RESEARCH, CLINICAL PRACTICE, AND THE HUMAN EXPERIENCE: PUTTING THE PIECES TOGETHER

PHYLLIS R. SILVERMAN
Institute of Health Professions, Massachusetts General Hospital, Boston, Massachusetts, USA

The work of the clinician and that of the researcher are presented as representing 2 cultures that cannot exist without each other. A third culture is described to reflect the common human experience of death and grief that invariably informs the work of both clinicians and researchers. At different times in our lives we can be both the subjects and the objects of the work in which we are involved. The author's experience as co-principal investigator with the Massachusetts General Hospital/Harvard Child Bereavement Study and the application of qualitative research is used to exemplify these ideas and demonstrate how the cultures can be integrated.

This article grew out of my participation in the panel discussion "Therapists are from Venus and Researchers from Mars" at the 1998 Annual Association for Death Education and Counseling Meeting. I wondered, at the time, if it was accurate to characterize the relationship between researchers and clinicians in this way? Several of us on the panel were both clinicians and researchers. If such vast differences exist between these two groups, how did those of us who embrace both identities understand and reconcile them? What I attempt to do in this article is present a very personal view of the kind of integration that I see possible. I see these two areas of work, especially work concerned with end of life and bereavement, as representing two cultures that in many ways cannot exist without each other. In addition, because we will all die and at one

Received 2 May 1999; Accepted 12 December 1999
Address correspondence to Phyllis R. Silverman, Ph.D., 18 Ingleside Road, Lexington, MA 02420. E-mail: silverman@helix.mgh.harvard.edu
time or another are bereaved, we are at different times both the subjects and the objects of the research and of the interventions in which we are involved. In this sense there is a third culture—one resulting from our common humanity. I use examples from my work as coprincipal investigator and project director of the Massachusetts General Hospital (MGH)/Harvard Child Bereavement Study\(^1\) to examine these differences as I experienced them and to show how all three cultures are present in my work and how the interface between them can be enhanced.

### The Cultures of Research and Clinical Practice

C. P. Snow (1964) used the concept of culture to describe the differences he observed in the way scientists and those in the humanities see the world. Culture, he said, links people by common habits, common assumptions, common standards, belief systems, and patterns of behavior. In this sense, he wrote, each of these professions has their own culture. Similarly, clinicians and researchers are each socialized by their education to share common belief systems, standards, and a body of knowledge that gives them a specific identity (Davis, 1968; Hughes, 1958). Each has different ways of generating knowledge and using this knowledge so that they conceptualize their work in different languages. Each seeks different answers to their questions about what needs to be known, who needs to know it, and how it is to become known (Beutler, Williams, Wakefield, & Entwistle, 1995).

In the clinical setting, there is the urgency of meeting a current need in response to an individual or group in distress. The applicability of the clinician’s knowledge base is being tested in the moment. Their excitement, the very sense of their identity, comes from the knowledge that they can help and from seeing some relief in the person who comes for help. Clinicians seek new information that enables them to accomplish this goal either by affirming what

---

\(^1\) The MGH/Harvard Child Bereavement Study was a longitudinal study of the impact of the death of a parent on children ages 6 to 17. It was funded by the National Institute of Mental Health Grant MH41971, the National Funeral Directors Association, and the Hillenbrand Corporation. I was co-principal investigator with J. William Worden. I am still actively involved in an ongoing analysis of the data.
they do or by expanding their understanding of the problems in ways that give them new directions for helping.

By contrast, the researcher's work is removed from day-to-day pressures. Their concern is with populations of people, with being able to generalize beyond the individual. The excitement for the researcher comes from uncertainty, getting a new understanding, or the verification of a hypothesis. They do not always recognize nor do they generally need to consider the clinical implications of their findings. The constraint on them comes from how science is viewed and what is considered acceptable methodology for good research.

The differences between these cultures are exacerbated by the fact that these are not, in themselves, homogeneous cultures. In the clinical culture, a range of disciplines and perspectives on how to help are involved and there is not always a common language between them nor is there consensus about what is good clinical practice (P. R. Silverman, 2000). There is little agreement on who would benefit from the different types of care that might be available, nor is there agreement about what research questions need to be asked about the nature of clinical practice or of what it accomplishes for people.

Just as clinicians do not represent a homogeneous population, neither do researchers. Psychological research is only one of the relevant disciplines involved. To do good research in this field, researchers must look beyond the individual to the social system and the values, attitudes, and belief systems that sustain them. We must include sociology, anthropology, religion, philosophy, and medicine. Each of these has their own language of science so that different researchers may not have a common methodology or language. There are disagreements about how to frame the question to be researched and how to test a hypothesis, or even whether hypothesis testing and prediction is the main work of science.

One approach that is prized across many disciplines uses a reductionist perspective. The data is organized so that it can be analyzed statistically to verify a hypothesis. This view, by eliminating the individual, creates the greatest distance between researcher and clinician in my opinion. Other views of science coming from anthropology and sociology offer an alternative. These fall under the heading of qualitative research. Researchers
using this method look at process and at the interaction between people in a social context and study the exceptional case (Glazer & Strauss, 1967; Reinhartz & Rowles, 1988; Strauss & Corbin, 1990; Weiss, 1994). This approach and their findings may be more meaningful and relevant to the clinician (P. R. Silverman, 1988). Qualitative research has opened up most of the new vistas in bereavement and end-of-life research in this century (P. R. Silverman & Klass, 1996). One of the better examples is the work of Glazer and Strauss (1968) and Quint (1967) in their observational studies of the trajectory of dying. This approach provides a way of becoming involved in the complexity of the situation and it is where the language of research and the language of clinical practice come together. In many ways I see this as the linking bridge between these two cultures, as the following example illustrates.

A key goal for the Child Bereavement Study was to establish whether there is a relationship between the death of a parent and the development of serious emotional problems in the surviving children. A statistically significant percentage of bereaved children compared with nonbereaved children were identified as having such problems (P. R. Silverman & Worden, 1993; Worden & Silverman, 1996). These findings were based on parents’ responses to a standardized instrument, the Child Behavior Checklist (CBCL), measuring emotional well-being (Achenbach & Edelbrock, 1983). The clinician side of me recognized that this finding had little immediate applicability if I wanted to be helpful to a particular bereaved child. In fact, it alarmed surviving parents who then feared that the death would invariably result in their children developing mental problems. In the normal stress associated with the death it was easy to lose sight of the more than 75% of the children who did not develop serious emotional problems.

The human experience is sufficiently complex that prediction in the classic scientific model becomes very problematic (Bruner, 1990; S. M. Silverman, 1979). As a clinician, I needed to know more about the individual children having difficulty. Was there something in their situation that distinguished them from the other children, and even from children in their own family? In my mind the statistical analysis is a first, not a final, step in the research process. Statistical findings can suggest the next step requiring a qualitative look at the data.
Qualitative research is very labor intensive. It requires the researcher to get very close to the pain in the family and the meaning the death has, not only for the child, but for other family members as well. This kind of analysis is best done with colleagues (Boerner & Silverman, 1999; Normand, Silverman, & Nickman, 1996; P. R. Silverman & Gross, 1996; Silverman & Nickman, 1996). Several colleagues, two of whom are primarily clinicians, recently joined me to examine some of this data. We decided to focus on the question of why the death of a parent could lead to increased problem behavior in some children. We have been reading interviews of families in which there was at least one child with an elevated CBCL score. We also looked at several families with children the same ages who did not have elevated scores. We looked for changing patterns in the family narratives over the two years that the Child Bereavement Study followed the family. We touched the data and interacted with it almost as we might in a clinical situation. Clinical experience can be invaluable here in identifying nuances in the data that might be overlooked by researchers without this kind of knowledge. We move away from the clinical experience as we systematically compare cases and generalize beyond the individual case (Strauss & Corbin, 1990). We have found one pattern in particular that stands out in these children. Some of the children seemed very fearful of dying from the same illness that caused their parent’s death. Several teenage girls feared that they would get the same cancer that led to the deaths of their mother and grandmother. In many of these families where children had elevated scores, the surviving parents were not responsive to or were unaware of these fears. In another family the mother did not talk with her child about what they both knew: He had the same genetic problem as his father. This would not be a fatal problem if he got preventive care, but the mother kept putting off taking him to the doctor. We began to talk about what legacy the cause of death could have left for these children. We are not trying to prove that this fear or legacy was the cause of these children displaying problem behavior. However, in reaching into

2 Since the fall of 1996, John Baker, Ph.D., a clinical psychologist, Katerin Boerner, a Ph.D. candidate in developmental psychology, and Cheryl-Ann Cait, a Ph.D. candidate in social work, and myself have been meeting once a week. We are now in the process of preparing our first paper resulting from this analysis of the data.
their lives and touching the data at this level, we begin to recognize a family process at work, to see the relationships between the many factors involved and what meaning this might have for a clinical intervention. These are the beginning fruits of a qualitative analysis in process.

A Third Culture

In one area of work both traditional researcher and clinician are alike. Both value systematic and objective viewing of the situation, one in the controlled conditions of the laboratory and the other in a clinical situation. Neither is comfortable advocating a way of knowing that makes their own personal experience public and a conscious part of what they do. This may be an impossible stance for scientists and clinicians in general but even more so when we are dealing with something that invariably is an extension of our own personal experience (S. M. Silverman, 1979). In this sense there is a third culture—the culture of the human condition. We are all researchers as we try to understand and gain new knowledge about what is happening to ourselves if we are dying or bereft, and we are all clinicians as we try to help ourselves deal with our own humanity.

It may be unrealistic to expect ourselves to be objective and not to use our own life experience to test our ideas and our findings (Field & Cassel, 1997). If we look at the field and begin to ask how people came to work in this area, we find that often their interest was much more than academic. For example, Geoffrey Gorer (1965), who identified death as a new pornography and was a key researcher in opening the dialogue about death in the professions, became interested in the subject when his brother died. Others have reported similar experiences (Berzoff, 1999; Kagan [Klein], 1998). We need to find ways of integrating this experience into the public dialogue.

Integrating the Cultures

How do we bring these cultures together to integrate our professional and private selves? Elbow (1973) provided one approach.
He described the doubting game and the believing game as two ways of approaching a problem. The doubting game challenges people by asking for proof of what is proposed. It examines the evidence and tries to find other evidence that will challenge and question what is being put forth. Those involved in the doubting game ignore their personal experience and feelings. In many ways doubters include the traditional researcher or clinician who value their objectivity and role as an outsider. In contrast, in the believing game the participants try to take each other’s point of view. Personal experience and feelings are valued as a reference point and a respected way of making meaning and learning. Clinchy (1996) described these ways of approaching knowledge as separate and connected ways of knowing. Separate knowers are clearly scientists and many clinicians who take the role of the doubter and the outsider and see their own experiences as irrelevant. Connected knowers acknowledge their own experience as informing how they think and how they react, and, together with the person they are talking to, they begin to develop a new understanding and perspective on the problem before them. This latter approach is consistent with a more qualitative view of science where the goal of research is not to verify an hypothesis but to clarify process, to understand the fullness and complexity of the situation. It may also be closer to how clinicians think, but they are often reticent to acknowledge how much their own intuition and experience influences their work. To bridge the gap between the researcher and the clinician, we need to appreciate these different ways of knowing. It means setting aside the role of outsider by seeing the limitations of objectivity and recognizing that we are dealing with issues of our common humanity.

Using an example from my experience as a researcher in the Child Bereavement Study, we see how this process can work. One of the common concepts in bereavement counseling is that it is important for the bereaved to let go of the past in order to move on to the future and to develop new relationships (P. R. Silverman & Klass, 1996). Early analysis of data from the MGH/Harvard Child Bereavement Study suggested that the majority of bereaved children talked about and dreamed of their deceased parent (Silverman & Worden, 1993). This was consistent with findings from other research I had done (P. R. Silverman, 1989, S. M. Silverman &
Silverman, 1979) suggesting that the bereaved remain connected to the deceased. Steven Nickman, a child psychiatrist, and I examined the data case by case. We began to see, in the children’s reactions, behavior that led to what we called constructing a relationship to the deceased (Nickman, Silverman, & Normand, 1998; P. R. Silverman & Nickman, 1996; P. R. Silverman, Nickman, & Worden, 1992). The research finding suggested that these bereaved children wanted to talk about who died rather than about their feelings. Their dead parent was an important and comforting presence in their lives. Nickman et al. tested this finding by asking bereaved children he saw clinically to tell him about who died, rather than how they felt about the death. The children were very easy to engage as they responded to this question, in contrast to their inarticulateness in responding when asked how they felt about the death.

It would seem that it is almost necessary for the clinician and the researcher to spend time together in the same room, looking at the same data, moving back and forth between the believing and the doubting game. They need to try out the findings and subsequent conceptualization in many dimensions. This includes testing it against their own personal experience with loss, as well as with other populations of bereaved people. Both my parents died while we were doing this work. It became very clear to me that I continued to have a relationship with them, and the Jewish mourning traditions I observed helped in this process in ways I could not have understood until I became an active mourner. I also realized how hard it is to be close to the pain of the children that we were studying until I had experienced a bit of this myself. I had the experience of a mature adult as I approached my pain. I also began to see how much more difficult dealing with the death was for these children. I began to look at the data with a new depth and perspective.

As we examine the differences and similarities between these cultures, it makes more sense to focus on what they have to offer each other. We need to expand the vision of each culture and to begin to look at boundaries between them and to recognize that perhaps both science and clinical work need to change. As we take into consideration the third culture, we begin to see the need to help both cultures become value free. This means for both cultures to
not judge either of them as better or having more worth than the other and to recognize their dependence on each other and on their own personal experience to guide and inform their work.

References


