Does group reflective practice change how trainee clinical psychologists think about their clients?

An Interpretative Phenomenological Analysis.

Submitted in partial fulfilment of the degree of

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By

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Declaration

I, Anya Biggins, confirm that this thesis is my own original work, excluding where other authors have been referenced. It has been submitted in partial fulfilment of the degree of Doctorate in Clinical Psychology. No part of it had been submitted for any other degree or academic award. I have checked that the thesis is complete prior to submission.

Does group reflective practice change how trainee clinical psychologists think about their clients? An Interpretative Phenomenological Analysis.

Section A – Thesis Abstract

Reflective practice groups are increasingly common in clinical services and training programmes in health and social care. They are seen as a method of learning from experience and thus as a way of supporting continued professional development and improving practice. Despite the growing popularity of reflective practice groups, the relevant research remains disparate, spread across multiple fields of practice and academia. Moreover, a large section of the current literature is focused on the impact of reflective practice and staff wellbeing, as opposed to the clinical value of attending a reflective practice group.

Literature Review

The literature review aims to highlight the experiences of those taking part in reflective processes within health and social care environments. Five themes were generated from twelve empirical studies exploring methods of reflective practice within professional training or practice. Key themes were: facilitator qualities; security in the setting and relational security; ambiguous experiences of written reflection; self-reflection and time and developing reflective skills.

Research Report

Semi-structured interviews were conducted with five Trainee Clinical Psychologists who had attended monthly reflective practice seminars as part of their training. Audio excerpts from previously recorded reflective practice seminars were played within the participant interviews; it was felt that the excerpts would support participants' recall of the seminars and facilitate the collection of rich and meaningful interview data. Interviews were analysed using Interpretative Phenomenological Analysis (IPA). The analysis highlighted how presenting clinical material and hearing multiple perspectives from group colleagues impacted on how participants' thought about their clients. Moreover, participants were able to appreciate the view point of their client, following discussing the case in reflective practice, and acquire an increased sense of compassion.

Acknowledgements

The work presented in this thesis has been the result of multiple collaborations and I would like to acknowledge the people that have contributed to its completion.

I would like to thank the members of my reflective practice group for their engagement with this research and their ongoing interest and enthusiasm for better understanding their experiences of reflective practice. I would like to thank you all for your taking time out of your busy lives to participate in research interviews alongside your willingness to have our seminars recoded. I would like to thank you all for your support and encouragement as a researcher but also as a group member.

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Contents

Section B – Literature Review

What do the professionals engaging in reflective practice consider to be the salient factors involved in reflective practice? A systematic review of the literature.

(Guidelines for authors for the journal targeted for the Literature Review can be found in Appendix A)

What do the professionals engaging in reflective practice consider to be the salient factors involved in reflective practice? A systematic review of the literature.

1. Literature Review Abstract

Objectives

The current review aims to elucidate how practitioners and students experienced the utility of reflective processes . It also endeavours to suggest how these findings can be utilised in the delivery of reflective practice within health and social care settings and identify areas for the development of future research.

Method

In consultation with academic staff, a search protocol was developed and utilised to search the relevant literature databases to identify high quality studies of reflective practice. Papers that did not meet the inclusion criteria and duplicated papers were removed. Twelve papers were deemed suitable for analysis.

Results

Key themes identified were: qualities brought by the facilitator to the learning dyad; security in the setting and relational security; ambiguous experiences of written reflection; bringing more of the self to clinical work and time and space to develop reflective skills as a salient factor. These results demonstrated the importance of creating security within reflective practice, security is connected to both the relationships and environmental structures that support reflective practice. The analysis emphasises the caution that should be employed when implementing written reflection and questions if this should be a standalone activity, without interpersonal reflective space.

Conclusions

Investigating the factors salient to reflective practice is challenging, with literature spread across multiple fields of study from around the world. The literature within the current review explores the factors deemed salient by those individuals involved in specific reflective practices, limiting the generalisability of these results. Finding was of measuring the outcomes of reflective practice participation in a more systematic manner is required. Moreover, in the context of reducing health and social care budgets, research is needed demonstrate the gains of reflective practice and justify the inclusion of reflective spaces in health and social care settings.

2. Introduction

2.1 Background

The concept of reflective practice stems from the seminal work of Donald Schön (1983). Endorsing the value of knowledge gained within professional practice. Schön encouraged professionals from all disciplines to recognise the unpredictability of their work and to value experiential knowledge within their practice alongside technical solutions (Kinsella, 2010). Schön (1983) specified two types of reflection: reflection-on-action and reflection-in-action. Reflection-on-action relates to a practice of looking back over what has already been done. Reflection-in-action is a process that enables a person to change the course of their actions or adjust their thinking, while engaging in an activity. At its best, reflective practice aims to enable personal and practice development on multiple levels. A core tenet of reflective practice is to facilitate the creation of links between theory and clinical practice (Moon, 2004).

Since its inception reflective practice has become increasingly embedded within the practice and development of healthcare professionals and is frequently a requirement to remain up to date with professional registration, for example nurses are required to submit a reflective log as part of their re-registration process (General Medical Council, 2009; Nursing and Midwifery Council, 2010). Moreover, reflective practice is cited consistently within education literature and included within an increasing number of training programmes (Health Professions Council, 2009). However, within different disciplines and intellectual traditions, what is understood by 'reflective practice' varies considerably (Fook & Askeland, 2006). Multiple understandings of reflective practice can be found within the same discipline or clinical setting.

Overall, reflective practice is understood as the process of learning through and from experience while concurrently gaining new insights into clinical practice and reflections on the self (Boud *et al*., 1985; Boyd & Fales, 1983; Mezirow, 1981; Jarvis, 1992). This frequently requires the examination of assumptions about day to day practice. Reflective practice typically engages the individual practitioner in being self-aware and critically evaluative of their own responses to clinical situations. The objective of reflective practice being to recapture clinical experiences and consider them

critically in order to acquire new understandings and improve future practice. This is understood as part of the process of continual learning and development.

Reflective practice can be seen as a key component of professional development; as professional identity is developed, an understanding of an individual's personal and professional values, beliefs and identity continues to mature. Reflective practice offers an open space in which these values can be integrated (Epstein, 1999, 2003). Moreover, building an integrated foundation of knowledge requires an approach to learning which supports the formation of links between existing knowledge and new ideas (Bandura, 1986).

2.2 How is reflective practice delivered?

Collaborative reflective practice or reflective practice groups have a place within many health and social care teaching curriculums. Moreover, an increasing number of institutions are including groups for reflection into their schedule. Reflective practice is also facilitated in one to one reflective supervision and incorporated in individual tasks such as keeping reflective journals or portfolios. Interestingly, the majority of studies that explore reflective practice centre on outcomes of the reflective processes, both personal and clinical; yet how these outcomes are facilitated and what makes these achievements possible is often overlooked.

2.3 Relevant previous literature reviews

Mann *et al*. (2009) reviewed the literature regarding reflective practice within the education and training of healthcare professionals. Their aim was to understand the variables impacting on the utility and efficacy of reflective practice. The 29 articles included by Mann *et al*. (2009) came from the various areas of healthcare research and predominantly followed a qualitative research methodology. The authors found that both the environment surrounding it, as well as support and facilitation are key to reflective practice experienced as effective by attendees. They found no evidence to confound or support the idea that reflective practice enhances clinical competence, despite this assumption being present in much of the literature. Moreover, the authors suggest that it is an ability to learn that

reflective practice can be shown to foster, and therefore it should be recognised as a method of enhanced learning.

Monk *et al*.'s (2018) systematic review focused on the literature exploring what medical students gain from participation in Balint groups. Balint groups are facilitator led reflective groups in which medical students present clinical material and use the group to reflect and discuss this material. Monk *et al*. (2018) concluded that Balint groups might help medical students to become more patient-centred, by increasing students' empathic abilities and supporting their personal and professional growth. They also reported that groups are more subjectively effective when participant attendance was optional rather than compulsory.

2.4 Rationale for current review

As mentioned previously, reflective practice is an activity increasingly required of healthcare professionals across disciplines. However, how effective reflective practice is achieved and what factors support reflection remain uncertain (Mann *et al.*, 2009). Moreover, the literature on reflective practice is spread across various academic areas, including; medicine, nursing, social work and psychology. In an attempt to overcome this gap within previous reviews and to provide an up-to-date synthesis of current literature, the present review will focus specifically on empirical research regarding the exploration of reflective practices within health and social care training and professional practice.

The research literature looking to evaluate approaches that foster reflection and implement formal reflective practice remains early in its development. In the scoping searches of the current review research studies rarely included direct comparison groups. At the time of this review, no randomised controlled trials were found. Nevertheless, many of the studies selected utilise carefully considered qualitative methods and analytic approaches to explore the experiences of those facilitating and taking part in reflective practice. Owing to the current stage of development within the literature, qualitative and exploratory research approaches exploring various forms of reflective practice were deemed to be appropriate for inclusion in the current review.

With this in mind the current review will seek to explore the experiences of trainee professionals and professionals involved in forms of reflective practice, within health and social care. Specifically, the current review will endeavour to illuminate the following question: What does the literature have to tell us about the experiences of those involved in practices that aim to foster reflection?

3. Method

3.1 Search Process

A systematic review of the research literature regarding methods of delivering reflective practice in health and social care settings was undertaken, a strategy to ensure a comprehensive and replicable exploration of the data. Before the main search was completed, an initial scoping search was undertaken to determine the type and amount of literature available. This initial examination employed the Google search engine and the University of Leicester library search function. This practice formed an iterative process, developing the aims of the current review and the search terms used in the main search.

On the 9th of August 2018 electronic searches of the following three databases were undertaken: PsyINFO, Medline and CINAL. The same search terms were applied to each database (see Appendices A and B for search strategy and search terms) The databases utilised were chosen with the aim of incorporating a variety of sources to identify the highest quality empirical papers. Searches were undertaken using both University of Leicester and NHS Athens access where possible, to broaden the selection of available of journals.

3.2 Inclusion/ exclusion criteria

A number of outlined criteria limited the searches. The relevance of studies was the primary inclusion criteria. Studies that collected the experiences of those involved in a method of reflective practice were shortlisted. In order to meet this criterion, the practice under investigation had to be defined as a practice that promoted reflection; in which participants engaged in a continuous cycle of self-

observation and evaluation in order to better understand their own actions and prompt further learning. These reflective practices were differentiated from other forms of supervision as practices that did not necessarily address a concrete problem or question as might be the case in clinical supervisions, but rather reflective practices aimed to observe and develop practice on an ongoing iterative basis. Furthermore, studies were only included if they were undertaken in a health or social care training or professional setting.

Shortlisted studies were published between 2013 and 2018 in order to focus this review on the most recent evidence. The papers had to be empirical in their nature, allowing this review to focus on and interpret first hand evidence. The criteria also required that papers be published in English, and in peer-reviewed academic journals (see Appendix C for more detail).

3.3 Study selection and Quality Appraisal

The process of selecting studies was undertaken in a number of stages. The short-listing process is described further in Appendix B. All electronic search results were imported to a reference management tool. This initial search retrieved 1,324 results (see Appendix B for more detail), the titles of which were checked for relevance and duplicates removed. Further to this, the abstracts and titles of 1,226 studies were then assessed for suitability using the inclusion/ exclusion criteria table (see Appendix C).

Subsequently, 25 articles were judged to be relevant and the full articles were obtained for review. To systematise this process and prevent data extraction bias, a data extraction form was developed (see Appendix D). The form was utilised to extract data from the remaining articles to decide whether they met the criteria and could be included in the review. 12 articles met the inclusion criteria. The Critical Appraisal Skills Programme (CASP) (Public Health Research Unit, 2006) appraised the quality of each selected paper (see Appendix G) This was combined with Duggleby *et al.*'s (2010) scoring method (see Appendix G). The CASP was adapted to allow for the appraisal of mixed method and quantitative studies. This was achieved by adapting question two of the tool from "Qualitative methodology is appropriate" to "Chosen methodology is appropriate" (see Appendix G).

4. Results

4.1 Characteristics of Selected Studies

Studies were conducted and published in various countries including the United Kingdom, Australia, the USA, the Netherlands, Singapore and Germany. Selected study sample sizes ranged from six to forty-five participants. Five of the included studies reported the sex of their participants, the combined total sample of which was 76.47% female. Two of the studies stated the age of participants, with only Lutz *et al*. (2013) reporting a mean participant age of 28 years. While Woodward *et al*. (2015). reported the ages of participants as between "late 20s and late 30s" None of the selected studies indicated the race or ethnicity of their participants. In all twelve selected studies participants were either qualified or undertaking training within a health or social care profession. Five of the studies recruited qualified professionals within health and social care fields. The participants in seven of the studies were undertaking training within health or social care.

The research questions posed by the selected studies varied, but all attended to the deeper understanding and evaluation of a form of reflective practice. The methods of reflective practice under examination were; a reflective practice group, Balint group, Video Enhanced Reflective Practice (VERP), reflective supervision, written reflection and individual reflective practice.

All twelve selected studies identified the method of data collection they utilised. Seven of the studies utilised semi-structured interviews as a means of data collection (Lutz *et al*., 2015; Fisher, Brown *et al*., 2013; Binks *et al*., 2013; Woodward *et al*., 2015; Newcombe *et al*., 2018; Murray & Leadbetter, 2018). Four studies employed questionnaires to collect participant data (Shea *et al*., 2016; O'Reilly & Milner, 2015; Tomlin *et al*., 2014; McKensey & Sullivan, 2016) and one study used pre-recorded naturally occurring data in the form of video recorded reflective practice sessions (Veen & de la Croix, 2016). All selected studies specified their method of data analysis method. Five studies employed a thematic approach (Brown *et al*., 2013; Lutz *et al.*, 2013; McKensey & Sullivan, 2016; Murry & Leadbetter, 2018; Newcombe *et al*., 2018), three employed Interpretative Phenomenological Analysis (IPA; Binks *et al*; Fisher *et al*., 2015; Woodward *et al*., 2015), one used Conversation Analysis (CA; Veen & de la Croix, 2016) and one employed the Delphi method (Tomlin *et al*., 2014).

The two remaining studies employed *t*-tests alongside a range of descriptive statistics (Shea *et al*., 2016; O'Reilly & Milner, 2015).

4.2 Findings

4.2.1 Facilitator qualities

The first theme concerns reflective practice which took place in person, either one to one or in a group and highlighted the role of the facilitator. Both the qualities demonstrated by the individual facilitating reflective practice, and the relationships they built with those attending were salient features. The qualities possessed by a supervisor were identified by Tomlin *et al*. (2014) as the most important aspect of effective reflective supervision. These qualities centred on a non-judgemental stance alongside remaining compassionate, tolerant, self-reflective and doing so in a consistent and predictable manner. Tomlin *et al*. (2014) also endorsed the idea that there are many similarities between the desired qualities for a supervisor and supervisee, centring on self-awareness, collaboration and open non-judgement. Tomlin *et al.*'s (2014) Delphi method analysis represents a high-quality analysis based on the views of expert individuals with extensive experience of reflective supervision.

Murry and Leadbetter (2018) also address the idea of collaboration between the roles they characterise as 'guider' and 'trainee'. Participants indicate that guiders actively try to manage the possible power imbalance in the relationship, "not wanting to come across as 'an expert'". Veen and de la Croix (2016) explore this point in greater detail, describing the complexity of moving between the multiple interactional positions inhabited by a facilitator. They focus on the complex interactions that take place within reflective practice when compared to more straightforward teacher student dyads. The authors describe the way in which facilitators continually move between the positions of teacher, expert and facilitator. These shifts in positioning, however, were explained as being linguistically negotiated between group members, and that positions were collaboratively shaped within the group.

Interestingly, the focus of Binks *et al*.'s (2013) high-quality IPA analysis was grounded explicitly on the experience of the facilitator of a reflective practice group. Authors drew attention to the challenges of collaborative reflective practice facilitation, participants expressed the challenge of "holding the boundary of the group". This was experienced in terms of maintaining a focus on clinical material and walking the line between reflective practice and group therapy. The task of defining the primary function of the group as clinical reflective practice while also acknowledging that some personal self-disclosure was appropriate appeared to be a key task for the group. Maintaining this balance appears to have been a salient factor for the participants, and one which they held the facilitators as responsible for. This spoke to a hierarchy of experience and challenges ideas of reflective practice as a consistently collaborative process, as the group facilitator participants took a more active role in defining the group and the discussions that took place within it.

Binks *et al*. (2013) also drew attention to the 'parallel process of evaluation' in which participants' competence as a facilitator was scrutinised. This was understood as a reflection of the attendees sometimes critical judgement of themselves and each other. Ultimately this raises questions about the context within which reflective practice is undertaken. Binks *et al*.'s (2013) participants considered the context of clinical psychology trainees being under ongoing evaluation and assessment, as a factor that impacted on perceptions of the facilitator. These findings highlight the dyadic relationship between facilitators and participators in reflective practice. Indicating that it is not only the qualities a facilitator possesses, but the interaction between these qualities and the context within which reflective practice takes place which form the culture of reflection experienced by those involved.

4.2.2 Security

A consistent theme arose across the articles concerning the sense of security required for reflective practice participants to find their experience valuable. This theme was reported by the authors of five of the selected studies and was the most reported element of reflective practice to be discussed. The concept of security was described in a number of different ways. Security appeared to be conceptualised both as pragmatic and relational. A need for consistency was described in relation to the time, location and format of reflective practice, as well as the interactions within which reflections

were expressed. Broadly security can be understood as two concepts, one regarding the concrete boundaries and consistency with which reflective practice was carried out, security in the setting, and secondly the safety afforded by the relationships and interactions with the group, relational security. To gain a deeper understanding of these concepts, they will be unpacked further separately.

Security in the setting

Lutz *et al*. (2013) defined having a 'secure space' as a helpful feature of the Clinical Reflective Training programme they explored. For participants this necessitated a "calm, secure space outside the ward, which made it possible for students to shift their focus from the external demands… to their own mental state". The location of reflective practice was also highlighted as a salient feature by Tomlin *et al.* (2014). Participants identified a "private, quiet space" and "regularly and consistently scheduled" sessions as being imperative features of effective reflective supervision. These two high-quality articles emphasise the importance of the physical setting of reflective practice, alongside the need for consistency and confidentiality. Moreover, Brown *et al*. (2013) supplement this understanding by observing the impact of a perceived lack of privacy. Participants' concerns regarding the security of their online e-portfolio was unearthed as a significant barrier to engagement in reflective practice, highlighting the importance of privacy and confidentiality when reflecting on practice.

Relational security

The concept of security was also explored by authors in relation to the interactions and relationships that facilitate and guide reflective practice. This was described in relation to the qualities demonstrated by those involved in reflective practice (Tomlin *et al*., 2014; Lutz, 2013; Murray & Leadbetter, 2018). The 'Qualities a Supervisor Demonstrates' listed by participants in Tomlin *et al*. (2014) contribute these ideas; reliability, predictability and confidentiality are all seen as imperative supervisory qualities. Similar concepts fed through into the relationship between those guiding reflective practice and those participating. Murray and Leadbetter's (2018) participants highlighted the relationship between the reflective practice guider and trainee as being central; suggesting that this

relationship dictated how comfortable both parties felt and therefore, how able to explore challenging clinical issues.

Studies which explored reflective practice taking place within groups stressed the cohesion and trust between group members as being of great importance. McKensey and Sullivan (2016) discussed the role that group cohesion played in allowing difficult topics to be discussed and feelings normalised. This was echoed by Lutz *et al*.'s (2013) higher quality analysis in which participants described interactions within the group, lessening feelings of being "the only loser who makes mistakes". The authors reflected that this was facilitated by a supportive group environment in which participants felt able to speak about problems.

In contrast to the previous points discussed Binks *et al*. (2013) put forward a high-quality analysis describing the experience of distress within a reflective practice group as inevitable. Distress was understood by participants in varying ways: an intrinsic part of the process of reflecting on difficult aspects of "the human condition"; a consequence of competition within the group and; an aspect of emotional learning. Some participants, however, expressed concerns that distress experienced within the group could be detrimental to the wellbeing of participants. Moreover, that an important aspect of group facilitation was to monitor and contain distress levels. Interestingly however, participants asserted that "absolute safety" was an impossibility and that only a "degree of safety" could be offered to reflective practice participants. The authors discussed the idea that the level of value or usefulness placed upon reflective practice might mediate any distress it caused. Moreover, that some trainees may have been unable or unwilling to draw meaning from their distress, and therefore experienced it as unhelpful. The authors hypothesised that trainee non-engagement may be compounded by the training course culture. If a course, as a whole, was unable to embody a philosophy consistent with personal reflection with peers or within a group this could decrease trainee engagement.

4.2.3 Ambiguous experiences of written reflection

Two of the selected studies explored the experiences of participants engaging in written forms of reflection (Newcombe *et al*., 2018 & Brown *et al*., 2013). These studies highlight the specific

challenges presented by written reflective practice and bring to the fore discussions regarding the depth and authenticity of written reflection.

Brown *et al*. (2013) found differences in engagement with written reflections in an 'e-portfolio' by post-graduate medical students. Although some participants found recording reflective entries in the e-portfolio helped them to explicitly reflect on emotional experiences, others made minimal notes as entries. The authors discussed the possibility that these short entries were indicative of limited reflective meaning, that they were an aide-memoir kept by participants to discuss in upcoming job interviews or with a supervisor in person at a later date. Brown *et al.* (2013) considered that the succinct nature of the written entries did not inevitably demonstrate a lack of reflection overall; a brief note may have acted as a reminder of the event and a prompt to reflect at a later time. The interview schedule used by the authors however seems to leave little space to discuss the ways in which minimal notes were used outside of the e-portfolio. These findings prompted a discussion of the value of standalone written reflections and the idea that case-based discussions with a supervisor might provide a more meaningful opportunity for reflection and learning, alongside the completion of the e-portfolio.

Newcombe *et al*. (2018) further questioned the value of written reflection, in this instance in the context of a formally marked assignment. Participants seemed to find balancing the academic requirements of their coursework and engaging in reflection challenging and as tasks that could be completed meaningfully in tandem, bringing into focus the idea of authentic reflection versus a tick box exercise. Participants described concerns about being judged by academics reading and marking their work, including fears of being pitied or negatively judged regarding personal disclosures. These concerns rendered the exercise unhelpful for some participants who described their reflective writing as fake and inauthentic.

It is important to note that these studies both utilise a group of participants still engaged in professional training. The impact therefore of written assignments and marked essays have a specific context of academic assessment. However, they do pose questions about the value of written reflection without face to face discussions taking place concurrently. The quality of the selected

articles which focus on written reflection is low when compared to the selected articles as a whole. Neither Brown *et al*. (2013) nor Newcombe *et al*. (2018) addressed the links between their research and the academic institutions at which participants were students at the time of their interviews. Little though appears to have been given to the power imbalance between participants as students and researchers as academics at the same institution. The dual role of the researchers may have influenced the responses that participants gave, attempting to give that the researchers wanted to hear. When considered alongside participants' concerns regarding the links between assessment and reflection it appears that the affiliation of the research to their academic institution may have impacted on the experiences shared within research interviews.

4.2.4 Self-reflection

This theme depicts experiences of self-reflection developed within reflective practice; the ability to engage in personal introspection and utilise this understanding within clinical practice. Although many of the studies outline the way in which clinical material is addressed within reflective practice, personal reflections and the development of self-awareness are also considered an important element of reflective practice. Participants from Fisher *et al*. (2015) described reflective practice as increasing awareness of personal issues and how they in turn impact on clinical work. Increased self-awareness was also described as supporting a more reflective understating of clinical interactions and how personal issues can affect clinical and therapeutic relationships. This was echoed by McKensey and Sullivan (2016), for whom the way in which participants "make use of themselves" in clinical interactions was seen as a skill built within reflective practice.

Moreover, within the context of professional training, Woodward *et al*. (2015) highlighted the balance reflective practice struck between aiding self-acceptance, while motivating further professional and personal development. Their participants spoke about coming to acknowledge and value personal aspects of themselves, experiencing this as a cyclic process between valuing themselves and feeling valued by others in reflective practice. The acknowledgement and discussion of personal attributes, and the iterative process described by Woodward *et al*. (2015) can also be seen in McKensey and

Sullivan's (2016) results. Expressing emotional responses to clinical material and reflecting on the personal feelings they evoked was a key feature for the Balint group attendees.

The mixed findings of Shea *et al*. (2016) demonstrated that some skills linked to reflection on emotional reactions to clinical encounters were sustained following engagement in reflective supervision; for example, "expressing both thoughts and feelings when discussing/ describing infant(s)/ parents(s)". The ability to articulate the emotions linked to clinical material significantly increased, as well as an ability to take a position of 'being with' emotions described by the authors as a "capacity to be quiet and hold parent's feelings to not know or not do". This appears to speak of the development of the capacity to 'be with' emotion rather than to adopt a 'doing' position. Interestingly, results did not demonstrate a sustained increase in supervisee participants' ratings of self-efficacy, indicating that although skills were significantly improved, confidence levels may take more time to go up. This highlights the possibility that professional and personal growth may develop at different rates and are not necessarily in step.

4.2.5 Developing reflective skills

This theme describes how engagement in reflective practice over time supports the development of reflective skills that continue to mature and progress with time. The development of reflective practice and changes in reflection over time were themes that arose from three studies. Participants in Fisher *et al*. (2015) found reflective practice a challenging concept to describe, pinpointing development and gradual evolution as a defining feature of reflective practice. The metaphor of learning to drive a car was used by one participant to depict their own developing reflective practice; a process that once required significant thought and concentration had become familiar and instinctive. Furthermore, the triggers and content of reflections were described as changing over time. Participants identified "encountering clinical difficulties" as an early prompt to reflect; over time reflection was more likely to occur when things were "going right".

Changes in reflective practice over time and with experience were captured by O'Reilly and Milner (2015). Participants were recruited from different stages of training and therefore with more or less experience of reflective practice. Authors observed that participants in their fourth year of training

reported fewer negative aspects of reflective practice compared to their third-year counterparts. Fourth-year participants also named independent methods of reflective practice, for example journaling and writing reflective summaries, as significantly more useful to them than to the third-year participants. This demonstrates the evolving nature of reflective practice as something that changes over time and within difficult contexts. The development of reflective practice over time is reflected in Lutz *et al.*'s, (2013) recommendation that introducing reflective practice earlier in medical training would benefit students' learning experience.

The difficulty participants had in describing reflective practice alongside the metaphor of learning to drive suggest that participants may possess unconscious knowledge with regards to their reflective skills. Cognitive psychology literature suggests that instances in which individuals demonstrate a level of knowledge or expertise but appear unaware of their knowledge and struggle to verbalise it are indicative of unconscious, or implicit knowledge (Schacter, 1992; Dienes & Perner, 2002).

5. Discussion

5.1 Summary of findings

The aim of the current systematic review was to determine what the published literature had to say about what those taking part in reflective practice identified as the salient factors involved. Five overarching themes were identified: facilitator qualities; security in the setting and relational security; ambiguous experiences of written reflection; self-reflection and time and developing reflective skills. Given the diversity of formats in which reflective practice was engaged in, the themes identified by the selected papers paint quite a consistent picture of the factors which are salient for reflective practice.

Although words like safety and security are frequently used to describe the prerequisites for supervision and reflective practice (Pack, 2009) it is often unclear precisely what this means in practice. This review identified and unpacked the idea of security as a salient factor of reflective practice. Security was articulated across aspects of reflective practice facilitation, both in the practical and interpersonal domains. However, within both of these areas consistency and predictability formed

a predominant premise. Consistency in the way the reflective practice was delivered seemed to support the development of trust in both the process and the other people involved. This supports the understanding of trustworthiness presented by Benade (2018), in which reliability is proffered as a key component of trust in reflective practice.

Limited previous literature addresses the role of facilitation in reflective practice, often focusing on what facilitators aim to achieve rather than the way they accomplish this (for example see Murrell, 1998). However, the traits displayed by the facilitator of reflective practice came through as a salient factor in the delivery of reflective practice within the current review. Johnston and Paley (2013) offer advice on facilitating collaborative reflective in an inpatient setting. The findings of the current review echo their guidance highlighting the important role of facilitation; outlining the qualities of compassion, non-judgement, tolerance and empathy, as key qualities for facilitation. Consistently demonstrating these qualities can be seen as maintaining the predictability of the practice and building the trust of participants. However, these ideas can also be seen to support an understanding of effective facilitation as a form of modelling reflective skills. Demonstrating the importance of modelling within the facilitator/ participant relationship, similarly to other learning dyads (Margutti, 2010).

The act of written reflection as a formative exercise or formal assessment is commonplace in many professional training programmes and in continued professional development courses (Pavlovich *et al*., 2008). However, the current review raises some questions over the implementation of these tasks and what needs to accompany them for reflective practice to be realised. As previously explored, the consistency of a reflective platform alongside the predictability of facilitation were both salient factors of reflective practice. These are achievements that are very difficult to gain through a written task alone. It is within interpersonal interactions that a sense of security can be built, and consistence of the reflective space can be established and could be seen to be missing entirely from a written reflection. Moreover, if reflection forms part of a summative assessment a further barrier to delivering the factors salient for reflective practice is in place. The centrality of the qualities demonstrated by the

facilitator of reflective practice, including non-judgement are inherently at odds with assessment and assigning a pass or fail to a reflective endeavour.

The findings of the current review suggest that stand alone written reflections, without the accompaniment of collaborative reflective practice or reflective supervision can be viewed by participants as 'tick box' and superficial (Newcome *et al*., 2018) and may not allow for full engagement in the process of reflection. The centrality of both the qualities of a reflective supervisor and the safety offered by reflective practice have been highlighted in this review as key features of reflective practice. Therefore, asking the question; if these things cannot be delivered through a written exercise alone, can this truly facilitate reflective practice? Based on the lower quality of the identified research studies concerning written reflection this appears as an area for further exploration.

Self-reflection and self-knowledge have been argued to be important components of effective clinical supervision (Falender & Shafranske, 2008) and reflective practice (Bolton, 2018). As found in the current study, wider literature describes reflective practice as being a combination of a clinical focus and reflection on personal responses and emotions. The findings of this review mirror these ideas and build on the concept that the clinical and personal reflection influence one and other. Having an increased capacity for self-reflection can support clinicians to consider themselves and their influence within clinical interactions and relationships.

The need for time and space to develop knowledge and reflective skills was also identified as a salient factor of reflective practice. This can be seen as running parallel to the other salient factors explored in the current review. That alongside all the other elements of reflection is the impact of time and the development of reflective skills. The ability to move away from addressing a specific problem and towards open reflection of all aspects of practice as described by Fisher *et al*., (2015) may be impacted by the time allowed for reflection in a given context or organisation. Interestingly the stance taken by the organisations in which reflective practice was being delivered was often unclear. The reasoning behind the choice of reflection implemented was frequently not discussed and the level of support that reflective practice was afforded by these organisations was minimal.

Within the adjacent body of literature on clinical supervision, Milne and Reiser (2017) point towards the importance of organisational culture and context in predicting the successful implementation of supervision. Further empirical research positions organisational support as critically important for the functioning of clinical supervision, and whether or not it is felt to be effective. However, there remains some incongruity within the literature as to how the time dedicated to reflective practice is predictive of its perceived quality (Gonge & Buus, 2015). The engagement with ideas of organisational support alongside team culture was at best minimally addressed within the papers selected in the current review.

5.2 Limitations

The limited number of empirical studies exploring reflective practice, alongside the heterogeneous nature of the published literature, brings into question the degree to which the findings of the current review are representative of reflective practice as a whole. Many studies did not identify the definition of reflection being used by the authors. Moreover, the terminology used to describe and classify reflective thinking drew on several fields, and therefore reflected the distinctive discourses of various professionals and institutions. These discourses and the epistemological stances that they influenced were often not readily explored within the research and impacted on the transparence and quality of the resulting analyses. However, these issues can also be seen as demonstrative of the lack of consistency with which reflective practice is implemented and utilised within professional health and social care settings. As a result of the variations in the literature, the definition of reflective practice used in the current review was broad and defining what is meant by reflective practice posed a challenge for this review.

The nature of the studies selected for the current review was such that their results were based upon the experiences and perceptions of individuals involved in reflective practice. The data gathered with the exception of (Tomlin *et al.*, 2014 & Veen & de la Croix, 2016) took the form of interviews, individual written feedback or self-report questionnaire data. A limitation of this review therefore can be seen as not addressing measurable outcomes of reflective practice. This appears to be reflective of a body of research lacking in specific well recognised outcome measures, or of research taking place

on a local level. Together these factors make gaining generalisable conclusions regarding the key factors involved in effective reflective practice challenging. Practical restrictions meant that a single reviewer was responsible for the selection and data extraction processes, increasing the risk of subjectivity and errors (Buscemi *et al*., 2006)

5.3 Implications for facilitation of reflective practice

While the literature is still early in development, and not conclusive, the current review offers the following suggestions to consider when implementing reflective practice. This review suggests that reflective practice develops over time and requires a consistent approach. Therefore, choice of delivery method should be carefully considered when implementing reflective practice and seen as a long-term investment of time and resources. The current review highlights the need for consistency to be established over time, to create both relation security and security in the setting. Moreover, attendees of reflective practice require time to develop their reflective skills and to feel safe enough to be open within the reflective space. Therefore, implementing reflective practice should not be seen as a quick fix or a way of creating a more reflective culture swiftly, more as an investment in the skills of attendees over time.

The evidence here would also suggest that facilitation is of high importance and is one way in which the safety of reflective practice is safeguarded. Particular attention should be afforded to the qualities that the facilitator(s) brings to reflective practice. Facilitators maintaining a stance of non-judgement, compassion, tolerance and self-reflection supports the creation of security within reflective practice as well as demonstrating these qualities to attendees as part of the reflective process. Furthermore, reflective practice facilitators should be supported to undertake this role, both in the form of training and ongoing supervision.

Regarding the point of safety, practical consistency and predictability should not be minimised in their importance. Holding reflective practice sessions in a consistent location, time and with a replicable format are salient features that are simple to implement and maintain, but easily forgotten in the face of service pressures and room booking procedures. Further to this, consistently upholding

these structural aspects of reflective practice demonstrates the esteem that with which the broader organisation holds reflective practice, creating a culture in which reflection is valued.

5.4 Conclusions and implications for future research

Owing to the limited size of the evidence base and the methodological weaknesses within some of the studies, the findings of the selected studies here do not form an exhaustive record of all the salient factors contributing to the implementation of reflective practice. Nevertheless, they do, in the author's opinion, form a foundation for understanding the factors pertinent to reflective practice within an emerging evidence base. Future research should continue to build on this and explore the process of reflective practice in specific clinical and training contexts to expand the body of literature in this area. Studies may also benefit from attempting to explore how the factors salient to reflective practice are comparable or different between training and qualification. Moreover, understanding the way in which the delivery of reflective practice impacts on its utility, for example one to one or within a group.

Future research should prioritise the use of both qualitative and quantitative methods to identify explicit links between salient components of reflective practice and the levels of engagement and outcomes. A research focus on the mechanisms of reflection (such as the salient factors discussed in the current review) and their relation to quantifiable aspects of the participant's functioning (including those linked to clinician and client outcomes, both cognitive and emotional) should be recommended.

Further research is required to understand the health system and societal benefits of offering reflective practice to health and social care students and professionals (Drummond *et al.*, 2015). Moreover, as health and social budgets are reduced understanding reflective practice within an economic context may support its continued inclusion within training and professional development. As suggested by Monk *et al*., (2018), future research could consider measuring burnout scores, using a measure such as the Copenhagen Burnout Inventory (Kristensen *et al*., 2005) or Maslach Burnout Inventory (Maslach & Jackson, 1981; Schaufeli *et al*., 2017) alongside measuring staff satisfaction and fulfillment using measures such as the Stanford Professional Fulfillment Index (Trockel *et al.*, 2018).

Some of the limitations of this review are linked to the topic of reflective practice itself. The subjective nature of engagement in reflection is challenging to quantify and evaluate; formulating a research question which can systematically explore the wide range of this current literature was also a challenge. Furthermore, systematically reviewing a literature that remains in the early stages of development was challenging. One particular challenge was the varied use of terminology used across studies and areas of practice. Many studies did not clearly define the definition of reflection or reflective practice employed by the authors. Moreover, the terminology used to depict reflective thinking was derived from various academic fields and therefore signified differing professional and disciplinary narratives. These professional contexts and the resulting terminology was not always explained or compared for the reader. Therefore, the synthesis of results from the literature can be seen as inherently challenging. Future reviews might benefit from selecting a specific professional category in order to increase to consistency of terminology and robustness of the resulting review. However, at this early stage of development exploring what qualitative research can support the introduction of common understanding of reflective practice in clinical and training environments.

In this review the findings of 12 studies of exploring the experiences of those involved in reflective practices have been analysed and five overarching themes identified. While the literature is early in its development, certain experiences were quite consistent across professions and stages of professional development. However, as the field of study matures, studies that explore and evaluate more homogenous reflective practices in similar environments will emerge, reducing the challenges associated with synthesising evidence from disparate contexts. There remains a need for the application of a range of study designs and methods to move to the next stage of exploration of reflective practices and the development of its application.

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*Denotes those studies included in the current literature review.

Section C – Research Report

Does group reflective practice change how trainee clinical psychologists think about their clients? An Interpretative Phenomenological Analysis.

(Guidelines for authors for the journal targeted for the Literature Review can be found in Appendix A)

Does group reflective practice change how trainee clinical psychologists think about their clients? An Interpretative Phenomenological Analysis.

1. Research Report Abstract

Objective

Reflective practice groups are commonly facilitated in healthcare settings and are increasingly incorporated into professional training courses. Currently, there is little research regarding the experience of group members when they present clinical material to the group and the way in which thinking about the client is affected by the process. The aim of this study is to explore the way in which reflective practice impacts on the way in which attendees' think about their clients.

Method

Semi-structured interviews were conducted with five Trainee Clinical Psychologists attending monthly reflective practice seminars as part of their training. To prompt the memories of participants and thereby support the generation of rich data, excerpts from previously recorded reflective practice seminars were selected and played within the participant interviews. Interviews were analysed using Interpretative Phenomenological Analysis.

Results

Five themes emerged from the analysis: am I right or wrong?; being right versus seeing multiple perspectives; sharing is never risk free; looking for the client's perspective and making sense of emotional responses. Rather than portraying a clear developmental trajectory the analysis highlighted feelings of exposure, vulnerability and concerns about 'getting it right' as pervasive but increasingly manageable elements of reflective practice.

Discussion

Results are considered in relation to existing theory and literature, and alongside a focus on co-production in mental healthcare provision and the possible conflict between the ideals of co-production and reflective practice groups. The idea that clinicians need distance to consider what their client is unconsciously communicating is discussed alongside psychoanalytic theory and literature. The ability of clinicians to connect with multiple perspectives and remain open and flexible in the light of new ideas is considered within the context of co-creating an intervention alongside their client.

2. Introduction

2.1 Background

Clinical supervision is a key feature of learning and development within mental health professionals' training and practice (Goodyear *et al*., 2005). Clinical supervision is described by Shulman (1982) as a process of engagement, exploring uncertainty and developing formulations. Models of supervision outline a process of integration between formalised theories, knowledge and practice-based experience and understanding. The Proctor model of supervision suggests that clinical supervision fulfils three functions; the formative, the normative, and the restorative (Proctor, 1986; 2008). The formative function focuses on the development of a clinician's skills, approach and abilities. The normative function allows a clinician to explore their work with another practitioner, helping them to observe and adjust their practice to support client experience and outcomes. The restorative function of supervision provides support, in areas such as dealing with stress, conflict and job satisfaction.

As such, supervision can occur in a one to one supervisor/ supervisee setting or within a group. Reflective practice is a form of group supervision that is increasingly embedded within the practice and development of many healthcare professionals; for example it is mandatory for Nurses to keep a reflective log as part of maintaining their registration (Nursing and Midwifery Council, 2010). Moreover, reflective practice is cited consistently within educational literature and included within an increasing number of training programmes. Although literature on reflective practice in healthcare seems to concur that reflection is an essential part of clinical practice, definitions of reflection, reflective thinking and reflective practice can differ across disciplines (Mann *et al.*, 2009; Regmi & Naidoo, 2013).

A reflective practice group attended by healthcare professionals provides an opportunity to confidentially discuss aspects of their client work. Examples of commonplace topics of discussion within such groups are; emerging dynamics within the therapeutic relationship, uncertainty about how to move forward, and barriers to therapeutic change and development. Attendees are guided through a model of reflecting on their clinical work by group facilitators. Practitioners can find these

discussions helpful in developing alternative standpoints and for their formative development (Knight, *et al*., 2010).

The concept of reflective practice stems from the seminal work of Donald Schön (1983). Endorsing the value of knowledge gained within professional practice, Schön encouraged professionals from all disciplines to recognise the unpredictability of their work and to challenge the notion that technical solutions should be the sole focus of discussion and innovation (Kinsella, 2010). Schön (1987) described two modes of reflection that contribute to learning and improved practice; reflection-in-action occurs as an interaction is occurring, whereas reflection-on-action takes place after the event. The practice of regularly reflecting-on-action supports the development of a practitioner's reflective skills, enabling them to reflect on what is happening in the moment, reflecting-on-action.

Various models of reflective practice are present in the literature, outlining the steps through which effective reflection occurs (e.g. Kolb, 1984; Gibbs, 1988). Within cognitive approaches, models of reflection are based around the interplay between declarative knowledge, procedural skill and the mechanism for reflection (Bennet-Levy, 2006). Mann *et al*. (2009) reviewed the literature regarding reflective practice within the education and training of healthcare professionals. Their aim was to understand the variables impacting on the utility and efficacy of reflective practice. However, how good reflective practice is achieved and what processes happen within reflective practice when it is effective remain under researched and indefinite (Mann *et al.*, 2009).

Reflective practice groups have been reported to be the most common medium for personal professional development within UK clinical psychology training programmes alongside one to one clinical supervision (Cushway & Knibbs, 2004; Gillmer & Marckus, 2003). The British Psychological Society states that psychologists should be "cognisant of the importance of self-awareness and the need to appraise and reflect on their own practice" (BPS, 2008, p. 8). Research in this area suggests that trainee clinical and counselling psychologists experience a range of benefits from being part of reflective practice groups, such as reflecting on their interactions, gaining an appreciation for the view point of a client and learning about group processes (Leva *et al*., 2009; Nathan & Poulsen, 2004). However, reflective practice groups can also be experienced as stress inducing and a source of distress

(Knight *et al.*, 2010). There is some discussion in the literature of those engaging in reflective practice experiencing discomfort or distress as an element of the reflective process, experiences often linked to feeling over exposed, judged or criticised. Making a distinction between discomfort that is an inherent part of reflecting on challenging situations and facilitates learning and development, and that which is gratuitous and detrimental to reflection remains ambiguous within the current literature (Youngson & Hughes, 2009).

Knight *et al*., (2010) explored the experiences of trainee clinical psychologists who had been members of a reflective practice group during their training. Their work utilised questionnaire data from a large sample to evaluate the experiences of the trainees. While the groups were seen as valuable by the majority of participants, questions remained over how engagement in reflective practice impacted on the participants understanding of their clients and the therapeutic work they were undertaking with them. This is reflected in the lack of literature on trainees' perspectives in relation to their experience of developing and applying reflective practice skills (Glaze, 2002; Ruth-Sahd, 2003). Moreover, this reflects a wider critique of the literature that it almost entirely focuses on whether clinicians find reflection helpful, not on how reflective practice is utilised, why or how it is helpful and if any benefit is translated into their clinical practice (Wigg *et al*., 2011).

2.2 Aims of the current study

Currently, there is very little research regarding the experience of group members when they present clinical material within a reflective practice group. This often takes the form of a group member talking through the details of a particular case alongside their own experience of working with this person or group. The current study aims to explore the experience of group members when then present their case, the way in which group members interpret and react to this shared narrative, and how such reflection is facilitated and thinking about the client and therapeutic relationship developed. Therefore, the aim of this study is to address the main question: Does presenting clinical material within group reflective practice affect how trainee clinical psychologists think about their clients? If so, what is the nature of this impact?

3. Method

3.1 Study Design

The intention of this research was to explore the experience of trainee clinical psychologists taking part in a reflective practice group within training. Interpretative Phenomenological Analysis (IPA) was selected as a method that aims to capture and interpret the experiences and meaning making of individuals within their own context (Larkin & Thompson, 2012). The current research aims to utilise IPA to "give voice" (Larkin & Thompson, 2012) to the experience of engagement in reflective practice in relation to participants' understanding of their clients (for a full statement of epistemological position see appendix H). To support this aim two excerpts from previously recorded reflective practice seminars were selected and played within the participant interviews; inviting participants to recall instances where their understanding of clients had been the focus of reflective practice. Furthermore, excerpts from this naturalistic data were chosen from both of the two years that the reflective practice group had been meeting, to support recollection of seminars over time.

3.2 Participants

As IPA is concerned with understanding a specific phenomenon in a particular context, a small homogenous sample from one UK clinical psychology training course was purposively selected to offer insights into the experience and phenomena under investigation (Smith *et al.*, 2009). Sample sizes of up to ten participants are typically recommended by Smith *et al*., (2009). Therefore, clinical psychology trainees attending mandatory monthly reflective practice groups were utilised for the sample. The 2016-19 cohort of clinical psychology trainees, of which the researcher was a member, attended monthly reflective practice group seminars. All participants attended the same group for the three years of training.

Within the 2016-19 cohort there were two reflective practice groups; the researcher was a member of one group. Membership of each group consisted of six trainee clinical psychologists and two qualified clinical psychologists, acting as facilitators. The researcher's academic supervisor undertook the role

of facilitator of the researcher's reflective practice group, alongside a clinical psychologist practicing in the local area. The researcher therefore, had a choice to recruit and investigate the experience of those within her own or the parallel reflective practice group. There were positive and negative aspects of the researcher also being a reflective practice group member. Maintaining group membership while also studying the experiences of group members brought up concerns regarding conflicts of interest for the researcher. The researcher's group had agreed to have their seminars recorded to support systematic reflection and to inform potential future inquiry into reflective practice (see appendix I for consent forms). Therefore, being a group member also put the researcher in a unique position in which she could observe and record the group sessions, utilising this knowledge to inform subsequent participant interviews.

Overall, it was felt that the advantages of the chief investigator being immersed in the reflective practice group outweighed the potential negative costs. The researcher and her supervisor were sensitive to their dual positions as researchers and members of the reflective practice group, a concerted effort was made to keep these two roles separate; this was achieved by utilising a reflexive research diary and research supervision. At commencement of the research process the researcher and her academic supervisor discussed the possibility of seeking external supervision for the researcher, particularly during analysis phase of the project. At the analysis stage it was not felt that this was required, however this decision continued to be discussed and reflected on within supervision.

3.3 Procedure

3.3.1 Data Collection

Semi-structured interviews were used to engage participants in a rich dialogue regarding their experiences. Prior to undertaking the interviews, the researcher listened to the recordings of the reflective practice seminars and selected excerpts between five and eight minutes in length from this naturalistic data to play back in the interviews. Excepts were selected from seminars in which the participant had presented a clinical case, included the participant sharing clinical material and their reflections, and included other group members sharing their reflections as well as the participant being interviewed. Two excerpts were selected, one from the first year of training and one from the

second, selecting excerpts from both years aimed to capture the experiences of participants over time and explore the development of the group. The researcher then prepared a short vignette summarising the content of the seminar from which the excerpt was taken, during the interview the vignette was read prior to the excerpt being played. An interview guide was used flexibly alongside the excerpts to prompt discussions pertinent to the research questions (see appendix J).

The rationale of choosing audio clips in which participants had presented a clinical case was that it would facilitate discussion of occasions when thinking about a participants' own clinical work was the focus of the seminar. Moreover, playing two clips from two years of meeting for reflective practice gave an opportunity for similarities and differences within the group over time to be reflected upon and discussed. Participants were asked to reflect on and compare their experiences of the two seminars captured in the excerpts and also consider how the reflective practice group has developed over the two years.

3.3.2 Transcription and Data Analysis

The researcher transcribed all the one-to-one interviews verbatim. This supported the researcher's full immersion in the data set, as recommended in IPA (Smith, Flowers & Larkin, 2009). To allow for the interview data to be represented accurately during the process of transcription a 'naturalistic' approach was employed (Oliver *et al*., 2005). This approach allowed vocalisations such as "erm", "err" to be transcribed alongside pauses, stutters and mispronunciations (see appendix K for example of transcription).

Following the guidance of Smith *et al*. (2009), each interview transcript was read and re-read by the chief investigator to ensure that the focus of the analysis remained on the participant's account of their experience. Preliminary thoughts were noted on each interview transcript and initial inductive themes within the data identified. Connections between these inductive themes within the interview transcript were noted before moving on to the next interview and repeating the interpretative process. Patterns across the transcripts were then explored, resulting in the development of themes. Quotations from interview transcripts were selected to highlight the analytic interpretations of the data.

Both the researcher and research supervisor were aware of the possibility that their roles as a member and facilitator respectively within the reflective practice group could impact on the analysis and interpretations made of the data. Every effort was made therefore, to guard against an analysis that was defensive or that shied away from critical or uncomfortable themes within the data. This included reflecting within supervision about the direction that the analysis was taking, for example maintaining an awareness of the researcher being pulled to paint a falsely positive picture of reflective practice. The researcher kept a reflexive journal through the research process, this also enabled her to reflect on her own ideas outside of supervision (see appendix L for extract from reflexive diary).

The researcher aimed to reduce the potential for a defensive or biased analysis by engaging in a process of participant credibility checking. Once this initial stage of analysis was completed, the researcher shared her findings with the reflective practice group in a specially designated meeting. This allowed the group to discuss and reflect upon the findings of the analysis, commenting on the extent to which the analysis resonated with their own experiences of reflective practice, without the presence of either facilitator. Sharing the analysis helped to maintain the spirit of group inquiry within the reflective practice group and supported the credibility of the analytic process.

The researcher was aware of the possibility for this meeting to breach the confidentiality and anonymity of participants and therefore the way in which the analysis was shared was carefully considered. A summary of each theme was shared with the group, without any illustrative quote which might have identified an individual group member. Moreover, during the meeting the status of group members as participants in the research was not disclosed. The researcher then invited a discussion with the group of the extent to which the themes resonated with participants experiences.

Presenting the analysis to the reflective practice group felt very valuable and increased the researcher's confidence in the analysis and its resonance with the experience of the group members. Although this meeting did not result in major changes to the original analysis it did increase the researcher's confidence that she had highlighted phenomena that the research participants could identify with and expressed were coherent with their experiences.

3.4 Ethical Issues and Approval

As the research involved the recruitment of trainee clinical psychologists by virtue of their position as students within the University of Leicester, ethical approval was sought via the University ethics committee before the research commenced (see appendix M and N). The researcher followed the procedures regarding confidentiality and participant safety as outlined by the University and completed the required training prior to ethical approval being sought.

This research raised ethical issues in relation to informed consent, participants right to anonymity and confidentiality alongside the way in which data was securely stored during data collection and analysis. The procedures relating to these issues were discussed fully with participants during their initial meeting with the researcher, before consent to take part in the research was gained, Participants were informed that their remarks would be anonymised to ensure that other members of the cohort would not be able to identify participants through the analysis of the research report. It was made clear to group members that they were under no obligation to take part in the research; that the researcher would not share with other cohort members who had consented to take part in the research and who had not; that participants were free to withdraw their participation from the research at any time during the process without this resulting in any negative consequences and that opting out or withdrawing from the research would have no impact on group members participation in the reflective practice seminars in any way (see appendix O and P for participant information sheet and consent form).

4. Analysis

4.1 Am I right or wrong?

This theme illustrates the nature of participants' desire to 'get it right' within what was experienced as a dichotomous model of being either right or wrong. Participants voiced concerns about getting things right in their clinical work and further being able to demonstrate this 'rightness' within reflective practice; all five of the participant interviews contributed to this theme. The need to be in the right,

and the possibility of being in the wrong, was a source of discomfort. Sophie in particular spoke openly about feeling she had got it wrong the first time she shared a case with the group:

"I do really vividly remember that feeling of everyone else talking about her in a way that I hadn't considered before and had that real feeling of oh my goodness I've come in and sort of (.) shared this really quite unkind view of reflection of this woman and everyone else has held this really compassionate view and just feeling like oh god I just feel really terrible about it" (Page 5)

The distress Sophie experienced when faced with the very different view of her client expressed by group members was linked to the perception that she had got it wrong:

"I responded in that way of oh no I've got the wrong answer… there was a right story and a wrong story and I'd given the wrong story and everyone else had given the right story" (Page 6)

This sense of 'wrongness' was compounded by the idea that group members had shared a more compassionate perspective on her client than the view Sophie had been holding. There was an assumption that having a compassionate view of a clinical case was right and holding mixed or negative feelings towards a client was wrong. Underlying Sophie's experience of feeling she was in the wrong was the context of getting it wrong in front of others. A suggestion that group members had made negative judgements about Sophie as a clinician seemed to sit just below the surface of her distress at having "given the wrong story".

Concern about the perceptions of others were illustrated in Ellen's reflections about being assessed within the context of reflective practice:

"at the beginning I think a sense of are we being marked? Are we being how much of this is going to be kind of not used but kind of how much of this is going to change how people see, how much of this is going to be like of I'm not doing well enough?" (Page 16)

This passage echoed the anxiety triggered by the thought of being in the wrong, and the impact that this might have on the way she was perceived. Moreover, being in the right or in the wrong seemed to extend outside of reflective practice seminars into all aspects of clinical practice and training. The

context of assessment was evident in Ellen's words; the pressure of being marked in other aspects of her practice created a concern about external judgements within reflective practice.

Becca spoke about good clinical practice as a kind of perfection that it was her job to attain:

"I put a lot of pressure on myself that these sessions were going to be perfect, that these were going to be goal focused and these were going to be, this is what we do every session and I'm gonna do a really nice write up of it and things are going to be different at the end" (Page 15)

Becca talked about a tick list of concrete targets that appeared to form her estimation of perfect therapy. Her description emerged as part of a narrative about academic and professional achievement; if all steps were completed in sequence then the eventual outcome would be successful completion. Furthermore, having successfully completed all stages of this process, Becca envisaged herself as being in the right, and in a position to demonstrate this to others in the form of a written case study.

4.2 Being right versus seeing multiple perspectives

This theme depicts the idea of multiple, often differing, perspectives as valid, in contrast to being in the right or in the wrong; four out of the five participant interviews contributed to this theme. Being in the right or in the wrong appeared to be experienced as personal, relating directly to the competence and attributes of the individual trainee. However, some participants could be seen to adopt an attitude towards differing perspectives as being informed by the relationships and experiences being discussed, as well as those of group members.

Sophie described the different perceptions that group members had about her clinical case as arising from the different positions they had in relation to the client:

"…actually think you know what that was really helpful and I can understand why I didn't have a similar picture… I was coming at it from a different point from the rest of the group… they were able to step back" (Page 6)

The fact that other group members were not working directly with her client meant that they were able to "step back" when this had not been possible for Sophie. Sophie also expressed a sense that hearing different ideas about her case was helpful, not representative of a flaw in her abilities:

"the position that I was holding was one of those and that position and reflections of other people just represented other aspects and other truths about the case not that one was right or one was wrong" (Page 10)

The value of hearing the perspectives of other group members was described by Sophie as being representative of different parts of the person she was working with. Moreover, these ideas did not seem to negate the feelings that Sophie was experiencing in relation to her client and their work together. Sophie was able to hold multiple perspectives about a client, taking a both/ and approach rather than seeing one idea as right and one as wrong.

Rose described experiences of other group members mirroring her perception of a client and at other times seeing things differently. She spoke about the culture of the reflective practice group allowing for different ideas to be shared without one being seen as right and one as wrong.

"I've felt a mirror the way I another person has felt in the group but then there's equally been times where I'm like oh I didn't get any of that, for me this came up erm and I think the group really fosters that and it isn't that anyone is right or wrong or sees it better than someone else"(Page 11)

The concept of group members acting as a mirror to the person presenting the case appeared as a way of validating their experience. However, Rose also spoke about instances when group members might raise ideas she had not considered or a point of view different to her own. This description indicated that holding multiple points of view, without judgements being made about which was correct, was something that was assisted by the group as a whole. On the surface Rose was saying *"it isn't that anyone is right or wrong or sees it better that someone else"* although underlying this was an understanding that the right or wrong dichotomy was a possible feature of reflective practice. The fact that Rose mentioned this dichotomy, in the context of rejecting its presence, suggested that she was aware that being either right or wrong could endure in a reflective practice group context.

Further to this, Rose referred to a hierarchy of someone *"sees it better than someone else"*, suggesting that the person making the comments, as well as content of their ideas might affect the perception of their 'rightness'. Differences in the perspectives of the group were perceived by Rose as positive,

without concerns of judgement or comparison; while the possibility that with different group dynamics, judgement could have been a part of the experience, remained.

4.3 Sharing is never risk free

Although participants described feeling safe within the group and able to share sensitive material, this was not experienced as completely risk free. Furthermore, the practice of sharing aspects of themselves and their clinical work influenced how they were able to use reflective practice and what they chose to share in the group. All of the five participant interviews contributed to this theme. Ellen discussed the process of negotiating the unspoken rules of the reflective practice group and how defining a role for herself was important:

"there was a slight sense of not knowing exactly what what (.) to offer how much detail to give or… what kind of bits are most relevant… although I think… it was quite good for me to present because there was a sense of I've got a role I know what I'm doing with this session" (Page 7)

Central to Ellen's description of being in reflective practice was the uncertainty of how to contribute, to give enough detail and speak to the most relevant areas. This uncertainly could be seen in Ellen's words as she tried to describe this experience, she appeared to be searching for the right words and paused before continuing "not knowing exactly what what (.) to offer how much detail to give". It appeared that presenting her own clinical case gave Ellen a distinct role and remit, a set of rules that reduced her uncertainty. Ellen went on to define speaking honestly as an aspect of the group's development:

"I think as the group's developed that feels like there is that sense that we can be really honest in this space and actually that's quite helpful not detrimental" (Page 16)

This description of honesty within the reflective practice group being "actually… quite helpful not detrimental" indicated that at one time a perception of honesty as potentially detrimental had been experienced, that time and group development brought about an attitude towards open honest discussions as useful, where they once may have seemed threatening and potentially harmful. Ellen's words also conveyed a sense that she was reassuring herself of the helpfulness of honesty and

underlying this was an awareness that the possibility of it being detrimental was ever present. Ellen's description conveyed the impression that sharing honestly with others about clinical practice requires a trust that it can be helpful, alongside an acknowledgement that you can never be certain it will be.

Jessica's explanation emphasised the vulnerability inherent in being honest about her own clinical practice:

"like well you're crap you didn't see that and you're working with someone I think to say that you have to feel quite comfortable like I missed that I hadn't picked up on that and it can feel it could feel really vulnerable to say that to be just to be able to say it without thinking that shows the development of the group and just to a bit more feels safe" (Page 14)

This description also spoke of the development of the reflective practice group in terms of the safety that group members required to be open and make themselves vulnerable. This excerpt portrayed the imagined judgements made by other group members when presenting a case *"you're crap you didn't see that"*. The strength of the criticism shows the perceived risk that was being taken by speaking openly about clinical work. Moreover, the personal nature of the imagined criticism, and the self-attacking character of Jessica's words demonstrated the emotion attached to potential exposure within the group. This risk seemed to be lessened by the perceived safety within the group, and the sense that this vulnerability would not be exploited.

However, the safety offered by the group was not unlimited, Jessica stumbled over her words as she tried to describe an increase in the sense of safety within the group *"the group and just to a bit more feels safe"*. Rather than describing feeling safer within the group, Jessica noticed her own behaviour, admitting she had *"missed that"*, and recognised this as an indication that she was felt safe enough to be vulnerable. Jessica stumbled over her words in conveying safety as something that had increased but was not complete or static: there was an uncertainty in her words. It is unclear what Jessica meant by *"a bit more"* this could have referred to her sharing *"a bit more"* with the group or to a feeling that she felt *"a bit more"* safe. Jessica termed safety as something that had increased, indirectly inferred from recognition of her behaviour within reflective practice, but this did not negate the potential to feel vulnerable.

Rose spoke specifically about voicing the difficulties she had in her clinical work, alongside a sense of uncertainty about what to do:

"not knowing what I'm doing and I suppose almost presenting that and letting people see that in a reflective space is quite exposing erm really I think you I think luckily it is a space that I felt safe enough to do that in and to feel exposed" (Page 8)

The sense of safety offered by the reflective practice group was described by Rose as allowing her to speak about her clinical work and feel exposed; it did not seem to lessen the experience of exposure or reduce the risk of sharing with the group. Rose's words "I felt safe enough" captured the core of this theme: sharing clinical practice did not become permanently risk free, but it felt "safe enough" to do so in the moment. The experience that Rose was describing allowed her to share her practice, and "feel exposed" in doing so and she was able to tolerate feeling exposed rather than feel totally invulnerable.

4.4 Looking for the client's perspective

Within this theme participants described a growing awareness of their client's position, seeing situations from their point of view. This awareness appeared to support a genuine empathy with their clients and saw participants adopt a more compassionate stance towards them. Three out of the five participant interviews contributed to this theme. Rose's description of the disconnect between a strong emotional response to her client and the image she held of herself as a clinician, demonstrated that a compassionate stance was not always easy to adopt.

"I don't understand why I'm not reaching it and I think it's hard because it challenges you know you like to see yourself as a professional I'm very warm, I'm very genuine, I'm very you know I want to show all this empathy to people and actually sometimes that's really hard to do when you're working with certain people" (Page 11)

The desire to be a warm and compassionate clinician brimming with empathy was apparent in Rose's words, alongside an acknowledgement that this did not always come easily. This conflict between the

feelings she was experiencing and those she wished to have was evident. Rose went on to describe her response to her client cancelling sessions after speaking about this case in reflective practice:

"when she cancelled sessions with me my response was different in terms of being like agggghhh or quite frustrated I think I was a lot more able to hold onto actually how difficult is it for you to sit in a room with me" (Page 12)

The reason for Rose's altered response to the sessions being cancelled was closely connected to a shift in her perspective, from what this situation meant to Rose, to what the experience of the situation was for her client. In doing this, Rose's frustration reduced, and an inherent compassion seemed to be accessed. Furthermore, connecting with this compassionate stance allowed Rose to consider her response to the cancelled sessions, and the meaning behind them, considering what was being communicated. Rose was able to reflect on what her response might mean to her client and act with this at the forefront of her thinking.

Reflecting on the experience of her client appeared to provide Sophie with an opportunity to consider the emotional communication that was taking place:

"I suppose be more in touch with that root message that she was giving of I'm really fighting here… when I responded to that feeling… I think she kind of relaxed a little more into therapy" (Page 7)

Gaining a different understanding of her client and what her actions might be communicating gave Sophie an alternative way of interacting with her. Sophie described responding to the underlying message of "I'm really fighting here" and that in responding to this communication rather than what was on the surface she allowed her client to "relax a little more into therapy". Connecting with this view of her client as fighting the whole world rather than feeling she was just fighting her allowed Sophie to reduce the sense of conflict in sessions and be alongside her client, deepening their relationship and her client's engagement in therapy.

When working in settings where those responsible for the direct care of a client are also part of an intervention, Becca described the challenges of adopting a compassionate and understanding stance

towards both client and their carers. Feeling empathetic towards her client made it difficult for Becca to connect with the care team and their perspective on the difficulties the client was experiencing.

"there was just a sense of just a lot of frustration towards that and I suppose that did plant a seed of ok there is another side to this as well as that's frustrating… erm but yeah it planted the seed of well what about them what's it like for them" (Page 16)

Presenting this case in reflective practice moved Becca's position from frustration towards the carers to one of wondering what the experience was like for them. Speaking about her frustrations within reflective practice "planted the seed" of curiosity and empathy for the situation from the other side. This suggested that Becca was able to take a both/ and stance towards the different perspectives and was able to hold on to both viewpoints.

4.5 Making sense of emotional responses

This theme depicts the way participants comprehended the significance of their emotional responses to clinical work, recognising the meaning they held in their practice. Rather than considering the emotions evoked by a client as a limitation, something to be ignored, they approached their reactions as a valid communicative tool within their work. All five of the participant interviews contributed to this theme.

The significance given by Sophie to her feelings towards her clinical work appeared to have been influenced by engagement in reflective practice:

"reflective practice has taught me not to be afraid of doing maybe that that is part of the work how I feel about that work with Amy is as important as what I'm doing practically with her and it's ok to share and talk about that" (Page 12)

Sophie gave herself permission not only to take notice of her own emotions in relation to her client, but to see these feelings as valuable, and worthy of exploration. This was reflected in the parity of esteem she placed on the practical, 'what am I doing with my client' alongside 'what am I feeling about my client'. There was a suggestion in Sophie's words that this was not always the case, that previously she had reservations about holding up her emotional response as clinically important.

Rose described how the modelling that took place within reflective practice offered her "permission" to consider emotional responses to clinical material, both her own and that shared by other group members.

"I think that is quite big I guess that modelling that they [the facilitators] *will talk about how they've processed information you've given so it kind of feels like then you have permission to do the same and to process your own feelings either about hearing material or presenting material" (Page 4)*

Experiences of the emotional impact of clinical work appeared to have been validated within the context of reflective practice. Both assuring participants that these were responses shared by others but also that there was a place for their feelings with clinical practice. Participants seemed to take the significance of their emotional responses and translate this understanding into their routine practice. Becca described the process that she engaged with following a session that left her with strong emotions:

"coming out confused and overwhelmed and rather than just sort of dismissing that and carrying on doing the notes and thinking about maybe the practicalities of that it was more around I actually thought about why it is that I feel like that around that person and think what, what is that about what sense do I make out of that and how does that link to the formulation maybe just noting it down or drawing whatever image I think I'm really pay attention to what images come as well" (Page 5)

The way Becca described taking time to consider the way she felt towards her client appeared as a way of enriching the formulation she held about them and their difficulties. Moreover, making notes about these reactions, in the form of words or pictures allowed for them to be retained and made sense of. Becca's words as she described this change in her perception showed a marked movement from confusion to a sense of focus and clarity. The contrast between dismissing her experiences of being overwhelmed and confused and her subsequent position of feeling that her responses were valuable and could be channelled in a meaningful way was considerable. Becca's description of her responses and reflections as images reinforced the sense of clarity that she gained, indicating the legibility that her emotion could hold.

Furthermore, reflecting on her emotional response in relation to her formulation and within a relational context, created a distance between Becca and the experience of those emotions, reducing the sense that her emotional response was overwhelming. The weight of these emotive responses seemed to lessen, allowing Becca to reflect on them thoughtfully, supporting her to build an understanding of her client.

5. Discussion

5.1 Summary of research findings

The current study explored experiences of reflective practice in clinical psychology doctoral training, considering the impact of reflective practice on participants' understanding of their clients. Five themes emerged from the analysis; the first 'am I right or wrong?' described the discomfort experienced when participants felt their response to clinical work was incorrect. Participants were anxious of being perceived as personally wanting, this linked to wider experiences of trying to 'get it right' all the time, to be a perfect psychologist. The second theme 'being right versus taking multiple perspectives' spoke of a different response to diverse, conflicting view points within the group. Participants described finding value in alternative perspectives, seeing their meaning as enriching rather than invalidating or critical.

The experience of sharing clinical material with the group was described in the third theme 'sharing is never risk free'. Participants highlighted the uncertainty that accompanied sharing their clinical work and attempting to gain insights from the group without feeling over exposed. This theme emphasised the risk being taken by group members when sharing their practice and emotional responses; it conveyed the experience of vulnerability that consistently accompanied sharing openly in reflective practice.

The fourth theme 'looking for the client's perspective' described how participants were able to access a compassionate response by placing themselves in the position of their clients. This was emphasised in instances when participants had found it challenging to connect with empathy for their client previously. The final theme 'making sense of emotional responses' described the how participants

recognised their emotional responses and developed ways of integrating their emotions into formulation and practice. This theme encapsulated the practical ways in which participants recorded the way they felt following clinical sessions, alongside coming to see these responses as valuable.

Given the two initial themes (Am I right or wrong? and Being right versus taking multiple perspectives) it might seem tempting to interpret their meaning sequentially, as a development from an early stage of reflective practice to a more developed position. However, the data would caution against this; participants' depictions of valuing multiple perspectives did not preclude the discomfort of feeling they were in the wrong. Rather than depicting a developmental model of reflective practice, these themes describe experiences that can switch, within the same discussion. Participants retained an awareness that the distress of being in the wrong remained a possibility, the chance that sharing their thoughts could result in feeling they had 'got it wrong' did not vanish.

Although, as a reflective practice group meets and develops over time, it would be hoped that more time would be spent taking multiple perspectives as opposed to wondering am I right or wrong?, the current analysis demonstrates the later remains a part of the landscape of the group seminars. Moreover, the act of sharing clinical material in reflective practice retains a sense of risk for participants. The theme 'sharing is never risk free' further demonstrates the development of reflective practice, not as a number of stages to move through, but as a process that requires continual support for attendees to tolerate feeling exposed and take the risk of sharing openly.

With the research question in mind, participants in the current study described a perception that their experiences in reflective practice had influenced the way in which they understood their clients. These experiences centred on an ability to hear numerous perspectives associated with their client, and to step into multiple positions in relation to their work with that person. This was described articulately in the theme 'being right versus taking multiple perspectives'. As the person working directly with a client, participants presenting clinical material felt close up to the challenges within therapy and the therapeutic relationship; group members had the distance to see other viewpoints.

5.2 Links to the current literature

Looking for the viewpoint of clients and accessing a more empathetic response was a meaningful way in which reflective practice impacted on participants thinking about their clients. Together, therapist empathy, genuineness, and alliance contribute to several therapeutic models. Empathy within the therapist/ client relationship has consistently been recognised as a strong predictor of the effectiveness of therapeutic input, across a number of therapeutic models (Norcross, 2010; Norcross & Wampold, 2011). Nienhuis *et al.*'s (2018) meta-analysis concluded that the constructs of empathy, genuineness and therapeutic alliance were experienced as so closely linked that research participants may struggle to rate them as distinctive elements within a therapeutic relationship. The authors found links between therapy outcome and the therapeutic alliance, therapist empathy and therapist genuineness.

Consequently, if participants in the current study experienced an increase in genuine empathy within the therapeutic relationship, this has the potential to impact on the outcomes of therapy. This is particularly applicable when those attending reflective practice have experiences of clients behaving in a hostile or aggressive manner, or when working systemically and feeling aligned to one member of the group or family. Moreover, gaining this distance appeared to reduce feelings of frustration and irritation that had been evoked within the therapeutic relationship and annoyance with their own reaction, which could be understood as countertransference (Lemma, 2003, p.68).

Literature from psychoanalytic psychotherapy describes creating meaning out of the powerful emotions that surface in therapy, as a task that requires space and distance from the therapeutic relationship for processing and reflection (Lemma, 2003). Moreover, the process whereby latent meaning is apprehended and understood involves listening for and comprehending unconscious communication (Casement, 1990). Casement (1990) depicts comprehension of unconscious communication as a task that cannot always be achieved within the therapeutic space; the therapist needs a safe space to explore the meaning being communicated by their client. The results of the current study echo these ideas, demonstrating how presenting clinical material in reflective practice allowed participants to consider what was being communicated, that they might previously not have attended to. Moreover, when presenting clinical material participants highlighted the value of other

group members reflections coming from a position of distance, a step removed from the direct clinical work.

Recent developments have seen the idea of a group of clinicians meeting to speak about their clinical work without the client themselves being represented, come under criticism. This criticism has been linked in part to the movement towards co-production of mental health service. The involvement of people who use mental health services in the planning and design of services, or co-production, has become an increasing part of the healthcare agenda over recent years. Boyle and Harris (2009) defined co-production as "delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours". In the last decade, there has been an increased interest in co-production, promoted by the suggestion that co-production is a way to combine social benefits with economic benefits (Alford, 2014; Ewert & Evers 2014; Ostrom 1990; Pestoff, 2014 and Verschuere *et al*., 2012).

The conflict between the ideals of co-production and the implementation of group reflective practice for healthcare professionals arises from the exclusion of the clients being discussed from the group. There is no space for the individual who is being discussed to attend and make clear their perspectives. Reactions on Twitter to a recent post by Dr Lucy Johnston on the Association of Clinical Psychologists (ACP) website (https://acpuk.org.uk/team_formulation/) about the benefits of team formulation, a multi-disciplinary team meeting to discuss the needs and care of a particular individual, demonstrate that this evokes a powerful sense of exclusion for some. However, with the high demands placed on healthcare staff and increasing levels of staff burn-out, opportunities for professionals to feel supported are desperately needed (Rimmer, 2018). The tension between these viewpoints raises questions over meeting the needs of clinicians alongside an agenda of co-production.

The results of the current study demonstrate that engaging in reflective practice can enable attendees to appreciate the perspective of their clients and gain an authentic sense of empathy. Sharing clinical difficulties in a reflective space, allowed participants to move between multiple perspectives and connect with a holistic and balanced view of their client. Rather than discounting ideas and increasing

rigidity, engaging in reflective practice opened up the perspective of the participant sharing their clinical work. A clinician who can stay open to multiple perspectives and not become married to one idea, could be more flexible and available to co-produce an intervention with their client. The results of the current study therefore, make a case for the idea that engaging in reflective practice might support the facilitation of co-production within therapeutic encounters.

5.3 Clinical recommendations

The findings of the current study emphasise the significance of enabling time to be taken to build the foundations of a reflective practice group. The importance of creating an atmosphere of trust and collaboration should not be underestimated. Trust is crucial for group members to feel able to take the risk of sharing aspects of themselves and their clinical work, to enable them to tolerate feeling exposed. Within the process of setting up group reflective practice opening up conversations about what attendees might expect from the group can support building trust and a culture of honesty within the group. Furthermore, explicitly discussing the nature of the group in relation to assessment should be seen as a priority. As reflective practice is increasingly implemented on training courses, a distinction should be made between activities that are being assessed and reflective practice as a space in which no formal assessment is taking place.

Creating a sense of structure and clarity within the reflective space alongside attendees can be seen as a way of co-creating the culture and norms of the reflective practice group. Utilising a flat hierarchy in which the ideas of both facilitators and attendees can be heard could support a collaborative approach in which all group members have created the structure of reflective practice sessions. Moreover, making participants aware that they might experience discomfort and anxiety within the setting of reflective practice could help to normalise these experiences and allow for them to be discussed within group discussions.

5.4 Research recommendations

The current study has considered how engagement in reflective practice impacts on the understanding that clinicians have of their clients. However, the remit of this research was to explore the experiences

of reflective practice attendees, rather than to investigate how these experiences translated into clinical practice. Finding valid ways of evaluating reflective practice and describing its impact remain important areas for future research. The current study highlights the increased levels of empathy that participants experienced towards their clients following discussion in reflective practice. Exploring the experience from the perspective of the client, if empathy levels are experienced as higher following a clinician attending reflective practice is an area for further research.

As previously acknowledged the findings of the current research may be unique to this particular reflective practice group, it would be pertinent for a future research study to recruit participants from reflective groups running concurrently, utilising a larger sample size with a questionnaire design. This may or may not lend support to the themes identified in the current study but may help to identify areas of similarity and difference between concurrent groups. Moreover, illuminating possible differences between reflective practice groups might support an understanding of what elements contribute positively to engagement with reflective practice and what may be a potential barrier.

5.5 Strengths and Limitations

The current study successfully made use of naturalistic data to support the interview process and gain rich, interesting qualitative data. In qualitative interview studies it is important to remember that who is asking the questions can significantly influence the responses given. In the current research the participants may have been motivated to supply the researcher with what they perceived she, and her supervisor wanted to hear. However, not all experiences described by participants were positive, or one dimensional. Despite the previously discussed ‘close up’ position of the researcher in relation to the research topic and participants, the current study was able to safely gain access to in-depth and thought-provoking interview data.

During interviews participants frequently found it difficult to identify specific instances from their experiences of reflective practice, often speaking general terms regarding these experiences. Listening back to the recorded excerpts seemed to help participants remember the specifics of what had happened, not only including content from the excerpt itself but also encompassing other aspects of the seminars that had not been listened to in the interview. It was between two and eleven months

between reflective practice seminars and participant interviews; therefore, owing to this time gap participants possibly could not remember the details of their experiences. Moreover, because of this time gap it was difficult to participants to identify if their thinking about clients had been impacted solely by engagement in reflective practice or other wider factors such as clinical supervision or teaching in a particular area.

Another limitation of this study was the time frame imposed by the deadline imposed by the submission of this research; this ultimately limited the scope of what this study could cover. A major consideration was being able to realistically manage the amount of data collected and complete a proficient analysis. Given more time or additional researchers more of the naturalistic data from the recorded seminars could have been utilised and potentially supported multiple participant interviews across the life span of the reflective practice group. It could have been extremely interesting to conduct further research with a focus on how a reflective practice group may change or develop over time. More specifically how this might impact on the clinical thinking of those attending the group at different stages of professional development.

5.6 Conclusion

In conclusion, the current study has demonstrated that presenting clinical material within group reflective practice has an impact on how trainee clinical psychologists think about their clients and clinical work. This impact can be seem in relation to looking for the view point of a client, and also in the way that participants responded to their own emotional reactions to their clinical work. The experience of taking part in a reflective practice group during clinical psychology training was highlighted; depicting the sharing of practice material as taking a risk, and as an inherent and enduring aspect of reflective practice.

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Section D – Appendices

Appendix A* – Intended Journal Guidelines

British Journal of Clinical Psychology - Author Guidelines

The British Journal of Clinical Psychology publishes original contributions to scientific knowledge in clinical psychology and Registered Reports. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

All papers published in The British Journal of Clinical Psychology are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

The following types of paper are invited:

- Papers reporting original empirical investigations
- Theoretical papers, provided that these are sufficiently related to the empirical data
- Review articles which need not be exhaustive but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications
- Brief reports and comments

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

The word limit for papers submitted for consideration to BJCP is 5000[1] words and any papers that are over this word limit will be returned to the authors. The word limit does not include the abstract, reference list, figures, or tables. Appendices however are included in the word limit. The Editors retain discretion to publish papers beyond this length in cases where the clear and concise expression

[1] For the submission of the current thesis to meet the requirements of the Doctorate of Clinical Psychology it was not felt that a limit of 5,000 words as outlined in the above document would be sufficient. Therefore, the word count will be reduced following submission to meet the requirements of the British Journal of Clinical Psychology.

of the scientific content requires greater length. In such a case, the authors should contact the Editors before submission of the paper.

3. Submission and reviewing

All manuscripts must be submitted via Editorial Manager. The Journal operates a policy of anonymous (double blind) peer review. We also operate a triage process in which submissions that are out of scope or otherwise inappropriate will be rejected by the editors without external peer review to avoid unnecessary delays. Before submitting, please read the terms and conditions of submission and the declaration of competing interests. You may also like to use the Submission Checklist to help you prepare your paper.

By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more at https://authorservices.wiley.com/statements/data-protection-policy.html.

4. Manuscript requirements

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. You may like to use this template. When entering the author names into Editorial Manager, the corresponding author will be asked to provide a CRediT contributor role to classify the role that each author played in creating the manuscript. Please see the Project CRediT website for a list of roles.
- The main document must be anonymous. Please do not mention the authors' names or affiliations (including in the Method section) and refer to any previous work in the third person.
- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript but they must be mentioned in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be

listed on a separate sheet. The resolution of digital images must be at least 300 dpi. All figures must be mentioned in the text.

- All papers must include a structured abstract of up to 250 words under the headings: Objectives, Methods, Results, Conclusions. Articles which report original scientific research should also include a heading 'Design' before 'Methods'. The 'Methods' section for systematic reviews and theoretical papers should include, as a minimum, a description of the methods the author(s) used to access the literature they drew upon. That is, the abstract should summarize the databases that were consulted and the search terms that were used.
- All Articles must include Practitioner Points – these are 2–4 bullet points to detail the positive clinical implications of the work, with a further 2–4 bullet points outlining cautions or limitations of the study. They should be placed below the abstract, with the heading 'Practitioner Points'.
- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.
- SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.
- In normal circumstances, effect size should be incorporated.
- Authors are requested to avoid the use of sexist language.
- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright. For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association.

If you need more information about submitting your manuscript for publication, please email Vicki Pang, Editorial Assistant (bjc@wiley.com) or phone +44 (0) 1243 770 410.

5. Brief reports and comments

These allow publication of research studies and theoretical, critical or review comments with an essential contribution to make. They should be limited to 2000 words, including references. The abstract should not exceed 120 words and should be structured under these headings: Objective, Method, Results, Conclusions. There should be no more than one table or figure, which should only be included if it conveys information more efficiently than the text. Title, author name and address are not included in the word limit.

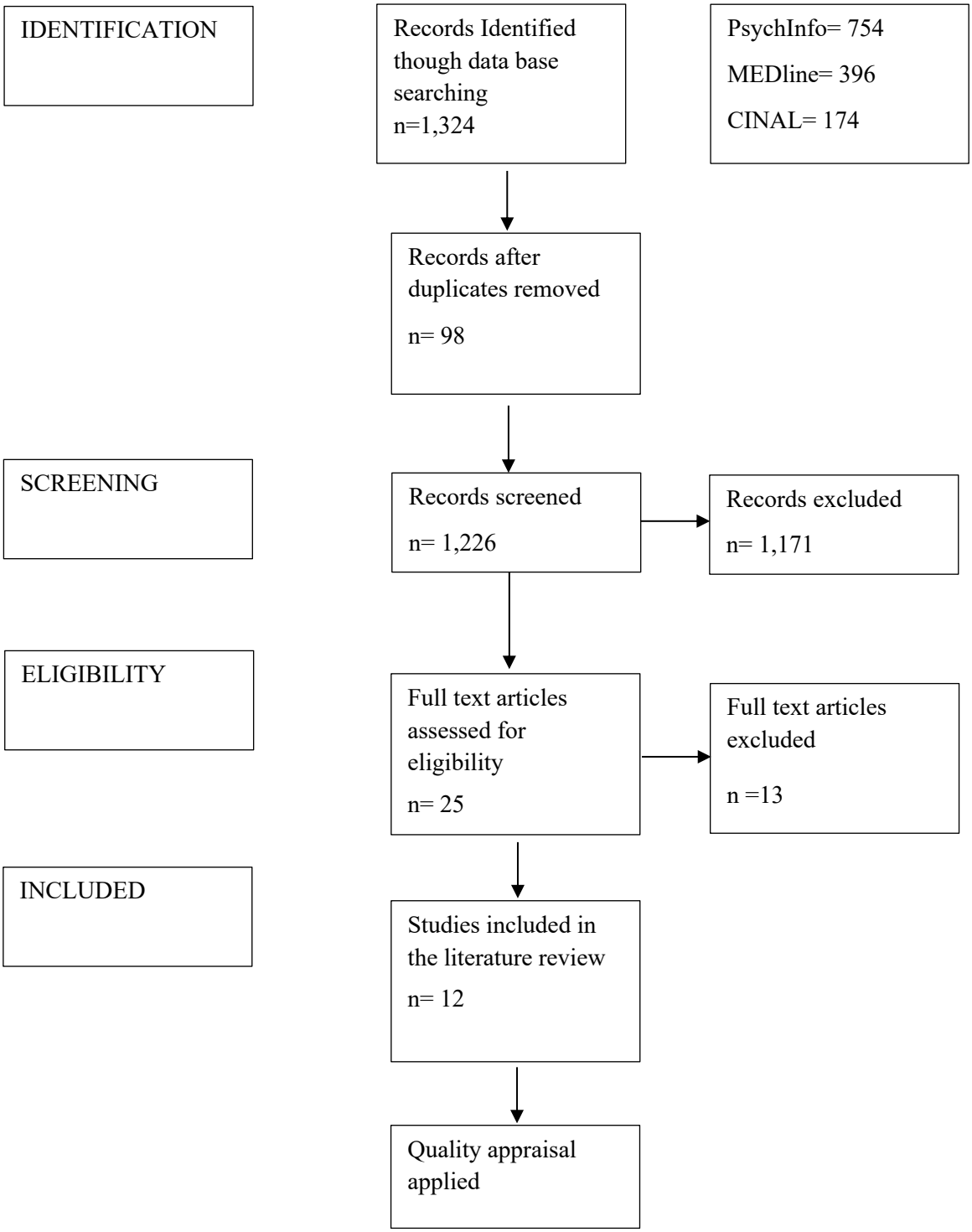
6. Supporting Information

BJC is happy to accept articles with supporting information supplied for online only publication. This may include appendices, supplementary figures, sound files, videoclips etc. These will be posted on Wiley Online Library with the article. The print version will have a note indicating that extra material is available online. Please indicate clearly on submission which material is for online only publication. Please note that extra online only material is published as supplied by the author in the same file format and is not copyedited or typeset. Further information about this service can be found at http://authorservices.wiley.com/bauthor/suppmat.asp

7. Copyright and licenses

If your paper is accepted, the author identified as the formal corresponding author for the paper will receive an email prompting them to login into Author Services, where via the Wiley Author Licensing Service (WALS) they will be able to complete the license agreement on behalf of all authors on the paper.

Appendix B – Flow chart demonstrating the shortlisting process



Appendix C – Database searches and retrieval numbers

All searches were conducted in August 2018

Database searched	Search terms	Number of articles retrieved
PsyINFO	((Reflective Practice) or (Reflective Supervision) or (Balint groups) or (Schwartz rounds)) and (Professional* or Nurs* or Physician* or Clinician* or GP or Consultant* or Specialist or Psychologist or Therapist)	754
CINAL	((Reflective Practice) or (Reflective Supervision) or (Balint groups) or (Schwartz rounds)) and (Professional* or Nurs* or Physician* or Clinician* or GP or Consultant* or Specialist or Psychologist or Therapist)	174
Medline	((Reflective Practice) or (Reflective Supervision) or (Balint groups) or (Schwartz rounds)) and (Professional* or Nurs* or Physician* or Clinician* or GP or Consultant* or Specialist or Psychologist or Therapist)	396
Total		**1,324**

Appendix D - Inclusion/ exclusion criteria

Inclusion criteria	Comment
Study: Published in Peer reviewed journal? Publication date between 2013-2018? Published in English?	
Context: Health and social care professions / training	
How:	
Issue of Interest: Does the study address reflective practice	
Population: Health/ social care students or professionals	
Analysis: Does the study employ a quantitative statistical analysis? Or a named qualitative method of analysis? Adequate description of methods used? Systematic and replicable?	
Findings: Are the findings are explicit? Are the implications for future research discussed? Are findings related to existing theoretical perspectives?	

Appendix E - Data extraction tool

Title:		
Authors:		
Publication Date:	Place of Publication:	
Journal		
Volume:	Number:	Pages:
Aim:		
Sampling / Participants: *(Total number of participants? Age range, who was studies, how was the sample recruited? Response rate?)*		
Study Type / Design: *(Randomised allocation? Is a control group used?)*		
Outcomes and Measures: *(What outcomes are being measured? What measures are used?)*		
Method/ analysis:		
Analysis: *(What statistical methods were used?)*		
Findings *(Clear, relate to aims):*		
Controls / Validity/ Reliability:		
Conclusions: *(What do the findings mean? Implications and for theory and future research?)*		
Additional Comment:		

Appendix F - Methodology and sample characteristics of included studies

Author/ title /year	Location	Aims/ Research Questions	Reflective practice being implemented	Method	Analysis	No/ Type of participant	Key findings relevant to the review	CASP score (out of 20)
1. Binks, Jones & Knight (2013) Facilitating reflective practice groups in clinical psychology training: a phenomenological study	United Kingdom	To explore group facilitators' perspectives, with a focus on how they made sense of (1) trainee distress, (2) the relationship between distress and outcome and (3) their facilitation role.	Participants in this study had facilitated reflective practice on a UK clinical psychology training course over the last 10 years. They had been qualified between 15 and 25 years and had facilitated between one and three reflective practice groups	Semi-structured interviews	IPA	Seven Qualified clinical psychologists who had facilitated reflective practice within clinical psychology training programme at a single university in the UK.	Three master themes: conceptualising the meaning and value of trainee distress/difficulty; complexity and challenge of the group boundaries; and experience of the facilitator's role. Distress during such groups may play an important part in the learning process for many trainees but need skilled facilitation in order to create a safe learning environment.	**19**
2. Brown, McNeil & Shaw (2013) Triggers for reflection: exploring the act of written reflection and the hidden art of reflective practice	United Kingdom, North of England	Explore how specialist trainee doctors engage in reflective practise and in particular how they use their e-portfolio to evidence this.	Participants had been recording reflection on an e-portfolio system as part of their studies. The length of time	Semi-structured interviews	Thematic Framework Analysis	Fifteen First year core medical trainees.	Four categories emerged from the qualitative analysis: help/hindering forces; strategic and superficial entries; triggers for reflection; and the role of others, including Educational Supervisors. This study identified	**11**

in postgraduate medicine.			they had engage with this practice was not reported in this study.				clear triggers for reflection but the art of writing it down often seems superficial, sometimes hurried, sometimes selective and often strategic.	
3. Fisher, Chew & Leow (2015) Clinical Psychologists' use of reflective practice within clinical work	Singapore	To understand how clinical psychologists experience reflection and reflective practice in their day to day clinical role.	This study did not report the details of the reflective practices which participants undertook or the length of time they had been doing so.	Semi-structured interviews	IPA	Six Qualified clinical psychologists practicing in Singapore	Superordinate Themes: -Reflecting on reflection -Knowing myself and my impact -My client and our relationship -My professional identity and the roles that I fulfil.	**17**
4. Lutz, Scheffer, Edelhaeuser, Tauschel & Neumann (2013) A reflective practice intervention for professional development, reduced stress and improved patient care – A	Germany	To evaluate students' perceptions of the helpfulness of the Clinical Reflection Training (CRT) and its effects on their medical education.	Participants had engaged in five 90 minute Clinical Reflection Training Sessions.	Semi-structured interviews	Thematic Content Analysis	Eighteen Medical students who has participated in the CRT. 12 female/ 6 male Mean age 28	Helpful features of the CRT: a secure space, focus on current and real problems, supportive group, experienced and supportive trainer.	**17**

qualitative developmental evaluation								
5. McKensey & Sullivan (2016) Balint groups – helping trainee psychiatrists make even better use of themselves	Australia	To test whether, in their training setting, it was possible for a cohesive group to form, such that trainees could make use of a Balint group experience.	Participants had met for three 90 minute Balint groups run on consecutive weeks.	Questionnaire with 13 open ended questions	Thematic Analysis	Nine Psychiatry trainees	Trainee's reported feeling less alone in their clinical work and also expressed learning to use and understand emotion clinically.	**8**
6. Murray & Leadbetter (2018) Video Enhanced Reflective Practice (VERP): supporting the development of trainee educational psychologists' consultation and peer supervision skills	United Kingdom	To seek trainee EP's views about their experience of using VERP to support their professional development.	Participants engaged in three cycles of Video Enhanced Reflection Practice following two days of Video Interactive Guidance training.	Semi-structured interviews	Hybrid Thematic Analysis (Fereday & Muir-Cochrane, 2006)	Opportunistic sample of trainee Educational Psychologists and Video Interactive Guidance supervisors.	Participants highlighted the relationship between the reflective practice guider and trainee as being central, enabled observing themselves in practice in a safe and productive way.	**13**
7. Newcombe, Burton & Edwards (2018) Pretending to be authentic:	Australia, University of South East Queensland	To explore the experience of engaging in a reflective writing assessment for students who have a	Participants had engaged in reflective writing for assessment on at least one	Semi-structured interview	Thematic Analysis	Twenty Undergraduate students in Social Work at the University of South	The influence of the power imbalance between the student and academic marker. The risk involved in	**11**

challenges for students when writing reflectively about their childhood.		history of adverse childhood events.	occasion as part of their professional training			East Queensland	writing a personal reflective essay for assessment. Issues with judgement and 'ticking boxes'.	
8. O'Reilly & Milner (2015) Transitions in reflective practice: exploring student development and preferred methods of engagement	Australia	To explore whether different technology-based methods supported student growth and skill development in reflective practice at separate developmental time points.	Participants had engaged with e-journals, group blogs and online reflective summaries as part of their professional training	Mixed methods – questionnaire with both qualitative and quantitative response styles	Brief Thematic Inquiry Descriptive statistics Independent t-test	Fifty-five Third (23) and forth year (22) dietetics students	Difference in the ways in which students engaged in reflective practice between third/ fourth year. Fourth year students used more independent methods, also described fewer negative opinions/ barrier to reflection compare to third years.	**12**
9. Shae, Goldberg & Weatherston (2016) A community mental health professional development model for the expansion of reflective practice and supervision: evaluation of a pilot training series for infant	United States of America	To provide preliminary findings regarding the impact of the reflective practice pilot training series on the self-efficacy and skills of Infant Mental Health clinicians.	Participants had all undertaken reflective supervision training, the study did not record the number of reflective supervision session that participants had	Longitudinal Questionnaire study.	Paired samples t-tests	Twenty-nine Including 13 Infant Mental Health supervisors and 16 Infant Mental Health supervisees.	Clinicians demonstrated an increase in the frequency of their reflective practice skills and supervisors demonstrated an increase in self-efficacy regarding their reflective supervisory tasks.	**15**

mental health professionals			undertaken following the training.					
10. Tomlin, Weatherston & Pavkov (2014) Critical components for reflective supervision: Responses from expert supervisors in the field	United States of America	To gain a definition of best practice when engaging in reflective supervision	Expert participants in this study included those who had or presented at professionals conferences about their experiences using reflective supervision. Some experts had experience providing reflective supervision or mentorship, individually or in groups, to mental health and non-mental-health professionals.	Researcher designed survey	Delphi Method	Thirty-five Experts in the field of reflective supervision	*Qualities a Supervisor Demonstrates* *Behaviors a Supervisor Demonstrates.* *Mutual Behavior and Qualities* *Structure of Reflective Supervision Sessions* *Process of Reflective Supervision Session* *Behaviors/Characteristics a Supervisee Demonstrates* Centrality of trust/ safety/ confidentiality or security within the supervisory relationship. Supervisor qualities are key – compassionate/ non-judgemental/ tolerant/ engaging	**18**
11. Veen & de la Croix (2016)	The Netherland	To describe the structure and	The data set comprised of	Naturalistic data,	Conversation Analysis	47 sessions of 13 groups, resulting in	Transitions are an arena for negotiations between	**16**

Collaborative Reflection Under the Microscope: Using Conversation Analysis to Study the Transition from Case Presentation to Discussion in GP Residents' Experience Sharing Sessions	s	characteristics of group reflection by describing transitions in interactions.	47 reflective practice sessions of 13 groups, resulting in 76 hours of video recording. The sessions, comprising five to 14 residents per group. The number of groups that individual attendees had taken part in was not reported.	recorded group reflective practice sessions		76 hours of video recording. The sessions, comprising five to 14 residents per group, were recorded.	case presenter, participants, and tutors, in which knowledge and the right to take the floor play an important part. The tutor can have different interactional roles, namely, that of teacher, expert, facilitator, and active participant. The role of the tutor is important as the tutor's interactional behavior is part of the hidden curriculum.	
12. Woodward, Keville & Conlan (2015) The buds and shoots of what I've grown to become: the development of reflective practice in Trainee	United Kingdom	How do newly qualified CPs experience their personal and professional identities during doctoral training?	The specifics of the Reflective Practice undertaken by participants during training was not reported.	Semi-structured interviews	IPA	Seven Newly qualified CPs 1-2 years post qualification 3 men 4 women Late 20's-late 30's "diverse ethnic and national	Superordinate themes: *Enhancing awareness of self and others; Taking risks and managing uncertainty; Developing self-acceptance* Learning to manage uncertainty and take risks within relationships was seen to	**18**

Clinical Psychologists						background”	contribute to reflective practice, as CPs may be more able to attend to process issues within the therapeutic context. Furthermore, greater self-awareness seemed to help trainees find a balance between self-development and self-acceptance.	

Appendix G – Table showing included/ excluded articles according to CASP score

	Study Number											
CASP Criteria	**1.**	**2.**	**3.**	**4.**	**5.**	**6.**	**7.**	**8.**	**9.**	**10.**	**11.**	**12.**
1. Clear statement or aims	2	2	2	2	2	2	2	2	2	2	2	2
2. Chosen methodology is appropriate	2	2	2	2	2	2	2	2	2	2	2	2
3. Appropriate research design	2	1	2	2	0	2	1	2	2	2	2	1
4. Appropriate recruitment strategy	2	1	1	2	1	2	1	1	2	2	1	1
5. Consideration of data collection	2	1	2	1	0	1	1	1	1	2	1	2
6. Consideration of research relationship/ biases	1	0	0	1	0	0	0	0	0	1	1	2
7. Ethical issues considered	2	0	2	1	0	0	1	0	0	1	1	2
8. Rigorous data analysis	2	1	2	2	0	1	1	1	2	2	2	2
9. Findings clearly stated	2	2	2	2	2	1	1	2	2	2	2	2
10. Value of the research	2	1	2	2	1	2	1	1	2	2	2	2
Total score	**19**	**11**	**17**	**17**	**8**	**13**	**11**	**12**	**15**	**18**	**16**	**18**

Scoring criteria

A score was allocated to each area from 0-2. A score of 0 was assigned to each CASP element if the article gave little or no information, a score of 1 was assigned if there was moderate information but more detail could have improved it and a score of 2 was allocated if there was sufficient information provided and demonstrated a rigorous and replicable method. Articles were compared on the total score out of 20. This allowed for a comparison of the quality of papers to be conducted and incorporated into the systematic review and synthesis of studies later.

Appendix H* - Statement of epistemological position

A considerable number of epistemological positions underlie the use of qualitative research methods (Guba & Lincoln, 1994). The orientation adopted in the current study is one of 'contextual constructivism' (Solomon, 1987; Sutton, 1989). In a contextual constructionist stance knowledge is understood as both culturally and historically specific; that meaning is constructed between people and that language is the mechanism through which we make sense of experience (e.g. Burr, 2003). This is not to say that there is a single discourse to which individuals or groups subscribe; discourses may come together and influence how people how people view themselves and others. The discourses that influence an individual's perspective may be shaped by their cultural identity across a variety of domains for example, social class, economic status, religion, ethnicity, geographical location and gender (Cobern, 1993).

Appendix I – Reflective Practice Seminar Recording Consent Form

We, Anya Biggins and Arabella Kurtz, would like to record our monthly reflective practice seminars. The purpose of this is to enable systematic reflection on an understudied activity related to the promotion of good clinical practice, with the potential to use selected material for a future research project after ethical approval has been sought and with the full consent of the group

As discussed, material will remain the property of the group. The group as a whole will take decisions regarding inclusion of materials in the potential research. Any plans to seek outside supervision or discussion of the materials outside of group members will only be taken after group discussion. Where there are any concerns about sensitive information being shared, we can review the situation at any point during recording. Recorded materials will not be disseminated in any way and will only be used as a source of data with the explicit consent of all group members

You are free to decide that you want to review or change this arrangement at any point.

By giving your permission to be recorded, you are agreeing for a single digital record of our seminars to be kept in a locked cabinet in Arabella's office. The current plan is that these recordings will be deleted on the completion of our cohort's training.

Name: _____

Signature: _____

Date: _____

From: Anya Biggins, Trainee Clinical Psychologist, and Dr Arabella Kurtz Senior Clinical Tutor & Honorary Senior Lecturer, University of Leicester Clinical Psychology Doctoral Programme, 104 Regent Road, Leicester LE2 3HP.

Appendix J – Interview guide and sample vignette

1. Interview Guide

Q: What has been your experience of Reflective practice on the course over the last two years?

P: Can you give me an example of that?

Q: What impact has reflective practice had on how you think about your clients?

P: Can you give me an example?

Q: To try and recapture the experience of being in reflective practice, and to help jog your memory I have prepared a short summary of one / two RP session in which you presented a case. I have then selected a small clip to play to you. Then maybe we can speak about your reflection on that experience?

P: Share vignette style summary of the session.

P: Play selected clip on Dictaphone.

Q: What is your memory of the seminar?

Q: Can you tell me about your experience of sharing the case with the group?

P: What was your reaction to hearing the group's reflections of your case?

Q: Did presenting the case in RP have any impact on your understanding of your client/ clinical work?

P: Did this feel helpful?

P: Why do you think that was?

Repeat summary/ clip for seminar two

Q: Did the seminar in Year 1 and the one in Year 2 feel different to you?

P: If so how?

P: Why do you think that is?

2. Sample Vignette

Maxine was referred for pain in her hip but there was a sense that this pain was not the focus for her. In your sessions she spoke predominantly about difficulties with her son, and she seemed to take control of the sessions. You shared your feelings of irritation and how this was a departure from your usual style of relating to clients. The group had various differing reactions to the image of Maxine you shared, and you spoke about feeling guilty that it was difficult to hold on to a compassionate understanding of Maxine.

Appendix K* - Extract from reflexive research diary

To illustrate the process of reflexivity the following extract of the researcher's dairy has been included below. This entry was made while the researcher was defining the final theme structure of her analysis.

> *"seems as though feeling you're in the right or in the wrong is more pronounced in the early stages of the group, but it doesn't quite disappear, it doesn't feel as neat as that. And even when it's not there participants are explicitly saying it's not there, it's still in their mind. I wonder if there is still a worry it might come back or it's somehow under the surface. I find myself thinking of layers of rock forming at the bottom of the sea, but that's not right because once a layer is formed you can't get back to it. Participants can take the multiple perspectives but being right or wrong is still there, maybe it's not rock yet, it's just under the surface of the water, floating around like sediment"*

The diary extract illustrates the researcher's uncertainty about how the themes she had identified might fit together; whether they could be seen within a developmental model of reflective practice or if more distressing elements of reflective practice remained even as the group developed over time.

Appendix L* – Samples from all stages of the analysis

1. **Sample of annotated transcript**

Initial Inductive Themes	Interview Transcript	Exploratory Comments Descriptive Comments *Conceptual Comments* **Linguistic comments**
Am I in the wrong? Being on the outside Am I in the wrong?	and just generally (.) erm and just kind of (.) I do really **vividly** remember that feeling of **everyone** else talking about her in a way that I hadn't considered before and I had that real feeling of oh my goodness I've come in and sort of (.) shared this really quite unkind kind of reflection of this woman and **everyone else** has held this really compassionate view and just feeling like of god I just feel **really feel** terrible about it erm which I think is (.) erm kind of both a reflection on erm how it can be for different people to hold different perspectives on a case you're working on but also kind of **personally** on the fact that	**Vivid repeated – clarity of memory** New, unconsidered view taken by others *Odd one out? Us and them?* **Repetition of everyone else** Own view as unkind – *value judgement, is it ok to find a client difficult or annoying and have unkind thoughts about them?*

Being wrong as not being good enough	that from those discussions that's a thing that I interpreted as that I'd done something wrong and that's just a position that I take more generally anyway (laughs) quite often so (.) so yeah I do remember that feeling I: And so that being your kind of first experience of presenting can you tell me anymore about what that was like for you in terms of sharing the case and then listening to the reflective practice group P: Yeah I think sharing the case felt quite difficult it felt like what are the bits that I need to give you and that felt really important to tell you a **good enough** story of this woman so you can sort of do what you need to do	Feeling terrible about own view of Maxine Multiple perspectives *An idea of there being a right/wrong* **Laughing – awkwardness saying this? Or common experience** Position taken of self in the wrong *Common narrative about self* Difficulty/pressure to share a 'good enough' story **Good enough** – *Winnicott? Links to being a good enough trainee discourse*

2. Inductive themes identified for each participant

Sophie

Themes	Quotes
Am I in the wrong?	"there was a right story and a wrong story and I had given the wrong story and everyone else had given the right story that's kind of what it felt like then"
Feeling exposed in reflective practice	"I had that real feeling of oh my goodness I've come in and sort of (.) shared this really quite unkind kind of reflection of this woman and everyone else has held this really compassionate view and just feeling like of god I just feel really feel terrible about it erm which I think is"
Seeing thorough multiple lenses	"as if you were wearing a pair of glasses with lenses in… it's like another sort of filter had been put in those lenses like… so I was seeing her through both my initial feelings towards her but also the groups' reflections of her" "the position that I was holding was one of those and that the positions and reflections of other people just represented other aspects and other truths about the case not that one was right or one was wrong"
Connecting with what is being communicated	"I suppose be more in touch with that root message that she was giving of I'm really fighting here… when I responded to that feeling… I think she kind of relaxed into the therapy"
Building meaning from emotional responses	"reflective practice has taught me not to afraid of doing maybe that that is part of the work how I feel about that work with Amy is as important as important as what I'm doing practically with her it's ok to share and talk about that"

Ellen

Themes	Quotes
Finding a voice in reflective practice	"I guess when you're bringing s case there's a definite role for you in reflective like you can see what your role is it's really clear isn't it (.) erm but then when you aren't in that role (.) while the groups was kind of feeling like it was developing it was difficult to necessarily be able to work out kind of my own role"
I've got to get it right (not be in	"didn't necessarily have the confidence in terms of my role

the wrong)	as kind of first year and several months in trainee (.) kind of feeling like oh I've got to do this right"
Space to take multiple perspectives	"thinking about her more broadly than just the cognitive assessment erm I think about attachments and thinking about her relational needs and how she does relationships erm (.) which has not really had space on placement"
Building meaning and seeing value in emotional responses	"having validation from other people that says this is this feeling you're having does have some value it does it does have a place to be able to raise that question"
Exposing your uncertainty in reflective practice	"there was a slight sense of not knowing exactly what what to offer how much to detail to give or how much or like what kind of bits are most relevant and kind of my stuff getting that balance right"

Jessica

Themes	**Quotes**
Taking a wider view	"I think it just widens up your perspective of how maybe different people have responded to him before how people experience him but also thinking why didn't I pick up on that or is there something then that is a sort of blind spot for me"
Being free enough to be exposed	"Possibly our own sort of barriers have why are we here are we good enough can we say these sorts of things have probably gotten a little bit freer maybe a little bit more disinhibited erm so there's thought to it which probably makes us feel a little bit more relaxed"
The vulnerability of getting it wrong	"Like well you're crap you didn't see that and you're working with someone I think to say that you have to feel quite comfortable like I missed that and I hadn't picked up on that and it can it could feel really vulnerable"
Putting words to feelings and finding value in the feelings	"I can't remember who first used the phrase inevitable but that really clicking for me that I'd felt something erm I had portrayed something through what I'd said and thinking that's exactly what this is that inevitability and that sort of labelling that for me was something that's definitely carried on through sessions"

Becca

Themes	Quotes
Connecting with the client and finding compassion	"I think I was more compassionate towards him and more understanding and I think I took more notice of actually all his history because he told me lots of stuff which just didn't seem to I it was hard to hold on to so I knew lots of things that had gone on in his past but I suppose that was really hard to hold on to"
Paying attention to emotional responses and seeing their value	"that feeling of coming out confused and overwhelmed and rather than just sort of dismissing that and carrying on doing the notes and thinking about maybe the practicalities of that it was more around I actually thought about why is it that I feel like that about that person and think what what is that about what sense do I make out of that how does that link to the formulation"
Needing consistency to feel safe in reflective practice	"I think the sharing the personal experience that sort of you could tell that we'd become a lot more comfortable with each other and it felt more ok to think about sort of our own personal experiences… we've had regular reflective practices they're always the same time you know when they're coming sort of we know who's in the group it's a consistent group every single time generally unless somebody's off ill but there's no extra people that are ever there erm for me it feels that it's just consistency it's knowing what to expect"
The pressure to 'get it right'	"I put a lot of pressure on myself that these sessions were going to be perfect that these were going to be goal focused and these were going to be this is what we do every session and I'm gonna do a really nice write up of it and things are going to be different at the end erm so yeah that trainee status along with the course requirements and those things definitely impacted I suppose reflective practice helped step out of that a little bit"

Rose

Themes	Quotes
Showing that you've got it right	"I'm a competent trainee and look at this case I've brought and look at my wonderful formulation look how this maps on and I'm sure it would have been nice to have ooh it look like you're doing a good job there

	with that"
Being exposed and vulnerable in reflective practice	"I'm in a room with someone with no idea what's going on and who she is and what she's doing and some in some ways it felt like we were just lost like there were there were two lost people in the room not knowing what to do erm and I suppose almost presenting that and letting people see that in a reflective space is quiet exposing"
Finding value in multiple view points	"you don't get this sense of oh everyone's just saying the same thing just to go along a cahoot of people saying the same thing and you're like oh I didn't see any of that it does feel like and its ok to have difference erm (.) so I think there's definitely been times when I've felt a mirror the way I another person has felt in the group but then there's equally been times where I'm like oh I didn't get any of that like for me this came up erm and I think the group really fosters that and it isn't that anyone is right or wrong or sees it better than somebody else I think it just enables all these different breaths of experience and viewpoints to come in"
Connecting with the perspective of the client, finding empathy	"my response was different in terms oh being like ahh or quite frustrated I think I was a lot more able to hold on to actually how difficult is it for you to sit on a room with me (.) erm… and actually I would want to avoid that as well because this isn't easy for you and your whole experience of professionals is probably not always been very helpful erm (.) and there's a part of you that does want help but doesn't know how to let go of the stuff to get the help and I think it just helped me to hold on to that little bit perhaps more"
Being given permission to have an emotional reaction to clinical work	"it's and I think because the facilitators they will talk about their feelings… and I think that is quite a big I guess that modelling that they will talk about how they've processed information you've given so it kind if feels like then you have (.) permission to do the same and to process your own feelings either about hearing material or presenting material"

3. Master themes

Master themes	Themes from individual participants
Am I in the right or in the wrong?	Sophie – A I in the wrong Ellen – I've got to get it right (not be in the wrong) Jessica – The vulnerability of getting it wrong Becca – The pressure to 'get it right' Rose – Showing that you've got it right
Moving between looking for the right answer and taking multiple perspectives	Sophie – Seeing thorough multiple lenses Ellen – Space to take multiple perspectives Jessica – Taking a wider view Rose – Finding value in multiple viewpoints
Sharing practice experience is never risk free	Sophie – Feeling exposed in reflective practice Ellen – Exposing your uncertainty in reflective practice Jessica – Being free enough to be exposed Becca – Needing consistency to feel safe in reflective practice Rose – Being exposed and vulnerable in reflective practice
Connecting with the view-point of the client and finding compassion	Sophie – Connecting with what is being communicated Becca – Connecting with the client and finding compassion Rose – Connecting with the perspective of the client, finding empathy
Building a sense of meaning from emotional responses to clinical work	Sophie – Building meaning from emotional responses Ellen – Building meaning and seeing value in emotional responses Jessica – Putting words to feelings and finding value in the feelings Becca – Paying attention to emotional responses and seeing their value Rose – Being given permission to have an emotional reaction to clinical work

Appendix M* – Confirmation of ethical approval

/
University Ethics Sub-Committee for Psychology

14/02/2018

Ethics Reference: 14797-ab895-ls:neuroscience,psychology&behaviour

TO:
Name of Researcher Applicant: Anya Biggins
Department: Psychology
Research Project Title: Does group reflective practice change practitioners understanding of clients? An Interpretative Phenomenological Analysis of the impact of monthly reflective practice groups within clinical psychology training.

Dear Anya Biggins,

RE: Ethics review of Research Study application

The University Ethics Sub-Committee for Psychology has reviewed and discussed the above application.

1. Ethical opinion

The Sub-Committee grants ethical approval to the above research project on the basis described in the application form and supporting documentation, subject to the conditions specified below.

2. Summary of ethics review discussion

The Committee noted the following issues:
This application has been approved.

3. General conditions of the ethical approval

The ethics approval is subject to the following general conditions being met prior to the start of the project:

As the Principal Investigator, you are expected to deliver the research project in accordance with the University's policies and procedures, which includes the University's Research Code of Conduct and the University's Research Ethics Policy.

If relevant, management permission or approval (gate keeper role) must be obtained from host organisation prior to the start of the study at the site concerned.

4. Reporting requirements after ethical approval

You are expected to notify the Sub-Committee about:

- Significant amendments to the project
- Serious breaches of the protocol
- Annual progress reports
- Notifying the end of the study

5. Use of application information

Details from your ethics application will be stored on the University Ethics Online System. With your permission, the Sub-Committee may wish to use parts of the application in an anonymised format for training or sharing best practice. Please let me know if you do not want the application details to be used in this manner.

Best wishes for the success of this research project.

Yours sincerely,

Prof. Panos Vostanis
Chair

Appendix N* – Evidence of University of Leicester sponsorship

1. Letter confirming sponsorship

UNIVERSITY OF LEICESTER

Research & Enterprise Division
University of Leicester
Research Governance Office
Fielding Johnson Building
University Road
Leicester
LE1 7RH
Email: uolsponsor@le.ac.uk
Admin Tel 0116 373 6410 / 223 1660

14 February 2018

Ms Anya Biggins
Trainee Clinical Psychologist
Leicestershire Partnership NHS Trust
Work Address Riverside House
Bridge Park Plaza, Bridge Park Road
Thurmaston, Leicester
LE4 8PQ

Dear Ms Anya Biggins

Ref: **UOL0651/ IRAS project ID: 232345**
Study title: **Does group reflective practice change practitioners understanding of clients? An Interpretative Phenomenological Analysis of the impact of monthly reflective practice groups within clinical psychology training.**
Status: **Approved**
End Date: **27/09/2019**

I am pleased to advise you that following confirmation of a Favourable Opinion from University Ethics Committee, and where relevant regulatory authority agreements have been received, the University are able to confirm sponsorship for the above research at the above site.

Please note you are required to notify the Sponsor and provide copies of:

- Changes in personnel to the Study
- Changes to the end date
- All substantial amendments and provisional and favourable opinions
- All minor amendments
- All serious adverse events (SAEs) and SUSARS
- Annual progress reports
- Annual MHRA (DSUR) safety reports (if applicable)
- End of study declaration form
- Notifications of significant breaches of Good Clinical Practices (GCP)or Protocol

If your study is adopted onto the Clinical Research Network Portfolio please ensure that your recruitment figures, end dates and study status are the same on the EDGE database and Open Database Platform (ODP) CPMS.

Please copy the Sponsor into all correspondence and emails by using uolsponsor@le.ac.uk.

Please note it is essential that you notify us as soon as you have recruited your first patient to the study.

I would like to wish you well with your study and if you require further information or guidance please do not hesitate to contact me.

Yours sincerely

Dr Michelle Muessel
Research Governance Manager

2. Confirmation of Indemnity Insurance

Our Ref: cas54 2017-2018 – 378

10th January 2018

ESTATES AND FACILITIES MANAGEMENT DIVISION
University Road
Leicester
LE1 7RH
Tel: +44 (0)116 229 7631
Fax: +44(0)116 229 7633

To whom it may concern,

UNIVERSITY OF LEICESTER CLINICAL TRIAL/PROFESSIONAL INDEMNITY INSURANCE

Title of Study – Does group reflective practice change practitioners understanding of clients? An Interpretative Phenomenological Analysis of the impact of monthly reflective practice groups within clinical psychology training.

Chief Investigator – Ms Anya Biggins

I confirm that the University of Leicester will provide Clinical Trials and Professional Indemnity insurance cover in respect of its legal liability in relation to the above trial within the UK only.

Any significant departure from the programme of research as outlined in the application (such as changes in methodological approach, large delays in commencement of research, additional forms of data collection or major expansions in sample size) must be communicated to us.

The cover is provided subject to normal policy terms and conditions.

Carol Maguire

Carol Maguire
Insurance Officer

University of Leicester

Appendix O* – Participant information sheet

Study Title: **Does group reflective practice change practitioners understanding of clients? An Interpretative Phenomenological Analysis of the impact of monthly reflective practice groups within clinical psychology training**

Introduction

You are being invited to take part in a study. Before you decide whether to do so, it is important that you understand the research that is being done and what participation will involve. Please take the time to read the following information carefully. Do not hesitate to ask me anything that is not clear or for any further information you would like to help you make your decision. Please do take your time to decide whether or not you wish to take part.

Who is involved?

The study is being carried out by Anya Biggins, Trainee Clinical Psychologist, as part of a Doctoral qualification in Clinical Psychology. The study is supervised by Dr Arabella Kurtz (Senior Clinical Tutor and Consultant Clinical Psychologist).

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and asked to sign a consent form. The original consent form will be stored by the Chief Investigator at the university and you will be given a copy if you decide to take part you are still free to withdraw at any time and without giving a reason. This will not affect your membership of the reflective practice group and this information will not be shared with other group members. Deciding not to participate in this research will not affect your attendance of reflective practice seminars or your completion of the Doctorate of Clinical Psychology as a whole.

What is the purpose of the study?

Reflective practice groups are one of the most common methods of promoting professional development on UK clinical psychology training programs. There has been a limited amount of published research exploring clinical psychologists' experiences of attending reflective practice groups throughout their training. Furthermore, there is little research focusing on how engaging in reflective practice impacts on trainee' understanding of their clients and the therapy that they undertake with them.

The aim of this study is to explore the experiences of trainee clinical psychologists attending a reflective practice group during their training to address the main questions. These are: Does group reflective practice discussion impact on the understanding of the client for the group member who

presents? If so, what is the nature of this impact? How does this happen within the reflective practice group?

Interviews will be used to engage participants in a conversation about their experiences within the reflective practice group. Excerpts from the previously recorded reflective practice group discussions will be used in the interviews to prompt discussions. The interview data will be analysed using Interpretative Phenomenological Analysis (IPA). This method of analysis focuses on understanding the experience of an individual in-depth through close and repeated readings of the transcribed interviews.

What if I am interested in taking part?

If you are interested in taking part, you can contact me by telephone/email (contact details below). We can then discuss any further questions you may have about the study. Once we have spoken you can decide whether you would like to take part in the study.

If you change your mind during the study, you can withdraw at any time without giving a reason. If you decide to withdraw from the study at a later time, your data will be destroyed. You can withdraw your data from the study up to 3 months after taking part.

What will happen to me if I take part?

Once you have agreed to consent to take part in the study, the first thing to happen will be to arrange a meeting with me. This will involve a discussion about your interests in the research and any areas you have concerns about. This will be an opportunity to discuss any topics that you do not feel comfortable discussing in the recorded interview. These concerns will be recognised and your choice to exclude specific topics from the interview will be respected. Following this meeting a face-to-face interview will be organised. It is anticipated the interview will last for 60-90 minutes. The interview will take place at a time and location that is convenient for you. The interview will focus on your experience of attending reflective practice groups during your clinical training. In addition, it will explore how you have experienced reflective practice in relation to your understanding of the clients you have discussed. Your interview will be audio recorded and then transcribed by me. In the event that I use a transcription service I will endeavour to use a reputable one and will make sure that a confidentiality agreement is signed. The data will be stored on a password protected and secure computer.

At the end of the interview we can have a debrief to discuss your experience of the interview, and any questions you may have.

Where will the interview happen?

The interview will happen at a place and time convenient to you, such as your home address or a private room at The University of Leicester.

Is what I say in the interview confidential?

Yes, it is. If you agree to take part in the study your information will be stored in a safe locked location which will only be accessible by the researcher named above. All data will be strictly confidential and anonymised, which means that no names or identifying features will be kept with any of the study information. A randomly assigned coded number and pseudonym will be given to each participant and stored on a password protected document on a secure computer.

The project may be published in a research paper and if your stories are used in the research your identity will be anonymised by changing your name and other details that would identify you. The only time that information cannot remain confidential is if there are serious concerns that you or someone else is at risk of harm.

Data may also be accessed by authorised individuals from the sponsor or host sites for monitoring and audit purposes.

What are the possible disadvantages, risks or side effects of taking part?

The possible disadvantages, risks or side effects to all participants have been considered. It is unlikely but it is possible that you may find the interview process distressing. In order to protect your welfare, I will aim to carry out interviews sensitively and take things at your pace. If you were to get very distressed, I would take this to my supervisor who, together with the co-facilitator of the reflective practice seminar would meet separately with you to think about how to manage the situation.

It is very unlikely that you would be harmed by taking part in this type of research study. However, if you wish to complain or have any concerns about the way you have been approached or treated in connection with the study, you should ask to speak to Anya or Arabella (contact details below) who will do their best to answer your questions. If you remain unhappy and wish to address your concerns or complaints on a formal basis, you should contact a member of the Clinical Psychology course team or the University of Leicester Research Governance Office.

What are the possible benefits of taking part?

The benefits of taking part in the research are to help understand the experiences of clinical psychologists training at the University of Leicester. Specifically, the experience of reflective practice groups and how these experiences may impact upon clinical understanding of clients. It is an

opportunity to have your experience heard and understood and may be useful for the university in terms of thinking about the usefulness of this part of the training programme. This will be helpful for researchers, healthcare professionals in general and to the profession of clinical psychology.

What will happen to the data collected within this study?

After all the data is collected, it will be analysed, and the study findings will be written in a thesis for doctoral-level research. An article will then be written and submitted to a relevant academic psychology journal for publication. There will be no identifying features or names written in the thesis or academic journal. There may be some direct quotes cited from the interview. However, anonymity and confidentiality will be maintained by altering any identifying information.

Who has reviewed this study?

The Chief Investigator will submit an application to the University of Leicester Research Ethics Committee board to seek approval to undertake the proposed study. However as the proposed research will be recruiting trainee clinical psychologists as NHS employees as participants HRA (Health Research Authority) ethical review will be sought. The University of Leicester Research Ethics Committee and the Health Research Authority will review to assess ethical compliance in all areas.

What happens next?

If you decide, after reading this information and asking any questions that you may have, that you would like to take part in the study we can arrange a convenient time for an initial meeting. I will also ask you to read and sign a consent form.

If you would like further information or would like to discuss the details and specifics of the project personally please get in touch with me.

Organisation and funding of the study

The research study is being conducted with the sponsorship of the University of Leicester. During your involvement in this study no travel costs incurred by yourself will be paid.

Who Should You Contact with Questions?

You will be given a copy of this information sheet and the signed consent form to keep. If you have any problems or questions about this study or your rights as a patient in clinical research you should contact:

Anya Biggins ab895@le.ac.uk 07747097261

Arabella Kurtz ak106@le.ac.uk

If you feel that you need some additional support after participating in this study, please contact your GP. The contact details for the Samaritans and MIND are included below:

- Samaritans: 116 123
- Mind 0300 123 3393

Thank you for taking the time to read this information sheet.

Appendix P* – Participant Consent Forms

Title of Project: Does group reflective practice change practitioners understanding of clients? An Interpretative Phenomenological Analysis of the impact of group reflective practice within Trainee Clinical Psychologists' monthly seminars.

Name of Researcher: Anya Biggins

Please initial box

1. I confirm that I have read the information sheet dated 04.01.18 (version 0.2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand what my involvement will entail and any questions have been answered to my satisfaction. ☐
3. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my reflective practice group membership being affected. ☐
4. I understand that all information obtained will be anonymised, that if I have any concerns about being identified by fellow group members further steps will be taken to maintain my privacy and anonymity. ☐
5. I agree that research data gathered for the study may be published provided that I cannot be identified as a subject. ☐
6. I understand that my interviews will be audio recorded and transcribed. ☐
7. I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used. ☐
8. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Appendix Q* – Chronology of the research process

October – December 2016

- Consultation with academic supervisor
- Utilisation of interim consent form with reflective practice group to record monthly reflective practice sessions. Group provide written informed consent for sessions to be recorded.

December 2016 – March 2017

- Initial research proposal
- Developing research proposal

June – September 2017

- Finalised research proposal
- Attended GCP training course
- Attended Informed Consent for Research training course

September – December 2017

- Internal peer review at the University of Leicester
- Service User Reference Group (SURG) review of proposal
- University of Leicester ethics application

January – June 2018

- Favourable decision from University ethics committee
- University of Leicester Sponsorship agreed
- Preparation for interviews, excerpt selection, vignettes written
- Semi-structured interviews with participants
- Transcription

June – November 2018

- Stage one of analysis – coding
- Initial Themes

November 2018 – April 2019

- Finalised theme structure
- Write up period
- Submission of thesis to University of Leicester (deadline: 26th April 2019)

May – July 2019

- Viva preparation and viva

July – September 2019

- Dissemination of findings
- Preparation for poster presentation

Appendix R* – Explanation and evidence of how quality, reliability, and validity were assured

A number of guidelines have been suggested for assessing the quality or validity in qualitative research. A number of checklists have been produced, against which a qualitative paper can be assessed by examiners, reviewers or editors. However, this can incur a danger of being over simplistic and more subtle characteristics of a qualitative inquiry can be missed. Smith *et al*. (2009) suggest that the frameworks for assessing quality created by Elliot *et al*. (1999) and Yardley (2000, 2008) offer more nuanced and diverse stance by which to assess quality. Table 1. bellow outlines the four essential qualities outlined by Yardley (2000) as representative of good quality qualitative research.

Table 1. Characteristics of good (qualitative) research

Essential qualities	Examples of the form essential qualities can take
Sensitivity to context	Theoretical; relevant literature; empirical data; sociocultural setting; participants' perspectives; ethical issues.
Commitment and rigour	In-depth engagement with topic; methodological competence skill; thorough data collection; depth/breadth of analysis.
Transparency and coherence	Clarity and power of description/argument; transparent methods and data presentation; fit between theory and method: reflexivity.
Impact and importance	Theoretical (enriching understanding); socio-cultural; practical (for community, policy makers, health workers).

In order to address the quality, validity and reliability of the current study Yardley's (2000) the way in which the current study delivers each principle will be attended to in turn. The first principle is sensitivity to context. The current study attends to the broader context, attending to the current literature relating to reflective practice within the literature review (Section B). Moreover, context of the participants in the research report (Section C) is explored. The rationale for selection IPA as a methodology was based on exploring the idiographic experiences of the participants. Furthermore, sensitivity to context was demonstrated by the extensive thought given to the context within which the research interviews took place, and the acknowledgement of these interview as an interactional

endeavour. The researcher was sensitive to her dual role as a group member and researcher, this context was attended to in depth within the method section of the research report.

Yardley's (2000) second principle of commitment and rigour can be seen throughout the selection and implementation of the chosen methodology. The method section describes in detail the measures that were taken to undertake a high-quality IPA analysis. Furthermore, given the researcher's position as a reflective practice group member, every effort was made to generate a curious and non-defensive analysis of the data. The details of these endeavours can be seen in the method section and are further evidence by the quality of the interpretations offered in the analysis section. The third principle of transparency and coherence that Yardley (2000) puts forward as a marker of quality qualitative research can be seen in the reflexivity employed by the researcher and her supervisor throughout the research report. This is particularly highlighted by the researcher engagement with participant verification, discussed in the method section. Presenting the analysis to the reflective practice group allowed for the spirit of co-production of this project to extend to the analysis stage, remaining open and transparent.

Yardley's (2000) final principle is impact and importance, reflective practice in healthcare practice and training is an area of significant clinical interest. Despite being a practice that is increasingly imbedded in the training of healthcare professionals the empirical literature on reflective practice is in its infancy. Therefore, the impact of the current research in exploring the experiences of those engaging in reflective practice and the impact that engagement on the understanding of clinical work is an important area of research. Gaining a greater depth of understanding of reflective practice and how it can be facilitated to benefit both those taking part and their clients is an area of importance and can impact on both clinical practice and the direction of future research.

References

Elliott, R., Fisher, C. T., Rennie, D. L. (1999). Evolving guidelines for publication for qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 97*, 483-498.

Smith, J. A., Flower, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: Sage.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health, 15*, 215-228.

Appendix S* – Quality appraisal checklists

CASP Criteria	Criteria met	Section/ Page of the current study
1. Clear statement or aims	✓	Introduction
2. Chosen methodology is appropriate	✓	Method
3. Appropriate research design	✓	Method
4. Appropriate recruitment strategy	✓	Method
5. Consideration of data collection	✓	Method
6. Consideration of research relationship/ biases	✓	Method
7. Ethical issues considered	✓	Method
8. Rigorous data analysis	✓	Method/Analysis
9. Findings clearly stated	✓	Analysis/Discussion
10. Value of the research	✓	Discussion

References

Critical Appraisal Skills Programme (2018). CASP Qualitative Checklist. [online] Available at: URL. Accessed: Date Accessed 27/08/2018.

Appendix T* – Checklist to ensure anonymity of clients/services

	Checked in Executive Summary/Abstract/ Overview (if included in assignment)	**Checked in main text**	**Checked in appendices**
Pseudonym or false initials used	✓	✓	✓
Reference to pseudonym/false initials as a footnote	✓	✓	✓
Removed any reference to names of Trusts/hospitals/clinics/services (including letterhead if including letters in appendices)	✓	✓	✓
Removed any reference to names/specific dates of birth/specific date of clinical appointments/addresses/ location of client(s), participant(s), relatives, caregivers, and supervisor(s). [For research thesis – supervisors can be named in the research thesis "acknowledgements" section]	✓	✓	✓
Removed/altered references to client(s) jobs/professions/nationality where this may potentially identify them. [For research thesis – removed potential for an individual research participant to be identifiable (e.g., by a colleague of the participant who might read the thesis on the internet and be able to identify a participant using a combination of the participants specific job title, role, age, and gender)]	✓	✓	✓
Removed any information that may identify the trainee (consult with course staff if this will detract from the points the trainee is making)	✓	✓	✓
No Tippex or other method has been used to obliterate the original text – unless the paper is subsequently photocopied and the trainee has ensured that the obliterated text cannot be read	✓	✓	✓
The "find and replace" function in word processing has been used to check the assignment for use of client(s) names/other confidential information	✓	✓	✓

Appendix U – Issues associated with the role of participant researcher

It is important to consider the multiple positions I encompassed as the researcher within this project as well as a trainee clinical psychologist and reflective practice group member, and the influence of these roles on the research itself. One of the ethical considerations for this project was whether the decision to recruit my own reflective practice group as the sample within this study and concerns that this would have a negative impact on my own ability to freely and openly participate within the process of reflective practice for my own learning. However, I was relatively confident that I would be able effectively manage the demands of being a researcher within the group as well as a participant of the group, and to continue to engage in a genuine manner. Nevertheless, I was concerned about the impact that my role as researcher would have on the decision making of my fellow group members and participants. It is possible that despite my efforts to separate the process of inviting group members to participate in my research from the reflective practice group itself; group members felt a pressure to participate owing to our relationship as fellow trainee clinical psychologists.

Moreover, the role of my research supervisor as co-facilitator of the reflective practice group added an addition dynamic into the undertaking of this research. I was conscious within the interviews that the interviewees may experience a sense of pressure not only to please me as the researcher, by giving accounts that reflect positively on our seminars even if this wasn't how they honestly felt about it, but also an awareness of the content of their interviews been seen by my research supervisor. As my research supervisor was also a facilitator of our reflective practice group and member of the wider course team, participants might have felt concerned about displeasing her in their account of reflective practice. In order to address this, in the short briefing before we began the interview, I attempted to give permission for each interviewee to speak honestly about their experience of the reflective practice group, including the aspects of it they hadn't necessarily enjoyed, and the parts they may have actually found unhelpful rather than helpful, with an understanding that this would not impact on their position within the reflective practice group. Consequently, the participants did discuss some of the aspects of the group that they had perceived as being more unhelpful than helpful.