DOES REFLECTIVE PRACTICE IMPACT UPON CLINICAL OUTCOMES AND IF SO, HOW? A

GROUNDED THEORY STUDY OF HOW TRAINEE CLINICAL PSYCHOLOGISTS EXPERIENCE THE

EFFECT OF A REFLECTIVE PRACTICE GROUP ON THEIR CLINICAL WORK

Thesis submitted in partial fulfilment of the degree of

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By

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Declaration

I, Mark Loveder, 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 has been submitted for any other degree or academic award. I have checked that the thesis is complete prior to submission.

Does reflective practice impact upon clinical outcomes and if so, how? A Grounded Theory study of how Trainee Clinical Psychologists experience the effect of a reflective practice group on their clinical work.

Section A: Thesis Abstract

Within the field of mental healthcare, clinical supervision has been increasingly rolled out not only as an attempt to safeguard patients from harm, but also to fulfil the functions of aiding staff development, reviewing of patient's clinical outcomes, and addressing levels of supervisee satisfaction or burnout. As with therapeutic clinical care itself, there is a need to ensure that the provision of supervision is based upon evidence-based practice. Although there has been much research into the impact of clinical supervision on staff outcomes, the related topic of the impact of clinical supervision on client outcomes has been relatively neglected within research.

The current literature review has aimed to review the quantitative evidence on the clinical impact of clinical supervision on client outcomes. Synthesis of the findings of thirteen empirical quantitative studies suggested that regular and planned supervision with a focus on clients, especially that which incorporates discussion of the results of session-by-session outcome measures can lead to significantly improved client outcomes. In addition, live supervision has the potential to result in improved outcomes.

The current research study aimed to generate an explanatory theoretical model of how the provision of a reflective practice group, as a type of clinical supervision, could impact on client outcomes upon attendees' subsequent contact with their clients. A Grounded Theory methodology was utilised in the collection and analysis of naturalistic data from a pre-existing reflective practice group. The theoretical model generated was discussed in relation to the existing theory and literature. Implications for clinical practice and future research were also discussed.

The critical appraisal offers a reflective account of the research process conducted. This aims to maximise transparency and offers a critique of the current research.

Acknowledgements

First and foremost I would like to sincerely thank all of the people who agreed to participate in this study. Without you this study would not have been possible. I would like to thank you for your willingness to participate despite the imposition of me recording our reflective practice sessions. I truly admire your bravery, integrity, and honesty within the group sessions which were recorded, and your willingness to still go there and open yourself up to the group when others may have thought it easier not to. In addition, although I have held a researcher role within the group, I am also a participant of the group, and I would also like to thank you for your support, encouragement, and the help you have given me with my client contacts. I have learnt so much from you and I will always remember this experience. It has been an absolute pleasure to be part of a reflective practice group with you.

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Thirdly, I would like to thank all of the other members of the training cohort who were not in my reflective practice group. Your support, friendship, and humour across the three years of this course have been one of the main things I have enjoyed, and definitely the main thing that has kept me going when the pressure has mounted up.

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

What can we determine from the evidence base regarding the clinical effectiveness or impact of clinical supervision?

1. Literature Review Abstract

Aim

This paper systematically reviewed the quantitative evidence on the clinical effectiveness or impact of clinical supervision. The findings of previous reviews in this area were synthesised with the findings of more recent studies identified by this paper in order to pull together the evidence base in an area which has been neglected within empirical research to date.

Method

Five electronic databases (PsycINFO, Scopus, Web of Science Core Collection, Applied Social Sciences Index and Abstracts, and Social Services Abstracts) were systematically searched and specified inclusion criteria were applied. The resulting studies were quality assessed, key information was extracted and the subsequent synthesis was conducted.

Results

Thirteen quantitative studies were included in the review. Each of these studies had utilised an experimental design in the comparison of a condition of supervision or incorporating a control group of practitioners who did not receive supervision. The studies were reflective of clinical supervision being conducted within the disciplines of Clinical Psychology, Psychotherapy, Nursing, and Counselling, and were conducted in various locations around the world. Five of the studies reported significant findings, indicating that a condition of clinical supervision had evidenced significantly improved outcomes as compared to another condition of the study. In, addition, although one other study did not report overall significant findings, one aspect of the study did evidence significant findings.

Conclusions

In conclusion, on the basis of the evidence reviewed, it is the author's opinion, and notably contrary to the conclusions reached in the prior reviews that there is an emerging evidence base which demonstrates that supervision does impact on client outcomes. Methodological weaknesses within some of these studies prevent the author from stating this confidently, and clearly further empirical evidence in this area is required. However, this does, in the author's opinion, constitute the basis of an emerging evidence base.

2. Introduction

2.1. Background

A widely accepted definition of clinical supervision is the one posited by Bernard and Goodyear (2004) that it is 'an intervention provided by a more senior member of a profession to a more junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s), monitoring the quality of professional services offered to clients, she, he, or they see, and serving as a gatekeeper for those who are to enter the particular profession' (p.8).

Within the discipline of psychology, clinical supervision has traditionally been viewed as an important part of the training and professional development of therapists, being highly rated in the experiences of trainees as well as practitioners in the field (Orlinsky *et al.,* 2001). Similarly, clinical supervision has an established background within Social Work practice (Kushadin, 1976). However, within the professional discipline of nursing, clinical supervision has not featured so prominently within its history. The trigger for the systematic approach to introducing clinical supervision to the discipline of nursing came following the publication of the Clothier Report (Department of Health, 1994) in the United Kingdom (UK), which was commissioned following the deaths and injuries on a children's ward at Grantham and Kesteven General Hospital during the period between February and April 1991 (Allitt Inquiry, 1991). This report raised concerns about the provision and standards of supervision and training for nurses. The subsequent examination of the systems within the nursing discipline resulted in the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC, 1995) position paper, which recommended clinical supervision as a means to ensure the safe delivery of care by nurses (Bulman & Schutz, 2004) and quickly became a central focus of clinical healthcare governance (Butterworth & Woods, 1998; Davey *et al.,* 2006; Department of Health, 1999; 2000). Therefore, clinical supervision has increasingly become recognised as an integral part of a modern, effective health care system. This has been evidenced in the UK, within National Health Service (NHS) policy, (e.g. 'A First Class Service', Department of Health, 1998), and also within guidelines in the NHS professions (British Psychological Society, 2005).

The Proctor model of supervision (Proctor, 1986; 2008), which has been implemented substantially within the nursing profession, proposed that clinical supervision fulfilled three main functions: the formative, the normative, and the restorative. The formative function refers to the development of a practitioner's skills, attitudes and abilities. The normative

function refers to a provision of quality control, enabling the practitioner to examine their work with another practitioner, thereby assisting them to be responsible for monitoring their practice. Whereas, the restorative function provides the supportive element of supervision, which includes assisting a practitioner to deal with burnout, stress, tedium, and factors relating to job satisfaction.

However, it has been reported that in practice, clinical supervision is often conceptually distanced from case review, personal performance review and therapy (White & Winstanley, 2009) therefore within some healthcare professions, there may be tendency for supervision to focus more on the formative and restorative functions, to the neglect of the normative functions. This appears to be true too of the research that had been conducted into the effectiveness of clinical supervision to date. It appears as though the research has also pointed its focus upon the formative effects of clinical supervision, regarding the development of practitioner's clinical skills through effective supervision (Lambert & Ogles, 1997). Or alternatively, the research has appeared to hold another focus on the restorative effects of clinical supervision (Berg *et al.,* 1994; Berg & Hallberg, 1999; Koivu *et al.,* 2012a; Koivu *et al.,* 2012b; Pålsson *et al.,* 1996). However, research concerning the normative function of supervision relating to the provision of quality control, and particularly with regard to evaluating the effectiveness of clinical supervision on client outcomes appears to have been seriously neglected. As far back as 1997, professionals were advocating for the need for studies to investigate the effects of training and supervision on clients' progress (Ellis & Ladany, 1997; Lambert & Ogles, 1997).

2.2. Previous reviews

There have been six prior reviews conducted of supervision-patient outcome studies to the author's knowledge to date. The first of these was conducted by Ellis and Ladany (1997), who identified nine such investigations, however their critique highlighted a variety of methodological problems and they concluded that there were 'few justifiable conclusions from this set of studies' (p. 488). Freitas (2002) identified four other studies that had not been incorporated within the earlier review, however found no more recent studies since the date of the previous review. The focus of Wheeler and Richards (2007) review was primarily on the impact of clinical supervision on mental health practitioners; the staff. However they did include a paragraph on supervision-patient outcomes, identified two further studies occurring since the Freitas review and commented on their appraisal of the limited focus on this important matter within the evidence base. Similarly, Inman and Ladany (2008) devoted only a

paragraph to the impact of clinical supervision on clients, identified that about 18 such studies had been conducted thus far, and similar to other reviewers, highlighted the difficulty in researching this subject. Three years later Watkins (2011) presented a review of 16 of those studies identified in the previous review, whilst identifying two other studies which had occurred since that date. Inman *et al.* (2014) within their review of factors related to supervisors, supervisees and clients from clinical supervision, identified another couple of studies not included within Watkins (2011), however, they appear to present selected findings and do not comprehensively cover all of the literature identified in previous reviews.

Within the modern profession of healthcare provision, providers are required to demonstrate that their actions are based upon evidence-based practice. This is true for the provision of clinical care, and it could be argued strongly that this should also be applicable for the provision of supervision, since this forms an increasingly integral part of practice and therefore within a publicly funded healthcare system, will have a cost attached to it with regards to use of professionals' time. Indeed, Ellis and Ladany (1997) stated that client outcome is the "acid test" of effective supervision. Therefore there is a need to investigate the salient factors that constitute effective clinical supervision.

2.3. Aims of the current review

The aim of the current review was to perform an updated search of the available literature a number of years on from the previous review in order to evaluate what we can currently determine from the available evidence base regarding the clinical effectiveness or impact of clinical supervision on client outcomes. As the previous reviews have consistently highlighted that a significant proportion of the studies conducted in this area contain critical methodological flaws, part of this process may be discarding those which are the most flawed, and thus leaving those which enable us to begin to make some conclusions about whether clinical supervision does impact upon client outcomes.

3. Method

3.1. Search Strategy

A comprehensive examination of the available literature was completed with adherence to a systematic search process. An initial scoping search developed the focus of the current review with the formation of search strings. Search strings permitted the identification of literature addressing the main aims of the current review. The full set of search strings entered into each database and the resultant number of articles found can be seen in Appendix B.

Searches were conducted in April 2017 using five databases: PsycINFO, Scopus, Web of Science Core Collection, Applied Social Sciences Index and Abstracts (ASSIA), and Social Services Abstracts. The rationale for this was to ensure a range of multidisciplinary literature was included in addition to psychological literature. Searches were not limited to studies from the UK, as there were few UK-based studies found. However, the searches were limited to empirical studies from peer reviewed journal articles in order to ensure high quality research, and they were also limited to those written in the English language. The titles of studies and their abstracts were screened against the inclusion criteria for this review.
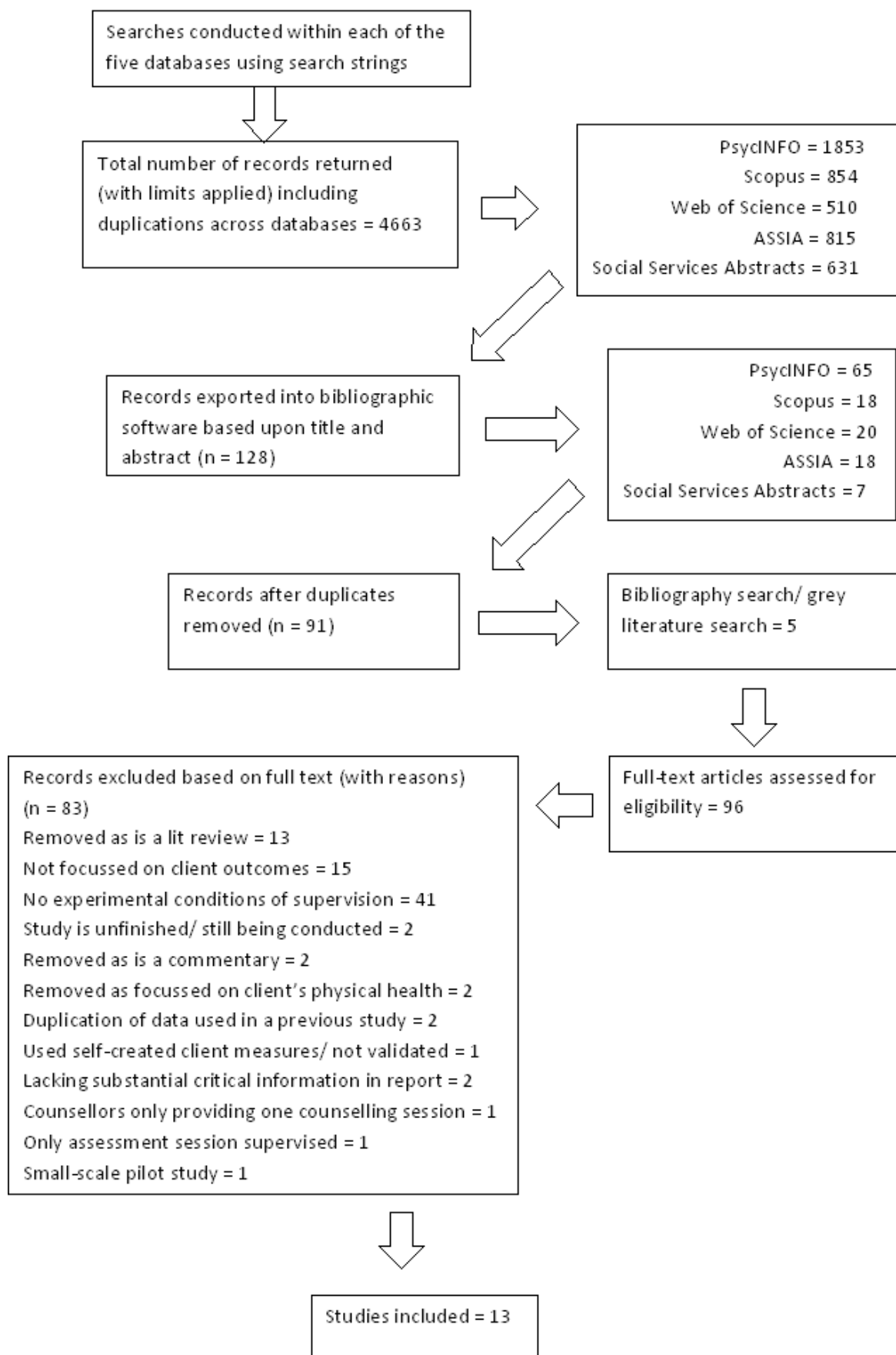
3.2. Inclusion/ exclusion criteria

The inclusion criteria were based around those criteria commonly used in the evaluation of the efficacy of psychological therapies: relevance, outcome and design (please see Table 1 below for details).

Table 1 - Inclusion criteria

Inclusion criteria	
Relevance	Studies that reported evaluations of the clinical effectiveness of a supervision intervention (some form of clinical supervision) on client outcomes within the field of mental healthcare (including counselling interventions) were shortlisted for full text appraisal as they were deemed most relevant to the topic of this review.
Outcome	*S*tudies that took some measure of client outcome (e.g. a standardised measure of psychopathology, working alliance between the therapist and client, or a measure of client satisfaction) were shortlisted.
Design	Studies that utilised an experimental design which incorporated quantitative assessment measures were shortlisted. It was conceptualised that in order to evaluate the effectiveness of a clinical supervision intervention on client outcomes over time, quantitative analysis would permit for this to be assessed at certain intervals of intervention.

After exporting all studies which had appeared to meet inclusion criteria into bibliographic referencing software, all duplicates were removed. The remaining articles were considered by examining the full text and checking against the inclusion criteria to ensure that they were suitable, as several studies had appeared to misidentify their design within the abstract. Reference lists from identified papers were examined to identify further relevant literature that may have not been captured by the search strings employed, and grey literature was also searched for relevant results. The search strategy is summarised in Figure 1 below. A total of 96 articles were found after duplicates were removed.

Figure 1 – Flow chart of studies identified through the search for inclusion within the review

Searches conducted within each of the
five databases using search strings

Total number of records returned
(with limits applied) including
duplications across databases = 4663

PsycINFO = 1853
Scopus = 854
Web of Science = 510
ASSIA = 815
Social Services Abstracts = 631

Records exported into bibliographic
software based upon title and
abstract (n = 128)

PsycINFO = 65
Scopus = 18
Web of Science = 20
ASSIA = 18
Social Services Abstracts = 7

Records after duplicates
removed (n = 91)

Bibliography search/ grey
literature search = 5

Records excluded based on full text (with reasons)
(n = 83)
Removed as is a lit review = 13
Not focussed on client outcomes = 15
No experimental conditions of supervision = 41
Study is unfinished/ still being conducted = 2
Removed as is a commentary = 2
Removed as focussed on client's physical health = 2
Duplication of data used in a previous study = 2
Used self-created client measures/ not validated = 1
Lacking substantial critical information in report = 2
Counsellors only providing one counselling session = 1
Only assessment session supervised = 1
Small-scale pilot study = 1

Full-text articles assessed for
eligibility = 96

Studies included = 13

3.3. Assessment of quality

In order to assess and compare the quality of the 13 articles which were shortlisted for inclusion within the review, a data extraction proforma was created for the purpose of this review. The proforma was created using five of the 12 quality criteria set out by Luborsky *et al.* (1993) in their review of the efficacy of psychotherapy, however in this instance applied to the effectiveness of clinical supervision (see Appendix C). For instance, aspects of this adapted quality criteria included an assessment of whether random assignment to conditions was utilised, whether supervisors and therapists were experienced in the model of supervision/ therapy they were providing, whether their adherence to their respective models of practice were assessed via fidelity checks, and whether the sample size was adequate.

Although Alper (1991), Friedlander *et al.* (1989), Iberg (1991), Mallinckrodt and Nelson (1991), Milne *et al.* (2003), and Sandell (1985) had been included within the previous review on this area, Watkins (2011) had identified that they had been misidentified and were not really supervision-patient outcome studies at all. Upon reading the full texts of these articles, this observation was upheld and hence they were excluded from the current review.

Similarly, although included within the previous review, Dodenhoff (1981), Steinhelber *et al.* (1984) and Vallance (2004) were excluded due to not using experimental conditions of supervision. Harkness (1995) and Harkness (1997) were excluded for replicating the data used within the Harkness and Hensley (1991) study, and Triantafillou (1997) was excluded due to being a small-scale pilot study.

Three studies that were conducted prior to 2011 but not included within the previous review were identified (Burlingame *et al.,* 2007; Crutchfield & Borders, 1997; Reese *et al.,* 2009) and have been included within the current review. In addition, four studies were identified that have occurred in the years since the previous (Watkins, 2011) review.

4. Results

For the purposes of clarity, the results have been structured into three distinct categories according to the design features utilised within the articles in attempting to measure the effectiveness of a specific supervision intervention on client outcomes. These categories are: i) studies which have used a control condition of no supervision in addition to at least one experimental condition of supervision, ii) studies representative of supervision focussed upon client's session-by-session outcome measures compared with supervision which does not take this focus, and iii) other studies which have compared two types of supervision intervention. The rationale for grouping the studies in this way is that studies which utilise a control group consisting of a no supervision intervention represent the highest quality of evidence as they have the potential to investigate the most basic research question of whether clinical supervision does actually have an impact on client outcomes. Whereas the other studies may be useful in identifying which aspects of supervision may have more of an impact than others.

It is worth noting that in order to conserve space within this review, evidence demonstrating the reliability and validity of each outcome measure utilised within the studies is not reported. However, outcome measures have only been discussed if they have well-evidenced reliability and validity, which has been demonstrated in other studies.

The 13 studies have involved the full spectrum of mental health disciplines, and have been conducted in various locations across the globe, with the most recent studies being conducted in the UK (Davidson *et al.,* 2017; Kellett *et al.,* 2014), Germany (Weck *et al.* 2016), the United States of America (Grossl *et al.* 2014) and Australia (White & Winstanley, 2010).

Table 2 – Thirteen Supervision-Patient Outcome Studies 1984 – 2017

Author	Study description	Findings	Methodological strengths	Limitations
Bambling *et al.* (2006)	127 clients (87f, 40m), 127 therapists (96f, 31m), and 40 supervisors (31f, 9m) participated. Clients with major depression were randomly assigned to either a supervised or unsupervised therapist for 8 sessions of problem-solving treatment (PST). The study involved 3 supervision conditions, to which therapists were randomly assigned: alliance process focus, alliance skill focus, and no supervision. The impact of supervision on client-rated working alliance on the Working Alliance Inventory (WAI) and symptom reduction on the Beck Depression Inventory (BDI) was evaluated.	Significant main effect for supervision in relation to WAI scores, $F(2,100) = 54.9$, $p<.01$. Clients in supervised treatment as opposed to unsupervised treatment rated the working alliance as higher, this result being significant ($p<.01$ in each pairwise comparison using Bonferroni corrections). However there was no difference between supervision conditions on the WAI ($p=.221$). Similarly, there was a	Use of a control group. All therapists were in receipt of manual-driven training on PST. All supervisors were in receipt of manual driven training in either alliance process or alliance skill supervision. Experienced supervisors and therapists. 3 intervals of assessment.	Supervisors not randomly allocated. It was identified that the supervision pre-treatment training session and therapist allegiance effects we potential confounds. Study not powered sufficiently to eliminate the possibility of Type II errors.

significant main effect for supervision on BDI scores, $F(2,100) = 6.8$, p<.01. Clients in supervised treatment as opposed to unsupervised treatment rated their symptoms of depression as lower, this result also being significant (p<.01 in each pairwise comparison using Bonferroni corrections). However, similarly, there was no difference between supervision conditions on the BDI (p=.503). Effect sizes were not reported in this study.

Bradshaw *et al.* (2007)	89 service users with schizophrenia (gender not reported), 23 mental health nurses (14f, 9m),	The study reported that service users in both the	Pragmatic design of a prospective study with	The nurses in the experimental group were

several supervisors (number not reported) participated. Supervisors attended a 2-day course about clinical supervision delivered by the study's first author. All nurses attended 36 days formal training in Psychosocial Intervention (PSI) and small-group clinical supervision. In addition, nurses in the experimental condition also received clinical supervision in the workplace (whereas control nurses did not). Patient's symptom change was assessed by the collection of data at the beginning of PSI training and at its end.

experimental and control conditions demonstrated significant reductions in affective and positive symptoms on the Krawiecka, Goldberg and Vaughan symptom scale [KGV(M)] and significant improvements on the Social Functioning Scale (SFS). Statistics not reported. However, comparison of between-group differences showed that service users in the experimental group demonstrated significantly greater reductions with both positive symptoms (p<.05) and total symptoms (p<.05). There were no

historical controls. Good description of process of workplace supervision: 2 students to 1 supervisor in the session, facilitated fortnightly and lasting for between 60-90 minutes, also describing the focus of supervision. An attempt was made to assess supervisor's fidelity to the model of supervision with monthly meetings with the first author, however no further information was provided on this.

older and more experienced than nurses in the control group. The training provided to supervisors was just a 2-day course, which was not described. Retrospective control group used. Study quasi-experimental, with no random allocation to conditions. No report of how many sessions service users received.

		significant differences between the groups in relation to affective symptoms (p=.16), or negative symptoms (p=.71). Likewise, no significant difference between groups on the SFS (p=.12). Effect sizes were not reported in this study.		
Burlingame *et al.* (2007)	Part 2 of their study reported that 41 severe and persistently mentally ill patients (27f, 14m), 11 mental health nurses (gender not specified), 1 supervisor (f; the fourth author of the study) participated. Within the previous study, half of the nurses had been assigned into a workshop training (12 hours of training) condition prior to facilitating a psycho-educational group. Within this study, this group of nurses were now provided with supervision whilst facilitating another psycho-	No differences between the two conditions with regards to patient outcomes on the Moller-Murphy Symptom Management Assessment Tool II (MM-SMAT II revised), $F(1,35) = 0.90$; p>.05; although patients did improve over the course of the group, $F(1,35) = 10.97$,	Use of a control group. Manual provided to the nurses at the workshop to guide facilitation of the group. Within the supervision condition, supervision sessions arranged weekly during the 12 week group intervention; 3 group	Non-equivalent group design. Small sample size. Potential confounds due to the nurses in the supervision condition having received their workshop training many months before the start of the current study.

	educational group with a new, non-overlapping sample of patients, whilst the other group were now trained via the workshop, but were not supervised whilst running the group. This study therefore investigated the effect of supervision versus no supervision conditions on client outcomes.	p<.05). Effect sizes were not reported in this study.	sessions supervised live.	Nurses were inexperienced before study number 1 in facilitating psych-educational groups.
Couchon & Bernard (1984)	32 clients (19f, 13m), 21 counsellors (17f, 4m who were all master's level students) supervisors (3f, 4m who were all doctoral level students) participated. Clients were attending sessions at a university clinic for a variety of personal issues. The effects of timing of supervision was investigated across three conditions: supervision facilitated 1) within four hours of the upcoming counselling session, 2) one day before the next session, or 3) 2 or more days before the next session. Client outcome was measured via client satisfaction ratings on the Counselling Evaluation Inventory.	The experimental effect of timing of supervision had no significant effect on client satisfaction (statistics not reported within the paper). It was reported that supervision conducted within four hours of next counselling session was more of a planning session in comparison to the other two conditions. The supervisor tended to act	Investigated three levels of independent variable. The order in which treatments were assigned to counsellors was randomised.	No random assignment of clients to counsellors or counsellors to supervisors. Small sample size. No control condition of no supervision. It was initially intended that each counsellor would participate in each of the three separate conditions, each involving a different client,

		more like a consultant and be more focused than in the other two conditions.		however that was not achieved, and 'some counsellors saw the same client twice (under different treatment conditions)' (Couchon & Bernard, 1984).
Crutchfield & Borders (1997)	Actual number of school student participants is not reported; 29 school counsellors (24f, 5m), 2 supervisors participated. 29 school counsellors in America were assigned into either dyadic peer supervision (n=8) where they provided peer supervision to each other, reflective group supervision (n=10) (in groups of 5) with an assigned supervising facilitator, or unstructured control group (n=11) who met only twice during the period of 9 weeks of the study. Client outcome measures were completed on a pre-post basis, and completed by school student's teachers.	No significant differences in client outcomes between any of the three conditions on the Teacher Report Form (TRF). There was no significant main effect of treatment group on the Internalising scale of the TRF, $F(2,145) = 1.06$, p=.35, the Externalising scale, $F(2,145) = 0.49$, p = .61, or on the Total scale, $F(2, 145) = 0.85$,	Counsellors in both experimental peer supervision conditions were provided with training and a manual guiding the practice of the supervision structure they were to engage in. Supervision provided once weekly for the 9 weeks of the study.	No randomisation of counsellors to conditions. Counsellors paid for their participation. Small sample size. The client outcome measure relied on the school student's teacher's rating of their psychological wellbeing, which may have been subject to bias.

		p = .43. Effect sizes were not reported in this study.		
Davidson *et al.* (2017)	125 patients (77f, 48m), 8 therapist/ supervisor dyads (precise working roles of staff participants not specified just that all were representative of psychology staff; gender not specified). Patient progress was monitored on a session-by-session basis via patient outcome measure. Therapists in both conditions received feedback on patient outcomes, however in standard supervision condition, this feedback was not passed on to the supervisor. In Measuring and Monitoring clinical Outcomes in Supervision (MeMOS) condition, therapist and supervisor also received email alerts when patients failed to improve or worsened, and discussions in supervision were focused around these clients via structured clinical tool. In addition, a longer version of the same outcome measure was administered at three intervals, and	This study utilised the Reliable Change Index (RCI) to assess for difference between the two conditions. A decrease in clinical score on the CORE-OM of at least 5 points is considered to be a reliable clinical change (Barkham *et al.,* 2006). The study reported that there was no significant difference between conditions with regards to scores on the CORE-OM [OR: 0.52 (0.17, 1.60), p = 0.26]. Patients in MeMOS condition were rated by therapists as	Therapist/ supervisor dyads randomised into one of the three wedges.	Retention of dyads was poor; of a total of 24 recruited, only 8 remained until the end. Therefore study did not achieve intended power. Non-equivalent intervention; patients in MeMOS condition received monthly feedback via email on their progress. No report of the frequency or duration of supervision sessions.

	after each session, therapists also rated patient's severity of illness and rate of improvement.	improving less (p<.001) and more ill (p<.001) on the Clinical Global Impression scale (CGI). Patients in MeMOS condition received fewer sessions than those in standard supervision condition (5.9 vs 9.4: p<.001). Effect sizes were not reported in this study.		
Grossl et al. (2014)	Extension of Reese et al. (2009). 138 clients (79f, 59m), 44 trainees (26f, 18m), 18 supervisors (10f, 8m) participated. Within this study, all trainees administered the client outcome measures in every session with clients. Trainees in the Feedback Supervision condition then reviewed these scores in their weekly individual supervision sessions for the study period of 16 weeks, whereas trainees in the Supervision-as-usual condition did	Analysis of the results indicated that there was no significant difference in client outcomes across the two conditions, $F(1,165)$ = .02, p>.05. The effect sizes were also reported to be roughly equivalent across conditions, d=0.84	Larger sample than Reese et al. (2009). Isolated the effect of supervision. All trainees and supervisors received one hour of manual-driven training provided by one of the study's co-authors	Inclusion criteria for incorporating the client outcome data just required clients to have attended at least two sessions; therefore relatively loose criteria. Fidelity to the supervision process in the Feedback

	not review the client's scores in supervision. Supervisors in the Feedback Supervision condition were provided with guidance on how to use and discuss the measures with trainees in supervision. The measures were used as a means of monitoring how clients were progressing in treatment.	(Feedback Supervision) and d=0.87 (Supervision-as-usual).	in using the client measures; plus given a brief manual for their reference for the study. Random assignment of trainees and supervisors to conditions.	Supervision condition was reported to be poor. Evaluation of client outcome data just across one semester (16 weeks) of trainees who had not used the measures before.
Harkness & Hensley (1991)	161 clients (87f, 74m), 2 female therapists (master's level social workers), 2 male therapists (master's level psychologists) and 1 supervisor (female, who was a certified social worker) participated. The therapists were firstly provided with 8 weeks of mixed-focus supervision consisting of case management, consultation and training, followed by a mix of 8 weeks of client-focused supervision/ mixed-focus supervision. The impact of mixed-focus versus mixed-focus/ client-focused supervision was evaluated for depressive symptoms and client satisfaction with worker	The study reported that within the client focus/ mixed-focus supervision condition, as opposed to mixed-focus only, client depression decreased, and ratings of therapist helpfulness, goal attainment and client-therapist partnership all increased. However, the study does not clearly report the results	Experienced supervisor. Experienced therapists. Supervision meetings audiotaped, and a fidelity check was attempted by two independent raters to ensure consistency with the models of supervision.	No control group. Study used a multiple-baseline research design; 'any combination of order effects, sampling error, and the interaction of testing and treatment may have confounded the findings' (Harkness & Hensley, 1991, p. 511) No report of how many sessions clients received

	helpfulness, goal attainment and worker-client partnership.	of it's statistical analyses with regards to the measures of client depressive symptoms or client satisfaction. Neither is there a clear report of the effect sizes.		within the 16 week study period, inclusion criteria just that clients included if they completed at least one questionnaire and four treatment sessions. Therefore, this weak experimental control allowed clients to complete questionnaires less than five times on average.
Kellett *et al.* (2014)	20 patients of an Assertive Outreach Team (AOT) (gender not specified), 8 care-coordinators and case managers (from the AOT incorporating mental health nurses, social workers, medics, and support staff; gender not specified) and clinical psychologists providing Cognitive Analytic Consultancy (CAC) (number or gender not specified) participated. Patients were randomly	The study reported that there were no significant differences evident between conditions with regards to patient outcomes. However they do not report the statistics of this analysis. However within groups	Pragmatic attempt to research implementation of a CAC intervention within a team context. Patient measures taken over four time points: pre-training, post-consultation, post-	No monitoring of actual attendance rates to team supervision. CAC and TAU arms existed within the same team and therefore staff participants had patients spread across both

	allocated to either the CAC or a treatment as usual (TAU) arm; 10 in each condition. Staff in the CAC arm received 2-day training on the theoretical basis of the CAT model, case consultation on 3 occasions per worker over a period of 3 months, and CAT team supervision for one hour a week for 4 months. Patients completed a measure of distress and a measure of social functioning on four intervals.	analysis demonstrated that there were no significant differences in psychological distress ($X^2(3)$ = 5.86, p=.11), or disability ($X^2(3)$ = 6.60, p=.08) within the TAU group. Nor were there any significant differences in psychological distress ($X^2(3)$ = 1.31, p=.72) or disability ($X^2(3)$ = 1.10, p=.77) for patients in the CAC. Effect sizes are not reported within this study.	supervision, and at follow-up. Random allocation of patients to conditions. Attendance to team supervision voluntary, but tended to be extremely well attended.	conditions; therefore possible risk of contamination of CAT model from CAC to TAU. Small sample size; increasing likelihood of a Type II error.
Kivlighan *et al.* (1991)	48 undergraduate students volunteering as clients (39f, 9m; who were awarded extra credit towards their course grade for participation) 48 master's-level counselling students (29f, 19m), and 17 supervisors (gender unspecified; 1 doctoral-level counselling psychologist, and 16 doctoral-level	Clients in the live supervision condition rated the working alliance as higher than those in the videotaped supervision condition. The results of	As part of their practicum teaching, counselling students provided with a treatment manual for the interpersonal-dynamic psychotherapy model.	Half of the working alliance questionnaire data could not be used due to a clerical error. No random allocation involved. A non-

	counselling psychology students) participated. Volunteer clients were seen for 4 sessions, each 50 minutes in duration. Study evaluated the impact of supervision conducted by review of videotaped session versus live supervision in which the supervisor knocked and entered the room approximately twice on client's ratings of the working alliance.	statistical analysis demonstrated a main effect of supervisory condition, Pillais $F(3,20) = 13.44$, p<.001 which was statistically significant. Effect sizes were not reported in this study.		equivalent groups design. Non-equivalent intervention. Counsellors in the live supervision condition received an extra 20 minutes of supervision for every session conducted.
Reese *et al.* (2009)	110 clients (78f, 30m, 2 did not indicate gender) 28 trainee therapists (18f, 10m), 9 supervisors (4f, 5m) participated. Clients seen at marriage and family training clinic or university counselling centre over the course of 1 academic year (2 x 16 week semesters). Trainees assigned to either client feedback condition or no feedback condition. Trainees in feedback condition used patient outcome measures with clients; administered the Outcome Rating Scale (ORS) at the beginning of a clinical session and the Session Rating Scale (SRS) at the end of the session, and	A repeated measures factorial analysis of variance, which used supervisor as a covariate, found that trainees in both conditions demonstrated statistically significant improvement overall with their clients, $F(1, 92) = 47.76$, p<.000, $\eta^2 = .34$. However, trainees in the feedback condition	Clients randomly assigned to trainees. Supervisors randomly assigned to conditions. Use of these two outcome measures in conjunction includes guidance for how trainees would proceed with their clients, and this formed the basis of the supervision.	Random assignment of trainee therapists to conditions was not possible for all trainees due to the practices of the worksites involved. Therefore only client outcome data collected by trainees in the marriage and family programme (n=19) used for analysis.

	the feedback was discussed directly with the client within the session, and later in supervision to monitor those clients who may not be progressing as expected, and who would need more attention in supervision. Trainees in the no-feedback condition administered the client measures, but did not observe, score or discuss the responses with clients and so did not engage in the monitoring of client outcomes in supervision.	evidenced significantly better client outcomes than trainees in the no-feedback group (Time x Condition), $F(1,92) = 6.88$, p<.05, $\eta^2 =$ .07. It was reported that the supervisor covariate was not statistically significant, $F(1,92) = 0.11$, p>.05, $\eta^2 =$ .00.		Confound in the type of therapy intervention used, trainees in no-feedback condition who administered outcome measures did not score these or address directly with clients, therefore the study is not able to isolate the effect of a supervision intervention.
Weck *et al.* (2016)	42 patients (26f, 16m) with heterogeneous mental disorders attending a university outpatient clinic, 23 trainee therapists (20f, 3m), and 9 supervisors (4f, 5m) participated. Study evaluated the effect of live bug-in-the-eye supervision with delayed video-based supervision on client outcome on two measures of psychopathology. In both conditions, trainees received 6 supervision sessions (every fourth session was supervised). In the live	ANCOVAs did not reveal significant differences between conditions with respect to the Brief Symptom Inventory (BSI), ($F(1,41) = 0.15$, p=.697) or Beck Depression Inventory-II (BDI-II), ($F(1,41) = 0.01$, p=.924) in the intent-to-	Study considered the first 25 sessions of treatments, of which 6 were supervised. Experienced supervisors. Supervisors blind to the hypothesis of the study. Trainees randomly assigned to conditions.	Relatively small sample size utilised (possibly due to the long course of therapy offered), therefore study insufficiently powered to detect moderate effect sizes. Study was optimised to measure

	supervision condition, 4 sessions were supervised live, and 2 sessions were conducted with delayed video review. In the delayed video-based supervision session, all supervision sessions were conducted by reviewing video recordings.	treat sample. Similarly, no significant differences were found between conditions for the BSI ($F(1,35) = 0.10$, p=.749) or BDI-II ($F(1,35) = 0.08$, p=.784) for the completer sample. Effect sizes were not reported in this study.	Utilisation of a real clinical sample of clients.	other factors other than change in client psychopathology; just two intervals of measurement: pre-test/ post-test.
White & Winstanley (2010)	170 patients (gender not specified), 186 mental health nurses (gender not specified), 54 unit staff (gender not specified), and 24 nurse supervisors (17f, 7m) participated. 24 nurses attended a 4-day intensive residential training course in clinical supervision which involved theory, experiential practice, and direct feedback on performance. They were then assigned to initiate and conduct a year's worth of group supervision of neophyte supervisees at their worksites. The control arm	The study reported that overall, statistically significant differences were not demonstrated with regards to either quality of care or patient satisfaction. However this paper does not report its statistical analyses for inspection.	Study incorporated 17 adult mental health facilities across 9 participating locations in both public and private inpatient and community settings. Research team were blind the characteristics of the facilities that met entry	Supervision within the study appeared to be defined as occurring in 'small groups individuals (n-6) attending a pre-arranged meeting with an appropriately trained clinical supervisor, for 45-60 minutes per session, on a monthly

incorporated sites where supervision practices were not in place. Quantitative data was collected from patients at baseline, 6 and 12 months.	criteria into the study. Use of a control condition. Supervisors had access at least once per month over the 12 months of the study to one of the three RCT-funded area Clinical Supervisor Co-ordinators for supervision, a review of progress, advice and support.	frequency, for facilitated reflective discussion, in confidence, around matters of professional relevance and importance' (White & Winstanley, 2010, p. 152). The disposition and support offered by middle managers with the facilitation of supervision as a new practice was adjudged to have seriously confounded the findings.

4.1. Studies which have used a control condition of no supervision in addition to at least one experimental condition of supervision

This grouping of studies includes Bambling *et al.* (2006), Bradshaw *et al.* (2007), Burlingame *et al.* (2007), Crutchfield and Borders (1997), Kellett *et al.* (2014), White and Winstanley (2010).

Two of these six studies report significant findings. Bambling *et al.* (2006) reported findings that clients in supervised treatment as opposed to unsupervised treatment rated the working alliance as higher on the WAI and their symptoms of depression as lower on the BDI. However, there was no difference between supervision conditions. Similarly, within Bradshaw *et al.* (2007), service users assigned to nurses who received workplace supervision (experimental group) demonstrated significantly greater reductions in both positive and total symptoms of schizophrenia as compared to service users assigned to nurses who did not receive workplace supervision (control group). Although White and Winstanley (2010) reported no differences overall in patient satisfaction or quality of care between supervised or unsupervised conditions, the results from one stand-out mental health ward within the study did report statistically significant improvements in both patient satisfaction and patients' ratings of the quality of their care. Whereas, within the remaining studies (Burlingame *et al.,* 2007; Crutchfield & Borders, 1997; Kellett *et al.,* 2014) no differences were demonstrated between supervised and unsupervised conditions with regards to client outcomes.

Within this grouping, Bambling *et al.* (2006) represents the best designed and best executed study, which leads the author of this review to place a great deal of confidence in their findings. The article provides a very clear description of the focus and content of supervision within each of the two supervision conditions (process-focus supervision focusing on understanding of the interpersonal dynamics occurring during therapy and skills-focused supervision focusing on developing specific counselling behaviours to enhance the client alliance), as well as the frequency (eight) of supervision sessions, which matched the number of therapy sessions provided across all conditions. Therefore, clients in each condition received an equal amount of therapeutic intervention, allowing for the isolation of the specific effect of supervision. However, importantly, and uniquely, the study recruited both experienced therapists and supervisors, and a supervision manual was used as guidance for the supervisors within the supervision sessions (and therapists were also provided with their own treatment manual).

The White and Winstanley (2010) study, is commendable as being an example of a well-designed and large scale RCT. However, qualitative findings from interviews with

supervisors who had implemented 12 months of clinical supervision into the working practices of the mental health nurses found that the study appears to have been let down by confounding factors within its execution. It was reported that although senior managers were extremely enthusiastic and supportive of the roll out and provision of supervision, middle managers were not. In some cases they had presented as 'frankly hostile and resistant' (White & Winstanley, 2010, p.159). On the one ward that evidenced significant improvements in patient satisfaction and quality of care, clinical supervision was found to be enthusiastically supported by all levels of the management structure. The supervision was provided by one supervisor who received their own regular clinical supervision, this supervisor demonstrated good supervisory relationships with supervisees, appeared to enjoy the confidence brought by supervision, and were so committed to providing supervision that it was occasionally provided in their own time. Clearly, this appears to signify a very different picture to what was experienced on the other wards. This then raises the question as to whether the overall results of the study may have been different if clinical supervision had have been much better supported across each of the experimental wards within the study.

The Bradshaw *et al.* (2007) study is representative of a well-designed, pragmatic, quasi-experimental cohort (prospective study) with historical controls. The article incorporates a clear description of the workplace supervision provided to nurses enrolled in an educational programme for training in psychosocial interventions with clients with severe and enduring mental health problems. Supervision sessions were conducted in groups of three: two students and one supervisor. Supervision was conducted fortnightly for between 60-90 minutes of each occasion, and the focus of the supervision is well described. Therefore, although not demonstrating the same level of sophistication in its design as Bambling *et al.* (2006), we can assess the findings of this study as being reliable and valid.

As stated above, the remaining studies did not evidence group differences between client outcomes in supervised and unsupervised conditions. Although it is indeed possible that there was no effect of supervision impacting on client outcomes, it is possible that the methodological weaknesses within the studies may have confounded the results and prevented an impact from being detected. One noticeable difference between these three studies and the three discussed above is their smaller sample size, although there is no report within Crutchfield and Borders (1997) of exactly how many students were recruited. This suggests that these studies may have lacked the power necessary to detect any group differences if they were indeed present. Furthermore, in Burlingame *et al.* (2007) although both groups of nurses did receive training in the use of psycho-educational groups, only one

group received this immediately before commencing facilitation of the psycho-educational groups in the study. The nurses who received the supervision intervention had attended the training many months previously within part 1 of this study and may have therefore been at a disadvantage as compared to nurses in the control condition. Therefore this presents a large confound to the training influence applied to the nurses in different conditions.

There are large methodological flaws within the Kellett *et al.* (2014) design. Not only did the study appear to fail to isolate the effect of the supervision intervention within its design, but staff participants had patients spread across both conditions (experimental and treatment as usual) and therefore there is a likelihood of contamination of the CAT informed practices used in the experimental condition into the treatment as usual condition.

Although Crutchfield and Borders (1997) is not the only study which fails to report the amount of therapeutic contact clients received (e.g. Bradshaw *et al.,* 2007; Kellett *et al.*, 2014, White & Winstanley, 2010), client outcome data was used from clients who school counsellors had seen a minimum of three times. The study does not report exactly how many sessions had been conducted, which therefore creates difficulty in assessing whether sufficient therapeutic contact had been provided for an effect of supervision to actually impact on the students. In addition, there are questions about the suitability of the outcome measure used, and criticisms that the outcome measure was completed by neither the counsellors or their student clients, but rather being completed by student's teachers, who may have been biased in their perception of their students' behaviour or difficulties.

4.2. Studies representative of supervision focussed upon client's session-by-session outcome measures compared with supervision which does not take this focus

This grouping of studies contains Davidson *et al.* (2017), Grossl *et al.* (2014), and Reese *et al.* (2009). One of these studies reported significant findings. Within the Reese *et al.* (2009) study, trainees in the feedback supervision condition evidenced significantly better client outcomes than trainees in the no-feedback supervision condition. Whereas, the results of the Grossl *et al.* (2014) study indicated that client outcomes were similar across the two conditions. Similarly, the Davidson *et al.* (2017) study found no differences in clinical outcomes between patients in the feedback supervision condition and standard supervision condition. Interestingly, patients in the feedback supervision condition were rated by therapists as improving less and more ill, and they received fewer sessions than clients in the standard supervision condition.

The findings of this grouping of studies highlight some interesting points to consider. The Grossl *et al.* (2014) study is representative of a well-designed trial with pseudo-randomisation which aimed to extend the Reese *et al.* (2009) study with two discernible differences: use of a larger sample size and an attempt to isolate the specific effect of feedback in supervision. Within the Reese *et al.* (2009) study, trainee therapists in both conditions administered ORS to clients, and those in the feedback supervision subsequently discussed clients' scores with supervisors. Trainees in the no-feedback supervision group did not discuss the results of the client outcomes in the session with the clients. This therefore limits the opportunity to isolate an effect of supervision, by introducing a potential confounding variable into the study. This methodological flaw was addressed in Grossl *et al.* (2014) and trainees in both conditions immediately informed their clients of their outcome scores within the session, therefore ensuring treatment was equal across conditions. However, as noted above, despite Grossl *et al.* (2014) being methodologically stronger, they did not evidence any differences between conditions with respect to client outcomes. In order to consider why this may have been so, it is useful to compare aspects of these two similar studies. In both studies, trainees received weekly individual supervision for the length of the study, however in addition, trainees in Reese *et al.* (2009) also attended weekly group supervision. Furthermore, the Reese *et al.* (2009) study was twice as long as Grossl *et al.* (2014); conducted over two 16-week academic semesters. It is possible that within the Reese *et al.* (2009) study, the benefits accrued from individual supervision focused on client feedback may have been carried over into the group supervision, such that these effects may have been compounded within the group supervision but solely to the benefit of the trainees in the feedback condition. For example, Reese *et al.* (2009) found that not only did the trainees in the feedback supervision condition demonstrate better outcomes from the beginning, but they also evidenced more improvement in the second semester. Therefore, the Grossl *et al.* (2014) study may not have been sufficiently long enough for the effect of the supervision condition to impact upon the results. Furthermore, the findings of a questionnaire used as a fidelity check within Grossl *et al.* (2014) indicated that fidelity was not consistent in either condition, with some trainees in no-feedback supervision discussing client outcomes, and trainees in feedback supervision not discussing client outcomes within every session. This is likely to have impacted upon the results. There was no assessment of fidelity within the Reese *et al.* (2009) study.

Although the Davidson *et al.* (2017) study was conducted over a period of 24 months, and had a similar level of client participation as the other two studies in this grouping, they

were able to retain substantially less therapists throughout the course of the study, which meant that the study was insufficiently powered to reduce the possibility of Type II errors. In a similar manner to Reese *et al.* (2009), this study is representative of a non-equivalent intervention. Patients in the feedback supervision condition received monthly feedback via email on their progress, whereas patients in the standard supervision condition did not. The results indicated that the average number of sessions delivered to feedback supervision patients was significantly fewer (5.9 vs 9.4). Perhaps this suggests that clients being informed of their progress remotely and not in the presence of the therapist was somewhat counterproductive, rather than therapeutic in this instance. In addition, similar to the Grossl *et al.* (2014) study, adherence to the model of feedback supervision was not satisfactory and this lack of adherence may have impacted on the results.

4.3. Studies which have compared two other types of supervision intervention

This grouping of studies includes Couchon and Bernard (1984), Harkness and Hensley (1991), Kivlighan *et al.* (1991), and Weck *et al.* (2016). Two of these four studies report significant findings.

Harkness and Hensley (1991) reported findings that within the client focus/ mixed-focus supervision condition, as opposed to mixed-focus only, client depression decreased, and ratings of therapist helpfulness, goal attainment and client-therapist partnership all increased. The findings of Kivlighan *et al.* (1991) indicated that clients in the live supervision condition rated the working alliance as higher than those in the delayed video-based (DVB) supervision condition. Whereas, within the remaining studies (Couchon & Bernard, 1984; Weck *et al.,* 2016) no differences were demonstrated between supervision conditions with regards to client outcomes.

Both Weck *et al.* (2016) and Kivlighan *et al.* (1991) have investigated the effect of a form of live supervision versus DVB supervision on client outcomes. However, although Kivlighan *et al.* (1991) present some interesting findings, it appears as though one cannot place quite as much confidence in the reliability and validity of their findings of as some of the studies above, due to the methodological limitations of the study. Due to a clerical error, only half of the clients completed the outcome measure (WAI) fully, therefore greatly reducing the data pool from which analysis of outcomes was conducted. In addition, the client sample consisted of student volunteers who were awarded extra credit towards their qualification for their participation. There was no fidelity check on therapists adherence to the manualised

form of counselling provided, other than the therapists own self-rating of their intentions upon each utterance when viewing back their own therapy sessions using a previously developed tool.

Perhaps the one aspect that lets the Weck *et al.* (2016) study down, in what is otherwise a well-designed and well executed study, is the limited amount of live supervision provided within this condition. In both supervision conditions, trainees received exactly six supervisory sessions (every fourth therapy session), during the first 25 sessions with each client. However, within the Bug-in-the-eye (BITE) live supervision, only four of the six supervision sessions were conducted live. Therefore, this may not have been a sufficient amount of live supervision to differentiate the impact upon client outcomes as compared to DVB supervision.

The other two studies within this grouping did not investigate the effect of live supervision, but instead compared other conditions of supervision. Within the Harkness and Hensley (1991) study, supervisees in the control condition received 16 weeks of supervision with a mixed-focus. This was described was described as being used for a mixture of administration, training and clinical consultation in ad hoc 1:1 supervision sessions. Supervisees in the experimental condition received eight weeks of mixed-focus supervision, followed by eight weeks of client-focussed supervision. Client focussed supervision was conducted on a 1:1 basis and scheduled regularly by the supervisor. However, various methodological limitations are present with the design of this study and again in the opinion of the author of this review, this limits the extent of the confidence we can have in the findings. These limitations include a small sample of social work professionals. Supervisees were randomised to conditions, however there is no specific mention of the method for allocating clients to conditions, and therefore it is very likely that client variables may have acted to confound the results. Additionally, weak experimental control over volunteer clients allowed clients to complete outcome measures less than five times on average.

Couchon and Bernard (1984) investigated the effect of the timing of supervision on client satisfaction ratings using three levels of independent variable (details noted in Table 2). As stated above, the study reported findings that the experimental effect of timing of supervision had no significant effect on client satisfaction. However, again this study appears to contain various methodological flaws. There is no report of exactly how many sessions the clients of each therapist received. There appears to be no standardised model of supervision utilised. This prevents the study from being able to isolate the effect of the timing of supervision. In fact, the findings suggested that supervision conducted just prior to upcoming

counselling session appeared more focused, but representative of a planning session. Whereas, supervision conducted one day before upcoming counselling session was characterised by a focus on conceptual material taught by the supervisor. Therefore, it is difficult in this instance to assess what we can discern from the results of this study about the impact of the timing of supervision.

5. Discussion

5.1. Discussion of findings

This paper has integrated the evidence identified within previous reviews with the findings of newly identified studies in order to answer the question of whether clinical supervision does impact on client outcomes. As the previous reviews have consistently commented that this area of investigation has been neglected within research, and that the studies that have been conducted have been limited by serious methodological flaws, it seemed pertinent to investigate if any newly identified studies could provide a further insight into this area.

5.1.1. Current findings and clinical implications

Following a comprehensive search of the available literature, it still remains the case that only a small number of studies have investigated the impact of clinical supervision on client outcomes. Based upon the inclusion criteria set for the current review, only 13 studies were identified as being appropriate for consideration. In relation to the Proctor model of supervision (1986, 2008), all of the studies reviewed took some focus on the normative aspects of supervision relating to client outcomes. However, only three studies exclusively focussed upon the normative function of supervision, using client outcome measures as their only dependent variables (Bambling *et al.,* 2006; Davidson *et al.,* 2017; Harkness & Hensley, 1991). The remaining studies also held an overlapping focus on either the formative and/or restorative functions of supervision in support of addressing their aims. In order to present a coherent narrative of the assessed methodological strengths and weaknesses of these studies, they were pragmatically organised into three groups based upon similarities in the design of the studies. However, this section will provide a discussion of the salient findings across all of the studies reviewed before then considering the implications with regards to clinical practice.

Firstly it is important to acknowledge that several of the studies reviewed have made interpretations about the meaning of their results, but without providing evidence of the

results of statistical analyses which would give support to these claims. Therefore, one must exercise a level of caution when considering the reported findings. Certainly, it has not been possible to provide an informative comparison of the impact of clinical supervision across the studies as only two of the studies have reported effect sizes.

Five of the 13 studies reported significant findings (Bambling *et al.,* 2006; Bradshaw *et al.,* 2007; Harkness & Hensley, 1991; Kivlighan *et al.,* 1991; Reese *et al.,* 2009). Plus, within another study (White & Winstanley, 2010), one stand-out ward evidenced significant outcomes despite the overall results of the study indicating no differences in the outcomes of clients in supervised versus unsupervised conditions. On the basis of the methodological strengths and weaknesses of the studies reviewed, the studies which have incorporated a control condition of no supervision form the most convincing evidence that supervision can and does impact on client outcomes (Bambling *et al.,* 2006; Bradshaw *et al.,* 2007). Of these, and consistent with the appraisal in the Watkins (2011) review, Bambling *et al.* (2006) forms the strongest piece of evidence, however, although the Bradshaw *et al.* (2007) study may not be quite as sophisticated in its design, it does add further weight to this conclusion. Furthermore, the findings within the White and Winstanley (2010) study highlight the fact that given the right environmental conditions, clinical supervision can impact upon client outcomes.

The other three studies which evidenced significant findings (Harkness & Hensley, 1991; Kivlighan *et al.,* 1991; Reese *et al.,* 2009), although not adjudged to represent the same strength of evidence as studies with a no supervision control condition, are able to provide informative insights into the aspects of clinical supervision which do impact upon client outcomes. Firstly, the results of Harkness and Hensley (1991) suggest that regular and planned supervision with a focus on clients can lead to significantly improved results as compared to ad hoc supervision more focussed on administration, training and clinical consultation. Secondly, supervision which is in part guided by a prioritisation of clients not making progress as expected, or deteriorating, as demonstrated by session-by-session client outcome measures, can lead to significantly improved outcomes as compared to supervision which does not take account of the results of these outcome measures (Reese *et al.,* 2009). Thirdly, the results of the Kivlighan *et al.* (1991) study suggest that live supervision can significantly impact upon the working alliance between the supervised therapist and their clients.

These findings are considered in the context of an evidence base in which few studies have controlled for a comparison group of no supervision. Therefore, when looking at an already very limited pool of evidence, the fact that only six of the thirteen identified studies

have utilised a no supervision control condition limits our ability to be more confident in making these conclusions. However, it is understandable as to why some studies may not have incorporated a control condition of no supervision into their design, and it is perhaps an ethical consideration more than anything else. As demonstrated within several of the papers in this review, supervision is progressively being implemented into healthcare systems and clinical training programmes for mental health practitioners. Therefore, the scope to conduct investigations which use a no supervision control condition is reducing, as clearly it would be unethical to remove or withhold supervision from practitioners for the sake of an empirical investigation. However, there will still be locations around the world in which supervision has not yet been implemented into the routine practices of mental healthcare professionals as of yet. It is in these locations that we should look to continue to investigate the impact of clinical supervision on client outcomes via the use of supervised versus unsupervised practices during their implementation procedures.

Another important observation when considering the studies included within this review is that some studies have failed to isolate the effect of supervision, or that other studies have omitted key information within the article about the specifics of the therapeutic contact provided, therefore preventing our ability to assess whether they were able to isolate the specific effects of supervision. Therefore, to some degree, it is unclear within these studies as to whether the results are attributable to different conditions of therapeutic contact, rather than conditions of supervision. Within future investigations into this area it will be imperative for the studies to ensure that the therapeutic intervention provided to clients is equivalent across all conditions.

In other studies, there is a lack of information provided about the model of supervision utilised, which can make it difficult to draw conclusions about the potential useful aspects of the clinical supervision. This is particularly important, as it is not only pertinent to investigate whether clinical supervision does impact upon client outcomes, but to be able to investigate what the active ingredients are of the clinical supervision which could have led to an impact. In most modern-day clinical settings, there is a need and requirement to use evidence-based practices, and therefore there is a need to have clear information within research articles that can help to guide professional practice. For example, within the workplace, most departments may state that they provide clinical supervision, however in some clinical settings this may be more akin to a once-monthly management supervision session as opposed to a more regular clinical supervision session focussed upon the progress of clients the practitioner is working with. This is not to say that clinical supervision should not

provide a space for administration tasks, training and teaching. However, that alongside this, the evidence appears to suggest that it is beneficial when supervision provides adequate space for the purposeful focus on discussing and reviewing either the clinician's perception of client progress, outcomes from measures administered during sessions, or the interpersonal dynamics occurring within the therapeutic contact.

Similarly, in many instances, although supervisors may provide or allow a space for discussions focused upon clients' progress, many supervisors may not base their supervisory practice within a specific model of supervision, and/ or possibly have never had specific supervisor training to aid the development of supervisory competencies. On the basis of the evidence reviewed, these factors do appear to be important. For example, studies which had provided specific training for supervisors on the model of supervision to be used, and in the instance of the Bambling *et al.* (2006) study, where they had also given manuals to supervisors to guide their practice of supervision, were adjudged to represent a higher quality of study. Within the Bambling *et al.* (2006) study, these factors could be considered to have contributed greatly towards their findings of significant impact.

Amongst many other models of supervision available, it appears as though the provision of live supervision may have a beneficial impact on the therapeutic working alliance between a therapist and their client. It is possible that this approach may assist practitioners of all levels of experience to evidence positive client outcomes from immediately implementing the suggestions provided from a supervisor who has been observing the session live. However, this approach may be particularly impactful on the development of trainees in assisting them to monitor the development and strength of the working alliance, and to then address this as necessary.

5.2 Limitations of the current review
It should be noted that there are several limitations to the current review. Firstly, due to the restrictions imposed by the word count of this paper, a decision was taken to exclude all investigations which had only utilised a qualitative form of client feedback. This was not to dismiss the incredibly useful insights these studies provide into clients' experiences, but rather for the purposes of aiding comparisons of quality between studies of a similar (quantitative) design. Therefore, as this review has opted to base a judgement of the impact or effectiveness of clinical supervision through scores on quantitative outcome measures, this has prevented the review from being able to draw upon clients' own rich accounts of exactly what they may have found useful or impactful within their therapeutic contacts within studies that could

potentially be traced back to the impact of the supervision provided. Secondly, by excluding studies that had not employed experimental conditions of supervision, several survey based studies were discarded which had sought to investigate aspects of the experience of clinical supervision or the supervisory relationship which may have had a subsequent impact on client outcomes. Again, the intention was not to dismiss the useful findings of these studies, but it was perceived that within the hierarchy of evidence, randomised controlled trials or well-designed quasi experimental trials would be better placed to answer the research question of this review.

5.3 Overall conclusions and recommendations for future investigations

In conclusion, it is the author's opinion, and notably contrary to the conclusions reached in the prior reviews (Ellis & Ladany, 1997; Freitas, 2002; Inman & Ladany, 2008; Inman *et al.,* 2014; Watkins, 2011; Wheeler & Richards, 2007) that there is an emerging evidence base which demonstrates that supervision does impact on client outcomes. Certainly, due to the limited size of the evidence base available for review, and due to the nature of some of the methodological weaknesses within some of the studies, the findings of the studies reviewed here do not form a strong evidence base from which we can confidently assert that clinical supervision does impact on client outcomes. However, this does, in the author's opinion, form the basis of an emerging evidence base. Clearly, further investigation into this area is required which will equip us to make a better informed assessment as to whether clinical supervision does impact on client outcomes. Experimental studies would be welcomed that conduct investigations incorporating the use of a control condition of no supervision, as this provides a higher form of evidence on which we can base our appraisals. As mentioned above, there are ethical considerations present here which may limit the number of studies which can be conducted which incorporate this kind of control condition. However, irrespective of the ability to utilise a control condition of no supervision, studies which are primarily an investigation of client outcomes rather than staff outcomes, that recruit both experienced therapists and supervisors, that isolate the specific effect of supervision, and are adequate in the length of both the number of supervision and therapy sessions would be welcomed. Furthermore, studies that utilise manuals to guide the provision of therapy, and importantly, utilise a manual to guide the model or provision of supervision would be welcomed.

6. Reference list

*Denotes references which form the basis of the current review.

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Does reflective practice impact upon clinical outcomes and if so, how? A Grounded Theory study of how Trainee Clinical Psychologists experience the effect of a reflective practice group on their clinical work.

Does reflective practice impact upon clinical outcomes and if so, how? A Grounded Theory study of how Trainee Clinical Psychologists experience the effect of a reflective practice group on their clinical work.

1. Research Report Abstract

Introduction

Reflective practice groups are commonly facilitated within healthcare settings and have also been incorporated into the training of Trainee Clinical Psychologists. One of the functions of a reflective practice group is to help an attendee to achieve positive outcomes upon their subsequent contact with their clients. However, at present, there is no known research which has investigated whether reflective practice groups do impact upon clinical client outcomes. Therefore, the current study aimed to develop an explanatory theoretical model of how the social processes occurring within a reflective practice group may impact upon attendees' later contact with their client with regards to their client's outcomes.

Method

The study adopted the qualitative methodology of Grounded Theory. Naturalistic data was collected from a pre-existing reflective practice group consisting of six Trainee Clinical Psychologists and two group facilitators. Six reflective practice group sessions were audio-recorded and analysed. Follow-up one-to-one interviews were conducted with each Trainee in order to seek participant validation of the emergent model and to explore their perspective of whether the group's reflective discussion of their case had subsequently impacted upon their client. Further participant validation was sought via a presentation of the analysis to the group and as a further opportunity to refine the model.

Results

A core category titled 'Deepening Understanding in the Context of Building Trust' emerged from the data and highlighted the crucial role that trust plays within a reflective practice group. It was found that the processes of group members suggesting practical action and reflecting from the perspective of people other than themselves subsequently impacted on the presenter's client's outcomes.

Conclusion

The key findings were discussed in relation to existing theory and research literature. Considerations were given to the clinical implications of the findings and also the implications for future research in this area.

2. Introduction

2.1 Background

The term 'reflective practice' was first developed by Schon (1983), who specified two types of reflection: reflection-in-action and reflection-on-action. Reflection-in-action is a process that enables a professional to adjust the course of their action or to reshape their thinking whilst engaged in an activity. Schon (1983) stated that reflection-in-action is: 'the spontaneous, intuitive performance of the actions of everyday life or thinking on your feet' (p.54). Reflection-on-action relates to the seminal work of Dewey (1938) with regards to his thoughts about looking back over what has been done. Schon (1983) commented that 'we reflect-on-action, thinking back on what we have done in order to discover how our reflection-in-action may have contributed to an unexpected outcome' (p.26). Schon argued that the concept of reflective practice was important because professionals are frequently required to quickly make complex decisions in difficult situations without access to all of the available information.

Since this time, the term 'reflective practice' has gained considerable interest within many contemporary fields of clinical practice including nursing (Taylor, 2000; Turner & Beddoes, 2007), social work (Gould & Taylor, 1996; Fook, 1999; Taylor, 2006), general health practitioners (Kember, 2001), medicine (Greenhalgh & Hurwitz, 1998), and education (Boud *et al.,* 1985; Jarvis, 1995). Similarly, the field of Clinical Psychology has increasing valued the concept, and it has been introduced into several clinical training programmes within the United Kingdom (UK) (Binks *et al.,* 2013; Knight *et al.,* 2010). Clinical Psychology training courses have taken different approaches in the promotion of reflective competencies and skills, including reflective practice groups, provision of personal therapy, reflective writing, and the use of a mentor during training (Bolton, 2003; Brown *et al.,* 2009; Gillmer & Marckus, 2003; Wigg *et al.,* 2011).

However, reflective practice groups are commonly facilitated across a variety of different healthcare settings and attended by members of multidisciplinary teams. A reflective practice group is a type of group clinical supervision attended by healthcare professionals where they have an opportunity to confidentially discuss aspects of their work with service users/ clients/ patients. Examples of common discussion topics within these groups are the dynamics arising within the therapeutic relationship between the healthcare professional and their service user(s), uncertainty with how to progress with their on-going contact with service users, and barriers or blockages to the anticipated progress made by service users.

Within the last twenty years, a number of studies have investigated attendees' experiences and outcomes of unstructured, facilitated, reflective practice groups within counselling and psychology training (Hall *et al.,* 1999; Ieva *et al.,* 2009; Kline *et al.,* 1997; Knight *et al.,* 2010; Lennie, 2007; Nathan & Poulsen, 2004; Robson & Robson, 2008). The findings indicate that at least some of the participants reported a range of benefits including experiencing the client position, learning about group process, reflecting on their impact on others, learning about the potential impact of personal issues on client work and development of their counselling skills (Hall *et al.,* 1999; Ieva *et al.,* 2009; Kline *et al.,* 1997; Nathan & Poulsen, 2004). The findings also indicated that attendees can be challenged by the ambiguous nature of the groups, that participants' openness can be inhibited if they know their fellow attendees outside of the group, and that attendees' typically need to perceive a certain degree of safety within the group before risking self-disclosure (Nathan & Poulsen, 2004; Robson & Robson, 2008).

However, in contrast to these positive outcomes, reflective practice groups can also be experienced as distressing by the attendees (Knight *et al.,* 2010). Although, these reports of distress are perhaps unsurprising given that some authors have suggested a degree of emotional pain will be inherent to the learning process in such groups (Smith *et al.,* 2009; Youngson & Hughes, 2009).

In addition, in applying the literature on clinical supervision, and namely, regarding the Proctor model of supervision (Proctor, 1986; 2008), it can also be seen that as well as fulfilling a formative function of supervision, reflective practice groups can also fulfil the restorative and normative functions. That is, respectively, as well as being a learning opportunity for practitioners to improve their clinical skills, they may assist in addressing a practitioner's well-being, as well providing opportunities for case review of a practitioner's clinical clients for the purpose of impacting on client outcomes. However, it appears as though the majority of the literature on reflective practice so far has been focussed on the formative and restorative functions, to the neglect of the normative function.

At present there is no known research available that has investigated the impact of reflective practice groups upon client outcomes. If client outcomes are to be viewed as the 'acid test' of effective supervision (Ellis & Ladany, 1997), this lack of research evidence can make the provision of reflective practice groups hard to justify in an overstretched NHS. Therefore, there is a need to investigate whether reflective practice groups impact upon clinical outcomes.

Although many reflective practice groups may indeed have an unstructured format, models such as the Kolb (1984) experiential learning cycle or the Gibbs (1988) model are commonly used as a loose guide for assisting attendees to work through the process of reflecting upon their client contacts. However, criticisms of the Kolb model include the lack of emphasis on the learning context, an equal emphasis on all four learning modes (when reflection appears to dominate in professional learning) and the lack of a supportive, empirical body of literature (Reynolds, 1997; Vince, 1998). It is this lack of knowledge about the learning context of the group that is the focus of this study. Therefore, how do the attendees of a reflective practice group make sense of how their participation in the group has impacted upon their clinical outcomes?

2.2. Aims of the current study

Specifically, the central aim of the current study was to explore how the attendees of a reflective practice group understood and experienced the group as impacting on their clinical outcomes. In order to investigate this, the aims of the study evolved to consider how the social processes occurring between group members within a reflective practice group may assist the attendees with their clinical work upon their future contacts with their clients. Therefore, the study aimed to develop an explanatory theoretical model of how the social processes occurring within a reflective practice group may impact on client outcomes upon attendees' future contacts with their clients. Furthermore, in line with the central aim of the study, the study aimed to seek validation of this model by exploring how the attendees of the group understood and experienced the group as impacting on their clinical outcomes.

3. Method

3.1 Design

The aim of the current study was to explore and generate a new understanding of how the attendees of a reflective practice understood and experienced the group as impacting upon their clients' clinical outcomes. A qualitative interpretative methodology was selected as this aligns with the stated aims and with the researcher's own epistemological position. A Grounded Theory methodology was selected as appropriate due to the lack of information related to the research question within the literature. Its emphasis on creating analyses of action and process rendered it ideal for a study of the social processes occurring within a reflective practice group, and furthermore, it fit with the researcher's preference for the use

of participant validation methods. An additional aim was to generate a theory with explanatory power that would be useful for those clinicians either facilitating or attending reflective practice groups. Grounded Theory has its focus on developing conceptual frameworks through an inductive analysis identifying categories that are 'grounded' in the data (Charmaz, 2006). Therefore, within this study, the application of the Grounded Theory methodology was consistent with that advocated by and used by Charmaz (2006), and this involved the use of ethnography (involving the researcher's own observations and experience of the group) which was incorporated into the analysis. This methodology incorporates a number of techniques which will be discussed.

3.2 Participants

3.2.1 Inclusion / exclusion criteria.
A decision was made for the purposes of this research that it would be important for the group to have met on several occasions previously, as it can often take group members some time to become accustomed to the processes of the group and also to other group member's interpersonal style. Therefore, it was decided that the study would collect naturalistic data from a pre-existing and already established reflective practice group. Inclusion criteria specified that this was a closed group, containing the same members on each occasion, except for occasions where a member may be unexpectedly unable to attend, such as due to sickness. Additional considerations were for the group to meet on a regular basis, for group sessions to be held for a similar duration on each occasion, and for the sessions to utilise models of reflective practice to aid discussions. Exclusion criteria included newly established groups that had only recently formed and had not established a regular routine of process, or groups who were close to permanently disbanding, which would have limited the amount of data available for collection.

3.2.2 The sample.
Therefore, on the basis of the inclusion and exclusion criteria, the researcher's own reflective practice group at the University of Leicester was deemed most suitable to approach for recruitment into the study. An additional consideration that informed this decision was that it would be easier for the researcher to operate the recording equipment within sessions rather than the necessity of asking another person to take this responsibility if another group was selected. Furthermore, it was considered to be less invasive for the researcher to record the conversations of his own reflective practice group, than a group that he had never been a part of. Therefore, the sample consisted of eight participants:

two group facilitators who were qualified Clinical Psychologists from the local NHS Trust (one female, one male), and six attendees who were Trainee Clinical Psychologists, including the researcher (four females, two males). All participants were randomly assigned a pseudonym in order to ensure their right to anonymity (e.g. Participant 1-6, and Facilitator 1 and Facilitator 2).

3.3 Procedure

3.3.1 Recruitment. The idea for this research project was mentioned to the sample on a number of occasions throughout the group's first year of meeting in order to introduce the idea for the project and to informally allow the group members to express their opinions about the possibility of participating. The consensus on these occasions where it was discussed appeared to be that group members would be willing to participate. Therefore, in accordance with the procedure specified in the research proposal, one week before the scheduled reflective practice session in the January of the second academic year of study, the researcher emailed the Participant Information Sheet to all potential participants within this group for their reference. At the beginning of the January reflective practice session, the researcher then engaged in formal consent procedures. The researcher read through the Participant Information Sheet in order to ensure that all potential participants had received this information. Time was allowed for the potential participants to ask any questions they had about the study (see Appendix D for all research tools) or for them to express any concerns about their participation, and for these issues to be discussed. As all present were expressing that they would like to participate, they were asked to provide their informed written consent for the research to commence data collection.

3.3.2 Data collection. The researcher used the triangulation of data collection and participant validation methods in order to both attempt to answer the research question, and also to maintain consistency with the grounded theory methodology. Therefore data collection occurred in three stages. Within stage one, the researcher used a digital voice recorder to record six of the once monthly reflective practice group sessions within the second year of academic study. Reflective practice group sessions were held at the University of Leicester within the teaching rooms used by the Doctorate in Clinical Psychology course. These groups formed part of the mandatory teaching that Trainees were required to attend and engage in, and therefore no changes were made to the location, date or times of these sessions for the purpose of the research. The only difference was the introduction of the recording equipment into the centre of the group and an awareness that the sessions were

being recorded. The entirety of each of these six sessions was recorded. Each session was two and a half hours in duration, inclusive of a fifteen minute break in the middle at which point the digital recorder was temporarily turned off until the session resumed after the break. The researcher transcribed these six initial pieces of recorded data and then analysed the transcripts using the grounded theory methodology.

Stage two of the procedure involved the researcher conducting a one-to-one interview with each of the Trainee attendees of the group. Interviews were conducted within the premises of the University of Leicester. Each interview was thirty minutes in duration and was recorded using the digital voice recorder. A semi-structured interview schedule was utilised, however with the flexibility to use the same overall structure but to change the questions asked to each participant dependent upon which main category was being followed up. The interviews were conducted at the beginning of the third academic year of study on the course. These interviews were transcribed and analysed. The analyses of the interviews were incorporated into the emerging theory as per the grounded theory methodology.

Within stage three, the researcher presented the analysis that had been conducted up to that point to the reflective practice group within one of the reflective practice group sessions in the third academic year of study. An hour was allocated for the presentation of this information and also the group's discussion of the analysis. This one hour discussion was recorded with the digital voice recorder. This data was then transcribed, and analysed, with the analysis being incorporated into the emerging theory. All confidential paperwork was kept in a locked filing cabinet along with the digital voice recorder when not in use. All electronic information was stored on a password protected computer.

3.3.3 Transcribing. The researcher transcribed all recorded group sessions and one-to-one interviews word for word. This ensured that they were immersed in the data, as is recommended when using grounded theory (Charmaz, 2006). In order to capture the richness of key social processes occurring during the audio recordings a "naturalist" approach was adopted within the transcribing process (Oliver *et al.,* 2005). This allowed the transcription of any pauses or hesitations including "erm" and "err" vocalisations, sounds of encouragement such as "mm" or "mmhmm", as well as stutters or mispronunciation of any words. In addition, the expression of emotion via laughter or sighs were captured.

3.3.4 Data analysis.

3.3.4.1 Coding. The data analysis involved several stages of a coding process (see Appendix E for examples). In order to effectively manage the large quantity of data that was

collected during the stage of conducting analysis, a pragmatic decision was made not to conduct line-by-line initial coding. Instead, each page of transcript was systematically split into unit chunks of approximately seven to eight lines of text. Therefore, each page consisted of approximately four unit chunks, each of which was treated as an "incident". This allowed the researcher to analyse the transcript 'incident-by-incident' (Charmaz & Mitchell, 2001) for interesting social processes occurring within and between group members such as 'recurrent actions, characteristics, experiences, phrases or explanations' (Birks & Mills, 2011, p.93). However, if it appeared as though there were interesting processes occurring more frequently than this, the researcher also had the flexibility to identify more than just four incidents per page. The next stage of analysis involved assigning codes to the underlying concepts behind the identified incidents. At this point the researcher began to assign names to these codes which later became categories. Charmaz (2006) suggested that "gerunds" (words ending in "ing") should be used when naming categories to help ensure the coding process remains focussed on the action of the social processes involved. Therefore categories were labelled in this way. The final stage of the analysis involved axial coding which required analysing the relationships between the generated categories and the properties within them. This resulted in many categories being combined and emerging from this process was a core category which encapsulated a phenomenon that linked many of the other categories.

3.3.4.2 Constant comparison analysis. Constant comparison in grounded theory refers to the process by which the researcher continually compares the initial codes, categories and concepts within and across all others. The study incorporated constant comparison into the iterative process required of conducting the analysis. In practical terms, this was facilitated through the use of cue cards, which kept an audit trail of the development of main categories within the analytic technique.

3.3.4.3 Theoretical saturation. Theoretical saturation is defined as the point at which further data collection yields no new information. This was monitored throughout and the subtleties involved were rigorously attended to following guidelines outlined by Glaser (2001). An audit trail noting emerging categories and properties examined the saturation progress. It was noted that 12 categories emerged from the analysis of the first reflective practice group session (Transcript 1), and reflective of a funnelling effect within subsequent sessions, only one new category emerged from the analysis of the sixth reflective practice group session (Transcript 6). Therefore, it can be stated that saturation was achieved following the collection of data from the sixth reflective practice group session (see Appendix F). Despite this, it is

acknowledged that the concept of theoretical saturation is highly dependent on a range of different factors, including the ability to sample theoretically, which this study did not do. Therefore, the claim of saturation is made tentatively.

3.3.4.4 Theoretical sampling. Theoretical sampling is enacted when the researcher chooses particular lines of enquiry to develop emerging categories or theory (Charmaz, 2006). This can involve the researcher seeking out participants due to their specific qualities, and when utilised to its full extent, the researcher may find themselves covering substantive areas. Within the current study, theoretical sampling was not used to its full degree. Due to the naturalistic design of the study opting to base itself within one reflective practice group and planning to follow up on the experiences of the attendees of this group within interviews, it was decided that the researcher would not then attempt to recruit participants from other reflective groups to investigate their experiences of their own group, as would be an example of the implementation of theoretical sampling. Instead it had been planned in advance that the researcher would conduct one-to-one interviews with Trainee attendees following the initial six reflective practice group sessions, however the amount of interviews that would be conducted was left open for consideration of what would be required following the analysis of the initial six group sessions. In this way, the study attempted to maintain some consistency with the concept of theoretical sampling, however in a pre-planned manner. Due to the practical issues of time constraints and also management of an already large data set, it was decided to conduct one interview with each Trainee attendee.

3.3.4.5 Memo writing. Memo writing is a crucial component of grounded theory. It forms an intermediate step between data collection and presenting the findings. Memos containing the researcher's ideas about emerging codes and categories were kept throughout the course of the study which facilitated the analysis and theoretical integration. Memos were kept in several different formats including word documents, hand written notations, and diagrams (see Appendix G for some examples).

3.3.4.6 Theory generation. This formed the final stage of the analysis in which the categories, and the relationships between them, were integrated into a theoretical framework. The aim of this was to go beyond a purely descriptive account of the findings in order to produce a model that held some explanatory power. It was the case that many of the initial codes and focussed codes utilised in vivo codes, stemming directly from what participants had said. However, as these codes were progressed up the levels of analysis, the main categories were developed through the process of constant comparison analysis; by

attempting to identify the phenomenology occurring within larger segments of the group, and specifically in an attempt to identify the social processes occurring between group members at these times. Within this process of constant comparison analysis, the researcher also drew upon their own observation and experience of the group in an interpretative manner, and consequently the codes were refined and renamed in the process of development of the main categories, which were then integrated into the theoretical framework.

3.4 Methods to Enhance Quality

3.4.1 Position of the researcher. The researcher's epistemological position was aligned with a contextual constructivist viewpoint (see Appendix H for more detailed information).

3.4.2 Reflexivity and theoretical sensitivity. Theoretical sensitivity reflects the level of insight the researcher has into their own internal world and their ability to consider the impact of this, along with the reality of being an active participant within the reflective practice group, upon the research process. The more a researcher immerses themselves within the data, the greater their theoretical sensitivity becomes. This is an important part of the research process and the researcher kept a reflective diary to monitor and enhance theoretical sensitivity, which was frequently discussed in supervision.

3.5 Ethical Issues and Approval

The study achieved favourable opinion to commence data collection from the University of Leicester Ethics Review Board in March 2016 (see Appendix I). The researcher had completed the necessary training requirements prior to this (see Appendix J). A chronology of the research progress can be found in Appendix K. The study raised several ethical issues relating to informed consent, rights to anonymity and confidentiality, and data storage which were discussed with participants prior to conducting consent procedures. Participants were informed that their comments would be anonymised and disguised, in order to ensure as much as possible that other Trainees within the cohort would not be able to identify participants through any quotations used in the research report. Participants were informed that they would be free to opt out and withdraw from the research at any stage without any negative repercussions, and that opting out would not affect their routine involvement or participation within the reflective practice group in any way. Participants were informed that if they opted out, any case presentations they had given including the resulting reflective discussions, as well as any interviews they had engaged in, would not be used within

the analysis. However, that the data relating to other group members who continued to consent would still be used. One additional consideration was whether data collection within the group would impact upon the researcher's own participation within the learning experience of the reflective practice group. However, this was monitored via the reflective diary and within supervision and was perceived not to have any negative consequences on the researcher.
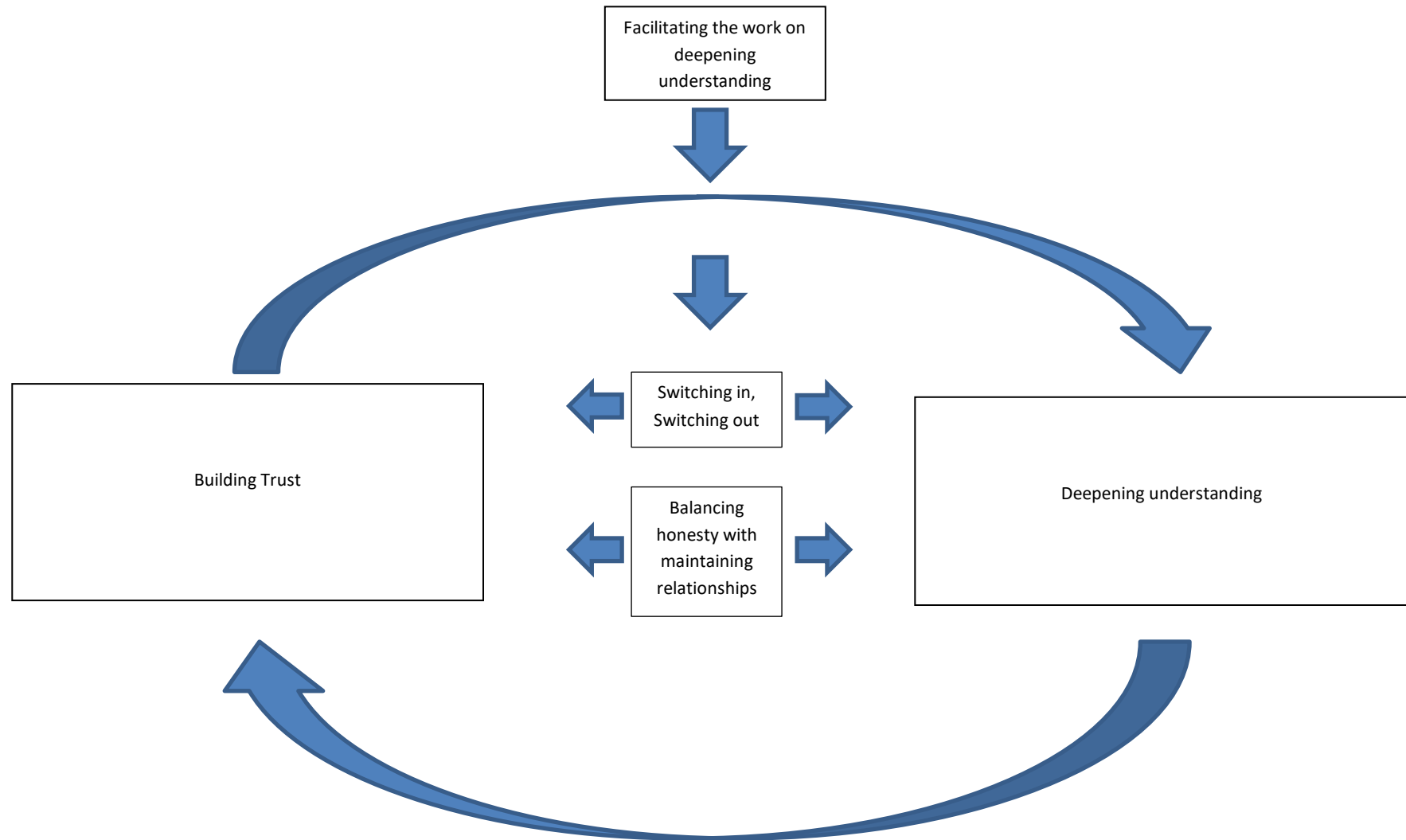
4. Results

This section will be structured by initially presenting the core category that has emerged from the analysis of the data. A visual overview of the developed theoretical model is presented in Figure 2 and a description of each main category will be briefly summarised. Quotations (*italicised*) have been used to provide evidence of the presented categories, as well as to enrich and illustrate the narrative.

4.1. The core category: Deepening Understanding in the Context of Building Trust

A core category emerged and was titled "Deepening Understanding in the Context of Building Trust". Analysis of the initial six group sessions highlighted that the reflective practice group operated as a communal thinking space, harnessed by the attendees for the purpose of deepening their understanding of the difficulties experienced within client work. However, in order for this process of deepening understanding to occur, it is essential that there is a degree of trust felt to exist within the group. Therefore, the process of building trust can be seen as central to the group's ability to be able to deepen an understanding of a case, and it is this process of deepening understanding which is experienced as helpful by the presenter with regards to their clinical client work. Consequently, the more the presenter feels as though they have been helped by the group, the more it impacts on their perception of their ability to place more trust within the group thereafter. However, trust cannot just be assumed to exist within the group, instead it must be felt and experienced as being present by the attendees during their active participation within the group. Therefore, in a sense, trust must be tried and tested, and this process happens continually throughout a group session, and across each group session that the group meets.

Figure 2: Deepening Understanding in the Context of Building Trust Within a Reflective Practice Group

Facilitating the work on deepening understanding

Switching in, Switching out

Building Trust

Balancing honesty with maintaining relationships

Deepening understanding

4.2. Main categories of the emergent theoretical model

4.2.1. Facilitating the Work on Deepening Understanding.

Analysis of the six reflective practice transcripts demonstrated that as a precursor to the process of deepening understanding, the group would engage in two processes that were reflective of Facilitating the Work on Deepening Understanding. These processes were Setting the Rules of Engagement and Fostering an Initial Understanding of a Case.

4.2.1.1 Setting the Rules of Engagement. Setting the rules of engagement involves negotiating how the group would like to make use of the reflective practice session, and then monitoring whether the group is maintaining the agreed structure throughout the course of the session. If the group has opted to present cases, a process of negotiating who will present is undertaken and the group will seek to reach an agreement as to the running order. The facilitator then often conducts the process of exploring the presenter's preferences for the format of the group's reflective discussions (e.g. the model of reflective practice to be used).

"And do we wanna use that sort of reflecting teams approach to considering the case again?" – Facilitator 1 (TR4: - L33-36)

Following this, the presenter will begin to foster the group's collective initial understanding of a case by presenting information about their client case, and this aspect of Facilitating the Work on Deepening Understanding will be discussed shortly. However, throughout the remainder of the case discussion, the group act in ways to uphold the rules of engagement. For example, upon reaching the end of the initial presentation of information, the presenter will engage in the process of inviting questions from the listeners if they have specified this earlier when stating their preferences.

"So if maybe for five minutes people can ask me questions, just until quarter past." – Participant 1 (TR1: - L154-155)

At a certain point, someone will enact the process of announcing transition into the next section of the discussions, in which the group will begin to provide reflective comments about the case material they have heard, before announcing another transition to invite the presenter back into the group to share their thoughts on the group's reflections.

4.2.1.2 Fostering an Initial Understanding of a Case. The process of Fostering an Initial Understanding of a Case commences when the allocated presenter begins presenting information about a client case. This information commonly consists of demographic details of the client, the reason for referral into the service and a description of the client's presenting problems. Furthermore, the presenter may then go on to describe the client's current level of engagement within the contact so far, and the experienced difficulty that the presenter is having within this contact. This latter information often forms the basis of providing the rationale for bringing the case to the reflective practice group for discussion.

> *"So I guess the thing that, the reason why it might be worth talking about her is, working with her really tough"…" it's really hard to kind of get her to sit with you and actually do anything." – Participant 2 (TR2: – L47–49) (TR2: - L53-54)*

Consequently, this may lead to making a request of the listeners. Often, it may be the case that the presenter does not have a specific question for the group, but rather they state they would just be interested to hear the group's reflections about the case.

> *"I guess I'd be interested in hearing any thoughts that you have about the case." – Participant 4 (TR4: – L209-210)*

However, on other occasions the presenter asks for the group to provide advice for practical action with a specific aspect of the engaging the client, and they ask a specific question of the listeners. In some cases they may not initially have a specific question that they'd like to ask, but the process of the group asking questions at the end of the presentation assists the presenter to be more specific about what they'd like to get from the group. The quote below is taken from the same case discussion as the one directly above, however, just from a later stage in the discussion.

> *"So I would just be interested I suppose to hear your thoughts about the case and you know, any suggestions about how I can be responding in those times when she's so upset." – Participant 4 (TR2: – L2007-2010)*

The rules of engagement are then enacted and maintained as the floor is then opened up to the listeners for a certain length of time in which they begin asking questions to the

presenter in order to begin the process of deepening the understanding by asking for further information. Either the presenter or the facilitator will then engage in announcing the transition into the next segment of the group, in which the listeners will begin to respond further to the information they have been presented with by offering their own reflective thoughts.

4.2.2. Building Trust.

As mentioned above, Building Trust is absolutely central to the whole functioning of a reflective practice group. Building Trust is a process which begins as soon as a reflective practice group forms. Within each session, this process is in operation as soon as the group commences with Setting the Rules of Engagement at the beginning of the session, and is active until the end of the session. Without the felt presence of a degree of trust, group members would not take the risk of bringing a case discussion to the group to present to others. Presenting a case involves taking the risk to open up, and in doing so, allowing yourself (both your personal self and your professional competence) to be exposed and vulnerable to the potential scrutiny or criticisms of others. Building Trust emerged as a main category from the analysis of the initial six reflective practice transcripts, however, its incorporation into the core category really stemmed from the focus given on this process by the participants within the follow-up interviews.

> *"It feels like it's the kind of space where you almost should be able to, have, you know, the ability to share with people what you're struggling with." Interview with Participant 4 (L100-103)*

The level of trust felt to be present influences what information the presenter chooses to provide in their presentation. For example, upon their allocated turn to present a case, a presenter will engage in the process of assessing the level of trust in the group. However, this is not necessarily a conscious process, and can very often occur outside of a presenter's conscious awareness. This assessment will be informed by both how they, individually, have been treated by the group on previous occasions as well as an observation of how other group members have been treated when presenting cases. This assessment of the level of trust in the group leads to a process of testing the water by opening up and informing of their experienced difficulty with a client. The nature of the group's responses to this opening up process can lead to one of two possible outcomes. This can lead to the presenter sensing that the response from the group is positive, and as a consequence will lead to the presenter

sensing an increased level of trust within the group. This can have the impact of the presenter being more likely to take the risk of opening up again, perhaps to a greater extent.

> *"Erm, but I guess that might be partly anyway how the process of, how, how trust is built up in the group is by people taking a chance and saying oh I'm struggling. And then the group seeing that people haven't kind of judged that person, that they've been supportive and then the next time someone else feels safe enough to say, actually I'm struggling a bit, you know." – Interview with Participant 3 (L494 – 502)*

However, if the presenter perceives that the response from the group is negative, this will lead to the presenter perceiving a reduced level of trust within the group, with the consequence of the presenter closing off and demonstrating greater inhibition in their answers. They would then be less likely to open up again, but if they did, it would be through the process of testing the water with a less significant statement than they have previously made, in order to check whether it is safe to risk opening up again in future.

4.2.3. Deepening Understanding

Deepening the understanding of a case is the main outcome of the communal thinking space of the group. It is the process of how the different perspectives of the members of the group enrich the initial understanding with additional layers of complexity.

4.2.3.1. Reflecting from a Personal Perspective. There are a number of ways in which the listeners act to deepen the collective understanding about a case. One way in which listeners contribute to deepening understanding is to offer reflections from a personal perspective such as by communicating their emotional reactions to a case.

> *"It made me feel really angry actually when you said that the mum, erm, barged in like that, and I think like you said it felt like a real intrusion." – Participant 6 (TR2: - L2198-2201)*

Another way that listeners reflect from a personal perspective is by sharing their own opinions/ perspectives. In addition, listeners may verbalise their own wonderings in the form of rhetorical questions which are used for the purpose of triggering reflections in others. Or alternatively, listeners may engage in the process of opening up by sharing an example of their

own experienced difficulty in some aspect of client work or in fact from their personal lives that is in some way related to the case material.

> *"I remember in a previous job feeling erm, I really didn't want to see a client because they lived in the same area as me, but because there were fewer and fewer people in the team it was like no you'll have to see this person. I remember feeling really, really uncomfortable about it because it was like well, there's only like one shop where we live so if I see them down the Co-op then, how's that gonna, how's that gonna be." - Participant 4 (TR5: - L454-461)*

Furthermore, if they have an area of knowledge that is relevant, they may engage in educating others for the purpose of deepening understanding.

> *"But erm, my supervisor said something to me that I didn't, erm, I dunno, kind of helped. She said it's helpful sometimes for someone to see that like although they got really, really distressed, that actually it does come back down again." – Participant 3 (TR2: - L2566-2571)*

4.2.3.2 Reflecting from the Perspective of Another. Listeners may also place themselves in the shoes of the client or another person in the client's network and offer a reflection from this person's perspective. Reflecting from the perspective of another has the function of introducing different perspectives into the developing understanding about the experienced difficulty and often leads to the listener strongly identifying with the difficulties experienced by the client. A common consequence of this type of reflection is that it tends to elicit the expression of empathy towards the client by other listeners once someone has made this type of reflection, and subsequently can lead to the presenter experiencing empathy towards the client.

> *"Their identifying and reflecting from a particular role, or the, or when I re-joined the group and there was further reflection from all of the roles about the whole thing. Definitely I remember erm, that it very, actually very positively informed how subsequent sessions with that, with that young person went"… "It impacted on our relationship I think, and, because I was working so differently with thinking about her as the, cos a lot of the things that resonated that day were much more about*

attachment theory, were much more about attunement and containment. So I think I went back in as the sort of, the container as it were. And, erm, we just approached it very, very differently." - Interview with participant 1 – (L149-153) (L185-191)

4.2.3.3. Offering a New Understanding. Within the reflective process of deepening understanding, one of the listeners may engage in the process of offering a new understanding which may be different to the initial understanding of an aspect of the client's presenting problems or the experienced difficulty already discussed. Alternatively, it may be the case that one of the listeners offers an understanding about one aspect of the client's problems or the presenter's experienced difficulty that until then had been unaccounted for or not addressed within the overall understanding.

"When you were talking erm, about the way that she presents in the session I guess it made me start to formulate that she has a high anxiety that she doesn't attend to." – Participant 6 (TR2: – L738-740)

4.2.3.4. Elaborating Further on an Understanding by Referencing Key Themes. As the reflective discussions progress, listeners may begin elaborating further on an understanding that either the presenter or another listener has offered, thereby deepening the level of understanding. At times this is aided by a process of referencing the key themes included within the presented information.

"And erm I was just thinking how could she poss, how could this woman possibly trust anybody who's in like that auxiliary parent, parental state for est, establishing a therapeutic rapport." – Participant 1 (TR3: – L1713-1715)

4.2.3.5. Bringing Ideas Together to Develop the Understanding. Consequently, as more aspects of the client's problems or presenter's experienced difficulty begin to be understood, listeners begin the process of bringing ideas together to develop the understanding further. This is where listeners begin to link aspects of understanding together to greatly deepen the degree of overall understanding. Included within this process is the act of linking aspects of the case to a psychological theory that listeners may have a personal

interest in, or substantial knowledge base that others do not, and in doing so can greatly enrich the quality of the overall understanding.

> *"Like if the mum's erm, escaping and withdrawing, withdrawing love and attachment, affection like does she see herself as kind of unimportant. And then if the dad's smothering her and not allowing her to do things but she's incapable of doing it, so she's unimportant enough to attend to her emotions but not capable enough to tend to them either at the same time." – Participant 6 (TR4:- L1281-1286)*

4.2.3.6. Scaffolding the Layers of Understanding. Throughout this process, the facilitators can engage in any of the above processes in making their own reflective offerings about the case material, however they also play a very important role. As well as seeming to be the most likely person to monitor and maintain the rules of engagement that have been set at the start of the session/ discussion, they play a role in monitoring the development of the understanding by scaffolding the layers of understanding.

> *"I think that it, that's, er, session highlighted all the other layers to this didn't it? That, and that potential of scapegoating almost, so she's the child with the problems." – Facilitator 2 (TR2: - L529-531)*

4.2.3.7. Suggesting Practical Action. As a deeper understanding of the complexities of the case develops and is enriched by the different perspectives of the group members in attendance, the reflecting listeners begin to engage in the process of suggesting practical action that the presenter could enact upon their future contacts with their clients.

> *"Like I said, you can explore his past as well, but whether you just reflect on that other people do sometimes see the world differently, some people do see it in this way. And in some ways, you know, the idea of continuums might come into it." - Facilitator 2 (TR2: – L1351-1356)*

Indeed, one participant, in the next session after their case presentation, reflected back to the group that one of the suggestions for practical action had impacted in an extremely positive manner upon their client.

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"Erm and I think Facilitator 2 suggested something that erm I actually used in the end, talking about erm understanding interaction and kind of social skills being on a scale and some people are very, very good at socialising and kind of social butterflies and get on in any group, and then yeah at the end of the scale are people who find it very, very difficult erm and that's kind of how I introduced Asperger's"... "And he said that although one or two of the things weren't quite him, he said a lot of it fit like a glove. Erm and actually it went, it went really well"... "Erm and he, he said that he, he wants erm to seek formal assessment." - Participant 3 (TR3: – L1041-1047) (L1058-1060) (L1073-1074)

4.2.3.8. Action Planning. Action planning often occurs on occasions where the presenter is invited back into the group to reflect upon the reflections of the listeners. Action planning is where a presenter may report which of the suggestions for practical action they intend to take forward and implement in their future contact with their client. This process is important as it may reinforce in the presenter's mind what action they would like to take, but it also has the role of building trust within the group, communicating to the listeners that their efforts have been worthwhile, and reinforcing the likelihood that they will offer reflections on other occasions.

"I'll have to think a bit more about that, about why it is that, you guys heard, interpreted mum as being neglect, neglecting, erm, but then she might be the first point of change in the kind of system." – Participant 1 (TR4: – L1481-1484)

Similarly, within the interviews, participants reported that they had later enacted the action plan made within the reflective practice session in their subsequent client contacts.

"I remember coming out of that that session that I was just speaking about, and I'd written down kind of bullet points in the group of, of suggestions that people had said of what I could do. Erm just because I, obviously I valued the discussions but just for my own memory aid and they were things that I went back and kind of, and tried. Kind of offering the separate time to the partner, and and trying to help her using the externalisation around the physical health difficulties but trying to get her to reflect on

maybe the way she was dealing with things wasn't the best way for him." – Interview with Participant 5 (L506-521)

4.2.3.9. Dealing with Unfinished Business. However, on some occasions the desired outcome for the presenter isn't necessarily for the listeners to make suggestions of practical action that would enable them to action plan what they will do upon their next contact with their client. Sometimes the desired outcome is more about the process of dealing with unfinished business. Dealing with unfinished business is a process that begins when a presenter takes the risk to test the water by opening up within a group about an experienced difficulty they have been having. This is particularly so when the experienced difficulty is something that has left the presenter feeling uncomfortable/ uneasy since their contact with the client. In this circumstance, instead of desiring suggestions for practical action, what the presenter desires is an acknowledgement of their difficulty, non-judgemental acceptance and for the group to help them to deepen their understanding about how and why this experienced difficulty has arisen. A presenter may be hoping that the group will help them with gaining closure, however it is also important to acknowledge that sometimes experienced difficulties never reach the point of closure. They may always remain unfinished to some degree, just less troublesome.

"So like to be able to say that I felt like I was at fault, or I was feeling guilty, or I was internalising it. To be able to say that in front of kind of colleagues and friends and have them kind of accept that, kind of makes you feel a bit better about the whole thing I think." – Interview with Participant 2 (L149-154)

This important aspect of deepening understanding for the presenter, in helping them to deal with unfinished business, appears to impact on the presenter with regards to their practice.

"Like people had, cos I remember saying I felt panicked and worried and I kind of froze. And I think I remember people saying that that was okay, you let it, it kind of played out around you and that was alright. So I think that then gave me the confidence to go back to the next sessions and adopt a similar stance and not feel like it was the wrong stance as such. But then I guess there was, it still peaked and troughed when I felt

really uncomfortable with that client because the sessions were diff, difficult." – Interview with Participant 2 - (L420-429)

However, it appeared to be difficult to establish, whether this had then impacted on the client.

4.2.4. Switching In, Switching Out

Analysis of the transcripts from the reflective practice sessions indicated that Switching in and Switching out appears to be a very important social process which plays a dual role in commencing the process of deepening the understanding of a case, but also influencing the experienced level of trust felt to exist within the group. Switching in and switching out is a process that occurs when there are opportunities to ask questions to the presenter, and therefore this occurs before the group begin to offer their own reflections about the case material. Typically, the types of questions asked by the listeners are either outward facing questions on behalf of the presenter's perspective, or inward facing questions. An outward facing question has a focus on things mostly external to the presenter. Examples of this may be asking the presenter to provide more information about the client, the service context, or the nature of the client's interactions with others either within their personal life or within a clinical setting.

Inward facing questions are those which require the presenter to take an internal focus and reflect on their own experience. Examples of these would be asking the presenter about how they feel towards the client, to reflect upon their experience of the dynamics occurring within the therapeutic relationship between themselves and the client, or to consider how and why these dynamics may be originating in the client. Furthermore, a more demanding inward facing question would be asking the presenter to consider how their own experiences from aspects of their own life may be influencing how they engage with the client and the client's difficulty, and therefore possibly contributing the experienced difficulty, or indeed maintaining the difficulty.

The group will often start with several outward facing questions, maintaining a switched out process, in order to gather further information to commence the deepening of the understanding about the case for the benefit of the listeners. However, the group will then switch in to ask an inward facing question, in which the purpose is to begin to involve the presenter in the deepening of the understanding process, but also for the listeners to aid their later reflections.

"But you said you still felt guilty, you even said you felt ashamed of having to sort of say I don't think I should be the one seeing you. Where did that come from? – Facilitator 1 (TR5: – L506-508)

"Does that erm kind of tap into something? That feeling of being belittled, for you? – Participant 1 (TR3: – L596-597)

A switched in question requires the presenter to take a risk to open up. Therefore, switching in is a process that requires a level of trust to be present within the group or else the presenter will either avoid answering the question, inhibit an important aspect of their answer and instead of opening up, begin the process of closing off . There may be a progression with regards to the depth of reflection that the switched in question may demand. For example, successive switched in questions may move from asking for the presenter's perception of the dynamics occurring in the therapeutic relationship, to their perception of what the client brings to this dynamic and how/ why, to what the presenter brings to this dynamic and the origins of this in the presenter's professional/ personal life.

However, the group plays a very important role in calibrating to the atmosphere of the group during this process. Hence switching in and switching out is a fluid process. For example, if the group is sensing great discomfort in the presenter with either the frequency or the depth of the switched in questions, a member of the group will step in and switch the process out by asking an outward facing question which has the function of giving breathing space to the presenter. Therefore, in the early stages of a group, it is likely that there may be few switched in questions at all, or that there will be a frequent process of switching in and then switching out shortly afterwards. As the level of trust builds within the group, the length of time that the presenter can tolerate a switched in process before someone switches it out can increase. However, ideally, this is something that the group should openly discuss, as to whether they are happy to answer these types of switched in questions, and the depth of question they would be happy to receive. Similarly, this is something that should be reviewed regularly, in order to gain group members' opinions of how it has felt to do this, and whether they are happy to continue doing this.

"I think it was helpful, erm, to be honest with you I'd already started switching in and having a lot of those thoughts before the session, so it's hard to pick apart maybe what, you know, what happened afterwards, whether that was more about stuff I'd

thought about, or thought about with my supervisor, or what was directly from reflective practice. Erm, but I was definitely aware to kind of take a step back a little bit and think that it was understandable why maybe I was offended by some of these comments and maybe that was me as well. And it also made me do a bit more research into the client's past, which did actually give me a lot more empathy towards his situation and, and actually his previous difficulties with women. So it, I think that was the turning moment that, that helped me with him in sessions that even if he were to make another comment, instead of getting really offended by it and taking it to heart personally, which I'll have to admit is what I was doing before, I felt more able to take a step back and, and, and use his formulation to try and understand perhaps why he was presenting that way." – Interview with participant 5 – (L380-406)

It is also possible of course, that the reason a group of listeners may seek to ask a number of inward facing questions could be because they believe the presenter has in a way given them permission to do so if the presenter has offered several inward facing reflections in the fostering of the initial understanding of the case.

4.2.5. Balancing Honesty with Maintaining Relationships

Similarly, another very important process that contributes to both the deepening of an understanding and the building of trust is Balancing Honesty with Maintaining Relationships. This is a process that occurs within the group when a listener would like to make a reflective comment about something they have heard in the case material. An example of this would be negotiating the process of disagreement with regards to the listener offering a different/ alternative understanding to that which either the presenter or another listener has stated. The function of offering their own reflective comment is for the purpose of being helpful in deepening the understanding both within the reflecting group, but also within the presenter, and in contributing to the group discussions. However, there is a balance to be struck between maintaining their own integrity in the honesty of their opinion but also maintaining their relationship with the person they would be disagreeing with and not damaging the level of trust felt within the group. Therefore, this is done by offering their own perspective but in a way that still acknowledges the opinion of the other, and in a way that is not critical or dismissive of the understanding offered by the other.

"So he might have like an uneven cognitive profile but to me it sounds more like maybe it's Autism related rather than necessarily having a learning disability. That's just my hunch." – Participant 1 – (TR2: – L1113-1119)

Therefore, if the listeners are able to find the balance between being honest and maintaining relationships, this can then provide the presenter with a useful new understanding and this can in fact increase the strength of the relationships further by boosting the level of trust within the group.

"Erm, and I think, yeah, maybe just, erm, building on what you've said already in your thoughts, erm, maybe because people, maybe because I, I knew that there would be that safe place where people try and maintain relationships and it's not about pointing out what you're doing wrong, it's about being supportive but suggesting maybe different ideas, but in a supportive way, erm, that it feels okay to, it feels okay to be wrong potentially or have an idea that maybe is not quite right. Because you know that, erm, I knew that, if it was an idea that was a bit different, that even if people disagreed with me, that it would be in a very supportive way and that suggestions would be given, so that I could move forward with the case." - Interview with participant 3 – (L256 – 274)

4.3. Reflexive account of the researcher's own observations of group processes and how these contributed to the development of the main categories

The researcher's use of the Grounded Theory methodology was aligned with that advocated by Charmaz (2006). Therefore, the researcher had the ability to use an interpretive approach to incorporating their own observations and experience of being a participant of the group into the development of the main categories within the analysis. Observationally, it appeared to the researcher as though this reflective practice group had the flexibility to function in different ways on different occasions depending on the preference of the presenter. However, the group mostly appeared to utilise a reflecting teams approach (Andersen, 1987). Therefore the researcher's observation was the reflective practice group sessions were generally organised and structured into discrete episodes of action mostly reflective of presenting a case, welcoming questions about the case, reflective discussion amongst the listeners whilst the presenter then sat out of the group, before the presenter then re-joined the group to reflect upon the group's reflections. Therefore although the vast majority of incident-by-incident initial codes were reflective of in vivo codes, the subsequent levels of the analyses

incorporated more interpretation of the data. Within the process of constant comparison analysis, the researcher drew upon their own observations and experience of the group processes in order to develop the focussed codes into the main categories. This was the case for all of the main categories within the emerging theoretical model. It is important to acknowledge that the researcher did not force the data into preconceived main categories. Instead, the researcher utilised their own experience of being a participant within the group as a helpful way of refining, developing, and organising the emergent theoretical model that had stemmed from codes grounded in the data, and in such a way that it did appear to encapsulate the phenomenology of what had been occurring within group sessions.

However, the interpretative process of incorporating the researcher's own experience of the group was particularly relevant for the main categories that were eventually named 'switching in, switching out' and 'balancing honesty with maintaining relationships'. For these two important social processes the researcher had directly observed that the atmosphere and emotions present within the group on a number of occasions had left an imprint on the researcher. This was something that had clearly resonated with the researcher, however the significance of which had not been fully understood until the researcher had become immersed within the data during the analysis. Specifically, the researcher had noted that there had appeared to be something significant about the types of questions that were asked to the presenter after the initial presentation of the case material, and that the nature of some of these questions could cause some potential discomfort to the presenter. However, from participation and observation of the group alone, the researcher had not been able to conceptualise the types of questions that were asked to the presenter, which the analysis had later elucidated.

Similarly, the researcher had also observed that on other occasions where there had been a relatively noticeable difference of opinion, group members could be quite careful about their choice of words used and the way they offered their own understanding. On some occasions, this appeared to involve a process of inhibiting a certain aspect of what they might have otherwise wanted to say, or even offering their understanding but then refraining from saying more. This was indeed a process which the researcher had personally experienced when wanting to offer what had been intended as a helpful reflective comment. However, again, this was a process that engagement with the data within the analysis helped to elucidate, and through an attempt at identifying the phenomenology of this process was subsequently named 'balancing honesty with maintaining relationships'.

5. Discussion

5.1 Summary of Research Findings

Within the current study, the use of a Grounded Theory methodology has enabled the author to successfully develop a new explanatory model of the social processes occurring within a reflective practice group that may have a subsequent impact upon attendees' client outcomes. The follow-up interviews conducted with participants and also the group session used to generate rich discussion about the emergent theoretical model were extremely useful for providing validation of many of the main categories which had emerged from the transcripts of group sessions, but also for refinement of the model.

The core category emerging from the analysis was titled 'Deepening Understanding in the Context of Building Trust' and appeared to encapsulate both the main social processes occurring within the group, and also participants' experience of the group. This core category highlights the necessity of building a safe and trusting atmosphere within the group in which participants may feel comfortable enough to risk opening up and informing the group of their experienced difficulty with a client. Following this, the group can then draw upon its communal resources to deepen the understanding of the experienced difficulty for the benefit of the presenter and the outcomes of their client. This process of being helped by the group will then consequently lead to a sense of experiencing greater trust within the group on future occasions.

With the full extent of the research question in mind, the participants of the study reported a perception that some of the identified social processes occurring within the reflective practice group had indeed impacted upon their client outcomes. However, it is the case that this study has fallen short of comprehensively determining the extent of this clinical impact with regards to client outcomes. An explanation of why this may have been the case is provided within the discussion of the limitations of the study below.

However, despite these difficulties, the findings indicated that Switching in, Switching Out as well as three aspects of the process of deepening understanding had impacted upon attendees' clinical practice: reflecting from the perspective of another, suggesting practical action, and dealing with unfinished business. Of these four processes, it was found that reflecting from the perspective of another and suggesting practical action had impacted upon attendees' client outcomes.

5.2. Links to existing theory and literature

It appears likely that one of the functions of both reflecting from the perspective of another aspect of deepening understanding and also Switching in, Switching out is to generate an experience of a greater degree of empathy towards the client. Research has consistently demonstrated that the experience of empathy towards a client is one of the strongest predictors of client progress in psychotherapy across all therapeutic modalities (Norcross & Lambert, 2011a, 2011b; Norcross & Wampold, 2011). Therefore, if attendees are able to experience a greater degree of empathy towards their client through engagement in a reflective practice group, this has great potential to impact upon their client's outcomes. This may be particularly useful when attendees' have had an experience of clients behaving in a rude or antagonistic manner towards them, and they have noted frustration within their own emotional reaction to the client; their countertransference (as described in Lemma, 2003, p. 68). Similarly, this may be extremely useful if attendees have become somewhat rigid or have invested heavily in one particular understanding of a client's difficulty.

The suggesting practical action aspect of deepening understanding appears to be relatively straightforward in terms of how this may have an impact upon the outcomes of an attendee's client. Quite simply, if a suggestion is appraised as being potentially useful, and appears to resonate with the presenter during the process of deepening understanding, trainees may experience benefits from acting upon these suggestions within their future client contacts. Consequently, if a presenter has successfully implemented suggestions for practical action following previous group sessions, thereby noting a positive impact on their client, they may be more likely to implement further suggestions for practical action made on other occasions due to Thorndike's Law of Effect (Thorndike, 1911). However, it is the forum of a reflective practice group that allows a group as one of its functions to fulfil the normative function of supervision as proposed by Proctor (1986; 2008); reviewing client progress within the process of deepening understanding. Research into the impact of clinical supervision on clients has demonstrated that supervision which took a focus on client feedback evidenced significantly better outcomes than supervision which did not focus on client feedback (Reese *et al.,* 2009). Although this was with regards to quantitative outcome measures and related to the feedback provided by clients, there may be some applicability to the qualitative feedback given by attendees within a reflective practice group about their client's progress, but also their own experiences. Indeed, it is based upon the information (feedback) provided within the process of fostering an initial understanding of a case that the deepening of the understanding can begin, and of which, suggesting practical action is a component.

The process of dealing with unfinished business however, which may be initiated either by the presenter or by the listeners, may serve the functions of seeking validation and/or containing of the presenter's distress. Validation refers to the experience of having been perceived, understood, and accepted as legitimate by another. Although related to empathy, validation is not only an empathic perception and understanding of the experience of another, but it also includes an appraisal of this experience: in what ways the experience is legitimate or justified (Linehan, 1997). Bion (1959) proposed that social groups can act as a type of container, helping to receive the extent of a group member's distress before transforming this from an experience of something unbearable into something that can be eventually thought about, held in mind and considered. Therefore, the reflective practice group may play a very important role in firstly accurately acknowledging something uncomfortable that has remained with an attendee after their client contact, before enabling them to safely explore this for the purpose of deepening their understanding of the issue. It is of course possible, that these left-over feelings of unease which are usefully brought to reflective practice may be representational of what some authors have described as a parallel process phenomena (e.g. Ekstein & Wallerstein, 1972). This refers to a process whereby a clinician presents to their supervisor in a similar manner as their client has presented to them. In this way, the containing aspect of a reflective practice group may enable an attendee to therefore feel more comfortable when returning to meet with their distressed client, and it may have role-modelled to the attendee the ability to contain the client's distress, thereby potentially impacting on the client's outcomes.

However, the findings have highlighted the need for these processes to be founded on the basis of a trusting environment, but also how these processes themselves contribute towards the development of trust within a group. Previous research into the impact of reflective practice groups on practitioners have identified the importance of building trust and experiencing a sense of safety within the group prior to attendees taking the risk to open up (Nathan & Poulsen, 2004; Robson & Robson, 2008). The results of this study appear to validate these findings. In addition, findings from research into the effectiveness of psychotherapy have demonstrated that the strength of the therapeutic relationship can account for up to 30% of the impact on a client (Lambert & Barley, 2001). Therefore, when applied to a supervisory group level such as a reflective practice group, the strength of the relationships between group members, of which trust is a key factor, can be seen as being crucially important.

Several aspects of the generated theoretical model appear to be consistent with elements of Kolb's (1984) experiential learning cycle. For example, the process of fostering an initial understanding of a case reflects Kolb's stage of the sharing of a concrete experience. The reflections given by the presenter during this time, as well as the subsequent processes of the listeners reflecting from a personal perspective or reflecting from the perspective of another are consistent with Kolb's stage of providing reflective observation. The process of bringing ideas together to develop the understanding appears consistent with the stage of abstract conceptualisation, with linking to other concepts and psychological theories. Similarly, the processes of suggesting practical action and action planning are consistent with Kolb's stage of active experimentation.

However, the features of Kolb's (1984) experiential learning cycle, as well as many other models of reflective practice (e.g. Brookfield, 1998; Gibbs, 1988; Johns, 1995; Rolfe *et al.,* 2001) appear extremely pedagogical in nature, rather than experiential, and representational of a process an individual could undertake alone. Therefore, the success of this study in generating a model of the social processes within a group undertaking the task of reflective practice is to the author's knowledge, a unique contribution to the evidence base.

What does not appear to be present within any other models of reflective practice is the importance of the processes of building trust, switching in, switching out, and also balancing honesty with maintaining relationships. These are social processes occurring between individuals, and therefore not accounted for those models of reflective practice which can be applied to an individual. Therefore, to the researcher's knowledge, the identification of the processes of switching in and switching out, and also of balancing honesty with maintaining relationships is a unique contribution to the evidence base.

5.3 Clinical Recommendations

The findings of the current study highlight the importance of investing time and effort into building the level of trust felt to exist within a reflective practice group. This trust is crucial for group members to take the risk to open up and for the group to then conduct the work on deepening the understanding of a case. It appears as though every part of the group session is an opportunity to work towards building trust, including any idiographic components of a group including processes engaged in before or after the discussion of clinical cases, such as an emotional check-in at the beginning of a group session or a check-out. At these times, as well as during case discussions, group members will be assessing the responses they receive from other members of the group and this will impact upon their sense of the level of trust within

the group. Therefore, it would be recommended that other reflective practice groups demonstrate an investment in building the level of trust within the group, within every part of the group session, in order for the group members to feel comfortable to relate to each in genuine, honest and helpful ways.

The process of switching in, switching out can involve asking direct questions to a presenter which require them at times to provide a searching and personal inward reflection. Therefore it would be recommended that when a reflective practice group first forms, there be an open discussion about the types of questions attendees would be happy to receive, and how comfortable they would be with exploring and reflecting inwardly. This is reflective of the process of contracting. In addition, it would be recommended that this is reviewed within the group at certain intervals in order to review how attendees may be finding this process. Furthermore, a purposeful point of review at certain stages could also be useful in order to explore attendees' perceptions of the level of trust within the group, and as an opportunity to consider if any changes need to be made to the functioning of the group.

Finally, it could be incredibly useful if a short period of time was allocated within each group session for the presenter/s of the previous group session to update the group as to whether their deepened understanding had impacted upon their client. Firstly, this may enable the group to identify the social processes that had been useful, and secondly, this may act to further increase the perceived level of trust within the group by reinforcing that the listeners' efforts of reflecting had been worthwhile.

5.4 Research Recommendations

The current study has generated a new theory regarding how the social processes occurring within a reflective practice group may impact upon client outcomes. However, as mentioned above, within the interviews participants appeared to have difficulty in identifying and recalling whether their deepened understanding had impacted upon their subsequent client contacts. Therefore, it could be extremely useful if future research projects could investigate the experience of participants of a reflective practice by utilising the model generated within the current study to guide the questions within interviews. Furthermore, if these future research projects could interview the participants much sooner after each occasion where they had presented a case to their group, participants may be better positioned to recall and assess whether this did impact upon their clients.

As it is acknowledged that that findings of the current study may be unique to this reflective practice group, it may also be pertinent for another study to employ a Grounded

Theory methodology to aim to generate a theory of how the social processes occurring within another group may impact upon the outcomes of the clients in attendance of that group. This may, or may not lend support to the constituent parts of the theoretical model presented within this paper.

5.5 Limitations of the Study

It was found that within the follow-up interviews, some of the participants experienced difficulty in identifying whether these social processes had indeed impacted on their clients' outcomes during subsequent contacts. There may be several reasons for this. The first potential explanation is that the interviews were conducted between seven to eleven months after they had presented cases within the reflective practice sessions recorded. Therefore, due to the long period of time that had passed, some of the participants stated that they simply couldn't remember how the reflective practice group session had impacted upon themselves, and also their client.

In addition, because of the time gap, a few participants perceived that it was hard to recall and distinguish between the impact of reflective practice at that time from the impact of more frequent, weekly clinical supervision. One participant commented that they had discussed their case with their placement supervisor first, who had advised them to bring the case to reflective practice. They perceived that a switched in process had commenced in one-to-one clinical supervision, which was then furthered through the reflective practice. Similarly, another participant commented that they had taken the insights gained from reflective practice and discussed these later in clinical supervision before incorporating these into their practice with their client. In addition, this participant highlighted that over the course of attending reflective practice, they had also discussed their deepened understanding of a case with another colleague within their clinical placement, and had sought out relevant books to further their knowledge, which they perceived had also contributed to impacting on their client's outcomes. Therefore, it was difficult to determine how much of the impact on their client was attributable to reflective practice.

Furthermore, it could be the case that because the interviews were conducted before the researcher had fed back the emergent theoretical model from the analysis to the group, participants may have had difficulty in conceptualising the social processes in the group that had not yet been identified and named.

Another limitation of the study was the time restriction imposed by the deadline of this empirical piece of research which ultimately determined the limit of the possibilities available within the procedure. One of the main considerations was being able to manage the

amount of data which would be generated by recording the number of group sessions specified, conducting the interviews, and then the group session used to discuss the emergent theoretical model. If other researchers had more time to conduct their study, it may be informative to initially record a greater number of group sessions, or to conduct several follow-up interviews with each participant, providing an opportunity to explore several of the emergent main categories with each participant. In addition, it could be extremely interesting to conduct an investigation as to how a reflective practice group may change or evolve over time, and specifically, how this may impact upon the outcomes of the clients within the group at different stages.

5.6 Conclusion

In conclusion, the current study has demonstrated that the social processes occurring within a reflective practice group can and do impact upon client outcomes. However, whether reflective practice has a direct impact, or may be helpful in conjunction with clinical supervision and other factors remains at present unclear. In addition, the current study has experienced difficulty in determining the extent of this clinical impact on clients over and above the impact on attendees' professional practice, and therefore further exploration into this area is required.

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Section D

Critical Appraisal

Critical Appraisal

1. Introduction

This paper will now provide a critique of the research process undertaken in working on this project. It is based on the reflective diary that I compiled throughout and is written in the first person as this will more effectively allow me to communicate the thoughts and feelings I experienced at various stages of the project. Therefore, an emphasis on the affective aspects of reflexivity will be elucidated. In qualitative research methods it has become widely accepted that a fundamental part of the process involves the researcher attempting to understand not only the participants' experiences, but also their own. King (2002) stated that a "blueprint" for understanding ourselves as researchers does not exist, and that the "self" is not a static concept, but an incredibly complex one containing many, often contradictory components. I share this view, and will now present a paper which will focus upon my own experiences of trying to make sense of myself as a researcher.

2. Planning the Study

2.1 Why an Interest in Reflective Practice?

Even before being accepted onto the Doctorate in Clinical Psychology, within my experiences as an Assistant Psychologist, I had developed an interest in both being part of reflective practice groups, and also in facilitating them. I considered myself to be very fortunate at this time to have the opportunity to work with a number of Clinical Psychologists and to be able to co-facilitate the groups with them. This experience enabled me to firstly begin to learn about a couple of models of reflective practice which my supervisors appeared to value and endorse. It seemed as though one supervisor had a preference in utilising the Kolb (1984) experiential learning cycle as their preferred model of reflective practice, and at times they would attempt to engage the group in reflecting within this model by drawing out the cycle either on a whiteboard or on a large sheet of A3 paper. Whereas another supervisor appeared to value the Gibbs (1988) model of reflective practice, which I perceived was attempting to take the attendees through a similar process of reflection, however with elaborations on each of the stages. Within these groups, I was witness to some quite remarkable shifts in staff's perception of, understanding of, and empathy towards client's presenting problems. Although there appeared to be much suspicion of the reflective practice groups initially, when they were offered on a continuing, consistent basis, the attendees levels

of suspicion and their guardedness appeared to reduce and they appeared more willing to open up and offer their accounts of situations they had been in with clients which had affected them in some way.

Therefore, due to my previous positive experiences of both being in and helping to facilitate reflective practice groups, when the opportunity arose to conduct a study into reflective practice for the empirical part of the thesis project, I had jumped at the chance.

2.2 Deciding on Methodology within the Research Proposal

During the process of developing the research proposal, in collaboration with my research supervisor, I began to consider the best way to attempt to answer my research question, but crucially, in a manner that was possible within the time frame given. The major consideration was with which methodology to use, and several options were discussed. One of the first options that I considered, but quite quickly dismissed was whether to attempt an ambitious quantitative project, where the clinical outcomes of clients of attendees of a reflective practice group were compared to the client outcomes of practitioners who did not attend reflective practice groups. I believe that my thinking at this time was inspired by several of the quantitative investigations I had been reading as part of the literature review for the first part of this thesis. It is a reflection that I have noticed that when I begin to imagine in my mind how a process could play out or be conducted, I can begin to invest in this idea and become excited about it. However, I took the time to ground myself at this time and to begin to consider the potential limitations of this type of methodology. It occurred to me that there would be many factors outside of my control within a project such as this. For instance, I would be dependent upon the actions of the practitioners in administering outcome measures to clients, and the findings could be severely affected by any client attrition. Also, as there appears to be a real paucity of literature about the impact of reflective practice groups, it seemed as though it would be more pertinent to conduct a qualitative project to initially explore this area and developing an understanding about how a reflective practice group might impact upon client outcomes, before considering conducting a quantitative investigation to add support to these findings.

At this time, the thought of conducting a large qualitative research project appeared extremely daunting, as the only qualitative research project I had conducted before had been a small-scale service evaluation which had used a thematic analysis. However, in collaboration with my supervisor, due to the lack of information within the evidence base, it seemed much more pertinent to conduct a qualitative piece of research. An Interpretive Phenomenological

Analysis (IPA) such as the framework outlined by Smith *et al.* (2009) was considered as an alternative methodology for the project. Therefore, consideration was given to just conduct interviews with the attendees of a reflective practice group to explore their experience of the group, rather than recording and analysing the contents of group sessions and then following up with interviews. The benefits of this would have been potentially a smaller data set. However it would have been the case that many more interviews would have been conducted. However, my interest was more aligned with the generation of a new theory in this area that has not been widely studied, and therefore, a Grounded Theory study appeared more appropriate.

3. Collecting the Data

3.1 Recruitment and Sampling

3.1.1 Impact on my own participation

One of the ethical considerations for this project was whether the decision to recruit my own reflective practice group as the sample within the naturalistic design of this study would have a negative impact on my own ability to freely and openly participate within the process of reflective practice for my own learning within this Doctorate in Clinical Psychology. This was especially pertinent as I had always enjoyed reflective practice groups, and saw myself as an active participant of my group within the University here. 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.

Once I had commenced the researcher project, within the first two monthly reflective practice group sessions, I did notice that my attention was distracted on a number of occasions by a concern as to whether the dictaphone was still switched on and was recording. I noted that I would attempt to remain in the position of how I was sat but look in the direction of my dictaphone, which I had placed on top of my diary, on the floor in the middle of the circle of the group. This was partly because I was attempting to be cost effective with purchasing batteries for the dicatphone and I would keep using the same batteries until they had run out of charge. The consequence of this checking the dictaphone within the session meant that on one or two occasions within these two sessions my attention was distracted and I temporarily lost hold of the thread of what someone was saying when they were speaking. Following this, I decided that it would be much more practical to put fresh batteries

into the dictaphone at the start of each episode of recording, and that I could use the replaced batteries up fully when listening back to the recordings in order to transcribe the audio material. This decision really seemed to take the pressure off as I did not feel as though I needed to check the dictaphone within any of the further group sessions, and could completely concentrate on the discussions being held.

Another reflection on this topic, was that throughout the course of this research project, within each reflective practice session I was aware that there may be a possibility that the other attendees may perceive that I had made a certain comment within my reflections just to attempt to sound good on the recording, and to skew the results of the study in a positive manner. I kept this reflection in mind throughout the course of recording the six sessions. I attempted within each of the sessions to just engage in the manner in which I had always done within these reflective practice sessions, and I did not notice myself being drawn to give a disingenuous reflection at any stage. Neither did I perceive any of the other attendees reacting to any of my reflections with suspicion.

3.1.2 Impact on others participation knowing they are being recorded

One of my other main concerns regarding the ethical considerations of the study was whether the other attendees of the group may feel somewhat inhibited in their ability to honestly and openly reflect on the material cases discussed knowing that the session was being recorded and that quotes would be included within the research report. Indeed, research into the area of nondisclosure in supervision (Reichelt *et al.,* 2009) has indicated that inhibition of information is not uncommon within supervision sessions. Although I had some concern that this could potentially affect the quality of my data, my main concern was whether this would affect the learning experience of the attendees. It is possible that the attendees may have felt inhibited to some degree, however, on reflection, my experience of the group sessions were that people did continue to take risks in opening up and making disclosures within the group, which, as stated above, is a process that is inherently exposing. Therefore, although they have been somewhat inhibited by the fact that the discussions were being recorded, it certainly didn't stop the participants from opening up about certain key issues, which always led to extremely interesting reflections from the group.

 Interestingly, in some ways, the fact that the discussions were being recorded seemed to influence the group discussions in a positive way at times such as being representational of the Hawthorne effect (Landsberger, 1958). This was the case, for example, within the very first group session that was recorded and one of the group facilitator's questions had appeared to

be influenced by the research question itself. This facilitator referenced the nature of the research question of the study before asking what the presenter had taken from the session which may impact upon their subsequent contact with their client. Although this was the only occasion that a question of this type was explicitly linked back to the research question, it is possible that it continued to stay in the minds of some of the participants throughout the research. Therefore, it is possible that at times the group may have actually maintained its focus more so, due to the fact that it was being recorded than may have been the case if it was not being recorded. A later reflection that I then made on this point within the reflective journal was that this is not necessarily to say that the group is unrepresentative of other reflective practice groups just because this group was being recorded, or that the findings are not valid. This may instead indicate that it would be useful for other groups to have an explicit focus and to ask directly what has resonated with the presenter that they intend to take forwards with their client upon future contacts.

3.2 Recording the Initial Six Reflective Practice Group Sessions

The process of recording initial six reflective practice group sessions appeared to go smoothly. As I began to conduct analysis on the first few group sessions, I noticed that some of the initial categories that had emerged from these early transcripts were in my mind when I was listening to other participants present their cases or reflect on what they had heard another say. On some occasions this seemed helpful, as it appeared to help me to structure my thinking and the reflection I had wanted to give. However, I was also aware that I did not want my thinking to be restricted to a reductionist set of topics as a result of being privy to the analysis of the transcripts. Therefore, I attempted to allow myself to continue to be creative with my thinking and to reflect in a similar way as I would have done before I had commenced this research project. It was at this time that I began to reflect that my intention for dissemination of the findings was that I wanted this to be helpful to other people, and in a similar way, for it not to restrict their thought processes or the manner in which they reflect to case material.

3.3 Conducting the Follow Up Interviews

3.3.1. Colleague/ friend vs therapist vs interviewer conflict

The process of conducting the interviews led to some interesting and unexpected experiences for me. Although I'd prepared very well myself, and also through discussions in supervision, when my participants arrived and sat down in the room for the interviews, I noted

that I became slightly anxious. This was quite unexpected as the participants were people I knew very well; people I would consider good friends. However, reflecting on this afterwards, I believe that as I'd become very invested in this research project, and I was wanting to do a good job within the interviews to produce some interesting data but also to appear competent as a researcher, this had added an element of pressure that I hadn't necessarily felt within the initial six reflective practice group sessions.

In addition to this, within the first two interviews I conducted, I noticed that I was perhaps being slightly overfamiliar with the interviewees due to the fact that I know them very well. Although, I was relatively effective at working through my interview schedule and covering the questions I wanted to ask them, I noticed that my manner was quite different to how I would have been if I'd have been interviewing a participant I hadn't known before. Although, the other aspect of this reflection is that my welcoming and friendly manner was hopefully something which had acted to put the interviewees at ease as much as possible, as they were possibly quite anxious too due to their reciprocal relationship to me as a friend and colleague.

I also noticed that my responses to the interviewees comments were often more representational of how I would respond in a clinical therapy setting rather than what might be beneficial in a research interview. For instance, I noticed that I often attempted to summarise what an interviewee had said or to reflect points back to them, rather than asking them to summarise what they had said. However, with each of these three issues, I attempted to adapt and amend my manner and approach in the subsequent interviews as a point of learning and development.

3.3.2. Pleasing the experimenter

I was conscious within the interviews that the interviewees may experience demand characteristics (Orne, 1959; 1962) and feel a sense of pressure to speak positively about the reflective practice group even if this wasn't how they honestly felt about it, due to the fact that this was my research project. Therefore, in order to address this, in the short briefing before we began recording or within the interview itself, 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. Consequently, the participants did discuss some of the aspects of the group that they had perceived as being more unhelpful than helpful.

Therefore, it did not appear as though demand characteristics were confounding the results of the study.

3.3.3 The unexpected emphasis on trust that came out of the interviews

Within the interviews I had originally planned to follow up on certain emergent themes within the analysis which had been relevant to that participant's presentation, and for the most part, this is what I did. However, many of the participants ended up independently and spontaneously getting onto the topic of talking about their perception of trust within the group. Therefore, the main category of building trust appeared to be very heavily validated through the interview process and it was at this stage that I gave consideration as to whether to incorporate this into the core category. Due to the prevalence of this as a discussion point within interviews, it enabled me to tailor an aspect of the final interview to expand upon my understanding of how the participants' conducted their assessment of the level of trust within the group. Specifically, I incorporated questions into this final interview such as asking about what were considered to be helpful responses from others in the group and what were unhelpful responses.

3.3.4. Remaining uncertainty about implications within university of being fully honest

I had several reflections over the course of this project about whether the university was the best choice of venue for the reflective practice group. It is indeed understandable as to why the group is facilitated within the university, for instance, such as ease of access to prior or subsequent teaching sessions in the teaching day, and so that another venue does not have to be provided either free or charge, or for a monetary charge. It is the case that trainee's participation/ performance within the reflective practice group is not assessed in any way that would contribute towards their academic grades, however it appears as though there was some confusion about this, especially within the first year of the group. On reflection, it was not clear initially as to whether this was the case, and even I was slightly suspicious that comments we made within the group may be reported back to our university tutors, and in some way affect our progress/ grading within the course, even despite the group facilitators had assured us that this was not the case. However, as time went on, and especially as we progressed through the second year and into the third year of study, I noted that I was experiencing greater confidence that we could be truly free to reflect as openly and honestly

as we want, and that our reflections would be received in confidence by the group facilitators, without information being passed back to our university tutors.

However, despite this development of my confidence in the confidentiality in the group, I began to reflect and wonder whether trainees may be able to arrive at this aspect of trust somewhat sooner if the group was facilitated outside of the university, in more of a neutral venue. My final position on this reflection is that I am not sure. It seems as though there may be several benefits with regards to the group being facilitated away from the context of an environment that is associated with assessments of performance and academic grades. However, it is surely the case that hosting the group within the premises of the university is extremely beneficial too.

3.4 Recording the Presentation of Analysis Reflective Practice Session

I noted that I was feeling understandably nervous about presenting the explanatory theoretical model to the reflective practice group in the hours prior to doing so. This was to form stage three of the data collection. I believe that this anxiety was stemming from the fact that I had worked very hard on the analysis of the initial six group sessions and I was keen to get the feedback of the group as to whether the model reflected their experience of being in the group. As a researcher, this was an important stage of seeking participant validation of the model and an important opportunity to refine the model based upon their feedback and the rich group discussions that I was hoping would ensue. I was aware that I wanted to uphold the integrity of the model, and present it in a way which was clear and concise. However, as a member of the group myself, I was aware that I also needed to present it in a way which would not feel threatening to any of the group members, and would not breach the right to anonymity of any of the members with regards to what they had spoken about within the interviews. This was particularly pertinent with regards to the way I would need to explain the processes of Switching In, Switching out, and also Balancing Honesty with Maintaining Relationships. I was aware that the model indicated that the level of trust within the group would be affected by the way that I presented the model to the group. Therefore, I attempted to present this in a way that validated the efforts of the group to be mindful of group member's feelings and the level of trust. I attempted to demonstrate my understanding of the way the group would calibrate to the atmosphere in the group when Switching In and Switching out and that no one was to blame if for any reason the group retained a Switched In position for some time before switching out. In addition, it was important to convey that Balancing Honesty with Maintaining Relationships did not convey that anyone had been wrong

in their initial understanding, but rather that others had useful other alternate understandings which they wanted to share. It appeared as though the group seemed to respond well to my presentation of the emergent model, and a rich group discussion ensued afterwards.

4. Analysing the Data

4.1 Using Grounded Theory

As I had never conducted a Grounded Theory project before I was initially very excited and enthusiastic about commencing the analysis once I had begun collecting data. I had purchased my own copy of the Charmaz (2006) book and was using this as guidance to help me to commence the analysis. Although the Charmaz (2006) book is extremely well written, I had some initial difficulty with fully understanding the process of how one level of coding would progress on to the next. However, it very much seemed to be the case that my understanding increased significantly through the process of experiential learning at the stage when I had a completed transcript in front of me and I could then attempt to commence the coding process. From this point onwards, the book was incredibly helpful in not only guiding my practice but also stimulating my thinking in creative ways when generating initial codes and then focussed codes.

My main difficulty, as I discovered, was my attempt to be extremely thorough and my difficulty in keeping the codes relatively short in length. In addition, I had a very frequent tendency to code more than the planned amount of approximately four times per page, and therefore, I generated a large amount of initial codes, and subsequently more focussed codes than I had initially intended. Although this was incredibly useful and informative with exploring the data, it meant that the process of conducting analysis took me much longer than I had initialled anticipated.

5. Personal and Professional Development

5.1 Developed Professional Skills

Through the process of conducting this research project, I believe that I have developed my competencies in many areas. Perhaps the most significant impact of this on me has been my confidence that I am able to plan, propose, conduct, and then analyse the data, and then write up a large scale qualitative project. This is something I had never done before and something that I had doubts that I would be able to complete due to my lack of experience. However, I have done it! In addition, the prospect of conducting further research

within my career is something that quite appeals to me and I would be very keen to think about how I could personally contribute further to the evidence base about the clinical impact of supervision and reflective practice on clients.

5.2. Personal Impact of the Research

Linked to the reflection above, I know feel as if I know something about the evidence base relating to the impact of clinical supervision and reflective practice on client outcomes. This will undoubtedly influence the way in which I engage in clinical supervision myself in the future, both as a supervisee and as a supervisor. I would definitely want to attend supervisor training and would like to base my style of providing supervision in one of the established models.

I would also like to be part of a reflective practice group again in the future, and similarly, either as an attendee, or as a facilitator. I will now forever keep in mind that it appears as though reflective practice is primarily about deepening understanding in the context of building trust. Therefore, I will ensure to invest fully within the process of building trust within the group, and will seek to initiate conversations at regular intervals to check in with attendees' perceptions of the level of trust within the group.

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Appendix A – Intended Journal Guidelines

Author Guidelines

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Author Guidelines

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Manuscripts for submission to *The Journal of Clinical Psychology* should be forwarded to the Editor as follows:

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2. Go to the URL http://mc.manuscriptcentral.com/jclp

3. Register (if you have not done so already).

4. Go to the Author Center and follow the instructions to submit your paper.

5. Please upload the following as separate documents: the title page (with identifying information), the body of your manuscript (containing no identifying information), each table, and each figure.

6. Please note that this journal's workflow is double-blinded. Authors must prepare and submit files for the body of the manuscript that are anonymous for review (containing no name or institutional information that may reveal author identity).

7. All related files will be concatenated automatically into a single .PDF file by the system during upload. This is the file that will be used for review. Please scan your files for viruses before you send them, and keep a copy of what you send in a safe place in case any of the files need to be replaced.

Timothy R. Elliott, Editor-in-Chief
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New York, NY 10027
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Manuscript Preparation

Format . Number all pages of the manuscript sequentially. Manuscripts should contain each of the following elements in sequence: 1) Title page 2) Abstract 3) Text 4) Acknowledgments 5) References 6) Tables 7) Figures 8) Figure Legends 9) Permissions. Start each element on a new page. Because the *Journal of Clinical Psychology* utilizes an anonymous peer-review process, authors' names and affiliations should appear ONLY on the title page of the manuscript. Please submit the title page as a separate document within the attachment to facilitate the anonymous peer review process.

Style . Please follow the stylistic guidelines detailed in the *Publication Manual of the American Psychological Association, Sixth Edition*, available from the American Psychological Association, Washington, D.C. *Webster's New World Dictionary of American English, 3rd College Edition* , is the accepted source for spelling. Define unusual abbreviations at the first mention in the text. The text should be written in a uniform style, and its contents as submitted for consideration should be deemed by the author to be final and suitable for publication.

Reference Style and EndNote . EndNote is a software product that we recommend to our journal authors to help simplify and streamline the research process. Using EndNote's bibliographic management tools, you can search bibliographic databases, build and organize your reference collection, and then instantly output your bibliography in any Wiley journal style. *Download Reference Style for this Journal:* If you already use EndNote, you can [download the reference style](#) for this journal. *How to Order:* To learn more about EndNote, or to purchase your own copy, [click here](#) . *Technical Support:* If you need assistance using EndNote, contact [endnote@isiresearchsoft.com](#) , or visit [www.endnote.com/support](#) .

Title Page . The title page should contain the complete title of the manuscript, names and affiliations of all authors, institution(s) at which the work was performed, and name, address (including e-mail address), telephone and telefax numbers of the author responsible for correspondence. Authors should also provide a short title of not more than 45 characters (including spaces), and five to ten key words, that will highlight the subject matter of the article. Please submit the title page as a separate document within the attachment to facilitate the anonymous peer review process.

Abstract. Abstracts are required for research articles, review articles, commentaries, and notes from the field. A structured abstract is required and should be 150 words or less. The headings that are required are:
Objective(s): Succinctly state the reason, aims or hypotheses of the study.
Method (or Design): Describe the sample (including size, gender and average age), setting, and research design of the study.
Results: Succinctly report the results that pertain to the expressed objective(s).
Conclusions: State the important conclusions and implications of the findings.

In addition, for systematic reviews and meta-analyses the following headings can be used, Context; Objective; Methods (data sources, data extraction); Results; Conclusion. For Clinical reviews: Context; Methods (evidence acquisition); Results (evidence synthesis); Conclusion.

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Software and Format . Microsoft Word is preferred, although manuscripts prepared with any other microcomputer word processor are acceptable. Refrain from complex formatting; the Publisher will style your manuscript according to the journal design specifications. Do not use desktop publishing software such as PageMaker or Quark XPress. If you prepared your manuscript with one of these programs, export the text to a word processing format. Please make sure your word processing program's "fast save" feature is turned off. Please do not deliver files that contain hidden text: for example, do not use your word processor's automated features to create footnotes or reference lists.

Article Types

- **Research Articles** . Research articles may include quantitative or qualitative investigations, or single-case research. They should contain Introduction, Methods, Results, Discussion, and Conclusion sections conforming to standard scientific reporting style (where appropriate, Results and Discussion may be combined).

- **Review Articles** . Review articles should focus on the clinical implications of theoretical perspectives, diagnostic approaches, or innovative strategies for assessment or treatment. Articles should provide a critical review and interpretation of the literature. Although subdivisions (e.g., introduction, methods, results) are not required, the text should flow smoothly, and be divided logically by topical headings.

- **Commentaries** . Occasionally, the editor will invite one or more individuals to write a commentary on a research report.

- **Editorials** . Unsolicited editorials are also considered for publication.

- **Notes From the Field** . Notes From the Field offers a forum for brief descriptions of advances in clinical training; innovative treatment methods or community based initiatives; developments in service delivery; or the presentation of data from research projects which have progressed to a point where preliminary observations should be disseminated (e.g., pilot studies, significant findings in need of replication). Articles submitted for this section should be limited to a maximum of 10 manuscript pages, and contain logical topical subheadings.

- **News and Notes** . This section offers a vehicle for readers to stay abreast of major awards, grants, training initiatives; research projects; and conferences in clinical

psychology. Items for this section should be summarized in 200 words or less. The Editors reserve the right to determine which News and Notes submissions are appropriate for inclusion in the journal.

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Production Questions:

Jackie Beggins
E-mail: jbeggins@wiley.com

Appendix B – Search terms used within Literature Review.

Database	Terms Used In Search
PsycINFO	Supervision AND impact* OR effect* OR outcom* OR evaluat* OR measur* OR benefit* OR influen* OR gain* OR improv* OR efficac* OR positiv* OR negativ* AND client OR patient OR service user
Scopus	TITLE-ABS-KEY(clinical PRE/3 supervision OR "psychotherap* supervision" OR "counsel* supervision" AND client OR patient OR "service user" AND impact* OR effect* OR outcom* OR evaluat* OR measur* OR benefit* OR influen* OR gain* OR improv* OR efficac* OR positiv* OR negativ*) AND (LIMIT-TO (DOCTYPE,"ar")) AND (LIMIT-TO (LANGUAGE,"English")) AND (LIMIT-TO (SRCTYPE,"j"))
Web of Science Core Collection	Clinical NEAR/3 supervision OR psychotherap* NEAR/3 supervision OR counsel* NEAR/3 supervision AND client* OR patient* OR "service user*" AND impact* OR effect* OR outcom* OR evaluat* OR measur* OR benefit* OR influen* OR gain* OR improv* OR efficac* OR positiv* OR negativ*
ASSIA	Supervision AND impact* OR effect* OR outcom* OR evaluat* OR measur* OR benefit* OR influen* OR gain* OR improv* OR efficac* OR positiv* OR negativ* AND client OR patient OR service user
Social Services Abstracts	Supervis* AND impact* OR effect* OR outcom* OR evaluat* OR measur* OR benefit* OR influen* OR gain* OR improv* OR efficac* OR positiv* OR negativ* AND client OR patient OR service user

Appendix C - Data Extraction Proforma

Title:-		
Author(s):-		
Publication date:-	Place of publication:-	
Journal:-		
Volume:-	Number:-	Pages:-
Aims:-		
Study type/ Design:-		
Experienced therapists/ supervisors?:-		
Is there a clear description provided of the model of supervision/ the supervision process (e.g. frequency of supervision sessions/ duration/ number of staff involved)?:-		
Outcome measures utilised which fit into account of the initial goals of the study? What intervals of assessment time points were used for data collection?:-		
Was the patient, not therapist, involved in measurement of treatment outcomes?:-		
Did the therapist use a manual for their therapy? And was their adherence to this checked?:-		
Was the sample size adequate within the study?:-		

Appendix D - The Research Tools

1. Participant Information Sheet

University of Leicester
Clinical Psychology
104 Regent Road
Leicester
LE1 7LT
Tel: 0116 223 1639

Research and Development department
Swithland House
352 London Road
Leicester
LE2 2PL
Tel: 0116 295 7641

Short title of the study: Does reflective practice impact upon clinical outcomes and if so, how?

Participant Information Sheet

Please read this information carefully and feel free to ask any questions or to request further information.

Chief Investigator: Mark Loveder, Trainee Clinical Psychologist
Date: 29/01/2016
Study number: PSYC0759

You are being invited to take part in a research study. Before you make your decision, it is important for you to understand why the research is being conducted and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask the Chief Investigator if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?:-
Clinicians may anecdotally report that they find reflective practice groups useful in helping them to reflect upon difficulties experienced in their contact with clients/ patients. Furthermore, they may report that the insights gained from the discussions within these groups can impact upon their client's /patient's outcomes upon future contacts with these clients/ patients. However, there is little published research evidence to support these anecdotal claims, and therefore the purpose of this study is to investigate reflective practice group members' perceptions of the impact of these groups on their clinical client outcomes.

Why have I been chosen?
You have been chosen because you regularly attend reflective practice group sessions within the Clinical Psychology department at the University of Leicester.

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 be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect your continued participation in the reflective practice group which you regularly attend.

What will participation in this study involve?:-
Participation will involve providing informed written consent for the chief investigator to audio-record six reflective practice group sessions that you routinely attend at the University of Leicester using a dictaphone across your second and third year of study. There is no requirement to do anything different than you would otherwise do within these reflective practice group sessions as the chief investigator will operate the dictaphone. Participation will also involve providing informed written consent to attend and engage within at least one follow-up 1:1 interview with the chief investigator after the sixth reflective practice group session has been recorded. Participants attending the 1:1 interviews will be asked a number of questions relating to the themes that have emerged from the analysis of the group's discussions as well as the participant's experience of the group's discussions. The chief investigator will audio-record these 1:1 interviews. Additionally, participation will also involve providing informed written consent for the chief investigator to utilise one of your reflective practice group sessions within your third year of study to present and discuss with the group the analysis from the prior stages of this study. The chief investigator will audio-record this dedicated reflective practice group session.

How will confidentiality and anonymity be ensured?:-
The chief investigator will safely and securely store the dictaphone used to make the audio recordings in this study in a locked drawer, in a locked room within the premises of the Clinical Psychology department in the University of Leicester when it is not in use. A password protected USB memory stick will be used to save the typed transcripts of these audio recordings and this,

Version 1   29/01/2016

along with the printed transcripts, will also be stored within this locked drawer when not in use. The chief investigator and the chief investigator's academic supervisor for this research project, Dr Arabella Kurtz, will be the only people to have access to these materials, and listen to/ view them during the conduct of the study. The audio recordings, digital files of typed transcripts and printed transcripts will be archived in this location for a period of 5 years after the completion of the study, and after this period of 5 years they will be destroyed. Paper documents will be destroyed by shredding, and the digital files will be deleted. Additional steps will be taken to ensure that the participants' rights to privacy are upheld. Within the analysis, the chief investigator will anonymise and disguise, via pseudonymisation, aspects of the discussions if necessary to make sure that participants will not be able to identify each other when being presented with the final analysis.

Ethical considerations:-

At every stage of this research study the dignity of the participants will be considered and they will be treated with the utmost respect. Efforts will be made to ensure that all processes will be made clear and transparent to the participants. Participants will be able to opt out of the study at any time without any negative consequences or repercussions. If any individual participants of the sample group opt out at any stage of the research, the audio recordings of this participant's case presentations within reflective practice group sessions and their 1:1 interviews will not be used within the analysis. However, the data relating to the other participants from this group who continue to consent will still be used. Opting out of the study will not affect reflective practice group members' involvement in their routine reflective practice group sessions.

Plans for dissemination

The final edit of the thesis will be submitted to the University of Leicester for grading. The chief investigator will then be required to undergo the Viva process and discuss aspects of this study with external examiners. Following this, the chief investigator will make arrangements to present the findings of the study to the participants of the research. Additionally, the chief investigator will present the findings of this research as either a verbal presentation or poster presentation at the University of Leicester Trainee Research Conference in September 2017. The chief investigator will then seek to submit this research report to an academic journal for publication.

How to contact the chief investigator

If you have any questions about the study, please don't hesitate to contact the chief investigator via email to: ML373@LE.AC.UK or through the Clinical Psychology department's telephone number (0116 223 1639)

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University of Leicester

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Leicestershire Partnership NHS

NHS Trust

Research and Development department
Swithland House
352 London Road
Leicester
LE2 2PL
Tel: 0116 295 7641

Study number: PSYC0759
Participant Identification Number for this trial: 1

CONSENT FORM

Title of Project: Does reflective practice impact upon clinical outcomes and if so, how?
Chief Investigator: Mark Loveder, Trainee Clinical Psychologist

Please initial each box

1. I confirm that I have read and understood the Participant Information Sheet dated 29/01/2016 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my participation in the reflective practice group being affected.

3. I agree to take part in the above study.

_____   _____   _____
Name of Participant (BLOCK LETTERS)   Date   Signature

_____   _____   _____
Researcher (BLOCK LETTERS)   Date   Signature

When completed: 1 for participant; 1 for researcher trial master file.

Version 1   29/01/2016

Appendix E - Examples of Coding

1. Initial 'Incident-by-Incident' Coding

Initial Coding	Section of TR3 (L954-971)
Stating intention to make one final point	Facilitator 1 – I, I just had one more point I was gonna (.) mention. I thought (.) erm (.) I was just curious as to (.) I know you've sort of suggested why it's gonna be difficult, but (.) you've talked about (.) not really wanting to do this, to have to sort of broach it with him, and you, you mentioned your fear that he might sort of close up
Asking direct question as means of exploring alternate hypothesis for not wanting to act	and not get something from the group. Do you think there's an element of (.) not wanting him to see you as someone who can't take it?
Pausing	(Five second pause)
Agreeing partially. Pausing	5 – Maybe secondary. Erm (Five second pause). I don't think it's kind of a one-upmanship with him,
Explaining partial agreement as more about his feelings than presenters	it woul, it would be more, I think he'd genuinely be upset to think he'd upset me.
	Facilitator 1 – Mmm
	5 – I wouldn't be worried about kind of (.) maybe putting to him a reflection of how it made me feel. (.) I don't think that would make me weak.
	(.)
Asking follow-up question requesting presenter to think and reflect	Facilitator 1 – But then I spose the question is, is, is that a bad thing for someone to be upset to know that-

Initial Coding	Section of TR3
	(L954-971)
Returning to case to ask another switched in question	Facilitator 1 – I, I just had one more point I was gonna (.) mention. I thought (.) erm (.) I was just curious as to (.) I know you've sort of suggested why it's gonna be difficult, but (.) you've talked about (.) not really wanting to do this, to have to sort of broach it with him, and you, you mentioned your fear that he might sort of close up and not get something from the group. Do you think there's an element of (.) not wanting him to see you as someone who can't take it?
Pausing to think	(Five second pause)
Avoiding answering the question	5 – Maybe secondary. Erm (Five second pause). I don't think it's kind of a one-upmanship with him, it woul, it would be more, I think he'd genuinely be upset to think he'd upset me.
	Facilitator 1 – Mmm
Disclosing own perception of related issue	5 – I wouldn't be worried about kind of (.) maybe putting to him a reflection of how it made me feel. (.) I don't think that would make me weak. (.)
Following up by asking another inward facing question	Facilitator 1 – But then I spose the question is, is, is that a bad thing for someone to be upset to know that-

Appendix F – Evidence of Saturation

Transcript Number	Category Title	New Category?
1	Setting the rules of engagement	Yes
	Fostering an initial understanding of a case	Yes
	Reflecting from a personal perspective	Yes
	Reflecting from the perspective of another	Yes
	Balancing honesty with maintaining relationships	Yes
	Communicating emotional reactions to a case	Yes
	Assigning importance to key points/ themes	Yes
	Suggesting practical action	Yes
	Bringing ideas together to develop understanding	Yes
	Offering a new understanding	Yes
	Scaffolding the layers of understanding	Yes
	Action planning	Yes
2	Making disclosures	Yes
	Dealing with unfinished business	Yes
3	Switching in, switching out	Yes
	Saving face	Yes
4	None	N/A
5	None	N/A
6	Building trust	Yes

Appendix G - Examples of Memos

1. Written Memo

③ Reflecting from your own perspective

Reflecting from your own perspective enables group members to express their reactions to hearing the case material. These reflections can be in the form of expressing the emotions listeners have experienced upon hearing about the case or the thoughts that have come up for them at this time. This can enable the listener's to empathasise with the presenter and invariably reflecting from your own position if you are a health care professional means placing yourself in the shoes of the therapist, the presenter.

Reflecting from your own (perspective/position) may occur if in the structuring of the session, the presenter has not allocated specific roles to the other group members. However even if group members have been allocated roles, they may still attempt to reflect from their own perspective if important things have come up for them that they want to express. Additionally, there may be time following reflecting from the perspective of an allocated role for group members to reflect from their own perspective. This, at times, includes talking time to think, and trying to find the right words.
This may also include reflecting on their countertransference feelings about the clients.
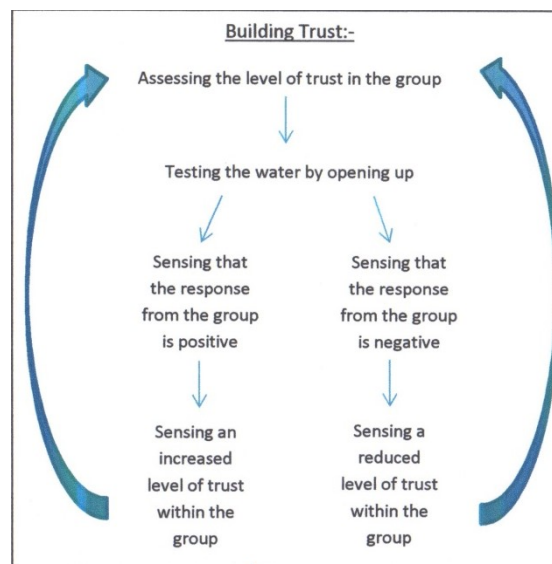
2. Electronic Memo

Memo: - Reflecting from the perspective of a specified, allocated role

Reflecting from the perspective of an allocated, specified role enables the attendees to consider other perspectives that they may not ordinarily consider. When they provide their reflections to the group, this gives voice to these identified people and provides additional information and layers of understanding to the developing formulation. This may then trigger further reflections which are offered by other members of the group.

This will ensure that everyone in the group speaks and contributes to the reflective discussions.

3. Diagrammatical Memo

Building Trust:-

Assessing the level of trust in the group

↓

Testing the water by opening up

Sensing that the response from the group is positive

Sensing that the response from the group is negative

↓

Sensing an increased level of trust within the group

Sensing a reduced level of trust within the group

Appendix H - Statement of Trainee's Epistemological Position

As stated in the main body of the research report, the researcher's epistemological position was aligned with a contextual constructivist viewpoint. Therefore, the researcher held a belief that social realities are created through individual and collective action. The work by Charmaz (2000; 2006) on constructivist grounded theory emphasised the imperative role and impact of the researcher within the research process, and the importance of ensuring that the analysis and the construction of theory are grounded in the data. This approach resonated strongly with the beliefs and epistemological position of the researcher, and therefore, was adopted principally over other grounded theory methods that were influenced by positivist approaches, such as Glaser and Strauss (1967). Charmaz notes 'a constructivist approach means more than looking at how individuals view their situations. It not only theorises the interpretive work that research participants do, but also acknowledges that the resulting theory is an interpretation. The theory depends on the researcher's view; it does not and cannot stand outside of it' (Charmaz, 2006, pp 130). Hence it is critically important that grounded theory researchers take a reflexive stance towards the research process.

References

Charmaz, K. (2000). Grounded Theory: Objectivist and constructivist methods. In N. K. Denzin & Y. S. Lincoln (Eds), *The Handbook of Qualitative Research (Second Edition)* (pp. 509-535). London: Sage

Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis*. London: Sage

Glaser, B. G. & Strauss, A. L. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. New York: Aldine.

Appendix I - Letters to and from the University Ethics Review Board

1. Confirmation of Ethical Approval

UNIVERSITY OF LEICESTER   University Ethics Sub-Committee for Psychology

07/03/2016

Ethics Reference: 6019-ml373-neuroscience,psychologyandbehaviour

TO:
Name of Researcher Applicant: Mark Loveder
Department: Psychology
Research Project Title: Does reflective practice impact upon clinical outcomes and if so, how? A Grounded Theory study of how Trainee Clinical Psychologists experience the effect of a reflective practice group on their clinical work.

Dear Mark Loveder,

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:
All ethics issues have been addressed.

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

2. Request for Amendment

This amendment concerns mainly urgent safety measures already implemented?
○ Yes ● No

This amendment is to notify a temporary halt of the research project?
○ Yes ● No

This amendment is to request the restart of a halted research project?
○ Yes ● No

This amendment is to notify a change to the Principal Investigator?
○ Yes ● No

Please describe the amendment request

I would like to request an amendment to the procedure as previously described on the 'Research Proposal version 12' form, and specifically regarding point '4' of the 'Procedure' list within section '6.Methodology'.

Within point 4 of the Procedure, it was stated: 'Following each session, the chief investigator will transcribe the recorded verbal discussions into Microsoft Word before printing the transcripts.' As referenced in point 3 of the procedure, this was referring to the chief investigator having recorded (via use of a dictaphone) the case presentations delivered

Please provide reasons for the request for amendment

It has become apparent from listening to the audio-recordings within this study that within reflective practice group sessions the way a presenter delivers the information about a client case to the group may have an impact upon the way that the group provide their reflections, or the type of reflective comments that are given. Consequently, this may have an impact upon what the presenter gets out of this session for the benefit of returning to meet with their client on the next occasion with new insights and understandings, that may positively impact upon the client's progress.

Amendment Request:

I would like to request an amendment to the procedure as previously described on the 'Research Proposal version 12' form, and specifically regarding point '4' of the 'Procedure' list within section '6.Methodology'.

Within point 4 of the Procedure, it was stated: 'Following each session, the chief investigator will transcribe the recorded verbal discussions into Microsoft Word before printing the transcripts.' As referenced in point 3 of the procedure, this was referring to the chief investigator having recorded (via use of a dictaphone) the case presentations delivered by a member of the reflective practice group and then the group's reflective discussions occurring immediately after each case based presentation. Point 4 states that it is the verbal discussions (referring to those reflective discussions occurring immediately after the case presentation) that will be transcribed, ready to be analysed using the Grounded Theory methodology.

However, I would like to request permission for the chief investigator to also transcribe the case presentation segment of each audio recording (as well as the segment of reflective discussions occurring immediately after the case presentation).

Reasons for requesting an amendment:

It has become apparent from listening to the audio-recordings within this study that within reflective practice group sessions the way a presenter delivers the information about a client case to the group may have an impact upon the way that the group provide their reflections, or the type of reflective comments that are given. Consequently, this may have an impact upon what the presenter gets out of this session for the benefit of returning to meet with their client on the next occasion with new insights and understandings, that may positively impact upon the client's progress.

As the focus of this study is on the impact of reflective practice sessions on client outcomes, the segment of case presentation is therefore very important also in addition to the reflective discussions occurring immediately afterwards, and warrants investigation through analysis.

Therefore, within the Grounded Theory methodology, it would be of great importance to be able to capture the social processes occurring within the presenter as they deliver their verbal presentation to the group about their client case. In order to evidence this within the analysis the chief

investigator would need to be able to transcribe the case presentation section of the recording, ready for this to be analysed.

There would be no requirement to alter the Participant Information Sheet or Consent Form, as the participants have provided informed written consent for the reflective practice sessions to be recorded.

There are no additional ethical concerns involved in the requested amendment to procedure above or beyond those listed within the Research Proposal form. All ethical considerations already listed would be applied to the process of transcribing and analysing this extra segment of the recording, including anonymisation of client information and also participant information.

3. Confirmation of Approval of Amendment

UNIVERSITY OF LEICESTER   University Ethics Sub-Committee for Psychology

07/03/2016

Ethics Reference: 6019-ml373-neuroscience,psychologyandbehaviour

TO:
Name of Researcher Applicant: Mark Loveder
Department: Psychology
Research Project Title: Does reflective practice impact upon clinical outcomes and if so, how? A Grounded Theory study of how Trainee Clinical Psychologists experience the effect of a reflective practice group on their clinical work.

Dear Mark Loveder,

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:
The proposed amendment does not pose any additional ethics issues.

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

1. Evidence of Good Clinical Practice (GCP) in Research Training

Assessment Certificate
Issued to
MARK LOVEDER
For completion of the University
Hospitals of Leicester NHS Trust
Good Clinical Practice
GCP1

*For clinical trials **NOT** involving*
Investigational Medicinal Products
Training and Assessment on
13ʰ January 2016

Authorised on behalf of the University Hospitals of
Leicester

Julie James
Aldona Kirkham
Anne Moore
Clinical Trial Monitors and Trainers

Valid until 12ʰ January 2018

Updated October 2014

Training Certificate

Issued to
MARK LOVEDER
For completion of the University
Hospitals of Leicester NHS Trust

Consent for Research
Training on the
13ᵗʰ January 2016

Authorised on behalf of the University Hospitals of
Leicester

Julie James
Aldona Kirkham
Anne Moore
Clinical Trial Monitors and Trainers

Valid until 12ᵗʰ January 2018

Updated October 2014

3. Letter of NHS Trust Approval

Research & Development
Investigating the Future, Today

Leicestershire Partnership **NHS**

NHS Trust

A University Teaching Trust

Research & Development
Swithland House
352 London Road
Leicester
LE2 2PL

Direct dial: 0116 295 7641
Email: david.clarke@leicspart.nhs.uk

Tel: 0116 295 7500
Fax: 0116 295 7599
Web: www.leicspt.nhs.uk

DC/AK/ML/PSYC0759

18th March 2016

Mark Loveder
Trainee Clinical Psychologist
University of Leicester
c/o Centre for Medicine
Lancaster Road
Leicester
LE1 7HA

Dear Mark

RE: Does reflective practice impact upon clinical outcomes and if so, how? A Grounded Theory study of how Trainee Clinical Psychologists experience the effect of a reflective practice group on their clinical work.

Study Codes:			
Trust Reference:	PSYC0759	IRAS (REC) Reference:	16/EE/0115 (194434)
CSP Reference:	N/A	Portfolio ID:	N/A
Study Sponsor:	Leicestershire Partnership NHS Trust		

Thank you for applying for NHS Permission to conduct recruitment for the above study within Leicestershire Partnership NHS Trust. This study has now been validated and reviewed according to the Standard Operating Procedure for research appraisal. Leicestershire Partnership NHS Trust has granted you full approval to conduct this research within the Trust on the condition that the Trust suffers no unforeseen costs as a result of this study being undertaken. Your research has been entered onto the Trust's Research Database.

All research studies taking place are potentially subject to monitoring in respect of NHS Permission timelines, recruitment to time and target and so on. As a result, some of this information is reproduced in the table below. The key monitoring target is a 70-day timeline from "NHS Permission", within which the first patient or participant should be recruited, please give due regard to this requirement and inform the R&D Office if this target is likely to be breached.

"NHS Permission" applies only to the Trust issuing this letter and does not imply that permission to conduct this study is valid in any other organisation unless specifically indicated. This correspondence may be useful in securing appropriate permission in other organisations if required.

APPROVAL STATUS						
Full Approval	☒	Approval in Principle	☐	Approval refused	☐	
TIMELINES						
Date of Favourable Ethical Review (A)	07/03/2016 (University)	Date Full Documentation (Valid Application) Received (Site) (B)	14/03/2016	Sign-off timeline (A-B) 6 Days		
Date of Funding Agreement/SIV[1]	N/A	Date of Final NHS Permission (C)	18/03/2016	Sign-off timeline (B-C) 5 Days		
Target Date: First Patient/Participant Visit (FPFV)	16th May 2016					

---

[1] Underline as appropriate

Trust Headquarters: Bridge Park Plaza, Bridge Park Rd, Thurmaston, Leicester, LE4 8BL
Chair: Cathy Ellis   Chief Executive: Dr Peter Miller

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The conduct of your study (including examination of the site file) at this site may be subject to audit for protocol adherence and other monitoring. This approval is subject to the accuracy of the following information:

Study Summary

Chief Investigator (Supervisor):	Dr Arabella Kurtz		
Principal Investigator (Local):	Mark Loveder		
Other Investigators:	N/A		
Indemnity Provider:	Leicestershire Partnership NHS Trust	Start Date (Local)	05/04/2016
NIHR Portfolio:	No	End Date (Local)	28/04/2017
Student Project	Yes	Target Recruitment	8
Funding Source:	N/A	Amount:	N/A
Local NHS Support Costs:	N/A		

Please note that all research with an NHS element is subject to the Research Governance Framework for Health and Social Care 2005. If you are unfamiliar with the standards contained in this document, or the LPT policies that reinforce them, you can obtain advice from the R&D Office or your Sponsor. You must stay in touch with the R&D Office during the course of the research project, particularly if/ when:

- There is a change of Principal Investigator;
- To fulfil requirements for performance reporting;
- The project finishes (please complete a summary report form);
- Amendments are made, whether minor or substantial;
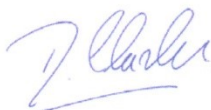- Serious Adverse Events occur (adhere to local and Sponsor SOPs).

This is necessary to ensure that your indemnity cover is and remains valid. Should any issues arise that inhibit study delivery it is essential that you contact the R&D Office immediately. If patients or staff members are involved in an incident, you should also contact the Clinical Risk Manager and report as per Trust Policy.

Provision against NHS Costs: The Trust reserves the right to invoice the study team, in the unlikely event of any unexpected costs arising from this study, including, but not limited to:

- Staff Time attending interviews.
- Travel and administrative costs

I hope the project goes well, and if you need any help or assistance during its course, please do not hesitate to contact the Office.

Kind regards

Dr. Dave Clarke
[Operational Lead: Research & Development]

C.C. Dr Arabella Kurtz (Academic Supervisor)

Trust Headquarters: Bridge Park Plaza, Bridge Park Rd, Thurmaston, Leicester, LE4 8BL
Chair: Cathy Ellis   Chief Executive: Dr Peter Miller

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Appendix K - Chronology of Research Progress

October - December 2014

- Consultation with academic supervisor

December 2014- May 2015

- Initial research proposal
- Developing research proposal

June- December 2015

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

January- February 2016

- Attended GCP training course
- Attended Informed Consent for Research training course
- Utilisation of interim consent form within Reflective Practice group to record January group session. Group provide informed written consent to begin collecting data.
- Recording of February Reflective Practice group session as per interim consent form

March 2016

- Recording of March Reflective Practice group session as per interim consent form
- Preparation and submission of electronic University ethics application form
- Favourable opinion received from University Ethics Review Board, 7th March 2016
- R&D application
- Approval from research site's Research and Development team, 18th March 2016

April – May 2016

- Recording of April Reflective Practice group session
- Recording of May Reflective Practice group session

- Recording of second Reflective practice group session at end of May due to allocation of timetable by University
- Transcription of audio data collected in Jan- March group sessions

June – July 2016

- Transcription audio data collected from April and 2x May group sessions

July – November 2016

- Conducting stage one of analysis – analysis on transcripts from the 6 reflective practice sessions

December 2016 – January 2017

- Follow-up interviews with participants
- Transcription of recorded interviews

January - February 2017

- Conducting stage two of analysis – analysis of transcripts from interviews
- Request for Amendment submitted to University ethics board via electronic application
- Amendment approved, 18th February 2017

March 2017

- Presentation emergent theoretical model from analysis to Reflective Practice group. Session recorded.
- Transcription of analysis feedback discussion in Reflective Practice group
- Stage three of analysis – analysis of transcript from analysis feedback session

March – May 2017

- Write up period
- Submission of thesis to University of Leicester (deadline following extension: 26th May 2017)

June- July 2017

- Viva preparation and viva

August- September 2016

- Dissemination of findings

- Preparation for poster presentation

Appendix L – Supplemental Illustrative Quotes Which Evidence Establishment of Main Categories

<u>Facilitating the Work on Deepening Understanding</u>

Setting the rules of engagement aspect of Facilitating the Work on Deepening Understanding

"So how do you want to use your time? Do you want to break again at half ten? So, what do you want to, or did you want to do a few of them?" - Facilitator 2 (TR2: - L1-4)

"Shall we bring Participant 6 back in for a bit coz we're near the end?" - Facilitator 1 (TR3: - L1867)

"Well, how do you want it to go? Do you want everyone to have a bit of a chat and you listen, or do you want to be part of it?" – Facilitator 2 (TR2 – L439-440)

"How do you want to do it Participant 1? Do you want it to be like someone interviews you?" – Participant 3 (TR1: – L8-10)

Fostering an initial understanding of a case aspect of Facilitating the Work on Deepening Understanding

"So I guess the thing that, the reason why it might be worth talking about her is, working with her really tough, like what she brings to the sessions is really hard in the sense that she doesn't engage very well. She'll sit quietly, she's quite abrupt, kind of like in your face, I don't want to be here, like rolling her eyes, kind of huffing, shrugging her shoulders, staring at the clock. So it's really hard to kind of get her to sit with you and actually do anything." – Participant 2 (TR2: – L47–54)

"So I don't really know what we can do with it but I thought it was just an interesting, it was something different that I've not really experienced before." – Participant 2 (TR5 – L148-150)

<u>Building trust</u>

"I think well, and I think the way that trust is built is by people making disclosures. Erm, so I hope that, I hope that maybe it made people feel like oh maybe it's okay for me to say something like that then because, because (gender disguised) said it and everyone's okay with it. Erm, but I guess that might be partly anyway how the process of, how, how trust is built up in the group is by people taking a chance and saying oh I'm struggling. And then the group seeing that people haven't kind of judged that person, that they've been supportive and then the next time someone else feels safe enough to say, actually I'm struggling a bit, you know." – Interview with Participant 3 (L487 – 502)

"Yeah, I guess it's kind of like when you're first describing the transcript back, the first thing that came into my head was erm, kind of like testing the water type thing. So it felt like, you kind of said, I guess which is, which is something I wouldn't have done if I didn't feel comfortable. I would never have done that at the start of the, during the first year because I didn't feel quite, I didn't feel so comfortable for a little while. Erm, but as you feel more confident with the people you're with I think, erm, it's kind of like, kind of testing the water so like you kind of say something, oh I was in a tricky situation, what do you lot think? And then you kind of sit there, and you kind of, wait for the feedback like how they react, do they look shocked, do they listen, do they kind of pull a face. And then maybe also how do they respond in what they say as in like, have you been accepted or do they agree with me in that I shouldn't have necessarily

finished therapy. Do they agree it's difficult or do they think I'm kind of making a bigger deal out of something. So I guess it kind of felt like I was kind of testing to see what people fed back to me, if you know what I mean?" - Interview with Participant 2 – (L202 – 231)

"I think everyone was quite empathic, so I think I felt more kind of comfortable afterwards because I think I remember, I don't know who it was, but, erm, it might have been, might have been 3, was kind of like oh really, that sounds really tough, or it might have been 1 actually, I think it was one of those two. Erm, was saying oh it sounds really tough, and, immediately then you go, oh good, it's not me that's over-reacting and someone else would also struggle." - Interview with Participant 2- (L234 - 243)

<u>Deepening understanding</u>

Reflecting from the perspective of another aspect of deepening understanding:

"I wonder if that, that makes the parents really conscious of how, how much they have to sort of impose boundaries on the children erm when it comes to sort of erm health and support if you like. Because it's quite you know, it, it is erm very physical isn't it? And it's very uncomfortable and it sounds an awful thing to have to do, and at the same time then having to be afraid of like injury as well because of the, the medical condition." – Facilitator 1 (TR4: – L568-574)

Elaborating further on an understanding by referencing key themes aspect of deepening understanding

"And, it just reminded me of that, kind of when people who have been in that situation, how it plays out for them as adults. And I guess for her, not only in her relationships of maybe putting herself in those difficult positions again but then she's doing the opposite with her son. I'd, I'd want to know a bit more

about the relationship towards her son. If she's the abused, is she then really
protective, is it a really positive relationship with the son, coz she doesn't want
anything like that to happen, like it happened to her." – Participant 5 (TR3: -
L1818-1825)

Suggesting practical action aspect of deepening understanding

"So I wonder if she can pinpoint what she's feeling, erm and maybe if mum can
be doing that a little bit as well and gently, you know, I'm I wonder if you're
feeling x, y, or z?" – Participant 4 (TR2: - L823-825)

"There's been a couple of times I guess where I think sometimes a parent has
wanted to come and see me and what I've over time felt more confident in
doing is saying to them, erm, actually this is so-and-so's session." Facilitator 2
(TR2 – L541-544)

Action planning aspect of deepening understanding

"It brings me to Facilitator 1's point about is she ready for that, and I wonder
whether I've planted that thought in her mind rather than her being ready to,
erm, go on to some other type of therapy. I wonder whether it's that I've
suggested to her that this, I think this would be beneficial. But it might just be
that she's not ready to explore things, coz we've been speaking about the work
that we've been doing is to try and help with her anxiety, help her to become
aware of the ways that she blocks and denies her feelings and whether it
would be useful, for her to be referred somewhere where she could explore
whether she, if she felt comfortable to disclose the actual events that
happened. You know, maybe she's just not ready. Erm, so that is definitely
something, that we probably need to spend quite a lot of time on in the final
session. So maybe talking about, that there are options but really, giving her
some time to think about whether she feels she is ready for that, or whether

it's been the case that I've kind of thought ooh this will be useful and I've suggested it to her, but she doesn't want to." – Participant 6 (TR3 – L1880-1896)

Dealing with unfinished business aspect of deepening understanding

"But then like you said I think a big chunk of it was that I still felt quite guilty and unsettled about the whole thing. And I think I kind of, I guess without consciously knowing what I was trying to do, but then hearing you say that back and thinking back, I think I was kind of trying to kind of sound it off to people and see how people reacted back. I think I do remember thinking like, saying it all and thinking like and wanting other people's opinions. So wanting some sort of validation or understanding or someone to go oh yeah that sounds horrible, that sounds really tough. Erm, and then to hear if anyone else had had a similar situation, how they felt so I can kind of match myself to them I think. Erm, so I think I was using the group to kind of maybe help myself feel more comfortable and gage where I sat with other people I think maybe." - Interview with Participant 2 – (L105 -125)

"Erm, so I think in bringing it to the group I wanted to, yeah, I guess it still didn't feel quite right with me. It felt like there was still something there and I wanted people to kind of, to, for that to be accepted maybe or for that to be spoken about and for it not just be, me feeling uncomfortable." - Interview with Participant 2 – (L173-177)

"Erm, but yeah definitely I think, I think I remember talking about it and people agreeing that it sounded really tough and I think, I think there was just something about being able to be open about it, kind of getting it off your chest." - Interview with Participant 2 (L141-147)

"I think it had kind of probably, imagine like if you might, I guess the best way to describe it is the reflective practice helped me feel more settled and better about it all, and more comfortable with my approach. Still, when I saw her again I was okay to carry on doing the same things cos I felt like I was validated in what I'd done." – Interview with Participant 2 (L412-418)

"I think over time the combination of reflective practice and supervision allowed me to feel more comfortable to risk not having a plan, and to just be in a room with somebody and, and not have to have something kind of contrived and ready to go that I would be like forcing them to follow. So it felt more okay to just sit in a room and for her to be rolling her eyes and looking at the clock, and I'd just sit there and let her do it. Or I'd notice it with her, after I'd got more comfortable. And I think with that reflective practice and supervision, both of them have given me that message from kind of two directions to say that's okay. Without that I think I probably would have tried to have carried on with the heavy planning for longer. So yeah, yeah, I think it's helpful." - Interview with participant 2 – (L473-491)

<u>Switching in, Switching out</u>

"I think an aspect that really resonated with me Interviewer was the switching in switching out, erm and I liked how you described that that could be linked to building trust as well and within the group that we respond to that in the moment and that we can empathise, so for example if we observed a particular member of our group sharing something and we felt that there was a lot of switching in, it's almost like we find that helpful, but at the same point we might recognise when it's helpful for us to offer a switching out question almost to kind, I liked when you said, almost giving them that breathing space. Erm, I can see how that would support kind of trust in the group, that we're kind of looking out for each other, if we feel it's too much we can respond to

the atmosphere in the group and kind of send that lifeline." – Participant 5 - (Analysis feedback group discussion session - L448-467)

Balancing Honesty with Maintaining Relationships

"And I guess, erm I guess there's, there might be a bit of, some parallels between the process in reflective practice and the process that you have with a client. Erm, in that, sometimes when you're working with a client there might be something different that you want to bring up but you want to say it in a way that's kind of collaborative, erm, collab, collaborative, and erm, not, you don't want the client to feel like you're criticising them or that you're somehow invalidating them. But I guess it's about trying to, maybe like put a different idea to them, erm, in a supportive way, which I guess feels quite similar in a way to how reflective practice is. Erm, but I found, I found it really helpful and it definitely helped me to move forward, erm, and consider some different ideas." - Interview with participant 3 - (L309 – 325)

"No, I was just saying that I think, erm, the relationships between us all helps because I think we feel safe, erm, to say to things to each other, erm, and to kind of, erm, challenge each other I guess. Erm, and I use the word challenge like in a positive way, it's not a, you know, I guess you can, erm, disagree with someone and it can be a negative thing or it can be a positive thing. As in like chall, maybe challenging and questioning them a little bit and getting them to think outside the box but I think we all feel safe to do that with each other now because we, I think we, we all know each other quite well I think and there is that trust and sense of safety, and the sense that, erm, that I can go to reflective practice and say I'm really struggling and that no-one's going to judge me. Yeah, so I think that the main, the whole thing about maintaining relationships whilst still be honest helps in some ways to be more honest." - Interview with participant 3 – (L397 – 424)