

# **THE RELATION OF CLINICAL RESEARCH TO PRACTICE AND THE APPARENT CRISIS OF CONFIDENCE REVISITED**

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## **Abstract**

Thirty years after Strupp and Barlow criticized the bifurcated and insular state of psychology, with researchers situated on one pole and clinicians at the opposite end of the applied-research spectrum, the profession finds itself little moved toward a merger of the two branches. It is agreed that Barlow's appeal for the use of intensive local observation research 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. It is herein added that those being trained by our graduate schools are not simply being mis-trained or non-trained in appropriate research skills; we are possibly training the wrong future providers.

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

Barlow's (1981) rendering of Cronbach's (1975) "intensive local observation" approach to clinical investigations and his (Barlow's) suggestion that adoption of this approach will lead to a narrowing of the scientist-practitioner gap in experimentation is basically sound. Barlow outlines why the scientist-practitioner gap was then in existence and then persuasively argues how "intensive local observation" is the answer to the problems causing the gap. I will therefore attempt to follow his format. This will be followed by a review of changes in the field since the 1980's and a discussion of why little movement toward a therapeutic-applied synthesis has not transpired.

## **Review of the Problem**

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 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 researcher 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 “sizable 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 repeated measures technique. Precise behavioral recordings 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.

But, as will be elaborated in more depth later in this paper, much of this involvement will be determined by the students the professions attracts, trains, and sends forth as healers. And, more basically the character, background, and diversity of the future professionals will be determined in their interest and involvement in local research (Grubb, 1988).

The Old Solution and its Lack of Effect

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.

#### The Real Problem Revealed

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. Ever since the adoption of American Psychology Association endorsed a second non-research degree (Psy.D.) at the famous Vail Conference in 1973, even fewer clinicians have been produced by the profession with the expertise or interest in doing research.

Even the more classically trained psychologists are reluctant to engage in or are restrained from applied research. 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 test and the criterion (test

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?” Supervised practices and internships are focused on skill development: engaging the client; being open; listening; note taking; diagnosing; and assessment. Case management involves keeping good records, maintaining confidentiality, report writing, and treatment compliance. Research and clinical work are never addressed together in training sessions.

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. The public wants proof of treatment effectiveness. The insurance companies want to know what are acceptable and best practices. The government asks are any of the numerous interventions dangerous; what are the negative side effects. 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. Or, at least, why they do not innovate and add to the knowledge of the field at even a minute proportion as do their fellow psychological researchers/academicians. 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 nor 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 the 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. Not to belittle the varied histories of our graduate program students, but their differences just do not match the variety of racial, ethnic, language,

economic, religious, and geographic diversity these future clinicians will encounter in their professional careers.

### Discussion

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. It has been repeatedly documented that misdiagnosis is a tremendous problem in American (Zimmerman & Mattia, 1999) and other countries mental health delivery systems. The problem of incorrect or incomplete diagnosing becomes even worse when a major-culture therapist attempts to treat a minority client (Akhbar, Byme, & Doghramji, 1986). Many minorities will not even return to therapy after an initial meeting with a Caucasian therapist, one being the average number of sessions of Native American clients with White provider's (Sue, 1981).

With only six percent of all American psychologist being racial minorities (Hoffer, Selfa, Welch, Williams, & Hess, 2005), the crisis of misdiagnosis, incorrect treatment, and premature termination of treatment becomes catastrophic. How can research even commence under these strained "therapeutic" conditions, even using Cronbach's vaunted "intensive local observation" approach.

Now add the suspiciousness of minority communities and individuals concerning the motives of European American investigators, even clinical investigators (or particularly clinical-investigators), (Thomas, 1970) and the fact that these middle-and upper-class majority providers have little interest in research and almost no motivation to improve inter-cultural knowledge and skills. In a society with multiple minorities, becoming more diverse by the year. (Feldman, 2013), the disconnect between provider and her served population will only become greater.

Psychology needs to recruit, train and equip more minority (and majority) clinicians with cross-cultural knowledge, skills, and self- and other-awareness plus a commitment to not only make a therapeutic impact but gain information through the scientific method, including research, that will benefit others through the growth in the knowledge base. The clinician must be as much a community psychologist as a therapist. Our profession must convince a new diverse corps of counselors that research and its offshoot, understanding, is as immediately and distally meaningful as therapy. If our educational programs can do these things, the gulf between research and practice will be greatly reduced.

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