

Submitted in partial fulfilment of the Lancaster University Doctorate in Clinical Psychology

May 2021

Doctoral Thesis:

Clinical Psychologists' use of Reflection within their Clinical Work

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Word Counts

	Main Text	Appendices (including tables, figures and references)	Total
Thesis abstract	299	-	299
Literature review	7158	7482	14,229
Research paper	6908	6200	13,114
Critical appraisal	3392	564	3956
Ethics section	7816	5449	13,265
Total	25,573	19,695	45,268

Thesis Abstract

The therapeutic alliance is considered an important element of psychotherapy and a good alliance has repeatedly been linked with positive outcomes. Ruptures in the alliance can have negative effects, but if attended to, have been demonstrated to lead to even better outcomes than therapy when a rupture did not occur. A systematic literature review identified nine papers which included therapists' experiences of working with ruptures in psychotherapy. Meta-ethnographic methods were used to synthesise the findings in these studies and the following themes were identified; *hitting therapists where it hurts* which highlights that ruptures often result in therapists questioning their fundamental and valued skills and qualities, *ruptures as an opportunity* where ruptures provided additional information or opportunities within therapy and *understanding the causes of ruptures* in which therapists attributed ruptures to their own mistakes, contributions from clients or influences from third parties. The review emphasises some of the positive impacts ruptures can have but also highlights how challenging they can be for therapists.

Reflection is considered a vital skill within clinical psychology, but little is known about the processes involved when clinical psychologists reflect. Semi-structured interviews were completed with seven clinical psychologists and grounded theory methods were used to develop a model detailing the process of engaging in reflection. The model describes three internal stages to reflection; noticing something to reflect on, gathering information about this and then some form of internal change. This model provides an insight into the processes involved in reflection which can be used to support the teaching and further study of the skill.

The critical review outlines the lead authors interest in these topics and discusses the limitations of the papers. A particular focus is given to the lack of ethnic diversity within the sample for the empirical paper and more broadly within psychology research.

Declaration

The work presented in this thesis is the author's own and has not been submitted to support an application for another degree or other academic reward.

Name: Rosie Wheeler

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Date: 7th May 2021

Acknowledgements

Firstly, thank you to all the psychologists who took the time out of their busy days, whilst working in the middle of a pandemic to speak with me. Your insight is inspiring, not just for this project, but also for my future as a psychologist.

To Pete Greasley, who taught me the word nebulous and helped to make my project workable, I hope you're enjoying your retirement free from draft reads. Thanks for your support and willingness to let me research an area that was as new to you as it was to me. Thanks to Suzanne Hodge, for your ability to know the answer, but for also giving me the confidence that I might know the answer as well. To Anna Duxbury, for your enthusiasm and willingness to join the project, your passion for social justice and for sharing your own experiences so that mine didn't feel quite so overwhelming. And a special mention to Anna Daiches; I already didn't know how to thank you before the events of the last few months, and now you've made it even more difficult. But I will try; thank you, for your help with this project, but for so much more, your acceptance and belief in me throughout the course has meant more than I am able to put into words.

To the Norwich lot, for believing in me when I didn't believe in myself, and for the support I needed to get to this point, I am looking forward to being annoyingly present in your lives.

For the colleagues with whom I spend one day a week, thanks for being there for the highs and the lows, for all your support and for making me look good at Christmas parties. Special thanks to Sarah and Nat, you are there with love and support fighting my corner no matter what; it's difficult to express quite how much that means to me.

To Mum and Sharles, thank you for your love, unconditional support, encouragement and genuine interest (or excellent acting) in this piece of work. I just wish I could have written more

of it in closer proximity to you. To Dad, you would have been so proud, it breaks my heart that you're not here to see this. Although I should point out that you have terrible timing.

Finally to Matt, for moving 300 miles in support of my career, and for working tirelessly for a better future for us. I promise I will strip more wallpaper now.

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Chapter 1 Systematic Literature Review

Therapists' Experiences of Ruptures within the Therapeutic Alliance: A Systematic Meta-Ethnography

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Prepared for: Psychology and Psychotherapy: Theory, Research and Practice

**Therapists' Experiences of Rupture within the Therapeutic Alliance: A Systematic
Literature Review**

Abstract

Objectives: The therapeutic alliance has been widely researched and found to be an important factor in treatment outcomes for psychotherapy. Ruptures within this relationship can have a negative impact, but when attended to and repaired, ruptures have also been demonstrated to improve outcomes. **Methods:** Systematic searches identified nine papers detailing therapists' experiences of rupture within the therapeutic alliance. Meta-ethnographic methods were used to synthesise these papers. **Results:** Three themes were produced; 1. *Hitting therapists where it hurts*, which emphasises how challenging ruptures can be due to the way in which they call into question the most important aspects of the therapist's identity or their belief in the therapeutic process. 2. *Ruptures as an opportunity*, within which therapists identify ways in which ruptures can be useful within the course of therapy and 3. *Understanding the causes of ruptures*, where therapists outlined their own mistakes, client's contributions and where a third person's involvement led to a rupture. **Conclusions:** This synthesis suggests some of the ways ruptures can have a positive outcome on therapy, but also suggests that a better understanding of how therapists can utilise these opportunities in the face of difficult emotions is required.

Introduction

Therapeutic Alliance

The therapeutic alliance (TA) within psychological therapy has been widely researched and discussed, and despite assertions that this emphasis may be misplaced (Safran & Muran, 2006), has been found to be the most influential factor within studies attempting to identify predictors of treatment success (Flückiger et al., 2018; Horvath et al., 2011)). The concept of the TA was first discussed within psychoanalytic approaches under the term transference by Freud (Freud & Strachey, 1915). Freud used the term transference to describe the client's feelings towards the therapist, which he believed were based on the client's previous experiences. He asserted that the feelings and reactions from the client were what made up the TA, and that it had no basis in the actual relationship between the two people in the therapy room.

The importance placed on the relationship between client and therapist has varied over time (Horvath, 2000), but writing by Carl Rogers (1951) placed this relationship in the centre of the work, and the current emphasis on the importance of the TA has continued since this time. Since this focus on the TA has begun, it has been noted that it is a broad concept, with both positive and negative possibilities associated with this (Horvath, 2018). The nebulosity of the concept has resulted in issues within the evidence base, for example the development of measures of the alliance which do not share a definition of the TA, and therefore measure slightly different things (Horvath et al., 2011). The ambiguous nature of the term has however meant that it has been able to be adapted and adopted across psychological therapeutic approaches, as it is argued that it is the strength of the TA which is important rather than the form that it takes (Bordin, 1979). More recently, Bordin's (1979) depiction of the TA as a collaborative relationship between client and therapist, involving three main features; the

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development of bonds, the assignment of tasks and an agreement on goals, has been widely accepted within research (Hatcher, 1999; Safran & Kraus, 2014).

Research into the impact of the TA on therapeutic outcomes is plentiful with positive relationships between these two factors found across settings, client groups and therapeutic approaches. For example, a weaker TA has been linked to a higher likelihood of early termination of therapy (Sharf et al., 2010), a strong TA associated with improved outcomes in eating disorders (Graves et al., 2017), depression (Vernmark et al., 2019) and those with a diagnosis of borderline personality disorder (Spinhoven et al., 2007). Whilst most research relies on simply establishing a relationship between TA and outcomes, it has been argued that this is possibly just picking up on the likelihood that those who develop good TAs are more likely to have good outcomes from therapy regardless. Some have used statistical techniques in order to reduce the influence of this potential confounding variable and have produced a model suggesting that the TA is a causal factor in more positive outcomes (Goldsmith et al., 2015).

Alliance Rupture

Within the psychotherapy literature a rupture is defined as a deterioration within the TA, including a breakdown of the bond between client and therapist, and disagreement or lack of collaboration regarding tasks and therapy goals (Eubanks, Muran, et al., 2018; Safran et al., 1990). Although the use of the word rupture might conjure up images of breakdowns in relationships which will never recover, the term covers a spectrum of intensity, with minor misunderstandings at one end, and a complete breakdown in the TA, including the premature termination of therapy at the other (Kramer et al., 2014). If ruptures are left unaddressed they have the potential to have an ongoing impact on the TA and result in poorer outcomes in therapy, and several studies have identified that continuing with therapy as planned after a

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rupture may cause further damage to the TA (Mellado et al., 2017; Muran et al., 2009; Talbot et al., 2019). Where ruptures occur but are attended to and the TA then recovers (rupture repair), the therapeutic outcome is often superior to therapy where a rupture does not occur (Eubanks, Muran, et al., 2018). One reason attributed to this finding is that ruptures allow the client to try out repair techniques within the relatively safe and supportive environment which is the therapy room, through which they learn skills and develop confidence to be able to address difficulties in relationships outside of the TA (Safran et al., 1990).

Much of the research investigating ruptures has been prompted by the work of Safran and Muran (2000) who developed a stage-process model detailing the processes involved in resolving rupture to the alliance. They proposed that processes within psychotherapy occur in identifiable patterns, and that resolving ruptures in the TA can be condensed into five client states and three therapist responses that support the transition between these states for the client. During the first stage the client says or does something that indicates a rupture within the TA, which the therapist then explores. This either leads to the client and therapist exploring the rupture directly together or exploring the internal processes of the client which prevent the rupture being explored. This exploration of a block is thought to lead to its eventual removal, meaning that the rupture itself can then be addressed. The final stage involves clients taking responsibility for and asserting their primary needs and wishes to the therapist, which should be met with empathy from the therapist. The sequence proposed by this model has received some support empirically (Safran et al., 2011), but it has also been demonstrated that it is challenging for therapists to even notice when clients might be feeling dissatisfied within therapy, where this noticing by therapists has to form the first step of the sequence (Safran et al., 2002).

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This model introduced the concepts of confrontation and withdrawal ruptures. A withdrawal rupture occurs when a client distances themselves in some way from the therapy or therapist, and a confrontation rupture takes place when a client moves against the therapy or therapist (Boritz et al., 2018). Several studies support the differentiation between the two types of ruptures (Coutinho et al., 2014; Eubanks, Burckell, et al., 2018; Hill et al., 2003). This distinction is made on the basis of several factors including therapists recalling confrontation ruptures more readily, while withdrawal ruptures may be more challenging to recognise (Eubanks, Burckell, et al., 2018; Eubanks, Muran, et al., 2018), confrontation ruptures being more likely to lead to dropout from therapy (Coutinho et al., 2014) and therapists finding confrontation ruptures to be more challenging to manage than withdrawal ruptures, with research suggesting that therapists might find it easier to state what not to do during a confrontation rupture rather than what is the best course of action (Eubanks, Burckell, et al., 2018). Although the differences between these two types of rupture are well established, it is also possible for rupture events to include elements of both withdrawal and confrontation (Eubanks, Muran, et al., 2018).

Where different responses to alliance ruptures have been proposed, these can be broadly categorised into those that directly address the rupture itself, and those that take a less direct stance to rupture repair (Safran & Muran, 2000). The decision to take a direct or indirect approach includes consideration of which approach would best support the client to achieve their goals for therapy (Arnkoff, 1995), whether direct discussion might deepen the rupture (Omer, 2000) or indirect work might help to reduce friction in the TA (Rait, 2000) and whether a direct approach might provide an opportunity for new learning (Rait, 2000).

It is hypothesized that because therapists' and researchers' main exposure to the TA is during the therapy session, research has focused on ruptures within this element of the relationship. This results in neglect of the importance of the processes that occur between

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therapy sessions (Hartmann et al., 2011), with evidence suggesting that for many clients, the TA deteriorates between sessions, but improves during them (Weiss et al., 2014). This finding is supported by research that suggests that ruptures in the TA are more likely to occur between therapy sessions and thus the evidence base would benefit from further research into this area (Zlotnick et al., 2020).

Given these complexities, in addition to differences found in the ruptures and repairs in various types of therapy (Zlotnick et al., 2020), client groups (Boritz et al., 2018) and individual differences between both client and therapist (Omer, 2000), it is unsurprising that there is no consensus about the best approach to responding to ruptures.

Kazdin (2008) speaks of how research into therapeutic processes works as a colander, where a great deal of knowledge escapes through the holes, because there are not ways to quantify and measure many aspects of clients' and therapists' knowledge and experience. One way to 'plug these holes' is to use qualitative methods to analyse experiences of phenomena such as therapeutic rupture to capture elements that may be missed by quantitative methods allowing for a richer understanding.

Limited investigation has been conducted into client experiences of therapeutic rupture. When research has investigated how clients experience ruptures it has highlighted that they often link ruptures with difficult emotions, both prior to and during the rupture event (Coutinho et al., 2011; Haskayne et al., 2014). A study by Rhodes et al. (1994) investigated clients' experiences of being misunderstood by their therapist. Clients described the outcomes after the misunderstanding event as varying significantly with good outcomes being associated with their own willingness to assert their negative emotions and both the client and therapist making a mutual effort to repair the misunderstanding. Negative outcomes were associated with clients

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perceiving therapists to be unaware or unwilling to discuss clients' negative feelings regarding the misunderstanding.

Research investigating client's reflections on ruptures highlights how challenging these events can be, with the experience and expression of strong emotions within the therapy session (Haskayne et al., 2014). Given the difficult nature of these moments within therapy, the potential for negative outcomes when ruptures are dealt with poorly (Mellado et al., 2017), and positive outcomes when relationships can be repaired (Eubanks, Muran, et al., 2018), it is important to investigate how therapists experience, make sense of, and respond to rupture events in order to increase understanding and therapists' ability to respond in helpful ways. . With this in mind, the present study aims to synthesise the existing growing body of qualitative research which has addressed therapists' experiences of ruptures within the TA, including the impact of ruptures on the therapist, and how therapists respond to and make sense of these events and their consequences.

Method

Noblit and Hare's (1988) meta-ethnographic approach was used to synthesize relevant studies. This approach focuses on the use of comparison and analysis in order to create new interpretations of existing qualitative data, rather than simply bringing this data together and presenting it in one place (Britten et al., 2002; Saini & Shlonsky, 2012).

Search Strategy

An initial literature search was conducted in order to develop the research question 'what are therapists' experiences of ruptures within the therapeutic alliance?' The terms within this question were defined as follows:

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- Therapists: Any professional providing psychotherapy to a client, including psychologists or counsellors, in any setting or with any client group
- Ruptures: an occurrence that has a negative impact on a pre-existing relationship
- Therapeutic alliance: the collaborative relationship between client and therapist
- Experiences: qualitative data regarding therapists' encounters with this phenomenon

Once these terms were defined, further searches were conducted in order to establish a comprehensive range of relevant search terms. The full searches were then developed in PsycINFO using a combination of free-text and thesaurus terms relating to the terms above, and terms were adapted for use in Cumulative Index to Nursing and Allied Health Literature (CINAHL; Table 1). The PsycINFO and CINAHL databases were accessed as they were considered the most likely to contain relevant studies given the populations being investigated, particularly because the present study was interested in ruptures within the TA within psychotherapy. Additional databases were not accessed because of the large number of irrelevant results returned due to the use of the term 'rupture' within medicine (e.g., tendon rupture).

[INSERT TABLE 1]

Study Screening

Inclusion Criteria

Study screening was guided by the aim of the present study to summarize the current research investigating therapists' experiences of ruptures within the TA. Studies were eligible if they investigated therapists' views, and specifically focused on ruptures or impasses in the TA which occurred whilst providing psychotherapy. Studies had to be written in the English language due to resource constraints, but no restrictions by country or date were applied.

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Studies which focused on therapists' work with adolescents were included, as although work with adolescents is different in terms of the clients' developmental stage and the support structures around them (Gutgesell & Payne, 2004), these factors do not necessarily have a discrete boundary, as evidenced by the suggestion that child and adolescent mental health services move their upper age limit to 25 years of age, from the traditional limit of 18 (Appleton et al., 2019; Dunn, 2017).

Exclusion Criteria

Discussion papers, studies investigating ruptures in other relationships (e.g., supervisory relationships) and unpublished work were not included. Studies that investigated both client and therapist experiences of ruptures were not included if it was not possible to identify the therapist-only responses. Papers which investigated therapists' experiences of violent behaviour within a therapy session were also excluded as this was thought to be qualitatively different to a traditional rupture, both in its impact on the therapist and the priorities of the therapist after it has occurred. For example the therapist would be required to focus on their own safety, rather than rebuilding the TA. Studies focusing on challenges with establishing a bond were also excluded due to the way in which ruptures in pre-existing relationships had an established TA to compare the rupture to and return to, which, by definition, studies investigating difficulties establishing the TA will not.

Search results

Terms were searched for in both the title and abstract fields. Searches were conducted on 30th December 2020 (Figure 1). The search returned 4488 results which were imported into reference managing software. 292 of these studies were removed due to being exact duplicates. Studies were then screened by title which removed a further 4391 studies. The remaining 97 studies were screened by abstract, excluding an additional 75, the full texts of the remaining

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22 papers were accessed. Of these, eight remained after 14 papers were removed based on the inclusion and exclusion criteria (appendix 1-A includes details of why each study was not included at this stage). The reference lists of these included studies were searched and one additional study was identified.

[INSERT FIGURE 1]

Quality appraisal of the selected papers

The Critical Appraisal Skills Programme (CASP) Qualitative Skills Checklist (Singh, 2013) was used to evaluate the final papers. The first two questions (1. was there a clear statement of the aims of the research? and 2. is a qualitative methodology appropriate?) were used as an additional screening tool. All final papers met both these criteria (appendix 1-B). Papers were then assessed using the eight remaining checklist questions, using a three-point scoring system (Duggleby et al., 2010). A strong score (three points) was awarded to studies which provided justification, explanation and clarity in the relevant area, a moderate score (two points) given to those papers within which some justification, explanation and clarity was found, and a weak score (one point) awarded where these features were lacking. Papers were initially scored by the first author and an additional researcher independently, and these scores were then discussed. Where there was disagreement between the scores given, a discussion was entered into regarding each individual's justification for their score and through this discussion an agreement reached. The scores for each paper were calculated, with potential scores ranging from eight to 24 ($M = 18.11$, $SD = 2.52$). Papers were not excluded on the basis of having lower scores, to avoid the possibility of excluding studies with good face validity (Atkins et

al., 2008), in addition to the relatively low number of relevant papers in this area. These scores were then used to weight the findings, with greater emphasis placed on findings from papers which received higher scores. For example a quote from a lower scoring paper was only used if it supported a finding also found in a higher scoring paper.

Synthesis of the selected papers

Meta-ethnography allows for the interpretative synthesis of previous work, in order to generate new understandings, thus resembling in its methodology the studies that it aims to synthesize (Saini, 2012). Noblit and Hare's (1988) approach was followed and extracts from the included studies were treated as data, used for analysis in this study. The concept of first, second and third level analysis was used to guide the synthesis, with the first level involving the research participants' experiences (direct quotes), the second level including the original author's interpretations and the third level analysis consisting of the present researcher's interpretations, developed by using both reciprocal and refutational translation.

Papers were initially read in order of publication date, to account for the development of knowledge within the research area (Simpson-Adkins & Daiches, 2018). A table providing the context for and the main findings of each study is provided (Table 2). Each paper was read multiple times, and sections of text detailing the studies' findings were copied, using quotation marks, verbatim into the data extraction form (Daker-White et al., 2015), keeping in mind the aim of the synthesis in order to guide decision making in this process. (Atkins et al., 2008). A distinction was made between the research participants' experiences (first level of analysis), and the first author's interpretations and comments (second level of analysis), with the use of a data extraction form encouraging the retention of the relationships between concepts within accounts (France et al., 2014). Constructs from the data extraction forms were then copied onto post-it notes in order to conduct reciprocal and refutational translation (Noblit & Hare, 1988).

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This formed the third level of analysis and involved looking for commonalities (reciprocal) and differences (refutational) within the studies and to begin grouping these notes into themes. Once constructs were initially grouped into themes, reciprocal and refutational translation was again conducted between themes and their contents which resulted in three final superordinate themes (Noblit & Hare, 1988). An example of these comparisons is included (appendix 1-C) (Britten et al., 2002).

Rigor

To encourage objectivity, reliability and quality (Davies & Dodd, 2002) decisions regarding the analysis were recorded and regularly discussed with research supervisors. One example of such a decision was to reduce the total number of themes from eight to three, with the discussion focusing on whether detail was lost with the reduction in themes and if three themes represented the data. Research supervisors questioned the processes followed to conduct the synthesis, and inquired regarding the content of each theme and in which way individual constructs were considered to be related. The data analysis forms were referred back to as themes began to emerge in order to ensure that the context of the constructs had not been lost within the analysis.

[INSERT TABLE 2]

Results

Nine relevant papers were identified via the methods set out above. Of these nine papers two recruited participants who were providing cognitive behavioural therapy, two using psychoanalytic based techniques, one using either of these approaches and four either not reporting the theoretical orientation of participants or stating that they were eclectic with which approaches they used. Two papers were focused on ruptures when working with adolescents, with the remaining papers investigating work with adults. One interviewed trainee therapists, seven interviewed qualified therapists and one a mix of trainee and qualified. Two papers interviewed therapist and client dyads, presenting the client and therapist responses separately with the remaining papers involving only therapist participants.

Following the synthesis of the data, three third order themes were identified; hitting therapists where it hurts, ruptures as an opportunity, and understanding the causes of ruptures. Appendix 1-D details which papers contributed to which themes and specifies the identification number assigned to each paper.

Hitting therapists where it hurts

The intensity of the rupture events reported varied significantly, from the client taking a step back from the TA: “some kind of withdrawal on the adolescent’s part, either by being less active and showing more scepticism or negativism towards the therapist during sessions, or by dropping appointments” (S3) to more confrontational forms: “the therapist recollected that the client was furious and accused the therapist of using the sausage woman [another client sitting in the waiting room eating a sausage] as a confederate” (S2). Therapists consistently found withdrawal ruptures easier to respond to, with confrontational ruptures having a significant emotional impact on therapists: “therapists typically reported experiencing low levels of self-efficacy and ability to handle the rupture. One therapist said, ‘I felt lost and kind

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of brain -dead...for the first time in a long time I felt shaken, like I didn't know what to do” (S9).

Ruptures in the TA seemed to be particularly difficult because they challenged the core of the therapists' identities; ruptures cause therapists to move away from their skills such as being present and having patience: “[experiencing the feeling of] losing patience with the process and then starting to doubt oneself, because patience is part of one's therapeutic ideals” (S4).

Client withdrawal from the TA was also experienced as difficult by therapists where the lack of connection between client and therapist left the therapist without the support of the relationship on which they might usually rely: “[this] theme encompasses the claims of clients and therapists regarding the struggles in their therapeutic relationship...all descriptions of the struggle suggested a lack of contact emotionally and physically, which led to feelings of frustration and despair in the dyad” (S6). Similarly, therapists reported that they could not rely on their usual techniques during ruptures, thus leaving therapists feeling all the more stranded: “in the extraordinarily difficult processes described in the interviews...therapists found their usual personal and technical skills for handling difficult emotions in the therapeutic relationship less helpful” (S4).

Because of the increased duty of care when working with adolescents, therapists reported an additional sense of responsibility for the client's mental health. This additional responsibility resulted in ruptures within the TA feeling even more difficult and painful for the therapist:

When you think about suicide of teenagers and adults...they are different, but not because of the particular adolescent and adult, but because of the legal protection issues that underlie...right? Then children are objects of social protection...and one, as an agent

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working with minors, must always be watching over that...especially in terms of protection, when there is a therapeutic impasse that may affect the therapeutic bond, that is very complicated. (S8)

Interestingly, interplay between ruptures and risk was not discussed in the literature regarding adults.

Studies found that ruptures could be particularly difficult to cope with when therapists had difficulty dealing with the strong negative affect that clients can project during ruptures, when they begin to lose hope in the therapeutic process, or when ruptures reminded therapists of challenging relationships within their own private lives: “the therapist's family of-origin issues were stimulated by the client's issues (e.g., one therapist felt uncomfortable with extremely hostile and irrational clients who were like her mother” (S1).

Given this tendency for ruptures to unsettle therapists' core identities, it is perhaps not surprising that many of the studies found that therapists had strong emotional reactions to these events. Therapists were reported as experiencing self-doubt, feelings of incompetence and low self-efficacy during rupture events, with some reporting that they moved from relative emotional freedom to feeling trapped within their own emotional state.

As well as feelings of incompetence, therapists spoke of the vulnerability and hurt they experienced, in addition to the frustration and anger they felt whilst the rupture was occurring, suggesting that it is not only the client who experiences heightened emotions during a rupture event: “therapists (...) reported feeling anxious or incompetent and annoyed or frustrated and that they struggled to remain calm despite intense feelings in the hostile events” (S2).

Studies regularly found that after rupture events therapists were aware of an increased risk of acting out of negative feelings, which were directed both towards the self and the client. These feelings manifested as difficulty in remaining therapeutic, feeling pulled into unhelpful

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ways of relating with the client and becoming risk averse within the therapy. Therapists recalled that their responses varied from explicit anger to more subtle dismissing stances:

You get anxious and you start to act hastily, and you commonly concretize more...like ‘since we cannot go into that topic then let’s talk about weight... How many times did you go out and exercise today?’ or ‘How many times did you get distressed?’ (S8)

The studies highlighted that these less helpful responses, when both client and therapist are experiencing heightened emotion, can continue to have an impact with clients then feeling as though the therapist cannot cope with the client’s own overwhelming emotions: “this type of affect [feeling frightened] experienced by the therapist can be noticed by patients and contributes to create the expectation that they cannot be contained by the therapist” (S8). Therapists additionally reported longer term effects including feeling anxious about future work with that particular client, and this anxiety influencing work more broadly, including changing the strategies used with other clients.

In order to cope with and move on from the effects of the rupture event, studies found that therapists used a variety of different strategies. Therapists reported that they reflected on their emotions during the rupture event, either sharing this with the client in order to highlight changes required in the client’s wider life, or reviewing their feelings on their own in order to develop a deeper understanding of what happened: “some therapists reported that they typically searched for cues in their own feelings to understand what transpired in the relationship when they experienced the contact as weakening” (S3). Studies highlighted the importance of being transparent in attempts to repair ruptures including the therapist being honest with the client about their own emotional reaction: “when therapists turned negative feelings outward (i.e.,

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felt annoyed and frustrated at the client) instead of inward (i.e., felt anxious and incompetent), there was a better outcome” (S2).

Ruptures as an opportunity

Therapists consistently highlighted that if a rupture was successfully repaired, it could lead to a better understanding of the client and a stronger TA, with therapists experiencing the alliance as more productive and more genuine: “we have become closer because we’re more open and honest with each other...so it feels like our relationship has really improved” (S9). Having a strong TA before a rupture occurred was regularly cited as predictor of a good outcome from a rupture.

Several studies highlighted ruptures as an opportunity to gather rich information, either focusing on exploring the rupture itself or making links between the rupture and the client’s wider life. When the rupture itself was explored, therapists used it as a way to explore clients’ experiences of therapy and the TA, and to attempt to resolve any issues in these areas: “I told her that how I reacted to her accomplishment wasn’t how her former therapist would have reacted, and we talked about how what happened between us was disappointing and uncomfortable” (S9). Therapists also used ruptures as a way to make links with the client’s wider life, with studies reporting that therapists looked for patterns and similarities between the rupture and clients’ relationships outside of therapy: “I wanted the client to understand that her incoherence was a part of her need to protect herself” (S5).

The final way in which ruptures were perceived to be an opportunity was the way in which they often brought difficult emotions to the surface for clients, providing an opportunity for therapists to explore these emotions that might not normally be shared within therapy:

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Therapist Pat described these tensions in their relationship as an opportunity to bring emotions to the surface to think about. This suggested that the struggle in the therapeutic relationship was needed in order to make sense of the client's difficult feelings (S6).

Where studies distinguished between confrontation and withdrawal ruptures they reported that during withdrawal ruptures therapists were less likely to experience the difficult emotions and reactions outlined in the first theme, and more likely to feel a sense of concern for the client alongside a trust in the TA. This resulted in therapists feeling more able to view withdrawal ruptures as a possibility for change: "Generally, most participants described the initial emotional discomfort as manageable, suggesting that it can be made a focus for therapeutic exploration and dialogue based on each therapist's clinical experience" (S4).

Understanding the causes of ruptures

The perceived causes of ruptures were varied, but included attributions to therapists, clients, and individuals outside of the TA. Possible therapist mistakes were noted across several studies. Some therapists felt that their general approach to therapy was unhelpful, citing being pushy or being non-directive as reasons. However, therapists also reported that they felt that the rupture was a response to a specific incident, such as a disliked intervention of the therapist, or the client feeling invalidated by something the therapist said.

Broader therapist factors were also mentioned across studies. Some therapists spoke of their own characteristics contributing to the rupture, for example stubbornness and perfectionism. Others were aware that their own emotional responses were influencing the therapy in an unhelpful way:

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Therapists typically mentioned that they contributed to the rupture by managing their own reactions poorly. Case 4 said, During therapy I try to be neutral, but I wasn't able to be neutral about client's relationship...I was leaning towards questioning whether they may not be a good fit...and I think that made the client defensive (S9).

Client contributions to ruptures were also frequently cited. Therapists talked of how therapy involves discussing difficult and painful topics and that ruptures were more likely to occur during these discussions in general, but also that some clients were perceived as being particularly vulnerable within these discussions and may have difficulty processing and expressing these difficult emotions. Unrealistic expectations of therapy were also commonly cited. Ruptures within work with adolescents were particularly likely (Shirk et al., 2011), therapists understood this in terms of the way adolescents tend to view the world:

These evolutionary characteristics [of adolescents] include 'a high sensitivity to the environment.' As Therapist 5 states when comparing adolescents' and adults' psychotherapy: 'the sense of awe that adolescents have, their continuous search for discovery, for questioning the world of adults'. On the other hand, interviewees mention the low tolerance that young people show towards what they evaluate as "errors of their therapists. (S8)

Having a third person involved in the TA was recognised as a challenging situation, and a potential cause of rupture within the relationship between the client and the therapist. Therapists highlighted that ruptures could occur because of pressure from a third party, telling the client that the therapist was not doing a good job, expecting results to occur more quickly, or putting pressure on the client to choose between them and the therapist, as one author summarises: "having to choose between a therapist who provides support for one to three hours per week and a spouse or family member who, even if abusive, is available on a daily basis for

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the client, is often painful” (S1). The therapist directly involving a third person in therapy was also seen as a potential cause of a rupture event, where the client sees the therapeutic space as belonging to them and the inclusion of another individual as an invasion:

[he told me] he did not come [to therapy] to talk to his family and he felt very exposed by them, he felt that they criticized him...he said that this was not being well handled in the last few sessions...I was not serving him for what he needed. (S8)

Discussion

The present study aimed to synthesise existing literature in order to develop a better understanding of therapists’ experiences of ruptures within the TA. From the nine studies included in the synthesis, three themes were developed; hitting therapists where it hurts, ruptures as opportunities and attempting to understand the causes of ruptures.

Hitting therapists where it hurts encapsulated how difficult therapists find working with rupture events, because they often challenge the aspects of the therapy or the therapist themselves that are seen as highly important to them. The importance of the TA is emphasised across therapeutic approaches (Horvath, 2018) and therapists are likely to take pride in their ability to build and maintain the TA, therefore any threats to the alliance have the potential to undermine therapists’ key skills. Given that ruptures are conceptualised as occurring within the TA itself, therapists are likely to find these experiences difficult to handle, and studies reported that anxiety and self-doubt were present in both trainees’ (Kline et al., 2019) and expert therapists’ accounts (Moltu et al., 2010) of ruptures. The ability of the therapist to inspire confidence is considered an “essential” part of the TA (Ackerman & Hilsenroth, 2003; Johnson & Caldwell, 2011) so the impact of experiencing self-doubt at a point where the TA is already threatened has the potential to be highly significant.

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Alongside the threat to the TA, ruptures also have the potential to challenge other aspects of the therapist's identity or elements of the therapeutic process which they consider important, including beginning to doubt their therapeutic method, finding that skills that are usually relied on are not proving to be helpful or finding that a usually generous supply of patience has run out. These threats to identity, in addition to the experiences of self-doubt mentioned above, have the potential to significantly reduce therapist hope. Therapist hope is well documented as an important factor within psychotherapy (Coppock et al., 2010), and therapists spoke of this hope being threatened during rupture events (Moltu et al., 2010). Research suggests that when hope is threatened, therapists employ a number of actions to increase their feelings of hope, including identifying positive beliefs about the therapeutic process or the client themselves, or influencing the conversation in hopeful directions (Larsen et al., 2013). However, therapists highlighted how these responses became unavailable during rupture events, with the therapists instead experiencing strong negative emotions, including feeling excluded (Haskayne et al., 2014) and feeling anger and frustration toward the client (Kline et al., 2019).

Studies frequently found that therapists experiencing these heightened emotions found it difficult to respond to the rupture helpfully, instead feeling pulled into unhelpful ways of responding. Many studies spoke of therapist uncertainty regarding the best way to react, and that during these moments therapists struggled to remain therapeutic with clients, instead engaging in unhelpful ways of responding including becoming demanding toward the client, becoming too rigid and acting hastily. These findings support other writing which has suggested that ruptures are relational in their nature, and that the pull towards acting in certain ways that therapists experience during ruptures is a manifestation of countertransference (when a therapist's own emotional reaction is directed towards the client) within the TA (Safran & Kraus, 2014; Tishby & Wiseman, 2020).

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Although ruptures were often experienced as difficult times within therapy, therapists did mention times when they were able to manage the emotions that these events provoked. Therapists spoke of being open regarding their emotions during ruptures, either to themselves, to the client or to others. When being open with themselves therapists found benefit in acknowledging their own feelings in order to form a deeper understanding of what happened during the rupture, and to move to a place where they were able to forgive themselves for their contribution to the rupture. Therapists also found it helpful to speak with other clinicians regarding the rupture in order to take a step back from the event and reflect on it in a more productive way (Rober, 1999).

The findings suggest that the emotional reactions of therapists to ruptures can be both helpful and unhelpful depending on the intensity of the feeling; less intense reactions can provide insight, whereas particularly difficult emotions can be overwhelming and result in unhelpful therapist responses. Where ruptures felt or became manageable, therapists highlighted that they could often provide opportunities; to improve the TA, provide additional insight for both the client and the therapist and help to bring client emotions to the surface that may not have been expressed otherwise. These responses are supported empirically by research that suggests that therapy where a rupture and a repair occurs results in better outcomes than therapy with rupture and no repair, as well as therapy where no rupture occurs (Eubanks, Muran, et al., 2018). Where therapists felt that the TA had been strengthened by the rupture, they described a sense of having survived the rupture and therapy becoming more genuine (Nienhuis et al., 2018).

Therapists reported that ruptures often provided both themselves and possibly the client with additional information. The inner processes of the therapist are thought to provide valuable information regarding what is happening for the client (Rober, 2011), and this may be particularly true for the processes that occur during a therapeutic rupture (Safran & Kraus,

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2014). Likewise, therapists felt that rupture and repair events allowed for clients to develop their own understanding, including additional insight into their own emotional and cognitive processing, and increasing their confidence in their ability to be able to repair relationships in their life outside of therapy (Safran & Muran, 2000)

Where therapists sought to understand the causes of ruptures, they often focused on when they believed that they had made a mistake. In the search to understand what factors contribute to positive and negative therapy outcomes, a body of research has focused on therapist characteristics, which have been found to be predictive of therapeutic outcomes (Ackerman & Hilsenroth, 2003). It has been suggested that rigidity, feeling uncertain and tense, all experiences which therapists reported during ruptures, can contribute to a negative outcome in therapy (Ackerman & Hilsenroth, 2001).

Clinical implications

This synthesis of therapists' experiences of ruptures within the TA confirms previous findings that ruptures can be important opportunities within therapy, but also highlights just how emotionally challenging they can be. Although therapists spoke of heightened emotions and reacting unhelpfully, they also highlighted that they could find ways to cope with these difficult experiences, which allowed them to develop understanding and reconnect with the client. This review also suggests that there are times when ruptures were able to be viewed as an opportunity. Therapists being aware of strategies to be able to cope with ruptures and the potential positive outcomes from a rupture may help them to be able to hold on to hope within the rupture, feel better prepared and maintain their self-efficacy, and therefore be able to respond in a more useful manner during the event. Additionally, the therapist's views on why ruptures might occur provides the opportunity for interventions to take place that could help to avoid ruptures occurring in the first place. For example, having a conversation regarding

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realistic expectations for therapy early on in the relationship may help to prevent ruptures around client's unrealistic expectations from taking place. Involving the people who are important to the client in these discussions might also help to reduce the contribution that third parties can have to ruptures.

Research Recommendations

The present synthesis highlights that sometimes therapists find ruptures particularly difficult to deal with, while sometimes they are seen as an opportunity. It is not clear whether these are two separate categories (overwhelming ruptures vs helpful ruptures), or to what degree these groups overlap. For example, are there times where ruptures feel overwhelming to beginning with, but as they progress therapists begin to view the rupture as an opportunity or vice versa? If ruptures can move from overwhelming to an opportunity, are there things that therapists can do to facilitate this? Research focusing specifically on therapists interventions during ruptures would support our understanding of how best to treat ruptures as opportunities.

Additionally, it is important to note that therapist experiences are only one element of ruptures in the TA, and that client perspectives, especially given the fluctuations in the strength of the TA between therapy sessions (Hartmann et al., 2011) are important to consider in more detail to develop our understanding of this complex phenomenon (Miller-Bottome et al., 2019).

Limitations

This review is subject to the limitations that apply to any qualitative review. For example, although the CASP tool was used to assess the quality of the papers, studies with a low score were not excluded, and the CASP itself is not without its flaws (Majid, 2018). Therefore studies of various qualities are included, which in turn will impact on the quality of the present review. Additionally, although attempts were made to ensure a rigorous process

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was followed, another researcher completing the analysis process alongside the present researcher would have allowed for greater reliability and objectivity than can be achieved by one individual working alone.

Conclusion

Ruptures within the TA involve important and complicated processes, with the potential to significantly impact the outcome of therapy. Therapists often feel exposed to difficult emotions during these events which can pull them towards reacting unhelpfully and challenge their ability to remain therapeutic. Although challenging, ruptures can also be viewed as an opportunity with the potential to enrich the TA and provide additional insight. Increased understanding and knowledge of the potential opportunities provided by ruptures could support therapists to be better able to prevent ruptures or respond to the challenge when they do occur.

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Table 1

Search Terms

Databases Searched	Therapeutic Alliance	Rupture	Qualitative	Therapists
PsycINFO and CINAHL	“working alliance” OR “helping alliance” OR therap* OR psychotherapy* OR	Ruptur* OR Restor* OR Conflict* OR Resolution OR Strain* OR Repair* OR Re-establish*OR Impasse* OR “Empathetic failure” OR Breakdown OR “communication barriers” OR	Qualitative OR Interview* OR Experience* OR Perception* OR “focus group” OR View* OR Attitude*	Psychologist* OR Therapist* OR Psychotherapist* OR Counsell* OR
PsycINFO	“therapeutic alliance” OR “psychotherapeutic processes” OR “therapeutic processes”	Enactment*		“Therapist attitudes” OR “Psychologist attitudes” OR “Counsellor attitudes”
CINAHL	“therapeutic alliance”			Psychotherapist attitudes

Table 2

Context of Included Studies and Main Findings

Paper	Research Aims	Methodology	Participants	Main Findings
<p>Hill, Nutt-Williams, Heaton, Thompson & Rhodes (1996).</p> <p>Therapist retrospective recall of impasses in long-term psychotherapy: A qualitative analysis.</p>	<p>Investigating the therapists perspective on which therapist, client and interaction variables were related with impasses, how the impasses unfolded and the consequences of them.</p>	<p>Semi-structured interviews were analysed using a approach which combines grounded theory analysis, comprehensive process analysis and an interview approach.</p>	<p>Twelve therapists using humanistic, cognitive behavioural and psychodynamic approaches working in private practice and outpatient clinics in the United States</p>	<p>Ruptures characterised as involving ongoing general disagreement rather than a single event.</p> <p>Ruptures were described as charged with negative emotion, both during rupture and afterwards.</p> <p>Disagreement over strategies, possible therapist mistakes, triangulation, transference, therapist personal issues and the therapeutic relationship were all associated with ruptures.</p> <p>Exploring the rupture, becoming more active, not apologising for mistakes and engaging in self-analysis were responses to rupture events.</p>
<p>Hill, Kellems, Kolchakian, Wonnell, Davis & Nakayama (2003).</p> <p>The therapist experience of being the target of hostile verses suspected-unasserted client anger: Factors associated with resolution</p>	<p>Investigating both hostile and suspected-unasserted anger within the therapeutic relationship.</p> <p>Specifically addressing what led to the client experiencing anger, the therapists reactions to the anger, how the therapist they intervened and the outcomes.</p>	<p>Semi-structured interviews were analysed using CQR.</p>	<p>Thirteen therapists working in private practice using a range of therapeutic modalities in the United States</p>	<p>Therapists often had difficulty managing client anger due to the emotions it caused in themselves.</p> <p>Anger events were caused by the therapist doing something the client disliked or not doing something the client wanted.</p> <p>Therapists found working with unexpressed anger easier than hostile anger, where they struggled to be therapeutic.</p> <p>Better outcomes were described when therapists turned hostile anger outward.</p> <p>Hostile events were most often resolved when therapists had the goal of connecting with the client. Suspected anger events were more likely to be resolved when there was a good therapeutic relationship</p>

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<p>Binder, Holgersen & Nielsen (2008).</p> <p>Re-establishing contact: A qualitative exploration of how therapists work with alliance ruptures in adolescent psychotherapy</p>	<p>To investigate the challenges therapists face when they experience ruptures in the therapeutic relationship when working with adolescents and what strategies they use to re-establish contact</p>	<p>Semi-structured interviews analysed using a descriptive phenomenological method</p>	<p>Nine psychotherapists from outpatient child and adolescent psychiatric clinics in Norway, using predominantly eclectic approaches</p>	<p>Participants varied in whether they attributed ruptures to individual characteristics of the adolescent, or as a result of interpersonal dynamics. Examining their own feelings was seen as one way to understand and repair ruptures. Establishing a language for the adolescents fluctuating motivation and distress may be a way to increase communication regarding the therapeutic relationship.</p>
<p>Moltu, Binder & Nielsen (2010).</p> <p>Commitment under pressure: Experienced therapists' inner work during difficult therapeutic impasses</p>	<p>To explore how experienced and esteemed therapists of different theoretical and therapeutic affiliations experience and interpret ruptures or problematic relational processes.</p>	<p>Semi-structured interviews were analysed using hermeneutically modified systematic text condensation</p>	<p>Twelve experienced clinicians (either clinical psychologists or psychiatrists) working in a variety of settings and using a variety of theoretical approaches in Norway.</p>	<p>Sustaining hope and handling their own difficult feelings were cited as ways in which therapists handle ruptures. Therapists experience strong impulses to act out of negative affect, and highlighted the importance of not acting on these, but using them to provide insight.</p>
<p>Coutinho, Ribeiro, Hill & Safran (2011).</p> <p>Therapists' and clients' experiences of alliance ruptures: A qualitative study</p>	<p>To explore therapist's and clients' (who were diagnosed with a personality disorder) experiences of ruptures within the therapeutic relationship, including how the rupture evolved, what interventions therapists used to deal with the rupture and the impact</p>	<p>Semi-structured video assisted interviews were analysed using the consensual qualitative research (CQR) method.</p>	<p>Eight therapist-client dyads from a university counselling centre in Portugal, typically using cognitive techniques.</p>	<p>Ruptures had a negative impact on the TA, and stimulated strong internal reactions in therapists. Ruptures were perceived as having a repetitive nature, and thus should be addressed when they first emerge. Therapists had difficulty empathising with clients during confrontation ruptures</p>

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	of the rupture on the therapeutic process.			
Haskayne, Larkin & Hirschfeld (2014). What are the experiences of therapeutic rupture and repair for clients and therapists within long-term psychodynamic therapy?	To explore and compare clients' and therapists' experiences of rupture and repair during long-term psychodynamic therapy.	Semi-structure interviews were analysed using Interpretative Phenomenological Analysis (IPA).	Four client-therapist dyads from an outpatient psychotherapy service for people who experience complex, severe and enduring mental health difficulties within the NHS. Using psychanalytic psychotherapy.	Ruptures include a lack of emotional and physical contact which can lead to feelings of frustration and despair. Ruptures can be related to the negotiation of roles and responsibilities within therapy. Where ruptures are repaired, a positive connection between client and therapist can lead to a better TA and more genuine conversations
Moeseneder, Figlioli & Caspar (2018). Counfrounting patients: Therapists' model of a responsiveness based approach.	To construct a conceptual model of confrontation used by therapists including; what are the risks and opportunities of confrontation and how can these probabilities be influenced?	Semi-structured interviews were analysed used thematic analysis.	Fifteen therapists (some experienced and some in training) from a psychotherapy outpatient clinic in Switzerland using predominantly integrative cognitive behavioural therapy.	Confrontations have the potential to strengthen the TA. Where ruptures occur as a result of a confrontation, these must be actively managed. Responsiveness is key within a confrontation, particularly to notice whether attention needs to be pair to the therapeutic relationship.
Moran, Diaz, Martinez, Varas & Sepulveda (2019).	To characterise moments of rupture with adolescent clients form the therapists perspective, with a focus	Semi-structured interviews were analysed using IPA.	Eight clinical psychologists working in a variety of settings using a variety of	Therapists emphasised the importance of being sensitive rather than empathetic to adolescents needs. The potential influence of the family and the importance of therapists being aware of this influence is highlighted.

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The subjective experience of psychotherapists during moments of rupture in psychotherapy with adolescents.

on the cause and effects of these ruptures.

theoretical approaches in Chile.

Therapists working with adolescents can, because of the clients' age, perceived themselves as solely responsible for ruptures without identifying the client's contribution

Kline, Hill, Morris, O'Conner, Sappington, Vernay, Arrazola, Dagne & Okuno (2019).

Ruptures in psychotherapy:
Experiences of therapist trainees

To examine the experiences of therapist trainees who had ruptures with clients, specifically the antecedents, management and consequences of ruptures.

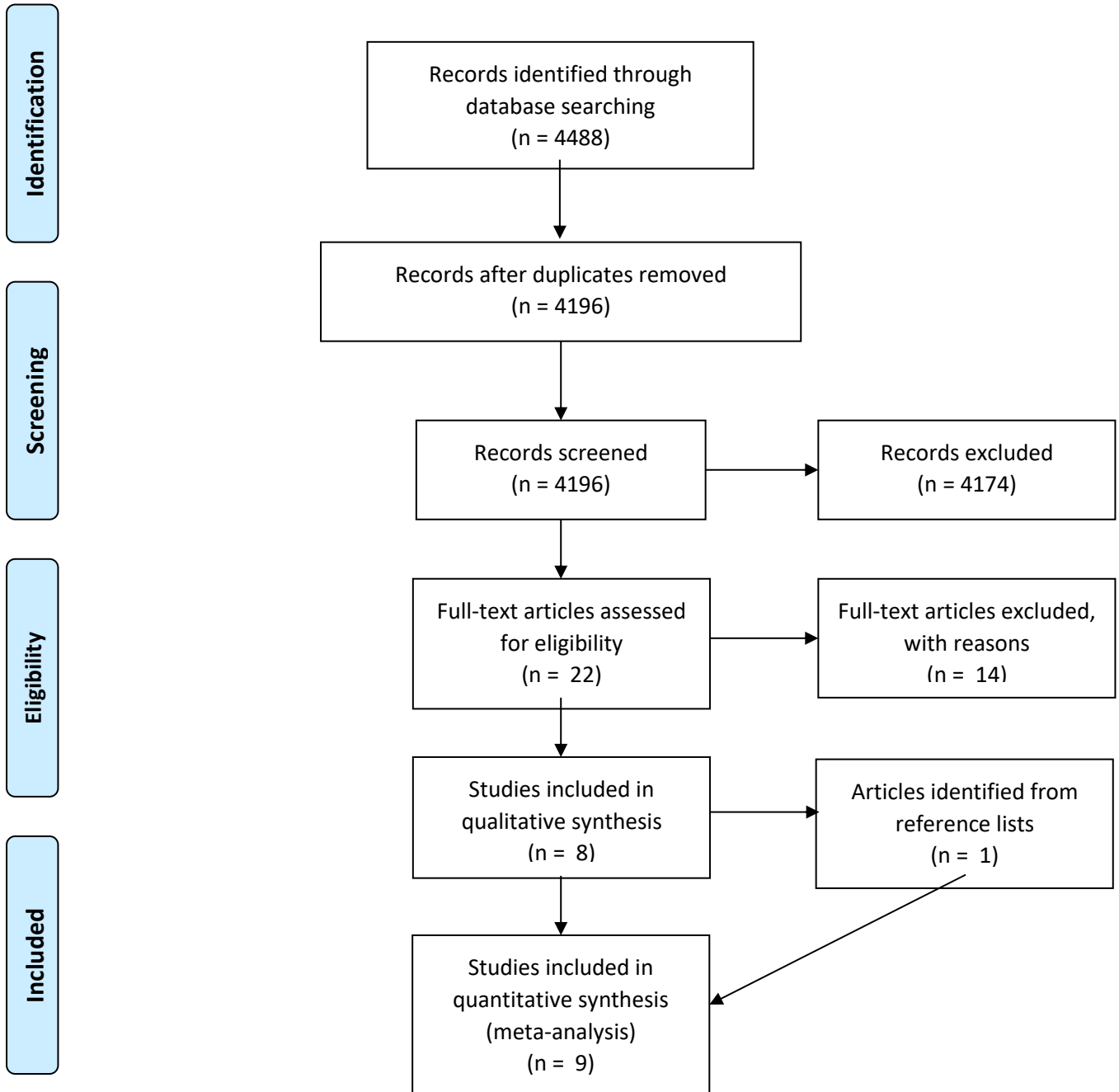
Semi-structured interviews were analysed using CQR.

Fourteen trainee psychologists using a predominantly psychodynamic-interpersonal approach in the United States

Ruptures were experienced as intense, unsettling events, where clients expressed anger and frustration at the trainee or the therapy. Trainees identified both positive (therapy became more productive) and negative (therapists felt anxious about continued work with client) outcomes of the rupture. Therapists understood ruptures as occurring because of the clients' interpersonal problems and the trainees poor management of their own reactions.

Figure 1

PRISMA Flow Diagram



Appendix 1-A

Reasons for Article Exclusion: Full Text Accessed

Reason	Number of Papers
Focused on violent behaviour	1
Focused on other relationships (e.g., supervision)	4
Thesis	2
Focused on challenges establishing bond	3
Discussion papers	4
Total	14

Appendix 1-B

CASP Scoring

Paper	1. Was there a clear statement of the aims of the research?	2. Is a qualitative methodology appropriate?	3. Was the research design appropriate to address the aims of the research?	4. Was the recruitment strategy appropriate to the aims of the research?	5. Was the data collected in a way that addressed the research issue?	6. Has the relationship between researcher and participants been adequately considered?	7. Have ethical issues been taken into consideration?	8. Was the data analysis sufficiently rigorous?	9. Is there a clear statement of findings?	10. How valuable is the research?	Total Score
Hill, Nutt-Williams, Heaton, Thompson & Rhodes (1996)	Yes	Yes	3	3	3	1	2	2	3	3	20
Hill, Kellems, Kolchakian, Wonnell, Davis & Nakayama (2003)	Yes	Yes	3	3	3	1	1	3	3	3	20
Binder, Holgersen & Nielsen (2008)	Yes	Yes	3	1	2	2	3	2	2	1	16
Moltu, Binder & Nielsen (2010)	Yes	Yes	2	3	3	3	1	3	3	2	20
Coutinho, Ribeiro, Hill & Safran (2011)	Yes	Yes	2	2	2	1	1	3	3	2	14
Haskayne, Larkin &	Yes	Yes	2	3	2	1	2	3	2	3	18

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Hirschfeld (2014)												
Moeseneder, Figlioli & Caspar (2018)	Yes	Yes	2	1	3	1	1	3	2	2	15	
Moran, Diaz, Martinez, Varas & Sepulveda (2019)	Yes	Yes	3	2	3	1	2	2	3	3	19	
Kline, Hill, Morris, O'Conner, Sappington, Vernay, Arrazola, Dagne & Okuno (2019)	Yes	Yes	2	2	2	3	3	3	3	3	21	

Appendix 1-C

Example of Analysis

Study	First Order	Second Order	Third Order
S5	Client experiencing difficulty processing and expressing negative emotions	Clients experiencing difficulty with the therapy itself	Therapy can cover difficult topics, which can leave clients feeling vulnerable. If clients do not feel equipped to cope with this it can lead to ruptures
S7	Strengthening client's self-esteem might mean that client's do not perceive confrontation as an attack	Client's feeling able to cope with the demands of therapy	
S3	Talking about difficulties can be painful which can lead to client's quitting therapy	Therapy can be painful	
S8	Clients more likely to withdrawn when complex family dynamics are discussed	Therapy can talk about difficult topics	
S5	Client perceived as uncomfortable and vulnerable when talking about painful topics	Therapy can leave client's feeling vulnerable	
S5	Rupture more likely to occur when client had been talking about painful topics	Therapy can be focused on painful topics	

Appendix 1-D

Overview of Themes

Paper	Allocated Number	Hitting Therapists Where it Hurts	Ruptures as an Opportunity	Understanding the Causes of Ruptures
Hill, Nutt-Williams, Heaton, Thompson & Rhodes (1996)	S1	Yes	Yes	Yes
Hill, Kellems, Kolchakian, Wonnell, Davis & Nakayama (2003)	S2	Yes	Yes	Yes
Binder, Holgersen & Nielsen (2008).	S3	Yes	Yes	Yes
Moltu, Binder & Nielsen (2010)	S4	Yes	Yes	Yes
Coutinho, Ribeiro, Hill & Safran (2011)	S5	Yes	Yes	Yes
Haskayne, Larkin & Hirschfeld (2014)	S6	Yes	Yes	Yes
Moeseneder, Figlioli & Caspar (2018)	S7	No	Yes	Yes
Moran, Diaz, Martinez, Varas & Sepulveda (2019)	S8	Yes	Yes	Yes
Kline, Hill, Morris, O'Conner, Sappington, Vernay, Arrazola, Dagne & Okuno (2019)	S9	Yes	Yes	Yes

Note. Where yes is recorded this theme was found to be present in the corresponding paper

Appendix 1-E

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Chapter 2 Empirical Paper

Clinical Psychologists' use of Reflection within their Clinical Work: A Qualitative Study

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The use of Reflection by Clinical Psychologists within their Clinical work: A Grounded Theory Analysis

Abstract

Objectives: Within clinical psychology reflection is an important skill with many benefits, but little is known about the processes involved when clinical psychologists engage in reflection.

Methods: The present study conducted interviews with seven clinical psychologists and used grounded theory methods to develop a model of the stages involved in reflection. **Results:** The model suggests there are three main internal stages; noticing, gathering information and change, which are set against a backdrop of internal and external factors which encourage or block the use of reflection. **Conclusions:** This model goes some way to operationalising the complex process of reflection in order to enhance the continued study and teaching of this skill.

Introduction

Reflection as a form of problem solving was described by Dewey (1910) as “an active, persistent careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it and the further conclusions to which it tends”. Dewey wrote about the use of reflection within the context of education, stating that one of the main aims of education is to promote the individual’s use of reflection, in order to support the move from routine thinking and action to more measured and contemplative ways of reasoning and behaving (Farrell, 2012). The importance of reflection has continued to be acknowledged within education, and has also been highlighted within the field of medicine, where elements of teaching reflection have been incorporated across all levels of medical education (Hatton & Smith, 1995; Ménard & Ratnapalan, 2013).

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Although reflection is considered to be an important process, there are clear issues within the literature, including difficulties around the definition of the term. It has been highlighted that because reflection is predominantly an internal process, not only is it difficult to study, but it is possible for every individual to have a different understanding of what reflection means for them, as suggested by the abundance of different definitions found within the literature (Atkins & Murphy, 1993). Some have argued that this has resulted in reflection becoming a catch-all term to which predominantly positive outcomes are attributed (Smyth, 1992). Because of the complexities around the definition and study of reflection, it is difficult to establish whether these positive attributions are justifiable, and whether there are any downsides to reflection (Cotton, 2001; Ruth-Sahd, 2003), with research methods relying predominantly on retrospective interviews (Burgess et al., 2013; Heneghan et al., 2014).

A further difficulty in studying reflection is highlighted by the distinction made in this area between reflection-in-action and reflection-on-action. Reflection-in-action involves using reflection to make decisions in the moment, whereas reflection-on-action takes place when looking back on behaviour to analyse and learn from it (Schön, 1938). The in-the-moment nature of reflection-in-action causes obvious methodological issues in terms of its study and thus there is little empirical evidence about its use, although it is thought to be a more challenging exercise, and a skill that is developed by practitioners over time (Burgess et al., 2013). Although the distinction between these two forms of reflecting is regularly referred to throughout the literature, it has also been argued that this might not be as clear as it first appears, where it has been highlighted that reflection-on-action and reflection-in-action are not mutually exclusive where reflection-in-action can also be, and often is, reflection-on-action (Eraut, 1995). It has also been argued that this way of categorising reflection diminishes the importance of reflecting on what might happen in the future, with the focus placed very much in the here and now (Wilson, 2008).

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Within the health sector, reflection within the context of clinical work has been described as the “thought process where individuals consider their experiences to gain insights about their whole practice. Reflection supports individuals to continually improve the way they work” (Health & Care Professions Council, 2019), and has been found to support the development of theory-practice links (Hatlevik, 2012), promote critical thinking (Forneris & Peden-McAlpine, 2007) and encourage enhanced patient care (Schmutz & Eppich, 2017). Reflective practice is a term often used within this sector and is understood as the act of using reflection to inform behaviour; “a mode that integrates or links thought and action with reflection. It involves thinking about and critically analysing one’s actions with the end goal of improving one’s professional practice” (Imel, 1992). The terms reflection and reflective practice are often used interchangeably, given that the difference between thinking about one’s past experiences (reflection) and using these thoughts to inform future behaviour (reflective practice) are difficult to disentangle. The way in which reflective practice focuses on the future does begin to address concerns that definitions can sometimes minimise the importance of reflection for thinking about future actions (Wilson, 2008). To encourage comprehensiveness, this study used the word reflection to encompass both thoughts about past experiences, and reflective practice.

Clinical psychology has been accused of being slow to recognise the importance of reflection, focusing instead on the “measurable” concepts prioritised by behaviourism (Bennett-Levy, 2003). However, reflection is now considered a central aspect of the profession (British Psychological Society [BPS], 2017), it is an essential component for professional registration for clinical psychologists and considered to be a “continuous and routine part of the work of health and care professionals” (Health & Care Professions Council, 2019). More recently the BPS (2017) have stated that the benefits of reflection include an increased awareness for the practitioner psychologist of the influence of internal and external factors on

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their work, including an individual's cognitive biases, their prior experiences and the political environment within which they operate. Reflection also serves to support practitioner psychologists to develop an understanding of the learning taken from professional development tasks, as a way to learn lessons from conflict with clients, and is seen as an essential element of supervision (BPS, 2017).

Reflection has been discussed as particularly important within clinical work where technical knowledge is often not sufficient to manage the complexities that often arise in this area of practice, with those who are more skilled in providing therapy being able to use reflection in the moment to guide their interventions (Burgess et al., 2013). Reflection has also been found to support therapists to facilitate genuineness within the therapeutic alliance (Germain, 2003) and develop an increased understanding of themselves and of others (Woodward, Keville & Conlan, 2015)

Although reflection is considered important, research in this area within clinical psychology lags behind other professions such as psychotherapy and counselling (Burgess et al., 2013) and issues around definition (Mann et al., 2009) have resulted in a lack of research involving qualified clinical psychologists. Studies that have investigated the use of reflection by qualified clinical psychologists have either focused on the implementation of reflective practice groups (Binks et al., 2013; Fairhurst, 2011; Heneghan et al., 2014), or have addressed the use of reflection more broadly within the role. Where reflection more broadly has been investigated studies have used an interpretative phenomenological analysis (IPA) approach (Carmichael, 2018; Fisher et al., 2015; Kiemle, 2008). IPA aims to investigate how individuals, in a particular context make sense of a particular type of experience. As such it emphasises transferability over generalisability (Smith & Shinebourne, 2012). These studies utilising IPA have found that clinical psychologists use reflection to manage their emotions, to understand how they are impacting on their clients and to develop a deeper understanding of their clients.

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Within these studies clinical psychologists highlighted how reflection can help them to feel more contained regarding their own emotions, which in turn can allow them to feel more prepared to support their client (Carmichael et al., 2020; Fisher et al., 2015). This is in line with other research that finds that introspection can counteract the negative impact of therapists' anxiety (Shamoon et al., 2017). Reflection has also been found to support clinical psychologists to be more comfortable with uncertainty, to the extent that uncertainty can come to be seen as an opportunity rather than a threat within their clinical work (Carmichael et al., 2020), allowing them to take a different perspective (Carmichael et al., 2020; Joireman, 2004).

Research that has been conducted within clinical psychology has highlighted the important outcomes that reflection supports clinical psychologists to achieve and why reflection is considered central to the role (BPS, 2017). However it has tended to focus on clinicians' experiences of reflection and what they use it for, rather than what processes are involved and how it is used (Carmichael, 2018). Developing theories which describe the processes that occur within a particular phenomenon allows for patterns and connections to be noticed, offers a different perspective beyond the sensed experience and creates the potential for wider application and study of the processes involved (Charmaz, 2006).

The aim of this study was to investigate how clinical psychologists use reflection in their practice, by addressing the following research questions:

- How are clinical psychologists using reflection?
- What does it help them to achieve?

Method

Ethics

Ethical approval for the study was provided by Lancaster University Faculty of Health and Medicine Research Ethics Committee (FHMREC). Full documentation of the ethics application is contained within section four of this thesis.

Design

A grounded theory informed approach was used. These methods aim to develop theories which are grounded in the data, by using a cyclical process of data collection, analysis and theoretical categorisation (Flick, 2018). The present research used grounded theory methods in order to develop a theory of how clinical psychologists use reflection in their clinical practice. Specifically Charmaz's (2006) social constructionist grounded theory approach was used. This method acknowledges that there is not one 'truth' waiting to be discovered, but that the researcher will play an important role in constructing knowledge, with the phenomenon influencing the researcher and the researcher influencing the phenomenon, whilst social structures continue to exert their impact (Levers, 2013). Data were collected via semi-structured interviews with qualified clinical psychologists in order to generate rich data regarding the participants' experiences of using reflection in their clinical practice (Flick, 2018).

Recruitment

The study planned to use purposive sampling to allow the researcher to make decisions about the individual participants who would be most likely to contribute to the developing model in line with theoretical sufficiency (Vasileiou et al., 2018). However, due to difficulties with recruitment, convenience and snowball sampling were relied on. Participants were required to be qualified clinical psychologists, working therapeutically in the UK, and English

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speaking, due to funding restrictions for translation services. No specified duration of post-qualification experience was required because it was thought that it might be of interest to explore how reflection is understood at different experience levels (Burgess et al., 2013), and additionally for recruitment reasons. The study was advertised on social media including in a specialist clinical psychology group, and those who participated were then asked if they were willing to forward the advertising flyer for the study on to individuals that they thought might be interested in participating. Potential participants were asked to make contact with the lead researcher, they were then supplied with information regarding the study, and were then contacted 48 hours later to establish informed consent. Seven participants were recruited, who worked in a variety of services and identified holding a range of theoretical orientations as outlined in table 1.

[INSERT TABLE 1]

Conducting Interviews and Transcription

Semi structured interviews were conducted using the interview topic guide (appendix 4-E), although it was used flexibly, with prompts and probes being used where necessary. The cyclical nature of grounded theory methods allowed for adaptation of the interview questions as areas of interest began to emerge, with an adapted topic guide developed after four interviews, allowing for a greater focus on the process of reflection (appendix 2-A). Interviews all lasted around 60 minutes ($M = 56.26$, $SD = 6.22$). Interviews were conducted via Microsoft Teams, and were recorded using the recording function contained within the programme. Once recorded, interviews were then transcribed by the lead author and stored securely.

Analysis

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Transcripts were analysed using Charmaz's (2006) grounded theory methods. Initial coding took the form of line by line coding for transcriptions of interviews one, two, five and six as interviews one and five contained new questions (appendix 2-B). The other transcripts were coded in the same way, staying close to the data and using codes which reflect action through the use of gerunds, but with codes only being recorded for data which was thought to be relevant, rather than for every line. Focused coding was then used to synthesize larger sections of data, for example, deciding which of the initial codes best represents a certain concept within the data. . Coding was used in order to begin developing, sorting and synthesising ideas grounded within the data (appendix 2-C). Memos were used throughout this process in order to bring potentially related codes together to then develop categories from these clusters, to develop understanding of the relationships between these categories and to explore ideas about processes that may be occurring and questions that might be relevant to the study (appendix 2-D). Memos provided direction about further data gathering and supported the development of themes which were brought together to form a theory.

Credibility and Reflexivity

Credibility within the study was enhanced by keeping initial codes close to the data to preserve the language used in interviews, in order to encourage the creation of final themes which reflect participants' contributions. Regularly referring back to the original data at all stages of the analysis, with particular emphasis on checking that the process described within the final themes was reflected in the data was an additional way to ensure credibility within the study (Chiovitti & Piran, 2003).

Charmaz's (2006) social constructionist approach acknowledges the researcher's influence over the study and posits that the researcher uses data to construct theory, taking an active role in creating the findings, not simply uncovering "truths" within the world (Charmaz,

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2006). With this in mind it is important for the researcher to position themselves in relation to the research. The lead researcher is a female trainee clinical psychologist with an interest in the benefits of using reflection within clinical practice, with a particular belief that reflecting on the impact of clinical work on the clinician and the clinician's impact on the clinical work is important. The researcher kept a reflective diary throughout the research, which paid particular attention to when they experienced an emotional reaction to any elements of the work, whether this was positive or negative. Discussions with supervisors were regularly held to provide oversight to the process and to monitor the researcher's influence on the process.

Results

Six themes were developed from the analysis; noticing, gathering information, internal change, factors that encourage reflection, factors that block reflection and external change. The first three of these themes speak to the process of reflection which participants spoke of, with the second three themes relating to the context within which reflection occurs.

Noticing

The first stage of the process of reflection was noticing; participants stated that something needed to be brought into awareness in order to be reflected upon, and it is this which separates reflection from automatic processes. Two ways in which this noticing can happen were discussed, either spontaneously or through planned reflection.

Spontaneous reflection tended to be discussed as more of an individual task, occurring in response to an event or because a choice had to be made and often prompted by emotionally laden thoughts and feelings, or difference and novelty. Difficult emotions included feeling confused, stuck or frustrated, whereas more positive prompts to reflection included feeling particularly warm towards a client or being interested in the work: "it might be that, if you feel

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particularly at ease working with a particular client, then you might question if there's some kind of a demand characteristic going on” (Nicky)

if you find you don't like somebody, you know you meet a family or a colleague and you get quite a strong personal reaction [for example] I'm really not looking forward to that session or something, then that would probably be a clue to me that I need to do some more reflecting on it. But also to be honest, the opposite effect that I love this family, you know? Yeah, that would probably also be something to just think over really (Peter).

Participants discussed how they felt that as psychologists they were particularly attuned to noticing when something might benefit from being reflected on, describing a consistent curiosity or background awareness for the potential for situations requiring more thought: “you know, during your training, hopefully everybody is taught to have your internal monitor going all the time” (Laura). This background monitor can also be turned up so psychologists become even more attuned to noticing, for example in therapeutic work: “a very immediate reflective space where you're reviewing what you're saying all the time before you say it and while you're saying it” (Laura)

Noticing was also discussed in the context of planned reflection, taking the form of supervision, writing up notes, within the process of formulation or during reflective practice sessions in teams. Participants spoke of how planned reflection tended to be more structured in its content than spontaneous reflection: “there's kind of those more dedicated, obvious spaces, like supervision is one and reflective practice or team meetings, but otherwise I see it as there's just kind of informal bits and pieces here and there throughout the day” (Jane)

Planned reflection was thought to support participants to notice things that they might have missed using only spontaneous reflection, including as a way of supporting participants

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to notice their blind spots, for example when they had stopped engaging in reflection because work had begun to feel repetitive: “it stops the ‘oh yeah’, I've dealt with this before, what we need to do is... you know it's more more person centred in that way then” (Ann).

Participants commented on the reduction in the intensity of emotion allowed by the distance between the reflected upon situation and the planned reflection, and how this allowed them to notice more. This was discussed both in situations where reflection felt impossible because the emotions being experienced were completely overwhelming, but also in a more discrete way: “that is the time [when I'm writing up my notes] often things will strike me, that didn't strike me in the session with the foster carer, and that's because there's a degree of anxiety no matter how long I've been qualified” (Ann)

Gathering information

Participants spoke of how gathering information allows the development of a deeper understanding of whatever has been brought into awareness by the process of noticing. In order to gather information, participants spoke of an attitude which was open to new information, and adopting a curious, questioning approach. Several participants highlighted a general stance of being open to new information during reflection: “I would use the word reflection to mean...to stop and think about something you know, and wonder... Opening your mind to different possibilities” (Peter)

In order to gather new information participants relied on the use of questions; either questioning themselves or other people questioning them, with questions being utilised in both planned and spontaneous reflection: “when you're with the young person and things are difficult you think actually is this something between me and you or something to do with you and what is going on in your mind right now?” (Suzy)

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Participants highlighted that the types of questions they asked and the language they used varied according to who they were reflecting with and what they were reflecting on: “I think it’s also about the amount of psychological theory that you use. Because obviously, in teams and organisations, you're not necessarily speaking the same language... not everybody is trained in psychology or psychological concepts” (Laura)

Participants did not necessarily require outside input in order to develop their understanding, with questions directed internally in order to improve comprehension of self within the wider context, to reflect on how the context is impacting on themselves and how they are impacting on the context: “What's it about me that keeps wanting to give and keeps wanting to meet their expectations and their needs, but what is it also about the organization?” (Laura)

Participants also spoke of asking question of themselves to evaluate their effectiveness in order to inform future work: “How can I help...what do I need to do to help this person hear what I've got to say and understand it and act on it?” (Ann).

Questions of themselves also allowed participants to evaluate the emotional impact of work on themselves: “you're kind of reflecting on some of your own values and your own emotional responses to things” (Alexandra).

Participants spoke of valuing questions from others that provided them with an alternative point of view “supervision or a reflective practice group; there's something else that's in the room that you didn't necessarily have or that wasn't apparent to you, and it might even be information that you have, but that you just haven't connected” (Nicky).

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Participants particularly valued the structure that input from other professionals provided: “she's a schema therapist as well, she'll relate it back to my schemas and what's going on for me. So in that way it it sort of does fit and frame my own reflections” (Jane).

When participants spoke of feeling stuck in a loop, the outside input that other professionals can provide helped them to move on: “in supervision you can do that in probably a more productive way, because you know it's it's always possible to just be ruminating without any additional input into your loop” (Nicky).

Change

The change section of the process is the final stage that occurs internally. At this point, psychologists combine the information they have gathered in the previously with existing knowledge to create some kind of internal change. Most often this was talked about in terms of a change in awareness and understanding, but it was also discussed as a place where psychologists felt more contained emotionally.

Participants spoke of how the emotional potency of the situation they had initially noticed had reduced due to going through the process of reflection, and that they felt more contained at this point: “For me, it was really helpful because it helped me to feel contained. After the session, I felt quite uncontained, so I think the process of reflection helps me to process and contain it and compartmentalize it” (Alexandra). This left participants experiencing more hope and motivation for their ongoing work.

Psychologists frequently mentioned how going through the process of reflection led to a change in their awareness and understanding. Changes in understanding were discussed with regards to the participants' conceptions of themselves, particularly in relation to self-

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development and what their own emotional pulls might be: “change that I felt within my own development as well in terms of about thinking about some of the more difficult emotional processes” (Alexandra).

Participants reported that through engaging in reflection they formed a clearer understanding of the situation they were working with. This was discussed as a broad outcome, but also in terms of developing a formulation and coming to an internal decision about whether change is possible:

sometimes I think there's a place for saying actually that's not going to change, it just needs to be managed, including things you do yourself, you know... if there's something that needs to be changed, can it be changed? Or do we just need to manage it better? (Ann).

Using the process of reflection to enable psychologists to see things from others' points of view was discussed: “I suppose that's a valuable dimension, it's about taking different positions. The idea being that that creates more possibility for change” (Peter).

The internal nature of this and other stages can result in reflection looking inactive, a finding which was often discussed in reference to attempts to encourage other, non-psychology professionals to engage in reflection:

It can feel kind of less obvious what the benefits to just reflecting with no end goal and I think that's something that maybe other disciplines struggle with or don't always see the point to, but I think it just helps, I think it helps you, your skills of thinking things through (Jane).

Encouraging reflection

Participants spoke of factors which encouraged their use of reflection, which impacted all three of the internal stages of the model. These factors highlighted that the internal processes of reflection sat within the broader contexts within which the psychologists worked, but also included factors internal to them which encouraged reflection.

Psychologists highlighted that working within an environment that promotes the use of reflection supported them to engage in the process more. Planned noticing was often discussed within this broader context and the importance of time, space and regularity of reflection being prioritised and the availability and willingness of other people to reflect with: “being amongst like-minded people who are willing to engage in it and encourage it” (Peter).

The importance of the quality of these relationships was regularly discussed, often with regards to supervision, with participants mentioning the vulnerability that they often experience when reflecting in supervision, due to the sometimes emotionally exposing nature of the process, or the fact that it can be focused on learning from mistakes and involves discussing some form of error. In order to be able to cope with these feelings of vulnerability, participants spoke of the importance of feeling safe within these relationships:

My supervisor takes quite a lot of care to make it a really emotionally safe environment, so I'm aware of her saying validating things... but just having that emotional safety to talk about things where you're not, you don't feel like you're doing a marvellous job (Nicky).

Participants spoke of a sense that some people just find reflection easier than others, understood as people being more open to the process, with some individuals thought to be more emotionally focused than others “[for some people] reflection is just a natural part of what they do, others they really need to work very hard on it” (Peter).

Blocks to reflection

Perhaps unsurprisingly, blocks to reflection were often discussed as the opposite of the factors that encouraged the use of reflection, and again formed the categories of broader context, relationship variables and individual influences.

As well as reflection not being prioritised and not having the time or space to reflect, contextual factors which reduced the use of reflection included working in a prescriptive way or becoming too focused on solutions, where there did not appear to be space for reflection; “I guess I'm a little bit more of a sceptic about the value of overly prescriptive approaches. Because I guess prescriptive approaches would be the opposite of reflection really” (Peter).

Working within an environment where the vulnerability often associated with reflection was not possible was referenced as a block to reflection. This included environments perceived as critical, and when responses and decisions regarding risk were viewed as taking over from a more reflective way of working. Some environments were described as understanding vulnerability as a sign of weakness: “there's a bit of a belief that you need to show resilience and not really show that you might feel upset by a patient or this might be bothering me personally” (Jane).

Where relationships were viewed as blocks to reflection this was due to a lack of feeling of safety or trust, or simply because the psychologist did not have anyone available to be able to reflect with: “If you haven't really got a good relationship with that person, not feeling safe enough might prevent reflection from happening because you don't feel safe enough to share some of the things that may need to be reflected upon” (Ann).

Individual factors cited as blocks to reflection highlighted the difficult and challenging nature of reflection and how this can be a barrier when energy levels are low:

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Being tired and overwhelmed... sometimes if I've got supervision at 3:30 and I just had a day of seeing patients I almost feel like my brain can't take reflection, reflecting on things is quite tiring, it requires a lot of mental energy (Jane).

Participants also spoke of how reflection is less likely to occur when someone is less emotionally attuned or they are experiencing certainty in their decision: "the less attuned people are to their feelings and the more concrete their thinking, the less able you are to reflect" (Laura).

External output

Although not always present in the process, participants regularly spoke of the external changes that reflection allowed them to achieve. These are the more tangible and measurable benefits of a process which can sometimes look inactive to the observer.

Similarities between psychologists' own use of the process of reflection and what they then supported others, often clients or colleagues, to achieve were notable. Once participants had been through the process of reflecting and had developed their own understanding they then worked to support others through, what was perceived by participants to be, a similar process; "in supervision I'm thinking about what I can personally learn or how I feel about something that's going to then influence the way I go back and work with that individual" (Peter).

The outcomes of supporting others through this process were thought to mirror the outcomes that psychologists achieved; changes in awareness or understanding, processing the emotional impact of events and to better understand what situations create emotional pulls; "I'm wondering whether there's a part of that where clients internalize some of these reflections and they're able to offer their own self-reflection as therapy progresses" (Alexandra).

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Participants highlighted that reflection allowed them to be more collaborative with clients, and reduced the risk of psychologists presenting themselves as an expert, instead joining the client at an equal level: “trying to get alongside the young person, really validate their experiences, that helps them to feel understood and helps you to change the way that you’re doing things too, to get a little bit more alongside” (Suzy).

Reflection and the increased understanding that psychologists experienced because of engaging in the process, allowed them to be more client centred; improving communication with clients and having a clearer understanding of client goals:

You kind of end up having a bit of a paradigm shift where, just by virtue of realizing that you don't really know what the goals are... I've been stuck in problem talk and I haven't really... You know, actually, that might be making it worse rather than better (Nicky).

Although at times participants attributed clear outcomes to reflection, there were also incidences where the causal link was less obvious, highlighting one of the difficulties in studying reflection: “The thing is, is that I can't be sure that it led to change. I think that's the issue is that I don't know it led to change because, how would I know that?” (Alexandra).

Discussion

This study used grounded theory methodology to develop an understanding of how clinical psychologists use reflection. The process of reflection involves three main active stages; noticing, gathering information and change. In order for a cognitive task to be considered reflection it must be noticed; be held in attention in a way that more automatic thinking would not necessarily be. Once noticed, clinical psychologists then gather more information regarding the reflected upon situation and combine this with existing knowledge

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to create some form of internal change. A fourth active stage of external output is often, but not always, present, and occurs when psychologists then adapt their behaviour in light of the change that has occurred due to reflection. The internal process is situated within a wider context where the environment and relationships, as well as internal factors, either encourage or block the use of reflection.

The findings from this study support a previous review of the literature on reflection, which found that the complexity and disagreement within the field is often due to terminology and other smaller details (Atkins & Murphy, 1993). This review set out a three stage model similar to the process presented here. Stage one involves an awareness of uncomfortable thoughts and feelings, stage two involves an analysis of the situation and stage three involves the emergence of a new perspective on the situation. The present study goes some way to confirm these findings, but also builds on them. Firstly, the present study provides additional detail regarding some of the processes occurring within the practice of reflection, but also includes the broader context within which reflection is operating, incorporating factors that promote and inhibit the process of reflection. Participants within the present study also discussed how reflection can occur in response to strong positive emotions, where previous literature has tended to focus on negative reactions. Finally, Atkins and Murphy's (1993) model draws on literature from several fields, while the present model focuses on clinical psychologists' use of reflection. This is relevant as different professions are likely to be using reflection in different ways, for example psychologists are likely to use reflection to focus on emotional reactions (Geach et al., 2018).

Participants spoke of two types of noticing; one which occurred within a situation where reflection was pre-arranged and noticing when reflection felt more spontaneous. The difference between this spontaneous and planned noticing can be understood in terms of the distinction between reflection-in-action and reflection-on-action. Both reflection-in-action and

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spontaneous noticing are understood to occur in response to a strong emotion; reflection-in-action has been associated with a feeling of surprise when 'knowing-in-action' falls short for the individual who is acting within and responding to a situation (Schön, 1988). Some have criticised the study of reflection as broadly accepting Schön's definitions without the critical examination usually applied before concepts are so widely embraced, stating that researchers who set out to discuss reflection-in-action actually end up highlighting the benefits of reflection-on-action (Yanow & Tsoukas, 2009). Although this study established a difference between planned and spontaneous noticing, and there were some differences in terms of how that noticing occurs, participants talked of both types of noticing following a similar process. Given the difficulties in studying in-the-moment reflection, and that currently at best it is possible to study after-the-event reflections on reflection-in-action, the process outlined in this paper could provide a structure to understand the similarities between these two forms of reflection. As with the arguments levelled against Schön, it is likely that planned and spontaneous reflection are not dichotomous, with some overlap. For example, it might be that during a planned discussion about a case in supervision, a psychologist might begin to experience a strong emotional reaction that they had not before, which might lead to reflection that appears to be more spontaneous in its nature.

Participants spoke of how utilising planned reflection allows some distance from the emotional impact of the situation, and this can result in noticing things that were not possible to notice in-the-moment, is in-line with Burgess' (2013) study of trainee clinical psychologists' use of reflection within sessions. This found that trainees had difficulty engaging in reflection when faced with something unexpected. Participants within the present study included qualified and often highly experienced clinical psychologists suggests that this difficulty with in-the-moment reflection does not disappear with experience, but the impact of these challenges can be mitigated somewhat with the additional use of planned reflection.

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The importance of curiosity in psychotherapy has been widely noted (Dyche & Zayas, 1995; Pattison et al., 2020), and participants discussed the relevance of adopting an open and interested stance in order to gather more information during reflection. This stage also often involved psychologists asking themselves questions. Studies of in-session reflection of family therapists' 'inner conversations' have found that reflections of this type are incredibly diverse in nature, and can be categorised into serving four purposes: focusing on the client's personal process, the therapist processing the client's story, the therapist focusing on their own experience and managing the therapeutic process (Rober et al., 2008a, 2008b). Although the present study's findings in this area would fit predominantly within the therapist's focus on their own experience and managing the therapeutic process, this is possibly because of the broad focus of the research. It is quite possible that the gathering information stage of the process would include many more types of questions if attention was more focused on this particular area.

Elements of both the internal change and the external output that participants spoke of resemble findings from previous research investigating the use of reflection within clinical psychologists' clinical work. Both Fisher et al. (2015) and Carmichael et al. (2020) found that reflection supported psychologists to understand and manage their own emotional reactions, which led to an increased feeling of containment, and that reflection led to additional understanding of clients, themselves, others or an experience.

Clinical Implications

The present study is the first to describe the internal processes that are used by clinical psychologists when they engage in reflection. Although it is acknowledged that this process has been developed with a limited number of psychologists and therefore cannot be considered

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generalisable, it does provide an initial insight which could be useful in several ways. Encouraging reflective practice in trainee clinical psychologists is an important aspect of doctoral training, but teaching the skill of reflection has been demonstrated to be challenging (Aronson, 2011; Watson & Kenny, 2014). This process provides a framework through which to understand and evaluate reflective abilities; is someone having difficulty noticing events which it might be important to reflect on, or failing to gather information regarding it or finding the incorporation of this information difficult? When these difficulties do occur, is that due to the wider context, the relationships that the individual is experiencing, or some kind of individual factors that are impacting? By making these internal processes clear it opens up the 'black box' of reflection and demystifies and objectifies the process. Thus it becomes easier to understand someone's abilities to use reflection, but also to teach how to use reflection more, and more productively.

Although particularly applicable to training, the processes detailed in the present study could also be used by qualified practitioners and supervisors to continue to encourage the development of reflection post-qualification. It is hoped that the overview of the processes involved in reflection detailed within this study will provide clinicians a structure which can be adapted so that it is most suited to their individual needs, for example, using theoretical orientation to be more specific about what is important to notice or to gather information about, and what kind of internal change or external output is hoped for. Given the finding that once psychologists have been through this process themselves, they often then support clients or other team members through what is thought to be a similar process, it is possible that this theory could also be used as a training tool or prompt for other professionals or clients who are hoping to build on their reflective abilities.

Future Research

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The theory proposed in this study provides a broad overview of the processes that psychologists use when engaging in reflection. Additional qualitative research would allow for a deeper exploration of each of the stages in order to clarify further what happens within each stage, and also how people decide to move, or to not move between the different stages. In order to do this, techniques such as Interpersonal Process Recall (Kagan et al., 1969) could be used, where events are recorded and then watched back as soon as possible whilst the subject of the video discusses what they were thinking at certain points in time.

Psychologists in the present study suggested that once they had achieved internal change via the process of reflection, they attempt to support other individuals to go through a similar process. Given that only clinical psychologists were interviewed it was not possible to establish if this was the case, future research assessing the similarities between the model proposed here and other professionals' and clients' use of reflection as encouraged by a psychologist may shed light on important similarities and differences, perhaps with a comparison between therapists using different therapeutic modalities.

Limitations

The complexity of the process of reflection and the interplay between experience and reflection result in it being a difficult process to investigate (Ruth-Sahd, 2003). Asking psychologists to recall their experiences of reflection without prompts is likely to have influenced what they chose to talk about, with participants more likely to remember the events that involved strong emotional reactions. Although this may have skewed the responses, it is also important to note that the situations which cause strong emotional reactions are the situations most likely to be reflected on regardless (Rober et al., 2008b). Additionally the way in which the questions were asked means that it was more likely that participants recalled when

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reflection was productive and were less likely to talk about a time when reflection was unhelpful

Conclusion

Although reflection is a difficult and complex process to understand, this research proposes that there are four main stages involved; noticing something out of the ordinary, gathering information about it, internal change in response to that information and sometimes some form of external output which follows. It is hoped that the processes detailed in this study can be a first step towards a more unified understanding of reflection across disciplines and a way to support clinicians, in training or otherwise, to develop their use of reflection in their clinical practice.

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Table 1

Participant Demographic Information

Pseudonym	Theoretical Orientation	Current Service	Time as Clinical Psychologist	Ethnicity	Gender
Peter	Systemic	Child and family, post adoption, looked after children	34 years	White British	Male
Jane	Attachment, Schema Therapy	Adult forensic inpatient	2 years	White British	Female
Laura	Cognitive Behavioural Therapy, Compassion Focused Therapy, Person Centred Therapy	Adult mental health, adolescent mental health	20 years	White British	Female
Ann	Cognitive Behavioural Therapy, Applied Behavioural Analysis, Positive Behaviour Support, Dyadic Developmental Therapy	Children and young people who are looked after in the care system	18 years	White British	Female
Alexandra	Cognitive analytic therapy, Cognitive Behavioural Therapy, Systemic approaches	Adult mental health, primary care	2 years	White British	Female
Suzy	Dialectical Behaviour Therapy Systemic Family Therapy Video Interactive Guidance	Child and Adolescent Mental Health	12 years	White British	Female
Nicky	Compassion Focused Therapy, Acceptance and Commitment Therapy, Eye Movement Desensitisation and Reprocessing, Narrative Therapy	Physical Health	6 years	White British	Female

Appendix 2-A

Topic Guide Version Two

1. Can you tell me about a time within your clinical psychology role when reflection lead to change?
2. What was the change that occurred?
3. At which points did you use reflection?
4. Why did you choose to use reflection at those points?
5. How did you use reflection?
6. How did reflection impact your (/others) thinking or behaviour?
 - a. How did reflection lead to change?

Appendix 2-B

Example Transcript with Coding

Line number	Transcript	Coding
6	Participant: Well, all aspects I'd say, I mean I'm not sure there's an area of working which I wouldn't do that. So seeing kid's families. Professional meetings, supervision. CPD. All aspects of professional life would include an element of reflection.	Reflection used in all areas of working. With families, in meetings, supervision, CPD.
7	Researcher: And do you think that the way that you use reflection does it vary kind of according to each of those different circumstances that you just named.	
8	P: Yeah yeah, uhm. I think, uhm. I guess there's always the question of what's the point of it really? Uhm, I suppose in my supervision and CPD it's about my learning and my development. Improve my practice. Um, I think with families it's to be helpful to whatever issues they're bringing. If I'm supervising somebody, it's about their learning and development. Hum. And if it's a meeting, uhm? I suppose it's in order to have a better meeting and pay proper attention to issues that might otherwise get neglected. So yeah. I suppose because I work a lot with social workers. It's quite striking how, um, some of the cultures, in their professional networks are different. And Uhm, it's all about action, really. And decision-making, and less about reflection. Uhm, it would seem to me, so I will often be working quite hard in those contexts to bring the reflection dimension into the work. Because I see a lot of decisions made with no reflection. And mistakes being made because of it.	What is the point of reflection? Using reflection to support own learning and development Using reflection to support the learning and development of others. Using reflection to help with family issues Using reflection to improve meetings and attend to issues that might be neglected. Being aware of the differences between professional cultures Focusing on action and decision making, less about reflection. Working hard to bring reflection to the work Deciding without reflection leads to mistakes
9	R: So kind of different circumstances might have an impact on how much you're using reflection.	
10	P: Yeah, yeah, by itself, I'm not sure it has any sort of intrinsic value, it's it's a means	Reflecting as a means to an end

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to an end, isn't it? I suppose, it's an opportunity to reduce uhm, the problems of taking action without sufficient thought. You know we're often dealing with complex situations that don't lend themselves to simple answers. And by reaching for a simple action or a simple answer, the danger is we miss something quite important. But also there's a whole culture, I guess I was raised in, to have a critical eye on your work. You know there needs to be an in built critique. Not so strong that it paralyzes you into inaction. I suppose I see reflection and action as on a continuum really. Hum. So, uh. So there's an interplay between action and reflection. And I don't know if you know much about family therapy approaches, but, um, the reflecting team approach, actually, uh, incorporates reflection into a particular ritual. So you take turns. You have conversations, and then you pause for reflection. Then you have some more conversations. So the reflecting team approach and the values and ideas in it, are a big part of what I do.

Using reflection to reduce the problem of acting without sufficient thought

Complex situations that don't lend themselves to simple answers

Risking missing something important through using simple answers

Being critical towards your work

Having an in built critique, but not so strong that it paralyzes you

Reflection and action as on a continuum

Reflection and action influencing each other

Reflecting as a ritual

Reflection is incorporated into the approach

Taking turns, having conversations, pausing for reflection, having more conversations

Incorporating ideas and values into practice

Appendix 2-C

Example of Analysis

Participant	Quote	Code	Extract from Memo
4	Although you want to stay present with people you can miss things and that comes out for me with my notes	Making notes helps to notice things	A space outside of the present moment which has reflection at its core allows for a reduction in emotion and other individual's input which supports reflection
1	The reflecting team approach incorporates reflection into a particular ritual	Incorporating reflection into a ritual	
2	When there's a complex or difficult case, that would usually prompt some of the staff to suggest maybe we should we do like some reflective practice	Using reflective practice to think about difficult cases	
2	And I think as well, people get very desensitized to things. And I think then maybe see less need to reflect because it's just kind of another day on the job	Becoming desensitised and therefore less reflective	
4	And that is the time [when I'm writing up my notes] often things will strike me. That didn't strike me in the session with the foster carer, and that's because there's a degree of anxiety no matter how long I've been qualified.	Noticing things once outside of the anxiety of the situation	
4	That could be my blind spot and that's why sometimes that's why I think it's helpful when you go to the supervision session is helpful because you've got somebody else who's putting a different take on it	Supervision helping to noticing things in blind spots and providing a different perspective	
5	I guess in terms of supervision, I think it's just, I don't know how else to say other than it's just a natural part of what we do within supervision is like sharing with reflection.	Sharing with reflection an integral part of supervision	

Appendix 2-D

Example Memo

Reflection and change

Is there a spectrum where reflection sits on one end and action sits on the other? Suggests all reflection is inactive? But reflection is actually a purposeful and effortful thing, which can be really challenging.

Reflection looks inactive, but actually it is an action within itself. Do the differences between professions come from the perception of action? So nurses are checking someone is taking their meds, that a risk assessment is up to date (tick tick) but reflection is perceived to be a less active process? - listening is perceived to be less important than talking but what's the point in talking if no one is listening? Listening **looks** less active than talking. But reflection is active, (always a purpose, not necessarily an end) so how is it related to change?

Are there times when reflection doesn't have an outcome? My gut feeling is that with "successful" reflection (e.g., not interrupted, individual is able to reflect) it always has an outcome, it's just that the outcome isn't necessarily tangible. So for example I might reflect on why I felt a certain way about something, and I might start to form an idea, which I don't articulate or write down, but that leads to something else, or another way of thinking about something, that I don't even necessarily attribute to reflection. - The extent to which reflection looks like action will vary greatly.

Appendix 2-E

Author Guidelines

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

Once the submission materials have been prepared in accordance with the Author Guidelines, manuscripts should be submitted online at <http://www.editorialmanager.com/paptrap>

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All papers published in the *Psychology and Psychotherapy: Theory Research and Practice* are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

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Psychology and Psychotherapy: Theory Research and Practice is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports which support evidence-based practice are also welcomed, as are relevant high quality analogue studies and Registered Reports. The Journal thus aims to promote theoretical and research developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

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- Articles should adhere to the stated word limit for the particular article type. The word limit excludes the abstract, reference list, tables and figures, but includes appendices.

Word limits for specific article types are as follows:

- Research articles: 5000 words
- Qualitative papers: 6000 words
- Review papers: 6000 words
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In exceptional cases the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). Authors must contact the Editor prior to submission in such a case.

Please refer to the separate guidelines for [Registered Reports](#).

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Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

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All articles must include Practitioner Points – these are 2-4 bullet point with the heading 'Practitioner Points'. They should briefly and clearly outline the relevance of your research to professional practice. (The Practitioner Points should be submitted in a separate file.)

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Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

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Author Guidelines updated 28th August 2019

Chapter 3 Critical Review

Reflecting on Reflection

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Critical Review

This critical appraisal will first provide an overview of the research findings, with an explanation of why the research study was conceptualised, focusing on the development of my personal interest in reflection. It then discusses how my relationship with Cognitive Analytic Therapy (CAT) played a role in the development of the research. It goes on to address my epistemological stance and then highlights limitations of the research with a focus on the lack of ethnic diversity within the present study, but also psychology research more broadly.

Summary of Research

To explore the process of how clinical psychologists use reflection, seven psychologists were interviewed and a grounded theory informed approach was used to develop a model of reflection within clinical practice. The model suggests that the internal process of reflection begins with noticing that something out of the ordinary, in some way, needs to be brought into conscious awareness to be reflected upon. Once noticed, the clinical psychologist then gathers information, which is supported by adopting an open and curious stance, and the asking of questions. This information is then combined with existing knowledge to produce some form of internal change for the clinical psychologist. This process all sits within contextual, relational and individual features which can either encourage or block the use of reflection.

The systematic literature review investigated therapists' experiences of ruptures in the therapeutic alliance and established three themes. 'Hitting therapists where it hurts' was the first theme, which highlighted that therapists found ruptures to be particularly difficult to cope with as they often challenged characteristics of the therapist that they considered to be central

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to their practice. For example, some therapists spoke of feeling as though they were losing their patience with a client, when patience was a skill they believed to be fundamental in their practice. The second theme encapsulated when therapists perceived ruptures to be an opportunity to strengthen the therapeutic alliance and to bring emotions to the surface that perhaps would not have been expressed within the therapy room usually. In addition, a rupture could provide, for both the client and the therapist, additional insight into the client's ways of reacting in difficult situations. The third theme focused on therapists' perceptions of the causes of the rupture, which included therapist mistakes, client contribution and when someone outside of the therapeutic alliance became involved in an unhelpful way.

Reflections on the Empirical Paper

The topic for this study was borne out of my own personal interest in the area of reflection, which I will detail here, for reasons of reflexology, but also because of my belief in the benefits of engaging in reflection. Early on in my journey to becoming a clinical psychologist I completed a counselling course, through which I came to understand the benefits of sitting with and deepening my understanding of the difficult emotions I experienced, even though this process in itself could be painful. I continued to focus on developing these skills, often accessing private psychological support to do so. Thus my initial interest in reflection was due to my experiences of the benefits of reflecting on my own processes and emotions.

Whilst my belief in the importance of reflection continued to grow, I still had difficulty understanding and articulating the broader benefits and applications of reflecting within clinical psychology. I found this particularly frustrating as I felt it prevented me from sharing these benefits with other people and from understanding how best to encourage other people to

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engage in reflection. In the hopes of developing my own understanding, and progressing the evidence base, I decided to conduct this research.

In preparing to complete this piece of research I engaged with the literature around reflection-in-action; the process of in-the-moment reflection. During this endeavour I became increasingly frustrated at the number of different concepts that focus on very similar processes but because of different names and being studied within separate fields of psychology the findings do not become adopted more broadly. Whilst I maintained an awareness that my research was conducted with clinical psychologists and my priority was to understand the process of reflection within this population, I was also aware of a desire to create a model which could be applicable more broadly. I hoped that the nature of the model will mean that it has the potential to be used as a way to structure research in order to be developed and used across psychological studies and perhaps even within teaching and medicine (Harvey et al., 2016; Norrie et al., 2012). Research regarding reflection has predominantly focused on using qualitative techniques in part because the concept of reflection is challenging to quantify (Marshall, 2019). It is hoped that by making the internal processes that occur during the process of reflection explicit, and highlighting that these occur within a broader context it will be possible to build upon the existing research by using both qualitative and quantitative models. This will further examine factors which block or encourage reflection, develop a deeper understanding of when reflection is or is not useful and help understand what methods best support individuals to develop skills of reflection.

Wanting to understand the internal processes that occur when reflecting was also related to my frustrations regarding the way terminology is sometimes used more broadly within the field of psychology. For example, whilst in the process of applying for the clinical psychology doctorate I was aware that I should be demonstrating my ability to be a “reflective practitioner”, but was unable to find out what this really meant or how I would go about becoming one.

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Where reflection is encouraged, it is often through the provision of a space and the time to reflect, and professionals being informed that reflection is important. Whilst these factors are necessary, they are not sufficient to produce useful and meaningful reflection. It is my personally held belief, which was also regularly mentioned within the interviews on this topic, that, for many reasons, some individuals find reflection a more interesting, natural and less difficult process than others. Without understanding the processes involved it is incredibly challenging to encourage reflection in those who do not have this potentially more natural affiliation. It is hoped that through the articulation of the internal stages this might become more achievable. For example, using the model it might be possible to identify which stage(s) of reflecting an individual finds challenging, and then specify whether this is due to environmental factors, issues in the relationships with those they are reflecting with, or whether there are individual factors that they might benefit from working on. Whilst I am aware that this model does not solve all these problems, and will require further development, it is hoped that it represents another step towards a more practical understanding of reflection.

Reflexivity is the notion that researchers are not neutral in completing research and their pre-existing ideas and experiences will influence what and how they research, and impact on the findings (Palaganas et al., 2017). It is important, especially within qualitative research to acknowledge the potential impact of the researcher. The research initially planned to focus on whether clinical psychologists' therapeutic orientation(s) or the population they work within have any influence on their use of reflection. Over the course of training I have developed an interest in the type of work and modality clinical psychologists feel drawn towards and how this might be related to who they are as an individual. I was aware during the process of conducting the research of feeling unhelpfully inclined to focus on times where participants spoke of how their personal experiences had affected how or where they worked. I found the semi-structured nature of the interviews helpful in this regard as I had the pre-agreed questions

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to return to, and I found asking questions more than once helpful in both generating richer responses but also ensuring my own interests were not overwhelming the interview process. Ultimately there was not enough data to suggest that therapeutic orientation influenced the way in which clinical psychologists use reflection, so in line with grounded theory methodology (Charmaz, 2006) the questions were adapted to follow more promising lines of enquiry.

Cognitive Analytic Therapy

During training I was introduced to, and immediately drawn to, the concepts contained within Cognitive Analytic Therapy (CAT), particularly the concept of reciprocal roles and the therapists' use of self within the session. Reciprocal roles are ways in which we relate to other people which we have learnt and internalised from the ways that others have related to us (Ryle & Kerr, 2020). The focus on relationships and the way in which previous relationships can explain current behaviour particularly appealed as a model within which I could sort and understand my previous reflections on my own experiences. CAT also emphasises the therapists own emotional reactions within relationships, stating that these feelings can highlight important details about the way the client or therapist relate to others (Ryle, 1998). For me these concepts not only provided me with a structure through which I could formulate my understanding of my own experiences, but also a way to understand why reflection was important. This was beyond the often referenced "learning from experience" and the models of reflection I had previously come across that did not seem to provide particularly rich information beyond some practical advice on how to reflect (Dennison, 2010). I also found CAT highly valuable, reassuring and containing when I had experienced challenges with clients in my own therapeutic work, which then led to the formulation for my topic for my systematic literature review.

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Reflections on the Systematic Literature Review

Investigating therapists' experiences of ruptures within the therapeutic alliance appealed to me in part because of the way that CAT formulates and helps to understand what might be happening when a significant event happens between the client and the therapist. Formulation within CAT is used in order to support the client to understand how past experiences might continue to have a current impact on their personal lives, but with the knowledge it is also likely that these ways of relating will also play out within the therapeutic relationship (Ryle, 1998). Thus if someone experienced rejection within their childhood, there is likely to be a pattern of actions they learnt to utilize to move away from the difficult experience of feeling rejected, which they will return to both in day to day life, but also within the therapy room if they perceive any suggestion of rejection from the therapist (Ryle & Fawkes, 2007). Therapists working within this method might, through the development of a formulation with the client, have an idea of what events could lead to potential ruptures. The formulation can again work as a tool in dealing with ruptures in that it can be referred to when the rupture occurs, in order to reduce blame on one individual and to highlight that the issue may well exist between the client and the therapist. In this way, the method for predicting and responding to ruptures is built-in to CAT, and I was interested in seeing what this might look like in practice within both CAT and other therapeutic orientations.

Whilst conducting the literature review I was aware of being particularly interested when papers talked about the emotional reactions of the therapists, and when these or the ruptures themselves were treated as something to learn from. I believe this interest stems from my experiences of using my own emotional reactions, both within and outside of therapy as points where I can learn more about myself and why I might be feeling a certain way. I was also aware that my experiences of CAT were influencing my interests, in particular how I have come to understand that CAT views ruptures within therapy as a reflection of the clients'

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relationships outside of therapy and therefore ruptures within the therapeutic alliance can be perceived as an opportunity for learning why the rupture occurred or to test out repairing relationships within the relatively safe environment that is the therapy room. How I managed these influences is set out below.

Reflections on Epistemological Stance

In completing both the literature review and the empirical paper I adopted a social constructionist stance (Charmaz, 2006). This for me meant acknowledging that my preconceived ideas and biases would impact on the findings to some extent, but being accepting and open about this because firstly, I do not believe it is possible to avoid this from happening and secondly, because all humans understand the world from their particular viewpoint and therefore there is not one objective truth in the world waiting to be discovered. However, in order to minimise the impact of my own interests and beliefs on the processes involved in the literature review, my general stance was to ensure that decisions were grounded in logic and findings grounded in data. For example, during screening I was aware that I was particularly drawn to papers which mentioned in-the-room processes occurring between client and therapist (e.g., transference and countertransference). To counter this I made sure that my inclusion and exclusion criteria were clear, and returned to these whenever I felt an emotional pull to want to include a paper. During the analysis I again found myself more interested in findings that were connected to my interests as set out above, and although themes related to these areas were ultimately included, I ensured that this was because they were present across several papers and therefore had the data to confirm that they should be.

In order to ensure that the findings were grounded within the data within the empirical paper I used a cyclical process of first coding the interviews, then writing memos which started to bring some of these codes together, then beginning to develop a draft model once I had

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sufficient data to do so. This model was then shared with my research supervisors who provided feedback and clarified points. Then additional interviews were conducted and coded, new memos written or existing memos added to and the model amended. Through this process three draft models were developed. Once the final model was in its draft stage, the transcripts were returned to and the data again checked to examine the fit between the data and through this process final changes were made to the model.

Limitations of the Research

Coronavirus Disease

It is important to mention that this research took place against the backdrop of coronavirus disease (COVID) and consider the potential implications of this. Participants were predominantly working in the NHS at a point where the pressures on staff were significant (Cole et al., 2020). Although unlikely to be working directly with clients with COVID, the wider effects of the pandemic in both physical and mental health have been widely discussed (Pfefferbaum & North, 2020), and are likely to be impactful in the services within which clinical psychologists do work. Participants were also having to navigate their own way through the changes implemented in order to prevent the spread of the disease. It is thought that these additional pressures for clinical psychologists at this time are likely to have been one cause of difficulty with recruitment, where the hope initially was to recruit 10 to 12 participants (British Psychological Society, 2020). Additionally, asking psychologists to participate in this research is effectively asking them to reflect on reflecting. Given the additional stressors that participants were experiencing at that time and the importance of environmental and individual factors (such as stress) which was highlighted in the model, it is possible that the model may have looked different if interviews were conducted at a different point in time. Although the impact of COVID has been challenging, it also increased the use of video calling significantly,

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which decreased my anxiety around using this as a way in which to conduct interviews and potentially resulted in participants feeling more comfortable as well, potentially leading to richer interviews.

Race

It feels important to discuss that all participants in this study identified their ethnicity as White British and were predominantly female (six out of seven participants), and that I myself am a White, British female. This reflects the well-established problem of a lack of diversity within clinical psychology more broadly (Wood & Patel, 2017) where even against the backdrop of the Black Lives Matter movement (Watson et al., 2020) the importance of race is ignored and claimed to be “unscientific” (Wood, 2020). The vast majority of psychological research is conducted with white and western participants (Roberts et al., 2020) and therefore the majority of the understanding of human behaviour is based upon a population that makes up just 12% of the world’s inhabitants (Henrich et al., 2010a). The issues with this as an approach to scientific study become even more concerning when set against the evidence that there is significant variability in cognition and affect between different populations which is broadly ignored in psychology (Henrich et al., 2010b). For example, Norenzayan et al. (2002) found that East Asian participants were more likely to rely on intuitive reasoning when completing a cognitive task, whereas European Americans relied on formal reasoning techniques. For the present study, this means not only has the research itself been conducted by a white, western researcher, but it investigated the experiences of white, western participants and was set within a context of existing white, western research.

It is clear that the model produced represents a white, predominantly female, western approach to reflection, meaning the use of reflection outside of this group is likely to look different. This is perhaps particularly likely to be true in more collectivist cultures, who, when

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compared to people living in individualist cultures are more likely to define themselves as part of a group, prioritise the group goals and pay more attention to external, social processes than to internal processes (Triandis, 2001). Therefore it is possible that for those living in collectivist cultures, the background upon which the internal process of reflecting sits in the model will be far more important than the internal process itself, or the model may not translate from individualist to collectivist cultures at all. Research on reflection with clinical psychologists' in Singapore has begun to provide some diversity within the literature, although half of the participants completed their training in Australian universities, which may have included more individualistic approaches to reflection being taught (Fisher et al., 2015).

Although considerations of race and culture are important across all aspects of psychology it is thought particularly relevant to the study of reflection. This is firstly because of the expectations of both the Health and Care Professionals Council and British Psychological Society that practitioners will use reflection in their day-to-day practice (Health and Care Professionals Council, 2019; British Psychological Society, 2017) and the importance of all organisations across clinical psychology to amend their structures in order to increase diversity and ensure that the cultures within systems welcome people of colour (PoC) into the profession (Fernando, 2017). In addition to this are the findings of the present study that often the process of reflection begins with noticing difference, including, as mentioned in interviews, when the person you are reflecting with or about, has different coloured skin to you. This means that at present not only is the model generally missing the input of any PoC, but also any understanding of how reflection may be different when PoC are reflecting with other PoC or white people, and how intergenerational racial trauma (Watson et al., 2020) and present day racism (Byrne et al., 2020) may influence the processes involved in reflection.

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Final Reflections

One of my clear objectives when setting out to complete this project was to create a model of reflection which was easy to understand, apply and that helped to reduce the complexity of the language and number of concepts that are used in this area. Although I am by no means the first to attempt this (Marshall, 2019), I do believe the model has a simplicity and applicability to it that could help to inform future research across disciplines. Future research into the use of reflection needs to include more diverse populations so we can begin to better understand some of the cultural influences on the processes involved, and be able to adapt environments and systems in order to support the development and use of reflection in all.

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Chapter 4 Ethics Section

Rosie Wheeler

Doctorate in Clinical Psychology

Division of Health Research

Lancaster University

ETHICS SECTION

Faculty of Health and Medicine Research Ethics Committee (FHMREC)

Lancaster University

Application for Ethical Approval for Research

Title of Project: How do Qualified Clinical Psychologists use Reflective Practice in their Practice?

Name of applicant/researcher: Rosie Wheeler

ACP ID number (if applicable)*: N/A

Funding source (if applicable) N/A

Grant code (if applicable): N/A

***If your project has *not* been costed on ACP, you will also need to complete the Governance Checklist [\[link\]](#).**

Type of study

Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. **Complete sections one, two and four of this form**

Includes *direct* involvement by human subjects. **Complete sections one, three and four of this form**

SECTION ONE

1. Appointment/position held by applicant and Division within FHM Trainee Clinical Psychologist, Doctorate in Clinical Psychology, Division of Health Research

2. Contact information for applicant:

ETHICS SECTION

E-mail: r.wheeler6@lancaster.ac.uk
which you can be contacted at short notice)

Telephone: 07703013338 (please give a number on

Address: Lancaster University, Lancaster, LA1 4YT

3. Names and appointments of all members of the research team (including degree where applicable)

Pete Greasley, Teaching Fellow, Anna Duxbury, Clinical Tutor

3. If this is a student project, please indicate what type of project by marking the relevant box/deleting as appropriate: (please note that UG and taught masters projects should complete **FHMREC form UG-tPG**, following the procedures set out on the [FHMREC website](#))

PG Diploma Masters by research PhD Thesis PhD Pall. Care

PhD Pub. Health PhD Org. Health & Well Being PhD Mental Health MD

DClinPsy SRP [if SRP Service Evaluation, please also indicate here:] DClinPsy Thesis

4. Project supervisor(s), if different from applicant: Pete Greasley, Anna Duxbury

5. Appointment held by supervisor(s) and institution(s) where based (if applicable): Pete: Teaching Fellow, Anna: Clinical Tutor. Both based at Lancaster University

SECTION TWO

Complete this section if your project involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants

1. Anticipated project dates (month and year)

Start date:

End date:

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2. Please state the aims and objectives of the project (no more than 150 words, in lay-person's language):

Data Management

For additional guidance on data management, please go to [Research Data Management](#) webpage, or email the RDM support email: rdm@lancaster.ac.uk

3. Please describe briefly the data or records to be studied, or the evaluation to be undertaken.

4a. How will any data or records be obtained?

4b. Will you be gathering data from websites, discussion forums and on-line 'chat-rooms' no

4c. If yes, where relevant has permission / agreement been secured from the website moderator?
 no

4d. If you are only using those sites that are open access and do not require registration, have you made your intentions clear to other site users? no

4e. If no, please give your reasons

5. What plans are in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

6a. Is the secondary data you will be using in the public domain? no

6b. If NO, please indicate the original purpose for which the data was collected, and comment on whether consent was gathered for additional later use of the data.

Please answer the following question *only* if you have not completed a Data Management Plan for an external funder

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7a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

7b. Are there any restrictions on sharing your data?

8. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications?

b. How will the confidentiality and anonymity of participants who provided the original data be maintained?

9. What are the plans for dissemination of findings from the research?

10. What other ethical considerations (if any), not previously noted on this application, do you think there are in the proposed study? How will these issues be addressed?

SECTION THREE

Complete this section if your project includes *direct* involvement by human subjects

1. Summary of research protocol in lay terms (indicative maximum length 150 words):

Reflecting on experiences has long been considered an important way in which we learn; looking back and evaluating the way we behaved in certain situations allows us the time and space to adapt our behaviour in the future. Reflection is considered to be a central aspect of clinical psychology, but to date there has been little research investigating how clinical psychologists use reflection in their day to day practice.

This study aims to investigate how clinical psychologists use reflection and what it helps them to achieve. Additionally it will explore which factors influence the process of reflection, for example whether the way that clinical psychologists reflect is related to the therapeutic approach that they use in their clinical work, or the clinical area that they work in. To do this interviews will be conducted with qualified clinical psychologists and analysed using a grounded theory approach.

2. Anticipated project dates (month and year only)

Start date: 07/2020

End date 03/2021

Data Collection and Management

For additional guidance on data management, please go to [Research Data Management](#) webpage, or email the RDM support email: rdm@lancaster.ac.uk

3. Please describe the sample of participants to be studied (including maximum & minimum number, age, gender):

Participants will be qualified clinical psychologists, working in the UK. Participants will be English speaking as funding for an interpreter is not available. No specified duration of post-qualification experience will be required because how reflection is understood at different experience levels may be a component of the process that is interesting to explore. The total number of participants will be dependent on “theoretical sufficiency”. There will be no restriction on age although due to the time it takes to qualify as a clinical psychologist all participants will be over 24 years old. Participants of any gender will be welcome to take part. Theoretical sufficiency means that once existing categories do not require revision or alteration in respect of new data then no new participants need to be recruited. The researcher anticipates that this will be attained through 10 to 20 participants. Purposive sampling will be used to select who takes part in the study. This means that participants included in the study will be selected by the researcher, based upon a variety of criteria. For this study that may include time in the job role, therapeutic orientation, the service context they work in. This will allow the researcher to make decisions about the individual participants who would be most likely to contribute to the developing model in line with theoretical sufficiency. Participants will be asked to take part in one interview (see procedure section), with the option of interviewing a participant for a second time if emerging themes within the data suggest this would be of benefit.

4. How will participants be recruited and from where? Be as specific as possible. Ensure that you provide the *full versions* of all recruitment materials you intend to use with this application (eg adverts, flyers, posters).

As stated above, recruitment will use purposeful sampling. This will mean that the researcher will make decisions on who is recruited into the study based on a variety of factors, in line with grounded theory methodology. In order to achieve this, participants will be asked to complete a demographic data form (appendix A) which asks participants to provide information regarding their current role, preferred therapeutic approaches and how long they have been practicing, alongside

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basic demographic data. These forms will be used to inform which participants are interviewed, and in what order. It is possible that the demographic data forms may have to be amended if themes emerge from the data that have not been predicted. If this is the case, amendments will be focused on the individual's professional life, and therefore unlikely to be of a sensitive nature.

To support this purposeful sampling approach, the wording alongside advertising posts will be amended. For example, the post (see next paragraph) could specify that individuals working within a certain area or using a particular theoretical model are required. Participants will be asked if they are willing to forward the advertising flyer for the study on to individuals that they think might be interested in participating.

The study will be advertised within "UK based Clinical Psychology" from Facebook, a private specialist group containing 5690 clinical psychologists who qualified in the UK. The advertising flyer (appendix B) will be posted by the lead researcher, from a profile created using their Lancaster University email. Twitter will also be utilised for recruitment. A professional Twitter account (handle @RosiePsychology) will advertise the research, using the advertising flyer. Posts will be worded "Are you a qualified Clinical Psychologist working in the UK? Rosie (Trainee Clinical Psychologist) is looking for English-speaking participants to talk via phone or video call about your experiences of using reflection within your work. Please see advertisement for contact details." As stated above the wording may change in line with purposive sampling e.g. "Are you a qualified clinical psychologist working with children in the UK? Rosie (Trainee Clinical Psychologist) is looking for English-speaking participants to talk via phone or video call about your experiences of using reflection within your work". The researcher will ask other relevant Twitter pages to "retweet" their advert. For example, the Lancaster Doctorate in Clinical Psychology Twitter account (Twitter handle @LancsDClinPsy). When potential participants make contact, they will be sent a copy of the participant information sheet (appendix C), consent form (appendix D) and a demographic data form (appendix A). After 48 hours potential participants will be contacted to ask if they agree to take part. The researcher will also answer any questions about the study that the potential participant may have. If potential participants agree to take part, they will be asked to return a completed copy of the consent and demographic data form via email. They will be reminded that they may be asked to take part in the study immediately, may be contacted at a later date to interview, or may not be included in the study at all. The demographic data form will be reviewed, and the participant will be contacted, and an interview time arranged if it is thought that an interview with that participant would add to the development of the model at that time. If an interview is not arranged immediately, the individual's details will be stored on the researcher's One Drive, with the option of contacting that individual at a later date if this would add to the development of the model. Participants who are not interviewed will be informed at the end of the data collection period that they were not required.

5. Briefly describe your data collection and analysis methods, and the rationale for their use.

The researcher will use the interview topic guide (appendix E) to inform the interview, although this will be used flexibly, with prompts and probes being used where necessary. All interviews will start with the researcher introducing themselves and then reading through the first paragraph of the

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interview topic guide (appendix E), which will introduce the study, state that interviews are likely to last around 60 minutes, and that they are welcome to ask for a break as and when needed, and they are able to stop the interview at any point, for any reason. Then the researcher will read through the 12 points on the consent form, confirm that the participant consents to the interview taking place and then start the recording. The researcher will conduct the interviews from a private room at their home address. At the end of each interview the researcher will enquire about the participants' wellbeing, and the debrief sheet (appendix F) will be sent to the participant via email. If participants are distressed, they will be signposted to the support systems detailed on the debrief sheet.

Interviews will be audio recorded using a digital recording device provided via the Lancaster Doctorate in Clinical Psychology and will be uploaded to the university virtual private network (VPN) immediately after the interview takes place. Once uploaded the recording will be immediately deleted from the audio recorder. Transcription will be completed by the researcher on a password protected word document, and information will be anonymised at the point of transcription, including third party information.

Transcripts will be printed and stored in a locked storage unit at the researcher's home address. Transcripts will be analysed using Charmaz's (2006) grounded theory methods, which use a social constructionist approach. This approach acknowledges the researchers' influence over the study and posits that the researcher uses data to construct theory, taking an active role in creating the findings, not simply uncovering "truths" within the world. Grounded theory methods use data collection, codes, memos and themes in a dynamic, cyclical way, with each informing the other. Coding the data involves studying the data very closely, to begin developing, sorting and synthesising ideas. These codes are then analysed and developed into memos, which allow for comparison of the data and provide direction about further data gathering. The relationships between these memos are then investigated to develop themes which are brought together to form a model.

6. What plan is in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc.)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

Recordings of interviews will be transferred and stored on the university VPN at the earliest possible opportunity. All paper-based participant information (i.e. printed transcripts) will have no personal participant information on them and will be stored in a locked filing cabinet to which only the

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researcher has access. They will be destroyed once all data have been analysed. Electronic information (consent, screening, demographic data forms and transcripts) will be deleted from email and stored on the lead researchers OneDrive until examination of the thesis. Any personal identifying document (i.e. consent form) will be saved separately from recordings and the transcript. Once the thesis has been examined all electronic data securely sent to the research custodian in the Division of Clinical Psychology, who will be responsible for the deletion of this data once 10 years has elapsed. Participants will be asked not to share any client or colleague details during interviews, but should confidential data be mentioned, this will be removed at the point of transcription. Audio data and printed copies of transcripts will be deleted once the thesis has been examined.

7. Will audio or video recording take place? no audio video

a. Please confirm that portable devices (laptop, USB drive etc) will be encrypted where they are used for identifiable data. If it is not possible to encrypt your portable devices, please comment on the steps you will take to protect the data.

All confidential data will be transferred on the universities VPN at the earliest possible opportunity. All electronic documents will be saved to the researchers' OneDrive and then immediately deleted from the email account which they were sent to.

b What arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

Audio data will be deleted once the thesis has been examined.

Please answer the following questions *only* if you have not completed a Data Management Plan for an external funder

8a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

All relevant files with documentation will be stored in Lancaster University's VPN where it will be preserved according to Lancaster University's Data Policy for a minimum of 10 years.

8b. Are there any restrictions on sharing your data ?

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Due to the small sample size, even after full anonymization there is a small risk that participants can be identified. Therefore, access will be granted on a case by case basis by the Faculty of Health and Medicine.

9. Consent

a. Will you take all necessary steps to obtain the voluntary and informed consent of the prospective participant(s) or, in the case of individual(s) not capable of giving informed consent, the permission of a legally authorised representative in accordance with applicable law? yes

b. Detail the procedure you will use for obtaining consent?

When potential participants make contact they will be sent a copy of the participant information sheet and consent form. After 48 hours potential participants will be contacted to ask if they agree to take part. If potential participants agree to take part they will be asked to return a completed copy of the consent form via email and a time for an interview will be arranged.

10. What discomfort (including psychological eg distressing or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks. State the timescales within which participants may withdraw from the study, noting your reasons.

Risks for participants taking part in this study will be minimal, as discussions will be focused on reflection, which is highly likely to be an everyday part of their job. However, participants will be discussing their beliefs and experiences and therefore it is possible that participants may experience distress. Therefore an appropriate level of support will be offered to participants, including a debrief at the end of the interview when required, and a debrief sheet detailing useful contacts that could be utilised for support.

There is the potential for poor practice to be highlighted during interviews, and safeguarding concerns may arise. Should this occur the researcher will discuss with the research supervisors, and the appropriate action, in line with the Health and Care Professionals Council's (HCPC) advice will be taken.

Participants will be expected to give up around an hour of their time to complete an interview, as is made clear in the advertising flyer.

Participants will be welcome to withdraw from the study at any time before or during the interview and up to two weeks following their interview, as after this point responses will be incorporated into the analysis.

11. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, noting the support available to you; counselling considerations arising from the sensitive or distressing nature of the research/topic; details of the lone worker plan you will follow, and the steps you will take).

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Researchers are unlikely to encounter any risk above and beyond what they would usually come across in their work. If difficult issues do arise during the course of conducting this research, existing supervision structures will be used.

The researchers' university email address and a university issued number will be used for all contact with participants.

12. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.

There may be no direct benefit to participation in this study, however, participants may find the time spent thinking about how and why they reflect has a positive impact on their future clinical work.

13. Details of any incentives/payments (including out-of-pocket expenses) made to participants:

None

14. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications? yes

b. Please include details of how the confidentiality and anonymity of participants will be ensured, and the limits to confidentiality.

Participants will be assigned with a pseudonym to ensure data (including transcription and analysis) included in the report is anonymous. Effort will be made to ensure that verbatim quotes used in the write up do not contain identifying details. As interviews may take place over video web services, participants will be reminded that these methods cannot be guaranteed to be secure. Confidentiality may need to be broken should the researcher feel the participant or any other person is placed directly at risk of serious harm, there are safeguarding or concerns around the individual's practice. This will be set out in the participant information sheet.

15. If relevant, describe the involvement of your target participant group in the *design and conduct* of your research.

A qualified clinical psychologist is supporting the study in the role of field supervisor.

16. What are the plans for dissemination of findings from the research? If you are a student, include here your thesis.

All research team members will have access to the data produced in the study. The study will form the DClinPsy thesis for the researcher. Results of the research may be submitted for publication in an academic journal.

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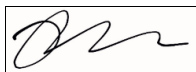
17. What particular ethical considerations, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek guidance from the FHMREC?

None

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SECTION FOUR: signature

Applicant electronic signature:



Date

19/05/20

Student applicants: please tick to confirm that your supervisor has reviewed your application, and that they are happy for the application to proceed to ethical review

Project Supervisor name (if applicable): Pete Greasley

Date application discussed

19/05/20

Submission Guidance

1. Submit your FHMREC application by email to Becky Case (fhmresearchsupport@lancaster.ac.uk) as two separate documents:
 - i. **FHMREC application form.**
Before submitting, ensure all guidance comments are hidden by going into 'Review' in the menu above then choosing *show markup>balloons>show all revisions in line*.
 - ii. **Supporting materials.**
Collate the following materials for your study, if relevant, into a single word document:
 - a. Your full research proposal (background, literature review, methodology/methods, ethical considerations).
 - b. Advertising materials (posters, e-mails)
 - c. Letters/emails of invitation to participate
 - d. Participant information sheets
 - e. Consent forms
 - f. Questionnaires, surveys, demographic sheets
 - g. Interview schedules, interview question guides, focus group scripts
 - h. Debriefing sheets, resource lists

Please note that you DO NOT need to submit pre-existing measures or handbooks which support your work, but which cannot be amended following ethical review. These should simply be referred to in your application form.

2. Submission deadlines:
 - i. Projects including direct involvement of human subjects [**section 3 of the form was completed**]. The *electronic* version of your application should be submitted to [Becky Case](#) by the **committee deadline date**. Committee meeting dates and application submission dates are listed on the [FHMREC website](#). Prior to the FHMREC meeting you may be contacted by the lead reviewer for further clarification of your application. Please ensure you are available to attend the committee meeting (either in person or via telephone) on the day that your application is considered, if required to do so.

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- ii. The following projects will normally be dealt with via chair's action, and may be submitted at any time. **[Section 3 of the form has *not* been completed, and is not required]**. Those involving:
 - a. existing documents/data only;
 - b. the evaluation of an existing project with no direct contact with human participants;
 - c. service evaluations.
3. **You must submit this application from your Lancaster University email address, and copy your supervisor in to the email in which you submit this application**

Governance checklist

Introduction

Please complete all sections (1 to 4) below. If none of the self-assessment items apply to the project then you do not need to complete any additional LU ethics forms.

Further information is available from the [FREC webpage](#)

Note: The appropriate ethics forms must be submitted and authorised to ensure that the project is covered by the university insurance policy and complies with the terms of the funding bodies.

Name: Rosie Wheeler

Department: Doctorate in Clinical Psychology / Division of Health Research

Title of Project: How do qualified clinical psychologists use reflection in their practice? **Supervisor** (if applicable): Dr Pete Greasley

Section 1A: Self-assessment

1.1 Does your research project involve any of the following?

- a. Human participants (including all types of interviews, questionnaires, focus groups, records relating to humans, use of internet or other secondary data, observation etc)
- b. Animals - the term animals shall be taken to include any non-human vertebrates or cephalopods.
- c. Risk to members of the research team e.g. lone working, travel to areas where researchers may be at risk, risk of emotional distress
- d. Human cells or tissues other than those established in laboratory cultures
- e. Risk to the environment
- f. Conflict of interest
- g. Research or a funding source that could be considered controversial
- h. Any other ethical considerations

Yes - complete Section 1B

No - proceed to Section 2

Section 1B: Ethical review

If your research involves any of the items listed in section 1A further ethical review will be required. Please use this section to provide further information on the ethical considerations involved and the ethics committee that will review the research.

Please remember to allow sufficient time for the review process if it is awarded. The ethical review process can accommodate phased applications, multiple applications and generic applications (e.g. for a suite of projects), where appropriate; the [Research Ethics Officer](#) will advise on the most suitable method according to the specific circumstances.

ETHICS SECTION

1.2 Please indicate which item(s) listed in section 1A apply to this project (use the appropriate letter(s), eg a,c,f)

Items: a

1.3 Please indicate which committee you anticipate submitting the application to:

- NHS ethics committee
- Other external committee
- LU FASS/LUMS Research Ethics committee
- LU FST Research Ethics committee
- LU FHM Research Ethics committee
- LU AWERB (animals)

Section 2: Project Information

This information in this section is required by the Research Support Office (RSO) to expedite your proposal.

2.1 If the establishment of a research ethics committee is required as part of your collaboration, please indicate below. (This is a requirement for some large-scale European Commission funded projects, for example.)

- Establishment of a research ethics committee required

2.2 If the research involves either the nuclear industry or an aircraft or the aircraft industry (other than for transport), please provide details below. This information is required by the university insurers.

Click here to enter text.

Section 3: Guidance

The following information is intended as a prompt and to provide guidance on where to find further information. Where appropriate consider addressing these points in the proposal.

- If relevant, guidance on data protection issues can be obtained from the Data Protection Officer - see [Data Protection website](#)
- If relevant, guidance on the Freedom of Information Act can be obtained from the FOI Officer - see [FOI website](#)
- The University's Research Data Policy can be downloaded [here](#)
- The health and safety requirements of each research project must be considered, further information is available from the [Safety Office website](#)
- If any of the research team will be working with an NHS Trust, consider who will be named as the Sponsor (if applicable) and seek agreement in principle. Contact the [Research Ethics Officer](#) for further information
- If you are involved in any other activities that may result in a conflict of interest with this research, please contact the [Head of Research Services](#) (ext. 94905)

ETHICS SECTION

- If any of the intellectual property to be used in the research belongs to a third party (e.g. the funder of previous work you have conducted in this field), please contact the [Intellectual Property Development Manager](#) (ext. 93298)
- If you intend to make a prototype or file a patent application on an invention that relates in some way to the area of research in this proposal, please contact the [Intellectual Property Development Manager](#) (ext. 93298)
- If your work involves animals you will need authorisation from the University Secretary and may need to submit an application to AWERB, please contact the [University Secretary](#) for further details
- Online Research Integrity training is available for staff and students [here](#) along with a Research Integrity self-assessment exercise.

3.1 I confirm that I have noted the information provided in section 3 above and will act on those items which are relevant to my project.

Confirmed

Section 4: Statement

4.2 I understand that as researcher I have overall responsibility for the ethical management of the project and confirm the following:

- I have read the Code of Practice, [Research Ethics at Lancaster: a code of practice](#) and I am willing to abide by it in relation to the current proposal
- I have completed the [ISS Information Security training](#) and passed the assessment
- I will manage the project in an ethically appropriate manner according to: (a) the subject matter involved; (b) the code of practice of any relevant funding body; and (c) the Code of Practice and Procedures of the university.
- On behalf of the institution I accept responsibility for the project in relation to promoting good research practice and the prevention of misconduct (including plagiarism and fabrication or misrepresentation of results).
- On behalf of the institution I accept responsibility for the project in relation to the observance of the rules for the exploitation of intellectual property.
- I will give all staff and students involved in the project guidance on the good practice and ethical standards expected in the project in accordance with the university Code of Practice. (Online Research Integrity training is available for staff and students [here](#).)
- I will take steps to ensure that no students or staff involved in the project will be exposed to inappropriate situations.

Confirmed

Please note: If you are not able to confirm the statement above please contact [Faculty Research Ethics Officer](#) and provide an explanation

Applicant Name: Rosie Wheeler


Date: 19/05/20 Signature:



***Supervisor (if applicable):**

Name: Pete Greasley

Date: 19/05/20 Signature:



ETHICS SECTION

**I declare that I have reviewed this application, and discussed it with the applicant as appropriate. I am happy for this application to proceed to ethical review.*

Head of Department

(or delegated representative)

[Redacted area]

Name: Bill Sellwood

Date: 20/5/20

Signature:



Please return this form to your Faculty Research Ethics Officer

**How do Qualified Clinical Psychologists use Reflection in their Practice?
Research Protocol**

Applicants

Rosie Wheeler

Trainee Clinical Psychologist, Doctorate in Clinical Psychology, Lancaster University,
Lancaster, LA1 4YT

Tel: 07703 013338 email: r.wheeler6@lancaster.ac.uk

Principle Investigator

Dr Pete Greasley

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Supervisor

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Clinical Tutor, Doctorate in Clinical Psychology, Lancaster University, Lancaster, LA1
4YT

Tel: +44 (0)1524 592974 email: a.duxbury@lancaster.ac.uk

Introduction

The introduction will firstly introduce and define the concept of reflection, and how and why reflection is considered an important tool for those working as clinical psychologists. It then goes on to summarise the existing literature into the use of reflection by clinical psychologists, focusing on what reflection supports clinicians to achieve in their work. Lastly, gaps in understanding of the use of reflection by clinical psychologists will be identified.

Reflection as a form of problem solving has been written about for many years (Dewey, 1993) and has been described as the “thought process where individuals consider their experiences to gain insights about their whole practice. Reflection supports individuals to continually improve the way they work” (Health & Care Professions Council, 2019). The benefits of using reflection are widely acknowledged, including increased self-awareness, supporting the evaluation of actions taken and the examination of feelings and knowledge (Morgan, 2009). Reflection has long been considered important within the professions of teaching and medicine (Hatton & Smith, 1995; Ménard & Ratnapalan, 2013).

Reflective practice is the act of using reflection to inform behaviour; “a mode that integrates or links thought and action with reflection. It involves thinking about and critically analysing one’s actions with the end goal of improving one’s professional practice” (Imel, 1992). The terms reflection and reflective practice are often used interchangeably, given that the difference between thinking about one’s past experiences (reflection) and using these thoughts to inform future behaviour (reflective practice) are difficult to disentangle. Therefore this protocol will use the word reflection to encompass both thoughts about past experiences, and reflective practice.

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Another distinction made in this area is between reflection-in-action and reflection-on-action. Reflection-in-action involves using reflection to make decisions in the moment, whereas reflection-on-action takes place when looking back on behaviour to analyse and learn from it (Schön, 1938). Reflection-in-action is thought to be a more challenging exercise, and a skill that is developed by practitioners over time (Burgess et al., 2013).

Using reflection is considered a central aspect of clinical psychology (British Psychological Society, 2017), it is an essential component for professional registration for clinical psychologists and considered to be a “continuous and routine part of the work of health and care professionals” (Health & Care Professions Council, 2019). The British Psychological Society (BPS) state that the benefits of reflection include an increased awareness for the practitioner psychologist of the influence of internal and external factors on their work, including an individual’s cognitive biases, their prior experiences and the political environment within which they operate. Reflection also serves to support practitioner psychologists to develop an understanding of the learning taken from professional development tasks, as a way to learn lessons from conflict with clients, and is seen as an essential element of supervision (BPS, 2017).

Although reflection is considered important, issues around definition (Mann et al., 2009) and a focus on trainees as participants (Burgess et al., 2013) has resulted in a lack of research involving qualified clinical psychologists. This is particularly noteworthy as there is evidence that there is a significant difference in the quality of some aspects of reflection between novice and experienced therapists (Williams et al., 2003). Clinical psychology has been accused of being slow to recognise the importance of reflection, focusing instead on the “measurable” concepts prioritised by behaviourism (Bennett-Levy, 2003). Research that has been conducted within the

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area of psychology has tended to focus on whether clinicians find reflection useful rather than what processes are involved in reflection or what they use it for (Carmichael, 2018).

To date, three studies have investigated the use of reflection by qualified clinical psychologists; two within the United Kingdom (UK) (Carmichael, 2018; Kiemle, 2008) and one in Singapore (Fisher et al., 2015). All these studies used an Interpretative phenomenological analysis (IPA) approach. IPA is a qualitative research approach aiming to investigate how a particular person, in a particular context makes sense of a particular experience. As such it generates an idiographic account of an individual's experience (Smith & Shinebourne, 2012).

All three studies found that clinical psychologists use reflection to manage their emotions, to understand how they are impacting on their clients and to develop a deeper understanding of their clients (Ferreira et al., 2017). Participants within Carmichael's (2018) study reported that reflection allowed them to feel more contained regarding their own emotions, which in turn allowed them to feel more prepared to support their client. This finding is in line with other research that finds that the negative impact of therapists' anxiety can be negated by ongoing introspection (Shamoon et al., 2017).

Kiemle (2008) and Carmichael et al (2018) found that reflection helped clinical psychologists to become more comfortable with uncertainty, with some participants reporting that reflection has allowed them to view uncertainty as an opportunity within their clinical work. Where the studies investigated how individuals relate to the concept of reflection, they had opposing findings. Kiemle (2008) concluded that reflection is strongly linked to personal identity, where reflection is seen as part of the individual

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regardless of context, whereas Fisher et al (2015) reported that using reflection is considered to be part of clinical psychologists' professional identities.

Two of these studies found that the therapeutic orientation of the clinical psychologist was related to their use of reflection. Kiemle (2008) found that clinical psychologists who practiced in a psychodynamically-informed way were more likely to cite in the moment reflection (in contrast to reflection after the event) when they were asked about reflection in general. This is possibly linked to the importance placed on in the moment occurrences such as transference and countertransference in psychodynamic therapy (Kudler et al., 2000). Carmichael's (2018) study using IPA to focus on individual experiences of using reflection found that a participant's interest in Acceptance and Commitment Therapy (ACT) and its concept of the "observing self", a technique used to help individuals take a more objective view of their behaviour (Harris, 2006), was related to the way in which she used reflection as a way to take a step back from her thoughts.

A divide between areas in which clinical psychologists worked was also noted within Kiemle's (2008) research, where those who worked in areas where there was more indirect work (child and family and learning disability) were more likely to proactively talk about reflections on how they affect others. Those who worked psychodynamically or had experience of personal therapy for themselves were more likely to mention reflections about themselves, and their personal reactions to their work.

Research focusing on the in the moment reflections of family therapists in therapy sessions (Rober et al., 2008a) found that these reflections could be categorised into serving four purposes: 1. focusing on the clients' personal process; 2. the therapist

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processing the client's story; 3. the therapist focusing on their own experience; and 4. managing the therapeutic process. It is not currently clear if these uses of reflection are unique to family therapy or are used more widely amongst those who work therapeutically with clients.

Although there is an understanding of the importance of reflection, there has been little research into *how* qualified clinical psychologists use reflection within their work. Studies that have been conducted in the UK have used IPA to analyse the findings meaning the particular participant's experience is prioritised and may not be representative of other clinical psychologists more widely. These studies have found some evidence that suggests the area which the participant works in and the therapeutic approach they tend to use may impact on the use of reflection, but this has not yet been the focus of any study.

Aims

The aim of this study is to investigate the process of how clinical psychologists use reflection in their practice. In particular:

- How are clinical psychologists using reflection?
- What does it help them to achieve?
- What factors influence the use of reflection?

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Method

Design

A qualitative method will be used in order to generate rich data regarding the participants' experiences of using reflection in their clinical practice (Flick, 2018). Due to the lack of research in the area, a grounded theory informed method (Charmaz, 2006), will be used for collecting and analysing data. Grounded theory methods aim to develop theories which are grounded in the data, by using a cyclical process of data collection, analysis and theoretical categorisation (Flick, 2018). This allows for adaptation of the interview questions as areas of interest begin to emerge, and theoretical sampling; using the data collected and themes developed to inform the selection of participants. Grounded theory will allow for the development of a model to explain the processes involved when clinical psychologists use reflection. This will follow on from previous studies that have used an IPA approach. This research will use a social constructionist approach to grounded theory which acknowledges the researcher's role and influence over the process and findings of the study (Charmaz, 2006).

Participants

Participants will be qualified clinical psychologists, working in the UK. Participants will be English speaking as funding for an interpreter is not available. No specified duration of post-qualification experience will be required because how reflection is understood at different experience levels may be a component of the process that is interesting to explore (Burgess et al., 2013). The total number of participants will be dependent on "theoretical sufficiency" (Vasileiou et al., 2018). Theoretical sufficiency means that once existing categories do not require revision or alteration in respect of new data

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then no new participants need to be recruited. The researcher anticipates that this will be attained through 10 to 20 participants. Purposive sampling will be used to select who takes part in the study. This means that participants included in the study will be selected by the researcher, based upon a variety of criteria. For this study that may include time in the job role, therapeutic orientation, the service context they work in. This will allow the researcher to make decisions about the individual participants who would be most likely to contribute to the developing model in line with theoretical sufficiency. Participants will be asked to take part in one interview (see procedure section), with the option of interviewing a participant for a second time if emerging themes within the data suggest this would be of benefit (Charmaz, 2006).

Procedure

Recruitment

As stated above, recruitment will use purposeful sampling. This will mean that the researcher will make decisions on who is recruited into the study based on a variety of factors, in line with grounded theory methodology. In order to achieve this, participants will be asked to complete a demographic data form (appendix A) which asks participants to provide information regarding their current role, preferred therapeutic approaches and how long they have been practicing, alongside basic demographic data. These forms will be used to inform which participants are interviewed, and in what order. It is possible that the demographic data forms may have to be amended if themes emerge from the data that have not been predicted. If this is the case, amendments will be focused on the individual's professional life, and therefore unlikely to be of a sensitive nature.

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To support this purposeful sampling approach, the wording alongside advertising posts will be amended. For example, the post (see next paragraph) could specify that individuals working within a certain area or using a particular theoretical model are required. Participants will be asked if they are willing to forward the advertising flyer for the study on to individuals that they think might be interested in participating.

The study will be advertised within “UK based Clinical Psychology” from Facebook, a private specialist group containing 5690 clinical psychologists who qualified in the UK. The advertising flyer (appendix B) will be posted by the lead researcher, from a profile created using their Lancaster University email. Twitter will also be utilised for recruitment. A professional Twitter account (handle @RosiePsychology) will advertise the research, using the advertising flyer. Posts will be worded “Are you a qualified Clinical Psychologist working in the UK? Rosie (Trainee Clinical Psychologist) is looking for English-speaking participants to talk via phone or video call about your experiences of using reflection within your work. Please see advertisement for contact details.” As stated above the wording may subsequently change in line with purposive sampling e.g. “Are you a qualified clinical psychologist working with children in the UK? Rosie (Trainee Clinical Psychologist) is looking for English-speaking participants to talk via phone or video call about your experiences of using reflection within your work”. The researcher will ask other relevant Twitter pages to “retweet” their advert. For example, the Lancaster Doctorate in Clinical Psychology Twitter account (Twitter handle @LancsDClinPsy). When potential participants make contact, they will be sent a copy of the participant information sheet (appendix C), consent form (appendix D) and a demographic data form (appendix A). After 48 hours potential participants will be contacted to ask if they agree to take part. The researcher will also answer any

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questions about the study that the potential participant may have. If potential participants agree to take part, they will be asked to return a completed copy of the consent and demographic data form via email. They will be reminded that they may be asked to take part in the study immediately, may be contacted at a later date to interview, or may not be included in the study at all. The demographic data form will be reviewed, and the participant will be contacted, and an interview time arranged if it is thought that an interview with that participant would add to the development of the model at that time. If an interview is not arranged immediately, the individual's details will be stored on the researcher's One Drive, with the option of contacting that individual at a later date if this would add to the development of the model. Participants who are not interviewed will be informed at the end of the data collection period that they were not required. Interviews will be conducted via video and telephone to limit barriers (such as location and social distancing) to participation. For video calls either Skype or Microsoft teams will be used, depending on which platform participants have access to. Where possible Microsoft Teams will be utilised as it uses end to end encryption. Participants will be made aware that conversations over other platforms cannot be guaranteed to be secure. Consent forms will be saved to the lead researcher's OneDrive and deleted from the email account. All participants will be allocated a participant number which will be used in place of a name on all documentation with the exception of the consent form.

Demographic Information

Demographic information will be a requirement for taking part in the study and so all participants will need to consent to this within the procedures outlined above. A table of demographic information will be included within the final research paper to provide

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context for the sample. This is in line with the Grounded Theory approach. The demographic data form (appendix A) includes questions regarding:

- Length of time in job
- Therapeutic orientation
- Gender
- Ethnicity
- Area of work

These questions have been developed using existing research (Carmichael, 2018; Kiemle, 2008) and it is likely that additional questions will not need to be added. However, there is a possibility that as themes begin to develop, the demographic data form will need to be amended to include other questions focused on the individual's work.

Conducting Interviews and Transcription

The researcher will use the interview topic guide (appendix E) to inform the interview, although this will be used flexibly, with prompts and probes being used where necessary. All interviews will start with the researcher introducing themselves and then reading through the first paragraph of the interview topic guide (appendix E), which will introduce the study, state that interviews are likely to last around 60 minutes, and that they are welcome to ask for a break as and when needed, and they are able to stop the interview at any point, for any reason. Then the researcher will read through the 12 points on the consent form, confirm that the participant consents to the interview taking place and then start the recording. The researcher will conduct the interviews

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from a private room at their home address. At the end of each interview the researcher will enquire about the participants' wellbeing, and the debrief sheet (appendix F) will be sent to the participant via email. If participants are distressed, they will be signposted to the support systems detailed on the debrief sheet.

Interviews will be audio recorded using a digital recording device provided via the Lancaster Doctorate in Clinical Psychology and will be uploaded to the university virtual private network (VPN) immediately after the interview takes place. Once uploaded the recording will be immediately deleted from the audio recorder. Transcription will be completed by the researcher on a password protected word document, and information will be anonymised at the point of transcription, including third party information.

Analysis

Transcripts will be printed and stored in a locked storage unit at the researcher's home address. Transcripts will be analysed using Charmaz's (2006) grounded theory methods, which use a social constructionist approach. This approach acknowledges the researchers' influence over the study and posits that the researcher uses data to construct theory, taking an active role in creating the findings, not simply uncovering "truths" within the world (Charmaz, 2006). Grounded theory methods use data collection, codes, memos and themes in a dynamic, cyclical way, with each informing the other. Coding the data involves studying the data very closely, to begin developing, sorting and synthesising ideas. These codes are then analysed and developed into memos, which allow for comparison of the data and provide direction about further

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data gathering. The relationships between these memos are then investigated to develop themes which are brought together to form a model.

Practical considerations

Audio-recording equipment, printing and photocopying costs will be provided by Lancaster University.

Ethical considerations

Data protection

Recordings of interviews will be transferred and stored on the university VPN at the earliest possible opportunity. All paper-based participant information (i.e. printed transcripts) will have no personal participant information on them and will be stored in a locked filing cabinet to which only the researcher has access. They will be destroyed once all data have been analysed. Electronic information (consent, screening, demographic data forms and transcripts) will be deleted from email and stored on the lead researchers OneDrive until examination of the thesis. Any personal identifying document (i.e. consent form) will be saved separately from recordings and the transcript. Once the thesis has been examined all electronic data securely sent to the research custodian in the Division of Clinical Psychology, who will be responsible for the deletion of this data once 10 years has elapsed. Participants will be asked not to share any client or colleague details during interviews, but should confidential data be mentioned, this will be removed at the point of transcription. Audio data and printed copies of transcripts will be deleted once the thesis has been examined.

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Risk to participants

Risks for participants taking part in this study will be minimal, as discussions will be focused on reflection, which is highly likely to be an everyday part of their job. However, participants will be discussing their beliefs and experiences and therefore it is possible that participants may experience distress. Therefore, an appropriate level of support will be offered to participants, including a debrief at the end of the interview when required, and a debrief sheet (appendix F) detailing useful contacts that could be utilised for support.

There is the potential for poor practice to be highlighted during interviews, and safeguarding concerns may arise. Should this occur the researcher will discuss with the research supervisors, and the appropriate action, in line with the Health and Care Professionals Council (HCPC) advice will be taken.

Participants will be expected to give up around an hour of their time to complete an interview, as is made clear in the advertising flyer (appendix B).

Participants will be welcome to withdraw from the study at any time before or during the interview and up to 2 weeks following their interview. This is because after 2 weeks, transcripts will have been analysed and themes already incorporated into the developing model.

Risk to researchers

Researchers are unlikely to encounter any risk above and beyond what they would usually come across in their work.

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Timescale

May2020	Submission of ethics
July 2020	Begin recruiting and interviewing participants, with concurrent analysis
August / September 2020	complete first stage of interviews, transcribe and analyse data
October / November 2020	complete second round of interviews, transcribe and analyse data
December / January 2020	if necessary complete third round of interviews, transcribe and analyse data
December 2020 - March 2021	Write results and submit piece of research

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Appendix 4 -A

Demographic Data Form

V 1.0 Date 14/05/20

Demographic Data Form

Please complete this form and return to the lead researcher along with the consent form.

Gender.....

Ethnicity.....

How long have you been practicing as a qualified clinical psychologist?

.....

What is/are your preferred therapeutic orientation(s) (e.g., cognitive behavioural therapy, narrative therapy etc)?

.....

.....

.....

Which area(s) do you currently work in (e.g., learning disabilities, child and adolescent mental health etc)?

.....

.....

.....

Appendix 4-B

Advertising Flyer

V 1.0 Date: 14/05/20

Clinical Psychologists: We are interested in your experiences of using reflection

Research participants needed

Who is eligible to take part?

- Clinical Psychologists
- Working therapeutically in the UK

What is the research about?

The research is investigating qualified clinical psychologist's use of reflection in their work, including how they use it and what it helps them to achieve. There will be a particular focus on what factors influence the process of reflection.

What will it involve?

Participants will be asked to take part in an interview about their use of reflection for around an hour. This interview will be conducted via telephone or online video call.

If you are interested, please contact Rosie Wheeler (Trainee Clinical Psychologist at r.wheeler6@lancaster.ac.uk, on XXXXXXXXXX or on Twitter [@RosiePsychology](https://twitter.com/RosiePsychology)

Appendix 4-C

Participant Information Sheet

V 1.0 Date: 14/05/20

Participant Information Sheet

How do Qualified Clinical Psychologists use Reflection in their Practice?

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection

My name is Rosie Wheeler and I am conducting this research as a Trainee Clinical Psychologist in the Doctorate of Clinical Psychology programme at Lancaster University, Lancaster, United Kingdom.

What is the study about?

The purpose of this study is to investigate how qualified clinical psychologists use reflection in their practice. I am particularly interested in how you use reflection and what you think reflection helps you to achieve. I am also investigating what factors influence the use of reflection, for example the field in which you practice, or the therapeutic model(s) that you use.

Why have I been approached?

You have been approached because the study requires information from people who are qualified clinical psychologists, working in the UK.

Will I be asked to take part?

As this research will investigate different factors influencing reflection it is possible that you will not be asked to take part. If you return the consent form, but you are not required to take part you will be informed of this at the end of the data collection period, which is likely to be in November 2020.

Do I have to take part?

No. It's completely up to you to decide whether or not you take part.

What if I change my mind?

If you decide to take part and then feel that you do not want to continue, you have the right to withdraw at any point before or during the interview. You will have up to two weeks after your interview to withdraw your participation in this study, as after this time your responses will be integrated with other data. If you decide to withdraw within this time scale any information you have provided will be destroyed.

What will I be asked to do if I take part?

If you decide you would like to take part, you would be asked to take part in an interview with myself via an online video call or by phone. The interview will focus on your experiences of using reflection in your clinical practice. It is envisaged that the interview will last for about an hour. It is possible that after this interview takes place I may contact you to ask if you would be willing to take part in a second interview, based on themes that have emerged from the previous interviews.

Will my data be identifiable?

The data collected for this study will be stored securely in university approved secure cloud storage and only myself and my supervisors will have access to this data:

- Audio recordings will be destroyed and/or deleted once the project has been examined, although the files will be transcribed into an anonymised electronic form
- Hard copies of documents will be kept in a locked cabinet.
- The files on the computer will be encrypted (that is no-one other than the researcher will be able to access them) and the computer itself password protected. All files will be deleted once the thesis has been examined.
- The electronic transcript of your interview will be made anonymous by removing any identifying information including your name. Anonymised direct quotations from your interview may be used in the reports or publications from the study, so your name will not be attached to them. All reasonable steps will be taken to protect the anonymity of the participants involved in this project.
- All your personal data will be confidential and will be kept separately from your interview responses.
- Transcribed data will be kept in password protected secure Lancaster University data storage for 10 years in line with the university's data policy.

There are some limits to confidentiality: if what is said in the interview makes me think that you, or someone else, is at significant risk of harm, I will have to break confidentiality and speak to a member of staff about this. If possible, I will tell you if I have to do this. Additionally, if the interview is conducted online or over the telephone, I cannot guarantee that these channels will be secure.

What will happen to the results?

The results will be summarised and reported in a thesis and may be submitted for publication in an academic or professional journal. You will be asked if you would like to receive a summary of the results.

Are there any risks?

There are no risks anticipated with participating in this study. However, if you experience any distress following participation you are encouraged to let me know. I will provide you with a debrief sheet including contact details for support resources.

Are there any benefits to taking part?

ETHICS SECTION

Although you may find participating interesting, there are no direct benefits in taking part, although you will help to develop our understanding of the use of reflection by clinical psychologists.

Who has reviewed the project?

This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

Where can I obtain further information about the study if I need it?

If you have any questions about the study, please contact the Principle Investigator:

Principle Investigator: Rosie Wheeler

Email: r.wheeler6@lancaster.ac.uk Phone number:

Chief Investigator: Dr Pete Greasley, Teaching Fellow, Doctorate in Clinical Psychology, Lancaster University, Lancaster, LA1 4YT

Email: p.greasley@lancaster.ac.uk Phone number: +44 (0)1524 593535

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Dr Ian Smith
Research Director
Health Research Division,
Faculty of Health and Medicine
Lancaster University
Lancaster
LA1 4YG

01524 592 282

i.smith@lancaster.ac.uk

If you wish to speak to someone outside of the Lancaster Doctorate Programme, you may also contact:

ETHICS SECTION

Professor Roger Pickup Tel: +44 (0)1524 593746
Associate Dean for Research Email: r.pickup@lancaster.ac.uk
Faculty of Health and Medicine
(Division of Biomedical and Life Sciences)
Lancaster University
Lancaster
LA1 4YG

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

Appendix 4-D

Consent Form

V 1.0 Date: 14/05/20

Consent Form

Study Title: How do Qualified Clinical Psychologists use Reflection in their Practice?

We are asking if you would like to take part in a research project looking at how clinical psychologists use reflection in their practice.

Before you consent to participating in the study, we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the principal investigator, Rosie Wheeler.

Please initial each box

- 1 I confirm that I have read the information sheet and fully understand what is expected of me within this study
- 2 I understand that returning this form does not guarantee that I will be asked to participate in an interview
- 3 I understand that my interview will be audio recorded and then made into an anonymised written transcript.
- 4 I understand that audio recordings will be kept until the research project has been examined.
- 5 I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.
- 6 I understand that I have **two weeks from my interview date to withdraw from the study**. After that date, the researcher will make their best efforts to remove the data, but this cannot be guaranteed.
- 7 I understand that the information from my interview will be pooled with other participants' responses, anonymised and may be published; all reasonable steps will be taken to protect the anonymity of the participants involved in this project.
- 8 I consent to information and quotations from my interview being used in reports, conferences and training events.
- 9 I understand that the researcher will discuss data with their supervisors as needed.
- 10 I understand that any information I give will remain confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the principal investigator will need to share this information with their research supervisors.
- 11 I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has finished.
- 12 I consent to take part in the above study.

ETHICS SECTION

Name of Participant.....

Signature..... Date.....

Name of Researcher.....

Signature..... Date.....

Appendix 4-E

Interview Topic Guide

V 1.0 Date: 14/05/20

Interview Topic Guide

This study is investigating the use of reflection by qualified clinical psychologists. The interview will focus on your use of reflection (however you personally define this) within any of your practice. The interview is likely to last around 60 minutes, and you are welcome to ask for a break as and when you need one. You are welcome to stop the interview at any point, for any reason. Wherever possible, please avoid using identifiable information such as colleagues or service names, but please be reassured that if you do, these will be removed at the point of transcription. Before we start, do you have questions?

1. In what circumstances are you likely to engage in reflection?
2. What do you think are the benefits of engaging in reflection?
3. What supports your use of reflection?
4. What prevents you from engaging in reflection?
5. How does the speciality you work in impact on your use of reflection?
6. How does your therapeutic orientation impact on your use of reflection?
7. Are there other factors which influence your use of reflection?

Appendix 4-F

Debrief Sheet

V 1.0 Date: 14/05/20

Debrief Sheet

Study Title: How do Qualified Clinical Psychologists use Reflection in their Practice?

Thank you for taking part in this study which is investigating the ways that Clinical Psychologists use reflection and how it informs their work. Once all interviews have been conducted the data will be analysed and submitted as part of a doctoral thesis, in partial fulfilment for a doctorate in clinical psychology. If you have questions regarding the study, please contact Rosie Wheeler (r.wheeler6@lancaster.ac.uk or XXXXXXXXXXXXX)

If the interview has raised difficult feelings for you and you wish to seek support to below organisations will be able to help you with this. Or you may wish to speak to your clinical supervisor or GP.

Mind – Mental Health Charity

Mind.org.uk

info@mind.org.uk

0300 123 3393

Mind Infoline, PO Box 75225, London, E15 9FS

NHS Services

www.nhs.uk

Tel: 111

Samaritans

samaritans.org

jo@samaritans.org

116 123

Appendix 4-G

Ethical Approval



Applicant: Rosie Wheeler
Supervisor: Pete Greasley, Anna
Duxbury Department: DHR Clinical
Psychology FHMREC Reference:
FHMREC19103

18 June 2020

Re: FHMREC19103

How do Qualified Clinical Psychologists use Reflective Practice in their Practice

Dear,

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for the amendment to this research project.

As principal investigator your responsibilities include:

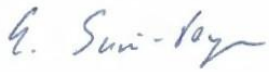
- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further

information. Email:- fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

ETHICS SECTION

A handwritten signature in blue ink, reading "E. Suri-Payer". The signature is written in a cursive style with a large initial "E".

Dr. Elisabeth Suri-Payer,
Interim Research Ethics Officer, Secretary to FHMREC.