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The Local Clinical Scientist, Evidence-Based Practice, and Personality Assessment

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The local clinical scientist model was devised for clinical practitioners including those engaged in personality assessment. It emphasizes the importance of local data, the consideration of each clinical encounter as a mini-research project, and the incorporation of existing research data where relevant. It is consistent with, but goes beyond, evidence-based practice. There is a need to guard against the operation of cognitive heuristics for the model to be applied effectively.

I am grateful to the Society for Personality Assessment for recognizing my work and most appreciative of this award. It gives me the opportunity to bring together several issues that have concerned me over the past few years. I review briefly the local clinical scientist (LCS) model (Stricker & Trierweiler, 1995; Trierweiler & Stricker, 1998), talk about the use of evidence in practice (Stricker, 1996, in press), look at some of the problems for the model inherent in our cognitive heuristics (Tversky & Kahneman, 1974), and throughout try to bring it all home to personality assessment.

The LCS model begins with the assumption that science is not defined by activities or generalizations but by attitudes. It is this feature of science, the variability of activities and generalizations accompanied by the stability of attitudes, that allows me to attempt to show the applicability of the model to personality assessment, and it originally was constructed with all of clinical practice, and not just psychotherapy, in mind. I describe the model at first in general terms, but then try to specify its relationship to personality assessment.

Activities vary widely from area to area and discipline to discipline. Generalizations often decay rapidly, and practice based on scientific conclusions today can be hopelessly dated tomorrow. The half life of psychological knowledge should give us pause when we express certainty about our conclusions. However, attitudes cut across areas, disciplines, and findings and typify the scientist regardless of the area of inquiry. All scientists should be keen observers who are characterized by disciplined inquiry, critical thinking, imagination, rigor, skepticism, and openness to change in the face of evidence. The LCS carries these attitudes into the practice setting, raising hypotheses in the consulting room and seeking confirmatory or disconfirmatory evidence in the immediate response of the patient (hence, the local component of the LCS model). A careful distinction can be found in the writings of the Spanish poet and writer, Miguel Unamuno. He told us that "True science teaches, above all, to doubt and to be ignorant" (Unamuno, 1913/2005), but also "The skeptic does not mean him who doubts, but him who investigates or researches, as opposed to him who asserts and thinks that he has found" (Unamuno, 1924/1996). The LCS is a skeptic, but

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the skepticism leads him or her to try to learn more rather than to withdraw from scholarship into solipsism.

The key concept in trying to understand the LCS is to view each clinical interaction as a research project. This does not necessarily mean that formal data are collected, but it does mean that we approach the patient bringing whatever we can gather from the literature; apply it to the best of our ability; supplement it by our intuitive grasp of the situation; observe the effects; in the best circumstances, record the information; and learn from it so that we can apply what we learn to our next patient/research project. Thus, as clinicians, we are always learning and using the product of our learning to apply to new situations.

Paul Meehl (1954) once stated that statistics were unavoidable for clinical practice. Most of us think that we have proven him wrong and avoid statistics regularly. However, what he had in mind was much of what has been stated for the LCS. We owe it to our patients to collect data systematically about what we do so that we can learn from our experience and do better next time. Some people have 20 years of experience—others have 1 year of experience 20 times. The only way experience can accumulate is if we systematically study what we do and improve our functioning on the basis of past experience.

What activities might we expect LCSs performing personality assessment to engage in?

1. In the process of doing personality assessment, they display a questioning attitude and search for confirmatory evidence.
2. They apply research findings directly to personality assessment.
3. They undertake a documented evaluation of their individual assessment practices.
4. They produce research, either collaboratively or more traditionally.

These activities are presented in descending order of importance to the LCS, with the attitude the most pervasive and critical and actual formal research activity least likely to occur, although desirable when it does.

Here is a description of an ideal psychologist, to my way of thinking:

> A person who, on the basis of systematic knowledge about persons obtained primarily in real-life situations, has integrated this knowledge with psychological theory, and has then consistently regarded it with the questioning attitude of the scientist. In this image, clinical psychologists see themselves combining the idiographic and nomothetic approaches, both of which appear to them significant. (Shakow, 1976, p. 554)

This can be taken as a good description of the LCS, but it was not intended as such. Rather, it is David Shakow's (1976) description of a scientist–practitioner (S–P). How do the LCS and the S–P differ? To my mind, they do not differ greatly—the LCS is the realistic implementation of what Shakow had in mind when he formulated the influential S–P model. However, the usual implementation is so much more heavily weighted toward research production that it is forbidding to the practitioner, and most graduates, whether of professional or university science programs, find themselves engaged in clinical activity. Unfortunately, they often turn their back on science because they find direct implementation so difficult and overlook the critical lessons about the mental activity of the scientist, lessons that would serve them well in their daily, local clinical activity.

The crucial distinction between idiographic and nomothetic, noted in Shakow's (1976) statement, is between nomothetic data, or data that characterize large groups, and idiographic data, or data that characterize single individuals. The major task for the clinician is how to apply nomothetic conclusions to local, idiographic presentations or more simply, how to apply group findings to individuals. Note that Shakow does not ask us to choose between the two, but talks about how best to combine them. The clinician is faced with the need to assess an individual and should incorporate whatever generalizations might apply, keeping in mind that there will be gaps, nomothetic conclusions cannot be applied blindly, and we owe it to our patients to learn from any deviations from protocol so that we hone our technique with experience.

We also should keep in mind the distinction between the context of discovery and the context of justification (Reichenbach, 1951). The context of discovery refers to a situation in which hypotheses are generated, whereas the context of justification refers to a situation in which hypotheses are tested. Clearly, the person who sees himself as practicing assessment is more likely to operate in the context of discovery, and the person who sees himself as a scientist is more likely to operate in the context of justification. The LCS treats the clinical situation as a context of discovery but also seeks an approach to a context of justification through careful observation, record keeping, and testing of clinical hypotheses. These will not satisfy the rigorous scientist, and it points to the need for a synergy between the two contexts, but anybody who works in one context in disregard of the other is shortchanging whichever operation he or she favors.

The LCS model is subject to frequent misunderstanding. I often will have people come up to me and congratulate me on formulating a model that captures so well what they do. Unfortunately, when they explain what they do, it is not what I had in mind at all. The LCS model is not a substitute for scientific activity; it is an implementation of a scientific attitude. The result of LCS activity is not a firmly established set of conclusions and generalizations but a loosely determined set of hypotheses. The value added of the LCS over the ordinary clinician is the systematic study of the clinical work so that observations are not subject to the distortions of the cognitive heuristics that plague all of our thinking. We cannot

blithely ignore the results of research but must thoughtfully consider whether and how they can be incorporated in our activity. The distinction between the contexts of discovery and justification are crucial, and the process of discovery should not be confused with the relative certainty of justification. Subscribing to the LCS model does not provide us with an excuse to ignore research or to cloak what we ordinarily do in the prestigious mantle of science. Rather, it asks us to attend to research done by others and apply it where applicable and to study what we do so that hypotheses can be raised a step closer to generalizations, all the while aware of the shortcomings and need for correction and continuous iteration of our activities. By the way, some of these same cautions can be directed to practicing psychological scientists who also have an inflated sense of the certainty of their approximations of knowledge and a reluctance to abandon old approaches in the face of new evidence, but that is a story for another day.

In discussing the tension between research and practice, we cannot help but recognize similar dichotomies throughout the history of ideas. We have seen tension between Plato and Aristotle, between idealism and materialism, between faith and reason, between empiricism and romanticism, and between science and several alternative modes of knowing. In a contemporary setting, there is tension between modernity and postmodernism, between intuition and data, between quantitative and qualitative data, between process-oriented and outcome-oriented therapies, between reality testing and constructed reality, and between perception and reality. These are not simply intellectual dichotomies or disputes but have led to what Messer (2004) referred to as culture wars, with one aspect of the binary privileged over the other, whether in a traditional or an inverted manner. In every case, the clear solution, rarely adopted, is to seek a synthesis rather than perpetuate a battle between thesis and antithesis. We should have learned by now that fusion is more powerful than fission. However, the culture wars rule out the likelihood of the higher order synthesis that itself is not an answer but part of a process leading to higher order syntheses as we continuously learn and adapt. It is this seeking of a synthesis, a higher form of knowing, that led to the S–P model, and we have seen that the model often was given lip service while being enacted in a way that did not conform to Shakow's initial vision (Stricker, 2000). The LCS model was introduced as a bridge between science and practice and was a proposed method of achieving a true S–P model. The seeking of a synthesis also has led to the psychotherapy integration movement, but that too is a story for another day.

This brings us to the contemporary question of the relationship between research and practice. The current vogue, in psychology and in health care in general, is what is known as *evidence-based practice.* This is an evolving term, and in psychotherapy, the original attempt was to establish a set of empirically validated practices (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). It quickly became clear that this term did not capture what anybody versed in assessment knows, and that is the meaning of validity. It is unlikely that any practice can be considered valid as an all-encompassing term just as it is unlikely that any Rorschach interpretation can be considered fixed and valid. The terminology then changed to *empirically supported practice* (Chambless & Ollendick, 2001), a better choice of language although one that often is interpreted as though support is equivalent to validity without sufficient consideration given to the conditions under which the support was established. Finally, we have grown more accustomed to thinking in terms of evidence-based practice largely because of the currency of that term in the larger health care field (Roth & Fonagy, 1996), and that is the term favored by American Psychological Association (APA) in their recent policy statement (APA, 2005). This term, too, begs the question of what constitutes evidence. My own preference, and I do not think of it simply as a matter of nomenclature, is for the term Wolfe (2005) has used, *research-informed practice,* which is consistent with the activities of the LCS.

How would research-informed practice differ from empirically supported practice? I have heard, informally, proponents of empirically supported practice suggest that we should limit ourselves to such practices, and in the absence of the establishment of an empirically supported approach, we would be better off doing nothing lest harm be done. If medicine were to follow this same strategy, most medical practices would be discontinued. Over the centuries, many medical interventions have proven to be ineffectual and some even harmful, but others have worked for reasons not yet understood, whereas others achieved their effects through the power of the placebo. We can assume much the same to be true for psychotherapy, but there is an important additional consideration with psychosocial interventions. Much of the research literature has suggested two overwhelmingly repeated findings: psychotherapy works, yet the difference between different approaches usually is negligible (Wampold, 2001). One reason for this is that the primary source of change lies in the common factors that cut across different approaches, particularly those connected to the relationship. However, although these are not easily incorporated in randomized controlled trials, specific interventions readily can be incorporated in such a design. Thus, much as the drunk looking for keys under the lamppost where it is light, even though they were dropped down the block where it is dark, overly scientistic investigators study specific interventions and give short shrift to common factors.

In research-informed practice, the therapist would attend to whatever information was available in the research literature including the effects of different interventions, the characteristics of the condition being treated, and general principles of psychology. Such a practitioner, unless such research proved definitive, also would draw on previous experience and clinical intuition and would record the results of each encounter so as to be able to offer better informed treatment to future patients. By the way, this formulation is con-

sistent with the position espoused by the APA in its draft policy statement, although that document generally does not consider assessment issues. It is not unethical to practice in a way that is not empirically supported, but it is unethical to practice in a way that definitively has been shown to be ineffective. The research-informed practitioner knows that the absence of evidence is not the same as the evidence of absence. The research informed practitioner is an LCS.

Personality assessment carries a clear parallel to the lists of empirically supported interventions that have been developed. These are the various cookbooks that have been developed leading to offerings that range from computer-assisted scoring to textbooks that propose uniform interpretations for given Rorschach responses. The cookbooks vary in usefulness, with some capable of adding a good deal to our interpretive skills and others producing little more than error dressed up in certainty.

The original call for a cookbook came from Meehl (1956) who provided much to the field of personality assessment and who has been widely misinterpreted. As Sawyer (1966) pointed out years ago and Westen and Weinberger (2004) reiterated recently, a sharp distinction must be made between data sources and data combination. Meehl was clear that there is much room for the clinician in the generation of data, whether in interviews, assessment devices, or inferences. All of these, along with many sources of more objective data, then can be combined either actuarially or clinically. Meehl's position was that the superior method of combination was actuarial, and he provided many research examples showing the superiority of actuarial prediction (Meehl, 1954). Thus, he felt that the clinician searching through personal experience to modify the equation simply will be adding error variance.

There are two problems with the conclusion that actuarial prediction is superior and clinical prediction should be abandoned. The first is the distinction, acknowledged by Meehl (1954), between prediction and personality description, and often those of us doing personality assessment are more concerned with the description of the personality rather than the simple prediction of some singular behavior. The second is that actuarial prediction may produce algorithms that are superior to the clinician for certain predictions, but the number of well-developed and validated algorithms hardly match the number of situations in which we are asked to function. Just as the psychotherapist should choose the empirically supported technique if the circumstances match those for which the technique amassed evidence, the assessor should use the algorithm if it was developed for the assessment situation in question. In doing so, a nomothetic solution is chosen for an idiographic concern. The problem is the shortage of available, empirically supported techniques and algorithms for the many situations that we find ourselves in, thus requiring something other than a simple application of a nomothetic formula.

This shortage forces clinicians, both therapists and assessors, back to their experience and back into the role of the LCS. We must look to whatever research evidence is applicable, search our experience for guidance, and make a careful record of our actions so as to learn for the next similar situation. In doing so, we are faced with the problem that cognitive activity rarely is pristine. We all use cognitive heuristics or mental shortcuts that disregard some of the available information to allow us to make judgments that are quick but often may be in error (Tversky & Kahneman, 1974). These cognitive strategies enable us to approach a difficult problem in a simplified manner. Among these strategies is the availability heuristic or the tendency to favor solutions that come to mind more easily. We can recall a dramatic example of a correspondence between a test response and a personality characteristic and easily overlook all the disconfirmatory examples that have occurred, thus drawing an incorrect conclusion by noting an illusory correlation. Similarly, the representativeness heuristic will link judgments to signs that are representative of the group in general. Thus, having identified a patient with a particular group, we will attribute other characteristics of that group to him without sufficient supportive evidence. The anchoring heuristic will lead to drawing early conclusions during an evaluation, seeking confirming evidence afterward, and discarding evidence contrary to this early hypothesis. In each case, the heuristic keeps us from attending to all the available information and reduces the likelihood of a sound decision.

How can we guard against cognitive heuristics? First, we can guard against them by being aware of them so that they have less influence over our decision making. Second, we can guard against them by being well grounded in the literature so that we are less likely to introduce fallacious considerations about frequency of occurrence, among other things. Third, we can guard against them by keeping track of our experience rather than relying on it through memory so that our view of availability and representativeness is tempered by data rather than memory. By doing all of these things, we become a better LCS and are likely to perform more accurate assessments.

Meanwhile, as much as you (and I) would like to know exactly what to do, what works, and what doesn't work, I would like to leave you with a quote from Voltaire, an important voice of the Enlightenment and one who always favored skepticism and rational decision making in human affairs—"Doubt is uncomfortable, but certainty is ridiculous."

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