# Trainees' reflections on developing personal and professional skills through managing risk

**Kate Ward**

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Supervisor:
Dr Jennifer Moses

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# Abstract

The development of competency in personal and professional skills and values is likely to increase in importance as Clinical Psychologists in-training take on leadership and consultancy roles and work with greater complexity on qualification. However, the literature on *how* this competency develops and what helps and hinders this within Clinical Psychology training programmes is very limited. An understanding of the experience of Clinical Psychologists' in-training development of this competency is important to inform teaching and supervisory practice and to promote development of self awareness, professional effectiveness and resilience. Given the lack of literature and the exploratory nature of the research question, a qualitative approach was undertaken which explored Clinical Psychologists' in-training lived experience of developing personal and professional skills (PPD) through managing risk. A focus on such situations was chosen because managing risk is experienced by many trainees as taking them to the limits of their competence and to often demand interprofessional working. The research explored how the experience of managing such risks and complexity enhanced or diminished PPD learning. A systematic review of the extant literature was conducted and semi-structured qualitative interviews were pursued with ten Clinical Psychologists' in-training across the UK, from a range of doctoral training programmes. An interpretative phenomenological approach was employed to analyse participants' accounts. Four themes which interlinked to form a learning cycle: 'event perception', 'managing the professional self', 'reflective practice' and 'identity'. The emergent themes were interpreted with reference to the literature on PPD in broader populations of health professionals. The findings have a range of implications for training programmes, supervisors, trainees, and for the British Psychological Society/The Committee of Training in Clinical Psychology accreditation criteria which is currently being revised. Implications of the findings for risk management in clinical practice and recommendations for future research are also presented.

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# Chapter 1: Introduction

## 1.1. Overview

The focus of this study is to understand clinical psychologists' in-training (CPITs')[1] reflections on their personal and professional development (PPD) through their clinical experiences of managing risk. Clinical experiences may in themselves be challenging (Bischoff *et al.*, 2002) but risk management is a potentially potent example and opportunity to explore CPITs' PPD, whilst working at the limits of their competence. In this chapter, the broad systemic context in which CPITs are situated and its implications for PPD is discussed. An overview of the relevant literature on PPD, perceived competency development and key models of learning follow. Finally, a systematic review of the nearest literature and the rationale for this study will be presented.

## 1.1 The changing NHS context and implications for PPD of Clinical Psychologists (CPs)

This section will refer to the UK context, and will note particular differences in NHS Wales.

### 1.2.1 CPs and the NHS

Although there are increasing employers of CPs outside the NHS, for example charities (Hall & Llewelyn, 2006) and in the private sector (predominantly UK), the profession of clinical psychology is still strongly embedded and influenced by the structures governing the NHS (Cheshire & Pilgrim, 2004; Wright, 2012). The prevailing government policies consequently exert a considerable influence on the role of CPs and the requirements of clinical psychology training courses. The Welsh context has been different historically and NHS Wales has become more divergent from NHS England and Scotland in recent years in both policy and commissioning practice (Wright, 2012).

### 1.2.2 Economic and political context

Currently, the UK is in economic recession and considerable reductions have resulted in public sector spending. This has placed increased pressure on the need for CPs to demonstrate and evidence their worth, efficiency and efficacy.

[1] CPIT is used as an acronym to refer to the singular 'clinical psychologist in-training'

### 1.2.3 Relevant changes within NHS policy and legislation (UK)

The most relevant recent policies which have impacted upon the profession of clinical psychology and CPITs' role will be discussed.

Agenda for Change (DOH, 2004) introduced new pay and conditions of service for most NHS staff groups as specified by and operationalized in the Knowledge and Skills Framework (KSF). CP jobs, partly due to their requirement for doctoral level training, scored highly relative to other staff groups with whom CPs work (Wright, 2012). Given the current economic climate, Wright (2012) argued this has led to a closer scrutiny of CPs' role by service managers, to interrogate whether some aspects of their work can be fulfilled by lower paid staff groups. This may have influenced the CPs' role, and increased the level of responsibility expected.

In England, Improving Access to Psychological Services (IAPT) (DOH, 2007a) provided greater funding for psychological therapies and was welcomed by the British Psychological Society (BPS) (Kinderman and Tai, 2009). A significant budget was invested in training new psychological practitioners to be proficient in Cognitive Behavioural Therapy (CBT), initially to treat people with mild to moderate common mental health problems. These practitioners are generally paid at a lower banding than CPs. This initiative instigated many changes in psychological therapies service delivery, but most important in the context of this study's remit is its impact on the CP's role. This initiative has arguably more tightly aligned CPs' role with the most complex cases, with the implied need for high levels of psychotherapeutic competence and an advanced knowledge of risk formulation and management.

Further white papers, 'First class Service' (DOH, 1998) and 'The National Service Framework' (DOH, 1999) have heralded a requirement for life-long learning and reflective practice. Noted skill gaps influenced these requirements, one of which was risk management (Shiekh *et al.,* 2007). 'Organising and Delivering Psychological Therapies' (DOH, 2004), a policy document written in response to these gaps, emphasised the need for systematic training. Reflective practice has been enforced as a critical skill and process for professionals, signified by its role as one of the ten shared essential capabilities (DOH, 2004). Sheikh *et al*. (2007) state that PPD was instated in the training of CPs as a response to recommendations arising from these early policies and frameworks (BPS, 2001).

The cumulative impact of these changes may be an increase in expectations of competence in high level knowledge, skills and values at the point of qualification for CPITs with the implied increased importance of competence in PPD.

### 1.2.4 Welsh context – relevant policies.

The Welsh situation is different in a number of key ways. NHS Wales does not have the IAPT initiative but the 2010 Mental Health (Wales) Measure (WAG, 2011) brought in a number of changes which may affect CPs, most notably the re-structuring of primary care and secondary care demarcation and service standards.

'Save 1000 Lives Plus' is a new national programme in the NHS in Wales aimed at improving patient safety and reducing risk of harm to patients, which has increasingly recognised the importance of extending this aim beyond physical health to mental health services. This programme has the potential to shift focus to risk management in mental health, which is arguably under-resourced. This shift reflects a wider social and political recognition of the economic costs to society of poor mental health and the costs of not addressing mental health issues, co-occurring with physical health conditions (e.g. NHS Confederation, 2012; The Kings Fund & Centre for Mental Health, 2012). It also fits with the NHS's equality and diversity aims (DOH, 2007b). The role of CPs in leading on and operationalizing this agenda is likely to be central, given their positioning in mental health services and banding within the NHS.

### 1.2.5 The role of CP

The changing role seems to be highlighted in a number of policy documents which originated at governmental level. Policies, such as New Horizons (DOH, 2010), Together for Health (Welsh Government, 2011b) and Psychological Therapies in Wales (Welsh Government, 2012), have led to re-organisation of service structures and staff roles. The BPS, the accrediting body for CP, has issued policy statements emphasising the need for CPs to work therapeutically with the most complex clients and in leadership roles within teams, combining supervision, consultancy and leadership (BPS, 2007a; BPS, 2007b; DCP, 2010).

> *Psychologists should seek to develop their role in contributing to the improved effectiveness of services through process consultancy at systems level, peer consultation and supervision, leadership…* (BPS, 2007a, p4)

#### 1.2.5.1. Core Competencies for CPITs

Competence has been defined as 'the ability to perform the activities of an occupation to the standards expected in employment' (University of Exeter, 2013, p1.) and 'the capacity and *tendency* (emphasis added) to engage in specified behaviours' (Baron & O'Reilly, 2012, p.41). The latter definition is important in the rationale of this study, in examining how competence is developed in clinical practice, which this author suggests is potentially different to ability or capacity.

The required professional competencies for CPITs are: Research, Psychological Assessment, Psychological Formulation, Psychological Intervention, Psychological Evaluation, Transferable Skills, Personal and Professional Skills and Values, Communication and Teaching and Service Delivery (BPS, 2010a). Doctoral training programmes in the UK aim to develop CPITs' competence within a context that facilitates personal and professional growth and fulfils the standards set by the regulatory body, the Health and Care Professional Council (HCPC) and the BPS. These competencies are under review by The Committee on Training in Clinical Psychology (CTCP) and a revised set of competencies (BPS, 2013a) are being proposed.

Some of the proposed changes reflect the role adjustments discussed. The competency entitled 'Service Delivery' is proposed to become 'Organisational and systemic influence and leadership' (BPS, 2013). This change also seems to reflect a greater shift in emphasis towards more active leadership and consultancy and influential roles across the range of organisational contexts in which it is envisaged CPs will work. For example, a new criteria has been added:

> *Indirect influence of service delivery including through consultancy, training and working effectively in multi-disciplinary and cross-professional teams. Bring psychological influence to bear in the service delivery of others*. (BPS, 2013, p.13)

A further point has been added to the existing criteria, which had been 'Understanding of leadership theories and models, and their application to service development and delivery.'

The addition is proposed as:

> *Demonstrating leadership qualities such as being aware of and working with interpersonal processes, proactivity, influencing the psychological mindedness of teams and organisations contributing to and fostering collaborative working practices within teams* (BPSa, 2013, p.13).

CPITs' views on these proposed accreditation standards were sought in a recent survey (Weiner and Mumford, 2013). A content analysis of the received responses suggested that some trainees felt that:

> *(*the) *skills frameworks needed updating to fully prepare newly qualified psychologists for work in the changing NHS environment. Trainees expressed a need for greater emphasis in 'higher' skills, such as management and leadership, consultancy and service and policy development*. (Weiner & Mumford, 2013, p.4)

PPD is arguably a key requirement to underpin and sustain fitness to practice in these demanding roles.

### 1.2.6. Learning outcomes for PPD competency

It is important to outline what the BPS's (2013) definitions of learning objectives for PPD are. These are reproduced below from the BPS/CTCP (2013) consultation document and the proposed changes have been underlined.

1. *Understanding of ethical issues and applying these in complex clinical contexts, ensuring that informed consent underpins all contact with clients and research participants*
2. *Appreciating the inherent power imbalance between practitioners and clients and how abuse of this can be minimised.*
3. *Understanding the impact of differences, diversity and social inequalities on people's lives, and their implications for working practices.*
4. *Understanding the impact of one's own value base upon clinical practice.*
5. *Working effectively at an appropriate level of autonomy, with awareness of the limits of own competence and accepting accountability to relevant professional and service managers.*
6. *Capacity to adapt to, and comply with the policies and practices of a host organisation with respect to time-keeping, record keeping, meeting deadlines, managing leave, health and safety and good working relations.*
7. *Managing own personal learning needs and developing strategies for meeting these. Using supervision to reflect on practice, and making appropriate use of feedback received.*
8. *Developing strategies to handle the emotional and physical impact of own practice and seeking appropriate support when necessary, with good awareness of boundary issues. Capacity to recognize when own fitness to practice is compromised and take steps to manage this risk appropriately.*

9. *Working collaboratively and constructively with fellow psychologists and other colleagues and users of services, respecting diverse viewpoints.*
   (BPS, 2013, p.12)

The BPS/CTCP 2013 Accreditation criteria also propose two relevant overall learning outcomes for CP Programmes: 'A professional and ethical value base, including that set out in the BPS Code of Ethics and Conduct, the DCP statement of the Core Purpose and Philosophy of the profession and the DCP Professional Practice Guidelines' and 'High level skills in managing a personal learning agenda and self-care, in critical reflection and self-awareness that enable transfer of knowledge and skills to new settings and problems and professional standards of behaviour as might be expected by the public, employers and colleagues' (BPS, 2013, p8). These are not specified as learning outcomes for PPD but both appear to map most closely to the 'PP skills and values' competence. The authors acknowledge that the current CTCP standards (criteria) for clinical training represent 'an evolution of such over a great many decades' (BPS, 2013, p4).

The author suggests that PPD competency is increasingly important given the high level skills required of CPITs and the necessary resilience required to work with the most complex cases either directly or indirectly.

### 1.2.7 The implications for CPITs and risk management

Risk management is a generic competence for mental health professionals (DOH, 2007c) and is increasingly under scrutiny at a national and service level. Risk management is potentially elevated in importance for CPITs on qualification, as they will increasingly be required to take on roles which demand leadership responsibilities and direct or indirect work with the most complex clients. Risk situations are inherently anxiety provoking and unpredictable and provide clinical situations in which a CPIT is likely to work at the limits of their competence. They require a sound base in personal and professional skills and values, and provide a potentially fertile ground to examine the perceived evolution of competence in PPD over the course of training.

### 1.2.8 Summary

It has been suggested that policy changes and structural changes within the NHS have impacted on CP and CPITs. CPITs will be increasingly required to take on leadership, consultancy, supervision roles and work with the most complex clinical cases on qualification. The author has argued that PPD is an essential competence in preparing CPITs for the demands of this role. Risk management has been highlighted as an area for improvement in mental health at policy level. Newly qualified CPs will increasingly take on leadership in these roles, and it has been suggested that learning to manage risk situations may involve CPITs working at the limits of their competence. It has been suggested that a CPITs' *ability* may be different to *actual practice.* It is proposed that examining competence development in risk management situations potentially provides a context to explore the development of competency in personal and professional skills and values.

## 1.2 Personal and professional development

PPD is not unique to CP and is widely adopted as a core competence for health professionals. As previously suggested, PPD's systematic integration into the curriculum and its statement in the learning objectives of Clinical Psychology training criteria (BPS, 2001) was partly a consequence of the DOH (1998;1999) White Papers' demands for more systematic training in life-long learning and reflective practice. The increasing role of reflectivity in CP practice, supplementing scientist-practitioner roles (Youngson, 2009; Scaife, 2010), was also influenced by the changing Zeitgeist. For instance, there was a shift in the dominance of positivism and the idea of truth in favour of multiplicity of perspectives and social constructionism (Cheshire & Pilgrim, 2004; Scaife, 2010).

### 1.3.1. Defining PPD

The learning objectives for PPD as defined by the BPS (2013) have already been outlined, but it is important to consider this competency's broader meaning. The literature on PPD suggests that it is unclearly defined.

Hughes (2009) noted how the terms 'personal development' and 'PPD' are often used interchangeably, sometimes describing different processes. Others (e.g. Donati & Watts, 2005; Sheikh *et al*., 2007) noted the inter-related nature of the personal and professional parts: 'that aspect of personal development that is about knowing yourself and understanding how your experience shapes your subsequent encounters with the world' (Sheikh *et al*., 2007,

p.279). Hughes & Youngson (2009) suggested that although personal and professional are inter-linked they can be conceptually separated. They suggested that the personal dimension consists of learning about the self and the impact of this on understanding and clinical practice and the professional dimension is learning that adds to psychological knowledge and skills. Gilmer and Marckus's (2003) definition related to PPD as a holistic concept. Their definition is more specifically related to the clinical psychology curriculum. They suggested it is 'that part of the curriculum that is dedicated to reflect critically and systematically on the work-self interface…fostering a personal awareness and resilience' (*ibid.*, p3.) In summary, most authors acknowledge that the two components are invariably interlinked and generally it is recognised that PPD is the interface of 'the self' and 'the professional' (Zhao-O'Brien, 2011).

There is also a lack of clarity over the term 'reflective practice' which is also used interchangeably with PPD at times. Shiekh *et al.* (2007) suggested that reflective practice and reflection are the main *methods* of PPD. Dewey's (1933) definition of reflection is often cited and seems helpful in defining reflective practice: 'the active, persistent and careful observation of any belief or supposed form of (*personal-professional)* knowledge in the light of the grounds that support and further conclusions to which it leads' (*ibid.*, p9, words in italic added. Cited in Sheik *et al.*, 2007). It seems useful to distinguish reflective practice from PPD and this view of it as a facilitating process seems appropriate.

### 1.3.2 The rationale for PPD as a competency

PPD is an essential requirement for regulation and accreditation (BPS, 2006; BPS, 2012), but it seems necessary to consider what underpins this requirement. PPD can be viewed as a foundation for Continuing Professional Development (CPD), which is a life-long learning requirement regulated by the HCPC and an essential aspect of clinical governance (BPS, 2010b). Gilmer and Marckus (2003) suggest that the *process* of PPD leads to three core benefits: increased self-awareness, increased resilience and enhanced practitioner reflectivity. These three areas will be discussed.

Self-awareness is important given CPITs' work with people and systems in distress and their need to develop strategies to manage these processes. These processes will both impact on the person and vice-versa. (Sheffield University Clinical Psychology Handbook, 2011). Increased self-awareness is suggested to have a number of positive implications. It can alert a

practitioner to the triggering of personal vulnerabilities in psychotherapeutic work, which may otherwise be inaccessible (Edelwich, 1982). An awareness of, and an ability to contain and use such feelings, may facilitate a richer understanding of a clients' difficulties and any blocks that might exist in the counter-transference to supporting them (Falendar & Shafranske, 2004; Lavender, 2003; Mearns & Thorne, 1988). An appreciation of this is important in direct and indirect work, such as supervision and consultancy, and potentially particularly so with more complex cases.

Resilience is an essential quality in order to enable the practitioner to work in the face of managing complex, highly emotional clinical situations through potentially enabling the transference of theory to practice (Stedmon *et al.*, 2003). One element of developing resilience can be the maintenance of appropriate boundaries, in order to 'gradually increase the ability to differentiate client and practitioner responsibilities and to relate in functional ways' (Rønnestad & Skovholt, 2003, p.48). Boundaries can help limit the flow of distressing emotional content of sessions into the developing practitioners' everyday life. Research has suggested that the nature of a clinician's emotional boundaries may affect practitioners' vulnerability to stress and burnout (Ackerley *et al.,* 1988; Rodolfa *et al.*, 1988).

Reflective practice connects the three core benefits, according to Bolton (2003), through its ability to increase self-awareness and facilitate outcomes essential to effective practice. These outcomes include enabling: a critical review of aspects of one's practice, critical awareness of relationships with colleagues, awareness and consideration of skills and knowledge gaps and acknowledgement of learning needs, management of stress through reflection on painful or difficult episodes, the distribution of experience and expertise to others and ultimately increased confidence in practice (*ibid*). Some of these outcomes highlight the potential benefits of PPD in working with teams and systems. The importance of this goal is underlined in the National Workforce Programmes, 'New Ways of Working' in mental health (Onyett, 2007).

Reflection, according to Schön (1987), is essential in facing new and complex situations and can enable the development of professional competence. For Schön (1987), professional competence may be defined by one's capability to manage ambiguity, to tolerate uncertainty and form and act on decisions in spite of incomplete information. This implicates the value of

reflection and PPD for newly qualified CPs and CPITs in managing risk and challenging clinical situations. It can potentially enable an awareness of one's limitations and to know the limits of competence. Reflection on clinical work may also, for example, enable trainees to move from an expectation of being an 'ideal' practitioner to a more realistic one (Rønnestad & Skovholt, 2003). Rønnestad & Skovholt (2003) suggested that novice therapists and counsellors have a notion of 'the ideal practitioner', which they believe can be achieved through observed improvements in clients' mental health. They suggested that a more realistic notion of the work develops over time with an increasing recognition of the role of the clients' motivation for change.

Whilst there are many cited benefits of reflective practice, other authors have highlighted the need to understand the processes involved better, to identify when reflection is a facilitator of learning and when it is less effective and akin to rumination (Ayduk & Kross, 2010; Bennett-Levy, 2003). Ayduk & Kross (2010) suggested that self-reflections on distress can sometimes make people feel worse and that individuals need to create a psychological distance from the self to enable adaptive self-reflection.

#### 1.3.2.1 PPD as challenging

Although PPD has many potential benefits, some aspects of its development can be challenging for CPITs. Zhao-O'Brien (2011) stated 'self-knowledge may provoke feelings of shame and inadequacy often making it a painful process, and understandably self-reflection is often feared and resisted' (p.46). PPD may also not be valued by all supervisors. CBT supervision, for example, is not historically associated with the emotional processing of trainees' reflections (Lombardo *et al.*, 2009). Additionally, time is a pressured commodity in clinical training and self- reflection may sometimes be overlooked.

#### 1.3.2.2. Stress amongst CPITs – a case for improved PPD

It has been suggested that PPD is an important competency with multiple benefits, such as increased resilience, improved self-care skills and effective management of learning needs. However, empirical evidence into stress amongst CPITs implicitly suggests that some may struggle with achieving competency in some aspects of PPD, notably resilience. Although there are undoubtedly multiple influences on stress, this finding may amongst other things, indicate a need for improvement and a better understanding of the impact of the PPD curriculum. Research amongst qualified CPs also reinforces the need for PPD, with a number

of studies suggesting up to 40% of CPs reporting caseness levels of psychological disturbance on the General Health Questionnaire (Cushway *et al.*, 1996; Hannigan *et al.*, 2004; Radeke & Mahoney, 2000).

There is empirical evidence that self-care and resilience can be severely challenged during training. A number of studies suggest that some CPITs experience considerable psychological distress during training (Brooks *et al.*, 2002, Cushway, 1992; Kuyken *et al.*, 1998). These studies vary in the proportion reporting distress from 8% to 75%. CPITs are not alone in this struggle, with similar issues reported in psychotherapeutic training literature, where trainees notably reported struggles with anxiety. (Duryee *et al*, 1996; Frielander *et al*., 1986; Skovholt & Rønnestad, 1992). This is also replicated in the training of other mental health practitioners (Burrows & McGrath, 2000; Edwards *et al*., 2002; Moore & Cooper, 1996). Hayes *et al.* (1991) suggested that critical to the effective development of trainees is the need to manage their anxiety and personal affect (*ibid.)*. Studies have also suggested that this anxiety reduces across training (Nutt-Williams *et al.*, 1996, Skovholt & Rønnestad, 1992). PPD is clearly important and the evidence suggests that its competence is greatly tested during training.

Without the self-care skills that effective PPD is purported to enable, some CPIT's overall learning could be affected due to the negative impact of 'stress' on the resources required for learning. Pakenham and Stafford Brown (2012) cited a number of studies which associate stress with negative performance of: declarative memory (Kirschbaum *et al.*, 1996); attention and concentration (Skosnik *et al*., 2000); decision making skills (Klein, 1996) and the clinicians' ability to form strong relationships with clients (Enochs & Etzbach, 2004). Other studies specifically examining the role of learning and its transfer to practice, suggest the importance of emotion in this process (Atkins, 2002; Colquitt *et al*., 1998; Lombardo *et al.*, 2009). Self-esteem issues, neuroticism and anxiety have been associated with style of learning. Watkins (2001) meta-analysis of factors associated with learning suggested that self-esteem issues are related to less deep and strategic approaches, although not a more surface approach.

Within the context of CP training, it is acknowledged that there are a number of intrinsic stressors that might affect PPD (Pakenham & Stafford Brown, 2012). Learning to manage these stressors potentially offers an opportunity and a challenge to the enhancement of PPD skills. It is important to understand what these stressors are and what helps trainees to overcome them. Previous studies which have explored resilience amongst trainees suggest

that reported distress and psychological adaptation are related to course-related *and* person-related factors (Brooks *et al.*, 2002; Kuyken *et al.*, 2000). The construct 'psychological adaptation' is suggested to have three components: morale (about self and life conditions); social functioning (social roles and interpersonal relationship satisfaction) and somatic health (the impact of coping style on physical health) (Brooks *et al.*, 2002). In Kuyken *et al.*'s (2003) study, trainees who appraised training demands as manageable reported greater access to appropriate support, less avoidant coping, fewer psychological adaptation issues and a greater propensity to use appropriate learning styles and show resilience. It seems important to consider the role of PPD in moderating these CPITs' experiences.

Research has shown that some CPITs experience considerable stress during training which can be associated with the development of low self-esteem, anxiety, depression and poor work adjustment. Stress, and its negative emotional sequelae, may also be related to the adoption of less deep and strategic learning styles and may impact on professional effectiveness. PPD is important in building resilience, and is at the same time challenged by dealing with some of the stressors, such as managing challenging clinical situations.

### 1.3.3 Methods of facilitating PPD during training

There is limited literature on the efficacy of different modes of facilitating PPD in clinical psychology training in the UK. It is important prior to reviewing the literature on efficacy, to outline *how* clinical psychology training programmes aim to develop personal and professional skills.

PPD was developed as a 'core competency' in 2002 and the only review of PPD curriculum across courses in the UK that the author uncovered (Gilmer & Marckus, 2003), was conducted around this time. This study (*ibid.*) highlighted a range of structures across programmes to facilitate PPD: buddy systems (where CPITs are 'buddied' with another from the preceding year), personal development mentors (who are usually recently qualified CPs, with no direct affiliation to the course, and with whom trainees can discuss developmental issues), variously defined groups (Balint groups, reflective practice groups or PPD groups), problem-based learning (PBL), supervision, course/appraisal tutors, reflective accounts in course work, provision of funding or support for personal therapy. Although PPD is emphasised across training courses, Gilmer and Marckus (2003) suggested that it is often peripheral to the curriculum and there are a lack of unifying processes in place for developing PPD across clinical psychology training programmes. Participation in many of the scaffolds

for developing personal and professional development are not mandatory and it was unclear how widely used the different methods are and to what affect.

More recently, Sheikh *et al*. (2007) outlined how PPD was nurtured within the Newcastle doctoral clinical psychology programme. The authors distinguished between parts of the curriculum aimed at declarative and procedural learning, and suggested that PPD was both embedded within and discrete from other modules, as well as being integrated into routine practice like clinical supervision.

#### 1.3.3.1 Empirical evidence for efficacy of methods of facilitating PPD

More literature exists on the contribution of various individual scaffolds to PPD. The author has highlighted reflective practice (RP) groups and supervision, since these are the dominant and compulsory modes of PPD, for which some literature exists. Some evidence also exists for the relationship between PPD and personal therapy in the broader psychotherapeutic literature (Rake, 2009), but is not discussed as personal therapy is not mandatory on CP training programmes.

Although reflective practice groups are often provided to facilitate PPD (Gilmer & Marckus, 2003) only a few studies have examined their perceived value in CP training (Binks *et al.*, 2012; Knight *et al.*, 2010; Wigg, 2009). These studies found that groups can benefit the development of reflective skills, but may also cause distress. It is suggested that personal growth can occur from distress, but the likelihood of this is mediated by the quality of facilitation and the provision of containment. Binks *et al.'s* (2012) qualitative study with group faciliators suggested that trainees' *commitment* to engage with distress was also important to emotional learning. Wigg (2009) suggested RP groups enabled the development of a professional self, provided a supportive function and laid down foundations for CPD. They suggested that not all trainees engaged with the process, which again highlights the importance of individual commitment and motivation. Knight *et al.* (2010) have queried the ethics of mandatory group attendance. Given the potential for distress, this seems an important consideration. It is also suggested that the number of participants in RP groups can impact on the likelihood of distress (*ibid,* 2010). Research in the related fields of counselling and psychotherapeutic training (Smith *et al.*, 2009) reported similar findings (Donati & Watts, 1999; Irving & Williams, 1996; Izzard and Wheeler, 1994). The methodological validity of some of these studies is however questionned. For example, Izzard and Wheeler's (1994) study used self-disclosures as a measure of self-awareness. However, self-disclosures

may occur without subsequent reflection and critical consideration and without growth in self awareness. Additionally, there is a lack of quantitative studies in this area.

Supervision may play an important role in facilitating PPD for CPITs (BPS, 2006). There is a considerable literature on different aspects of supervision, for example, factors impacting on effective supervision (Ellis *et al.*, 1996). The process and outcomes of supervision involve a multitude of variables, including interpersonal variables of client, supervisor and supervisee, which are challenging to account for in empirical research. It has been suggested that many of the studies in this area have methodological flaws (*ibid*; Fleming & Steen, 2004). Much of the research on supervision has focussed on the supervisory relationship, and it has been suggested that interpersonal variables are critical to effectiveness *(ibid*).

Although there is a wide literature on supervision, there is little specifically on the contribution or process of PPD through supervision in clinical psychology training. The author only found one relevant emprirical study with CPs. Miller (2009) conducted a qualitative study with CPITs on the Leeds DClin Psy training programme, which explored CPITs' perceptions of *how* personal development occurred through clinical supervision. The study utilised an online survey in which CPITs reflected on the process of personal development during supervision following a 'critical incident'. Miller (2009) used thematic analysis to analyse the data and suggested that the findings confirm the interface between the personal and the professional. He suggested that the process of personal development was initiated by a CPITs' subjective sense of 'uncomfortable thoughts and feelings'. Transparency, namely honesty and directness, was considered important in the supervisory relationship in facilitating exploration of these incidents. Miller (2009) also suggested that growth cycles are highly individualised and need space and time to develop and supervision should ideally allow for these individual differences. It was also suggested that personal growth may be intiated within supervision but develops beyond this, and additional scaffolds are therefore needed to support this process. Miller (2009) suggested that his conceptualisation of the process broadly maps onto the model developed by Hughes and Youngson (2009), which will be discussed later in this chapter. Miller's (2009) study has some acknowledged limitations. It was based on retrospective accounts, which may be subject to biases and distortions, and is limited to a small sample within one training course, which arguably places considerable value on personal development than others. It is also noted that analytic rigour was considered through the triangulation of the analytic process

with the clinical supervisor. The clinical supervisor was Sheila Youngson, who originated the model which his study claimed to support. To some extent, given the relatively small research community within clinical psychology such relationships between researchers on studies are inevitable, however there may have been unavoidable bias (i.e. confirmation bias) in the interpretation of data. Other authors have suggested that development through supervision may be impacted upon by tensions between the 'restorative' and 'formative' functions of supervisors and their 'normative' role in deciding whether a trainee is fit to practice (O'Donovan *et al*., 2011; Scaife, 2009).

Scaife (2009) suggested that the broader psychotherapeutic and counselling literature supported a positive association between personal development and supervision (see Arvidsson *et al.*, 2000; Berg & Hallberg, 1999; Bowles & Young, 1999; Wulf & Nelson, 2000) but noted that the literature has not been thoroughly empirically interrogated.

The research evidence for these methods of facilitating PPD is not currently robust. Fairhurst's (2011) systematic review of the empirical evidence of RP groups highlighted the limited research evidence, the lack of theoretical understanding of the processes of PPD through RP groups and in particular highlighted the need to understand better the role of inhibitory and distressing group experiences (Knight *et al.*, 2010). The research evidence for supervisions' contribution to PPD is similarly limited. In both areas, there is a lack of longitudinal research and lack of theoretical development of the factors which hinder and enhance PPD.

### 1.3.4. Assessing PPD within clinical training

One of the challenges for training programmes is ensuring that academic and theoretical learning in the university is integrated with the experientially based learning that occurs during clinical practice (Stedmon *et al*., 2005). *Knowing how* does not necessarily translate into effective practice and yet it is clearly imperative that courses produce CPs who are fit to practice. This challenge has motivated the development of more experiential teaching methods within some university's teaching methods, but also raises questions about the meaningful assessment of competencies. This seems particularly challenging for PPD, given its more nebulous and abstract nature. It also seems of fundamental importance given the foundational benefits of this competency to future professional practice.

There are a number of challenges in the assessment of competence in PPD (Smith, 2010). One issue, raised by Gilmer & Marckus (2003), is that of how to reduce the holistic developmental process of PPD into clear, measurable valid learning outcomes. In 2001, when Gilmer & Marckus (2003) surveyed UK doctoral courses provision for PPD, they reported considerable variation between courses, with many demonstrating poor specification of PPD aims, assessment and definition. Courses stated that assessment was via mixed methods using 'essays, assignments, reflective journals, portfolios and group work' (*ibid.,* p.23). It is noted that these methods of assessment are predominantly university bound. The definition of competence cited earlier, as 'the capacity and *tendency* to engage in specified behaviours' (Baron & O'Reilly, 2012) highlighted that there can be a distinction between ability and tendency. Clearly, the BPS (2013) has defined learning outcomes for PPD, but it is unclear whether competence defined by the measurement of these outcomes translates into professional effectiveness.

The author was able to find only one other article within the literature on assessing PPD on CP training programmes within a UK context. Sheikh *et al.'s.* (2007) study sought to examine the mechanisms of provision for, and efficacy of PPD, through the learning experiences provided by the Newcastle CP Doctoral training programme. The modes of assessment were broadly similar to those in Gilmer and Mackus's (2003) study. Sheikh *et al.* (2007) also reviewed reliability of their assessments, using multiple sources of information on trainee competence and concluded that their learning outcomes were being achieved. The authors did not comment on the need for a more holistic assessment. However, given the previous evidence of poor resilience and psychological adaptation amongst some CPITs and qualified CPs, it does raise the question of whether discrete learning outcomes represent the process they are designed to measure. The measurement of what someone *knows* does not necessarily translate in to a prediction of their *actions* in clinical practice. Current methods of assessment generally used in CP seem limited in their ability to account for this known phenomena (Smith, 2010; Tweed *et al*., 2010).

Within other health professions, the issue of assessment has been widely debated. In medicine and nursing in particular, there is a greater use of in-vivo assessment in an attempt to measure the transference of knowledge to clinical practice. Miller's (1990) pyramid framework of clinical competence has been influential in the move towards in-vivo assessment, as part of an assessment repertoire. Miller (1990) described four levels of clinical competence: knows (knowledge), knows how (competence), shows how

(performance), and does (action) and purported that knowledge does not necessarily correspond to competence in terms of performance or action. This model seems to have useful application to CP assessment of PPD, although it has been noted that the model neglects the invisible qualities of professional competence such as attitudes, values and moral development (Gallichan & Mitchell, 2008; Redfern *et al*., 2002).

The application of this model in nursing and medicine has influenced the development of multiple modes of assessment to capture the different levels of competence. However, it is acknowledged that challenges exist across the dimensions (van der Vleuten, 2010). These issues include: self-report bias in clinical cases that CPITs present (written or oral) (Adams, 2006; Scaife, 2001; Tweed *et al.*, 2010); cases presented having selectivity bias, as CPITs report on material fitting the assessment framework (*ibid.*); leniency bias in assessors who have a formative role (Bullock *et al*., 2009; Gonsalvez & Freestone, 2007); unreliable self-assessments (Davis *et al.*, 2006; Eva & Regehr, 2007); lack of consistent standards adopted by assessors (Bullock *et al.*, 2009; Fleming & Steen, 2004); observer bias, which can be positive or negative (Redfern *et al.*, 2002); overburdening of the assessers (Chana & Stern, 2005).

One implication of the aforementioned challenges with assessment tools is the move towards multi-modal assessment measures. This includes examining issues in the context in which they will be applied, involving managing uncertainty and often incorporating assessment in-vivo (Epstein & Hundert, 2002: Gallichan & Mitchell, 2008; Smith, 2010). Gallichan & Mitchell (2008) argued that clinical psychology training should use in-vivo assessment alongside other methods, to raise the standard of competency assessment during training. This is the subject of debate currently between representatives of the Group of Trainers in Clinical Psychology.

### 1.3.5 Summary

It has been suggested that assessing PPD competence within clinical psychology training is challenging due to lack of clarity over definitions, the difficulties of measuring a holistic developmental process through discrete outcomes, and due to validity and reliability issues with measurement tools commonly used. It has also been suggested that the empirical evidence of some CPITs' and CPs' poor psychological adaptation may partially highlight that PPD competency is not currently consistently maintained in its aims of improved resilience and self care, at least in the personal domain.

## 1.4 Perceived competence

Given the challenges of assessing and measuring PPD, another mode of enquiry into competence development is CPITs' self-reflections or perceived competence. This is a relatively new area of enquiry and consequently this review will draw on literature beyond clinical psychology and within competence development in general.

### 1.4.1 Defining perceived competence

Perceived competence is not clearly defined in the literature, and seems to be used synonymously with self-efficacy, self-reflection, self-confidence and self-assessment. Self-assessment of competence has been defined as 'a form of appraisal that makes a comparison between behavioural outcomes and an internal or external standard' (Boekaerts, 1991, p.11, cited in Mathieson *et al.*, 2009). Trainee/counsellor self-efficacy has been defined as 'trainees' beliefs about their ability to perform the tasks associated with the therapist role, such as delivering helping skills, managing session process issues, or negotiating challenging client scenarios' (Lent *et al.*, 2009, p317). Perceived competence could be defined as an individual's internal sense (belief or feeling) about their ability with regard to a specific area of knowledge, skill or value (competence) and may include a global sense of their ability to fulfil the requirements of their professional role.

#### 1.4.1.1 Internal benchmarks for assessing perceived competence

Someone's perceived competence is inevitably subjective. CPITs may benchmark themselves against different standards and this may then impact on their judgement of their competence. This benchmark, in addition to the accuracy of the assessment of their own skill, may be unrealistic if one considers Skovholt & Rønnestad's (2003) concept of the ideal practitioner, where self-efficacy is determined by making clients *better*. They argued that this ideal is common amongst novice psychotherapeutic practitioners. If one holds this as a benchmark, this is likely to impact on perceived competence in a different way to, for example, holding the more rationally held concept in CP training of the 'good enough' practitioner.

### 1.4.2 Why study perceived competence?

There are a number of reasons why studying perceived competence has potential utility. Firstly, perceived competence may be linked to therapeutic outcomes (e.g. Bennett-Levy & Beedie, 2007; Hackney & Goodyear, 1984; Kell & Mueller, 1966; Orlinsky & Howard,

1986). Bennett-Levy & Beedie (2007) cautioned that, although there is not specific empirical data linking therapists' confidence (and by implication perceived competence) to outcomes, a correlation was likely. They cited Milne *et al.'s* (2001) addition of 'charisma and flair' to the revised Cognitive Therapy Scale (CTS-R), as endorsement of the importance of this quality. It is equally arguable however that confident performance may not necessarily relate to perceived competence, instead representing an over-compensation for an internal sense of incompetence.

Secondly, it is acknowledged in the wider literature that stress, self-doubt and feelings of incompetence are common occurrences on psychotherapeutic and clinical training programmes (Bischoff *et al.*, 2002; Brooks *et al.*, 2002; Pakenham & Stafford Brown, 2012; Rönnestad & Skovholt, 2003; Thériault *et al.*, 2009). Feelings of incompetence are not evidentially linked to actual performance (Johnson *et al.*, 1989) but research suggests that such feelings can impact negatively on the process of psychotherapy and on practitioner well-being (Thériault *et al*. 2009). Guy *et al.'s* (1989) study with qualified psychologists suggested that poor psychological adaptation may adversely affect professional functioning. Current studies (e.g. Bennett-Levy & Beedie, 2007) into the development of perceived competence over time, suggest the need to understand this process and the factors which contribute to or impede growth, both within and between individuals. This understanding could assist curriculum development on CP Doctoral Programmes.

Thirdly, *realistic* self-assessment is an important part of PPD competency, for example, utilised in assessing the limits of one's competence and managing learning needs. A capacity to more or less accurately estimate one's own ability may be crucial in developing confidence, professional self-esteem and in preventing harm. Self-assessment and perceived competence may affect whether a practitioner seeks further knowledge, support, instils confidence in others and may impact their likelihood of taking on tasks (Bjork, 1999, cited in Mathieson *et al.*, 2009). Kennedy *et al.'s* (2009) study with medical trainees suggested that medical trainees consider their professional credibility when seeking help. The authors concluded that the formative role of the supervisory relationship may be compromised by the concurrent summative or appraisal role of the supervisor. This finding is obviously important when considering developing competence in challenging clinical situations, where the ability to feel confident to seek support may be essential for harm prevention and patient safety.

#### 1.4.2.1 Limitations of perceived competence

Many studies have shown that subjective measures of competence are often poorly related to 'objective' measures (James *et al*, 2001; Perlesz *et al*., 1990). Perceived competence, like all methods of assessment, has challenges to its utility. Studies suggest that there is a tendency for over-estimation and confidence in reporting self-perceived competence (SPC) (Alicke *et al.*, 1995; Ames & Kammrath, 2004; Bjork, 1999; Kruger & Dunning, 1999). However, used in conjunction with other measures, the trainee perspective may be valuable in contributing to a 360-degree assessment of competence (Kaslow *et al*., 2009).

#### 1.4.2.2 Empirical evidence on perceived competence

It is acknowledged in the recent literature that there is scarce research into how therapist competence, in general, is acquired particularly from the trainee perspective (e.g. Bennett-Levy, 2006; Kamen *et al.*, 2010). However, there is a growing literature on perceived competence, predominantly in the field of Cognitive Therapy training programmes. Bennett-Levy, a key researcher in this field, has focussed on modelling the role of self-reflection in the development of advanced competence as a CBT therapist (e.g. Bennett-Levy & Lee, 2012; Bennett-Levy & Thwaites, 2007). Recent studies have highlighted the need to understand better the developmental pathway of perceived competence in different skills required of cognitive therapists, and to understand what impacts on the nature and pace of learning from the perspective of the trainees (e.g. Bennett-Levy & Beedie, 2007; Niemi & Tiurniemi, 2010).

Bennett-Levy & Beedie's (2007) longitudinal study with 24 trainees on a one year diploma in Cognitive Therapy, aimed to examine the trainees' perspective on self-perceptions of competence (SPC) during training. It examined how SPC developed over time, varied between individuals and skills learnt, and what environmental and internal factors were perceived to impact on SPC. The sample comprised trainees who already had professional qualifications (e.g. 67% were clinical and counselling psychologists) and whose average age was 37 years. The sample profile therefore differed from CPITs in which applicants are typically undertaking their initial core training. The study employed a mixed qualitative and quantitative design, which was clearly outlined and procedurally and ethically robust. The study's sample size however was small and taken from one training course, which may limit the generalisability of the study's findings. Trainees were required to estimate their

competence on the cognitive therapy self-rating scale (CTSS) developed by Bennett-Levy based on the supervisor rated and validated Cognitive Therapy Scale (CTS). The scale used has not yet been tested for reliability and validity. This scale examined 13 items which clustered under three categories: general interview procedures, interpersonal effectiveness and specific CBT techniques and required participants to rate their SPC on a 10 point Likert scale, ranging from no-skill (1) to master-skill level (10). This measurement occurred at six time points every six-seven weeks, starting at the beginning of the course. The study also required supervisors to assess their trainees' competence at the same time-points on the CTS. After scoring on the last five occasions, participants were reminded of their previous score and asked to record their belief about changes if their score changed by a specified amount. The qualitative data from the open-ended questions was analysed using grounded theory. The authors specified a rigorous account of the analysis process and checks for clarity and reliability, using triangulation via multiple researchers and checking with participants and other trainees and cognitive therapists. The quantitative data was analysed using repeated measure analysis of variance. No account of the power of the analysis was given and it is noted that the sample size is small.

Bearing the above limitations in mind, the study demonstrated that SPC increased significantly over the year training, but with variability between individuals and skills. Greater gains were perceived in general interview skills and cognitive behavioural techniques with smaller gains in interpersonal effectiveness. The different pace of growth in inter-personal skills versus technical skills has also been noted by others (e.g. Orlinsky & Rønnestad, 2005; Brosan *et al.*, 2007); These findings were mirrored closely by the supervisors' assessments in this study and previous studies with supervisors (e.g.Milne *et al*., 1999). The authors suggested that the smaller gains in inter-personal effectiveness (which comprised of the skills of empathy, interpersonal effectiveness and professionalism) may be explicated by: the fewer number of items in the category which lead to lower variability; a higher level of transferable skill at entry to the course, as initial scores were higher and they also suggested that focus on this skill development may be reduced due to a concentration on technical skills. The authors noted that previous research (e.g. Henry *et al.*, 1993; Stolk and Perlesz, 1990) have found that inter-personal skills can be reduced due to this focus. This finding is interesting in relation to PPD as this skill set arguably maps most closely to PPD. Individual variation was also a feature of the data which has also been found in studies of family therapy training (Perlesz *et al.*, 1990).

Emergent themes from the grounded theory analysis suggested that key influences on the development of SPC were 'self-reflection on recent learning and performances, increased awareness of the standards required of a cognitive therapist, and emotional state, derived from emotionally salient memories and current levels of stress.' (Bennett-Levy & Beedie, 2007, p.72). This is shown diagrammatically in Figure 2.(see 1.5.4). Credibility about the notion of the importance of self reflection is built by the fact that self-reflection is identified as central to professional development in many other studies (e.g. Bennett-Levy, 2003; Schön, 1983). The authors also explained clearly how they adopted their method to account for possible bias, given that a key author has previously espoused the importance of self-reflection. The emergent model suggests that growing awareness of the standards of a cognitive therapist can temporarily depress perceived competence ratings. The authors also stressed the importance of emotionally salient memories from events like client sessions or supervisory feedback on SPC. The authors suggested that, as part of an orientation programme, trainees may benefit from understanding that fluctuations in competence and awareness of standards will impact on confidence and are 'normal'. They also highlighted the importance of supervisory feedback, and suggested that it may be helpful for the supervisee and supervisor to discuss how this can be most constructively given. Bennett-Levy and Beedie (2007) also noted that comparative levels of past experience of trainees were not accounted for in their model, as grounded theory methodology dictates that models are grounded in the data from the study. The authors also noted that the model is tentative and requires testing with different cohorts preferably using a quantitative study.

Although to the author's knowledge, Bennett-Levy's study has not yet been replicated and validated, Niemi and Tiurniemi's (2010) study explored cognitive therapist trainees' perceptions of what is important and difficult to learn during their training. Their research questions were influenced by Bennett-Levy's (2006) Declarative-Procedural-Reflective (DPR) model, which conceptualised therapist skill development and highlighted the importance of reflective skills in facilitating learning. Niemi and Tiurniemi (2010) sought to understand: what trainees perceived to be important to learn in training; the foci of trainees' self-reflective processing and how they assessed their competence as psychotherapists.

This study was conducted in Finland, where the cognitive training programmes are four years in length, and employed a mixed qualitative and quantitative approach. Trainees' self assessments were carried out after two years and four years training. The study design was not clearly explicated but it appears that the study design was longitudinal with a proportion

of participants assessed at both time points. A number of study programmes were used. Similarly to Bennett-Levy's study (2007) the sample consisted of practitioners who already held a core mental health profession, with an average age of 41.3yrs at the first inquiry. Three assessment measures were used which differed from those employed by Bennett-Levy & Beedie's (2007) study. The first measure the Finnish Inventory of Cognitive therapist skills, designed by the authors, examined 54 items clustered into the folllowing categories: cognitive, behavioural, experiential and constuctivist interpersonal therapies. Participants rated the importance, mastery and practice of these skills on Likert scales (0-3). The second measure, was a global self-appraisal of psychotherapeutic competence on a scale of 0-100, and self-assessments of technical expertise, basic and advanced relational skills and self-awareness. Finally, open-ended questions were asked about: what was the most important thing learnt during training, the most difficult thing to learn or practise and targets for future CPD.

T-tests were used to compare students' self appraisals and the qualitative approach used was described as similar to grounded theory. The latter process was not clearly explained. Quotes and explanations of the categories derived were clearly explicated. The authors noted that trainees reported that cognitive and constructivist inter-personal skills were the most important to be learnt at both time points and corresponded with the higher scores on self-assessed mastery. Global self-assessment of psychotherapeutic competence was significantly different and greater at the second time point. The qualitative data suggested that participants felt that the most important learning outcomes were in technical knowledge and skills and strategic procedures and that interpersonal perceptual and relational skills were perceived to be less important. Difficulties in learning were related to practising technical skills and strategic control of the therapeutic process. The authors suggested that trainees may have felt that they already had considerable interpersonal skill, although the authors also suggested that their perceived mastery may not be directly transferable to cognitive therapist skill. The conclusions drawn by the authors did not always seem to clearly derive from the data presented. For example, they suggested that 'increased mastery of techniques was seem to support the felt sense of competence, which in turn was likely to encourage more challenging goal setting' (p.268). It is not clear how they made this link from the data.

Both studies suggested that different skills developed over different time periods, and inter-personal effectiveness was less privileged by trainees. It is noted that the second study has some methodological limitations and is less rigorous and clear in its analysis and derivation

of findings. It is also noted that both studies used small samples, and with trainees who already hold a core professional qualification with an implied level of experience which is likely to be greater than the typical CPIT. Both studies are also with cognitive therapist trainees and although it is suggested that inter-personal effectiveness may most closely overlap with PPD, the skill sets examined are different to those required in the competence of PPD.

#### 1.4.2.3 CPITs' experience of competency development

The author is not aware of any UK research examining CPITs' perceived competency in PPD and their perceptions of what helps and hinders this process. Studies which have explored the CPITs' perspective have tended to focus on specific elements of the learning process, such as the nature of the clinical placement (Paynter, 2010) or the supervisory relationship (Miller, 2009).

Kamen *et al.'s* (2010) study is worthy of more detailed consideration as it explored CPITs' perspectives on more generic competence development. This Canadian based study aimed to assess the acquisition of competencies, and to explore the relationship of trainees' charcteristics and professional interests to competence development. The study's authors employed a quantitative, cross-sectional design with a sample of 641 graduate students with an average age of 28 years. The participants fell into four groups representing increased levels of study, ranging from pre-internship, current internships, applicants and current interns. The authors developed measures to assess core competencies and the trainee characteristics which extant research suggested are important in working as CPs. These measures have not yet been tested for reliability and validity. One measure examined each of the core competencies (as identified by Kamen *et al.,* 2004) and asked participants to rate their ability to perform each competency task with minimal guidance on a Likert scale from 1 (extremely poor) to 5 (excellent). They were also asked to estimate how much time as a percentage they felt they would spend doing clinical versus research activities in their ideal job.

Data was analysed using a series of one-way analysis of variance on five clusters of competency factors. The findings suggested that different competencies developed at

different rates: 'assessment' competency developed from first to third year but subsequently lacked growth, whereas 'intervention', 'research' and 'empathy' took longer to develop and were only fully present when trainees applied to clinical internships. The authors suggested this finding validated the idea of a developmental trajectory of competency. There were limited differences in self-assessed competence between internship applicants and current interns. The authors suggested this could be due to the measures being insufficiently sensitive and because interns were only three-to-six months into the programme. It is also suggested that trainees' perceived ability in different competencies was associated with their career goals i.e. those with more clinically orientated goals assessed their competency in clinical skills as greater versus those with more research-orientated goals. This study, whilst using a relatively large sample, does not report the power of its effect sizes and was overly represented by graduate students with relatively few current interns. The study's findings could be strengthened by the use of a longitudinal design which could assess competence development throughout the programmes. The analysis was only undertaken at a group level and so prohibits understanding of individual differences. Given Bennett-Levy and Beedie's (2007) finding about individual difference, this level of analysis seems important. Finally whilst the study makes suggestions about the developmental pace of competence development, it does not offer any guidance as to what impacts on the learning process.

Two recent studies conducted in the UK (Nel *et al*., 2012) and Australia (Scott *et al.,* 2011) stated the need for research into the perspective of CPITs into the effectiveness of aspects of training. Scott *et al.'s* (2011) Australian-based study explored students perceptions of eighteen aspects of training, such as overall quality of training, effectiveness of teaching and assessment methods, clinical training, supervision and programme workload. The survey was developed by the study's authors based on a six-month review of clinical psychology literature. It used a variety of rating scales ranging from two-to-ten options to attitude statements, as well as open-ended questions. 190 students participated in the study, which also examined the perspective of 35 clinical directors using a telephone survey. The qualitative responses of students were analysed using manual and computer assisted content analysis, which was both summative and thematic. The key relevant findings were that students expressed an overwhelming preference for practical, interactive and competence-based teaching to the didactic, written and exam-based alternatives that were still widely used in most programmes. It was noted however that these findings based on the quantiative data were only presented as descriptive statistics, with no statistical analyses of significant

differences. Issues reported to negatively affect the quality of student's clinical training included clinical issues, insufficiently modern or practical coursework and limited access to resourses, supervisors and support. Students also felt that clinical competence was only 'adequately' tested and felt that 'supervision, placement, recorded therapy sessions, viva and role plays best assessed such competence.' (Scott *et al.*, 2011, p.87). It was also reported, based on the interviews with clinical directors, that student failure related primarily to failure to maintain professional practice standards, as well as personal or inter-personal qualities. The study did not examine or comment on what specifically might have contributed to these failures of professional competency. Course directors, amongst other things, expressed concerns about the adequacy of supervision and the competency of students on graduation. The authors acknowledged the limitations of the findings due to the reliance on self-report and the lack of outcome data with which to compare these findings to. However they also commented on the consistency of responses.

Nel *et al.'s* (2012) retrospective UK study with 357 qualified CPs used self-report questionnaires to investigate their perceptions of the value and usefulness of learning activities during training. An anonymous survey was sent out from the Division of Clinical Psychology (DCP) to 1900 randomly selected members. The survey was developed by one of the study's authors who is an experienced trainer in CP and was pre-tested with other team members. It covered three areas: learning methods or activities typically found in academic, clinical, research and PPD and asked participants to indicate whether they have experienced different methods and if so, to rate the importance of the learning method on their practice on a likert scale of 1-5; to identify the three learning methods which best prepared CPs for their post-qualification practice and to explain why; demographic data was also collected. Analysis firstly explored frequency of responses, and importance of these variables was compared to gender and years qualified. Statistical significance was assessed using two-tailed tests. Thematic analysis was conducted on emergent themes from the open-ended questions. Traingulation was used to ensure greater reliability.

Participants consistently perceived the most effective learning to be facilitated through direct clinical experience, experiential and problem-based learning and through conducting research and writing up for publication. This was reported across competencies and included PPD. The findings also highlighted the importance of observational learning. The authors noted that this finding is suported by social learning theory. They also highlighted the dilemma

within training of providing 'good enough' supervisors and the need for continued CPD of placement supervisors. The authors suggested that CP is 'lagging behind in this area of developing trainer competence.'(*ibid.,* p.1070). CPs also emphasised the importance of quality relationships with tutors, supervisors and peers for learning. The authors noted the implied importance of interpersonal expertise which would include supervisors' ability 'to respond with empathy to the trainees' explicit and implicit concerns, to develop learning outcomes in collaboration with the trainee, to be responsive to the trainees' feedback…and to be able to challenge trainees in a supportive way that fosters exploration, openness and change.' (*ibid.,* p.1071). In this sample, personal therapy was deemed important in becoming a competent practitioner, and especially so for CPs from a psychodynamic, integrative or systemic orientation. Nel *et al. (*2012) suggested that more training is required for trainers, notably clinical supervisors. Whilst the study is well -designed and transparent and rigorous in design and analysis, the authors noted the limitations of self-report and reliance on retrospective memory (especially since some participants were twenty years post-qualification). They suggested the need to conduct comparison studies to assess the actual efficacy of learning methods. The authors also recommended further research to develop an understanding of which learning activities contributed most and least to developing competence. They stated that to achieve an 'in-depth understanding of people's lived experiences of participating in different learning activities during clinical training, it is recommended that future studies employ methods such as semi-structured interviews to collect data that can be analysed qualitatively' (Nel *et al.*, 2012; p.1072).

### 1.4.3 Summary

There is a small evidence base pertaining to trainees' perceptions and self-reflections during training (Bennett-Levy & Beedie, 2007; Kamen et al., 2010; Niemi & Tiuraniemi, 2009) but little which has directly involved CPITs. No studies have looked at CPITs perceived competence development in PPD. Developing an understanding of CPITs perceived competence and reflections on their PPD could help develop an understanding of their perceptions of what helps and hinders growth within training. It is recognised that this understanding would be subjective and partial, but in conjunction with other approaches may help to develop a better understanding of how to enable learning in PPD during clinical psychology doctoral training.

## 1.5 Models of learning – *How* is competence acquired in PPD?

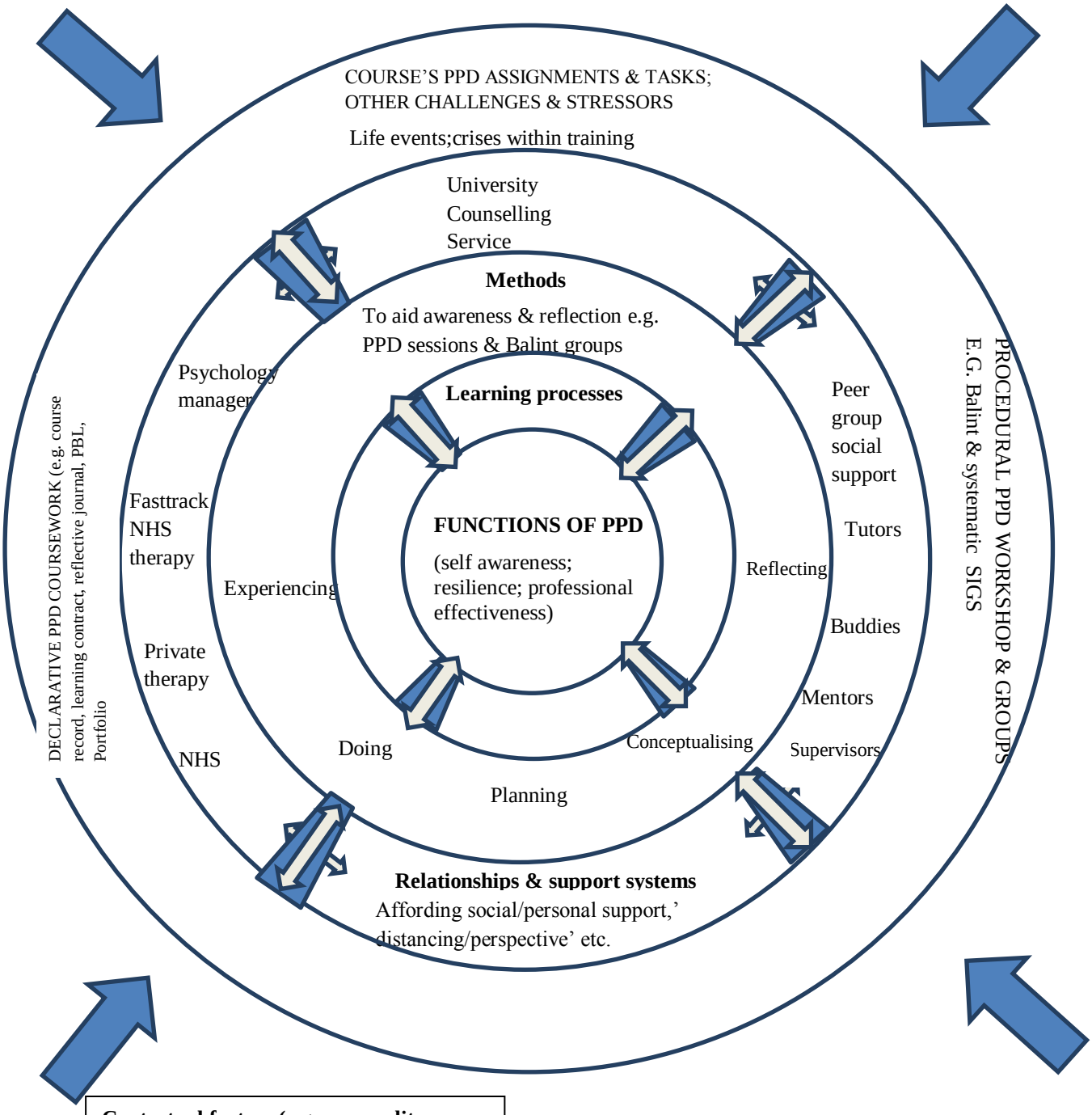
It is important to consider what is known about how competence is acquired in PPD during training. Given the lack of literature within CP in this field, the author has drawn on models from related literature which may have relevance.

### 1.5.1 The circumplex model of PPD

Within the clinical psychology literature, the author is aware of one model of PPD; the circumplex model of PPD (Sheikh *et al*., 2007) (See Figure 1). Sheikh *et al.'s* (2007) model draws on reflective practice theory to explicate the process of PPD, notably Schön's (1987) 'reflection in action' and Eraut's (1998) belief in the role of 'deliberation' and 'metacognition'. The former refers to the process of critical reflection as an individual's understanding of a situation in which they are involved. Deliberation is similar to Schön's 'reflection on action', representing the idea of setting one's thoughts on a particular topic in order to consider it. Metacognition is the notion of 'thinking about thinking'. Sheikh *et al.* (2007) also drew on Boud *et al.'s* (1985) framework of methods of reflection; reflecting on thought patterns, summarising or describing assumptions, encouraging association, interpreting, extrapolating and evaluating. These ideas all inform the *methods* of PPD. These ideas also parallel Kolb's experiential learning model (1984), which Sheikh *et al.(*2007) suggest has good resonance with PPD. Kolb's theory defines learning as a 'continuous process grounded in experience, rather than being regarded as an outcome' (Scaife, 2010, p.10).

Kolb's (1984) learning model consists of four stages: concrete experience; reflective observation; abstract conceptualisation and active experimentation. Sheikh *et al.'s* (2007) model describes fluid movement between the different layers of the model, which conceptualises the required outcomes of PPD at the centre. *Methods,* which borrow from Kolb's model and incorporates formal modes of reflective practice such as balint groups, interact with the '*relationships and support systems'* and '*declarative and procedural teaching and course assignments'*. They suggested that reflection was necessary but not sufficient for PPD and needs to be supplemented by other modes of learning. The authors

**Figure 1: The circumplex model of Personal Professional Development (Sheikh *et. al.*, 2007, p.282**



argued that their model adds the learning context to the process, which is missing from Kolb's (1984) model. Additionally, they emphasised the role of individual agency to drive the learning process and suggested that an individual's personality, learning history and personal context will impact on their training journey. For example, a person's attachment style and core beliefs may impact on their utilisation of support.

This broad, inclusive model whilst intuitively logical and grounded in theory, albeit in the case of Kolb's (1984) model lacking empirical support, does not address which elements of the framework are fundamental to PPD. It could be the case that some aspects of the model are more peripheral to PPD than others. They argued that the model accounts for negative learning, as they argue that poorly functioning support systems or reflective practice groups for example, could impact negatively on self awareness and coping. Given that it is known that a minority of trainees experience some distress during training (e.g. Cushway, 1992), it may be that different aspects of the model are more significant to enable or hinder learning when psychological adaptation is poor. This is not specified. The authors suggest that their model has strong parallels with Lazarus and Folkman's (1984) transactional stress model which conceptualised 'stress' as a transaction between the person and their environment and the appraisals made regarding the manageability of the stressor (Lazarus and Launier (1978) cited in Ogden, 2004). *Stressors* are suggested to be equivalent to the outer circle; *social support* to 'support systems' and *appraisal* and *personal coping strategies* to 'functions'. However, given what is known about aspects of support, for example, the importance of the quality of the supervisory relationship (e.g. Miller, 2009), these may act as stressors as well as supports.

The authors acknowledged some potential limitations of the model. CPITs may not learn like scientists, as implied by Kolb's learning cycle, at the heart of this model. For example, it is not clear how emotional arousal, perhaps as the result of a disorientating dilemma, would impact on the learning cycle. Sheikh *et al.* (2007) also acknowledged that mental health professionals may already possess the necessary reflective and emotional skills to propel learning and that aspects of these skills may not be directly teachable. They also recognised that adult learners will have pre-existing knowledge, experience, personality, attitudes and contextual factors, which will affect their level of competence as they enter the model. Beliefs and values are arguably an important influence too.

### 1.5.2 Model of personal development processes

Hughes & Youngson (2009) have proposed, based on extensive consideration of the literature, a model of personal development processes. They have developed a *cyclical* flow chart to represent the development of personal development during training. They suggested that entry in to the learning cycle is initiated with the CPIT responding to a '*clue*' that something is not entirely right. They suggested that recognition of this may originate from within the individual or from others and that the CPIT engages in a process of reflection on the meaning of the clue and ascertains whether further work needs to be done. The CPIT may conclude that understanding is in place and no further work is needed, or there may be a recognition of the need to reflect further to seek satisfactory understanding. The CPIT will then consider the *impact of change on self and others*. This may result in a decision not to pursue the issue further, which they related to the CPIT being in a pre-contemplative stage of motivation to change (drawing on Prochaska and DiClemente's (1983) model of change). Alternatively, they suggested that the consideration of the impact of the insight may lead to the *utilisation of personal development methods*, which may be internal/intra-psychic or external involving self in relation/community/multiple roles. The end of the flow diagram is characterised by *personal growth and application* which they suggested leads to change 'on many levels and the person will have a new/assimilated sense of self' (Hughes & Youngson, 2009, p.56) which will then impact on other aspects of the person's life, for example, an intra-psychic change may impact on their roles, and relationships and changes within the workplace may impact on the internal self.

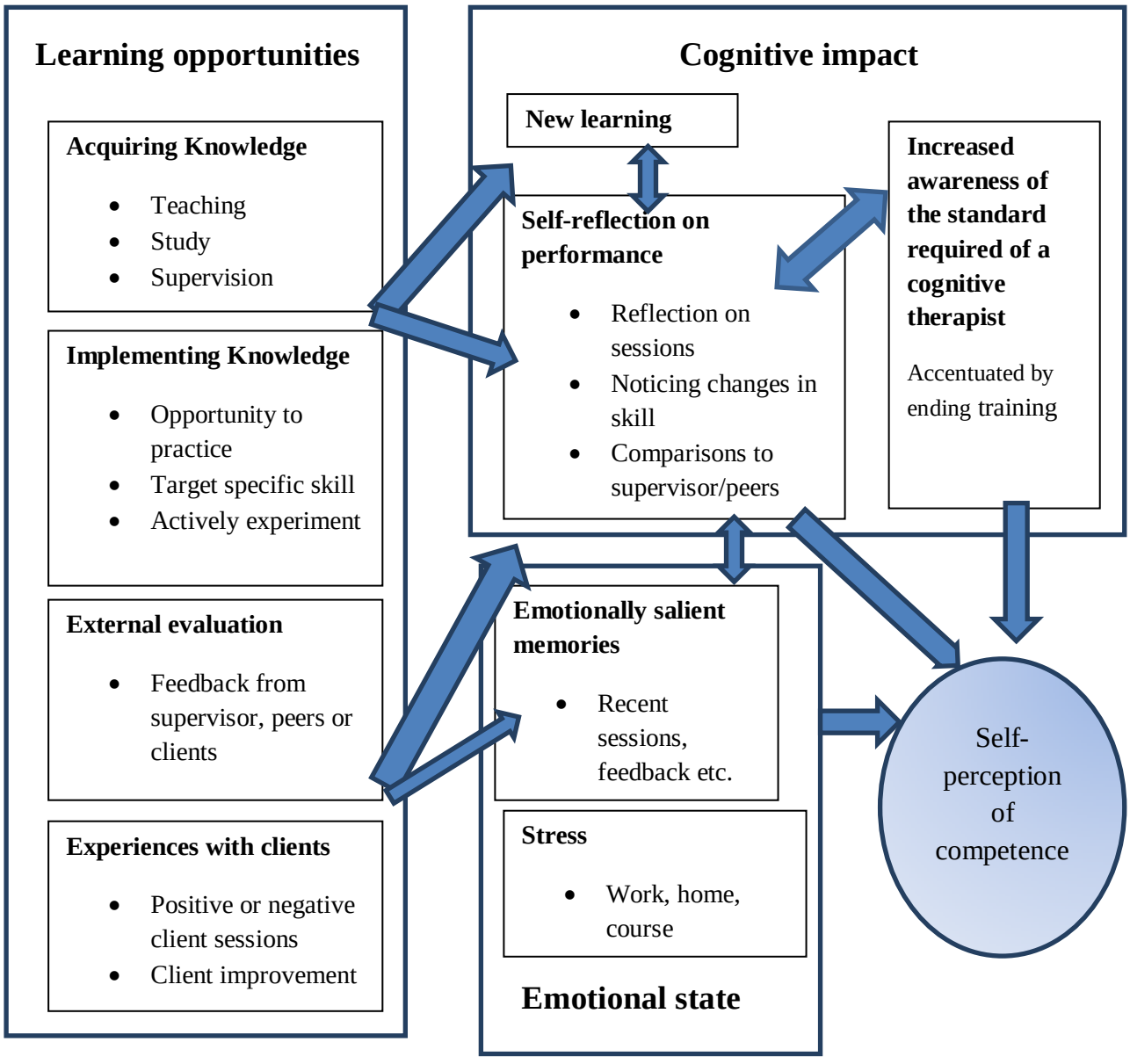
Hughes and Youngson (2009) suggested that personal growth may often follow 'crisis' and involve emotional distress, and that strategies undertaken to cope with 'clues' can be avoidant, and individuals may move around the change cycle rather than flow directly to actively coping and resolving. They also suggested that there are a number of internal barriers to growth, such as limited reserves to engage in a change process, lack of knowledge of how to facilitate growth, and certain personalities and styles of learning may support personal growth and reflection more than others. Also, self-appraisal biases may limit the self awareness required to initiate the cycle. External barriers are suggested to include limited personal space to attend to self, lack of finances to gain necessary support, lack of managerial and personal support, differences within communities (*ibid.*, p.58).

This model is not grounded in empirical study and currently lacks sufficient empirical support, although Miller's (2009) study does confirm some aspects of the model. The model does not fully explicate how personal growth extends to professional development. There is a need for empirical study to interrogate the process, the suggested moderating variables and to consider the relationship to professional development. Additionally, the process does not account for what specifically enables the growth via the internal methods and seems to imply that simple engagement in the 'methods' inevitably leads to change. This author suggests that engagement with methods may vary in its utility and that this is not examined in this model. For example, although personal therapy is linked to positive influences on professional development as a therapist (Rake, 2009), that is not always the case and there is limited evidence of its consequent relationship to therapeutic outcomes (e.g. Macran & Shapiro, 1998). Similarly, reflective groups may be seen as distressing and whilst attended, may be poorly engaged with (Binks *et al*, 2012).

### 1.5.3 Model of the influences of self perception of competence (SPC)

Drawing on the cognitive therapy training literature, Bennett-Levy and Beedie (2007) have developed a model representing the influences on SPC (See Figure 2). This model was formed from grounded theory analysis of trainees' self-reflections on what contributed to increased or decreased in their SPC as described in 1.4.2.2. The model relates to the development of skills as a therapist not specifically PPD, and not as a CPIT. Although from a different perspective, it seems to offer value in considering competence in PPD. Their model suggests that three core components interact to influence SPC; *Learning opportunities* experienced, their *Cognitive impact* and the trainee's *Emotional State*. This model greatly privileges the emotional aspect of learning that is lacking from other models, such as Miller's (1990) pyramid of clinical competence. They suggested that different types of learning have cognitive and emotional effects. Some learning experiences, such as external evaluation and client experiences, involve greater emotional salience than others. *Emotional memories* are suggested to have an excessively large impact on SPC. Other learning experiences, such as academic exercises or trying out techniques with clients, have a greater *cognitive* impact and can lead to refinement of conceptual, technical and interpersonal knowledge and procedural skills. Similarly to Sheikh *et al.'s* (2007) circumplex model, reflection is at its heart: trainee's cognitive reflections on their performance are suggested to have a key impact on SPC, and reflection links the various elements of the model. The authors also suggested that

**Figure 2. Model of the influences on self-perception of competence (Bennett-Levy & Beedie, 2007)**




developing awareness of 'standards to be a cognitive therapist' also impacted on SPC over time. The model does not specify what might mediate the emotional state resulting from experience.

### 1.5.4 Other relevant learning theories

Although again relating to generic skill development as a cognitive therapist, Bennett-Levy's (2006) cognitive model of therapist skill development seems to offer a relevant framework for this study. This model higlighted three systems as critical in developing psychotherapeutic skill: the declarative, procedural and reflective systems. Bennett-Levy (2006) has built this model from the extant literature, drawing on Binder's (1993) declarative-procedural model and is grounded in information processing theory. Reflection is pivotal to the system, enabling the development of procedural and declarative knowledge. Bennett-Levy (2006) suggested that the model explains aspect of therapeutic skill development, such as the different rates of growth of different skills. The perceptual system is seen as influencing the pace of skill development and the development of 'when-then rules' which the therapist uses to determine how to deal with an increasing range of situations. The personal ('self-schema') and professional self ('self-as-therapist') are conceptually distinguished, whilst also inter-related. The model is comprehensive and the author has highlighted some predictions around skill development derived from the model which require empirical investigation to ensure their validity. The author for example, hypothesised that experimental manipulation in a training group to increase trainee reflection should enhance learning and trainees engaging in self-reflection practices should show enhanced perceptual skills. The model offers no explication of what enables or detracts from learning the required elements of the skill.

Another important theory in considering PPD is transformative learning, which relates to the adult learner model (Mezirow, 1997) and involves holistic change in a person (Hughes, 2009). Mezirow's theory acknowledges that adults, unlike children, have a well-developed and relatively stable frame of reference, which include cognitive, conative and emotional impacts on SPC over time.

Adult learners have a tendency to fit their experiences in the world *into* their preconceptions, and transformative learning involves movement towards a more 'inclusive, discriminating, self-reflective and integrative of experience' frame of reference (*ibid,* p.5.). Mezirow argues transformational learning can occur from a 'disorientating dilemma' (Mezirow, 2000, p.22), which seems to be reflected in Hughes and Youngson's (2009) model. It can be encouraged through 'critical reflection of assumptions, validating contested beliefs through discourse, taking action on one's reflective insight, and critically assessing it' (Mezirow, 1997, p.11).

Mezirow proposed a hierarchical framework for reflective practice; with two levels; moving from the 'consciousness level' to the higher level of 'critical consciousness'. Scaife (2010) argues that these levels equate to 'thinking' and 'metacognition' respectively. These levels of processing are important in becoming aware of one's assumptions in order to critically appraise them. At the consciousness level there are four layers: becoming aware of habits of one's perceiving, thinking and acting (*reflectivity*); awareness of feelings about these habits (*affective reflectivity*); the process of assessing the efficacy of these habits (*discriminant relectivity*) and awareness of how one makes judgements about these habits (*judgemental reflectivity*). At the critical consciousness level there are three layers; critically appraising the worth and morality of the concepts used to evaluate one's experiences (*conceptual reflectivity*); recognising the prejudices implicit in values and their impact (*psychic reflectivity*) and being aware of the influence of underlying assumptions and experimenting with other modes of seeing, thinking and doing (*theoretical reflectivity*) (Scaife, 2010).

The transformational theory of learning can be paralleled with Marton and Säljö's (1979) concept of Deep, Strategic and Surface Learning (Hughes, 2009). These learning styles are not attributes of an individual but styles that may be used at different times, although learners may preferentially use one over the other. Deep learning requires making sense of abstract meaning and relating subject matter to the external world and interpreting and understanding reality in a different way. It would seem that PPD involves more than surface learning. Although aspects of risk management may involve surface learning, for example in learning risk protocols, there is a need for deep learning too. Emotions may, as Bennett-Levy & Beedie's (2007) model suggested, impact on SPC but may also impact on learning. Lombardo *et al.'s* (2009) review of the role of emotions in professional development through clinical supervision suggested a need for 'moderately charged emotional environment' to facilitate deep learning, with the supervisor needing to work around the zone of proximal development (Vygotsky, 1978).

### 1.5.5 Summary

Relevant models of learning which relate to the development of PPD competence have been discussed. Sheikh *et al.'s* (2007) circumplex model of PPD focuses on the relationship of the individual CPIT with their learning context and the sets of process which develop learning and potentially acts as buffer against stressors. Reflection is considered central to the learning processes. Bennett-Levy and Beedie's (2007) model on the influences on SPC also emphasise

reflection as a core process and highlight the overly influential role of emotional memories on SPC. Bennett-Levy's model of therapist skill development suggests the systems which operate in therapist skill development but do not explicate what enables or detracts from learning. Mezirow's (1997) transformative learning model also highlighted the importance of reflection in challenging the adult learners' rigid frames of reference. All have the potential to explain aspects of the process of PPD amongst CPITs. Their utility in explaining the CPITs' reflections on managing risk and PPD will be evaluated in the discussion.

## 1.6 Systematic Review

### 1.6.1 Developing the scope of the Systematic Review and Question

The literature review so far has identified the different modes of acquisition of clinical PPD competence and highlighted the importance and challenges of transferring theoretical knowledge to clinical practice. There is a need to consider how learning and PPD competence occurs within clinical practice and this study will explore CPITs' reflections of their competence development in the context of managing risk situations at the limits of competence. A systematic review was initially focused on addressing the question: "*how do trainees develop psychotherapeutic PPD competence at the interface with managing risk in mental health?"* Examination of the extant literature, revealed insufficient literature to review. The examination of qualitative literature was prioritised given the nature of this study, although this was very limited. The scope of the search was consequently broadened in terms of *context* and *profession* of learner. The new refined research question was: "*In developing PPD competence, how does managing challenging situations including risk, impact on trainee health practioners' perceived learning process*?" It is acknowledged that the organisational context and role of health professionals is different to those in mental health. However, given the lack of literature on the process of developing competence in managing risk and PPD, it was felt that this literature would usefully illuminate the trainees' experience of learning through challenging clinical experience and the processes involved.

This review presents a structured and critical synthesis of previous research in order to provide an up-to-date knowledge of trainees' perceptions of their personal and professional competence development in the context of managing challenging clinical situations. This section outlines the search process, describes the included studies, critically evaluates the

quality of studies, and provides a narrative synthesis of research findings and implications for future research.

### 1.6.2 Search Strategy

The following databases were searched: OVID database including 'PsycINFO' and 'PsycARTICLES Full Text' and 'Ovid MEDLINE® without Revisions', ASSIA, Scopus and The Cochrane Library.

#### 1.6.2.1 Search Terms

Three separate searches were carried out to ensure relevant studies were identified. The search terms 'trainee' and 'risk' and 'mental health professional' and 'competence' and 'anxiety' (and all relevant variants of these terms, see Appendix 1) were combined using Boolean operators. Given the lack of relevant articles yielded, the search terms were modified and the 'anxiety' terms were replaced with 'clinical experience' related terms. Given the lack of relevant articles yielded again, the key terms in the most relevant articles were interrogated and a further search was conducted adopting these terms. 'Risk' was supplemented with terms related to 'challenge', professional roles were adapted to include 'nurses' and 'GP's, and 'trainee' was supplemented with 'recently qualified' and 'newly qualified'. The search was limited to 2002-2013 as the BPS/CTCP have only been specified learning outcomes using the 9 competencies since 2002.

#### 1.6.2.2 Inclusion and Exclusion Criteria

Inclusion criteria:

- qualitative studies
- studies which explore health professionals' experience of managing challenging clinical situations *and* what impacts on their professional development and learning.

Exclusion Criteria:

- reviews or meta-analyses
- studies which addressed PPD but not in the context of managing risk/or challenging clinical situations
- studies which addressed managing risk but not PPD

- studies which address the interface between challenging situations and PPD indirectly, for example, focusing on trainers, clients (not the therapist themselves)
- studies which are quantitative
- studies which use risk management guidelines and check whether the clinician is meeting these guidelines
- studies which use competence/learning outcomes and check if the professional has completed and demonstrated that they can meet these criteria.

#### 1.6.2.3 Search Process

The search generated 13,554 titles, which were reviewed according to the exclusion and inclusion criteria (see Appendix 1 for a detailed breakdown of the three searches). Ninety two papers were examined in more detail and 87 were excluded on the basis of the specified criteria. Grey literature (including Clinical Psychology Forum (1999-2001; 2008-present), Google Scholar, Google and reference lists from articles found were also searched which generated a further three articles. In total, 8 studies were retained for inclusion in the review.

### 1.6.3 Summary of Included Studies

Table 1 presents a detailed description of the studies included in the review. A short narrative account of the included studies is provided below to illustrate the design, method and characteristics of the participants across the literature reviewed. [2]

#### 1.6.3.2 Sample

Half of the studies selected their sample purposively (3,4,5,6). Three studies used convenience sampling (1,2,8) and one used theoretical sampling (7). The professional groups were varied in the sample: Half of the sample were medics: Post-graduate GP trainees (first, second and third year) (5): Second year, final year GP trainees and three newly qualified GPs (3); medical students who had completed 18 month internship in last six months (4) and junior doctors (Foundation Years one and two and SpRs (7). Two studies involved baccalaureate nursing students: second, third and fourth year (6) and senior nurse students (1). One of the study's sample consisted of second year MA students in Counselling Psychology (2) and the other was of dental undergraduates (1st year) and dental therapy students with one year's experience.

[2] The numbers shown in parentheses refer to the numbered studies listed in Table 1

**Table 1: Summary of studies used in systematic review**

| No | Author | Aim | Method(design, data collection & analysis | Participants | Quality Rating (Derived from Figure 2) | Findings | Discussion |
|---|---|---|---|---|---|---|---|
| 1. | Cooper, C, Taft, L.B. & Thelen, M.C. (2005)<br><br>Conducted in USA. | To understand students' reflections on their final clinical experiences before graduation. To inform strategies to smooth the transition from being a student to becoming an registered nurse(RN) | Qualitative design, using naturalistic inquiry. Content analysis/thematic analysis of student nurses' reflections on their weekly clinical experience posted on website 168 descriptions of clinical situations or incidents, including thoughts and feelings were analysed by 2 researchers. | Convenience sample: 32 senior baccalaureate nursing students enrolled in one nursing programme. All were female; 99% Caucasian. Average age- 23 years | 11/20 | Seven themes:<br>*-being aware of human vulnerability*<br>*- feeling the weight of RN responsibility*<br>*- recognising limits*<br>*-evaluating self*<br>*-seeing things from the patient/family perspective*<br>*-confronting ethical issues*<br>*-facing reality versus expectations* | Most students' self evaluations were of feeling 'capable and effective' towards end of training. Authors concluded students need to be able to discuss: ethical issues and professional issues, and clinical tensions and dilemmas to foster understanding and growth in professional practice. Recommend that staff help students identify their resources. Improved staff understanding of trainees' anxieties may allow for development of proactive rather than reactive strategies. Students' benchmark themselves against qualified staff which can negatively affect self esteem.. Authors suggest reflective writing important as learning tool. |
| 2 | De Stefano, J, Atkins, S. Noble, R.N. (2012)<br><br>Conducted in Canada | To understand how trainees react to and resolve the challenges presented by difficult counselling cases & what their | Qualitative research design. Semi-structured interviews (45-60 mins). Interviewed by 4th year PhD student in school of psychology. Question areas: understanding of self-injury (SI); ideas of prevalence of SI in the population; their experiences of working with | Convenience sample from 2nd yr MA students in counselling psychology programme from 1 university. 12 female pts. Aged 23-37. All | 15/20 | Three general themes:<br>*- trainees create intuitive model of SI* - that reflects some understanding of phenomenon despite lack of previous knowledge<br>*- stressful & challenging at many levels* - provokes multiple emotions, stimulates focussed attention & alertness, uncertainty stirs up feelings of incompetence, | Trainees manage multiple tasks: their emotional arousal, non verbal communication, suicide assessment & clinical strategies. Given naivety often use 'relational bond' as main technique. Supervision as main support but different goals between supervisee and supervisor may lead to disappointment. Trainees lack a cohesive narrative of overall impact |

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| | | experiences reveal about their evolving clinical development & training | clients who SI, interventions used & outcomes; their feelings in this work, supervision; their ideas about how they would intervene in the future. Analysis using Consensual qualitative research which uses research teams to reach consensus of ratings and ratings checked by auditor | Anglo-European All to have worked with 1 or more clients who had engaged in SI in last 9 months | | resolving ethical/legal conflicts frees trainees to focus on clients' behavioural & emotional issues *-experiences provide new but incomplete learning* - supervision provides mixed benefits. | of experience. Supervisees use supervision for procedural goals but not more complex tasks of professional development. Specific training in working with SI needed. |
| 3 | Dory, V., Beaulieu, M-D, Pesiaux, D., Pouchain, D., Gay, B., Rocher, G & Bocher, L. (2009).<br><br>Conducted in Belgium & France. | To explore trainees' vision of general medical practice and subjective preparedness for practice. | Qualitative research design. Open-ended questions exploring: feelings around entering profession, challenges faced, how training has prepared them for practice, anxieties and resources held. Analysis using immersion-crystallisation method. 3 out of 7 researchers in team, immersed in data to find themes, then generate hypotheses and link to theoretical frameworks. | Purposeful sampling. 24 final year GP trainees, 1 second year trainee and 3 recently qualified GPs. 5 focus groups (3 in Belgium; 2 in France) | 14/20 | Self-efficacy beliefs developed in two stages:<br>*-incompetent beginning with low self-efficacy beliefs.* Faced with novel situations, felt training too theoretical & can feel overwhelmed. Lack experiences of success with patients led to low self-efficacy beliefs.<br>*-stage 2- training as potential path to mastery*. Some trainees used avoidance; others more problem-focused coping. Constantly developing competence, gaining positive feedback. | Suggest initial low self-efficacy may be linked to lack of transferability of successful experiences from hospital settings to GP & unrealistic patient expectations. Strategies to cope follow Bandura's Self Efficacy model. Some trainees 'get on with it' whilst others doubtful about competence. Further research needed in development of self-efficacy beliefs during training and on educational strategies employed. May be beneficial to reassure trainees that initial feelings of incompetence 'normal'. Individual training strategies needed to help programme appropriate level of autonomy to enable PPD of different trainees. |
| 4 | Høifødt, T.S., Talseth,A-G. & Olstad, R. (2007)<br><br>Conducted in Norway. | To explore the meaning of newly educated physicians lived experiences of learning processes related to treating patients | Qualitative using phenomenological hermeneutic method. Semi-structured narrative interviews (90-120 mins). Participants discussed treating suicidal patients. Analysis using a phenomenological-hermeneutic approach. | 13 medical students who had completed 18 month internship in last 6 months. 9 working in general practice, remaining in hospitals. None | 12/20 | Main theme: *Being in a transitional learning process.*<br>Four themes:<br>*- preparing for practice*<br>*-gaining experiences from treating patients.*<br>*-participating in the professional community*<br>*- developing personal competence*. | Beneficial aspects of medical training for working with suicidal patients: practical guidance, role-play and developing awareness of own attitudes in interactive workshop. Experience necessary to develop theory practice links. Develop databank of patient histories helps develop competence. Supervision may not adequately |

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| | | | | currently working in mental health. 7 men and 6 females. All about 30 years of age. | | | addressing learning needs. Need for more systematic critical reflection on and in practice, attention to feelings and more performance feedback from supervisors. |
| 5 | Sagasser, M.H., Kramer, A. & Van der Vleuten, C P M (2012).<br><br>Conducted in The Netherlands | To explore how postgrad trainees regulate their learning in the workplace, how external regulation promotes self regulation and which elements facilitate or impede self-regulation and learning | Qualitative study using American phenomenological approach. Semi structured interviews (30-45 mins). Participants asked to describe a difficult situation in practice & reflect on this: what they did to handle the situation, what they did to keep records of things to learn, how they pursued learning and they eventually estimated what they learned. | Stratified purposeful sampling. 21 participants: 10 1st year and 11 3rd year trainees in postgrad training in General practice. All from one university. | 14/20 | Two main themes of GP trainees' self-regulation:<br>-*self regulation loops* – short & long<br>Short loop regulated internally and related to more easily solved problems. Motivation to seek declarative knowledge. Clinical outcomes and supervisors' opinion can influence trainees' self confidence<br>Long loop for complex or recurring problems.<br>-*elements influencing self-regulation*- personal (e.g. motivation to do well vs. poor concentration; passive vs. active learning style), interpersonal (supervisory relationship, peers, mentors) & contextual elements (organisational culture, patient types, time pressure) | Long & short loop learning as reactive learning sparked by situation and awareness of knowledge gap. Schön's reflection in action and on action. Self assessments based on confidence to perform competently. Trainees should seek supervisory opinion about competence to develop accuracy.<br>External assessments not very conducive to motivation & suggest that supervisors/mentors should promote use of assessments by alerting trainees to relevance of this feedback for their performance in practice. |
| 6 | Sharif, F. & Masoumi, S. (2005)<br><br>Conducted in Iran. | To investigate student nurses' experiences of their clinical practice | Qualitative research design. Focus groups & 'qualitative content analysis' adapted from approaches of Granheim & Lundmann (2004) & Stewart & Shamdasan(1990).<br>9 open-ended questions were used to elicit experiences about being a | 30 students from the 2nd,3rd and 4th yr. of baccalaureate nursing studies from Shiraz university of Medical sciences. 94% female; 86% | 10/20 | Four main themes:<br>-*initial clinical anxiety*: worries about lack of competence; fear of harming patients, fear of failure. stress reducing as progress.<br>-*theory-practice gap:* can be dissonance between meeting needs of tutor & practising nurses in clinical situations<br>-*clinical supervision:* feeling that | Students experienced clinical work as very stressful, especially in second year. Need to develop confidence in order to increase competence. Clinical supervision instrumental in developing confidence, role socialisation and independence. Professional role – self evaluation contributes to self-concept and professional socialisation. A need to |

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| | | | student in nursing and to talk about clinical experiences which find anxiety producing and enjoyable. | single aged between 18-25. | | instructor is evaluative more than formative<br>-*professional role:* feeling work was not 'professional'- as blurring of roles of professional nurse and auxiliary nurse. | improve clinical skills training especially around making theory-practice links and quality of supervision to increase self perceptions of competence. |
| 7 | Tallentire, V.R., Smith, S.E. & Skinner, J. & Cameron, H.S. (2011)<br><br>Conducted in Scotland. | To explore what factors influence the behaviour of junior doctors in caring for acutely unwell patients in an acute care context. To develop a framework that promotes understanding of these processes. | Qualitative study using focus groups and grounded theory approach.<br>6 focus groups (70-95 mins) with 4-8 participants.<br>Discussions based on: What factors do you feel affect newly qualified doctors' behaviour when caring for acutely unwell patients? How well do newly qualified doctors cope when faced with an acutely unwell patient? In what ways does undergraduate training prepare the newly qualified doctor to deliver care to an acutely unwell patient? | Theoretical sampling model. 36 clinicians with variety of clinical experience (Foundation year 1(11) and 2 (12)) and Specialist Registrars (SpRs)(13) | 17/20 | Six main themes within three overarching themes:<br>***Cognitive challenges***<br>-*transferring knowledge into practice* - challenge of knowing 'how' feeling unprepared<br>- *decision making and uncertainty* - challenge of treating without knowing diagnosis etc., tend to prematurely diagnose to create certainty.<br>***Roles and responsibilities***<br>-*acts and omissions* - worse to act in error than to harm through not acting<br>-*identity and expectations*- disparity between level of responsibility received and what felt comfortable. Fear of critical judgement of seniors.<br>***Environmental factors***<br>-*the medical hierarchy*<br>-*Performing under stress*- can feel overwhelmed. Seniors tend to ignore emotions. | Authors have developed a conceptual framework showing the major influence, and their inter-relationships, on the behaviour of newly qualified doctors caring for acutely unwell patients.<br>Cognitive challenges may be enabled by improving situation awareness. Role of others in reducing medical errors. Rigid hierarchy of medical environment unhelpful and need to encourage junior doctors to accept gradual acquisition of responsibility. Simulation important in training but needs to recreate the hierarchical and stressful environment of clinical practice. Need for junior doctors to be aware of interplay of emotion, affect, decision making and behaviour in influencing errors. |
| 8 | Woodman, T., Pee, B., Fry, H. & Davenport. (2002). Conducted in UK. | To gain information on dental undergraduate and dental therapy students' perspectives of | Qualitative study& simple thematic content analysis in naturalist tradition on a reflective learning activity 'learning experience'.<br>Questions focussed on: Students' reflections on their learning and what was | 37 students (21 dental undergraduates with one year's clinical experience, and 16 1st yr. dental therapy | 11/20 | *Emotions* in learning experiences cited were mostly negative; anxiety and hopelessness.<br>*Development as professional:*<br>Value in the ability to feel and appear calm in clinical situations; clinical competence, perseverance and managing uncertainty. | Students reflections focussed on weaknesses in performance. Need for educators to encourage reflection on positive learning and positive feedback.<br>Students' idea of professional identity is confident inside and outside yet they lack confidence and must appear |

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| | | their training, development and emerging professional characteristics. | important.<br>Students' feelings about their learning experiences<br>Students' perceptions' of their development as professionals and ways of knowing | students).<br>Dental undergraduates all aged between 20-23 years (mix of Male and female).<br>Therapy students were all female, aged 20-48 years). | | | confident. Students' emotions may not be apparent but may need attending to by teachers to optimise learning & to improve students' self worth. |

Ethnicity was mentioned in only two of the studies. Study (1) was 99% Caucasian and Study (2) Anglo-European. The studies were from a range of countries. Five were conducted in Europe: Belgium and France (3), Norway (4), Netherlands (5), Scotland (7), UK (8). The others in USA (1), Canada (2) and Iran (6).

### 1.6.4 Quality Review

A critical evaluation of the studies will be advanced. The aim of this review is to establish the quality of the research findings using a number of criteria. Frameworks have been developed to guide the assessment of quality in qualitative research (e.g. CASP, 2010; Elliot *et al.*, 1999; Spencer, 2003; Tracy, 2010). This study assessed quality using the CASP criteria as it has been developed and tested over time and is recommended for use in the NHS (Campbell *et al.* 2011).

A scoring system was applied to the ten criterion for quality assessment outlined in the framework. This offered a systematic method for comparing and contrasting quality between articles (Chenail, 2011). Each criterion was rated as either 0 (no fulfilment of criteria), 1 (partial fulfilment) or 2 (fulfilment of criteria) and a summative score was given out of a total of 20.

The results of this process are summarised in Appendix 2. The articles were of variable quality with scores ranging from 11/20 to 17/20.

#### 1.6.4.1 Narrative of Quality Review Research

##### 1.6.4.1.1 Aims, Methodology and Design

All studies had a clearly stated aim and had appropriately used a qualitative methodology. Only two studies (3,5) discussed and fully justified their choice of research design. The others only partially justified their design. The epistemological position of the research is not discussed in any articles.

##### 1.6.4.1.2 Recruitment and Data Collection

All studies, except study (5), were transparent about the process of participant recruitment. No study fully explained their sampling decisions or considered why participants might have declined or accepted. The method of data collection was clear across all the studies, but all studies only partially fulfilled the overall criteria for quality. None, where relevant, discussed

data saturation and only the studies which used narrative accounts made it clear where data was collected (1,8). No study mentioned a requirement for modification of their studies during the process.

#### 1.6.4.1.3 Reflexivity

Only one study (7) explicitly considered the position of the researcher and the potential biases and influences of this position. Studies 1,4,5,6,8 totally neglected this criteria and this was a notable weakness.

#### 1.6.4.1.4 Ethical Issues

Half the studies (3,4,5,7) clarified the ethical issues of consent, confidentiality and ethical approval. Confidentiality was not mentioned in 3 of the articles (1,2 ,6).

#### 1.6.4.1.5 Data Analysis

Only 2 studies were considered to be fully rigorous in their explanation of the data analysis process, and also considered researcher bias and triangulation (2, 7). All studies adequately supported themes with quotes.

#### 1.6.4.1.6 Findings and Value of Research

In all studies, findings are explicitly presented with supporting quotes. Only one paper (7) derives a conceptual framework demonstrating the relationships between themes and with clear implications for practice. All relate findings to current practice with practice implications. Some papers show evidence of a more thorough analysis with greater distillation of themes (2,3,5,7) and stronger links to theory. Others are overly descriptive. Credibility is discussed in most studies, although not at all in study 6. None of the studies triangulated the emergent themes with participants, but referred to triangulation predominantly through use of more than one analyst. Only three of the studies discuss implications for future research (2, 3,5).

#### 1.6.4.1.7 Summary

The quality of these articles is variable, as suggested by the total scores. Although all studies defined their aims, method and design clearly, other aspects of their quality are less transparent. Most of the studies defined the recruitment process, the method of analysis, and mode of data collection. In some articles, the brief and general descriptions of the analytic

process suggest a lack of rigour. None of the studies explored issues of epistemology, and reflexivity was also often neglected. All the relevant ethical issues were not explicitly discussed in most articles. None of the articles explicitly referred to quality frameworks in critiquing their own studies. These limitations are borne in mind when considering the findings of the literature. The quality review however, does strongly highlight the need for further quality research in this area and specifically within clinical psychology.

### 1.6.5 Thematic Narrative synthesis

A thematic narrative synthesis of the whole body of literature is presented. Lucas *et al.* (2007) suggested that thematic synthesis is useful in attempting to draw conclusions based on common elements across otherwise heterogeneous studies. This style of synthesis therefore seems particularly pertinent to this study, since the literature has been drawn from a diverse literature, conducted in the context of different health professions and with differing aims. The commonality of the studies is their implicit exploration of the learning process and PPD through the experience of managing challenging clinical situations. The author followed Walsh & Downe's (2005) method of conducting thematic narrative synthesis, which involves analysing similarities and difference across the literature reviewed. Initially, the articles were read and initial codes derived from the studies. Homogeneity was then explored across the studies (see Appendix 3). Finally, themes emerging from across the studies were developed. The occurrence of the themes in the individual studies is presented in Table 2. This process was triangulated with the clinical supervisor. These emergent themes are now discussed, drawing particularly on the papers with higher quality ratings from the CASP methodology and commenting on the credibility of the findings where lower quality papers are referenced.

#### 1.6.5.1 Emotional experience

In the majority of the studies, including the papers with more rigorous analysis and clear statements of findings (e.g. de Stefano *et al.,* 2012*;* Tallentire *et al.,* 2011*),* trainees[3] described the experience of managing clinical situations as emotionally intense, often with 'powerful, multiple emotions' (De Stefano *et al.*, 2012, p.296). These emotions were often fear based: 'anxiety' (De Stefano *et al.*, 2012; Sharif & Masoumi, 2005; 'panic' (Tallentire *et al.*, 2011); 'overwhelmed' (Dory *et al.*, 2009); helplessness (Woodman *et al.,* 2002). A few

[3] The term 'trainees' will be used to describe the learner status of the participants when referred to generically across the sample.

**Table 2 : Occurrence of themes across the literature (X indicates presence)**

| | Learning & performing promoted through stress | Emotional experience | Reflection on action | Building self efficacy and confidence | Self –regulation and reflection | Factors enabling and inhibiting use of supervision | Identity & Expectations |
|---|---|---|---|---|---|---|---|
| Cooper *et al.*, 2005 | x | x | x | x | x | | x |
| De Stefano *et al.*, 2012 | x | x | x | | x | x | x |
| Dory *et al.*, 2009 | x | x | | x | x | | x |
| Høifødt *et al.*, 2007 | | x | x | x | x | x | x |
| Sagasser *et al.*, 2012 | | | x | x | x | x | x |
| Sharif & Masoumi, 2005 | | x | x | | x | x | x |
| Tallentire *et al.*, 2011 | x | x | | | x | x | x |
| Woodman *et al.*, 2002 | | x | x | | x | | x |

studies suggested some experienced positive affect: 'excitement' (Cooper *et al.,* 2005); 'pride' (Woodman *et al.*, 2002). However, both of these studies lacked analytical rigour and based on the CASP methodology are less credible. The function of this emotional experience was not explicitly discussed in the process of PPD. Woodman *et al.* (2002) speculated that trainees may mask anxiety in order to present a confident exterior. The authors suggested that trainers should prompt and offer support, as otherwise trainees' hidden anxiety may impede learning. They did not comment on the nature of this process nor did they justify the premise of this conclusion.

Across the literature, authors emphasised the need for structures to enable trainees to manage emotional skills. Emotional regulation was explicitly discussed in De Stefano *et al.'s* (2012) study, notably in relation to its benefits to professional effectiveness within the therapeutic context. Regulation was reported to enable trainee counselling psychologists form secure therapeutic alliances with people who self-injure (SI). Tallentire *et al.* (2011) highlighted the need for emotional skills training in basic medical training, due to the potential for unmanaged emotions to affect performance in 'dynamic high stakes situations' (p. 1003). The basis of this recommendation was grounded in the themes and reinforced by quotes. Based on their reported findings, they conceptualised that the strength of these emotional reactions were exarcerbated by a number of factors within the junior doctors themselves and the learning environment: for example, challenges with role adjustment and unrealistic expectations of the self reinforced by demanding culture of hospital medicine (*ibid.*, 2011). Dory *et al.* (2009) noted a 'split' between most trainees 'getting on with it', whilst other displayed anxiety and doubts about becoming competent practitioners. The authors (*ibid*) did not interrogate the factors which influenced this difference and overall their analytical process was less clear and credible. The phenomenon described however, does potentially echo the split in 'psychological adaptation' and functioning amongst CPITs (e.g. Kuyken *et al.*, 2000). The authors highlighted the need for trainers to consider individual difference when establishing the pace at which autonomy is introduced in clinical practice.

#### 1.6.5.2 Learning and performing promoted through stress

In many of the studies, trainees reported feeling out of their depth in some clinical situations but reported learning about their capabilities and their performance gaps, and uncovered ways of coping through these experiences. De Stefano *et al.* (2012) described how trainees, often

with insufficient theoretical knowledge to apply to working with people who self-injure, intuitively fell back on a person-centred approach with clients. They suggested this strategy provided sufficient safety to allow them to develop skills within the therapeutic encounter and build competence. Stress was also suggested to heighten attention and motivation to learn (Tallentire *et al.*, 2012; Dory *et al.*, 2009).

Whilst, for most trainees, the experience of stress was described as transient, it was suggested that it can potentially interfere with decision-making. In contexts of high risk, this has important implications. Tallentire *et al.* (2012) highlighted how many junior doctors sought to perform at the competence level of 'master practitioners'. The authors suggested that this aspiration can increase the junior doctors' anxiety, in the context of their fear of making mistakes and fear of judgement, and the other stresses of working in acute care. These combined factors, it was suggested, may affect clinical decision making. The authors recommended that a culture shift is required from top down, in order to recognise that human fallibility and help seeking is acceptable. They suggested that senior medical staff need to promote more realistic models of performance and help seeking, so as to improve patient safety.

#### 1.6.5.3 Reflection on Action

Reflection on action refers to the active focus on a clinical event and critical analysis and synthesis of cognitions, behaviours and emotions experienced which are evaluated to inform learning (Atkins & Murphy, 1993; Orchowski *et al.*, 2010). Whilst these processes are alluded to in many of the studies, the majority of these studies are of low quality. None of the studies interrogated the *process* of reflection on action or distinguished how specifically it enables or detracts from PPD learning. A number of the lower quality studies suggested the importance of reflection on action in supporting emotional growth and learning but did not explain how this occurs or what might hinder this process (e.g. Høifødt *et al.*, 2007; Sharif & Masoumi, 2005; Woodman *et al.*, 2012). This finding needs further empirical evidence to be qualified.

A number of the authors recommended the need to enhance reflective practice as a tool for learning (e.g. Høifødt *et al.*, 2007; Sagasser *et al.*, 2012: Woodman *et al.*, 2002) but these claims do not seem founded in the reported findings. Furthermore, reflective practice is not

well specified and the use of terms such as 'critical reflection'(Sagasser *et al.*, 2012) or 'describe and go through the situation' and 'reflecting together' (Høifødt *et al.*, 2007) are vague. Sagasser *et al.* (2012) suggested that trainees used a long self-regulation loop, alongside external regulation, to guide learning from clinical work or organisational difficulties. They related this process, which utilised consultation, supervision and knowledge acquisition, to 'reflection on action'. The authors also stressed the importance of critical reflection to examine 'one's attitudes, and frames of references on (implicit) habits, behaviours, professional acting and professional learning' (*ibid*, p.73). The process described as 'reflection on action' was not rigorously interrogated but the authors suggested that the process should be guided by supervisors to ensure that trainees are not learning inadequate competencies, habits or behaviours.

#### 1.6.5.4 Building self-efficacy and confidence

This theme emerged in half the studies, three of which were studies with medical trainees. In Sagasser *et al.'s* (2012) study, it is noted that trainee GPs' approach to supervision changed with increasing confidence. Initially, trainees checked most actions undertaken with patients, but over time this reduced to discussion of specific issues needing clarification. Supervision and positive clinical outcomes after consultation were perceived to contribute to this confidence development. This finding was well grounded in the themes and quotes.

In Høifødt *et al.'s* (2007) study of young physicians treating suicidal patients, participants were reported to develop a 'gut feeling' based on patient contact that enabled greater security and confidence in their judgments. Confidence was also attributed to incrementally developing an understanding of client's narratives over time, which in turn was enabled by greater confidence in asking questions. The authors concluded, amongst other things, that tacit knowledge guiding 'gut feelings' needed to be made more explicit and accessible in order to be validated and refined. Whilst the analytic process and overall quality of this paper was low, this finding gains credibility due to its replication in Sagasser *et al.'s* (2012) higher quality study. The authors (*ibid.*, 2012) similarly expressed concerns about the quality of learning from self-reflections and the need for assessment of this. These studies noted the importance of accuracy in self-assessments of confidence and self efficacy in order to ensure safe, autonomous practice.

#### 1.6.5.5 Self-regulation and reflection

All studies highlighted the role of regulating one's own learning to identify gaps in declarative knowledge, make theory-practice links, and evaluate performance skills. Self-regulation was seen to be an important foundational skill which can inform productive CPD. It was also considered essential given the number of situations faced in which trainees may not know the procedures to follow, or the inter-personal approach to adopt to enable effective management of a situation (e.g. De Stefano *et al.*, 2012). An important part of self-regulation was reported as the ability to work more comfortably with uncertainty, and using this feeling to motivate learning where possible. Sagasser *et al*. (2012) highlighted that GP trainees often self-directed their learning and assessed their performance through self-evaluations of confidence or checking against guidelines.

De Stefano *et al.* (2012) suggested the importance of reflection with a supervisor in making sense of emotionally arousing clinical experiences. They noted that:

> *participants often presented a fragmented, difficult to articulate understanding of their learning when asked about the overall impact of the experience…this tacit knowledge was not converted into a more nuanced and complex understanding of their work or the phenomenon of non suicidal self-injury (NNSI)* (p.301).

The authors argued that supervision should be used to consider the more complex aspects of personal development, as well as procedural issues, as an 'antidote to feelings of incompetence' (p.302). Barriers to self-regulation processes were referred to, in Sagasser *et al.'s* (2012) study as time pressure, time management and absence of certain types of patients to learn from. None of the studies considered what enables effective reflection or self regulation and there seems to be an implicit assumption that it in itself, no matter what form it takes, is positive.

#### 1.6.5.6 Factors enabling or inhibiting use of supervision

Half the studies emphasised the role of facilitators, although two of these studies were assessed as being of lower quality (Høifødt *et al.,* 2007; Sharif & Masoumi, 2005). Supervisors are considered important in supporting learning and motivation, through encouraging trainees to discover things (Sagasser *et al.,* 2012). Other studies highlighted the importance of supervision in developing and broadening tacit knowledge and enabling

learning (Sagasser *et al.*, 2012) as well as supporting and counteracting feelings of inadequacy (De Stefano *et al.*, 2012) which are argued to help with clinical skills.

Quality of supervision was often described as variable and a number of the authors described aspects of supervision that can be inhibiting. Tallentire *et al.* (2011) reported on the lack of attention to processing or considering the emotional experience of trainees. Others reported limited or distant supervision as unhelpful (Sagasser *et al.*, 2012) and supervision which lacked direct guidance and support for learning (De Stefano *et al.*, 2012). De Stefano *et al.*(2012) hypothesised that dissatisfaction in the supervisory relationship may result from differing perceptions of supervision goals. Trainees are suggested to want to receive procedural guidance and discrete techniques (the know how) and supervisors may instead focus on enabling trainees to develop sense of own resources and autonomy.

#### 1.6.5.7 Identity and expectation

Identity and expectation emerged as a theme across all the articles. Trainees, through managing challenging clinical situations, were confronted with understanding and resolving ethical dilemmas (e.g. Høifødt *et al.'s* 2007; De Stefano *et al.*, 2012), developing confidence in their emerging professional identity (e.g. Sagasser *et al.*, 2012), recognising the limits to their autonomy (Tallentire *et al.*, 2011). Some of these dilemmas were initiated by the immediate clinical experience and their subsequent reflections. Supervision was often reported to be important in processing these issues (e.g. De Stefano *et al.*, 2012).

#### 1.6.5.8 Implications for future research.

It is evident from this systematic review that there is very limited qualitative research on the development of PPD in the context of managing clinically challenging situations. Many of the studies which exist are of limited quality, seem to lack analytical rigour and limit the processing of the results to a descriptive level. There has been little attempt in the literature to develop an understanding of the process of *how* PPD competence is perceived to develop. The studies found were also dominantly from the perspective of medical and nursing trainees in health professions, whose professional role, responsibilities, training and PPD supports are different from CPs. Only one study explored the development of professional competence in the context of managing risk from a psychologists' perspective (albeit counselling psychology) but was largely focussed on the specific area of managing self-injury (De

Stefano *et al*., 2012). Consequently the relevance of these findings to clinical psychology may be limited.

The author was unable to find any studies exploring the perspective of CPITs. Although some PPD issues are shared with other health professionals, the context of mental health may present different challenges to be overcome in developing personal and professional skills competence. For example, supervision needs and provision is different amongst mental health professionals, due to the particular sets of competencies to be developed (Binnie, 2011). Additionally, the articles that have been reviewed make little attempt to link experiential knowledge with psychological theory. Some articles refer to specific theories, such as Bandura's (1994) self-efficacy theory and self-regulated learning (Boekarts, 1991) but none have attempted to model the development of PPD competence within existing psychological theories of learning.

The issue of patient safety emerges in a number of the studies, and in particular how some clinical practices might compromise this. This reinforces the importance of understanding the development of competence in this area, and the challenges of working at the limits of one's competence. It also highlights the significance of developing an accurate appreciation of ones' competence in order to ensure that trainees are taking on appropriate levels of autonomy and the importance of trainees' perceived safety in seeking a second opinion or support. It is important to understand whether these processes are similar in the context of CPITs, especially given their potential for undertaking leadership, consultancy roles as NQCPs and the consequent need for safe practice.

The articles, although exploring competence whilst working in challenging clinical practice, do not mostly focus on risk management. There seems to be a real gap in the literature around understanding PPD through the management of challenging clinical situations and risk. PPD is an important area to understand in order to inform its facilitation on training courses, and particularly in the context of risk given government policies current emphasis of the need to reduce harm.

#### 1.6.5.9 Conclusion

In conclusion, the author was unable to find any qualitative studies exploring CPITs professional development in the context of managing risk. There is a small literature on trainee health professionals' experiences of managing challenging clinical situations, which

has been reviewed. The systematic review included eight qualitative studies which met the inclusion criteria and were explored in more detail. A summary of these studies, a review of the quality, and narrative synthesis of the findings were presented. Given the lack of research with CPITs' experiences of managing risk and perceived competency development, it is recommended that further research in this area is conducted.

## 1.7 Current study

### 1.7.1 Study rationale

PPD is a core competency requirement and is fundamental to becoming a competent, autonomous professional. The role of CPs is evolving and increasingly involves supervision, consultancy and leadership for other professional groups, early in the career progression. The role of PPD is therefore vital in order to have the required level of competence in understanding and managing complexity, but also in managing one's learning requirements, self care and resilience in coping with the challenges implied.

PPD is still in its infancy as a competency. As stated in the introduction there is still considerable variation in definitions and understanding of processes of PPD and reflection. Lack of clarity in definitions inevitably impacts on the transparency and transferability of empirical knowledge gained across studies. It has been suggested that efficacy and appropriateness of teaching and assessment methods has not been rigorously interrogated. In addition, there is a lack of research on the development of personal and professional skills, per se, which seems important in informing teaching and assessment.

Although there has been limited research into PPD through specific modes such as RP groups and supervision, no research has examined the learning process of PPD that occurs through the management of clinical experiences. Given the potential difference between what is *known* and *reported* and *application* of knowledge and skills in practice, it is suggested that learning and demonstrating PPD through clinical practice may be different to that demonstrated in other learning environments and assessments provided through training. Clinical experience is potentially a powerful stimulus for PPD learning, but there may also be stressors involved which could impact on the efficacy of the learning process. It seems pertinent to expore this learning process and gain a better understanding of what detracts from and enhances it.

The majority of research into PPD is from the perspective of trainers. There is very little from the CPITs' perspective. It has been argued that although perceptions of competence have limitations, they do offer another valuable perspective. It is also important to understand how prepared and competent CPs feel as they approach qualification.

Risk management presents a particular example of challenging clinical situations, which is likely to stretch CPITs to work at the limits of their competence. This study therefore seeks to develop an initial understanding of CPITs' reflections on developing PPD skills and values in the context of managing risk. Competence in risk management is also vital given the safety implications of poor management and the fact that CPITs may well have a leadership role within MDTs in managing risk on qualification. It is also an area spotlighted in recent government policies.

### 1.7.2 Study aims

Influenced by the existing literature on perceived competency development (Bennett-Levy & Beedie (2007), the research question developed was "How is perceived competence in the 'self as clinical psychologist' developed through the management of risk?". The objectives of this study were to understand the challenges of working with complexity without high level competency and to ascertain what enables or hinders PPD. The author also aimed to understand how CPITs identify the limits of their competence when working with complexity and risk and what the perceived stressors are and how trainees learn to manage these. Furthermore, it was intended to explore how CPITs learn their position and identity as a CP, in relation to self, within teams and with other professionals.

This study is inherently exploratory in its aims and has a concern with the meaning for CPITs of their clinical experiences and what is learnt from these. A qualitative methodology, specifically Interpretive Phenomenological Analysis (IPA) was considered to be most appropriate approach to answer these objectives and to capture the subjective lived experience of CPITs. The rationale for this will be presented in the methodology.

To meet these aims the author sought to interview current CPITs from a range of Doctoral Programmes across the UK. They needed to have had sufficient experience managing risk and so were recruited from the second and third years of the three year training programme.

# Chapter 2: Methodology

## 2.1 Overview

In this chapter, a detailed explanation of the methodology employed in the study will be provided. Initially, a brief overview of the philosophical basis of qualitative methodologies and the utility of a qualitative approach in addressing this research question will be presented. The rationale for using Interpretative Phenomenological Analysis (IPA) will be outlined and its principles summarised. The research design, including a discussion of the procedures followed to ensure quality, is then discussed. Finally, the approach to data analysis is elaborated.

## 2.2 Qualitative Methodologies

### 2.2.1 Shared Concerns

Qualitative research has been defined as 'the interpretative study of a specified issue or problem in which the researcher is central to the sense that is made' (Parker, 1994, p.2). Willig (2001) suggests that although qualitative methodologies are employed by researchers from different epistemological positions, there are a number of aspects which are central to a qualitative approach. Qualitative methodologies are concerned with *meaning* and *specificity*. They are utilised to investigate how people make sense of their experiences and interactions in the world and seek to elucidate the finer qualities and nuances of people's experiences of particular phenomena. Social interaction, language and culture are considered to be inextricably linked to the meaning and function of phenomena and qualitative approaches consequently privilege understanding the 'normative, ideological, historical, linguistic and socioeconomic influences on the beliefs, objectives, expectations and talk of all participants' (Yardley, 2000, p.220). The aim of qualitative research is to 'describe and possibly explain events, but never to predict' (Willig, p9). Qualitative approaches emphasise the role of the researcher in constructing interpretations, and of *process* and *context* in shaping narratives: recognising the constant interaction between people and their environment (Parker, 1994).

### 2.2.2 Rationale for undertaking a qualitative approach.

Consideration was given to how a quantitative methodology might meet the study aims. Various options were reflected upon: an experiment or controlled study as to how CPITs demonstrate learning outcomes consistent with risk management performance (such as

assessment of risk or risk prevention) or enhanced PPD competence (such as use of support, pursuit of own learning agenda) when they are exposed to risk situations or to PPD dilemma scenarios associated with managing complexity and/or risk. However, these were not deemed suitable to meet the aims of the study in capturing the experiences and what is perceived to be learnt from lived (not simulated or scenario based) experiences of risk and complexity in routine clinical placement. The study aimed specifically to examine how such lived experiences contribute to PPD.

There is very little research in this area, specifically in relation to clinical psychology trainees in the UK. Fossey *et al.* (2002) suggest that qualitative research is particularly suited to less well researched areas. The influence of different variables on the phenomena have not been investigated before. It is envisaged, however, from an understanding of related literature on PPD, risk and perceived competency development that there will be multiple variables impacting on PPD. These may originate within the CPIT, their relationships with client(s), other professionals and the service, as well as the organisational context and culture. An exploratory, qualitative approach would seem particularly suited to understanding this topic, given the current limitations of the extant literature.

### 2.3 Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) is a relatively recently developed approach within qualitative research (Smith *et al.*, 2009). Fundamental to this approach is the concept that people are actively engaged in 'sense making', that is interpreting events, experiences and objects in their lives (Smith & Eatough, 2006). IPA consequently has a central focus on the detailed exploration of the experience and meaning of phenomena for a participant (Landridge, 2007) and is necessarily idiographic (Willig, 2001).

The methodology of IPA assumes that the research endeavour involves a double hermeneutic; that is both the participant and the researcher are invested in the meaning and interpretation of the data. IPA recognises that, through the medium of interviewing and analysis, the interpretation of experience is influenced by the biases stemming from the researchers' world view of the researcher. As Smith (1996) stated: 'while one attempts to get close to the participant's personal world, one cannot do this directly or completely. Access is both dependent on and complicated by, the researcher's own conceptions which are required in order to make sense of that other personal world through a process of interpretative activity' (p.264). It is assumed that the researcher's position will influence the research process from

design to interpretation and writing up. The researcher's aim is to reflect on these biases and on the preconceptions that they bring to the research and to minimise their impact as much as possible during the research process. Banister *et al.* (1994) also suggested it is important for the researcher to be transparent in their construction of the research question and about their way of interacting with the material.

Samples are generally purposive as the aim is to investigate phenomena from a specific perspective and therefore to focus on a small, homogenous group of participants. Pragmatically, small numbers are essential due to the amount of data that is produced in the data collection process. Analysis within IPA studies is undertaken rigorously on a case-by-case basis, so that one can understand and explain the individual's phenomenological experience. From this case-by-case analysis, the researcher can begin to explore themes emergent across cases, and through a cyclical and iterative approach, build master themes and constucts.

### 2.3.1 Epistemological Underpinnings of IPA

IPA has been developed from three key areas of epistemology: phenomenology, hermeneutics and idiography (Smith *et al.*, 2009). Barker *et al*. (2002) distinguish four main assumptions of phenomenology, which can be sourced to Husserl's philosophy. First, *perceptions* are privileged and perceived meaning is considered more important than objective reality and facts. Understanding is the aim of the scientific endeavour, and multiple perspectives are valued and assumed. Phenomenologists will seek to uncover the presuppositions implicitly made. IPA is also influenced by hermeneutics and is necessarily *interpretative* as has been discussed previously. It is also *idiographic* with a concern for detail and the experience of a particular phenomenon for particular participants in their particular context. Platt (1988) suggests that a concern with the particular can point to gaps or flaws in existing theory and can challenge assumptions. General claims may be developed, but secondarily to a rigorous investigation of the individual phenomenon.

### 2.3.2 Rationale for the use of IPA

Willig (2001) highlights the importance that the approach used fits the particular research question in ensuring quality in the research design (Willig, 2001). The primary intention of this research was to understand the experience and the impact on PPD of working at the limits of competence. The research question which developed was: How is perceived

competence in the 'self as clinical psychologist' developed through the experience of managing risk. An understanding of 'how' competence developed was envisaged to be developed from an analysis of the narratives co-created between the participant and the researcher. A model could be implicitly derived from the analytic process, but was not the central aim of this research endeavour.

A number of methodologies within the qualitative approach were considered. Although, as stated above qualitative methods share some concerns and epistemological underpinnings, they also have distinct theoretical and methodological emphases. Given the aims of the study some, such as action research or discourse analysis, were clearly less relevant. However, careful consideration was given to whether grounded theory (GT), thematic analysis or IPA would be the most appropriate method of analysis. Thematic analysis does not have such a well developed epistemological underpinning and is less commonly used in DClin Psy theses. It was discounted for these reasons.

GT is similar to IPA, in that it also provides rich descriptions based on systematic procedures for analysing data, but unlike IPA it is also centrally concerned with the outcome of the analysis which is *theory* grounded in the data (Barker *et al.*, 2002). GT could equally illuminate the participant experience, but is more driven towards the development of theory and models. Given the lack of research in this area, it was felt that the development of theory and models was not the focus of concern. Additionally, it was felt that the use of GT methodology would potentially shift the emphasis and the focus of the interview questions more directly towards participants accounts of how they perceived PPD occurred through managing risk. It was anticipated, based on an understanding of the literature, that emotions generated by the learning environment could have a significant impact on the learning process. It was considered important to use a method of enquiry that would *focus* on CPITs' lived experience of managing risk, capturing accounts enriched with the emotional experience, rather than focusing on accounts of *how* they learnt from these experiences. IPA's central concern is with a detailed exploration of the participant experience and its meaning for participants and for this reason seemed to be the most suitable methodology. Although theory and model development is not focal to IPA studies, theory can be derived from the analytical process and interpretation of the meaning in participants' accounts. IPA seemed to offer the best fit: in terms of epistemological assumptions, based on the limitations of the existing literature, the particular demands of the research question and the requirements of a doctoral thesis in clinical psychology.

## 2.4 Design

### 2.4.1 Research context

The participants were recruited from a number of doctoral clinical psychology training programmes, across England and Scotland. Participants from the South Wales training programme were not sought.

### 2.4.2. The researcher's position

The researcher was mindful of the need to be clear about her assumptions entering into and during the research process, especially as she occupied the same professional role and trainee status as the sample.

The researcher is a 41 year old white, English female, who is in the third and final year of the South Wales doctoral training programme in clinical psychology. The researcher identified herself epistemologically with the concept of the 'social construction' of meaning (Barker *et al.,* 2002). This position is named to ensure transparency, and to demonstrate an awareness and desire to engage in the research process with awareness of the ways in which the researcher might construct and direct the study. The researcher was curious about the development of professional identity as a CP over training. She had experienced a sense of being aware of and yet distant from her perceptions of this 'identity' at entry to the training programme and felt at times both dissonance and connection between her 'personal' and 'professional' identity. She was curious as to how other trainees experienced and negotiated this changing identity over time, and what enabled and hindered this developmental process and the learning of professional skills.

The author began the research process with a limited knowledge of the literature on PPD. She had however a keen interest in personal development and a pre-conceived belief of its influence on professional development and psychotherapeutic effectiveness. She was a trainee representative on South Wales's training programmes' reflective practice forum, and valued highly modes of developing personal reflection. She had utilised personal therapy, mainly in the psychodynamic psychotherapy model and had a keen interest in the use of yoga and meditation in building self-awareness. The author was mindful to be aware of her sense of what impacts on professional effectiveness, and to remain open to alternative

accounts of this process. She developed this awareness through procedures which will be described later in this chapter (e.g. 2.4.3.1).

The subject area of risk management was chosen as it was topical and seemed to provide a suitable probe for exploring how such experiences during training might result in re-evaluations and reflection on personal and professional role congruence. The author had no special interest in risk management but had worked in a number of mental health service contexts during and prior to training, which have exposed her to the importance and challenges of managing risk whilst working at the limits of her competency. She had no experience in forensic settings and had worked mainly in community settings, including a Crisis Resolution and Home Treatment team, CAMHS and Assertive Outreach.

### 2.4.3 Quality

It is widely acknowledged that methods of ensuring quality in quantitative studies such as reliability, validity, generalizability are not necessarily meaningful quality checks on qualitative studies (Smith, 2003; Willig, 2001). A number of frameworks have been developed to quality in qualitative research (CASP, 1998; Elliott, 1999; Henwood & Pidgeon, 1992; Yardley, 2000) with considerable overlap between them (Willig, 2001). The researcher has used the Elliott *et al.* (1999) framework to demonstrate how quality has been ensured in this research process, mainly as it was developed within a clinical psychology context (Barker *et al.*, 2002). The seven attributes that Elliott *et al.* (1999) consider important will be discussed.

#### 2.4.3.1. Owning one's perspective

The disclosure of one's own values and assumptions is important to allow readers to interpret the analysis in light of this knowledge. Although not necessarily intrinsic to IPA, the researcher felt given her closeness to the sample, that she would attempt to 'bracket' off these assumptions and values as much as possible, or at least acknowledge and maintain an open mind to issues that participant's independently raise (Smith *et al.*, 2009). The researcher followed the format suggested by Rolls & Rolf (2006). The process involved the researcher being curiously questionned about her assumptions by another peer, who was acquainted with the method. This process was observed by another peer, who took notes on the process and acted as a reflective observer (Appendix 4). The researcher became more aware of her assumptions about risk management and PPD which enabled her to listen more effectively to

what was being actually being said in interviews. The researcher also transcribed the discussions soon after the interviews were conducted. The interviews themselves were staggered over a number of weeks to allow for learning about the interview process to occur. The process of transcription enabled her to reconnect with the ways in which meaning was constructed in the interviews, and to really engage with participant's accounts. It also allowed the researcher to 'observe' the ways in which she affected and directed the conversation, which helped her to be mindful of this in subsequent interviews. Inevitably, there was a flow directed by the structure of the interview schedule, however the researcher aimed through mindful awareness to follow the participants' accounts as much as possible.

The researcher reflected on the challenge of understanding the meaning of participants' accounts whose views and experiences of PPD were more closely aligned to her own. The researcher noticed, whilst transcribing an interview with a CPIT with whom she noticed greater affinity, the tendency to make assumptions about meaning. Following this, the researcher endeavoured to stay present, and check herself during interviews if she might be making assumptions. She noticed how curiosity and really probing the participants' account of meaning seemed less challenging where the CPITs were less similar to herself (e.g. younger, different clinical experience and values).

The researcher used other checks to build and consider the impact of her own assumptions. A reflective diary (Appendix 5) was used throughout the research process. The researcher also used supervision with her clinical supervisor throughout the research process to help gain another perspective, and elucidate more clearly her own position. The researcher also stated her position in relation to the research topic, her epistemological position and some key features of her experience that have impacted on her values to help guide the reader.

#### 2.4.3.2. Situating the sample

The participants and their circumstances (as relevant to the research question) are outlined in some detail (in Table 4) based on information gathered from the participant check list (Appendix 6). Pseudonyms are used to ensure participant confidentiality. The level of information presented should enable the reader to consider the relevance and more general application of the results of the study. These details also allow the homogeneity of the sample to be established.

#### 2.4.3.3 Grounding in examples

The researcher has put anonymised excerpts from two annotated transcripts in the appendices to demonstrate the analytic process (Appendix 7). These examples show the initial coding and early themes that were derived from the data and allow the reader to make a judgement about the goodness of fit between data and interpretation.

#### 2.4.3.4 Providing credibility checks

In order to determine the credibility of the analysis, participants were sent summaries of the themes from the study and invited to comment on the resonance and their subsequent reflections on these themes. This process was conducted by written communication. Four of the ten participants participated in this process. It is acknowledged, as Henwood and Pidgeon (1992) stated, that participants may disagree with the analysis for a number of reasons which do not necessarily invalidate the findings. However, the researcher has sought to reflect on any differences which were manifest.

Examples of the annotated transcripts were also examined and discussed with the clinical supervisor in order to gain a credibility check on the emergent themes and provide another perspective. The researcher had hoped to conduct a focus group with a separate group of CPITs (for pragmatic reasons due to the geographical distribution of the sample) to explore credibility of the themes that emerged from the interviews. Due to time constraints this was not possible.

#### 2.4.3.5 Coherence

It is suggested that the analysis should demonstrate coherence and integration, as well as illustrate and illuminate individual nuances. The researcher has presented her findings in the form of themes, whilst also drawing on individual experience, illustrating this using quotes and seeking to make links within and across emergent constructs. This is fundamental in IPA since this approach fundamentally recognises multiple perspectives, whilst also aiming to demonstrate the essence of phenomena.

#### 2.4.3.6 Accomplishing general versus specific research tasks

This criterion refers to the importance of being specific about aims of the research tasks. In this study, the aim was to gain an understanding of the CPITs' development of personal and professional skills and values through the experience of risk management. This requires a

breadth of perspective, as well as a detailed examination of specific instances of risk management in an attempt to capture an impression of the experience of the phenomena itself. The researcher sought to draw on multiple specific instances of managing risk. A pre-task (Appendix 8) instructed participants to consider three specific instances involving risk in which they had felt they were working at the limits of their competence prior to attending the interview. This was intended as an aide memoire. The researcher utilised interview questions to help the participant explore specific risk experiences and associated learning opportunities systematically and rigorously. The limitations of the application of the findings are considered in detail in the discussion chapter.

#### 2.4.3.7 Resonating with readers

It was also important that the study resonated with the readers, in terms of deepening their understanding of the topic. The researcher has drawn on a wide yet focussed contemporary literature to frame the study and sought to synthesise this in the analytic process and production of themes. The researcher read widely on the subject before, during and after the data gathering process. The researcher felt that this enabled her to develop a better understanding of her perspective and enabled a more informed inquiry within the interview process (Harper, 2013).

## 2.5 Ethical Issues

### 2.5.1 Ethical Approval

The research has been granted ethical approval by the School of Psychology Ethics committee, who are accountable to Cardiff University Research Ethics Committee (Appendix 9). The project proposal has also been scrutinised by the academic director and developed under the direction of the research director of the South Wales DClin Psy programme.

### 2.5.2 Consent

The participants are all CPITs, who are adults with the capacity to consent. Participants were informed about the study via an email with an invitation letter, and were invited to ask any questions or raise any concerns they might have prior to giving informed consent. All participants signed a consent form (Appendix 10) prior to taking part in the research.

Participants' consent to be re-contacted for phase two was requested at the interview stage. Phase Two invited them to consider and comment on the credibility of the themes that

emerged from the data. Participants were reminded, in signing the consent form, that they were not obliged to take part and could withdraw at any time.

### 2.5.3 Anonymity

All participant information has been presented using pseudonyms. Any potentially identifying information in the written report has been changed to ensure their anonymity. Names and identifying characteristics of any workplaces, educational institutions and/or staff/clients that participants disclosed were expunged from their transcripts.

Participants were allocated identification numbers. A record of this number was held in a separate place to the transcripts and participant checklist. All identifying information on the transcript was anonymised. Transcripts were held in a locked filing cabinet in a secure environment and were held separately from the anonymised participant information checklists.

### 2.5.4 Confidentiality

All interviews were transcribed by the researcher. Following transcription, recordings were deleted from the digital recorder. The time that the interview was held on the device was kept to a minimum: no more than two weeks from the date of the interview. Between interviews the device was kept in a locked filing cabinet in a secure environment. Only the researcher had access to this cabinet.

### 2.5.5 Harm

The interview required participants to talk about clinical situations in which they managed risk. They controlled which scenarios that they chose to talk about and were forewarned by the pre-task given to them prior to the interview. The discussion encouraged them to reflect on their PPD and possibly consider their feelings of incompetence in managing risk. Although this conversation was challenging for some at times, it was not envisaged nor did it cause them distress or harm. As part of their training, CPITs are regularly required to reflect on their experiences and it was believed that they would be able to manage any difficult feelings that might arise.

### 2.5.6 Duty of care

It was possible that in the process of reflection, CPITs may have considered that they omitted to act appropriately on the risk implied in the situation discussed. It was made clear that the duty of care rested with the participant. However, should the need have arisen, the researcher would have suggested that the participant take the issue back to the appropriate supervisor.

### 2.5.7 Right to withdraw

It was made clear to participants (in the information sheet and consent form and through discussion prior to the interview) that they could withdraw from the study at any point without needing to give a reason and without any negative consequences. Participants were informed of this right before agreeing to take part in the study.

### 2.5.8 Risk

It was not anticipated that the participants would represent any risk to the researcher during the study. All participants had been CRB checked at admission to their respective DClin Psy programmes. However, measures were taken to reduce risk, such as abiding by a lone-worker policy.

It was not anticipated that the study would have adverse effects on the researcher. The researcher was a CPIT in her third and final year and had considerable experience of working with people experiencing psychological distress. Clinical supervision and support was available from a qualified clinical psychologist, if needed.

## 2.6 Participants

Sample sizes in IPA studies are invariably small and purposive. The sample size of ten participants was developed based on discussion between the researcher and her supervisor on the basis of qualitative research standards. IPA is concerned with the detail of individual experience, and as such typically uses in-depth interviews with a small number of participants. The proposed sample size was sufficient to explore similarity and difference between cases, without the researcher being overwhelmed by data (Smith *et al.*, 2009).

The sample was drawn from six clinical psychology programmes (across the UK) and consisted of three second and seven third year CPITs. To ensure homogeneity and relevance

of the sample to the research question and study aims, a number of inclusion and exclusion criteria were established(see 2.6.2) Table 3 (overleaf) describes the sample composition.

### 2.6.1 Recruitment

Clinical directors of all the DClin Psy programmes in England and Wales (except South Wales) were contacted by email to request permission to alert CPITs on their courses to the study and invite participation (Appendix 11). South Wales CPITs were excluded due to concerns about anonymity and confidentiality given the researcher's position on the course. Once approval was gained, emails were sent out via the Course administrator using the course's mailing list, inviting CPITs to participate in the study. Based on the number of programmes that gave approval, the invitation was sent out to nine courses in total. These emails included information sheets (Appendix 12) and an invitation letter (Appendix 13) summarising the study and providing the researcher's contact details. The information sheet clarified the purpose of the research, the nature of the involvement required and the procedure.

**Table 3: Sample composition**

| Participant | Year | Age | Location of DClin Psy | Interview context |
|---|---|---|---|---|
| Anna | 3 | 25-29 | North (a)[4] | Tel |
| Bronwen | 2 | 25-29 | South (b) | Tel |
| Catherine | 3 | 25-29 | South (c) | Tel |
| Donna | 3 | 25-29 | North (d) | Tel |
| Emma | 2 | 30+ | South (c) | Face-to-face |
| Frances | 3 | 25-29 | North (d) | Tel |
| Gloria | 3 | 30+ | North (e) | Tel |
| Helen | 2 | 25-29 | North (d) | Tel |
| Imogen | 3 | 25-29 | North (e) | Tel |
| Jenny | 3 | 25-29 | South (f) | Face-to-face |

Participant anonymity was protected by ensuring that trainees responded directly to the researcher and did not need to notify their participation to course staff or administrators. Participants and programmes of study were all given pseudonyms.

[4] The letters in parentheses refer to the training programmes. For example the two c's siginify that two CPITs attended the same training programme.

Word-of-mouth was also used, and snowballing recruitment strategies to gain further participants through responders. The researcher recruited the sample from six courses and avoided high numbers of CPITs from any one programme dominating the sample. This was deemed important given that the nature of training differs between courses.

### 2.6.2 Inclusion/exclusion criteria

*Inclusion*

CPITs in the second or third year.

Those who had experience in working therapeutically with clients using at least two models, one of which was CBT.

Those who had worked with at least six clients for more than six sessions.

Those who were able to identify at least three personally important experiences in managing risk during training.

*Exclusion*

CPITs who were known personally to the researcher.

CPITs who had not yet completed one clinical placement.

### 2.6.3 Response Rate

The researcher was contacted by 12 participants. The first ten of these were recruited to take part. This was considered a low response rate given that the invitation went out to nine courses. This could be explained by the timing of the invitation, which was fairly close to the submission dates of a number of assignments in both second and third years. The emails were also sent out at a time when there was an online discussion on the Group of Trainers in Clinical Psychology circulation list about the advantages and disadvantages of facilitating the recruitment of CPITs to research projects (Personal Communication, 30th May 2013). It is uncertain however whether there were a significant number of other requests for CPITs to participate in research that were circulating at the time of recruitment.

### 2.6.4 Participant Descriptions

Information about the participants ages, placement types, therapeutic models preferred, and experience of personal therapy are given to situate the sample (Table 4). Across the sample

## Table 4 : Participant Information

| Participant | Year of training | Clinical experience | Forensic experience | Personal therapy | Placements[5] | Models used in therapy[6] |
|---|---|---|---|---|---|---|
| **Anna** | 3rd | 5-6 yrs | Yes | Yes | AMH;LD, CAMHS;OA & NP Forensic MH | CBT, PD, IPT, BT |
| **Bronwen** | 2nd | 6-7 yrs | Yes | Yes | AMH CMHT/Comm. Outreach; AMH (IP/IAPT); OA(CMHT/memory clinic). Child health | PD , S. |
| **Catherine** | 3rd | 4-5 yrs | Yes | No | Forensic LD IP, Perinatal MH( comm.); IP ED: OA; psychotherapy/Comm LD | CBT, PD, S |
| **Donna** | 3rd | 4-5 yrs | Yes | Yes | Forensic AMH, CAMHS, Health & Adult low secure forensic; YO Prison IP | CBT, PD, ACT ,S |
| **Emma** | 2nd | 6-7 yrs | No | Yes | LD, CAMHS, AMH, OA | PD, I, CAT, H, MBT, ACT |
| **Frances** | 3rd | 5-6 yrs | No | No | CAMHS, AMH (IP); OA CMHT; LD (Comm/IP); Secondary Care recovery /PD | CAT & I |
| **Gloria** | 3rd | 5-6 yrs | Yes | Yes | CAMHS, AMH (step 4), OA (CMHT) & LD forensic (IP) ; Adult Step 4 Recovery service | CBT, CAT, S |
| **Helen** | 2nd | 5-6 yrs | Yes | No | CAMHS, AMH, OA (IP/ Comm) | H, IPT, CAT, MBT |
| **Imogen** | 3rd | 6-7 yrs | No | Yes | CAMHS, AMH (IAPT), Neuropsychology/Comm Rehab, LD (Comm); Neuropsych. (IP/Comm) | PD, CAT, ACT, I. |
| **Jenny** | 3rd | 4-5yrs | No | Yes | CAMHS; Adult LD (Comm), CMHT OA; AMH (CMHT); Adult psychotherapy & E.I.P. | CBT, PD, H, IPT, I S |

[5] Placements Acronyms used: Adult Mental Health (AMH); Community Mental Health Team (CMHT); Older Adult (OA); Neuropsychology (NP); Mental Health (MH); Commuity (Comm); In-Patient (IP); Improving Access to Psychological therapies (IAPT); Learning Disabilities (LD), Eating Disorders (ED), Youth Offending (YO),Early Intervention in Psychosis (EIP)
[6] Models Acronyms used: Cognitive Behavioural Therapy (CBT); Psychodynamic (PD), IPT( Interpersonal Psychotherapy), Behavioural Therapy (BT); Systemic (S); Acceptance and Commitment Therapy (ACT); Integrative (I); Humanistic (H); Mindfulness Based Therapy (MBT), Cognitive Analytic Therapy (CAT)

the median age of participants was 27 years. All participants were female. Ethnicity and marital status information was not collected.

### 2.7 Procedure

Once potential participants contacted the researcher, they were called to ensure that they understood the purpose of the study, the tasks involved and how their information would be used. This was also detailed in the information sheet (Appendix 13). Those who still wished to participate returned a consent form to the researcher (Appendix 10). A participant information checklist was sent to participants (Appendix 14). Participants returned these forms to the researcher.

Due to the wide geographical spread of the sample and time and cost limitations of the study, the majority (eight) of the interviews were conducted by telephone. The remaining two were conducted face-to-face. Face-to-face interviews took place at the home of the participant. It was recognized that both methods have advantages and drawbacks. Greater rapport could be achieved face-to-face, and this method allowed the researcher to observe non-verbal communication. Telephone interviews afforded potentially greater anonymity which could be argued to be useful in this relatively exposing topic, when being interviewed by a peer.

The researcher is experienced in conducting research interviews, having worked in commercial qualitative research for 12 years prior to training and has developed research and clinical skills on the clinical psychology doctoral programme sufficient for sensitive responding to any emotive elements of the narratives to be elicited.

Prior to the interviews, participants were instructed to reflect on three situations in which they have encountered and managed clinical risk (Appendix 8). This process was influenced by the critical incident technique (Flanagan, 1954) and was designed to interrogate in detail clinical experiences in which CPITs perceived themselves to be at the limits of their competence. It was felt that this may be challenging to recall without forewarning. Interviews lasted 75-90 minutes, and followed a semi-structured interview schedule (Appendix 15).

#### 2.7.1 Interview method

Prior to deciding on using an interview method, the researcher considered a range of possible approaches to exploring the phenomena from the first person perspective, such as reflective diaries, interviews, focus groups and participant observation. Following discussions with the

supervisor it was thought that significant incidents involving risk are not common-place on training. Although it would be potentially enlightening to incorporate a diary study and observations within the method, as these methods may circumvent problems of honest disclosure about processes, it was felt that for pragmatic reasons this was not possible within the time available. Alternately, a focus group was considered because it could provide peer support for participants to speak openly about difficult ethical, professional issues although it may also be intimidating. However, a focus group method would not have allowed access to the same level of detail about the individual perspective and experience. Smith *et al.* (2009) suggest that interviews and diaries can be the most effective methods for eliciting detailed personal accounts of experience.

Individual in-depth interviews were considered to be the most suitable method, supplemented with the pre-task as previously discussed. The researcher sought intially to understand in depth the trainees' specific experiences of managing risk situations and of their perceptions of their competency development within this. The researcher then moved on to explore the more theoretically driven question of how perceived competence in the 'self as clinical psychologist' is developed through the experience of managing risk.

### 2.7.2 Interview content and style

Consistent with IPA methodology, it was important that the participant was able to describe their experience in a way that was meaningful to them. Consequently, the interview schedule was semi-structured and designed to be flexibly utilised, so that the interviewer to a great extent followed the flow of the narrative of the participant (Appendix 15). This style is consistent with Smith *et al.'s* (2009) view of the process: 'the participants are the experiential expert on the topic in hand and therefore they should be given much leeway in taking the interview to 'the thing itself'(p.58). However, there was a *planned* structure, designed to explore the topic in the light of the extant theory. The questions were designed to prompt participant disclosures, which when analysed would inform the research question, rather than directly questioning them about their views on their PPD and learning processes. The research question was in the mind of the researcher throughout the interviews and informed the way the interviewer responded to the narrative. The researcher was mindful that the interview process is interactive and that the emerging narrative is a co-construction.

The aim of the interview process in IPA is to understand the phenomena from the perspective of the participants, not to be directed by or to directly confirm or disconfirm existing theory.

Initially, the questions were designed to encourage open accounts of experiences. They were designed to explore *specific* instances in which CPITs were involved with managing risk in depth, so that sufficient detail and richness could be acquired. Further stem questions were derived from Bennett-Levy's Declarative-Procedural-Reflective (DPR) model of therapist skill development (Bennett-Levy, 2006) which is suggested to provide a model of therapist skill development. Although this model relates to skill development not PPD, it examines the development of the 'self as therapist', and was felt to usefully inform enquiries into PPD and the development of the self as CP. Prompts were used flexibly during the research process to deepen the participants' accounts. The interview schedule was prepared in consultation with two CPITs, and piloted on one CPIT. It was also discussed with the clinical supervisor to check issues such as sensitivity, relevance, comprehensibility and achievability.

## 2.8 Data analysis

### 2.8.1 Transcription of interview data

Data from the interviews was audio-recorded and transcribed verbatim by the researcher (Appendix 7). Listening intently to the data in the transcribing process allowed the researcher an initial opportunity for immersion in the data (Smith *et al.*, 2009). The analysis process is concerned with interpreting the *content* of the participant's account, and as such the transcript primarily displayed the semantic content of the discussion without recording the timing of pauses and non-verbal utterances, unless they were important to gaining an accurate, unambiguous account of the meaning (Smith & Osborn, 2003; Smith *et al.*, 2009).

### 2.8.2 Analysis of interview data

The analysis process was pursued via a systematic, iterative and inductive cycle (Smith & Eatough, 2006). The analysis process began with the detailed analysis of a single interview.

Stage 1: Initially, the researcher fully acquainted herself with the data, through repeated and thorough interrogation of the transcript; both understanding the meaning for the participant, and stepping back and considering the narratives in light of psychological theory (Smith & Eatough, 2006; Willig, 2001). Comments about the *meaning* of particular parts of the text were added into the left hand margin. The way the participant talked about the subject and other comments on the use of language or sense of the person were also noted. At this stage

the aim was to stay close to the meaning without more interpretation. (Landridge, 2007; Willig, 2001). This stage was repeated several times. (Appendix 7) Stage 2: The researcher then identified and named themes which emerged from different sections of the text, and recorded these in the right hand margin. These themes aimed to reflect the essence of what was stated in the text, as well as more theoretical concerns drawing on the extant literature.

Stage 3: The researcher then listed the themes on a piece of paper (Appendix 16) identified from stage two and considered the relationships between them, emphasising similarities and difference and hierarchical relationships. These emergent themes were labelled, using terms generated by the researcher or the participant which reflected their essence. The researcher at this stage moved back and forth between themes and original data, to ensure that the themes captured the meaning of the data.

Stage 4: The researcher produced a table of the themes with quotations to illustrate the theme and line references. The themes included were only those related to the participant's experience of the target phenomena, and consequently some of the themes emergent at stage 2 were abandoned.

Stage 5: Each case was interrogated individually and a summary of themes for each produced before integration of the themes was begun. A master table of themes was then developed reflecting the experiences of the group of participants. Themes were included if they were supported by more than half of the interviews. A few were also included due to their importance in the minority accounts and these are highlighted as minority themes in the results. This process was cyclical, with the researcher checking emerging themes against the data (Willig, 2001). The master themes were checked to ensure that they represented the participants' experience and captured the 'essence' of the phenomena under investigation. The master themes were underscored by constituent themes and examples of quotes from the different participants (Appendix 18). The process was completed when the themes identified between participants were represented in superordinate themes.

As stated previously, processes were followed to ensure quality in this process, with triangulation with the clinical supervisor and with the participants. All of the four participants who responded, reported that the themes had resonance with their experiences. Some individuals inevitably reported that some themes had greater salience for them. One participant commented that whilst the themes resonated, she felt that she had a less anxious

experience than that evoked by the themes and quotes. The author felt that her experience as expressed in the interviews were notably different to the majority in the sample. Her examples were drawn predominantly from experiences of positive risk taking. These differences may be attributable to numerous factors, for example, personality, experience with risk and possibly the fact that the majority of this participant's placements had been in-patient/forensic contexts, in which the experience of risk was deemed to be different to community. The participant subesequently informed the author that since her initial comments she had more experiences of risk which were closer to those evoked in the themes.

# Chapter 3: Results

## 3.1 Overview

The main themes that emerged from the data will be presented in this chapter. As specified in the method section, the author initially familiarised herself with each interview, through repeated reading and listening, before annotating areas of interest within each individual interview transcript. This led to the development of emergent themes. This process was repeated for each interview and led ultimately to the development of themes emerging from across the interviews. Some of these themes were more prevalent than others and generally have been included if they were present in more than half the interviews. A few themes were only present in a minority, but have been included due to their importance within the interviews, and due to their relevance to the extant literature. The superordinate themes and the master themes will be defined and direct quotations from the transcripts will be used to illustrate these definitions. Where possible, quotes have been used to name or illustrate the theme. The relationship between themes will also be explored.

Many of the quotes selected inevitably reflect CPITs experience of risk management, since this was the phenomena explored with participants. From these experiences and subsequent reflections, themes relating to PPD have been extrapolated. These links will be drawn out further in the discussion.

Within the text, **MAIN THEMES** are written in bold uppercase font, **superordinate themes** are written in bold lowercase font and **subordinate themes** are written underlined in bold lowercase font.

The results are strongly embedded in the context of risk management, but through this participants and the author co-construct an understanding of their PPD.

## 3.2 MAIN THEME 1 - EVENT PERCEPTION

An overview of the themes that emerged from analysis are presented in Table 5.

**Table 5: Superordinate and subordinate themes – MAIN THEME 1**

| | |
|---|---|
| **Sense of threat 'alarm bell'** | ***"Overwhelmed"*** |
| | **Stretched and challenged** |
| | **Manageable and positive** |
| **Safety** | **Repercussions: *"if something did happen"*** |
| | **Support** |
| **Personal resources** | **Knowledge & skills** |
| | **Attitudes & values: *"I'm the kind of person who"*** |
| | **Cumulative stressors** |

### 3.2.1 Superordinate Theme 1: Sense of threat

| | |
|---|---|
| **Sense of threat: 'alarm bell'** | ***"Overwhelmed"*** |
| | **Stretched and challenged** |
| | **Manageable and positive** |

In order to manage risk, CPITs firstly had to recognise risk. Participants inevitably spoke predominantly about risks that had been noticed. Although they did not reflect on becoming more aware of risks over time, they reflected on being aware of the wider implications of risk within a system (this is discussed under **REFLECTIVE PRACTICE**).

Managing risk invariably evoked emotional responses in clinical situations. These emotional reactions informed CPITs about the PPD issues regarding the limits of their competence and autonomy issues. Most described a *sudden* arousal which alerted them to the risk and threat, although at times this may have been precipitated by a building sense of foreboding or anticipation during a clinical session.

> "*I knew that something would happen that I would feel like I couldn't prepare for.*" (Jenny, Line 197)

The moment of threat was variously recognised cognitively, physically and/or emotionally:

> "*…alarm bells going off…*" (Bronwen, line 100)
> *"I can remember when she was talking about it, this feeling of panic…'"* (Jenny, line 157)
> "*…oh God, what am I doing? I can't do any of this…*" (Frances, line 34)
> "*…when the sweaty palms were kind of starting…*" (Helen, line 116)

### 3.2.1.1 Subordinate Theme 1: *"Overwhelmed"*

Many CPITs had experiences managing risk in which they felt **"overwhelmed".** These experiences were more commonly in their first two placements, or a feature of the beginning of a placement, when the risk context was more unfamiliar. Feeling overwhelmed was usually only a transient feeling which dissipated when CPITs took various actions to respond to risk (which will be described through the emergent themes). At times, this sense of being overwhelmed was present throughout a clinical session and represented a feeling of being ill-prepared; not knowing what to do for the best and feeling overwhelmed by the responsibility and potential consequences of a 'wrong' action.

> *"terrifying. I think the thing that was most terrifying was how quick it arose. It really felt like it came out of nowhere…"* (Catherine, line 161)

> " *…when she was first describing it, I was a bit floaty and detached. I was so worried and concerned that if I said the wrong thing that it was going to make the situation even worse."*(Imogen, line 120)

No serious 'wrong' actions in relation to risk were disclosed across the interviews, although a few CPITs wondered whether they had closed sessions down too early, as a way of disengaging. Feeling overwhelmed however was perceived to be unhelpful in managing the therapeutic relationship and in managing risk. It was perceived to lead to a single-minded internal focus on following risk assessment and prevention procedures, affecting the CPITs' ability to think more systemically and to listen to the clients. At times, the CPIT responded by shifting focus entirely to a safety agenda, which may have had consequences for the therapeutic relationship.

> *"…the first time she talked about the abuse, she went into quite a lot of detail and I think I found myself a bit overwhelmed and also a bit panicked that she was telling me about this stuff, and in the back of my mind thinking, 'oh God these people could be harming children still'…I was just feeling a bit panicked and I probably scared her out of saying more…"* (Jenny, line 317)

> *"I had no experience of child protection issues and I was sitting there thinking what do I do, she's still talking, and I'm feeling panic! I kind of closed down. For me it closed down my ability to explore what she was talking about as she had moved on by this time…"*(Anna, Line 148)

> ". *she was safe, but she ended up disengaging with the service as she was angry at the way it was handled. So yes, it did have negative implications, not for her safety but for her engagement with us..."* (Bronwen, line 48)

Generally being overwhelmed was perceived as a threat to aspects of PPD; which often threatened notions of professional effectiveness and testing resilience. However, this threat when experienced could be a powerful motivator for learning.

> *"I'm very much like if something catches me out once I don't want it to catch me out again. I would go seek out some support or do some reading, so I'm more prepared for it next time."* (Anna, line 185)

For a minority of CPITs "overwhelmed" became a more long-lasting emotional state, which impacted on their overall well-being and perceived sense of competence for some time. The development of this state seemed to be influenced by a number of factors, which affected their appraisal of their ability to cope with the situation in the longer term if the particular risk or overall risks were on-going. The nature of a CPITs' appraisal links with other themes, such as personal resources and support. The threat was perceived to impact on their sense of self or goals.

> *"In the first year, I was looking forward to it, because I thought that I wanted to work in in-patients. I got there and to be honest it was horrendous. I think the reason for that was that I did feel that I was working at the edge of my competence for the whole of the 6 months and it didn't feel like it got especially any better."* (Frances, line 94)

> *"I couldn't do anything more with risk than general engagement and nothing more effectively than that. I was literally counting the number of placement days and was counting down the placement days until it was finished, because it just felt awful."* (Frances, line 124)

> *"I think, my last year, by the time I got through, I didn't want to finish the placement. I felt such high levels of anxiety because it wasn't the only risky situation that I was dealing with. That was just the one that stood out. I was just so exhausted. You know what it is like when you are anxious all the time. I couldn't sleep, you end up so exhausted. I was just completely worn out by the end of it..."* (Emma, line 235)

The experiences that both trainees described appeared to have inhibited learning and competence development as their focus shifted to simply surviving the placement. At the time of their participation in the interviews both showed evidence of having developed resilience and PPD competencies but their self-reported emotions and cognitions at this earlier time were consistent with significant levels of anxiety.

#### 3.2.1.2 **Subordinate Theme 2 : Stretched and challenged**

These experiences were more characteristic of the risk situations described by the CPITs in this sample. Although these situations were often anxiety-provoking, the CPITs had a sense that these situations were manageable. These situations were at the edge or just beyond the

CPITs current competence, and seemed to offer great potential to be more positive learning opportunities for PPD. The difference between an experience of being 'overwhelmed' and 'stretched' seemed to lie partly in the CPITs' perceptions of the system around them, and their appraisal as to whether there were resources to draw on.

> *"Because it was right at the beginning of the placement, not knowing the process, not knowing where I needed to go to, who to refer to, how to do that, how to make a referral. That would be an example, of feeling that the situation at that moment is beyond my competence and I need to seek support from my supervisor."* (Bronwen, line 99)

> *"Yeah probably she was the hardest. I dreaded the sessions. I knew that something would happen that I would feel like I couldn't prepare for. I wasn't quite sure, I was learning, it was a bit of a trial and error. No-one had really set you up for this, if she was to say that and how to handle that situation"* (Jenny, line 197)

Although Jenny reported that she often felt anxious during the sessions, she continued to work with the client for about 20 sessions. The anxiety around managing the on-going risk and personal dynamics of these sessions precipitated considerable PPD learning and ultimately SPC. Jenny reflected on complex ethical issues around the needs of various 'clients' in the system around the presenting client and developed more refined skills in managing her emotions, inter-personal style of communication, and self-care needs. She reflected on her "compassion fatigue" and her ways of managing this, protocols within the service, policy issues relating to risk and the challenges of being a learner within a MDT, whilst forming inter-disciplinary relationships which enabled safer practice. Her learning was supported through reading, a supportive team and collaborative relationship with her supervisor. This became an important learning experience in which Jenny utilised support available. This was Jenny's 4$^{th}$ placement.

> *"At times in a real state of anxiety, because I was just should I call the crisis team? Because you have a dilemma with the crisis team; you don't really know, until you've had experience of risk, you don't know when they're really appropriate to ring."* (Jenny, line 217)

> *"My first thought was trying to make her feel that what she is telling me was ok and that she can continue to do so, but being clear that there are boundaries in place as well - reminding her of confidentiality I suppose."* (Jenny, line 264)

> *"You already felt like you were treading on egg shells so then when that stuff was coming out, I just felt like I couldn't do anything right or say anything right."* (Jenny, line 280)

Another example of an overall sense of being stretched and challenged was captured in Gloria's experience.

> *"She was describing the way she might explode at home and throw things at her partner and things like that. I suppose that was a new kind of risk that I have not had much experience of, the risk to others. So that was immediately making me feel a little more anxious and a little less confident."* (Gloria, line 163)

Although Gloria felt anxious she perceived the system around the client to be containing and supportive. The team she worked with knew the client well, she had co-worked with another member of the MDT whom she was able to discuss and share ideas with, and her supervisor was available. This made it feel manageable rather than overwhelming. Through this process she too learnt about ethical dilemmas, team roles and reflecting on the challenges of being heard within the team. Her PPD competence was also stretched and challenged in being heard in team meetings.

> *"In allocation meetings when you are trying to make a suggestion about something or ask a few questions… you kind of get dismissed in those meetings. I've been told once or twice 'oh no offence love but we need the qualified to deal with this kind of thing' which can be invalidating and dismissive sometimes."* (Gloria, line 250)

Gloria used reflection and observation of other newly qualified CPs to reflect on this issue with the team, learning to 'drop in hints' about her length of experience, and she developed resilience through attributing the team's response to external issues and using supervision to reflect on this.

> "*When maybe I'm feeling incompetent in that team meeting, then I think this isn't about me ..it doesn't mean that there is something wrong with my formulation. It's a different way of working and the team is in quite an unsettled place at the moment where psychology has only just started integrating into the bigger team."* (Gloria, Line 296)

Both 'overwhelmed' and 'stretched and challenged' often involved situations in which a client was at risk of suicide, or involved potential risk to children, or there was a sense of risk to the self. They were common in community work.

#### 3.2.1.3 <u>Subordinate Theme 3:</u> <u>Manageable and positive.</u>

These represented situations in which the CPIT felt at the edge or within their current level of competence. Often these situations were perceived to hold a lower level of overall risk. The CPIT may have experienced a similar situation before, held a clear sense of protocols and procedure to be followed, or had developed a strong therapeutic alliance with the client. These situations tended to offer positive learning opportunities and were perceived to be important in incrementally building the CPITs' perceived sense of their PPD competence.

They also demonstrated to CPITs that their competence had grown by comparison to previous experiences.

> *"You just know when you need to check something out with your supervisor. Occasionally there are risky situations in sessions where you feel like I've handled that fine and I feel like I'll make a note of it on the system, I know what to do and I can save that for supervision next week and I'll just mention it."* (Gloria, line 134)

> *"And I guess to compare it to the previous example that I gave before I started training I didn't know what I was doing. I can see a real difference in me and how I was in that situation just in terms of knowing what to do and the questions that I need to ask and what I need to do."* (Bronwen, line 205)

These situations were more common across all mental health contexts, including in-patients where although the clients may be high risk, the level of support was greater and the CPIT's personal responsibility was experienced as lower. The narratives associated with manageability were demonstrably different to those in which CPITs were overwhelmed and seemed to be more processed, linear, succinct, less emotional and more clearly in the 'past'. Others are difficult to quote due to their lengthy nature. Anna's experience with an adolescent who had been self-harming, illustrated this. Anna had little experience of working with adolescents:

> *"This placement was four on, so I was like let's have a bit of a discussion around this. She was very open to talking about her self harm and she hadn't done it in 3 months so that's good but it had been a feature of her younger adolescence so I thought I'd better keep this in mind. She'd been involved with other services so I had a chat with them…'* (Anna, line 355)

### 3.2.2 Superordinate Theme 2: Safety

| | |
|---|---|
| **Safety** | **Repercussions: *'if something did happen'*** <br> **Support** |

The feeling of **Safety** contributed to the overall appraisal of the threat posed by the challenging risk situation, and importantly contributed to providing a more containing and positive learning environment. The unsafe uncertainty associated with the overwhelmed state could promote considerable learning but equally could be de-stabilising.

#### 3.2.2.1 Subordinate Theme 1: Repercussions: *"if something did happen"*

The envisaged repercussions of a mis-handled risk event could impact on learning positively or negatively. A fear of negative repercussions could result from a realisation of the demands

of the professional role and provide a powerful source of *motivation* to seek out risk protocols, learn local procedures and to learn to respond with due concern for duty of care. Fear of being blamed and that your failure could lead to negative consequences for you personally and professionally appeared highly motivating for some participants.

> *"I've always got this worry in my mind that what if? ...how awful it would be if something did happen and you didn't do something that you needed to do or you didn't notice and ask the right questions. Or that something did happen and then it came back on you and all this culture of blame and all these root cause analysis things that you have to do, and you kind of panic and you need to document everything…"* (Jenny, line 86)

Sometimes, learning and the development of professional values was motivated by a sense of one's own capacity to cope with mistakes.

> *"If something had happened, I wouldn't be able to live with myself as a person, taking away the fact that I was a clinician. I wouldn't be able to live with myself and there was no way I was going to leave that without telling somebody else."* (Anna, line 207)

Sometimes safety was threatened by concerns about how one's competence was perceived within the team. For example, Catherine was concerned about the repercussions of her abandoning a challenging session with an aroused client in an In-patient setting:

> *"So essentially, he got wound up very quickly and I had to make that decision of do I stay here and try and de-escalate that, or do I just leave the room 'cos I might make it worse. I was quite new to the placement, didn't know the staff team that well and kind of aware of this idea of psychologists winding up the clients and then other staff having to deal with the aftermath if you like. We were kind of based outside the ward and that kind of thing… so the other staff came running in, he kept shouting and staring at me the whole time, so I decided to leave."* (Catherine, line 128)

This concern about repercussion motivated Catherine to reflect with others and with herself. Catherine admitted to still thinking about this scenario, and felt that supervision did not help her process this. It seems to raise the issue of what style of reflecting helps develop productive learning.

> *"I went to the ward office to wait for the other ward staff to come back and talk to them, kind of have a bit of a debrief with them, and tell them how I felt in terms of the dilemma of whether to stay or go and then leaving them to deal with it, and not really understanding where it came from and that sort of thing."* (Jenny, line 133)

> *"As soon as I had got myself into a safe place, I was immediately aware of the other staff in there dealing with him. I immediately began to question what happened in my head…"* (Jenny, line 175*)*

For a minority of CPITs, attributions relating to the quality of their risk assessments and how they would be viewed in the team seemed to impact on well-being and may have impacted negatively on learning processes. These experiences of intense self doubt however served to promote the need to develop resilience.

> *"…the clinical leader was making her judgement on what I was telling her which was that he'd said this and this and this is why he'd said he wouldn't, but if I'd presented that slightly incorrectly to her, then that clinical decision could have been wrong. He could have .. I didn't know what to look for really in terms of... so I was utterly terrified.."* (Emma, line 157)

#### 3.2.2.2 Subordinate Theme 2: Support

The level of support perceived seemed to impact on the comfort of a CPITs' journey with PPD. Support was perceived to vary considerably between placements and supervisors. CPITs often noticed that different services had different policies for managing risks and there was a sense that some were more supportive and 'safer' than others. A sense that other professionals are involved with a CPITs' clinical case greatly influenced beliefs about the manageability of the situation.

> *"It was in quite a safe environment because the person was in a supported home, so I felt safe to be able to walk away and get supervision and then call the home back. I wasn't leaving someone vulnerable on their own completely."* (Gloria, line 29)

> "*I was much more frightened in a community setting than I ever was in a forensic setting. I think within those settings you feel very much supported, as you are very much observed not in a 'making sure you are doing your job properly' way, but making sure that everyone is ok. Everyone knows the patient much more in depth than you ever would in a community setting…*" (Anna, line 56)

Some CPITs spoke of their role in creating a supportive environment within the system around them.

> *"By the end of the 6 sessions I had been liaising with the crisis team and been making sure that anybody who was involved around her were all talking to each other and keeping in communication and letting her know what was being shared within the team as well. I guess I just used my more LD experience of MDT working and applied that in an IAPT environment."* (Imogen, line 162)

> *"We're a really close year and so whenever any of us had more difficult times on placement, whether that was because of our cases, the team or our supervisor, I think we were all very comfortable talking to each other about it and getting a bit of support."* (Imogen, line 264)

A fundamental influence on the overall appraisal of manageability of the risk was through building resilience by making sense of events, building skills and emotional containment, and

by the use of supervision. When the supervisory relationship was perceived as supportive, this significantly minimised the appraisal of the threat. Most relationships with supervisors were viewed as supportive.

> *"Also having really supportive supervisors who are there if I need to check something and are ok with me approaching them. I think that has made it a lot easier not to be afraid of risk and to feel competent and confident in approaching it and managing it on placement"*(Imogen, line 25)

Over time, some CPITs explicitly spoke of gradually letting go of support and increasing autonomy as they moved through training. This was clearly an important part of PPD, however it seemed necessary for the relationship to feel safe and supportive to optimise learning. A nurturing environment seemed to facilitate more questions and prompted greater evaluation of values, appraisals and expectations of self and others (to be discussed under **REFLECTIVE PRACTICE** and **IDENTITY**).

It was noted that often the nature of the supervisory relationship was attributed to factors outside of the CPITs' control, such as the supervisor's character or style of working or luck.

> *"And perhaps I've been lucky with supervisors in that way, but I think they've always validated my concerns; its right that you've come to seek supervision in this, so yes I've been quite lucky in that."* (Bronwen, line 138)

> *"I think he* (the supervisor) *would have heard it through the grapevine, or I might have seen him and briefly mentioned. Yeah and he sort of laughed it off and said 'oh so you're another victim in one of this person's episodes' sort of thing,…more sort of character building. He was quite a sort of macho supervisor who'd worked in forensics with very dangerous men and so I think I was a bit of a naïve wuss in his eyes."* (Catherine, line 194*)*

Some CPITs reported feeling that the evaluative role occupied by their supervisor impacted on their judgement as to what to bring to supervision. This seems at odds with the competency of building and maintaining collaborative relationships with supervisors, but also it may be that some CPITs had negotiated these positive working relationships with their supervisors but were not highlighting their role in engineering this.

> *"I should have raised it as a bigger issue but also you think as a trainee 'should I be able to deal with this, so you think actually do I need to be able to do this?' So I didn't realise at the time that no-one I knew on the course was managing anywhere near that level of risk…"* (Emma, line 273)

> "*Being in a position as learner, you're already in that less powerful place with a supervisor. So I think if you are working with someone who is very experienced, then the default position is kind of I'm wrong and they are right, and not really wanting to*

> *be a challenging trainee and wanting to have a mutually respectful relationship with my supervisors as well."* (Catherine, line 574)

When difficulties were encountered in negotiating the supervisory relationship it sometimes had a negative impact on effective use of this support and on learning:

> *"I think it was something about the service as well, because it was chaotic in-patients, and because I didn't find my supervisor particularly helpful. I didn't feel like I could talk to her about anything that was going on, or if I did try and talk to her about how I was feeling it was kind of shut down and it was kind of either you are in work and you can cope or you go home. (*laughter*)…"* (Frances, line 136)

> *"I found it difficult in this case though as I wasn't that keen on my supervisor, so I didn't feel that comfortable sharing any concerns that I had.."*(Anna, line 454)

### 3.2.3 Superordinate Theme 3: Personal resources

| | |
|---|---|
| **Personal resources** | **<u>Knowledge & skills</u>**<br>**<u>Attitudes & values:</u> <u>*'I'm the kind of person who*</u>"**<br>**<u>Cumulative stressors</u>** |

Manageability of risk situations and CPITs' sense of their professional status and well-being was also influenced by the CPITs' sense of their own personal resources.

#### 3.2.3.1 <u>Subordinate Theme 1</u>: <u>Knowledge and skills</u>

Risk situations and how they are experienced in clinical practice could clarify awareness of knowledge and skills gaps. No harm was disclosed to have resulted from these gaps. It was evident that CPITs felt that risk should *always* be discussed with one's supervisor or team.

Gaps were commonly perceived when starting a new placement or working with a new client group with whom the CPIT had no prior experience. These gaps motivated learning.

> "*If it was working with a group of people I hadn't worked with, like children or older adults then I would also feel that. Because I think that different groups of people have specifics in terms of risk, and you need knowledge of that, working with that particular type of client…"* (Emma, line 47)

> *"And I can just remember no-one has told me* (laughter) *what to do here. No-one tells you what to do when this happens* (laughter) *and this isn't in the manual"* (Jenny, line 184)

Increasing knowledge and skills occurred through various modes of learning and particularly through application in clinical practice. Many CPITs spoke of the influence of experiences prior to training, as well as via formal teaching and experience during training.

> *"Having had quite a bit of experience over the training of, not necessarily risky incidents, but exploring very similar incidents of patterns of behaviour, triggers, recognising signs, and de-escalation techniques… I think it felt much more familiar and so I wasn't quite as out of my depth as I was when I was an assistant psychologist"* (Gloria, line 197)

> *"Nowhere near as anxiety provoking at all. I felt much calmer. I think what really helped was I'd seen this client more than once. I think again it was dealing with, not with risk to themselves, but it was others being a risk to them, so that was probably a bit more of a familiar zone for me. So I felt confident and competent in the questions I needed to ask, the process that I needed to follow and I was ok with that."* (Imogen, line 312)

Also CPITs began to learn that they do not need to know everything, and yet could still maintain safe and professional practice. This learning seemed principally to be modelled by supervisors.

> *"When I spoke to my supervisor what was quite interesting is that she said that she wanted to think about it with the manager of the service 'cos she wasn't sure on a service level how we needed to follow this up…"* (Helen, line 374)

### 3.2.3.2 <u>Subordinate Theme 2:</u> <u>Attitudes and values:</u> <u>***" I'm the kind of person who"***</u>

CPITs' values and attitudes may be challenged by or congruent with the requirements of the work and impact on whether clinical situations feel manageable. These challenges could be quite idiosyncratic, influenced by the CPITs' personal values, attitudes and life experiences. The experience of incongruence could be uncomfortable but promotes professional development.

Gloria's sense of 'doing her best' was helpful in managing risk situations, as she knew there was a finite point to what she could do.

> *"I think I've always had somewhat of an attitude of 'I can only do my best'. I've never been one to strive for perfection; like I got Bs in my GCSEs and I was happy with that because that got me onto the A levels that I wanted to do. So I think that's always been a part of me. I can do my best and I'm not perfect…"* (Gloria, line 429)

Jenny's more exacting beliefs that 'she should know…more' were anxiety provoking but also motivated her to learn and develop.

> *Interviewer:"So the worry is if I need to I'm not allowed to ask or it's less acceptable?"*
>
> *Jenny: "more of a 'well surely you should know by now'. And if anything people are going to be asking you, that's the worry. Suddenly you're going to be the person that whoever might turn to and say I don't really know what to do."* (Jenny, Line 635)

Bronwen, was challenged by the need to ask direct questions, which was incongruent with her inter-personal manner in her private life. This realisation had come about through the discomfort of clinical experience, self reflection, teaching, supervision and experimentation.

> *"I guess in terms of who I am and my values, I'm not particularly a direct person. I don't like asking questions that make people feel uncomfortable…But I think that's something with managing risk, it's almost like it's a necessity, you can't not do it. You have to ask those kind of questions and you have to be ok with asking them. You know, you can't not. So in a way that makes it easier."* (Bronwen, line 530)

Some CPITs' attitudes, beliefs or perhaps even attachment styles, may also have influenced their ability to utilise available support. Emma's experience of being overwhelmed during a placement, and particularly in managing one case, was arguably partially influenced by her values about sharing risk. This proved to be an area that Emma learnt to develop primarily through the anxiety of striving alone.

> *'I couldn't sleep, I was up, I was just terrified ..about what was going to…and also because I come from a different field of work, I'm very much hold the risk myself. I didn't know how to spread that risk at that stage, and it was only then, after this happened that my supervisor said right go and see the psychiatrist, get them to make an appointment and make sure the psychiatrist is involved. And that became more sort of a team effort after that. And he improved later, but I felt completely traumatised by this in a sense …"* (Emma, line 173).

For others, sharing risk was viewed as essential. Donna, for example, had a very different attitude towards sharing, again influenced by her previous work, which was helpful in developing competence.

> *"I've been lucky to feel safe and I'm the kind of person who thinks, and maybe as I used to be a supervisor, I used to be much more impressed by people who admitted their incompetence than people who tried to appear competent. So I think because I knew I was being assessed, I didn't ever feel oh I need to come across as competent…"* (Donna, line 654)

#### 3.2.3.3 Subordinate Theme 3: Cumulative Stressors

Although a theme that was only mentioned in two of the interviews, it is included based on the strength of the participants' phenomenological experience as well as resonating with the

extant literature on stress amongst CPITs. For a minority, managing complex risk situations was compounded by other on-going stressors. Cumulatively these stressors seemed to become a threat to well-being and again to provoke a shift in the CPITs' coping strategies. At the time however, these cumulative stressors and the distress they generated could be a barrier to learning.

Both Emma and Frances, who mentioned the most overwhelming experiences, referred to other stressors which may have contributed to their appraisal of whether they had the resources to manage.

> *"I was moving house. It was in placement two. We were in three days a week and then one day teaching.. I was just crying* (laughter), *it was awful. We were moving house around the same time, at least we were trying to find a house and that was all going up and down, and we were losing houses and all that."* (Frances, line 129)

> *"I think my ability to manage risk is also profoundly affected by the fact that I probably suffered from a lot of vicarious trauma in my previous job. I mean it is not uncommon for people to go off sick for 6 months quite regularly. Most people I know that I worked with had a long period of illness or something if they hadn't gone on maternity leave they'd gone on sick leave. So I think I had this convergence of anxiety disorder level type anxiety, then vicarious trauma from a risky working environment, which all added up to me being quite vulnerable to managing risk in quite an anxious manner…"* (Emma, line 618)

Emma adjusted her attitudes to sharing risk and using support, to enable her to build resilience and self awareness.

### 3.3 MAIN THEME 2 – MANAGING THE PROFESSIONAL SELF

An overview of the themes that emerged from analysis are presented in Table 6.

**Table 6: MAIN THEME 2: Superordinate and subordinate themes**

| | |
|---|---|
| **Emotional regulation** | **Managing emotions:** ***"making myself calm down"*** <br> **Containment: supervisors who** ***"have been there"*** |
| **Cognitions** | **Formulating** <br> **Managing uncertainty:** ***"you just learn to be ok with it"*** <br> **Knowledge and skills/developing risk templates** |
| **Behaviour** | **Assertiveness:** ***"becoming more assertive"*** <br> **Pro-active behaviour:** ***"a bit more pro-active"*** |

In order to remain open to learning opportunities implied in managing risk events, CPITs learned to manage their own anxiety which has emotional, behavioural and cognitive components. Some of these themes aligned with themes in **EVENT PERCEPTION**.

### 3.3.1. Superordinate Theme 1: Emotional regulation

| | |
|---|---|
| **Emotional regulation** | **Managing emotions: *"making myself calm down"*** <br> **Containment: "*supervisors who have been there"*** |

#### 3.3.1.1 SUBORDINATE Theme 1: Managing emotions: "*making myself calm down*"

All CPITs perceived that they have been through a process of learning to manage their emotions in the moment of a threat event. Strategies they learnt to adopt which were helpful, included positive self-talk, or falling back on a familiar therapeutic approach.

> "*So I think that even when I feel anxious or nervous at any moments on the course, maybe even generally in life as well, I feel most comfortable in that more person-centred counselling approach. So I probably would go to that as the first port of call, and I think that's probably why I did in that setting as well."* (Helen, Line 226)

> *"But then I was very aware that if I allowed myself to become far too anxious I would stop being effective and that I would miss things so… I just made myself calm down, take a few breaths and 'right we've had teaching on this. We've done this risk before, what is it that I know that I can do? And do that to the best of my ability and then I can ring my supervisor and at least I've made some steps and if there is anything else that needs doing then at least someone more experienced and competent than myself can come and step in and help with the situation. So I just kind of sat with my anxiety for a bit and ultimately felt this is not wholly helpful, I just need to do what I can."* (Imogen, line 123)

Emotions were also managed so that they did not subvert difficult inter-professional negotiations. This was also demonstrated by Gloria's quote in '**Stretched and Challenged'** (3.2.1.2), where she used attributions to maintain her confidence in a dismissive team meeting, and in the next quote in which Donna described managing her anger with other professionals within the system around the named client.

> *"Then I felt really strongly that I wanted to get, what I felt were basic rights for the client. So I was feeling, not emotional, I guess passionate, fired up. I was quite angry with the prison officers, 'this is basic human rights that he needs and he's not getting it'. And it's kind of like, if you have to compromise sometimes, I think on,* ***this,*** *I shouldn't have to compromise, because this should be non-negotiable. But then it's taking a step back and thinking will I need to negotiate this in order to get anywhere*

> *and if I go and say 'No! you need to do this, this and this' they're going to be like 'f*** off', so I think that sits hard for me."* (Donna, line 190)

Jenny also recounted learning to pay more attention to her emotional instincts and learning to manage them in the session. This strategy seemed to have been partly motivated by negative reinforcement due to previous experiences which resulted in anxious weekends worrying about clients.

> Interviewer: "*What do you think you learnt through that case?"*
>
> Jenny: *"Definitely how to sit with it…I'm definitely more in touch with it. I can definitely notice it more, because I've had the experience of panic and anxiety afterwards and the worrying and then going in on Monday and being relieved. And that whole experience I've never really had before…*(Jenny, line 366)

### 3.3.1.2 Subordinate Theme 2: Containment: *"supervisors who have been there"*

Containment related primarily to the use of the supervisor to help process emotions. CPITs perceived that they benefitted from having a secure base in supervision which allowed them to feel safer in dealing with challenging risk situations. This containment seemed vital for learning in early placements, and at the beginning of unfamiliar placements.

> *"I knew I didn't need to ask anything right there at the end of the session, but that she* (supervisor) *would be around later on if there was anything else that I needed to do to follow up and if there were any questions that I had. So I knew that she was around. I think that increases your confidence too knowing that help is around if you need it."* (Bronwen, line 212)

Feeling uncontained could inhibit learning.

> *"I definitely think it would have been harder to share, because I didn't feel like I was in a really safe relationship. I found it harder to ask for help, for advice or to say things that I wasn't sure about. And I felt like I wasn't really committed to reflect."* (Donna, line 648)
>
> "*Also the supervision style I had was CBT, because he was a purist. CBT supervision is not about what the impact is on you as an individual. None of that was discussed in supervision. It was all 'what technique', 'what's the cross sectional diagram that you're going to do with him', 'what's your goal for the next session'... so that was the type of supervision. There was none of that 'that sounds really difficult. What was the impact on you? None of that kind of stuff*." (Emma, line 226)

This theme connected with the main themes of '**REFLECTIVE PRACTICE'** (3.4) and '**IDENTITY'** (3.5). Through a safe experience of containment, CPITs learned to feel they could contain situations themselves.

> "*You're distracted by the information that you've just been told and you're already thinking of the conversation that you're going to have with your supervisor when this person leaves. But I don't think that would necessarily be the case now, because I've had enough instances of that type of thing happen. Not necessarily child protection but other risky situations, where I've gone 'this is a good opportunity to explore these situations' so that I can make a more informed decision about what I'm going to do about it."* (Anna, line 237)

> "*She wasn't always there, so even though you knew that she was on the other end of the phone, it almost gave you that push into, you can deal with it. And she would just kind of say things that made you feel like you can do this, and I suppose we'd formulate risk enough in supervision so that it felt containing. And that could hold us enough until the next week*." (Gloria, Line 328)

Imogen's comments again suggested that trainees' downplay their influence on the supervisory relationship. CPITs seemed reluctant to see this as within their control.

> *"And I've been fortunate enough to have good supervisors who have backed me up, who have been there when they agreed they would be, and made me feel like I am competent in that as well. Not molly coddling and spoon feeding and making me feel that I'm not competent has increased my confidence. That very sort of attachment thing of 'it's ok you'll be fine' makes you feel like you will be."* (Imogen, line 615)

Although earlier in the interview, Imogen had discussed how she *ensured* that she felt contained by supervision. Perhaps the training course sanctioning this helped her to be pro-active.

> *"I've always ensured that by saying I need your mobile number. Part of our course again is that you should be able to contact your supervisor should there be a risky situation, and if they are not there on the day, you need to know who else you can contact. It's worked into our psychological contract that we have, which covers all aspects of supervision, the relationship, supervisor - supervisee relationship and things like managing risk and being contactable."* (Line 444)

Imogen also articulated an implicit theme across many of the interviews about how supervisors tended to be idealised and how learning could be facilitated by confronting this tendency.

> *"When I first got on the course it was like my supervisor is never challenged* (laughter) *they're fantastic, they know exactly what they are doing. It was really good from the course 'cos it gave me permission to ask about that. Not that I needed permission, but it opened that door and that was so helpful; just talking to the supervisor and having had so many supervisors as well, you get so many different perspectives and experiences and reflecting on the teaching with them. "* (Imogen, line 515)

### 3.3.2. Superordinate Theme 2: Cognitions

| **Cognitions** | **<u>Formulating</u>**<br>**<u>Managing uncertainty:</u> <u>*"you just learn to be ok with it"*</u>** |
|---|---|

#### 3.3.2.1 <u>Subordinate Theme 1</u>: <u>Formulating</u>

A key skill which CPITs perceived to have enabled their development of competence in managing risk and PPD is learning to apply formulation skills. Formulation was perceived to enable the development of a shared understanding of the risk with the client and the team, improved communication across the system, and could increase the sense of the 'problem' being shared.

> *"Especially when it became ok to have the conversations with my client, it made me feel more capable of managing risk and not taking all onto myself. I think that was an important shift. I think beforehand it had felt like the buck stopped with me entirely and actually I saw it as an opportunity to give my client some autonomy and power back over her situation and her decisions because that all kind of fed into her formulation."* (Imogen, line 258)

Jenny commented on how sharing the formulation with her challenging client allowed a measure of change to be considered and improved the relationship and her confidence.

> *"I think I was doing what she* (client) *wanted, and in the long run it wasn't helpful, because she pulls everyone in and then she pushes everyone away. So she constantly pushed out services and people. It was like all caught up in her relationship with others really. So I think once we'd made that quite explicit, it got a bit more why? and what function was it? I suppose it opened a door, that she felt a bit more understood maybe. So it didn't feel scary. It felt like we knew* ***why*** *a bit more."*(Jenny, line 309)

Donna expressed a similar idea:

> *"It's kind of feeling like I'm more aware of what underpins people's risk, so being able to formulate and be more collaborative with the client and being more comfortable to ask."* (Donna, line 44)

CPITs also learned that the process of seeking information and developing the formulation helped risk management, their anxiety and the team's understanding.

> *"I suppose I'd had some ideas from other members of the team about how she'd communicate her needs and from meeting her. The more we were trying to explore the examples that she was giving, the more I was thinking it was just her trying to get across how awful she is feeling at the moment. It felt less and less risky and less like it would actually happen, because she could also tell me lots of strategies that she uses*

> *to avoid getting so angry, de-escalation strategies, that she had learned over the years."* (Gloria, line 182)

### 3.3.2.2 Subordinate Theme 2: Managing Uncertainty: " *you just learn to be ok with it*"

Managing uncertainty was perceived to be a key skill that developed over time; through the experience of managing risk without negative consequences occurring, and understanding and *knowing* that risk is unpreventable. This was part of handling the emotional impact of the work.

Bronwen reflected on her perceptions in the first year, when uncertainty felt far less manageable:

> *"I think particularly with suicide, we'd had the training sessions on the course and I remember thinking that sounds like a really scary situation to be in; someone sitting there and telling you that they are having thoughts of ending their life. I remember thinking that's got to be a really hard one to cope with, I wonder how I will cope with that?"* (Bronwen, line 262)

Others reflected on their increased flexibility or acceptance of risk:

> *"I think that actually being more competent is being more able to raise things that you are concerned about, and being ok with not knowing."* (Catherine, line 623)

Often this ability, came through practice; reflecting on the inevitably of risk and reassurance of *knowing* that professionally one has fulfilled one's obligations. Another factor seemed to be the knowledge and acceptance that to worry is 'normal' in managing risk situations. This tended to follow discussions in supervision and with peers.

> *"I don't know if that will ever go away. I think that regardless of how good an assessment, how supportive an environment or team I'm in, if someone's in a risky situation they're in a risky situation. I think what will change, is how comfortable I feel with that anxiety..."* (Imogen, line 190)

> *"I knew my boundaries and that I could be ok with being uncomfortable, and through talking with a supervisor knowing that no one finds risk a comfortable situation to be in."* (Imogen, line 250)

### 3.3.2.3 Subordinate Theme 3: Knowledge and skills/developing risk templates

CPITs also developed knowledge and skills over time which they drew on to manage risk situations. This has been covered in '**knowledge and skills'** (3.2.3.1)

### 3.3.3. Superordinate Theme 3: Behaviour

| | |
|---|---|
| **Behaviour** | **Assertiveness: *"Becoming more assertive"*** <br> **Pro-active behaviour: *"A bit more pro-active"*** |

#### 3.3.3.1 Subordinate Theme 1: Assertiveness: "*becoming more assertive"*

In developing appropriate boundaries and ensuring a psychological perspective got heard, some CPITs recognised their need to develop assertiveness. This was important in developing their esteem, resilience and competence in managing conflicting agendas with clients, teams and supervisors. For some this did not feature as a key concern, but for others their experiences on placement emphasised the need to develop this skill.

> *"In allocation meetings when you are trying to make a suggestion about something or ask a few questions… you kind of get dismissed in those meetings. I've been told once or twice 'oh no offence love but we need the qualified to deal with this kind of thing' which can be invalidating and dismissive sometimes…."* (Gloria, line 250)

A number of CPITs discussed situations where they felt that their lack of assertiveness had been unhelpful in managing situations involving risk. Bronwen reflected on a clinical experience with a family, in which she felt the client's wife had some mental health difficulties but felt unable to ask her in the room.

> *"I think again I learnt that I can manage that situation, and I think what I perhaps didn't feel so confident about in that situation is my ability to act very immediately and on the spot…"* (Bronwen, line 406)

Reflection on these encounters and challenges seemed to promote further learning. Some CPITs reflected on ways that they had been helped to develop assertiveness, such as through therapy and supervision.

> *"I think overall we* (Donna & supervisor) *probably agreed on most things. I think perhaps the main thing she helped me to work through, was how I manage my anger at the system."* (Donna, line 264)

> *'I am becoming more assertive. I am able to say when I am not happy about something now, whereas before I probably would have gone along with it. I think that's what has shifted for me. But I think that's because I'm doing personal therapy and also because I am working with good supervisors now: one of them can be quite tough and the other is very validating.'* (Emma, line 634)

### 3.3.3.2 Subordinate Theme 2: Proactive behaviour: "*a bit more pro-active*"

This theme refered to the growth in pro-active behaviour; in *seeking* knowledge and skills and support and in working with the team context. This refers to self-directed behaviour. Some felt they were already proactive, and that this behaviour was influenced by their experiences working in multi-disciplinary teams (MDT). Nevertheless, they often felt they had grown to increasingly value this behaviour.

> *"My supervisor did pick her up straight after me, but certainly by the end of the 6 sessions I had been liaising with the crisis team and been making sure that we were all talking to each other and keeping in communication and letting her know what was being shared within the team as well."* (Imogen, line 157)

Catherine reported how she had become more comfortable with seeking help, and how she felt this reflected her growing confidence and competence.

> *"I think probably before training I was more anxious about if I brought up issues it meant something bad about my competence, whereas now I think the opposite…"* (Catherine, line 623)

Emma, on perceiving a skill and knowledge gap in working with service users who are suicidal, was self funding additional training in this area.

> *"I'm now going to do Christine Padesky's CBT for Suicide in London. I'm not a great CBT person but I think in a crisis situation that CBT is probably going to be the most useful, immediate way… I don't just want to manage risk, it's also about working with that person to get them to a position where they feel better…*" (Emma, line 360).

Many of the CPITs spoke of their recognition of the need to seek out knowledge of policy and local procedures as soon as they started on placement.

> *"I think moreso this placement, even though it was still new and it was still getting your head around services, I felt I could be a bit more proactive… whereas in previous placements I would have waited for something to happen and then gone 'oh shit I need the referral form', or 'I need to know where this person is' or 'I need the contact number.'* (Frances, line 82)

> *"It's something that is on my mind, certainly in starting new jobs and something I will be raising with supervisors very early on. I'm going to be looking at the local policies very early on and be talking to my colleagues about what they do, because it feels like something that is possibly make or break in terms of how your career goes.."* (Catherine, line 608)

## 3.4. MAIN THEME 3: REFLECTIVE PRACTICE

**Table 7: Superordinate and subordinate themes - MAIN THEME 3**

| | |
|---|---|
| **Reflection on event** | **Scaffolding**<br>**Making sense** |
| **Reflection about event** | **Adjusting values: 'something shifted in my thinking'**<br>**Thinking systemically: 'see the whole picture'** |
| **Reflection in the event** | |

### 3.4.1 Superordinate Theme 1: Reflection on event

| | |
|---|---|
| **Reflection on event** | **Scaffolding**<br>**Making sense** |

Reflective practice was felt to play a key role in managing risk and developing PPD skills. This occurred on a number of levels within the process of reflecting *on* the risk event.

#### 3.4.1.1 Subordinate Theme 1: Scaffolding

CPITs perceived that being scaffolded in their understanding of clinical work was important in PPD. Usually, their supervisor was reported to be the person who challenged and guided them to another level of understanding and skill. This was perceived to be a key way of developing competence in managing risk and in their general professional development.

> *"And my supervisor kind of taught me assessing what level someone has thought about it, whether they have made any plans, what access they might have and what the protective factors are. So almost like a bullet point list of things that you have to hold in mind that are important to consider, which before that situation had arisen I had never had any training on that and I wouldn't have known."*(Gloria, line 61)

> *"I do a lot of thinking by myself, but then I think it's useful to…you can get so far thinking by yourself, then you have to have your view challenged, not necessarily directly but hear another person's view to spur you on to think more. So that using supervision and talking to others is really important as well.*" (Donna line 623)

However, scaffolding could also occur with other members of the team in which they worked:

> *"The most useful one was the social worker, as they are trained in that kind of thing and he was just really good at being like you've done the right thing, or maybe you should do this and check this out, but he was just quite useful in giving me a few more pointers."* (Jenny, line 211)

> *"I've learnt that I've never really been in a position where I've been able to joint work before, and actually how in complex cases when you are feeling at the limits of what you can do, it's nice to have someone to bounce ideas about with and to have someone who challenges you, who's also there."* (Donna, line 313)

#### 3.4.1.2 Subordinate Theme 2: Making sense

CPITs also used reflection to make sense of their difficulties in managing risk events; to help process what happened, what they learnt and to develop procedural and declarative knowledge and skills from engaging in this process. This could occur intra or inter-personally.

In an effort to make sense of a situation, Frances reflected on a session with a client with a mild learning disability, who had refused to let her exit her bedroom when the session ended. She also discussed this in a client case review and with peers.

> "*I was trying to think back to what I had said immediately before I was leaving, because me leaving had never been a problem before and then I was thinking maybe it was related to the fact that we only had one session left, and because we had been working together for a long time and the fact that she doesn't see anyone else to talk about music with. Her mum and dad won't entertain talking about music with her so… I was wondering like that really and she just didn't want me to go. And went about it in a bit of a difficult way*." (Frances, line 299)

Interestingly, her concerns focussed on *why* this had happened, and she seemed less concerned about her own safety, and her failure to follow lone worker policy.

Some commented that opportunities for reflection were not optimised within some supervisory relationships. This difficulty was generally attributed to the weakness of the supervisor.

> *'…if the supervisor was a bit more in tune with my experience and a bit less, dismissive I guess, and a bit more reflective and thoughtful about what was happening or how they might have done things differently. I don't feel like much time was really spent on unpicking that event or even thinking about its impact on me or what it might have been like, particularly in my first placement as a trainee and all that sort of stuff.'* (Catherine, line 234)

> *"I might have held back on my personal reactions to team discussions and things. If there has ever been any concerns regarding risk or whether proper decisions have been followed, yeah I've always been able to bring that and my supervisor has been*

> *very responsive. But yeah I just notice that I haven't been as open about more of my personal side of things within this placement."* (Helen, line 562)

For Imogen, the process of making sense also involved monitoring her own behaviour and interpreting her motivations. In the process, self-awareness of a desire to rescue the client was developed.

> *"And it's something that even now I still feel a bit, grinding isn't the right word, something I come up against feeling like I'm going to go in and save the person and find myself working till 7 o clock at night* (laughter) *so .. I've completely gone off track there."* (Imogen, line 228)

'Making sense' also involved reflecting about a current event to inform the evolving formulation. In Jenny's example, she attempted to make sense of the client's recent episodes of suicidal behaviour.

> *"…and she was telling us that she was going to do this on a certain day, she had a real plan, over the weekend. So we did have to call the crisis team and I rang and spoke to her partner and set up how he would be with her over every point at the weekend. I think post that, we had that whole thing and when you reflected on it a bit more, you were a bit like there is more to it than that, and then she would kind of allude to stuff. So maybe to have had that one, and we'd handled it, I felt a bit more confident to be 'what is this really about?' and you know you didn't last time"* (Jenny, line 301)

CPITs reported that they may feel reluctant to discuss challenging issues if the supervisory relationship was not felt to be safe.

> *"The being assessed for some people might mean that they don't want to raise certain things, because they might think it looks a particular way to the supervisor or they might think that they shouldn't have said something that they did."* (Catherine, line 403)

> *"But I certainly think that the supervisory relationship has an impact on the way that you might bring risk issues up, how you talk about them, how long you talk about them for, how confident you feel in talking about them.*" (Catherine, line 423)

This was also how medical students and newly qualified doctors are reported to frame seeking supervisory advice so that they protect themselves and their professional image.

### 3.4.2. Superordinate Theme 2: Reflection about event

| | |
|---|---|
| **Reflection about event** | **Adjusting values:** ***"something shifted in my thinking"*** <br> **Thinking systemically:** ***"see the whole picture"*** |

CPITs also perceived PPD to occur through reflecting about risk events. This process seemed to enable a gradual adjustment of some unhelpful personal values which might jar with their professional work and a tendency to increasingly think systemically.

### 3.4.2.1 Subordinate Theme 1: Adjusting values: *"something shifted in my thinking"*

During the training process, manageability of risk events and developing competency was often perceived to be accompanied by a shift in the CPITs' idiosyncratic value base and growing self-awareness. This was a common experience amongst CPITs and could lead to increased resilience. This theme intersected with '**reflection on event'** (3.4.1.) and '**support'** (3.2.2) and **'realistic limits'** (3.5.2).

Bronwen reflected on her shifting beliefs about her intended role in her clients' recovery journeys. Bronwen's views shifted within the interview between an 'older' belief and the new belief. During the interview she reflected on a conversation with a colleague:

> *"She didn't say it wasn't our role but she did say that I don't think we can do anymore and I thought we can always do more …"* (Bronwen, line 640)

Earlier in the interview she had reflected on her realisation that there is only so much that CPITs could do.

> *"…again perhaps this is something that I've thought about since I've started training. I do still, there's this part of me that thinks, ah no, quite a strong part of me that thinks, we can only do so much. And at the end of the day if someone is going to take their life, we know that there is only so much that we can do."* (Bronwen, line 551)

Frances reflected on her shift in position from feeling that she had to be all-knowing at all times, to a position of greater flexibility regarding her need to be certain. This may impact on a CPITs openness to working with others and help manage anxiety. This realisation may be set in motion by supervisors' styles of working, reflection with self and with others.

> *"I think it's just over time. I think when I first started training the biggest thing for me was learning that I can get things wrong, and I think that that's the biggest change in me over the 3 years. Now I'm ok at not knowing 100%..."* (Frances, line 671)

> *"So I found that group to be really useful to get me to think about things differently and just to recognise that we are in training, we're not expected to know everything and we will all have very different personal reactions to the work that we are doing."* (Helen, line 592)

> *"I think she was just quite openly like, I don't really feel like I totally know what I'm doing yet but we'll work it out together and a bit more like that's ok. Not kind of*

> *portraying this uber-confidence, knowing everything, how the hell am I going to be like her* (laughter) *when I qualify."* (Jenny, line 262)

A few CPITs highlighted how teaching or a conversation with another professional shifted their thinking about events. Imogen talked about how teaching impacted on her thinking about risk:

> *"I think what shifted my idea in terms of risk was some teaching that we had, about seeing risk as protecting human rights. And that to me made a lot more sense, that risk instantly makes everyone concerned and anxious. But the way that she was talking about it was that what you're doing is safeguarding people's human rights and I think that safeguarding has a bit more of a protective and positive connotations to it. So in the ward environment trying to safeguard the staff's right to not experience physical or verbal abuse and safeguarding the client's right to health care, to equality and to not be ostracised within the ward because of something that is beyond their control, I think that completely changed my view on risk."* (Imogen, line 324*)*

> *"So risk has been quite a recurrent theme in that* (therapeutic) *group and I think something shifted in my thinking based on what had happened in that group."*(Catherine, line 293)

CPITs also referenced how more formal mechanisms on the training programme have enabled this process, such as mid-placement meetings or reflection groups.

> *"It's a really important reflection to have with yourself, to notice, because now I'm certainly aware of that trend in me. When I'm spending time on one person and I'm staying late because I just need to get that done for them, that I'm going into more of that rescuing mode, which isn't always a good thing to fall into. So I think the course, our cohort, are really supportive of each other in terms of reflection"* (Imogen, line 244)

> *"At the mid placement it came up that they were aware of my own core values and beliefs, and that I would always try and work in congruence with that. They could see the difference but they were very curious about that and wanted to develop that but wanting me obviously to be open to and aware of alternative ways of viewing things. So I think that has been helpful."* (Helen, line 552)

#### 3.4.2.1 Subordinate Theme 2: Thinking systemically: *"see the whole picture"*

CPITs perceived that developing their ability to think systemically about case work was helpful in managing risk. This competence also seemed to develop PPD competency, in terms of ability to consider the wider social and cultural context around a person and to consider complex ethical issues.

> "*Over about 20 sessions I'd say that about half of them were risk conversations in some way...it was probably because there were so many of them. It kept flipping between her risk to herself, to her children, to are there people out there still*

> *potentially harming children and you're telling me about the abuse as a child and actually am I beginning to find out details that I can then know enough that social services might do something.. it was all those 3 different areas that we kept dipping in and out of a bit."* (Jenny, line 274)

Some CPITs recognised that they had a tendency to adopt an 'advocate' position but they were learning to think more broadly. This seemed to enable working with the system.

> "*I think one of the things that I am a bit prone to is not blaming the clients for all the bad things that they do and formulating that, but not extending that kind of compassionate formulation to staff… it's how do you need to formulate the staff attitudes just as well as the clients. That helped me to be a bit more productive in the way that I interacted with the system then, rather than coming at it from my more, I don't know advocacy…*" (Donna, line 270)

> "*I think one of my values is always holding onto the client and putting the client's needs first and thinking about that in a very PC way… I've been able to hold onto that when it's been more kind of risk issues, when actually maybe my core values of always working for the client, when actually sometimes the client gets broader; it might be the client's child or other people on the ward setting who are at risk from that particular client. So I guess I've had to adapt on who I'm actually maybe advocating for or needing to work for.*" (Helen, line 616)

Some CPITs also explicitly demonstrated their consideration of the broader context of social inequalities, power relationships, exclusion and cultural narratives and how this impacted on their practice.

> *"I guess it would be the kind of questions I might ask and the way that I might think about something like positive risk taking, for example, and going back to my forensic setting … you know the people there that I worked with might have had very deprived lives in terms of growing up in learning disability institutions in the old days, being pretty much treated like animals, not like people you know, being humiliated regularly, quite possibly abused by multiple different people, being in enormously vulnerable positions. I suppose I think if I come from that understanding and that thinking then I'm more thoughtful about that in terms of risk, what their behaviours are now and what risk they are to others and to themselves and that would inform my thinking in terms of planning for if they were wanting to start taking leave and people were worried about their risk to others say in that example."* (Catherine, line 511)

> *"So when I am working with that individual client I find myself thinking about all the other things that might have easily led to those difficulties and how within society, or the family maybe maintains things or triggered things for that person…"* (Helen, line 640)

### 3.4.3. Superordinate Theme 3: Reflection in the event

Although a less frequently referenced theme, it seemed important due to its presence in the wider literature and as its infrequency may support the notion that this is a more advanced skill.

Some CPITs observed their increased ability to reflect on experience and knowledge *in* the context of a clinical session and use this to guide action and learning. This theme related to the themes of acquiring **knowledge and skills** (3.2.3.1; 3.3.2.3), **assertiveness** (3.3.3.1), **managing uncertainty** (3.3.2.2) and **understanding the position** (3.5.1.1) of a CP. Emma and Jenny spoke of their reflections in session on the *meaning* of a client's words when expressing suicidal thinking.

> *"I also think now I understand more about suicide and self harm. I know what I am looking for in terms of what the person is saying to me, so I think that I am able to judge the risk a little bit better now. I know the dialogue that I need to listen out for, so I feel a little more confident actually. I don't think I would be put off now. …"* (Emma, line 334)

> "*Probably learning a bit more to gauge when it is risky and when it really isn't. I've learned a bit more about someone can say that they want to kill themselves…I suppose that it can mean something different to what they're actually saying, how important…"* (Jenny, line 66)

Frances noticed how she was more able to mobilise a conscious process of weighing up options during sessions.

> *"With my first placement I was a bit more intuitive about it and did whatever felt right and wouldn't necessarily be able to think back and think I was thinking about risk then or this then, and I was thinking I can't stand up because that will make me look more aggressive so I'll stay sat down …Yeah, whereas I don't know if that would have happened as much on 1st placement. I think I would have just gone 'oh my gosh!' and almost reacted without really being able to think it through."* (Frances, line 388)

These skills seemed to develop over time through a variety of learning processes and PPD. The development of greater self-awareness and increased knowledge and skills seemed to be important and could create greater cognitive capacity to reflect in the session. Growing from experience increased confidence; anxiety was more contained and thinking became less effortful through some level of familiarity. This seems to fit with the Lazarus and Folkman (1984) model in that the participants are evaluating the situation as a threat but observing it to be more manageable because they feel it more within their resources as they gain knowledge and skills and master a range of reflective practice strategies.

### 3.5. MAIN THEME 4: IDENTITY

An overview of the themes that emerged from analysis are presented in Table 8.

**Table 8: Superordinate and subordinate themes – MAIN THEME 4**

| | |
|---|---|
| **Role** | **Understanding the position: *"what you can do"*** <br> ***"What kind of a psychologist am I?"*** |
| **Realistic limits** | |
| **Self-esteem** | **Feedback & validation** <br> **Developing skills and knowledge: *"it grows a little bit"*** |

#### 3.5.1 Superordinate Theme 1: Role

| | |
|---|---|
| **Role** | **Understanding the position: "*what you can do*"** <br> **"What kind of a psychologist am I?"** |

##### 3.5.1.1 Subordinate Theme 1: Understanding the position: *"what you can do"*

CPITs reported developing a fuller appreciation of what a CP's role entails. This could develop through their experiences in different teams and services. This involved contrasting and comparing the style of management and issues involved in risk management and the implications for working as a CP.

> "*Everytime you go to a new placement you have to navigate your way round that team feels about risk and how they manage risk. At the moment I'm in a Step 4 Adult secondary care team and the things that they consider risky might be quite different to what I consider risky, especially maybe looking at it from a psychologist angle rather than other team members.*" (Gloria, line 90)

> "*I think what I've found going from placement to placement is that it seems to be almost like a core business. Whatever the service is, there will be something at the core that seems to transcend all the clients and all the pieces of work that you do. For me that has definitely been physical health care co-morbidities alongside mental health and needing to know the impact of people's physical health on their mental health and vice versa. That's come from the group work that I've done, even getting people physically off the ward to the group room, and everything that I've needed to think about.*" (Helen, line 500)

This understanding could inform more critical thinking about team approaches to risk management and greater consideration of service delivery issues. Frances reflected back on

the way that risk was handled in an earlier placement in an in-patient environment, and how she might respond to it as a qualified CP.

> "*…it feels like you might be in more of a position to think about long-term strategies and think about risks over 2 years rather than 2 months and you might be more in a position to change services. Like in the in-patient one. If I was qualified there, maybe I would be more in a position to change the way the team manages risk or the team chats to each other or interacts with each other. I'd hope that you'd be a bit more able to do things like that when you're qualified.*" (Frances, line 507)

CPITs also reflected on the role of the psychologist within teams and ways of ensuring that their psychological viewpoint gets heard.

> "*So I think that psychologists are better positioned to hold that kind of uncertainty and talk about that and reflect on that with people but it's not always welcome or wanted and it wasn't necessarily the position that my supervisor held in that service."* (Catherine, line 471)

> "*This psychiatrist is acting like an expert when he doesn't have all the information. I could easily go at this, trying to fight my battle when actually I should just present my information and do what I can and trust the process then and try and hold myself back and present it in a way that was calm and considered. And know my place within the MDT rather than panicking and trying to trump his expert position with my expert position.*" (Donna, line 497)

#### 3.5.1.2 <u>Subordinate Theme 2:</u> "<u>*What kind of a psychologist am I?"*</u>

Through reflection on placement experiences in different service contexts, CPITs considered fundamental questions about their professional identity and future professional practice. This process could be enabled by a process of observation, imitating and then differentiating from supervisors.

> "*… moving from placement to placement, you always have supervisors who do things in different ways and all think that they are doing things right or not. I had one supervisor, who I really didn't get on with, but I think I learnt just as much from thinking that I don't want to do it like her actually. But also sometimes I have had two supervisors who do things very differently. In the first year, I used to try and be like my supervisor and that worked because I felt very unconfident and I thought well if she is doing it right then I will try and do it like her. I had two supervisors who were very different and then I thought I can't do it like both of them and that made me think actually I need to learn. I need to be developing my knowledge and skills, but I need to be doing it in a way that fits with me so that I can come across as genuine to others…"*(Donna, line 602)

This process could also occur through reflecting on the different experiences with supervisors and across the training.

> *"Just talking to the supervisor and having had so many supervisors as well you get so many different perspectives and experiences and reflecting on the teaching with them. And about how it's influenced my own thoughts..*" (Imogen, line 518)

During the training process, consideration of what kind of CP am I going to be was challenging for some participants. It raised doubts about professional identity especially when the lived experience was disappointing or overwhelming:

> "*I was so annoyed because literally, I'd thought ever since I wanted to be a psychologist, that I wanted to work in in-patients and when I found out I was going to do that placement, and then it was awful, and I didn't know what I wanted to do then. It was like if I can't do this, then what kind of psychologist am I? If I can't work with people in this setting and manage risk in this setting, then I'm a bit useless really."* (Frances, line 153)

For one CPIT, her experience of managing risk in an early placement was overwhelming. It made her question her entry into the profession:

> *"I definitely have questioned it. I've thought this is what I feel like now what am I going to feel like when I'm qualified CP? How am I going to deal? I can't deal with things at this high level of anxiety or I'll just burn out in 3 months. And it is a question I continue to ask myself. But what's made a difference is now I'm working with teams where it's very shared and supported with supervisors, who are very on top of things and very good supervision. I feel more confident now as a result of that.* (Emma, line 322)

But over time (through reflection, increased knowledge and resilience amongst other things) a few CPITs' perspectives changed as their appreciation of the possibilities of the role developed.

> "*I kind of thought I just want to work with clients one-on-one and you know see as many people in a day as I can and then go home. Whereas now I'm thinking I want to do all those things because that's kind of why I originally wanted to get in the profession, but also I feel like we're in quite a privileged position sometimes of being able to be in positions where you feel like you hold some sort of authority where you feel like you might be listened to. So it feels like why not use that status or use that knowledge and try and make proper differences and be more proactive about it, rather than again just feeling that you're firefighting all the time*." (Frances, line 545)

For some, this involved a consideration of which settings best fitted their sense of competency and values.

> *"I think it will depend a lot on what job I got. I think if I got one in the community I would feel a lot less competent than if I had one in an in-patient unit and just because that's not where I have been.* (Donna, line 749)

> *"I hope to be in adult mental health service, whether it's in a forensic situation or in the community. It depends on the team and how the team is structured whether it's a truly multi-disciplinary team or not, I think for me. What I'm hoping for is a situation*

> *like what I'm getting on placement, where risk is really shared and talked about and if you have care-coordinators that makes your life so easy."* (Emma, line 706)

### 3.5.2 Superordinate Theme 2: Realistic limits

For many, the step to becoming a newly qualified clinical psychologist was conceptualised as another stage in the journey, rather than an endpoint, with a recognition that to *not* know everything is acceptable. This realisation came from having learnt to work effectively with teams, an understanding of what contributes to change in clients and the need for a more resilient position in the work.

Helen reflected on her supervisor's role in modelling the position of not needing to know everything. This was also referenced in under '**Reflection about event'** (3.4.2) where trainees recognised that they did not need to know everything and in the theme **'Role'** (3.5.1) in which a trainee recognised that she did not need to take the expert position.

> *"A big part of that was being able to see my supervisor's vulnerability in that. The questions that she still had that she wasn't sure of as a qualified CP who was supervising, that there were certain areas that she felt she would have to seek support. So I suppose with me coming through, even when I am exclusively the named person for somebody's care, you have on-going clinical supervision and line managers there for a reason, as there may be times when things feel outside of my competency so that needs to be taken to a higher supervisor or manager."*(Helen, line 665)

Reflections on limits and possibilities also focussed on shifting perspectives of what was achievable and what represented sustainable expectations.

> *"I'd always* (sigh) *got a lot of satisfaction from improving situations and making something better and then being placed in a situation where you could only have so much of an impact was very frustrating and almost felt a bit disempowering…But then seeing changes and seeing people get enough difference to feel better really brought me round, and made me realise you can be good enough. You can make even small differences which can have an impact and you don't need to go in and fix everything because you can't always fix everything. I think that kind of shift happened over that 6 months period during that adult placement."* (Imogen, line 208)

> *"I think one of the lessons that I learnt from that placement overall was not wanting to be the kind of main rescuer who solves someone's every problem but you know part of a team, part of a journey even and if you can have some small influence and just a little bit of that is enough really in terms of your job."* (Catherine, line 224)

> *"I've always found that in a forensic setting. You didn't really feel like you were getting very far with people. You make very, very, small tiny improvements and maybe not anything for weeks, a month, a year, whereas in a community setting that can happen in a matter of weeks. So it's bearing that in mind and being kinder to yourself when you go back into a forensic setting."*(Anna, line 701)

These quotes seem to illustrate that the trainees are better able to use systemic approaches to promote difference rather than seeing a fixed outcome as an endpoint.

### 3.5.3 Superordinate Theme 3: Self-esteem

| | |
|---|---|
| **Self-esteem** | **Feedback and validation**<br>**Developing skills and knowledge: "*it grows a little bit*"** |

The process of developing self esteem and perceived competence in PPD skills and values seemed to occur in a number of ways.

#### 3.5.3.1 Subordinate Theme 1: Feedback and validation.

A cycle of action, checking out, feedback, validation and experimentation was perceived to enable the growth of competency.

Many of the CPITs perceived benefits from 'checking out' their thinking, actions and potential actions with their supervisors. This theme aligns with **'support'**(3.2.2.2). This process provided them with an increased sense of safety, helped them refine their inter-personal communication with the team and to trust their clinical judgement.

> *"It's just all about the checking it out and having people sat with you who say 'yeah that sounds fine I wouldn't have done that any different'. That's the thing I think when a peer or supervisor says 'I wouldn't have done anything majorly differently'. That's what makes you think ok."* (Gloria, line 712)

> *"When I'd written my letter to the psychiatrist I got my supervisor to check it and we discussed it in terms of did we think that we were giving information that needed to be heard, did we think we were putting forward enough without being forceful or reactionary, had I consulted everyone that I should have consulted within that…"* Donna, line 519)

> *"I think that I learnt that I could manage risk independently if I needed to. That was one situation I think it was helpful to have managed risk by myself, and as far as I knew everything was ok for that person and I'd been able to do everything that I needed to. So I think it was a confident boost for me. I guess one of the biggest things for me in risk managing is the confidence, and then feeling competent because you're confident, if that makes sense. So yeah I think it increased my confidence massively.*" (Anna, line 251)

Validation and reassurance that CPITs' practice is 'good enough' often comes from external sources like supervision, course staff and self-reflection.

> *"I went and I took it to my supervisor and she was happy with the way that I had dealt with it in that session."* (Anna, line 370)

> *"I suppose there's been a lot of positive reinforcement for what I did do in those risk situations, both from my clinical supervisor on placement and my clinical tutor when they've come out for my more formal assessment. My clinical supervisors have reflected on the piece of work and felt that I was able to manage it very well and equally my clinical tutors have confirmed 'yes' for both my level of competence and actually that I managed that more than they would have thought of at that stage of being a 1st year trainee. So I suppose getting that sort of feedback from the course and it hasn't ever hindered an assessment, it's actually been used as evidence that I've been doing quite well within my core competencies."*(Helen, line 682)

Catherine also commented on the role of validation from clients.

> *"I've certainly had experiences where people have told me later on in their therapy that they were concerned about me being a trainee and not being confident at the beginning and then kind of realised that I was or felt safe enough with me, that I was experienced enough."* (Catherine, line 388)

Imogen, highlighted the role of peer feedback.

> *"They usually put us in 3s or 4s and have somebody playing the psychologist, somebody else playing a risky person and the other observing and they can reflect back about what they thought and then you all rotate. So it's really helpful to have that outside feedback. I know that everyone is generally quite nice, 'yes you did very well', but you know we're quite close so they might say 'I would have said this, but I think you got it with saying this'. So you have an in-depth discussion about why you asked something and not something else, so those have been really helpful and I think all the risk teaching has followed that structure."*(Imogen, line 579)

Validation also came from the realisation that your view is shared by other health professionals.

> *"And I guess speaking to a lot of health professionals about the same thing... the more people who say the same thing, you feel more confident in thinking if they've got the same knowledge and I'm building my knowledge, but also being reassured and consolidating what I already knew is the right thing to do."* (Donna, line 74)

Some commented that it might be helpful to have closer assessment of risk management. One CPIT felt that she would like to gain more feedback from clients.

> *"I've never asked a client how the risk assessment process has been for them but I guess you might ask how a session has been for them or whether the questions were helpful, but I've never got systemic feedback from the client on how the Risk assessment process has been.*" (Bronwen, line 769)

> *"I think what the course has done, they have given us good training on how to manage risk but we haven't necessarily been specifically assessed on it. It's something that always comes up in our mid-placement visits. I guess that's the more informal assessment; it is covered in our supervisor feedback form as well but there's no actual formal assessment."* (Imogen, line 507)

Although this was a minority comment, there was a sense from other trainees that they benefitted from being *seen*; that being seen and validated in action somehow increases the credibility of feedback.

> *"I've never been observed in a risky situation. By chance risk hasn't come up as a real issue, so that's not really gone through the appraisal process…so that would be helpful whilst carrying out risk assessments."* (Bronwen, line 760)

> *"I've just found you get to observe a lot of assessment sessions and end sessions but not that much in-between. You sometimes think I'm just making this up as I go along …"* (Anna, line 543)

#### 3.5.3.2 Subordinate Theme 2: Developing skills and knowledge: *"it grows a little bit"*

CPITs also reported feeling more competent in their professional judgement as their knowledge base grows. This theme was similar to **knowledge and skills** (3.2.3.1) in **EVENT PERCEPTION**, but referred to observing the *growth* rather than the presence or not of skills and knowledge.

> *"Obviously having experiences of different client groups and obviously different types of risk come up in different settings, there tends to see some things happening everywhere. Once you get a bit more experience of different types of people and how your supervisor deals with these situations, you start to know that what you do isn't wrong."* (Anna, line 535)

> *"I think it's almost like those first few experiences were like a huge learning curve and then after that everytime it comes up or everytime you might have training about it, it grows a little bit. But I think those early experiences were the most significant."* (Gloria, line 79)

Gloria also reflected her belief that competence will continue to grow through the knowledge and skills that can develop further when you stay in a service for longer.

> *"I think feeling more stable and having more experience in this specific area would help you to feel a bit more confident."* (Gloria, line 124)

Some CPITs, like Imogen, highlighted how supervision had been explicitly used to mark the development of skills through increasing autonomy. This also linked to the discussion of safe supervisory relationships above.

> *"We'd had discussions at the beginning of placement that I was going to start managing risk and I was going to start trying to be more autonomous and what was appropriate and what would we agree would be a trigger for contacting. So again having that very explicit conversation."* (Imogen, line 465)

### 3.6 Summary

These results have highlighted how participants' clinical experiences are perceived to have impacted on their competence in PPD through managing risk and complexity. Although all CPITs felt they had increased their competency in managing risk and in their PPD, some CPITs reflected that risk management may not have been sufficiently covered in the training programmes.

> *"In terms of competencies I wonder if it could probably be a bigger aspect of the course overall, because I wonder if it is something that is kind of pushed to one side because people feel uncomfortable about it or because there is no sure fire 'this is the right way to assess risk or manage risk.'* (Catherine, line 446)

> *"I don't think anything is done about risk. I don't feel that the course has put anything in place that I've pulled out and thought that's been useful. The main thing that's covered is in your placement review meetings or goals to set up your placement. There's nothing that really feels like that you're thinking about your competence in managing risk. It's not an area that's flagged up"* (Jenny, line 585)

> *"I think we need whole modules or we need a module or a day just on risk but not risk in a theoretical way. I think we need risk taught in a practical way; taught from the perspective of a CMHT and also what best practice is. I still have no idea really what best practice is."* (Emma, line 719)

It is also important to state that CPITs reported unanimously that they would *always* raise situations involving risk with their supervisor, although they may portray themselves as more confident in that experience than they felt. They regarded this safeguard as recommended and accepted practice within CP.

> *"I think risk is something that you can't worry about, you can't worry about how it's going to make you look…if you're not doing things right, then you're putting someone's life at risk, so I would always go to a supervisor.*" (Bronwen, line 125)

> *"I think that if I have a risk issue that is bothering me, I am not someone that would keep it to myself 'cos its only going to make it worse."* (Catherine, line 425)

The relationship between the themes (see 4.2) and the utility of the methodology in addressing the research question (see 4.4) will be critically appraised in the discussion. The findings will be related to extant theory and to the narrative and systematic reviews (see 4.3.1 and 4.3.2) which were presented in the Introduction.

# Chapter 4: Discussion

## 4.1 Overview

This study was designed to develop an understanding of the CPITs' experience of the challenges of learning to work clinically, with complexity, without high level competency and to explore how these experiences impact on their personal and professional development. The objective was to gain a sense of CPITs' perceptions of managing this process and of what enabled or hindered their perceived competency development in personal and professional skills and values. The author also aimed to understand how CPITs identify the limits of their competence when working with complexity and risk, what the perceived stressors are and how trainees learn to manage these. Furthermore, it was intended to explore how CPITs perceive such experiences to influence their position and identity as a CP, in relation to self, within teams, and with other professionals. An IPA methodology was used to elicit, analyse and interpret the data generated by a sample of 10 CPITs.

The study incorporated a systematic review of the literature which examined the evidence base pertaining to the question "In developing PPD competence, how does managing challenging situations including risk, impact on trainee health practitioners' perceived learning process?". These studies were critically appraised and it was shown that no previous studies have explored how working with complexity and risk contributes to perceived competence development in this population of trainee health professionals. Where relevant, findings from the systematic review will be used to support or refute the evidence which emerged from the analysis of the data derived from this sample of CPIT.

This chapter will be structured in the following way. Initially, a summary of the key themes is presented and discussed in relation to the existing literature on PPD. The implication of the findings are then discussed. A critical appraisal of the study is finally presented with suggestions for future research.

## 4.2 Interpretation of results

### 4.2.1 Overview

In considering the emergent themes, it seems worthwhile to reiterate the required PPD learning outcomes that CPITs are aiming to gain competence in. These are often summarised as self-awareness, resilience (Gilmer & Marckus, 2003; Zhao-O'Brien, 2011) and

professional effectiveness (Sheikh *et al.*, 2007). The specific learning outcomes as specified by the CTCP (BPS, 2013) are cited in the Introduction (p.5). It will be suggested that the narratives constructed between the participants and the author revealed that these challenging clinical experiences can promote professional competence in managing risk *and* more generic personal and professional development. It is acknowledged that the data has given an insight into only a subset of the PPD competence requirements; notably understanding of the impact of one's own value base upon clinical practice, autonomy and working within competency, managing learning needs, managing emotional and physical impact of work and capacity to recognize fitness to practice and collaborative working. Although only a sub-set of the required PPD outcomes, these seem to be key outcomes which are most clearly and exclusively demonstrated in-vivo.

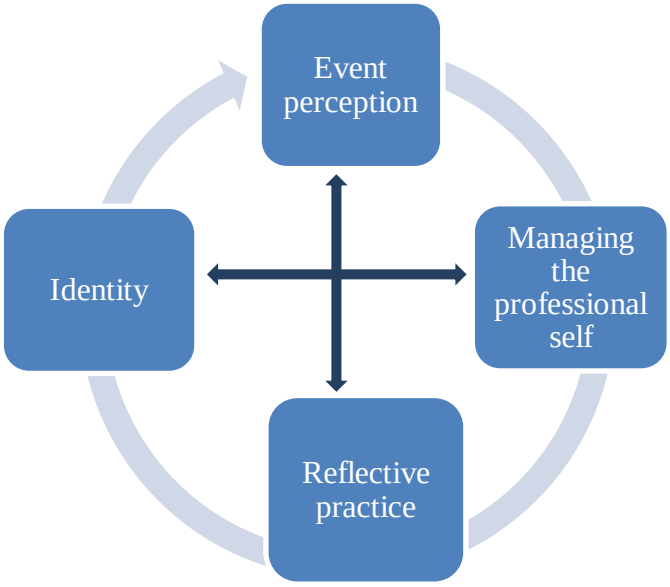
### 4.2.2 A cyclical learning process

Although the **MAIN THEMES** were presented in a linear manner in the results section, they seem to relate in a cyclical learning process (Figure 3). Each discrete risk event can provide a potential opportunity for Personal and Professional Skills competency development which may occur over a relatively short time frame but cumulate over a longer time period. A longer time frame can be implicated particularly when the learning cycle involves the more challenging development of personal and professional values and beliefs. A discrete learning cycle also occurred when a CPIT identified a knowledge and skills gap. This may also trigger a secondary longer learning cycle involving shifts in thinking, for example, developing a more systemic approach to clients' difficulties.

The learning cycle is often initiated by an awareness of anxiety or uncertainty, which provides a clue that there is a learning need, as identified in previous studies (Hughes & Youngson, 2009: Miller, 2009). CPITs reported that in the context of risk it was imperative to attend to this clue due to the significance of errors or omissions in their actions. These situations then seemed to propel the CPIT to enter the learning cycle and to create impetus for PPD. However, it was noted that in some of the narratives, avoidance was evident and the PPD learning cycle may not be launched at that stage. For example, some CPITs described doing the minimum needed to 'survive' and only initiated more fundamental self-development work later, when they felt more contained.

Initially, the threat (i.e. the risk related event) is appraised in the initial **EVENT PERCEPTION**. The event is primarily appraised to determine whether it is significant and threatening to the CPITs' goals (e.g. becoming/being a competent practitioner or occasionally physical well-being) and secondly as to whether to use the available personal and coping resources to deal with the stressor. Given the focus of discussions on risk management at the *limits* of competence, risk situations perhaps inevitably were not seen to be irrelevant to CPITs' goals. Instead, they were appraised as potentially threatening ('overwhelming' and 'stretched and challenged') or benign ('manageable and positive'). 'Overwhelming' in particular stretched coping and personal resources and could result in elevated stress levels.

**Figure 3: Learning Cycle**




The degree of threat was seen to vary according to an appraisal of safety and personal resources which broadly respectively related to external and internal factors, although the two could be inter-related. These processes were consistent with the primary and secondary appraisals in Lazarus and Folkman's (1984) Transactional model of Stress. In the face of the risk event, CPITs often set in motion a number of cognitive, behavioural and emotional responses which enabled **MANAGING THE PROFESSIONAL SELF**. These discrete experiences were critically appraised to examine the *meaning* of the event and its implications for learning and actions through **REFLECTIVE PRACTICE** which in turn influenced transformative learning about the CPIT's personal and professional **IDENTITY.**

CPITs perceived that their sense of PPD competency incrementally increased over the course of training; although this developmental course could fluctuate *within* each discrete learning cycle. Generally over time, events that were once experienced as overwhelming become more manageable. At times, for a minority, a particular risk event could cause disruptions to competence and identity development. When a major disruption to PPD occurred, participants reported gradually feeling their sense of professional effectiveness to be restored. Some participants portrayed such disruptions as promoting significant growth in aspects of PPD and suggested that they created opportunities to build resilience and prompted shifts in their value base. Through managing risk the participants perceived learning to have occurred, not only in risk management, but also in transferable generic professional skills and knowledge and, more broadly, in how to *be* a CP in the workplace. The CPITs' narratives however suggest that at times this process of learning was not necessarily straightforward and there were identifiable factors, often extraneous to the risk event itself, which could enhance or detract from this process.

These main themes are now summarised and related to the extant literature.

### 4.2.3 THEME 1: EVENT PERCEPTION

This theme referred to how CPITs appraised the manageability of the risk event. Within this were the three superordinate themes: **Sense of threat, Safety and Personal resources.**

#### 4.2.3.1 Superordinate Theme 1: Sense of threat

CPITs reported that their anxiety was more disabling in risk situations in early placements (or occasionally at the beginning of later unfamiliar placements), and that this experience motivated them to pursue further professional competence development. This resonates with other studies (Nutt-Williams *et al.*, 1996; Skovholt and Rönnestad, 1992) which found that anxiety was a central issue in the first year of training.

CPITs clinical experiences with risk broadly fitted into three overall appraisal categories: **"*overwhelmed"*,** '**stretched and challenged'** or '**manageable and positive'**, all of which presented opportunities for deep learning. However, the learning process was perceived to be less personally distressing in the case of the latter two categories which seem to offer

moderate levels of emotional activation to enable learning (Lombardo *et al.*, 2009). The experience of being ***"overwhelmed"*** could be a strong motivator for learning about risk and PPD, however in a minority of cases, it also presented a temporary disruption to PPD learning through increased stress and poor psychological adaptation.

Situations which fitted the appraisal '**stretched and challenged'** were generally experienced as more positive learning experiences, and often involved feeling supported and enabled to learn. These situations sometimes involved direct work with a challenging client, and/or meeting the challenges of team work. The latter might imply consultation and so provide opportunities to learn to manage the learning agenda, to learn to consider and manage ethical dilemmas and to learn to work effectively as a psychologist within a team. Manageable and positive experiences appeared to have been experienced less commonly in this sample, but this may be an artifact of the interview's focus on experiences at the limits of competence. The exemplars of the 'stretched and challenged' theme, however, were invariably positive learning situations which seemed to incrementally build confidence and develop autonomy, through a process which fitted with Kolb's (1984) learning cycle.

#### 4.2.3.2 Superordinate Theme 2: Safety

CPITs' assessment of the threats to their professional effectiveness was influenced by their sense of the '**repercussions'** of a risk event, and their perceived level of '**support'.** Their sense that they are *supported* by other professionals, notably the supervisor, was suggested to greatly facilitate the learning process. Some CPITs were able to actively create a supportive environment through increasing communication with other professionals in the system, but in a minority of cases it was felt that affecting the system and or supervisory relationship was beyond their control. This idea is supported by Sheikh *et al.'s* (2007) model and the notion that the learning process can be hindered or facilitated by the nature of the support systems in place. However, what the model does not specify is how to remediate these processes and transform available supports when/if they are not working to good effect. The model also does not specify what factors influence the occurrence of these difficulties. Although CPITs narratives seemed to focus on the barriers within their environment, rather than those within themselves, there were clearly a range of internal and external factors which impacted on the development of less productive learning cycles. This finding seems to be consistent with Hughes and Younson's (2009) model of professional development.

**Repercussions** commonly referred to a fear of making mistakes and the potential for personal and professional ramifications arising from this. This fear could be heightened where CPITs perceived a blame culture to exist within teams and services. In light of the recent Francis (2013) report and the need to learn from errors, it seems important that trainers and supervisors promote the message that errors need to be recognised and learned from as systems' failures (e.g. Reason, 1998; Vincent, 2010) not personalised to the professionals involved (Gray, 2010, Francis, 2013).

#### 4.2.3.3 Superordinate Theme 3: Personal resources

Through managing risk events, CPITs sometimes learnt that they needed to affect change in '**Attitudes and Values'** and **'Knowledge and Skills'**. The recognition of absence of skills and knowledge often motivated CPITs to develop learning strategies to fill these gaps. At times, the management of risk situations could trigger a realisation that some core assumptions and beliefs were barriers to competence and professional growth and could begin an important PPD learning cycle. This process seemed to be consistent with Mezirow's (1997) transformative learning model with development of beliefs leading to greater flexibility and resilience.

Beliefs around the 'acceptability of support seeking' were important in affecting approaches to managing risk and PPD. For some CPITs, the tacit belief that support-seeking indicated personal weakness or incompetence seems to represent a misunderstanding of PPD. This resonated with studies with medical students in which they framed their support-seeking to preserve their professional identity (e.g. Kennedy *et al.*, 2009). Over time the difficulties that such beliefs created for managing risk and on personal resources, was perceived to promote growth typified by greater openness to support-seeking and more effective collaborative work with colleagues and service users. This learning cycle often extended beyond the risk incident and placement and drew on a number of resources, such as personal therapy and peer support.

Supervisory relationships were considered to be the key facilitator or barrier to development of the self as CP. It could be that if a trainee holds an expectation that the use of self is a large component of the supervisory interaction, then there is potential for mismatch as trainees move between therapeutic approaches and supervisors. Different therapeutic approaches place different value on the use of 'self' and the use of self differs across

supervisory approaches. Other support mechanisms purported to be available to CPITs (e.g. Gilmer and Marckus, 2003; Sheikh *et al*., 2007), such as buddies, developmental mentors, reflective practice groups and therapy were not greatly referred to in this study. This could be for a number of reasons; for example, it may reflect their lower priority or be a function of the interview process. However, the existing literature would suggest that there are limits to their utility for some trainees which may also explain their infrequent citing. In the context of negative beliefs about support-seeking, it may be that the more public arena of RP groups are seen as threatening rather than supportive. Binks *et al.'s* (2012) study noted that trainees' commitment to engaging with distress was important to learning and that this could be a potential barrier to engagement. A significant proportion of CPITs had experienced personal therapy and it may be that PPD also occurs here; however, only one trainee mentioned this in the interviews.

#### 4.2.3.4 Cumulative stressors

For a minority of CPITs, the anxious response in early placements developed into a state of being overwhelmed and more globally distressed. These CPITs primarily located the cause of these difficulties in the external environment, however they also referenced personal vulnerabilities or other external stressors. At these times, in particular, it seemed challenging for CPITs to use the range of available supports to progress their PPD as they were overwhelmed by feelings of vulnerability. At worst, feeling overwhelmed could impact on motivation, problem-solving, self-esteem, and resilience and the CPIT's well-being. The prevalence of stress and poor psychological adaptation and coping is reflected in the clinical psychology professional literature (e.g. Cushway, 1992; Dory *et al.*, 2009; Kuyken *et al.*, 2000).

### 4.2.4 THEME 2: MANAGING THE PROFESSIONAL SELF

Through managing risk, all CPITs discussed the development and use of a range of self regulation strategies to manage their emotional responses

#### 4.2.4.1 Superordinate Theme 1: Emotional regulation

CPITs showed awareness and ownership of the need to utilise and sometimes develop their ability and strategies for '**managing emotions'** and create greater equilibrium in their emotional state in sessions with clients, with other professionals and within teams. In doing so, CPITs demonstrated self-awareness, self-regulation and potentially developed resilience. The use of strategies to manage frustrations in team working was often perceived to be motivated by the desire to promote the client's well-being and promote a systemic perspective, integrating the psychological perspective where differing conceptualisations of the 'problem' may be held. The development of higher skills in emotional regulation was thought to be enabled through a number of factors: for many CPITs a *collaborative* supervisory relationship was used to reflect upon such challenges and to potentially develop skills, as well as utilising therapeutic techniques for the self, such as relaxation strategies, cognitive re-framing and adopting a curious and accepting stance to felt emotions and thoughts. From CPITs' narratives it was hard to discern precisely how these skills developed but it seemed that CPITs were able to manage their emotions and learn to attain greater equanimity in highly emotive situations. A longitudinal study would be required to capture how and over what time period this develops.

#### 4.2.4.2 Superordinate Theme 2: Cognitions

CPITs also learnt that they needed to seek support to develop their thinking, to become more professionally effective and to manage uncertainty. They also recognised that they needed to be able to apply formulation skills in using systemic thinking at the individual level and at the level of the team. Seeking out appropriate knowledge and skills helped trainees with '**managing uncertainty'** through supporting their sense that they had fulfilled their professional responsibilities, for instance, when they encountered risk. Supervision was perceived to be utilised to develop skills in **'formulating'** which in turn helped to establish a role for the CPIT as a psychologist in the team and service. Improved management of uncertainty via these routes also benefitted the CPITs' perception of their ability to manage the self. These findings demonstrate how PPD can be inter-linked within the development of other competencies (Gilmer and Marckus, 2003). CPITs' accounts of how formulation enabled their development of competency in risk management and PPD aligns with a number of the benefits claimed for formulation in the BPS Formulation (2011) guidelines.

#### 4.2.4.3 Superordinate Theme 3: Behaviour

Many CPITs also reported learning that they need to behave more assertively with clients and in teams and professional relationships, including supervision. For others, '**assertiveness'** was evident in their narratives but not reflected upon as a skill that had been developed during training. The feeling of being or having one's ideas dismissed within teams, or challenges in negotiating situations involving challenging clients or complex family dynamics, motivated some CPITs to reflect on their experiences and move to positions of greater assertiveness. Supervision (and for one trainee, personal therapy) was perceived to enable this process, which could involve adapting the tone or style of inter-personal communication, as well as learning to consider and develop compassion and understanding of other professionals around the client. CPITs' narratives did not always reflect an understanding of the need to behave assertively as a responsibility that had to be assumed on behalf of the client, but focused more on a sense of personal responsibility.

CPITs also learnt that it was their responsibility to structure their own learning, to use the expertise of other health professionals and to draw on the principles inherent in learning protocols. This realisation followed the *experience* of not knowing and reflection as suggested by Kolb's (1984) learning cycle and reflects Mezirow's (1997) Adult learner approach. This responsibility was not necessarily understood and operationalized by trainees at the beginning of placements and may be an important area for supervisors and trainers to reinforce, given the potential implications for self, client and service of lack of awareness of service protocols and procedures in relation to risk management.

### 4.2.5 THEME 3: REFLECTIVE PRACTICE

CPITs learnt to use reflection on, about and in the event as a framework for thinking about and setting actions in relation to an event. The use of reflection as a facilitator of PPD competence is commonly suggested in the extant literature (e.g. Bolton, 2003; Sheikh *et al.*, 2007) and supports Schön's (1987) claim that it is essential to facing new and complex situations.

**Superordinate Theme 1: Reflection on event** occurred in the time period shortly after the risk situation and was primarily perceived to occur within the supervisory relationship through '**scaffolding'** and '**making sense'** of actions undertaken and for refining inter-

personal communication in the therapeutic relationships and within the system around the client. If the supervisory relationship was not felt to be safe, some CPITs felt that this mode of reflection was more limited: "… *the supervisory relationship has an impact on the way that you might bring risk issues up, how you talk about them, how long you talk about them for…"*(Catherine, line 423) Some trainees reported that reflection carried out without another was more limited in its productivity.

**Superordinate Theme 2: Reflection about event** occurred more intermittently after the event and may recur over different placements in a wider variety of modalities beyond supervision, such as teaching, reviews and discussion with peers and other HPs: "*learning that I can get things wrong and I think that's the biggest change in me over the three years…"* (Frances, line 671). Over time, this could facilitate shifts in beliefs and values, as discussed previously, and develop understanding of the limits and responsibilities of the professional role (as discussed later).

**Superordinate Theme 3: Reflection in the event** describes the ability to cognitively and emotionally consider what one is doing *in* the moment and what one should do next (Lavender, 2003; Hughes & Youngson, 2009). This was perceived to be a more cognitively demanding and sophisticated mode of reflection, given the need to develop this skill whilst also managing emotions and negotiating the inter-personal dynamics. It was a less frequently referenced theme in this study, and may be one that develops over a longer time, with experience and increasing knowledge and skills. It may also be that this skill is developing and more easily utilised in less emotionally charged clinical situations which allow more space for metacognitive processes. The ability to achieve this in risk situations is however perhaps an indicator of more advanced personal and professional skills, which for many CPITs may develop later.

Engaging in effective reflective practice could support the letting go of systematic case-by-case supervision, the development of increasing autonomy, professional self-esteem and awareness of their role in relation to the self, with other professionals and within teams. CPITs considered the nature of the supervisory relationship to be especially important in enabling or hindering the reflective process. Although, as suggested by others (e.g. Sheikh *et al.*, 2007: Hughes & Youngson, 2009) reflection occurred across a number of modalities, in this study it was generally cited as being a dialogue with the self, the supervisor and peers. Reflective journals were not mentioned. Other mandatory modes of reflection such as

academic assignments or RP groups were (as discussed previously) less mentioned. Quinn (1998 & 2000), writing from a nursing perspective highlighted ethical concerns about RP, namely in relation to confidentiality, rights to privacy, informed consent and professional relationships. It is not clear whether this was a factor impinging on their utility but may warrant further investigation.

Given the difficulties some CPITs experienced in managing risk in some placements, and the 'live' quality of some of the narratives around specific episodes: " *I was feeling kind of shut down and it was either you are in work and you can cope or you go home, ok, so I'll have to be in and try and keep going…"* (Frances, line 136) it seems pertinent to question the efficacy of some of the modes or processes employed to reflect. Some CPITs' narratives overtly highlighted dysjunctions in the reflective process. For example, noticing a tendency to get stuck in unhelpful rumination or in dichotomous thinking about an issue: *"I go round and get caught in a bit of a circle and … I think that I need to talk that through to feel ok with that"*(Donna, line 425*).* Some cited instances when a negative view of the self could be challenged by the perspective of another, which then lead to a different direction in thinking or development: "*I found that group really useful to get me to think about things differently and just to recognise that we are in training, we're not expected to know everything…"* (Helen, line 592). This seems to resonate with the existing literature (e.g. Ayduk and Kross, 2010, Quinn, 1998 & 2000) which highlights the importance of the *process* of reflection and the potential for negative impacts of reflection. It has been noted by other authors (e.g. Hobbs, 2007, 2002; Boud & Walker, 1998; Orchowski *et al.*, 2010) that the process of reflective practice engaged in is not necessarily critical or effective and can, for example, support prejudices and neglect contextual influences. It may be that in order to achieve productive reflection, without reflection with another, some CPITs may benefit from learning different strategies to move reflection beyond less productive rumination. Finlay (2008) highlighted the question of how reflection is supported and nurtured within the organisational context. This issue seemed pertinent in this study and it could be the case that the tendency to locate the failure or success of reflective practice within the nature of the supervisory relationship was related to the absence of other supports or space within the organisational context or working cultures within MDTs. The NHS Wales staff survey (2013) shows that staff perceive the organisation to be strong in eliciting incident reporting but poor in then providing feedback on how incident reports change working practice (39% reported getting such feedback). The organisation has a responsibility to support reflective practice cycles

and to disseminate information on the changes generated from 'lessons learned'. In this study, the supervisory relationship was considered critical by CPITs and the barriers and enhancers of this will be discussed in clinical implications.

### 4.2.6 THEME 4: IDENTITY

Identity change is perceived to occur as a consequence of the processing of clinical experiences through the learning cycle. The change of the professional self seems to be inter-linked with changes in the personal self, as suggested by the extant literature (e.g. Gilmer & Marckus, 2003; Hughes & Youngson, 2009).

#### 4.2.6.1 Superordinate Theme 1: Role

The experience of reflecting on the different challenges and procedures for managing risk often evoked wider change. It appeared to prompt growth at the personal level, understanding of the role of psychology within teams and services and of how CPs can affect direct and indirect client work and how they can engage with ethical and power issues, service delivery issues and systemic working. These developments could be intra-personally challenging, due to high, sometimes unrealistic self expectations which could provoke feelings of low-confidence and insecurity: "*If I can't work with people in this setting, then I'm a bit useless really…"* (Frances, line 153). This finding resonates with those reported in the literature (Hughes & Youngson, 2010, Zhao O'Brien, 2011). Much of this work involved self-reflection and reflection with the other, and was perceived to be particularly challenging if the CPIT felt uncontained in their current supervisory relationship and/or service context. At such times, CPITs can struggle with reflective processes, which can lead to the adoption of avoidant strategies: such as minimising client contact and effort and 'counting down days to the end of placement'. Other spaces and modes to manage difficulties more effectively seem to be overlooked. CPITs reported however developing resilience subsequently which led to a feeling of greater professional effectiveness. It is not clear however whether this was associated with internal growth and/or whether the external context was in fact more supportive. This is important to consider in training given the potential need to assume leadership roles on qualification and managing complexity within client work, teams and systems.

#### 4.2.6.2 Superordinate Theme 2: Realistic limits

CPITs also learnt about their limits, and realistic limits of the role with a greater appreciation of systemic working and influences. This theme inter-links with growing self-awareness and adjustment of values, developed through reflection on and about events. A barrier to this growth was the adoption of the position of 'rescuer': *"…something I come up against feeling like I'm going to go in and save the person…"* (Imogen, line 228). The position of ''advocate' was also a barrier… "*that helped me to be a bit more productive in the way that I interacted with the system, rather than coming at it more, I don't know, advocacy"* (Donna, line 270). CPITs reflected on their increasing awareness and shift away from these tendencies. It was not clear what prompted this. For example, does the experience of discomfort in managing risk provoke an internal reflection on these tendencies or are they brought into awareness by reflection with others, for example, in supervision. However, it seems important that such value bases are brought into consciousness due to their potential negative influence on professional effectiveness.

Another change in values that was mentioned was that of becoming more aware and accepting of not being able to know *everything*, which facilitated a drive away from taking an expert position. This promoted more collaborative working within teams, and consideration of psychology's place within them. This shift seems essential to safe practice in managing risk and, for example, reflects the policy recommendations of 'New Ways of Working' (BPS, 2007a). Resilience also seems to develop from the dawning realisation of the *limited* changes that might be possible for clients, and importantly the recognition of the clients' motivation and role in this.

#### 4.2.6.3 Superordinate Theme 3: Self-esteem

CPITs perceived that confidence and self esteem developed through processes of **feedback and validation** and **developing knowledge and skills**. SPC and self esteem were seen to develop over placements whilst also fluctuating within placements, depending on the CPITs' ability to manage a particular task/situation. This supports the idea that 'emotionally salient memories' and 'self reflection on performance' influence SPC (Bennett-Levy & Beedie, 2007). This study additionally suggested that supervision plays a key moderating role between learning opportunities and cognitive impact and emotional state in developing personal and professional competence through managing clinical risk situations.

Feedback and validation which influence SPC are generally based on accounts of events as perceived by the CPITs themselves, as risk management is rarely witnessed by other professionals. It is not clear how accurate these accounts and consequent judgements are. CPITs claimed to report events as they occurred, however this may not always be the case in reality: due to unreliability of memory under stress, given the literature on how HPs may self present in the most acceptable ways in supervision (e.g. Kennedy *et al.*, 2009) and that CPITs suggested that they sometimes minimise disclosure to supervisors if they perceive the relationship as unsafe. Given that some trainees mention the desire to be *seen* by their supervisor to be managing risk events, this may suggest that SPC may be fragile for some. This may contribute to an argument for more simulated assessment and observation in assessing competence and building confidence in competence.

### 4.3 Implication of the findings

#### 4.3.1 Relationship to existing models of learning

Whilst the overall processes of taking responsibility for learning are reflected in the models (e.g. Sheikh *et al*, 2007; Mezirow, 1997; Miller, 2009; Hughes & Youngson, 2009) they do not provide guidance on how the learner in a busy workplace/team should create space, interactions and hypothesis testing opportunities to pursue their learning objectives. The models de-contexulalise learning processes and do not provide suggestions as to how to negotiate learning opportunities when working in a team where, for instance, other qualified HPs may be assuming responsibility for effective and efficient management of risk but have no designated responsibility to train CPITs or to structure their inter-professional roles. The learning models to this extent are simplistic and do not take in the inter-professional and inter-agency learning context, which is encountered by CPITs when dealing with complexity and risk.

Moreover, the existing models do not address how the learner should construct the pre-requisite conditions for learning in complex learning environments and neither do they coherently address the systemic elements of these learning cycles. Sheikh *et al.'s* (2007) model of PPD emphasises the importance of reflection and a variety of relationships and supports, which they noted may inhibit or facilitate learning. However, their model does not yet offer guidance on a number of issues: whether different methods of reflection vary in their contribution to learning? is reflection with a more experienced other necessary and/or more important than with self? any sense of when their utility may vary (for example,

depending on service context, style of supervision, stage of training) nor any consideration of the issue of the utility of the style of 'reflection' pursued by a trainee. For instance, how to ensure reflection is distinct from rumination. These aspects seem important to consider further in enabling courses to support trainees in becoming proficient reflective practitioners and to maximise PPD. Increasingly, trainees and qualified clinical psychologists are being asked to develop leadership roles in applying reflective methods, helping to train other HPs in these processes and in delivering consultation in inter-disciplinary settings (e.g. McCusker, 2013).

This study's findings supported Mezirow's (1997) notion of the potential for transformational learning from 'disorientating dilemmas'. However, as discussed previously, it may be that CPITs are threatened by the change implied in the disorientating dilemma, and that the role of the supportive other is necessary in enabling CPITs to notice and consider shifts in personal values or core beliefs. If CPITs are to become efficacious practitioners post-qualification, it is necessary that they recognise the learning opportunities inherent in 'disorienting dilemmas' and also learn from supervisors and other HPs how to construct the conditions supportive of transformational learning so that they can also construct these and go on to support others through this process in due course.

This study supports the idea that the CPITs' emotional state can significantly affect SPC and that experiences with clients can impact on this. Whilst Bennett-Levy and Beedie's (2007) model highlights the role of external evaluation on emotional state and self-reflection on performance, it does not capture the moderating role that supervision and reflection about the event can subsequently have on SPC. These were important elements in this study. The findings of this study also suggest that there is a feedback loop from self-reflection on performance to acquiring knowledge, as reflections on perceived gaps led to the CPITs seeking out knowledge and skills.

### 4.3.2 Relationship to literature from other health professionals

The systematic review demonstrated a very limited literature on PPD through managing challenging clinical situations, and that which was present was found to have considerable limitations in methodological and analytical rigour. None of the studies were undertaken with CPITs. Whilst acknowledging these limitations, the narrative synthesis of the themes in the studies included in the systematic review showed similar themes to those reported in this study; underlining the importance of emotional regulation, reflection and the moderating role

of the supervisory relationship. Additionally, Tallentire *et al.'s* (2011) study supported the notion that fear of mistakes and judgement can increase trainee anxiety, may impact on clinical judgement, and highlight the need for cultural change in services and the practices used by senior staff towards errors and help-seeking.

### 4.3.3 Clinical implications

Within and across the themes there are three important recurring issues that seem important in promoting to PPD: namely managing the supervisory relationship and/or developing alternative sources of support with whom or with which to reflect and develop; the processes of reflection utilised; and the significance and enabling of values development.

#### 4.3.3.1 Training programmes

##### 4.3.3.1.1 Reflection

CPITs' narratives of developing personal and professional skills through managing risk have highlighted a central role of reflection in, on and about the event in facilitating growth. However, it has also suggested that some modes of 'reflection' do not seem to lead to more professional effectiveness and resilience, can be more akin to rumination and may contribute to poor psychological adaptation, at least in the short term (Ayduk & Kross, 2010). Orchowski *et al*. (2010) note that temporary states of self awareness can be linked to a negative state of self consciousness and state the importance of 'identifying strategies for promoting self-reflection that results in positive clinical gains' (p.64).

Reflection has been perceived to occur primarily within the self, with peers and within supervision. It seems that that CPITs' reflective practice within the workplace and outside of the supervisory relationship can be more limited. Furthermore, when the process of reflection recruited in supervision fails to match expectations, learning is perceived to be impaired. It may be that clearer guidance and consideration could be given as to how CPITs develop a space for reflection within the busy workplace context, especially given the challenges that some CPITs reported in chaotic, 'reactive' team environments, where they tended to get swept along within this mode of being.

Given that reflection was often described as an intra-personal activity in this study, it is not clear how this mode is assessed and competence identified by the self and supervisors. It is also not known whether the challenging of tacit assumptions and the change that occurs

through this process truly represents productive development in personal and professional skills. It would seem to support the necessity of the development of an assessment measure of the quality of CPIT's self-reflections (Orchowski *et al.*, 2010) and to overtly consider the issue of 'reflective practice' when drawing up the supervisory contract. Attention to this element of the supervisory contract could allow for consideration of its purpose, the modes that will be employed and for checking that expectations of the process are matching. Similarly, negotiation of reflective practice with peer groups during training might be enhanced by utilising these principles. It could also encourage the CPIT to engage with the literature and explicitly explore different modes and consider how to develop a productive and systematic approach within the specific contexts in which they are embedded within placements.

CPITs did not often refer to specific models or modes of reflection but to the generic term 'reflection'. Given differences between courses, models and outcomes, it seems important that more consideration is given to considering the meaning of the term, the process and measuring outcomes. Orchowski *et al.*( 2010) has noted that it may also be useful to consider how trainees make time and create a protected space for the activity within the workplace, especially when reflection on challenging cases may be difficult due to concerns about being assessed.

#### 4.3.3.1.2 Supervision

The supervisory relationship is widely acknowledged as central to PPD and to facilitating and enabling reflective practice (Neufeldt *et al.*, 1996; Miller, 2009). Although CPITs generally perceived this to be the case, some had experienced supervisory relationships which they regarded as less satisfactory. These trainees reported that the supervisory process reduced the quality of their learning in PPD because it caused them to become less open to reflection about their actions, their values and their feelings. Given this study accessed CPITs' *perceptions,* it is difficult to gain a balanced perspective on the causes and development of these relational difficulties and failures to meet CPITs' expectations. Problems with the supervisory relationship are well documented in the literature (e.g. Grant *et al.,* 2012). Previous literature has highlighted a number of factors which can impact on reflection within the supervisory relationship: including the role of the environment, trainee personality and cognitive capacities (Neufeldt *et al.,* 1996); role conflicts; gender-related misunderstandings (Grant *et al.,* 2012). The problems perceived are important in relation to PPD and managing

risk and highlight that CPITs are, at times, struggling to manage their own personal learning needs and to develop strategies which meet these. Both supervisors and CPITs required skills in using reflection and both may need to acknowledge that impaired learning may result from a sub-optimally managed reflective process during supervision.

Difficulties with the supervisory relationship were sometimes perceived by CPITs to be insurmountable: due to power imbalances, a perception that the issue lay in the personality or working style of the other and perceptions that honest disclosure about feelings or actions may have negative consequences for how their competence is perceived. It seems important, given the effect on learning and potential transparency about disclosures around risk management, that CPITs are encouraged to develop strategies to repair and take more responsibility for their role in repairing ruptures in the supervisory relationship. CPITs need to be guided by courses to accept this responsibility, to be aware of the mechanisms that could assist them to enact it and to ensure that the necessary conditions continue to be in place for reflection on their clinical practice even when there is a perceived breakdown in the supervisory relationship. Although CPITs reported being honest and open about disclosures around risk in this study, previous research has suggested that difficulties in the supervisory relationship can affect disclosures (e.g. Ladany *et al*, 1996) and this might warrant further research using a different methodology.

In this study, being assertive about one's own needs and expectations of supervision and drawing up a satisfactory supervisory contract was deemed helpful in achieving a positive relationship and some equity of power, as well as using mid-placement meetings and discussions with course tutors to help resolve differences. Some of the problems in this study arose from working with supervisors who worked from models which were less aligned to the supervisees' own perspectives. It may be important for CPITs to consider how to maximise the learning opportunities inherent in these situations independent of the lack of fit between perspectives and preferred practice.

#### 4.3.3.1.3 Feedback

Feedback has been perceived to be important in enabling PPD and also developing accurate self-awareness, and yet feedback on managing risk or challenging clinical situations was rarely attained on the basis of direct observation of the CPIT's practice. Whilst CPITs

reflected that their early encounters with risk may have adversely affected the therapeutic relationship, this perception was based mainly on observations of client behaviour, such as the client dropping out of therapy or on trainee self-reflection. This lack of observation, coupled with the challenges of achieving observation in practice, may implicate the role of more in-vivo assessment, joint working and simulated assessment with risk, so that feedback on actual performance can be achieved and learned from. Another mode of feedback which seemed to be currently under-utilised, is that of service users, carers, services and families themselves. It would seem pertinent, given policies of inclusion of the service user and carer perspective, to consider more systematic collection of the service user viewpoint, as this could inform PPD and safe and effective risk management. The importance of this is emphasised in the literature (Sheldon, 2011; Luxton, 2011).

#### 4.3.3.1.4 Values

Whilst BPS (2013) guidelines are explicit about the need to be *aware* of the impact of values, it may be the case that some values held, which might negatively impact on practice, are outside of CPITs consciousness and/or are emotionally challenging to consider. CPITs were able to reflect on changes in values, but it was not clear *how* these changes had been enabled, and to what extent an external agent was necessary to prompt re-evaluation. Supervision is likely to be an important vehicle to explore a CPIT's value base as it is exhibited when managing risk situations. However, given that this work can be emotionally challenging and possibly distressing, it seems important to consider the necessary conditions for disclosure and constructive critical appraisal of the value base brought by individual CPITs and inherent in teams and services. Their ethical and professional examination needs to acknowledge power differentials in the CPIT's relationship with supervisors, service users and carers, other HPs and employers.

Given the guidelines and CPITs' views on the importance of value change, it seems pertinent to consider how to optimise this development over the training. It may be useful to adopt measures for CPITs to consider their values base (above and beyond specific attitudes to issues such as race, ethnicity, gender etc.) and to discuss the implications of different values within teaching. Bennett-Levy's *et al.* (2012) methods of using self practice/reflection (SP/SR) in cognitive therapy training could prove a useful model for this. SP/SR is a training tool which uses CBT techniques such as thought diaries and behavioural experiments, either with a co-therapist or workbooks primarily to facilitate CBT knowledge and understanding,

skill and metacognitive abilities. Potentially these methods could be used to develop self awareness of values in an environment that for some may feel safer than within supervision. It may be helpful also for the supervisory contract to consider how values might be challenged and how the partnership might seek to optimise this process within their working relationship.

#### 4.3.3.1.5 Risk management

It was evident in the CPITs' narratives how infrequently CPITs acknowledged getting anything wrong or errors arising from the processes they pursued. Their main disclosures in the study were around uncertainty about their actions and this may be influenced by their self confessed fear of the personal and professional consequences of error. There is a top down drive for improving safe practice in mental health (e.g. Save 1000 lives plus campaign, 2013). It is recognised that there needs to be a cultural shift towards recognising errors and learning from them in a way which is not personalised to the professional involved NHS Wales staff survey (BMG Research, 2013); Save 1000 Lives plus campaign). It may be important for trainers to enable trainees to understand the checks and balances in the NHS to protect but also potentially sanction those that get things wrong or make poor decisions. It is also recognised though that some CPITs may be working in cultures in which this message is not embedded, which may make openness more challenging. As potential leaders within services, it could be an important area to reflect on and to consider how change might be affected within teaching and through supervision.

Many of the participants' accounts captured an initial sense of aloneness with risk situations and often a lack of awareness or confidence in the appropriate actions to take into the room with the client. This was often in spite of having received some training on risk and awareness of standard and local risk procedures. Whilst this is perhaps inevitable when faced with novel, complex clinical situations, it does highlight how challenging it can be to apply theoretical knowledge when faced with intensely arousing experiences. Whilst these situations commonly seem to motivate a learning cycle, there may be an argument to support the introduction of more simulated role plays within training, which aim to capture the essence of the pressure, demands and difficulties that are faced in these situations.

In allocating appropriate cases to trainees it may be helpful to discuss, not only their experience with the client group and therapeutic models, but also their experience and knowledge of managing the different types of risk that may feature in the placement. In

conjunction with this, it could be helpful to systematically alert the trainee to the important local risk processes and educate them about the particular risk management culture which exists in that service.

### 4.3.4 Implications for BPS accreditation criteria 2013

The BPS (2013) learning outcomes are specific in their statements about the need to develop understanding of the impact of CPITs' *values* on clinical practice and for *reflection to be used in supervision*. There is, however, no guidance on what *values* refers to nor explicit consideration of whether some might be supportive or detrimental to professional growth. This study has defined values pragmatically as being principles held by participants which are emergent when CPITs either directly name them or indirectly disclose them as underpinning their actions (e.g. the belief that their role is to advocate for clients etc). It has highlighted some core values that CPITs perceived to commonly support or hinder PPD, but it could be useful to give more specific guidance to supervisors and trainees about recognition and enactment of values in clinical and professional practice. It may also be the case that simple *awareness* of the impact of values is insufficient and in fact management or adjustment of values is sometimes essential in PPD and building professional effectiveness and resilience. If supervisors were to be involved in facilitating this change, consideration would need to be given to the ethics of this.

The BPS (2013) statement also does not acknowledge that some styles of reflection are more helpful than others and does not define what it means by 'reflection'. As suggested in the empirical literature (e.g. Ayduk & Kross, 2010) and in this study, reflection may not be helpful to PPD when it is closer to rumination and yet these two may superficially appear similar in CPITs' accounts. Reflection seems to be a catalyst for learning and building self awareness and resilience, but it is important to clarify what are the identifying features of a helpful reflective process. Helpful reflection seems to differ from rumination in terms of its outcomes: specifically in its ability to generate some degree of closure on an event, to generate some clarity of thinking about events and actions arising from these reflections. This may benefit from greater clarity and depth of definition in the BPS guidelines.

### 4.3.5 Implications for CPITs

It may be useful for training programmes, through teaching or supervision, to help normalise CPIT's initial feelings of perceived incompetence in risk management. This may be

beneficial to self esteem and may allow for a more free discussion of feelings and judgements made in clinical situations. Kennedy *et al.'s* (2009) paper outlines how medics seek to preserve professional identity and choose how to frame their interactions with supervisors to minimise appearing 'incompetent'. It may be important to discuss evidence such as this within clinical training, as such behaviour potentially drives up the risk of potential errors and their obfuscation.

### 4.4 Critical appraisal of study

Methodological design strength and limitations will be discussed below in relation to the quality markers for qualitative research and IPA.

#### 4.4.1 Systematic review

The systematic review is a strength of the study as it attests to the originality of this research and it also shows that there has been little systematic testing of the models of learning that have been reviewed. It also addresses a specific question to the literature and then critically appraises the quality and utility of the existing evidence base in relation to that question. The rationale for the current study is grounded in the findings of the systematic review and the narrative review of the learning models.

#### 4.4.2 Sample

The sample size of ten participants fits with IPA recommendations (Smith & Osborn, 2003), which suggest that smaller sample sizes facilitate exploration of the richness of personal and shared experiences (Elliott *et al*. 1999; Smith *et al*. 2009) and larger data sets can lose subtle nuances of meaning (Collins & Nicolson, 2002).

The sample was exclusively female as no males volunteered for the study. In 2011, the equal opportunity data suggests that 81% of applicants accepted onto clinical psychology training courses were female. Consequently, this sample is broadly representative of the CPIT population (Clearing house for postgraduate courses in clinical psychology, 2013). The ethnicity of the sample was not collected and so it is unclear how representative the sample was in terms of ethnicity. CPITs in the sample had a median age of 27 years which is fairly representative. In 2011, 53% of applicants were aged 25-29 years and 16% over 30 years (*ibid.*, 2013).

The CPITs were drawn from a diverse range of courses across the UK (six in total) and were representative of courses which privileged different styles of teaching and different therapeutic models and placement structures.

IPA research emphasises the need to recruit a homogeneous sample rather than one which is representative of the population for the purpose of generalizability of the findings, although it is recognised that claims made from small samples may have generalizability (Smith & Osborn, 2003). The purpose of this study was to present a detailed picture of the experiences and self-reflections of CPITs in order to inform the understanding of trainers and CPITs about the experience of acquiring PPD competence through managing complex clinical situations.

### 4.4.3 Recruitment

The recruitment strategy may have introduced bias into the results as participants were self-selecting. This is often the case with qualitative research and inevitable to some extent given the relatively high demands on time that the research makes (Smith, 1999). It is not known who did not elect to participate, and their reasons. However, the author was informed by a few participants that they were very interested in risk. It may be that the CPITs who participated had a particular interest in risk management, either due to a level of expertise born of their forensic training or perhaps due to their particular experiences with risk. Many of the CPITs however had also worked in other clinical settings prior to and during training and had a wide variety of experience to draw on, and four in the sample had not worked in forensic settings.

### 4.4.4. Data collection and analysis

The aim of the study was to develop an understanding of the CPITs' experience of the challenges of learning to work clinically with complexity without high level competency, and to explore how these experiences impact on their personal and professional development.

The interview schedule was developed with this broad aim in mind and was used flexibly to follow the narratives of the participants and capture the particular individual's experience. Barker *et al.* (2002) recommend open-ended questions for studying complex questions. The

discussion captured retrospective accounts of how CPITs perceived their competency developed over the course. It is acknowledged that retrospective accounts may involve more selective recall than current accounts and could lead to less rich information. Participants accounts may not account for the 'truth' but the story they wish to be heard (Barker *et al*. 2002). However, this study used a method of interrogating the lived experience of *specific* accounts of experiences with risk and these narratives were observed to often have a 'here and now' quality to them. The author feels that the richness of the experience captured is the strength of this study, and highlights features of the clinical experience which were previously unexplored in the PPD literature. The data produced is argued to be richer than that which could have resulted from the use of a scenario based method for instance.

The author's position is arguably a strength and limitation. The author's closeness to the position of the participants has advantages, for example, in knowing the territory herself and being able to use this knowledge to sensitively explore issues during the interview process and follow up hunches about what was being disclosed. The author was mindful of some subjective discomfort in taking the neutral position of interviewer in the data collection process, feeling at times a desire to reassure the CPIT about the normality of their experiences. The author reflected on these countertransference feelings in the research process, and their possible communication of CPITs feelings of insecurity about competency and the fear of wrong doing or error. Within all studies, and arguably particularly qualitative studies, there is a potential bias of the researcher imposing a perspective and research agenda upon participants. The author had to be very mindful of this due to her close position to the subjects of the enquiry. The study was conducted with awareness of this potential, and monitored using supervision, the bracketing interview, reflective diary and constant self reflection throughout the process. The Academic Supervisor is a member of the training group for CPs and an experienced appraisal tutor. The different position occupied by the Academic Supervisor provided a valuable other perspective to challenge any potential biases and to offer a different perspective in the analysis of themes and enabled greater rigour in the interrogation process.

The author and academic supervisor reflected on the different ways the data could have been analysed in accordance with the IPA methodology and are aware that a different approach to analysis, or different qualitative methodology, may have yielded different results. As discussed in the methodology the aim was to capture how trainees understand, make sense of

and learn from the experience of managing complexity and risk. The themes derived captured this and their interactions fitted with patterns identified with the extant literature and to learning models as explained above. The researcher is satisfied that the analysis style used was appropriate to the research question.

The methodology pursued conformed to Elliott *et al.* (1999) criteria for quality in qualitative research and this is perceived to be a strength. However, it is acknowledged that self-report, inherently relied on in IPA studies, has potential validity problems – data are necessarily idiosyncratic and personal and may differ from the view of others (Barker *et al*, 2002). However, the strength of the use of the participants in this IPA study was their reflective capacity and articulacy which allowed for a vivid impression of their lived experience. The researcher had intended to use a focus group with different CPITs to gain a sense of the resonance of the themes with others but unfortunately was unable to use this style of triangulation due to time constraints and the pragmatic challenges of achieving this. However, themes were communicated back to the participants who endorsed them and did not feel that they jarred with their experiences.

### 4.4.5 Conducting the study

The study had some potential to draw on memories that may have been difficult for participants, however no distress was evident in the process of collecting the interviews. Two of the interviews were conducted at the participants' homes. Given the CRB checks and professional codes of conduct followed by the participants, this was not felt to represent a risk, however lone worker policy was pursued. In an ideal world, the author would have conducted a greater proportion of the interviews face to face as this can bring a different dimension to telephone interviews. However, the author felt that both modes had advantages and that the anonymity of the telephone may have been facilitating of openness.

## 4.5 Future research

The author was unable to find any empirical research on CPITs experience of developing perceived competence in personal and professional skills through the experience of managing challenging clinical situations. The findings of this study have suggested that these situations do provide valuable opportunities for PPD and therefore warrant more systematic and

rigorous research. The utility of existing learning models can also be questioned when applied to the process of PPD development and require further testing and development. These models to some extent are currently largely descriptive and do not easily support the development of predictions that can be tested which limits their applicability.

This study did not explicitly address learning about *all* aspects of the specified PPD criteria. The aims of the study were to explore the CPITs' perspective on their PPD rather than to pursue an evaluation of specified learning outcomes. A future study could examine the perceived utility and applicability of different academic and supervisory support for PPD learning at different stages of training, both within and between cohort years. Some modes of academic and supervisory support may be more nurturing of psychological well-being for trainees or encourage trainees to more explicitly apply adult learning principles to negotiation of the supervisory contract.

The findings of this study highlighted a central moderating role of the clinical supervisor in PPD and in optimising learning about risk management. Although there have been a number of studies within CP and related disciplines of psychotherapy and counselling which have examined the supervisory relationship, these relational difficulties and the factors which affect their development and resolution are not currently well understood or researched. A study exploring the perspectives of CPITs, supervisors and possibly CP appraisal tutors who have experienced difficult supervisory relationships could be illuminating. A qualitative and follow-up quantitative study which explored the different perspectives on these difficult relationships and the perceived contributory factors could help promote a better understanding of this phenomenon and highlight strategies to ameliorate these difficulties when they arise.

Although disclosures about risk situations were not reported to be minimised in this study, it could be the case that the intimacy of the methodology and the position of the researcher may have created a self presentation bias. A quantitative methodology may be useful to explore what impacts on honesty in disclosures to supervisors about risk, for example, exploring what helps and hinders honest disclosures and the nature of content or process that may be minimised in self reports. An observational study could also be illuminating, but would be challenging due to the relatively low incidence of risk events and the confidential nature of CPITs' relationships with clients.

This study confirmed the perceived importance of reflection in PPD and also highlighted the need to understand this process better. A qualitative study using diaries and interviews or focus groups could be helpful to explore CPITs' reflections on their use of reflection, with self, other HPs, and in supervision over a placement, specifically exploring the perceived utility of different reflection methods. The diaries could describe the events reflected on and the manner in which they were reflected and the interviews could follow up the nature and outcomes of these reflections.

As discussed by previous authors (e.g. Orchowski *et al.*, 2010), it would also be helpful to develop a measure of gauging the quality of self-reflection and reflection in supervision.

The PPD learning outcome criteria (BPS/CTCP, 2013) specify that CPITs should develop an understanding of the impact of their value base on their work. The value base is not defined, the process by which its impact could be traced is not specified and how this learning outcome could be assessed is also unexplained. This study has highlighted the importance of certain values in enabling or detracting from PPD; such as self-expectations of performance and knowledge, respecting the views of all in risk scenarios and the meaning of sharing responsibility with others. In this study, there was little mention of many other personal values which might impact on practice, for example views about self harm, suicide, ethnicity, and parenting. A study which explores CPs views about the impact of values and explicitly naming challenges that have been encountered could be helpful.

This study used retrospective accounts taken at one point in time. It would be useful to examine the development of perceived competence, using longitudinal research to explore SPC competence in PPD over the course of training and into working as a newly qualified clinical psychologist. This could help understand the nature of fluctuations over time and the likely progression of certain aspects of the competency.

### 4.6 Conclusions

The literature review revealed that currently there are few studies examining PPD through the management of challenging clinical experiences, and that existing models of PPD and learning are predominantly descriptive and limited in their ability to make and test predictions. It is hoped that this study has added to the understanding of how PPD occurs

through managing risk and what enables and hinders this process, and how CPITs learn about their position and identity in relation to self, within teams and with other professionals.

A qualitative design was employed in order to capture the richness and complexity of participants' experiences. Whilst this study does support some aspects of existing models, it also strongly highlights limits in their applicability. In particular this study has highlighted the importance of: the learning environment and service context on PPD, the values held by CPITs, the nature of the supervisory relationship and the quality of reflective processes employed. This study also suggested that although there are in principle many supports for PPD it is not clear how many of these are utilised and how their utility varies for individual CPITs. Implications for clinical practice, accreditation guidelines and future research have been discussed.

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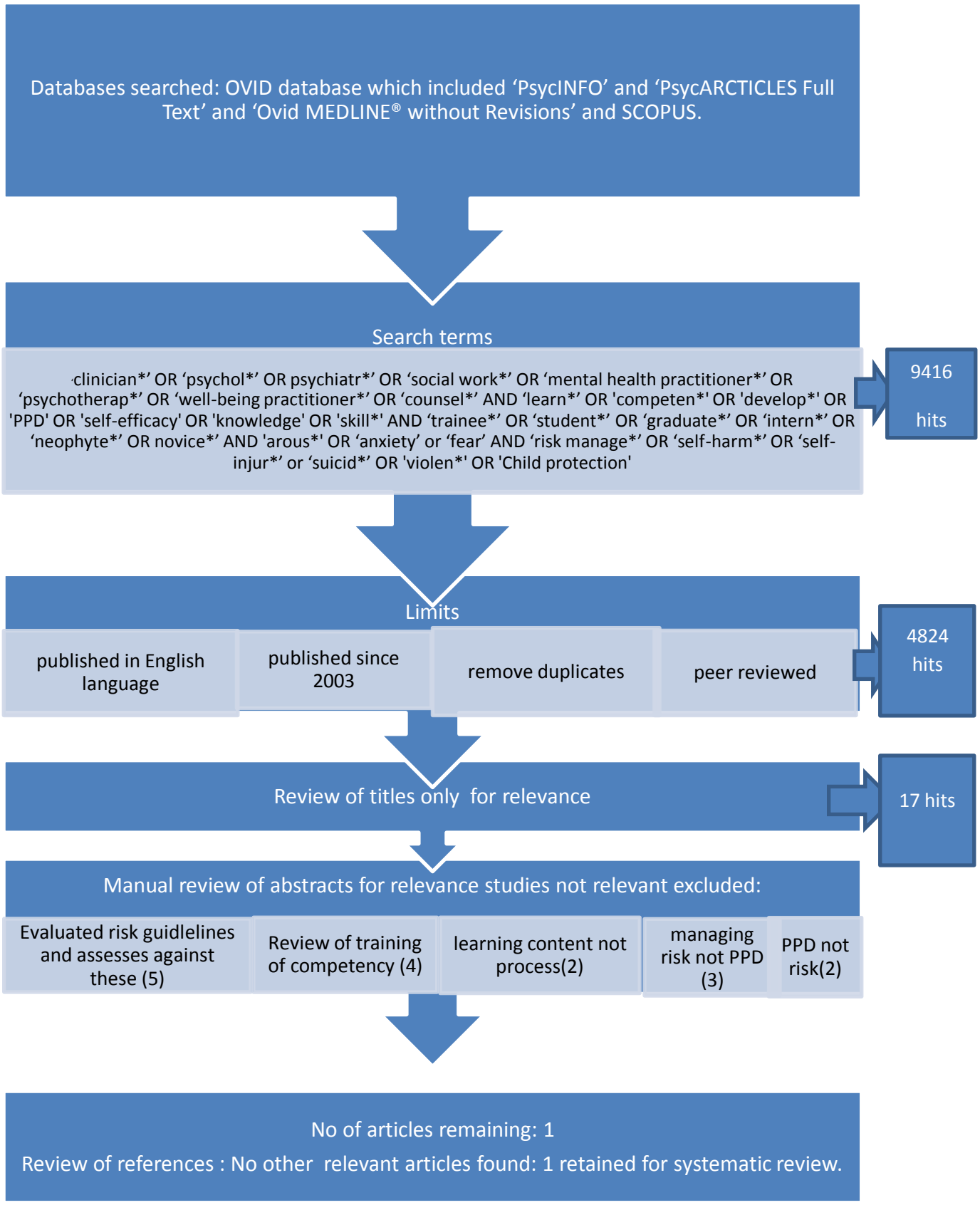
# APPENDICES

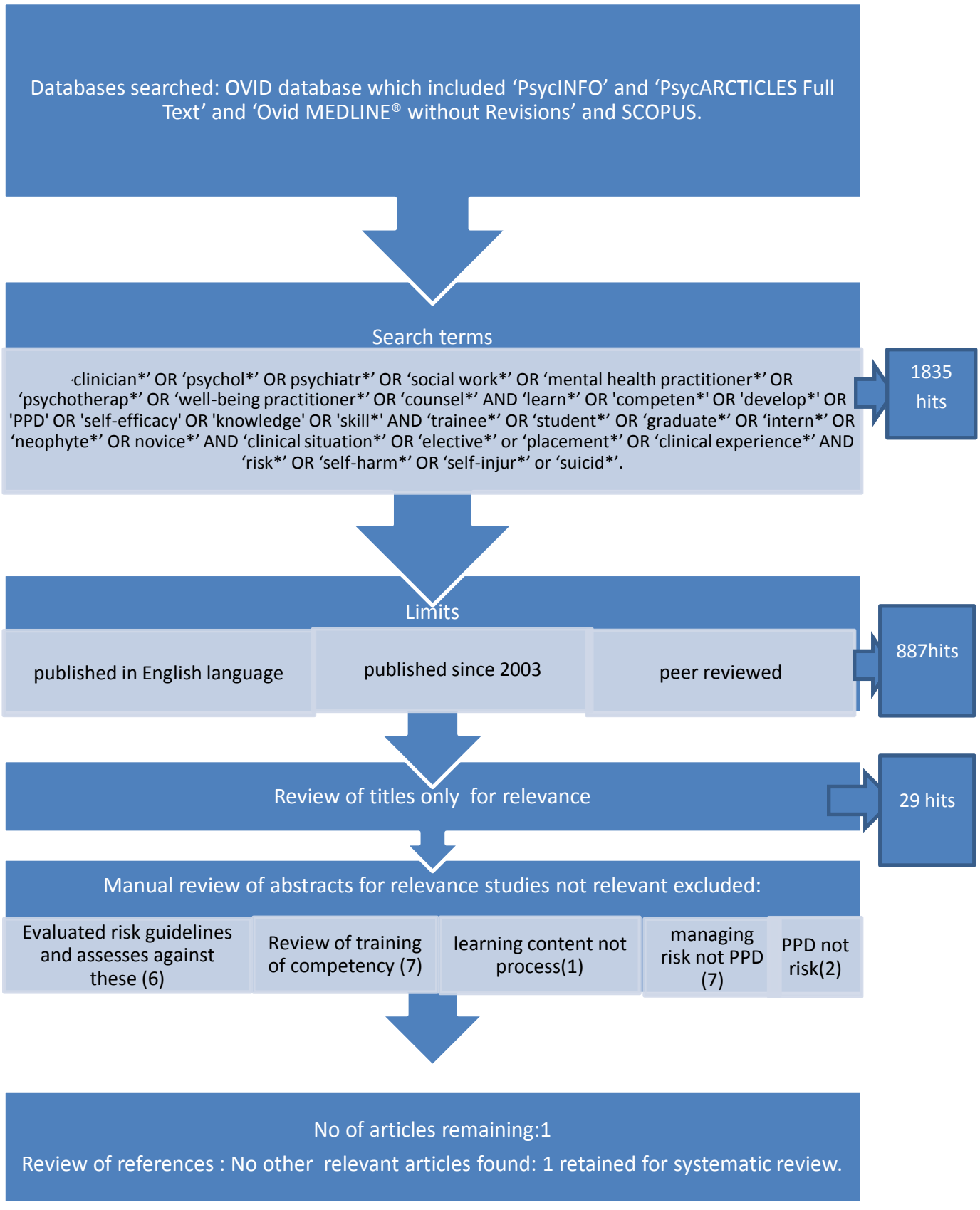
# Appendix 1

# Systematic literature review search strategy

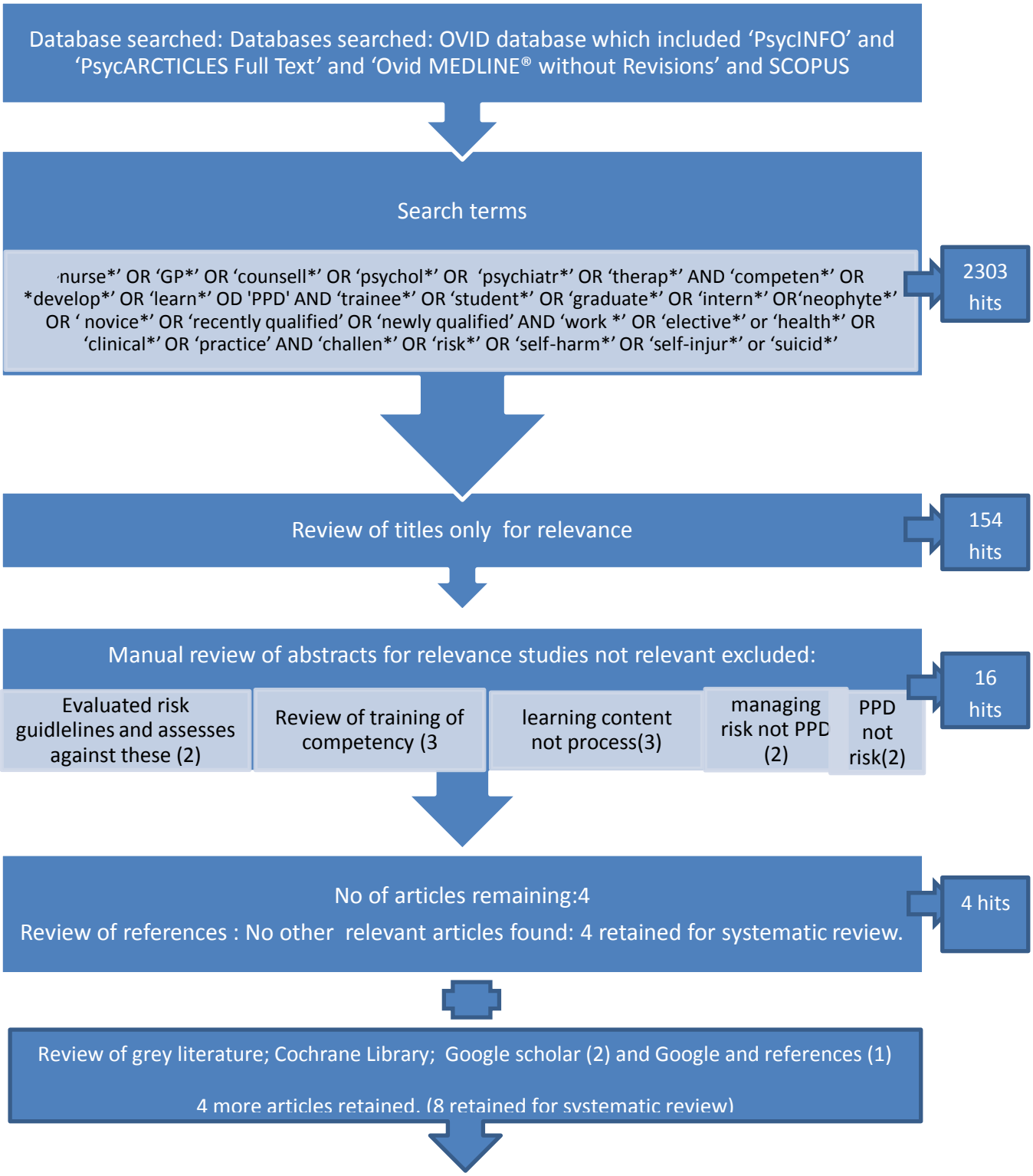
Appendix 1: Summary of Systematic Review search 1.



Appendix 1 : Summary of Systematic Review search 2.



Appendix 1 : Summary of Systematic Review search 3



# Appendix 2

# Quality review summary table

**Table 2: Summary of Quality Review**

| Reference | Aims<br><br>Was there a clear statement of the aims of the research? | Methodology<br><br>Is a qualitative methodology appropriate? | Design<br><br>Was research design appropriate to address aims of the research? | Recruitment<br><br>Was recruitment strategy appropriate to address the aims of the research? | Data collection<br><br>Were the data collected in a way that addressed the research issue? | Reflexivity<br><br>Has the relationship between researcher and participants been adequately considered? | Ethics<br><br>Have ethical issues been taken into account? | Data analysis<br><br>Was the data analysis sufficiently rigorous? | Findings<br><br>Is there a clear statement of findings? | Value of research<br><br>Does researcher discuss contribution of research? | Total score |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Cooper, C., Taft, L.B. & Thelen, M. (2005)<br><br>*(Study 1)* | Clear aim, importance & relevance stated.<br><br>(2) | Research seeks to understand the cognitive and emotional *experience* of clinical practice. Qualitative method appropriate. (2) | Explanation of and suitability of method. No discussion of other methods that could be used or particular advantages of one chosen. (1) | Recruitment strategy based on convenience. Transparent description given. No discussion of alternative methods or limitations of method chosen. (1) | Clear how data collected. Some justification of method given. Saturation of data not discussed. (1) | No discussion of researchers' role. (0) | Consent and ethical approval explained. No mention of confident-iality. (1) | Data analysis process was explained briefly. Little attention to contradictory data. Researcher own role not examined. (1) | Findings are explicit. Credibility discussed & reassured by triangulation. Findings relate to research question but mainly descriptive. Little examination of contradiction. (1) | Researchers examine contribution of research to knowledge and clinical practice.<br><br>Future research not considered nor transfer-ability. (1) | 11/20 |
| De Stefano, J, Atkins, S. Noble, R.N. (2012)<br><br>(*Study 2*) | Clear aim, importance & relevance stated.<br><br>(2) | Research seeks to illuminate & interpret trainees' experience in working with | Explanation for design given – but limited discussion. Appropriate to aims. (1) | Selection criteria outlined. Limited discussion about criteria chosen. (1) | Data collection process was transparent & justified. No discussion of setting of | Epistemolo-gical position of research method not stated. Researcher's assumptions | Ethical issues approval sought but no discussion of ethical procedures | Transparent in-depth description of data analysis, emergence of themes, & quotes included. | Explicit description of findings, discussion of credibility results explored & discussed in | Research discussed in relation to literature, clinical implications. Transfer-ability | 15/20 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | self-injury. (2) | | | interviews or data saturation. (1) | stated. No discussion of setting or impact of researcher's position on trainees. (1) | (1) | Some triangulation reported. Researcher position discussed. (2) | relation to research questions. (2) | discussed. Future research mentioned. (2) | |
| Dory, V., Beaulieu, M-D, Pesiaux, D., Pouchain, D., Gay, B., Rocher, G & Bocher, L. (2009).<br><br>(*Study 3*) | Aim of research, relevance & importance stated. (2) | Aim to understand how general self-efficacy beliefs develop during training and feelings of preparedness for practice. (2) | Design appropriate although limited discussion of choice of method. (1) | Recruitment method was transparent. Some discussion of why participants chosen. Limited discussion of reasons for participation or not. (1) | Method and justification of data collection were transparent. No discussion of setting. Saturation of data discussed. (1) | Researchers' position not discussed although reflexivity mentioned and mixed background of research team. (1) | Ethical issues of consent & confidentiality & ethical approval reported. (2) | Shallow description of analysis, unclear how themes derived from data. Quotes presented. Limited critique of researcher's role. (1) | Explicit findings. Little evidence for & against arguments but related to research questions. Some discussion of credibility– multiple researchers.(1) | Findings discussed in relation to policy, theory & practice and future research implicated. (2) | 14/20 |
| Høifødt, T.S., Talseth,A-G. & Olstad, R. (2007).<br><br>(*Study 4*) | Aim of research & relevance & importance stated. (2) | Aim to illuminate the meaning of lived experience of newly educated physicians' learning processes through working with suicidal patients. Appropriate methodology | Design appropriate although limited discussion of choice of method. (1) | Recruitment methods were transparent, but limited discussion of why particular sample selected. No discussion of why some invited participants declined. (1) | Data collection process was transparent. Methods justified by researcher. No information on setting. (1) | No discussion of researcher's position or bias in relation to participants. (0) | Ethical issues of consent & confidentia l-ity & ethical approval reported. (2) | Fairly detailed description of analytic method but at times ambiguous. Quotes provided. Some discussion of researcher bias. (1) | Explicit findings. Little discussion of arguments against their interpretation. Triangulation process. Discussed in light of research questions (1). | Research findings linked to theory & practice. No discussion re future research. Discussion of implications for practice. (1) | 12/20 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | used. (2) | | | | | | | | | |
| Sagasser, M.H., Kramer, A. & Van der Vleuten, C. P. M. (2012).<br><br>(*Study 5*) | Aim of research & relevance & importance stated. (2) | The study aimed to gain in-depth insight into trainees' learning experiences. Methodology was appropriate. (2) | Design and discussion of design appropriate. (2) | Recruitment methods was transparent, and discussion of why particular sample selected. No discussion of participation rates. (1) | Detailed and transparent discussion of data collection. No justification of interview method chosen or information on setting. (1) | No discussion of researcher's position or bias in relation to participants. (0) | Ethical issues of consent & confidentia l-ity & ethical approval reported. (2) | In-depth description of analytical process. Some discussion of conflicting data. Quotes presented. researcher bias under-emphasised .(1) | Explicit findings. Little discussion of arguments against findings. Triangulation via more than one analyst. Discussion of results in relation to research question. (1) | Research findings linked to theory and practice. Further research implicated discussed. Relevance of findings discussed. (2) | 14/20 |
| Sharif, F. & Masoumi, S. (2005)<br><br>(*Study 6*) | Aim of research & relevance & importance stated. (2) | The study aimed to gain insight into the nurses' experience of clinical placement and a qualitative methodology was appropriate. (2) | Discussion of design given albeit at very basic, descriptive level. (1) | No explanation of how sample selected nor discussion of why particular groups were selected nor participation rates. (0) | Discussion of data collection method used (but unknown setting & if recorded). Questions used clear. No mention of data saturation. (1) | No discussion of researcher's position or bias in relation to participants. (0) | Ethical issues of consent & ethical approval reported. No discussion of confidentia lity.<br><br>(1) | Analytic process description was shallow. Limited quotes provided. Conflict in data neglected. Researcher bias not mentioned . (1) | Findings are explicit albeit very descriptive. No discussion of arguments against findings. Triangulation not mentioned. Results related to research question. (1) | Some attempts to link findings to existing research & practice. No reference to future research. (1) | 10/20 |
| Tallentire, V.R., Smith, S.E. & Skinner, J. & Cameron, | Aim of research & relevance & importance stated. (2) | Study aimed to investigate the factors which influences the behaviour of junior doctors | Design is explicitly & appropriately justified. (2) | Explanation of how sample selected but no information about participation | No information about setting Clear description of how collected | Discussion of researcher's position in forming questions and analysis. | Ethical issues of consent, confidentia lity & ethical approval | Detail of analytic process. Own bias reflected upon. Contradictions in emergent | Explicit findings. Consideration of complexities, credibility discussed and | Strong linking of findings with existing theory. Application of research stressed. | 17/20 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| H.S. (2011)<br><br>(*Study 7*) | | in acute care contexts, and to develop a framework to promote understanding. Qualitative methodology was appropriate. (2) | | rates. (1) | (method, questions, recording). Saturation discussed. (1) | (2) | reported. (2) | data discussed. Appropriate and clear supporting quotes. (2) | findings related to research question. (2) | Implications for future research are neglected. (1) | |
| Woodman *et al*., 2002<br><br>(*Study 8*) | Aims, importance & relevance clearly stated. (2) | Aim was to understand the meaning students attributed to their learning. A qualitative methodology was appropriate. (2) | The research design was appropriate to aims, but no discussion about the design chosen or other the alternatives. (1) | The process of selection was transparent but no discussion of appropriateness nor discussion of reasons for non-participation. (1) | Data setting & method of collection clearly explained. Justification of method n ot made clear (1) | No discussion of researcher role & bias. (0) | No discussion of ethical approval. Consent and confidentiality discussed. (1) | Brief discussion of analytic process. Quotes used to demonstrate themes, Contradictory data accounted for. Analysis largely descriptive No discussion of researcher position. (1) | Findings are explicit, & linked to research question. Credibility referred to via triangulation in analysis process. Limited discussion of alternative explanations. (1) | Researcher links findings to theory & derives service implications and refers to extant literature. Future research not discussed. (1) | 11/20 |

# Appendix 3:

# Incidence of codes developed from the systematic review literature

## Appendix 3: Incidence of codes developed from the systematic review literature

| | Article 1 | Article 2 | Article 3 | Article 4 | Article 5 | Article 6 | Article 7 | Article 8 |
|---|---|---|---|---|---|---|---|---|
| 1. Being aware of human vulnerability | x | | | | | | | |
| 2. Responsibility of role | x | | | x | x | x | x | x |
| 3. Recognising limits | x | | | | | | | |
| 4. Evaluating self | x | | | x | | | | x |
| 5. Seeing things from patient perspective | x | | | | | | | |
| 6. Confronting ethical issues | x | x | | x | | | x | |
| 7. Growth through recognition of strengths | | | x | | | | | x |
| 8. Feeling incapable | | | x | | | | | x |
| 9. Feeling anxious/overwhelmed | x | x | x | x | x | x | x | x |
| 10. Feeling excited/proud | x | | | | | | | x |
| 11. Facing reality | | | | x | | | | |
| 12. Staff/teacher support in facilitating growth | x | | | | x | | | |
| 13. Learning through experience | | x | | x | x | | | |
| 14. Managing emotional arousal | | x | x | | | | x | x |
| 15. Managing competing demands | | | x | | | | | |
| 16. Managing self | | | x | x | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 17. Learning through stressful situations | x | x | x | | | | x | |
| 18. Developing coping strategies | | | x | x | x | | | |
| 19. Developing competence | | | x | | | | | x |
| 20. Challenges applying theory to practice | | x | | | | x | x | |
| 21. Positive experiences build self efficacy | | | x | x | | | | |
| 22. Reflection on action | x | x | | x | x | | | |
| 23. Scaffolding in supervision | x | | | x | x | | | |
| 24. Learning the professional role | x | | | | x | x | x | x |
| 25. Managing uncertainty | | x | | | | x | x | |
| 26. Fear of making mistakes | | | | | | x | x | x |
| 27. Fear of supervisor judgement | | | | | | | x | |
| 28. Performing under stress | | x | | | | | x | x |
| 29. Differences in expectations of supervision | | x | | | | x | | |

| **Learning & performing promoted through stress** | **Emotions felt** | **Reflection on action** | **Building self efficacy and confidence** | **Self regualtion and reflection** | **Facilitators faciliating and inhibiting use of supervision** | **Identity & expectation** |
|---|---|---|---|---|---|---|
| 17,29,13,27 | 9,10,11,8 | 23,4,5,1,20 | 22,19,7 | 14,15,16,18,26,21 | 12,28,24,29 | 2,3,6, ,25 |

# Appendix 4

# Excerpt of notes from bracketing interview

- Emotion of guilt, hard not to feel responsible. Helplessness in situation.
- Appreciated importance of supervision - can listen to emotional response during interviews.
- Supervision expected to be a theme prior to research starting.
- Not had difficult experience of supervision self although had from other cohorts.
- Supervision - practical processes to manage risk.
  (what want from it)
  - emotional aspects e.g. makes me feel anxious (had this experience in supervision)
- Not included 1st yrs as not had enough experiences.
- Retrospectively - ~~had~~ thought could have been more proactive? in risk.
- Impact on competence: halo - confidence in trainees.
- Different ways of managing risk - Doers (more confident in your eyes?)
  - thinkers
- Risk to others - more important now

Learning

- Self-criticism - lack of knowledge re. risk
- Noticed participants reflecting on their doubts + fascinated by others confidence in learning.
- Bennett, Levy model - based on this.
- Moved from structured view of risk when first reading - more to more

# Appendix 5:

# Excerpt from reflective diary

## Appendix 5: Excerpt from reflective diary

17th March 2013 – after pilot interview

"feeling slightly overwhelmed by the amount of information generated from one interview. I noticed that it was difficult to think during the interview process, as the participant's narrative seemed to move all over the place. I was struggling to think about the private, personal self and the professional self and how they unite, differ and develop. … after the interview I was left thinking about a 'critical internal supervisor' and the fear of being 'de-registered' and how this impacts on PPD. I noticed that the risk was considered mainly in the context of the current placement and I need to encourage CPITs to consider other perspectives too. I was also left wondering about the impact of my position as a CPIT and how this was impacting on the emerging narrative…"

27th March 2013 – after 1st interview

" thinking about CPITs motivations for taking part. A number of CPITs seem to have had a great deal of experience in forensic contexts – am wondering if a segment of the sample are 'risk experts'? and wondering how this might differ from CPITs who have not worked in forensic settings. I find myself interested in the impact on the therapeutic alliance if risk is foremost in your mind and how it differs if it is a more peripheral concern. Where should it be? Interested by the idea that anyone in a community setting could be a risk so need to be vigilant. Making me think about *how* different individuals' perspectives on risk might be…. Thinking about certainty vs uncertain. What are the disadvantages to feeling certain about risk?"

31st March

"Thinking about supervision as secure base and attachment literature. Seems really important in the 1st four interviews…"

11th April

"Have transcribed 3 of the interviews- not sure of themes arising yet. Was thinking it would be useful to have another stage of research to explore NQCPs perspectives on risk management and how they feel their perceived competency has developed . Thinking about the theme of power – powerlessness experienced by CPITs in training and power in therapeutic relationships and with managing risk. Thinking about the concepts of scaffolding in relation to supervision and peers and transactional model of coping."

17th April

"did 'bracketing' interviews with peers who are also using IPA methodology. Thinking about my biases and assumptions re risk and CPITs perceived competency development. Reflected on my own experiences managing risk and the importance that I attribute to supervision, based on experiences managing risk in positions prior to training where supervision was inadequate and training minimal. Reflected on my observation of two poles in managing risk – 'doing to' and 'reflecting with client'. Think I might sit nearer the reflection side, but think it's important to adopt flexibly aspects of both… need to manage risk in professional position; duty of care responsibility. The process of studying this subject has crystallised in my mind the importance of sharing within risk management and this being a sign of competence.

23rd April

"Had strong desire to offer opinion and reassure a participant during interview. It can be challenging trying to remain neutral, particularly when I am a CPIT too. Was wondering whether the interview format made a difference as it was face-to-face?

I still can't see the themes that unite trainees at the moment. Can only see the differences. Interested in the idea of trainees as being like 'tenants' – think it highlights the constraints and protection of the trainee role.

Supervision still seems to be at the heart of learning about and growing in perceived competence in managing risk… also thinking about the impact of being a NQCP in band 7 post and the importance of hierarchies in the nursing profession. Does this affect expectations of NQCPs?"

17th May

In the process of going back and forth from data to theory from theory to data – from intro to methods to results and discussion and everywhere in-between. The thesis seems to have taken over my mind and life at the moment. Feel entirely immersed (perhaps drowning!) in data and literature. But starting to make sense of it all….."

# Appendix 6

# Participant checklist

In reporting the results of the this study, it is intended to write an anonymised description of participants to help situate the sample.

In order to be able to do this, I would be grateful if you could fill in the following form and email it back to me at kate.ward2@wales.nhs.uk. I will print off your responses and delete your email from my file immediately. The print out will not have your name on it and for my purposes will be allocated an identification number. Only I will know to whom the number responds.

Gender

Male ☐ Female ☐

Age: yrs

Years of clinical experience (both in paid and voluntary work):

0-1 yrs ☐ 1-2yrs ☐ 2-3 yrs ☐

4-5 yrs ☐ 5-6yrs ☐ 6-7 yrs ☐

More than 7yrs: _____(Please specify)

Locality of D Clin Psy Programme:

Wales
Scotland
Ireland
England

Experience of personal therapy:

Yes ☐ No ☐

Dominant models taught on training course (please tick those given significant focus in teaching)

Cognitive Behavioural Therapy ☐
Psychodynamic Therapy ☐
Acceptance and Commitment Therapy ☐
Humanistic Therapy ☐
Dialectical Behavioural Therapy ☐
Interpersonal psychotherapy ☐
Systemic Therapy ☐
Cognitive Analytic Therapy ☐
Mindfulness Based Therapy ☐
Existential Therapy ☐
Behavioural Therapy ☐
Intensive short-term psychodynamic therapy ☐

Other (please fill in )……..

Description of own theoretical orientation (please tick models that you draw on most frequently)

Cognitive Behavioural Therapy ☐
Systemic Therapy ☐
Psychodynamic Therapy ☐
Cognitive Analytic Therapy ☐
Acceptance and Commitment Therapy ☐
Mindfulness Based Therapy ☐
Humanistic Therapy ☐
Existential Therapy ☐
Dialectical Behavioural Therapy ☐
Behavioural Therapy ☐
Interpersonal psychotherapy ☐
Intensive short-term psychodynamic therapy ☐
Integrative ☐

Other (please fill in ):_____

Brief description of services worked in during clinical training on the D Clin Psy

Please can you list below the services that you have worked in e.g. Child & Family; Drug & Alcohol. Please identify any split placements.

Placement 1:_____

Placement 2:_____

Placement 3:_____

Placement 4:_____

Placement 5: _____

Placement 6: :_____

Please give details of any training attended on risk management below:

_____
_____
_____
_____
_____*T*

*o what extent have you had opportunites to apply this risk management training?*

*Not at all* *A little* *To some extent* *To a large extent* *To a great extent*

***Many thanks for your time and co-operation in filling out this form.***

# Appendix 7

# Annotated excerpts from two transcripts

I: did you call someone when you left or anything like that?

lone worker policy?

P6: no, no. we would just manage our own time, manage our own diaries

I: so if you got stuck no-one would have known?

P6: no. not especially.

I: they thought it was more risky and when they explored it with you did you think maybe they're right or were you more...actually it wasn't?

P6; I think at first I thought maybe there is something and I was kind of describing the way my supervisor handled it and she was kind of this is going to happen at some point so lets chat about it , earn from it and try and make sure that this doesn't happen again but obviously seeing people in people's houses is... with people with LD who aren't going to be able to communicate how they are feeling all the time um whereas him not being in LD took it as something that really shouldn't have happened and was like a needless risk and then I think I got more annoyed cos he disregarded all the way I tried to, you know I had wrote it in the notes so that anyone picking up would know, I had talked about it in supervision, I had talked to her in the next session and had made an agreement and he kind of thought all that wasn't nearly enough and it was really really risky so yeah

→ criticised by tutor - felt it wasn't nearly enough.

I: looking back on it if that situation were to arise again is there anything that you would do differently?

P6: um...(pause) I think its tricky because I kind of understand the reasons why we had the sessions in her bedroom because she didn't want her mum and dad to listen and it was a capacity assessment so it probably wasn't helpful for mum and dad to be right there um so I don't really know how you would get round not having sessions in the bedroom which was one of the major problems but I guess it was one of those where because I had known her for so many weeks I kind of got used to her not being a risk and so that wasn't really a priority when I'm thinking about our sessions and I guess now I'm more mindful about risk in every session whether you've known the person for one session or 20 um I'd , I think I'm more aware of where I sit in the room now regardless of how well I know the person and whether I've got alarms nearby

→ more mindful of risk in every session now.

I: did you have alarms on that placement?

p6: no no we didn't. it was a bit risky.

I: how did you feel about talking to your supervisor about it?.. etc

348 P6 : I think I thought about it a little bit because originally I was thinking that I must have said
349 something so I was thinking telling her what had happened and we'd have to think about what I'd
350 said to make that situation.. so that would involve me looking kind of not the best but I don't think it
351 was an ever an option not to tell her or no to explain it properly....

352 I: what made that not an option?

353 P6; cos she was so knowledgeable on LD, she had worked within it forever and she was just quite
354 calm and this is how it is and I think that's why I was so surprised at my tutor's response to it cos he
355 was, he had a completely different view. Cos I was fine chatting about it on the course as an example
356 of something that I had learned from and then he had quite a big reaction to it, you know you should
357 have done this and we need to do this and you need to write it down in this way and I was like oh
358 gosh you know I was kind of thinking it was ok and resolved and it had been managed quite well and
359 now its kind of bringing it all up again and then I felt like he was questionning my supervisor's
360 judgement and I was quite happy with my supervisor's judgement um.. does that answer your
361 question

362 I: and that fact that she was quite knowledgable about LD and quite calm why did that make it ok to
363 tell her?

364 P6: yeah.. um cos I knew I could talk about it properly and I'd have a chance to explain it properly
365 and explain how I felt and the reasons why I did what I did um and then I also felt that because that
366 was the first thing that had happened to me, I hadn't worked in LD forever um that I thought maybe
367 I have missed something or maybe I have done something that made that situation worse, or made
368 that situation happen and maybe she can tell me what I'd done or tell me how better to handle it
369 next time and to stop it from happening again so I wanted her involvement.

370 I: so it was kind of I don't need to know everything and this is a learning opportunity so I need to
371 understand..?

372 P6: yeah I think so,

373 I: and it sounds like she understood those parameters as well unlike the tutor from the course who
374 was being more critical by the sounds of it?

375 P6: yeah that's how it felt and similarly with my supervisor on the IP I felt like I couldn't be wrong, I
376 couldn't have just tried something I couldn't have come to her and gone oh gosh that didn't go

and I guess maybe that's where my minimising comes in cos ultimately you don't want people going round punching each other either whereas I'm thinking well he throws one punch and I think maybe that is me working coming from an adult prison where people would fight all the time and I would think what is the big deal you would let the boys who you don't think are mentally ill fight and then you just punish them for it., Whereas this boy who you think is mentally ill you're getting really really anxious and restricting him so much in case he does something and if he does something it wouldn't be any worse than the other aggressive lads on the other wings who just get into fights over silly things.So that was something I had to be aware of and I was thinking you know what actually whoever, I had to take a step back and I think this is something I said in supervision at the end of the day if he wants to go ut and punch someone the other boy who gets punched is not in here to be beaten up, he has a right to not get beaten up so therefore they do have to protect the other boys on the wing .. what happened when all this was fed back I just went up the wing to speak to the officers about how they were feeling about it and they were saying that he is a really nice boy, we usually get on with him really well we have really good chats with him but you know we don't want the other boys on the wing to be made vulnerable by him. So I guess that's my bias once again putting to much on the client and not thinking actually there are other people who need protection as well and I guess the prison officers are responsible for everyone on that wing whereas I've got one client on that wing

I: what was the sign to you that that was at the limits of your competence or at least quite challenging. What clues came up for you that that was something that you needed to seek help on?

P4: I think its kind of like when I'm trying to be reflective if I'm circling round and round so I'll go to the point thinking I'm minimising the risk here, there's this and this and this but then I'll go ah but that isn't that bad and that isn't that bad and then I'll circle back to the risk and I notice that my thinking that I talk myself into being more risk averse and then I talk myself back into minimising it again and I go round and get caught in a bit of a circle and that's when I know when I need to either find a happy medium or tolerate the idea that we don't know and I think that I need to talk that through to feel ok with that (47.54)

I:so sometimes when you talk things through you don't swing from one pole to the other you can reach the middle ground more easily?

P4: well I guess that would be what I am aiming for and if I notice that I am swinging round and round if I talk to someone else that helps me reach some kind of middle ground, yes. I think I can, not necessarily middle ground that is between the two but middle ground that is holding both in mind as true at the same time, but it can be yes he is risky but also he is a low risk and we have to hold both in mind and do what is right for him but also do what is right for everyone else cos I guess that is another thing that I fall into when it comes to managing risk is um is thinking there is one right answer when actually everyone who's thinking about this risk, including the client and the other

professionals they've all balanced their view on something, well not always well informed, mostly but sometimes I guess professionals will be led by other things that aren't relevant but most of them will have well formed opinions that are based on something and true to an extent, not thinking my way is the right way and your way is the wrong they're all right is some context, for some reason and we have to incorporate them all into the way that we understand this and they all need to be heard

I: so what's happened with this case?

P4: I guess its escalated a little bit because the psychiatrist he didn't want to take his medication, the boy, and this was something that we had talked about in our sessions and I knew that it was because he doesn't like feeling different. There aren't many boys on medication and you have to go down and queue for them in front of everyone and the fact we were working was not necessarily anything that was wrong with him but more his worry about what might wrong with him., so obviously taking medication was a reminder really that people think there is something wrong with him. So he didn't want to take his medication so I think there was a lot of panic about he's not taking his medication so he's even more likely to do something so it got to the point where he was due to be assessed to be sectionned out and I fel t oh very strongly that that shouldn't happen cos I know that if there is a lot of panic in the system he comes across quite odd cos he's got a few tics and a nervous laugh I thought I could quite easily see him getting assessed him not performing very well in the assessment because he's so anxious, the system around him being really panicked and trammelled and given the information him getting sectioned out and I really really don't think that's what would be good for him. So then, because the psychiatrist works part time and works in a different base from me he didn't consult my opinion and my formulation and he organised this so then I guess was all the things that I had been thinking about became very urgent to try and talk with the wing, talk with the psychiatrist and actually what is this risk, is this risk so high that we have to get an assessor in because I was thinking the damages of him being assessed is actually quite high to what I think is whole presentation is his anxiety about having something wrong with him rather than actually having something wrong with him. So if he's shown that he needs to be assessed that's going to buy into that so then I had to really rush through my thinking and think through what's my place in this?no I'm not an expert,no-ones an expert but I have my opinion and I've done a formulation with regard to his presentation and it hasn't been looked at by anyone yet and he's going to get assessed and I think that's not good so I have to kind of.. I wrote a long letter with the formulation to the psychiatrist, I went and spoke to the wing, and actually I think this happens quite a lot in the prison, by the time I went up to the wing and spoketo them, the panic had actually gone cos he had settled down and there was no problem cos I had a meeting with them earlier in the week and had said explained my views about how you know if he's disclosing stuff it might be cos he wants your help and a bit of chill time rather than actually that he wants to kill someone. Because if he wanted to kill someone you might think that he wouldn't tell you cos then he'd be more likely to do it, whereas he wants you to stop him and so actually they were really calm and actually they said we don't think he should be sectionned cos he's getting on really well and we

think that would damage him. I was actually aware that my role wasn't to try and save this boy and it wasn't to try and interfere with telling the psychiatrist he was wrong it was more trying to make sure that everyone;'s opinions were heard cos there wasn't very good communication so it was making sure that what the client thought, what I thought, what the psychiatrist thought, what the officers thought was all heard by everyone and actually all heard by the psychiatrist because he hadn't chosen to try and hear it before he made his decision. So I think that was at the edge of my competence again probably for a similar reason to the first example, cos when you start getting angry at something within the system its pullin gmyself back and thinking.this psychiatrist is acting like an expert when he doesn't have all the information I could easily go at this trying to fight my battle when actually I should just present my information and do what I can and trust the process then and try and hold myself back and present it in a way that was calm and considered and you know in my place within the MDT rather than panicking and trying to trump his expert position with my expert position.

I: what did you learn again about your professional autonomy?

P4; similarly I guess with the joint working with a case like this it was so useful , both in supervision but also to talk with the nurse that had been working with him as well and to consider that our role within this whole scenario that lasted about 2 weeks was to try and be a calming in fluence and if we can just hold everything together and ensure that everyone communicates with each other then actually we don't even have to give our opinions we just have to be calm and allow others to notice other people's opinions through and once again taking a step back and not panicking and not rushing in and getting heavy handed cos you think that you are right so a lot of the time I think I am right and I'm not and a lot of the time, even if I am right that is irrelevant really because me going around telling everyone that I am right is not useful for anything but then if we're on the cusp of something that I think is a bit of a disaster then the ante is up and I think that was the first time that I had to rush in to try and do something but without looking like I'm reacting. I just wanted to try and take it slow and be like I don't think this is a risky situation, well I didn't even say that because I didn't give my opinion. This is the formulation, this is the information and trying to speak about it calmly

I: how did you use superivison in this case?

P4: on a practical level, when I'd written my letter to the psychiatrist I got my supervisor to check it and we discussed it in terms of did we think that we were giving information that needed to be heard, did we think we were putting that forward enough without being forceful or reactionary, had I consulted everyone that I should have consulted within that and facilitated a calm dialogue and remained calm and not let my , I was reeally angry, really angry about the potential, this over, about what I perceived to be this overinflated perception of risk that was ultimately going to really really set this client back and had I contained that within what I was doing.

I: It sounds like in the cases that you talked about you had strong feelings and you described almost taking like an advocate position for the clients that you were working with, I was just wondering about how your own personal value system has impacted on

# Appendix 8

# Pre-task instructions


**Pre-Interview task**

Thank you for agreeing to take part in this study. Before the interview, it would be helpful if you could have a think about some of your experiences in relation to managing risk.

The interview will be asking you about situations over the training programme, and possibly reflecting on situations in clinical settings prior to training, in which you encountered important experiences in learning to manage risk.

These experiences could vary greatly depending upon the context. For example, they could include:

- suicidal risk
- self harm
- child protection
- vulnerable adults
- faciliating positive risk taking

Please try and bring to mind at least three examples.

Could you try and recall the nuances of the experience, how they impacted on your learning and perceived competence development as a Clinical Psychologist in training.

Tel/Ffon: 029 208 70582 Email/Ebost: CAV_Psychology.Training@wales.nhs.uk

# Appendix 9

# Email feedback of ethical approval

-----Original Message-----
From: psychethics [mailto:psychethics@Cardiff.ac.uk]
Sent: 11 March 2013 11:33
To: kateward
Cc: Jenny Moses (Cardiff and Vale UHB - Psychology)
Subject: Ethics Feedback - EC.13.03.05.3433R

Dear Catherine,

The Ethics Committee has considered your revised postgraduate project proposal: Managing risk:trainees' experience and perceived competence development (EC.13.03.05.3433R).

The project has now been approved.

Please note that if any changes are made to the above project then you must notify the Ethics Committee.

Best wishes,

Natalie Moran

School of Psychology Research Ethics Committee Tower Building Park Place CARDIFF
CF10 3AT

Ffôn /Telephone: +44 (0) 29 2087 0360
Ffacs/Fax: +44 (0) 29 2087 4858

http://psych.cf.ac.uk/aboutus/ethics.html
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Confidentiality

This message is strictly confidential and intended for the person or organisation to whom it is addressed. If you are not the intended recipient of the message then please notify the sender immediately. Any of the statements or comments made above should be regarded as personal and not necessarily those of Cardiff & Vale University Health Board, any constituent part or connected body.

Email communication is subject to monitoring; for further information
http://www.wales.nhs.uk/sitesplus/864/page/50329

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# Appendix 10

# Consent Form

# Consent Form

## Managing risk: Trainees' experience and perceived competence development.

***If I decide to take part in this study, all of the information I provide will be treated in strict confidence. My participation is completely voluntary and I am free to withdraw from the study at any point, taking any information I have provided with me. Please sign below to confirm you understand and consent to the following:***

- **I confirm that I have been provided with information about this study (Information sheet) and have had the opportunity to ask questions** ☐
- **I understand that my participation is voluntary and I am free to stop at any time, without giving any reason.** ☐
- **I understand that the information I give will be kept private, without my name, and used for research purposes only** ☐
- **I give permission for my interview to be audio-recorded. I understand that the recordings will be deleted once they have been typed up and that my name will be deleted from the information** ☐
- **I give permission for the information that I provide to be anonymised and included in the doctoral thesis that the researcher (Kate Ward) will submit as part of a doctoral qualification** ☐
- **I understand that this thesis will be will be available at ORCA (Online Research @Cardiff) which is Cardiff University's institutional repository and will be freely available over the internet** ☐
- **I understand that the information from this study, may also be used for publication in a peer-reviewed journal and presented at conferences.** ☐

**I agree that I will participate in the study.**

**Name of participant**

**(print)**_____

**Signature of participant**_____**Date:**_____

**Name of researcher (print)**_____

**Signature of researcher**_____**Date:**_____

# Appendix 11

# Invitation Email to course directors

Dear Course Director,

I am a third year trainee clinical psychologist on the South Wales D ClinPsy training programme. I am writing to ask your permission for your course administrators to distribute an invitation to the second and third year trainees on your training programme to participate in my doctoral research project.

The study is entitled *'Managing risk: trainees' experience and perceived competence development*' and is supervised by Dr Jennifer Moses, Academic Director on the South Wales D ClinPsy. There is little literature on the trainee experience in clinical work and perceptions of competency and its limits. Clearly, developing and assessing trainees' competency is an important part of training. It has been shown that competence in clinical skills is difficult to measure, for instance, due to selection bias in presentation of cases (e.g. Scaife, 2001; Smith, 2010). It is increasingly recognised that another measure of competency is trainees' *perceived* competence. Perceived competency, it is argued may impact on treatment outcomes and on patient safety, due to its impact on trainees' confidence and ability to ask for appropriate support (Bennett-Levy & Beedie, 2007; Kennedy *et al.,* 2009). Bennett-Levy and colleagues identify this as critical to the development of a 'therapist schema'. Trainees will often encounter clinical situations which are outside of their competency, and it seems likely that how trainees appraise these situations will affect their ability to seek help appropriately and to learn constructively from their experience.

This research study will explore the experience of trainees of managing risk in their clinical work with clients, and in particular how perceived competency develops and limits are recognised. It will employ a qualitative methodology, specifically interpretative phenomenological analysis (IPA). Eight to ten TCP's will be interviewed using semi-structured interviews. It is hoped that this study will give a better understanding of an under-researched learning process. Its findings will have particular relevance for training courses, supervisors and trainees themselves.

<u>Trainees' time</u>

I am mindful of the pressures on trainee's time and so have summarised what the project will entail for participants. I am writing to a significant number of the training programmes and aim to get a spread of trainees from different courses. It should therefore involve few trainees. The trainee will be asked to:

- fill in a checklist (which should take 5-10 mins)

- to reflect on 3 cases in which they negotiated an 'important ' risk situation ( ie one which they felt was important in their PPD).

- to participate in an in-depth interview, lasting 1-1.5 hours (either by telephone or at their home or place of work).

- they will also be invited to comment on a summary of the emergent themes by email

Anonymity

During the analysis process and written thesis, no participants, staff, training programmes or clients will be identifiable.. All information will be anonymised.

Ethical approval

The research has been approved by Cardiff University Ethics committee ( see attached evidence).

Confidentiality

All information given by participants will be confidential. In the unlikely event, that a trainee discusses a situation, in which it becomes clear that a risk is still current, unmanaged and un-disclosed to a clinical supervisor , the researcher will advise the trainee to speak to the supervisor and help them to form a plan to manage communicating this.

Please do let me know if there is any further information that you require to make a decision about this. My contact details are:

Email:

I look forward to hearing from you.

Yours sincerely,

Kate Ward

Trainee Clinical Psychologist

# Appendix 12

# Participant information sheet

**Title: Managing risk: Trainees' experience and perceived competence development.**

**Participant Information Sheet**

You are invited to take part in a new research study. To help you decide whether you consent to take part, you need to understand why the research is being done and what it will involve for you. Please take some time to read this information sheet carefully and please speak to others about the study if you wish.

Part 1 of this information sheet tells you the purpose of this study and what it would involve for you if you take part.

Part 2 gives you more detailed information about the conduct of the study.

You are more than welcome to ask us if there is anything that is not clear or if you would like more information.

**What is the purpose of the study?**

Developing and assessing trainees' competency is an important part of training. It has been shown that competence in clinical skills is difficult to measure, due to biases in presentation of cases, for example. Another measure of competency is trainees' perceived competence. Perceived competency, it has been argued may impact on treatment outcomes and on patient safety, due to its impact on trainees' confidence and ability to ask for appropriate support. Trainees will often encounter clinical situations which are outside of their competency, and it seems likely that how trainees appraise these situations will affect their ability to seek help appropriately. The study is being carried out to find out more about trainees' perceptions of their competence in their clinical skills over training, and will explore this in relation to managing risk.

**Why have I been invited?**

You are invited as you are a trainee clinical psychologist in the second or third year of a doctoral training programme. We are hoping that 8-10 trainee clinical psychologists will take part in this study.

**Do I have to take part?**

No, you don't have to take part. It is up to you to decide. If you would like to take part, then please send an email to Kate Ward, the researcher at (insert email address), stating that you are interested in taking part. Please give your name, email address and contact telephone number. The researcher (Kate Ward, Chief Investigator) will then contact you to answer any questions that you have about the study or interview, and to arrange the most convenient time for us to meet or converse. The interview can either be by telephone or at your home or place of work, whichever is convenient for you. Before we start the interview I will ask you to sign a consent form to show that you have agreed to participate in the interview. If we conduct the interview by telephone, I will send this in the post with a SAE and ask you to kindly send this back to me. You are free to change your mind at any point, before or during

the interview, and to withdraw from the study. You would not need to provide any reason for your decision. This decision would not affect you in anyway.

**What will you be required to do if you take part?**

Prior to the interview, I will email you a short questionnaire (this should take no more than 10 minutes to fill in) asking a few basic demographic questions, and about your previous clinical experience.

I will also send you a 'pre-interview task' which simply asks you to think about three situations in your clinical experience as a trainee where you have had to manage risk. As the interview will ask about managing risk, this is intended to help you access relevant memories and information in the interview. The interview itself will last approximately 1-1.5 hours depending on how much you have to say, and will take place either by phone or at your home or place of work.

The interviews will be digitally audio-recorded. The recording will then be transcribed to help with the analysis of the information. Following analysis, the recordings will be destroyed. If at any point before, during or after the interview you wish to withdraw from the study for any reason, then you are fully entitled to do so and the information that you have provided will be destroyed and not included in the research.

The researcher will analyse the data and produce a set of themes which have emerged from the data. You will be invited to comment on these themes. If you are willing to do this, the researcher will send a short document by email (1-2 sides of A4) outlining the themes and ask for any comments that you might have on them. The information that is generated from this research will be written up in a report.

It is important for you to know that ALL of the information that you provide will remain completely confidential. When writing the report I will use a pseudonym (a different name) for each person that was involved in the study to maintain anonymity. You are entitled to have the summary of the findings if you wish. This summary will be a collated response,once anonymised, and will not be individual findings.

**Expenses and payments**

There are no payments for participation and there will not be any expenses to you.

**What are the possible benefits of taking part in the study?**

There are no overt benefits of taking part in the study, although it may be helpful, as part of your PDP to reflect on your perceptions of developing competence in relation to managing risk.

The findings from this study may help the development of course programmes, provide important information for supervisors and help normalise future trainees' experiences. This is an opportunity for you to contribute to this.

**What are the possible disadvantages and risks of taking part?**

It is not envisaged that there will be any disadvantages in taking part. The subject should not be distressing, and if at any stage, you do not wish to continue for any reason, then I will stop the interview straight away. It will then be up to you whether you wish to continue with the interview, postpone for another date, or withdraw from the study altogether.

**What if there is a problem?**

Any complaint about the way that you have been dealt with during this study would be addressed. The detailed information on this is given in Part 2.

**Will my participation in the study be kept confidential?**

Yes. The study will follow ethical and professional practice and all information about you will be handled in confidence. The details are included in Part 2.

**This completes Part 1 of the information sheet**

**If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making a decision**

**Part 2**

**What will happen if I don't want to carry on with the study?**

You are entitled to withdraw from the study at any point. You may also choose to ask for any information that you have provided not to be included in the report. If you choose to withdraw you do not need to provide a reason.

**What if there is a problem?**

If you are concerned with any aspect of the study or with how I conduct the interview, please do let me know and I will try to address these concerns. However, if even after my attempts to resolve your concerns you remain unhappy and wish to make a formal complaint you can do so following the NHS complaints procedure or by contacting the course or research director of the South Wales DClin Psy Doctoral Programme.

Course director – Dr Reg Morris. Email:

Research Director – Professor Neil Frude. Email:

**Will your participation in this study be confidential?**

Yes. All the information that you provide in the interview will be kept in the strictest confidence. You will be given an identification number that will be stored separately to your information. In the final report your identity will be protected and you will have a pseudonym.

As mentioned previously, the digital recordings will be transcribed so that I don't forget any important details. Your name will not be used in this transcription. The anonymised transcripts will be stored in a locked filing cabinet and the recordings will be destroyed once they have been transcribed. The consent forms with your signature on them will be stored separately from their transcribed interview and kept in a locked filing cabinet in a secure place. These will not be labelled with your identification number. Data obtained from this study will be stored on a computer and in accordance with the data protection procedures and policies stipulated by the Cardiff and Vale UHB. Only I will have access to this information.

**What will happen to the results of this study?**

The information generated from this study will be used to write a report on how trainee clinical psychologists experience managing risk in a clinical setting. This is as partial fulfilment of a Doctorate in Clinical Psychology of which I am in my third year of study. The information will also be used to help inform doctoral courses and supervisory practice. It is intended that the study will be written up for a peer-reviewed journal and that this may help normalise future trainee's experiences in working outside of competency and developing perceived competency.

You not be identified with in this report, as mentioned previously their anonymity will be maintained throughout the study. The thesis will be available at ORCA (Online Research @Cardiff) which is Cardiff University's institutional repository and will be freely available over the internet

**Who is organising and funding the study?**

This research is being organised through the South Wales Doctoral Programme in Clinical Psychology and Cardiff University. Cardiff and Vale NHS Trust fund the research.

**Who has reviewed the study?**

The research has been carefully checked and monitored by the School of Psychology ethics committee who are accountable to Cardiff University Research Ethics Committee The psychology ethics committee can be contacted on: email: Psychethics@cardiff.ac.uk. Or Tel: 02920 870360. The independent group of people protect the rights, safety, welfare and dignity of anyone who participates in a research project. It has also been scrutinised by the academic director and developed under the direction of the research director of the South Wales D Clin Psy programme.

**Do you have any more questions?**

If you would like any further information about the study before you decide to take part, then please do not hesitate to contact me or Dr Jenny Moses (Consultant Clinical Psychologist and academic supervisor for this study) on the following number:

**Thank you very much for your interest and for taking the time to read this information sheet**

# Appendix 13

# Participant invitation email

Dear Trainee,

My name is Kate Ward and I am a Trainee Clinical Psychologist (TCP) studying on the South Wales Doctorate of Clinical Psychology Programme. I am in my third year of study and am currently undertaking my thesis entitled 'Managing risk: trainees' experience and perceived competence development'.

I am writing to you to briefly introduce my project and ask if you would consider taking part.
As a trainee CP myself, I am mindful of the pressures of training and the requirement to achieve competency in a broad range of high level skills. There is much discussion within the profession about the future role of CP's. Although much of this discussion is centred on the increasing role of CPs taking on leadership and consultancy roles within the NHS, there is also an increasing need to be competent to work on qualification with people with the most complex and challenging difficulties.

There is evidence to suggest the importance of competence on a variety of factors, for instance, treatment outcomes and stress. There is also a more recent literature suggesting the importance of perceived competence which has focussed on trainees undertaking cognitive therapy training. It has suggested that perceived competence may also impact on outcomes via therapist confidence, and may have implications for the management of clinical risk. Although there are a handful of studies using trainees that explore professional identity and roles, in general there are no studies exploring the experience of developing competence in managing risk in clinical work and of working at the limits of competency. It is hoped that this study may help inform supervisory practice, course curriculum and may provide normalising information for future and current trainees.

I would be grateful if you would consider taking part in this piece of research. Details of how you can become involved are provided on the enclosed information sheet. If you have any queries regarding this project please do not hesitate to contact me at (email address) or on (tel number).

Thank you for taking the time to read this letter.

Yours sincerely

Kate Ward
Trainee Clinical Psychologist
Doctorate in Clinical Psychology, Cardiff University

# Appendix 14

# Participant checklist

In reporting the results of the this study, it is intended to write an anonymised description of participants to help situate the sample.

In order to be able to do this, I would be grateful if you could fill in the following form and email it back to me at kate.ward2@wales.nhs.uk. I will print off your responses and delete your email from my file immediately. The print out will not have your name on it and for my purposes will be allocated an identification number. Only I will know to whom the number responds.

Gender

Male ☐ Female ☐

Age: yrs

Years of clinical experience (both in paid and voluntary work):

0-1 yrs ☐ 1-2yrs ☐ 2-3 yrs ☐

4-5 yrs ☐ 5-6yrs ☐ 6-7 yrs ☐

More than 7yrs: _____(Please specify)

Locality of D Clin Psy Programme:

Wales
Scotland
Ireland
England

Experience of personal therapy:

Yes ☐ No ☐

Dominant models taught on training course (please tick those given significant focus in teaching)

Cognitive Behavioural Therapy ☐
Psychodynamic Therapy ☐
Acceptance and Commitment Therapy ☐
Humanistic Therapy ☐
Dialectical Behavioural Therapy ☐
Interpersonal psychotherapy ☐
Systemic Therapy ☐
Cognitive Analytic Therapy ☐
Mindfulness Based Therapy ☐
Existential Therapy ☐
Behavioural Therapy ☐
Intensive short-term psychodynamic therapy ☐

Other (please fill in )……..

Description of own theoretical orientation (please tick models that you draw on most frequently)

| | | | |
|---|---|---|---|
| Cognitive Behavioural Therapy | | Systemic Therapy | ☐ |
| Psychodynamic Therapy | ☐ | Cognitive Analytic Therapy | ☐ |
| Acceptance and Commitment Therapy | ☐ | Mindfulness Based Therapy | ☐ |
| Humanistic Therapy | ☐ | Existential Therapy | ☐ |
| Dialectical Behavioural Therapy | ☐ | Behavioural Therapy | ☐ |
| Interpersonal psychotherapy | ☐ | Intensive short-term psychodynamic therapy | ☐ |
| Integrative | ☐ | | |

Other (please fill in ):_____

Brief description of services worked in during clinical training on the D Clin Psy

Please can you list below the services that you have worked in e.g. Child & Family; Drug & Alcohol. Please identify any split placements.

Placement 1:_____

Placement 2:_____

Placement 3:_____

Placement 4:_____

Placement 5: _____

Placement 6: :_____

Please give details of any training attended on risk management below:

*To what extent have you had opportunites to apply this risk management training?*

*Not at all* *A little* *To some extent* *To a large extent* *To a great extent*

***Many thanks for your time and co-operation in filling out this form.***

# Appendix 15

# Semi-structured interview schedule

Research Question: How is perceived competence in managing risk developed during training and how does this contribute to the assuming a therapist self-schema?

*Researcher introduction: I'm interested in understanding your experience of being clinical psychologist. In particular, how you feel your sense of identity and perceived skills have developed over time and in relation to managing risk.*

| | |
|---|---|
| To what extent did you perceive yourself to be a competent therapist at entry to CP training?<br><br>Scale of 1-10 Why not at 1, why not at 10?<br><br>How about now? | |
| *If the trainee judges themselves to be below 10 re competence then this implies that there will be work which they feel will be beyond their current level of competence.*<br><br>How do you know if a piece if work is outside the current limits of your competence?<br><br>What do you do when you recognise this? | |
| Working with complexity<br><br>Clinical psychologists are increasingly being asked to work with the most complex and chronic conditions in clinical settings. I am particularly interested in the instances when you recognise that the risk implied in working with a case was high and challenged the limits of your competence. I would like you to think back to such an experience. *Imagine yourself back in the room with the client, try and recall what you were thinking, feeling and then take a step back as if you were observing yourself.*<br><br>**Repeat with a number of scenarios that the participant identifies.** | How did you manage the situation in the room?<br><br>What steps did you take to make the situation safer?<br><br>What competencies did you draw on to assist you? (knowledge, skills, non-verbal skills, values, service structures etc.)<br><br>How did you decide what assistance to seek?<br><br>What help did you then seek if any?<br><br>What was the outcome?<br><br>Reflecting on this incident what would you have done differently, if anything?<br><br>What did you learn about your professional |

| | |
|---|---|
| | autonomy?<br><br>How did it make you feel about yourself as a therapist? |
| <u>Role</u><br><br>Previous research has highlighted tensions in representing yourself as a student on a training programme and a professional in a clinical setting.<br><br>I am curious as to whether you might have felt these tensions and how you dealt with them?,<br><br>I am particularly curious as to how you managed them when working with complexity and risk in your caseload? | How do you make sense of the two positions? These tensions?<br><br>How do you manage any potential conflicts?<br><br>How your role as student influenced you when managing risk?<br><br>How has this impacted on you?<br><br>Has this changed over time?<br><br>How do you feel about this in moving forward to qualified status? |
| *<u>The person (self-schema) of the CP and risk</u>*<br><br>Previous research has suggested that your own sense of self and value systems impact on your professional self.<br><br>In managing risk how have drawn on your own values, self awareness, personal knowledge and experience? | Can you describe this situation?<br><br>How did your values impact on your thoughts, feelings, actions?<br><br>How did you reflect on this at the time and after the event?<br><br>What did you learn from this experience?<br><br>What did this tell you about yourself as a clinician?<br><br>How do you think that this might differentiate you, if at all, from other health professionals? |
| *<u>Supervision</u>*<br><br>How have you used supervision to reflect on the management of clinical risk and how services in which you have been placed manage risk?.<br><br>How did you feel your concerns were received? | What sort of cases/situations have you spoken to your supervisor about?<br><br>How do you decide whether to bring a case to supervision?<br><br>What is involved in weighing up the decision? (prompt: perceived competence, professionalism)<br><br>Has this judgement varied on different placements? (e.g. supervisor style, placement type, increased confidence over time versus feeling should know as gain in experience, perceived differential in skill and ability between self and supervisor)<br><br>How has this impacted on your sense of yourself as a clinical practitioner?<br><br>How has it impacted on your sense of autonomy/dependence? |

| | |
|---|---|
| | What have you learnt from these encounters?<br><br>What helps to make these a positive learning experience? |
| *Applying declarative knowledge*<br><br>How have you applied what you have learnt about managing risk through course tutorials, reading etc. to clinical practice? | What challenges have you found in applying learnt knowledge?<br><br>What aspects of this have you found most challenging?<br><br>What has helped you to learn skills?<br><br>Have you developed any 'when… then' rules in relation to risk? What has enabled this process?<br><br>Have you changed the way you learn and apply learning over the course in response to these challenges? What has affected this? |
| Assessment<br><br>How has the process of competence appraisal on the course helped or hindered your ability to manage risk?<br><br>In what ways does your sense of your own competence in this regard differ, if at all, from the course's assessment? | How does the course's assessment procedure impact on your sense of competence as a clinician managing risk?<br><br>What promotes and hinders your sense of perceived competence?<br><br>In reflecting on aspects of the assessment process re risk what have you learnt? |
| Identity development<br><br>How has managing these processes impacted on your sense of yourself as a therapist whose future career will demand a high level of competence in dealing with risk in the context of complexity, severity and chronicity of mental and physical health difficulties? | What has been the role of comparison to: previous self, other members of your cohort, other professionals, sense of what you *should* be?<br><br>What has helped to foster a positive growth in your sense of perceived competency?<br><br>How has the training programme structure facilitated this growth?<br><br>How has this changed over time? |
| Future Development<br><br>In summary, what do you feel has been helpful in facilitating your sense of competence in managing risk? | How do you feel about working as a newly qualified CP in the near future?<br><br>What concerns do you have about this regarding your competence in managing risk?<br><br>What gives you confidence in your ability?<br><br>How do you see your skills complementing and adding to the work done by teams of health and social care professionals?<br><br>Is there anything else you would like to add, that you feel I might have missed?<br><br>Thanks and close. |

# Appendix 16

# Initial themes from analysis of one participant's data

**Themes – Participant 5**

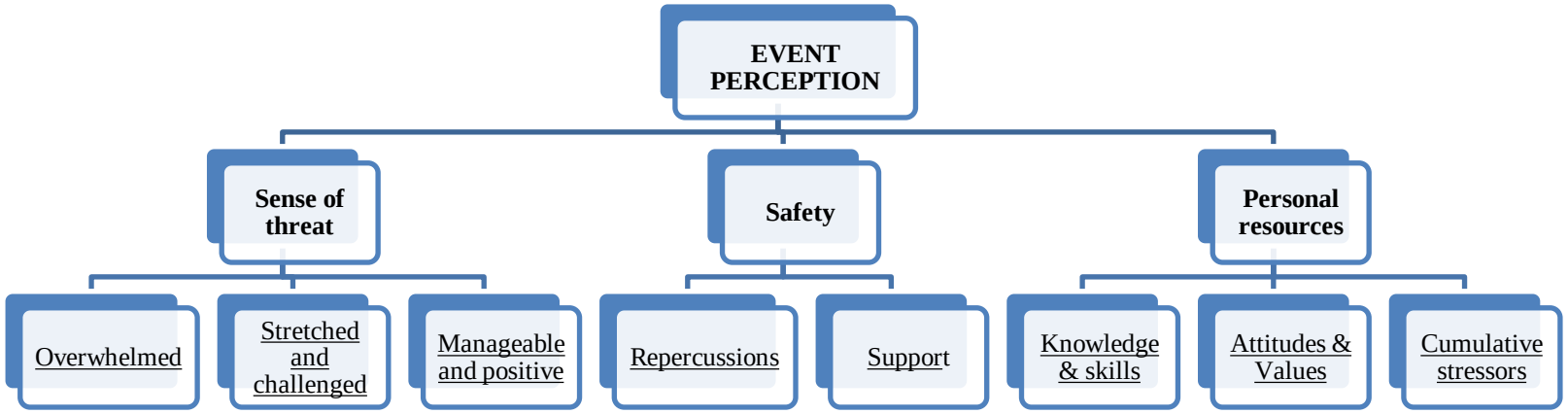
1. Considering who I am as psychologist /developing my professional identity and skill : "*I think risk should be…*" (line 4); "*My supervisor…"* (line 197); *"I do think that psychologists…"* (line 354); "*I don't just want to…*" (line 366); "No*, and again*…" (line 454).
2. Competence can be context dependent: " *Because everywhere I've worked risk* …" (line 8); "I*f I go to a new…*" (line 48)
3. Pre-training experience created base level skills: "*My background*…"(line 9); "C*hildren is a very different*…" (line 14); "*I also knew because I asked him*…" (line 115)
4. Need to learn protocols within context: "*Within the criminal justice system...*" (line 16) ; "*I talked to the team leader...*" (line 143)
5. Considering broader context/ culture/system factors/ dominant discourse: "*I have more insight…"* (line 24)
6. Experience of managing situation builds autonomy : "*I'd be thinking…"* (line 41)
7. Developing rules of when to seek support : "*So I would automatically…*" (line 42)
8. Realising competence is a journey: "*I think if I went into…"* (line 55)
9. Learning to appropriately share risk concerns with colleagues: "*I would want to make sure…"* (line 60)
10. Developing more person-centred approach to risk / Being able to think about risk with a client: "*I think it's interesting*…"(line 63)
11. Listening and responding to gut instinct: "*If I started panicking…*"(line 69; "*If I'm feeling really anxious…"* (line 72); "*trust in myself*…"(line 258); *"I really felt that level of uncomfortableness*…" (line 455)
12. Sharing with supervisor to manage own anxiety: *"it's like a feeling…"* (line 74)
13. Learning to use structured tools: *"a lot of consultancy…"* (line 87)
14. Moving from position of being dependent to pro-active in seeking professional growth: " *I didn't hadn't been told*…" (line 99); "*Because I was being supervised…"* (line 100); *"None of this had been …."* ( line 151); "*I'm now going to do…*"(line 360); "*I offered to do…*" (line 402)
15. Previous roles can impact and lead to unhelpful assumptions: "*Because normally in probation…*" (line 108)
16. Learning to manage different opinions and maintain own position: "*You're going to have…"* (line 122); "*I'm probably going to* …"(line 269)

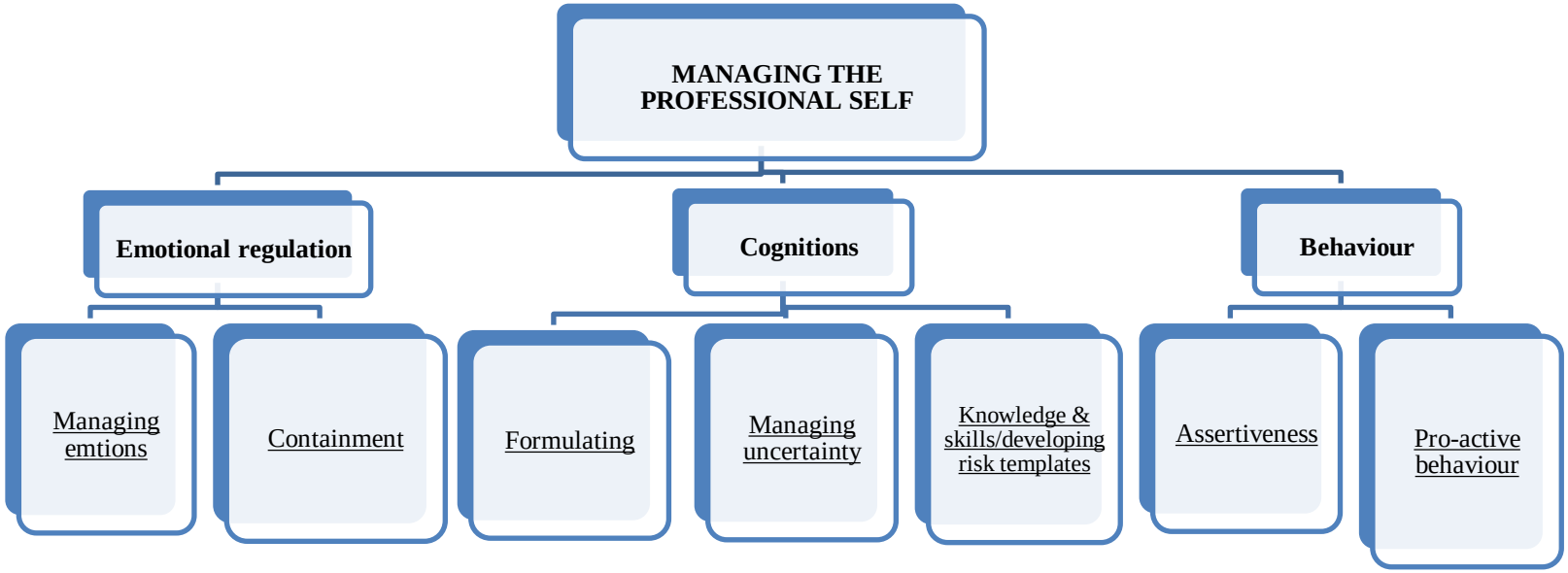
17. Experiences can encourage deep learning : "*So at that point felt utterly awful…"* (line 126)
18. Formulation guides confidence in clinical judgement: " *they were saying…*" (line 132)
19. The need for validation and checking out your actions: "*I emailed my supervisor…*" (line 142); "*the supervision style*…' (line 226)
20. Anxiety provoking experiences can be good learning experiences but can be *too* anxiety provoking: "*yeah absolutely terrified…*"(line 157); *"I felt personally….*"(line 169); "*I didn't want to finish….*" ( line 235); "*I was so stressed out…"* (line 292)
21. Learning to trust clinical judgement: *"Because the team leader…"*(line 158); "*It seemed to me…*" (line 423); *" I thought maybe…"* (line 434)
22. Learning through experience of holding one's own negative emotions (helplessness) in and after sessions: *"I couldn't sleep…."* (line 172)
23. Working within a blaming culture can feel unsafe if unprotected by supervisor: "*There were lots of…"* (line 182)
24. Sense of high stakes due to experience of suicides: "*Because I've worked in…"* (line 192)
25. Importance of scaffolding in risk management: "*But they had a conversation…"* (line 201); "*I felt very much alone*…"(line 214)
26. Experience with client groups and situations: "*there was more support…"*(line 210); "*By the end of the placement"* (line 249)
27. Learning to be assertive about own rights: "*Not being able to say…*" (line 240); *"I think being assertive*…" (line 256)
28. Supervisors who normalise anxieties / Unsafe supervision as limiting wider reflection on self as therapeutic tool : "*Very egotistical…"*(line 247); "It *probably wouldn't have*…" (line 263); *"I'm working with* teams…" (line 326); "*Really attentive*…" (line 470)
29. Feelings of powerlessness increase stress: "*My clinical tutor…"* (line 288)
30. Role ambiguity – unsure of what I should know: "*I should have raised*…." (line 273)
31. Comparing self and other supervisors : "*No-one I knew…."* (line 277)
32. Core values can motivate and add stress: " *I am the sort of person…*" (line 285); *'I've always found…" (*line 406); "*I'm just concerned that*…" (line 504)
33. Adult learner – identifying and meeting own learning needs: "*But I did learn a lot…"* (line 305)
34. Self reflection on progress: "*I've thought this…"* (line 322)
35. Attributional style can ameliorate or add to personal stress: *"So I did question…"* (line 330)

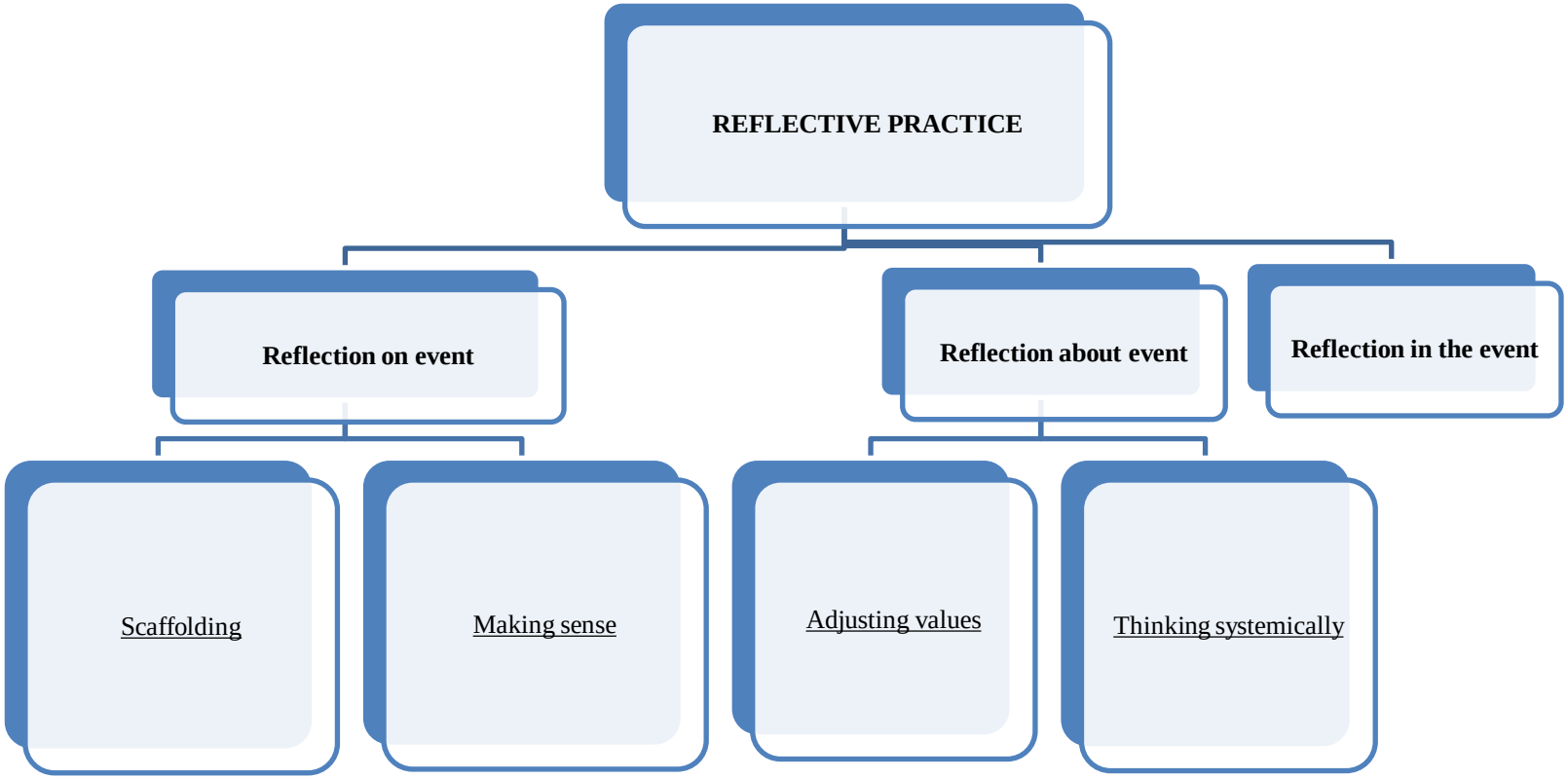
36. Developing clinical knowledge/templates: " *I also think* …" (line 334); "*All sorts of…*" (line 413)
37. Managing emotions as helpful tool: "*The only thing…"* (line 342)
38. Working with increased complexity and increased clinical responsibility: "*It's quite common*…" (line 385)
39. Learning to develop appropriate autonomy and manage situations appropriately: "*In a way…"* (line 404)
40. Reflection with supervisor (or impact of not being able to access this): ''*No...not at all…*" (line 451); *"I think I'm bringing*…" (line 511)
41. Learning that sharing dilemmas is actually a sign of competence not weakness : *"I will bring in my supervisor…"*(line 481); "*But last year*…" (line 658)
42. Assessment process can affect how clinical information is discussed: "*You don't want to make* …" (line 493)
43. Therapeutic alliance helping risk management: "I think clients are very good at describing…" (line 527)
44. Thinking about your boundaries and limits as CP via modelling: "*I'm asking the questions…*" (line 532)
45. Perception of role as trainee shifts in different contexts: "*In terms of you fitting into the team…*" (line 580); *"I'm not actually…*" (line 583)
46. Assuming that someone else has all the answers (omnipotent other): " *I'm working with a lot of clients*…" (line 588)
47. Developing and questioning sense of identity as CP through placement experiences: "*I've had to work* …" (line 595); *"Which all added up to me*…" (line 625); "I *hope to be in…*" (line 706)
48. Working on self: "*I made the decision…*" (line 613)
49. Impact of unprocessed trauma: "*I think my ability to manage risk*…" (line 618)
50. Being more self aware: "*I think its made me*..." (line 630)
51. Learning to self-regulate: *"a more compassionate*…" (line 633)
52. Validating supervision: "*I'm doing personally…"* (line 637)
53. Cohort as source of support and stress: "*I think being a group*…" (line 641); "*I think we all felt*…" (line 650); "*a couple of them*…" (line 654)
54. Learning to formulate formally helps clinical work: "*I think writing*…" (line 688)
55. Importance of scaffolding : "*I would have liked to have been*…" (line 744)

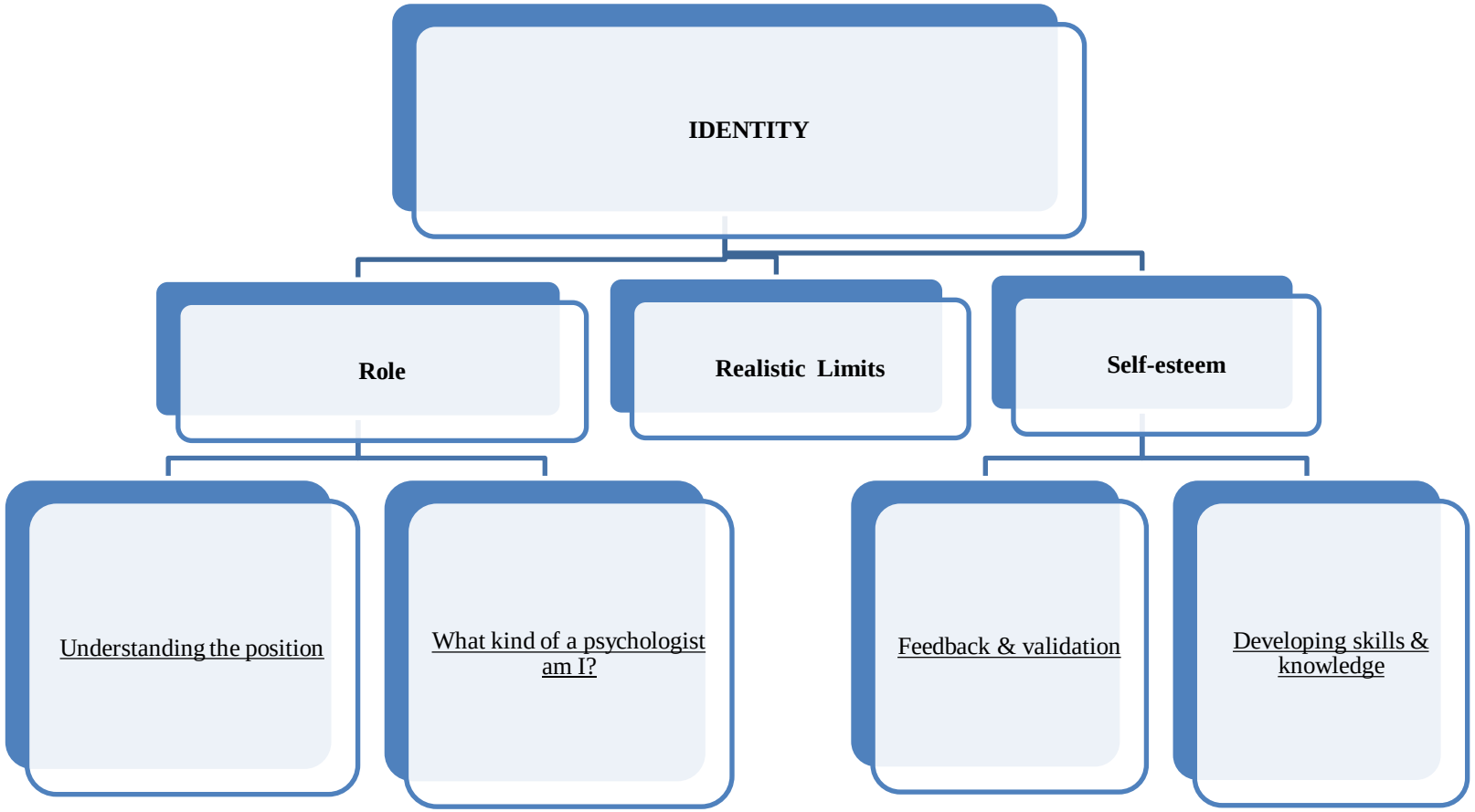
# Appendix 17

# Breakdown of main, superordinate and subordinate themes


EVENT PERCEPTION
Sense of threat
Safety
Personal resources
Overwhelmed
Stretched and challenged
Manageable and positive
Repercussions
Support
Knowledge & skills
Attitudes & Values
Cumulative stressors


MANAGING THE PROFESSIONAL SELF
Emotional regulation
Cognitions
Behaviour
Managing emtions
Containment
Formulating
Managing uncertainty
Knowledge & skills/developing risk templates
Assertiveness
Pro-active behaviour


REFLECTIVE PRACTICE
Reflection on event
Reflection about event
Reflection in the event
Scaffolding
Making sense
Adjusting values
Thinking systemically


IDENTITY
Role
Realistic Limits
Self-esteem
Understanding the position
What kind of a psychologist am I?
Feedback & validation
Developing skills & knowledge

# Appendix 18

# Excerpt from master theme table (quotes across participants by subordinate themes)

| | |
|---|---|
| Repercussions | ‘ If something had happened I wouldn’t be able to live with myself as a person, taking away the fact that I was a clinician. I wouldn’t be able to live with myself and there was no way I was going to leave that without telling somebody else.’ pt 1 line 207<br>‘I guess for my own safety not knowing whether he would then assault me, and then I think that was fairly quickly followed by anxiety about whether I had done something bad clinically, had I caused that to happen, whether I should have seen the warning signs, whether I’ve stirred things up for the staff..’ (pt 3 line 170)<br>‘yeah absolutely terrified, I was absolutely terrified because I had to effectively sort of., cos the clinical leader was making her judgement on what I was telling her which was that he’d said this and this and this is why he’d said he wouldn’t but if I’d presented that slightly incorrectly to her then that clinical decision could have been wrong. He could have .. I didn’t know what to look for really in terms of.,.. so I was utterly terrified..’pt 5 line 157<br>‘I was anxious yes because I, cos I’ve worked in xxx I’ve worked with people, working in xxx, people commit suicide, not frequently, but its not infrequent that you will work with someone and someone will… cos its such a traumatised population and so from my experience the reality of someone going out and committing suicide is very real whereas for a lot of the mental.. for example I know for a fact that my supervisor had never been in the situation where someone has committed suicide so it’s a VERY different, cos psychologists tend to be quite well protected from that kind of frontline risk management.’ Pt 5 , line 192<br>‘When I was working in the community brain injury teams you would be visiting people’s houses a lot. Now at the time that seemed ok to me but looking back now it was, it was far more risky than I appreciated at the time, cos I would be like 22, going into someone’s house that I’ve never met before, who’s had a brain injury and suffers from MH problems and I’d just rock up with a referral and just meet people for the 1st time.’ Pt 6 line 9<br>there were a couple of families that were really volatile so you would be dealing with risk between family members and there would be a couple of times where I would be on my own in a new house in a not particularly nice area but its only that side of things that I’ve thought was more risky looking back. It felt ok at the time, but looking back I think oh I wasn’t in the best position there. Pt 6, line 24<br>‘I think it was more that I felt like a lot of my clients were really really risky and I felt worried that I was going to see a few of my clients on the news after they had been discharged’ pt 6, 160<br>‘it was in quite a safe environment cos the person was in a supported home so I felt safe to be able to walk away and get the supervision and then call the home back if that makes sense. I wasn’t leaving someone vulnerable on their own completely’ pt 7 (line 29)<br>‘I think it was the level of that risk, you know like, walking out cos we used to see her at home it was quite scary walking out of that door and coming back and knowing that you are leaving that family in a really vulnerable situation.’ Pt 7 line 378<br>‘I said I am concerned I think it was during the summer as well so it was school holiday time so I was like I am concerned. I think there is considerable risk to the children, especially at the moment when mum is under a lot of pressure during school holidays trying to keep her children occupied. I am concerned firstly whether she can keep her younger child safe from the son that she’s worried has been violent to the younger sister in the past but equally that mums at her wit’s end and could be you know use physical discipline on her son today you know from leaving the room’ pt 8 line 291<br>‘The first thing that they said when they came in and sat down was that they hadn’t come the previous week because they had tried to commit suicide which (Laughter) I instantly felt really anxious almost feeling sick at the thought of is there anything that I’ve done or could have done that would have perhaps not have left her in that a situation.’ Pt 9, 56<br>‘she didn’t want to upset me so she got me off the phone as quickly as possible, so that was running through my mind is she just going to tell me what she wants to so that she doesn’t feel that she has upset me or something so that’s why I thought I need to ring my supervisor so that things are in place to keep this woman as safe as possible’ pt 9 line 114 |