

## Letter to Editor

# Clinician/Researcher Role

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## DEAR EDITOR,

The concept of being both a clinician/researcher has been very important to me. Being both a researcher and a clinician, I want to share what I do in the realm of group psychotherapy.

A clinician/researcher combines the best of both worlds. For example, Fisher et al. [1] suggest that a clinician's referral appears to be most effective when the principal investigator is also a practicing clinician who has good relations with the referring clinicians and offers something in exchange. However, a long-standing reason for the lack of integration or uptake of new findings generated from efficacy-based studies has been the controversy between practitioners and researchers regarding the differences between efficacy and effectiveness research [2,3]. Efficacy research is about systematically evaluating treatments under controlled conditions in a clinical research context. The prominent research elements of efficacy studies, which contribute to their internal validity typically, include a control condition (s), random assignment, treatment manuals, and diagnostically homogenous groups. On the other hand, effectiveness research is about evaluating the applicability and feasibility of treatments in real-world settings in order to determine the generalizability of treatments with demonstrated efficacy.

Bridging the scientist-practitioner gap requires a different clinical research paradigm: participatory research that encourages community agency-academic partnerships. In the context, clinicians help define priorities, determine the type of evidence that will have an impact on their practice (affecting the methods that are used to produce the evidence), and develop strategies for translating, implementing, and their findings into evidence-based practice [4].

My experience as a clinician/researcher has evolved in considering the research design and includes:

- Ethical dilemmas that can arise, for example, when patients do not comply with data

Collection: Some patients, for example, became very angry over having to stay after group to fill out the forms and stormed out before completing the data collection for that day. One patient declined to complete most of the forms. People ask whether the patients signed a contract after having been given a detailed description of the study and their involvement. Yes, they did but these were assaultive patients "coping with aggression" who would become easily agitated. They did continue to come to the group, though, which in real life was the most important thing to keep in mind.

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Submitted: 05 March 2015

Accepted: 06 March 2015

Published: 09 March 2015

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- There is the potential that what is best for the patients may threaten the goals of the research, creating for the clinician/researcher a potential conflict of interest.

Some specific recommendations which I have advocated for those choosing the role of psychiatric nursing clinician/researcher and current concerns with mental health care are to be aware that one must be very self-disciplined in following the research protocol. Clearly anticipate any potential role conflicts and prepare to address them. The anticipation might be done by role playing or pilot testing the research procedure. Another recommendation is that the research design must protect against bias in data collection procedures. Use random assignment of subjects, if possible [5]. Consider offering something to control subjects so that they will participate

A quasi-experimental design may be considered more effective in some situations. One may decide to conduct one group with multiple stages of data collection. Another option is to have two groups but without random assignment of subjects to groups. A qualitative instead of quantitative design may be preferable in some cases. The qualitative design allows for examination of research themes and for the clinician to have a detailed description of the group process.

To deal with countertransference feeling and avoid acting on these feelings, it is important to have ongoing expert clinical supervision to process the leader's feelings and examine group process. The leader's feelings, fantasies, hopes, etc., must be addressed both from the position of clinician and researcher and from the combined role position. Examples of feelings from each perspective are:

- a. *Researcher* - proud, thinking this is a clever project.
- b. *Clinician* - anxiety about safety in the group.
- c. *Clinician/researcher* - Proud he or she can do what colleagues cannot (combining both roles) but then worrying about criticism in the professional community.

In summation:

1. Develop the most scientifically sound research methodology possible, given the level of experience of staff involved, resources and time. Employ a research consultant to assist either in developing the project or at least in reviewing it. Another safeguard for scientific rigor

is the multiple reviews by research committees that any project receives if developed in a hospital or university before it is either submitted to outside funding agencies or conducted within an institution.

The same safeguards are not necessarily used by the private practitioner. The only review for scientific adequacy may be by funding agency, if financial support is sought, or a journal reviewing a manuscript after the research is conducted.

2. If utilizing an experimental design, those who are reluctant to use a control group

Might look at other fields with more advanced bodies of research providing the foundation for their interventions than the field of group therapy currently possesses. In such fields as industry, for example, a control group is essential before the intervention is judged efficacious and marketed. The confidence in saying that a patient outcome was produced by an intervention such as a particular group therapy is best achieved with use of an experimental design. The ability to infer causal relationships between what clinicians do and improvement for the patient is required in these days of managed care and third-party reimbursement.

3. Utilize a very clear and detailed research protocol, including a decision tree that eliminates the influences of the investigator. The PI's influence is appropriate during the creation of the project and generally not when the project has begun.
4. Have others collect and score the data. If the PI is involved in making interpretation or inferences about data, it should be done in collaboration with others to compare views.
5. Employ quality control checks on data collection procedures at predetermined intervals. Such mechanisms

as inter-rater reliability are commonly used.

In conclusion, it is important to keep in mind that a major issue in the conflict between clinical and research orientation is that clinicians believe or feel that group therapy is effective and that it is unfair to withhold it from some. This position is hard to justify if there is not substantial evidence that the group is effective. To hold such a position without documentation may be more withholding treatment. On the other side of the dilemma is the ethical issue of weakening a research design by not having a control group and diminishing our knowledge base for treating our clients. Research allows the clinician to know more confidently if group therapy is effective and, if so, how and in what ways. The role of clinician/researcher forces clinicians to be responsible for what they practice.

## ACKNOWLEDGEMENTS

This material is based upon work funded by Central Office and is supported by the Edith Nourse Rogers Memorial Veterans Hospital, Bedford, MA 01730.

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### Cite this article

Lanza M (2015) Clinician/Researcher Role. *Ann Psychiatry Ment Health* 3(2): 1025.