CLINICAL PSYCHOLOGY TRAINING AND PREPARATION FOR MULTIDISCIPLINARY TEAM WORKING: A GROUNDED THEORY MODEL AND THE REFRAMING OF REFLECTIVE PRACTICE

by

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A THESIS SUBMITTED TO THE UNIVERSITY OF BIRMINGHAM FOR THE DEGREE OF DOCTOR OF CLINICAL PSYCHOLOGY

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May 2016

THESIS OVERVIEW

Clinical Psychology Training and Preparation for Multidisciplinary Team Working: A Grounded Theory Model and the Reframing of Reflective Practice

This research explains how recently qualified clinical psychologists described clinical psychology training as preparing them for multidisciplinary team working. Grounded theory methodology was adopted. Eleven clinical psychologists participated in one semi-structured interview. Training was described around, 'Doing the work,' 'Clinical supervisor,' 'Placements cultures' and 'Peer group.' Data is explained through three theoretical categories of a grounded theory model. 'Trust and exposure' to MDT working provided a foundation for 'Inclusion and belonging,' leading to 'Sense making and discovery.' Making sense of MDT experiences required trainee clinical psychologists to engage with risk in reflection and in relationships, with supervisors, peers and themselves. Supervisors' proximity to MDTs mediated trainees' exposure to MDT working. Implications for providers of clinical psychology training included the need to develop openness in trainees' reflection, and to explore varieties of risk encountered during training. The subsequent systematic literature review explores the evidence for reflective practice as a meaningful and valued aspect of clinical psychology training. The nine reviewed papers' methodological quality was weak to moderate. Definitions of reflective practice varied whilst a sizeable minority of trainee clinical psychologists experienced distress, low value or resistance to group-based reflective practice. Learning mechanisms in trainees' reflective engagement are yet to be established. Skilled facilitation was crucial to groups' commitment to reflective engagement. Self-

acceptance and relating skills were important to individuals' development. An action research process to develop a psychological model for reflective skills development was proposed. Interventions would tailor training activities to individuals' process-based needs. Recommendations for further research are described.

ACKNOWLEDGEMENTS

In supporting my preparation and production of this research and literature review, I am grateful to Professor John Rose for constructive feedback and discussions that helped to develop my thinking. Also at the University of Birmingham, I appreciated Professor Gerry Riley's thoughtfulness and approach to appraisal tutoring. Dr Michelle Fisher also provided good listening and perspective as past and possible placements were weighed up. Otherwise, I learned much from my training peers and am grateful to the administration team and the in-house and associate teaching staff of Birmingham's Doctorate of Clinical Psychology. Each placement supervisor and line manager demonstrated a unique style, which were collectively good for confirming that our clinical psychologist roles can legitimately be inhabited with difference. Similarly, those multidisciplinary teams that I worked with were always good for confirming how important the present research topic is. And before all of this could be realized, it was through Katy Vigurs, Becky Daw, Ruth Springthorpe, Christine O'Neill and Harriette Marshall that I came to believe that my returning to Psychology was viable, and might even be a good idea. For all support, I am sincerely grateful.

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WHICH ASPECTS OF THEIR PROFESSIONAL TRAINING DO RECENTLY QUALIFIED CLINICAL PSYCHOLOGISTS DESCRIBE AS BEST PREPARING THEM FOR MULTIDISCIPLINARY TEAM WORKING?

[Paper to be edited for submission to *Journal of Occupational and Organizational Psychology*]

ABSTRACT

Objectives – The objective of the study was to explore the ways in which recently qualified clinical psychologists described experiences of doctorate training that prepared them for multidisciplinary team working. These accounts were located in a context of clinical psychologists' professional roles rapidly evolving.

Design – An exploratory grounded theory methodology was adopted.

Methods - Eleven recently qualified clinical psychologists, each with training and post-qualification experience of MDT working, participated in one individual semi-structured interview.

Results – The clinical psychologists acknowledged opportunities for MDT working during training. The extent to which these were embraced relied on trainees diminishing their focus on direct individual therapy. Training experiences were described around four main categories, 'Doing the work,' 'Clinical Supervisor,' 'Placements Cultures' and 'Peer Group.' Data is explained through three theoretical categories of a nested grounded theory model. 'Trust and exposure' to MDT working provides a foundation for 'Inclusion and belonging,' which leads to 'Sense making and discovery.' To make sense of MDT experiences requires trainee clinical psychologists to engage with risk in reflection and in relationships, with clinical supervisors, peers and themselves.

Conclusion – Trainee clinical psychologists engagement with MDT working can indicate their understanding of the clinical psychologist role. Clinical supervisors' own relational and physical proximity to MDTs can facilitate or inhibit trainees' exposure to MDT working. Implications for providers of clinical psychology training included the

need to develop openness in trainees' reflection, and to explore the varieties of risk that are encountered during training.

INTRODUCTION

Clinical Psychology and Working with Teams

Changes in the professional landscape for clinical psychologists were noted in 'New Ways of Working,' with the invitation to locate Clinical Psychology within a wider complex of socio, medico and health organizational contexts, and in so doing suggested the more educative role of 'psychologizing teams' (Onyett, 2007; Christofides, Johnstone and Musa, 2012). The task of developing the psychological-mindedness and work-based learning of fellow health and social care professionals typically occurs through the provision of training – commonly in techniques associated with cognitive behavioural therapy, but also through clinical supervision. Such roles exist alongside the traditional direct therapeutic work that is associated with clinical psychology. In this context, it is now common for clinical psychologists to work alongside multidisciplinary colleagues from medicine, psychiatry, nursing, occupational therapy, social care, and beyond. Whilst general guidelines encourage tentativeness in the use of psychological formulation with teams (Division of Clinical Psychology, 2011; Onyett, 2007), there is not, currently, a unified or singular approach that psychologists employ in terms of *how* they work with multidisciplinary teams. As such, it may be that clinical psychologists' approaches to working with multidisciplinary teams vary substantially.

In New Ways of Working, Onyett (2007, p. 6) utilizes the definition of a team outlined by West (2004). This begins with the presence of members with different and defined roles working together to achieve shared objectives. Teams have as many members as are required to perform team tasks, have the opportunity to review team

performance and how it could be improved, and will have a team identity such that others recognize the team as such. Variations in clinical psychologists' work with teams will in part reflect variations in the position of Clinical Psychology as core or peripheral to teams, with the clinical psychologist integrated or separate from the team. Variation in psychologists' integration and subsequent practices will be reflected in the extent to which generic team tasks and processes, such as conducting initial assessments and participating in client review and team meetings, are undertaken. Further variations can occur in the formality surrounding referral processes for the input of psychologists, and in their physical location in or apart from teams. At an operational level, whether the psychologist is managed from within a team could also inform their integration or separation. Across different services, the roles that clinical psychologists perform can within teams can include providing direct individual and group therapy to service users, modeling values-based practice, leading reflective practice, providing individual and group supervision to staff, and undertaking service improvement, development and evaluation work. In recent years, psychologists utilising core formulation skills in collaboration with MDT colleagues has been recognized in the emerging literature on the use of case formulation in teams (Johnstone, Whomsley, Cole and Oliver, 2011; Cole, Wood and Spendelow, 2015; Dexter-Smith, 2015; Unadkat, Quinn, Jones and Casares, 2015). Johnstone (2014, 2015) suggests that at its best, team formulation can provide the structure and emotional containment for staff that begins to enable cultures to shift towards psychosocial models of understanding people's distress and difficulties. This posits the team-based psychologist as a potential leader of change. Skinner, Toogood, Cate, Jones, Prescott, Coak… Rooney (2010) describe clinical, professional and strategic drivers for clinical psychologists' fulfillment of clinical, team and organizational

development roles. Emphasising the relational skills of clinical psychologists, this can include developing networks, and encouraging contributions, closer collaboration and working in partnership in complex systems and decision-making processes. The literature discussing professionals', teams' and service users' experiences of Clinical Psychology in the post New Ways of Working era is in its infancy. Some organizational challenges and helpful insights from practicing professionals have begun to emerge, though.

In terms of the experience of teams being required to adjust to and increase their inter-profession collaboration within the context of devising and implementing a care pathway within an acute adult mental health setting, research has identified policy direction being towards greater MDT working (Jones, 2006). In his action research study featuring nurses, social workers, occupational therapists, junior and senior medical staff, and a psychologist, Jones observed 'professional defensiveness' as participants discussed their roles and functions – in a sense, the resistance of blurred professional boundaries. Within a context of all professional groups claiming to work with a specific aspect of patients' illness, a protectionist mentality saw 'jealous guarding against giving away any of this ground.' In a scathing critique, an 'intriguing finding [was] the readiness for some clinicians to establish for themselves a mandate to critique their colleagues… achieved by exploiting a perceived position of power to expose perceived faults in practice' (p. 26). Specific points of inter-professional challenge concerned the evidence base on which some clinicians practice, and the effectiveness and efficacy of their practice. Where there appeared to be greater concern for protecting a professional image, this was said to effect the acceptance of the new way of structuring patient care. Implicit to Jones' account is participants' experience of

vulnerability - feeling at risk - from other professions.

In a grounded theory study that modelled clinical psychologists' perceptions of risk and recovery, the authors describe individual practitioners' own limitations and organizational cultures denying recovery-oriented approaches being integrated into practice (Tickle, Brown and Hayward, 2012, p. 99). Narrow conceptions of risk were said to be problematic, with professionals' accountability concerns regarding harm and danger outweighing consideration of the risk of social exclusion and poverty to service-users. To move organizations' cultures towards being better able to incorporate recovery-based practice, it is suggested that the collaborative construction of cultures that reward behaviours which support change, innovation and even risk would be desirable. The ideal, here, would be to transform cultures of blame into cultures of learning, where professionals, service-users and carers sharing decision-making and responsibility would reduce anxieties about risk and create the possibility of positive risk taking to promote recovery (Garside, 1995; Senge, 1990). Whilst the need for collaboration positions singular professions as unlikely to shift cultures, it would be helpful to this study to understand how clinical psychologists seek to work across professional boundaries. This is especially pertinent to settings that are consistently described as difficult in establishing deeply collaborative MDT working.

In a study of clinical psychologists' accounts of their use of case formulation in MDT settings, the merits of informally offering psychological perspectives on casework have been described (Christofides, Johnstone and Musa, 2012). In contrast to others' bold and perhaps naïve calls for professions' explicit collaboration, the subtle act of psychologists 'chipping in' during teams' discussions was said to be a more common way of sharing psychological formulations than through more formal approaches, such as

staff training or case presentations. Whilst the authors acknowledge that to date there is no known research that looks at the impact of this on either service-user experiences or teams' functioning, this observation raises wider questions. It is suggested that informal means of engaging and supporting teams in psychological thinking can go unrecognized in MDT practice, to NHS commissioners, and through psychologists' training (p. 433). It is thus recommended that those working at more influential levels be encouraged to support their staff with skills, confidence-building, recognition and time to develop this delicate aspect of their work.

In light of transitions in both the profession of clinical psychology and in the wider health and social care sectors, there is now cause for critical reflection upon what clinical training in psychology entails, and what those who undertake it describe as best preparing them for practice in multidisciplinary contexts.

The Clinical Psychology Doctorate – Training and Learning

In 2015, in Britain, 591 individuals out of 3698 applicants commenced NHS funded Clinical Psychology Doctorate training (16% success rate). This compared with a peak of 623 training entrants, from 2342 applicants (27% success rate), in 2009. Currently, training follows a competencies model, with university-based teaching complementing six- to 12-month clinical placements (British Psychological Society Committee on Training in Clinical Psychology, 2007). An individual trainee's clinical placements portfolio would typically include positions with services working with children, adults of working age, and older adults. Placements would typically include working with people with learning disabilities, and with neurological or physical health

issues, whilst specialist forensic placements may also be accessed. Placements are primarily with NHS services, though can also occur with voluntary sector providers and independent sector organizations. Most commonly, trainees follow a three-year full-time route through training.

There is little published research that discusses UK-based clinical psychology training experiences and learning activities from the perspectives of trainees, past or present. By far the most comprehensive study in this area, to date, is based on the self-report questionnaire responses of 357 members of the British Psychological Society's Division of Clinical Psychology (Nel, Pezzolesi and Stott, 2012). In response to queries regarding the perceived value and usefulness of learning activities experienced during training, 'doing' and 'observing others' clinical practice' were both commonly experienced, whilst also being most highly valued. Learning relationships – primarily those between trainees and their clinical supervisors, and with course team members - are described as vital for the development of confident and independent practice. On this, good learning relationships were said to mediate against the experience of course stress, whilst poor learning relationships tended to exacerbate stress. Additionally, the authors identify personal therapy as being a highly valued training experience, albeit one that only 26% of participants were exposed to. Of particular interest to this research were participants' responses to the experience and valuing of (undefined) 'Multi-disciplinary team working,' as one of 10 discrete forms of clinical learning activity. Of the 93% of participants exposed to this, 85% of these (282 out of 332) rated MDT working as important or very important. Within this subset of data, 68% of those qualifying within the past three years and 55% of those qualifying more than 20 years ago rated this as 'Very important.' This detail could justify several hypotheses: there are

now increased demands on qualified clinical psychologists to perform multi-disciplinary team working; with greater experience, clinical psychologists' valuing of MDT working during training tends to diminish; MDT working within clinical psychology training has become more relevant and has increased over the past 20 years.

Aims of the Study

This study builds on research that has sought to identify qualified clinical psychologists' perceptions of the value and usefulness of learning activities experienced during training (Nel et al, 2012; Knight, Sperlinger and Maltby, 2010). In contrast, however, this research particularizes multidisciplinary team working as central to data that is to be generated. As participants integrate and make sense of talk and experiences from across discrete academic, clinical, and personal and professional contexts, this creates the possibility for developing a nuanced explanatory framework.

In seeking to model links between clinical psychologists' recent training and their practice in multidisciplinary teams, the proposed research is unique. Through adopting a grounded theory methodology, interest will span individual learning experiences as well as the professional cultures (organizational and disciplinary) that participants draw upon. Analysis will also consider the ways in which participants innovate to make sense of their training and practice, and their roles and responsibilities, in the service – or otherwise – of the multidisciplinary team's work.

The main aim of the research was to answer the question, 'Which aspects of their professional training do recently qualified clinical psychologists describe as best preparing them for multidisciplinary team working?' Secondary aims concerned

identifying insights and incidents that aided readiness for working in complex multi-disciplinary teams and informal strategies to aid psychologists becoming established in complex teams.

METHOD

The research followed the grounded theory method described by Charmaz (2006). In relation to working psychologically with multidisciplinary teams, the absence of any established theories to explain how clinical psychologists derive value and benefit from their professional training in this area provides a suitable context for a grounded theory study. Characterized as a non-linear method of data collection and analysis, where new data raises the possibility of new theoretical directions, grounded theory offers resonance to an under-theorized field of study.

Participants

Twelve clinical psychologists were contacted and invited to participate through professional networks (word-of-mouth followed by direct email, Appendix I and II). Eleven accepted this invitation and participated, one declined. Phase I of data collection (interviews 01 - 06) adopted a dispersed purposive sampling technique (Willig, 2001: 58), with recently qualified clinical psychologists (less than five years post-qualification) sought from across a range of Doctorate in Clinical Psychology university training programmes. In line with grounded theory methodology, with analysis ongoing, phase II of data collection followed a theoretical sampling approach. Phase II of data collection was therefore concerned with conceptual and theoretical development, rather than increasing the representation of the population or the statistical generalizability of findings as would be the case in many quantitative studies (Charmaz, 2006: 100). Theoretical sampling involved a conscious commitment to recruiting participants who

would be well positioned to discuss and develop those main categories of data raised through analysis of phase I data. In practical terms, phase II recruitment included approaching clinical psychologists who were known to have qualified through training programmes with well-established reflective practice group programmes. It was assumed that all prospective participants would be well positioned to discuss and develop other main categories from phase I that were based around placement experience - clinical supervision, in particular.

Of the 11 participants, eight were female and three were male, with eight describing their ethnicity as white British, one as white European, and two as Asian British. The eight training programmes of participants were located in the north west (one programme, one participant), west midlands (three programmes, four participants), east midlands (one programme, two participants), south west (one programme, one participant) and south east of England (two programmes, three participants). No participants were drawn from the same trainee cohort of individual programmes. The time elapsed between participants' training programmes ending and their being interviewed for this research ranged from six months to four years and four months (mean average one year and 11 months). All participants were employed as clinical psychologists, within the NHS, within two months of their training programmes ending. All participants continued to be employed as clinical psychologists, in either band 7 or band 8a posts, 10 of these in the NHS, and one for a third party provider of NHS services. Participants were employed in a range of services covering the lifespan, including some employed in highly specialist children's, adults' and forensic services. All participants confirmed experience of working with multidisciplinary teams since qualifying.

Ethical considerations

Full ethical approval was acquired through the University of Birmingham Science, Technology, Engineering and Mathematics Ethical Review Committee (Appendix III). All interview transcript data was anonymized, with place names, specific workplaces, training programmes and service details further de-identified. Upon commencing data collection, it was anticipated that participants would be keen to ensure anonymity if discussing past or current professional difficulties, or where they may choose to reflect critically on aspects of their own professional training. Participants were provided with the contact details of the research supervisor, should they wish to discuss any difficulties raised through participating in the research (Appendix II and IV).

Procedure

Participants took part in one semi-structured interview in their own time, with flexibility offered regarding an interview venue. Nine participants were interviewed privately near to their workplace; two were interviewed in their own homes. Participants were advised of the right to withdraw from the study, without question, at any time from agreeing to participate, to up to one week post-interview. All interviews were audio recorded and transcribed by the researcher. Interview duration ranged from 57 minutes to one hour and 27 minutes (mean average one hour and seven minutes).

All interviews began with the main research question, and utilized intensive

interviewing techniques. This allows for the in-depth exploration of a research topic around which the participant has experience (Charmaz, 2006, p. 25). Whilst for some interviews the first question 'may suffice for the whole interview if stories come tumbling out' (p. 29), at other times more active elicitation of accounts would be necessary. As participants began to describe and position themselves and their training within social, relational, personal and professional contexts, attempts were made to uncover individuals' own understandings and sense-making of their experiences.

From the outset of each interview, participants were provided with a broad interview framework that featured the main research question, plus four prompts lists that featured learning activities associated with doctoral training in clinical psychology (Appendix IV). These lists covered academic, clinical, research, and personal and professional development experiences. These lists were drawn from previous research with qualified clinical psychologists that sought to describe effective learning activities in clinical psychology training (Nel *et al*, 2012). The interview framework ended with four questions related to behaviours associated with transformational leadership (inspirational motivation; intellectual stimulation; individual consideration; idealized influence), each self-explanatory. These were available for participants to reflect upon where the content of interviews indicated participants positioning themselves as leaders within their teams, either during training, presently or in the future.

Participants were finally given the opportunity to reflect upon the content of the interview conversation, and to make any final remarks or return to earlier discussion points for additional comment.

Reflexive Note

Reflexivity has been described as the researcher's scrutiny of their experience, decisions, and interpretations such that the reader may assess how and to what extent the researcher's interests, positions and assumptions influenced inquiry (Charmaz, 2006, p. 188). Several observations from early in clinical training impacted on the generation of this research and, in part, the lens through which data was reviewed.

Across all five clinical placements, I learned and benefited from sharing office space with MDT colleagues, and from their willingness to discuss clinical cases and organisational matters. These MDT colleagues were qualified nurses, psychiatrists, social workers and support workers. Where I observed tensions within some teams, these tended to show in unfiltered remarks during moments of frustration. In seeking to formulate this, one hypothesis that recurred was that in some situations, MDT colleagues' limited capacities to meet existing and reportedly increasing workloads were not fully acknowledged. This led to the perpetuation of views of organisations' leaders as remote and punitive. This led to my reflecting on the task and viability of delivering psychological interventions through MDT colleagues where such collaboration was expected. This also provoked my reflecting on the actual and potential breadth of roles of teams' clinical psychologists. Reflecting on my own, and my peers' and supervisors' preparation for those roles, I was inconsistent in my readiness and willingness to raise this in clinical supervision. Broadly, with subsequent clinical placements and supervision, the breadth of what I deemed to be professionally safe and relevant to take to supervision increased. This coincided with my confidence in utilising supervision for reflection on systemic and team-based matters increasing.

From the outset of training, since when I have taken a lot of value from MDTs, my valuing of MDT working and of good relationships within teams remains undiminished. I believe that these can confer advantages to service users and to the workforce. Clinical placements were helpful for illustrating diverse relationship skills that might be called upon within clinical psychologists' MDT working, as well as circumstances in which ruptures can arise.

Within this research process, I wanted to extend my experience of qualitative research methods, thus I elected to develop a grounded theory that would yield a grounded theory model. Previous research experience and the lack of an agenda regarding the research question informed a relaxed interviewing style. Otherwise, my being male, in training, older than average for a trainee, having no prior knowledge or relationship with participants, and training with a university that has a good reputation for its academic standing, may all have impacted on participants' expectations and talk. Previous employment concerned with organisational (school) development had given me experience of professionals (teachers) struggling to adapt to working with others' professional languages and processes; unconsciously, this likely supported my preparedness, interest and adaptability for MDT working. At the time of developing this research, I perceived this main interest to be atypical for a trainee.

Analysis

Data is analysed in accordance with principles associated with grounded theory methodology (Charmaz, 2006; Tickle et al, 2012; Anderson, Standen and Noon, 2005; Burnard, 1991). From the first act of data collection, analysis begins, with subsequent interviewees discussing, developing and critiquing the connections between training

and MDT working described up to that point. Through this process, a nuanced 'grounded' theory is built. Figure 1 details the stages of analysis. Interview transcripts' open codes characterize the main explanations, justifications and descriptions that each speech-turn makes. By contrasting open codes, and refining later interviews' codes, codes are raised to categories. As categories become stable, with no new codes being developed or added, this marks 'category saturation' (Strauss and Corbin, 1990: 136). Through constant comparative analysis - a back and forth between transcripts, codes and categories, explanations for relationships between categories sees the development of theoretical concepts that give structure to the grounded theory. The emergent model is presented as it satisfies category saturation and claims to credibility, originality, resonance, and usefulness, as set out in Charmaz (2006: 182).

Stage One
Transcription of interviews within 24 hours of recording.

Stage Two
Reading of transcripts. Line by line (speech-turn by speech-turn) open coding (see Appendix V for examples).

Stage Three
Interviews re-listened to - memo-writing with key terms, questions arising and (for interviews 7-11) sketches of theoretical models (see Appendix VI).

Stage Four
With each subsequent openly coded transcript, codes are compared across interviews to identify possible descriptive categories.

Stage Five
Interviewing and analysis (interviews 7-11) ensures development of possible categories identified through interviews 1-6 (reflective practice; placement experiences; clinical supervision).

Stage Six
Ongoing contrasting of transcripts, codes and categories; raising descriptive categories to theoretical categories to move from description to explanation of data.

Figure 1. Stages of analysis

In grounded theory, the task of devising theory is to outline 'a set of well-developed concepts related through statements of relationship, which together constitute an integrated framework that can be used to explain or predict phenomena' (Strauss and Corbin, 1998, p. 15, cited in Charmaz, 2006). In developing theoretical categories, grounded theory analysis moves beyond the description of *what* is being said to understand and hypothesise *why* things are as they are, making connections with existing theories, and proposing new explanatory models in light of the data. Throughout analysis, questions were asked of how the studied experiences (training in clinical psychology; multidisciplinary team working) were embedded in larger positions, networks, situations and relationships for participants (Tickle et al, 2014, p. 104; Charmaz, 2006). The development of theoretical categories seeks, therefore, to take into account the social and professional contexts in which participants explain their views and experiences.

Where analysis and results in positivist research would seek to achieve validity, grounded theory aspires to verification and trustworthiness. In the earliest conception of grounded theory, the researcher's standpoint and identity remaining outside of the frame of analysis was desirable. With variations and developments in grounded theory methods and outputs, this study holds with the perspective of Charmaz (1990, 2006) for acknowledging and enabling the reader to assess how researcher interests and positions may influence inquiry. To support verification, the inclusion of a substantial reflexive note that discusses experiences pertinent to the research question, plus illustrative memos (Appendix VI), and examples of data being raised through to theoretical categories (Appendix VII) and a descriptive category raised to theoretical category

(Appendix VIII), seek to aid transparency. The regular use of research supervision and sharing of the complete data set through this research process further added to efforts towards trustworthiness, or credibility, originality, resonance and usefulness.

RESULTS

Four main descriptive categories are introduced, covering 'Doing the Work,' 'Clinical Supervisor,' 'Placements Cultures' and 'Peer Group.' Three theoretical categories – 'Trust and Exposure,' 'Inclusion and Belonging' and 'Sense-Making and Discovery,' are then proposed to explain the data within a preliminary grounded theory model of recently qualified clinical psychologists preparation for MDT working (Figure 2). Each category is illustrated and discussed below.

Descriptive Categories

Across all eleven interviews, participants' initial responses to the research question was to identify 'placement experience' as being the main contributor to best-preparing themselves – as previously trainee clinical psychologists - for post-qualification multidisciplinary-team working. Again, across all interviews, as this was discussed and explained, 'placement experience' was described in relation to three main categories, these relating to clinical psychological practice in MDT settings, working with clinical supervisors in MDT settings, and details of placements' environments and cultures that set the scene for forays into MDT working. Table 1 shows descriptive categories' subcategories.

Table 1. Summary of descriptive categories' subcategories

	Descriptive Categories			
	Doing the Work	Clinical Supervisor	Placements Cultures	Peer Group
Sub-categories	Adaptation Responding to expectations (own and others) Becoming the psychologist	Supervisor as:- - Gatekeeper - Role model - Reflective resource (interactive / independent)	Place and space Communications norms and expectations	Reflective conversations Analogies to difficult MDT experiences

'Doing the Work'

As participants spoke of beginning to practice as clinical psychologists, during their doctoral training, three subcategories were devised to synthesize information in this area: 'Adaptation,' 'Responding to expectations,' and 'Becoming the psychologist.'

All participants placed value on the diversity of placements. The basis for this was the demand for adaptation that new teams' organization, practices, and professionals, placed on the trainee clinical psychologist.

> The placements – doing the work – were most useful for preparing me [for MDT working]. I had quite diverse placements. I think as a trainee having to adapt to a new team every six months was good for preparing to work with people. (Interview 03)

> My experience was you can do as much theory and practice outside of the work environment, but the breadth of experience from working in lots of different multidisciplinary teams, then reflecting and relating that back [to taught material], that's where the learning - or preparedness - comes from. (Interview 07)

Recognizing the irony, the speaker in Interview 07, above, then went on to describe not recalling having ever received any teams-specific taught material during training. This was a common feature across interviews, with speakers accepting to varying degrees that learning of working with multidisciplinary teams would largely be in the 'doing,' or in directly observing at least.

One allied process of adapting to placement environments involved participants developing understandings of other professionals' expectations of the clinical psychologist role. One trainee specifically linked their own awareness of their relatively high salary banding, to the perception that others expected and invited the trainee clinical psychologist to be capable and competent in leading clinical activity.

> Being in settings where I was challenged due to being on a relatively high banding, compared to others, was good for me – having to get on with it. (Interview 06)

As participants presented accounts of their working with several multidisciplinary teams across three years of training, parallel processes were described. Within the interviews conducted, here, placement 'difficulties' tended to be described in relation to early training. Often implicated in *difficulties* was the mediating role played by the clinical supervisor in obscuring or inhibiting the trainees' relationships with their teams (see 'Clinical Supervisor', and 'Trust and Exposure,' below). Across training, however, participants' accounts were of their acquiring the skills and experiences, whether opportunistically or planned, that enabled the more comfortable self-identification as a, or 'the,' clinical psychologist for their services' teams, for example,

> Early in training, I was keen to understand what the expectations were of me in the MDT [meeting] setting. Then, I would only tend to speak if we were discussing someone I was working with. Much later, it was often the case that I'd be involved having done the triage, or neuropsych assessment and so I'd be more involved then. There was a point in training where – not by design or intention – I was supervised by someone not in the team, and to all intents and purposes I was effectively the psychologist in and for that team. In that situation I was able to change the terms and function of some meetings. I think that was good for staff as well as patients – especially in terms of relationships between the two. (Interview 10)

Clinical Supervisor

In response to the open main research question, all participants' accounts featured substantial reflection upon their experiences of receiving clinical supervision across the whole of their training in clinical psychology. These accounts outlined clinical supervision as having the potential to facilitate or inhibit the practical tasks of working with multidisciplinary teams, and the intellectual task of making sense of the positions and roles of clinical psychologists carrying out this work. Subcategories devised to synthesize information around the clinical supervisor concerned, 'Supervisor as gatekeeper,' 'Supervisor as role model,' and 'Supervisor as reflective resource.'

> In terms of my MDT working on training, that was partly mediated by how much the supervisor was invested in my spending time working with or knowing the team. (Interview 03)

> My experience of working with MDTs was hugely influenced by the supervisors' relationships with the team. One placement stands out in particular – that supervisor sat separately from the team, didn't attend the team meeting – based on a view of psychology being more of a tertiary service. I followed that at first, but then was faced with a lack of referrals, which as a trainee, would have been an issue, so then I started attending those meetings and working to get referrals. (Interview 08)

In the above extract, the participant describes a situation in which treating one

clinical supervisor as a role model led to difficulties in terms of limiting opportunities to demonstrate competencies through clinical practice. At other times, supervisors' own work with multidisciplinary teams provided a good model for the trainee to aspire to.

> Observing another clinician working – seeing supervisors work in the MDT, that was massive for me. One supervisor who was in to solution-focused therapy, listening to some of her really neat questions, that was really helpful. (Interview 04)

> I always saw supervision as a gift, even if there was discordance or a challenge. For me the supervisor was like a parent figure – even when I didn't know how or why something was as it was, I followed the supervisor and I wasn't let down. I was very fortunate – some colleagues were not. I had no reason to complain. I found observing the supervisor in the MDT meetings to be useful, too, just to understand how to behave – what to do, how to respond… (Interview 11)

Whilst clinical supervisors' openness to being observed was described as helpful, their openness to discussing multidisciplinary team working in clinical supervision was also valued. As in the extract below, participants were keen to acknowledge clinical supervisors as occasionally faced with conflicts and dilemmas, where their own relations with teams were deemed to be problematic, or where the clinical supervisor was described as a relatively powerless figure.

> It was good for me to have a supervisor who I could take team dynamic issues to, and to then try to apply some theory to that… I think if the supervisor is feeling powerless and unable to effect change in team dynamics, then that can have an impact on how open they are to discussing team dynamics, too. (Interview 07)

Placements' Cultures

With placement changes occurring every six months, or annually, participants

described being repeatedly exposed to new and unfamiliar professional settings, and local service and team cultures. As participants described aspects of particular placement experiences that were characterized as peculiar to specific settings, the subcategories of 'Place and space,' and 'Communications norms and expectations' were devised to synthesize information in this area.

One recently qualified clinical psychologist discussed their experience of highly contrasting placement locations as relevant to their developing working relationships with MDTs. Where a training placement was located in what appeared to be a predominantly white and socio-culturally homogenous location, this was posited as creating unspoken social and professional barriers that inhibited *others'* preparedness to collaborate and engage with culturally diverse colleagues.

> I think the location of the placement – which town or city – seemed to make a difference to how prepared staff were to engage with some of the diversity issues that I feel are a strength and interest to me. (Interview 06)

To varying degrees, all participants made reference to the layout of placements as impinging on the quality of engagement and collegiality that was experienced with MDTs. Co-location, especially in terms of sharing open-plan workspace, was described as helpful in bridging the development of social and professional ties with colleagues. Co-location also supported the acculturation to new environments, systems, and understanding and appreciation of other professions' contributions to services.

> Sharing office space helped promote professional relationships – that was through developing personal relationships, but also observing other professions or hearing them on the phone, or talking to their colleagues, and just being able to quite informally share info – like if I'm sitting next to the social worker or music therapist, I can say 'I've just seen so-and-so who you're seeing, what are you making of him or her at the moment?' – things that

wouldn't happen if I was in an office down the corridor. (Interview 08)

Participants recognized that upon seeking to engage with consecutive MDTs through training, each had its own customs and culture, from expectations and habits around the conduct of team meetings, to social minutiae such as where staff ate lunch, and with whom. As details of team-level cultures were outlined, participants' described their learning of these cultures as being derived from time spent with teams, rather than from advice from clinical supervisors. In particular, direct experience of observing and engaging with teams' communications was said to be indicative of MDTs' cultures of openness.

> I think the difficulties in the team were historical, really. It was very psychiatry-dominated. I remember when I raised a question about the team providing some information for me, a psychiatrist shouting at me [laughs]. I suspect other team members felt a bit dominated or threatened by that sort of thing, and so wouldn't be likely to try anything different. To me, my supervisor seemed quite reasonable, so… I don't know if there was anything else going on. I think it was their [psychiatrist's] issue, really. I think they felt threatened. (Interview 05)

Conversely,

> The placement that felt most like an MDT was the [specific] unit, and that was about us just all being there – together; also, in that team, the psychiatrist was really good – people were clearly valued – opinions were heard and taken into account. (Interview 09)

Peer Group

Whilst participants' training placements and clinical supervisors changed, one constant through training was the cohort of fellow trainee clinical psychologists that

participants belonged to. Participants referred to their training peer groups as they explained those formal structures of training whereby some degree of collaborative discussion and working was expected. Whilst this included problem- or enquiry-based learning activities, and clinical seminars, each of the first six interviews saw participants cite reflective practice groups as valuable aids to MDT working. As 'Reflective practice groups' was being handled as a main category of data at that time, this was explored in greater depth in later interviews (07 - 11). With that, participants offered diverse views and perspectives on the degrees to which both they and their training programmes had invested in reflective practice group participation. All participants did, however, value reflection with and through peers, albeit not always within training programmes' formal structures. As such, 'Reflective conversations' was devised as a subcategory for synthesizing data on the peer group. The second subcategory, overlapping at times, was 'Analogies to difficult MDT experiences.'

Where participants described reflective conversations usefully occurring within formal group settings, the specific value of these to MDT working could be practical, social and emotional, and intellectual.

> Even though in our RPG sessions we're a group of psychologists, I think having a forum to discuss with colleagues your training experiences is really important – for sounding things out, for making sense of training, for building confidence, and for being able to facilitate discussions, too. (Interview 04)

Where clinical supervision might be expected to serve similar functions, one participant outlined the relative value of the peer group for not being embedded in the same team, around which neutral alternative perspectives were desired, for example,

> …We had reflective practice groups across the three years. If I went to a

> specific placement and there was a negative experience – something I was struggling with, then the first point of contact would be my supervisor. If I was unable to get what I needed, then I would go back to my cohort about how to manage that situation. Like if there were very different opinions about how to deal with a client, sometimes risk takes over – some services can be risk averse – medication can take over a care plan. I might sometimes have to gently bring some psychological theory to a situation where maybe [pause] where maybe my supervisor is already a part of that system – that's a normal thing, maybe it will happen to me here – but they have a position, and so I'm there asking critical questions. Where it was hard for me to get a neutral opinion, then the cohort [fellow trainees] were my grounding place. (Interview 11)

Reflective practice groups were also described as live settings for observing at close quarters difficult and adversarial communications and relationships that were described as comparable to difficulties that trainees encountered in their placements' MDTs.

> People in the reflective group talked about their placement difficulties – so you learned vicariously through that. Also, though, there were sometimes a lot of conflict within those groups, and that would then be reflected upon... (Interview 03)

Also, one participant acknowledged that the peer group and reflective practice group did not guarantee the experience of a safe and secure outlet for reflection and sense-making around the MDT. Here, competing ways of constructing the peer group was offered.

> The reflective bit from our course was hugely substantial… you contributed as much as you liked or you didn't, and I didn't. For me, it didn't feel safe. I'm not opposed to group therapy, but in group therapy you don't see the people the next day in a lecture. It didn't make sense to me how you could be so open with that group in that setting, however you think of your peers – whether as peers, as colleagues, or maybe competitors. (Interview 09)

In the extract, above, where the lack of a clear relationship to the peer group is

revealed, this can be read as analogous to the position of not knowing how the role of clinical psychologist is either understood or whether welcomed by an MDT. Where the trainee clinical psychologist was able to elect to not participate in formal reflective practice, this raises the question of how relational not trusting or not knowing would be handled in the MDT context.

Theoretical Categories

Three theoretical categories were constructed to assist in developing an understanding of participants accounts of their preparation, or otherwise, for working with MDTs. These categories are explained and presented as a 'nested model' – '*Trust and Exposure*' within '*Inclusion and Belonging*,' all within '*Sense-Making and Discovery*' (Figure 2).

FIGURE 2. A grounded theoretical model of training experiences that best prepared recently qualified clinical psychologists for working with multi-disciplinary teams.

Trust and Exposure

In discussing MDT working, participants variously constructed the MDT as an inter-professional object (specialisms working with specialisms), a physical object

(comprising people, in a place), and a complex social and relational object (rife with interactions, communications and meaning-making). In doing so, the MDT was something that participants valued gaining exposure to, as they developed the competence and confidence to work with and within it. For the development of good learning and post-qualification preparedness, access was especially important during times of conflict and tension occurring within teams. This was not always a straightforward matter, though. In speaking of supervisors 'protecting' trainees from (not exposing them to) difficult team dynamics, participants invoked the concepts of risk, and trust. In positioning clinical supervisors as occasionally uneasy about exposing trainees to complex team dynamics, this further extends the conceptualization of risk, and the implications of rising professional accountability and blame in clinical settings (Tickle et al, 2012). None of the participants described fully 'knowing' or understanding the individual, supervisory, or team processes that undermined demonstrations of trust and exposure to difficult MDT matters, and so were left to speculate, for example,

> I had one supervisor who appeared to have a really unusual way of working with the team, and in trying to 'protect' me from some of the negative team dynamics ended up effectively removing me from the team; I wasn't invited to team meetings. That didn't help me, in terms of learning how to deal with difficult team dynamics. There were systems changes occurring there that made for a lot of people feeling unsettled, too. (Interview 07)

Whilst trust and exposure were typically invoked in accounts of clinical supervisors' gatekeeping trainees' access to MDTs, these concepts were raised more broadly. Participants' accepted degrees of autonomy – 'pushing' for MDT working, say - in devising routes through training, thus selecting learning experiences - participating or not in various settings. Here, trust and exposure surrounded trainees' handling and

management of guidance likely to relate to later feelings of preparedness or under-preparedness for different areas of practice, for example,

> When I started my first job post-training, what I noticed was how little prepared I was, or how little prepared I felt, for working in the MDT group, whether facilitating RP sessions, or supervising other professions, doing consultations and doing all of that applied stuff. All of that was maybe half of my work then, probably two thirds now. The one-to-one clinical work, which is maybe what I felt most prepared and well-trained and skilled in, well it was half of my work rather than 90 percent as I thought. I guess my training experiences were more aligned to individual working. With the MDT stuff, it always came up filling out placement forms – the tick box ones – it always came up, but I guess I didn't push it, but also, supervisors would say 'Well, you're a trainee, you can't really get involved in that kind of stuff cos you're not here for long, or skilled enough to do it.' Then you get your job, and you're expected to do it. In some ways, I didn't choose well with my placement choices, but on the other hand, a bit of thought about how to find opportunities for trainees would be helpful. (Interview 09)

In terms of placement experiences – whether around clinical activity, or relationships with clinical supervisors, participants tended to locate difficulties within the earlier period of training. Four participants described their own difficult experiences being followed by more self-consciously trusting themselves to pursue specific experiences, whether through doing-the-work opportunism, or through negotiation with supervisors and teams.

Inclusion and Belonging

As participants spoke of MDT working, it was treated as a given that it is generally preferable to experience a sense of collegiality, inclusion and belonging with fellow team members. In practical terms, this was most commonly described in terms of

colleagues at least listening to alternative perspectives on case work, whether those alternatives were accepted or not. On this, team meetings and teams' lead decision-makers – usually the most senior medical staff, were identified as the most explicit indicators of this.

As trainees from any professional group enter a clinical placement environment, they do so in the knowledge to all, of their position being time-limited, and likely paired with additional academic and evidence-building interests. Aside from possessing less clinical knowledge and experience, this distinguishes the trainee from permanent MDT staff. In describing their pre-qualification positions in relation to MDTs, participants acknowledged this as a potential hurdle to being accepted as part of the MDT and of their subjectively feeling included, for example,

> I was very much aware of my status as a trainee, and not wanting to burden others. I think the more casual interactions made that easier. (Interview 08)
>
> …it was hard to make sense of. In the end, I ended up offering to do a specific administrative role, and from that, the team opened up a lot to me – I kind of bought my way in. (Interview 05)

Participants' handling of this, as illustrated above, resonates with research that saw clinical psychologists claim the more effective sharing of psychological knowledge through informal means (Christofides et al, 2012). Such processes have gone unrecognized in surveys of the value placed on formal training activities, though (Nel et al, 2012).

All participants acknowledged that MDT working could be complex, with the position of the supervisor and the profession of clinical psychology *not* assumed to be fully integrated into teams. Psychologists' line management and post-qualification

supervision often being located outside of their teams were cited as structural examples of difference. Participants described clinical psychology as a minority profession in MDTs, often outnumbered by nursing staff, lower in status to medical staff, and typically offering alternative – or 'competing,' depending on the setting – explanatory models of service users' difficulties. Despite this, all participants readily identified occasions in which staff from other professions demonstrated openness to psychological thinking and ways of working. This was rarely consistent across the whole of individuals' training.

Whilst feeling and believing in professional inclusion and belonging made intuitive sense to trainees' preparation for MDT working, the concepts of inclusion and belonging were more far-reaching. As trainee clinical psychologists managed the ongoing task of evidencing multiple professional competences, they were necessarily yet to achieve the status of fully 'belonging' to their chosen professional group. Furthermore, participants acknowledged training within a same-profession group of peers as heavily implicated in several aspects of training. With training programmes' cultures and participants' openness, or otherwise, with their peers mediating experiences of 'belonging' – or identifying with - training cohorts, participants observed this as a process parallel to that of MDT working.

Sense-Making and Discovery

Participants described various contexts within which sense was made of MDT working and inter-professional relationships. Two participants described clear episodes in training, in which this occurred *within* their own acts of MDT working. Where

participants described placement experiences that saw MDT colleagues expecting – or trusting in - competent practice, this was valued. In 'getting on with it' at such times, participants took value from their own and colleagues' immediate responses (acceptance), of integrated psychological working, usually in the form of discussing clients' difficulties and developing case formulations. More commonly, ongoing processes of sense-making and discovery involved reflective discussions and practice, supported by good experiences of clinical supervision, and some of the formal structures of clinical training – reflective practice groups, and problem- or enquiry-based learning. The complexity of such processes was neatly encapsulated early in data collection,

> Without a shadow of a doubt the most helpful thing for me was observing my supervisor do these things [MDT working]. And having the freedom – being able to say – 'I don't know how to do this, I've never done this.' Even in the third year, I found the feeling of 'should' be able to do stuff grew, at times. We talked a lot of that in our reflective groups – 'if there's stuff you don't know how to do, then you should say so – surely that's what this is all about.' Reflective group was quite important. But yeah, being told by the course that it's okay to not know, and then to get guidance from your supervisor. But then you've got the dynamic of being assessed by your supervisor, and you don't want them thinking you don't know what you're doing. The combination of reflective groups, and time on placement – relationship with supervisor – observing and engaging in MDT working if you can – that's important. (Interview 01)

Some participants described their reflective practice group experience as flawed. This was for reasons of facilitation by individuals 'too close to the course team,' facilitation style, group size, or the influence of a minority of peers. Despite this, participants were able to take value from reflective practice groups – for what was learned from others' experiences, or for group dynamics paralleling those of MDTs. Whilst this echoes research findings identifying distress and value being mutually experienced through reflective practice group participation (Knight, Sperlinger and

Maltby, 2010), a minority of participants described alternative sense-making practices - reflecting alone, 'making sense on the drive home,' for example. This form of sense-making was not recorded or explicitly recognized within training, though.

In terms of participants understanding their preparedness for MDT working as, in part, demanding their making sense of MDT processes, one suggested caution in setting expectations around *knowing* about MDT working.

> I think sometimes in MDT work, you can't always know what's going on. You can see and hear so much, but… there's often more. (Interview 05)

As participants' experiences of MDT working grew through training, aside from reflection and sense-making around specific experiences within teams, a wider sense-making process was described around understandings of clinical psychology. Four participants clearly stated that upon qualifying they found that their roles called for considerably more involvement with MDTs than had been imagined upon commencing training. Counter to this was a diminished role in providing individualized therapy. Whilst accumulating experience of diverse clinical settings and teams through training, trainees would experience the interaction of the nested model's theoretical categories.

Relationships between the theoretical categories

The theoretical categories interact and overlap, both within and across training placements. Most straightforwardly, the categories can reflect linear experiences. At best, trainees described *trust* being demonstrated towards them by a clinical supervisor, in the form of access being provided to the multidisciplinary team and thus *exposure* to

its working and inter-professional dynamics. With trainees located within teams, and becoming a part of MDT working on a day-to-day basis, with non-psychologist colleagues echoing the trust and expectation of competence shown by the supervisor, the trainee begins to work psychologically with and within the MDT. This practice is received as *belonging* to the MDT's day-to-day functioning, and along with informal signs and gestures, this signifies the trainee practitioner's *inclusion* in the MDT. With the clinical supervisor, and in parallel with the peer group of trainees, *sense-making and discovery* occurs through reflection upon individual practice and the professional role, and their relation to team functioning and dynamics. Moving through training, the richness of context that is experienced by the individual trainee grows, both through additional training placements and this process unfolding further, and through exposure to others' equivalent experiences and processes. With this, trainees will to and fro within the nested model, in relation to varying experiences. For example, through a trusting relationship experienced with a clinical supervisor later in training, sense may be made of thwarted or unsatisfactory experiences of MDT working much earlier in training, and vice versa.

Examples of these connected processes being most vividly experienced occurred in settings whereby the trainee was at a physical distance from the clinical supervisor, there then being the freedom to respond directly to MDT expectations – thinking and doing on their feet, and quickly gauging reactions, or the lack of reaction – other than within themselves. Perhaps least helpfully to post-qualification MDT working, one trainee neatly acknowledged that through their own decision-making within training, their own sense-making and discovery around MDT working was delayed until this occurred in relation to their first job post-qualifying. From such an account, the wider

matter of trainees' contrasting ways of making sense of and inhabiting clinical psychology training, and the role of a trainee clinical psychologist becomes apparent.

DISCUSSION

The main research question was, 'Which aspects of their professional training do recently qualified clinical psychologists cite as best preparing them for multidisciplinary team working?' Tickle et al (2012, p. 10) explain that although not a formal procedure of grounded theory methodology, a one-sentence summary of the gist of what is being conveyed through the theoretical categories can be useful, thus: *Early career clinical psychologists described exposure and belonging to MDTs as integral to becoming prepared for post-qualification practice, though it is reflective discussions within mutually trusting relationships with supervisors and with peers that enable sense-making to occur*. Through the development of the nested model, each interview was reviewed in search of statements that contradicted the central tenets of the model. No 'negative cases' were identified, as none of the participants made remarks that undermined either the theoretical categories or the structure of the proposed model. Suggesting a process for clinical psychologists' preparation for MDT working, the model makes intuitive sense.

As participants developed accounts of *trust and exposure* - the foundation of best preparation for MDT working, they drew on the learning relationship with supervisors. Where Nel et al (2012) recognised learning relationships during training as highly valued by qualified clinical psychologists, this research identifies MDT working as benefiting from those. Conversely, with openness, transparency and candour taken to indicate the health and safe functioning of teams and organizations (Jones, 2006; Mowbray, 2014), the nested model indicates that a lack of those qualities within in-training relationships might undermine preparedness for multidisciplinary practice.

As trainee clinical psychologists develop through *inclusion and belonging* within

MDTs, the nested model describes the context in which clinical psychologists begin to develop subtle and informal means of conveying psychological ideas in MDTs (Christofides et al, 2014). Participants spoke of preparation for MDT working being hastened through clinical placements' calling for the sharing of locations and workspace with MDT members, especially where the clinical supervisor was *not* always present. This was said to aid observations of inter-professional communications, whilst facilitating social ties and relationship building. Through co-location, the valuing of direct exposure to and incidental observation of other professions' practices is set against shifts in some organizations that seem likely to reduce the scope for this. For example, 'agile working' is described as empowering people to work when, where and how they choose, with maximum flexibility and minimum constraints (Employers Network for Equality and Inclusion, undated, p. 3; Leybourn, 2013). In principle, this is appealing, however, such business modelling may overlook some of the unwritten mechanisms that aid those working in, learning from and using complex public services. Where agile working can amount to staff having no say in being located away from MDT colleagues, whether to work remotely from home, the car or the coffee shop, the risk of losing subtle, informal and effective means of communication and learning is raised. As Alimo-Metcalfe, Bradley, Alban-Metcalfe and Locker (2013) advise, in service redesign towards agile working, the means of maintaining effective and engaging communication need to be considered. Where a means of achieving effective communication, such as sharing a workplace, is not fully recognised, then its maintenance is at risk.

In *sense-making and discovery*, the nested model identifies preparation for MDT working as placing reflective demands on the trainee. Through the model, trainees and supervisors are invited to reflect on their supervisory relationship and the MDT, and

trainees are invited to reflect with their peer group in collaborative learning. Preparation for MDT working is therefore a highly relational process. This resonates with research that suggested that relationships, and the emotional experience within these, should be a focus of all aspects of the clinical psychologist role (Woodward, Keville and Conlan, 2015, p. 786; Thexton, this volume).

In its three-part structure, the nested model invites structured reflection, rather than a set of 'how to' behaviours. In its non-directive presentation, trainees and supervisors might apply and adapt the model to suit a wide range of settings and therapeutic orientations. By avoiding a highly prescriptive or complex offering, the model's three-part structure also projects easy-to-reference and easy-to-recall qualities that encourage use and accessibility.

Some participants described surprise at the relatively diminished scale of their providing individualised therapy in their first posts following qualification. This led to some reflection on the extent to which they had understood the breadth of the role of the clinical psychologist during training. Rather than suggesting a fundamental miscalculation, it seems apt to characterize this as reflecting the pace and depth of culture change occurring within the wider psychological therapies workforce over the past decade – a period incorporating all of the participants' training and post-qualification experience. As clinical supervisors were positioned as assessors of trainees' professional competence – gatekeepers to professional recognition and inclusion, this presented a dilemma to some trainees, who described that relationship as one of negotiating risk, and of maintaining good will. With ten of the eleven participants in this study describing at least one placement experience and supervisory relationship

that was not helpful to developing skills for multidisciplinary working, the model could be helpful in training, currently.

Implications for developing training in Clinical Psychology

Participants accepted that over the course of three years of full-time training, that they have opportunities to pursue work with and through MDT colleagues. Whilst clinical supervision and environmental factors can facilitate or inhibit this, the trainee can be opportunistic and self-determining as they navigate a path of their choosing through clinical training. For the trainee clinical psychologist who is able to acknowledge to themselves and others their own lack of knowledge or experience of MDT working, there is a greater chance of professional development needs being identified and addressed within training. Where a trainee elects to maintain a focus on the provision of direct therapy, this can be at a cost to more deeply engaging in MDT working and with the breadth of the clinical psychologist role. This presents a challenge to training programme providers. The challenge is how to support trainees' open reflection - with themselves, supervisors and programme staff, such that best preparation for MDT working can be achieved through training. Helpfully, the Clinical Leadership Competency Framework (Skinner et al, 2010) describes five domains, including 'Working with others,' which amount to a menu for graduated MDT working, and organisational and professional leadership. This is accessible to training programmes, practicing clinical psychologists and trainees. To support trainees' meaningful engagement with this, conditions for deeper learning need to be satisfied.

Whilst the mandating of openness would be nonsensical, trainee clinical

psychologists might more usefully be invited to discuss and reflect upon the varieties of risk that they experience within themselves, and that they are exposed to and manage through training. Existing programme structures may be helpful, here. In line with the trust and openness that the nested model encourages, the clinical supervision relationship could be a means of prompting and promoting trainees' efforts towards measured relational risk-taking in MDT working (Woodward et al, 2015). This could be raised and documented in placement planning and reviews, trainees' appraisal processes, and regular supervision. Varieties and sources of personal and professional risk and risk management would also be appropriate material for structured peer group reflection. With skilled facilitation, this would provide training programmes with the opportunity to communicate acceptance, permissiveness and appreciation of trainees' open communication of not knowing, and of working to face difficulties (Binks, Jones and Knight, 2013; Brown, Lutte-Elliott and Vidalaki, 2009; Punzi, 2015). Alternatively, trainees' structured self-reflection - on risk and MDT working - could occur more privately through written assignments or other means negotiated with training programme providers. This would be valuable – perhaps as an optional addition or alternative to group participation, where individuals' participation in groups is observed to be minimal, inhibited or inhibitory to others. Conceptual thinking, as could occur around risk, may lack the instrumental appeal of 'what to do, how to ask' training methods. Despite this, opportunities to identify and manage individual, dynamic and organizational factors and sense making that suppress openness would be a valuable and professional response to past failings in health and social care.

Where trainees, supervisors or others frame the loss of trainees' time to provide direct therapy as a cost of greater MDT working, the underlying feelings and beliefs

behind this are worth exploring. In a context of the profession and forms of MDT working rapidly evolving, understandings of service users' and teams' 'need for a psychologist' versus their 'psychological need' are worth exploring.

As clinical supervisors are heavily implicated in the suggestions for scrutiny and support for trainees' openness to MDT working, the implications of this to supervisors becomes important. Along with reflecting on the impact of their own relational and physical proximity to the MDT, there may be opportunities for experienced clinicians and supervisors to learn from trainees' perspectives of teams and organizations. Here, training providers might wish to explore characterizing the supervisory relationship as one of *mutual* learning, as well as one of guidance and assessment. To explore the potential for supervisors' team-related learning *from* trainees' perspectives would be to encourage access - trust and exposure - to MDTs.

Evaluation of the research

In producing a preliminary grounded theory model of recently qualified clinical psychologists' explanations of aspects of professional training that best prepared them for MDT working, the core evaluation principles of results being credible, original, resonant and useful were held in mind (Charmaz, 2006). The iterative analytic process – systematically moving between data and codes, and codes and categories - ensured that the resulting model is firmly grounded in the data.

In subsequently discussing the proposed model in workplace settings with experienced, recently qualified and current trainee clinical psychologists (all involved in supervisory relationships and MDT working), as well as with academic psychologists

with interests in clinical supervision and reflective practice, responses have supported the model, in line with Charmaz' evaluation criteria. Particular resonance has been described in relation to the model's foundational theoretical category, *Trust and Exposure*.

The categories are presented in a clear and organized framework for reflecting upon the preparation of trainee clinical psychologists for MDT working. As such, this is an original contribution to psychological theory. The model would be useful to clinical psychologist supervisors, for locating their role in supporting learning processes around MDT working. As clinical psychologists' practice has shifted into the domain of MDT working, the model may be especially useful to those whose own qualification and subsequent practice was founded on an understanding of the profession as emphatically and necessarily concerned with the provision of direct therapy.

Limitations of the research

The research has been produced at a specific moment in the development of Clinical Psychology, and in the evolution of austerity era commissioning and monitoring processes. As such, the research is highly situated in time, and in professional, social, economic and policy context. Also, the grounded theory model developed within this research was generated from the data of participants who had in common only their recently qualifying as clinical psychologists. Whilst the model describes and explains a process for training-based preparation for MDT working, this was constructed following data collection that did not pursue talk of specific kinds of MDT experience. Variations in the MDTs or related experiences to which participants had been exposed during

training were not systematically distinguished or analysed, thus the model is broad and so cannot be claimed to address preparation for particular forms of MDT working. Variations in MDTs would likely have included contrasts in the professions that made up teams and their leadership, as well as contrasts in teams' socio-cultural, organizational and clinical contexts and specialisms. With variations in such team factors, it seems plausible that variations in clinical psychologists' required skill-sets would vary, and so too the means by which preparation for practice in such teams would be achieved.

Whilst grounded theory model development did involve contrasting the final model, here, against each individual interview, this was short of formal respondent validation (Torrance, 2012). Follow-up research, or the development of new studies in this area might usefully feature research design and analysis that is informed by participants and other key stakeholders, including service users and non-psychologist MDT members (see below).

The proposed model was developed out of interviews with 11 recently qualified clinical psychologists, with regards to subject matter (training in clinical psychology, and MDT working) whose inter-relation are under-researched, under-theorized and yet have also been at the centre of the profession's development over the past decade. As such, the research and model would benefit from being located within a more rich and varied arena of related studies.

Recommendations for further research

A large-scale mixed methods survey of the of the impact of doctorate training on

clinical psychologists' subsequent MDT working would provide a useful foundation for further research in this area, and for identifying good training practice. Based on the development of the nested model in the current study, quantitative survey items could explore the features of trainees' placements' teams (professional composition, size, physical environment), clinical supervisors and supervision, trainees' decision-making, peer group relationships, and training expectations. Quantitative items could further explore clinical psychologists' formal and informal practices with MDTs, as well as perceived competences. Open-ended qualitative items could invite identification of encounters, tasks and relationships that demonstrated individuals' strengths and developmental needs around MDT working. In an under-theorized research area, such surveys could usefully begin at the level of individual training programmes.

The model developed here invites questions of individual, service and organizational variables that facilitate or inhibit openness and transparency (or *Trust and Exposure*, and *Belonging and Inclusion*) in professionals' learning relationships. Within this, research identifying good practice, facilitators of and leadership factors in cultures of learning - over cultures of blame - would be useful. As participants described difficult supervisory experiences, the matter of research to date under-theorizing 'risk management' (and professional defensiveness) became apparent. Equally, the possibilities for positioning trainees in clinical psychology – and other professions – as representing opportunities for systems' learning – fresh eyes brought to bear on challenging circumstances – would be worth exploring.

Whilst the research saw participants openly reflect on training content, experiences and relationships, offering examples of moments of insight, the research did not discuss non-psychologists' experiences of working psychologically in MDT settings.

Whether in terms of other professions' engagement and work with qualified or trainee clinical psychologists, it would be valuable to have clinical psychologists' MDT training practices informed by those MDT colleagues and allied professions with whom good working relationships for best service user outcomes are sought. Action research methods would likely have much to offer professions' and service user groups' co-production of integrated teaching and learning to support psychological practice with and for MDTs (see Gillard, Simons, Turner, Lucock and Edwards, 2012).

CONCLUSION

Within the data there were variations in the degrees of participation in and openness to MDT working that the recently qualified clinical psychologists described in themselves and their clinical supervisors during their professional training. One misconception that several participants described taking into training was the view of clinical psychology being necessarily a profession of direct therapy delivery. Still, it seems plausible that the wider profession comprises practitioners of highly contrasting views and valuing of clinical psychologists' work being integrated into MDTs. Despite this, all participants described experiences of MDTs being open to psychological knowledge and ideas. As the profession of clinical psychology further develops its professional training, the growth of research and practice knowledge around clinical psychologists' learning relationships and MDT working, through training, could inform wider organizational and leadership developments. In particular, challenges in fostering openness and transparency within cultures of mutual learning could usefully contribute to displacing wider cultures of blame that have previously failed service users. To

stimulate cultures of learning, openness to reflection and reflective practice may be helpful. The grounded theory, described here, provides a preliminary model for furthering this enterprise.

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Reflective Practice in Clinical Psychology Training: A Systematic Literature Review

[Paper to be edited for submission to *Reflective Practice: International and Multidisciplinary Perspectives*]

ABSTRACT

Background – The professional narrative of clinical psychology is that practitioners rely on a reflective scientist practitioner model.

Objectives – By exploring the strength of evidence for reflective practice as a meaningful and valued aspect of clinical psychology training, the aim was to use findings to inform training for reflective practice.

Method – Combining the terms 'reflective practice,' 'clinical psychology' and 'training,' twelve research databases covering clinical psychology, or education and learning were searched. The application of exclusion and inclusion criteria led to the identification of nine papers for critical review.

Results – Comparing papers against criteria for establishing truth-value, applicability, consistency and neutrality, the overall methodological quality of papers was evaluated as weak to moderate. Definitions of reflective practice varied in their clarity, consistency and transparency. A sizeable minority of trainee clinical psychologists were recognised as experiencing distress, low value or resistance to group-based reflective practice. The learning mechanisms involved in trainee clinical psychologists' reflective engagement are yet to be established. Skilled facilitation was identified as crucial to groups' commitment to reflective engagement, whilst self-acceptance and relating skills were identified as important to individuals' development.

Discussion and Implications – Given the quality of evidence and the limited transferability of research to date, an action research process aimed at developing a psychological assessment and formulation model for reflective skills development was proposed. Interventions would seek to tailor training activities to individuals' process-

based needs. Recommendations for further research in this area, and the timeliness of this enterprise are also described.

OVERVIEW

The professional and regulatory bodies of clinical psychologists in the UK currently describe professional practice as relying on an integrated reflective scientist practitioner model (British Psychological Society, 2014; Health and Care Professions Council, 2015). A review of research examining reflective practice in clinical psychology training would go some way towards providing evidence for this claim. This review aims to establish the weight of empirical evidence for clinical psychology training developing trainees' reflective practice, and to inform training programmes in support of the current professional narrative. To do this, four objectives are set out. First, theories and understandings of reflective practice are described, followed by an account of how reflective practice is currently positioned within clinical psychology doctorate training in the UK and how papers have been selected for this review. Second, existing review papers that discuss the efficacy of reflective practice for clinical and educator learning and practice are critiqued with a view to their informing the focus of the current review. Third, original research and evaluation papers that discuss reflective practice within clinical psychology training are described and critically evaluated. Finally, based on research evidence, recommendations are made for developing and integrating reflective practice participation in UK-based clinical psychology training, along with recommendations for advancing research in this area.

PART I: REFLECTIVE PRACTICE AND HOW DOES IT RELATE TO CLINICAL PSYCHOLOGY TRAINING

What is reflective practice?

Prior to describing frameworks that support reflective practice, it is important to first distinguish reflection from reflective practice. Scaife (2010) explains that reflection can be understood as thoughtful practice or thinking about past actions. Reflection alone can be sufficient for learning, however, when critical reflection shapes future practice then reflective practice can be said to have occurred (p. 9).

In the context of teaching and learning in clinical psychology training, reflective practice might plausibly occur when disparities arise between espoused theories (a theory of how to behave or practice) and theories-in-action (theories implied by behaviour) (Argyris and Schön, 1974). Conceived as critical reflection shaping future practice, reflective practice would *theoretically* offer the potential to address and resolve dilemmas arising from such disparities. Where practitioners remain unaware of their own theory-action inconsistencies (Lewicki, Hill and Czyzewska, 1992, illustrate such a possibility), then there is a need for training provision to structure the kind of reflection that might yield insights that would aid reflective practice. As defined by Scaife, clinical psychologists' reflective practice would have the potential to improve professional practice, patient safety, and outcomes for service users. To inform reflective practice within clinical psychologists' training, a review of research would be appropriate, along with an overview of frameworks that support reflective practice.

In the reflective practice literature, the most regularly cited concepts and

theoretical framework are Schön's (1983, 1987) distinguishing between reflection in and on action, and Kolb's (1984) experiential learning cycle. The latter, a framework for conceptualising learning, is popular for making specific reference to reflective observation (reflection-on-action) as part of a four-component cycle. Beginning with the individual learner's *concrete experience*, as perceived by himself or herself, the learner engages in *reflective observation* – an attempt to watch or reflect upon their experience from a position of the 'hawk in the mind,' including themselves in the frame and examining feelings, thoughts, actions, values, and beliefs (Scaife, 2010, p. 26). This leads to a phase of *abstract conceptualisation*, in which the learner seeks to make sense of patterns of experience and relationships, whilst seeking to apply theories, and develop and revise hypotheses. The final component of the cycle sees the learner engage in *active experimentation*, a phase of doing – putting in to practice decisions to act, in line with Scaife's definition of reflective practice. Criticism of the experiential learning cycle has tended to focus on its lack of reference to context, its assumption of rational decision-making, and its simplicity (Webb, 2003; Desmond and Jowitt, 2012), though for its face validity and ease to recall, it maintains wide appeal (Sheikh, Milne and MacGregor, 2007). Gibbs (1988) reflective cycle – a development of Kolb's model - maintains its cyclical form, with stages reworded and added to aid practitioners' operation of it.

In addition to cyclical models, structured models for reflective practice tend to pose a series of cue questions to guide thinking and action-planning. Extending Carper's (1978) framework, Johns' (2004) model for structured reflection describes five *ways of knowing* that invite individuals' exploration of the unfolding situation (*aesthetic*), mental constructs (*personal*), dilemmas (*ethical*), observable and measurable details (*empiric*),

and tacit knowledge that becomes apparent during reflection (*reflexivity*). As with Smyth's (1991) 'describe, inform, confront, reconstruct' model, guiding questions can invoke interrogation of social and political conditions and values. Such possibilities might also occur through following Mezirow's (1981) hierarchical model that outlines seven levels of reflection that span *consciousness* (thinking) and *critical consciousness* (thinking about thinking, or meta-cognition) domains. It is likely that more complex frameworks and models would support reflection on action, rather than reflection in action.

Lavender (2003), introducing reflective practice to an audience of clinical psychologists, outlined four reflective processes. As well as Schön's reflection in and on action, processes concerned with reflection about the individual's impact on others, and reflections leading to self awareness and development were included. Further, Lavender relates the paucity of reflective practice in clinical psychology to the emergent discipline and profession's twentieth century commitment to a positivist approach to science. In setting such a course, Eysenck's (1949, p. 174) reaction to 'the spurious orthodoxy' of Freudianism in contributing to the American Psychological Association's training of the 'young and relatively defenceless student' was highlighted. To engage with the subjectivity or personhood of the individual practitioner has been characterised as a behavioural scientist's nightmare – almost impossible to define tightly, and well nigh uncontrollable (Bennett-Levy, 2003, p. 16). Accepting some residual tension linked to its empiricist past, the relationship between clinical psychology and reflective practice has seen considerable movement.

Reflective practice and training in clinical psychology

In recent years, social and economic conditions have likely added to health and social care professions' critical reflection. This might be understood in terms of professions' and services' preparation for raised external scrutiny and monitoring, as would be anticipated with more fragmented and complex service commissioning processes (Miller and Rees, 2014). Also, with high-profile failings in health and social care, concerns for public and patient safety have raised 'an unpalatable truth,' demanding that 'all who work in healthcare learn… from reflecting on their own work, attitudes, and collective culture' (Francis, 2013, p. 36; Department of Health, 2012). Through such economic and socio-political drivers of change, the commissioning and delivery of health and mental health services now parallels clinical psychologists' reflection upon their roles and contributions to health, and social and economic life.

Aimed at informing the Health and Care Professions Council's (HCPC) (2015) review of the standards of proficiency for practitioner psychologists, the British Psychological Society (BPS) (2014) discussed 'Clinical psychologists as *reflective* scientist practitioners' (emphasis added). This covered their abilities to 'critically consume research,' 'contribute to the [psychological] knowledge base through research benchmarked at doctoral level,' and 'embrace an ethos of practice-based research' (p. 6). Within the same section of their report into *Standards for Doctoral Programmes in Clinical Psychology*, clinical psychological practice was also discussed in terms of clinicians 'utilising outcomes frameworks, informed by well-being and recovery principles, as well as the values and goals of the service user,' as well as 'leading on developing systems of practice-based evidence within services.' Also, reflective practice

would be promoted through 'the effective use of supervision, and collaboration with service users and other colleagues in setting goals and monitoring progress.' The HCPC (2015, p. 9) also linked critical reflection and self-awareness to clinical psychologists' ability to 'transfer knowledge and skills to new settings and problems, whilst informing professional standards of behaviour as might be expected by the public, employers and colleagues.'

Addressed to education providers, the HCPC's (2014) *Standards of education and training* made little reference to reflection or reflective practice, insisting only that 'programmes must support and develop autonomous and reflective thinking' (p. 9). Elaborating further, the HCPC's (2009, 2015) *professional standards for practitioner psychologists* appear to reflect some of Schön's (1983, 1987) theoretical perspectives on reflection, whilst also requiring monitoring of trainees' reflective practice. For example, the standards call for psychologists' 'understanding the value of *reflection-on-practice* and the need to record the outcome of such reflection,' (HCPC, 2015, p. 12, emphasis added) and 'using professional and research skills in work with service users based on a scientist-practitioner and reflective practitioner model that incorporates a cycle of assessment, formulation, intervention and evaluation' (p. 22). Here, no specific direction is given as to how the relationship – theoretical or practical – between the scientist-practitioner and reflective practitioner models would be conveyed through teaching and learning, or be specifically monitored during training. Evidence of how programmes address this is relatively sparse, with a highly mixed picture being suggested in a survey of 17 programmes' approaches to personal and professional development that identified features of reflective practice (Gillmer and Marckus, 2003). Individual training programmes have attempted to integrate, embed and co-ordinate their understanding

and operation of reflective practice for teaching, assessment and clinical practice (Stedmon, Mitchell, Johnstone and Staite, 2003). Examples included mandatory weekly personal development groups (Cushway and Gatherer, 2003), reconfiguring personal awareness groups into reflective practice groups (Powell and Howard, 2006), and a programme of three-monthly half-day reflective practice sessions (Johnstone and Staite, 2010).

Despite variations in programmes' provision of teaching and assessment for reflective practice, both in terms of activities tailored to the individual and those delivered at group level, recent survey data provides clinical psychologists' accounts of the value and usefulness of these activities (Nel, Pezzolesi and Stott, 2012). Under the academic heading of 'reflective accounts' (writing), 55 per cent of 357 respondents claimed exposure to such activity during training. Of those claiming a cognitive behavioural therapy practice orientation, 32 per cent viewed this as a 'very important' learning activity, in contrast to 47 per cent of those claiming an integrative orientation. Under the personal and professional development heading of 'reflective group work,' 60 per cent recalled exposure to such activity. Of these, 19 per cent of the CBT respondents regarded this as very important, in contrast to 36 per cent of the integrative group. The data from this study suggests considerable variation in training activities for respondents. It is not clear whether that variation was mediated by the theoretical orientation of programmes, or by programmes' content changing over time. The contrasting valuing of reflective elements provides grounds for querying how practitioners' theoretical orientations mediate the valuing of reflective practice, and how a person's valuing of reflective activity might mediate a therapeutic orientation and programme preference.

In a context that remains open to contrasting interpretations of calls for an integrated *reflective* scientist-practitioner model, there is value in reviewing research that discusses reflective practice in relation to clinical psychology training.

Paper selection and evaluation framework

Methods of Paper Selection

Combining the terms reflective practice and clinical psychology, initial searches (November 2014) of Google Scholar and the CINAHL Plus database suggested that the reflective practice literature spanned diverse professional and academic fields, but predominantly those concerned with nursing and medical education, and teacher education. During that initial scoping stage, three peer-reviewed published literature reviews concerning reflective practice were identified (Ruth-Sahd, 2003; Mann, Gordon and MacLeod, 2009; Platt, 2014). Whilst none of these reviews acknowledged any link between reflective practice and training in clinical psychology, each acknowledged difficulties associated with inconsistent definitions of reflective practice, and the dispersed nature of its literature. From this, Platt advocated profession- and discipline-specific practice and research of reflective practice in future. To utilise those reviews' general strengths, weaknesses and findings to inform a critical literature review of reflective practice specific to training in clinical psychology, those reviews are briefly summarised and criticised at the beginning of the next section.

To identify papers that would inform a review concerning the meaning and impacts of reflective practice in UK-based doctorate training in clinical psychology, the

process set out in Table 2 was followed.

Table 2: Process for identifying and selecting papers included in this critical literature review.

Stage – Aim	Activity
I - Scope literature – generate broad impression of reflective practice literature	Initial searches to identify the particularity (or otherwise) of research concerning reflective practice
II – Gain understanding of what past (general) research on reflective practice has established	Having established that clinical psychology is a relatively minor domain of reflective practice research, closely examine those peer-reviewed and published review papers identified during Stage I
III – Identify University of Birmingham research databases most likely to contain research on reflective practice in clinical psychology training	Examine University of Birmingham database descriptions, select those that feature psychological, clinical psychological or teaching and learning research
IV – Determine exclusion and inclusion criteria ahead of systematic searching	Draw up initial exclusion and inclusion criteria
V – Identify potential papers for inclusion in review	Systematically search all selected databases combining terms 'reflective practice' AND 'clinical psychology' AND training
VI – From the results of Stage V, identify papers that will not be included in review	Apply exclusion criteria to combined results' titles and abstracts – exclude those evidently not concerned with studying reflective practice in the context of clinical psychologists' training
VII - Confirm papers for inclusion in review	From those papers retained following Stage VI, compare inclusion criteria against the full paper – where satisfied, retain paper for review

VIII – Where ambiguity existed during Stages VI-VII, observe and record clear reasons for exclusion and inclusion	Where the decision to exclude or include a paper is arbitrary, take into account the combined recommendations made in the generic review papers - include those which advance recommended directions for research

The research databases explored through stages V-VIII were NICE, PsycINFO (1967-2015), Education Abstracts, Education Administration Abstracts, Applied Social Science Index and Abstracts (ASSIA), EMBASE: Excerpta Medica (Ovid), Cochrane Library (search necessarily limited to title, abstract and key words), PsycARTICLES, Taylor and Francis Online, PubMed, CINAHL Plus, and Google Scholar (2010-2015). Where not otherwise specified, all text searches were conducted for all available dates. Where not otherwise specified, searches combined the terms reflective practice, clinical psychology and training. Additional restrictions were placed on the searches of PsycINFO and Google Scholar due to their exceptionally high return of results not relevant to the current review. With results compared with the exclusion and inclusion criteria set out in Table 3, below, databases were searched in November 2014 (seven papers identified), March 2015 (Punzi, 2015 added) and November 2015 (Woodward, Keville and Conlan, 2015 added). Details and full results of the final search (November 2015) are set out in Table 4, below. Nine papers were identified for inclusion in the review. Summaries of these papers are in Table 5 (see Part III).

Table 3: Exclusion and inclusion criteria for the selection of papers for critical literature review

Exclusion criteria	Inclusion criteria
Paper does not position reflective practice as a main element of study	Paper describes reflective practice as a main element of study
Paper does not provide a definition or context for reflective practice	Paper defines reflective practice, or provides an elaborate description or theorisation of context-specific reflective practice
Paper does not link study to clinical psychology training	Paper describes research that directly concerns training in clinical psychology
Paper describes a professional context whereby training in clinical psychology is substantially different to current UK context (e.g. USA, for highly variable content of doctoral training programmes)	Paper describes UK research or research that can be straight forwardly related to clinical psychology training in the UK
No evidence of publication following a blind peer review process	Paper is published following blind peer review process
Paper does not describe original empirical research (e.g. describes a training protocol)	Paper describes original empirical research (any methodology)
Paper does not detail processes and methods of data collection and analysis to enable their critical evaluation	Paper describes processes and methods of data collection and analysis in such detail as to support critical evaluation

Table 4: Database Literature Search, Exclusion and Inclusion Results

Database	**Search 1: 'Reflective Practice' (all available years)**	**Search 2: 'clinical psychology' AND training (all available years)**	**Combine Searches 1 and 2**	**Meets exclusion criteria based on review of title and abstract (inc. duplicate papers)**	**Does not meet exclusion criteria based on review of title and abstract**	**Meets inclusion criteria based on review of full text – included in systematic review**
NICE	570	1224	43	42	1	1 (Wood et al, 2013)
PsycINFO 1967-2015	6315	72261	435 (14 - search limited to abstract and subject headings)	9	5	4 (Binks et al, 2013; Burgess, 2013; Knight et al, 2010; Sheikh, 2007)
Education Abstracts	829	899	0	-	-	-
Education Administration Abstracts	244	18	0	-	-	-
Applied Social Science Index and Abstracts (ASSIA)	700	878	14	13	1	1 (Brown et al, 2009)
EMBASE:	296	112	3	3	0	-

Excerpta Medica (Ovid)						
Cochrane Library (Title, Abstract, Key Words)	1	26	0	-	-	-
PsycARTICLES	128	5881	52	52	0	-
Taylor and Francis Online	7694	11318	94	82	12	2 (Keville et al, 2013; Punzi, 2015)
PubMed	805	2507	4	1	3	0
CINAHL Plus	1702	581	7	7	0	-
Google Scholar (2010 - 2015)	-	-	266 – 'Reflective practice' AND 'clinical psychology training' (202) OR 'training in clinical psychology' (64)	262	4	1 (Woodward et al, 2015)
Total	19284	95705	918	471	26	**9**

Framework for the Critical Evaluation of Papers' Methodological Qualities

Sale and Brazil's (2004) cross-paradigm framework for the critical evaluation of mixed-methods studies was used to assess the qualities of the reviewed papers. This framework, which draws from Lincoln and Guba's (1985, 1986) framework of trustworthiness and rigour, is appropriate in reviewing papers on a research topic – reflective practice in clinical psychology training - that is immature, and without uniform definition or established paradigmatic assumptions. The framework's four main categories (goals of evaluation criteria) can accommodate the evaluation of research that draws on qualitative, quantitative or mixed methods, and that relies on positivist, constructionist or interpretivist paradigmatic assumptions. Within the corpus of reviewed papers, there was a predominance of qualitative research, though relations to particular paradigms were often unstated.

Using a simple red (not stated), amber (stated with limited detail), and green (stated with clear detail) coding system, Appendix IX provides detailed tables (Tables 9 - 12) of the critical appraisal of papers' methodological qualities. All ratings attributed to two papers (Brown et al, 2009; Binks et al, 2013) were audited by a colleague, with a total of five criteria-specific red/amber inconsistencies discussed and rechecked with reference to the paper. One item was then changed from amber to red. This was taken to indicate a good level of consistency across ratings. Papers' overall goal category ratings (for truth value, applicability, consistency and neutrality) – based on the balance of criteria-specific red, amber and green ratings - are provided in Table 5, below.

Table 5: Overall methodological quality ratings, by criteria goal domain, as set out in Sale and Brazil (2004) [see Appendix IX for detailed evaluation of papers, by domain]

	Paper Authors and Publication Year									
Goals of Evaluation Criteria	Knight et al, 2010 (qualitative;		Brown et al, 2009	Binks et al, 2013	Burgess et al, 2013	Keville et al, 2013	Wood et al, 2013	Sheikh et al, 2007	Punzi, 2015	Woodward et al, 2015
Truth value (credibility)										
Applicability (transferability)										
Consistency (dependability)										
Neutrality (confirmability; objectivity)		-								
Overall										

In a relatively immature research area, methodological quality is varied, and often poor. Authors were generally plausible in recognising the limitations of the applicability of individual pieces of research. This was often based on the reliance of small sample sizes drawn from settings of which the characteristics (format and breadth of clinical psychology training activities) could not be assumed to be typical. In Part III, Lavender's (2003) description of reflective practice is used to structure the description and critical review of papers. Before that, it is important to summarise and acknowledge the findings from past reviews that overlooked – or narrowly pre-dated – clinical psychologists' research in this area.

PART II: PAST REVIEWS INTO REFLECTIVE PRACTICE

Table 6, below, provides a summary of three general reviews into reflective practice, indicating those professions and disciplines from which reviewed papers were drawn. Given that reflective practice is heavily implicated in the professional narrative of clinical psychology (BPS, 2014; HCPC, 2015), the absence any papers relating specifically to clinical psychology in these inter-disciplinary reviews is surprising.

Ruth-Sahd (2003, p. 488) explained that nurse practitioners and educators were encouraged to engage in reflective practice despite being shown very little evidence that it actually improved practice. Twenty papers were reviewed. Positive outcomes from 'the reflective process' included identifying and increasing theory-practice links, experiential learning, self-esteem through learning, acceptance of professional responsibility, continuing professional growth, critical thinking and judgment making in complex and uncertain situations, practitioner empowerment, social and political emancipation, self-awareness, and the development of clinical knowledge and skills. Benefits from reflective practice were associated with individual characteristics (flexibility, mindfulness, and openness) and safe learning environments (openness, honesty, trust). Two studies identified educators as not reflecting, due to reasons of not seeing the personal or educational value in the practice (Teekman, 2000; Wellard and Bethune, 1996).

Mann, Gordon and MacLeod (2009) noted that it was assumed that reflection would enhance competence, though evidence neither supported nor refuted that. Having reviewed 29 papers, it was suggested that early in studies and training, learners might need a structure to guide reflection, whilst researchers needed to utilise more

diverse study designs and methods to evaluate the effects of different educational strategies for reflective practice development (p. 615).

Platt's (2014) review and recommendations aimed to reduce 'faked' reflection in learners. This was identified as a problem where learners were required to evidence reflection for evaluation purposes, as had been observed within one university-wide programme. 'Real' reflection, in writing, was dependent on the progression of time and students' affective 'journey' (Clegg and Bufton, 2008, p. 446, in Platt, 2014, p. 47). This led to calls for reflective practice to be understood in process-driven terms rather than as outputs-driven. To this end, the challenge to embed reflection and reflective practice across curricula, in place of task-based approaches, was outlined.

Across the three reviews, common observations were that the definition of reflective practice was vague, learning cultures could either promote or inhibit reflection, the strength of evidence for impacts of reflection on practice remained weak, and the assessment of reflective practice risked learners presenting 'fake' reflection. Common recommendations were that learners could be guided in both cognitive and affective reflection, educators have a role to play in demonstrating the valuing and modelling of reflective practice, and feedback to learners on both the content and process of reflection would be helpful.

In concluding her review, Ruth-Sahd (2003, p. 495) stated that educators must seek to clarify the vague process and identify essential practices for reflection. Platt (2014, p. 50) added that a disciplinary rather than general approach to reflective practice would enable greater staff and student or trainer and trainee ownership of reflective processes. Each of these recommendations is taken up in Part III as this review continues with a focus on reflective practice in clinical psychology training.

Table 6: Summaries of past general reviews concerning reflective practice

Review, review type, audience and aims	Reviewed papers' disciplines and publishing period	Main findings	Key recommendations
Ruth-Sahd (2003) Review type • Critical analysis (otherwise unspecified; systematic / narrative synthesis) Audience • Nursing educators Aims: • Identify scope of reflective practice • Identify gaps in literature • Discuss implications of fostering reflective practice in nursing education • Encourage nurse educators to practice reflection	Papers' disciplines:- • Higher education (general) • Nursing • Social work • Science education • Pastoral education • Management and leadership Publishing period • 1992-2002	• There is a lack of empirical research on reflective practice, much literature remains theoretical • Reflective practice involves a questioning of practice which can be risky, painful, stressful, and is not easy • Novice nurse educators neither valued reflective practice nor saw it as significant in improving practice. This may be due to vague definition, time constraints and contrary learning culture	• Engage learners cognitively and affectively • Educators must believe in, practice and model reflective practice

Review, review type, audience and aims	Reviewed papers' disciplines and publishing period	Main findings	Key recommendations
Mann, Gordon and MacLeod (2009) Review type • Systematic review Audience • Medical and wider health professions educators Aims:- • Identify variables influencing reflection and reflective practice • Identify gaps in literature • Identify implications for practice and research	Papers' disciplines:- • Nursing • Medicine • Health Sciences • Dentistry • Physiotherapy Publishing period • 1995-2005	• No study addressed outcomes of reflective practice • Reflective thinking is associated with deeper learning and meaning-making • The learning environment can encourage or inhibit reflective thinking • The behaviour of mentors and supervisors is important to learners' reflection	• Educators' modelling their own reflective practice would benefit learners • Feedback on the content and process of their reflection (reflection-on-action, reflection-in-action) may be helpful early in learning • The wider learning culture and environment must demonstrate a valuing of reflection in order to support learners' reflective practice

Review, review type, audience and aims	Reviewed papers' disciplines and publishing period	Main findings	Key recommendations
Platt (2014) • Narrative review (including institution-wide case study) Audience • Teaching staff in higher education (general) Aim: • Identify challenges and effective strategies for incorporating student reflection into curriculum	Papers' disciplines:- • Teacher training • Medical professional training • Nursing education • Sociology • Psychology • Tourism and leisure studies Publishing period • 2001-2012	• 'Fake' reflection is a problem • Differentiating between 'good' and 'bad' reflection is difficult • Formal assessment of reflective practice 'forces' reflection • Reflective practice tied to employability agenda leads to focus on outputs rather than process • Centralized (cross-disciplinary) policy-making around reflective practice overlooks important subject-specific information	• Reflective practice ought to be facilitated as a developmental process • Raise staff and student ownership of reflective practice through specific disciplinary (not generic) approach • Research must be generated from within specific disciplines

PART III: REFLECTIVE PRACTICE AND TRAINING IN CLINICAL PSYCHOLOGY: A CRITICAL REVIEW OF ORIGINAL RESEARCH USING LAVENDER'S (2003) FOUR-PROCESS FRAMEWORK

As indicated in Table 6, below, there was variation in the sources of definitions ascribed to 'reflective practice,' along with methodological variation as researchers sought to explore this within clinical psychology training. The potential for inconsistent handling of the concept risks confusion and so needs to be managed. Thus, the structure for this part of the review follows Lavender's (2003) four-process overview of reflective practice. Whilst only three of the nine reviewed papers drew upon Lavender's account, all – given their specific foci and findings – lend themselves to critical review under the four process headings of 'reflection on action,' 'reflection in action,' 'reflection about the self (awareness and development),' and 'reflection about the impact of self on others.' These are organized in two sections. The first section discusses reflection on and in action. The second section discusses reflection and self, incorporating awareness and development, and the impact of self on others. Departing from Lavender's reflective processes, a final section begins a critique of research that discusses training programme communications and organization.

Only one paper (Burgess et al, 2013) was unambiguously linked to just one reflective process (reflection in action). Papers tended to be concerned with one of Lavender's (2003) four processes whilst also making minor references to the others. In such cases, papers are discussed only under their major (most relevant) reflective process heading. Where ambiguity might exist in terms of the reflective process that is most relevant to a paper, the position of the paper within this review is determined in

view of its reported aims and findings.

In line with Pyrczak's (2005) guidance on writing literature reviews, attempts are made to distinguish between researchers' assumptions, findings and theoretical propositions. Attempts are also made to identify insights, limitations and commonalities of the research beyond those that their authors recognize. Table 7, below, provides a summary of the nine featured papers' study and findings details.

Table 7: Extended summaries of reviewed papers

Study Details (Authors, Year of publication; Source publication; Aim; Reflective practice (RP) defined by; Related concepts within study)	Participants and Setting (Sample size; Recruitment process; Key characteristics; Location)	Methods (Design and data collection; Dataset; Data analysis)	Findings (Main findings; Recommendations; Acknowledged limitations)
Knight, Sperlinger and Maltby (2010) Clinical Psychology and Psychotherapy Aim: Investigate the impact of RP groups for former trainees. RP defined as per Schön (1983), Lavender (2003) Related concepts: Personal and professional development (PPD)	n = 124 Purposive sample of clinical psychologists, qualified 1986 – 2007, from one training programme 85% female, 15% male; 86% white British; 57% aged 31-40; 14-73% of year group cohorts participated; 57% participated in RP group of 10-13 people UK	Design and data collection: Analytic survey design (questionnaire – 113 items – 98 Likert scale questions, 15 open (qualitative) items) Dataset: Completed questionnaires Analysis: Principal components analysis (PCA) of 98 items; Thematic (numeric) analysis of 15 open items	Findings: PCA of RPG questionnaires yielded two dimensions: perceived overall value and perceived distress 43% described RPGs as producing high distress; 29% described RPGs as of low value Group size and facilitation potency significantly predict perceived value and distress. Recommendations: Facilitators require training in group processes; Alternative means of RP development ought to be available. Limitations: none stated.

Study Details (Authors, Year of publication; Source publication; Aim; Reflective practice (RP) defined by; Related concepts within study)	Participants and Setting (Sample size; Recruitment process; Key characteristics; Location)	Methods (Design and data collection; Dataset; Data analysis)	Findings (Main findings; Recommendations; Acknowledged limitations)
Brown, Lutte-Elliott and Vidalaki (2009) Clinical Psychology Forum Aim: To gain an insight into the usefulness of (case discussion) groups which were set up explicitly to develop reflective practice. RP defined as per Schön (1983, 1987) Related concepts: Facilitation; group processes	n = 10 Convenience sample of volunteers from one training programme Participants were either Year 1 or Year 2 trainees, or under one year post-qualification UK	Design and data collection: Qualitative, semi-structured interviews Dataset: Interview transcripts Analysis: Interpretative phenomenological analysis	Findings: Reflection was understood as either an introspective observation of the self, or as a process prompted by a negative feeling, emotion or evaluation. Active facilitation, some form of structure and a willingness to confront group process issues were necessary for developing groups and for developing reflection in participants. Recommendations: Facilitators of groups aimed at developing reflective practice must be willing to manage group processes. Limitations: none stated.

Study Details (Authors, Year of publication; Source publication; Aim; Reflective practice (RP) defined by; Related concepts within study)	Participants and Setting (Sample size; Recruitment process; Key characteristics; Location)	Methods (Design and data collection; Dataset; Data analysis)	Findings (Main findings; Recommendations; Acknowledged limitations)
Wood, Lea and Holttum (2013) Journal of Mental Health Training, Education and Practice Aim: To bring about change through reflective practice group exploration of links between personal/life experiences, and their relation to training as mental health practitioners, learning processes and a training programme RP defined as per Schön (1983) Related concepts: Equality Act (2010); Service-user involvement	n = 20 Voluntary self-selection from one training programme 6 programme staff; 14 trainee clinical psychologists (no further details indicated) UK	Design and data collection: Action research design incorporating 4 RP group sessions, one focus group (10 participants – seven trainees, three staff) and one interview (one staff member) Dataset: Focus group and interview transcripts Analysis: Thematic analysis	Findings: Overarching theme of tension; Issues of parenthood, carer-responsibilities and social class regarded as areas of neglected (personal, hard to talk about) experience within RP group. Recommendations: For new ways of working to evolve, new dialogue must take place; Action research process offers preliminary evidence for developing new dialogue, collaborations and training for mental health professionals. Limitations: RP group - group size too large, sessions few and infrequent; History of service-user and carer involvement within programme may provide different context to other programmes, thus impacting on applicability of findings.

Study Details (Authors, Year of publication; Source publication; Aim; Reflective practice (RP) defined by; Related concepts within study)	Participants and Setting (Sample size; Recruitment process; Key characteristics; Location)	Methods (Design and data collection; Dataset; Data analysis)	Findings (Main findings; Recommendations; Acknowledged limitations)
Burgess, Rhodes and Wilson (2013) Clinical Psychologist Aim: To identify in-session reflective capacity of trainee clinical psychologists and identify training needs RP defined as per Schön (1983) Related concepts: Therapeutic relationship; transference; countertransference	n = 10 Selection process unstated All participants Year 1 trainee clinical psychologists (4 year programme full-time); 8 female, 2 male; Ages 22-46 (average: 30.8) Australia	Design and data collection: Interpersonal process recall design (interview, referring to video-recording of participants' delivery of a therapy session – nine sessions with adults presenting with anxiety/depression, one session with a couple with relationship difficulties – sessions utilising CBT) Dataset: Interview transcripts Analysis: Grounded theory analysis	Findings: All participants experienced distress when confronted by unexpected processes in the therapy room; Distress tended to involve interpersonal differences between trainee and client. Recommendations: More research on systematic approaches to teaching and learning of in-session reflective practice is required. Limitations: Homogeneous sample may have limited richness of theory development.

Study Details (Authors, Year of publication; Source publication; Aim; Reflective practice (RP) defined by; Related concepts within study)	Participants and Setting (Sample size; Recruitment process; Key characteristics; Location)	Methods (Design and data collection; Dataset; Data analysis)	Findings (Main findings; Recommendations; Acknowledged limitations)
Binks, Jones and Knight (2013) Reflective Practice Aim: Explore RP group facilitators' perspectives on trainees' distress, and its relationship with RP outcomes, and the role of facilitator RP defined as per Schön (1987), Lavender (2003) Related concepts: Personal professional development; facilitation; trainee distress	n = 7 Purposive opportunistic sample from one clinical psychology training programme Four male, 3 female; Participants qualified 15-25 years, had facilitated 1-3 unstructured RP groups (of 8-20 trainees) in past 10 years UK	Design and data collection: Qualitative (interview-based) phenomenological design Dataset: Interview transcripts Analysis: Interpretative phenomenological analysis	Findings: Trainees' commitment to engaging with distress was perceived as significant to emotional learning; Supervision important for containing facilitators in their role; RP groups are not a helpful means of PPD for all trainees. Recommendations: Training programmes that mandate RP group attendance should clearly communicate the philosophy underpinning them at selection and during training; Further research may describe learning processes that connect trainees' emotional experiences within RP groups to PPD. Limitations: Homogeneity of sample may limit theoretical transferability to other contexts.

Study Details (Authors, Year of publication; Source publication; Aim; Reflective practice (RP) defined by; Related concepts within study)	Participants and Setting (Sample size; Recruitment process; Key characteristics; Location)	Methods (Design and data collection; Dataset; Data analysis)	Findings (Main findings; Recommendations; Acknowledged limitations)
Keville, Siddaway, Rhodes, Horley, Brown, Dove and White (2013) Reflective Practice Aim: To explore learning experiences of a group of trainee clinical psychologists RP defined as per Nel et al (2008), Pica (1998) Related concepts: Problem-based learning (PBL); personal development; evaluation; personal professional development	n = 6 Opportunistic purposive sample that constituted one problem-based learning group Five female, one male; Year 3 trainee clinical psychologists UK	Design and data collection: Qualitative critical reflection - individually written reflective accounts Dataset: Six written reflections Analysis: Thematic analysis	Findings: Negative evaluation and life experiences may have an inhibitory impact on trainees' developing professional identities. Recommendations: Evaluation of trainees can be a double-edged sword; Trainers enacting a nurturing role may foster a learning environment in which trainees might safely engage and connect with personal vulnerability, one another and case material, enhancing clinical work. Limitations: The data offers only a small proportion of participants' thoughts and feelings, and may have been influenced by their (PBL) facilitator.

Study Details (Authors, Year of publication; Source publication; Aim; Reflective practice (RP) defined by; Related concepts within study)	Participants and Setting (Sample size; Recruitment process; Key characteristics; Location)	Methods (Design and data collection; Dataset; Data analysis)	Findings (Main findings; Recommendations; Acknowledged limitations)
Sheikh, Milne and MacGregor (2007) Clinical Psychology and Psychotherapy Aim: To develop a model of PPD that integrates and makes explicit the ideas and methods of reflective practice RP defined as per Schön (1987), Eraut (1994) Related concepts: Personal professional development; evaluation	n = unclear (programme-level study, including current and past trainees, academic staff, NHS colleagues and NHS line managers) Opportunistic purposive sample Participant characteristics not provided UK	Design and data collection: Case study (document collection and review) Dataset: Exit interview data (n=20); internal and external course review documents; consultation, audit and survey reports; trainees' feedback and academic work (self-reflection, PBL portfolio – reflection on group processes, learning contracts) Analysis: Thematic analysis and systems analysis	Findings: The proposed model provides a map for organising PPD; the model is relatively successful at making links between course components, experiential learning, and person-centred trainee development. Recommendations: Future research and training programmes would benefit from making explicit the role of trainees' personal coping strategies. Limitations: The PPD model does not locate trainees' personal coping strategies and implies that trainees start training from a state of deficit, thus presenting a risk to motivation and effectiveness; the proposed model is described at the level of a programme, without confirming individual staff members' acceptance or valuing of reflective practice and PPD.

Study Details (Authors, Year of publication; Source publication; Aim; Reflective practice (RP) defined by; Related concepts within study)	Participants and Setting (Sample size; Recruitment process; Key characteristics; Location)	Methods (Design and data collection; Dataset; Data analysis)	Findings (Main findings; Recommendations; Acknowledged limitations)
Punzi (2015) Reflective Practice Aim: To explore how soon-to-graduate clinical psychologists perceived that education had prepared them to develop the practical wisdom that would be necessary in future clinical work with clients RP defined as per Schön (1983), Keville et al (2013) Related concepts: Practical wisdom; personal development	n = 7 Voluntary self-selected purposive sample drawn from one clinical psychology education programme Four female, three male; Ages 25-40; Final year of 5-year clinical psychology education [masters level] Sweden	Design and data collection: Qualitative (interview-based) phenomenological design Dataset: Interview transcripts Analysis: Interpretative phenomenological analysis	Findings: Practical wisdom perceived as the outcome of a reflective process; Diversity of teaching methods supports personal development and practical wisdom; Participants expressed doubt re educational programmes' ability to necessitate students' reflection upon their own relating styles. Recommendations: Action research methodologies may help overcome hindsight issues and bias; Educators should devise learning situations that are based on reflection, dialogue and that are characterised by support and permissiveness; Implicit norms ought to be identified and counteracted (interactions within learning groups and neglected topics ought to be raised). Limitations: Applicability to other countries' educational / clinical psychology contexts may be limited; Participants' self-selection and thus the risk of low generalizability / applicability.

Study Details (Authors, Year of publication; Source publication; Aim; Reflective practice (RP) defined by; Related concepts within study)	Participants and Setting (Sample size; Recruitment process; Key characteristics; Location)	Methods (Design and data collection; Dataset; Data analysis)	Findings (Main findings; Recommendations; Acknowledged limitations)
Woodward, Keville and Conlan (2015) Reflective Practice Aim: To explore the processes of PPD during clinical psychology training and implications for the development of reflective practice among trainee clinical psychologists RP defined as per Schön (1987), Lavender (2003) Related concepts: Personal and professional development; self-acceptance	n = 7 Purposive sample of individuals who had graduated from one UK-based clinical psychology training programme one or two years previously 4 females, 3 males; Age range: late 20s to late 30s; diverse ethnic and national backgrounds UK	Design and data collection: Qualitative (interview-based) design Dataset: Interview transcripts Data analysis: Interpretative phenomenological analysis	Findings: Participants described developing deeper personal awareness through training, plus greater awareness of others. Participants described developing acceptance of themselves, both personally and professionally. Across training, participants described becoming more comfortable with uncertainty, and with taking relational risks in both personal and professional relationships. Recommendations: Training of clinical psychologists would benefit from explicitly discussing what trainees personally bring to their role. This could be facilitated through reflective practice groups, which would also seek to validate current stages of training. Limitations: none stated.

The table above summarizes the main aims, research methods, findings and limitations of the nine papers featured in this review. The studies concerned with reflective practice in clinical psychology training have tended to be inductive, rather than deductive, and with the exception of Knight et al (2010) have tended to be based on low sample sizes. The broadly discursive nature of these papers is reflected in their summaries, below. Collectively, papers' findings are offered cautiously, indicating limited transferability. This casts reflective practice as an under-developed area of research.

Reflection and action

Reflection on action is an after-the-event process for raising experiential learning. This would typically involve action within an event or encounter, followed by looking back and thinking about that action and its context from the perspective of the hawk in the mind (Schön, 1983; Scaife, 2010).

Punzi (2015) presents an account of pre-qualification clinical psychologists' reflection that informs 'the practical aspects of clinical work,' in complex contexts that are *not* about applying specific methods and interventions in the resolution of well-defined problems. In coining the phrase 'practical wisdom,' Punzi describes a set of relational skills 'that have to be developed in order to encounter clients and make well-founded clinical evaluations and interventions' (p. 2). These include active listening, the abilities to relate empathically to others, reflect on oneself and one's work, and accept constructive criticism and advice – much of which are said to be derived in interaction. The seven participants in Punzi's IPA study gained method-specific supervision for their

practice of cognitive behavioural therapy and psychodynamic therapy during their clinical psychology education, in Sweden.

Whilst Punzi offers a nuanced rationale for the use of 'practical wisdom,' this is explained in terms of Schön's (1987) account of reflection on action, with a primary interest in informing clinical psychologists' relationships with clients. The terms reflective practice and reflective practice skills are used interchangeably with practical wisdom, throughout. Thus, the paper is sufficiently concerned with reflective practice for in-training clinical psychologists to justify inclusion, here.

From a well-outlined six-stage IPA process, four themes are described. These are 'practical wisdom as a reflective process,' 'personal development,' 'students left to their own devices,' and 'lack of integration' between theory and practice. Echoing topics of the interview schedule, the former two of these themes are no surprise. The latter two, however, speak of criticism of the structure of training, in terms of the process of participants becoming exposed to clinical activity. This resonates with the account of Burgess et al (2013, below), and leads to the suggestion that there would be value in novice practitioners observing interventions in the hands and voices of those who are more experienced, thus enabling students to understand these without having to worry about performing them properly (p. 9). This invites a guard against interventions being presented as merely technical practice, with observation followed by reflective dialogue. A wider perspective on this is to suggest that in conveying protocol-driven interventions, in particular, in ways that understate the relational aspects of therapeutic change, the risk is to overstate technical explanations of therapies' mechanisms of change (see, for example, Ciarrochi, Bilich and Godsell, 2010; Doss, Thum, Sevier, Atkins and Christensen, 2005). In terms of participants making sense of tensions and

dilemmas, Punzi writes of surprise at the impact of continuous discussions with peers, within which matters of practical wisdom were omnipresent. For reflecting on action, this suggests participants taking value from reflecting on their own *and others'* practice (see also, Thexton, this volume). This is said to have occurred – perhaps most usefully and openly – with peers outside of the formal group structures of the clinical education process. Where unwritten group norms emerged, these are said to have inhibited genuine dialogue and reflection, for reasons of a non-permissive climate developing.

Where group activities are designed to foster learners' reflection, Punzi suggests that norms ought to be acknowledged and counteracted. Facilitation, therefore, ought to model permissiveness or, put another way, might agitate for difference and discussion. In the views of participants, such facilitation would demand courage from teachers and students. Here, perhaps, the voluntary self-selecting nature of participation reveals itself. Whilst this could bias the range of perspectives and explanations raised by participants, so too might past or desired future encounters with the senior clinician researcher, who taught participants during an earlier phase of their education.

Offering a contrasting perspective, Binks, Jones and Knight (2013) present an interpretative phenomenological analysis of seven reflective practice group facilitators' attempts to make sense of their experience of their reflective practice groups (p. 308). The authors' understanding of reflective practice is grounded in Schön's (1983, 1987) accounts of reflection-in-action and reflection-on-action. The authors extend this to include reflection about the impact of one's interpersonal style on others, and reflection on the self that develops increased awareness of how one's vulnerabilities might play out in clinical practice (Lavender, 2003). This specificity implies a conceptual tailoring of reflective practice to fit the therapeutic and wider inter-professional role of clinical

psychologists. The most fundamental criticism of this study relates to the level of analysis. Comparing what the study sought to explore with its emergent master themes illustrates this. Where facilitators' sense making of trainee distress was explored, the master theme of 'conceptualizing the meaning and value of trainee distress/difficulty' emerged; where the relationship between distress and outcome was explored, the master theme of 'complexity and challenge of the group boundaries' emerged; and where the facilitation role was explored, the master theme of 'experience of the facilitator's role' emerged. With the research questions appearing to strongly pre-empt emergent findings, the level of analysis could be said to be thin. Usefully, analysis organizes the data under those areas of exploration. Where phenomena are under-researched this can be sufficient for affording original insights. Beyond all other studies' acknowledgement of such matters, this study draws out data concerning 'conceptualizations of clinical psychology and engagement,' and 'trainee rebellion against forced participation.' As group facilitators observed trainees competing and confused understandings of their future professional role (p. 311), and in some the openly expressed view of groups as an undesirable means to an end in becoming a qualified clinical psychologist (p. 313), the study identifies training process phenomena which challenge the fidelity of RPGs, and the reflective practitioner narrative. The question arising from this asks, what are the barriers to identifying and taking value from reflective practice group participation during clinical psychology training.

Earlier, in summarizing the PPD outcomes of attending unstructured, facilitated, reflective practice groups within counselling and psychology training, Binks et al conflate studies with these separate (albeit related) professional groups. No reference is made to the training or professional requirements that distinguish clinical psychologists

from counsellors. This is inconsistent with the claimed specificity of IPA studies, which seek to understand 'a particular phenomenon in a particular context' (p. 307). Also, the specificity of the studied phenomenon, here, is limited. Whilst participants' facilitation of reflective practice groups occurred around one clinical psychology training programme, it did so across 'the last 10 years,' and for groups of 'between approximately 8 and 20 trainees' (p. 307). From the outset, this may be an under appreciation of the extent to which context shapes the multi-perspective phenomenology of reflective practice groups. Helpfully, participants 'wondered whether trainee non-engagement might be compounded by the training course failing to sufficiently embody and/or communicate a philosophy consistent with personal learning within the groups' (p. 316; Smith, Youngson and Brownbridge, 2009). The authors end their paper with the suggestion that training programmes might consider whether trainee engagement would be increased by offering a range of different methods of reflective practice, with groups as one option (p. 317). Youngson and Hughes' (2009) cautionary note is sensibly attached to this, acknowledging that this may open up 'easy,' albeit less valuable learning from reflective practice, as indicated by the 'high distress, high value' respondents to Knight et al's (2010) survey (see below).

Burgess et al (2013) produced the only research that sought to investigate reflection *in* action with trainee clinical psychologists. Reflection in action requires the individual to think on their feet, to actively process phenomena as they are being experienced (Schön, 1983). The methods of investigation – interpersonal process recall paired with semi-structured interview, relied on their 10 participants to review a film recording of a therapeutic session that they themselves led immediately prior to being interviewed. Analysis of interview transcripts followed grounded theory principles.

The authors describe substantial distress being experienced as planned and anticipated session content did not unfold as expected. At observing such occurrences, participants tended to attribute difficulties to interpersonal issues with and within the client.

The methods and proximity of data collection to the trainees' practice demonstrates thoughtfulness in the researchers' attempts to get close to in-session reflection. Participants' wider context may have impacted on their preparedness to think on their feet, and demonstrate flexibility, adaptive skills or attendance to in-session processes between themselves and their clients. All participants' clinical psychology training and all sessions recorded for data production were closely aligned with cognitive behavioural therapy (CBT). Rather than criticize CBT, here, for its focus on technical rationality over say interpersonal dynamics and therapeutic alliance (Antonio González-Prendes and Brisebois, 2012, provide a credible defence against such criticism), the matter of participants being *novice* practitioners is important. It is reasonable to assume that during training a concern to teach and confirm trainees' *competence* in the *technical* aspects of such a therapeutic model would be a chief concern. Burgess *et al*'s research might be read as raising questions regarding how CBT is taught and learned – with what degree of flexibility might it be delivered, and with what possible gains and costs. Along with attempts to control conditions in support of developing a scientific evidence base, factors such as transference, counter-transference and the therapeutic relationship have tended to be understated in CBT. Whilst the messy business of interpersonal processes - part of Eysenck's 'premature crystallizations of spurious orthodoxy' (Eysenck, 1949, p. 174) - have been recognized, it has been as afterthoughts to the main theory (for a discussion of this, see Beck and Beck, 2011). It follows that this inter-subjectivities gap – into which reflecting in action, and

other reflective processes would fall - may indicate how CBT is understood by *novice* practitioners whilst still developing their understanding and practice.

As Burgess et al (2013, p. 128) discuss their participants' reactions to difficult interpersonal issues, trainees less confident of their therapeutic alliance appeared less likely to discuss this with clients. Instead, these trainees reverted to risk-free non-directive counselling. To manage in-session difficulties, participants' internal dialogue tended to reference the expert (ask 'what would my supervisor say and do, now?'), engage with transference (recognize distress as felt by clients), and engage in self-talk (normalizing difficulties and calming). The authors suggest that such covert reflections indicate trainees' supervision needs.

Reflection and the self

Reflection on the self can be described as the process of raising one's awareness of one's own beliefs, values and attitudes, whether they are associated with personal life, professional life, or both. Ideally, this form of reflection informs us of our own developmental needs. *Reflection on the impact of self on others* refers to the process of raising our awareness of others' experiences as they encounter us. This can refer to simple or complex reactions – thoughts, emotions, and physical feelings, behavioural or relational responses – that are elicited in others as we interact with them (Lavender, 2003). The former of these two processes has been implicated in each of the studies described below, the latter features much less.

Brown, Lutte-Elliot and Vidalaki (2009) explain that at their UK university, case discussion groups form the backbone of the approach to reflective practice, adding to

the personal and professional learning occurring in the clinical supervision relationship. Based on interpretative phenomenological analysis of ten interviews with current and recent trainees, the study aimed to gain insight into the usefulness of groups explicitly set up to develop reflective practice. Details of groups' facilitation are scant, not indicating how directive or structured this was, and so not clarifying any intention of prompts towards any of Lavender's (2003) specific reflective processes. The first of four themes describes variation in participants' understandings of reflection. This was understood as either thoughtfulness regarding the self and interactions with the environment, or as a process that was provoked upon being faced with a dilemma, something 'not working' or a strong negative emotional reaction. This was echoed in Burgess et al's (2013) observations of what yielded trainees' efforts towards reflection in action. Further variation was observed in participants' incorporation of reflection within the self. This theme described the distinction between those participants for whom reflection required conscious effort and time set aside, and those who claimed to reflect without parameters as 'a way of thinking' (Brown et al, 2009, p. 44). The third theme identified consensus regarding group facilitation being an important role that demanded activity, and attention to group structure and processes. Finally, as the theme of case discussion groups as safe environments for reflection was outlined, positive and negative experiences of receiving feedback and being heard were introduced. Acceptance and permissiveness were markers of safety, raising trainees' willingness to 'share more personal material and hear feedback in a less threatening way' (p. 45). Again, themes appear to closely follow the interview schedule, which explored 'understandings of reflection and aspects of trainees' experience of case discussion groups' (Brown et al, 2009, p. 42).

A point of potential confusion arising from Brown et al's (2009) study is the interchangeable use of the terms reflective practice and reflection, corresponding with the study's aim and findings, respectively. A major limitation, therefore, is the authors' inability to address whether groups' activity related to reflective *practice*, and if so, in what emerging form. Such variation reflects the profession-wide position of reflective practice at that time.

In the absence of a profession-wide review of the impact or effectiveness of reflective practice groups (RPGs) for trainee clinical psychologists, a valuable study is that of Knight et al (2010). This single-programme survey of RPGs' personal and professional impacts on 18 cohorts of former clinical psychology trainees describes such groups as 'a major method for personal and professional development and the training of reflective scientist practitioners' (p. 428). Specifically, RPGs are said to provide the opportunity to learn about and experience group dynamics, aiding reflection on action, reflection about impact on others, and reflection about self (three of Lavender's (2003) four reflective processes). The authors' caveat is that group members must be willing to share their experiences, and that trust, support and active participation are necessary for challenging and productive learning experiences (see Williams and Walker, 2003). Through principal components analysis of 98 Likert scale items from their RPG questionnaire, Knight et al identified two distinct dimensions from 105 validly completed questionnaires. These dimensions were participants' perceived overall *value* of groups, and their perceived *distress*. Seventy one per cent of participants rated their RPG experience as high in value (29 per cent rated this as low), whilst 43 per cent rated their group experience as producing high distress (57 per cent described low distress). Combined, 27 per cent (28 out of 105) rated their experience as both high in distress

and high in value – perhaps justifying that distress. In stark contrast, 16 per cent (17 out of 105) described an experience that was high in distress yet low in value. Trainees' experiences of groups are therefore highly mixed, raising questions of how and whether to differently accommodate those who claimed low value being drawn from the experience. Here, the authors adhere to Lavender's (2003) point that psychologists need to be able to confront and work with distress in themselves, along with potentially painful information about themselves, their attitudes, values and how they interact with others. Thus, self-awareness should not be an optional activity, though which methods would best achieve this remains unclear (Knight et al, 2010, p. 435). In setting out this position, the authors make the assumption that for those claiming a high distress and low value experience of reflective practice groups, they are resisting or opposed to the process of reflecting on the self. For this, no supporting evidence is provided.

As well as reflective practice groups, collaborative experiential (enquiry- or problem-based) learning has been described as offering a platform for the demonstration and development of reflective practice. Keville, Siddaway, Rhodes, Horley, Brown, Dove and White (2013) explore the learning of six trainee clinical psychologists following the third of five problem-based learning (PBL) exercises that occurred during training. To do this, written reflections of the trainees (all but the first author) were subjected to thematic analysis. Each PBL exercise was accompanied by a 20-minute group presentation and a 1500 word reflective essay, and with the exception of the first exercise, each had to be passed in order for the trainee to qualify. As the trainees received a negative evaluation following their first (unmarked) group presentation - being advised that had it been formally assessed it may have been graded as a fail, the context for subsequent PBL exercises was rich with risk and uncertainty.

Trainees' openness to authentic reflection – versus the *performance* of pass-worthy PBL-engagement - thus became an issue.

One strength of the paper is that all written data is made available, demonstrating trainees' experiences through highly emotive language. With the first author having facilitated the group's PBL exercises, the potential for this biasing both the data and its interpretation must be considered high. Nonetheless, both the data and analysis elucidate the complexity of trainees' decision-making in how – or whether – to approach further reflective inquiry with openness.

Having at first 'dived in' to expose their individual doubts and personal vulnerabilities, which then informed their negatively evaluated PBL presentation, the trainees reflected upon a shared sense of hurt (Keville et al, 2013, p. 8). Following negative evaluation, trainees were reluctant to be open, though four of the six make the claim – as does the first author – that there followed the re-emergence of congruency and an openness to express differing positions within the group (Keville et al, 2013, p. 9). The qualities of group facilitation – unconditional acceptance, support and faith, translating into validation and containment – are said to have been pivotal in this process, allowing for greater self-awareness and acceptance. The authors recognize that individual learning experiences may be facilitated or hindered by those around them, whether peers, families, teachers or trainers, or employers. In the example of encouraging reflection and reflective practice through problem-based learning, trainee clinical psychologists are said to have to take the risk of self-disclosure, as they encounter uncertainty and hope. Whether those risks are encountered individually or collectively would vary with facilitation, individual and group factors.

Later, from the same university and lead author, Woodward, Keville and Conlan

(2015) sought to identify recently (less than two years) qualified clinical psychologists' experiences of becoming reflective practitioners. Seven participants from one training programme were interviewed for this IPA study. The sparse details of training that are outlined mention reflective opportunities based around peer-working and problem-based learning tasks, with reflective practice group participation and reflective discussions with clinical supervisors briefly acknowledged. No evidence is provided for planning or learning processes that link specific elements of training programme activity to particular reflective processes. Instead, the authors draw loosely on the circumplex model of personal professional development (PPD) (Sheikh et al, 2007, see below) for its mapping the learning context of clinical psychology training, adding that PPD enhances self-awareness, resilience-building and reflective abilities, and caution that trainee engagement can depend on personality and attitude. The absence of strategic planning or detail, here, echoes past findings concerning a lack of consistency and transparency in training programmes' provision for PPD (Gillmer and Marckus, 2003).

Observing that theories of reflective practice call for awareness of the *personal* self as a means of maintaining and improving *professional* practice, the authors challenge any suggestion of separateness between 'the Ps' of personal and professional development. Superordinate themes 'Enhancing awareness of self and others,' 'Taking risks and managing uncertainty' and 'Developing self-acceptance' are introduced. Illustrative data extracts tend to refer to trainees encountering clients, and to reflections on the self. Raised self-awareness is attributed to relationships and interactions with peers and clinical supervisors. The authors explain that self-awareness and self-acceptance were closely linked in participants' experiences, with development in these

leading to their more ably working with uncertainty. This incorporated 'relational risk-taking.' Participants' allowing themselves to 'be vulnerable and open' in personal and professional relationships – not having to have all of the answers, all of the time – enabled a deeper connection with others, which was valued. This encouraging note is linked to likely demands arising from managing, supervising and consulting post-qualification. The authors suggest that relationships, and emotional experiences within these, 'should be the central focus within all aspects of the clinical psychologist role' (Woodward et al, 2015, p. 786). This may be achievable via the adoption of a personal focus within the training of reflective practitioners, thus linking self-awareness, improved reflective practice, therapeutic and inter-professional relationships, and the effectiveness of interventions.

There remains, however, an oversight in Woodward et al's discussion of how training programme learning contexts come to be shaped. As well as trainees' own personalities and attitudes mediating engagement, there will be encounters with the personalities, attitudes and communications – formal and informal, consistent and inconsistent - of staff and other local professionals, who hold assessment and evaluation responsibilities over trainees. Knight et al (2010) and Brown et al (2009) demonstrated that communication and relationships do impact on trainees' perceptions and reflective engagement. In stating the benefits of staff and facilitators *supportively* challenging and confronting trainees (to reflect on themselves and on group processes), the authors indicate an awareness of the positioning and relational power of programme staff and facilitators. On this, Woodward et al find that the modelling of a permissive culture – one that invites and encourages the exchange of diverse experiences and perspectives – is an important means of fostering trainees' increased self-awareness, self-acceptance,

and ability to reflectively encounter new and uncertain relationships.

In contrast to the studies above, reflective practice (group participation) has been positioned within an action research process (Wood, Lea and Holttum, 2013). Regarding the personal-professional interface, the study sought to explore (professional) training experiences whilst living with (personal) protected characteristics of the Equality Act 2010. Those characteristics are age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity. The action research process is based on a cyclical collaborative process of action and reflection aimed at social change (Wood et al, 2013, p.17). Six members of training staff and 14 trainees volunteered participation. Participants attended five 50-minute reflective practice group sessions, with data collected from one subsequent focus group (of staff and trainees) and one interview (staff member) subjected to thematic analysis.

The authors describe an overarching theme of tension, and outline experiences and characteristics that remained difficult for participants to openly reflect upon within clinical psychology training. Neither through the taught content of training nor within reflective practice groups did there appear to be a straight-forward way to raise and reflect upon personal experiences of social class, parenthood or mental distress, none of which fall neatly into the protected characteristics of the Equality Act 2010. These findings are consistent with past research that suggested the need to avoid being perceived as mentally unwell for those in mental health professions (Goodbody and Burns, 2011; Gough, 2011; Stanley, Ridley, Harris and Manthorpe, 2011). Where training staff and clinical trainees hold back in reflecting openly about their own experiences, this leaves it to formally recognized *others* - service-users and carers - to be

the voices of and for mental distress. Wood et al explain that their study took place in the context of a rising *them* (professionals) and *us* (service users) critique, which became a matter for further exploration as the reflective practice group and action research process continued.

A necessary criticism of this study relates to potential bias. Participants' self-selection may indicate standing interests in reflective practice and learning processes, or a desire to raise issues that were previously silenced. The use of reflective practice groups within an action research process supported this, however, access to those who may have experienced the reflective practice *group* format as a barrier to participation would not have been achieved. Similarly, the participation of staff tasked with evaluating trainees alongside those same trainees brings to mind others' criticism concerning trainee engagement being inhibited where groups' facilitators were perceived to be involved in training programme organization and trainee assessment (Knight et al, 2010; Binks et al, 2013). No substantial discussion of this was raised, though.

Training programme communications and organization

This section concerns the messages that training programmes communicate to trainees regarding reflective practice. Research that made comments on organizational factors relating to reflective practice is also featured.

In linking the delivery of psychological therapies to staff development and training, Sheikh, Milne and MacGregor (2007, p. 278) state that the reflective practitioner model is vague and needs refinement. From this, the case study of one

training programme's attempt to make reflective practice explicit is presented. Centred on raising awareness, resilience and professional effectiveness (the functions of PPD), Sheikh et al propose a model that is based on Kolb's (1984) experiential learning cycle. This provides an overview of programme activity and learning context. The model recognizes declarative coursework (including a reflective journal), PPD assignments, tasks and other challenges (including life events), and procedural workshops and groups as occurring against a complex mix of personal and professional relationships and support systems. With formal methods (such as Balint groups and PPD sessions) aimed at raising awareness and reflection, the learning processes that would yield the functions of PPD are not specified.

Overall, the authors' attempt to make reflective practice explicit does not emerge from their account, however, they provide a helpful overview of the complex training environment within which future studies might seek to connect specific learning activities to specific reflective processes or practice outcomes.

Two further criticisms of Sheikh et al's model relate to crucial matters. First, in its 'circumplex' presentation, the model is complex and does not immediately suggest instrumental value to those seeking to develop reflective practice and PPD. Second, there is no evidence of their own training programme's staff's commitment to teaching and learning for reflective practice or processes, or the functions of PPD. Such a blind spot, or the assumption of enthusiasm and commitment, overlooks the potential for inconsistent messages regarding the place of reflective practice and PPD in clinical psychology training and practice. As other studies emphasized reflective practice, PBL and case discussion groups' facilitation as critical to reflectively engaging trainees, the attitudes, communication and practices of programme staff and related professionals

must be regarded as a key detail of learning context, here (Binks et al, 2013; Knight et al, 2010; Brown et al, 2009).

In light of Sheikh et al's observations regarding the vague reflective practitioner model, the positioning of reflective and PPD activities as discrete 'add-ons' to programmes' core taught content passes without evident reflection, too. Such detachment hardly suggests training based on an integrated reflective scientist-practitioner model, but rather parallel models. To encourage maturation of the reflective scientist-practitioner model, it would seem reasonable to explore how reflection might be invited and evidenced, or modelled, *within* - rather than alongside - the core taught clinical content of training.

Returning to Knight et al's (2010) survey study, the belief of having initially received a good explanation of the reflective practice group was positively correlated with a high-valuing perspective. Details of group facilitation also formed some substantial observations. Where participants understood their group's facilitation to be informed by a clear and open psychodynamic or group analytic style, this was linked to significantly higher valuing of experience than for those who were unsure of their facilitator's model or approach. Higher valuing of groups was also significantly correlated with facilitators commenting a lot on group processes, and the facilitator being very active in the group. Conversely, a remote style of facilitation was negatively correlated with perceived value, and positively correlated with higher distress. In Brown et al's (2009) account of case discussion groups, facilitation perceived as *laissez faire* was met with a low valuing perspective. In contrast, when facilitation was described as 'brave' - for observing 'something wrong' in a group, and asking why a group 'doesn't work' – this challenge became a positively transformative moment. Also,

although 'structured' facilitation could feel 'constrained,' the emotional containment that this provided was linked to more participation and value being derived across one year of fortnightly group meetings (p. 44).

The findings above point towards specific recommendations for how best to facilitate groups such that trainees will describe them as high in value. This does not, however, confirm or disconfirm whether any of Lavender's (2003) processes for reflective practice took place. This is due to the learning mechanisms occurring in such groups not being revealed in studies, despite claims of providing insight into the perceived impact of RPGs (Knight et al, 2010, p. 436). Given Burgess et al's (2013) findings, where trainees are anxious to acquire and demonstrate technical knowledge during training, it may be that greater value is drawn from clearly psychodynamic facilitation, for example, for the modeling of theoretically informed handling of groups. In such a circumstance, a valuable learning experience may not depend on active reflection on self, on action or on impact on others, but simply observation.

As Keville et al (2013) advocated problem-based learning as a viable context in which to hold honest and open explorations of personal and group experiences, this would risk isolating reflection within training programme organization. With the same authors acknowledging that it would be natural for trainees to listen to core lecture content via one's own personal experience (p. 10), it may be that studies to date have overlooked *reflective teaching* as a model for initiating an integrated reflective scientist-practitioner handling of knowledge. The formal teaching environment might equally provide a platform for acknowledging complexity and uncertainty, in likely clinical encounters, in inter-professional practice and in emerging professional identities.

PART IV: DISCUSSION – WAYS FORWARD FOR REFLECTIVE PRACTICE IN CLINICAL PSYCHOLOGY TRAINING

Below, the main findings from the review (Part III) are discussed with reference to training in clinical psychology, as summarized in Part I. Following this, a new model for engaging clinical psychology trainees in reflective practice is outlined. This draws on the principle of psychological formulation that is central to professional practice. This accommodates individuals' contrasting personal professional development and training needs. Concluding remarks highlight the timeliness of this review, and conditions that encourage further research.

Discussion

As summarized in Table 5 and detailed in Appendix IX, the overall methodological quality of the reviewed papers was weak to moderate. This echoed observations from earlier general reviews; as a research topic, reflective practice is under-developed and often vaguely defined (Ruth-Sahd, 2003; Mann et al, 2009; Platt, 2014). Research on reflective practice in clinical psychology training is at an early stage of development; the strength of evidence is insubstantial, and findings and recommendations are of limited transferability. This is in stark contrast to the strength of the professional narrative that posits reflective practice as fundamental to a clinical psychological model of practice (HCPC, 2009, 2014, 2015). Whilst some studies proposed seeking alternative formats for reflective practice, where trainees do not currently demonstrate commitment to group-based activities (Knight et al, 2010; Binks

et al, 2013), others maintained that engaging with distress - in order that trainees observe and clarify their own coping strategies – was vital (Sheikh et al, 2007; see also, Lavender, 2003). Across studies, the role of facilitator – whether of RPGs, case discussion groups or problem-based learning – was observed to demand activity and skills around group processes that were not always evident or clearly expressed. On a similar theme, many studies fail to develop research around discrete reflective processes, leading to research findings that do not always lend themselves to clear development or application. It is with this in mind that the recommendations below are proposed.

Recommendations: An integrated psychological model for raising trainee engagement and programme research in reflective processes

Following Wood et al (2013), this model begins with programmes initiating action research processes to guide training for reflective practice development. Such a process necessitates a collaborative approach between training providers, trainees, and other stakeholders, which shares responsibility and ownership of training for reflective practice. The objective here is to position trainees such that self-reflection and self-assessment informs an individualized portfolio or programme for reflective engagement. Whilst there is currently no evidence of uniform approaches to reflective practice between training programmes, neither is there evidence of variation of approaches *within* programmes. With several papers suggesting that trainees' theoretical orientation (CBT, in particular) can be linked to lower valuing of activities for reflective practice, the implication is that trainees' unique interests and developmental

needs are not being recognized or met (Nel et al, 2010; Burgess et al, 2013; Punzi, 2015). As such, this model does not rely on a one-size-offered-to-all approach, and instead aspires to select and tailor elements of training (interventions for reflective practice) in light of the assessment and formulation of trainees' strengths and weaknesses.

Assessment - To assess individual trainees' strengths and weaknesses for reflective practice, Lavender's (2003) four-process framework offers a helpful starting point for training providers' facilitation of teaching and guided self-assessment for reflective practice. Here, it would be helpful to link training activities' learning outcomes to reflection on and in action, reflection on the self (for awareness and development needs), and reflection on the impact of self on others. This requires programme research to explore the value - reflective or otherwise - that trainees draw from such activities as reflective practice group participation (or non-participation), problem-based learning, case discussion groups, written reflective assignments, other PPD activities, as well as core teaching. As ongoing within-programme research, this task might initially draw on past evaluations, where quality and records are rich. As well as trainees' guided self-reflection and self-assessment, individuals' needs for reflective processes might also take account of the perspectives of clinical supervisors and colleagues, training programme staff, and training group peers. The extent to which trainees demonstrate openness to a broad and invitational self-assessment process might itself inform training programme staff of potential blind-spots or trainees' avoidance of distressing information about the self – an important matter for reflection (Lavender, 2003; Sheikh et al, 2007; Binks et al, 2013). To determine the *process* for trainees' self-assessment for reflective practice, the use of integrated staff, trainee, and other stakeholder reflective practice groups – regular and from early in training, could

be drawn from Wood et al (2013).

Formulation and Intervention - Self-assessments paired with inputs from other sources would enable training programme staff to formulate reflective skills profiles with trainees. Participatory action research could be useful here to explore the usefulness, effects on learning outcomes, and impact on trainees of contrasting reflective skills formulation formats. To capture and analyse trainees' responses could be to contribute to research that explores formulation as a specific intervention (Johnstone, Whomsley, Cole and Oliver, 2011). Within this process, caution would need to be exercised to minimise the risk of facilitators' theoretical orientations biasing assessment, or constraining what might count as legitimate means of intervention for reflective practice development. In addressing areas of relative need, trainees might engage with existing training activities, or devise unique personal professional challenges. Here, there would be scope to validate both individualised and collective means of reflection - both on and in practice, and on the self. Within action research processes, trainees' learning could be derived from both the content and processes of collaboratively devising training for reflective practice.

Evaluation - To evaluate trainees' activities for reflective processes development - that could be highly contrasting in form and content, the ethos of reflection on the self for awareness and development would suggest some means of self-evaluation. Feedback from training programme staff and those who informed assessment could add to this. A mixed methods evaluation of whole cohorts' reflective processes development would feed into the action research process, whilst also standing as a useful source of information for other training providers. Occurring across entire training cohorts, the structure of this model seeks to balance a respect for personal and professional diversity

and a systemic need for mental health professionals capable of modelling openness, deep collaboration and reflective practice.

Recommendations for Research

Local research and evaluation is integral to the proposed assessment and formulation model, above. This review has also observed substantial gaps in the knowledge base regarding trainee clinical psychologists' engagement – or otherwise – with training activities for reflective practice. In line with the findings of the review and the integrated model, a firm recommendation from this review is that a shift towards research around reflective processes could be a helpful shift away from vaguely defined research and concepts that likely create a barrier to some psychologists' understanding and engagement (Lavender, 2003).

In training, examples of trainees' passivity, distress, resistance and low valuing of reflective practice were identified, though no research has sought to explore, explain or quantify this, nor those factors underlying trainees' deep and high valuing reflective engagement. Whilst no individual study was focused on trainees' preferred therapeutic orientation or personal style, tentative connections could be drawn between a primary focus on CBT within clinical psychology training, and either difficulties in reflection or in valuing current training practice (Nel et al, 2012; Burgess et al, 2013; Punzi, 2015). The systematic exploration of this would be helpful to beginning to elaborate on learning mechanisms or needs that underpin trainees' responses to current training activities. At a programme level, several authors recognized that demonstrable valuing and commitment to reflective practice was a foundation to engaging trainees (Sheikh et al,

2007; Binks et al, 2013). The ways in which this is communicated or perceived have yet to be clarified. With this, attention has yet to turn to the sense that training programme staff and other professionals make of reflective practice and how clear, open and helpful any communication of this is.

Whilst only Knight et al (2010) was identified as a substantial quantitative study, this was focused on just one training programme. An audit and exploration of reflective practice in training at a national level would provide scope for identifying examples of good and valued training practices, as well as context for developments in training practice and further studies.

Conclusion

Reflective practice is said to be integral to the training model and PPD of clinical psychologists, yet research has shown that some experience RPGs and similar activities as distressing whilst also low in value (Knight et al, 2010; Binks et al, 2013). The lack of research attempting to explore such phenomena is conspicuous. Currently, the scale of research surrounding clinical psychology trainees' engagement, learning, and meaning making through reflective practice raises questions over the depth and integrity of claims to the profession drawing on the reflective model. Both academically and in practice, clinical psychologists as reflective scientific practitioners are more credible for the demonstration of openness to alternative and competing perspectives, and for transparency regarding the shaping of research questions, teaching and learning activities, and clinical practice. In a period of considerable change to the commissioning and delivery of mental health services – a period marked by reflection on value, values

and professional roles, there is scope for further research in this area.

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PUBLIC DISSEMINATION DOCUMENT

Clinical Psychology Training and Preparation for Multidisciplinary Team Working: A Grounded Theory Model and the Reframing of Reflective Practice

Audience and Overview

This document is aimed at research participants, clinical psychology training programme managers and teaching staff, and trainee clinical psychologists and their supervisors. The briefing seeks to convey the rationale, process and main findings of the research paper, 'Which aspects of their professional training do recently qualified clinical psychologists cite as best preparing them for multidisciplinary working?' As a result of findings from that study, the subsequent paper, 'Reflective Practice in Clinical Psychology Training: A Systematic Literature Review,' is also outlined.

Clinical Psychology Training and Preparation for Working with Multidisciplinary Teams

New Ways of Working for Applied Psychologists in Health and Social Care (Onyett, 2007) marked a milestone for the profession of Clinical Psychology in describing the role of clinical psychologists as one that now demands preparation for greater indirect working. In addition to providing direct therapy to service users, clinical psychologists must also be prepared to develop psychological assessments, formulations and

interventions in collaboration with teams comprising and often led by non-psychologists. To that end, teaching, consultation and wider service development duties are expected of many newly qualified clinical psychologists. At a time of many health and social care services facing considerable scrutiny and financial pressure, this research sought to explore the ways in which recently qualified clinical psychologists explained their professional training as preparing them for this new way of working.

Given there is no published evidence of the main research question being previously pursued, methods for generating new understandings driven by data were selected, thus a grounded theory approach was employed (Charmaz, 2006). Eleven recently qualified clinical psychologists participated in one semi-structured interview, with each subsequent interview seeking to include and develop the main categories of talk that had been developed up to that point. Through constant comparative analysis (data coding and categorization), data collection and data analysis run parallel to one another.

The resultant grounded theory model that is proposed features three integrated theoretical categories that explain a process for recently qualified clinical psychologists' preparation through training for multidisciplinary working. The theoretical categories are 'Trust and Exposure,' 'Inclusion and Belonging,' and 'Sense-Making and Discovery.' The grounded theory is summarized, thus: *Early career clinical psychologists described exposure and belonging to multidisciplinary teams as integral to becoming prepared for post-qualification practice, though it is reflective discussions within mutually trusting relationships with supervisors and with peers that enable sense-making to occur.*

In its three-part structure the model is relatively easy to recall as a framework for inviting structured reflection by trainee clinical psychologists and their supervisors.

The model would be applicable across a wide range of placement settings and in work with various therapeutic orientations. A major implication for training programmes concerns how to achieve open reflection in trainees, and how to support clinical supervisors. Existing training programme structures may be useful for inviting structured reflection on the varieties of risk that trainees encounter during training; this could include relational risks, and could thus prompt collaborative learning around how to best negotiate and achieve openness with supervisors (Woodward, Keville and Conlan, 2015). Where training programmes are able to communicate acceptance, permissiveness and appreciation of trainees' open communication of *not* knowing and of their facing difficulties, this could be helpful to fostering cultures of openness and reflective learning (Binks, Jones and Knight, 2013). As this research developed, clinical psychology trainees' engagement with reflective practice became a matter of raised interest, and thus the focus for the subsequent literature review.

Clinical Psychology Training and Reflective Practice

Currently, clinical psychologists are described as working to a reflective scientist practitioner model (British Psychological Society, 2014; Health and Care Professions Council, 2015). Through a systematic search and review of literature, the question of whether there is evidence to confirm reflective practice as a meaningful and valued aspect of clinical psychology training was explored. To that end, searches identified nine papers for inclusion in the review. Reflecting an immature field of research, the overall methodological quality of papers was evaluated as weak to moderate, with most studies employing qualitative methods (Interpretative Phenomenological Analysis, in

particular) and maintaining vague definitions of reflective practice. These tended to draw loosely on the concepts of reflection on and in practice (Schön, 1983, 1987).

In seeking to establish clarity, where definitions and foci of research papers were variable, a four-process framework was used to distinguish between varieties of reflective practice. These processes concerned reflection on action, reflection in action, reflection on the self (for awareness and development), and reflection on the impact of self on others (Lavender, 2003). A final category for review involved training programme communications and organization. Knight, Sperlinger and Maltby (2010) identified a sizeable minority of trainees experiencing distress and little value from group-based reflective practice, skilled group facilitation, and individual trainees' self-acceptance and relating skills were identified as important to development through training. The learning mechanisms underlying engagement with reflective practice were not detailed across any of the studies, and so the findings of studies rarely leant themselves to straightforward application.

Recommendations for developing reflective practice provision in clinical psychology training seek to ensure that responsibility for crafting access to and the content of reflective processes is shared amongst training providers, trainees and other stakeholders. Several authors suggested that trainees' theoretical orientations (cognitive behavioural, in particular) may be linked to lower valuing of activities for reflective practice, and that trainees' unique interests and developmental needs may not be fully recognized, currently (Nel, Pezzolesi and Stott, 2012; Burgess, Rhodes and Wilson, 2013; Punzi, 2015). Lavender's (2003) four reflective processes are suggested as a more helpful framework for describing individual learning activities and their desired outcomes than the term reflective practice. Wood, Lea and Holttum (2013)

illustrate how action research and reflective practice group participation can be utilized for training programme development. That model combined with a model of trainees' self-led assessment and staff-supported formulation, intervention (tailored training) and evaluation for reflective processes development is recommended. The case for developing research around reflective processes at the level of individual training programmes is also advanced. Of particular value would be research that monitors and later explains trainees' understanding, engagement with and valuing of reflective processes as these evolve during training and following qualification. Evidence of a wider commitment to research on reflective processes would also lend greater credibility to the profession's current claims to practice based on the reflective scientist practitioner model.

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APPENDIX I: Recruitment Email (follow-up to word-of-mouth contact regarding study)

Reply Reply All Forward

D.Clin.Psych. res. interview?

Wayne Thexton

To:

Attachments: REB-R&D-APPDXII-InfoSheet-1.docx (18 KB) [Open as Web Page]

01 February 2015 21:14

,

Thanks for being open to contact re my D Clin Psych research (see attached) (passed your email address to me). In short, the research is interview-based, and poses the question, *'Which aspects of their professional training do recently qualified clinical psychologists describe as best preparing them for multidisciplinary team working?'*

If you are willing and can be available for a one-hour interview, in-person, that would be very pleasing. I am able to travel to wherever would suit you best (am assuming you're based). If an interview were to take place during working hours, in line with university ethics clearance, I need to remind/suggest to you that you have permission from your line manager to participate in such research.

Assuming you are able to participate, the following dates/times would be good for me. Please advise if any, or any alternative, would be okay for you - and where.

Friday 06 Feb 2015 - any time [or Sat 07 / Sun 08 Feb.]
Tuesday 10 Feb 2015 - any time from 3PM
Friday 13 Feb 2015 - any time
Thursday 19 Feb 2015 - any time
Friday 20 Feb 2015 - any time 8AM to 2PM

Best wishes,

Wayne Thexton

[Mob.]

Wayne Thexton, B.Sc. (Hons), Ph.D.
Trainee Clinical Psychologist
Univ. of Birmingham

APPENDIX II: Research Interview Information

This information concerns research that investigates links between the professional training and preparedness for multidisciplinary team working, of clinical psychologists. The following information details the purpose of the interview and what this will entail. Please read and consider prior to deciding whether to participate.

What is the purpose of the interview?

The purpose of the research interview is to inform the development of a grounded theory of factors that recently qualified clinical psychologists cite as best preparing them for work in the multidisciplinary team.

What will the interview involve?

The interview will involve gathering thoughts and reflections of participants (recently qualified clinical psychologists) on how they prepared, adjusted, and learned to work in a multidisciplinary team. The interview will begin with the main research question, with follow-up discussion of aspects of professional training (available as a prompt list) and other related experiences. The interview will follow a semi-structured format. The interview will last for up to one hour, and will be conducted by Wayne Thexton, a Trainee Clinical Psychologist at the University of Birmingham.

Anonymity and Confidentiality

The interview will be recorded so that no comment is missed. The interview will then be transcribed by the interviewer, with names and other identifying information changed. In line with university policy, interview data will be securely stored (in electronic format) for ten years post-interview. De-identified quotes from interview may be used in the research thesis, and in subsequent published papers. The grounded theory model that the research yields will be provided to participants for optional critical feedback. Participants will also be given the option to receive a copy of the final thesis.

What if I change my mind about participating?

Participants have the right to withdraw from participation - at any time and without question, from the time of initially agreeing to participate up to one week post-interview. This could be communicated by email, by telephone call, or in person at the end of the interview. For anyone choosing to withdraw from the study, post-interview – or requesting that their data not be used for illustrative purposes in the final thesis or in subsequent papers for publication, the interview data generated would nonetheless remain available for analysis towards the generation of the grounded theory model. Thus, interview data would remain confidential and as an appendix to the thesis.

Further information

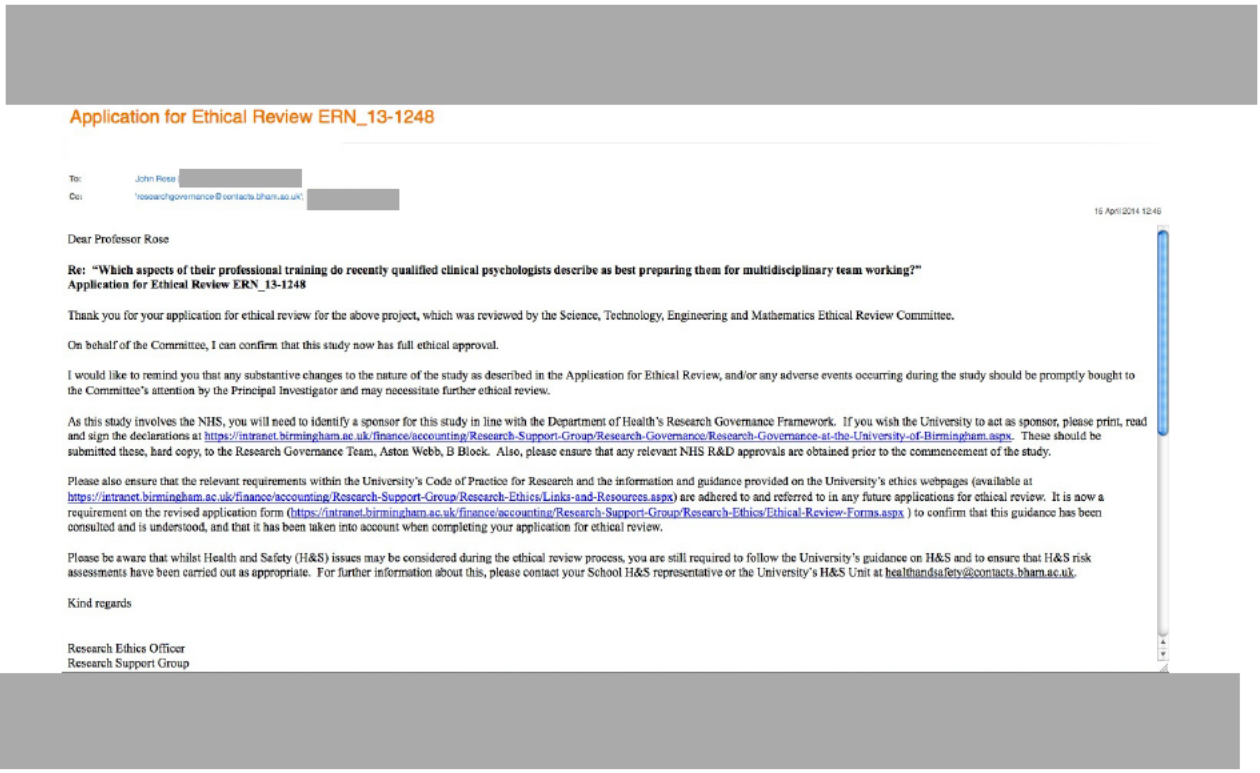
If you are interested in participating in this research, or if have any related queries, please contact Wayne Thexton, by email [redacted]

Thank you.

Wayne Thexton (Year 2, Trainee Clinical Psychologist)
University of Birmingham

Academic supervisor / Principal Investigator: Prof John Rose

APPENDIX III: Confirmation of Ethics Approval by the University of Birmingham Science, Technology, Engineering and Mathematics Ethical Review Committee



Application for Ethical Review ERN_13-1248

To: John Rose [redacted]
Cc: 'researchgovernance@contacts.bham.ac.uk'; [redacted]

16 April 2014 12:46

Dear Professor Rose

Re: "Which aspects of their professional training do recently qualified clinical psychologists describe as best preparing them for multidisciplinary team working?"
Application for Ethical Review ERN_13-1248

Thank you for your application for ethical review for the above project, which was reviewed by the Science, Technology, Engineering and Mathematics Ethical Review Committee.

On behalf of the Committee, I can confirm that this study now has full ethical approval.

I would like to remind you that any substantive changes to the nature of the study as described in the Application for Ethical Review, and/or any adverse events occurring during the study should be promptly bought to the Committee's attention by the Principal Investigator and may necessitate further ethical review.

As this study involves the NHS, you will need to identify a sponsor for this study in line with the Department of Health's Research Governance Framework. If you wish the University to act as sponsor, please print, read and sign the declarations at https://intranet.birmingham.ac.uk/finance/accounting/Research-Support-Group/Research-Governance/Research-Governance-at-the-University-of-Birmingham.aspx. These should be submitted these, hard copy, to the Research Governance Team, Aston Webb, B Block. Also, please ensure that any relevant NHS R&D approvals are obtained prior to the commencement of the study.

Please also ensure that the relevant requirements within the University's Code of Practice for Research and the information and guidance provided on the University's ethics webpages (available at https://intranet.birmingham.ac.uk/finance/accounting/Research-Support-Group/Research-Ethics/Links-and-Resources.aspx) are adhered to and referred to in any future applications for ethical review. It is now a requirement on the revised application form (https://intranet.birmingham.ac.uk/finance/accounting/Research-Support-Group/Research-Ethics/Ethical-Review-Forms.aspx) to confirm that this guidance has been consulted and is understood, and that it has been taken into account when completing your application for ethical review.

Please be aware that whilst Health and Safety (H&S) issues may be considered during the ethical review process, you are still required to follow the University's guidance on H&S and to ensure that H&S risk assessments have been carried out as appropriate. For further information about this, please contact your School H&S representative or the University's H&S Unit at healthandsafety@contacts.bham.ac.uk.

Kind regards

Research Ethics Officer
Research Support Group

APPENDIX IV: Semi-Structured Interview Schedule

MAIN RESEARCH QUESTION

- Since qualifying as a clinical psychologist, have you had experience of working in a multidisciplinary team?

- Since qualifying as a clinical psychologist, through to the present day, how well prepared for working in a multidisciplinary team did – or do - you believe yourself to be? Please explain.

- **Which aspects of your professional training would you say best prepared you for multidisciplinary team working?**

PROMPTS LISTS:-

As you reflect on how you became prepared for working in the multidisciplinary team, the following lists of learning activities from a typical training programmes in clinical psychology may be useful to you (from Nel, Pezzolesi and Stott, 2012):-

Academic learning activities

Didactic Lectures

Experiential teaching sessions

Class seminars

Role plays

Film of clinical work

Academic essays

Problem-based learning (PBL)

Reflective accounts

Small group discussion

Written exams

Oral exams

Clinical learning activities

Direct clinical case work

'Live' clinical supervision

Case reviews with a supervisor

Observing another clinician working

Clinical activity (case) report

Logging of placement activities

Keeping process notes

Clinical activity (case) presentation

Clinical supervisor reports

Multi-disciplinary team working

Research learning activities

Research teaching lectures

Class exercises

Small-scale service related project

Major research project

Thesis supervision

Thesis defence

Disseminating research results

Preparing a journal-ready paper

Personal and professional development learning activities

Individual tutorials

Reflective group work

Personal therapy

Peer support

Annual appraisal report

External workshop / conferences

Self-study

Comments on mark sheet

Other individual, experiential and environmental factors

Age	Gender	Other work experiences
Personality	Learning style	Other life experiences
Work setting	Specific job role	Therapeutic orientation/s

MULTI-DISCIPLINARY TEAMS, TRANSFORMATIONAL LEADERSHIP AND CLINICAL EXPERIENCE (adapted from Bass and Bass, 2008, p618)

- Have you found yourself adapting your practice to support the needs of colleagues? Please explain, and give an example. [Individualised consideration]

- In the course of working with MDT colleagues, what has been the scope for supporting innovation and creativity in your colleagues' practice? Please explain, and give an example. [Intellectual stimulation]

- Within the team environment, what is the main vision or goal, and how do you contribute to that? Please explain, and give an example. [Inspirational motivation]

- What are the main values that underpin your way of working? Please explain, and give an example. [Idealized influence]

FURTHER COMMENT/S

That concludes all that I wanted to cover with you. Are there any further comments that

you would like to add?

Thank you for your time and comments.

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FURTHER INFORMATION

For further information on this research, please contact Wayne Thexton, by email, [redacted]

Thank you.

Wayne Thexton (Year 2, Trainee Clinical Psychologist)

University of Birmingham

Academic supervisor / Principal Investigator: Prof John Rose
[redacted]**)**

Appendix V: Openly Coded Data Extracts (all interviews)

INTERVIEW 01:

PROFESSIONAL IDENTITY AND SUPPORT, AND THE MDT [1 – 3m45s]
Although I sit with the MDT, I'm not managed by the MDT manager, and that can create a bit of resentment because other disciplines don't have that. I feel well represented, well supported, I think there's a strength in Psychology. I think other disciplines don't get that. We have our own management, Psychology meetings, Psychology education training days - that builds the sense of community. There's pros and cons to it - others' resentment, and a separation in the MDT that I sit within – I wouldn't want to lost it, though.

FEELING UNPREPARED FOR MDT WORKING [4m – 5m20s]
I knew before I qualified - I said it during training, I've been open about it – in my view, I hadn't done enough to warrant ticking the consultation box during training. Others thought I had, but I didn't.

PERSONAL/PROFESSIONAL INSECURITY [6m35s – 7m20s]
There's an apprehensiveness in a lot of psychologists of 'being found out' – I have that

REFLECTIVE PRACTICE AND OBSERVING SUPERVISOR [7m30s – 9m50s]
Without a shadow of a doubt the most helpful thing for me was observing my supervisor do these things [MDT working]. And having the freedom – being able to say – 'I don't know how to do this, I've never done this.' Even in the third year, I found the feeling of 'should' be able to do stuff grew, at times. We talked a lot of that in our reflective groups – 'if there's stuff you don't know how to do, then you should say so – surely that's what this is all about.' Reflective groups was quite important. But yeah, being told by the course that it's okay to not know, and then to get guidance from your supervisor. But then you've got the dynamic of being assessed by your supervisor, and you don't want them thinking you don't know what you're doing. The combination of reflective groups, and time on placement – relationship with supervisor – observing and engaging in MDT working if you can – that's important.

FINDING A BALANCE – ANTICIPATING CONFRONTATION [12m35s – 13m10s]
When you're on a six month placement and you're not wanting to be coming and going, 'Hey! Look at me, I'm the psychologist, I can solve all of your problems,' you've a situation whereby if you do that it'll be a case of 'Who do you think you are?' but if you don't it'll be a case of 'Why are you paid so much?'

TIME AND WORKING WITH THE MDT [13m15s – 13m50s]
On placement – with a trainee label, not there for long really – it can be difficult to integrate and get into that consultation style of working

MANAGING MDT ANXIETIES [14m50s – 15m35s]
There is an enormous pressure in teams to provide answers. Maybe more training on

not diving in – which I sometimes do – and providing answers would have been helpful.

VALUING THE PEER GROUP [16m50s – 18m15s]
…I'd had a previous career; I also happen to be a self-doubter… I think in some ways the orientation of my training programme may not have helped. To have the cohort to fall back to is always a good thing, though.

PERSONAL QUALITIES [21m – 22m40s]
In some ways, I think having a bit of self doubt goes down well – people appreciate that I'm not arrogant, and that I won't always have an answer, really. I find I'm listening a lot – even though people might seem like they're wanting answers a lot of the time

REASSURING THE MDT – ROLE/MEANING OF PSYCHOLOGY [24m30s – 25m15s]
The sense that I get from the team often is that they want reassurance, and if the psychologist can't offer any more, then I [they] must have done enough. In a way, I think I'm broadening their view of themselves – I think reassurance is what they're seeking.

MDT EXPECTATIONS AND THE SUPERVISOR [28m10s – 29m20s]
One of my supervisors was very fixed in a certain model, and did tend to provide answers, and so there was an expectation and a pressure to do that.

ORGANISATIONAL PRESSURES - VALUING THE VISIBLE [35m10s – 38m]
The team I'm in now is very 'fixy,' I think that's partly about people being rushed off their feet – being seen to 'do' something makes it okay – you've 'done' your bit. Whereas, just sitting with someone – being with them – those more person-centred things, that's a bit more difficult to explain in that kind of setting.

KNOWING WHAT YOU KNOW [38m – 39m50s]
In some ways the training was so broad, in terms of what to come back to. I think when you're newly qualified it's important to have something to come back to – although I guess my old programme might not agree with that. I think there's a lot to be said for being specially trained in one or two approaches.

KNOWING WHERE YOU'RE GOING [42m – 43m]
I've been on a lot of training courses since I finished, and I always end them thinking 'Yes, that's brilliant,' but I think the important thing, really, is to feel – to believe – that you know what you're doing, you know where you're going.

ORGANISATIONAL PRESSURES – INHIBITING CREATIVITY [45m45s – 48m25s]
In terms of supporting other staff's creativity, there's so much of a sense of being monitored – having to justify what you're spending your time on – having to justify what you're spending your time on – that unless you know something's gonna work, then… [pause] well, just be careful. There's a real bare minimum feeling at the moment.

NOTICING DURING TRAINING / THE MDT PERSPECTIVE [48m30s – 50m30s]
I think as a trainee, there was a sense of protection that I didn't fully appreciate at the time. As a trainee your mind is on so many other things – your thesis and so on, that you

don't see or feel everything. Maybe the thing to do is to be asked to really imagine yourself in their [MDT colleagues'] shoes, to think about what that means, or feels like.

ORGANISATIONAL PRESSURES AND PROFESSIONAL VALUES [56m20s – 57m30s]
I get really angry about target-setting when it comes to working with people we work with [clients]. I think that partly comes from having worked previously in systems where having targets does make sense, but based on a very different set of conditions and values.

ORGANISATIONAL PRESSURE / PROFESSIONAL INSECURITY [59m – 1h]
The pressure – the main aim of the current service – is working to get as many clients through as possible. It's a bit sad, really, as the people I work with – colleagues – good people with good values – there ends up being a bit of learned helplessness.

KNOWING WHAT YOU KNOW, BELIEVING WHAT YOU DO [1h 4m – 1h 6m 30s]
The main things that I think I'm involved in, and that I think are important for the clients and the MDT are slowing things down for some people – containing the anxiety that goes with uncertainty – saying it's okay to feel uncertain. I suppose it's just being there for someone – being a real person. In a way, I'd say psychology's role is to be there to listen, to be a counselor to staff. There are a lot of pressures to 'do' things, so you can put things down as contacts on the electronic system. I also think it's important to promote psychology – it gets lost, it's important not to lose sight of the diverse range of skills that you've demonstrated through training.

ON-THE-SPOT SKILLS - PRACTICING DOING [1h 8m – 1h 10m]
Really honing those on-the-spot formulation skills, I think that's something that I'd encourage from the academic side – more real world practice, more role-play – we're interactionists, we're psychologists – more role-play would have been really helpful in terms of preparing for the MDT.

INTERVIEW 02:

PREPAREDNESS FOR MDT WORKING [45s – 1m 15s]
Upon qualifying I felt well prepared to be in an MDT, though I wasn't so prepared for the depth of the work of the MDT.

THE ENVIRONMENT OF THE MDT / CO-LOCATION [2m 45s – 4m 25s]
Placements were inherently MDT – all were a year long, some split; sometimes it was just sitting with the MDT – exposure to it, rather than working within it. Other placements were more entrenched, in terms of the sharing of open space, lots of conversations about the work, about cases.

THE SENSE OF TEAM [5m – 6m 30s]
I've been in situations where the multi disciplines were present but the 'team' was missing.

FEELING UNPREPARED [9m 40s – 10m 45s]

When I first qualified I felt like I knew nothing – everyone tells you that that's normal and everyone feels like that, but that's not what you want to hear.

PERSONAL QUALITIES - CHOOSING BATTLES [12m – 12m 50s]
My 'man-ness' was an issue at times. One team, inherently sexist, saw me ask myself 'Do I do what I've always done and speak up and say 'That's sexist,' or do I think longer term and ask myself what it would be like to be having to share the office with those people after doing that.'

(MANAGING) OTHERS EXPECTATIONS [13m – 14m]
My first supervisor spoke of the Columbo approach – arrive in a dirty mac, and always end with 'And one more question' – under-promise, over-deliver.

EXPECTATIONS, AIMS AND EXPERIENCE [17m30s – 19m]
I wanted to be the psychologist who could coach and inspire, but sometimes there's just too much resistance. Sometimes it's like working with a defended family, like you've got to earn your stripes before they'll let you in.

SYSTEMIC PRESSURES AND THE MDT [25m30s – 26m45s]
…the thing that I most admire about my current team is the fierce advocacy for the people who use the service. I advocate in other ways, but there's a feeling that the service is at risk of being lost – as in gone – subsumed into another umbrella service, so the main service goal at the moment feels like it's to stay open.

THE FUNCTION OF TRAINING [29m – 29m50s]
What I think training does is it creates a sense of adaptation – not like jack of all trades – I think far beyond learning any theory or model, it prepares you for change. You might be shit-scared, but you get on with things anyway.

REFLECTIVE DISCUSSION / VALUE OF PEER GROUP [34m30s – 35m50s]
I think the reflective discussion was really helpful during training. Being able to sit in a room of trainees and filter and work out what people want or are trying to say – that was hard, cos everyone wants to present themselves as awesome and smart. It's that assistant psychologist ethos that follows some people around. I would sit there and say, 'I'm terrified.' I learned more from those I was training with than anything else. That journey would only be half a journey without those who you're taking the journey with.

PRE TRAINING EXPERIENCES / MAKING SENSE OF TRAINING [39m – 40m]
One of the advantages for me of having done what I'd done before psychology – working as a manager of people, I think it meant that coming into this, I was able to 'see the strings' a bit – I could see the fear in the people around me.

ACCEPTING 'NOT KNOWING' [42m – 43m30s]
I don't know where I got my integrative approach from – I just did it; I think one thing that's maybe different for me is that I think I'm quite good at 'not knowing' – I'd still get scared, still want to be the best that I can be, but I'm not looking for any kind of manualised approach to tell me what to do or how to be

UNDERSTANDINGS OF REFLECTIVE PRACTICE [44m – 45m]
I think from a lot of training, 'trainee as human being' is a bit missing. I think I do quite well at understanding myself

REFLECTIVE PRACTICE / SELF IN RELATION TO PEER GROUP [46m – 48m]
I think the thing that I got out of reflective practice was that the people I was around were really not comfortable at not knowing, and being okay like that. There maybe wasn't enough exercising of that muscle that we require the clients to exercise – not knowing, being resilient, accepting that 'anxiety' is a normal human emotion or response to scary stuff, and being okay with that. Instead, we just wandered around comparing scores, and asking how many clients have you got on your caseload.

INTERVIEW 03:

PLACEMENT CHANGE, ADAPTATION, WORKING WITH OTHERS [1m50s – 2m30s]
The placements – doing the work – were most useful for preparing me [for MDT working]. I had quite diverse placements. I think as a trainee having to adapt to a new team every six months was good for preparing to work with people.

PSYCHODYNAMICS AND REFLECTIVE PRACTICE [3m – 5m 30s]
We had a lot of psychodynamic teaching – power relationships, [Malan's] triangles, that sort of thing. We also had a reflective group that met regularly. At the time I begrudged going every other week. We were a highly diverse group – in lots of respects – educational background, cultural background. There ended up being lots of philosophical debates.

REFLECTIVE PRACTICE – CONFLICT, LEARNING, NORMALISING [6m – 7m]
People in the reflective group talked about their placement difficulties – so you learned vicariously through that. Also, though, there were sometimes a lot of conflict within those groups, and that would then be reflected upon… endlessly [laughs]

PERSONAL EXPERIENCES – PREPAREDNESS FOR CHANGE [8m – 9m]
I'm quite international in my outlook. I travelled a lot as a child. That was likely good preparation for adapting in training; adapting was the norm.

OBSERVING POWER RELATIONS IN TEAMS [10m 10s – 13m 45s]
I had an idea of MDTs from before training… one of the teams I worked in was so old-fashioned, very psychiatry-led – the psychiatrist would tell the psychologist what tests to do, and the psychologist would do that. I didn't detect any tension in that team, though I found it a bit bizarre – from my supervisor's point of view – a senior person. I would have imagined more conversations about measures being used. Sometimes I thought diagnoses were being made a bit too… freely, where maybe they weren't appropriate or necessary.

POWER RELATIONS IN TEAMS - CHOOSING BATTLES [14m15s – 15m]
My supervisor took the view that 'I've given my opinion, they chose not to follow that,

I've done what I can. That was a quite assertive person, but maybe one who would choose her battles.

SUPERVISOR AS MEDIATOR OF MDT EXPERIENCE [16m15s – 17m15s]
In terms of my MDT working on training, that was partly mediated by how much the supervisor was invested in my spending time working with or knowing the team.

THE FEELING OF MDT-WORKING [18m40s – 21m]
This [current] team is quite small, I think I work best in teams of maybe 10 to 15 people… Here, when we do MDT-working, it really does feel like we're working together. In much bigger teams, where lots of people are maybe being copied into emails, that doesn't feel so much like team-working.

GOOD PRACTICE - LISTENING AND BEING HUMBLE [21m30s – 24m45s]
Here, the experience of team-working – which is good – I think is a lot about the individuals. People are listened to, yes it's a small team – but it feels like there's not so much of an imbalance… I think that's about openness. One thing that really struck me is that if a mistake or something happens, people just say 'I'm sorry, I totally forgot that,' rather than 'Oh but this happened or this' – it's open, not so defensive. Cases get properly discussed here, too. The psychiatrist is very humble, too – not superior.

'SMALL THINGS' - THE TEAM OF MDT [25m40s – 26m15s]
In [this] team, we have lunch together – every day. It's maybe a small thing, but it helps.

VALUING MDT REFLECTIVE PRACTICE [27m45s – 29m]
Here, we have a reflective practice group for the team, whereas elsewhere it tends to be just for the psychologists. It's well attended, too.

POWER RELATONS [33m – 36m]
Ward round experiences, I found to be illuminating, in adult acute settings. Patients would have to enter a room, with maybe a dozen people or professionals in there. Whilst that was an MDT setting, it didn't feel very therapeutic, especially when the psychiatrist would just – if we're being generous – 'talk to' the patient, then tell others what to do.

GUARDEDNESS AND NEGATIVE DYNAMICS [44m – 45m30s]
I find it really difficult to communicate with colleagues who are guarded… one thing that I get really irritated with, though, is where people can sometimes use talking negatively about others in order to connect with other people.

ROLE-PLAYS, EXTERNAL FACILITATION [47m – 47m45s]
Role-plays specific to systemic teaching was quite good, those were facilitated not by psychologists, but by family therapists. That immersive experience – putting yourself into other people's shoes – was good.

TEACHING AND REFLECTIVE GROUPS - NAMING PROCESSES [48m – 50m]
What's coming to mind is from psychodynamic teaching – splitting – that's hugely

relevant to working with teams. I think psychologists are in a good position for spotting when that's happening. In teaching and reflecting groups where that kind of thing was pointed out, I found that helpful. More recently, I've started to use these ideas with colleagues.

THESIS DEFENCE - POWER DIFFERENTIALS [52m – 53m30s]
Thesis supervision and thesis defence can be interesting – I felt quite child-like and defenceless ahead of the thesis defence. I didn't feel very much attached to my thesis – it was just something we had to do. Maybe that fear of mine was about the incredible power differential.

AGE, INSECURITY, OTHERS' VIEWS [58m – 59m30s]
I was one of the younger people on my course… then qualifying at the age I did, I think I felt that others were not positive about that, but maybe that was my own insecurity.

INTERVIEW 04:

FALSE EXPECTATIONS / PIVOTAL LECTURE / ROLE OF PSYCHOLOGIST [3m – 4m]
When I first came into training, I thought the role of the psychologist was of being a therapist. Throughout training, it became clear that working through and with teams would increasingly be part of what we'd be doing. One lecture in particular – from someone outside of the course team – was particularly pivotal for my understanding that.

JOINT-WORKING / BUILDING TRUST WITH MDT COLLEAGUES [7m45s – 9m]
Now, I make sure I do assessments with multi-professional colleagues – that serves several purposes. People appreciate it – getting chance to think whilst I lead that bit. And I get to begin to build trust and relationships with my new colleagues.

CONTRIBUTING TO MDT / OPENNESS OF TEAM LEADERS [9m30s – 10m30s]
Feeding back – or rather, the team manager being open to and inviting my feeding back – on the team meetings and how they work and run, that felt like a useful early contribution in relation to the MDT.

REFLECTIVE PRACTICE GROUPS – SOUNDING OUT, MAKING SENSE [11m30s – 12m45s]
Even though in our RPG sessions we're a group of psychologists, I think having a forum to discuss with colleagues your training experiences is really important – for sounding things out, for making sense of training, for building confidence, and for being able to facilitate discussions, too.

FACILITATING RPGS / OPENNESS WHILST BEING ASSESSED [14m – 17m]
Someone with a gentle, non-judgmental approach – someone who allows you to be yourself – not other groups' experience – but that was good; and that there was a bit of distance between them – the facilitator – and the course team. I'm not sure how open we'd have been with a member of the course team – about our practice, and about our being constantly assessed.

LEARNING ABOUT MYSELF / UNDERSTANDING COLLEAGUES [18m]
I've learned a lot about myself through training. I get and recognize those critical negative thoughts. That's helpful for sometimes helping to understand colleagues' experiences, too.

CONTRASTING PLACEMENT EXPERIENCES [20m – 27m]
I think in year one it was good to work with a supervisor who demonstrated that formulating wasn't necessarily about fitting info into the models that we were taught about. Year two was interesting, I think I lost a lot of confidence – that was in a service where there was a lot of negativity, and a service that wouldn't be a comfort zone for me.

VALUING PEERS / THE PSYCHOLOGY COMMUNITY [31m30s – 32m]
I do like having contact with other psychologists – people who've also had training that might at times be about tuning into their own thoughts and feelings and so on. There are times when I wonder what other professions make of that.

SUPERVISORS WORKING WITH THE MDT [34m20s]
Observing another clinician working – seeing supervisors work in the MDT, that was massive for me. One supervisor who was in to solution-focused therapy, listening to some of her really near questions, that was really helpful.

PERSONALITY – BEING ASSESSED, FEELING VALUED [36m – 36m30s]
Engagement skills – and personality – largely things I think I came into training with, but I think training helped me to more fully identify and value these. I think really you need to be the kind of worker who wants to integrate, who doesn't want to be entirely autonomous… it helps when you get the end of placement forms that back up positive aspects of yourself and your work.

FAMILY EXPERIENCES / PROFESSIONAL INTERESTS [42m30s – 43m30s]
My mum tells me that when I was very young, even before I knew what one was, I wanted to be a psychologist. I could relate personal experiences and family interests to my having interests in this field, too.

FORMULATING WITH THE MDT [48m30s – 53m]
We had a [profession] student, recently, who raised a query in a team meeting - a case for concern, and suggested that it might be 'one for psychology.' Immediately, everyone looked at me, but I gave myself time to think, and in that time everyone started chucking ideas in and it was great. I thought, 'These people know what they're talking about,' but it was something that occurs so rarely that I thought, 'All we need for more of this kind of sharing is a forum that people will use, and a framework,' so I'll be doing a bit of training around formulating.

CONCEPTUALISING MDT WORKING – LOOKING AFTER STAFF [55m20s – 55m50s]
In terms of working with teams, I tend to think of that in terms of taking care of – looking after – the staff, too.

INTERVIEW 05:

LEARNING STYLE - NETWORKS AS MDTS [10s – 1m20s]
When I think about MDT working I think about placements, which I think is about my learning style – having to experience things, but also, it makes me think about more than just the 'team,' but about those third sector organisations that were out there – we were really encouraged to explore those, with specific project work aimed at supporting that – that systems ways of thinking – other ways of helping people. It kind of fed into MDT working.

NETWORK AS MDT [3m40s – 4m30s]
Nowadays I engage a lot with social workers and the MDT, so we have network meetings, where we involve a lot of people – who attend – that gives a good idea of the network, which I guess is like an MDT, here.

(LIMITED) SCOPE OF ACADEMIC TEACHING [5m45s – 6m30s]
We had leadership teaching, I don't recall much on consultation, [pause]. Maybe that was part of the leadership teaching.

UNDERSTANDING THE SELF – LEARNING STYLE [7m15s – 7m50s]
I think training gave me the words – a way of making sense of – my learning style.

VALUING THE PEER GROUP [8m30s – 9m20s]
Group activities – they helped. There was a research task on learning about the third sector organisations that we then presented back to the course.

PREPARING FOR DIFFICULTIES IN THE MDT [12m20s – 13m]
Role plays and MDTs, that would have been useful – like, how you resolve some of these professional issues.

SUPERVISOR AS MDT GUIDE [13m40s – 14m40s]
I had a particular supervisor who had a phrase about 'narcissistic collusion' – it sounds bad, but he explained that if you can enable everyone to feel validated, then you can more likely guide them, I suppose…

SUPERVISOR 'PROTECTING' TRAINEE FROM MDT [15m30s – 19m50s]
…Crucially, I saw that pivotal supervisor do that. I saw him do that with families, and that team – it was quite a difficult team… the supervisor later told me that he'd been quite protective of me – he had wanted me to not react to some things going on there. I think much of that ended up coming through when the team didn't support a piece of service-related work that I was doing. Basically they didn't like the supervisor – which I hadn't already realized.

THREATENING TEAM LEADER / IDENTIFYING WITH THE MDT [20m10s – 21m]
I think the difficulties in the team were historical, really. It was very psychiatry-dominated. I remember when I raised a question about the team providing some information for me, a psychiatrist shouting at me [laughs]. I suspect other team members felt a bit dominated or threatened by that sort of thing, and so wouldn't be

likely to try anything different. To me, my supervisor seemed quite reasonable, so… I don't know if there was anything else going on. I think it was their [psychiatrist's] issue, really. I think they felt threatened.

BUYING FAVOUR / ACCESSING THE MDT [23m15s – 24m20s]
…it was hard to make sense of. In the end, I ended up offering to do a specific administrative role, and from that, the team opened up a lot to me – I kind of bought my way in.

THE KNOWABLE AND UNKNOWABLE OF MDT WORKING [25m50s – 26m30s]
I think sometimes in MDT work, you can't always know what's going on. You can see and hear so much, but… there's often more.

GAUGING MDT CULTURE / VALUING SIMPLE INTERVENTIONS [27m45s – 28m30s]
In a very difficult team, I remember giving a trainee therapist a lot of resources – just cos I thought they'd be relevant to what she was doing, and I remember her being really shocked and saying 'Wow! I would never have done that.' I think that spoke of a lot of the problems with that team. What it also showed was that maybe simple actions – a bit of kindness – might go further than trying to talk about difficult team issues.

MODEL TEAM WORKING – EASY COMMUNICATION AND RESPECTING DIFFERENCE [30m – 33m30s]
Prior to training I did some good varied things. In fact, as a healthcare assistant, I worked in a healthy team which ever since I've held everything up against. I think that was about everyone communicating so easily, it felt easy – the majority of staff were person-centred; everyone seemed to compliment one another. For the most part, even differences of opinion were respected… tolerated in cases, but largely respected.

TEAM AS FAMILY [34m – 35m]
There was something about the smallness of that team – it felt quite familial – a good family; even after nearly everyone moved on, we still got together – still do, even though we've gone off in very different directions.

PRE-TRAINING EXPERIENCE / SIMPLE GESTURES, BEING LIKED [40m40s – 43m15s]
This might sound strange but I think one of the best things I did before training – but also for training – was I worked in the coffee shop of a hospital overseas, during a year out. In that place, I met everyone – senior medical staff, patients who just wanted to have a chat, and everyone in between – really informal, really nice… one Wednesday, I must have been bored, I drew smiley faces on the paper cups. And later – a week later, people were coming back in – still with their paper cups – asking for those to be refilled. Small things – people respond well. I did that elsewhere, too – baking generally goes down well – that'll make people like you.

REFLECTIVE PRACTICE GROUPS – LEARNING THROUGH PEER GROUP [47m55s – 48m40s]
RPGs were useful for hearing of – and learning through – others' difficult experiences of MDTs.

PERSONAL THERAPY – NON-ALIGNED SELF AND SERVICE [48m50s – 51m10s]
Personal therapy was useful, too, I really struggled with how one particular service was run – its ethos – nice people, but I felt unhappy with it. It was a private organization… I think a lot of decisions were made for financial reasons rather than with some particularly vulnerable young people in mind.

PREFERRING MULTIDISCIPLINARITY [56m – 56m15s]
I quite like MDT working in that it's not all psychologists

VALUES AND SERVICE DEVELOPMENT / REFLECTING WITH THE MDT [1h1m45s – 1h3m]
My current service won a tender, recently, and that has led to some thinking and discussions in team meetings, recently, about how our values will relate – what it will look like – for us to extend our service, as we're required to. I think there was some stuff in the tender that maybe wasn't such a good idea. I think it'll be interesting to see or hear what service users make of that.

RECOGNISING AND UTILISING OTHERS' STRENGTHS [1h6m – 1h6m45s]
In terms of using people's strengths, I've a new colleague who is super-organised – not a strength of mine – very systematic, full of flow charts. I think we're complimenting each other well. I think it's good when different people's strengths get recognized and utilized.

INTERVIEW 06:

NON MENTAL HEALTH SETTINGS – DIVERSE TEAMS [1m – 3m]
…I think in non Mental Health settings was best for me in terms of working with the MDT – they were really very diverse teams.

SUPERVISION - MAKING SENSE OF COMPETING EXPLANATORY MODELS [3m – 5m]
In physical health, staff from different professions had such different explanatory models for understanding patients' difficulties, so that created the need to manage lots of professions, and personalities… it was really important to have a space in supervision to make sense of that. Patients themselves would often have taken on some of those explanatory models, too.

MAKING SENSE OF AND VALUING SELF [6m – 7m]
I think my own experience of or dealing with personal differences – like, who I am – looking at a lot of other people on training, they look the same, have the same hand gestures and so on, and I think I wanted to be clear about who I was. I'm very middle class, I'm aware of that. Where I trained, for the first two years, I saw no clients that weren't white – that really bothered me. I have a cultural heritage that was unique within my cohort, and I have a religious faith, too…

PLACEMENT GEOGRAPHY – STAFF EXPECTATIONS AND COMPETENCES [12m – 13m]
I think the location of the placement – which town or city – seemed to make a difference

to how prepared staff were to engage with some of the diversity issues that I feel are a strength and interest to me.

TEAM-RELATED SUPERVISION [14m – 15m 30s]
Within the physical health environment, the supervision was much more about the team – which maybe was about being a third year trainee, too. I guess that follows some of the supervision models. At that time, too, I was more with the team.

PLACEMENT, MDT LAY-OUT AND VALUING SUPERVISOR OPENNESS - [17m – 21m]
Sharing an office with the supervisor made a difference – opportunities for more informal supervision, maybe also a bit less boundaried or containing, too – they would have difficult experiences and would vent at times… For me it was valuable to be exposed to that sort of thing – seeing that at the end of the day we're all just human beings – it was real and honest. When my supervisor said [she] wasn't able to provide supervision just because of exhaustion, I liked that openness.

SUPERVISION AND UNFAVOURABLE POWER DYNAMICS [22m45s – 24m45s]
In some supervision it felt like I was asked some very personal questions, so the supervisor knew a lot about me; after six months, I knew nothing about that person. And whilst being boundaried – from their perspective that might have been the idea, it sat very badly with me – totally exposed a power dynamic that didn't feel good.

STATUS, BEING CHALLENGED, HAVING TO GET ON WITH IT [26m – 27m30s]
Being in settings where I was challenged due to being on a relatively high banding, compared to others, was good for me – having to get on with it.

OBSERVING OR BEING OBSERVED BY OTHER PROFESSIONS [28m – 29m10s]
Observing others – and being observed by other professions – that was really valuable. It was really valuable and valued where the team was highly diverse. I've found that there's less of that where the team feels samey.

OBSERVING SUPERVISOR [29m10s – 30m20s]
I've tended to ask supervisors if I could observe or do joint working – sometimes it's been avoided, but really valuable where it's happened.

FAMILY AS A FOREBEAR OF WORKING WITH THE MDT [30m45s – 35m]
I think for people who apply to get into training for a lot of years, then there's going to be a big chance of feeling let-down, and then they feel angry. That wasn't me – I didn't have any strong theoretical ideas already, I didn't know much at all really. There were other things that I'd have been happy doing – this was never 'the one thing' that I 'had' to do. And my mum is a psychiatrist, so we've had a lot of conversations and disagreements about mental health and work.

LEARNING FROM FAMILY / FORMULATING SELF [35m30s – 36m15s]
I think from my family I grew up understanding that you do lots of things – not just one thing. I understand that might be about not wanting to get too attached, but I can live with that.

PEER GROUP AS ANALAGOUS TO MDT [40m – 42m]
In some ways – people's theoretical opinions, social background, disabilities and so on – we were quite a diverse group, and sometimes discussions got really heated and were difficult. For me there were parallels with then going out on placement and being prepared for teams that weren't so cohesive. Personality is a factor, too – managing different personalities is a real task – even psychologists have different personalities.

OWNING RESEARCH / PREPARING FOR MANAGING CASELOAD [43m45s – 44m45s]
Owning my research – not really wanting or requiring a lot from the supervisor – was probably good for preparing for managing my own caseload.

RPGs: FACILITATION AND OTHERS' RESISTANCE [45m15s – 46m]
The RPGs were facilitated by someone who was close to the course team and worked locally, too – that wasn't ideal. Some people clearly didn't want to be there [in reflective practice] – their influence was a bit 'toxic' – for all of three years, and that made for an interesting - not easy – set of relationships.

RPGs: INVESTMENT, DISINVESTMENT, FAIRNESS [49m20s – 51m30s]
The reflective group didn't always feel fair to me - my view, my experience – others were okay with it. To me, it didn't feel right that I was sharing, acknowledging or making myself vulnerable, whilst others just didn't, and that then could lead to me feeling like I maybe didn't want to share.

SUPERVISION / RECOGNISING AND VALUING THE SELF [52m40s – 54m15s]
It was only when working in the more diverse setting – late in my training – that anyone – the supervisor – asked if there was anything about me that was different or relevant to the work, like say in terms of values.

SELF IN RELATION TO THE PEER GROUP [56m – 57m30s]
Doing a lot of ACT training was interesting – although everyone claimed to have the same values, what really gets exposed is that we had the same goals, but very different values.

FOSTERING RELATIONSHIPS - ADAPTING COMMUNICATION, RESPONDING TO DISCOMFIT [1h2m – 1h3m45s]
I think through training, relationships [with MDT colleagues] has been the most important thing – whether easy or not, and that's often about adapting communication, especially where I experienced or felt a bit of resistance or distance, initially. There was one setting where as soon as I walked in, I could see and feel there was a 'Oh, right…' response. There, I chose to let people know a little bit about myself just to, well, say 'I'm okay.' I wouldn't automatically do that, usually.

INTERVIEW 07:

THEORISING BROAD MDT EXPERIENCES [40s – 1m25s]
My experience was you can do as much theory and practice outside of the work

environment, but the breadth of experience from working in lots of different multidisciplinary teams, then reflecting and relating that back [to taught material], that's where the learning - or preparedness - comes from

LEARNING FROM THE SUPERVISOR [3m10s – 4m]
It's interesting the idea of your question. I know you'll hear often about psychologists being 'taught' about working with teams, and I'm not sure we are. I think we get a lot of experience, we'll learn from the supervisor, but I'm not sure we're 'taught.'

KNOWING MODELS, KNOWING CLIENT GROUPS / NOT KNOWING TEAMS [5m15s – 5m45s]
I'm not sure that I knew much about teams upon qualifying. I felt like I'd learned about various models and working with various client groups, but teams, I'm not sure.

OPENNESS OF SUPERVISOR [7m50s – 9m]
It was good for me to have a supervisor who I could take team dynamic issues to, and to then try to apply some theory to that.

SUPERVISOR 'PROTECTING' TRAINEE - NOT HELPFUL [9m40s – 12m30s]
I had one supervisor who appeared to have a really unusual way of working with the team, and in trying to 'protect' me from some of the negative team dynamics ended up effectively removing me from the team; I wasn't invited to team meetings. That didn't help me, in terms of learning how to deal with difficult team dynamics. There were systems changes occurring there that made for a lot of people feeling unsettled, too.

REFLECTING WITH THE SUPERVISOR – AS GOOD AS IT GETS? [13m – 14m]
Service structure and hierarchies would often seem to be related to team dynamics. Being there for six months, getting to reflect on those things with the supervisor – if that suited the supervisors' style and personality – would maybe be as much as could be done.

THE SUPERVISOR AND THE MDT [14m50s – 15m30s]
I think if the supervisor is feeling powerless and unable to effect change in team dynamics, then that can have an impact on how open they are to discussing team dynamics, too.

PERSONALITY, OPENNESS, POWER AND RELATIONSHIPS [18m – 20m30s]
I think the personality of the team members is really important – I work now, with some really open senior medical people – in a team that's not so used to psychology, but they're able to explore and consider things that may not have been considered previously. I think that suggests something about power and how some people are okay to include others, other professions, in thinking about cases or patients.

TRAINING CULTURES AND OPENNESS TO REFLECTIVE PRACTICE [22m30s – 23m20s]
I don't think the RPGs were prioritized at university. I think more about my reflective discussions as having been with supervisors, where they did happen – some supervisors were more open to that than others.

FACILITATED REFLECTIVE PRACTICE ADDED VALUE [24m – 25m15s]
Even though we didn't do much reflective practice and it didn't feel valued, I think it did add value. I'd have been happy to have more. There was something quite validating about having a facilitator of the RPGs. Self-facilitated groups – later in the programme – ran the risk of turning into a moan, or just sharing experiences - which could be valuable, but might not be so helpful for offering up new ideas.

REFLECTIVE PRACTICE AND PERSONAL DEVELOPMENT [28m20s – 29m]
With the facilitated RPGs, it was like secondary supervision – a back-up, if you like, but that wasn't so case-driven, more about your own experience.

MDT WORKING AND ADAPTING THEORY [38m – 39m30s]
Although it was never my experience, where there might be an impasse with a colleague, then some of the theoretical ideas related to client work could be applied just as much.

OBSERVING OTHERS WORKING WITH TEAMS – EXPOSURE TO DIFFICULT TEAM SITUATIONS [41m30s – 42m45s]
Observing other clinicians working with teams, as well as with clients, was helpful. And just being invited into a team – and being welcomed into conversations of clients, that was helpful. In training, that's about the expectation, ideally, of being involved in what your supervisor does – or what they attend, such that you could even be a proxy for if they weren't available. Really important that you're not 'protected' too much - where I wasn't invited in or welcomed, I'd have much preferred being told 'I'd be interested in what you make of the meeting,' say – even if it was a difficult situation.

MAKING SENSE THROUGH THIRD PARTIES [47m45s – 48m30s]
The clinician who came and did my mid-placement visits was really helpful, for helping me to make sense of my broader experience, including team-working.

PERSONAL THERAPY [48m30s – 50m]
Having personal therapy was useful – albeit after training – for helping me to understand how I was within supervision.

HOLDING BACK - PROFESSIONAL INSECURITY AND ENGAGEMENT WITH TEAMS [50m – 51m]
Being assessed and later in short-term jobs, those things definitely had an impact on how I was in teams – so concerned about not ruffling feathers and being really boundaried. Now, I've allowed myself to form closer – personal – relationships with my team.

HOLDING BACK – MANAGING THE SUPERVISORY RELATIONSHIP [52m – 54m]
Through training, too, I did feel a pressure to not step on supervisors' toes – through taking a different view to the supervisor. I'm more able or willing to hold a different view to my supervisor, now.

PRE-TRAINING EXPERIENCES – LIVING WITH DIFFICULT DYNAMICS [1h0m45s –

1h2m]
Prior to training, having lived in a group and encountering difficult dynamics, I think that was a good grounding for later working with team dynamics. Although it's different in a professional environment and people's expectations might be different, I think it was useful to have had those experiences, to have had those difficulties and to have had to live with them – the difficulties and the people.

INTERVIEW 08:

OPPORTUNITIES FOR MDT EXPERIENCE [1m – 3m]
Across all of my placements, I was fortunate enough to be based within MDTs, with a supervisor who was based within the MDT. Where other trainees were based within Psychology services, that seemed to offer less MDT experience. In particular, I found physical health and forensic placements to be good for MDT working or experience.

PLACEMENT LAY-OUT – ACCESS, RELATING AND WORKING WITH THE MDT [3m30s – 4m30s]
Sharing office space helped promote professional relationships – that was through developing personal relationships, but also observing other professions or hearing them on the phone, or talking to their colleagues, and just being able to quite informally share info – like if I'm sitting next to the social worker or music therapist, I can say 'I've just seen so-and-so who you're seeing, what are you making of him or her at the moment?' – things that wouldn't happen if I was in an office down the corridor

UNDERSTANDING MY STATUS – INTERACTING TO SUIT TEAM [6m15s – 7m]
I was very much aware of my status as a trainee, and not wanting to burden others. I think the more casual interactions made that easier.

SUPERVISORS RELATIONSHIPS MEDIATING MDT EXPERIENCE [8m – 10m]
My experience of working with MDTs was hugely influenced by the supervisors' relationships with the team. One placement stands out in particular – that supervisor sat separately from the team, didn't attend the team meeting – based on a view of psychology being more of a tertiary service. I followed that at first, but then was faced with a lack of referrals, which as a trainee, would have been an issue, so then I started attending those meetings and working to get referrals

TRAINING CULTURE – LIMITED VALUING OF REFLECTIVE PRACTICE [23m30s – 26m]
I did discuss MDT difficulties up to a point with my reflective practice group. My training course had a reputation for not being an especially reflective course. Put simply, we just didn't have many reflective practice sessions – seven or eight across three years.

TRAINING CULTURE – UNDER-UTILISING RPGs [27m – 31m]
There was a requirement for us to write something reflective into our reports for the course – but it was literally just a paragraph. And in terms of our core competencies, there was nothing that required us to demonstrate a capacity for reflective practice. The RPGs ended up being a bit like groundhog day. We suggested they be more frequent, not

much changed – not enough space in the timetable – stalemate.

FACILITATION OF REFLECTIVE PRACTICE [34m30s – 36m15s]
The systemic psychologist who we had facilitate us in year three, I think he held a lot of deeply divergent positions on RP such that those who wanted to actually make use of the group could try to do so. The group was very close, but also quite varied in our views of the usefulness of – or openness to – RPGs.

TEACHING FROM NON-PSYCHOLOGISTS [41m30s – 43m]
A couple of teaching sessions delivered by non-psychologists – providing a broad impression of what working in their settings was like, they were helpful – not specifically psychology sessions, but useful.

PLACEMENT-BASED RESEARCH – VALUING INTER-PROFESSIONALITY [43m – 45m30s]
…research was taken seriously at one placement. I'd go to research meetings – attended by professionals from different backgrounds, they were useful for giving an idea of what different roles involved.

PRE-TRAINING EXPERIENCES AND NOT BEING PSYCHOLOGY-CENTRIC [45m45s – 48m]
I think from having done the work I'd done in the past – multidisciplinary, no suggestion that I'd be heading into Psychology; it meant that I didn't have a Psychology-centric way of thinking. That was helpful, but also, it 'may' have made it harder for me to reflect on my own position.

GOOD MODEL FOR MDT PRACTICE [51m45s – 54m]
In the forensic setting, having a chair who would completely scaffold the service-users' involvement – 'Do you know everyone, here,' introductions, good sharing of perspectives and listening, offering very human support – 'Would you like anyone to support you [in the ward round]' – that was a good model

OTHERS RESISTING REFLECTIVE PRACTICE GROUP PARTICIPATION [58m – 59m]
I think there were some people for whom the view was, 'We don't have to do this [participate in reflective practice groups], so why should we?'

REFLECTIVE PRACTICE – PLANNED AND NATURALISTIC [1h – 1h1m]
I think in training reflective practice would sometimes feel quite solitary – when with the group; but I found that whilst driving – to and from placement – that was where I was running through things, making sense of things.

INTERVIEW 09:

FEELING UNPREPARED FOR THE MDT / PLACEMENT CHOICES [30s – 4m45s]
When I started my first job post-training, what I noticed was how little prepared I was, or how little prepared I felt, for working in the MDT group, whether facilitating RP sessions, or supervising other professions, doing consultations and doing all of that applied stuff. All of that was maybe half of my work then, probably two thirds now. The

one-to-one clinical work, which is maybe what I felt most prepared and well-trained and skilled in, well it was half of my work rather than 90 percent as I thought. I guess my training experiences were more aligned to individual working. With the MDT stuff, it always came up filling out placement forms – the tick box ones – it always came up, but I guess I didn't push it, but also, supervisors would say 'Well, you're a trainee, you can't really get involved in that kind of stuff cos you're not here for long, or skilled enough to do it.' Then you get your job, and you're expected to do it. In some ways, I didn't choose well with my placement choices, but on the other hand, a bit of thought about how to find opportunities for trainees would be helpful.

OBSERVING THE MDT [5m – 6m]
In some placements there were reflective practice sessions, for lots of different professions, and I got the opportunity to observe, so, I took those opportunities, but to actually do the MDT work, to lead on it, I didn't really get to do that.

SENSE OF SELF / OBSERVING INSPIRING PRACTICE [8m – 8m30s]
Over training, I definitely developed a greater sense of myself – realized there were bits of practice that I observed that were inspiring, other bits less so…

AUTONOMY / SUPERVISORS OVER-PROTECTING TRAINEE [10m - 11m]
In my first placement, I felt like my learning was restricted. I think that was about the level of autonomy I was given – some supervisors were more restricted or narrow-minded about what I – or about what a trainee at my stage of training – would be capable of – a bit over-protective – not really given the opportunity to go and learn and make acceptable mistakes… classic attachment stuff, really

SUPERVISORS' OPENNESS / PROVIDING A CONTEXT [12m15s – 14m]
I felt like I got more from supervision and supervisors who would share something of themselves. There were a few blank slate kinds, but, I preferred those who were just a bit more… like human beings with me. With the good supervision, I'd have a supervisor who would be willing to describe their own experiences to help provide context, rather than everything being just about what I brought.

FACILITATION OF REFLECTIVE PRACTICE GROUPS [20m – 22m]
In the reflective practice group for much of the time, we were facilitated by someone who I think was psychodynamically-oriented… linked to my preferred learning style, again, we knew nothing <u>at all</u> of that person, and I just don't like that

SERVICE INSECURITY / VULNERABILITY FOR NHS STAFF [26m30s – 29m30s]
Although I didn't feel like I'd much experience of the team-working as I started my Band 7 job, I had spent a lot of time thinking about teams and team dynamics. One service I'd been in saw a lot of anxiety in the team – that service was going out or was up for tender. I took from that that the NHS can be a place where there's a lot of vulnerability for staff.

REFLECTIVE PRACTICE, THE 'GOOD PSYCHOLOGIST' AND KNOWING MYSELF [32m – 34m]
The reflective practice side of things at [place] university definitely appealed to me. It

was sold as quite a reflective course. For me, to be a 'good psychologist,' that would require me to know myself, and to have an understanding of myself

WRITING A REFLECTIVE ACCOUNT / CLARIFYING THINKING ON TEAMS [38m45s – 40m]
Writing reflective accounts – we had to do several of those – I specifically chose to write of team dynamics at one point; that was good for developing or clarifying my thinking on teams and team-working.

FIRST JOB / PREPAREDNESS FOR WORKING THROUGH OTHERS [40m45s – 41m15s]
As soon as I started working I realized that I'd not done enough working through others.

CONCEPTUALISING THE MULTIDISCIPLINARY TEAM - SHARING SPACE, VALUING OTHERS' PERSPECTIVES [51m – 52m30s]
The placement that felt most like an MDT was the [specific] unit, and that was about us just all being there – together; also, in that team, the psychiatrist was really good – people were clearly valued – opinions were heard and taken into account.

PLACEMENT LAY-OUT, TEAM-WORK, STRAIGHT-FORWARD CONVERSATIONS [52m30s – 54m45s]
…another thing, people ate lunch together, and chatted – you got to hear about each others' lives. Geography, or layout, the way in which a team either sits together – or doesn't, I think that's massive to understanding the way a team works. Conversations around discharge always felt more straight-forward in those environments – where the team were always mixed together

CHOICE AND RANGE OF PLACEMENTS [56m – 57m30s]
As we're talking I'm really aware of my being here, as we talk; having to think back to placement is a bit difficult. Thinking back, I don't think I'd put my experiences or perspective so much down to what occurred through my university; I think choice or range of placements is much the more important factor, there.

HOLDING BACK – REFLECTIVE PRACTICE AND PEER RELATIONS [58m – 1h1m]
The reflective bit from our course was a hugely substantial part of the course, you contributed as much as you like or you didn't, and I didn't. For me, it didn't feel safe. I'm not opposed to group therapy, but in group therapy you don't see the people the next day in a lecture. It didn't make sense to me how you could be so open with that group in that setting, however you think of your peers – whether as peers, as colleagues, or maybe competitors.

INTERVIEW 10:

DOING THE JOB – ACROSS CONTEXTS [3m30s – 5m30s]
I would say the clinical placements – if you think in terms of the two sides of the DCinPsy training, for the MDT working it would have been the placements. I don't remember any specific lectures about MDT working… what prepared me the best was I suppose working in different types of teams – the range of experiences across the three years –

hospital, CAMHS, older adult, working with medics. Yeah, definitely, what prepared me was constantly having to manage difficult relationships in MDTs, managing strong characters or maybe psychiatrists who have a very heavy medicalized view of treating psychiatric difficulties.

(DIFFERENCES AMONGST) THE TRAINING COHORT [7m – 7m 30s]
…it's interesting in terms of the academic side, we had a few seminars and meetings and what have you, with people who were my friends and colleagues but who were quite difficult, and actually that didn't feel too different to managing some of the difficult relationships in teams…

(DIFFERENCES AMONGST) THE TRAINING COHORT [8m – 8m 30s]
Having people with different viewpoints – albeit all psychological – was quite useful, and was quite similar to some of the recent discussions I've had in my current job – very much an MDT context. I suppose to give credit to the course, the clinical seminars were helpful.

DIS/LOCATING REFLECTIVE PRACTICE [10m 30s – 12m 30s]
The reflective practice seminars had quite a different feel – we had reflective seminars, clinical seminars, and more of a research one. The topic of discussion for the reflective practice seminars was pre-determined as a jumping off point – we had a list and most people were like, 'Yeah, we'll talk about that, that'll be fine'… the reflective practice were always put in before or after lectures, so generally lectures started at 10AM, and reflective practice would be nine til ten. Then people were like, 'Why am I coming in for nine? This isn't my job.' It often felt like an add-on, so that probably contributed to the general ambivalence.

TRAINING PROGRAMME CULTURE [12m 30s – 14m]
I think generally reflective practice is a looser structure and depending on the trainees' perspectives, too… I think my programme tended to attract people who were quite 'methodological' in their thinking and reflective practice doesn't necessarily sit with that very clearly. We had the odd trainee who was very reflective and who wanted to deconstruct things, but the vast majority were problem-solvers and doers.

LOCATING REFLECTIVE PRACTICE [17m 30s – 18m 30s]
…most people in my current team do go to the reflective practice session if they can. Those meetings are after a big team meeting in which discussions of high risk clients happens, so I think reflective practice gives a space for discussing difficulties that don't get raised in the previous meeting.

FUNCTION OF REFLECTIVE PRACTICE FACILITATION [19m 15s – 19m 45s]
Currently, trainees choose to have facilitation of the reflective practice – they say that they like the containment of, or from, someone who's come through training.

PROXIMITY OF SUPERVISOR, INDEPENDENCE OF TRAINEE [21m – 25m 30s]
Early in training, I was keen to understand what the expectations were of me in the MDT [meeting] setting. Then, I would only tend to speak if we were discussing someone I was

working with. Much later, it was often the case that I'd be involved having done the triage, or neuropsych assessment and so I'd be more involved then… There was a point in training where – not by design or intention – I was supervised by someone not in the team, and to all intents and purposes I was effectively the psychologist in and for that team… in that situation I was able to change the terms and function of some meetings. I think that was good for staff as well as patients – especially in terms of relationships between the two.

THE STRUCTURAL LIMITS OF / DECONSTRUCTING MDT [25m 45s – 26m 15s]
There was one team whereby patients felt like stakeholders, or members of the actual MDT. Yes, their position was that of service-users, but for as long or as much of meetings as they were able to participate in, their contribution was valued.

SERVICE USER INVOLVEMENT [29m – 29m 45s]
[University context] Here, we've added a member of staff – paid – so a member of a university MDT – who is an ex service user, who will link with third sector organizations, and will link into committees here.

SUPERVISION – MORE AND LESS HELPFUL [32m – 32m 45s]
The helpful supervisors saw me being supervised around not just clinical stuff, but relationships and communication in the team, like if there was a notoriously problematic psychiatrist that was not open to Psychology, then how best to communicate with them. Less helpful would have been those supervisors who very much made it clear that I wasn't to speak in some situations.

OWNING SUPERVISION [33m – 34m]
I'm definitely the kind of person who – I can remember detailed conversations in training whereby – I'd ask to put on the agenda the matter of supervision.

DIFFICULTIES IN SUPERVISION [37m 45s – 39m 30s]
Where I had difficulties [in supervision] I think there was a very clear difference of opinion – clinically, and maybe their having perspectives that I thought were inappropriate. Partly that spoke of the time and model they were trained in… partly.

SYSTEMIC QUESTIONS – MANAGING DIFFICULTIES [45m – 45m 30s]
Even though I don't work systemically, I think some of those style of questions that we heard about in teaching – like circular questions – I do use still, especially in managing difficulties in teams.

ADDITIONAL TRAINING [46m 15s – 47m]
There was additional training that I accessed – through a supervisor – that I attended that helped in terms of working with clients who would split teams.

GETTING SUCCINCT – ACADEMICALLY AND CLINICALLY [47m 45s – 48m 30s]
I found the academic reports – the clinical reports – often an account of an account – to be quite washed down by the time submitted. There might be some similarity there with what I do writing notes now. I know that for other workers, I need to relay very

highly behavioural matters, rather than the details of what was covered in sessions. The more academic reporting – and feedback on case reports – was useful. Over the series of reports, they became more succinct – tapped less into the complexity of the work, but a more succinct account of that work – tailoring the work for the audience or purpose.

PERSONALITY COUNTS – NO ONE RIGHT WAY [51m 30s – 52m 45s]
Observing others' – supervisors' – working was helpful, especially supervisors who were working in the same setting as one another - that was good for indicating that personality matters, and there is no 'one right way' to work with the team

IMMOVABLE BARRIERS TO TEAM OPENNESS [58m – 1h 1m]
[Following a description of difficulties related to having a research proposal accepted by a team that had previously faced criticism in the report of research that it had hosted]
The underlying message of that [past] research was that the service wasn't delivering what it was intended to. Results weren't 'bad,' the difficulty ultimately was with a position taken by the leader of that team – not being ready for any further criticism until past matters had been dealt with.

AGE, GENDER AND FAMILY BACKGROUND [1h 5m – 1h 8m]
I think age and gender has had an impact in teams. For me, my gender has been viewed positively – being quite different to the early to mid 20s female trainee psychologist that they'd have been used to. Also, I'm from a big family – it was like an MDT from birth!

ACCESS TO INFORMAL ACADEMIC SUPPORT [1h 11m – 1h 13m]
Whilst training, there were one or two members of university staff who I could easily approach – very informal, open door policy – if I had any difficult MDT issues. It was then that more got covered than in some of the more formal meetings.

INTERVIEW 11:

UNDER-THEORISED EXPERIENCE OF MDT WORKING [0-2m]
…when I was thinking back to the third year of training, and aiming to be an inclusive professional – a psychologist in a real life situation, my view was that one of my weaknesses was working in the MDT setting. At [university], we got teaching on working systemically, and there was reflection on working as a leader or as a manager within the context of big teams, but I didn't feel there was enough. I mean, through training, most of what I got was through placements. I made sure that for each placement one of my placement goals was to get as much MDT experience as possible.

THE MDT, THE INDIVIDUAL PERSONALITY AND THE TRAINING/PROFESSIONAL CONTEXT SYNCHRONICITY [2-6m]
…I see myself as not a 'strong' person – not having an extravert character or personality. Like in the team setting, if there is a team decision to be made, I tend to be quite quiet, to stay in the background and reflect a lot, and go with the majority. I guess that's about my view of myself. But also, when training, despite being told to go to placement, get as much experience as possible – go to meetings, observe your supervisors, reflect, read and all that, by the end of training there was the sense that Clinical Psychology itself was

changing – less about being a clinician, maybe more about being managerial. I didn't feel that those changes were being transferred much into lectures or preparation. I think maybe we got half a day on leadership skills; we got a bit more on MDT work in the child teaching.

SOUNDING OUT THE REFLECTIVE PRACTICE GROUP - WHEN CLINICAL SUPERVISION FALLS SHORT [7-11m30]
…We had reflective practice groups across the three years. If I went to a specific placement and there was a negative experience – something I was struggling with, then the first point of contact would be my supervisor. If I was unable to get what I needed, then I would go back to my cohort about how to manage that situation. Like if there were very different opinions about how to deal with a client, sometimes risk takes over – some services can be risk averse – medication can take over a care plan. I might sometimes have to gently bring some psychological theory to a situation where maybe [pause] where maybe my supervisor is already a part of that system – that's a normal thing, maybe it will happen to me here – but they have a position, and so I'm there asking critical questions. Where it was hard for me to get a neutral opinion, then the cohort [fellow trainees] were my grounding place.

TRUSTING IN THE SUPERVISOR [13 – 16m]
I always saw supervision as a gift, even if there was discordance or a challenge. For me the supervisor was like a parent figure – even when I didn't know how or why something was as it was, I followed the supervisor and I wasn't let down. I was very fortunate – some colleagues were not. I had no reason to complain. I found observing the supervisor in the MDT meetings to be useful, too, just to understand how to behave – what to do, how to respond…

ACKNOWLEDGING RELATIVE WEAKNESS – INVOLVING THE SUPERVISOR
I don't know how it is on other programmes, but at the start of the placement, I would have to fill out paperwork stating my expectations, and the supervisor would have to agree and sign, such as systemic working, MDT working, some leadership stuff. These were some of my emphases. I would maybe neglect to focus on the models, as I thought that my area of weakness was the MDT working.

ACKNOWLEDGING RELATIVE WEAKNESS – FOR ME TO DEAL WITH [16m15s – 17m 50s]
…being confident and assertive in the MDT context – that is a challenge to me. Maybe that's something the course can't do anything about, maybe that's for me to deal with.

PROBLEM-BASED LEARNING - LISTENING [18m – 19m]
Problem-based learning was a good one for reflection around working systemically. There was emphasis on listening in the meeting – not that meetings are where all of the MDT working occurs.

LOCATING MDT WORKING [19m 50s]
Where I am now, the real MDT work is working [with staff on the wards] – on the shop floor with staff; hearing about a problem in a meeting is the beginning of planning the

MDT working.

EMPLOYMENT HISTORY - MULTIPLE PERSPECTIVES [20m – 21m 15s]
I started working in the kitchens, initially – far far away from any clinical tasks. Then I got my degree and took various assistant jobs, then I did the clinical psychology training – and now I'm back – I've been everywhere.

(DIFFERENCES AMONGST) THE TRAINING COHORT [25m – 26m 40s]
What was problem-based learning about that gave us relevant skills, feels like a long time ago. There were about seven or eight of us. Not everyone got on well together which was interesting, so it was like a difficult MDT – but all one profession. People took different approaches, had different views. Maybe looking into it, the course gave us more than we – I – realized; all practical, but still.

SELF-MONITORING [26m40s – 27m30s]
I lost a lot of confidence in the past – I used to be very expressive – that's how people are where I come from, but on the course I became very self aware – even like watching what I do with my hands. People kept saying 'Be professional blah blah blah,' and so I became really aware of how I was and questioning of everything I was doing.

PROFESSIONAL RISK AND THE MDT (MEETING) [27m40s – 28m40s]
The accountability side of things – as a psychologist [in this country], that's something that scares me – make a mistake, you're likely to lose your registration. That detracts from my saying or doing a lot in the MDT context, so I listen and observe a lot before I comment in that context.

HARSH SELF-MONITORING [29m – 30m35s]
There's a big dissonance between what I think of myself and what I thought was happening, in terms of being monitored and so on. I now realize I had a very smooth experience through training – compared to others. I didn't require any extra support from the course or supervisors – I think the course happened at the right time for me. I was given a lot of independence to do whatever I wanted to do, but that feels a bit intense for me, 'cause I wanted more guidance.

FUNCTION OF REFLECTIVE PRACTICE MEETINGS [33m – 39m]
At first our reflective practice groups – though they weren't called that – they were facilitated and we were given topics. Second year, we were given topics and facilitated ourselves. Third year – free run. There were about eight people per group. By the end it was very much about what people were going through here and now; I think it was about providing reassurance and guidance, I'm not sure how much that's the same as reflective practice.

SETTING THE TONE OF REFLECTIVE PRACTICE [39m20s – 42m 30s]
The way it was set up in the first year, like based around an ethical problem, say, maybe set a tone of problem-solving, but that was the closest thing that we had to a structured reflective practice arrangement. We didn't for example follow any models... In fact, most of what I know about reflective practice came from before training, or from where

I am now – we get a lot of supervision and peer support.

CLINICAL SUPERVISION – THE REFLECTIVE SUPERVISOR [42m30s – 43m45s]
…honestly, through all of the training, I would say I only had one supervisor who was genuinely reflective – also the only man I had. Often my female supervisors were very task-focused – have you done this, what have you done there, and so on. Whereas this guy, it was 'Tell me how you felt with this client…' – so it felt quite psychodynamic, though he was a different kind of therapist. It was a lot about feelings and relationships. It was a good experience, I got a lot from him.

POPULARITY AND REFLECTIVITY [44m30s – 47m00s]
I chose that supervisor as he had a reputation for being reflective, and he was also trying to improve himself more – always trying to better himself. He was very popular as a supervisor. I would want to know what makes him so popular as a supervisor. Interestingly, in that service, there was no MDT work – just seeing clients back to back, like in a GP surgery.

CONFIDENT SUPERVISOR VERSUS PROFESSIONAL MASK [56m45s – 59m30s]
That supervisor was the only one who brought the relationship into the picture – it was all about the relationship. It threw me in the beginning. Of course the course teaches about that but most supervisors don't feel confident enough to go that way. Even now – here – people don't ask how I feel about the clients. It's 'professional' to the point of wearing a mask where you don't have feelings at all. It didn't feel reactive or like he was telling me what to do, it was like he was exploring with me how I was and could work – it was up to me. That felt empowering to me, and it challenged my view that I needed guidance. I guess others were reacting more to my anxieties, my 'Ah, help me!'

BEING A SUPERVISOR, MONITORING AND CONFIDENCE [1h 5m – 1h 10m]
In terms of my own [present and] future style of being a supervisor, I'm not a checker. I don't like checking, having a checklist. My approach is, 'You're an adult, you know what you have to do…' – that's about responding to the individual – it's good for my current assistant's confidence.

CULTURAL DIFFERENCES AND SUPERVISOR MODELING [1h 13m – 1h 14m]
I'm from a different culture, where I like to be straight to the point – direct. I sometimes just don't know how to behave – like going around things, being 'PC.' So I sometimes ask my supervisor, who's a consultant, if I can come along to meetings, just to observe and learn how to behave. Modeling is very important to me – in how to learn, and how I try to teach or guide others – like a healthcare assistant in how to implement some intervention. I think though, system to system, the modeling might vary.

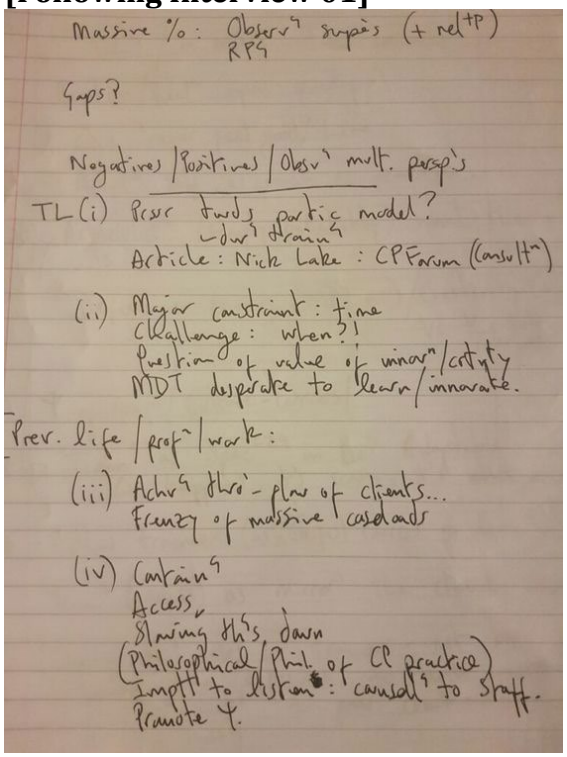
APPENDIX VI: Memo-Writing to Support Theory Development

The following memos are included to illustrate the development of descriptive, conceptual and theoretical insights from reflection on a selection of interviews. These include extracts from transcribed post-interview audio memos, which were a way of recording immediate responses in the hour or so following formal data collection. These were usually spoken whilst driving away from an interview and were not intended as formal or complete reflections. These are interspersed with images of other written notes and sketches made during and after interviews, as data collection challenged emerging concepts and categories. These were not written to be published, but are shared with an accompanying sentence to indicate the thoughts and concerns that were being conveyed within my research process. Memos 01 – 07 begin to record and confirm what were to become the descriptive categories. Memo 08 sees the beginning of a higher level of conceptual abstraction, with openness being noted as a means of explaining some of the relational process matters that participants repeatedly raised. This appendix ends with a table summarising how each memo related to data, and how this contributed to the development of understanding (pp 171-174).

With each memo, questions that were held in mind were:-

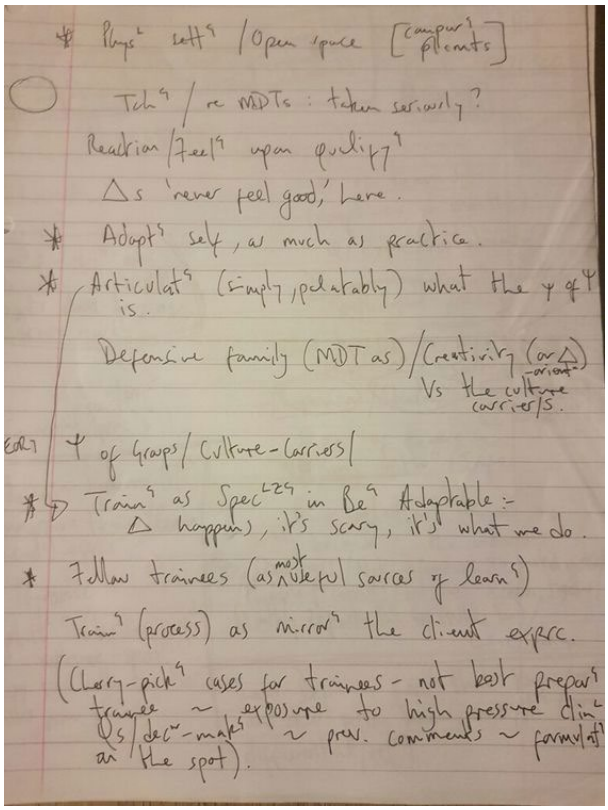
- In what way does the new data speak to the research question?
- How does the new data contrast with that collected previously?
- What does the data describe in response to the research question?
- What does the data explain in terms of facilitators and/or barriers to preparing for MDT working through training?

Memo 01, written note, 28/08/14 [Following Interview 01]

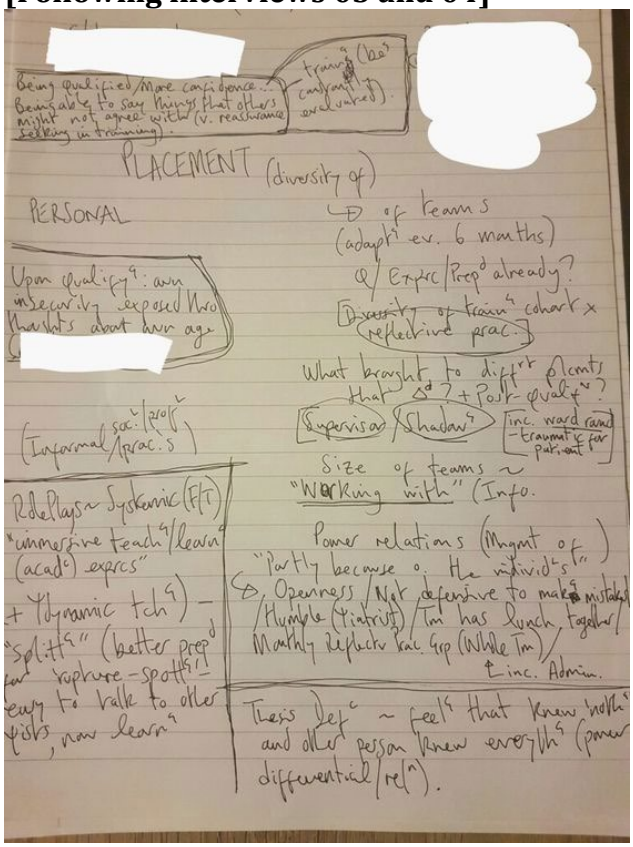


This conveys the first interviewee's emphatic references to clinical supervisors, supervisory relationships and reflective practice group participation as a first line response to the research question. The participant also outlined current difficulties in MDT working, and began to discuss their role in responding to those difficulties with and for the team.

Memo 02, audio, and Memo 03, written note: The Early Emergence of Reflection and Peer Group as Key Concepts, 03/09/14
[Following Interview 02]
'Similarities and differences - a bit like the first interview, it was interesting to hear of how programmes can be structured differently, with different ranges of organization types hosting placements, which I hadn't anticipated. That didn't seem to impact on the relevance of the research question, which remains non-specific in terms of the kinds of MDTs which it speaks to – it's general. There was a sense of [interviewee] having a clear sense of their own training programme differing from others - was clearly talking to me as a Birmingham trainee – aware that I'd be unfamiliar with some of [their] previous placement and coursework experiences. The stand-out feature was other trainees – emphatic about that being the source of most learning – related to reflective practice - again came up without explicit prompting – formal or organized, and informal – learning about self through noticing and listening to peers, noticing similarities and differences. There were more differences, which is where I guess the noticing comes from. The fact of the first two interviews, bit fluky, being with people who have a clear sense of their own working lives before any hint of clinical psychology training was interesting, though I'd imagine these to be a couple of the oldest participants. Still no substantial references or leaning towards taught content within training.'



Memos 04 and 05, written notes: Variation in Placements, Parallels with Reflection Practice
[Following interviews 03 and 04]



Memo 04 - written note (photograph above) reproduced for clarity

Being qualified / more confidence… - training (being constantly evaluated)
Being able to say things that others might not agree with (versus reassurance-seeking in training)

PERSONAL
[Upon qualifying own insecurity exposed through thoughts about own age (edit for deidentification)]

(informal social/professional practices)

Role Plays related to Systemic (Family Therapy) 'immersive teaching/ learning (academic) experiences

PLACEMENT (diversity of)
- of teams (adapting every 6 months)
Question: Experience / Prepared already?
[Diversity of training cohort and reflective practice]
What brought to different placements that changed? And post-qualification?
[Supervision / Shadowing (including ward round – traumatic for patient)]

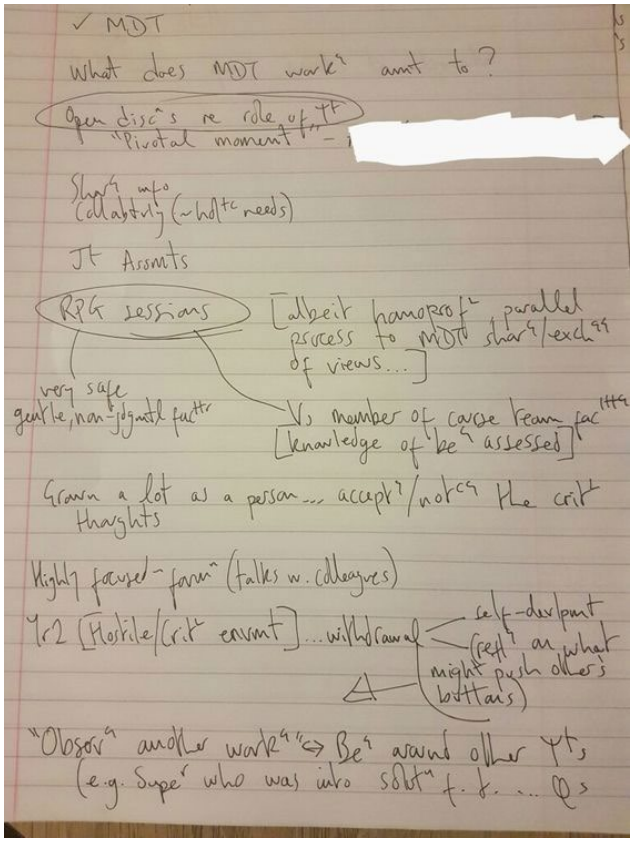
Size of teams relates to 'working with'

Power relations (management of)
'Partly because of the individuals' -

Psychodynamic teaching – 'splitting'
(better prepared for rupture-spotting
- easy to talk to other psychologists, now learning

Openness / Not defensive to making mistakes / Humble (psychiatrist) / Team has lunch together / Monthly reflective practice group (whole team, including admin.)

Thesis defence related to the feeling that knew 'nothing' and the other person knew everything (power differential / relation)



Memo 05 - written note (photograph above) reproduced for clarity

[Experiences of MDT working confirmed]

What does MDT working amount to?

Open discussions re role of psychologist
'Pivotal moment' – [edit for deidentification]

Sharing information
Collaboratively (related to holistic needs)

Joint assessments

Reflective Practice Group sessions	[albeit homoprofessional, parallel process to MDT sharing or exchanging of views…]
Very safe – gentle nonjudgmental facilitator	Versus member of course team facilitating [knowledge of being assessed]

Grown a lot as a person… accepting / noticing the critical thoughts

Highly focused formulation (talks with colleagues)

Year 2 [Hostile / Critical environment] … withdrawal	self-development reflecting on what might push others' buttons

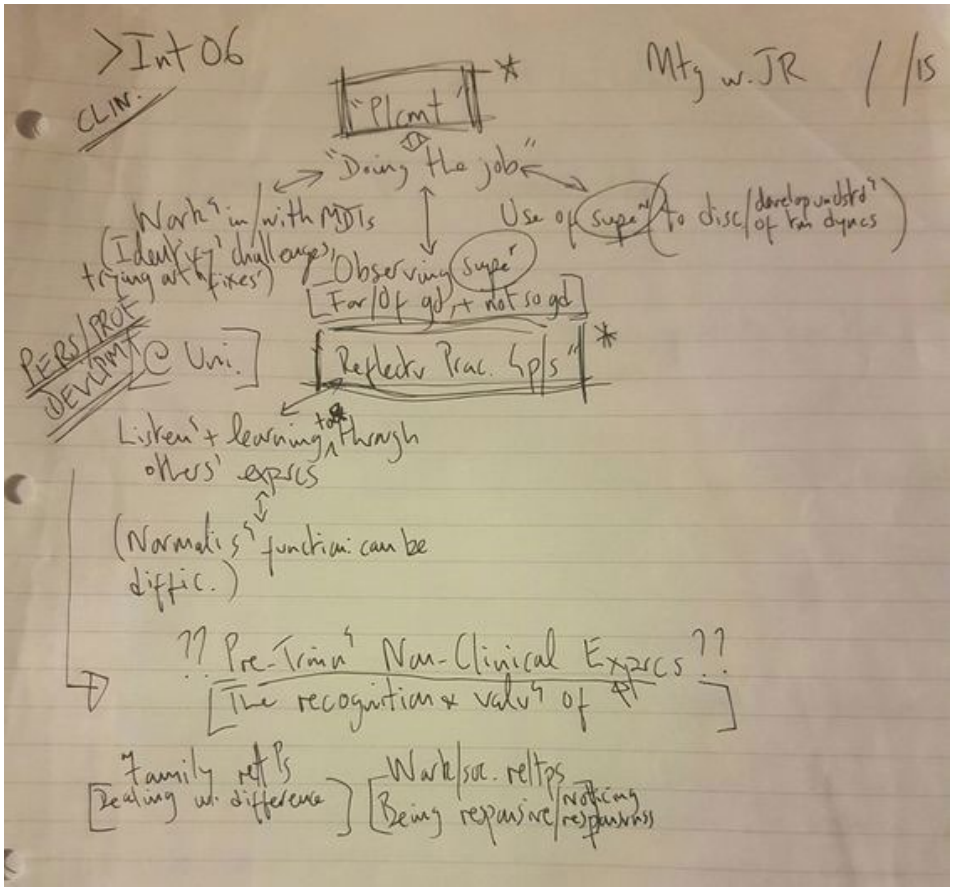
'Observing another working' – being around other psychologists (example of the supervisor who was into solution focused therapy questions)

Memos 04 and 05 demonstrates the observation of links being made within interviews and data between reflective experiences with peers and the demands of MDT working, as participants acknowledge parallel uneasy experiences in both. Power, social relationships and having and choosing (or not) to use the voice are raised in relation to both contexts; this gives rise to conceptualizing safety in trainees' encounters with peers reflecting, and with fellow professionals in MDT settings. Both memos pick up the participants' separate points related to shadowing or observing clinical supervisors' handling of the same.

Memo 06, audio: Confirming Descriptive Categories and the Task of Tentative Theorising, 28/01/15
[Following Interview 06]
'As with the last interview, that felt quite ploddy - like we were confirming the main areas of talk and description – placements and 'doing the work' in whatever shape that came, supervisors, and still the peer group. Where there's been only light touch reference to the peer group or reflective practice, something seems to happen as the participants look over the prompts list towards the end of the interview. In the context of what we've spoken about, which tends to be the particularities of placements and being supervised that stand out, a moment to think about interactions with the peer group then seems to take on greater significance… as if bits of what might be taken for granted or undervalued make a lot more sense now. That might be a not knowing thing, perhaps something that is borne more easily with greater confidence or experience. It feels like there's a need to start drilling down a bit more, now, discussing with the participants the emerging model after initial responses to the research question have been explored. The prompts list is still useful, if only to jog memories. Training as one big blur seems to be the thing that we're unpacking and unpicking. People do seem to appreciate being interviewed as a dedicated invitation to reflect, which is I guess what

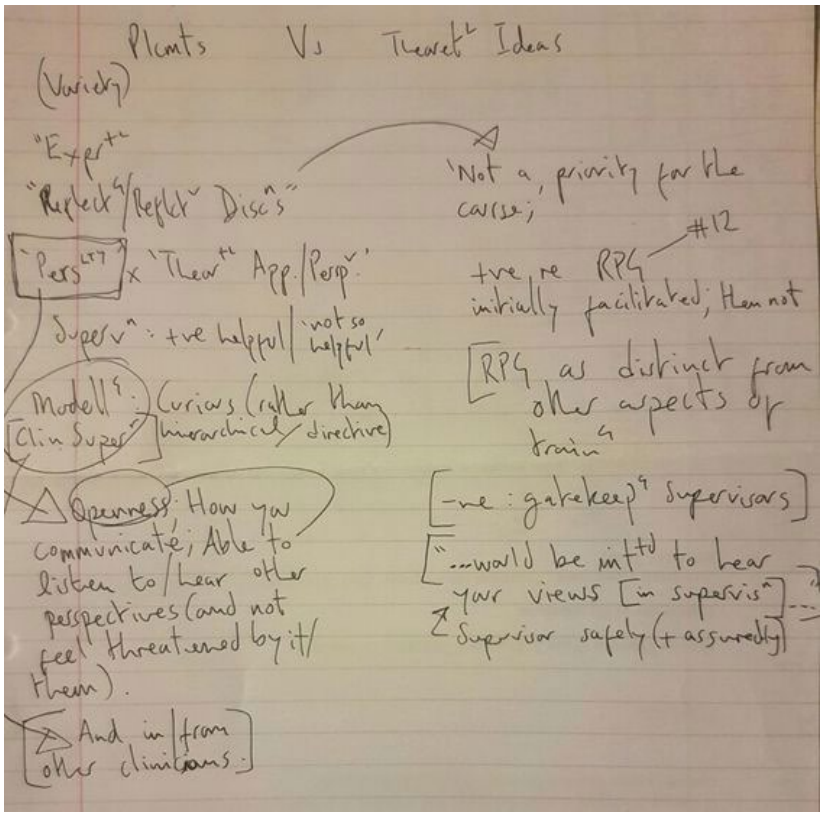
they are, though I still hadn't anticipated reflection coming up so much in terms of direct responses and participants' answers to the research question.'

Memo 07, written note / sketch following meeting with supervisor to discuss interviews to date: Relationships Between Descriptive Categories: Learning Domains and Learning through and with Others
[Following Interview 06]



This memo features notes made whilst talking and thinking through the data from interviews 01 – 06 in a research supervision meeting. The emerging parallel between personal professional development aspects of training and 'doing the job' clinical activity sees the location of the descriptive category of (use of) the clinical supervisor/supervision as more typically informing the clinical or professional part of trainees' development or emerging identities and roles. Although distinctions between personal development, professional development and personal professional development can be subtle and arbitrary (see Literature Review, this volume), the sense of a domain-distinct parallel occurs here. The parallel to clinical descriptions of valuable (supervisory or doing the job) learning concerns experiences that also draw value from listening to and learning through others' (trainees') experiences, such as in reflective practice settings. In terms of holistic processes, this may present a challenge for trainees of recognizing the compatible values of different aspects of training activity, especially where links may not always be fully explicated or formed prior to engaging in learning activity.

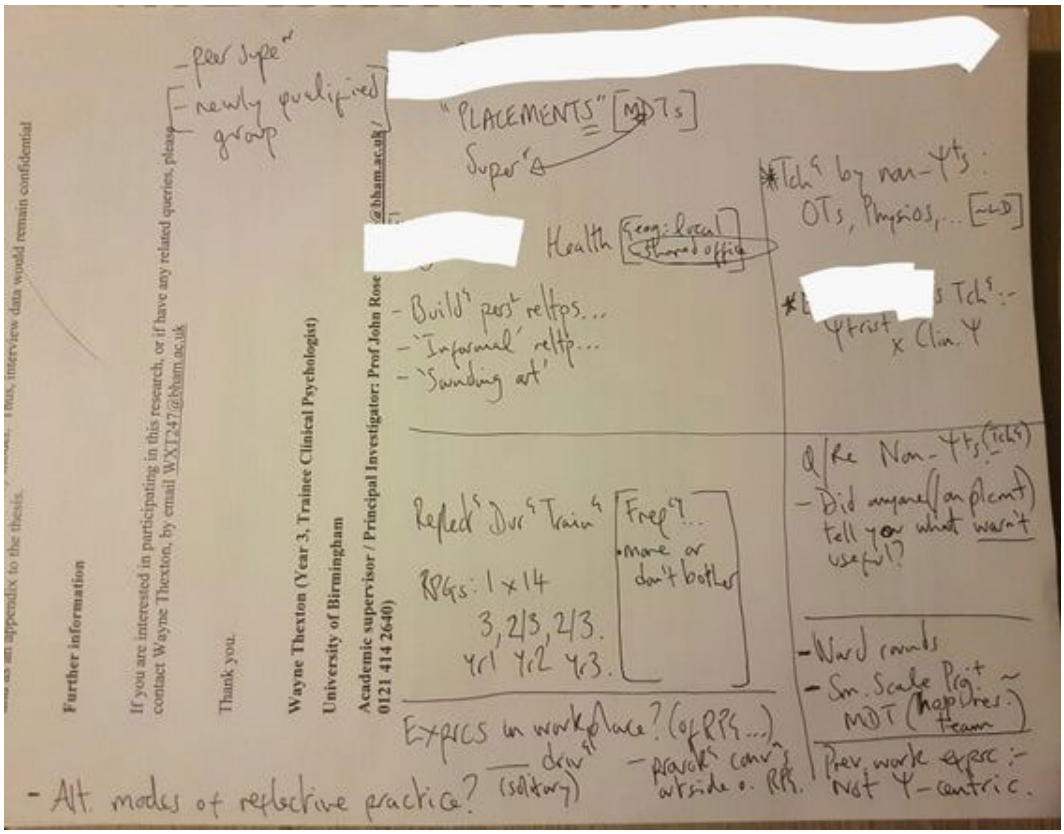
Memos 08 and 09, written notes: Conceptualizing Openness
[Following Interviews 07 and 08]



Memo 08 - written note (photograph above) reproduced for clarity

Placements (Variety)	versus	Theoretical Ideas
Experiential 'Reflecting / Reflective Discussions'		'Not a priority for the course'
[Personality] and theoretical approach perspective		Positive re reflective practice groups (12 members; initially facilitated, then not)
Supervision: positive: helpful or 'not so helpful'		[Reflective practice groups as distinct from other aspects of training]
Modelling [clinical supervisor]: curios (rather than hierarchical or directive) [And in or from other clinicians]		[negative: gatekeeping supervisors]
Openness; How you communicate; Able to listen to or hear other perspectives (and not feel threatened by it or them)		['...would be interested to hear your views [in supervision]...']

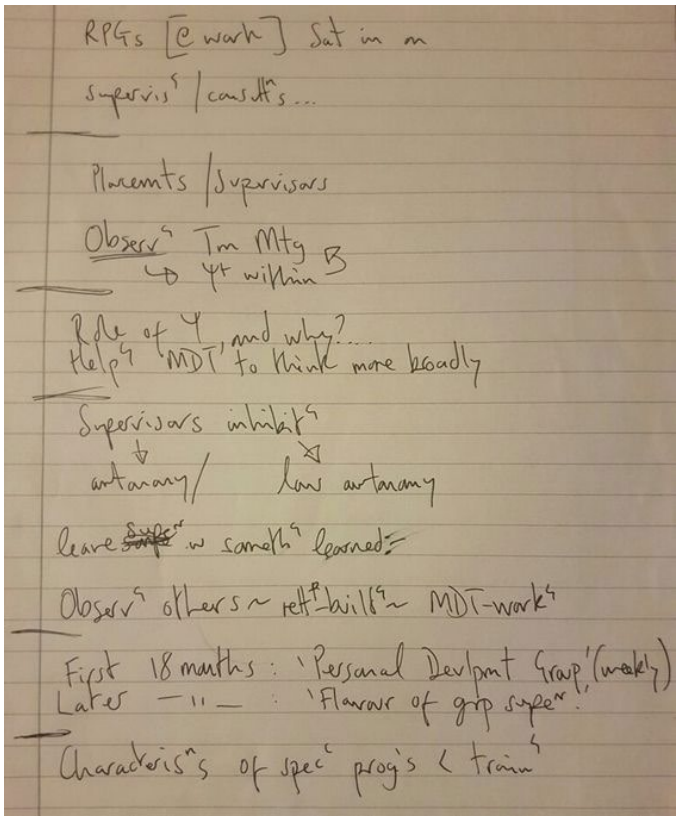
(supervisor safe and assured)



These two memos demonstrate more questions being asked and analytic reflection on the nature of relationships that helpful learning activity seem or need to be predicated on, this is an attempt to move beyond describing the data to explaining what is or needs to be achieved for helpful learning to inform preparedness for MDT working. Though mentioned very early in data collection, it is at this point that the concept of openness becomes a substantial component of the emerging model.

Memo 10, audio, and memo 11, written note: An Interview/ee with a Difference – Something Akin to Negative Case Analysis, 18/02/15
[Following Interview 09]
'That was an unusual interview, bit uncomfortable at times. Talk flowed well enough, but was qualitatively different from others so far. [Interviewee's] perspective on the peer group was at odds with all others' - quite defensive - peers as competitors, which may be fair enough but I couldn't help thinking and feeling that had been a costly perspective. Seemed to describe a fairly isolated route through training, not open to expressing [...]self with peers and very cautious or guarded with supervisors and course staff where they had a role in evaluating trainees. Also suggested a struggle in adapting to team working activities in current role, but was open about that being the elephant in the room through training – forever being picked up in end of placement reviews, though not ever actioned. Was willing and able to own the decision-making process and own under-preparedness for team-related activities; straightforwardly put that down to giving precedence to working as an individual therapist through training – which is not

what is massively required in the current position – tricky. As much as this would be a case of not being well prepared through training, that seems to be down to choice and decision-making – maybe conveying some avoidance, but what wasn't worked through – either planfully or by chance – was something like the model. If the trainee is not seeking to work to achieve access to MDT activity, and they're self identifying or focusing on lots of direct one-to-one therapy, and also choosing to not engage with the peer group, then… what? Brings to mind what would have come up during recruitment to training, and whether that is a position or situation that ought to be permissible. Might have enabled them to get through training, though it might not have done them many favours in terms of readiness or anticipating working closely with MDT colleagues. As it is, the broad perspective that this speaks to is that the model might stand – it hasn't been undermined or discounted here, but trainees will have the opportunity to overlook it as a suggested process. Maybe this speaks to the value of such a model being held in mind by each of course and placement staff, and trainees. [Recorded later] Another thought – what [interviewee] said they didn't do during training – speak openly, acknowledge vulnerability, or engage in talk or practice of MDT working – they were doing with interest, here. When I suggested that referring to some of [their] own experience as they were now supervising others, and that that might be a way of building rapport and trust – making connections, that did seem to be received as a bit of a light bulb moment. Maybe – hopefully – these are signs of a growing albeit uncomfortable openness to engaging openly, trusting and not always having to be on guard or fully on top of things. Seemed happy enough as the interview ended.'



Memo 12, audio: Relational Matters and Keeping the Model Simple - an Interview (and Model) that Flowed, 23/02/15
[Following Interview 11]
'That was enjoyable, really interesting and flowed well. Although there was the standard late check of the interview schedule, there was a sense that [interviewee] got the model, and had quite self-consciously enacted the elements of it, through training. Interview could have gone on for hours. That shows how these interviews – in themselves a reflective space for participants, can generate a lot of energy and enthusiasm and maybe even validation where the participant has intuited a way of being and working that has or is serving them well. Also, the nested model stands. Although John [supervisor] suggested it be called the fried egg model and has been open about misgivings for it being so simple – could there be more arrows or more circles, the simplicity and it being minimally directive is important. That goes with a grounded theory output. As well as erring towards what sense the individual makes of where they are now, and to what extent – or how and why - that is or is not attributed to training and post-qualification experiences, this interviewee began to discuss the kinds of organization that early career experiences are picked up in and how that can either stimulate or inhibit personal professional development. That can be the stuff of another project.'

Table 8: How thinking (partially conveyed in memo content) fits with data and the development of understanding

Memo number (following interview number) and memo format	How thinking (in part conveyed by memo content) fits with data	How this thinking moves understanding on
1 (1) Written note	A balance of inputs and learning activities from different settings and relationships within training was summarized as most helpful. That covered relationships with and observing supervisors, and reflective practice groups. Pressures on and from organizations (values) and teams (workload) were said to inhibit some aspects of MDT working.	Interviewing style, with available prompts, worked well. Early interest (background reading, not featured in thesis) in transformational leadership likely to be abandoned (participant did not naturalistically err towards matters of leadership). Talk of organizational pressures more substantial than anticipated or queried.
2 (2) Audio recorded reflection and 3 (2) Written note	Adaptability of the person and their psychological practice is valued. The research question is received as highly pertinent. New data outlined the merit (necessity) of exposure to high-pressured clinical questions and decision-making in training. Again, negligible reference to formal teaching on working with MDTs.	Participants have clear sense of own training programmes as distinct from others (which can be helpful and unhelpful). The research question assumes that participants gained access to and experienced MDT working. Again, peer group and reflective practice elaborated upon and valued highly.
4 (3) Written note	Training can amount to becoming a specialist in adaptation and sensitivity to imbalances in power relations. New data characterized supervisors as having highly contrasting investments (and defences) in trainees' working with MDTs. A perspective shift that occurs upon completing	Preparation for MDT working includes noticing the breadth of possibilities in how MDTs function, and how that can position all staff. There is value in noticing through experience, which can occur whilst observing supervisors or other professionals engage in MDTs. Noticing teams' ways

	training and qualifying can be stark. Beyond the gaze of supervisor assessors comes a greater freedom to disagree (or maintain a perspective).	of working can rely on such proximity as to reveal the value of non-clinical informal and relational details.
5 (4) Written note	There can be value to the newly qualified clinical psychologist in having encountered struggle and hostility within training experiences. New data discussed this in terms of parallels between reflective practice groups and MDTs, and openness to colleagues' experiences of MDTs.	Access to MDTs does not demand over-exposure of novice practitioners, which could be inhibitory or damaging. Valuable observation or shadowing of supervisors engaged in MDT working may rest upon both parties accepting that there can be valuable learning in uneasy experiences.
6 (6) Audio recorded reflection and 7 (6) Written note and sketch, post-supervision	There is such recognition and naturalistic elaboration on the main themes that data collection justifies a turn to theoretical sampling. New data confirmed the main areas of talk: adaptation and sensitivity to working in, with and for distinct placements, the clinical supervisor, and making sense with and through peers in reflective practice.	To notice the value of reflective practice may be something that relies on substantial focused reflection, such as occurs during interviews for this research. Whilst participants seem to value being interviewed on the research question, further data collection will seek to unfold more elaborate accounts that can invoke reflective practice groups.
8 (7) Written note	The demonstration of listening to and hearing alternate perspectives, modeling curiosity and valuing of trainees' and other colleagues' understandings and not demonstrating feeling threatened by these were valued in clinical supervisors. New data discussed the qualities conveyed by clinical supervisors that best facilitated helpful and trusting learning experiences and openness (in talk and to new	In terms of clinical supervision, the contribution of this to answering the research question is drawn from a much wider range of experiences than routine supervision sessions. The supervisor's example in engaging with and inviting others' openness, which communicates a lack of defensiveness and is trusting and supportive of the trainee accessing the MDT, is crucial to this. This does not discount

	clinical experiences). Parallels with positive experiences of reflective practice discussions with peers were outlined.	that there will be occasions of supervisors struggling with MDT working. Where that is the case, then it is that that the trainee might be helpfully exposed to.
9 (8) Written note	It may be that the act of devoting dedicated time and commitment to reflection on training experiences is a better framing for provoking valuable insights that are more typically assumed to arise out of reflective practice groups. New data discussed alternate modes of reflection, both at the level of the individual and involving peers, whilst suggesting that programmes can convey ambivalence about reflective practice by devoting little programme time to this where trainees do value this.	In addition to open reflection with supervisors, which has typically been valued, the equivalent practice individually or with peers does not rest entirely on the presence or experience of reflective practice groups, important though they are. Trainees have the autonomy to raise or practice this outside of the formal structures of programmes, though there is a role for programmes in communicating a valuing of such practice, where that is the case.
10 (9) Audio recorded reflection and 11 (9) Written note	A trainee can encounter many potential threats (to senses of their professional security, progress and competence) (depending on perspective) in training. New data featured a training counter narrative – one of explicit avoidance of MDT-related undertakings; all set against a focus on being a most capable and adaptable one-to-one therapist. Sensitivity to the risk of openly expressing difficulties before assessors and peers (competitors in the jobs market) was outlined.	The 'access-inclusion-reflection' model seemed to be implicitly supported in terms of 'I chose not to follow such a process, and I was hugely underprepared for MDT working.' The research question assumes (and any outputs will rely upon) trainees being invested in pursuing preparation for MDT working. Where a trainee is singularly focused on delivering one-to-one therapy, then this research will be unlikely to reach them. The model may be helpful for making visible barriers to best preparation.
12 (11) Audio recorded	Where participants speak of being satisfied with their	The theoretical model satisfies the quality criteria of

reflection	current approaches to MDT working, this can be a matter that has received no formal validation, but at best acceptance from colleagues. Researcher and interviewee agreed that new data described a self-directed approach to training (including targeting MDT working, a particular supervisory style and reflection with peers) that was taken to be validating of the nested model (outlined at the beginning of interview 11), as well as validated by the model.	credibility, originality, resonance and usefulness for the purpose of introducing an indicative model to an under-developed area of research. Albeit occurring opportunistically, interview 09 stands as an example of a negative case analysis for so clearly representing an approach to training that was largely at odds with the model.

Appendix VII: Two examples of transitions of data extracts through coding to descriptive category and theoretical category

Example 1

Extract of data (from interview 02)

- 'I think the reflective discussion was really helpful during training. Being able to sit in a room of trainees and filter and work out what people want or are trying to say – that was hard, cos everyone wants to present themselves as awesome and smart. It's that assistant psychologist ethos that follows some people around. I would sit there and say, 'I'm terrified.' I learned more from those I was training with than anything else. That journey would only be half a journey without those who you're taking the journey with.'

This extract has been selected as it presents an early example (without direct prompting) of a participant raising reflective practice and discussions with their peer group in response to the research question. Though the extract alone does not indicate the participant's connection of these elements to multidisciplinary team working, that came about with reflection and talk later in interview, as well as within the wider dataset.

Open code explained

- Reflective discussion / Value of peer group

The participant's framing of this talk around *reflective discussion* was used as an initial open code. Returning to the extract through the course of constant comparative analysis and the coding of further interviews, the additional feature of the extract - valuing of the peer group - was added to the coding. This acknowledges the extract beginning to describe and explain more than trainees' exchange of information and development of perspectives through reference to reflective discussion and reflective practice.

Early subcategory labeling (through constant comparative analysis)

- Reflective practice (groups); valuing peer group; making sense of training

Relating to reflection on a wide set of learning experiences and views across both phases of data collection (interviews 01-06, and 07-11), 'reflective practice' was quickly adopted as a tentative descriptive sub/category. Ahead of data collection there was no conscious expectation of this featuring prominently in participants' talk. The analytical step of raising this from open coding to tentative descriptive categorization was in part a result of the consistency and ease with which participants discussed this as relevant to the research question, regardless of the qualities of their unique experiences. As in the extract, some participants spoke of the reflective practice discussion forum without prompting, whereas others picked this out from the activities of clinical training prompts lists that were available to all participants. With the later addition of 'valuing

peer group' and 'making sense of training' as subcategory labels, the analytic movement from describing data to explaining data begins to be indicated.

Stable descriptive subcategory in which this extract was located

- Reflective conversations (with peers)

Still at the level of description, the extract was located within the stable subcategory of reflective conversations.

Stable descriptive category in which this extract was located

- Peer group

With the collection of further data and intensive interviewing around the emerging descriptive categories (in particular, from interview 07 onwards), discussion of reflective practice elicited talk of commitment and investment, dynamic processes and the qualities of facilitation that related to that forum. As such, this began to inform wider talk of the experience of training as firmly located within a unique social context. With such accounts often beginning with reflection upon reflective practice, these were elaborated upon to include other aspects of shared learning activity, with a range of analogies to MDT working being described. The unifying stable category in such talk was the peer group.

From description to explanation: the generation of theoretical concepts and categories

- Sense-making and Discovery

Shifting from description to explanation, the non-linear analytic process is apparent thus. Constant comparative analysis continues, referencing initial open codes and their extracts of interview data, whilst the main research question is regularly returned to. Data and subsequent codes and categories are then tentatively linked to a chronological explanation of participants' becoming best prepared for MDT working. This does not assume that participants have laid claim to being or feeling best prepared for MDT working, but that they have spoken of how their own experience bore strengths and limitations that related to preparation for MDT working.

In raising the level of analysis from description to explanation, theoretical category labels were generated so as to offer credible, original, resonant and useful explanations of a training process. The extract in this example was substantially and stably located with explanations of sense-making and discovery. As well as a shared process occurring with peers or clinical supervisors, the process of sense-making and discovery could also be a matter of private unspoken reflection.

Example 2

Extract of data (from interview 03)

- 'The placements – doing the work – were most useful for preparing me [for MDT working]. I had quite diverse placements. I think as a trainee having to adapt to a new team every six months was good for preparing to work with people.'

This extract is chosen as an illustrative example, for the participant's summary integration of key concepts. Reference to 'diverse placements,' which typically refers to variations in therapeutic services and service users' demographic profiles and presenting difficulties, is integrated with the recurrent task of adapting to new teams, all framed in terms of 'doing the work.'

Open code explained

- Placement change, adaptation, working with others

At open coding, early in the data collection and analysis process, three features of the extract are picked out to represent the summary offered by the speaker. This retains a degree of complexity by not being reduced to a single feature or concept, and highlights the extract as likely relatable to other participants' data, later in the analysis process.

Early subcategory labeling (through constant comparative analysis)

- Practicing / Doing; contrasting teams and placement experiences

With the to and fro process of constant comparative analysis, the development of subcategory labels captured the possibilities for describing the extract in terms of the participant's own umbrella term of 'doing,' with later consideration of that as valuable for it being a repeated process which offered a particular kind of perspective, as well as placing particular demands on individual trainees.

Stable descriptive subcategory in which this extract was located

- Adaptation

At the level of description, the extract was located within the stable subcategory of adaptation, itself a refinement of the open code.

Stable descriptive category in which this extract was located

- Doing the Work

The subcategory of adaptation was located within the descriptive category of 'Doing the Work,' a term used by the participant. This category label incorporates the core business of practicing clinically with service users, though also accounts for the more

subtle business of the novice practitioner remaining sensitive to new forms of multidisciplinary team working and the related demands for flexibility and relational work.

From description to explanation: the generation of theoretical concepts and categories

- Trust and Exposure

Though the speaker went on to outline greater degrees of complexity (as discussed under theoretical category, 'Trust and Exposure'), this extract conveys gaining access to new multidisciplinary teams as a straightforward matter that comes with each new placement experience. It may be inferred from the extract that the participant's talk is dependent on having worked within MDTs (that she experienced a degree of inclusion and belonging), and that repetition of this supported sense-making and discovery. The extract is founded, though, on the concept of exposure, which is the foundational theoretical category of preparation for MDT working that is explained by the model.

APPENDIX VIII: Movement from descriptive to theoretical categories: an example

The movement from stable categories, which described data, to a theoretical framework of categories that explained the data began by changing the question that was asked of the data, whilst stepping back from the data and its organization around what was being said. The process, in effect, became one of putting the data back together, so as to construct a framework in answer to the new question of:

What Does the Data Explain?

The analytical shift from description to explanation rested heavily on the back and forth movement between raw data and its open codes, descriptive subcategories and new conceptual labels. Some early conceptual labels 'fit,' and were retained, whilst others were integrated into other category labels. Openness, for example, was integrated into Trust and Exposure. Whilst some in vivo terms utilized in open codes, such as trust, exposure and making sense, were retained through to theoretical category labeling, the retention of category labels drawn direct from the data was not a requisite of this version of the grounded theory approach. Charmaz (2006, p. 55) explains that all codes, in being subjected to comparative and analytic treatment, are subject to integration into conceptual labels brought to the data. Where there is the risk in such processes of imputing pre-existing beliefs, issues or ideas into analysis, for already observing data so heavily invoking and describing features of training (reflective practice and the peer group) which were a surprise to the researcher, this process continued with the use of research supervision and interview data against which to challenge conceptual ideas. This occurred with coding and descriptive categories available for discussion, too.

Towards Theoretical Categorization: Sense-Making and Discovery

Taking the example of how the theoretical category of Sense-Making and Discovery was largely, though not entirely, rooted in the descriptive category of Peer Group, three features of analysis are highlighted below to indicate substantial movements in this area of theory building. This category was developed in parallel to the working up of the foundational theoretical categories of the model: trust-building and exposure to MDT working ahead of trainees achieving degrees of inclusion and belonging.

Peer Group as an Under Appreciated Means of Explaining Sense-Making and Discovery

In returning to data, codes and subcategories which informed the descriptive category of Peer Group, what began to stand out with further comparative analysis, was that participants were utilizing a wide range of references to the peer group to explain unanticipated sense-making processes. Whilst discussing training experiences and subsequent team working, participants elaborated on the utility of training within a peer group, for the distinct learning benefits that were accrued through this. Such remarks as 'learning vicariously through others' began to reveal the ways in which individuals' perspectives on team working were developed, challenged, contrasted and affirmed through noticing others' parallel personal professional development journeys. Where group-based reflective practice may be expected to generate learning opportunities,

interview data suggested that only after such experiences – such as when faced with interview questions that invite reflection – did some participants begin to identify, connect and value some areas of training to specific team-related practice. Further data that explained processes of sense-making and discovery, was located in the descriptive category of Clinical Supervisor.

The Clinical Supervisor as a Parallel Resource for Developing Sense-Making and Discovery

Whilst data which described Doing the Work and the mediating – facilitative or inhibitory - role of the Clinical Supervisor largely informed the theoretical category of Trust and Exposure, descriptions of clinical supervisors as reflective resources informed explanations of sense-making and discovery. For this occurring ahead of, following and interchangeably with comparable accounts of the peer group, data in the descriptive category of Clinical Supervisor further supported the theoretical category Sense-Making and Discovery as a discrete phase of the preparation for MDT working process. By noticing and naming roles and relationships with clinical supervisors, participants explained sense-making processes to which talk of the peer group substantially contributed to, too. In this analysis, such observations and parallels were enabled through an approach which more closely followed Charmaz' (2006, p.61) flexible guide and return to and refining of descriptive subcategories, than that of Strauss and Corbin (1990), which relied more heavily on formal procedures and preset structures of axial coding.

Sense-Making and Discovery: Reflective Practice and Beyond

In comparing data, codes and descriptive categories, whilst asking questions of what was being explained, early references to the peer group were synonymous with data on reflective practice. This was captured in interview 06 and its audio and written memos (06 and 07), prior to data collection phase II attempting to theoretically sample and develop this reflective practice angle. Located under the descriptive category of Peer Group, later contrasts of data from interview 08 and memo 09 with other data and coding related to reflective practice led to one participant's account of private reflection paired with self-directed reference to the peer group, heavily shaping the final theoretical category label. Whilst reflective practice and the peer group were highly valued by participant 08, their value did not rely on formally timetabled reflective practice groups, nor any other element of training programme structure. This autonomous and flexible account of reflective practice, when contrasted with earlier data (interview 06, in particular) was made sense of as remaining consistent with other accounts for explaining a process of sense-making and discovery. In noticing this, further parallels between the Clinical Supervisor and Peer Group categories were observed. Based on the three-category structure of the nested model that is presented in this research, comparisons with interview data enabled its review with quality criteria of credibility, originality, resonance and usefulness in mind.

APPENDIX IX: Reviewed papers' methodological qualities based on the criteria set out in Sale and Brazil (2004)

Key for Tables 9 - 12:-	Element not present / not satisfied	
	Element partially satisfied	
	Element present / satisfied	
	Element not relevant to paper	X

Table 9: Papers' truth value methodological quality based on the appraisal criteria set out in Sale and Brazil (2004)

	Paper Authors and Publication Year								
Element of qualitative methods [Goal of criteria: Truth value / credibility]	Knight et al, 2010	Brown et al, 2009	Binks, 2013	Burgess, 2013	Keville et al, 2013	Wood et al, 2013	Sheikh et al, 2007	Punzi, 2015	Woodward et al, 2015
Triangulation (sources)									
Triangulation (methods)									
Triangulation investigators									
Triangulation theoretical									
Peer debriefing									
Negative case analysis (disconfirmation check)									
Member checks (participant feedback)									
Use of quotations									
Informed consent stated									
Ethical review stated									
Confidentiality protection stated									
Consent procedures described									
OVERALL									

Table 10: Papers' applicability methodological quality based on the appraisal criteria set out in Sale and Brazil (2004)

	Paper Authors and Publication Year								
Element of qualitative methods [Goal of criteria: Applicability / transferability]	Knight et al, 2010	Brown et al, 2009	Binks, 2013	Burgess, 2013	Keville et al, 2013	Wood et al, 2013	Sheikh et al, 2007	Punzi, 2015	Woodward et al, 2015
Statement of purpose									
Statement of research questions									
Phenomenon of study stated									
Rationale re use of qualitative methods stated									
Rationale for the tradition within qualitative methods									
Description of study context / setting									
Statement re how setting was selected									
Sampling procedure described									
Justification for sampling strategy									
Description of participants									
Data gathering procedures described									

	(continued from above) Paper Authors and Publication Year								
Element of qualitative methods [Goal of criteria: Applicability / transferability]	Knight et al, 2010	Brown et al, 2009	Binks, 2013	Burgess, 2013	Keville et al, 2013	Wood et al, 2013	Sheikh et al, 2007	Punzi, 2015	Woodward et al, 2015
Audio recording procedures described	X				X				
Transcription procedures described	X				X				
Field note procedures described									
Data analysis procedures described									
Coding techniques described									
Data collection to saturation specified									
Statement that reflexive journals / logs kept									
Description of raw data									
OVERALL									

Table 11: Papers' consistency and neutrality methodological quality based on the appraisal criteria set out in Sale and Brazil (2004)

	Paper Authors and Publication Year								
Element of qualitative methods [Goal of criteria: consistency / dependability]	Knight et al, 2010	Brown et al, 2009	Binks, 2013	Burgess, 2013	Keville et al, 2013	Wood et al, 2013	Sheikh et al, 2007	Punzi, 2015	Woodward et al, 2015
External audit of process (OVERALL)									
Element of qualitative methods [Goal of criteria: neutrality]	Knight et al, 2010	Brown et al, 2009	Binks, 2013	Burgess, 2013	Keville et al, 2013	Wood et al, 2013	Sheikh et al, 2007	Punzi, 2015	Woodward et al, 2015
External audit and reconstructions of data									
Bracketing									
Statement of researcher's assumptions / perspective									
OVERALL									

Table 12: Quantitative methodological quality of Knight et al (2010) based on the appraisal criteria set out in Sale and Brazil (2004)

Domain: Truth value (credibility; internal validity)			
Extraneous variables identified		Statement re confidentiality protected	
Extraneous variables controlled for in analysis		Statement comparing control group and intervention group at baseline	X
Informed consent stated		Statement that comparison group treated equally aside from intervention	X
Ethical review undertaken		OVERALL (domain)	
Domain: Applicability (transferability; external validity; generalizability)			
Statement of purpose		Selection of controls stated	X
Objective of study stated explicitly		Control group described	X
Description of intervention (where applicable)		Statement re non-respondents	
Outcome measures defined		Missing data addressed	
Assessment of outcome blinded	X	Power calculation to assess adequacy of sample size	
Description of setting / conditions of data collection		Statistical processes referenced / described	
Design stated explicitly		p values stated	
Sampling selection described		Confidence intervals given for main results	
Sampling randomly selected		Data gathering procedures described	
Inclusion / Exclusion criteria for participant selection stated		Data collection instruments or sources of data described	
Study population defined / described		At least one hypothesis stated	
Source of participants stated		Statistical and clinical significance acknowledged	
Source of controls stated	X	OVERALL (domain)	
Domain: Consistency (dependability; reliability)			
Standardization of observers described (OVERALL)			
Domain: Neutrality (confirmability; objectivity)			
No appraisal criteria listed for the evaluation of neutrality or objectivity in quantitative research			-