RESEARCH INTO PRACTICE/PRACTICE INTO RESEARCH

Practice and Research: Odd Bedfellows or Symbiotic Necessity?

Practice and Research? In my academic years the two seemed at opposite poles. If research is to be introduced into today's real-world practice, there must be clear and identifiable benefits to both client and practitioner.

In fields of science or medicine, the 'problem' under investigation and its solution are usually readily identifiable. Thus, Edison had an definable 'back-room' problem (to develop a working light bulb), and a readily identifiable solution—a light bulb that worked without rapidly self-destructing. Similarly, Pfizer, presumably, had a definable problem and an easily recognised solution when they discovered Viagra!

Actually, neither research project went smoothly. Edison used exhaustive trial and error before stumbling on a filament that worked. And Pfizer ... ! Their research on Viagra said nothing about the main problem nor the solution, until numerous men, testing it for other effects, stubbornly refused to stop using it, or to say why! Perhaps Simon Kennedy[1] was right in saying 'the most important findings are initially peripheral to the central research questions, or are stumbled on accidentally'.

So, even if the problems are definable and solutions recognisable, the research path can be difficult. In clinical practice, all too often the problem (and its cause) are intangible and difficult to identify, as is the solution. People are complex, their environments are complex, and their responses to change are complex. Only rarely can we create their problems in a laboratory or test them out on guinea pigs.

With each client we make judgements and opt for some 'treatment'. We cannot assume that termination from therapy demonstrates success. We must measure our results to determine our level of success. This measurement requires research, design and analysis skills often rusty or missing from clinicians' toolsets. Measurement of our clinical efficacy, though somewhat subjective, must be quantified.

The Times they are Achanging

Clinical practice is ever changing for a variety of reasons. Life's increasing complexity and demands lead to increased demand for professional assistance for a wider range of problems. As experienced consumers, clients have learnt to question and demand service. Continual government cost-cutting means ever-reducing professional resources. Clinicians are under increased pressure to apply overly simple solutions to increasingly complex problems due to time, money and resource constraints (as in the 'Ritalin' debate and issues of induced iatrogenic illnesses). The introduction of performance based indicators results in more critical evaluation of service delivery.

What type of research should practitioners undertake? Clearly few of us will move to Honduras to study the implications of dolphin play in assisting children with post-traumatic stress disorder[2]. Semi-random, trial and error experiments with our clients raise ethical (if not legal) problems. Field research therefore, must be evolutionary rather than revolutionary. In my research, I am examining the efficacy of single session therapy[3] with children and adolescents with mental health problems. Increasing demand and limited resources will inevitably lead to briefer therapy or single session therapy (or zero session therapy, i.e. 'sorry we have no resources'). It is essential to determine the impact of the session(s) we are providing.

Practitioners can take one of five roles in agency research initiatives. Firstly, they can initiate and *lead* research. Secondly, research into clinical efficacy requires large numbers of subjects and many practitioners as trained 'research assistants' to *assist*. Thirdly, research requires *support* from all quarters—from senior management, team leaders, professional staff, administrative staff, clients, etc. It takes considerable effort to build and *maintain this support* against an overwhelming range of competing interests. Without support, the research will die out as other 'urgent' issues take over.

The fourth role a practioner can play is to *be apathetic*, which is a natural (and sometimes appropriate) response. Apathy arises from people who do not want the status quo to change. These people can destroy initiatives, block professional team development and best practice. And fifthly, some 'professionals' may actively *block* research initiatives. For some organisations, this is appropriate at particular times. The decision to conduct research needs to be an informed organisational response recognising that such blockages inhibit needed improvements in the profession, as our society changes.

Clinicians must continually change and improve their methods to sustain and improve their success rates. Achieving this requires the involvement of clinicians in research on existing and evolving methods of assessment and treatment. An emerging science like ours is dependent on this symbiotic relationship between research and practice.

References

[1] Kennedy, S. 1998. In Search of the Counter-Intuitive, *ANZJFT*, 19, 1: 38–39.
[2] Refer Dolphin Therapy Research—www.westwave.com/dtr.
[3] Talmon, M., 1990. *Single Session Therapy*, San Francisco, Jossey-Bass.

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