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Becoming a researcher: psychotherapists' experience of starting a professional doctorate

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ABSTRACT

This paper explores the journey taken by experienced psychotherapists as they embark on doctoral research, highlighting the adjustments involved in moving from being a clinician to becoming a researcher. Having touched on the complex relationship between psychotherapy and research as a whole, including how badly this has affected the development of a robust evidence base for many approaches, the paper describes the development of a post-qualifying research programme for those grafting research skills onto their clinical roles. The paper then considers how the kind of research undertaken by psychodynamic psychotherapists has shifted from being primarily focussed on single case studies – so remaining closer to the clinical writing of the past – to including both more general social science research methodologies and more precise psychoanalytic methodologies, capable of exploring in depth the processes at work in the therapeutic encounter. The main focus of the paper is on the impact on the students of undertaking their first research project. At the beginning of this process nearly all students underestimated just how much of a shift in their thinking it would involve, and the paper captures some of the key issues and powerful moments reported after their first year. They speak of the humbling impact of conducting a structured literature review and of the complexity of finding a truly researchable question and viable design, as well as the appreciation of the difference between clinical illustration and evidence. They speak of the impact of thinking about the ethical issues involved in research, and of the need to interrogate their design in order to minimise bias. One of the interesting – and to them surprising – effects is that the shift to research-mindedness feeds back into their clinical identities, in a way that is both challenging and invigorating, overall boosting their confidence as practitioners.

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Introduction

In this paper we follow the experiences of a cohort of doctoral students, the majority of whom are ACP child psychotherapists, as they embark on a professional doctorate, highlighting their journey from being a clinician to becoming a researcher. This is both

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an exciting and highly challenging adaptation, involving learning many new ways of thinking – experiencing the encounter with the rigour of research thinking, and grafting it into one's clinical identity. At the beginning of this process nearly all students underestimated just how much of a shift in approach the transition would involve, so it is interesting to try to capture some of the key issues and powerful moments.

We have written this paper to encourage others to follow the same path, while at the same time to explore some of the difficulties faced, so as to elucidate the process.

The programmes described here are the top-up doctorates at the University of Essex. This suite of degrees provides support for research projects undertaken by already qualified psychotherapists, child psychotherapists and psychodynamic counsellors, who for a range of reasons did not pursue research as part of their training.

The students' contributions to this paper are derived, with their permission, from interviews conducted as part of their assessment at the end of year one, rather than as a piece of formal research. They were required to answer questions about their experience of becoming a researcher and on matters of ethics and potential bias. Perhaps paradoxically, given the topic in hand, this is not a research paper, but a collaboration between staff and students to convey their experiences. As a result, the students are being presented here as contributors rather than anonymous research participants. The whole cohort were interviewed in the same way, and extracts have been chosen to illustrate the ideas which emerged.

Psychoanalysis and research – a tense but evolving relationship

It is a commonplace observation that psychoanalysis and psychotherapy have had – and to an extent still have – an uneasy relationship with research. The idea that research can only 'measure what doesn't matter and cannot measure what does' (a much-quoted paraphrase of something Einstein once said) has long been held in psychoanalytic circles, where the emphasis on the unconscious has been seen to exclude the positivist and objective mindset assumed to be that of the researcher. Kernberg (2006) urged us to increase our focus on research, with Perron (2006) responding with the concern: 'So, should we not explore new paths of research? Yes, of course we should, but using methods that do not kill their very object' (p. 931). Both Scott (2018) and Knox (2013) have written about the idea that the profession has preferred to remain in a 'psychic retreat' from research ideas, whether these be in relation to outcome measurement, treatment effectiveness or more in-depth enquiry into therapeutic processes. Tasca et al. (2014) described what they termed a 'significant practice – research divide' within psychotherapy, and stated that 'clinicians often do not use existing research to guide their practices, and researchers typically do not rely on clinicians' input when designing psychotherapy research' (p. 197).

It is important to remain thoughtful about the tensions in this debate, even as we endeavour to become more research minded as a profession. To quote one of the anonymous peer reviewers of this paper: 'There are very valid reasons as to why psychotherapists are keen to proceed cautiously and think very carefully about how, why, what and when we would want to make use of more formalised and structured research methodologies'. The essence of psychoanalytic psychotherapy is its emphasis on unconscious processes, and it is vital not to throw the baby out with the bathwater.

There are genuine fears that something precious needs protecting, existing alongside the possible reluctance to face scrutiny and the probability that we might need to change some of our practices.

However, this resistance to research has been somewhat in retreat in recent times. A concerted effort has been made to include research thinking in trainings, most notably in child and adolescent psychotherapy trainings, where most qualification courses can now be pursued as doctorates including a research dissertation, following modules promoting research skills and literacy. The main professional associations in both adult and child psychotherapy have research committees, which promote research thinking in the professions. Even more powerfully, the increasing wealth of evidence that demonstrates the effectiveness of psychodynamic therapy (Midgley & Kennedy, 2011; Midgley et al., 2021; Shedler, 2010, 2020) means that the avoidance of research resulting from the fear that our work is not 'evidence-based' is on the wane. It is still, however, possible to pursue a full clinical training in psychotherapy and psychoanalysis without having to encounter much in the way of research, and generations of psychotherapists who trained in earlier decades have often been unfamiliar with the results of recent research and even more unfamiliar with research methodologies and design. Furthermore, even among those who conduct research for their doctorates, until recently the methodologies employed have been somewhat restricted in range, with a predominance of single case studies using grounded theory (Rustin, 2016). This is partly because it is the methodology closest in approach to the in-depth clinical thinking that is familiar to practitioners, and partly as a result of the strong commitment to genuine and deep psychoanalytic learning from the clinical encounter (Rustin & Rustin, 2019). More recently, other methodologies have been more widely applied.

A professional doctorate like the one at the University of Essex encourages the students to explore a wide range of issues, moving beyond single case studies where appropriate. They are also encouraged to choose from the wide range of methodologies used in the social sciences more generally – as well as employing more essentially psychoanalytic methods – allowing them to draw on the strengths from both broad categories.

A brief history of the professional doctorate programmes at the University of Essex

The professional doctorate programmes were created in the 1990s, and were intended to give clinicians the opportunity to be taught all of the research skills they would need in order to conduct their own projects in a time and cost effective manner, as they 'topped-up' their existing clinical training, requiring therefore only half the time (three years part time study) and half the word length (40,000 words) of a PhD.

They enabled clinicians to train in research methods, enabling the production and development of high quality psychoanalytic research in the field. This was not only to address the wider needs of the profession as they competed with other therapeutic modalities, but also to create new vistas of psychoanalytic clinical research thinking.

These programmes were suspended when the departure of key staff left insufficient capacity, but in 2021 they were relaunched with an invigorated and re-structured teaching

programme. They were created to be accessible to more students from further afield, utilising the opportunity that online delivery affords for some of the teaching events, as well as potentially for academic supervision. This professional doctorate top-up model remains unique in the UK and internationally. Although psychoanalytic psychotherapy clinical doctorates are increasingly part of trainings, this top-up programme aims to enable seasoned clinicians to achieve doctorates through their own individual research projects.

Research done at this late stage of professional development can be undertaken in a different way from that done during clinical training. It can benefit from the greater experience of the researchers, but also can be given a greater focus as the imperatives of training are no longer a priority.

Outline of the professional doctorate programmes

Another important difference in the professional doctorate programmes, in contrast to the more conventional PhD programmes, is that the students are taught all the skills they need during their first year as a cohort within the department, with monthly workshops in years two and three, as well as the usual on-going monthly academic supervision throughout the programme. As it is not expected they will already have research skills from previous academic studies, potential students are given significant support before they submit an application to develop their ideas into proposals, which are then reviewed and accepted by the team.

In the first year there are structured taught modules on literature review, research processes, methodology, and research design, as well as support with ethical approval applications. The programmes start with in-person teaching in all modules, to help build a cohesive cohort. A mixture of online and in-person events follow, alongside regular 1–1 supervision. Students are also given a research fund by the University every year, to access additional training resources for their project, such as specialist research methods training or attending relevant conferences. The structure is demanding but containing. There are regular essays required, which are marked, and written feedback is given. This gives the programmes a different feel to a PhD. In the latter there is work regularly submitted to the supervisor and supervisory panel, but having an essay formally submitted and marked, one which could in theory fail, creates a very different atmosphere. While these essays make for a heavy workload and an increase in felt pressure in the first year, they can later become the core of chapters in the eventual thesis, meaning that once the first year has been successfully completed, the project is solidly on its way. Years two and three involve the students gathering and analysing data, as well as writing up the 40,000 word thesis, assisted by academic supervision and monthly workshops.

Research methodologies

A wide range of methodologies are supported, from qualitative social science methods such as thematic analysis, interpretative phenomenological analysis, conversational analysis etc., to pioneering psychoanalytic research methods as developed by R. D. Hinshelwood discussed below. Hinshelwood (2013) writes: 'The case study is observation under laboratory conditions', and he adds that it 'brings psychoanalysis

closer to natural science experiment than to psychological or medical research' (pp. 103–104). Hypotheses can be tested, utilising case material, which is like observing the consulting room under a 'microscope' (Hinshelwood, 2013, p. 97). This has its corollary in Rustin's work on the consulting room as 'laboratory' (Rustin, 2003, 2019) although there are some differences in the two approaches.

As D. L. S. Wright (2022) describes:

> Jan Abram and Robert Hinshelwood discuss that, 'there are also laboratory methods for scientific investigation of babies, developed by Margaret Mahler, Daniel Stern, Colin Trevarthen, and many others [...] However, clinical listening to conscious and unconscious expression of experience is the primary source for understanding the issues and puzzles arising in infancy.' (Abram & Hinshelwood, 2018, p. 42)

As Willemsen et al. (2017) write 'The clinical case study is clinical research *par excellence*' (pp. 91–92).

Case study data (as well as data from interviews with clinicians) can be analysed with classical sociological methodologies to test a hypothesis, discover themes and links, and explore the researcher's question relating to psychoanalytic issues, practice issues, and patient responses and changes in the clinical process. Case study data can also be analysed with approaches that utilise psychoanalytic concepts to understand the unconscious processes involved in the material. Wright (1999) utilises clinical case study material in a comparative analysis of psychoanalytic theoretical models to look at comparative understandings of unconscious processes and demonstrates how case study material can be utilised for research. Hinshelwood (2008, 2013) developed the psychoanalytic case study research method, within our department, in his 2013 book 'Research on the couch: single case-studies, subjectivity and scientific knowledge'. He discussed this further in 2018, and it was also explored by Figlio (2018), then further developed and utilised in clinical research by Wright (2022).

This method starts with something observed in the clinical work, which is to be the focus of the research. In Wright's case (2022) this is the relationship patients have with the consulting room, which potentially has its roots in the introjection and re-projection of an early experience of a room in childhood. The next step is to elaborate a conceptual framework, calling on relevant theoretical and clinical knowledge to define a number of ways in which the phenomenon under investigation could be manifested in the therapeutic work. These positions are then 'operationalised' by giving a detailed description of what these would feel and look like, including a triangulation with countertransference experiences as an additional source of clarity. As countertransference is a consistently important element in psychoanalytic work, it is just as essential to consider it, in this psychoanalytic case study research method, a crucial source of information. Hinshelwood discusses 'using the recommended method of selecting occurrences by triangulation of content and countertransference [... to ...] allow for a more reliable and secure interpretation, because it is supported by a credible exclusion of countertransference distortion therefore there is more surety of its reliability' (2013, p. 153).

When a detailed and thorough description is created, then the clinical data can be 'tested' to see if, when, why and how any of these positions can be seen in the data.

Hopkins suggests that Hinshelwood's method equates with Bayes' theorem where, 'explanatory hypotheses or theories are always also predictive [...] the hypothesis (or hypothesized mechanisms) must perforce confer a probability of the data given the hypothesis than is higher than the probability of the data given the negation of the hypothesis (supposing that there is no such mechanism)' (2013, p. 3). So, if the hypothesised phenomenon or dynamic appears to exist in the material at all, then the hypothesis can be demonstrated in the clinical data as well, considered as having a probability of further relevance. At the University of Essex these methods are developed and utilised in a cross-fertilising way, to further the robustness of all the research projects.

Clearly a core element in the psychoanalytic nature of the research is the attention paid to the unconscious. Data collected in any fully psychoanalytic research project are analysed utilising not only what is said and done, but also what can be inferred using more symbolic and interpretative means, as well as what is felt and experienced by the researcher. Countertransference is utilised whatever the chosen data analysis methodology used, as it is a core component of data in clinical research.

Becoming a researcher

Moving from being a clinician into becoming a researcher is always a profound process, but can also be a painful and difficult one. There are several different strands to this. One which is often a surprise to our students is the distance they have to travel from having a deep interest in something, to finding a way of researching it. The approach of potential applicants for the doctorate to our staff team is usually characterised by a passionate interest in a particular field or area of clinical concern, but the first task, long before a formal proposal is submitted, is to help this be shaped into a researchable question, which is a very different thing. Some of this is a matter of scale – what can be reasonably researched is generally a great deal more limited than is envisaged – but it is more often a matter of the need for rigorous logic and disciplined thinking. Defining a research question is the first, and often the most impactful, exercise in developing a research mindset. A good-enough research question is needed before an applicant is accepted on the programme, but during the taught component of the first year this, in almost all cases, undergoes many changes as any vagueness or potential for confusion is ironed out. This can be a difficult time, and students need to be supported in this stage of their project development.

We know we want to explore X – for example in our current cohort this could be 'parental alienation syndrome', the 'combined object' or 'the interpretation of drug dreams in addiction', to name a selection. To do research on X we have to define it, and be sure that if we see X we will know that is what it is. We need a research design that enables us to locate X and to see clearly whatever it is we want to know about X, whether this be its features, its causes, its impact or ... As clinicians we have a different way of finding things out, and a different way of establishing what we 'know'. These different epistemologies can create considerable tension, as described below:

> ***JL*** *'When I began the process I thought I was pretty clear on my research question. But on further investigation and in the process of defining it, it became apparent I was not. I felt*

confused and overwhelmed by this realisation and struggled with questioning what I wanted to know and how to express this coherently. Fortunately, my supervisor normalised these feelings and was a great support as I was seriously doubting that it was even possible to define the question. I felt able to be with this uncertainty in the knowledge that all would become clear as the process progressed.'

A related but different problem is the status of our material. All our training and almost all the texts we read, both classic and contemporary, use examples from clinical experience to illustrate their ideas. We are all so used to this that we hardly notice how selective these illustrations are, and are readily convinced by these often moving demonstrations of the 'rightness' of the formulations presented. However, in moving into being a researcher, we have to move from using clinical experiences as 'illustrations', to using clinical material as 'evidence'. As Kegerreis wrote elsewhere (2016):

> Evidence requires us to weigh up what happens using a recognised methodology for analysing content, rather than cherry-picking from a mass of material something that illustrates our hypothesis or 'proves' our point. Much of our highly valued and clinically useful case-study learning is based on the latter method, which is partly why other professions do not consider the psychoanalytic canon as having much validity as evidence. (p. 202)

Having seen many students through this process at both doctoral and masters level, it is continually illustrated to staff how alien the research way of thinking can be. Students at earlier (and sometimes later) stages often feel really tortured by the logical requirements of thinking like a researcher and can get quite angry about having to do so.

They are convinced that something is important or true – probably with very good reason – yet can get tied up in complex knots trying to work out how to go about actually extracting and identifying useful data about which they can ask the right question in order to demonstrate the validity of their conviction. Working psychoanalytically the need has been felt in the past to show that we are adhering to our forefathers' and foremothers' theoretical ideas, rather than to explore without that burden the demonstrable realities of what is in front of us. Yet if we are to think clearly and rigorously about our work, we need to be able to justify our ideas and give robust evidence for the way we are thinking and working.

Both Rustin and Hinshelwood in different ways have explored how to adapt the kind of learning we all do in the therapy room in every session to a more rigorous method – staying very close to the clinical encounter but subjecting it to a far more organised and searching scrutiny, rendering what used to be used for illustration the location for real evidence.

EQ *'I suppose there are some similarities and they're kind of on a scale, but one of the main differences which I felt was important was Hinshelwood's idea of the consulting room being like a scientific laboratory, so instead of patient/therapist it is thinking more in terms of a researcher and a participant.'*

The change of mindset comes more easily to some than to others, but for all it is a major shift.

JN *'I had some experience of doing research, but starting the preclinical and then continuing to the training I just thought "Let's think about this child and let's do research about this." I took it for granted that that was what we were going to continue doing in this professional doctorate, but then I realised that actually it's much more. I think even though you're*

researching in an area like psychoanalysis it doesn't involve the same kind of thinking - it needs to be different.'

***JL** 'Working as a researcher, for me, sets a different framework, perhaps a wider framework, a process, a relationship between practice and testing knowledge - testing my own ideas rather than accepting ideas from the community of which I am a member - I am now coming up with ideas myself!*

As a clinician, I felt immersed and contained in psychoanalytic knowledge and the practice of that knowledge - it was familiar. Being a researcher has changed that focus to something more practical, to "doing" and thinking about methods of academically recognised investigation which is testing out that knowledge and perhaps, for me, it's searching for certainties rather than "being" with uncertainties as a clinician. This does feel more practical and with a far wider framework. It's setting a question for something I want to know, I want some evidence that it exists - setting a question of what I want to know, defining it and directing my energy towards that end.'

The mission to prove something is often at the root of the doctoral student's motivation. This is both a blessing – as it provides the impetus to get started and to dedicate several years of work to the project – and a curse – as they rapidly learn that trying to prove something is a trap when it comes to the open-mindedness required in research.

***SH** 'I came to the professional doctorate wanting to prove my hypothesis (that a Jungian approach to drug-dreams would account for the clinical phenomena I observed in the dreams of patients in recovery, but which weren't accounted for in any of the literature I'd read on the subject.) However, during the first year's seminars I came to respect the research process as a valuable tool for finding out what I don't already know, or think I know. In other words, for its impartial ability to find answers which have no single value/one answer i.e. can be used in various ways to inform clinical interventions and theoretical advances in knowledge. Basically, that there's no right or wrong answer, and research isn't used to prove something determined in advance.'*

A further challenge is more emotional than cognitive – the blow to our confidence and the sense of being de-skilled by becoming a researcher, having formerly felt secure in our professional identity. This is not confined to psychoanalytic research of course. Mersky (2018) writes of the 'humiliations and challenges of the student role' (p. 155) later in life, and discusses her 'overwhelming negative transferential reaction – narcissistic wound and very deep feelings of failure' (p. 147) in getting feedback from a supervisor. She describes eloquently 'how extremely difficult it is to be an adult learner and to be the teachers of an adult learner. The transferential dynamic between the child learner and the teacher is completely different' (p. 147).

***EQ** 'So there's a whole different layer of thinking as a researcher that's different from a clinician and I suppose that's changed my identity as well as a therapist. I suppose you come to a point of feeling quite secure in my identity as a therapist … but as a researcher it feels much more exposing.'*

For psychoanalytic clinicians the hurdles can be complex in an additional way. Questioning our practice can feel heretical, with a whiff of betrayal in developing serious tools with which to analyse the psychoanalytic encounter. There can be

a sense that to become a researcher is somehow to 'go over to the dark side' – to sell one's psychoanalytic soul and join the 'evidence-based brigade', and/or to cast doubt on cherished certainties.

> *As **JN** put it: 'I read about fights within psychoanalytic psychotherapy about whether doing research, or not doing research, would be the death of psychoanalysis in a world of evidence-based medicine … My (possibly naïve) feeling was that I needed to be either academic researcher, or psychoanalytic clinician, but I couldn't be both. This has allowed me to see that I can be both and that there are ways of 'doing research' that don't have to diverge from "capable clinician"'.*

The literature review

As clinicians we know how to read our favourite journals or to look on PEP-web to see what else might be out there. However, very few of us look outside a small number of publications. This is unsurprising, as we may want to read something enlightening but we want it to be in a language we understand, maybe increasing our range but perhaps not moving too far outside it. As a result we do not know much of what might be out there. Looking in journals in different, but related, professional fields we can notice that what are presented as huge discoveries are commonplace in our psychoanalytic world, or that questions are being raised which we typically never ask about our techniques and approaches. Embarking on a rigorous search can upend cherished ideas, challenge our assumptions or make us question what our own project is going to add.

Nearly all in the cohort wrote or spoke about the impact of conducting the initial literature review. Some had been preoccupied with their area of interest for decades, but only when doing the systematic literature review found out more clearly what other people had thought and written about it. One doctoral student withdrew at this stage, as ideas that she had thought were her own turned out to have been widely argued over in the literature in many ways not hitherto known to her. The experience can be both humbling and exhilarating – discovering what others have been writing about our cherished ideas or pet topic and finding out how they have gone about researching it. On the one hand it can be disheartening to realise that our thoughts may be anything but new, but on the other hand it can be enlightening to register that our project is going to explore something others have felt to be important, and as a result exciting to devise a project that will break new ground and genuinely add to the knowledge in the field, maybe even more than had been originally in mind.

> **SH** *'From the outset I felt sure I had a distinct and clear research question based on clinical phenomena I had observed in practice. My question also involved a new dream methodology being pioneered in Germany. However, in supervision, and during the process of exploring my question during the research seminars with other staff and students, it became clear my research question also had the potential to critique this new method, and include more emphasis on my hypothesis. The idea of critiquing the new methodology felt daunting, as I realise now that I had an idealised view of the method which was unconsciously biasing my thinking.'*

Every member of the cohort found that their question needed to be refined or changed substantially as a result of their literature review. This happened even though for most

their question had been altered multiple times in order to put together a viable project to gain admission to the programme.

However, apart from the one who decided at this point to withdraw, having discovered how much of her thinking had already been explored, the overall effect was of a much greater confidence and sense of the contribution they could make.

> **JN** *'I was very uncomfortable at the start of the course with the fact that I might be showing something that could potentially have a very big impact on mental health and certainly could rock the boat in terms of the newer developmental status quo. And I'm a lot more comfortable with that now, because this is how we learn, and I can be somebody that is part of that.'*

Choosing a research design and methodology

Developing a clear research question is the first big hurdle, but out of this the design should – and will – emerge. The two are inextricably linked as, once a question is clear, the nature of what kind of material is going to constitute the data used to answer it will also have been clarified. If the area of enquiry is related to psychodynamic processes, then the phenomenon in focus will have to be operationalised – that is defined clearly enough with key markers to identify it as it occurs in the clinical work (Hinshelwood & Stamenova, 2018). If the area of enquiry is more to do with how therapists or patients experience or conceptualise something, then the kind of interviews or questionnaires needed to elicit this data will already be clear. If there is a question of effectiveness of an intervention, then the means of measuring this will have been identified and the mechanisms required to apply these measures will have been chosen. The most relevant means of analysing qualitative data will also have emerged in the process of defining the field of enquiry, as it will be evident whether the project is theory generating or hypothesis testing, so showing whether – to name a small selection – the need is for grounded theory, thematic analysis, operationalising, narrative analysis, conversation analysis, or q sort analysis.

However, in psychotherapy research the design of the project, challenging as it is in its own right, is beset with other difficulties in terms of the ethical issues in exploring clinical work with vulnerable people, particularly with children. Doctoral students are often taken aback at the complexities they encounter once they take these issues into account. There is another paper to be written about the problems of the ethical approval committee processes for clinical research, but even with that put to one side, all researchers need to tackle how they are going to get fully informed consent from patients, whether current or retrospectively, taking on board how this might affect them and potentially influence therapeutic outcomes. Some students are most concerned about consent being refused, but others are more concerned about the opposite outcome:

> **SH** *'Conversely, a drawback is that the participants may feel they are being taken advantage of, feeling like guinea pigs/research subjects. Often the experience of patients who have dual diagnosis is one of mistrust and scepticism about figures perceived to be in authority.'*

> ***MH*** *'I think one of the dilemmas I have is that she's very, very willing and I thought about the power differences and the kind of trust that we've got she's become . . . so the thing about*

using retrospective material is case studies needs to be completed, and I fully appreciate that because the level of trust is built up over time, so when you're ready to discharge that's when you get a sense of you know, the trust and power. She's very trusting and actually needed more therapy and so there was that kind of painful ending. And then I had to ask about the, you know, using her material and she was more than willing, but at the same time, I could sense that you know, this is about her love of me because she basically she loves me.'

It is a familiar experience for those of us teaching new researchers that the ramifications and implications of getting consent come as something of a surprise. Some did not include any suggestion of research in their engagement with the patient, while others come from agencies where global consent to be used for research is given at the outset of treatment, and therefore are shocked that this is not sufficient for most research projects using personal material in more detail. Many think that it will be fine, only to realise that the act of getting in touch with previous patients raises many thorny ethical issues which need to be addressed before the project can continue.

Working with practitioners as participants can seem a lot simpler, but here too there can be major challenges:

JL *'I am interviewing practitioners who will be discussing their patient work, so keeping their patients' identities anonymous is crucial. So I am asking them to change their identities even before we meet and maybe change some detail about them. This is not an ethical requirement when working with practitioners and their patients, but it feels as though it removes the risk of being identified even further.'*

Dealing with bias

The earlier section on developing a research mindset takes on a further dimension once the research design is more clearly defined, and the need to address and minimise sources of bias comes into focus. There are many levels to this, from the overall conception of the project, to the detail of what is observed, including which cases to include:

EQ *'One of the key places where I need to be aware of any bias, is to ensure that I don't cherry pick cases. I'm hoping that the material will show what I'm seeking to research, so I need to be really aware of bias in terms of trying to find cases that I think are going to and prove my hypothesis, and that my method - operationalisation - that by having a clear set of criteria before I start the work with the patient, then that will show what is there as I have set my criteria beforehand.*

But I am aware that I am part of the research and that I'm a participant as the therapist as well, so not objective, because I'm kind of situated in the research.'

***JN** 'I like to think that the process of writing and operationalising a set of definitions that I will be discussing in supervision - so it's not just me and my own biases - means that objectivity is sort of built into the research itself. Obviously, this (my idea) is a thing that I have seen already and believe to exist, so I'm aware that there are biases - I know that this is a thing and will want to be able to demonstrate it. But hopefully the process of writing the operationalisation criteria means that you know if it starts to go that way there's definitely already somebody that's there to say "hang on a minute James slow down, this is starting to not quite be as objective as it needs to be.'"*

Some manage the issue of bias by bringing in other people, apart from the supervisor, whether as gate-keepers to participation in the project, or to triangulate or check that the methods used are objective enough.

> ***JN*** *'Well that's part of the reason why the psychologist is identifying the participants that these are not, I mean they might be children who would have come to psychotherapy anyway, but it's not me popping up arranging an assessment and saying "Oh, by the way, there's some research going on". In which case they might feel like they were pressured into having to agree to it, because it would affect things. Having somebody else say "there's this research that's happening, are you interested in it?" makes it actually a choice for them. We say it's a choice, but it might not feel like it is, so I'm hoping that it can be managed mostly by my being as absent from the process as possible right up to the last minute.'*

In a way, psychoanalytic psychotherapists are particularly well-placed to consider issues of bias, as they are very used to processing their own countertransference. However, the clinical and the research encounter are not the same, so we need to be highly alert to what we ourselves are bringing into the process. It is important to note that even in our clinical work we do not always fully process the degree to which our own identity and personality affect our perceptions. This has been considered in greater depth in Kegerreis (2022) in relation to clinical work, but the issues raised in that paper are also relevant to researchers. If we do not process and attend to the effects of our gender, race, class and personal histories and experiences, we will inevitably bring them into our research process, which will bias our perceptions and our conclusions.

The students' journey during the first year involves looking very closely at these questions. One rich example of this is the student studying the experiences of being an adult 'only child'. Her own experience of this is at the root of her engagement with her project, but the process of refining her research question, design and methodology, has necessitated a great deal of personal work so that it aids the project rather than interferes with it.

Larger effects on the students

This paper has been written after only one year of the relaunched three-year programme. All the participants speak movingly of the effect the course has had on them. Their confidence as researchers has greatly increased, but what has also been commented on is the way in which the process they have been through over the year has fed back into their clinical identities as well.

> ***MH*** *'It's really fed back into how I see things even operating as a therapist. In a strange way it's giving me confidence. Not strange, but a new confidence in and having some sort of feeling of authenticity about something you know, having been forced to read up in that. I feel that it's really going to equip me to know a subject better and to be able to disseminate what I know. I'm already doing that and I will be running CPD so it's not just clinical, it's more that I feel so better equipped now that I've gone through this. I may have had to drag through it sometimes but it's been really valuable.'*

> ***JN*** *'Something in the course, and it might be the experiential groups, it might be the active teaching, it might be the space to sort of thrash it out and think, together with other people about it. That stuff that I already knew, I know differently now as a result of the course.'*

EQ *'So the way I kind of think about that time (the early part of the course) has also shaped my approach as a therapist. I'm more aware of seeking informed consent to treatment and whenever I'm going through this process, one of the questions was does the child have the mental capacity to give their own consent?*

The course is feeding back into our work in the way we think about our patients - it is starting to get integrated into the way I think as a clinician.'

JL *'You know my thinking is about 'finding a position' and I think that's really been highlighted, for me in the whole experience of the Professional Doctorate. So although that's perhaps been a bit uncomfortable it's also been very good learning.'*

As mentioned earlier, the programme is very different from that pursued by a typical PhD student in our department. The two intensive days at the beginning create a strong sense of being in a cohort, and the mutual support generated is invaluable, enhanced by regular teaching days throughout the first year. Being a doctoral student can be a highly isolating experience. This 'horizontal support' (Mersky, 2018, p. 155) has proven to be vital in managing the experience of being a new researcher, however experienced a psychotherapist they may be. As Mersky advises, 'be prepared for an experience that you never could have anticipated when you first started. While you may not "need" a doctorate for your professional career, you might find that the achievement of a doctorate profoundly changes your sense of yourself in relation to your professional world. And that is a great bonus!' (p. 158).

Concluding remarks

The students on this programme have contributed a great deal in shedding light on the complexity of the journey from clinician to researcher. They have spoken vividly about both the pains and the rewards of the process, highlighting their need to expand their identity, approach clinical material in new ways, ask different questions using unfamiliar epistemologies and apply a different logic to their experiences. They have embraced the difficulties and are now embarking on their original and useful empirical work with a solid foundation in research thinking. They are not alone, of course, but they constitute part of a movement within the profession to make research more centrally part of a psychoanalytic psychotherapist's skill set and identity.

While it is welcome that new generations of psychotherapists are more likely to have a research component in their trainings, there is still a very long way to go before it can be assumed that the profession, as a whole, has incorporated research thinking fully. Research done during a training is necessarily relatively limited in scope. For a trainee the primary focus has to be on one's development as a clinician, and there is rarely going to be enough time for a trainee to devote to their doctoral project for in-depth clinical research to be undertaken. They are likely to have maybe half a day weekly for research, rather than the several days a week required for a post-qualifying professional doctorate. In addition, as getting ethical approval for clinically based projects can be a lengthy process, trainees are most likely to steer towards projects involving other practitioners rather than patients, or to use existing data sets such as the IMPACT study (Goodyer et al., 2011). The latter, while very useful and generating important findings, nonetheless imposes a serious restriction on the scope and range of potential projects.

Furthermore, trainees by definition will not have acquired the clinical experience needed to inform the kind of in-depth clinical research which the profession needs so badly. The incorporation of research into trainings means that graduates will emerge much better-informed about research, but we cannot, and should not, expect trainee projects to fill the gaps and to generate the wealth of new knowledge that the profession requires.

There are of course many experienced and highly valuable practitioners who are not interested in embarking on research, and these will continue to be effective and fulfilled in their clinical work, getting the lived experience of helping their patients, teaching and supporting their supervisees and learning from their successes and failures – as child psychotherapists always have done. There is a large additional number who are interested in and willing to engage in research but do not have the time or the support necessary. A serious barrier for most child psychotherapists in grafting research into their work is that they are not usually funded to do so in their NHS posts. In the ACP research survey, lack of time, self-doubt about having the right skills, not being academic enough, lack of support and supervision and financial costs were the most quoted disincentives for embarking on research, and worries about confidentiality were a further challenge in relation to publishing (Association of Child Psychotherapists [ACP], 2021). The NHS and other career structures for child psychotherapists do not provide an obvious incentive to do research, or reward it if undertaken. Furthermore, for private practitioners embarking on research is not at all easy, as without institutional support it is difficult to navigate the important issues of confidentiality, ethical approval and research governance.

As a result, it is imperative that universities, wherever possible, provide suitable opportunities through the development of professional doctorate programmes. These can support clinicians in their journey into the world of research, helping them to develop research skills and research-mindedness, and thereby to contribute to the knowledge base for the profession as a whole, both with their individual projects and with their grafting of research and clinical approaches into a richer and fuller professional identity.

As can be seen in this paper, this is not an easy undertaking, but it is highly valued by the participants and could be of serious interest and benefit to many more.

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No potential conflict of interest was reported by the author(s).

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