

Positive and negative arguments for scientist practitioner model

[Science](#)



**ASSIGN
BUSTER**

The Scientist-Practitioner model has become the most prevalent and favoured training model for clinical psychologists (see Kanfer, 1990; Page, 1996). I will argue that despite there being (seemingly) far more negative arguments for this model that the scientist practitioner model is not 'outdated' and still has a lot to offer. In order to do this, it is essential to examine the positive and negative aspects of the model. However, it is necessary to first gain an understanding of the model. I will do this by discussing key elements of the model. Next, I will discuss the development and historical background of the scientist-practitioner model. After establishing these, I will then provide positive and negative arguments for this model. Then, I will discuss the future direction in psychological teaching for the scientist-practitioner model.

Key elements help provide an insight into what the scientist-practitioner model (or Boulder model) is. Stricker (2002) defines the key features of the model as:

(a) In the process of doing clinical work, they display a questioning attitude and search for confirmatory evidence; (b) they apply research findings directly to practice; (c) they undertake an evaluation of their individual practices, and; (d) they produce research, either collaboratively or more traditionally.

In summary, the scientist-practitioner model creates a basis for understanding on which science and practice are built together. Clinical psychologists should incorporate both these aspects when assessing/diagnosing, in therapy and research.

As early as 1947, there have been calls for psychologists to be trained as both scientists and practitioners (e. g. Thorne, 1947). Shakow (1947) proposed a report (' Shakow report) to the American Psychological Association (APA), requesting that training criteria be established which trained psychologists as scientists, with a specific focus on assessment/diagnosis, treatment and research. This report, according to Baker and Benjamin Jr (2000, p. 244) became “ the central working document of the Boulder conference”.

In 1949, the first national training conference for clinical psychologists was held in Boulder, Colorado (see Kanfer, 1990; Raimy, 1950; Thorne, 1947). At this conference, it was decided that an integrated approach to science and practice be applied by clinical psychologists, and as a result the scientist-practitioner model (or Boulder model) was established (see Page, 1996).

Now that it has been established how the model was developed, it is equally important to discuss the reasons as to why it was developed. As previously mentioned, the model was developed to encourage an integrated approach between science and practice; however, another important factor was the demand for psychologists post World War II. As John (1998), Barker, Pistrang, & Elliott (2002) & Baker and Benjamin (2000) discuss, adoption of the scientist-practitioner model occurred Post World War II. This set-up by the American government aimed to provide (mental health) support for returning veterans in the form of “ rehabilitation, care, and reintegration in civilian life” (John, 1998, p. 25).

With insight into key elements, the historical background and development of the scientist-practitioner model, it is now essential to examine positive and negative arguments for this model in order to establish whether or not it is 'out-dated'.

The scientist-practitioner model has received a substantial amount of criticism, and various weaknesses have been examined (e. g. Barlow , 1981; John, 1996; O’Gorman, 2001; Pfeiffer, Burd & Wright, 1992). John (1996), like many others (e. g. Kanfer, 1990; O’Gorman, 2001) claims that the view/philosophy that underpins the scientist-practitioner model (positivism) is out-dated, meaning there is a 'ban' on the expression of alternative philosophical views.

Page (1996) also adheres to the notion that the positivist approach is outmoded, however, believes that there are various scientist-practitioner models which are based on different philosophies, which he refers to as 'more faces than Eve'. This belief, i. e. that philosophical views affect decision making in assessment, therapy and research is consistent with the work John (1996) and Milne and Paxton (1998). For example, Milne and Paxton (1998) found that clinicians often focused on research information that fit in with their world views.

Another burgeoning argument is that whilst there is much emphasis placed on the research/science factor, few psychologists actually adhere to this, due to various factors (e. g. Gale, 1985; Pfeiffer, Burd and Wright, 1992; Vespia, 2006; Wilson, 1981), such as not having the required time, lack of funding, effort, motivation and skill to put it into practice. For example, O’Gorman

<https://assignbuster.com/positive-and-negative-arguments-for-scientist-practitioner-model/>

(2001) believes that low publication rates are evidence of practitioners not acting as scientists.

Even with, seemingly, a vast majority of ‘limitations’, there are still positive aspects that the model provide. The scientist-practitioner model has much to offer in terms of making research more relevant to practice, provides structure and a theoretical framework for practice, encourages life-long learning, and perhaps most importantly research-based practice provides for accountability. For example, Shapiro (2002, p. 233) believes that the “most compelling need for a scientist-practitioner arises when the evidence is equivocal or lacking”.

James (1994) and Richards (1994) are also advocates of the scientist practitioner model. James (1994, p. 10) acknowledges the criticism the model has received, but believes many of these derive from a “misunderstanding about the nature of science”; meaning that the role of science is being undermined. James (1994) believes that the role of psychology in the health-care system, and in particular, the scientist-practitioner model is important; not only can they be applied to other areas of health-care, but it may result in (or already has) in other health-care professionals incorporating evidence-based research into clinical practice.

Similarly, Richards (1994) also believes that the field of psychology has been extended across of other areas of public health, however, disagrees that a greater demand for psychologists will be needed straight-away.

Having examined positive and negative arguments for the scientist-practitioner model, it is now important to discuss what this means for the future direction in psychological teaching the model has. In light of existing, and seemingly overwhelming evidence, calls for the model to be 'renewed' (see Shapiro, 2002) may take place sometime in future. However, the fact that, despite concerns over the practicality and the implementation of the scientist-practitioner model, it still remains the dominant training model for psychology programs in Australia has to count for something. For example, Martin (1989) found in his study, that the scientist-practitioner model formed the basis for all (who responded) Australian and UK psychology programs. Thus, it may be likely that many practitioners will continue to adhere to the model, and just as many will reject it.

To say that the scientist-practitioner model is 'out-dated' is not the right word; it appears to have, somewhat, 'equal' weight on both sides of the argument. Based on the aforementioned research, one could argue that the model is out-dated because it is built on an outmoded notion of science (i. e. positivism), and that many practitioners rarely adhere to it. Just as it could be argued that the model isn't out-dated because it (in Australia at least), forms the basis for many psychological programs. Similarly, as touched on by James (1994) psychology training programs are increasingly being extended across health professionals.

In conclusion, I believe that the scientist-practitioner model is not out-dated and despite stated limitations, still has a lot to offer not only in the field of clinical psychology, but rather across the public health sector. I have shown

that the model is still widely regarded as the dominant training model for psychological programs. I have also demonstrated the positive and negative arguments for this model.

References/Works Cited

Baker, D. B., & Benjamin Jr, L. T. (2000). The affirmation of the scientist-practitioner: A look back at Boulder. *American Psychologist*, 55(2), 241-247.

Barker, C., Pistrang, N., & Elliott, R. (2002). Perspectives on Research. In C. Barker, N. Pistrang, & R. Elliott, *Research methods in clinical psychology: An introduction for students and practitioners* (2nd ed., p. 299). John Wiley & Sons.

Barlow, D. (1981). On the relation of clinical research to clinical practice: Current issues, new directions. *Journal of Consulting and Clinical Psychology*, 49, 147-155.

Gale, T. (1985). On doing research: The dream and the reality. *Journal of Family Therapy*, 7, 187-211.

James, J. (1994, March). Health care, psychology and the scientist-practitioner model. *Australian Psychologist*, 29(1), 5-11.

John, I. (1998, March). The Scientist-Practitioner Model: A Critical Examination. *Australian Psychologist*, 33(1), 24-30.

Kanfer, F. H. (1990). The Scientist-Practitioner Connection: A Bridge in Need of Constant Attention. *Journal of Professional Psychology: Research and Practice*, 2(4), 264-270.

<https://assignbuster.com/positive-and-negative-arguments-for-scientist-practitioner-model/>

Martin, P. (1989). The Scientist-Practitioner Model and Clinical Psychology. *Australian Psychologist*, 24, 71-92.

Milne, D., & Paxton, R. (1998). A psychological re-analysis of the scientist-practitioner model. *Journal of Clinical Psychology and Psychotherapy*, 5, 216-230.

O’Gorman, J. (2001, July). The Scientist-Practitioner Model and Its Critics. *Australian Psychologist*, 36(2), 164-169.

Page, A. (1996). The Scientist-Practitioner Model: More Faces than Eve. *Australian Psychologist*, 31(2), 103-108.

Pfeiffer, S., Burd, S., & Wright, A. (1992). Clinicians and research: Recurring obstacles and some possible solutions. *Journal of Clinical Psychology*, 48, 140-145.

Raimy, V. (1950). *Traning in clinical psychology*. Eaglewood Cliffs, NJ: Prentice Hall.

Richards, J. (1994). Giving psychology away? A comment: ‘ Health care, psychology and the scientist-practitioner model’ by James. *Australian Psychologist*, 29(1), 12-14.

Shakow, D. (1947). Letter to Committee on Training in Clinical Psychology (Shakow Papers, M1502) Archives of the History of American Psychology. Akron, OHIO: University of Akron.

Shapiro, D. (2002, May). Scientist Practitioner: Renewing the scientist-practitioner model. *The Psychologist*, 15(5), 232-234.

Stricker, G. (2002, October). What is a Scientist-Practitioner anyway? *Journal of Clinical Psychology*, 58(10), 1277-1283.

Thorne, F. (1947). The Clinical Method in Science. *American Psychologist*, 2, 161-166.

Vespia, K. (2006). Integrating professional identities: Counselling psychologist, scientist-practitioner and undergraduate educator. *Counselling Psychology Quarterly*, 19(3), 265-280.

Wilson, T. (1981). Some thoughts about clinical research. *Journal of Behavioural Assessment*, 3, 217-225.