

The Clinician As Researcher, Innovator and Communicator

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The author elucidates on how the clinical psychologist has developed various therapeutic skills that are ideally suited for innovative research.

The Clinical Psychologist is almost invariably regarded as a practitioner or clinician. To be more specific, he/she is more commonly sought after as a psychotherapist. Perhaps, this is because it is the clinician who deals directly and face to face with a person in crisis; who helps alleviate the pain, confront the problem or clarify the confusion. As a clinician or practitioner, the Clinical Psychologist is also often consulted for psychological testing, evaluation and diagnosis. Thus, the practitioner's time is mostly consumed by these worthwhile activities, and because of the urgent nature of these clinical services, the practitioner hardly has any time left for other activities.

But a lot more is demanded of the Clinical Psychologist as practitioner, because the Clinical Psychologist must be both a practitioner and a scientist.

As a scientist-practitioner, his/her task is not just to practice but to practice with mindfulness; that is, to be constantly aware of what is going on around him/her, to observe and to self-observe; to apply theory to practice and make modifications thereof; and most importantly, to formulate concepts, and to make theory from practice.

To add to those demands as a scientist-practitioner, the work of the Clinical Psychologist is not just confined to the clinic. Important work is being done as he/she steps out of the clinic to fulfill other roles such as that of a teacher or mentor, researcher, communicator.

This paper will focus on the role of the Clinical Psychologist as researcher, innovator and communicator. It will also challenge the commonly held belief that the clinical and research aspects of the profession are distinct and often conflicting endeavors. Instead, it will attempt to show that, contrary to this belief, the clinician's training and experience are appropriate preparations for conducting research.

The Clinician As Researcher and Innovator

The issue of whether the clinician can do creditable research has been a subject of controversy and debate, especially in the 1980s (Kendall and Norton-Ford, 1982; Kazdin, Bellack & Hersen, 1980; Bellack & Hersen, 1984). Aside from the obvious demands of time, the basic issue is the objective of the clinician as researcher (Carandang, 1989). In a paper entitled "The Reflections of the Clinical Psychologist as Practitioner and Researcher" I suggested that the gap between clinical practice and research is related to the limitations of the existing dominant traditional research methods at that time. I observed that at this stage of our development as a science, the Clinical Psychologist as "innovator" (Goodnow, 1989) needs to examine existing research methods. There is a need to invent new methods that will make a difference because there is a growing awareness that our present methods have become unimaginative and inadequate in capturing the rich data of experience. They are, for the most part, limited linear attempts to make piece-meal sense out of the complexity of human experience (which is the primary concern of the psychologist). There is an urgent need to try out new ways of explaining, conceptualizing and using research methods that do not delimit the data. There is restlessness to break away from the old models, to go beyond the existing scientific models and techniques that have intimidated our minds for a long time (Carandang, 1989). For example, when a clinician does research on family violence, there is a need to use creative methods that capture the nuances and complexity of the family dynamics and the *processes* that are occurring simultaneously and that are involved in the phenomenon of child abuse, viewed in the context of the family, embedded in a community. These processes are not linear or discrete and isolating

relevant variables or having preconceived categories may not be the best step. A more open, creative and non-linear approach may be more appropriate. Clinical researchers as “innovators” need to free their minds from the usual linear methods thinking in conceptualizing research designs.

As one writer puts it, “it’s only since the Newtonian revolution in Physics that the West has viewed the world as: predictable, orderly and linear, and the result of cause and effect. Conceiving the world as consisting of patterns and connections of individual events would not have appeared strange to inhabitants of the Middle Ages” (Cousineau, 1997).

I posed this challenge more than a decade ago in 1989 and it remained a challenge because no clear research direction was suggested at that time.

In the 1990s until the present time, the challenge is being met because “qualitative research is establishing itself in the social science as in psychology” (Flick, 1998). One solution seems to lie in qualitative research, which is to design methods so open that they do justice to the complexity of the object under study. Here, the object under study is the determining factor for choosing a method, and not the other way around (Flick, 1998). This point is important for psychologists in the academe as it addresses the perennial problem of graduate students finishing all the course work to obtain their degree except their thesis. They get so intimidated by the existing standardized research methods that they start their thesis by determining the method before even clarifying their research question. In the process their research loses its meaning and significance, and thus the thesis becomes an academic exercise rather than an exciting and meaningful scientific endeavor.

Furthermore, analysis of research practices has demonstrated that a large part of the ideas effectively formulated in advance cannot be fulfilled. Despite all the methodological controls, the research and its findings are unavoidably influenced by the interests of the social and cultural backgrounds of those involved. These factors influence the formulation of research questions and the hypothesis as well as the interpretation of data. It has also become clear that

social science results are rarely perceived and used in everyday life. This is because in order to fulfill the methodological science standards - investigations and findings often remain far removed from everyday questions and problems (Berg and Smith, 1985).

In qualitative-clinical research, unlike quantitative methods the fields of study are usually not artificial situations in the laboratory practices but behaviors and interactions of persons in everyday life.

The goal of qualitative research is not so much to test well-known theories already formulated in advance but to discover and to develop empirically grounded theories. The central criteria in quantitative research are whether findings are grounded in empirical material, whether the methods have been appropriately selected and applied to the object under study.

Traditionally, psychology and the social sciences have taken the physical sciences and their exactness as a model, paying particular attention by developing quantitative and standardized methods. Guiding principles of research and planning research have been used for the following purposes: to clearly isolate causes and effects, to properly operationalize theoretical relations, to measure and quantify phenomena and to create research designs allowing the generalization of findings to formulate general laws. Conditions under which the phenomenon and relations are studied are controlled as far as possible. Studies are designed in such a way that the researcher's influences can be excluded as far as possible to guarantee the objectivity of the study and whereby the subjective view of the researcher, as well as those of the individuals under study, are largely eliminated (Flick, 1998).

Unlike quantitative research, qualitative methods take the researcher's interaction with the "subject" or research participants as an explicit part of knowledge production instead of excluding it as far as possible as an intervening variable (Flick, 1998).

In other words, the subjectivity of the Researcher and those being studied are part of the research *process*. The researcher's reflections are their actions and behaviors, their impressions, their irritations, feelings and so on become data in their own right, forming part of the interpretation and are documented in research diaries and

protocols. Researchers are encouraged to keep personal journals to capture these rich data.

Before we proceed with the discussion in qualitative-clinical research, let us briefly review the history of research in social science and gain a perspective on the present need for qualitative research.

In the history of psychological research, qualitative research is not entirely new. It has had a long tradition in psychology, as well as in the social sciences. Wilhelm Wundt in the 1900s used methods of description and *Verstehen* alongside experimental methods. *Verstehen* is an epistemological principle which aims at the understanding of a phenomenon from the interior. Case studies and descriptive methods were central for a long time until the 1940s.

During the further establishment of both sciences, (the physical and the social) however, "hard, experimental, standardizing and quantifying methods" asserted themselves against "soft, understanding, open and qualitative, descriptive strategies." The latter are more within the discipline of clinical psychology, and this must lead the clinician not to lose sight of the distinct advantage of the clinical approach (Berg and Smith, 1985). At this point, it must be kept in mind that our purpose for devising and developing the clinical side of social research methods is not to replace what is knowable using traditional methods but rather to augment it. Our clinical engagement confronts us with thoughts, feelings and information that are not accessible under tightly controlled circumstances and forces us to expand our conceptual horizons beyond the boundaries of our predefined theories (Berg and Smith, 1985).

The 1960s brought the renaissance of qualitative research in the social sciences, and also, with some delay, in psychology. The classic work of Strauss and Corbin (1990) further elaborated on the need for qualitative research with social sciences. The question of the clinician's subjectivity as researcher was also reviewed.

Four tendencies for empirical social research led to the renaissance of qualitative research (Berg and Smith, 1985): the return to the *oral* trends in the formulation of theories; the return to the *particulars* - i.e. not to concentrate on abstract universal questions but specific problems in specific situations; the return to the *local* -

to study experiences, practices, etc. in the context of local traditions and ways of living in which they are embedded instead of attempting to test their universal validity; and the return to the *timely* - to study problems and solutions developed in their temporal historical context and to describe them from it - starting from people's expressions and activities in their local contexts and the meanings as they themselves describe these.

The Person of the Researcher

In qualitative research, especially in clinical research, the person of the Researcher has a special importance. Researchers and their communicative competencies are the main "instruments" of collecting data and of cognition (Mason, 1996). What information a researcher gains access to and what he remains debarred from depends essentially on the successful adoption of an appropriate role or position in the process of negotiation between the researcher and participants. This is where the clinical training becomes a distinct advantage because in clinical work it is also the "person" of the therapist that is the "instrument" for healing. The importance of this interaction is especially true when it comes to doing research on children.

Children As Research Participants

Questions and controversies abound when it comes to researches wherein "objects" of study are children. Validity and reliability issues become more emphasized. In the studies of children's understanding of illness, (Murray and Chamberlain, 1999) it has been shown that many of the underestimates of children's understanding of illness were due to methodological problems. For example, criticisms have been made regarding the way information is elicited from children - the repetitive nature of questioning and asking, and the asymmetrical power relationship between the child and the adult interviewer. Children's opinions are largely shaped by the context and interaction with others.

Criticisms have also come from other disciplines notably sociology and nursing which object to the artificial experimental situations favored by most psychologists. The traditional and often

preferred approach to investigating the impact of illness on children, for example, is to employ standardized assessment instruments. The method offers adequate reliability and apparent precision. Therefore, this "scientific approach" is much favored by journal editors and reviewers. Despite the apparent 'scientific rigor' one might question whether this method really provides comprehensive information about the child's thinking. Children need to express their views and not be restricted to a narrow range of answers that reflect the adult view. They have a different vocabulary from adults and may not be capable of abstracting their feelings to talk about them, depending on their developmental stage. The above criticisms emphasize the need for a qualitative and creative approach when studying children. These approaches may not be verbal in nature but may make use of creative expressions such as drawings, stories and play. These methods are the ones used in doing psychotherapy work with children and this is where the training of the child therapist becomes a distinct advantage.

In almost three decades of working directly with children and training child therapists and researchers, I find that, because of their clinical training, these therapist-researchers (Carandang, 2000) can naturally "enter the child's inner world," gain the trust of the children, and see things from the child's point of view as far as this is possible. This skill is essential in the repertoire of the child-therapist. It also fosters a genuine respect for the child's ability to "tell the story in his own way." Axline (1947) in her classic book *Play Therapy*, postulates this genuine respect as a basic principle in child therapy. This basic principle is also essential in doing research with children. As Alderfer (1983) states, "they are experts in their play; the researcher must learn from them and might do well to focus on the child's experience rather than his/her opinions."

Methodological flexibility and ingenuity are needed. Children deserve and demand sensitive methods of data-gathering. Impersonal questioning cannot provide this while actual clinical work with children prepares the therapist-researcher for this.

In this light, Berg and Smith (1985) emphatically tells us "what is needed is not the development of research techniques but the development of researchers." Researchers with sensitivity, self-critical and truth-seeking people who will communicate the totality

of the research experience and their meanings to others. The process of *self-scrutiny* is central to our definition of clinical because it can yield information regarding the intellectual and emotional factors that inevitably influence the researcher's involvement and activity. After all, in social science, the perceptions, thoughts, emotions and beliefs of people constitute the primary subject matter of an investigation (Berg and Smith, 1985).

They further say that data-gathering very much like psychotherapy is both a science and an art. "When we no longer distinguish between art and science as separated processes but experience their holism, we will have tapped the real meaning of the term "clinical." Knowledge through encounters, valid because it fits with the experience, real, because it touches the core - the universal and particular simultaneously."

The Clinician As Communicator

As a communicator, the clinician translates, as it were, scientific principles, theories, and research findings in psychology into understandable language for end users - the persons who will ultimately use them to help them in their daily lives.

To be involved in clinical research requires that we worry a lot about how to communicate research findings to others (Keen, 1975). It is also important to point out that we do not just communicate the research findings themselves but how they are arrived at.

To make rigorous the process of communicating, science has always insisted that the communicator describe not only the event in itself, but also the *procedures* that have led to a particular interpretation.

Writing, talking and otherwise communicating phenomena like the routines of reporting in physical science, must convey not only what is understood but also the *perspective* from which it is understood. The contours of meaning in the investigation must be exposed. This requires constant awareness of one's own issues and experience as researcher, owning one's issues and putting them in their place.

Inevitably, an integral factor in the training of the scientist-practitioner as researcher must be: how one can become an affective communicator.

Keen (1975) sums up very simply for us: "We seek to understand something, which means that we seek to make its meaning clear to ourselves. After we understand something, we seek to communicate what we understand to others. This is the essence of science in its broadest sense."

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