large group-comparison research is an impossibility. Additionally, if such a pool of subjects were within reach, the costs in money and manpower would be beyond the budget of any single practitioner. The fourth reason for the split between research and practice has to do with ethics. Clinicians find it difficult to withhold treatment to certain clients just in order to have a comparison group.

Another reason is the over reliance of experimenters on statistical significance to determine treatment effects. Clinicians have often found statistical significance to be virtually worthless. Barlow summarizes the feeling: "Statistical significance, even when properly interpreted, bears no relation to importance of size of effect." A related reason, number six, is that statistical significance in nomothetic research cannot predict a treatment's effectiveness with an individual client at the time seen by the practitioner in his specific locality.

The seventh reason for the gulf between practitioner and research is the

practitioner's awareness that each client is different. He rejects the false assumption under which most nomothetic research is interpreted by researchers and what Kiesler (1971) terms "the patient uniformity myth". This myth assumes that group norms and differences are based on homogeneous populations and therefore the treatment tested is either proven effective for the clinical condition or not. The truth is however, that most research groups are heterogeneous on a number of variables that are relevant to the dependent variable being manipulated.

The eighth reason for the experimenter-practitioner non-mutuality is again statistical. Noting that some have proposed using factorial designs by clinicians, Barlow again appeals to Cronbach (1975) when he states that the investigator employing a factorial design will allow "sizeable interactions" to be suppressed "just because any interaction that does not produce a significant F ratio is treated as nonexistent." This will happen even though some interactions of manipulated conditions will be detected. Thus, here like elsewhere, data lost in the statistical manipulation is that which is most needed by the clinician.

The final reason given by Barlow for the rift is a simple one. Clinicians have a goal to get clients better as swiftly as possible. Research thwarts these goals, as currently practiced.

Barlow, having given several important reasons why clinicians do not become involved in research, suggests that the answer to this problem is to change our experimental methods to meet the particular demands of practice. One form of clinic based research he describes as a solution is outlined by Cronbach (1975) and called "intensive local observation".

Intensive local observation is simply a series of single case studies using each patient seen by a therapist as a self-contained experiment. Subjects act as their own control through the use of the repeated measures technique. Precise behavioral recording are taken of problem behaviors with changes noted as different therapies are initiated. Only those therapies that work are ever continued with any particular patient, thus allowing for adaptability and immediate response to the clients' individuality. This method of research should therefore be able to involve clinicians in research.

This paper also endorses Cronbach's approach to closing the scientist-practitioner gap. Below will be outlined the manner in which every major objection to practitioner research is effectively answered by this system.

It is an idiosyncratic approach and therefore does not necessitate the formation of large groups and thence the cost in manpower and money is drastically reduced.

It obviates the ethical dilemma of withholding treatment to certain clients. In fact it is more ethical in the sense it encourages the change of treatment throughout the period of observation in order to arrive at the maximally effective conditions.

It sidesteps the troubling problems of comparative inferential statistics. Either the client under treatment is improving or the treatment strategy is changed until the right combination of treatment conditions is arrived at where there is improvement. And the clinical ideal of getting the client better as quickly as possible is actively encouraged by "intensive local observation" technique.

The most important way that this method of investigation, if adopted and legitimized by clinicians, would affect clinical research in general, would be to

get clinicians doing research. This alone is reason to encourage its dissemination.

The effect that this method would have on traditional clinical research is also important. It would allow clinicians to help direct the course of future traditional nomothetic studies. Clinicians, by observing what works, where, when, and on whom and by also observing and recording the obverse (what does not work, where, when, and on whom) could compile data on hundreds or thousands of cases over the years.

These series could then be analyzed by the traditional clinical research centers to determine what those individuals, that a certain treatment has a positive effect upon, have in common and what differentiates them from other individuals on which the treatment was ineffective. This would then allow these clinics to develop nomothetic based group studies based on these different groups to determine which variations of effective treatment would possibly be effective on the nonimproved individuals. Theoretical explanations of which variables differentially affect treatment and how, and entire explanations of when and why one should use a particular treatment and not another could be formulated.

Strupp (1981), however returned the ball to Barlow's court with the following backhand:

> The crisis facing psychotherapy today, couched in the demand for better scientific evidence on the safety and efficacy of our services, is part of a larger issue. . . . It reflects a crisis of trust. Though clearly essential, research by itself cannot solve this issue.

Strupp concludes that this lack-of-trust is a result of the poor way our graduate schools train clinical psychologist. It would be tempting to agree with this and end this discourse here. And even though, as Strupp States. "the mental

health professions have not done an impressive job of training truly first-rate clinicians and practicing therapists," the fault lies prior to graduation, even before training begins.

The more basic underlying reason that clinicians do not engage in research, clinicians are not trusted by the public, and clinicians are ineffective is that psychology is a victim of its most infamous invention: the psychometric test. Our graduate schools put too much emphasis on various standardized intelligence tests in determining entrance.

So each year all over the country, freshly scrubbed little underdeveloped faces show up at our teaching institutions and are admitted into the fraternity of healing. And four or five years later these same young and now thoroughly perplexed individuals are given the right to go forth and heal. Yet they know not what they do.

And all through their graduate careers they take tests and pass and everyone believes that they know. The entrance tests and the criterion (tests throughout their stay in graduate school) correlate highly, so the teaching institutions believe they are doing their job. And of course, clinical practice is not graded for, "how can you grade it?"

So, this is our professional problem. What we do not assess about ourselves, that is just what the public, the legal system and government does assess about us. But the problem does now wholly belong with how we teach future practitioners as Strupp suggests, but also with whom we teach.

We search out the brightest-the best-and wonder why these future clinicians do so poorly when turned loose on the public. Our experimental psychologists are of the same vein, yet their research careers are true reflections of our expectations.

The higher institutions train experimental psychologists who develop new theories, prove and disprove ideas, develop intervention techniques, and all-in-all seem to fulfill all expectancies held of them. Yet in the clinical arm of psychology, where the scores on the IQ measures are just as high, the results are disappointing.

Whereas experimentation and statistics can be taught and learned, psychotherapy does not seem to be as easily taught or learned. At least, not with the bright young middle-class population we are trying to train. Many are fresh from undergraduate school, 21 or 22, and before that - from a sheltered life in the suburbs where their biggest fear was not having a date for the prom.

It is my contention that if clinical psychology is intent in improving its effectiveness it must put less stress on abilities like memorization and social conformity (measures on most tests of intelligence) and start attracting students who have lived more than one sterile existence in their life, students who are emotionally mature and have a greater knowledge of the world than just that glimpsed from the back seat of a wood-sided station wagon.

Children are very capable of manipulating variables and constructing castles in the air (experimentation and theorization) but a childish mind has no right manipulating the well being of a person in crisis or carving out a livelihood on the battered souls of those mistakenly coming to him for assistance.

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