Ethical Aspects of Outcome Studies in Social, Behavioral, and Educational Interventions

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Abstract
The domain of outcome research is enormous and the consequences weighty. Ethical, practical, and political goals of evaluation have insured a multitude of outcome studies concerning social, behavioral, and educational interventions as well as critiques thereof and descriptions of how to conduct related research. We have a rich literature guiding the design, conduct, reporting, and dissemination of outcome studies as well as a rich literature showing that such studies are often flawed and often hype inflated claims of knowledge (or ignorance). Uncertainties are often ignored resulting in harm to clients. I suggest that a focus on avoidable ignorance and its harmful consequences as well as taking advantage of Grice’s maxims of discourse guided by ethical obligations of professionals to do more good than harm will increase the percentage of sound outcome studies and accurate reporting.

Keywords
ethics, evaluation, ignorance

Volumes have been written about evaluating outcome. Related discussions include questions as to whether we should or can evaluate outcome and how to do so, critiques of related conceptual and methodological issues, and thoughtful discussions of the inevitable uncertainties in evaluating practices and policies and related obstacles (e.g., Chalmers, 2003; Ioannidis, 2005; Patton, 1997; Rossi, Lipsey, & Freeman, 2004; Shadish, Cook, & Leviton, 1995) In the midst of this plenty, we continue to see outcome research that cannot answer questions addressed and publications with misleading claims. There is a large information use gap resulting in a large relevance gap—information gained is not of value in discovering what works (or not), for whom, in what circumstances. There is an advertisement-like quality to many published outcome studies in both goals and strategies that contributes to avoidable ignorance, for example, inflated claims of knowledge and weasel words and phrases such as “It is well known that ...” Ethical obligations of professionals provide a mandate to increase the utility of outcome research for clients.

1. Are we helping? Who are we helping and in what ways? How can we find out?
2. Are we harming? Who and in what ways? How can we find out?
3. Are decisions well-reasoned and informed by related research and theory?
4. Are clients involved as informed participants? Have they been accurately appraised concerning the benefits and risks of recommended procedures as well as the benefits and risks of alternatives (including doing nothing or watchful waiting)?

Well-designed outcome studies are vital to satisfy Gray’s (2001) recommendations for practices and policies, including continuing and disseminating services found to be effective, stopping services found to be harmful and placing services of unknown effectiveness in well-designed research studies (see also Chalmers, 2003). It could be argued that no topic is more political than the evaluation of outcome (Baer, 2004). All involved parties have a stake in how problems are framed, what outcomes are chosen, what measures are used to assess them, and how (or if), resultant information is distributed. Billions

Evaluation: A Bird’s Eye View
The domain of evaluation research is enormous and the consequences weighty. The quality of education children receive, which may affect the rest of their lives, is influenced by evaluation practices and policies and related values and obstacles. Outcome research in the social, behavioral, and educational areas is drawn on to suggest prevention and intervention guidelines. Key questions include:

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of dollars are involved and peoples' jobs are on the line as witnessed by the current turmoil regarding education in the United States (e.g., teaching to tests or not, criteria to use to judge teaching performance). Politics are inevitably present when jobs and money are at stake and there are clashing views concerning outcomes and how (or if) to assess them and multiple players seeking profit. Where there are politics there is an interest in obscurity. Both for-profit and not-for-profit organizations have a vested interest in their continuation and growth. Millions of quarterly, biannual, and yearly reports pour out each year from nonprofit and for-profit organizations required to maintain funding, many of which (most?) have a promotional character rather than one of critical appraisal of interventions used and outcomes attained (Altheide & Johnson, 1980; Combs & Nimmo, 1993).

The play of values is a major factor which influences which problems are selected for attention and which are not (Loeske, 1999) and which measures are used and which are not. Thousands of agencies have been created around scores of problems, including various forms of alleged addiction, domestic violence, relationship problems, job training, school dropout, delinquency, unplanned pregnancies, wellness, crime, poverty, each claiming to provide a vital service. Agencies and professions guard their turf from interlopers, in part by preparing obscure, misleading evaluation reports which hide (rather than reveal) lack of effectiveness in achieving outcomes pursued. In addition to agency personnel and staff, armies of researchers conduct outcome studies and hundreds critique flawed methods in reports thereof in the professional literature.

What is Wrong?

Many outcome studies reported in professional sources are of high quality; authors use methods that can answer questions raised and are honest brokers of knowledge and ignorance. They accurately describe what they hoped to find and what they did find as well as conceptual and methodological limitations. But many do not share these characteristics. These publications are more advertisements than material designed to forward discovery of what is true, what is false, and what is uncertain. Articles and reports which purport to "tell the truth" may, in reality, function as advertisements for the individuals publishing the report, a journal, a profession, a medication manufactured by a pharmaceutical company, and/or an owner of an assessment method; they may be more of an advertisement for a product promoted rather than a scholarly description. Common ploys include inflated claims regarding "what we found,"; hiding or distorting well-argued alternative views, appeal to unfounded authority such as consensus (authority of "the many"), bogus citations (e.g., they do not provide support for claims), and vague descriptions. Weasel words and phrases are common such as "It is well known that ...." "It is widely accepted that ...." (when there is controversy). Misleading professional discourse provides an illusion of knowledge; it hides ignorance as well as knowledge, for example, about well-argued alternative views. As a result of reading an article, we may think we are more informed, but we may have acquired or strengthened beliefs that are false. As a result of reading a misleading outcome report, clinicians may recommend interventions which not only are ineffective but harm in the process (Moncrieff, 2008).

Similar purposes and strategies are evident in misleading professional literature and advertisements. In both, there is distortion of reality in favor of the interests of those who promote dubious claims (Gambrill, 2010a). Certainly they are not depicted equally in any given product (e.g., article, text), but, overall, there are striking similarities. In both, technologies are perfected to suggest consumer benefits (e.g., learn about "best practices"). In both, images and discourse are used to encourage us to use products and to adopt related lifestyles (e.g., "Be your-self"), such as medication. In both, realities are distorted by exaggerating the accuracy of some content and hiding other content such as counterevidence to views promoted and alternative well-argued views (Marchand, 1985; Rank, 1984). In both, the trappings of science are used to create credibility (Jacobson, Foxx, & Mulick, 2005; Lilienfeld, Lynn, & Lorh, 2003). As in advertisements, so too in propagandistic professional discourse, it is hoped that we will suspend critical appraisal and trust "the experts." We are lured by hopes of solving problems and satisfying our deepest longings.

If bamboozled, we are deprived of opportunities to make informed decisions. This is also true of reports by organizations and governmental agencies as described by Altheide and Johnson (1980) in Bureaucratic Propaganda. There is partiality in the use of evidence, a hallmark of propaganda (defined here as encouraging beliefs and actions with the least thought possible, Ellul, 1965). Evidence may even be fabricated to sell a product such as a particular view of anxiety and a related alleged remedy. Concerning discourse in reports of outcome studies, such as inflated claims of effectiveness, provide rich opportunities for those who critique them. Bero and Rennie (1996) described ways in which research can be designed to reach a certain conclusion: (a) asking too narrow a question, (b) playing tricks with randomization, (c) inappropriate dosing, (d) inappropriate comparisons, (e) lack of blinding, (f) inventing your own scale, (g) first shoot the arrow, then draw the target, (h) don't ask, don't tell, (i) protocol violations and poor record keeping, (j) if you get good results, publish and publish again, (k) sales pitch in the article's abstract, (l) lying with statistics, (m) refuse to publish unfavorable results, (n) hide company sponsorship (pp. 125–128). Hilgartner (2000) argues that scientific writing can be viewed as public drama. This metaphor is valuable in highlighting back-stage activity—omitted evidence, well-argued alternative views, and counterevidence to views promoted.

Increasing attention has been given to the quality of publications in professional sources, including outcome studies, as illustrated by the invention of the systematic review and the creation of the Cochrane and Campbell Collaborations. The sheer enormity of misleading claims about causes, alleged problems and risks, and remedies in the professional literature as well as in the media, including Direct-to-Consumer advertising in the United States, has spurred a vigorous counterreaction. The
relentless medicalization of problem-in-living forwarded by the pharmaceutical industry and biological psychiatry and related conflicts of interests and their harmful consequences are almost weekly fair in daily newspapers in the United States (e.g., Cosgrove, Bursztajn, Krimsky, Anaya, & Walker, 2009; Lo & Fields, 2009). Revelations of fraud and corruption on the part of academics with ties to pharmaceutical companies are common (Angell, 2009). This biomedicization of life influences views of behavior in the social, behavioral, and educational arenas and encourages selection of medication as a remedy (e.g., Clarke, Mamo, Fosket, Fishman, & Shim, 2010; Conrad, 2007; Moynihan & Cassells, 2005).

Our Ethical Obligations as a Guide

Ethical obligations described in professional codes of ethics, as well as those regarding the conduct of research, provide a guide for the design, conduct, reporting, and dissemination of outcome research. Although these offer a broad brush regarding conduct as an educator, researcher, administrator, or clinician, this broad brush can suggest a path in the many specific circumstances that arise in related venues. Ethical issues are moral-value issues suggesting that some ways of acting are bad, good, wrong, or right. Some values stress fairness for the least advantaged individuals in society. Utilitarian values emphasize pursuit of the greatest good for the greatest number of people. Related differences of opinion are at the heart of different points of view about the "best way to live," the most moral way to behave and how to structure society (e.g., Sen, 2009). Decisions we make about ethics include:

- What questions we view as a matter of ethics.
- What principles to use as a guide.
- How consistently to act on them: Are they universal?
- What to do if we cannot fulfill them.
- Whether to involve others in confronting ethical challenges.
- How to appraise ethical dilemmas: as burdensome, or as inevitable challenges to be struggled with in an honest, open manner in which we learn how to best handle them in a just way.

Greater attention has been paid to the ethics of helping over the past years including research ethics. Ethical obligations of researchers include: (a) to use research methods that critically test questions addressed; (b) to accurately and clearly describe what was done to what effect; (c) to accurately describe biases and limitations of research reported; (d) to accurately describe well-argued alternative views (e.g., of problem framing); and, (e) to avoid inflated claims (of knowledge or ignorance). Core ethical obligations in the helping professions include the following.

Beneficence

Beneficence is a key obligation. Elements include: (a) one ought to prevent evil or harm, (b) one ought to remove evil or harm, and (c) one ought to do or promote good (Beauchamp & Childress, 1994; Sharpe & Faden, 1998, p. 86). Complexities include imbalances between obligations related to nonmaleficence and those related to beneficence. Questions arise such as Whose interests count? and Whose interests count the most? Faden and Beauchamp (1986) suggest that the principle of beneficence should not, as a principle, be restricted to single parties even in special contexts such as the [client-helper] relationship. Thus, the principle itself leaves open the question as to whom one's beneficence should be directed (p. 11). This point is important in situations such as child welfare in which staff have duties to their employers.

Nonmaleficence (The Obligation to Do No Harm)

This obligation requires professionals not to inflict evil or harm and not to impose unnecessary or unreasonable risks of harm (Beauchamp & Childress, 1994). Sharpe and Faden (1998) suggest that the moral obligation to do no harm can be justifiably overridden but it can never be erased (p. 85). Nonmaleficence specifically involves refraining from an action whereas beneficence involves positive actions. These are overlapping principles and some authors combine them into one category of beneficence (Faden & Beauchamp, 1986, p. 85). For example, we may be able to prevent harm by actively benefiting a client. Calls to reveal rather than hide uncertainties emphasize the harms done by not revealing them (Chalmers, 2008) and has resulted in establishing the BMJs Uncertainties Page.

Self-Determination, Informed Consent

Informed consent requires balancing four principles: autonomy, beneficence, nonmaleficence, and justice. It involves issues about the equitable distribution of knowledge (who should know what at what point). It calls for clear description of the risks and benefits of recommended procedures as well as a clear description of the risks and benefits of alternatives. Self-determination and empowerment involve giving clients real (rather than merely perceived) influence over the quality of their lives and involving clients in making decisions that affect them. They require a candid recognition and discussion of any coercive aspects of contact between social workers and clients (e.g., see Szasz, 1994). Focusing on outcomes that clients value (whenever they do not compromise the rights of others) respects self-determination. Clearly describing goals and methods (including their costs and benefits as well as the costs and benefits of alternative options) and any coercive aspects of contacts (including negative consequences dependent on participation) provides a degree of self-determination that contrasts with the pursuit of vague goals and use of vaguely described methods (e.g., Cohen & Jacobs, 1998).

Justice

Justice is another value emphasized in professional codes of ethics. What may be justice for some may be injustice for
others (Hayek, 1976). Beneficence as related to an individual may clash with increasing justice for others (e.g., a more equitable distribution of resources). In their discussion of the philosophy of evidence-based practice, Guyatt and Rennie (2002) call on physicians to be effective advocates for their clients: "physicians concerned about the health of their patients as a group, or about the health of the community, should consider how they might contribute to reducing poverty" (p. 9). Such calls for this kind of advocacy are also contained in professional codes of ethics. For example, the Code of Ethics of the National Association for Social Workers (NASW), emphasizes the social justice mission of social work on "behalf of vulnerable and oppressed individuals and groups." Justice-based problems include allocating scarce resources and evaluating claims to services. What is valued for a population may not be by an individual. Money spent on ineffective and harmful services limits opportunities to purchase services that have been found via critical testing to be effective (Gray, 2001).

**Key Questions Regarding Ethics and Outcomes**

The following questions are key in outcome research. Each can be answered in ways that reflect or discount the obligations described in professional codes of ethics and descriptions of ethical obligations of researchers. Each involves one or more decisions which affects how other questions are answered. This is why the planning phase of outcome research is so important. Consequences of decisions made at the early stage should be clearly described in the reporting stage (e.g., a decision to promote social anxiety as a mental illness). Outcome data may be gathered using secondary data such as administrative data. Such data may or may not provide answers about outcomes that are most enlightening to involved parties. Here too, researchers are obligated to clearly describe limitations of theories and data used to answer questions raised.

1. **Who will select the questions to focus on and on what basis?**
   - Will these be determined by funding priorities of federal agencies? What criteria are used to select these questions? Of all the avoidable suffering in life (Popper, 1994), what is chosen for attention and what is ignored?

2. **What outcomes will be focused on, who will select them and on what basis?**
   - Will outcomes focused on be those of most concern to clients and their significant others? Will they be those that are most easily measured but not most relevant to clients? What range of outcomes will be considered (e.g., psychological, sociological, biological)?

3. **How will outcomes be measured? Who will make these decisions?**
   - Will multiple methods be used to capture both subjective and objective indicators of hoped-for-outcomes? Will relevant, valid measures be used? Will multiple measures be used?

4. **How will problems of concern be framed?**
   - Will they be framed as a psychological, biological, moral and/or social problem? The framing of concerns affects almost all other decisions in outcome research.

5. **What interventions will be used? Who will select them? On what basis?**
   - Should they be individually focused and/or focused on a system—as in a school and community wide program designed to decrease bullying? What theory will be used to select them? Is this empirically based?

6. **How and in what ways will clients and significant others be involved?**
   - Will they be involved in making decisions regarding questions to pursue, outcomes focused on and how they are measured? Will they be involved in decisions about interventions, reports, and dissemination efforts?

7. **How rigorous should we be in the evaluation of outcome? Should we use a method that can critically test the question? Is there a good match? Should we examine long-term as well as short-term effects?**

8. **How transparent should we be in the reporting of results? Should we be honest about biases and limitations? Should we tell all?**

9. **How will decisions be made about dissemination? Effective programs should be disseminated. What steps will be taken to do so?**

10. **How systemic should we be? This question concerns all other questions.**

All research is selective of necessity, including outcome research. All the questions above require selection of some options rather than others. This selectivity is vital to candidly discuss in reports of research. Otherwise, what is a necessity of the research process becomes an occasion to mislead involved parties. Social and personal problems occur in a context which is often ignored. That is, there is often a focus on individuals, ignoring contextual influences such as school and neighborhood quality and related political and economic policies and legislation. Ellul (1965) suggests that we live in a technological society pervaded by propaganda which creates alienation and anxiety, one in which there is a separation of belief and action in that we cannot act on our beliefs and our beliefs do not lead to action. Wacquant (2009) provides a compelling description of the creation of ghettos which promote behaviors viewed as crimes which in turn result in residents’ involvement with the prison and social welfare systems used to exert “behavioral control of the marginal.”

**A Focus on Ignorance as well as Knowledge as a Remedy**

Proctor and Schriebinger (2008) argue that it is just as important to study the kinds and history of ignorance as it is to study the kinds and history of knowledge. They suggest that there are as many ways to study ignorance as there are to study knowledge. Indeed, the troubling characteristics regarding research
on outcomes in social, behavioral, and educational arenas, is closely tied to ignorance and its uses and abuses. There are many kinds of ignorance including ignorance concerning avoidable miseries. Discourse in some publications is directed toward revelation of avoidable ignorance contained in others. Kerwin and Witte (1983) suggest the following kinds of ignorance:

- **Known unknowns**: All the things you know you don’t know.
- **Unknown unknowns**: All the things you don’t know you don’t know.
- **Errors**: All the things you think you know but don’t.
- **Unknown knowns**: All the things you don’t know you know.
- **Taboos**: Dangerous, polluting, or forbidden knowledge.
- **Denials**: All the things too painful to know, so you don’t (Kerwin & Witte, 1983).

There is ignorance that has harmful consequences and ignorance that has positive consequences. Clearly ignorance is not always negative, for example, in diplomacy, politeness in everyday exchanges, and concerning results of a genetic test. Ethics review boards specialize in the maintenance of ignorance as noted by Proctor and Schriebinger (2008). There is avoidable and unavoidable ignorance. There is ignorance that may be decreased some day and ignorance that will probably never lessen. Different types of ignorance may be visible to different parties at different times who are involved in, or affected by outcome evaluation, including politicians, funding agencies, legislators, agency administrators, clients, staff, and the general public.

What ignorance is revealed and what is not?

Proctor and Schriebinger (2008) suggest three kinds of ignorance: (a) native (a challenge to be overcome), (b) ignorance as lost realm (selective choice; we always make choices in what to study, for example), (c) ignorance as a strategic ploy. Questions arise such as “Who did not know, what, when, who was affected, and in what ways? Who at what time deliberately created ignorance that could never be recaptured? Ignorance as lost knowledge may be deliberate—a choice of what to study and how to do so leaving out other possibilities, or not. The examples given in this article fall into the second two categories of ignorance. The concept of ignorance is closely related to doubt and uncertainty. The creation of doubt concerning research linking smoking and health consequences was a key strategy used by the tobacco companies.

### Examples of the Promotion of Avoidable Ignorance

Here, I focus on avoidable ignorance and its harmful consequences and suggest that such a focus will be useful in decreasing ethical concerns related to outcome research such as inflated claims of effectiveness and hiding well-argued alternatives. Many steps in this direction have taken place over the past years in recognition of the need to reveal (rather than hide) flaws in research and conflicts of interests between researchers and academics and the biomedical industry in diagnoses and remedies promoted. A research report regarding outcome can be viewed as an argument (Janicek & Hitchcock, 2005). We can (and should) examine the argument and see what is missing and what propaganda methods (marketing in the guise of scholarship) have been used. Most will fall into one or more of four categories: censorship, confusion, distortion, and fabrication. All contribute to avoidable ignorance.

### Promoting Avoidable Ignorance Concerning Problem Framing

Great strides have been made in developing tools for reporting different kinds of research including CONSORT guidelines for randomized controlled trials and PRISMA for systematic reviews and meta-analyses. No attention is given in these filters to how problems are framed. This lack is key in forwarding questionable views about what is a problem, how it is most accurately framed, and how it can be remedied (or if it should). How problems are framed directly influences how they are treated. Problem framing suggests measures as well as remedies. Advocacy statistics may be used (Best, 2004). The framing of problems is of key concern in evaluating outcomes. An exploratory study of the framing of social anxiety in a convenience sample of five recent RCTs in a variety of journals by different authors revealed a high rate of propagandistic framing (e.g., disease mongering) and the inability of readers to detect such framing (Gambrill, 2009). Although use of a propaganda index increased detection of concerns such as disease mongering (e.g., claimed underdiagnosis), reviewers still missed many indicators. Glaring flaws in research studies may be easily detected but not deceptive problem framing promoted by the pharmaceutical industry (e.g., Moynihan & Cassells, 2005; Moynihan, & Mintzes, 2010).

### Hiding and Distortion of Alternative Well-Argued Views and Hiding Counter-Evidence to Views Promoted

Hidden by misleading assertions regarding a biomedical framing of social anxiety is a learning view accompanied by a robust empirical literature regarding causes, measures, and remedies (e.g., Brewin, 2006). This view normalizes anxiety by viewing this as a learned reaction; people have different learning histories and thresholds. Lost are opportunities to understand anxiety and related behaviors as acquired by the same learning principles that apply to all behavior and as changeable by application of these principles. Well-argued alternative views (Timini, 2002) and counterevidence to views promoted are often ignored in descriptions of ADHD (e.g., Barkley et al., 2002). No mention is made of Boyle’s (2002) critique of the validity of the diagnosis of schizophrenia in most related discussions. Selective reporting of clinical trials is another partiality in the use of evidence. Studies with negative or inconclusive results often are not publishing or mentioned. Hiding the
short-term nature (4–8 weeks) of drug trials is common. Also, obscured in some research reports is the role of allegiance effects as a contributor to the effectiveness of an intervention (e.g., Wampold, Imel, & Miller, 2009). Illoz (2008) argues that therapeutic discourse has resulted in a mass cultural recoding of what was previously defined as immoral behavior into a disease in which the self’s capacity to monitor its actions and to change them has lapsed. Censored information includes candid description of the lack of empirical evidence for many (most?) service methods used by professionals including the results of critical tests falsifying claims (e.g., Jacobson, Fox, & Mulick, 1995; Lilienfeld et al., 2003; Pignotti & Thyer, 2009). Distorting positions and then attacking the distortion promotes avoidable ignorance. This misinforms rather than informs. Too seldom are professionals educated about the construction of social and personal problems and the play of cognitive illusions and biases among professionals and scientists (Gambrill, 2005; Pohl, 2004). The incidence, prevalence, or danger value of “problems” is often exaggerated to maintain or expand resources. We find propagandistic advocacy rather than accurate reporting of related facts and figures (Best, 2004). Or, the incidence, prevalence, and danger value may be minimized. Distortion is often combined with the suppression of contradictory views and related evidence.

Hiding Ignorance via Inflated Claims of Knowledge

The professional literature abounds with exaggerated claims of knowledge (what we “know”). What is allegedly “known” is exaggerated and ignorance and uncertainties are hidden. Claims based on flawed methodology are common as are misleading uses of statistical tests (Altman, 2002; MacCoun, 1998). Lists of programs distributed by governmental agencies alleged to be “evidence-based” have been found to be based on research which has significant methodological flaws (Gandhi, Murphy-Graham, Petrosino, Chrismmer, & Weiss, 2007; Gorman & Huber, 2009). A variety of strategies are used to give the illusion of successful outcomes including focusing on surrogates (reducing plaque rather than mortality), data dredging (searching for significant findings unguided by specific hypotheses), describing only outcomes found to be positive and not reporting negative ones, folding outcome measures not found to be significant into a composite score and arguing that the composite is effective. Ioannidis (2005) argues that most published research findings are false (see also Ioannidis, 2008). Thornley and Adams (1998) reviewed data in 2,000 trials on the Cochrane Schizophrenia Group’s register and found consistently poor quality of reporting, which they suggest “is likely to have resulted in an overly optimistic estimation of the effects of treatment” (p. 1181).

Flaws in methodology are often hidden in published reports. In place of critical, systematic reviews of research we often find haphazard reviews which do not inform readers how authors searched, where they searched, what criteria they used to review studies and do not include a search for unpublished as well as published reports. Conclusions drawn based on such reviews are often misleading. Rigorous critiques of research regarding programs touted as effective such as Multi-Systemic Family Therapy suggest that such programs are no more effective than are others (Littell, 2006; Littell, Popa, & Forsythe, 2005). The questionable quality of material, including articles in peer-reviewed journals, was a key reason for the creation of the process and philosophy of evidence-based practice and problem-based learning in professional education (Gray, 2001; Straus, Richardson, Glasziou, & Haynes, 2005). Reliability and/or validity of measures may not be clearly described. This is why the call for transparency in the philosophy of evidence-informed practice is so vital and why it meets such resistance.

Relying on Fallacies Such as Appeal to Consensus

Advertisements make use of informal fallacies such as glittering generalizations, begging the question, and bandwagon appeals (e.g., Lacasse & Leo, 2005). This can also be seen in the professional literature as illustrated by reviews of research revealing little relationship between conclusions and methods used to reach them (e.g., Ioannidis, 2005; Rubin & Parrish, 2007). We are encouraged to hop on the bandwagon of what is promoted as good, desirable, effective, to join the latest fad, to follow the crowd into the fields of evidence-based practices. But what criteria are used to describe a practice or policy as “evidence-based”? What criteria are used to claim that (mis)behaviors are due to mental illness? Consider appeal to consensus in the International Consensus Statement regarding ADHD signed by 85 people (Barkley et al., 2002), as if consensus is equivalent to accuracy. Instead of encouraging critical inquiry, a variety of methods are used that discourage probing questions such as bold assertions (simply asserting what must be argued), appeal to consensus, case examples, and pictures of brains. McCabe and Castel (2008) showed that we are more likely to believe claims in an article if they are accompanied by pictures of brains (see also Beck, 2010). Constant repetition of some views increases belief in these views.

Hiding Context

In the culture of therapy encouraged by the biomedicalization of life, focus is on the individual as the locus of problems. The effects of living in a technological society permeated by propaganda, such as anxiety and loneliness (Ellul, 1965), are often cast as remediable by self-help or thinking positive thoughts. Environmental contributors to troubling behaviors such as ghettos are obscured, they are hidden; they are off stage (e.g., Wacquant, 2009). Viewing problems as the result of personal deficiencies is one of four factors Goldberg (1978) suggests make up and encourage oppression, defined as “a state of continual marginality and premature obsolescence.” Labeling behaviors as healthy or sick depoliticizes related issues.
Use of Misleading Surrogates of Hoped-For Outcomes

Does a decrease on the Hamilton Scale of Depression reflect a clinically significant outcome? Studies show it does not, yet this measure is often used in research.

Eclipse of the Subjective

Individual differences are ignored in outcome studies in a myriad of ways, especially the subjective ones influenced by different environmental realities. We see the press for standardization and the neglect of the subjective. Illoz (2008) suggests that the press for standardization objectifies emotions, transferring them into static objects, like exhibits in a museum, hiding their variations and contextual influences. We know little concerning the subjective effects on children of taking medication.

Promoting Ignorance via Avoidable Vagueness

Advertising is filled with words and phrases such as “revolutionary,” “new,” “best seller,” “lowest price.” Similar kinds of vagueness abound in the professional literature. Consider this description in a report of an RCT regarding social anxiety: “Social phobia is a common and disabling anxiety disorder associated with considerable social and occupational handicap that is unlikely to remit without treatment” (Mortberg, Clark, Sundin, & Wistedt, 2007). What is common? What is disabling? What is comparable? What does “unlikely to remit” mean? What is a disorder? Do citations used provide evidence for claims made? Are well-argued alternative views described? Vague terms such as “high,” “low,” “least likely,” “more likely” are classic weasel words. The professional literature is filled with vague claims of association between variables as in, “most people . . . ,” “X is associated with Y . . . ,” “We found a high association . . . ,” What is the correlation? Such terms have different meanings for different people. Acceptance of vague phrases and words gives an illusion of shared understanding. Asking What does ‘high,’ ‘low,’ etc. mean, is key to avoiding acceptance of misleading beliefs that, if acted on, may result in actions that harm rather than help.

Bogus Citations

Misleading citations are a key form of propaganda in the professional literature. They give an illusion of credibility. Professional publications appeal to the “authority of the text” (to the “authority of the word”) and especially, “the authority of the citation.” But how many citations actually contain evidence in support of the claim or description? Examination of this question reveals a high rate of bogus citations—those that provide no support for the claim made, or which do only in some people’s eyes. Citation analyses have found them wanting. Greenberg (2009) found distortions that included bias (systematic ignoring of articles that contain content conflicting with the claim), amplification (expansion of belief without any data), and invention (conversion of hypotheses into fact through the act of citation alone). He argued that these “information cascades” result in unfounded authority for claims (see also Abbott, 2010). The printed word, in this sense, serves a ceremonial/ritualistic function similar to the laying on of hands. Citations become like slogans, and like slogans, the more they are repeated, the more we may be influenced. This ritualistic function designed to lend authority to material that does not warrant it, together with lack of critical appraisal skills on the part of readers (or motivation to use them), help to account for the extent of uncritical reading and propaganda-like material in the professional literature.

But Can a Story Ever Be Complete?

Can a professional publication ever tell the whole truth and nothing but the truth? And, who is to say? Given the complexity of life including the many different realities and views of different players and the challenges of accurate communication, perhaps a story can never be complete. The story will typically be incomplete in terms of the many twists and turns made on the way to a question and the method used to investigate this, mainly as a result of journal requirements of brevity. As many have pointed out (e.g., Aronson, 1984), this gives those who do not engage in the messy business of research the false idea of a lockstep march to the final product, leaving out all the uncertainties and related decisions. But aren’t some accounts more “truthful” (transparent) and complete than others? If authors accurately describe what they did, reviewers and readers may catch problems that researchers overlooked, which is how science works—self-correction. Omitting descriptions of limitations of research methodology and making inflated claims of knowledge and ignorance is deceptive (Chalmers, 1990; Rosenthal, 1994).

Antidotes to Avoidable Ignorance

Placing ethical obligations to clients front and center should serve as an antidote to avoidable ignorance (including ignoring uncertainties) which violates ethical obligations entailed in the planning, conduct, reporting, and dissemination of the results of outcome research. Popper (1992) suggests that we are all equal in our vast ignorance. “It is important never to forget our ignorance. We should therefore never pretend to know anything, and we should never use big words. What I call the cardinal sin . . . is simply talking hot air, professing a wisdom we do not possess” (p. 86). We can draw on literature describing the multiple ways in which clients have been involved in all stages of research including its planning (e.g., Hanley, Truesdale, King, Elbourne, & Chalmers, 2001). We can honor the Gricean Cooperative Principle (contribute what is required by the accepted purpose of the conversation) and associated maxims to decrease misleading discourse:
Maxim of Quantity: (a) Make your contribution as informative as required for the purpose of the exchange. (b) Do not make your contribution more informative than is necessary.

Maxim of Quality: Be truthful: (a) Do not say what you believe to be false. (b) Do not say that for which you lack adequate evidence.

Maximum of Relevance: Be relevant (i.e., say things related to the current topic of the conversation).

Maximum of Manner: Be clear: (a) Avoid obscurity of expression; (b) Avoid ambiguity; (c) Be brief (avoid unnecessary wordiness); and (d) Be orderly.

We can draw on Walton’s (2008) pragmatic view of argument highlighting that when critical inquiry is of concern, questions are never out of place and use of fallacies to avoid them are out of place. We should have a glossary of weasel words and phrases flagged as unacceptable (e.g., “is associated with”). Without facts and figures, these serve a ritualistic function to impress the gullible. We can draw on literature describing cognitive biases and how to avoid them (e.g., Gambrill, 2005; Janicek & Hitchcock, 2005; Pohl, 2004). DUETS (http://www.duets.nhs.uk) offers a valuable source highlighting uncertainties. This is a database describing uncertainties regarding the effects of interventions. Reporting guidelines such as PRISMA and guidelines for preparing systematic reviews (Higgins & Green, 2008) encourage accurate descriptions. Sociologists have been and are in the forefront of critiquing healthism and medicalization, including their service in “Punishing the Poor” (Wacquant, 2009). An understanding of interlinked contingencies at different levels (e.g., how public policy and related legislation affects options for attaining hoped-for-outcomes) is needed to identify constraints and opportunities. Seeing the “big picture” and being historically “savvy” are antidotes to propaganda about what “should be” and what “should not” (and what “is” and “is not”) (e.g., Gambrill, 2010; Illouz, 2008; Young, Ioannidis, & Al-Ubaydli, 2008). Contextual frameworks reveal (rather than hide) environmental contingencies related to personal and social problems. Literature concerning deviance highlights the social judgments involved in viewing certain behaviors as bad or good, healthy or sick (Conrad & Schneider, 1992).

Perhaps we should require a warranty (as for consumer products) to be attached to reports of outcome research. This might look something like the following:

Warranty for this report
1. Limitations of this research have been clearly described including problems framing.
2. Possible harmful effects of the above limitations are clearly described (e.g., opportunity costs of wasting money on research that cannot answer the question pursued).
3. Reliability and validity of all outcome measures are clearly described using figures and describing sample sizes and sources.
4. The rate of vague terms (e.g., “Is associated with”; “There is a high correlation”), is low (less than 2% of opportunities).
5. There is a low rate of inflated claims. Of all the claims made, less than 2% are exaggerated (in relation to the related empirical evidence).
6. There are no bogus references; all citations are relevant and accurate in relation to content.
7. There is a low rate of promotion of avoidable ignorance (e.g., well-argued alternatives to views promoted are clearly and accurately described; figures are given when needed rather than vague statements).

Signature:

In Conclusion
We have a rich literature to guide us in honoring ethical obligations when planning, conducting, reporting, and disseminating outcome research as well as a rich literature that shows that we often fail to use the guides. Lapses in evidentiary quality of content in professional sources shows that, just as advertisers judged their audiences as incompetent, lazy, and gullible (Marchand, 1985), so too do many authors (and editors and reviewers?) of material. Or, authors, reviewers, readers, and editors are mainly interested in material that appears credible (palaver). Combs and Nimmo (1993) describe palaver as a kind of discourse in which truth and falsity are irrelevant (see also Frankfurt, 2005). Readers, unless well-educated in critical thinking skills, are easy victims waiting to be hoodwinked by vague, pseudo-scientific discourse in both the professional literature and professional education programs as well as the media. Stivers (1999) suggests that techniques have assumed a magical status, the indicators of success being the use of the technology itself (e.g., of evaluation), rather than outcomes seen. The evaluation of outcome is a highly political process with many potential consequences including loss of funding. All major methods of propaganda including confusion, distortion, censorship, and distraction are used to obscure outcomes of practices and policies—to promote ignorance rather than knowledge. I suggest taking advantage of literature concerning ignorance and uncertainty as this may have utility for increasing the percentage of sound outcome studies and accurate reporting.

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References


A Collaboratively Designed Child Mental Health Service Model: Multiple Family Groups for Urban Children with Conduct Difficulties

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Abstract
This article presents preliminary outcomes associated with an experimental, longitudinal study of a Multiple Family Group (MFG) service delivery approach set within 13 urban outpatient clinics serving children and their families living in inner-city, primarily African American and Latino communities. Specifically, this article focuses on parent reports of child oppositional behavior and parenting stress over time. The MFG is a flexible, protocol-driven approach designed to address the most common reason for referral to outpatient child mental health clinics, childhood behavioral difficulties. The MFG also aims to enhance family-level engagement and retention in ongoing care. Further, the service delivery model was collaboratively developed with intensive input from parents rearing children with conduct difficulties, parent advocates, community-based child mental health providers, and services research staff in order to ultimately expand the number of effective service models that can be situated within “real world,” urban child mental health settings.

Keywords
outcomes, collaborative research, mental health services, prevention programs, urban families, children and youth, longitudinal study, multiple family group

Each year, billions of dollars are spent responding to the legal, correctional, educational, and psychological needs of disruptive youth (Burke, Loeber, & Birmaher, 2002; Foster & Jones, 2005). Nationwide, oppositional or aggressive behaviors are found among 5–10% of 8 to 16-year-olds and account for one-third to one-half of all youth mental health referrals (Angold & Costello, 2001; Frick, 1998; Frick & Muñoz, 2006; Rowe, Maughan, Pickles, Costello, & Angold, 2002). However, within urban, low-income communities, significantly higher prevalence rates of childhood conduct related difficulties, ranging from 24 to 40%, have been found (Gorman-Smith, Tolan, Henry, & Florsheim, 2000). Thus, addressing urban child conduct difficulties is a serious public health need. Further, emerging evidence suggests that despite recent advancements in the development of effective child mental health service models, there continues to be serious barriers in connecting the most vulnerable of children and their families with care. Therefore, the development of effective interventions associated with high engagement and retention of youth and families residing in urban, low-income communities is greatly needed.

A disproportionate number of children with mental health problems do not receive adequate mental health care (National Institute of Mental Health, 2001; Ringel & Sturm, 2001; U.S. Department of Health and Human Services, 2010; U.S. Public Health Service, 2000, 2001). Specific to minority youth, addressing the serious disparities regarding receipt of appropriate, quality mental health service has also been urgently emphasized (Garland et al., 2005; Kataoka, Zhang, & Wells, 2002; Padgett, Patrick, Burns, & Schlesinger, 1994a, 1994b). This is particularly important since urban minority youth are most deeply affected by the stressors that exist within inner-city communities, notably poverty, community violence, inadequate child-serving resources, under supported schools, and substance abuse (Attar, Guerra, & Tolan, 1994; Gorman-Smith, Tolan, & Henry, 1999; Grant et al., 2005; Hess & Atkins, 1999; Weist, Acosta, & Youngstrom, 2001). Further, the number of children in need of care within urban communities far outstrips the availability of services and the number of service providers. Waiting lists for care within

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