

EVEN SUPERVISORS THINK BADLY

“Bad thinking leads to bad clinical decision-making – and bad decisions hurt clients,” asserts Michael J Taleff. How do we fix it?

One powerful solution is to use the principles of critical thinking.

Nobody is immune to poor thinking, no matter what the clinical experience, years of recovery, the pretty credentials after a name, or the prestigious positions held. So, you might ask, what’s the big deal about poor thinking? The big deal is that bad thinking leads to bad clinical decision-making (Gambrell 2005). And bad decision-making hurts clients, which is a major problem.

How do we fix this? One powerful method is to use the principles of critical thinking.

If practiced well, such thinking can bring about better decision-making in all realms of the addiction field (Taleff 2006). Moreover, improved thinking and decision-making skills hold special significance for addiction supervisors.

A SHORT LESSON IN CRITICAL THINKING.

In the parlance of critical thinking, any supervisory decision is an argument.

Basically, arguments are sets of reasons or premises which support a conclusion – in our case, a supervisory decision. Come up with really good reasons and you cannot help but get a solid conclusion.

BASIC ANATOMY OF AN ARGUMENT.



On the other hand, poor arguments result from sloppy reasoning plus factors called fallacies: for example, mistakes, omissions, faults or false beliefs. Sloppy reasons explain themselves, but what often goes undetected are those pesky fallacies. They can ruin good decision-making in a second.

To illustrate what we mean, a hypothetical case is presented which illustrates poor thinking and its powerful impact on supervisory decision-making. Although hypothetical and a bit exaggerated, it does demonstrate how resorting to one fallacy can be instrumental in encouraging the use of others.

CASE HISTORY: WHAT AUTHORITY?

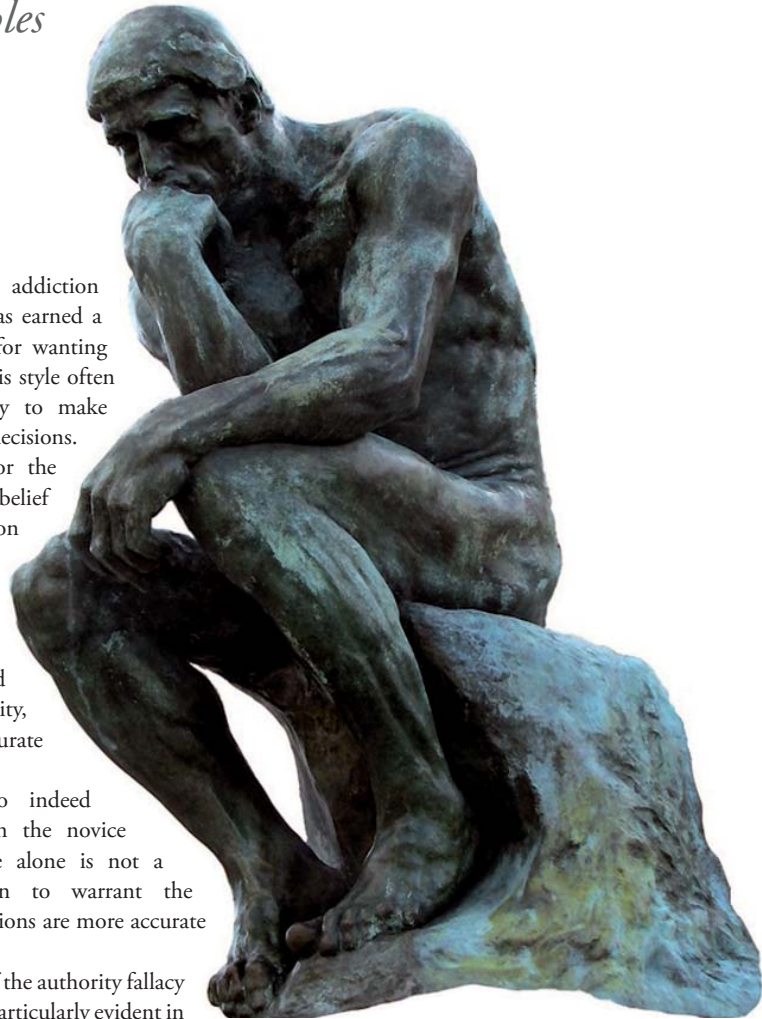
Elaine, an outpatient addiction supervisor for 10 years, has earned a hard-working reputation for wanting things done “my way”. This style often interferes with her ability to make quality supervisory decisions. One significant reason for the interference is her false belief that her supervisory position automatically grants her a high level of expertise. This is called a direct appeal to authority fallacy – as in “I’m the boss. And because I am the authority, my decisions are more accurate than yours”.

Some supervisors do indeed have more expertise than the novice counsellors. But expertise alone is not a satisfactory-enough reason to warrant the conclusion of “...my decisions are more accurate than yours”.

You can see this aura of the authority fallacy used again and again. It is particularly evident in the advertisement business where “four out of five dentists recommend” Pearly White Toothpaste, or where some national speakers use their celebrity status – read authority – and eloquent language to support a product or service.

A major problem with this fallacy is that it makes a case for a claim or, in our case, a clinical decision which is often based on authoritative status but little else. Decisions made in this manner use very little data, research, or statistics. That is a noteworthy absence with the direct appeal to authority fallacy.

The fallacy usually comes with additional baggage. It renders it difficult for the authority figure to use new ideas, especially if other ideas counter the claims of the authority figure. In our situation, the significant negative consequence for



Elaine is her reluctance to use the newer evidence-research based counselling methods that exist today. In her mind, such treatments collide with her authority-based beliefs.

Additional ‘support’ for Elaine’s authority-based beliefs often comes in the guise of simply citing other authority figures who happen to have the same basic position as she does.

Lastly, to her add to her authority framework, Elaine often refers to the long established customary manner of doing things (appeal to tradition fallacy). “That’s how things have been done around here for years, and that’s how we will continue to do things.” The problem with tradition is that longevity does not always equate with effectiveness.



MORE SUPERVISORY FALLACIES.

The authority fallacy sets the stage for other fallacies. For example, when some of Elaine's staff request trying treatment approaches other than those supported by her, they are often met with a fallacy called selection bias.

Here, Elaine counters the introduction of new counselling strategies into "her programme" by supporting beliefs which confirm only the evidence and viewpoints of her choosing.

Such bias goes hand in hand with confirmation bias. In this case, Elaine confers exaggerated importance to certain research findings which justify only her favoured beliefs.

Further, her combined selection and confirmation bias ensure that she uses only information or research which fit her beliefs. These biases clearly ignore and omit counterarguments which might prove beneficial to clients and programmes alike.

Acting from these kinds of bias, Elaine clearly commits another fallacy called "ignore the data fallacy". That pretty much explains itself.

SAD STATE OF AFFAIRS.

Over the years, Elaine has created forceful counter arguments to new ideas that do not match her beliefs. Those counterarguments make her look good and feed her sense of authority.

Also, as a long-time supervisor accustomed to her authority, Elaine likes to believe that she is the programme's clinical role model. She feels that others should follow her style. But doing things in her authority-driven way for years eventually comes at a price.

For one, Elaine feels an obligation, perhaps even a certain need, to protect the *status quo* she has established, as well as maintain what she believes is the reputation of her programme. All these fallacies bind Elaine into a false belief of personal and programme effectiveness.

Moreover, they create the erroneous belief that she is making the best decisions possible. Fallacies can do that.

USING CRITICAL THINKING: A SET OF QUESTIONS.

Hopefully, *Addiction Today* readers have recognised the flaws in Elaine's thinking. A giant step in identifying flaws such as these comes from the ability to construct good questions. Forming good questions are the cornerstone of good thinking.

Below are a few key critical thinking questions. Mull them over. Do not be afraid to use these and other thought-provoking questions in your everyday work.

1. When someone makes a claim or clinical decision, ask if they can supply their reasons and premises for that clinical decision.
2. Ask if s/he claims to be as free of bias as possible.
3. Ask for evidence for a particular clinical decision.
4. Ask if any key facts were omitted in terms of a clinical decision.
5. Were alternative views or other evidence entertained before the clinical or administrative decision was made.
6. If a clinical decision has been made, ask who made it. This endeavours to separate administrators or other stakeholders from clinical input.
7. Ask if there were any other vested interests associated with the clinical or administrative decision in question.

Questions such as these clear the air of muddled thinking and fallacies.

CONCLUSION.

This article is intended to introduce *Addiction Today* readers to the need for critical thinking as it applies to addiction supervision. We sampled just a few of the many thinking fallacies which can and will interfere with making quality clinical decisions at that level.

Embedded in the article is a call for the field to evolve to a more accountable level of treatment by applying critical thinking principles to all that we do. The winners of improved thinking will be our clients.

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