Reflective Practice and Continuing Professional Development

Among Qualified Clinical Psychologists

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ABSTRACT

Reflective Practice (RP) and Continuing Professional Development (CPD) have become key concepts in the post-qualification education and training of healthcare professionals, linked to maintaining and improving competence and fitness to practice in a modernised health service. There is little empirical research about this in relation to clinical psychologists. This qualitative study explored how clinical psychologists experience RP and CPD and apply this to their professional practice. A focus group generated the topics for 16 semi-structured interviews with a diverse range of qualified clinical psychologists. practising in a Strategic Health Authority Region in England. Using Interpretative Phenomenological Analysis, four higher-order themes and associated sub-themes emerged: (1) *clinical psychologists as reflective practitioners*, including the understanding of reflection, influences on development, and reflection and professional identity; (2) *the reflective space*, including supervision, enablers and obstacles in reflective practice; (3) *functions of CPD and reflection*, including quality and enhanced service provision, safety and clinical governance, and professional requirements; and (4) *linking reflection and CPD*, including the link between reflection and action, reflective practice as CPD, and CPD and life-long learning. Seven second interviews were conducted for member-validation, and a final focus group was convened for triangulation and validation of the thematic analysis. The findings are related to the existing literature, and to learning theory and attachment theory. The relevance of this research is discussed in relation to clinical psychology practice and the implications for training and CPD. The importance of the present findings to the issue of the professional identity of clinical psychologists is outlined, and suggestions for future research are proposed.

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OVERVIEW

The aim of this thesis is to explore qualified clinical psychologists' understanding and experience of reflective practice and continuing professional development (CPD).

Chapter 1 reviews the literature and evidence base for reflection and reflective practice, and CPD. Theories of reflective learning in CPD are discussed, and the aims and rationale of the present study, and the research questions, are stated.

Chapter 2 includes an overview of the design, and addresses the rationale for the chosen research methodology and method of analysis. Methodological issues concerning the interview participants, procedure, analysis and member validation are also discussed.

Chapter 3 presents the results, beginning with a description of the participant characteristics. The thematic analysis consists of four higher-order themes, each with three associated sub-themes, which are illustrated with quotes from the interviews.

Chapter 4 contains a discussion of the findings in the context of the prevailing literature on reflective practice and CPD, and relevant theoretical models. A methodological critique then precedes a consideration of the relevance and implications of the study, and the conclusion.

CHAPTER 1: INTRODUCTION

1.1 Overview of the Introduction

This chapter will begin by providing a summary of the historical developments and proponents associated with theories of reflection. This is elaborated on with regard to the concept of reflective practice in healthcare professionals generally, and more specifically in clinical psychology.

The development and practice of continuing professional development within the NHS is considered next, with reference to relevant strategy and policy in the context of applied psychology, clinical psychology and statutory regulation.

The evidence base for reflective practice and CPD in the healthcare professions is summarised, and the implications of this for clinical psychology are outlined.

Reflective practice and CPD are set within a theoretical context with reference to experiential learning theory, and single, double and triple-loop learning theory. The relationship between underpinning theory, adult learning and practice at both an individual and systemic/organisational level is described.

Finally, the aims and rationale for the present study, search strategies employed for the literature review, and research questions, are stated at the end of this chapter.

1.2 Reflection and Reflective Practice

1.2.1 Overview

Reflection is a concept that has been explored by many writers. It has been linked to effective practice and self-development in meaningful and practical ways. For example, Osterman and Kottkamp (1993) describe it as "a means by which practitioners develop a greater level of self-awareness about the nature and impact of their performance" (p.19).

Moon (2004) refers to reflection as a process whereby "we reflect in order to learn something, or we learn as a result of reflecting" (p.80).

Boud, Keogh and Walker (1985) outline a model to promote reflective learning, which posits the reflective process between the initial experience(s) and the outcome(s). The three important elements of the reflective process include a returning to the experience ('what happened?'), attending to feelings ('so what?'), and re-evaluating the experience ('what next?').

Haigh (1998) suggests that experience that is available to reflection includes noticed or recalled observations, thoughts, actions and feelings. He proposes that the following include ways of thinking about experience:

- Identifying what is known, uncertain and not-known,
- Identifying what is meaningful and not meaningful,
- Going beyond first thoughts, taken-for-granted meanings and explanations,
- Making connections between thoughts/feelings/actions,
- Recognising limitations in existing knowledge and ways of thinking and acting,

- Explaining experiences,
- Recognising criteria being used for judgements,
- Making judgements (for instance, validity, appropriateness, effectiveness),
- Conjecturing about what the future might be, given what the present and past appear to mean and to be explained by.

Reflection can be seen as a part of reflective practice, which has been described as

> "...a mode that integrates or links thought and action with reflection. It involves thinking about and critically analyzing one's actions with the goal of improving one's professional practice" (Imel, 1992),

and can be

> "...a tool for revealing discrepancies between espoused theories (what we say we do) and theories-in-use (what we actually do)" (Imel, 1992).

Haigh (1998) suggests that three requirements for reflective practice are belief in the value of reflection, knowledge of what would be a worthwhile focus for reflection and a rich repertoire of reflection skills. Reflective practice is increasingly used in the training of healthcare professionals (Tate & Sills, 2004) and for continuing professional development or CPD (Cole, 2000). The latter is important to professional activity in the context of clinical governance, and to ensure that health and social care staff are fit for purpose and fit for practice.

1.2.2 Historical Development of Reflection and Reflective Practice

This section summarises the main theorists who have developed the concept of reflection and reflective practice over the course of the last century. Primarily, this has been in the context of teaching and learning, and adult education.

John Dewey (1859 - 1952) was known for teaching and writing in the areas of educational reform, philosophy and psychology. In his seminal work 'How We Think' (1910), he considered that:

> "Reflection is turning a topic over in various aspects and in various lights so that nothing significant about it shall be overlooked – almost as one might turn a stone over to see what its hidden side is like or what is covered by it" (Dewey, 1997).

Dewey regarded human experience as central to reflection, and reflection as essential to learning and development. His description of reflective activity in learning included the lower-order process of trial-and-error, and the higher-order process of reflection without which activity would be reduced to the level of a blind impulse. Redmond (2006) makes reference to Dewey's emphasis on the importance of the reflective teacher/coach as a reflective researcher and major influence on students' practice.

Jürgen Habermas's 1971 work "Knowledge and Human Interest" (Redmond, 2006) describes three separate areas of knowing and learning, in the technical, practical, and emancipatory learning domains. Habermas's view was that the empirical (technical) domain is concerned with analysis, scientific wisdom and control, whilst the hermeneutic (practical) domain is

about the quest to understand meaning by way of interpretation and explanation. However, it is only knowledge in the emancipatory domain that leads to real freedom because emancipatory knowledge includes self-knowledge or critical reflection. This is seen to result in individuals being able to question powerful ideologies as potential agents of social control, and through this process achieving a transformed consciousness (an example of this would be feminist theory).

Three common themes – centrality of experience, critical reflection, and rational discourse - characterize Mezirow's theory of transformative learning (developed in the 1990s), which is based on psychoanalytic theory and critical social theory (Taylor, 1998). According to Imel (1998), for Mezirow:

> "transformative learning occurs when individuals change their frames of reference by critically reflecting on their assumptions and beliefs and consciously making and implementing plans that bring about new ways of defining their worlds".

However, there have been a number of critiques to Mezirow's theory of transformative learning; for instance Imel (1998) refers to Boyd's theory of transformative education based on analytical psychology, emphasising the role of emotion and intuition instead of Mazirow's critical reflection and discourse.

Redmond (2006) has summarised the theoretical developments from Freire to Mezirow. Paulo Freire (born 1921) viewed education as an emancipatory and liberating force for the weak and powerless, a view that was influenced by the prevailing context of poverty, illiteracy and military oppression in Brazil in the 1960s and 70s. He warned that education without

reflection is dangerous, as it will encourage unquestioning acceptance of what is being taught, and that only critical reflection would allow a person to evaluate, recreate and improve their reality. Freire felt that education had to be 'problem-posing', thus facilitating a circular dialogue between student and teacher, which allows the former to constantly reform his reflections in the reflection of the latter. However, Freire has been criticised by Mezirow for being too simplistic in failing to acknowledge the difficulties inherent in perspective transformation, such as stalling or self-deception, and for assuming that critical reflection *will* occur, given the correct educational environment (Redmond, 2006).

Stephen Brookfield (1998) developed his ideas on critical reflection in the area of adult education. He stipulated four types of action necessary for critical thinking: identifying and challenging assumptions, underlying ideas, values, beliefs and actions; challenging the context within which a problem exists that can influence thinking and action; exploring alternative actions; and becoming reflectively sceptical, i.e. challenging the appropriateness of any approach in relation to the theory or practice that tends to support it. Brookfield is similar to Mezirow in that both emphasise the importance of the critically reflective teacher as a way of modelling reflection for students, and he advocates the use of critical incidents as "critically reflective practice in action" and a way of "seeing practice through the lens of learners' eyes" (Brookfield, 1998).

Dewey, Habermas, Mezirow, Freire and Brookfield have all developed the concept of reflection in various ways, but it was Donald Schön, in collaboration with Chris Argyris, who described the central role of reflection in professional action, and in reflective learning, such

that it became applicable to *all* professional practice, not just to the fields of teaching and adult education (Argyris & Schön, 1974).

Ghaye and Lillyman (2006) have reflected that Schön (1983) was opposed to the prevailing way in which knowledge about and for practice was ascertained. He was critical of the separation between means and ends, research and practice, and knowing and doing. He critiqued 'technical rationality' which is linked to practice being divorced from theory, with the worker being seen as a 'technician' who unquestioningly applies the knowledge handed down from higher-education institutions in order to solve practical problems or achieve certain 'ends'. Schön stated that the knowledge of the practitioner is inherent in the action, and that the knowledge developed by practitioners about and through their work should be valued and used in the workplace (Ghaye & Lillyman, 2006). This became a quest for an alternative to technical rationality (Schön, 1983), an

> "epistemology of practice implicit in the artistic, intuitive processes which some practitioners do bring to situations of uncertainty, instability, uniqueness, and value conflict" (p.49).

'Reflection-in-action' involves 'thinking on your feet', 'keeping your wits about you', and 'learning by doing' and, according to Schön (1983), "suggests not only that we can think about doing but that we can think about doing something while doing it" (p.54).

It involves a restructuring of our understanding of a given situation, often triggered by a surprise or a realisation that our existing knowing-in-action is no longer adequate:

> "The dilemma of rigor or relevance may be dissolved if we can develop an epistemology of practice which places technical problem solving within a broader

context of reflective enquiry, shows how reflection-in-action may be rigorous in its own right, and links the art of practice in uncertainty and uniqueness to the scientist's art of research. We may therefore increase the legitimacy of reflection-in-action and encourage its broader, deeper, and more rigorous use." (Schön, 1983, p.69).

Thus, improving professional practice begins with a reflection on our actual practice and experience, and this may transform what we do. Collective 'knowing-in-action', which is reflected in our professional practice by what we do and how we do it, becomes tacit knowledge or 'knowledge-in-action' over time.

Whilst 'reflection-in-action' occurs in the 'action-present' – "the zone of time in which action can still make a difference to the situation" (Schön, 1983) and therefore requires a rapid decision regarding further action, 'reflection-on-action' refers to reflection after the event, perhaps away from the workplace. It is a deliberate and conscious process designed to bring a greater understanding of practice and thus improve future practice. For healthcare professionals and particularly clinical psychologists, the most common form of 'reflection-on-action' or reflection on practice is clinical supervision.

The ideas and concepts contained in Schön's seminal works, "The Reflective Practitioner" (1983) and "Educating the Reflective Practitioner" (1987) have been applied and further developed by practitioners in nursing, teaching and education, organisational psychology and psychotherapy, health services, social work, and public planning and policy making (Redmond, 2006). However, Schön has been criticised for neither analysing everyday practice nor attempting to consider how reflective processes might serve different functions, or change

in different contexts. His concept of reflection-in-action has been described as over-extended and over-generalised, as 'knowledge-in-action' created by working professionals is seen to be the result of a more deliberate reflection-on-action rather than reflection-in-action (Eraut, 1995).

Redmond (2006) refers to other problematic aspects of Schön's work, such as his lack of acknowledgement of other contemporary theorists working in similar areas, the 'professional mystery' surrounding his reflective coaches which makes it difficult to see how change actually happens, and the lack of exploration regarding non-reflective teachers applying reflective approaches in a potentially abusive manner.

Finally, Ghaye & Lilliman (2006) warn that:

> "We need to think carefully and critically about the nature and potency of reflective practice in healthcare, or we may well be accused of 'jumping upon (yet another) bandwagon" (p.51).

Nevertheless, Schön's contribution to our understanding and development of reflective practice is enormous, especially with regard to its application in the training of healthcare professionals, as outlined in the next section.

1.2.3 Reflective Practice in the Healthcare Professions

As outlined above, the concepts of reflection and reflective practice are rooted in observations of teaching and learning, and much of the present literature is still in this area. Thus, reflective practice has been described by many commentators (with key references included below) in relation to:

- teaching practice (Coldron & Smith, 1999),
- promoting cultural change and school improvement (Barnett & O'Mahony, 2006),
- teacher training (Hatton & Smith, 1995; Russell, 2005), and
- higher education (Clegg, 2000; Hackett, 2001; Clegg, Tan, & Saidi, 2002; Peel, 2005; Cowan & Westwood, 2006).

Continuing professional development is now seen as an essential part of being a healthcare professional, with CPD increasingly moving from a voluntary to a mandatory process. Cole (2000) notes that "the luxury of relative autonomy that has traditionally been enjoyed by professions in society is being eroded by a balancing pressure to ensure their accountability in action". The concept of reflection and reflective practice now seems enshrined in much of the literature and policy describing CPD for healthcare professionals, within teaching and learning, and adult education. Indeed, reflective practice has been taken as a defining characteristic of professional action, and there is " ... a strong argument in favour of all who are involved in 'in-person service' in healthcare to reflect on their practice, regardless of their occupational status" (Cole, 2000).

In relation to the healthcare professions (excepting clinical psychology, which is referred to separately in the following section), reflective practice has been described in the literature (key references are listed) regarding:

- pre-and post-qualification nursing training (Clarke, James, & Kelly, 1996; Andrews, Gidman, & Humphreys, 1998; Williams & Lowes, 2002; Ruth-Sahd, 2003) ,
- midwifery (Yearley, 2003),
- occupational therapy (Murray, McKay, Thompson, & Donald, 2000; Khanna, 2004),

- social work(Taylor, 2006; Yip, 2006),
- physiotherapy (Plack, 2004; White, 2004; Clouder & Sellars, 2004),
- radiography (Castle, 1996; Williams, 1998),
- podiatry (Young, 2004),
- dietetics (Fade, 2004),
- pharmacy (Tomlin, Costello, Kostrzweski, & Dhillon, 2006; Rees, 2004),
- dentistry (Simpson & Freeman, 2004), and
- medicine (Brigley, Young, Littlejohn, & McEwen, 1997; Richards, 1998; du Boulay, 2000; Sandars, 2006; Launer, 2006)

Indeed, Redmond (2006) notes that the term 'reflection' has become so ubiquitous in much of the health and social care literature, that it is

> "being used to describe anything from a passing deliberation on a topic to a fundamental re-assessment not only of a personal stance but also of the discourse within which it [exists]" (Preface, *X*).

To describe the ways in which reflection and reflective practice have been depicted in relation to each of the different professions listed above, is outside the scope of this thesis. Moreover, many of the publications on reflection and reflective practice in the healthcare professions are not based on empirical research findings, such as systematic attempts to explore *what* reflection actually means to certain groups of practitioners, or *how* they practise reflectively. Instead, many of the articles and books published are essentially descriptions of various pragmatic models or frameworks for reflection/reflective practice, and proposals as to how these may be used by certain professional groups with the goal of improving their practice.

Whilst there is a plethora of books and journal articles containing practical suggestions and techniques as to how to 'do' reflective practice, there is far less research evaluating the application in practice, and outcomes associated with these same methods.

The only critical analysis concerning reflective practice was conducted by Ruth-Sahd (2003), and comprised 20 articles, 12 dissertations and 6 books published between 1992-2002. Inclusion criteria were: reflective practice having been defined according to key theorists in the field, evidence of a clearly defined methodology, and emphasis on reflective practice in an educational setting. Reflective practice was described in a range of settings such as higher education, nursing, social work, education, and management and leadership training. Most of the studies assessed reflective practice from the students' or practitioners' perspective.

Positive outcomes of reflective practice noted from all the literature surveyed included:

- helping students to develop their clinical knowledge and skills,
- integration of theoretical concepts to practice,
- increased learning from experience,
- improvement in practice by enabling greater self-awareness,
- enhanced critical thinking and the ability to make judgements in complex and uncertain situations,
- acceptance of professional responsibility and continuous professional growth,
- improved self-worth through learning,
- empowerment of practitioners, and
- increased social and political emancipation.

A number of key issues were identified from the literature reviewed, including:

- reflection is an ongoing and developmental process, often triggered by an initial feeling of inner discomfort;
- flexibility, mindfulness, introspection, imagination, motivation, and active involvement by the student are necessary conditions for reflection to be successful;
- learning environments have to be safe, open, honest, and trusting in order to facilitate reflection and enhance reflective practice;
- finding time to reflect, the timing of the reflection in relation to the issues being thought about, and valuing the reflective process are all important issues for educators as well as students;
- novice educators do not seem to value the reflective process, nor see it as important in improving their practice;
- multiple reflective teaching strategies are best for eliciting reflection in students;
- there are different levels of reflection, and successful reflection must include affective (emotional) and critical (continuously examining experience and the self) components, and
- issues related to power between students and teachers are real and may present obstacles to reflection.

A variety of methods have been described in the literature to facilitate reflection and reflective learning. For example, Price (2004) illustrates how learners can combine the skills of critical thinking and reflective practice by way of a number of staged exercises focused on professional practice in nursing.

Brookfield (1998) describes four 'lenses' through which educators can critically evaluate their practice, and suggests the use of the Critical Incident Questionnaire or CIQ [1] as a way of seeing practice through the lens of learners' eyes.

Creative writing, in the form of poems or narrative stories, has been advocated as a means of supporting professionals to gently examine their own and others' practice, and to question and challenge issues around professional identity and boundaries in a safe way (Bolton, 2001; 2006). In a similar vein, a number of exercises and resources to promote reflective writing are outlined by Moon (2004).

Guided reflection as a tool for CPD and quality assurance has been found to be helpful within a midwives' clinical supervision group (Yearley, 2003). Fowler & Chevannes (1998), in a postal survey of 558 qualified nurses (52% response rate) from various NHS trusts in one particular area, found that staff were positive about the implementation of clinical supervision. Respondents perceived it as a way of reflecting upon and influencing patient care, and 68% felt that clinical supervision would reduce the stress they experienced at work.

Clouder & Sellars (2004) argue that supervision in physiotherapy is both necessary and beneficial, and found that individual practitioners clearly viewed clinical supervision as a reflective opportunity and a means of addressing CPD needs. Shepherd & Rosebert (2007), who developed a reflective practice group for inpatient nursing staff and professionals involved with a ward in an acute adult inpatient setting, found that it created a space for staff to take time out to reflect on difficult situations or complex individuals, and helped them to

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[1] *Brookfield's (1998) Critical Incident Questionnaire (CIQ) includes 5 questions, which focus on critical moments in a class as judged by the learners, for instance "At what moment in the class this week were you most distanced as a learner?". The CIQ is handed out at the end of each day or week, and copies of the responses are written to each question are retained so that learners can review over time their habitual preferences and points of avoidance.*

develop new ways of thinking or understanding. Johns (2004) describes in detail the issues inherent in clinical supervision and guided reflection in nursing practice.

By far the most frequently described method to aid reflective practice is the reflective learning journal (also referred to as reflective learning log, portfolio, or diary). For instance, Mount (2002) described the benefits of a structured reflective learning journal (RLJ) for the Professions Allied to Medicine (PAMs), whilst Rees et al. (2003) piloted reflective practice workbooks with 4th year pharmacy students. Thorpe (2004) employed RLJs with nursing students, whilst Dornan, Carroll & Parboosingh (2002) evaluated the use of an electronic learning portfolio for CPD with consultant physicians. Additionally, reflective learning portfolios have been used in the pre-qualification curriculum for physiotherapy (White, 2004), occupational therapy (Khanna, 2004), dietetics (Fade, 2004) and in the training of paramedics (Jones, 2004).

However, whilst the benefits of reflective learning journals as an aid to reflection are frequently extolled in the literature, there are few studies that have mentioned any disadvantages associated with this. Perhaps this is because reflective learning journals or diaries are commonly used in pre-qualification training and therefore, whether formally assessed or not, they are a compulsory part of the curriculum and therefore disadvantages might be less apparent.

In Rees et al.'s (2003) study with final year pharmacy students, it was found that whilst 63% of the sample considered reflective practice to be a good idea in theory, 79% did not think that this was the case in practice. Completion of the reflective workbook was considered to be tedious by 99%, time consuming by 88% and repetitive by 98%.

Similarly, the study by Dornan et al. (2002) found that only a small number of consultant physicians were actually using the electronic learning portfolio (PC diary). Of the sample of 87 consultants, 10 (11%) decided not to use the PC diary, 18 (21%) planned to use it but never set it up on their own computer, 21 (24%) set it up but used it infrequently, 6 (7%) used it twice per month and 3 (3%) used it once per week or more on average. Thus, only 10% used the PC diary regularly. Time pressures, lack of computer access, literacy and support were dominant obstacles to adoption. Dornan et al. (2002) conclude that the balance for consultants between workload demands and support provided did not favour a reflective type of learning.

Much of the evaluation of experiential learning methods is done by way of subjective feedback, and reflective practice accounts. Taylor (2006) applied techniques from narrative and discourse analysis to the study of social workers' reflective practice accounts, and found that they were written to persuade educators and supervisors that the social worker can pass as a competent practitioner, thus performing "particular rhetorical work to accomplish professional identity". Taylor concludes that we need to move beyond taking texts (and talk) as fact, and that we should treat language merely as the medium for expressing inner thoughts and feelings. She warns that therefore, a more self-conscious approach needs to be taken to the way professional and client identities are produced in practice.

A number of authors have described and evaluated the integration of reflection and reflective practice into the pre- or post-qualification training curriculum of healthcare professionals. For example, Tomlin et al. (2006) developed a new course for pharmacy postgraduate education, based on modified problem-based learning (PBL) to incorporate experiential, work-related

learning. Evaluation by way of structured feedback from students and tutors was largely positive, and emphasised PBL as a tailored and supported approach to adult learning.

Plack (2004) described a week-long integrative case-study course for doctoral-level physiotherapy students, which demonstrated how the reflective process can be incorporated into teaching in preparation for clinical practice. It evidenced the ease of facilitating theory – practice integration, critical thinking skills, and professional behaviours in a classroom setting. The reflective component of the model enabled students to explore the potential biases and assumptions underlying their thoughts, and to think about how their new understanding would impact on their future practice.

Murray et al. (2000) employed a medical humanities approach (using literature in health professional education) which was found to be effective in the training of undergraduate and post-graduate occupational therapy students, and for lifelong learning with experienced practitioners. The authors identified a progression from raising awareness of patients' and others' perspectives, to developing critical appreciation of practice, and finally to further developing and sustaining reflective practice. At the CPD level, reflective skills brought a growing understanding not only of the role of reflection in learning but also of the process of enabling reflection in others.

Whilst the necessary conditions/enablers and associated tools to enable reflection and reflective practice by healthcare professionals have been described above, the barriers to this process are less frequently mentioned.

Ruth-Sahd (2003), in her critical anlysis of data-based studies from the fields of education, health and social care, found evidence that the current culture or environment in which nurses and midwives work present barriers to reflection. Furthermore, previous rationalistic, educational experiences were shown to militate against learners' willingness to be open and expose themselves to the opinions and judgements of others. Reflective learning in a classroom may be an adverse experience if the other group members are not equally committed to it. Additionally, lack of time and valuing of reflection and reflective practice by students and educators present major barriers. Covert power issues between teachers and students, particularly in relation to grading reflective pieces of work, may result in additional barriers to reflection for the person who is being assessed.

Additional barriers to reflection mentioned by Haigh (1998) include:

- the view that reflection may sometimes disrupt, and detract from, good performance;
- doubts about whether reflection is an activity that will have significant payoffs, particularly when 'habitual routines' have been established;
- beliefs about the relative value of knowledge derived from personal reflection compared with that derived from a 'technical-rational' approach to enquiry;
- the preoccupation of novices with acquiring a set of 'know-how' rules which may mean that they have neither the desire nor the capacity to engage in productive reflection;
- psychological states (such as anxiety, fear, loneliness, helplessness, hostility);
- unsympathetic colleagues who see reflection as unnecessary or potentially destabilising;
- uncertainty about what would be a worthwhile focus for reflection;

- not having a shared language for talking about what is reflected on and the reflection process;
- a limited repertoire of reflection skills that can be controlled well and used with sensitivity; and
- lack of appreciation of the demands of establishing such a repertoire of skills.

Finally, Yip (2006), writing about social workers' practice of self-reflection as part of their reflective practice, sounds a note of caution. Yip states that under appropriate conditions, social workers' self-reflection can be a rewarding and constructive experience, which results in enhanced personal and professional development. However, under inappropriate conditions it can be highly destructive to the social worker's self-development. Such conditions include, for example, an oppressive social environment, demanding working environment, and social workers' poor physical and mental health. Yip proposes that if the social worker has a negative self-image or unresolved past trauma, s/he may internalise negative comments from a critical/authoritative supervisor, leading to the practitioner constantly reminding him/herself of personal weaknesses and shortcomings. Furthermore, Yip warns that under inappropriate conditions, self-reflection in reflective practice may threaten a social worker's self-identity and professional identity. Moreover, spontaneous self-analysis, self-recall and self-evaluation may uncover unresolved inner conflicts and dynamics.

Thus, the literature would suggest many benefits to reflective practice (albeit with a paucity of empirical research to back this up), but it is important not to overlook the disadvantages, obstacles and even risks associated with reflective practice in different contexts, as these can be crucial in determining why reflective practice may not be engaged in.

1.2.4 Reflective Practice in Clinical Psychology

This section will summarise research, practice reports and other publications regarding reflective practice in clinical psychology, in relation to pre-qualification training (the area about which most has been published), supervision and supervisors, and post-qualification practice.

1.2.4.1 Reflection and reflective practice in pre-qualification clinical psychology training

Lavender (2003), in posing the question "Why is reflective practice important?" states that it might be helpful to consider the alternative:

> "What would it be like to be an *unreflective practitioner* and, if you were, what would that mean for your practice, and do you think anybody would want to see you?"

Drawing on Schön (1983), he distinguishes between 4 different processes involved in reflective practice, namely reflection in action, reflection on action, reflection about the impact on others, and reflection about the self (awareness and self-development). Examples of how these processes can be translated into different methods and integrated into clinical psychology training are discussed, for instance through workshops, reflection on real life situations, feedback from others, video observations, and personal therapy. Echoing sentiments expressed by Galloway, Webster, Howey and Robertson (2003), Lavender states that:

> "...there is a need to balance our longstanding position as scientific practitioners with an understanding and use of the processes of reflective practice."

Gillmer and Marckus (2003) summarise the findings from a reflective workshop conducted to examine the personal and professional development (PPD) in clinical psychology training. Seventeen courses were represented, generating 5 key points as follows:

- Legitimising the personal in the professional, i.e. a professional acceptance that 'the personal' is a legitimate area in which to locate a core competency;
- It is the process of PPD – seen as a reflective competency – that enables trainees to become competent reflective scientist practitioners;
- PPD requires a public validation, and modelling by, clinical psychology trainers and supervisors;
- The diversity of individual PPD experiences needs to be recognised and supported, and
- PPD inevitably promotes a deconstruction of the self during training, which is in direct conflict with the competent image demanded of trainees.

Gillmer and Marckus (2003) conclude that:

> "...PPD is that part of the curriculum that is dedicated to developing in trainees a capabililty to reflect critically and systematically on the work-self interface. This process is directed towards fostering personal awareness and resilience."

Reflective practice as an integral part of training in the South West (Plymouth, Bristol and Exeter courses) has been described by Stedmon, Mitchell, Johnstone and Staite (2003). A psychodynamically informed model of supervision (Hawkins & Shohet, 1989), a reflective diary kept throughout the 3 years of training, and dedicated teaching time for sessions on reflective practice are included as part of the curriculum.

Nokes (2005) emphasises the importance of another person (such as a mentor or supervisor) in order for reflective practice to be effective, and highlights the role of reflective practice in the development of cultural and self-awareness. Reflecting on her experience as a new trainee starting her first placement, she comments on the reassuring presence of a space for integrative and reflexive formulation, self-exploration, reflective tutorials and a reflective diary.

Reflective practice groups of 8-9 clinical psychology trainees, facilitated by 2 qualified clinical psychologists, are described by Powell & Howard (2006) for the Birmingham Clinical Psychology Doctorate training course. Evaluations after the end of first year revealed benefits related to Lavender's "reflection on self" (Lavender, 2003), i.e. a greater awareness of the emotional impact of client work. However, the groups appeared to be less influential in relation to affecting behaviour change in trainees, for instance greater self-care or seeking appropriate support. Reflection on action, such as more helpful ways of working with clients, was also reported as a benefit of the groups. Nevertheless, trainees reported feeling only "fairly comfortable" discussing their own issues.

Galloway et al. (2003) describe a model of facilitated personal professional development groups for clinical psychology trainees on the Teesside course. The groups aimed to encourage trainees to reflect on clinical experiences and academic material, to integrate this within the context of their own personal development, and to increase their awareness of their own training needs in relation to their level of personal professional development. The feedback from trainees' written evaluation included themes of normalisation and validation (of emotional responses), group support, developing insight into clinical work, recognition of achievements, self-awareness, assertiveness, and integration of experience with personal

development. Galloway et al. conclude that "...by actively encouraging reflective practice in this way, it provides a good model for trainees to acquire when considering their CPD needs as qualified clinical psychologists".

1.2.4.2. Supervision and reflective practice

Cushway and Knibbs (2004), in reviewing the literature on trainees' and supervisors' perceptions of the helpful and unhelpful aspects of supervision, remind us that most of the published research in this area is descriptive, and is not by, or about, British clinical psychologists. Nevertheless, many of the process issues in clinical supervision are applicable to most, if not all, of the therapy professions. Cushway and Knibbs summarise the themes arising from a supervision workshop attended by 33 trained clinical psychologists who were asked to reflect on their supervision experiences as trainees. Giving space to reflect about clients, helping to explore counter-transference, and linking clinical work to theory were cited as examples of helpful aspects of supervision, which illustrates the importance of supervision being reflective and integrative in nature.

More recently, research in the UK which is relevant to clinical psychology and reflective practice has focused on clinical supervision (Milne, James, & Sheikh, 2005; Milne, 2007) and the training of supervisors. However, as noted by Milne, Aylott and Fitzpatrick (2007)"...the empirical literature is dominated either by pragmatic studies of supervision with little explicit theorising, or by a theoretical literature replete with model-building but lacking in empirical emphasis". Independent or critical reviews of the effectiveness of clinical supervision are scarce. Milne and colleagues (2007b) propose that supervision is a complex activity which

must be understood in the context of at least 5 major moderating variables (such as the work environment) and implemented through 28 different mechanisms of change (for example, providing feedback, modelling, and guided practice). These methods are thought to work primarily through promoting experiential learning: 23 of these 28 mechanisms (82%) can be mapped onto Kolb's (Kolb, 1984a; Kolb, 1984b) experiential learning cycle. Milne and colleagues (2007b) note, therefore, that reflection is the most frequently-cited example within the literature in relation to mechanisms of change within supervision.

1.2.4.3. Supervisor training and reflective practice

Green and Dye (2002) describe a Delphi approach which was used with an expert group of UK clinical psychologists, to ascertain a consensus view of the most important components of a basic supervisor training programme. These included ethical aspects of supervision (such as boundary and safety issues), practical management issues (for instance, the tasks involved in establishing a placement), and 'gate-keeping' responsibilities (for instance, when and how to fail a trainee on placement). Although reflection is not explicitly referred to as an essential supervisory skill in relation to these main areas of supervisor training, it is implicit that a reflective stance would be required in order to address and resolve ethical issues, or concerns regarding a trainee's competence to progress, in an appropriate and sensitive manner.

Newnes, Hagan and Cox (2000) describe a workshop for clinical psychology supervisors in Merseyside to look at opportunities for offering placements with an explicitly critical and reflective stance. The seminar was structured around 2 questions: "What opportunities do you have as a supervisor for critical reflection?" and "What would you want from a supervisor to

facilitate critical reflection?" The authors comment that "...it is in departments of clinical psychology where the key restrictions to critical self-reflection are to be found", although they also acknowledge that the often unhealthy physical and psychological environment in which clinical psychologists work, does little to foster an atmosphere conducive to critical self-reflection.

Carroll and Holmes (2006) report the findings of a supervisor workshop in terms of pre- and post- assessed learning outcomes and learning needs. It is significant to note that the learning needs of the 23 participating new supervisors were primarily task-focused (for example, roles and responsibilities of supervisor, evaluation of trainee), and only 4 of the 24 advanced supervisors who attended a separate workshop listed 'general need for reflective space' as a pre-workshop learning need.

Milne, Aylott, Dunkerley, Fitzpatrick and Wharton (2007) report the results of a best evidence synthesis comprising 24 rigorous and successful studies in which the training of the supervisor resulted in positive evaluations of the impact of supervision on the supervisees and clients concerned. The authors found that the respective percent effectiveness decreased from supervisor (87%) to patient (70%). Of the 7 competencies theoretically utilised by supervisors, the three most commonly reported competencies in the studies surveyed were observation and feedback (accounting for 26% of all methods used) and clinical reasoning. Reflective practice was reported in 8 of the 48 studies, with examples including reflecting, challenging supervisees' thinking, and learning-to-learn. Milne and colleagues (2007a) state however, that while the methods of supervision were emphasised (for example, observation, feedback and goal-setting), as were aspects of performance monitoring (such as supervisee learning, and

clinical impact), the competencies of communication, clinical reasoning, reflective practice and adopting an appropriate affective stance, were reported infrequently and in an insignificant way. The authors conclude that this suggests a highly variable approach to the development of competence, and highlights the need to include all 7 aspects of supervisor competence in supervisor training.

However, Milne et al.'s (2007a) paper also states that where supervision research includes studies based on a general theoretical or explicit empirical foundation, it is usually focused on cognitive-behaviour therapy. This raises methodological difficulties in terms of researching clinical psychology supervision as a process, or its efficacy in relation to outcome, given that it tends to draw on a variety of theoretical models and usually involves a range of therapies. Methodologically, it is easier to carry out robust research by including studies where the supervisor training in question is model-specific, as opposed to generic. Likewise, when measuring behaviour change (in the supervisor and/or supervisee) as a result of supervisor training, it is probably easier to measure task-oriented processes as opposed to the broader supervision competencies, such as reflection or reflective practice. Therefore, the apparently lesser importance of reflective practice, compared to other supervisor competencies, in the research to date, may be a reflection of the sampling criteria of the studies included (focusing on model-specific supervisor training, predominantly CBT–based), as opposed to it being evidence of reflection and reflective practice really being of lesser importance.

Fleming (2004), in discussing clinical psychology supervisor training in the UK, comments that until recently, little attention has been paid to the therapeutic relationship and process, as more 'technical' therapeutic skills have had greater emphasis. Furthermore, he states that the

emphasis on a scientist-practitioner model within clinical psychology "...may have made it difficult to assimilate some of the complexities of supervision" (p.91).

1.2.4.4 .Supervision practice

Within the last 10 years, there have only been 2 publications of surveys regarding clinical psychologists' supervision practice in the UK (Gabbay, Kiemle, & Maguire, 1999; Golding, 2003b). Golding et al.'s (2003b) study will be discussed later. Gabbay et al. (1999) sent anonymous questionnaires to 321 practising clinical psychologists in the Region, and obtained a response rate of 40%. The most satisfying aspects of supervision mentioned did not emphasise the structural or task-focused elements of supervision, but instead referred to the supportive element of supervision, particularly for respondents in peer supervision groups, and highlighted the actual quality and availability of supervision in providing time and space to reflect.

In the literature surveyed, it appears that reflection and reflective practice in clinical psychology training, and post-qualification practice, are most frequently linked to clinical supervision – either implicitly or explicitly. However, despite the increasing popularity of reflective approaches, empirical investigations regarding clinical psychologists' practice of supervision, or the application of reflection in their professional practice are still sparse. Furthermore, although a reflective stance towards one's personal professional development may be endorsed by the majority of clinical psychology training courses, its importance in the training of clinical psychology supervisors is yet to be agreed. The work of the DROSS (Development and Recognition of Supervisory Skills) project, a collaborative undertaking

between a number of English and Scottish Clinical Psychology training courses, is relevant in this regard (DROSS project working party, 2007). DROSS has been gathering resources and supporting a number of projects since 2004, in order to improves the quality and consistency of supervisor training. In the context of the present research, this has included an agreement on the core competencies and skills for supervisors.

1.3 Continuing Professional Development

1.3.1 Continuing Professional Development in the NHS

Over the past few years, professional bodies representing clinical psychologists in the UK have increasingly stressed the importance of continuing professional development (CPD) and the role of supervision within this. The Professional Practice Guidelines (British Psychological Society, 1995) and the policy document on Continued Supervision for Clinical Psychologists (British Psychological Society, 2006a) emphasise the importance of regular supervision and supervisor training. This is linked to CPD in the context of delivering a high quality and safe clinical service (Department of Health, 2004a). The past decade has seen significant efforts to reform the NHS and, in particular, the workforce required to deliver a modernised health service. CPD has been seen as the key to developing staff fit for purpose and fit for practice, in the context of lifelong learning across all professions. Gray (2005) offers a clear and concise summary of the main policy documents relating to CPD between 1997 and 2004.

In 1997, the government outlined its commitment to improving quality and standards via national guidelines in "The New NHS: Modern, Dependable" (Department of Health, 1997).

This white paper links CPD explicitly to the principles of clinical governance to guarantee quality.

One year later, the theme of quality was developed further via the setting and monitoring of quality standards in "A First Class Service: Quality in the New NHS" (Department of Health, 1998). One of the key components of clinical governance emphasised in this consultation document is CPD, aimed at meeting the development needs of the individual and the organisation. In "Clinical Governance in the New NHS" (Department of Health, 1999a), CPD is defined as:

> "...a process of lifelong learning for all individuals and team which meets the needs of patients and delivers the health outcomes and health priorities of the NHS and which enables professionals to expand and fulfil their potential".

The CPD cycle outlined in the above document includes assessment of individual and service needs, which leads to a Personal Development Plan (PDP), the implementation of which is then evaluated for effectiveness, leading on to a further cycle of assessment.

Subsequent guidance in "Continuing Professional Development: Quality in the New NHS" (Department of Health, 1999b) emphasises that CPD should be purposeful, patient-centred, educationally effective, and part of a wider developmental plan to support local and national service objectives. Furthermore, CPD is linked with Agenda for Change to pay reform.

In the context of considering future NHS staffing requirements, "Developing the NHS Workforce" (House of Commons Health Select Committee, 1999) recommended full financial support by the NHS for the educational needs of all staff.

In the late 1990s, the establishment of Workforce Development Confederations (WDCs), which superseded the previous Education and Training Consortia, were charged with the strategic development of post-qualification training for healthcare staff. "A Health Service of all the Talents: Developing the NHS Workforce" (Department of Health, 2000b) also urged NHS Trusts to develop strategies for CPD and lifelong learning in order to skill up their workforce.

The modernisation of the NHS proceeded with The NHS Plan (Department of Health, 2000a) which emphasised the need for organisations to invest in the training and development of their staff, and the promise of an extra £140 million investment by 2003/04 to improve access to, and support for, learning. Again, CPD was tied to the requirements of clinical governance and revalidation.

A significant document in relation to CPD is "Working Together, Learning Together: A Framework for Lifelong Learning in the NHS" (Department of Health, 2001). This paper describes what staff can expect from employers in relation to support for lifelong learning, via open and flexible access to education, training and development. Chapter 5 states that:

"Continually updating and extending knowledge and skill is essential to professional life – post-registration education and CPD frameworks must constantly evolve to take account of developments in health and social care, primarily for protection of the public".

Mandatory re-registration and revalidation are seen as an essential part of quality assurance via regulatory bodies and employers' clinical governance responsibility. These processes are inextricably linked to CPD, which should meet the needs of local services as well as the personal and professional development needs and aspirations of individuals.

In "Funding Learning and Development for the Healthcare Workforce" (Department of Health, 2002) the concept of multidisciplinary training being supported by a common funding stream is introduced. This aims to end the demarcations between the different professions by striving for greater transparency, equity, integration and comprehensiveness in the way financial support is given.

As concluded by Gray (2005), government policy has developed from broad statements of intent and principle in the late 1990s to more detailed documents specifying the nature, content, structure and process of CPD in recent years. At the core of the government's strategic approach to post-qualification learning and development is its aim to deliver a modernised NHS.

Alsop (2000) summarises the dimensions and expectations of CPD as follows:

- A process (rather than a product);
- Lifelong, ongoing throughout professional life;
- Systematic;
- Embracing formal education and informal learning, including on-the-job learning;
- Building on what is known, in order to:
  - Assure competence,
  - Develop personal qualities,

- Enhance professional and technical skills,
- Maintain, enhance and broaden professional knowledge,
- Expand and help fulfil potential,
- Have a positive impact on health outcomes,
- Maintain quality and relevance of professional services,
- Develop and enhance practice,
- Prepare for changing roles in service delivery.

Thus, Alsop (2000) states that the purpose of CPD is:

> "...to ensure competent practice that will maximise the potential and professional performance of the therapist, minimise risk to service users and lead to improvement in service efficiency and effectiveness" (p.3).

Agenda for Change comprises the three core elements of job evaluation, harmonised terms and conditions, and the Knowledge and Skills Framework or KSF (BPS/ Amicus Family of Psychology, 2005). As a system of pay reform, Agenda for Change links CPD to career and pay progression via the KSF for all NHS staff. The latter incorporates personal development plans, regular development reviews and appropriate support for training and CPD to meet the required knowledge and skills. The development review is defined as an ongoing cycle of review, planning, development and evaluation for staff in relation to their personal, professional and organisational development needs.

Although many healthcare staff, particularly in the professions, now regard CPD as an automatic entitlement, it is salutary to remind ourselves that this has only been enshrined in

formal policy for the past decade. However, whilst the entitlement and requirement for continuous professional development can now be taken for granted, in practice the extent to which this is supported (financially and otherwise) varies widely between individuals, services, and employing organisations, and at times of financial stringency, support for CPD is often under threat.

1.3.2 Continuing Professional Development for Applied Psychologists

In addition to the guidance summarised above, there have been further reports that have implications for CPD specifically in relation to the mental health workforce.

The Department of Health's policy document on "Organising and Delivering Psychological Therapies" (Department of Health, 2004a) aims to review and improve the delivery of psychological therapy services via highlighting issues such as access, waiting times and care pathways. It calls for a "psychologically literate mental health workforce" via a co-ordinated training strategy and CPD, in order to develop a capable workforce (paragraph 2.14), and emphasises that "the importance of staff training and support cannot be underestimated" (paragraph 5.16). CPD is explicitly linked with quality and safety:

> "An effective program of continuing professional development (CPD) is also needed to help staff with their professional development and support the quality and safety of their clinical work. This will ideally be integrated with routine staff appraisal and clinical supervision to ensure a high quality of practice and also to ensure that any problems that arise in the interaction with patients are understood and monitored." (paragraph 5.17)

Relating specifically to mental health, the concept of the "capable workforce" is developed further in "The Ten Essential Shared Capabilities: A Framework for the Whole of the Mental Health Workforce" (Department of Health, 2004c). In this report, coherent programmes of CPD are seen as essential to develop the workforce and support clinical governance. This should be integrated with appraisal and personal development plans. Practitioners are urged to be proactive in seeking opportunities for supervision, personal development and learning and to have a sense of personal responsibility towards their professional development. Interestingly, this report makes explicit reference to (though does not elaborate on) the importance of reflective practice and supervision being integrated into everyday practice.

"The National Service Framework for Mental Health – Five Years On" (Department of Health, 2004b) states that:

> "Despite an impressive series of policy documents, we have yet to bring about the universal improvement in the skills of frontline staff that a modern mental health service needs." (p.48)

Referring to the research evidence on the benefits of training in mental health, the report highlights the fact that robust evidence is scarce, meaning that much of the training provided is unproven. The estimated annual cost of pre- and post-registration training for nurses and clinical psychologists, according to this 2004 document, amounts to £110 million.

In "Applied Psychology: Enhancing Public Protection: Proposals for the Statutory Regulation of Applied Psychologists" (Department of Health, 2005), the protection of the public against

the risks of poor practice is a key driver in the move towards statutory regulation. CPD is an important element in this, as:

> "Practitioners need to ensure that they maintain and develop their skills in the interests of public safety and to make sure that they meet current and evolving needs of the service."

The progress report "Mental Health: New ways of Working for Everyone" (Department of Health, 2007) describes new and enhanced roles and responsibilities for mental health staff, in order to develop and sustain a capable and flexible workforce. The report states "Learning and development is a key function of NWW if staff are to extend roles and practice and if organisations are to introduce new roles" (paragraph 4.8.1), and makes reference to the learning and development toolkit that has been produced for this purpose.

Furthermore, the Career Framework for Health, which is a part of the Government's 'Skills for Health' programme (Skills for Health, 2007) introduces the concept of a flexible career and skills escalator that enables staff to progress in the direction of individual, service and workforce need. Although this progress report does not explicitly address CPD, the implications are clear; upskilling a workforce in order that individuals can work differently in a safe and competent way has implications for pre-and post-qualification training, and for CPD.

1.3.3 Statutory Regulation for Applied Psychologists

The subject of statutory regulation for applied psychologists merits a separate sub-section, given that the present study aims to relate its findings to the present and future practice of CPD, and CPD is closely connected to statutory regulation.

The Department of Health's NHS Plan (2000a) introduced the Health Professions Council (HPC) as the new regulatory body for professions allied to medicine. The HPC is concerned with patient safety, setting and monitoring standards of professional training, performance and conduct, and linking registration with evidence of CPD. Currently the HPC registers and regulates 13 professions, whose titles are protected. The HPC defines CPD as "a range of learning activities through which health professionals maintain and develop throughout their career to ensure that they retain their capacity to practice safely, effectively and legally within their evolving scope of practice" (Health Professions Council, 2006).

Registrants must:

1. maintain a continuous, up-to-date and accurate record of their CPD activities;
2. demonstrate that their CPD activities are a mixture of learning activities relevant to current or future practice;
3. seek to ensure that their CPD has contributed to the quality of their practice and service delivery;
4. seek to ensure that their CPD benefits the service user; and
5. present a written profile containing evidence of their CPD upon request.

It was expected that registration of applied psychologists with the HPC would occur in 2005, as the government did not support the British Psychological Society's (BPS) long-held ambition to establish its own separate regulatory body. However, in its response (British Psychological Society, 2005) the Society opposed the proposals for statutory regulation by the HPC on the grounds that the latter was not fit-for-purpose. For the past 2 years, the BPS has been engaged in a process of discussion and negotiation with the Department of Health to attempt to reform the HPC, so that its processes provide an acceptable level of public protection. Statutory regulation with the HPC now looks likely to take place in 2008.

The recent briefing paper by NHS Employers, which is part of the NHS Confederation, and is responsible for workforce and employment issues (NHS Employers, 2007) summarises the main documents regarding the future of professional regulation and explains the implications for employers. It emphasises the government's intention to ensure that an efficient and effective system of appraisal and professional education is in place, and calls for a requirement for all health professionals to revalidate their professional registration on a regular basis.

It is anticipated that in late 2007 or early 2008, the government will be introducing a "Health and Social Care Bill", which will bring together various elements of the health inspectorate systems as well as introduce changes to the regulation of the medical profession. However, it is also likely to bring about changes to the way the HPC currently operates. Thus, the present discussions between the BPS and the HPC regarding the regulation of applied psychologists may end up being overtaken by the introduction of legislation in 2008.

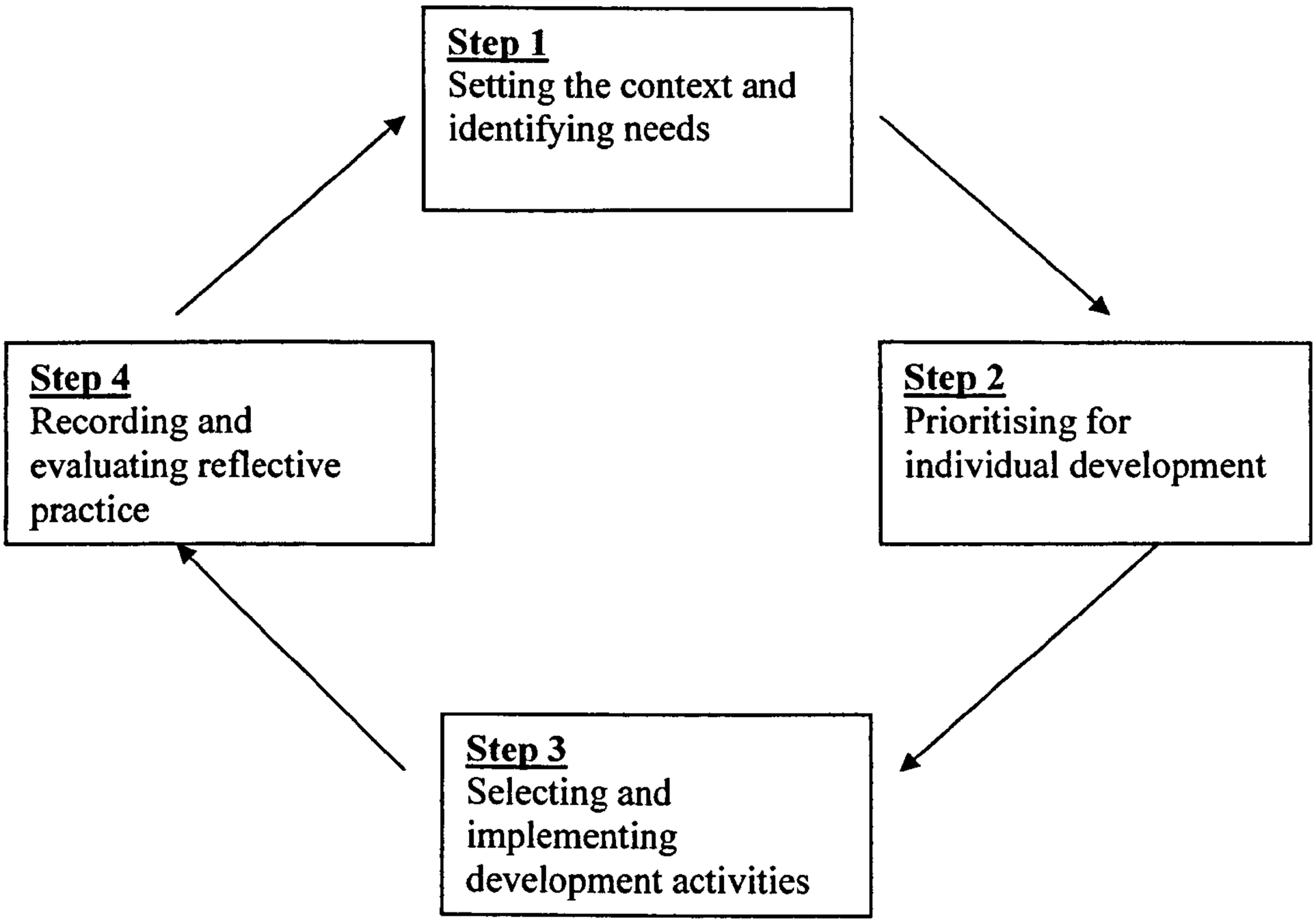
If reflection is seen as a form of CPD, and CPD is a mandatory part of statutory regulation, then this begs the question as to whether reflecting on one's work might be enough to fulfil (most of) one's CPD requirements? When CPD budgets are under threat, this might be seen as a cost-effective solution by employers to enable employees to meet their statutory requirements. On the other hand, psychologists may view reflection as only a part of CPD, which in itself may encompass a much wider set of skills and knowledge. The present study aims to explore clinical psychologists' views about the links between reflective practice and CPD at a time when both of these concepts have far-reaching implications in terms of professional regulation and mandatory professional requirements.

1.3.4 Continuing Professional Development and Clinical Psychologists

The Division of Clinical Psychology (DCP) states that clinical psychologists have an obligation to the public and to their profession to maintain and develop their professional competence throughout their working lives (British Psychological Society, 1995). In 2000, British Psychological Society (BPS) members voted in favour of CPD becoming mandatory, as opposed to obligatory, for all chartered psychologists. The BPS's (2000) guidelines on continuing professional development provide an enabling approach to CPD for clinical psychologists at all stages of their career. The link between actual practice and identifying the CPD activities needed to maintain or improve competence, is addressed in recent guidance (British Psychological Society 2001b, 2004).

The recommended process of identification of CPD needs, followed by action, reflection and implementation is illustrated in Figure 1 overleaf.

Figure 1: Cyclical four-step model of CPD (taken from Division of Clinical Psychology Personal Record Log Book, 2001)



CPD is seen to encompass a broad range of formal and informal learning opportunities. The aim of reflection is to identify what has been learned and how this learning will be used. Knowledge gained from learning must be integrated into the practitioner's repertoire and applied in practice.

The Society CPD Guidelines (British Psychological Society, 2002) for chartered psychologists outline the CPD requirements for chartered psychologists holding practising certificates. Since October 2005 all such psychologists have been required to submit an annual record of their CPD, a proportion of which are qualitatively assessed by the BPS. The BPS Code of Ethics and Conduct (2006b) emphasises the importance of psychologists practising within the

boundaries of their competence, remaining up-to-date, seeking consultation and supervision, and remaining aware of and acknowledging their limitations.

The relevant BPS guidance in relation to clinical psychologists assessing and meeting their CPD needs is discussed more fully by Kiemle, Gray, Kaiser, Golding and Collins (2006). There is little systematic investigation in relation to the actual CPD activity of clinical psychologists, with the exception of the work undertaken by the Regional Clinical Psychology CPD Project and subsequent CPD Scheme (Golding 2003 a & b, Sadler & Golding 2006).

Golding (2003b) carried out a survey of the CPD needs and activities of clinical psychologists in the relevant Region in 2002, which was repeated in 2004-05 (Sadler & Golding, 2006). A number of areas of similarity and difference were identified relating to CPD needs. The 2004-05 survey included a total of 174 replies (28% response rate); respondents were generally representative of the total Regional sample and the national picture, in terms of the demographic descriptors. Levels of activity indicated that respondents were involved in a wide range of CPD activities, consistent with DCP guidelines (British Psychological Society, 2001a), as illustrated in Table 1 overleaf. In addition to the above, 107 (61.5%) of respondents provided 208 examples of multi-professional CPD undertaken during 2004, yielding 118 categories of response.

Table 1: Level of CPD activity (Sadler & Golding, 2006)

CPD Activity	% Respondents
Reading relevant literature	100%
Attending training courses/workshops	91.8%
Visiting example of good practice	26.2%
Research	45.3%
Audit/service evaluation	68.5%
Writing for publication	41.8%
Consult colleague with specialist knowledge	86.3%
Deliver courses/workshops	68.5%
Professional activity	77.4%
Being supervised	96.4%
Supervising others	85.5%
Attend post-graduate training course	22.4%
Other	27.1%

(CPD activities undertaken in 2004, N = 165)

This demonstrates that almost two-thirds of the clinical psychologists in this survey were engaged in multi-disciplinary learning, although a number of disadvantages as well as advantages were associated with this.

Table 2: Factors encouraging CPD activity (Sadler & Golding, 2006)

10 most frequently cited factors for encouraging CPD	**Number of responses (out of 499) in order of importance (most – least)**
Motivation/enthusiasm/interest	60
Competent to practice/client safety	49
Develop clinical skills	35
Updating	31
Further knowledge	24
Relevant topics	23
Statutory regulation	20
Support from manager	18
Networking	18
Personal need to develop further	17

Factors impacting on CPD activity were also examined; details of the 10 most frequently cited enablers and obstacles to CPD are shown in Table 2 (above) and Table 3 (overleaf).

It is encouraging that the 3 most frequently cited factors encouraging CPD concerned respondents' intrinsic motivation and interest, concerns for safety and competence, and professional skills development (see Table 2).

Table 3: Factors preventing CPD activity (Sadler & Golding, 2006)

10 most frequently cited factors discouraging CPD	Number of responses (out of 417) in order of importance (most – least)
Time pressure from admin/clinical roles/waiting lists	149
Lack of financial support for CPD	96
Lack/availability of suitable CPD opportunities	30
Distance	29
Cost	13
Lack of management support	7
Change from regular childcare needed	6
Lack of info on available opportunities	5
Lack of information resources	5
Working part-time	5

Over half of the total responses cited "time pressure from admin/clinical role/waiting lists" (149 responses; 35.7%), or "lack of financial support for CPD" (96 responses; 23%) as main factors preventing CPD activity (see Table 3). These two barriers to CPD are consistent with the two most frequently cited responses in the 2002 survey.

When asked to rank-order 14 factors for their importance, "good/regular supervision" was ranked second in terms of keeping respondents in their current post (after "opportunity to work with a good team"), but first in terms of its importance for professional competence, followed by "post-qualification training opportunities and finance". This demonstrates that the clinical psychologists who took part in this survey rated clinical supervision in particular, and support for post-qualification CPD, as the most important aspects of professional competence.

Finally, almost 62% of identified CPD needs were rated by clinical psychologists as being directly relevant to their employers' strategic priorities, and the majority of the remaining 38% of needs were rated as being somewhat relevant. This suggests that the process of identifying and prioritising CPD needs by individual clinical psychologists is appropriate and effective for both personal professional and service development.

As pointed out by Green (2000): "Those who play the system most effectively are able to demonstrate that the training ambitions of the individual practitioner are in line with service priorities and hence to the ultimate benefit of the employing Trust".

Moreover, this is consistent with the aims of CPD within the NHS in terms of its links to clinical governance and life long learning: "A process of lifelong learning for all individuals and teams which meets the needs of patients and delivers the health outcomes and healthcare priorities of the NHS and which enables professionals to expand and fulfil their potential" (Department of Health, 1999a).

The two surveys described above (2002 and repeated in 2004-05), are the most comprehensive investigations carried out to date with regard to the CPD needs and activities of clinical psychologists. Whilst they are very relevant to the present study, given that respondents were

from the same Regional pool of clinical psychologists, it is not known whether the findings obtained are applicable to other parts of the United Kingdom. The Region has benefited from a relatively high level of financial support through ring-fenced Education and Training Consortium/Strategic Health Authority funding of CPD for clinical psychologists from 2001-2008. This may have resulted in a particularly positive picture of clinical psychologists' CPD activity, which may not be representative of colleagues' experience elsewhere in the UK.

Golding (2003a) also examined the CPD needs of 30 Regionally based clinical psychology service managers via a questionnaire survey and subsequent focus group. This showed that this group was committed to facilitating CPD activities for their staff in order to maintain and improve competence, and thus ensure safety to practice. Focus group participants felt that they needed to be flexible as managers in identifying the CPD needs of their staff, and strike a balance between meeting individual and service need. They felt that the relationship they formed with those whom they managed was key. Another issue highlighted by this group was the link between being able to offer good CPD experiences and recruitment and retention of staff, although there were varying experiences of the levels of financial support for CPD within participants' employing organisations.

A recent electronic national survey (via the DCP's Managers' Faculty e-forum) by Gray of 25 clinical psychology managers (Kiemle et al., 2006) showed that managers in charge of their own CPD budgets averaged £344 per whole-time equivalent (wte) member of staff, in contrast to £150 per wte staff member for managers who did not have their own CPD departmental budget. However, the latter were able to access additional CPD monies via central Trust funds. As recommended by Department of Health guidance discussed above, personal development

plans allied to service needs were the main principle in deciding the allocation of CPD funds. However, the findings of this survey must be interpreted with caution due to the small number of respondents involved.

Finally, CPD for clinical psychologists at different stages of their career is discussed in detail by Latham and Toye (2006) in relation to those who are newly qualified, by Daiches, Verduyn and Mercer (2006) for psychologists who are mid-career, and by Caine and Golding (2006) for senior managers. Primarily these contributions focus on the identification of CPD needs in line with clinical psychologists' development, and describe some of the examples post-qualification training schemes and other examples of good practice available to meet those CPD needs.

1.4 The Evidence Base for CPD and Reflective Practice

1.4.1 The Evidence Base for Reflective Practice

As mentioned above, despite the popularity of reflective approaches in CPD and the increasing requirements for mandatory CPD, there are very few robust, empirical studies to support the alleged benefits and outcomes associated with CPD and reflective approaches. The studies below have attempted to examine the evidence base for the actual practice of CPD and reflective approaches (in other words, do health care practitioners actually participate in CPD and reflective approaches?), and the links between this and changes in practice, or improved patient outcomes (what difference does it make in practice?).

Lowe and Kerr (1998) report the effect on educational outcomes from learning by reflection in two matched groups of nursing students, comparing reflective teaching (a group of 26 students) with conventional teaching methods in a group of 34 students. The assessment measure comprised a written test covering the curriculum that had been delivered in the two modalities. Their prediction that the reflective methods group would score higher on the test was refuted; there was no significant difference between the mean test scores of the two groups. However, the fact that reflective teaching methods did not produce the expected better result is then positively reframed by the authors in their discussion, when they conclude from this finding that students "learnt just as well" using reflective methods when compared to students exposed to conventional methods.

In attempting to compare reflective with conventional teaching methods, it would appear however that the authors chose neither the most apposite teaching material, nor the most suitable outcome measure. Lowe and Kerr do not actually specify what the reflective teaching approach consisted of; the material that was taught (both "reflectively" and "conventionally") was part of a biological health sciences module – in itself perhaps not the most suitable subject matter for a reflective approach. The outcome measure was a test covering this module, with students having to answer 4 out of 8 questions, and each question being subdivided into knowledge, comprehension and application. Time taken to complete the test was 15 minutes. The fact that those students who had been taught in a more (undefined) reflective way, did not score more highly on an extremely brief test designed primarily to assess factual knowledge, and resulting in a quantitative final score, is not really surprising. If the value of reflection is to enable a deeper understanding of the relationship between the reflector and the material being thought about, and a stronger link between theory and practice, then a 15-minute factual knowledge test on biological health sciences could hardly be expected to be the most suitable

outcome measure. Furthermore there is no evidence presented that the sample size they used was sufficiently powered to be likely to show a significant difference between the experimental groups, nor is it clear, if, or how the participants were randomised, only that they were matched at outset by exposure to current course content and amount. Thus there may be in fact a true difference not demonstrated within this non-randomised, small, experimental matched pair design, with groups of different sizes with respective dropout rates of 5/26 (19%) and 9/34 (26%) who undertook the training but did not sit the assessment outcome measure.

It is generally believed that nurses who use reflection do so in order to improve their practice. The UKCC (United Kingdom Central Council for Nursing, Midwifery and Health Visiting), as part of its framework for post-registration education and training, requires all nurses to engage in reflection and to provide written evidence (reflective accounts) within a personal professional profile. The guidance is now published within the Nursing and Midwifery Council post-registration education and practice framework, which has statutory regulatory standing (Nursing and Midwifery Council, 2004). In addition, reflection forms the basis for practice development within the framework for CPD. However, there is little evidence to suggest that nurses readily engage in reflection in a meaningful way.

Andrews, Gidman and Humphreys (1998), in drawing on a number of published studies which examine reflective practice in nursing, assert that reflection generally remains an occasional and unplanned activity rather than a systematic part of practice. The authors state that there is a lack of empirical evidence to indicate that engaging in reflection changes practice or brings about specific benefits in terms of improved patient outcomes. Perhaps nurses who engage in reflection are more likely to develop their practice, as they may be naturally more thoughtful

and competent, but whether one is a direct result of the other is not known. Therefore, it is difficult to claim that reflection influences patient care. Reflecting on one's own, not having access to a supervisor to help one reflect, or having a supervisor who is not adequately skilled in reflecting and in facilitating reflectiveness in others, are all possible reasons for nurses' failure to practise reflectively. If teachers cannot define the necessary skills and the appropriate teaching and learning strategies to foster reflection, then learning may take place by trial and error. Andrews and colleagues warn that when reflection is not used systematically in clinical practice, there is a danger that it becomes something to "be done" in order to fulfil the UKCC requirements, rather than a framework or tool for developing practice. Furthermore, expanded responsibility for patient care, increased accountability, inappropriate staffing levels, poor skill mix and decreasing resources make it difficult for nurses to find the time to engage in planned and structured, rather than ad-hoc reflection. Keeping reflective accounts is not an effective way to monitor performance or standards, particularly as there is no effective external scrutiny for the reflective activities nurses engages in, or the written evidence they are expected to produce. Relying on self-evaluation alone lacks validity, given that the reflective process, recall of events, or written account may all be flawed. In conclusion, Andrews et al. (1998) state that:

> "Reflection is a purposeful activity which is more than just a recall of events. Implicit within reflection is a need on the reflector's part to change his/her behaviour. However, there is little documented evidence to support the view that reflection improves outcomes for patients."

These views are echoed by Burton (2000) who examines a number of studies claiming that reflective practice is linked to improved patient care, and greater integration of theory with

practice. It is not clear how the literature searches were undertaken, nor what methods were used to critically appraise their content. However Burton suggests that there is an emerging theme across almost every aspect of reflection that there is a "dearth of robust empirical evidence to support the claims made by reflective theory and reflective proponents".

There is a lack of evidence to demonstrate theory being generated by practising nurses, thus leading to a paucity of practice-based theory. It is not clear whether nurses are generally not reflecting because they do not feel equipped enough to meet the requirements, or because they lack the necessary skills. In summarising a number of studies, Burton states that there is little evidence to demonstrate that personal benefits in relation to using reflection are transmitted to patients, making it impossible to claim that reflection improves patient care, but despite this concludes:

> " Notwithstanding all the criticisms presented, it is felt on balance that there should be a place for the application of reflective principles because if reflection really can inform nursing practice, help nurses think critically before, after and in practice with subsequent improvements in the care that patients receive, its plausibility as an essential skill for the profession to acquire becomes evident. At present, a conceptually defined, less flawed, more supported, but equally practical alternative, is simply not available."

Lowe (2004) examined the use of reflection in implementing learning from a continuing education (CE) course into occupational therapy practice. Using a multi-method approach, qualitative and quantitative data were obtained from occupational therapists who participated in a CE course in Canada, as they attempted to put their learning into practice. Evidence for

the discriminant use of reflection showed that reflection was typically used when learning was complex; the integration of basic skills into practice rarely required the use of reflection. Reflection was used prior to, during and after participating in the CE course.

Given that, as previously described, clinical supervision is a reflective activity and linked to reflective practice for many healthcare professionals, particularly clinical psychologists, what do we know about the effectiveness of clinical supervision? Ellis, Ladany, Krengel and Schult (1996), in a systematic review of 144 empirical studies in supervision between 1981 – 1993, found that much of the research surveyed was not methodologically rigorous. A median effect size of .05 across studies does not allow for a valid evaluation of the effectiveness of clinical supervision.

Fleming and Steen (2004) comment that when it comes to evaluating supervision, "...many brave research studies have floundered on methodological rocks in the process" (p.7), given the difficulties in accounting for and controlling the interpersonal variables that exist in the relationship between supervisor, therapist and client.

However, is important to remember that within clinical psychology there is now emergent research that addresses questions concerning methodological rigour, and assesses the relation to outcome, by focusing on certain defined aspects of the supervision process (Milne et al 2005, (Milne, 2007), Milne et al 2007 a&b).

1.4.2 The Evidence Base for CPD

Regarding CPD for healthcare professionals in general, Brown, Belfield and Field (2002) state that it must be cost effective to avoid a waste of resources. The NHS annual budget of £3 billion for learning and personal development (Department of Health, 2002) is considerable, particularly when resources for health care are scarce, and money spent on CPD is competing with money used for direct patient care. Brown et al. (2002) conducted a critical review of the cost effectiveness of CPD in healthcare, by identifying evaluations of CPD interventions that included some form of economic analysis. Only 9 such papers were found, and the evidence that does exist was not consistent in its approach to costing or analysis. The authors state that:

> "Overall, it is impossible to draw any feasible conclusions regarding the cost effectiveness of different modes of CPD for healthcare professionals".

Extending effectiveness beyond cost-effectiveness, what then is known about the practice and effectiveness of CPD amongst clinical psychologists, and some of the healthcare professionals previously mentioned? There is some evidence to suggest that the provision of good quality, targeted CPD activity and support promotes clinical psychology recruitment and retention (Golding, 2003b, Sadler & Golding, 2006).

As regards other professions, Attewell, Blenkinsopp and Black (2005) investigated community pharmacists' ideas about CPD, and their actual CPD activities. CPD has been a mandatory requirement by the Royal Pharmaceutical Society of Great Britain since 2005, and is linked to the retention of practising certificates. A qualitative method was employed, involving semi-structured, tape-recorded and transcribed interviews and content analysis. Of the purposive

sample of 21 pharmacists, few seemed to understand the principles of CPD, most found it hard to systematically assess their own learning needs. Only one pharmacist did so and, on further questioning, needs were often identified opportunistically, i.e. through a situation in practice, which had made the pharmacist feel uncomfortable by highlighting an area they felt unfamiliar with. There was little reported formal evaluation of learning and any evaluation that did take place, tended to be subjective self-assessment and feedback. A recurring theme was that pharmacists queried the relevance of CPD once their career had progressed as far as they desired or thought possible, and they were in 'maintenance' mode. Attewell and colleagues (2005) conclude that pharmacists need further support to enable them to participate in CPD, and that attention needs to be paid to pharmacists' differential motivation to engage in CPD at different stages of their career.

Davis, Mazmanian, Fordis, Van Harrison, Thorpe and Perrier (2006) conducted a systematic review of physicians' self-assessment of predictive, summative and concurrent performance, compared with observed measures of competence. A total of 725 articles detailing studies in the United Kingdom, Canada, United Stares, Australia and New Zealand was then limited to 17 publications which met all inclusion criteria; any studies which were based on self-report were excluded. Their analysis suggests a poor relationship between physician self-ratings of performance and external/independent ratings. Of the 20 comparisons between self- and external assessment, 13 showed little, no, or an inverse relationship and 7 demonstrated positive associations. Rather worryingly, a number of studies revealed the worst accuracy in self-assessment in those physicians who were the least skilled and those who were the most confident. According to Davis and colleagues (2006), these findings are consistent with studies in other disciplines, namely law, engineering, guidance counselling, behavioural

science, psychology, and medicine. The authors conclude that the results of this systematic review "...prompt reflection on the use of self-rated assessment and its role in lifelong learning and value in regulation and patient care".

In a similar vein, Duffy and Holmboe (2006) comment that one reason why clinicians may not be good at recognising deficiencies is that they often confuse confidence with competence:

> "The medical culture of 'see one, do one, teach one' not only over-emphasises confidence to the detriment of acquiring true competence, but likely leads to the erroneous conclusion that actual performance data are not needed".

They state that physicians' self-assessment must be carefully structured and externally audited in order to achieve public accountability and veracity. Furthermore, the authors conclude that applying subjectively-determined standards for acceptable performance is risky and undesirable.

These findings raise pertinent questions in relation to reflection as a solitary activity, as opposed to reflection during supervision with a supervisor, or in a peer-group setting. The extent to which it is important to clinical psychologists to reflect with others, for a whole host of reasons, including the idea that this might be one way of safeguarding against poor practice, is one that the present study has aimed to explore.

Cantillon and Jones (1999) conducted a systematic review of continuing medical education, with a particular focus on postgraduate continuing medical education in general practice, to see whether educational interventions based on general practice change doctors' behaviour

and improve patient outcomes. Of the 1032 articles describing educational or audit activities in general practice between 1990 and 1999, only 69 papers met the inclusion criteria. Seventeen of the 18 audits showed a positive influence on doctor behaviour, of which only one found the behaviour change to be sustained. The 51 educational intervention papers included 14 studies using multiple educational strategies and 37 using single strategies. Of these, 7 did not change doctor behaviour. The authors comment that the most striking feature of this review is the lack of robust evaluations of general practice based educational interventions. Of those studies that did produce generalisable findings, only a very small proportion was designed with follow-ups to see whether behavioural change was maintained.

Finally, a Cochrane review of the effects on professional practice and health care outcomes via continuing education meetings and workshops was conducted by O'Brien, Freemantle, Oxman, Davis and Herrin (2001). Thirty-two studies with a total of 36 comparisons were included, involving a total of 2,995 healthcare professionals (mainly doctors) ranging from 13 – 411 per study. These were deemed to be of moderate or high quality, although there was generally a poor reporting of methods. Planned educational activities included meetings, conferences, lectures, workshops, seminars, symposia and courses that took place off-site from the practice setting. The review found that interactive workshops could result in moderately large changes in professional practice, whereas didactic methods like lectures or presentations alone were unlikely to change professional practice.

1.4.3 Difficulties with Establishing the Evidence Base

When it comes to assessing healthcare professionals' use of reflective approaches in practice, and the links between reflective practice and changes in outcome, there is a lack of robust empirical evidence to support the claims made by reflective theory and its proponents. However, Burton (2000) reminds us that whilst reflective theory and practice has not been adequately tested, neither has it been rejected. Reflection is not necessarily incapable of fulfilling the many claims made for it – it is rather that the claims have not, to date, been empirically evidenced. Perhaps the methodological complexities involved are too great to ever be able to design, conduct and evaluate a robust enough study to answer these questions.

Is it any easier to establish the evidence base for CPD more generally? For a number of years, for example, Milne and colleagues (2005) have been considering effectiveness in the context of systematically investigating the essential factors in supervision. A simple yet powerful, practical model for evaluating the effective delivery of appropriate CPD, illustrated with clinical supervision, is described by Milne, James and Sheikh (2005). The framework, which is embedded within an experiential learning cycle and emphasises reflection as a major ingredient, poses the following key questions to guide a systematic evaluation for evaluating the effectiveness of CPD:

- What is the right thing to do?

i.e. the 'right' form of CPD will be guided by theory, guidelines, and professional opinion

- Has the right thing been done?

i.e. is there good adherence to the 'right' CPD method approach?

- Has it been done right?

i.e. has the CPD activity been provided with the necessary skill and competence?

- Did it result in the right outcomes?

i.e. how did the CPD activity relate to learning outcomes and changes in practice?

- Was the CPD context right?

i.e. did the CPD activity have the 'right' kind of facilitating environment and support?

Milne and colleagues (2005) state that these 5 basic questions apply equally to CPD activities other than clinical supervision, to brief workshops or lengthy part-time courses. However, whilst the suggested framework can help us evaluate adherence to theory/models and outcomes (what *has* been done?), it has less to say about evaluating the process and the practice (*how* was it done?). Green (2005) concludes that:

> "Contemporary CPD practice, in clinical psychology as in all other healthcare professions, cannot be presented as an empirically based endeavour" (p.15).

The assumption that engaging in CPD activity will result in predictable and measurable improvements in patient outcomes has not been established. Moreover, changes in professional practice tend to be measured on completion of the CPD activity, whereas the maintenance of skills or changes in behaviour is rarely measured in studies. However, evidence-based practice research leading to recommendations of good practice is beginning to emerge in certain areas in clinical psychology (Fleming & Steen, 2004; Golding & Gray, 2006). As Green (2005) encourages us:

> "Rather than sit on our hands bemoaning the absence of research findings to inform our CPD decisions, clinical psychologists need to make good use of the evidence that

is available and contribute to expanding that knowledge base by conducting their own applied research" (p.17).

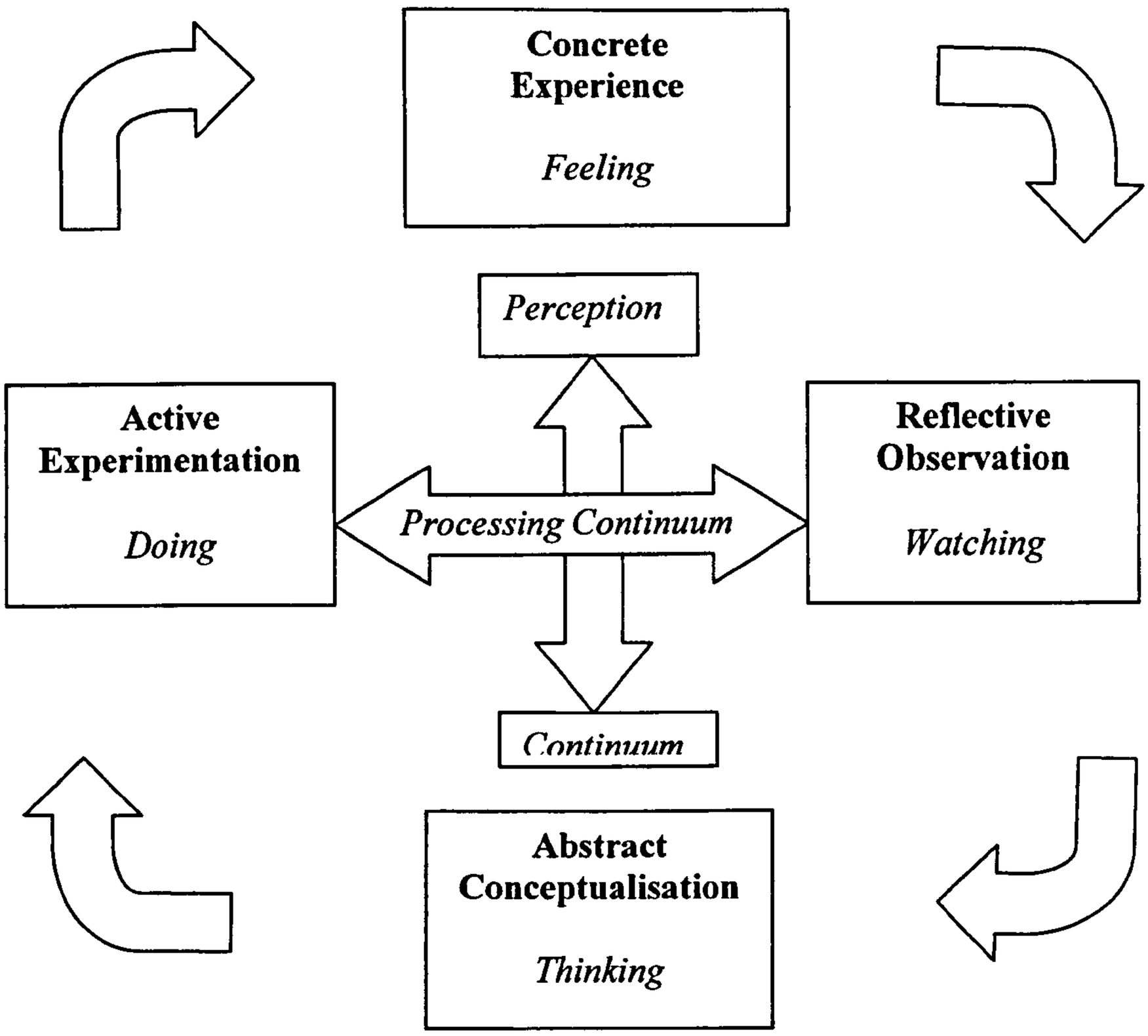
1.5 Theories of Reflective Learning in Continuing Professional Development

1.5.1 Kolb's Experiential Learning Cycle and Learning Styles

Kolb (1984 a&b) developed a theory of experiential learning which became known as the Kolb Experiential Learning Cycle (Figure 2 below), and which was further developed into a model of corresponding learning styles (Kolb's Learning Styles Inventory). It builds on the work of Rogers, Jung and Piaget, and relates to adult learning and development.

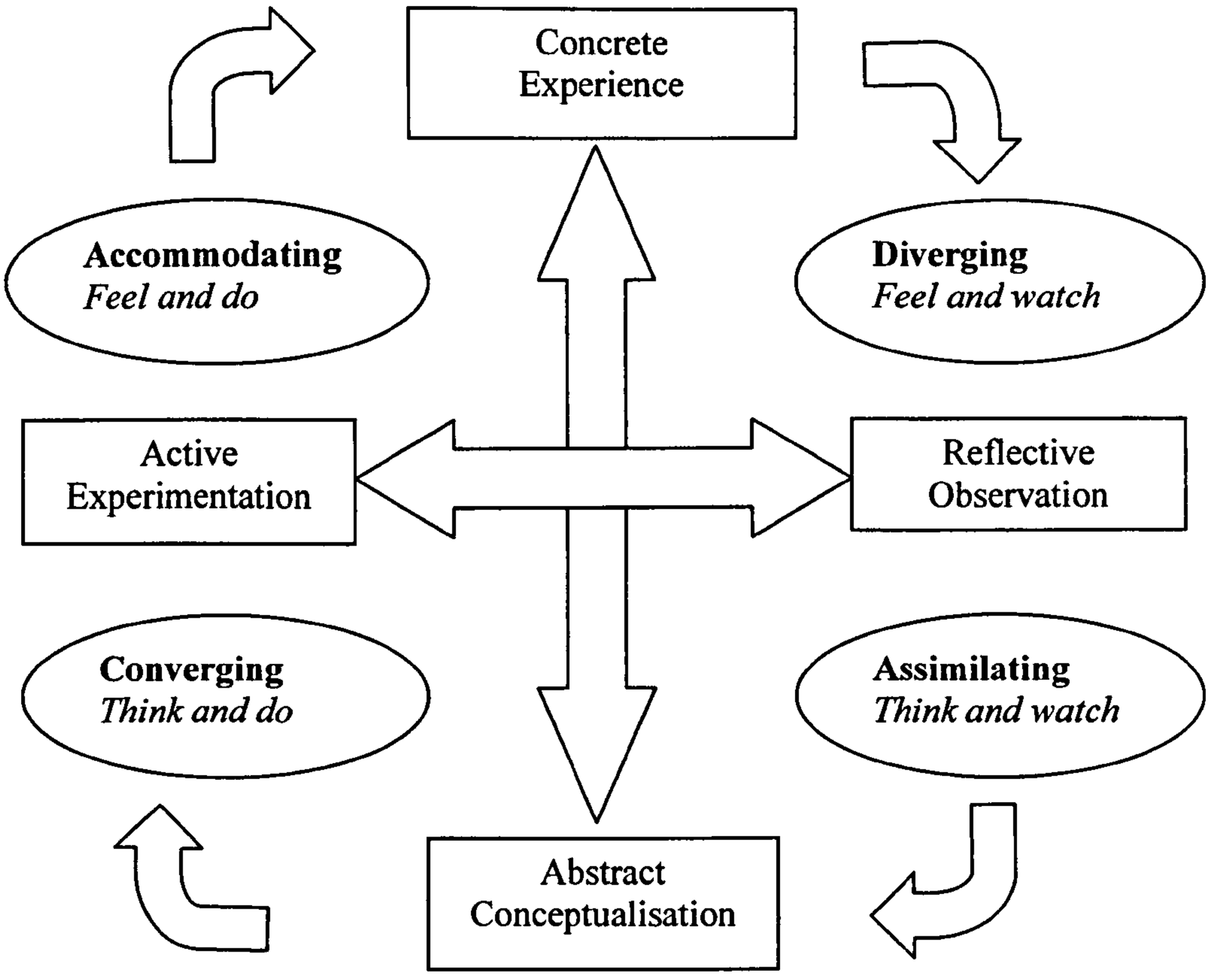
The Learning Cycle includes 4 different stages of learning, in which immediate or 'Concrete Experiences' provide the basis for 'Reflective Observation'. This is then crystallised into 'Abstract Conceptualisation', which can subsequently be tested out through 'Active Experimentation', which in turn can lead to new experiences. In other words, when a person is experiencing something, the process of reviewing and reflecting on that experience leads them to draw certain conclusions from it, which can be tested out in practice, thus leading to further new experiences. Therefore, Kolb's Learning Cycle proposes that simply doing something (having an experience) is not enough in order to learn. Rather, it is necessary to reflect on the experience in order to make generalisations, or formulate ideas and concepts that can then be applied to new situations. This learning must be tried out in novel situations. The learner must thus make the link between theory and action via planning, trying out and doing, reflecting and then relating it back to the theory.

Figure 2: Kolb's Experiential Learning Cycle (after Kolb, 1984a&b)



Kolb's (1984 a&b) model of Learning Styles (Figure 3 below), derived from the Experiential Learning Cycle, explains why people naturally lean towards different, preferred approaches to learning. Therefore, individuals will learn more effectively if learning methods and resources are orientated towards their preference. The 'Diverging' learning style is characterised by a preference for watching rather than doing, gathering information and using one's imagination

Figure 3: Kolb's Learning Styles (after Kolb, 1984a&b)



for problem-solving. An 'Assimilating' learning preference is for a concise, logical approach, with ideas and concepts seen as more important than people and practical situations. Learners with a 'Converging' style are problem-solvers, using their learning to find practical answers to questions and theories. Finally, the 'Accommodating' style relies on intuition rather than logic, with individuals employing a practical, experiential approach based on someone else's analysis. Individuals who can 'style-flex' and employ a range of different learning styles, are likely to be better learners than those who have a marked preference for only one or two learning styles, which may not be suited to all conditions.

According to Kolb (1984 a&b), the stage of a person's development is an important influence on the choice of learning style, and he suggests that we are more likely to integrate and reconcile the four different learning styles as we mature. As a model to describe reflective practice, Kolb's Experiential Learning Cycle and Learning Styles model is particularly appealing, as it offers both an individual and universal understanding of learning. Thus, the cycle of experiential learning applies to us all, and explains the importance of reflection in the creation of knowledge, and the way in which we derive evidence-based practice and practice-based theory. The concept of individual learning styles also explains why some people may be naturally more reflective than others, whereas others prefer a more hands-on approach to practice.

1.5.2 Single, Double and Triple-Loop Learning

A crucial question in relation to CPD is whether it changes professional behaviour; Sandars (2006) asserts that the reason why this often fails to happen is because most reflective practice in CPD is single-loop learning.

The concept of single- and double-loop learning was first described by Argyris and Schön (1974) through their research on the learning of managers and professionals. As these theories were developed, it has been suggested professionals use two types of theory – 'espoused theories', i.e. to explain and justify what they were doing – and their 'theories in use', which are those often implicit theories that actually determined what they were doing. Argyris and Schön, in noticing the significant gap frequently in evidence between the two theories, explained this in terms of learning habits. Not only were the theories in use habitual, they also

pre-determined the way in which the professionals interpreted their environment. Thus, selective attention was in operation in that individuals looked for evidence to back up their expectations, but ignored or paid less attention to other kinds of evidence. Such a narrow, 'single-loop' focus left their basic assumptions intact (Eraut, 2004).

Whilst the first loop of learning will often be triggered when something is wrong, double-loop learning takes place when there is a more questioning approach taken to identify why something went wrong in the first place. Sandars (2006) illustrates this in relation to CPD with an example of a general practitioner who is unsure about the most effective treatment for a certain condition. Single-loop learning means that the identification of this as a learning need would be to find the effective treatment, perhaps via further reading or asking a colleague. Double-loop learning would lead to the GP examining why they were uncertain of the treatment in the first place. Perhaps this might be due to not having kept up-to-date about treatments. This might then reveal that that doctor had hitherto been too reliant on opportunistic learning, as opposed to systematically identifying their learning needs.

Sandars (2006) asserts that the application of single- and double-loop learning to the understanding of organisations has revealed that most organisations only use single-loop learning, which is linked to a failure to flourish. In relation to healthcare organisations, this might explain why service improvement has not been successful at times, because of a failure to challenge and change underlying organisational beliefs, objectives and processes.

Triple-loop or 'transformative learning' concerns an acknowledgement and examination of the underlying power relationships in society, and their influence on actions, by asking the

question "Why should we do it that way?". Only by discussing the underlying purpose and intention of actions, within the systemic context in which they take place, can present approaches be challenged and new strategies be considered.

The ability of organisations to learn about the contexts of their learning – when and how they do and don't learn - can be described as 'learning about learning' or 'meta-learning'. Therefore, successful learning organisations build on their experience of learning to develop and test new learning strategies. Davies and Nutley (2000) state that experience in healthcare has shown us that meta-learning will be difficult to achieve due to the relative ineffectiveness of standard approaches in continuing medical education.

In conclusion, it is clear how the Experiential Learning Cycle and Learning Styles described by Kolb can be used as a framework for adult learning and reflective practice, explaining both individual and universal learning processes. The role of reflection is seen as crucial in enabling experience being transformed into theory. Triple-loop or meta-learning enables us to understand learning in an organisational context, by drawing attention to the systemic conditions that must be in place in order for learning to be effective and change to occur, so that the organisation as a whole can become a 'reflective learning organisation'.

1.6 The Present Study

1.6.1 Aims and Rationale of the Present Study

The available literature has highlighted the popularity of reflection as an important construct and method in the education, training, and continuing professional development of diverse groups of healthcare professionals. The government has clearly linked CPD to life-long learning, maintaining and improving competence, ensuring patient safety, and the provision of high quality care in a modernised NHS.

However, the relationship between reflection, reflective practice and CPD is not clear. It may not be simplistically linear, i.e. CPD activity followed by reflection, when *all* professional activity could potentially be construed as CPD as long as it includes reflection and learning, i.e. reflective practice *as* CPD. There is a paucity of empirical research concerning qualified clinical psychologists' understanding and application of reflection in their everyday professional practice, as part of CPD, and the relationship between CPD and reflective practice. It is not known to what extent the research by, and of, other healthcare professionals, applies to clinical psychologists.

Qualitative research is necessary in order to explore clinical psychologists' experiences of reflective practice and CPD in depth. The factors that help or hinder reflection in CPD, and reflective practice, need to be identified, and examples of good practice described and disseminated. This should add to the knowledge base concerning the theory – practice link in CPD, both for the practitioner and consumer of CPD activities, and for educators involved in

the design and delivery of CPD programmes. The findings need to be related to prevailing theories of teaching and learning, and located within the current and future context of mandatory CPD and statutory regulation for clinical psychology.

1.6.2 Search Strategies

An electronic search was undertaken using the following search terms: 'reflective practice', 'continuing professional development', 'CPD', 'reflective practice and CPD', 'reflection and CPD', 'reflection and clinical psychology', 'CPD and clinical psychology', 'reflective practice and clinical psychology'.

The following databases were searched electronically: AMED, CINAHL, DH-DATA, King's Fund, MEDLINE, PsycINFO, PubMed, and the Cochrane Database of Systematic Reviews.

A search on 'Google' using the above search terms was also conducted.

All publications obtained in this way were then examined manually in terms of their references listed, and further relevant references were obtained.

The literature search was conducted at the beginning of the study (2005) and repeated prior to the study being written up (2007).

1.7 Research Questions

1.7.1 Overall question

What is clinical psychologists' experience of reflective practice in relation to their continuing professional development?

1.7.2 Subsidiary questions

- What do clinical psychologists understand by 'reflective practice' and 'continuing professional development'?
- How do clinical psychologists reflect in relation to CPD, and how do they link this back to their professional practice?
- What are the enablers and obstacles to reflective practice in CPD, and what factors enhance reflective practice in CPD?
- How do the findings relate to the current and future professional practice of CPD?

CHAPTER 2: METHOD

2.1 Overview of the Design

This is a qualitative study, which aimed to explore clinical psychologists' experience of reflective practice and how this relates to their continuing professional development. An initial 'expert' focus group was used to construct a topic guide, which formed the basis of individual interviews with qualified clinical psychologists. These were tape-recorded and transcribed, and analysed using Interpretative Phenomenological Analysis (IPA), aided by Atlas-ti (a software package). Member validation interviews and a final focus group were employed for validation and triangulation.

2.2 Rationale for Research Methodology

2.2.1 Rationale for Qualitative Research Methodology and Interpretative Phenomenological Analysis

Smith (2003) asserts that qualitative methods are:

> "generally engaged with exploring, describing and interpreting the personal and social experiences of participants" (p.2).

Whilst in quantitative research, pre-existing theory is being tested out, in qualitative research the aim is to build new theory. Qualitative research is useful in exploring issues about which little is known, and therefore it is inductive, i.e. it does not rely on an a priori conceptual framework, or a set of hypotheses to be tested (Morse & Field, 1995).

Murphy, Dingwall, Greatbatch, Parker and Watson (1998) suggest that qualitative research practice is characterised by six key features. First, qualitative researchers are intent on adopting the perspective of the people being studied, and through a process of selection and interpretation, influenced by the researcher's theoretical framework, the meanings of participants' behaviours are hopefully uncovered and made sense of. Second, describing the setting of the study is seen as essential, including the researcher's theoretical position. Third, qualitative research aims to study phenomena in context and understand them holistically, whereas quantitative research seeks to isolate and manipulate variables. Fourth, there is an emphasis on process ("how") as opposed to output ("what") data. Fifth, aspects of the design are often changed or adapted as the study progresses, and sixth, a process of progressive focussing as opposed to an a priori framework is thought to best facilitate the discovery of the phenomenon in question.

There is little existing research in the area of reflective practice, and therefore a qualitative (as opposed to quantitative) methodology was considered to be the best approach. Interpretative Phenomenological Analysis (IPA), which aims to explore how individuals make sense of their world, was chosen as the method for qualitative analysis:

> "The approach is phenomenological in that it involves detailed examination of the participant's lifeworld; it attempts to explore personal experience and is concerned with an individual's personal perception or account of an object or event, as opposed an attempt to produce an objective statement of the object or event itself" (Smith & Osborn, 2003).

Given the relative paucity of directly relevant and comparable research, the researcher's main interest was in exploring how clinical psychologists made sense of reflective practice and its relationship to CPD, as opposed to attempting to build novel theory to explain this. The latter would require grounded theory methods which, according to Charmaz (p.109),

> "...offer psychologists exciting possibilities for revisioning psychological theory as well as useful strategies for rethinking psychological research methods" (Charmaz, 2003).

It was not the researcher's intention to revise psychological theory or construct new theory in this area. A grounded theory approach would have been suitable for a more substantive piece of work than the present research. Likewise, other qualitative methods, such as narrative psychology, appear to be more appropriate to an exploration of life events, where the purpose of analysis might be for the teller to locate themselves within a narrated structure that has a beginning, middle and end, and causal connections between. Whilst such an approach might be very suitable for exploring, for example, individuals' adjustment to a serious illness from diagnosis through to treatment to recovery, the subject area for exploration by the present study seemed less suitable for a narrative approach.

The detailed analysis of Conversation Analysis seemed to the researcher to be more concerned with patterns in conversation, according to Drew (2003) aiming to show:

> "how conversational and other interactions are managed and constructed in real time, through the processes of production and comprehension employed by participants in co-ordinating their activities when talking with one another" (p.134).

As the present study was more concerned with an exploration of professional practice that aimed to address the 'what', 'where', 'why' and 'how' of reflective practice and CPD, conversation analysis was therefore deemed a less suitable form of analysis.

Qualitative methodology rejects the quantitative research concept of the supposedly neutral relationship between the researcher and the researched (Richardson, 1996). In IPA, an understanding and explicit account of the researcher's role and position in the research process is seen as essential. The qualitative researcher tries to see the world through the eyes of the participants engaged in the research process. However, given that it is impossible, as an outsider, to have total insight into the world of another person, a degree of interpretation on behalf of the researcher is not only inevitable, but also necessary in order to make sense of the data. Therefore, IPA involves " a two-stage interpretation process, or a double hermeneutic" (Smith & Osborn, 2003, p.51). The participants are trying to make sense of their experiences, and the interpretation of this by the researcher represents his or her attempts to make sense of this process. IPA was therefore considered the most appropriate method of analysis.

2.2.2 The Researcher's Position

As a clinical psychologist and CPD tutor, the researcher was interested in exploring, describing and interpreting clinical psychologists' experience of reflective practice and CPD within the context of their professional practice. The researcher is a part-time CPD tutor with a Regional Clinical Psychology Continuing Professional Development Scheme, and part-time consultant clinical psychologist, who has worked in that Region for over twenty years. At the start of the present study, the researcher was informed about CPD in clinical psychology,

local, regional and national patterns of CPD activity, and relevant professional developments that might influence these, through her professional CPD role. The researcher's clinical practice is informed by post-qualification training in psychodynamic therapy, and through involvement in the psychodynamic training of other therapists. Continuous psychodynamic supervision in different formats (one-to-one, in a pair, in a group with a supervisor) and with different supervisors, for the past seventeen years, has been an essential feature of the researcher's clinical practice. Therefore, the researcher's previous training, personal therapy and experience of an explicitly reflective style of supervision are important influences on the development of her own reflective practice. In psychodynamic supervision, explicit reflection is encouraged not only in relation to the overt content of a session, but also of the therapist's thoughts and feelings in relation to the patient, and the meaning of experiences in the patient's life and relationships (past and present) as they are re-enacted in the therapeutic relationship.

Aspects of IPA – although a method for analysing research data – felt 'familiar' to the researcher who had previous experience of transcribing psychotherapy tapes and analysing the content in detail, in order to find repeating patterns, themes, and underlying meanings. The researcher's general clinical practice relies on the use of formulations – taking the patient's account of his/her experiences, but transforming it in such a way that a new understanding of the same material can be achieved.

The study is therefore informed by, and informs, both the researcher's clinical and CPD tutor roles. An epistemological statement describing in more detail how the researcher's assumptions, expectations and experiences influenced the research process is found in Appendix 1.

2.2.3 Reflective Diary

Within qualitative research, the role and personal beliefs of the researcher are acknowledged as being influential in shaping the research process, and potentially influencing the outcome. The researcher kept a reflective diary throughout the study in order to capture her thoughts, feelings, ideas, questions, and any observations in relation to the research process (an excerpt of this is found in Appendix 2 as an example).

The researcher's position as a fellow professional/peer and CPD tutor clearly informed the research, but also – inevitably - impacted on the process (particularly during the interview phase). Reflecting on this by way of noting down related thoughts in the diary was one way of acknowledging this given dynamic, and to make any potential bias more conscious.

2.3 Initial Development Work

2.3.1 Initial Focus Group

In order to construct the interview schedule or topic guide, a focus group was conducted prior to applying for ethical and research governance approval. This was considered essential development work. Six 'expert' clinical psychologists were invited to discuss their views on reflective practice and CPD. Of these, 5 were able to attend on the day; the sixth person was consulted later the same day by telephone. Four of the attending group members were female. The group participants were selected according to three main criteria: Firstly, they were senior members of the profession (the average age was 48 years, ranging from 38 – 64 years) with

considerable post-qualification experience (average 21 years). Secondly, all had extensive involvement in CPD at a professional level (three members at a national level), and all were members of the British Psychological Society and Division of Clinical Psychology. Thirdly, they were known to the researcher because of their substantial knowledge of reflective approaches, both in clinical practice and training (4 of the group members were involved in clinical psychology training, and two had additional psychodynamic and cognitive-analytic training).

As the group facilitator, the researcher asked the participants to discuss their experiences and views regarding reflective practice and CPD. A brief explanation of the proposed study was given at the start. The group was tape-recorded and verbatim notes were made throughout by a psychology assistant attached to the Clinical Psychology CPD Scheme. The group ran for 75 minutes with minimal prompting. Subsequently, the contemporaneous notes were compared to the tape-recording.

2.3.2 Topic Guide

The main themes from the focus group resulted in 22 research questions which, following discussion in supervision, were collapsed into six main topics, or areas for further exploration. These included participants' understanding and experience of reflective practice and CPD, developmental influences, reasons as to why one might engage in reflective practice, enablers and obstacles to reflective practice, and the relationship between reflective practice and CPD. Additional and optional prompts were also included (see Appendix 3). The topic guide was

designed to be flexible so that if unforeseen issues emerged during data collection, these could be introduced in subsequent interviews and focus groups[2].

2.4 Interview Participants

2.4.1 Selection and Recruitment: Ethical and Research Governance Approval

The research proposal was peer reviewed and approved by the Department of Clinical Psychology, University of Hull (Appendix 4), and the Local Research Governance Group.

R&D approval was sought and obtained from eleven relevant NHS trusts across the relevant areas. These included mental health trusts, acute (hospital) trusts, a primary care trust (PCT), a joint mental health & social care trust, and a university teaching hospital trust. The trusts were selected to provide diversity in terms of geographical location, type of organisation, and size of clinical psychology workforce employed.

Each application included an R&D application form, full research proposal, recruitment and consent information, and any additional documentation as requested by each trust. The R&D application form (Appendix 5) and approval letter (Appendix 6) issued by the researcher's employing trust were used as the basis for all subsequent R&D applications to all other trusts. NHS ethical approval was not required for this study (Appendix 7); instead, ethical approval was sought from and granted by the University of Hull's Postgraduate Medical Institute (Appendix 8). Moreover, the Local Research Ethics Committee confirmed that notification of

[2] In the event, the topic guide development process of literature review, initial focus group and pilot interviews did cover all the themes that emerged during the data collection.

all relevant Ethics Committees (of the trusts involved in the study) was not necessary, as this was a "No Local Investigator" study, therefore not requiring site-specific assessment.

2.4.2 Selection and Recruitment: Procedure and Response Rate

An estimated 380 clinical psychologists are employed in the NHS trusts from which approval was sought, amounting to approximately two-thirds of the total number of qualified clinical psychologists in that region. All the major clinical specialties were represented in this recruitment pool, i.e. adult mental health (primary and secondary care, and specialist services), child and family, older adults, learning disabilities, physical health, neuropsychology, forensic psychology, and substance misuse.

Recruitment adverts were sent to departments (see Appendix 9), and additional recruitment information to each clinical psychologist employed by the identified Trusts (see Appendix 10). Interested participants then returned the enclosed reply slip, stating specialty and length of qualification, following which they were sent a participant information sheet (Appendix 11), giving further details of the study. At interview, further demographic and other details were ascertained verbally (Appendix 12). Twenty-four respondents (6.3% response rate) from 9 different trusts responded to the invitation to participate in the study.

2.4.3 Interview Participants – Sampling Strategy

Sixteen of the twenty-four respondents were selected for interview. As successful recruitment occurred in a staggered fashion in response to R&D approval being granted at different times by different trusts, participants were initially chosen for interview in order of making contact

and subsequently, according to the specialty and length of time they had been qualified for. A range of specialties, and experience from recently qualified to very senior, was considered important in order for the whole sample to reflect a diversity of experiences of, and influences on, reflective practice and CPD. It has been suggested that in making sampling decisions in qualitative research,

> "...pragmatic considerations should be integrated with sampling in a systematic way just as in quantitative research..." (Murphy et al., 1998).

2.5 Procedure

2.5.1 Informed Consent and Confidentiality

Interviews were conducted in a variety of locations across the Region, primarily in participants' work settings. Prior to the start of the interview, participants were re-issued with the participant information sheet as a reminder and invited to ask any questions they might have about the study. Two copies of a consent form (Appendix 13) were signed by the participant and the researcher (one copy for each to keep). Participants were reminded of the BPS Professional Practice Guidelines (British Psychological Society, 1995) and the BPS Code of Ethics and Conduct (British Psychological Society, 2006b) with regard to ethical principles in informed consent, competence, and professional conduct.

Confidentiality was ensured by assigning a simple numerical code to the tape and transcript of each interview. Any personal identifiers relating to the participant and his/her workplace, clients or colleagues, were anonymised in the transcript of the interview.

2.5.2 Interviews and Transcripts

The first two interviews were used as pilots to test out the topic guide. As the questions were not substantially revised, the transcripts were subsequently included in the analysis. All interviews were tape-recorded and transcribed. Participants were asked to discuss their experiences regarding the key topics, and supplementary questions were used as prompts if necessary. Interviews varied in length, but typically lasted 45-50 minutes, with transcripts averaging 5,000 words per interview. All transcripts were sent back to participants in order to ensure that they represented an accurate and verbatim record of the interview, and participants were asked to make any corrections or comments on the transcript, which was then corrected.

2.5.3 Interview Feedback

Each participant was invited to give feedback about the interview process. All participants completed a written feedback form (Appendix 14), either at the end or within a few days of the interview.

2.6 Analysis

2.6.1 Atlas-ti Scientific Software

Atlas-ti is a software package that facilitates the analysis of large qualitative datasets involving much cross-referencing between different sources. It is useful for generating codes and the rapid comparison of areas of coded material ("quotes"). It enables the systematic storage,

retrieval and comparison of large numbers of codes and quotes between different transcripts. Atlas-ti does *not* replace the researcher in performing the actual analysis, but it does enable retrieval and comparison of text across different transcripts to be done much faster than would be possible by relying on manual searching methods.

2.6.2 Analysis of Transcripts

As well as listening to the tape of each interview, transcripts were read several times in order to become familiar with the data. Initial thoughts and observations were noted as "memos" in Atlas-ti.

Line-by-line coding was performed for all sixteen transcripts. Comparative analysis, i.e. constantly comparing codes and associated quotes across transcripts, was employed in order to ensure that a code retained the same meaning when applied to different quotes within the same script, and across different transcripts (Charmaz, 2003). Some codes were chosen to represent a specific meaning from the start (for instance, "CPD and need to keep updated", whilst other codes were initially very broad (for example, "Reflection – Action link") until the meaning of the associated material became more clear, which was only possible with progressive analysis. A list of all the codes generated (in alphabetical order) can be found in Appendix 15. Once all transcripts had been coded, broad codes were subdivided into more specific codes. Comparative analysis throughout this process resulted in some codes being merged (on the basis of identical meaning), some codes being renamed, and some quotes being reassigned to different codes.

When all coding was completed, codes and associated quotes were clustered into a number of themes on the basis of similar meanings, generating a number of code-families (see Appendix 16). These "sub-themes" were finally clustered together into four "super-ordinate themes".

2.7. Reliability and Validation

Reliability and validation of the coding and thematic analysis was achieved in three main ways, as follows:

2.7.1 Reliability

The first 6 interview transcripts, and all associated codes and quotes, were sent to the researcher's supervisor. The process of analysis, coding, and the codes and quotes determined up to this point, were discussed at a subsequent meeting. No procedural changes were advised, and the same procedure therefore continued for the remaining transcripts.

2.7.2 Member Validation Interviews

Seven participants were contacted for a second interview at which they were presented with the key themes from their initial interview (see Table 4, column 5, below). The purpose of this was to validate the process of analysis, to invite any comments or questions on the themes presented, and to allow a further opportunity for any new material to emerge in response to the researcher's thematic feedback. Full notes were taken during and immediately after these face-to-face interviews, which were subsequently included within the qualitative data analysis.

2.7.3 Final Focus Group and Triangulation

All 5 members who had attended the initial focus group, and 4 interview participants (see Table 4, column 6, below) attended a final focus group. The main themes and sub-themes were presented to the group by the researcher, illustrated with quotes, and comments were invited. As with the member validation interviews, the purpose of the final focus group was to validate the analysis and also to enable any new material to emerge that might not have been captured during the individual interviews. The focus group was tape-recorded, and contemporaneous notes were made throughout by a psychology assistant attached to the Clinical Psychology CPD Scheme.

CHAPTER 3: RESULTS

3.1 Overview of the Results

This study aimed to explore how qualified clinical psychologists experience the relationship between reflective practice and CPD. In this chapter, the participant characteristics are described first, followed by a consideration regarding sample representativeness, and the characteristics of those participants who were recruited but not interviewed. The analysis revealed four higher-order themes: 'Clinical Psychologists as Reflective Practitioners', 'The Reflective Space', 'Functions of CPD and Reflection', and 'Linking Reflection and CPD'. Associated sub-themes and illustrative quotes are presented for each of these themes. Finally, there is a summary of the written feedback given by participants about the process of the interview itself.

3.2 Participant Characteristics

3.2.1 Characteristics of Interview Participants

The gender, length of post-qualification experience and clinical specialism (columns 2, 3 and 4) of the 16 interview participants are shown in Table 4 below (columns 5 and 6 are explained in section 3.3.2 below).

Table 4: Characteristics of Interview Participants

1. No	2. sex (Female/ Male)	3. Post-qual. experience (yrs/mths)	4. Specialism	5. Member validation interview	6. Final focus group participation
P1	F	19.6	Enduring mental illness/rehab. (secondary care) & CPD	yes	
P2	F	16.6	Physical Health	yes	
P3	F	0.9	Child and Family		
P4	F	1.9	Adult Mental Health (CMHT)		
P5	M	24.9	Learning Disability & Clinical Psychology Training	yes	yes
P6	F	2.9	Adult Mental Health (primary and secondary care)		yes
P7	F	10.9	Adult Mental Health (primary care)		
P8	M	1.9	Child and Family		
P9	F	6.9	Learning Disability and Clinical Psychology Training	yes	
P10	F	5.10	Adult Mental Health (secondary care)	yes	yes
P11	M	3.11	Child and Family	yes	
P12	F	13.0	Adult Mental Health (secondary care)	yes	
P13	F	11.0	Child and Family		
P14	F	17.0	Adult Mental Health (Psychotherapy/Therapeutic Communities)		yes
P15	M	6.1	Child and Family		
P16	F	10.1	Forensic Clinical Psychology		

There were 12 female and 4 male interviewees, with a mean age of 37 years at the time of interview (range 28 – 52 years). Length of post-qualification experience ranged from 9 months to 24 years 9 months, with an average of 9 years 6 months. Participants were employed in 9 different NHS trusts (5 Mental Health Trusts, 2 Acute Trusts, 1 Children's Hospital Trust and 1 Primary Care Trust). Eight interviewees were based in sub-region 1, 5 in sub-region 2 and 3 in sub-region 3. Ten participants worked full-time; 6 were part-time. All 16 were members of the BPS, and 12 were also DCP members.

All interviewees were receiving regular formal clinical supervision as follows: 9 were in individual supervision, 4 were in a peer supervision group, and the remaining 3 had both 1:1 and peer group supervision. Four participants also reported ad-hoc clinical supervision and/or consultation, as and when necessary.

The average amount of time spent in formal clinical supervision was 3 hours per month, but the frequency of supervision ranged from weekly to bi-monthly. In addition, 7 participants received formal line management supervision on a regular monthly or bi-monthly basis.

Seven participants had undertaken additional psychodynamic or systemic/family therapy training; of those, 2 were trained to professional registration level. Eight participants had previous experience of personal therapy.

3.2.2 Representativeness of Interview Participant Sample

Although - as with many qualitative studies - the present sample size is relatively small, it is nevertheless considered to be representative of those clinical psychologists in the Region who have demonstrated that they will respond to surveys. Certain demographic and other characteristics of the present interview sample were compared to those of 174 of the 620 clinical psychologists registered on the Regional CPD Scheme database in 2005 (Sadler & Golding, 2006).

The present interview sample (recruited in 2006) is remarkably similar to the 174 CPD survey respondents from 2005 (who then made up just less than one-third of the clinical psychology workforce in the Region), as illustrated in Table 5 below. Where the present sample differs from the 2005 survey cohort, is in relation to age –a greater proportion of the current interviewees were aged less than 45 years (although the mean age of the two groups of participants was the same), and professional body membership and supervision - all of the current sample were BPS members, a greater number had DCP membership, and all were receiving clinical supervision, compared to the 2005 respondents.

Table 5: Interview participants' demographic and other characteristics compared to 2005 CPD Survey respondent sample

Sample Characteristic	Current Research Interview Participants	2005 Regional CPD Survey Respondents (Sadler & Golding, 2006)
Mean age	39.75 years	39.5 years
Age range	28-51 years	21-58 years
Age less than 45 years	87.5%	69.5%
Age less than 50 years	93.75%	82.6%
Largest age group	30-34 years	30-34 years
Female respondents	75%	78%
Male respondents	25%	22%
BPS membership	100%	90%
DCP membership	75%	63%
Part-time status	37.5%	34.5%
Employed in sub-region A	50%	47%
Employed in sub-region B	31.25%	25%
Employed in sub-region C	18.75%	28%
Receiving regular clinical supervision	100%	93.5%
Mean number of hours of clinical supervision (per month)	3 hours	3.6 hours
UKCP registration	12.5%	8.5%

3.2.3 Participants Recruited but not Interviewed

Table 6: Additional participants recruited/not interviewed

Reserve No.	Gender	No. of years qualified	Specialty
R17	F	16	Learning Disability
R18	F	20	Child and Family
R19	F	1	Older Adult
R20	F	1	Adult (primary care)
R21	M	8	Child and Family
R22	F	16	Physical Health
R23	F	20	Child and Family
R24	F	12	Learning Disability

Table 6 above describes the characteristics of the remaining 8 potential participants who were recruited but not interviewed ("reserves"), as thematic saturation was reached after 16 interviews. They were qualified for a mean of 12 years, and worked in 6 of the 9 trusts across the Region (3 each in sub-regions A, B and 2 in C). The individuals not selected for interview did not appear to differ significantly from those who were interviewed, on the basis of the demographic and professional information obtained on recruitment.

3.3 Thematic Analysis

3.3.1 Overview

The results are divided into 4 super-ordinate themes, the first focusing on clinical psychologists' understanding and experience of reflective practice ('what?'), the second on supervision as the reflective space ('where?'), the third on the functions of reflection and CPD ('why?'), and the fourth on the links between reflective practice and CPD ('how?'). All associated themes and sub-themes are shown in Tables 7 and 8 below. Each theme is discussed in a separate section, including illustrative examples from the transcripts. A summary table showing the frequency of individual participants' coding can be found in Appendix 17.

3.3.2 Member Validation

The themes determined from 7 individual interviews were considered to be valid and meaningful when presented to the participants at a second interview. This did not result in any refutation of themes, or produce any new issues/ themes. Any additional comments offered by participants during this process have been absorbed in the findings described below. All themes and associated sub-themes described below were presented to a final focus group, comprising the original 5 focus group members and 4 interview participants, for the purpose of validation and triangulation of findings. Again, there was no refutation of themes, and no new issues or themes emerged from this process, but valuable comments were made regarding some of the findings presented. These have informed the discussion, and have therefore been incorporated into the subsequent chapter.

Table 7: Key Themes 1 & 2 , Sub-Themes and Related Issues

THEME (1): CLINICAL PSYCHOLOGISTS AS REFLECTIVE PRACTITIONERS	
Sub-Themes	**Related Issues**
Understanding of Reflection	➢ Reflection as the "pause-button" ➢ Making changes to practice ➢ Examination of the self ➢ Systemic perspectives ➢ Dealing with uncertainty
Influences on Development	➢ Personality ➢ Pre-qualification training ➢ Psychodynamic/systemic exposure ➢ Positive role-models ➢ The self as part of the wider community
Reflection and Professional Identity	➢ Reflection as essential and fundamental ➢ Reflection and professional identity
THEME (2): THE REFLECTIVE SPACE	
Sub-Themes	**Related Issues**
Supervision as the Reflective Space	➢ Reflective practice and supervision ➢ Supervision style ➢ Work as emotional business ➢ The safe container
Enablers in Reflective Practice	➢ Protected space and time ➢ Value and support ➢ Need for others
Obstacles in Reflective Practice	➢ Time and performance pressures ➢ Lack of valuing and support ➢ Fear of being judged ➢ Personal stress ➢ Comfort zone ➢ Blind spots ➢ Proscribed reflection

Table 8: Key Themes 3 & 4 , Sub-Themes and Related Issues

THEME (3): FUNCTIONS OF CPD AND REFLECTION	
Sub-Themes	**Related Issues**
Quality and Enhanced Service Provision	➢ CPD examples ➢ CPD and service improvement ➢ Reflective practice and client benefits ➢ Dilemmas and conflicts
Safety and Clinical Governance	➢ Performance monitoring ➢ Safety to practice ➢ Risk factors for poor practice
Professional Requirements	➢ BPS/DCP requirements for reflective practice and CPD

THEME (4): LINKING REFLECTION AND CPD	
Sub-Themes	**Related Issues**
The Link between Reflection and Action	➢ Reflection - action link ➢ Problems with the reflection - action link ➢ Reflection leading to CPD ➢ Planned v. unplanned CPD ➢ Reflecting on CPD
Reflective Practice as CPD	➢ Reflective practice as one form of CPD
CPD and Life-Long Learning	➢ CPD forever ➢ Creativity and satisfaction

3.4 Clinical Psychologists as Reflective Practitioners

This theme was sub-divided into sub-themes concerning 'Understanding of Reflection', 'Influences on Development', and 'Reflection and Professional Identity'.

3.4.1 Understanding of Reflection

This sub-theme included the concept of reflection as a "pause button", making changes to one's practice, examination of the self, systemic perspectives, and dealing with uncertainty.

All participants described reflection as a deliberate process involving stopping and standing back in order to think about one's activity (past or current); a process of detaching oneself from the activity in order to examine the reasons for one's behaviour:

"I think good reflective practice is a little bit like pressing a pause button on a video or tape recorder and saying, let's run that routine again, why did you do it like that?" (P1: 19-21).

"I think it's, for me, the ability to be able to stand outside of myself and look at what I'm doing and how I'm doing it and why I'm doing it..." (P10: 5-7).

Participants also clearly linked reflection to making changes to one's practice, as necessary – doing things differently to improve one's practice, learning from mistakes, or settling disagreements:

"I try and do something differently, I suppose. I suppose sometimes I use my thinking to resolve conflicts, something I feel uncomfortable with and so I can maybe keep working with somebody or so I can keep doing something that maybe feels difficult or is a struggle." (F6: 336-340)

Most participants also talked about the idea of reflection as a "mirror to the self", acknowledging that an important aspect of reflection concerns a recognition of the ways in which the personal (self) can impact on the professional (the client, the session):

> "There is also the bit about the reflection in a mirror of thinking about how you, as a person, as a practitioner, affect your practice, so it's a kind of issue about bringing yourself as a person into your professional work and thinking about how aspects of your personal self, affects how you practice" (P1: 6-10).

This was felt to be particularly noticeable when things were happening in one's personal life that might impact on clinical work.

The recognition of the personal-professional interface also worked in the opposite direction, i.e. reflecting on the ways in which the professional (for instance, the client) can affect the personal (the psychologist); for example:

"...but there are other times when my reflection is much more about how is this client making me feel, what does that mean about what's going on in the session..." (P7: 190-192)

Some psychologists noted how reflection could be useful in moving beyond understanding from just an individual perspective, to a more systemic and critical appreciation of issues. Psychologists who worked more systemically (for example, in child and family or learning disabilities services) or who had psychodynamic experience (through further training and/or personal therapy) gave examples of using reflection in order to see ourselves as our clients might see us, understand dynamic processes and the relationships between people within teams, and consider the organisational context around us:

> "I firmly believe that intra-psychic dynamics are reflected interpersonally, are reflected organisationally and beyond into wider society…an organisation can be a reflective organisation just as an individual can be a reflective individual." (P14: 258-263).

Some of the discussion of reflection given by participants with a more systemic or psychodynamic perspective focused on a critical examination of current organisational processes, structures, and approaches to treatment and care, and a need to challenge the status quo:

> "But you can moan and cause some discomfort, but for some people they would find that very threatening and horrible even, so even close off that part of their thinking maybe. I find it to some extent difficult, but to some extent there is something energising about it because I like to kick against something, at least sometimes" (P11: 482-487).

For those participants, an added purpose of reflection was the ability to critically think about their role in relation to issues at an organisational level, and not just in the context of relationships with clients.

Finally, using reflection as a positive way of dealing with uncertainty was noted by some participants, in terms of not having to be an expert:

> "I'm more comfortable with not knowing or not having the answers or not solving things for people" (P13: 86-87);

Reflection was also seen as an enabler to staying with uncertainty, when it might be necessary to so do:

> "I can think of situations where I don't know what to do or what the best thing to do is for quite a long period of time. The reflective practice there might actually be about trying to stay with the uncertainty for a bit longer which you can't always do of course because sometimes things just have to happen. But sometimes you can, you just don't realise you can. You just wait."(P14: 301-307).

3.4.2 Influences on Development

Significant influences on development which were discussed included personality, pre-qualification training, exposure to psychodynamic or systemic models, positive role-models, and viewing oneself as part of the wider community.

Half the participants mentioned personality as an innate influence on their development as a reflective practitioner:

> "Well I suppose at a personal level, I've always been a slightly critical person...I suppose I've always been willing to ask questions about things I do." (P5: 86-87, 91-92).

A common explanation in this regard was the description of oneself as always having been a "naturally reflective person", in contrast to others who were seen to be less (naturally) reflective. A reflective person was seen as someone for whom reflection was more of a way of "being", as opposed to the emphasis being on skills or techniques.

All participants talked about the influence of pre-qualification clinical training. There was a marked difference between more senior psychologists who had been qualified for longer, and those who were more recently qualified. The former, on the whole, tended to have a balanced view of clinical training in terms of mentioning positive as well as negative examples of the way in which training had influenced them. A number of participants in this age-range

discussed specific examples of positive influences on their development as reflective practitioners:

> "I think looking back on the clinical training there were certainly good aspects to it and bad. There were supervisors, bits of the academic training, interactions with colleagues and of course my fellow trainees that encouraged a critical and reflective stance." (P5: 156-160).

However, more recently qualified psychologist tended to have a more negative view of attempts by training courses to encourage a more reflective style through, for instance, personal development groups or activities that involved some personal disclosure:

> "That was difficult really for some trainees and difficult for me, I have to admit, to sit and reflect with people that you could potentially be working with in the future, and could potentially be interviewing in the future, you just never know; that restrained a lot of us in being able to talk openly." (P3: 354-359).

Negative perceptions tended to relate to an experience of lack of safety, and a perceived blurring of personal/professional boundaries when a degree of self-disclosure seemed to be expected, with some participants feeling that the reflective/experiential elements of the course felt more like personal/group therapy, but in an unsafe way. However, some interviewees criticised courses for not having encouraged, in their opinion, a *more* reflective approach to practice. In a few cases, a negative stance by the training course towards a more openly

reflective approach had been perceived, with the then trainee feeling pathologised for reflecting on personal issues within a professional context:

> "I think there were times when I was quite critical of the course because when I was raising these things they were almost picked up as almost inappropriate and anxiety based really and almost things you don't need to worry about." (P16: 82-86).

An exposure to psychodynamic or systemic therapy, either via personal therapy, further training, or supervised clinical practice in such a model, was cited by half the participants as a crucial influencing factor in terms of developing their own reflective skills:

> "I went through my own personal therapy over the last couple of years and that has made a vast difference, that's helped me enormously to sit back and reflect as well." (P13: 104-107)

> "…a step after that really has been to seek personal therapy and to, as a way of trying to understand more about myself, and the things I might be bringing to situations at work with both clients and other professionals." (P10: 97-101)

Positive role-models were mentioned by three-quarters of the participants; many of these were supervisors encountered during training, who were experienced as being more reflective and "human"; for instance:

"I think I've had a few … almost exclusively excellent supervision experiences which makes me really fortunate really… [ ] …and I think those supervision experiences have never been the sort of cool, aloof – they have always been very real and have always included supervisors talking about their struggles, their needs of growth, and that's always, I think, helped me feel quite comfortable about the idea of the growing I have to do." (P15: 152-160).

In addition to supervisors, some participants cited colleagues or professional contacts as role-models who had influenced and inspired them:

> "I mean you learn by watching other people and people you admire and how they manage their careers, I mean you look at the way they are constantly open to new information and development." (P2: 109-112)

> "I think I've also had quite, kind of inspirational people that I have had involvement with. So people that haven't necessarily been supervisors, but that have been around who have had a real passion for what they are doing or who had really useful insights." (P15: 173-178).

Finally, thinking about the self in a wider social context was an important influencing factor for a number of psychologists, primarily those who were working with children and families, or with other client groups (such as learning disabilities) but in a systemic way (as opposed to individual therapy):

"I've always been interested in thinking about an individual's wider role in terms of their role or community in which they live. So I think that's also contributed to just thinking more about what I do and thinking about the accepted psychological stances towards things" (P5: 103-108).

3.4.3 Reflection and Professional Identity

This sub-theme included the concept of reflection as a fundamental part of professional practice, and as a part of clinical psychologists' professional identity. Nine participants discussed reflection as an essential element of professional practice; for instance:

> "It is a part of what we do. It's a fundamental part. It's not just me being indulgent. That is actually a critical part of the process" (P7: 257-259)

> "I think the necessity to work in that way has become really apparent. I don't know. I don't think I could have survived in this kind of a job if I didn't have the space to think about and reflect" (P13: 101-104)

Some participants emphasised that they experienced reflection more as a state of mind and a way of being, rather than a skill or technique.

Three-quarters of the participants linked reflection to being a professional, and specifically to their professional identity as a clinical psychologist; for example:

"I think it's really valuable. I guess as clinical psychologists it's probably implicit to what we do... [ ]... the reflecting is constantly there, it's there so much that you don't always think about it, and becomes part of what we do and how we do things" (P9: 202-203, 206-208).

Retaining one's professional identity as a clinical psychologist was seen as important, but increasingly difficult for some. A number of participants spoke about issues regarding recent changes in management structures, in accordance with wider NHS changes. In some cases, this had resulted in a feeling of threat and a fear that reflection and supervision may need to be defended as a necessity and not a luxury, as a result of professional line management no longer being provided by a clinical psychologist.

3.5 The Reflective Space

This theme was divided into 'Supervision as the Reflective Space', 'Enablers' and 'Obstacles' in reflective practice.

3.5.1 Supervision as the Reflective Space

This sub-theme concerned reflective practice and supervision, supervision style, work as emotional business, and the concept of the safe container. All participants talked at length about supervision as the main space for formal reflection, which in turn informed their practice and thus enabled it to become reflective; for example:

"It's funny because supervision is in my mind a lot while we've been talking. Maybe because that's a place where reflective practice takes places, it's very consciously a process that is there to facilitate reflective practice, but it's also for me one of my greatest learning environments. It's one of the ways I have continued to develop professionally." (P7: 506-511).

All participants placed great value on having supervision as an identified and protected space where they could formally take time out to reflect on their work. Some participants talked more specifically about the need for a certain supervisory style in order to be able to reflect in supervision; for instance:

> "I know personally for me that I feel I've worked better when I've had a supervisor who has encouraged me to be more reflective and I've found it more difficult with supervisors who have taken a more dominant role and still trying to teach sometimes..." (P4: 287-291).

In addition, some participants highlighted the need for a supervision contract that made a reflective style of supervision explicit, so that there would be a shared expectation and understanding of reflection by both the supervisor and supervisee. The concept of psychological therapy being an "emotional business", was discussed by most of the interviewees; for example:

> "I think it's something we need particularly in our profession because of the nature of the work we do, so it's just working with people who have perhaps experienced

> massive trauma in their lives and have emotional and psychological problems, and just the feelings that could evoke in us. It's important to have the space I guess to talk about how that's affected us." (P3: 21-27).

However, the concept of "emotional business" extended to work beyond therapy as well:

> "You know when you've been through a very difficult meeting, all the politics, all the dynamics are going on, families in great distress you know you just carry that round with nowhere to process it, nowhere to reflect then you are going to internalise it so, from a personal point of view, I thinks it's really important…" (P13: 203-208)

The statement by one participant that "…it is right and proper to use yourself in this work" (P1: 183-184), linked to:

> "… not trying to pretend that I'm not a person, I'm not a conduit for psychology if you like. I'm a person. I interact with people as a person and not just a psychologist." (P11: 218-220),

which emphasises the role and use of the personal self in the work that we do. Participants talked freely about the emotional impact of their work on themselves as people, and the need for this to be accepted as a normal and important part of practice; for example:

> "…doing this kind of work affects you emotionally, that who you are outside of work affects how you do that sort of work, that you need a space where that is not

pathologised, where that can be talked about, where the use of yourself and the understanding of yourself as a professional tool is normalised and valued instead of [ ]...only thought about if it's causing a problem." (P1: 176-180).

The acknowledgement of the emotional impact of our work linked to the idea of the supervisory space as the "safe container", i.e. the need for this to be a safe place, which three-quarters of all interviewee emphasised; for instance:

"...if there hadn't been throughout my professional career, people who had the knack for and the intention of providing emotional safe places of all kinds, then there wouldn't have been any space for development as a reflective practitioner." (P1: 162-166).

Participants elaborated on this by discussing the necessary qualities of the supervisory relationship as a crucial element in providing safety and containment; for instance:

"Having somebody, again it's about safety, that feeling that you are not going to be judged or marked down. So it's trusting the person that you are with that helps." (P3: 409-411)

"It would be people I don't feel judged by or that I feel safe with. Some degree of trust. That would be enabling. It would be people who I have high regard for. I do think the relationship is very crucial. It's all about the nature of the relationship with the person, the quality of the relationship." (P14: 346-351).

This was seen as particularly important in relation to discussing things that might have gone wrong; for example:

> "I suppose what's helpful is having that supervision space where I can really think I've messed that up or I don't know where this is going, for there to be a safe space at least where you can just think like that and don't have to think about the value judgements other people will make..." (P11: 403-407).

One participant concisely summed up the ideas around safety expressed by participants:

> "...it's about making space and that's finding a safe space, and that's internally and externally..." (P12: 277-278).

3.5.2 Enablers in Reflective Practice

This sub-theme included protected time and space, the need for others, and value and support for reflection.

All interviewees talked about the need for protected time and space as the main enabler for reflection – "having that protected time that's not bitten into" (P9: 344); in the main, this was linked to protected time and space for supervision:

> "...how closely it's linked to supervision, yes and how closely it's linked to having the time and the space for it..." (P7: 515-517).

Some participants discussed ways of enabling this space to remain protected, such as better time management, making a decision to limit the number of clients seen in any one day, blocking out "thinking time" in the diary, and pushing for protected supervision time. In addition, some interviewees also discussed examples of informal or opportunistic reflection as other enablers, such as reflecting on the way home, when driving between meetings or visits, or reflecting outside of work with colleagues, friends or partners.

All participants talked about the need for reflection to be valued in order for it to happen. This included the need for support and recognition from line managers and supervisors; for example:

> "Well, what enables it is a recognition from my manager that this is an appropriate thing to do – I'm including supervision and reflective practice, that the different kinds of supervision I receive is supported and that enables it. How management think enables it." (P13: 294-298)

> "...having a supervisor who sees the value of supervision, as if they don't see it as being that important then it probably wouldn't be high on their agenda and probably wouldn't happen." (P9: 344-347).

Reflective practice being valued at a more systemic (organisational) level was also described as an important enabler:

> "I think the other bits are more about a culture of reflection and some sort of a capacity to build it into working pattern" (P14: 372-374).

There was much agreement about the fact reflecting by oneself is always limited by subjectivity, and therefore there is a need for others to point out "blind spots":

> "And I think people who can point out the unconscious processes so that means they are recognising errors that I'm probably avoiding, defending against them in one way or another" (P14: 343-346).

All participants stated that they were able to reflect better with like-minded others, as opposed to reflecting on their own. A number of reasons were given, such as:

> "There has been another big one for me, which is about being around colleagues and listening to them and their ideas and their reflections. I find peer supervision incredibly important and that has really influenced the way that I have thought about reflection and getting a totally different perspective on things from other people" (P7: 152-158)

> "I joined CONTACT *[a CPD scheme for newly qualified clinical psychologists]* and I think that gave me the space to reflect on what it was like to be a newly qualified clinical psychologist, and obviously being with other people who were at the same stage was a very normalising experience, so I guess that helped." (P10: 121-125)

Although all participants described reflection as a process that initiates within themselves, the presence of helpful, supportive, reflective others as a way of facilitating better reflection was seen as crucial.

3.5.3 Obstacles in Reflective Practice

Obstacles mentioned were mainly the opposite of issues included in the previous two sub-themes, namely time and performance pressures, fears of being judged, and lack of valuing and support for reflection and supervision. In addition, personal stress, being in a comfort zone, having blind spots, and proscribed reflection were also mentioned.

Not surprisingly, all participants cited time and performance pressures as the main obstacles to reflection:

> "Waiting list pressures, pressures of the service, time pressures, having to fit in clients, your manager having to go to lots of meetings for things…" (P3: 391-393)

> "I think when I'm less busy I am better at doing that really. I am conscious that when I am very, very busy, my work is not reflective. That's a terrible thing to say. But it's not." (P15: 410-412)

The pressure to see lots of clients was felt keenly by participants, many of whom were concerned about the impact on quality of service:

"...That feeling, almost, if you do have the chance to stop and formulate the case, it's a luxury. And you are expected to do one session assessment, and sometimes that's ok, but other times it isn't. Even if it is ok, it doesn't feel ok with you because you want to feel confident that you are being as thoughtful and careful about trying to help someone who is in distress..." (P8: 634-640).

Some participants were also affected by pressures affecting their supervisors or managers, which in turn impacted on them:

> "...my manager is very often running late because she has just got so many other things in her diary so very often she is twenty minutes, half an hour late sometimes which I know isn't her fault, she's probably got stuck in traffic, whatever, but it always seems like that kind of bites into our time, which can be difficult and I feel really sorry for her because I know she is up to here with demands, so I sometimes feel this is yet another demand on her time which is unfortunate." (P9: 316-324).

Many interviewees viewed the pressures on them as an inevitable part of working life in the NHS:

> "The context of working within the NHS means that we constantly have more demands than we are able to meet, and usually we manage somehow to survive that and to kind of organise it, but sometimes too many things come at once and you are just not going to be able to be reflective, or it's going to more of challenge, probably more important to be able to do but probably more of a challenge." (P13: 346-352).

Other pressures affecting reflection which were mentioned, were a perceived threat that quality might be sacrificed to value for money (particularly in the context of waiting-list targets), resource pressures (for example, limited opportunities for CPD; not having adequate office space), coping with organisational change, and having part-time status.

Reflection and reflective practice not being valued or supported by one's supervisor, line manager, or the employing organisation, was felt to be another significant obstacle:

> "So what hinders it is the opposite, is it not being valued or justifiable under the pressure of the waiting lists or activity data...[ ]... in the current climate in the NHS I am worried about how that's interpreted by maybe a manager who has a nursing background. We might just look like precious psychologists saying well I need an hour a week for supervision or to do this that or the other, and those things could hinder my reflective practice" (P7: 427-430, 436-441).

A fear of being judged was mentioned by some participants; whilst this experience was often recalled in relation to being assessed by a supervisor during training, in the here-and-now this anxiety continued for some interviewees when clinical supervision was also provided by their line manager, and there was a blurring of roles:

> "...if you are getting clinical supervision from your manager, then there is that problem as well, it's a similar sort of problem which I didn't appreciate really, that you are talking to your manager about your clinical practice and as much as you would again like to be open and honest, I do wonder to what extent things will be sort of kept

in the manager's mind and used in the future, so I guess that stops me as well from being as reflective as I would like to be." (P3: 93-100)

Stressful life events were cited as another obstacle to reflection by some participants; in those circumstances, reflection was felt to be either too painful or anxiety provoking, or even impossible:

"...a bereavement happened in my life and I came back to work, perhaps, well I felt that I needed to get back to work after a couple of months but I couldn't actually do the job at the time, but didn't fully know that and wasn't able to reflect because I was too in-it to be able to stand back and see what impact that was having upon me; but now, ten months down the line, I'm in a different place again and am therefore more able to understand what was happening clinically and professionally ten months ago." (P10: 257-265).

Being stuck in a comfort zone (for example, a peer supervision group that is too "comfortable", i.e. not sufficiently challenging or critical, or remaining too long in the same post) was quoted as another example by some participants:

"...peer supervision can be a bit sometimes comfortable. 'Oh, you are wonderful'. 'Aren't we both wonderful'. Or you can just talk about technical aspects about what you do." (P5: 419-422).

This linked to the idea of "blind spots"; for instance:

> "I think probably one of the other obstacles would be kind of blind spots really. You can only reflect on things that you are conscious of...[ ]... so there may well by blind spots in my clinical work that don't get addressed because they are not – I'm not supervised in my clinical work" (P15: 627-629, 633-635).

Finally, reflection being too "proscribed" was mentioned as an unhelpful factor by some interviewees; for example:

> "I think a very instrumental action-orientated, evidence-focussed, protocol-based kind of way of doing things can hinder." (P1: 353-355).

3.6 Functions of CPD and Reflection

This theme includes sub-themes covering 'Quality and Enhanced Service Provision', 'Safety and Clinical Governance', and 'Professional Requirements'.

3.6.1 Quality and Enhanced Service Provision

This sub-theme included examples of participants' involvement in CPD, followed by issues around CPD and service improvement, reflective practice and client benefits, and dilemmas and conflicts.

When discussing their CPD activities, initially most participants readily named examples of more formal learning opportunities, such as training courses and conferences, but subsequently discussed other activities such as supervision (for oneself and of others), going to meetings, reading, taking part in a personal development group, being involved in professional groups or societies, or gaining experience of a new service.

Nearly all participants discussed taking part in CPD in relation to keeping up-to-date with new knowledge or skills, which in turn was linked to service improvement; for instance:

> "Keeping up with current developments in one's field, ensuring quality in terms of the jobs we are doing in the services we are delivering and not just kind of resting on our twenty year old laurels, very easy to do but very unrewarding actually, and work does change quite rapidly around us, so it's about staying a part of the contemporary

professional world and doing that in a systematic way, with a plan around it; it's governed by service needs as well as personal, professional needs and those two things come together; ideally it works through an appraisal process and is translated into CPD targets." (P14: 87-96)

All interviewees linked the function of CPD and reflection quite specifically to improved outcomes for clients; for example:

> "It's about making sure I'm aware of developments and information that enable me to do the best that I can for my clients." (P7: 82-84).

> "I think from a client's point of view, somebody that reflects - they are not just getting you, they are getting also the team around you because it's all those different inputs from people around you, the supervisor, or when you are looking at the wider literature base, CPD activities like conferences, so they are not just getting you as the person, they are getting all these bolt-ons and added value, if that's the right language, and in terms of your service, I think it's very evident if clinicians aren't allowed the space to reflect, to take part in supervision, then they are not really going to be working effectively with cases." (P9: 265-275).

Half the participants mentioned reflection as a way of managing dilemmas or conflicts more appropriately, and in particular, as a means to help them avoid premature responses or acting out. A number of examples from practice were discussed where conflict seemed to be

particularly apparent as a consequence of inter-professional differences, for instance within multi-disciplinary teams:

> "...I can think of an example recently where a CPN and I even struggled to speak to one another and could not speak to each other and it became apparent this was becoming a problem and I, in my role as a psychologist with this person, thought no I'm not speaking to anyone else, this is confidential... [ ] ...And I thought, what would be helpful to the team, without compromising myself or my client's boundaries and it was quite hard, but had I not thought about it I might not have done anything and this could have left us all feeling quite fragmented and isolated from each other." (P6: 370-375, 394-399).

3.6.2 Safety and Clinical Governance

This sub-theme focused on performance monitoring, safety to practice, and risk factors for poor practice.

Being mindful of one's professional performance was discussed by a number of participants, primarily in the sense of having a self-motivated, internal monitoring process as opposed to external scrutiny; for example:

> "I think reflective practice is a sort of bottom-up thing where you are continually watching what you do and you would hope that that was something that people who were professionals sort of just did within them..." (P2: 80-84).

Nearly every participant discussed the function of reflection in relation to safety to practice. This linked to concepts such as professional accountability and responsibility, quality assurance, and critical incidents (all of which could be described as aspects of clinical governance), as illustrated by the following quotes:

"I think there is a big safety use. I think it's about monitoring whether you are practicing in a safe, sensitive, humane, ethical fashion. Monitoring whether you are up to that, so I think it's got a kind of safety function." (P1: 284-287)

"I guess it would be quite dangerous to practise in your own little cocoon and not talking to others about what you're doing because for all you know you could be practising for twenty years and doing something that is quite dangerous or unprofessional and you might not have realised it and so it is just helpful to bounce ideas off other people to see if they would be doing something different." (P3: 259-266)

"Personally there have been times when things have impacted on me that much in a certain way that I would have to think about how it might be impacting with my clients. I have noticed times where I felt what I have done with clients has been different, with what's been going on with me. That sounds like an awful kind of scary thing to say because it feels like it shouldn't happen. But it does, if you don't admit that it does, I think that's more dangerous." (P7: 143-150)

The need to reflect on the more difficult things from our professional practice was summed up succinctly by one participant:

> "It's what you can't think about that causes the most difficulty in your life, personal and professional; my experience of that really reinforces that there is all kinds of things going on in the world, but it's what you can't think about that causes more struggle." (P6: 250-254).

Some participants also felt that reflection enabled them to practise safely because it helped them to maintain the separation between personal and professional boundaries more clearly; for example:

> "It supports me tremendously. It helps me to leave some of what needs leaving behind and not take it home although I'm not much good at that really, generally. But I do think it helps and I think it makes me feel safe, safer." (P14: 224-228)

> "I actually think it keeps you sane. You know it's almost therapeutic in itself. There's a sort of continuum between supervision, consultation, receiving therapy and giving therapy and it is very important to keep all those boundaries pretty clear but I think that if I didn't have the opportunity to actually reflect on my work, I would go nuts." (P13: 198-203).

Linked to these issues was the identification of risk factors for poor (i.e. non-reflective) practice. One participant, echoing the sentiments of others, described the consequences of not reflecting as:

> "...getting stuck in a rut...[ ]...doing things or going through clinical or professional routines because that is the way you have always done them." (P1: 16-19),

which was felt to compromise the quality of service.

Ensuring that good enough supervision actually happens was felt to be crucial, as

> "...not finding time to have good quality supervision...[ ]...very quickly starts to feed into whatever the opposite is of continuing professional development is ..... continuing professional regression, digression?" (P1: 435-438).

Supervision that is too comfortable and not critical or challenging enough, was cited as another risk factor, and the difficulties with peer supervision were described thus:

> "I think peer supervision is really quite difficult because you are asking somebody to be prepared to be critical about what you are offering, or to help you to be critical about it..." (P5: 372-375)

The need for psychologists to be reflective about their position and use of power was expressed by a number of participants. One psychologist, when discussing the influence of critical mental health practice on reflective thinking, stated:

"...that has certainly made me reflective about professionalisation, and I am ambivalent about it and concerned to think about when professional change and professional development is for the aggrandisement of the profession or professional, rather than the good of the patient." (P1: 111-115).

3.6.3 Professional Requirements

This sub-theme concerned the influence of professional bodies (for instance, the BPS or DCP), and organisational requirements, on participants' CPD activity and their actual reflective practice.

As regards professional/organisational influences, opinions were divided. The majority of psychologists felt that the BPS or DCP (or similar organisations) had not influenced their practice of reflective practice. However, most interviewees did state that a mandatory CPD requirement, linked to statutory regulation, regular appraisals, personal development plans, and the KSF (Knowledge and Skills Framework) was positive and important in that it made the profession "fit for purpose, fit for practice". Furthermore, many psychologists felt that professional regulation legitimised their involvement in CPD activities, and in some cases, provided 'protection' against an employer who might otherwise not permit professional development, including clinical supervision:

"It's important to have an institutional level that my professional body says I need to have this amount of CPD because otherwise I wouldn't get it. I would have to.... No, I wouldn't get it." (P11: 255-258)

"I think being able to show that you are continuing your professional development is really, really important and I kind of welcome the statutory regulation type of thing coming in. I think we should be able to show that we are doing something to keep developing ourselves and think we should be transparent in that way." (P6: 510-515)

However, others spoke negatively of the approach to mandatory CPD taken by the BPS:

> "I do sometimes think this is something the BPS has discovered rather late in the day and realised it's something we should all being doing, and it's been set up like a goal we all have to achieve, without a huge amount of thought being put into it necessarily." (P5: 42-47).

In particular, negative views were expressed by some participants about a perceived over-emphasis on the more 'bureaucratic' aspects of CPD, which seemed to be at odds with the spirit of CPD and reflection; for example:

> "I find it hard that CPD is all about guidelines and you know, tick this box and do this and do that, you can do it and not think, that's not how I understand it....[ ]...for me, the most important thing about continuing to develop professionally is just to keep thinking and be given some space to do that and given opportunities to do different things, but also being able to think about that, and you know, it would be a shame if you just had to jump through hoops and for other things not to be recognised." (P6: 86-88, 90-95).

As stated above, most participants agreed that professional or organisational requirements had little or no influence on whether or not they were reflective in their work, other than (as with CPD) give certain legitimacy to that activity:

> "I don't know actually that being told I have to be reflective and being told about it has actually influenced me that much." (P3: 174-176)

Moreover, many psychologists were critical of the ways in which reflection and reflective practice were evidenced in CPD logs:

> "I don't know that the increasing emphasis on being able to demonstrate that you have done it has made any difference to me really, I think it's something that I did anyway, and in some way that having to sort of demonstrate that you have done it in that structured way, doesn't actually reflect the process very well. I find it a bit like a task you have got to do, but actually the way that you have to demonstrate that you have done it, I am not sure it measures very well what people are doing really…" (P2: 117-125).

3.7 Linking Reflection and CPD

This theme illustrates the way in which psychologists experienced the relationship between CPD and reflective practice – in particular, the link between reflection and action, reflective practice *as* CPD, and CPD as lifelong learning.

3.7.1 The Link between Reflection and Action

This included an exploration of participants' understanding and experience of the link between reflection and action, and issues concerning planned versus unplanned CPD, reflection leading to CPD, and reflecting on CPD.

Three-quarters of all participants discussed at length the link between reflection and action, often with specific examples from their practice. Most of the examples were about discussing difficult cases or situations in supervision (reflection-*on*-action), with one's subsequent action being informed and possibly changed by the process of reflection that had taken place in supervision (action *following* reflection); for example:

> "...it feels quite clear to me, if you want to draw a picture of the process of therapy, that you are going in a particular direction and you stop and go into supervision, and you go out and back to the patient and take another tack, and I think you could map real qualitative shifts in direction on the basis of stopping and reflecting." (P1: 315-320)

The link between reflecting and acting was summarised clearly as follows:

> "...for me the link between action and reflection is that it is making me think clearer, enabling me to formulate whatever it is I'm reflecting on so that I can think about actions, and I can think about goals..." (P7: 335-338)

Whilst reflection-*on*-action describes a process of retrospective analysis, reflection-*in*-action refers to an examination of issues and processes as they occur in the here-and-now. Although the latter was implied in some of the examples from practice, very few psychologists highlighted this type of reflection specifically. One participant described the experience thus:

> "I think one of the things that was a big impact for me when I was training was Patrick Casement's idea of the internal supervisor and finding that space to reflect, you know even when you are with people, and I remember thinking how does that work? I didn't know how you could really be with someone and be reflective at the same time. Whereas now it just seems kind of automatic, and so I think a lot of it has been through more sort of psychodynamic ways of working..." (P12: 92-100)

Most psychologists discussed the need for action to follow reflection, as reflection without action was not felt to be helpful in changing practice. However, the link between reflection and action was not presumed to be automatic one:

> "So it's not necessarily a straightforward link between going and reflecting and doing, it might be reflecting and then continuing the way you were doing it before. Not just

about how somebody else might have dealt with it. It's just about thinking about it."

(P3: 315-319)

Many participants commented that the result of reflection, in some cases, might be *no* action, in a consciously thoughtful way:

"I can consciously use it to stop me from doing something that I'm not sure what my reasons are for it. Sometimes it stops actions. Sometimes it means there is no different action to what I would have normally done." (P6: 347-351)

Some participants gave examples of using reflection in order to avoid an impulsive (rather than thoughtful) *re-action*; for instance:

"The amount of times after some reflection I've actually done nothing is amazing, and I think that might sound strange, but that's been the most precious thing really, to not get drawn into doing something or responding to crisis but to just, and so just not doing something in a totally thoughtful and intentional way is really… so that's been one of the really very strong links between reflection and action for me." (P13: 220-227)

Several psychologists gave detailed examples of conflicts or professional disagreements, where they had wanted to respond angrily or impulsively but through reflection, had managed to avoid acting out and thus achieve a better resolution of the situation.

The link between reflection and CPD (with the former leading to the latter in a linear, logical fashion) was described very clearly by many participants, as exemplified by the following quote:

> "So reflective practice is where you're thinking on hopefully a very habitual level about what you're doing day to day, and what the job requires, and how well you're doing, and that CPD is your way of, erm, it's the sort of planned way of addressing those reflections, if you like. CPD is almost the action you take in response to the thoughts that you have been having and the issues that you are facing in the nature of things at work. So CPD would be your output in a way, your actions and these are the things that you have done because these were the areas of development that you identified for yourself." (P2: 313-322)

A number of interviewees commented however on the planned and unplanned nature of CPD; for example:

> "And for me what's been interesting about CPD again is that sometimes it works in a planned fashion and sometimes you develop and you learn almost by accident." (P7: 95-97)

Some interviewees expressed ambivalence about a framework that seemed to favour a very structured, pre-planned, pre-determined approach to CPD:

"Now whilst that is logical and makes sense, I'm not quite sure for me how that actually fits with the way I work. I think some learning and some reflective practice is sort of almost gratuitous, it happens, you don't think in advance about these things." (P5: 68-72)

Many of the interviewees stated that, whilst CPD activity was sometimes the outcome and result of reflection, so the subsequent reflection on the CPD undertaken was also a necessary step in the learning cycle:

> "There's not much point reading stuff or going to conferences and just thinking about them if you don't do anything with it, and sometimes you might think, well actually I'm not going to do anything differently, I'm just going to keep doing what I'm doing, but if you don't think, you might have done something different. I suppose you have to do something with it or not to something with it, and I suppose that's how you use it." (P6: 345-351)

> "...what makes complete sense is the emphasis on reflecting on what you're doing in CPD, rather than just saying – yes, I attended this. So what happened, what did you get from it, what did you learn, how did it change you? So I actually think that's really good, and I think that makes complete sense that CPD is structured in that way, and the fact that there it is. It is required that I report the outcome of my CPD activity in a way that has made me think about, a bit anyway, think about the fact that CPD is about reflecting on what you have learned." (P14: 390-399)

The importance of processing in a more personal way what might have been acquired as a result of CPD, was highlighted by one participant:

> "I think really, you can go on a course and learn how to do things but it's something about how you assimilate that for yourself or how does that affect you, or how you work – so much of our work is about who we are - and I think it's probably something about that." (P12: 187-191)

The difficulties of evidencing reflection were discussed by some participants; the expected, 'set' way of reflecting in writing was described as ' a bit of a game' by one participant, whilst another commented:

> "…what can be really difficult sometimes is how do you show you are reflecting because it is such an internal process, how do you show it other than doing something with it, that might be in the therapy room and you can't show that, and how can you check that people are reflecting if they say they are? How do you know they are?" (P6: 515-521).

3.7.2 Reflective Practice as CPD

Participants agreed that CPD included more than just reflection, although all CPD, in order to be effective and meaningful, should involve reflection:

> "I mean CPD, there are obviously different aspects of CPD, training and conferences, but it's not necessarily reflective - but then the reflective bit is always CPD. So they are both important separately, but I think reflective practice is a part of CPD, but you need more that just reflective practice to be able to say that you are engaging in CPD, I think. You can't have just your weekly or fortnightly supervision, there are other things that make up CPD." (P3: 459-466)

All interviewees spoke emphatically about the link between reflective practice and CPD in terms of experiencing reflection, and reflective practice, *as* CPD. In other words, to reflect and to practice reflectively *is* to develop yourself professionally, and reflective practice *as* CPD seemed to be an important and shared core concept amongst participants. For instance, the link between reflection and supervision – a key CPD activity – was described thus:

> "I think for me it is probably one of the best ways of continuing professional development that I think I have. Yes, I think the self-reflection and clinical supervision as being some of the things that have helped me develop my practice most, as opposed to formal training courses or conferences, you know, yes." (P16: 54-60)

The interdependent relationship between reflection and CPD was highlighted thus:

"I think it's symbiotic, that would be the word to describe it. So I think that not only developing continually informs how I reflect, but also the other way – reflecting informs me of what my CPD needs might be. So that's how I see the relationship – symbiotic. The one kind of enriches the other and facilitates the other." (P7: 460-466)

Finally, the circular relationship between reflective practice and CPD was expressed succinctly by this participant:

> "I think reflective practice is continuing professional development really. I don't think it's the only form of CPD, but I think it is CPD....[ ].... If you reflect then you learn, that's one thing, so therefore every time I reflect then I guess I'm learning, and so I'm developing professionally in a continuing fashion." (P13: 361-363, 383-386)

3.7.3 CPD and Lifelong Learning

A number of interviewees clearly expressed the idea that CPD was a lifelong process; for instance:

> "It's about continually learning, I guess, learning about every aspect of your profession, your specialty. It's attaching importance to that continuing learning and not just that once you've trained for three years, that's it and you don't have to learn anymore..." (P3: 109-113)

> "It means, for me, development never stands still. The process of learning never stops and I think if you assume that it does, it feels like a kind of dangerous position to be in. It's not like you're qualified and you know it all." (P7: 76-79)

Although there was recognition that lifelong learning was now an accepted and even mandatory aspect of being a professional, it was evident from the interviews that participants' involvement in CPD was more than the fulfilment of such a requirement. Satisfaction, creativity, interest, intellectual stimulation and professional fulfilment were all mentioned as reasons for engaging in CPD; for example:

> "I think it has benefits for an individual psychologist in that I think it keeps us intellectually stimulated, it keeps us on our toes rather than become complacent about what we do and I know all of us probably wish that we didn't struggle with so many dilemmas and perhaps had an easy life, but I think questioning what we do, is enable stimulating so I think we all benefit from that individually and collectively." (P5: 242-249)

The relationship between psychologists' personal and professional motivations for engaging in CPD, and the implications for the quality of services provided, were expressed clearly in this final quote by one of the more experienced participants:

> "The romantic end is more about the professional aspirations of groups of psychologists, which are to be interested and use their creativity in their work, and be satisfied by their work, and have quite a lot of their spiritual and existential needs met

at work, which is about staying creative and adaptive and interested and curious and alive in your work. And I know this sounds romantic, but I do think that when you lose that, you are at risk of bad practice, at risk of sort of psychological abusiveness or insensitivity, so although I say it's romantic, I think it's got real consequences in the terms of the quality of the service you provide." (P1: 67-78)

3.8 Interview Feedback

3.8.1 Validation interviews

Seven individual member validation face-to-face interviews were conducted with a sample of respondents, chosen to represent the variety originally interviewed. The interview was based around the thematic interpretation of the participants' individual interview (acknowledging the influence of all the interviews in the overall thematic framework).

The ensuing discussion focused on clarification, refutation and confirmation of the thematic analysis, and any additional information arising from the validation interview was recorded as part of the data collected through contemporaneous note-taking by the interviewer, supported by subsequent reflection as part of the final analysis.

No new themes emerged, and all participants were in broad agreement with both the thematic interpretation of their own interview, and the overall thematic framework.

3.8.2 Written feedback

All 16 interview participants completed a written feedback form about the process (see appendix 13). All agreed that they had had sufficient information about the aims of the research study prior to taking part in the interview, that the procedure had been clearly explained to them, and that the length of the interview was appropriate.

Fifteen participants felt that they had been able to answer the questions in sufficient depth; one stated that it was difficult to answer all the questions quickly without time to reflect or think more about them (there had been a technical problem with the tape recorder at this interview, not reducing the length of the interview itself but making the process feel more rushed).

Fourteen participants said that they had not felt uncomfortable about any aspect of the interview; one expressed a degree of concern about sharing some more personal information but stated that she had not felt unduly uncomfortable in doing so, whilst another commented on some initial anxiety about not wishing to sound "unintelligent or unreflective". One participant stated that it was possible to present oneself, one's practice and knowledge in an overly positive light. Finally, and perhaps more importantly, 6 participants commented specifically on the interview providing a useful opportunity to reflect on their professional practice, and on the meaning of reflective practice.

3.8.3 Validation Focus Group

As described in section 2.7.3 this was conducted with 9 clinical psychologists. The group was largely in agreement with the thematic analysis, which they described as "really interesting"

and "making sense" for example. However they did not concur with interviewees' apparent perception that professional bodies had little influence on their development as reflective practitioners. The groups' concerns were not with the interpretation of the data, but the data itself being inconsistent with the key role, as the focus group members expressing this concern were aware of their own involvement as senior practitioners in the evolution of CPD as practiced within the profession. They were familiar with the substantial influence, as they saw it, of the role of the key professional bodies in developing and influencing change and embedding reflective practice as the norm.

CHAPTER 4: DISCUSSION

4.1 Overview of the Discussion

This section discusses the main themes and sub-themes arising from the analysis, in the context of the literature previously reviewed. The findings are then related to theory, with reference to psychodynamic theory, primarily attachment theory (Bowlby, 1973; Bowlby, 1977; Bowlby, 1988) and learning theory, particularly Kolb's Experiential Learning Cycle (1984 a&b) and triple-loop learning theory (Davies & Nutley, 2000; Sandars, 2006).

The study is methodologically critiqued in relation to issues concerning the sample, recruitment, role and position of the researcher, and validity. The relevance and implications of this research are discussed in relation to clinical psychology practice, relevant theory, and the implications for training and CPD.

Finally, the implications for future research are outlined, and the importance of the present findings to the issue of professional identity are described.

4.2 Higher Order Theme: Clinical Psychologists as Reflective Practitioners

This theme included sub-themes concerning clinical psychologists' understanding of reflection, the main influences on their development as reflective practitioners, and the importance of reflection as part of their professional identity.

4.2.1 Understanding of Reflection

Reflection as a deliberate 'pause-button' or 'freeze-frame' activity, which allows the psychologist to take a step back and examine his/her actions, practice, or feelings, was described clearly by all participants. In general, it was portrayed as a retrospective process, often linked to supervision but also sometimes expressed as happening in a less planned, more opportunistic manner, but always with the aim of improving one's practice.

This type of retrospective reflection is closely linked to Schön's (1983) concept of reflection-*on*-action, a deliberate and conscious process designed to bring about a greater understanding of practice and improve future professional activity. Whilst Schön's concept of reflection-*in*-action – reflecting in the here-and-now - was implied in some of the examples of reflective clinical activity discussed by a number of interviewees, these were not usually explicitly referred to as examples of reflection. Although reflection-*in*-action occurs a lot of the time in clinical psychology practice at a micro-level – for instance, as in 'thinking-on-your-feet', constantly reflecting on what you are doing and feeling in order to determine what to do or say next in a session with a client – on the whole, when asked to give examples of reflection and reflective practice, this group of interviewees did not give many instances of reflection-*in*-action. However, those that did were more often practising in a psychodynamic or psychodynamically-informed way. Therefore, examples of reflection-in-action seemed to appear as part of a theme, but not in response to questions asked about the conceptualisation of reflection. Perhaps for many reflective psychologists, reflection-*in*-action is such an automatic and implicit part of professional activity that it is not seen as something formal or distinct in the way that reflection-*on*-action appears to be. The latter is perhaps more easily identified as

reflection because it occurs as a separate activity, and at a different time, to the clinical activity. However, Schön's notion of reflection-*in*-action did seem to be present as a defining characteristic, rather than an activity as such, in the sub- theme concerning professional identity (see 1.2.2 below).

Reflecting about our impact on others, and reflecting about the self, as described by Lavender (2003), were clearly emphasised in the interviews as important aspects of reflection. Reflecting on how we affect others (clients, colleagues, or systems) was more often highlighted by those participants who worked in child & family or learning disability services where much of the work is indirect or systemic (working with and/or through others), as opposed to working with clients on an individual basis. Reflecting about the self and one's personal responses and feelings in relation to clients, colleagues or organisational factors was mentioned particularly by participants who worked psychodynamically, who had additional psychotherapy training and experience of personal therapy. It would appear, therefore, that additional therapeutic training, therapeutic orientation and specialty were influencing factors in relation to the examination of the self in reflection.

It seems, therefore, that all participants reflected on their professional activity (what they did) at various times. In addition, some reflected on the impact of themselves and their actions on others and vice versa. Finally, a number of psychologists also reflected on the impact of the personal self on others and vice versa. The last two types of reflection were more commonly found in participants who worked systemically and/or who had psychodynamic training or experience.

Reflection as a helpful way of dealing with uncertainty was also described by a number of interviewees, both in relation to the often uncertain (and frequently changing) context in which we work, and also in relation to our own uncertainties regarding how to act in certain situations. Schön (1983) stated that the idea of reflective practice:

> "...leads us to recognise that the scope of technical expertise is limited by situations of uncertainty, instability, uniqueness, and conflict. When research-based theories and techniques are inapplicable, the professional cannot legitimately claim to be expert, but only to be especially well prepared to reflect-in-action" (p.345).

Whereas at one time, expertise was seen to derive from research-based knowledge and theory, it now goes beyond this and has developed into a concept that includes the ability to tolerate uncertainty. These sentiments are echoed by Bolton (2001) who states that paradoxically, in order to become an effective practitioner, one has to let go of certainty:

> "Reflective practice entails an embracing of: uncertainty as to what we are doing and where we are going; confidence to search for something when we have no idea what it is; the letting go of the security blanket of needing answers. This kind of work will lead to more searching questions, the opening of fascinating avenues to explore, but few secure answers" (p.15).

In summary, therefore, participants' understanding and experience of reflection included both cognitive and affective components at an individual, group or systemic level, frequently

triggered by uncertainty or conflict, and always with the goal of improving professional practice.

4.2.2 Influences on Development

It was striking that half the participants interviewed mentioned 'personality' as a significant influence on development; a typical statement made was "I'm just a naturally reflective person", which would be linked to a preferred or predominant style of thinking and analysing situations and behaviour. The idea that some people are naturally more reflective than others was proposed by Kolb (1984b), in his discussion of preferred learning styles (diverging, assimilating, converging and accommodating), and further developed by Honey and Mumford into a learning styles questionnaire or LSQ (Honey & Mumford, 2007), which distinguishes between activists, reflectors, theorists and pragmatists. A reflector is an observer, someone who gathers information before coming to a conclusion, and who thinks deeply before making decisions. Reflectors learn best when they can observe others and review what they have learnt at the end of the day.

Sussman (1992) comments on a significant degree of emotional disturbance described in a number of studies of US clinical psychology students, echoed by Cushway (1992) who found distress/disturbance rates of 59% in a sample of British trainees. It is not known to what extent these studies measure (dis)stress caused by the process of training, or whether they reflect something about clinical psychology trainees being more in touch with their own emotional distress as a result of undertaking such training. Alternatively, the qualities that enable certain individuals to be more psychologically-minded and in touch with their own distress may make

them naturally more reflective, and therefore more drawn to a career such as such as clinical psychology or psychotherapy. On the basis of the results, it can be stated that half the sample mentioned personality as a significant influence on their development, but this finding may have been influenced by the sample, 50% of which included participants with previous psychodynamic or systemic training and/or personal therapy.

The influence of clinical psychology training was discussed by all participants, with a marked theme arising from some interviews concerning the lack of safety in relation to some personal development activities encountered during training. In particular, a number of participants described what had often felt like an unclear or fluid boundary between trainees' personal issues, which might have been more appropriate for personal therapy, and personal/professional issues in relation to the training course. Moreover, where participation in personal awareness/development groups was mandatory as opposed to voluntary, this seemed to add to feelings of lack of safety.

Mitchell (1995) noted that control by group members, clarity about boundaries and provision of safety, independence from the course and confidentiality, and validation of group members' own needs were cited as important factors cited by clinical psychology trainees participating in a personal support group.

Similarly, Powell and Howard (2006), in reviewing reflective practice groups for clinical psychology trainees, found that although trainees felt moderately happy with the given level of safety and support, they felt only 'fairly comfortable' discussing their own issues, although the main benefits from the groups were related to a recognition of the emotional impact of client

work. It would appear from the interview findings and the above studies, that the discussion of personal issues and feelings in a compulsory peer-group, which is part of a training that is ultimately linked to the attainment of a professional qualification, is very difficult for trainees, even when the group appears to be 'good enough' in terms of safety and support. Clarity about boundaries and when it is and is not appropriate to discuss personal issues and feelings in such a context is imperative.

Exposure to psychodynamic or systemic theory and practice was a significant influencing factor cited by half the participants. In this context it must be noted that half the interviewees had had some personal therapy at some point before, during or after qualifying as a clinical psychologist. Although it is not known what percentage of current UK clinical psychologists have had personal therapy at some point, it is likely to be less than 50%, which would make the present interview sample different to the general population of clinical psychologists.

Lavender (2003) comments on the universality of psychological vulnerability, and the importance of personal development for clinical psychologists as a way of enabling them to gain a greater awareness of these vulnerabilities. This includes working through issues when vulnerabilities are triggered, in order to avoid blind spots and increase one's understanding of clients' difficulties. Those interviewees who had had personal therapy were quite explicit about its value in enabling their understanding of themselves personally and professionally, and in being able to empathise with the role of the client.

Timms (2007), in a brief review of personal therapy for psychotherapists and clinical psychologists, concludes that that there is some, limited, evidence to suggest that there can be potential benefits of psychotherapy for this group of professionals.

Examples of reflective and inspirational supervisors, mentors, or colleagues who were seen as role models were discussed by a number of interviewees as having had a significant influence on their own development as a reflective practitioner. Participants often tended refer to specific supervisors encountered during their clinical training, more than any other category of professional, as positive role models with a lasting impact.

In summary, the three main factors influencing participants' development as reflective practitioners were personality, pre-qualification training and further psychodynamic or systemic training, including personal therapy and mentoring. Although the present study explored reflective practice in post-qualification clinical psychologists, it is important to note that certain aspects of clinical psychology training seemed to have a profound impact on participants' subsequent development as reflective practitioners. The degree to which some participants did or did not feel safe with the person(s), context and environment was key in determining the extent to which it was possible for them to be reflective about personal professional issues. The relevance of these findings is discussed further in relation to attachment theory below.

4.2.3 Reflection and Professional Identity

Reflection was strongly linked to professional identity by three-quarters of the interviewees, who typically tended to describe it as 'a way of being', rather than just a set of skills, and as an implicit, essential and fundamental part of being a professional and a clinical psychologist. Social identity theory, as developed by Tajfel and Turner (Tajfel, 1982), is concerned with when and why people identify with social groups, which includes the sharing of attitudes and values. Ethier and Deaux (Ethier & Deaux, 1994) discuss the impact of change in the context of the negotiation and maintenance of social identity. Their findings (in relation to ethnic identity) revealed that students with a strong cultural background were more likely to show an increase in their cultural identification when moving to an ethnically different context, whereas students with initially weaker identification perceived more threat in their new environment, and showed lower self-esteem and decreased identification with their (original) ethnic group. Ethier and Deaux (1994) refer to 'remooring' to describe the process of maintaining one's identity when confronted with a new environment, and emphasise the importance of supportive elements in the new context.

A number of interviewees who had experienced organisational change or who anticipated such change in the near future felt that having a strong professional identity as a clinical psychologist was particularly important to them. This response appeared to be in relation to actual or perceived threats to their professional identity, for instance service restructuring, which had resulted, or might result, in individual psychologists being line managed by non-psychologists, and being based in teams where they were or would be the only clinical psychologist, often with little regular contact to their psychology colleagues.

Although Ethier and Deaux's (1994) findings relate to ethnic identity, it is possible to speculate that a similar mechanism may account for the importance of a strong professional identity for some 'transplanted' clinical psychologists now working in non-psychology contexts (for instance, multi-disciplinary teams or multi-professional services), given that clinical psychology as a profession has developed quite a strong identity over the past few decades. Retaining a strong professional identity may be a helpful and supportive factor in adjusting to a different work environment. However, social identity theory not only discusses the idea of identity, but also the concepts of comparison and categorisation. In reality, a strong professional identity in a context where one is in a (professional) minority may be a help as well as a hindrance. For example, if the perceived or actual difference and distinctiveness of clinical psychologists working in settings where they are in a minority is related to professional identity and categorisation, then maintaining a strong professional identity by way of comparison with other professional groups may also result in psychologists being seen as 'precious', 'not fitting in', and not being a 'team-player'.

In summary, for participants in this study reflection and reflective practice appeared to be a core part of their professional identity, and in turn, the latter seemed to be an enabler of reflection. Whilst the whole of the mental health workforce is encouraged to use reflective practice as part of their personal development and learning, best practice guidance such as 'The Ten Essential Shared Capabilities' (Department of Health, 2004c) is not actually explicit as to how this should be done. In contrast to many other healthcare professionals, clinical psychologists, by virtue of their training, reflect on and formulate individuals' distress and difficulties by drawing on different models of theoretical understanding, and utilise diverse methods of assessment and therapy.

4.3 Higher Order Theme: The Reflective Space

4.3.1 Supervision as the Reflective Space

The relationship between reflective practice and clinical supervision becomes clear when considering that clinical supervision is underpinned by the belief that it is about learning from practice (Clouder & Sellars, 2004).

All participants discussed supervision as the space and mechanism that allowed them to reflect formally on their professional practice, and on the personal-professional interface inherent in work that so often feels like 'emotional business'. The idea of supervision and the supervisory relationship as a 'safe container' to help contain and process issues which are frequently difficult at a professional and personal level, was one that the majority of participants discussed. Safety, trust, and a non-judgemental attitude by the supervisor were seen as crucial in this regard.

Scaife (2001), in the context of discussing supervision in the mental health professions, states that "...one of the most important factors that contributes to sustaining a functional working relationship is the creation and maintenance of safety for all the parties involved..." (p. 67).

Mollon (1989) discusses the function of supervision as 'a space for thinking', in the context of clinical psychologists learning psychotherapy (where reflection on the more emotional aspects of work, and reflection of the self, are imperative in supervision). He states that:

"...the aim of supervision [...] should not be to teach a technique directly and didactically, but rather to facilitate the trainee's capacity to think about the process of therapy – on the assumption that technique grows out of this understanding." *['Trainee' in this case refers to qualified clinical psychologists who are trainee psychotherapists].*

Therefore, Mollon (1989) concludes that the supervisor's task is to help create:

> "...a space for thinking, a space for reflection with a tolerance for not knowing and not understanding..."

A number of interviewees in the present study referred to feelings of anxiety or shame that might result from feeling that they had done something wrong, or at least not as well as they had intended, and highlighted the importance of a supervisor who can accept, contain and support such feelings without making value judgements. Nearly 20 years ago, Mollon highlighted this when stating that:

> "...the crucial task is to create a supervisory setting in which uncertainty, ignorance and feelings of incompetence can be tolerated and discussed...".

The importance of being held in a safe and supportive relationship, and not being left to reflect on one's own when feelings of shame or anxiety are present, cannot be over-estimated. Beinart's (2004) mixed quantitative-qualitative empirical study explored the factors which predict the quality of the relationship in clinical supervision amongst trainee and newly

qualified clinical psychologists. Satisfaction with supervision, rapport between supervisor and supervisee, and the supervisee feeling supported were the qualities of the supervisory relationship perceived to be the most effective by supervisees. A grounded theory analysis revealed 9 categories that suggested a framework (boundaried, supportive, open, respectful, committed) and process (collaborative, sensitive to needs, educative and evaluative) for effective supervisory relationships. Structural boundaries (for instance, time, place and frequency of supervision) and personal/professional boundaries enabled the supervisee to feel emotionally contained.

The strong emphasis on the quality of the supervisory relationship being crucial to reflection, as expressed by participants in the present study, confirms Beinart's conclusion that the supervisory relationship is central to the understanding and practice of effective supervision.

4.3.2 Enablers in Reflective Practice

Interviewees emphasised the importance of protected time and space, value and support for reflection (particularly at a managerial and organisational level), and the need for others, as essential enablers for reflective practice. As previously mentioned, BPS guidance (British Psychological Society, 2000; British Psychological Society, 2004) emphasises the need for reflection in CPD.

Ruth-Sahd (2003), in her critical analysis of data-based studies on reflective practice, highlights the issue of time and value in the literature surveyed. Finding time to reflect and valuing the reflective process are crucial requirements for reflective practice.

Lockyer, Gondocz & Thivierge (2004) state that in order for the work environment to facilitate reflection, there needs to be a suitable framework and process in which reflection can happen. Organisations can stimulate reflection in a variety of ways, according to Lockyer et al., and the value of this is that reflection appears to be the 'engine' that changes surface learning to deep learning by transforming knowing in action to knowledge in action. Similarly, Clarke, James & Kelly (1996) assert that organisational cultures which stress collaboration as a way of working are likely to encourage reflection.

The presence of others was described as important by all participants; having witnesses to one's reflections was not only seen as supportive, stimulating, and normalising, but also as crucial in avoiding blind spots which would not be apparent through solitary reflection. This notion has been captured by Brookfield (1998) who states that:

> "Talking to colleagues about what we do unravels the shroud of silence in which our practice is wrapped. Participating in critical conversation with peers opens us up to their versions of events we have experienced. Our colleagues serve as critical mirrors reflecting back to us images of our actions that often take us by surprise."

The differences between group (including peer group) and individual supervision are discussed by Hawkins & Shohet (1989) and Proctor & Inskipp (2001). However, there is a

paucity of published material on the issue of reflecting by oneself, as opposed to reflecting with others, in relation to issues of subjectivity/objectivity, which ultimately links to clinical governance issues. Ghaye & Lillyman (2006) state that reflective clinical conversations are an exercise in the construction of realities:

> "...through the conversational process we build meanings and construct identities for ourselves within a cultural, historical, clinical and political context. We co-construct and re-construct realities. Personal realities differ. We all see things differently. In and through reflective conversations we can explore these different realities. By so doing, practice becomes a process of coming to know." (p.76)

4.3.3 Obstacles in Reflective Practice

Time and performance pressures, fears of being judged, and reflection not being a valued and supported activity were all obstacles to reflection and reflective practice, which mirrored their counterparts as enablers. Personal stress, being stuck in a comfort zone, and reflection being (too) proscribed were additional obstacles mentioned.

Insufficient time, valuing and support for reflection and reflective practice, combined with workplace pressures, have been notes as obstacles by a number of authors (Haigh, 1998; Burton, 2000; Williams et al., 2002; Ruth-Sahd, 2003; Lockyer, Gondocz, & Thivierge, 2004).

Although for many clinical psychologists, clinical supervision (and therefore a reflective space) may be an established part of their professional practice in the workplace, the culture of

the wider NHS at present with its emphasis on targets, competition, payment by results, and commissioned services, may not always feel like an organisation that values collaboration and taking time out for reflection.

A large-scale multi-method survey of CPD and support for reflective practice was carried out by the Professional Associations Research Network or PARN (Friedman, Davis, & Phillips, 2001), based on 19 associations from diverse sectors (for example, construction, finance, management, medical, educational, scientific, social). The main obstacles mentioned were lack of time, lack of money, lack of access to relevant activities, a workplace culture hostile or indifferent to CPD, lack of incentives for doing CPD, an overly constraining CPD scheme, and lack of professional association support. Thus, the main obstacles of time, lack of support and workplace pressures reported by participants in the present study can be seen as indicative of a more generalised problem concerning many other professionals and organisations.

Yip (2006) warns against self-reflection in reflective practice at a time of poor physical or mental health, as it may cause more harm than good when experiencing intense personal stress.

Reflection being too proscribed a process (for instance, in terms of having to follow a set format or protocol as part of a CPD log or appraisal form) was mentioned by a number of participants as an obstacle which detracted from their motivation and enjoyment of reflection. This therefore presents a challenge between the practice of reflection, and the requirement to evidence this. Williams (2002), in discussing a range of models of reflection, makes the point that some individuals find models too prescriptive or too difficult to use.

Fears of being judged, once again point to the importance of the supervisory relationship as a safe container, as previously discussed. Safety can therefore be understood as both an enabler and a function of reflection and reflective practice, and CPD.

4.4 Higher-Order Theme: Functions of CPD and Reflection

Participants in the present study strongly linked CPD and reflection to concepts of quality and enhanced service provision, and to issues of safety and clinical governance. Safety appears to be a function of CPD as well as an enabler of reflection. This demonstrates a clear awareness in interviewees of the link between CPD and reflective practice on the one hand, and the provision of a quality service in the NHS, safeguarded by clinical governance standards, on the other hand, as highlighted in relevant government documentation (Department of Health, 1999a; Department of Health, 2001; Department of Health, 1997; Department of Health, 1998; Department of Health, 2000b).

This is an important finding, as it demonstrates knowledge of the wider NHS context and a very explicit understanding of the functions of CPD in relation to the needs of the service, service users, and the NHS as a whole. This is in contrast to viewing CPD and reflective practice as 'something of a luxury', or an activity that is primarily for personal-professional benefit.

Cole (2000) makes the point that it is argued, especially in healthcare settings, "...that the safety of clients can only truly be maintained if professionals are committed to constantly

updating their knowledge and practice". Clinical governance reflects the government's determination to ensure that health service provision is not only transparent but also of the highest quality (Clouder & Sellars, 2004). One of the key components of clinical governance is the importance of CPD and lifelong learning to enable service providers to be appropriately skilled and competent. Clouder & Sellars (2004) mindful of the need for transparency and professional accountability, discuss clinical supervision in physiotherapy as an "ethical form of surveillance", alongside its other function as a reflective opportunity and a means of addressing CPD needs.

The government's publication 'Organising and Delivering Psychological Therapies' (Department of Health, 2004a) identifies the need for an effective CPD programme to support not only quality, but also the safety of clinical staff (paragraph 5.17). Unfortunately it is not possible to determine the number of complaints (in any given period) made to the BPS in which CPD – or the lack of it - is implicated in some way (for instance, poor performance due to a failure to keep up-to-date). Only complaints that go to a hearing and result in a finding (i.e. where the complaint is upheld) are in the public domain, but the BPS does not have the resources to collect information regarding the various elements contained in the charge or subsequent finding (personal communication, May 2007). Therefore it is impossible to quantify the link between (lack of) CPD and (lack of) competence in chartered clinical psychologists, as evidenced by successfully upheld complaints.

In the government documentation reviewed earlier, themes of safety and quality are primarily addressed via the practice of CPD, linked to improvements in practice and keeping up-to-date. However, for many of the clinical psychologists interviewed, safety and quality were achieved

specifically through reflection. A number of examples of conflict in work situations were volunteered, where non-reflective practice could have compromised not only inter-professional relationships, but also the safety and quality of the service provided. Greater self-awareness through reflection, recognising when personal issues could have a detrimental impact on work or vice versa, and safe-guarding against poor practice through reflection with others, were all described as important functions of reflection in relation to safety and quality.

Participants in the present study also linked CPD and reflective practice very clearly to professional requirements, such as the completion of the BPS CPD Log which is linked to re-registration for chartered clinical psychologists (British Psychological Society, 2000; British Psychological Society, 2001b; British Psychological Society, 2002; British Psychological Society, 2004).

A number of participants spoke about the Knowledge and Skills Framework (BPS/ Amicus Family of Psychology, 2005) as legitimising their CPD activity, and thus enabling them to maintain and improve their professional practice in a way that might be more difficult to achieve without such a formal framework. However, many of the interviewees were also quite dismissive of the influence of professional bodies, and critical of the way in which CPD and reflective practice had become formalised and enshrined in policy. When presenting this finding to the final (validation) focus group, there was a feeling amongst members of that group that interviewees had not paid sufficient regard to the role played by professional organisations in achieving and maintaining the protected and legitimate status of CPD from which they were now benefiting. This was the only occasion on which the validation group raised some doubts about the legitimacy of the opinions expressed by the interviewees.

4.5 Higher-Order Theme: Linking Reflection and CPD

This theme illustrated the way in which participants experienced the relationship between CPD and reflective practice.

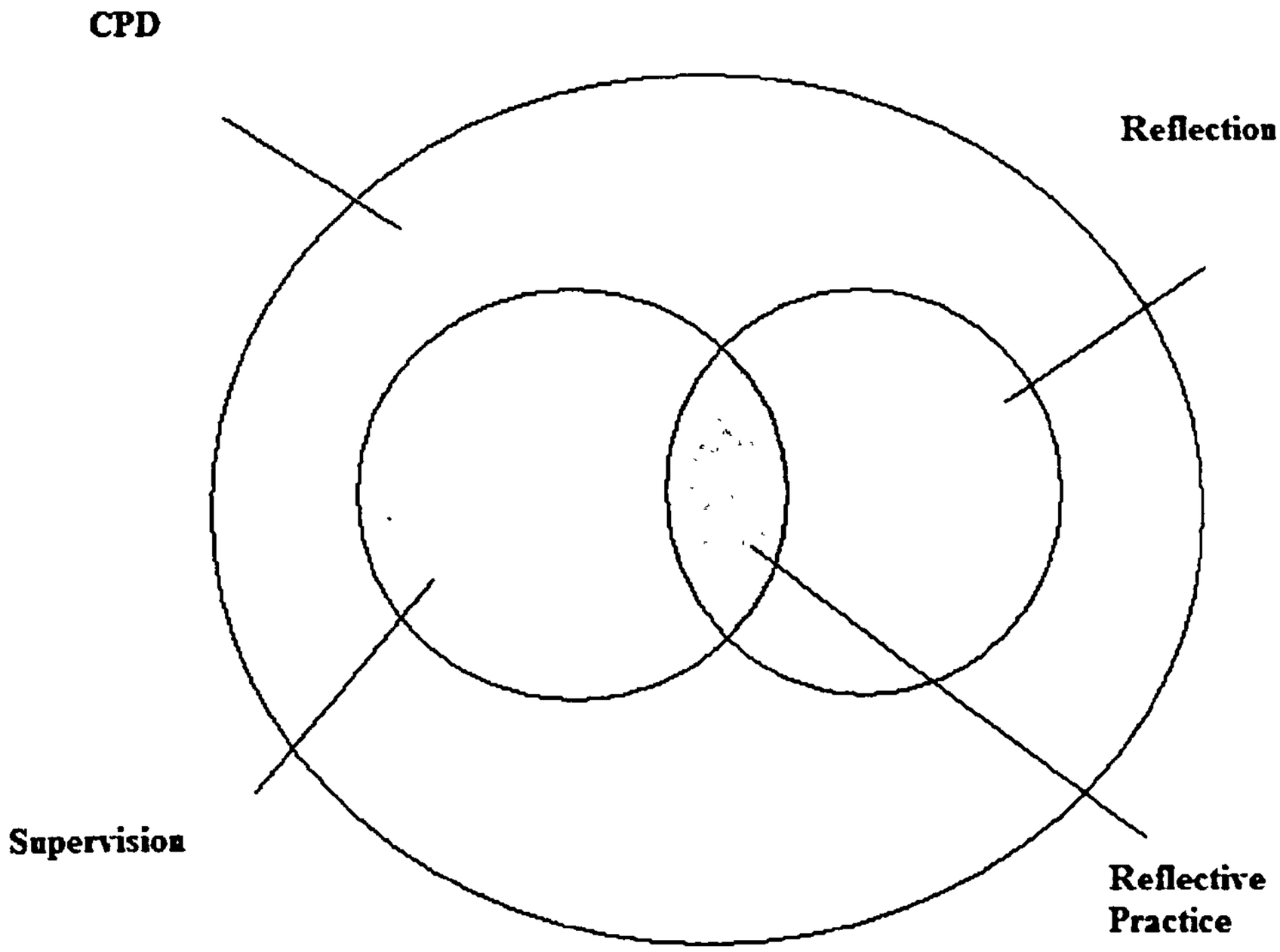
Clegg et al. (2002) have commented on a cognitivist strain in much of the writing on reflective practice in the past decade, which has directed attention away from doing, and argue that a refocusing on action is important in response to the over-emphasis on thinking as opposed to acting. Deriving a simple yet elegant model of the relationship between action and reflection, from a data-based study in higher education, they distinguish between 4 different positions: immediate versus deferred action (following reflection), and immediate versus deferred reflection (following action). Clegg et al. (2002) state that the importance of action as the basis for reflection needs to be understood in order to avoid reflective practice drifting into a form of philosophical idealism.

The majority of the interviewees linked reflection to action – put simply, "reflection needs to have a consequence" (Ghaye & Ghaye, 1998). In most cases, the resultant consequence or action following reflection was described as a desired change or improvement. Kolb's Experiential Learning Cycle (Kolb 1984 a&b) includes the element of active experimentation ('doing') as an essential part of the cycle. In the same way that simply doing something is not sufficient to learn, because one needs to reflect on the experience to learn, it is equally important to put one's reflections into practice in order to have new experiences, thus leading to further learning.

However, a number of interviewees commented that following reflection, sometimes the most appropriate action would be to take *no* action – often as a way of avoiding an unthinking *re-*action to a certain situation. One criticism of Kolb's experiential learning cycle is that it does not include the notion of 'doing nothing' as a response, as it emphasises active experimentation as the necessary step following reflection and theorising.

Interviewees in the present study were all in agreement that reflection was an aspect of CPD, that ideally all CPD should involve reflection in order to make it meaningful, but that CPD as a whole involved a lot more than 'just' reflection. The view that CPD could be characterised by discrete activities that were carried out, and upon completion reflected upon, in a sequential fashion, was seen as simplistic and falsely dichotomous by participants. Therefore, the relationship between reflection and CPD is not merely described as reflection *on* CPD, but also as reflection *in* CPD, and reflection *as* CPD. This understanding echoes Cole's (2000) view that the relationship between theory and practice is less uni-directional and more circular: "Professional practice, whilst guided by the existing corpus of professional knowledge, actually begets theory". Cole asserts that in this sense, the government's attempts to control professional activity through CPD misses the point, as CPD is not something external to professional activity – "...it is an integral and essential party of that action".

Figure 4: Interrelationship between CPD, Reflection, Supervision and Reflective Practice



Given the predominance of supervision in participants' accounts of reflection and CPD, the relationship between reflection, CPD, supervision and reflective practice is illustrated in Figure 4 above. CPD includes a number of different activities, of which supervision is one. Whatever the ideal, in practice not all forms of CPD are reflective, nor is all supervision reflective. However, when supervision is reflective, thus forming a reflective CPD activity, then the consolidation and learning that takes place from it can inform our subsequent practice and therefore make it a truly reflective practice (theory begets practice). Reflective practice is

in itself a form of CPD, given that we constantly learn and develop through our practice, if we take the time to critically reflect upon it (practice begets theory).

Ghaye & Lillyman (2000) assert that clinical supervision must be reflective process, if it is to be a learning experience:

> "If it is merely viewed as technical problem-solving and fire-fighting, and does not involve a consideration of goals and values, means and ends, then it is something else and something less. Clinical supervision viewed in this way reduces healthcare professionals to technicians and enslaves us once more in what Schön (1983) called 'technical rationality'. If clinical supervision is not richly permeated by the principles and processes of reflective practices, how can we make claim to be anything other than 'technicians'?" (p.90)

Finally, the values of lifelong learning, enshrined in government policy (Department of Health, 2001), and hence lifelong reflection, were clearly referenced by a number of participants. However, over and above the mandatory professional requirements and the raft of government policy that emphasise the importance of lifelong CPD, many participants expressed a view of CPD and lifelong learning that went far beyond such directives. An intrinsic belief in the value of CPD and an enjoyment of the process of continuous learning, reflection and intellectual stimulation were very evident in a number of the interviews.

Longworth & Davies (1996) remind us that successful lifelong learning motivates individuals to participate further in learning, but that it has to be enjoyable if it is to be successful and of

tangible benefit. They suggest that there is more to lifelong learning than learning itself, that is, a dimension to learning that can help to liberate the mind, to broaden personal horizons and to empower individuals to develop their personal potential to the full. Whilst the increasing emphasis on CPD and lifelong learning being a mandatory requirement has been a positive development in many ways, both for the providers and recipients of services, the wealth of relevant government policy neither adequately captures nor promotes the enjoyment of CPD and lifelong learning for its own sake.

In summary, therefore, safety appears as a key theme and acts as both an enabler of reflection, and a function of CPD. Supervision and reflection, both key features of CPD, can combine to provide reflective supervision leading to reflective practice. The key drivers for reflective practice and CPD are both internal (e.g. intrinsic motivation) and external (e.g. professional requirements).

4.6 Links to Theoretical Models

4.6.1 Attachment Theory and Psychoanalytic Theory

Attachment theory was developed by John Bowlby (1988) to explain a child's emotional relationship to the main care-giver, and the effects of disruption through separation, loss, deprivation, neglect, and bereavement. Attachment is defined as "the propensity of human beings to make strong affectional bonds to particular others" (Bowlby, 1977). Bowlby believed that many types of psychological distress and emotional disturbance could be explained by disruptions in the development of normal attachment, due to absent or inadequate

care-giving. The exploratory behavioural system is linked to attachment, in the sense that the attachment figure (if present and attentive) provides the essential secure base from which the child learns to explore. The absence of the attachment figure inhibits exploration. Therefore secure attachment can be expected to be beneficial to a range of cognitive and social capacities (Fonagy & Target, 2003).

Hughes (2003) states that "although no research has clearly shown the link between supervision and therapy outcome, the importance of developing a positive supervisory alliance seems fundamental to the supervisory process". Hughes goes on to describe her basic philosophy concerning her supervisory practice as "the need to develop a secure base within supervision", and outlines the important elements of the supervision contract and the contracting process:

> "A way to influence the beginning of a positive therapeutic alliance is to be open, clear and explicit about the supervisory contract. The aim is to create a mutually respectful relationship where it is possible to engage in creative dialogue."

Participants in the present study clearly described clinical supervision as a 'secure base' which enabled exploration through reflection during the actual supervision session (for instance, an exploration of personal feelings in relation to a client or work situation), and which also facilitated subsequent exploration in practice (for example, doing things differently, or trying out new interventions), thus making the link between reflection in supervision, and subsequent action. The importance of protected time and space, and the valuing and support of supervision, can be understood as the fundamental conditions that must be met in order for the

base (supervision) to feel secure, as disruptions to these conditions are likely to make supervision feel unreliable and unsafe.

In a study of 196 UK clinical psychologists which examined the relationship between their attachment organisation and clinical practice, it was found that 70% of respondents rated themselves as securely attached, but the sample as a whole scored higher on the attachment pattern of 'compulsive care-giving' than on any of the other insecure patterns of attachment (Leiper & Casares, 2000). Significant differences were obtained between secure and insecure sub-groups in relation to work, interest in working with different clients and difficulties experienced in therapeutic practice. Leiper & Casares (2000) state that these results have particular relevance for the training and support of clinical psychologists who rate themselves as insecure, as it is they who may be more at risk of work stress and may need more support. The authors conclude that this study validates the importance of supervision in supporting therapists and helping them to make sense of the difficulties they are experiencing.

In attachment theory, care-giving is seen as a complementary behaviour to attachment behaviour, enabling children to become secure, self-reliant, trusting, co-operative and helpful. The importance of the supervisor as a care-giver, and the supervisory relationship in providing supervisees with an experience of secure attachment so as to facilitate reflection, exploration and new learning, was made explicit by all the interviewees. Bowlby referred to the set goal of the attachment system as maintaining the caregiver's accessibility and responsiveness, which he described as 'availability' (Bowlby, 1973). Hughes (2003) refers to the importance of open communication, mutual trust, and a consideration of the supervisee's interpersonal style, needs, and previous experience. Only by being available and empathically attuned to the

supervisee in this way can the supervisor be experienced as being 'available' in a securely attached relationship. The importance of an accessible and responsive supervisor/care-giver in enabling supervisees to be care-givers to others was expressed by some participants with reference to times when their supervision was absent, infrequent or 'not good enough'. It was at those times, when not having an experience of secure attachment to support and sustain them in their work, that participants felt their clinical work was suffering, that they did not provide the best quality service to their clients, and that they found it difficult to be emotionally available to others.

Similarly, Winnicott's notion of 'holding' and 'the holding environment' (Winnicott, 1965), is applicable to this discussion. In Winnicott's eyes, the 'good enough mother' is a mother who is consciously and unconsciously attuned to her baby at different stages of his/her development. The holding environment – a physical and psychical space within which the infant is protected - allows him/her to progress at its own rate to a more autonomous position.

Bion's concept of the 'container – contained' (Bion, 1959) describes the essential relationship between thinking and communicating. The mother acts as the container for the child's fears by receiving and modifying them, so that the infant is able to take them back in a 'detoxified' form.

Whilst Bowlby, Winnicott and Bion discuss the concepts of attachment, availability, holding and containment in the context of the relationship between mother and infant, and by extension, therapist and patient, these models can equally be applied to the relationship between supervisor and supervisee. The parallels between the supervisor/therapist and

supervisee/client relationship are discussed by Hawkins & Shohet (1989), and also by Hughes (2003) specifically in relation to the supervisory relationship in clinical psychology, and attachment theory. Furthermore, the present findings illustrate the importance of reflective practice being enabled by the employing organisation, when it acts as a secure base to which psychologists can feel securely attached. Frequent NHS reorganisations and service restructuring can threaten the availability and safety of the base and therefore, psychologists' relationship to the organisation may become insecurely attached (and vice versa).

4.6.2 Learning Theory

Many of the participants referred to professional role models as important influences on their development as clinical psychologists and reflective practitioners. Of significance in this regard is the importance of previous supervisors encountered during clinical training, and the extent to which their positive influence on interviewees' learning and development was recalled often many years later. Social learning theory (Bandura, 1977) describes the importance of observing and modelling the behaviour, attitudes and emotional responses of others. Observational learning is said to occur when an observer's behaviour changes after viewing the behaviour of a model.

The significance of having a reflective style, the meaning of reflecting on experience in order to learn and develop, and the importance of linking reflection and learning to action, were all clearly illustrated in the themes arising from the interviews. Therefore, the present study provides evidence of clinical psychologists' reflective practice and CPD in support of Kolb's theory of experiential learning and learning styles (1984 a&b).

All participants described examples of single-loop learning (for instance, situations where they had been aware of something having gone wrong, or of not knowing how to deal with a particular situation or client, and the steps taken to address this), through a process of reflection and, where necessary, specific CPD to address what they did not know.

Many interviewees also gave specific examples of double-loop learning; for instance, reflecting on *why* something had gone wrong, or *why* they had not known how to respond in a certain situation. The desired or actual changes in practice resulting from this were often linked to CPD as an enabler of such changes.

A number of participants discussed critical reflection and reflective practice as a way to challenge the status quo in the context of the wider healthcare system, questioning prevailing approaches to treatment and care in term of the structures, ethics and power relationships that influence what we do. These 'meta-reflections' led, in some cases, to a critical examination of prevailing professional practice within the current healthcare system, and a questioning of issues related to power, and the ethical and political principles of care. In general, such critical and challenging perspectives were more commonly expressed by clinical psychologists who tended to work systemically or psychodynamically, and who were more experienced (10 –25 years qualified). This type of learning has been described as triple-loop learning (Sandars, 2006), or 'learning about learning' (Davies et al., 2000), and the present study therefore provides evidence of this type of reflective learning being related to therapeutic orientation, specialty, and length of post-qualification experience. The implications of this in relation to learning organisations as reflective organisations is discussed in section below.

In conclusion, therefore, it would appear that in order to understand clinical psychologists' experience of reflective practice and CPD, it is important to draw on both attachment theory (to explain *what* we need in order to be able to learn) and learning theory (to describe *how* we learn).

4.7 Methodological Considerations

4.7.1 Recruitment

Only 24 (6.3%) of the 380 clinical psychologists, who were invited to take part in the study, did so. This is a very low response rate, although in itself the respondent sample was sufficient in size for the study (only two-thirds were required for interview). There are a number of possible reasons for the low response rate.

Firstly, the ever-increasing pressures on time and demands on performance might have been an impediment to many clinicians to take part. At a time when the value of professional activity is frequently measured in the number of clients seen within any given period of time, clinical psychologists may not be able to spare the time to engage in a process that may potentially equate to two new clients being seen and taken off the waiting list.

Secondly, recruitment followed less than a year after a large-scale CPD survey was conducted in the same geographical area, sampling the same population (Sadler & Golding, 2006). This consisted of a detailed paper-based survey and three further prompts for participation, due to the initially low response rate to the survey. Given the researcher's position within a regional

Clinical Psychology CPD Scheme, and the fact that CPD was part of the title of the present study, it is possible that clinical psychologists who were invited to take part in the study thought that it might be a similar study to the survey which had been conducted a year previously. Moreover, psychologists might not have had sufficient interest in the topic to take part in another study concerning CPD.

Thirdly, there are a number of factors connected to the position of the researcher herself that might have impacted on the response rate. As someone who had trained and worked for over 20 years in the same geographical area in which the study was based, the researcher was already known to quite a number of clinical psychologists in the region, but through her position as tutor with the regional CPD Scheme she became known to a large proportion of the regional psychology workforce. Therefore, the researcher was not unknown and neutral; indeed, she might have been perceived as an 'expert' on CPD and reflective practice, and therefore might have felt intimidating to individuals who were then invited to speak about this topic in a tape-recorded interview. Arguably, by virtue of her position as CPD tutor, the researcher *was* more 'expert' on CPD than the psychologists she wished to interview; however, whilst the researcher's knowledge as a CPD tutor concerned local and national CPD policy, guidance, and practice, as a researcher she was interested in clinical psychologists' personal-professional understanding and experience of reflective practice and the links to CPD.

The researcher might also have been perceived as someone in a position of some authority over the clinical psychologists whom she was inviting to interview, or worse still, as someone

who might wish to use the interviews to monitor them in term of their professional practice and performance regarding CPD and safe/competent practice.

These issues were discussed with a number of senior colleagues and researchers when designing the study. One solution to this might have been to recruit all the participants for this study from outside the region in which the researcher was based. However, conducting 2 focus groups, 16 first and 7 second interviews in another part of the country, replicating the design that required R&D approval for recruitment from 11 different NHS Trusts, would not have been feasible in terms of the additional time required, especially time for travel to conduct the interviews. Instead, certain safeguards were put in place; thus, the participant information sheet stated that a decision to withdraw at any time, or not to take part, would not affect any current or future contact a participant might have with the researcher, or with the regional Clinical Psychology CPD Scheme. At the beginning of each interview, the researcher again emphasised her role as researcher, as distinct from that of CPD tutor.

Whilst the actual reason(s) for the low response rate can only be hypothesised, research is usually conducted with a self-selected sample, and therefore one can assume that potential recruits who had misgivings about the present study or researcher chose not to take part, and that those who did, did not have such concerns. However, it is also possible that those who decided to take part did so in the (mistaken) belief that participation might in some way confer favours in the future, in terms of benefiting from the CPD Scheme's activities over and above what they could otherwise expect. The role and status of the researcher as CPD tutor therefore could have had deterred as well as attracted potential participants.

However, as pointed out by Richardson (1996), qualitative methodology rejects the notion of the supposedly neutral relationship between the researcher and the researched. Furthermore, in IPA an understanding and explicit account of the researcher's role and position in the research process is seen as essential. The description of this in section 2.2.2, and the reflective diary kept throughout the study, were attempts by the researcher to remain mindful of her role and position, and the influence of this on the research process.

Strauss & Corbin (1998) suggest that a balance should be aimed for between objectivity and subjectivity. Whilst objectivity enables the researcher to be confident that the findings are an accurate representation of the phenomena researched, subjectivity facilitates creativity and development. However it is difficult to maintain a balance and be totally objective.

4.7.2 The Sample

Efforts were made (through a purposive sampling strategy) to obtain a diverse sample of clinical psychologists in terms of age, length of post-qualification experience, clinical specialism, geographical location, and type of employing organisation. The study managed to achieve such diversity by obtaining R&D approval to recruit participants from 9 different NHS trusts across the Region.

As previously reported, participants recruited but not selected did not appear to differ significantly from those who participated in the study, in terms of the demographic and professional information obtained.

The researcher succeeded in attaining a whole sample that was broadly representative of larger samples that had previously participated in studies on CPD in the same geographical are (Golding, 2003b; Sadler & Golding, 2006).

The sample sizes for the different elements of the study (5 participants for the initial focus group, 16 for individual interviews, and 9 for the final validation group) were deemed adequate for the methodology selected.

Seven of the 16 interviewees had undertaken additional psychodynamic or systemic training, and half the total sample had previous experience of personal therapy or counselling. Whilst it is not known how many clinical psychologists nationally have had personal therapy/counselling at some point, it is likely that the figure is less than 50%. A study by Leiper & Casares (2000) which involved questionnaires sent to 500 UK clinical psychologists found that 45.5% of the 196 respondents had or were having personal therapy – a very similar proportion to the present sample. However, as Leiper & Casares's (2000) study was about attachment organisation in clinical psychologists, it is therefore likely that their respondent sample was biased in favour of psychologists with an interest in, or experience of, psychodynamic psychotherapy, which is likely (in most cases) to include an experience of personal therapy. Likewise, the explicit focus on reflection and reflective practice in the present study might have attracted a disproportionately greater number of respondents with an interest in, or experience of, therapeutic approaches with an explicit reflective focus (i.e. systemic and psychodynamic therapies), and a concomitant greater likelihood of having had personal therapy.

On reflection, it would appear that the present sample may well be biased towards psychologists with a more psychodynamic/systemic/reflective approach to their work. However, as the purpose of this study is to explore clinical psychologists' experience of reflective practice and CPD, the researcher felt that the richness of data obtained in terms of the thoughtfulness and depth of responses was more valuable and important than considerations such as the generalisability of the sample.

4.7.3 Qualitative Methodology and Issues of Validity and Relevance

The study was a qualitative study, chosen for a number of reasons. The area of clinical psychologists' experience of reflective practice and CPD is under-researched. Most of the publications to date focus on reflection and reflective practice in pre-qualification training, and the links to CPD are not made very explicit. Qualitative research is useful in researching issues about which little is known, by way of exploring the personal experience of participants.

The rationale for qualitative methodology and IPA in particular has already been discussed previously (Chapter 2, section 2.2.1). Five of the six criteria for qualitative research practice described by Murphy et al. (1998) were met (section 2.2.1). Thus:

1. clinical psychologists' experience of reflective practice and CPD was explored through a process of selection and interpretation, influenced by the researcher's theoretical framework;
2. the setting of the study and the researcher's theoretical position were explicitly described;

3. reflective practice and its relationship to CPD were explored holistically and in context, i.e. in the context of clinical psychologists' everyday practice;
4. there was an emphasis on process ('how') as opposed to output ('what') data; and
6. the present study adopted an iterative process of progressive focusing, as opposed to a pre-determined framework, to explore the topic.

The 5th criterion concerns the fact that aspects of the design are frequently changed or adapted as qualitative research progresses; however, this was not necessary in the present study.

Murphy et al. (1998) discuss the need for the criteria of validity and relevance to apply to qualitative research as much as they do to quantitative research, but go on to outline a number of problems in this area. They state that respondent validation or member checking may not be a true test of validity, as respondents will have their own agendas and may not give consistent responses over time. Therefore it should be seen more appropriately as a further opportunity to search for negative evidence, rather than a validation exercise. Triangulation – using a combination of methods to study the same phenomenon – is problematic because, even if data from two different sources agree, this does not mean that the researcher's conclusions are valid.

In the present study, the second (member validation) interviews conducted with participants did not reveal any negative evidence, nor did the final focus group (which was used for triangulation, in combination with the member validation interviews) result in any negative evidence or refutation of the thematic analysis, except for one instance. This concerned the role of professional bodies in influencing interviewees' development of reflective practice and

CPD, as previously mentioned, where the validation group did not support the opinions of the participants. It is also possible that interviewees as well as focus group members said what they thought the researcher wanted to hear, i.e. that they gave an unrealistically positive view of their experience of reflective practice and CPD, possibly because of the influence of the researcher's role and position, as previously discussed. However, many participants disclosed examples of professional conflict and struggle, or reflected on times when they felt that personal or professional stress had negatively impacted on the quality of their work. Moreover, in the feedback about the interview, a number of participants described this as a helpful and thought-provoking experience, which had made them reflect on aspects of their professional practice, in a way that did not fit with an attempt to just 'please the researcher'. Therefore, it seemed unlikely that, as a whole group, participants gave a very biased account of their experience that would invalidate the findings. It is suggested, therefore, that the present findings meet the criteria for validity.

As regards the second criterion of relevance, Murphy et al. (1998) state that relevant research "will contribute to the cumulation of knowledge in a field rather than existing in magnificent isolation" (p.12). Furthermore, relevant qualitative research should produce findings that can be generalised beyond the circumstances in which they were produced. Whilst the contribution to existing knowledge is discussed below in section 4.8.2 below, the question concerning the generalisability of the present findings can only be truly answered by further research involving larger samples from elsewhere in the UK, possibly employing different methodologies and analyses.

Certainly aspects of the present findings in relation to professional identity, supervision, the functions of CPD and reflective practice, and the relationship between them, have been reported in the previous literature in relation to clinical psychologists elsewhere in the UK. Therefore it is unlikely that the present findings are unique and only applicable to the present small sample of clinical psychologists, and in the eyes of the author, the findings are generalisable because of the richness of the data.

4.8 Relevance and Implications of the Present Study

This study aimed to explore qualified clinical psychologists' experience of reflective practice and CPD, which is an under-researched area.

4.8.1 Relevance and Implications of Findings to Clinical Psychology

Reflection was understood as a largely distinct and separate activity to action (reflection-*on*-action), involving reflection on the self, as well as reflection of the impact on, and of, others on the personal-professional self. Reflection was closely linked to the concept of professional identity, with participants describing themselves as clinical psychologists who were practising reflectively as a fundamental 'way of being'.

This is an important finding in the context of the current discussion around new training models in applied psychology (British Psychological Society, 2007) and the proposal of some models which threaten the present distinction between clinical, counselling, health and forensic psychology. Given the increasing fragmentation of traditional clinical psychology services, and the NWW (New Ways of Working) recommendation in favour of applied

psychologists being integrated into multi-disciplinary teams and services (Onyett, 2007), clinical psychologists working in this way may wish to retain a distinctive professional identity as a way of preserving what they see as the unique contribution of clinical psychology to health and social care.

Whilst the NWW guidance on this states that there was an overwhelming preference by stakeholders for the integration of psychologists within teams, "...but only if psychologists retained their unique identity and contribution (e.g. offering an authoritative and constructive counterbalance to the medical model)..." (Onyett, 2007, p.3), it must be noted that NWW concerns all applied psychologists, and not just clinical psychologists.

Furthermore, the recent debate concerning the retention of adjectival titles for psychologists (such as 'clinical') provides some evidence of the importance of professional identity for clinical psychologists. Many other professions claim reflection and reflective practice as an integral part of their professional identity. However, the distinctive contribution of clinical psychology as a discipline is that it combines reflective practice with clinical approaches that are evidence-based, linking assessment to formulation by drawing on variety of models of understanding human emotions, cognitions, behaviour and psychopathology, and resulting in diverse approaches to treatment and therapy. Therefore, clinical psychologists in teams are best placed to encourage reflection in others and offer diverse perspectives of assessment and management to their colleagues.

Participants referred to supervision as the formal space for reflection concerning all aspects of their practice. Of paramount importance was the quality of the supervisory relationship in providing a secure base for the exploration of issues that were often felt to be emotionally challenging, and supervision being valued and supported by supervisors, line-managers and

employers alike. Reflecting in the presence of others (often through peer- or group-supervision), as opposed to by oneself, was seen as facilitating an awareness of one's blind-spots, preventing poor practice and promoting good practice. The presence or absence of these factors could enable as well as impede reflection, and therefore reflective practice.

This finding is important, given that as clinical psychologists, we probably give and receive more supervision than any other healthcare profession. At a time when the culture in the NHS may seem to be more concerned with quantity (number of clients being seen) than quality (of the service provided), retaining the entitlement for what may be seen by many as a great deal of supervision time, especially at post-qualification level, may be difficult. This may be the case particularly for clinical psychologists who are based in multi-disciplinary teams or services where their operational line-management is separate from their professional line-management (as is increasingly the case), and where they may be perceived by some as being expensive professionals requiring more CPD than other (non-psychology) colleagues.

The third higher-order theme linked CPD and reflection firmly to quality and service improvement, particularly improved outcomes for patients, as well as safety and clinical governance, thus reflecting an understanding of the wider NHS context (Department of Health, 1998, 1999 a&b, 2000). This demonstrates that the clinical psychologists in the present study were clearly able to link the functions and practice of reflection and CPD to the wider strategic objectives of the NHS, as reflected in government policy over the past decade. With reference to the third theme of the need for supervision and reflection, this finding is important in terms of placing CPD, including supervision as a space for formal reflection, in a context of quality, accountability, and protection of the public.

Finally, the link between reflection, CPD and reflective practice was explicitly articulated by participants in the present study. Reflection, consolidated through supervision, can lead to reflective practice. Reflection, supervision and reflective practice are all aspects of CPD, as they help us to continually develop ourselves. Whilst reflection is frequently linked to supervision, both in this and other studies previously mentioned, the relationship of reflection to CPD, lifelong learning, and the wider NHS context of quality, safety and clinical governance, is often overlooked in the published literature. Available guidance on CPD is sometimes characterised by what feels like a compartmentalised view of planning and implementing CPD activity, followed by reflection and evaluation, as separate entities. This is in contrast to the present findings which evidence clinical psychologists' understanding and experience of reflection as an essential part of CPD at all stages, and reflection leading to reflective practice, which in itself is CPD.

4.8.2 Relevance of Findings to Theory

Kolb's Experiential Learning Cycle (Kolb, 1984a) may explain the process of reflective practice, but it does not pay sufficient regard to contextual factors that can facilitate as well as hinder learning. This theory also does not pay sufficient regard to the importance of the quality of the relationship(s) that is (are) necessary to enable reflection and experimentation (action) to take place, in order to promote reflective practice. For clinical psychologists in the present study, this concerned the supervisory relationship in particular.

Triple-loop or meta-learning theory emphasises the need to learn about learning. Learning organisations must learn about the contexts of their learning – when and how they learn, and

when and how they do not, and then adapt accordingly (Davies & Nutley, 2000). The failure of organisations to learn, particularly from their mistakes, may result in serious untoward incidents. Specific types of adverse event tend to repeat themselves at regular intervals, which demonstrates that lessons have not been learnt (Department of Health Expert Group, 2000). If organisations can learn from their mistakes, including learning the lessons about the learning that has and has not taken place, and why, then they can become reflective learning organisations.

Whilst triple-loop theory and the concept of the learning organisation is characterised by a much-welcomed emphasis on the wider structural, systemic and cultural factors that may enhance as well as impede learning, such a meta-perspective of the conditions necessary for learning must not overlook the very basic (i.e. fundamental) conditions for effective learning at an individual level, such as the presence of an enabling supervisory relationship.

The present study demonstrates that for this sample of clinical psychologists, reflection is best done as a separate activity, reflection-on-action, and in the context of a safe, supportive and supported relationship. However, the reflective learning organisation is also necessary as the 'holding environment' and 'container' for both the supervisor and supervisee, whose activity must be supported and valued by the wider organisation if it is to continue. Therefore, both learning theory and psychoanalytic/attachment theory are necessary in order to best explain how clinical psychologists practise reflectively, and what conditions are necessary in order to for them to do so.

4.8.3 Implications for Training and CPD

This study provides evidence of the importance of a safe and supportive space for formal reflection with one or more others. When this feels unsafe, because there is a perceived blurring of the personal-professional boundaries, or when participation is not voluntary and in the context of assessed pre-qualification training, reflection - and subsequently reflective practice - may be inhibited. However, there is evidence of reflection having been encouraged and nurtured during training, often in the context of a supervisory relationship on placement that role-modelled the qualities of an available and safe attachment/holding/containing relationship, enabling personal-professional development. This seemed to be particularly successful when the supervisor's personal (human) qualities were more apparent to the trainee, which in itself enabled a greater recognition and discussion of the personal-professional issues experienced by clinical psychologists in training. Therefore these factors need to be addressed in the context of pre-qualification training.

At post-qualification/CPD level, there is a continued need for the availability of a supportive relationship and a safe space for reflection and supervision, and for this to be recognised and supported as a valid need by managers and employers. Whilst NHS policy on CPD and its emphasis on clinical governance and patient outcomes legitimises CPD, it also runs the risk of reducing it to the level of 'technical rationality' described by Schön, if it does not pay sufficient regard to the contextual factors and enablers of learning.

On the other hand, the more recent emphasis on developing 'reflective practitioners' must link reflection and reflective practice closely to the wider strategic context of service improvement,

safety and clinical governance in the NHS, if it does not want to be seen as an expensive luxury that may come under threat because of financial or performance pressures.

In general, therefore, professional (BPS/DCP) and government (Department of Health) guidance should aim for a closer integration between the theory and practice of learning, by including reflection as an integral aspect of professional practice and CPD at all stages, and by recognising the importance of safe and supportive supervisory relationships to facilitate reflection and therefore, reflective practice and CPD.

4.9 Conclusion

4.9.1 Implications for Future Research

There are a number of possibilities to develop some of the findings from the present research. The development of reflective abilities is important in professionals who have been asked to change from 'scientist-practitioners' to 'reflective scientist-practitioners', with clinical training reflecting this shift in emphasis. Future research could combine a quantitative and qualitative approach by focusing on the commonalities and differences between different groups of clinical or applied psychologists with different learning styles (as assessed by learning inventories), in terms of their approach to learning and professional practice. Such research might be helpful in exploring how best to introduce reflective approaches in clinical or applied psychology training (at pre- or post-qualification level) and practice with individuals with different learning styles.

In addition, the link between reflection and theoretical orientation, as found in the present study, could be further explored by comparing the difference between clinical psychologists with a psychodynamic/ systemic background to colleagues from a cognitive/ cognitive-behavioural orientation. Two such groups could be compared with regard to differences between their preferred learning styles and their approach to reflective practice, particularly with regard to Lavender's (2003) description of the processes involved in reflective practice. The aim of this would be to test a hypothesis that more practitioners from a psychodynamic or systemic background score highly on reflective learning styles, and engage more than their cognitive/ cognitive-behavioural colleagues in reflections on their impact on others, about the role of the self.

In contrast to the present study's investigation of reflection and reflective practice with interested and – by their own definition – reflective participants, there is also a need to explore the views of professionals who are critical to such approaches. Given the increasing emphasis on including reflection as an integral part of pre- and post-qualification training and CPD, practitioners who do not endorse reflective approaches are an important group to investigate, as they may struggle to comply with recommended or required ways of working or recording their professional or CPD activities, with potential repercussions in terms of professional requirements linking reflection to CPD and re-registration. A thematic analysis of their criticisms and difficulties might also help to inform educators as regards the design, acceptability and accessibility of teaching and learning materials for a wider audience, including not only learners who are sympathetic but also those who are critical to reflective practice. However, it might be difficult to recruit the latter for such a study.

The theme concerning the link between reflective practice and CPD on the one hand, and safety and quality on the other, deserves further study, given the importance of this in the context of delivering healthcare. For instance, the theme of safety (clinical governance) could be examined by exploring in what way the absence or presence of a reflective space might affect clinicians' ability to work effectively and safely. Linked to this, the theme of quality (enhanced service provision) could be investigated by asking how the quality of the supervisory relationship (with regard to the provision of a reflective space) impacts on clinical psychologists' ability to practise reflectively.

More studies examining in detail the process and skills characterising effective supervisors in facilitating reflection in supervisees, for instance through careful analysis of audio- or video-taped supervision sessions, could add to the existing information regarding the training of supervisors in future.

Given that an increasing amount of healthcare is being delivered by services other than the NHS, i.e. the third sector and the private sector, it would be interesting to explore differences as well as similarities in professional practice between clinical psychologists working in these different settings. As the private sector does not have the same mandatory requirements concerning CPD for its staff than the NHS, there may be differing levels of access and opportunity for CPD, including clinical supervision and the provision of a safe and reflective space. Furthermore, the quality of the attachment relationship (particularly the extent to which it feels secure) between the employing organisation and the supervisor may be influenced by whether the former is NHS, third sector, or private, and this in turn may affect the quality of the relationship between the supervisor and the supervisee/ practitioner.

Finally, the importance of professional identity as a clinical psychologist, and reflection and reflective practice as an essential part of this identity, should be researched as a concept in its own right in the face of proposed future changes in applied psychology training and practice.

4.9.2 Research Questions and Conclusion

The themes derived from the interviews conducted describe clinical psychologists' understanding and experience of reflection, reflective practice, and CPD, the inter-relationship between these activities, and important enablers and obstacles. The research questions posed at the beginning of the study have therefore been addressed. The findings are discussed in the context of current and future professional practice, and the wider NHS context.

For many clinical psychologists, their professional identity is commensurate with a value system that includes critical reflection as an essential part of continuous professional development. The current emphasis on breaking professional activity into separate component parts that may be measured in terms of time, money, and relation to outcome, may be necessary in order for clinical psychology to survive in an increasingly competitive healthcare system. However, such an approach does not take account of the fact that the whole is greater than the sum of its parts, nor does it recognise the intrinsic motivation of many clinical psychologists for entering this profession, and of the factors that reward and maintain safe and competent professional practice.

This research has overall demonstrated the overarching benefit of reflection as a fundamental underpinning of CPD, enabling clinical psychologists to challenge and engage in theoretical

and skills-based reflection. The purpose of this is to continually improve the quality of service and care they provide in the NHS.

As professional bodies, practitioners, management and government organisations continue to consider ways to continue to enhance service quality, a programme of research into the impact of different methods of CPD, and in particular the role of reflection, in professional activity, patient outcome and service development, needs to be sustained.

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APPENDICES

1. **Epistemological Statement**
2. **Reflective Diary Excerpts**
3. **Topic Guide**
4. **Peer Review of Proposal**
5. **R&D Application Form**
6. **Research Governance Approval**
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8. **Ethics Approval**
9. **Recruitment Advert**
10. **Recruitment Information**
11. **Participant Information Sheet**
12. **Demographic Information**
13. **Consent Form**
14. **Interview Feedback Form**
15. **All Codes List**
16. **All Codes Families List**
17. **All Codes x All Participants Frequency Table**

App.1: Epistemological Statement

The researcher's epistemological position was explored in terms of its influence on the rationale for the chosen research design and methodology. Therefore, this included questions regarding the researcher's a priori assumptions, expectations and experiences, and how these influenced the research process.

At the start of the study, the researcher was a clinical psychologist with 17 years experience of psychodynamic psychotherapy practice (including previous personal therapy, continuous and ongoing high-quality clinical supervision, and involvement in the training and supervision of clinical psychologists and other psychological therapists working in this model). Her interest in a therapeutic model which requires explicit exploration and reflection of the role of the personal and professional self in interaction with others therefore influenced and shaped her assumptions and expectations about reflective practice. In particular, this related to the need for effective reflective practice to involve the personal self in reflection, and the requirement for clinical supervision to provide a safe reflective space as an enabler in this process. Therefore, the researcher did not question the inherent validity, or value, of reflective practice as a concept, but instead took this as a given.

Furthermore, the researcher's role as CPD Tutor involved the researcher in promoting CPD for clinical psychologists, and in the design and delivery of several novel CPD activities she included an explicitly reflective element as a way of relating theory and practice, and in order to promote a more reflective style of practice. Thus, the researcher's inherent standpoint assumed that reflective practice is a desirable and important element of clinical psychologists'

professional practice, that it should involve reflection of the role of the self (and not just a reflection of activities undertaken), and that CPD should involve reflection at all stages, in order to facilitate reflective practice and improvements in service delivery.

The researcher's prior assumptions and experiences regarding reflective practice and CPD also influenced her selection of the literature, i.e. initially focusing widely but then narrowing down to literature concerning reflective practice and CPD in relation to healthcare professionals', particularly clinical psychologists', post-qualification training and practice. Whilst her educative/ training role as CPD tutor initially led her to the literature relating to learning theory, the findings which related to the use of the personal self and the importance of the supervisory relationship resonated with her psychodynamic experience, which then drew her to the literature on attachment theory.

The researcher's role as CPD Tutor enabled her to gain a regional overview of clinical psychology services, and this perspective coupled with access to a regional CPD Scheme database therefore allowed her to sample research participants systematically and strategically across the Region. Given the CPD Scheme's explicit *region-wide* focus and remit for *all* clinical psychologists in that area, the researcher deliberately sought to recruit participants in approximately equal numbers from each of the 3 sub-regions, whilst ensuring that a wide range of clinical psychologists were represented in terms of length of post-qualification experience and clinical specialism.

The researcher's role and experience as a clinical psychologist, psychodynamic psychotherapist, and CPD tutor, therefore directly shaped and influenced the interpretation and

discussion of the findings – in particular, those concerning the importance of the concept of professional identity (as a clinical psychologist), the need for supervision to provide a safe and reflective space in order to enable reflective practice, and the link between reflective practice and CPD to safety (clinical governance) and quality (enhanced service provision).

App.2: Excerpts from Researcher's Reflective Diary

The following excerpts are transcribed entries made in the early stages of data analysis:

8.10.2006

I have finally understood why the word "immerse" is used in the context of doing qualitative research – i.e. "you must immerse yourself in the data". It's because you are literally submerged in the data, given the amount that's being generated! I feel as though I am actually going into something (submerging, immersing myself into something) every time I sit down to do some more coding and analysis, and every time I finish I feel as though I am coming up and out of something. Quite a strange sensation; almost physical. I don't feel as though I am drowning, though; I think I am still swimming (just...), because I can see some connections beginning to emerge as I am doing the coding and doing more and more interviews. I am jotting down ideas, possible themes, and thoughts, anything that might help with the actual analysis. I have decided to use the memo-function in atlas-ti; I didn't think I would want to but it's actually really useful to note down ideas etc on each transcript separately, so that the idea can be linked back to the text.

15.10.2006

It comes as a pleasant surprise that I am really enjoying the research, particularly the analysis, which I consider to be at the heart of the research. Despite the fact that it is a struggle (due to competing, and at times overwhelming professional and personal demands), I am really enjoying the process of being immersed in the data. It feels rewarding, satisfying, validating and also at times surprising.

28.10.2006

I have just realised that there was something familiar about the process of qualitative research, and particularly IPA, even before I started doing this (even though I have never done IPA before) - it fits with my practice and enjoyment of working psychodynamically,

where I am constantly looking for themes, recurrent patterns, and interpreting the information given to me so that I am putting things back in a transformed way. Also, working in a psychodynamic way (and receiving psychodynamic supervision) requires a high degree of reflection, particularly reflecting on the personal/ professional interface (what's my material, what's the client's - how much of this is due to what's happening in the session and with the client and how much of this is due to what's happening in my life at the moment?).

Feels like the process of IPA is a bit like constructing a clinical formulation. You receive a lot of information (interview data), and then you transform this information so that when you've constructed your formulation, and you've put it back to the client, it contains all the (relevant) information they have given you, but you have done something extra to it in the way that you represent the information (interpretation). The client still recognises it as their own ("yes, that's me") but the information has been changed, particularly with regard to major themes being represented in the formulation - the raw data has been transformed by an interpretative process (common response by clients "I never thought of it like that, but that makes sense"). This is akin to the process of member validation. As with a clinical formulation, the coding done in IPA is a work in progress - through member validation, you're able to change your formulation/ analysis, taking away/ adding or changing the information from the initial information gathering stage.

I feel quite excited by this – by seeing this connection between an aspect of clinical work which is so fundamental to how clinical psychologists work (formulation) and a particular type of research methodology. I had never realised this before, and I think it explains why the approach feels "familiar" to me and why, as someone with a reflective/ psychodynamic bent, I find a quantitative approach less interesting and satisfying.

App 3: Topic Guide (for semi-structured interviews)

[The questions set out below will be preceded by a statement about the overall aim of the research, confidentiality, ethical and R&D approval, and informed consent. Consent will be obtained verbally and in writing. Interviews will be tape-recorded and transcribed].

1. What do you understand by the term "reflective practice?"

Prompt:

- Further exploration of reflective practice with reference to participant's own professional practice.

2. What do you understand by the term "continuing professional development" (CPD)?

Prompt:

- Further exploration of CPD with reference to participant's own professional practice.

3. What has influenced your development as a reflective practitioner over the years?
Prompts:

Further exploration of

- Influence of clinical (pre-qualification) training
- Influence of post-qualification training
- Influence of personal development (e.g. personal therapy)
- Influence of professional bodies (e.g. BPS, UKCP)

on participant's personal/ professional development as a reflective practitioner.

4. What use is reflective practice?
Prompts:

- Further exploration of the usefulness of participant's own reflective practice.
- Further exploration of the link between reflection and action.
- Illustration of the link between reflection and action by way of an example from participant's own practice.
- Further exploration of the usefulness of reflective practice to the service/ organisation within which the participant works.

5. What helps and hinders your own reflective practice?
Prompts:

- Further exploration of the enablers to reflective practice (personal/ professional/ organisational factors)
- Further exploration of the obstacles to reflective practice (personal/ professional/ organisational factors)

6. How do you experience the relationship between reflective practice and CPD?
Prompts:

- Further exploration of participant's understanding of the meaning of "reflective practice *in* CPD".
- Further exploration of participant's understanding of the meaning of "reflective practice *as* CPD".
- Illustration of the link between reflective practice and CPD by way of an example from participant's own practice.

- Further exploration of the factors that facilitate the link between reflective practice and CPD in participant's own professional practice.

7. Any final comments you wish to make on reflective practice and CPD, and about the interview?

App 4 : Peer Review of Proposal - 08/11/2005

Reflective practice and continuing professional development (CPD) among qualified clinical psychologists – Gundi Kiemle

A. General comments:
This candidate proposes to investigate the impacts of reflective learning on CPD and professional practice among clinical psychologists. The topic is of interest to clinical psychology practice and training. Because of the nature of the area of research and because the area is relatively under-investigated, it is appropriate to use a qualitative methodology rather than quantitative methodology.

B. Specific comments:

1. Literature review:
The brief literature review was adequate and covered a variety of areas relating to the proposed project. The review led to critical appraisal of the area and formulation of research questions.

2. Design and methodology:
Both were appropriate and the proposed research was modest and achievable. The candidate also took care to "situate the sample". Furthermore, the candidate seemed to have good access to potential subjects.

3. Analyses:
Interpretative phenomenological analysis (IPA) was appropriate for the proposed investigation. In addition to the IPA, the candidate proposed to use computer-aided software, Atlas.ti, to assist with thematic data analysis. This provides a credibility check by using more than one qualitative perspective. However, I would like to see more than just one credibility check. The candidate should obtain the views of experts in reflective learning or CPD to check if the categories and analyses resonate with the experts. Alternatively, the feedback of a small subsample of participants should be sought.

C. Summary:

This is a good proposal. The results of this study will be of interest to clinicians and trainers. I do not see any ethical objection to this investigation.

Dominic Lam, PhD
Professor of Clinical Psychology

App 5: R&D Application Form

R & D Office Reference No:	**bstmht**
Related to:	

Bolton, Salford and Trafford Mental Health NHS Trust
DECLARATION FORM FOR RESEARCH AND DEVELOPMENT PROJECTS

Details of Principal Investigator:

	Surname	Initial(s)	Title	Employer/Department	NHS Post held (please state if student)
Principal Investigator	**Kiemle**	**G.**	**Ms.**	**North West Clinical Psychology CPD Scheme, Psychology Service (Salford), BSTMHT**	**Consultant Clinical Psychologist and CPD Tutor**
Email Address:	**gundi.kiemle@bstmht.nhs.uk**				

1. **Details of investigators EMPLOYED BY BSTMHT (please continue on an additional sheet if necessary) N/A**

	Surname	Initial(s)	Title	Department	NHS Post held (please state if student)
Investigator 2					
Investigator 3					
Investigator 4					
Investigator 5					

2. **Details of EXTERNAL investigators (please continue on an additional sheet if necessary) N/A**

	Surname	Initial(s)	Title	Employer	Post held/Grade
Investigator 1					
Investigator 2					
Investigator 3					
Investigator 4					

3. **Which organization is the sponsor of this research project?**

Doctorate Programme in Clinical Psychology, University of Hull

4. **Where is the work performed? (please list all centres and estimate the percentage of activity at each)**

The project will involve interviews with approx. 20 staff (qualified clinical psychologists) selected from different areas in the North West. Interviews will take place in locations most convenient for the participants. All non-interview research activity will be performed in the principal researcher's work base (which is actually home).

5. **Full title of the proposed research or clinical outcomes project**

Reflective Practice and Continuing Professional Development among Qualified Clinical Psychologists

6. **The principal research question being addressed**
(A single sentence if possible. Where a specific hypothesis is being tested, please give the hypothesis)

What is clinical psychologists' experience of reflective practice in relation to their continuing professional development?

7. **Methodology description**

Participants: Selection

Eligible participants are qualified clinical psychologists practising in the North West of England. Purposive sampling will be employed in order to include a range of demographic and other factors such as sex, age, grade, length of experience, clinical specialism, geographical location, and professional setting. (Appendix A of the research proposal lists the details to be recorded for each participant).

Participants: Recruitment

All eligible participants will be identified and contacted via the CPD Scheme electronic database. Participants will be invited to participate in the research via targeted letters of invitation (individual letters, letters to departmental and service heads), notices in the CPD Scheme newsletter, and flyers about the research sent to the organisers of other professional regional groups (e.g. Special Interest groups, CONTACT Scheme for newly qualified clinical psychologists, Division of Clinical Psychology North West branch). Interested participants would be able to obtain further information about the research on request.

Instruments and Data Collection

The initial peer reference group was facilitated by the researcher, and tape-recorded. An observer (Assistant Psychologist) was present to make written notes and observations. This information was used to construct a topic guide for subsequent one-to-one interviews (Appendix B of the research proposal), which will be piloted on a small number of participants and modified, as necessary. The procedure for data collection from the later focus (feedback) group following the interviews will be the same as for the initial peer reference group.

8. **Start date** 9. **End date**

Jan 2006		**Jan 2008**

10. **Please indicate study type (categories devised by the Department of Health) - please tick applicable boxes**

Re-analysis of original data	☐	Randomised Controlled Trial	☐	Research on tissue/DNA samples	☐
Laboratory Study	☐	Controlled Trial without randomisation	☐	Imaging and technology research	
☐					
Case note review	☐	Before-After study	☐	Research with in-patients	☐
Database analysis	☐	Case-Control study	☐	Research with out -patients	☐
Questionnaires	☐	Cohort observation	☐	Clinical Trials	☐
Participant observation	☐	X-sectional study	☐	HSR	☐
Interviews Yes	☐	Epidemiology	☐	Population based research	☐
				Behavioural research	☐

Secondary research ☐

11. Outcome measures (describe endpoints or factors used to evaluate health status e.g. survival discharge status or quality of life. Can also be a symptom e.g. reduction in blood pressure)

Thematic analysis will be used to identify enablers and obstacles in clinical psychologists' ability to use reflective practice in continuing professional development. It is envisaged that this will lead to the identification and dissemination of examples of good practice, with resultant benefits for CPD and clinical practice.

12. Outcome Type(s):

Clinical practice Yes ☐ Further study ☐ Intellectual Property ☐ **Publications Yes** ☐

13. RESEARCH AREAS:

Please indicate which specialties the proposed research/outcomes project relates to

Clinical Psychology/ Continuing Professional Development/ Education

14. Will the proposed project involve support departments, eg extra tests, finance, medical records etc Please specify

Yes ☐
No ☐

No other departments involved

15. Is BSTMHT the lead institution for the project? Yes

Yes ☐
No ☐

if No please identify lead institution below:

Lead institution:

16. Will the project receive any funding? No **Yes** ☐ **No** ☐

Was advice sought on costing? Yes ☐ **No** ☐

If Yes, is the funder a:

Research council	☐	Commercial/industrial	☐
UK-based charity	☐	European Union	☐
UK central government	☐	Other overseas	☐
UK health/hospital authority	☐	Other	☐
Endowment funds	☐	Specify	

Grant reference number	Grant Holder

17. Please give the name(s) of the funding body (EXTERNAL funding) N/A

Name of funding body AND FUNDING REFERNCE	Contact person (if known)

18. Who administers the funding?

Trust ☐
Univ. ☐
Other ☐

19. Please estimate the percentage of funding for activity based at BSTMHT: _32_____%

(This includes £2,792.57 total project costs, and £3,000 tuition fees for university registration for 2 years)

20. Please summarise the funding requested / awarded by the funder (please continue on an additional sheet if necessary)

See research proposal pp21-22 for full costings.

The total amount of support requested (£1,829.57) has been granted (see confirmatory letter from Dr. Laura Golding, line manager)

SUMMARY OF SUPPORT REQUESTED	YEAR 1 £	YEAR 2 £	YEAR 3 £	YEAR 4 £	YEAR 5 £	TOTAL £
DIRECT STAFF COSTS						0.00
CONSUMABLES						147.00
EQUIPMENT						123.10
OTHER COSTS						1,559.47
INDIRECT COSTS						
GRAND TOTAL						1,829.57

21. Please summarise SERVICE SUPPORT requested from BSTMHT (please continue on an additional sheet if necessary) – N/A

SUMMARY OF SUPPORT REQUESTED	YEAR 1 £	YEAR 2 £	YEAR 3 £	YEAR 4 £	YEAR 5 £	TOTAL £
DIRECT STAFF COSTS						
CONSUMABLES						
EQUIPMENT						
OTHER COSTS						
INDIRECT COSTS						
GRAND TOTAL						

22. Please summarise TREATMENT COSTS requested from BSTMHT (please continue on an additional sheet if necessary) – N/A

SUMMARY OF SUPPORT REQUESTED	YEAR 1 £	YEAR 2 £	YEAR 3 £	YEAR 4 £	YEAR 5 £	TOTAL £
DIRECT STAFF COSTS						
CONSUMABLES						
EQUIPMENT						
OTHER COSTS						
INDIRECT COSTS						
GRAND TOTAL						

23. Do you expect the research findings to have any potential for commercial exploitation? Yes ☐
No No ☐

24. <u>INVOLVEMENT OF PATIENTS/SUBJECTS and USE OF SAMPLES</u>

(a) Will the proposed project involve patients OR patient material from BSTMHT? No Yes ☐ No ☐

If Yes:

- **At which Clinical Directorate(s) will the patients be presenting? _____**
- **How many patients will be involved in total? _____ ☐**
- **SAMPLE GROUP DESCRIPTION (describe the notional population from which a sample is drawn for the purposes of the study):**

- **Please give details of Ethics approval (tick where appropriate): NHS ethics approval not necessary (see e-mail from Salford & Trafford REC). Currently applying for university ethics approval, University of Hull (see e-mail from research supervisor)**

APPROVED☐ PENDING☐ TO BE SUBMITTED☐ APPLICATION ATTACHED☐
UNNECESSARY☐

- **Have you checked the requirement for ethics approval with the Ethics Committee and/or R&D Unit?** **Yes** ☐ **No** ☐

(b) Please give Salford & Trafford Research Ethics Committee or Bolton REC number(s) relating to this project: N/A

LREC Number: _____ **Date of approval:**

_____

(c) Please give Multicentre Research Ethics Committee number relating to this project: N/A

MREC Number: _____ **Region:** _____ **Date of approval:**

_____

25 FOR PROJECTS WITHOUT EXTERNAL FUNDING Please specify external peer review arrangements - PLEASE ATTACH REVIEWS.

Peer review is in the post – see e-mail from research supervisor (Sue Clement). Peer review was satisfied that no changes to the proposal are necessary. Peer review will be forwarded to R&D bstmht as soons as it has been received.

	Surname	Initial(s)	Title	Institution	Post held	Date of Review
Reviewer 1	Lam	D	Prof.	Doctorate in Clinical Psychology, University of Hull	Course Director	November 2005
Reviewer 2						

	Signature	Name in block capitals	Date
PRINCIPAL INVESTIGATOR		GUNDI KIEMLE	1.12.2005

Contact telephone/extension number of PRINCIPAL INVESTIGATOR: 0161-772 3612 and 07985 054386

Address for correspondence of PRINCIPAL INVESTIGATOR: North West Clinical Psychology CPD Scheme, Psychology Services, BSTMHT, Bury New Road, Prestwich,

Manchester, M25 3BL.

Please supply any SUPPORTING INFORMATION on an additional sheet.

All supporting information has been forwarded electronically to Jennifer Higham (ie. confirmatory e-mails re. non-requirement of COREC approval, non-requirement of LRECs notification, financial support granted, peer review conducted).

APPROVALS (Please do not complete, The R&D Office will obtain the relevant signatures following approval of the research by the Research Governance Group)

I have reviewed and agree the cost calculations on this form

	Signature	Name in block capitals	Date
DIRECTOR OF FINANCE			

I have read this form and approve this project. I have had the opportunity to review the full protocol if I considered it necessary. The direct cost calculations are correct and will be met by the research sponsor and/or my directorate if the project goes ahead.

	Signature	Name in block capitals	Date
SERVICE DIRECTOR			

Based on the information in this form I approve this project to be submitted to a sponsor/hosted in this Trust.

	Signature	Name in block capitals	Date
TRUST R&D LEAD			

Please return the completed form to: Jennifer Higham, Research & Development, Room 109 Harrop House, Bolton, Salford and Trafford Mental Health NHS Trust, Bury New Road, Prestwich, Manchester M25 3BL
Tel: 0161 772 3954. Email: jhigham@trusthq.bstmhp.nhs.uk

App 6: Research Governance Approval

Bolton, Salford and Trafford
Mental Health NHS Trust

Research & Development Office
Room 109, Harrop House

Bury New Road
Prestwich
Manchester M25 3BL

Tel: 0161 772 3591/3954

Fax: 0161 772 3550
Email: kathryn.harney@.bstmht.nhs.uk
jennifer.higham@.bstmht.nhs.uk

9 December 2005

Ms G Kiemle
Consultant Clinical Psychologist
Psychology
Harrop House
BSTMHT

Dear Ms Kiemle

BSTMHT 436: Reflective Practice in Continuing Professional Development among qualified Clinical Psychologists

I am pleased to inform you that the above project has received management approval from Bolton, Salford and Trafford Mental Health Trust. The following conditions apply:

- You will be contacted by Prof Linda Gask who reviewed your study on behalf of the Research Governance Group. Linda would like to recommend what she feels would be improvements to the study, making it more worthwhile.

- All research which involves Bolton, Salford and Trafford Mental Health NHS Trust staff, patients, their organs or data must comply with the Research Governance Framework for Health and Social Care.
  http://www.dh.gov.uk/Home/fs/en

- We note you do not require ethical approval from the Ethics Committee.

- Please note that in undertaking this research the Principal Investigator is responsible for ensuring that the project is conducted in accordance with the protocol which has been subject to independent ethical and peer review. In particular, all research participants must give voluntary, informed consent and proper records of consent must be kept including, where appropriate, a copy on the patient's file.
- In order to demonstrate compliance with the standards of Research Governance the Trust is introducing a system of audit to ensure that research is carried out in accordance with the protocol and that informed consent is

given. All research will be monitored annually. ***As part of this process we require you to send a copy of the annual progress report you will need to submit to the REC which approved your research.***

- We note you are a Trust employee and that the study involves staff and not patients. Therefore you and any other researchers will not require honorary contracts.

- The R&D Office must be informed of any changes to the protocol.

- Unless you inform me that there are commercial confidentiality requirements we will register the project with the National Research Register.

- The research governance framework requires us to have clearly documented agreements on responsibilities of parties involved in research. An outline of the roles is attached. We note that the sponsor of this research is University of Hull.

- You must inform the R&D Office when the research has started, or if it is delayed for a long period of time, or if it is abandoned. Progress will be monitored regularly.

Please sign the duplicate copy of this letter, and ask a representative from the Sponsor organisation to sign also, and return to the R&D Office.

R&D Risk Checklist We also attach a Risk Checklist for this project, which is aimed at helping you assess the general risks associated with your research. Could you please complete the form and return to us, attaching additional information if you have answered "No" to any of the questions.

If you have any queries arising from this letter please contact the R&D Office as above.

With best wishes for your research

Yours sincerely,

Dr Steve Colgan
Medical Director

BSTMHT 436: Reflective Practice in Continuing Professional Development among qualified Clinical Psychologists

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I confirm receipt of this letter and understand that Trust approval of research is dependent upon compliance with the Research Governance Framework and local Trust policies.

.....	.....
Principal Investigator	**Date**
.....	.....
Signed on behalf of Sponsor	**Date**

.....

Print Name/Job Title of Sponsor Contact

.....

Sponsor Organisation

App 7: Confirmation of Non-COREC Requirement

From: Maggie Twiney <maggie.twiney@gmsha.nhs.uk>
To: 'Gundi Kiemle' <Gundi.Kiemle@bstmht.nhs.uk>
Date: 17/11/2005 09:49:10
Subject: RE: Ethics application query - response !!

I'm very relieved to be able to copy **Dr Addison's, Chairman, Salford and Trafford LREC, opinion** re your study 'Reflective Practice and Continuing Professional Development'

"This is educational in content as well as being for an educational degree. Needs University ethics review not NHS".

At least we have not delayed your application for REC submission as it is not required on this occasion.

Good luck with the project, and huge apology for keeping you waiting for this response.

Best wishes,
Maggie

Maggie Twiney

Salford and Trafford LREC

Gateway House

Piccadilly South

Manchester M60 7LP

Tel: 0161 237 2438

Fax: 0161 237 2383

App 8: Ethics Approval

NDS/JBK

6th March 2006

Dr G Kiemle
Consultant Clinical Psychologist
North West Clinical Psychology CPD Services
Psychology Services
Bury New Road
Prestwich
MANCHESTER M25 3BL

Dear Dr Kiemle

Re: Ethics Approval - Top-Up Doctorate Research Project

I am writing to inform you that your research proposal for a study entitled, 'Reflective practice and continuing professional development among qualified clinical psychologists' was considered by the Executive Committee of the Academic Policy & Resources Committee (APRC) on Monday, 20th February 2006 when ethical approval was granted.

Yours sincerely

C M LANGTON
Deputy Director for Research

c.c. Ms S Clement
Senior Lecturer
Clinical Psychology
Hertford Building
University of Hull

Professor Nicholas D Stafford MB FRCS
Director - Postgraduate Medical Institute
Postgraduate Medical Institute, Hertford Building (Room 203)
The University of Hull
Hull, HU6 7RX, UK
T: +44 (0) 1482 465348/464213
F: +44 (0) 1482 463421
N.D.Stafford@hull.ac.uk

App 9: Recruitment Advert

Version 1 (4th November 2005)

Reflective Practice and Continuing Professional Development among qualified Clinical Psychologists

This is your opportunity to take part in a qualitative research project, which aims to explore how clinical psychologists relate reflective practice to continuing professional development (CPD), and how this may improve their professional practice.

If you are a qualified clinical psychologist practising in the North West of England (Greater Manchester, Cheshire and Merseyside, Cumbria and Lancashire), then you are eligible to take part.

Participation involves an initial interview in which you will be asked to describe your views on professional issues relating to reflective practice and CPD. A subsequent interview will be used to feed back to you the main themes from your previous interview, and to elicit any further thoughts you might have.

This research is carried out for the Doctorate in Clinical Psychology (Top-Up), and has received full ethics and R&D approval.

If you are interested in participating, please contact me at gundi.kiemle@bstmht.nhs.uk.
Further information about the study will be e-mailed/ sent to you.

Alternatively, you can take a flyer (attached), and return the reply slip to me by post.

If you have any queries about the study which you would rather discuss by phone, please contact me on 07738392054.

Thank you for taking the time to read this advert.

App 10: Recruitment Information

Version 1 (4th November 2005)

Dear Colleague,

I am currently conducting research to complete the award of Doctorate of Clinical Psychology (Top-Up). I want to explore what qualified clinical psychologists understand about the meaning of reflective practice and continuing professional development. This is an area which has been investigated in other healthcare professions, but there is virtually no research in relation to clinical psychologists.

What will participating in the study involve?

It will involve two interviews (approximately two hours of your time in total), on two separate occasions. In the first interview, you will be asked to talk about your understanding and experience of reflective practice, and how this may link to continuing professional development. The transcript of this interview will be sent back to you to check for accuracy. Following thematic analysis of the transcript, the second interview will be used to present to you the main themes from your initial interview and to elicit any new themes that may arise in response. The interviews will take place at a time and place to suit you.

Am I eligible to take part?

If you are a qualified clinical psychologist working in the North West of England (Greater Manchester, Cheshire and Merseyside, Cumbria and Lancashire SHA areas), then you are eligible to take part. I am hoping to recruit clinical psychologists from a range of specialties, geographical locations, professional services, and differing in length of post-qualification experience.

What should I do if I am interested in taking part?

If you decide that you would like to participate in the study, please contact me, Gundi Kiemle, by e-mail at gundi.kiemle@bstmht.nhs.uk. If you have any queries at this stage which you would rather discuss by phone, please contact me on 07738392054.

Alternatively, you can complete the reply slip below and return it to me, so that I can contact you to discuss your participation.

Title of Study: Reflective Practice and Continuing Professional Development among qualified Clinical Psychologists

I am happy to be contacted about participation in the above study.

Name:_____ Tel. contact no.:_____

E-mail:_____

The best time to contact me is:_____

I would prefer to be contacted by telephone/ e-mail (please delete)

App 11: Participant Information Sheet

Version 2 (20th March 2006)

Title of Study

Reflective Practice and Continuing Professional Development among qualified Clinical Psychologists

Researcher

Gundi Kiemle, Consultant Clinical Psychologist & CPD Tutor

- North West Clinical Psychology CPD Scheme, Psychology Services, Bolton, Salford & Trafford Mental Health NHS Trust, Bury New Road, Prestwich, Manchester, M25 3BL.
- E-mail: gundi.kiemle@bstmht.nhs.uk
- Tel: 0161-772 3612 (Clinical Psychology CPD Scheme)
- Tel: 07738392054 (Personal mobile)

Invitation to participate in this research

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others, if you wish. Do not hesitate to ask for clarification or further information, if necessary. Thank you for reading this.

What is the purpose of the study?

The proposed qualitative study aims to explore how qualified clinical psychologists relate reflective practice to CPD, and how this may improve their professional practice. Recent NHS policies and professional guidance have highlighted the importance of lifelong learning and continuing professional development (CPD). Increasingly, CPD will emphasise outcomes and reflective evaluation, linking learning to practice and focussing on learning from practice.

Reflective practice – critical reflection linked to one's professional practice – has increasingly informed educational theory and the pre- and post-qualification training of the healthcare professions, particularly those allied to medicine. However, there is virtually no research in this area in relation to clinical psychology.

Individual interviews will be conducted with a sample of clinical psychologists from the North West of England. Data will be thematically analysed, and individual member checking will be employed as a means of validating the analysis. Triangulation of the findings will occur via feedback and further discussion of the key themes presented to a focus group.

This study has received full university ethics and NHS R&D approval, in accordance with research governance requirements.

Primary purpose of research

To complete the award of Doctorate of Clinical Psychology (Top-Up Doctorate).

Why have I been chosen?

If you are a qualified clinical psychologist working in the North West of England (Greater Manchester, Cheshire and Merseyside, Cumbria and Lancashire SHA areas), working for one of a range of NHS Trusts/ PCTs from whom the relevant research approval has been obtained, then you are eligible to take part in this study. It is hoped that clinical psychologists will be recruited from a range of specialties, geographical locations, professional services, and differing in length of post-qualification experience.

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 any current or future contact you may have with the researcher, or the North West Clinical Psychology CPD Scheme, either now or at any point in the future.

What will taking part in the study involve?

It will involve one to two interviews (approximately one to two hours of your time in total), on two separate occasions. In the first interview, you will be asked to talk about your understanding and experience of reflective practice, and how this may link to continuing professional development. The transcript of this interview will be sent back to you to check for accuracy. Following thematic analysis of the transcript, a second interview (face-to-face or by telephone) will be offered to you, in order to feed back to you the main themes from your initial interview and to elicit any new themes that may arise in response. The interviews will take place at a time and place to suit you.

What will happen to the results of the study?

The findings will be written up and submitted to an academic journal for publication. You will be asked if you would like to receive a summary of the results. All the findings will be reported anonymously Tapes and transcripts will be kept in a locked filing cabinet in

accordance with the Data Protection guidelines, and destroyed at the end of the study. It is anticipated that the findings will be available by autumn 2007.

Any other questions?

Please do not hesitate to get in touch if you have any other questions about the study. You will have time to ask questions before and after the interviews. Alternatively you can ask questions by e-mail or phone (mobile tel no.). Contact details are given above.

App 12: Demographic Information

(for individual interviews)

1. Code No.
2. Name
3. Gender
4. Age
5. Location/ Work address
6. SHA area
7. Employer (Trust/ PCT)
8. Size of Psychology Department (no. of staff)
9. Contact details (e-mail and tel.no.)
10. Specialism(s) and major client groups worked with
11. Grade/ Band
12. Part-time/ Full-time
13. Years since qualified
14. Registration/ accreditation with any professional organisation (e.g. BPS, DCP, BACP, UKCP)?
15. Additional post-qualification training in a therapeutic modality (e.g. psychodynamic psychotherapy, CAT, family therapy)?
16. Current supervision arrangements (type of supervision, how much, how often, type of supervisor)?

App 13: Consent Form

Version 1 (4th November 2005)

Title of the project: Reflective Practice and Continuing Professional Development among qualified Clinical Psychologists

Name of Researcher: Gundi Kiemle
Affiliation: North West Clinical Psychology CPD Scheme
Bolton, Salford & Trafford Mental Health NHS Trust

Name of Research Supervisor: Sue Clement
Affiliation: Dept. of Clinical Psychology, University of Hull

Please tick:

- ☐ I confirm that I have read and understood the information sheet dated ..... for the above study and have had the opportunity to ask questions.

- ☐ I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

- ☐ I agree for the interviews to be tape-recorded and for the tape-recording to be transcribed.

- ☐ I understand that the tapes and transcripts of my interviews will be stored in a locked filing cabinet in the researcher's home, in accordance with Data Protection Guidelines.

- ☐ I agree that any extracts from the transcripts of my interview may be included in the final write-up, but only on the condition that I shall have previously been asked for my specific permission to include them and that I shall have given my permission in writing.

- ☐ I understand that the tapes will be destroyed and the transcripts will be shredded at the end of the study.

- ❑ I understand that the study will be written up for publication in an academic journal, and I can receive a summary of the findings if I wish.

- ❑ I understand that my participation (or subsequent refusal to continue to participate) in this study will not have any bearing on any contact I might have with the North West Clinical Psychology CPD Scheme, either now or in the future.

- ❑ I agree to take part in the above study.

Name of Participant (Print) Date Signature

Name of Researcher (Print) Date Signature

(1 copy for participant, 1 copy for researcher)

App 14: Interview feedback form

Version 1 (4th November 2005)

COMMENTS/ FEEDBACK ON THE INTERVIEWS (PILOT AND SUBSEQUENT INTERVIEWS)

Did you find the interview too long/ too short/ about right?

Did you have sufficient information about the aims of the research study prior to taking part in the interview?

Was the procedure clearly explained to you? If no, please comment.

Were you able to answer the questions in sufficient depth?

Did you feel uncomfortable about any aspect of the interview? If so, please comment.

Space is provided below for any other feedback.

Thank you for your participation and time

App 15: All Codes List

```
|HU:  CPD & RP
File:  [c:\Latest version MasterCPD & RP]
Edited by: Super
Date/Time: 29/02/08 13:07:36
-----------------------------------------
Code-Filter: All
-----------------------------------------!
```

1. acceptance of emotional aspects of work
2. ambivalence about evidence-based practice
3. ambivalence about personal therapy to promote RP
4. anxiety/ uncertainty & drive for improvement
5. avoiding assumptions and getting feedback from service users
6. benefits and dangers of professionalisation
7. client benefits of RP
8. comparison of other pre-qual. courses
9. conscious/ unconscious competence
10. containment as a precursor to reflection
11. containment in reflection: example
12. CPD activity examples
13. CPD and desire to progress
14. CPD and evidence -based practice
15. CPD and formal training
16. CPD and funding issues
17. CPD and lifelong learning
18. CPD and need to keep updated
19. CPD and organisational needs
20. CPD and reading
21. CPD and safety to practice issues
22. CPD and sharing of information
23. CPD and striving for improvement
24. CPD and time pressures
25. CPD as a planned activity
26. CPD as challenging
27. CPD as the result of RP
28. CPD diverse perspectives
29. CPD in relation to clients' needs
30. CPD professional requirements
31. CPD to increase knowledge and skills repertoire
32. CPD, personal fulfilment and job satisfaction
33. CPD: interface btw. personal and professional motivation
34. CPD: learning from patients
35. creativity and aliveness to aid RP
36. critical stance towards psychology
37. Dealing with stuckness
38. developing reflection in others
39. difficulties in assessing RP potential in others
40. difficulties of linking RP to CPD
41. emotional safety in relationship context
42. emotional safety in work context
43. everything we do is CPD
44. evidence-based CPD
45. examination of self in session
46. example of RP: new and challenging work

47. factors inhibiting RP: lack of challenging others
48. factors inhibiting RP: lack of change
49. formal and informal CPD
50. helpful factors: acceptance of personal/ professional interface
51. helpful factors: admin support
52. helpful factors: adversity as a challenge
53. helpful factors: assertiveness
54. helpful factors: core needs
55. helpful factors: listening skills
56. helpful factors: presence of reflective other
57. helpful factors: protected space/ time
58. impact/ influence of philosophical understanding
59. influence of social role on professional practice
60. influencing factcors: social conscience
61. influencing factors from everyday life
62. influencing factors: experience of different services
63. influencing factors: experiential learning
64. influencing factors: faith
65. influencing factors: focus on outcome
66. influencing factors: interest in personal development
67. influencing factors: involvement in training
68. influencing factors: learning from others
69. influencing factors: maturity
70. influencing factors: personal therapy
71. Influencing factors: personality
72. influencing factors: positive role-models
73. influencing factors: proof of competence
74. influencing factors: psychodynamic exposure
75. influencing factors: RP and rewarding struggle
76. influencing factors: supervision
77. influencing factors: support for development
78. influencing factors: theory-practice link
79. influencing factors: therapeutic training
80. influencing factors: trainees
81. inhibiting factor: dogmatic stance
82. inhibiting factor: hopelessness
83. inhibiting factors: blindspots
84. inhibiting factors: comfort zone
85. inhibiting factors: need for evidence base
86. inhibiting RP: lack of time
87. inhibiting RP: not accepted or valued
88. inhibiting RP: pathologising the use of the self in professional practice
89. inhibiting RP: perceived as attacking
90. inhibiting RP: performance pressure
91. inhibiting RP: personal stress
92. inhibiting RP: resource pressure
93. inter-professional perspectives
94. interface between personal self and work
95. interview as RP activity
96. intra-professional differences
97. involving service users in decision making
98. keeping up-to-date
99. learning from mistakes
100. learning from observing oneself
101. learning from unhelpful influences
102. legitimising RP as work

103. limitations of solo RP
104. limited impact of personal therapy on clinical practice
105. line management and RP/CPD issues
106. live supervision to help RP
107. managerial support
108. meaning of reflection - external gaze
109. meaning of reflection - mirror to self
110. need for challenging reflection
111. need for external feedback from others
112. negative influences on practice
113. opportunistic reflection in crises
114. opportunistic RP
115. organisational benefits of RP
116. organisational complacency
117. organisational influence on RP
118. organisational priorities and RP
119. own internal capacity for supervision
120. peer-based, collaborative reflection
121. performance monitoring (self)
122. personal therapy and empathy with client's position
123. personal therapy for RP
124. personal therapy: mandatory v. obligatory
125. pre-qualification training influence on RP development
126. presence of other(s) as inhibiting RP
127. Proscribed approaches as a hindrance to RP
128. quality control and accountability
129. reading as a prompt to RP
130. reflecting endlessly
131. reflecting through questions
132. reflection - action bias
133. reflection - action link
134. reflection - action, not reaction
135. reflection about failure & learning from success
136. reflection as a motivator for CPD
137. reflection implicit and constant
138. Reflection in mentoring
139. reflective organisation
140. reflective S/V as essential
141. reflective stance in CPD
142. reviewing practice to identify alternative actions
143. reviewing tapes of practice by oneself
144. risk factors for poor practice
145. risks of longterm routine practice
146. role of training courses re personal therapy
147. RP & CPD loop: affective outcomes
148. RP ability range
149. RP and boundaries
150. RP and certainty/ uncertainty
151. RP and CPD directional link
152. RP and CPD loop
153. RP and dilemmas
154. RP and empowerment
155. RP and ethics
156. RP and evidence-based practice
157. RP and freeze-frame function
158. RP and gut instinct
159. RP and need for space

160. RP and need for structure
161. RP and pause button function
162. RP and professional identity
163. RP and relation to outcomes
164. RP and S/V link
165. RP and safety to practice issues
166. RP and satisfcation
167. RP and sense of entitlement
168. RP and skills development
169. RP and supervision
170. RP and teams
171. RP and uncertainty
172. RP and values
173. RP as a culture
174. RP as a form of CPD
175. RP as a questioning stance
176. RP as a risky activity
177. RP as a struggle
178. RP as a valid and valued activity
179. RP as creative process
180. RP as critical thinking
181. RP as deliberate process
182. RP as empathy with service user
183. RP as essential
184. RP as making the unconscious conscious
185. RP as motivated by self
186. RP as professional health check
187. RP as state of mind
188. RP changes in pre/ post qualified
189. RP defined by its opposite
190. RP example from work
191. RP for clients' benefit
192. RP for constructive management
193. RP for improvement
194. RP for support
195. RP for systemic perspective
196. RP in order to keep an open mind
197. RP in risk assessment
198. RP inhibiting factor: anxiety
199. RP inhibiting factor: personal life events
200. RP inhibiting factors: boundaries
201. RP inhibiting factors: fear of being judged
202. RP inhibiting factors; assessment
203. RP specific to clinical psychology
204. RP subjectivity
205. RP survival tactics
206. RP through service user contact
207. RP through use of formulation
208. RP to facilitate flexible approach
209. RP to influence personal life
210. RP to modify practice
211. RP via continuous feedback on activity
212. RP/CPD link: knowing and not knowing
213. S/V and safe space
214. S/V and value
215. S/V contract
216. S/V for emotional validation

217. S/V style
218. supervision and RP development as a trainee
219. supervision in CPD
220. support for RP
221. teaching RP
222. theories of change & effect on practice
223. time management
224. unconscious RP/ CPD link
225. understanding theoretical underpinnings of models and therapies
226. unplanned CPD
227. use and abuse of psychologists' power
228. use of personal material to help clinical practice
229. use of reflection as a therapeutic intervention
230. use of supervision as RP: example
231. use of tapes in supervision
232. valueing the use of self as a professional tool

App 16: All Code Families List

HU: CPD & RP
File: [c:\Latest version MasterCPD & RP]
Edited by: Super
Date/Time: 29/02/08 12:51:10

Code Families

Code Family: 1 (a) reflection on action, and reflection about the self
Created: 14/01/07 16:47:42 (Super)

Comment:
1 (a) reflection on action, and reflection about the self:

- reflection as the "pause-button"
- making changes to practice
- examination of the self
- systemic perspectives
- dealing with uncertainty

Codes (13)
[examination of self in session] [learning from mistakes] [meaning of reflection - external gaze] [meaning of reflection - mirror to self] [reflecting through questions] [RP and certainty/ uncertainty] [RP and freeze-frame function] [RP and pause button function] [RP and teams] [RP as critical thinking] [RP as deliberate process] [RP as professional health check] [RP for systemic perspective]

Code Family: 1 (b) influences in development
Created: 14/01/07 16:53:45 (Super)

Comment:
1 (b) influences in development

- personality
- pre-qualification training
- psychodynamic/ sytemic exposure
- positive role-models
- the self as part of the wider community

Codes (15)
[influence of social role on professional practice] [influencing factcors: social conscience] [influencing

factors: personal therapy] [Influencing factors: personality] [influencing factors: positive role-models] [influencing factors: psychodynamic exposure] [influencing factors: supervision] [influencing factors: therapeutic training] [limited impact of personal therapy on clinical practice] [personal therapy and empathy with client's position] [personal therapy for RP] [personal therapy: mandatory v. obligatory] [pre-qualification training influence on RP development] [RP ability range] [supervision and RP development as a trainee]

Code Family: 1 (c) essential reflection and professional identity
Created: 14/01/07 16:58:41 (Super)

Comment:
1 (c) esential reflection and professional identity

- reflectiona s essential and fundamental
- reflection and professioanl identity

Codes (7)
[reflection implicit and constant] [RP and professional identity] [RP and values] [RP as critical thinking] [RP as essential] [RP as state of mind] [RP through use of formulation]

Code Family: 2 (a) supervision as the reflective space
Created: 14/01/07 17:39:00 (Super)

Comment:
2 (a) supervision as the reflective space

- reflective practice and supervision
- supervision style

Codes (5)
[RP and need for structure] [RP and S/V link] [RP and supervision] [S/V contract] [S/V style]

Code Family: 2 (b) containment and emotional safety
Created: 14/01/07 17:41:00 (Super)

Comment:
2 (b) containment and emotional safety

- work as emotional business
- the safe container

Codes (8)
[acceptance of emotional aspects of work] [containment as a precursor to reflection] [containment in reflection: example] [emotional safety in relationship context] [emotional safety in work context] [helpful factors: listening skills] [interface between personal self and work] [valueing the use of self as a professional tool]

Code Family: 2 (c) enablers in reflective practice
Created: 14/01/07 17:43:16 (Super)

Comment:
2 (c) enablers in reflective practice

- protected space and time
- need for others
- value and support

Codes (22)
[helpful factors: acceptance of personal/ professional interface] [helpful factors: admin support] [helpful factors: assertiveness] [helpful factors: presence of reflective other] [helpful factors: protected space/ time] [influencing factors: learning from others] [legitimising RP as work] [limitations of solo RP] [managerial support] [need for challenging reflection] [need for external feedback from others] [opportunistic reflection in crises] [opportunistic RP] [peer-based, collaborative reflection] [Reflection in mentoring] [RP and need for space] [RP as a culture] [RP as a valid and valued activity] [RP as making the unconscious conscious] [S/V and value] [support for RP] [time management]

Code Family: 2 (d) obstacles in reflective practice
Created: 14/01/07 17:49:15 (Super)

Comment:
2 (d) obstacles in reflective practice

- time and performance pressures
- fear of being judged
- lack of valueing and support

- personal stress
- comfort zone
- blind spots
- proscibed reflection

Codes (23)
[CPD and funding issues] [CPD and time pressures] [factors inhibiting RP: lack of challenging others] [factors inhibiting RP: lack of change] [inhibiting factors: blindspots] [inhibiting factors: comfort zone] [inhibiting factors: need for evidence base] [inhibiting RP: lack of time] [inhibiting RP: not accepted or valued] [inhibiting RP: performance pressure] [inhibiting RP: personal stress] [inhibiting RP: resource pressure] [line management and RP/CPD issues] [negative influences on practice] [organisational priorities and RP] [presence of other(s) as inhibiting RP] [Proscribed approaches as a hindrance to RP] [RP inhibiting factor: anxiety] [RP inhibiting factor: personal life events] [RP inhibiting factors: boundaries] [RP inhibiting factors: fear of being judged] [RP inhibiting factors; assessment] [RP survival tactics]

Code Family: 3 (a) reflective practice, CPD, and enhanced service provision
Created: 14/01/07 18:05:38 (Super)

Comment:
3 (a) reflective practice, CPD, and enhanced service provision

- reflective practice and client benefits
- CPD examples
- CPD and service improvement
- dilemmas and conflicts

Codes (17)
[client benefits of RP] [CPD and desire to progress] [CPD and formal training] [CPD and need to keep updated] [CPD and striving for improvement] [CPD in relation to clients' needs] [CPD to increase knowledge and skills repertoire] [Dealing with stuckness] [inter-professional perspectives] [keeping up-to-date] [organisational benefits of RP] [reading as a prompt to RP] [reflective stance in CPD] [RP and dilemmas] [RP for clients' benefit] [RP for improvement] [RP to facilitate flexible approach]

Code Family: 3 (b) clinical governance
Created: 14/01/07 18:12:48 (Super)

Comment:
3 (b) clinical governance

- performance monitoring
- safety to practice
- risk factors for poor practice

Codes (13)
[benefits and dangers of professionalisation] [CPD and safety to practice issues] [meaning of reflection - external gaze] [performance monitoring (self)] [quality control and accountability] [risk factors for poor practice] [risks of longterm routine practice] [RP and boundaries] [RP and evidence-based practice] [RP and safety to practice issues] [RP as motivated by self] [supervision in CPD] [use and abuse of psychologists' power]

Code Family: 3 (c) professional requirements
Created: 14/01/07 18:24:16 (Super)

Comment:
3 (c) professional requirements

- BPS/ DCP requirements for reflective practice and CPD

Codes (6)
[CPD and evidence -based practice] [CPD and need to keep updated] [CPD and organisational needs] [CPD professional requirements] [organisational influence on RP] [reflective organisation]

Code Family: 4 (a) reflection leading to action
Created: 14/01/07 18:33:46 (Super)

Comment:
4 (a) reflection leading to action

- reflection - action link
- problems with the reflection - action link

Codes (6)
[reflection - action bias] [reflection - action link]

[reflection - action, not reaction] [RP and CPD loop] [RP as deliberate process] [use of supervision as RP: example]

Code Family: 4 (b) reflection and CPD
Created: 14/01/07 18:38:06 (Super)

Comment:
4 (b) reflection and CPD

- planned v. unplanned CPD
- reflection leading to CPD
- reflecting on CPD

Codes (10)
[anxiety/ uncertainty & drive for improvement] [CPD as a planned activity] [CPD as the result of RP] [difficulties of linking RP to CPD] [formal and informal CPD] [learning from observing oneself] [reflection as a motivator for CPD] [reflective stance in CPD] [RP and CPD directional link] [RP and CPD loop]

Code Family: 4 (c) reflective practice as CPD
Created: 14/01/07 18:42:53 (Super)

Comment:
4 (c) reflective practice as CPD

- reflective practice as one form of CPD

Codes (9)
[influencing factors: experiential learning] [live supervision to help RP] [reviewing tapes of practice by oneself] [RP and CPD directional link] [RP and CPD loop] [RP and skills development] [RP as a form of CPD] [RP to modify practice] [use of tapes in supervision]

Code Family: 4 (d) CPD and life-long learning
Created: 14/01/07 18:46:52 (Super)

Comment:
4 (d) CPD and life-long learning

- CPD forever
- creativity and satisfaction

Codes (4)

[CPD and lifelong learning] [CPD as challenging] [CPD, personal fulfilment and job satisfaction] [creativity and aliveness to aid RP]

App 17: All Codes x All Participants Frequency Table

HU: CPD & RP
File: [c:\Latest version MasterCPD & RP]
Edited by: Super
Date/Time: 29/02/08 13:01:20

Codes-Primary-Documents-Table

Code-Filter: All
PD-Filter: All

	PRIMARY DOCS															
CODES	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16 Totals
acceptance of emotio	2	0	1	0	0	0	0	0	0	0	0	0	1	2	0	0 6
ambivalence about ev	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0 1
ambivalence about pe	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0 1
anxiety/ uncertainty	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0 4
avoiding assumptions	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0 1
benefits and dangers	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0 1
client benefits of R	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0 1
comparison of other	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0 1
conscious/ unconscio	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0 2
containment as a pre	1	0	1	0	0	0	0	0	0	0	0	0	2	0	0	0 4
containment in refle	1	1	0	0	0	0	0	0	0	0	0	0	3	1	0	0 6
CPD activity example	0	0	7	4	0	3	0	0	1	0	0	0	2	0	0	0 17
CPD and desire to pr	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0 1
CPD and evidence -ba	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0 1
CPD and formal train	0	0	0	0	0	0	0	0	1	0	0	1	0	0	1	2 5
CPD and funding issu	0	0	1	0	0	1	0	0	2	1	2	0	0	0	0	0 7
CPD and lifelong lea	0	0	2	0	0	1	1	3	1	0	0	0	0	0	2	0 10
CPD and need to keep	2	4	0	1	0	0	1	1	1	1	0	0	0	1	0	0 12
CPD and organisation	1	0	1	0	0	0	0	0	1	2	1	0	0	1	4	0 11
CPD and reading	0	0	0	0	0	0	0	0	3	1	0	0	0	0	0	0 4
CPD and safety to pr	0	1	0	0	0	0	1	0	0	0	0	0	0	0	1	0 3
CPD and sharing of i	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0 1

CPD and striving for	0	1	0	0	0	0	1	0	0	0	0	0	0	1	0	0	3
CPD and time pressur	0	2	1	0	0	0	1	0	3	0	0	0	0	0	0	0	7
CPD as a planned act	0	3	0	0	3	0	2	0	0	0	1	0	0	1	0	0	10
CPD as challenging	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	2
CPD as the result of	0	3	0	0	1	1	0	0	2	0	2	0	0	0	0	0	9
CPD diverse perspect	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
CPD in relation to c	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	2
CPD professional req	0	0	1	1	2	3	0	3	4	1	2	0	0	1	3	3	24
CPD to increase know	1	1	0	0	0	1	1	1	0	0	0	1	0	0	0	0	6
CPD, personal fulfil	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	2
CPD: interface btw.	0	0	0	0	0	0	0	0	0	3	0	0	0	1	2	0	6
CPD: learning from p	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
creativity and alive	2	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	3
critical stance towa	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0	4
Dealing with stuckne	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
developing reflectio	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	2
difficulties in asse	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
difficulties of link	0	0	0	0	1	1	0	0	0	0	2	1	0	0	0	0	5
emotional safety in	4	0	4	1	0	1	0	2	2	0	3	0	0	3	0	0	20
emotional safety in	2	0	0	0	0	0	0	0	0	3	0	3	0	0	0	0	8
everything we do is	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
evidence-based CPD	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	2
examination of self	1	0	0	0	0	1	2	0	0	0	0	0	0	0	0	0	4
example of RP: new a	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
factors inhibiting R	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
factors inhibiting R	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
formal and informal	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	2
helpful factors: acc	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
helpful factors: adm	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
helpful factors: adv	0	0	0	0	0	0	0	0	0	0	2	0	1	0	0	0	3
helpful factors: ass	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
helpful factors: cor	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	2
helpful factors: lis	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	3
helpful factors: pre	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2
helpful factors: pro	0	1	0	0	0	0	2	0	6	0	2	2	1	0	2	1	17
impact/ influence of	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
influence of social	1	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	3
influencing factcors	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
influencing factors	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	2
influencing factors:	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	2

influencing factors:	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	2
influencing factors:	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
influencing factors:	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
influencing factors:	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	2
influencing factors:	0	0	0	0	1	0	1	0	0	0	0	0	1	0	0	0	3
influencing factors:	0	2	1	0	1	0	0	0	0	0	0	1	0	0	3	0	8
influencing factors:	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
influencing factors:	0	0	2	0	0	1	0	0	0	1	0	0	1	0	0	0	5
Influencing factors:	0	0	1	0	1	1	1	0	0	1	1	1	0	0	0	1	8
influencing factors:	0	3	0	1	0	0	1	0	0	0	0	1	1	1	2	1	11
influencing factors:	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
influencing factors:	0	0	0	0	0	0	0	0	0	0	0	0	3	3	0	1	7
influencing factors:	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
influencing factors:	0	0	0	0	0	1	0	4	0	1	1	2	0	0	2	3	14
influencing factors:	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
influencing factors:	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	2
influencing factors:	0	0	0	1	0	0	0	0	0	0	0	1	1	2	0	0	5
influencing factors:	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	2
inhibiting factor: d	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
inhibiting factor: h	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
inhibiting factors:	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
inhibiting factors:	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	2
inhibiting factors:	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
inhibiting RP: lack	0	2	1	1	1	0	1	0	2	0	0	2	1	0	1	1	13
inhibiting RP: not a	0	0	0	0	0	2	2	0	1	0	0	0	0	0	0	0	5
inhibiting RP: patho	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
inhibiting RP: perce	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
inhibiting RP: perfo	0	2	2	0	0	3	2	2	6	1	1	2	3	2	2	0	28
inhibiting RP: perso	0	0	0	0	0	0	1	0	0	0	2	1	0	1	0	0	5
inhibiting RP: resou	0	0	0	0	0	2	0	0	2	0	0	0	0	0	0	0	4
inter-professional p	0	1	0	0	1	3	4	0	2	0	1	0	0	0	0	1	13
interface between pe	1	0	0	0	0	2	1	0	0	2	2	2	0	0	0	0	10
interview as RP acti	0	0	0	0	0	0	0	1	0	0	0	1	0	2	0	0	4
intra-professional d	0	0	0	0	0	0	2	0	0	0	1	0	0	0	0	0	3
involving service us	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
keeping up-to-date	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
learning from mistak	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	2
learning from observ	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
learning from unhelp	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
legitimising RP as w	1	0	1	1	0	1	0	0	0	0	0	0	0	0	0	0	4

limitations of solo	3	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	4
limited impact of pe	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
line management and	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	2
live supervision to	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
managerial support	0	0	2	1	0	0	1	1	1	1	0	0	1	1	0	1	10
meaning of reflectio	1	0	0	0	0	4	1	0	1	1	0	0	1	2	1	0	12
meaning of reflectio	1	0	0	1	0	1	1	0	1	0	0	2	1	2	1	0	11
need for challenging	1	0	0	0	2	0	0	0	0	0	0	0	0	0	2	0	5
need for external fe	2	0	1	0	1	0	0	0	0	2	0	0	0	0	2	0	8
negative influences	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
opportunistic reflec	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
opportunistic RP	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	1	3
organisational benef	0	0	0	0	0	0	0	0	3	1	1	0	2	0	0	0	7
organisational compl	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
organisational influ	2	1	2	1	1	1	1	1	0	1	2	2	1	4	1	1	22
organisational prior	0	2	0	0	0	0	0	0	1	0	0	0	1	0	0	0	4
own internal capacit	1	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	3
peer-based, collabor	1	0	0	1	3	2	4	1	2	3	0	4	1	2	0	0	24
performance monitori	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
personal therapy and	1	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	3
personal therapy for	0	0	0	0	0	2	0	0	0	1	0	1	0	1	0	0	5
personal therapy: ma	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
pre-qualification tr	0	1	2	4	4	4	2	5	2	2	0	2	2	0	0	2	32
presence of other(s)	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	2
Proscribed approache	1	0	0	0	0	2	0	0	0	0	2	1	0	0	0	0	6
quality control and	3	4	2	0	5	2	2	1	3	0	0	0	0	0	0	0	22
reading as a prompt	0	0	0	0	1	0	2	1	0	2	0	0	0	0	0	0	6
reflecting endlessly	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
reflecting through q	0	0	0	0	0	0	3	0	0	0	1	0	0	2	0	0	6
reflection - action	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
reflection - action	0	0	1	2	3	5	3	1	2	3	4	6	1	2	1	2	36
reflection - action,	0	0	0	0	0	0	2	0	0	0	1	1	1	2	2	0	9
reflection about fai	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1	3
reflection as a moti	1	0	0	0	0	1	0	0	1	0	0	0	0	0	0	1	4
reflection implicit	0	0	0	0	0	0	0	0	1	1	0	2	0	1	0	0	5
Reflection in mentor	0	0	0	0	0	0	0	0	0	1	0	2	0	0	2	0	5
reflective organisat	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	2
reflective S/V as es	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
reflective stance in	0	0	0	1	0	2	1	1	2	0	0	0	0	0	5	0	12
reviewing practice t	1	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	3

reviewing tapes of p	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
risk factors for poo	1	2	0	0	4	2	0	0	0	0	1	0	0	0	0	0	10
risks of longterm ro	1	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	3
role of training cou	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
RP & CPD loop: affec	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
RP ability range	0	0	0	0	0	0	0	1	0	0	3	3	0	0	0	1	8
RP and boundaries	0	0	0	0	0	0	0	0	0	3	0	0	1	1	2	1	8
RP and certainty/ un	0	0	0	0	0	0	0	7	0	0	1	0	1	2	0	0	11
RP and CPD direction	0	0	2	1	0	2	3	1	1	2	1	6	2	3	0	1	25
RP and CPD loop	0	3	0	3	2	6	4	1	3	2	0	3	1	2	2	2	34
RP and dilemmas	0	0	0	0	0	2	2	0	0	1	1	0	0	0	0	0	6
RP and empowerment	0	0	0	0	0	0	0	2	0	0	0	0	0	1	0	0	3
RP and ethics	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	2
RP and evidence-base	0	1	0	0	1	0	0	1	0	0	0	0	0	0	0	0	3
RP and freeze-frame	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
RP and gut instinct	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
RP and need for spac	0	0	2	1	1	1	0	2	2	0	0	1	1	0	0	0	11
RP and need for stru	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	2
RP and pause button	1	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	3
RP and professional	0	2	0	0	0	3	8	0	4	2	1	0	0	0	0	0	20
RP and relation to o	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
RP and S/V link	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2
RP and safety to pra	1	2	0	2	0	0	6	0	1	2	1	0	2	0	4	1	22
RP and satisfcation	0	0	0	0	0	1	1	0	0	0	1	3	0	0	0	0	6
RP and sense of enti	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
RP and skills develo	1	2	0	0	0	0	1	0	0	0	0	0	0	0	0	0	4
RP and supervision	0	0	2	6	3	4	5	3	9	2	2	4	2	1	3	2	48
RP and teams	0	0	0	0	0	2	2	0	1	1	0	0	0	0	0	0	6
RP and uncertainty	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
RP and values	0	0	0	0	0	0	0	0	0	0	4	1	0	1	0	0	6
RP as a culture	0	0	0	0	0	0	0	0	0	0	0	0	1	2	0	0	3
RP as a form of CPD	2	0	2	0	0	1	0	1	0	0	2	2	4	1	0	4	19
RP as a questioning	0	0	0	0	0	0	0	2	0	0	1	0	1	0	0	1	5
RP as a risky activi	0	0	0	0	0	0	0	1	0	0	2	0	0	0	0	1	4
RP as a struggle	0	0	0	0	0	1	0	1	0	0	0	2	0	0	0	0	4
RP as a valid and va	0	0	0	0	0	2	2	1	4	0	1	2	1	0	0	0	13
RP as creative proce	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1
RP as critical think	0	0	0	0	2	3	1	2	0	0	6	1	0	0	0	2	17
RP as deliberate pro	0	1	0	0	0	0	4	0	1	1	1	1	0	1	0	0	10
RP as empathy with s	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1

RP as essential	0	0	0	0	0	0	0	0	0	1	0	1	3	0	0	1	6
RP as making the unc	0	0	0	0	0	0	2	1	0	0	0	0	0	3	0	0	6
RP as motivated by s	0	5	0	1	0	0	0	0	0	0	0	0	0	0	0	0	6
RP as professional h	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
RP as state of mind	0	0	0	1	0	0	2	2	0	0	2	2	0	0	0	0	9
RP changes in pre/ p	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	2
RP defined by its op	0	0	0	2	0	0	0	1	0	0	0	0	0	1	0	0	4
RP example from work	0	0	0	1	1	2	5	1	0	1	1	2	0	2	0	1	17
RP for clients' bene	0	0	0	0	0	0	0	0	0	0	1	2	1	0	0	1	5
RP for constructive	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
RP for improvement	0	3	0	0	1	0	3	0	1	2	0	3	0	0	0	0	13
RP for support	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
RP for systemic pers	0	0	0	0	0	0	1	2	0	0	1	0	1	1	2	6	14
RP in order to keep	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
RP in risk assessmen	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
RP inhibiting factor	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0	2
RP inhibiting factor	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	3
RP inhibiting factor	0	0	4	1	0	0	0	0	2	0	0	0	0	0	0	0	7
RP inhibiting factor	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	2
RP inhibiting factor	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
RP specific to clini	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
RP subjectivity	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
RP survival tactics	0	0	0	0	0	0	0	2	1	0	0	0	0	0	0	0	3
RP through service u	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
RP through use of fo	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	2
RP to facilitate fle	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
RP to influence pers	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
RP to modify practic	0	0	0	0	0	0	0	1	0	0	3	2	0	0	0	0	6
RP via continuous fe	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	2
RP/CPD link: knowing	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
S/V and safe space	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
S/V and value	0	0	0	0	0	1	0	0	2	0	0	0	1	0	0	0	4
S/V contract	0	0	0	2	0	0	0	1	0	0	0	0	0	0	0	0	3
S/V for emotional va	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
S/V style	0	0	0	3	1	0	2	0	0	1	0	1	0	0	2	0	10
supervision and RP d	1	0	3	0	0	1	0	1	0	0	0	1	0	0	0	0	7
supervision in CPD	1	0	0	0	2	0	2	1	0	0	0	0	0	0	0	1	7
support for RP	0	0	0	0	0	2	0	0	0	2	0	1	0	0	0	0	5
teaching RP	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	3
theories of change &	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	2

time management	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
unconscious RP/ CPD	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
understanding theore	1	0	0	0	0	2	1	0	1	0	0	0	0	0	0	0	5
unplanned CPD	0	0	0	0	2	0	1	0	0	0	0	0	0	0	0	0	3
use and abuse of psy	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	2
use of personal mate	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	2
use of reflection as	1	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	3
use of supervision a	2	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	3
use of tapes in supe	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	2
valueing the use of	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Totals	79	75	63	52	66	101	121	79	104	74	79	98	61	74	70	53	1249