Values, Practices, and the Utilization of Empirical Critiques in the Clinical Triad
Michael E. Addis and Christina Hatgis
Clark University

Empirical science is composed of a set of mutually reinforcing values and practices. A potential difficulty arises when empirical knowledge products are disseminated to other groups with an interest in research findings. The danger is that researchers’ values and practices will be deemed superior to those of other parties, and codified across different contexts without consideration of their effectiveness in achieving broader goals of science (e.g., sharing important knowledge about treating problems in living). Alternatively, understanding and respecting how the values and practices of different groups are situated in local decision-making contexts can open up creative ways for enhancing collaboration between different members of the research and clinical practice community. Taking Scheel’s (this issue) thorough and well-crafted critique of research on dialectical behavior therapy as an example, we explore the way values, practices, and local decision-making contexts affect researchers’, practitioners’, and clinical administrators’ reactions to empirical knowledge products.

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One of the most instructive aspects of any well-crafted critique is the way it is received by different audiences. Clinical administrators, clinical practitioners, and clinical researchers (three parties we refer to collectively as the clinical triad) are all potential consumers of a review such as Scheel’s (this issue). Our central goal in this commentary is to explore how critical reviews of psychotherapy outcome research might be understood and used by different members of the triad. By considering what people do with a knowledge product, above and beyond critiquing its venuit, we become more aware of different parties’ goals and their means for carrying them out. This awareness can potentially open up creative ways of optimizing communication and collaboration.

We start with the assumption that the implications of such reviews rarely emerge naturally and unequivocally from the documents themselves. In other words, there are typically few self-evident “take home messages” when treatment research is critically evaluated. Instead, the implications of a review such as Scheel’s evolve in the concrete local practices of different parties as they respond to the situations of most concern to them. What will a practitioner do with the knowledge that there are several limitations to the studies supporting DBT’s efficacy, particularly when there are no other empirically supported treatments for such a difficult client population? What will a clinical administrator do with the finding that DBT is associated with a reduction in the number of inpatient hospital days, but is unrelated to changes in client hopelessness or depression? How should a clinical researcher communicate the relevance of these findings to either a clinician or an administrator?

Traditional models of the research–practice link have been predominantly hierarchical and unidirectional, with researchers developing and evaluating treatments and passing this knowledge on to practitioners. Other models encourage practitioners to conduct clinically relevant research in their local practice contexts. An alternative model, in which all members of the clinical triad make important contributions to shaping new research–practice relationships, has not yet taken shape. What seems evident to us is that, when such a model evolves, it will rest on a broader and deeper understanding of the contexts in which each party operates. Of course, not everyone would value greater bidirectional and egalitarian involvement between empirical research and clinical practice (see, e.g., Fensterheim & Raw, 1996; Schneider, 1998; Silverman, 1996). Accordingly, it is to the importance of different values and practices that we now turn.

EPISTEMOLOGY, VALUES, AND PRACTICE

The idea that researchers, practitioners, and administrators often think differently is certainly not a new one (Cordova & Koerner, 1993; Cronbach, 1975; Silberschatz, cited in Persons & Silberschatz, 1998). It has been suggested that practitioners think ideographically and researchers nomothetically, that researchers are interested in science and practitioners in art, that administrators

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120
think about the “bottom line” while practitioners are concerned with patient care, and so on. Indeed, if epistemology is defined as a theory of what can be known and how to go about knowing it, then there are, on average, significant epistemological differences concomitant with these separate roles. But the problem with an emphasis on different ways of thinking is that it does not go far in opening avenues for change. Ways of thinking are typically thought of as relatively stable traits (e.g., schemas) that can change only through logical argument and the gathering of new evidence. Clearly there has been much arguing and much citing of evidence. Yet the research-practice-administration schisms remain.

An alternative view is that knowledge production and utilization are always locally situated, with various players attempting to achieve particular goals within the contextual constraints currently operating. To adopt this view is to emphasize what people do with information and how these actions cannot be understood apart from the contexts in which they occur. This perspective makes more salient the values and practices of different players. Transforming relations between different members of the clinical triad requires a broad understanding of what each group values, their relevant practices, and how these are linked to particular contexts. The idea that a broader understanding depends on seeing the contextual nature of values and practices is highlighted by the etymological root of “understand,” literally, to “stand in the midst of.” For example, our response to Scheel’s review is shaped by a set of values (we value enhanced cooperation and communication between researchers, practitioners, and clinical administrators) and practices (we critically analyze claims, search for unarticulated assumptions, etc.) that are linked to the context of academic clinical research. Thus, whether different players find any knowledge product compelling is largely a product of what they value, where they stand, and where they want to go.

THE RESEARCHER
Rigor, critical-mindedness, thoroughness, objectivity, and tentativeness are some of the values commonly ascribed to researchers. So, for example, Scheel evaluates the research on DBT according to the adequacy of experimental controls (rigor), the reporting of data (thoroughness), the possible allegiance biases of the research group (objectivity), and so on. We typically think of researchers’ behavior, or practices, as reflecting values. The practices of experimental control and critical appraisal of findings, for example, are thought to reflect the values of objectivity and tentative conclusions. What is typically less emphasized is that practice in turn constructs values. We value objectivity and tentative conclusions because we practice carefully, objectively, and tentatively. Articulating the values supports our practices.

Foregrounding the culture of research allows us to better understand how to achieve the goals we value, in this case increased sharing of knowledge between different parties in the clinical picture. Consider an example in which a clinical administrator wants to know whether to adopt a certain treatment as the standard of care in a particular treatment setting. In consulting with a researcher, the administrator must “stand in the midst of” a context where individuals critically appraise evidence, police each others’ objectivity and logical reasoning, and are hesitant to draw firm conclusions. The administrator must also understand the rules of the dialogue. For example, in a research context it is wrong to place expedient decision making over careful analysis of evidence. If a researcher wants to communicate with an administrator, she or he must be able to stand in a culture where difficult decisions must be made, often in the absence of relevant or complete data. The rules of the dialogue require a careful consideration of options followed by a firm and confident decision.

By emphasizing the importance of understanding practices and values, we are not suggesting that the research-practice gap will be easily bridged by a little sensitivity and communication training. There are numerous political and economic obstacles to fostering better collaboration within the triad. What we are suggesting is that the existing difficulty is exacerbated when one set of values and practices is deemed superior to another, or the cultures are judged too separate to communicate. The former is more confrontational, the latter is more resigned, but the net effect is the same: less communication and more entrenched division. On the other hand, respect for (as in regularly re-inspecting) different values and practices within the triad keeps open the possibility of new and different working relationships.

THE PRACTITIONER
It is difficult to name a specific set of values held by the majority of practitioners, but some generalizations may apply. Clinical practitioners value healing, supportiveness,
balance, and self-preservation. For example, a practitioner would be likely to evaluate an empirical review on the basis of how well it has the potential to foster clients' well-being (healing), to encourage clients' efforts to articulate and achieve self-stated goals (supportiveness), to simultaneously address overall needs and pressing crises within a single case or across an entire case load (balance), and to build the capacity to manage the stresses of clinical work (self-preservation).

As with researchers, these values are related to certain practices. Foremost for many clinicians is the practice of psychotherapy. Practitioners are under increasing pressure to utilize brief interventions with demonstrated efficacy. Various administrative and financial contingencies may generate increased interest in empirical findings. These same contingencies may also create feelings of increased resistance to research findings. Consider the finding that a large portion of the change in depressive symptoms in cognitive-behavioral therapy occurs in the first 6 weeks of treatment (Ildardi & Craighead, 1994). Such a finding could be interpreted by a practitioner as supporting the value of cost containment over clients' well-being, particularly if received in a context where arbitrary session limits are already being introduced for fiscal reasons. Now consider a context in which administrators reinforce consideration of research findings by allocating, rather than withdrawing, resources (e.g., extending session limits) when practitioners provide appropriate evidence (e.g., published research findings, or local outcome evaluations). Such a context might be expected to generate more interest in empirical findings. The point is that different practice contexts interact with practitioners' values to determine reactions to research findings. In effect, there is a rich social psychology of the research-practice relationship, one that has, to date, been little explored.

Values and practices also affect what clinicians regard as compelling evidence. The current debate over manual-based treatments (Addis, 1997; Addis, Wade, & Hargis, 1997; Silverman, 1996; Wilson, 1995, 1996) is worth exploring in this respect because it provides a good example of the way certain practices shape criteria of evidence, and how the latter in turn affect reactions to research. Practitioners are likely to count direct experience rather than aggregate data as evidence, precisely because the decisions they make differ from those of researchers. Practitioners make decisions within a local context, and as such, they value information that is tailored to relevant particularities. For example, a therapist's past experience with a treatment provides information about the future likelihood of success in using that treatment. Of course, this information is based on a certain sample of experience that typically does not involve systematic follow-up of patients, assessment of early treatment dropouts, and so on (Dawes, 1994). Because researchers value experimental control and guards against bias, it seems logical to reject therapist experience as a valid criterion for evidence. Thus, differences in criteria for evidence are central to conflicts over empirically based practice.

The differences per se are not problematic. They become rigid and entrenched when one set of values is deemed superior to another. What are then lost are the potential recognition and respect of different sorts of evidence, and the subsequent sharing of different bodies of knowledge. For example, practitioners' values and practices allow them to gather personal evidence about how to use a treatment with particular patients, how to adapt a particular treatment protocol to their own personal style, how to navigate specific challenges of different service settings such as health maintenance organizations, and so on. This knowledge is increasingly relevant to treatment researchers' concerns. In turn, researchers' empirical knowledge about the general efficacy of different treatments is increasingly relevant to practitioners.

THE ADMINISTRATOR

Like researchers and practitioners, administrators are looking for particular kinds of evidence and information as they make decisions about clinical training, resource allocation, and service provision. Such decisions require administrators to negotiate the tension of two potentially competing values: clinical effectiveness and financial viability. These values in turn affect how knowledge products are received. For example, a critical review of treatment research would be evaluated according to whether it helps an administrator decide the best way to dedicate resources given the particular features of the mental health practice he or she administers. Does it offer a model of implementation and assessment that allows the administrator to try a product and assess its usefulness in his or her particular setting before buying the whole package? Does the research address concerns about risks as well as costs and benefits of a recommended course of action? Does the research review provide comparative informa-
tion about a range of available treatment packages in terms of these concerns.

Reviews such as Scheel's are likely to send a message to clinical administrators that they must await further input before they can make fully informed decisions. At the same time, Scheel's review offers some guidelines that are potentially useful to administrators. For example, Scheel suggests a model of implementation that involves using the full DBT treatment in a day hospital setting with standard DBT clients. She advises that such an adaptation be undertaken in conjunction with training and consultation by the DBT research team and with a program evaluation to assess effectiveness. This advice is consistent with a research orientation in that it is tentative and sticks close to the available evidence. Yet it speaks to administrators and clinicians seeking guidance in treatment decisions and invites their contribution to the research base. In these ways, it begins to span common interests within the clinical triad. Later, however, Scheel warns that DBT's practical requirements and the limitations of its research base warrant a wait-and-see stance for providers in the majority of treatment settings (i.e., those with limited resources and few parasuicidal BPD patients without comorbid diagnoses).

CONCLUSION

Our central premise throughout this commentary has been that values, practices, and the local contexts in which groups make decisions all affect how knowledge products are utilized. We have also argued that a more complete understanding of these variables will facilitate better transfer of knowledge between all three parties in the clinical triad. Self-reflexively, we should note that increasing the tridirectional transfer of knowledge is itself a value we have been supporting and, attempting to make more salient. It is probably not a value shared by everyone. However, we would argue that, to the degree clinical researchers are concerned with bettering the human condition, successful dissemination of our knowledge products is at least an implicit, if not explicit, goal that shapes and reflects our practices. Consistent with this goal, we close the commentary with some suggestions for general ways to move closer toward its realization.

The first step is to recognize and respect the communication process as no less important than research itself. Science is, in the end, no more and no less than a complex set of behaviors that can be evaluated with respect to its efficacy in achieving specific goals. If one of the goals is to better the human condition by effectively treating problems in living, then better communication within the clinical triad is an inextricable link in the process. The second step follows from the first. It involves turning clinical science toward itself and exploring the rich social psychology of the clinical triad. In effect, the mechanisms by which different types of knowledge products are transferred between different parties become legitimate areas of systematic inquiry. For example, to our knowledge there has never been a published systematic needs assessment of clinical administrators and practitioners conducted by clinical researchers. The third step involves becoming more cognizant of the different ways research is constructed in local interactions with individuals from nonresearch backgrounds. For example, one honest and potentially fruitful approach is to represent treatment research as having generated more questions than answers. Some of the questions that it raises are ones that therapists or administrators may have asked themselves or, even better, may be in a position to answer in their local contexts. Similarly, it may be helpful to think of empirical findings as potentially useful knowledge products, depending on how, when, and where they are received. In this representation, the knowledge produced by treatment research is not the received wisdom but rather raw material for practitioners, administrators, and researchers to use in producing further knowledge. A hierarchical and unidirectional model of knowledge transmission is thereby avoided and, instead, the growth of knowledge is constructed as an iterative and reciprocal process involving all members of the clinical triad.

NOTE

1. An adequate account of the ways clients understand and use clinical research would warrant an entire discussion unto itself. Furthermore, such a discussion would necessitate that we take the popular media into account as a primary site of dissemination of clinical research. Thus, we have chosen to limit the present discussion to issues pertinent to researchers, administrators, and clinicians.

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