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Rigour and Imagination in Research: Setting the Context

Family therapists have embraced Bateson's (1980) ideas on the complementarity of rigour and imagination in the clinical domain; like good therapy, if research is to end successfully, it should begin properly, with imagination being born from a sound foundation, a good fit between the research context and the researcher.

The primary aim of most research is to contribute originally and meaningfully to the field. Ideally, the clinician who is also a researcher has a question to address, prior to formalising a research program; however, as was pointed out in this column in Vol 18, No 3, these initial thoughts are often too broad. My own view is that it can be useful for the clinician to start by searching for areas which have been researched poorly, not researched at all, or only considered from one particular standpoint. The ability to see gaps, controversies, and dilemmas is a learned skill. Clinicians are in an enviable position to use their clinical experience as a starting point to compare against accepted wisdom in the literature, as suggested in the last issue, but they also need to consider their clinical experiences as anecdotal and to use them in the construction of hypotheses, rather than treating observations as truths.

It is certainly vital for clinicians to identify more broadly (personally, intellectually, professionally) what they wish to accomplish. The acquisition of specific research skills and knowledge is a modest but reasonable aim for many clinicians, so that they can then undertake future research in areas more central to the issues they really wish to explore. For others, the aim is to understand how to undertake research in a specific domain, such as the investigation of a therapeutic model. Others take on research with the aim of more fully understanding the nature of a particular body of literature and practice. How grand the aims are is often determined by the skills and knowledge the clinician has already in the area, and the complexity of the questions to be answered.

Family therapy has placed a high value on innovation in practice and theory, and has been inclined to ignore the historical roots of its practice, a trend Alan Gurman has whimsically dubbed as symptomatic of 'adult children of immaculate conceptualisation'. In research, by contrast, we need to 'stand on the shoulders of others'. This refers in part to previous research and partly to supervisors, or collaborators. Many clinicians come to research feeling ambivalent about the vast body of knowledge which has preceded them. Often they are daunted by its scope and the complexity, and tend to disregard or denigrate research traditions or previous findings. In addition, clinicians and researchers routinely polarise each other in the same way that most pure and applied disciplines have done for centuries. In fact, sound research training is both complementary to, and follows similar patterns to, clinical training, where one learns directly from those who have been productive in the field for many years. This process is usually anxiety provoking, as the clinician may well feel quite competent in the day to day work, only to feel all at sea in an area which may require rapid acquisition of complex and alien skills.

A further dilemma for many clinicians is related to whether to immerse themselves in a supervisor's field of research, or try to forge ahead alone in an area where a supervisor has little expertise. My view is that it is worth having at least one supervisor (more than one can be very useful) whose general area of interest matches your own, as well as having a shared commitment to a particular research methodology (e.g. quantitative rather than qualitative). There is much to be gained from being involved in a supervisor's area of research; s/he can guide the clinician into areas which may be difficult to understand or access otherwise. Research can be lonely, and to carry out projects with others can be exciting and more productive. Recently, I have supervised students carrying out research in small groups, and they report that their positive experiences of the research were influenced by the group processes. Research institutions tend to adopt team structures, precisely because teams have been consistently found to be more productive and satisfying for all concerned.

Having been both supervisor and supervisee, I tend to believe that learning occurs most coherently with supervisors whose interests intersect at some level with those of the clinician, but who are capable of embracing divergence of thought. If the research undertaken is in the general area of the supervisors' interests, the latter have more knowledge, technical expertise, contacts, established methods, and commitment; they also tend to be much more emotionally involved in the process. Publications are much more likely to come from a shared commitment. If the supervisee's research draws on, but diverges from, that undertaken by the supervisor, then this allows both to grow professionally.

SIMON KENNEDY
Lecturer and Clinical Psychologist, Department of Psychology, Australian Catholic University, Oakleigh, Victoria. Email: S.Kennedy@christ.acu.edu.au

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