

RESEARCH INTO PRACTICE/PRACTICE INTO RESEARCH

Olav Muurlink Responds to Simon Kennedy

Simon Kennedy (*ANZJFT*, 19, 1) points out an old truth that applies as much to butchers, bakers and candlestick makers as it does to psychological researchers: we do not look at what we do not look for. He notes the value of looking twice at research that fails to support our assumptions. An even more extreme case can be made: that these 'failed' experiments are the *only* truly remarkable experiments in psychology, because of the psychology of psychology experiments. The power of experimenter expectancy has been well documented (e.g. Rosenthal, 1966), but experimenters remain expectant.

As researchers we rarely sit back and observe the splendour of human behaviour in all its confusion. Like weather forecasters, we are sure there is a pattern here somewhere, but unlike weather forecasters, we are not observing cold fronts and shallow depressions, but subjects who are themselves certain that there is some sort of pattern in their lives. Even if we did not attempt to 'experiment' in order to demonstrate patterns in our subject matter, under these circumstances, patterns would be highly likely to appear.

But we *do* experiment. A good experimenter tries to create an environment in which the pendulum of response can swing freely—around a pivot fixed by the experimenter. Experimenters, furthermore, select a finite set of behaviours considered to constitute a 'response'. As a subject, I noticed that perception researchers were pointedly disinterested in my boredom, for example. Some examined my EEGs, others my eye movements ... Experimenters also take care to scrub the laboratory to ensure no extraneous influences

can contaminate the results. It is not as if as researchers we are not aware that we are sterilising the environment—we commonly ponder the validity of laboratory results. Good field studies, however, are becoming, if anything, less common.

So, we pour our subjects into a clean funnel, and allow their personalities to pour out through a limited number of predefined holes. We even eliminate from analysis renegade subjects who produce nonconformist responses. Then, we apply statistics sensitive to the slightest deviation from the bland.

Is it possible that as researchers, we have taken all these measures not just because we want valid results, but simply because *we want results*, and that we have tightly controlled independent and dependent variables not simply to ensure that these variables are indeed responsible for our results, but because *we* want to be responsible for our results?

Kennedy notes that often the most important findings are initially peripheral to the central research questions or are stumbled on accidentally. This is not what we were trained for. A beautiful research paper is not littered with gems that were stumbled over, but gems that Sherlock led the ignorant world to, through the powers of sheer deduction.

References

Rosenthal, R. (1966). *Experimenter effects in behavioural research*, NY, Appleton-Century-Crofts.

OLAV MUURLINK

Ph.D. Student in Psychology, Griffith University (Gold Coast), researching self-deception and cognitive dissonance.

Simon Kennedy Replies: The Act Of Observation Changes The Action

The immediacy and poignancy of clinical interactions can lure us into believing that the 'real' world is within our grasp, that our 'looking' does not affect interactions, and that we are privy to the study of psychological phenomena without the shackles of all the limitations of research, some of which were mentioned by Olav Muurlink. Similarly, we can fall into the trap of dichotomising research into right and wrong, just like therapy approaches. Both research and therapy show selective attention to specific human phenomena, select responses to study and report, and are simply more or less realistic analogues of the world. It is a mistake to

dichotomise research as 'naturalistic' or not. Research involves intrusion, observation, categorisation of responses (either before or after the observation); the 'world' is then described in some new way, in short, the act of observation changes the action. The usefulness of the information we derive depends on the question we posed.

Some human behaviour and emotion is context bound and cannot be adequately studied outside its natural environment, but most behaviour, attitudes and emotions can be meaningfully studied outside this original environment. We can both overestimate and under-

estimate the importance of context in research and therapy. In some areas humans behave, think, and respond quite predictably and are not significantly affected by the context of therapy or research. We can intrude into the context of some individuals or families and their behaviour remains almost impervious to these apparent intrusions. In other areas, behaviour, thoughts, interactions are so context bound that to generalise research findings to other domains is probably naive. We should be sensitive to these differences, and evaluate research

accordingly, and not pay homage to idealised, prototypic, or politically correct versions of what research should be.

Simon Kennedy

Lecturer & Clinical Psychologist
Department of Psychology
Australian Catholic University, Oakleigh, Victoria
Email: S.Kennedy@christ.acu.edu.au

And from Germany, Bengta Hansen-Magnusson, Ernst Hansen-Magnusson and Jürgen Hargens report on: Consultation with (a) Difference in the Medical Field

We would like to describe a project on which we have been working together since May 1997 in the context of a general medical practice in the rural north of Schleswig-Holstein, Germany. In doing so, we must leave to one side the whole issue of insufficient psychotherapeutic care in Germany. In Germany, it is not legal for a GP to *refer* a patient to a named psychotherapist outside the health insurance net. It is possible however to 'recommend' patients to consult any therapist. Doing so increases the possibility that patients will find appropriate psychotherapeutic treatment.

We have employed this form of cooperation between physician and psychotherapist productively since 1985. If as GPs we (Bengta and Ernst Hansen-Magnusson) thought that psychological treatment was necessary, we often recommended a particular therapist (Jürgen Hargens) because his therapeutic approach favoured systemic, resource- and consumer-oriented, brief therapy, and because appointments could be scheduled immediately. It became more and more obvious that within a general practice some kind of 'psychotherapeutically oriented consultation' could be of benefit—both for the general practitioner and for the patients. An increasing familiarity with each other's approach opened the way for closer cooperation between the three authors of this paper.

Within the mental health field a distinction is usually drawn between somatic and psychotherapeutic treatments. Within the psychosomatic field both mind and body are considered, but usually in distinct settings isolated from each other with treatment defined either as somatic or as psychotherapeutic. Yet it is well known that:

- *illness* cannot be treated; *people* can
- in treating any dysfunction *both* psychological *and* somatic factors are active.

In our project we wanted actively to acknowledge these principles, by having relevant professionals working together in the same room with the patients (clients). That is what makes this project special. We are not interested in offering ongoing psychotherapy but in approaching situations in a goal-focused manner so that we can assist the clients (patients) to handle their health and their symptoms positively. We employ brief approaches in order to utilise the resources we have. This in turn impacts upon all participants' ideas about illness and opens up yet more options for action. We emphasise that this is not meant to be 'crisis intervention' but rather an incorporation of additional perspectives within the ongoing (medical) treatment. Thus, this collaboration of experts is neither classical medical treatment nor classical psychotherapy—it is (as we came to realise) something different, for which we lack a fitting term.

For us the crucial aspect is the equal cooperation of all participants—patient, physician, and psychotherapist/psychologist. The common frame of reference is an interest in the patient's well-being, which is seen and valued differently by the participants. Our project aims to merge these different perspectives in a way which is more consistent with the participants' intention and with the patient/client's presenting problem. In this way somatic aspects are as much addressed as psychological or social aspects—which makes it simpler (not to be confused with easier) to identify the resources and competencies that are available and to utilise them without devaluing the illness, problem or dilemma.

From May to November 1997 we worked this way one afternoon a week. Whenever they thought it would be beneficial, the physicians suggested that their patients might like to have a conversation with the psychotherapist. The patients made up their own minds whether to accept this suggestion and they scheduled the appointment directly through the physicians' staff. The consultation then took place in one room in the

same suite, but clearly was independent from the physicians' practice. The psychotherapist/psychologist as well as the physician took part in the first consultation with the patient, in the course of which the ideas, requests, hopes, and goals on the part of both physician and patient were explored.

The advantages of this format include no waiting, brief treatment, incorporation of psychotherapeutic work into the somatic domain, and a goal- and consumer-oriented approach, with the patient as decision-maker. We see disadvantages only in the material domain: the patients had to pay and cooperation was limited by the legal embargo on referrals for free treatment. During the six-month project we solved the problem of payment by making the first conversation free unless the patient wanted another appointment. It was possible to negotiate about the fee—farmers have always bargained when selling and buying cows or horses (remember that we work in a rural area)!

We carried out a preliminary outcome evaluation in January 1998. We examined the patient's medical files with respect to diagnosis and frequency of visits. This information was compared with diagnosis and frequency of visits after the 'project conversation'. We worked with 32 people whose age ranged from less than one year to more than 60 years. Twelve of them were men or boys, twenty were women or girls. In 24 cases we undertook just one conversation, in four cases we had two and only in four cases did we have more than two conversations. Twenty-eight cases have been terminated; four cases are ongoing.

We rated the changes in symptom and frequency of visits on a five point scale. This (subjective) rating scale was intended simply to give us a first impression and cannot substitute for a more sophisticated method of rating later. In the project we gave the most positive

rating (++) in fourteen cases, and a positive one in (+) in thirteen cases. In four cases we were not sure what rating to give and thus we scored them as uncertain (?). Only in one case did we give the most negative rating (–).

Based on this preliminary rating, we feel very positive about the project. In conversations with our colleagues, we draw attention to a number of advantages in this new form of consultation:

- the work is coordinated by the treating physician
- somatic and psychotherapeutic aspects are incorporated and valued equally
- people are given the same length of treatment
- clients (patients) are familiar with the room and local arrangements (physicians' office)
- patients' self responsibility is valued and activated.

All this is supported by what consumers (patients/clients) report. On the one hand they stress that the short (and familiar) consultation in the medical context is very helpful and on the other hand that they are very pleased by the immediate appointment for the first conversation with the psychotherapist and the physicians together as soon as they have made up their mind to participate in the project. We would be very interested to learn about colleagues who work in a similar way, who have similar experiences, or who have ideas and suggestions for us.

**Bengta Hansen-
Magnusson
Ernst Hansen-
Magnusson
Poststrasse 2
24997 Wanderup,
Germany**

**Jürgen Hargens
Norderweg 14
24980 Meyn,
Germany.
juergenhargens@t-
online.de**

HEADING

Copy