Oxford Doctoral Course in Clinical Psychology

PERSONAL AND PROFESSIONAL DEVELOPMENT IN CLINICAL PSYCHOLOGY TRAINING AND PRACTICE: UNDERSTANDING EXPERIENCES OF REFLECTIVE PRACTICE AND THE EXPLORATION OF CULTURE AND DIFFERENCE IN SUPERVISION

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Personal and Professional Development in Clinical Psychology Training and Practice: Understanding Experiences of Reflective Practice and the Exploration of Culture and Difference in Supervision

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Abstract

Reflective practice and supervision are thought to be key components of personal and professional development within clinical psychology training and practice. Reflective practice is thought to foster increased self-awareness of personal biases and assumptions, greater understanding and empathy for clients, and therapist expertise in working with complexity. It is also thought to support the development of cultural competency, with the supervisory relationship being the primary mechanism by which issues of culture and difference can be explored in order to support supervisee learning.

The first paper systematically reviewed nineteen studies exploring experiences of reflective practice in clinical psychology and cognitive behavioural therapy training and practice. Each study was critically appraised and an inductive thematic analysis was undertaken to synthesise the findings. Methodological strengths and weaknesses were identified alongside themes pertaining to the benefits of reflective practice, challenging and distressing experiences and key processes which facilitate or hinder engagement in reflective practice groups. Recommendations for training, practice and future research are discussed.

The second paper employed a constructivist grounded theory approach to explore how issues of culture and difference are perceived and explored within the supervisory relationship. Five supervisory dyads were recruited from one doctoral clinical psychology training programme. Each participant attended one individual semi-structured interview. The resulting model highlights perceptions regarding the relevance, importance and risk associated with exploring

culture and difference. The development of safety within the supervisory relationship was essential for discussions to take place. Processes regarding initiating conversation and minimising risk were identified. Dyads reported perceived benefits to their understanding of the client which supported the development of culturally sensitive formulations and interventions.

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PAPER A

EXPERIENCES OF REFLECTIVE PRACTICE IN CLINICAL PSYCHOLOGY AND COGNITIVE BEHAVIOURAL THERAPY TRAINING AND PRACTICE: A SYSTEMATIC REVIEW AND SYNTHESIS OF QUALITATIVE FINDINGS

Charlotte McCann

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Experiences of Reflective Practice in Clinical Psychology and Cognitive Behavioural Therapy Training and Practice: A Systematic Review and Synthesis of Qualitative Findings

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Abstract

Background

Reflective practice (RP) is considered key to professional development in clinical psychology and cognitive behavioural therapy training and practice. Despite the acceptance and promotion of RP, the evidence base regarding the effectiveness of RP remains in its infancy. Of concern, studies have reported negative and distressing experiences resulting from RP. This systematic review aims to identify, critically appraise and synthesise the qualitative literature regarding experiences of RP in clinical psychology and CBT training and practice.

Methods

A systematic search of relevant databases and the grey literature identified studies published between 2000 and 2020. Papers were appraised using the CASP quality appraisal tool. An inductive thematic analysis was conducted to synthesise the findings.

Results

In total, 19 studies were identified. Methodological strengths and weaknesses across studies were reported. Shared themes across clinical psychology and CBT studies were: 1) Developing experiential understanding and competence in therapeutic skills, 2) Empathic understanding of the client, 3) Understanding the interplay between the personal and professional, 4) Course-related challenges, and 5) Challenging and distressing experiences. A further theme was identified within the clinical psychology literature pertaining to reflective practice group processes.

Conclusions

The findings indicate a number of perceived positive and negative outcomes of RP, as well as factors which appeared to facilitate or hinder perceived benefits. Implications for clinical practice, training and further research are recommended.

Key words: reflective practice, clinical psychology, cognitive behavioural therapy, SP/SR

Proposed journal: International Journal of Practice Based Learning in Health and Social Care (See Appendix A for manuscript guidelines)

Experiences of Reflective Practice in Clinical Psychology and Cognitive Behavioural Therapy Training and Practice: A Systematic Review and Synthesis of Qualitative Findings

A key part of professional practice in the helping professions is the ability to develop a capacity to reflect on the work undertaken so as to learn from experience, integrate new knowledge and make appropriate and ethically sound decisions (Beinart & Clohessy, 2017). Reflection is therefore a fundamental component of professional development (Catto, 2005; General Medical Council, 2005; Fouad et al., 2009). The purpose of this systematic review is to gain a greater understanding of experiences of reflective practice (RP) and methods of reflection within clinical psychology (CP) and cognitive behavioural therapy (CBT) professions.

Although the field of CP has been slow to embrace the concept of RP (Bennett-Levy, 2003; Lavender, 2003), it is now an integral component of professional development within doctoral training and professional practice (Rodolfa et al., 2005). The British Psychological Society's standards for the accreditation of doctoral programmes in CP (BPS, 2019) identify the importance of trainee demonstration of both scientist-practitioner and reflective-practitioner models. Reflective practice (RP) is also a requirement for continued professional registration for qualified psychologists (BPS, 2017).

Competence in CBT is a required training outcome for all UK doctoral training programmes in CP. Within CBT training and practice, reflection can be viewed as a means of developing therapist expertise and as essential for ongoing professional development (Bennett-Levy, 2006). Bennett-Levy's (2006) declarative-procedural-reflective (DPR) model suggests that one of the main aims of psychotherapy training should be to encourage the development of trainee reflective stance and continuous self-reflection (Bennett-Levy, 2006). The British Association for Behavioural and Cognitive Psychotherapies (BABCP, 2021) training standards require reflection on learning as part of continued professional development.

Definitions and theory of RP

The concept of reflection has presented a challenge due to difficulty defining the term (Cushway & Gatherer, 2003). RP was first conceptualised by Dewey (1933) who described it as intentional, active and persistent consideration and critical analysis of beliefs and knowledge. Schön's work (1983, 1987) developed from this, and emphasised RP as a process of continuous learning with two types of reflection; *reflection-on-action* (after an activity has occurred) and *reflection-in-action*

(during interactions). The *reflective-practitioner model* (Schön, 1987) requires clinicians to take a 'meta' approach by standing back and reflecting on oneself and their work. Within the field of education, RP forms an integral part of experiential learning theory (Kolb, 1984), in which reflection and learning are seen as a recursive, ongoing process.

Within CP and CBT professions, RP also includes reflection about one's impact on others and reflection on the self (Lavender, 2003; Bennett-Levy & Thwaites, 2007). Reflection on one's own vulnerabilities is thought to engender a greater understanding of the client position and opportunity for therapist self-care (Lavender, 2003).

Reflective practice is thought to help clinicians to acknowledge and consider the uncertainties and complexities inherent in situations and interactions, rather than reducing issues to fit pre-existing theoretical or personal understandings (Hoshmand & Polkinghorne, 1992; Lavender, 2003). In doing so, practitioner vulnerabilities and biases can be uncovered and the potential negative impact of these mitigated against during clinical work.

Given the complexities of client work, it is not always possible to simply apply theory to practice (Schön, 1983). Schön (1983) distinguishes between technical-rational knowledge (e.g., the learning of treatment protocols) and professional artistry (e.g., sensitivity to interpersonal processes and tailoring intervention accordingly). Several theorists have argued that professional artistry and therapist expertise are developed through practitioner self-reflection and RP (Rønnestad & Skovholt, 2003; Schön, 1983; Skovholt et al., 1997).

The declarative-procedural-reflective (DPR) model (Bennett-Levy, 2006) used in CBT training draws on these ideas. It emphasises the importance of reflection in analysing and comparing experience and knowledge, and identifying plans for action. This process is thought to contribute to new learning and increasingly more sophisticated 'when-then' rules; which therapeutic strategy or procedure is most appropriate for whom, under which particular circumstances.

Thus, RP can be conceptualised as an iterative process, occurring in the moment and after events, to explore one's understanding of actions and experience, as well as relational processes and their impact on the self. RP is thought to lead to personal and professional development via fostering greater self-awareness, uncovering personal biases and assumptions and providing opportunity for therapist self-care, developing a greater understanding and empathy for clients, and enhancing therapist expertise in working with complexity.

Methods of RP

A number of different reflective methods have been used within CP and CBT professions. RP is considered a key aspect of effective supervision in both CBT and CP training and practice (Bennett-Levy et al., 2009; Beinart & Clohessy, 2017). A range of reflective methods are suggested (Scaife, 2010). This includes supervisor feedback on observations/ recordings, as required in CP and CBT training; and possible use of therapeutic tools, such as genograms, Socratic or systemic-circular questioning, role-plays, sculpts and chair-work.

Reflective practice groups (RPGs) are a primary method during CP doctoral training (e.g., Knight et al., 2010). RPGs are usually facilitated and provide opportunity for group discussion about the experience of training, clinical work and the self.

Bennett-Levy and colleagues (2001) developed a method of RP called *self-practice* and *self-reflection* (SP/SR), in which CBT techniques are applied to the self and subsequently reflected on. This involves consideration of both personal and professional implications. SP/SR is a 6 – 12 week programme and can be delivered in groups, co-therapist dyads, or individually. Self-reflection is prompted by the use of questions pertaining to the exploration of the self, the therapeutic process, and theory-practice links.

Evidence base for RP

Despite the general acceptance and promotion of RP within professional training and practice in CP and CBT professions, the evidence base for RP is relatively rudimentary, particularly within CP (Lilienfeld & Basterfield, 2020) and consists of only qualitative studies.

There has been a greater level of research exploring RP within health professions such as nursing and medicine. Mann and colleagues' (2009) systematic review indicated that the tendency and ability to reflect varied across individuals. Reflection was stimulated by anticipation of complex clinical problems and perceived to be helpful in making sense of complexity and learning from experience. Busy clinical environments and time pressures inhibited RP, whereas mentor/ supervisor modelling, guiding and supporting RP helped to encourage reflection. Questions remain largely unanswered regarding whether RP enhances self-awareness, improves client outcomes and whether RP leads to negative outcomes, such as clinician distress. It is not known to what extent these findings may generalise to training or practice within CP and CBT professions.

Several studies have explored the impact of SP/SR on CBT competency development. McGillivray and colleagues (2015) conducted a meta-synthesis review including five qualitative and five quantitative published studies. Findings from qualitative studies indicated that SP/SR led to perceived improvement in clinical knowledge and technical skill, self-awareness, interpersonal and relational skills, enhanced critical awareness of the therapeutic model, a greater empathy for clients and appreciation of the discomfort associated with self-disclosure. The findings from quantitative studies indicated increased empathy, self-awareness and theoretical understanding of therapy. Questions remain unanswered regarding whether SP/SR improves case conceptualisation and therapeutic outcome. The extent to which these findings may be relevant to RP in CP training and practice requires further exploration.

There have been no systematic reviews of RP in CP training and practice and research in this area consists of only qualitative literature. Despite findings to suggest RPGs are seen as the most effective method for personal and professional development within CP (Horner et al., 2009), there is emerging literature reporting negative effects and the potential for distress (e.g., Knight et al., 2010). A close examination of the literature is needed to identify both positive and negative perceived outcomes, mechanisms associated with distress and how this could be managed to ensure valuable experiences of RP throughout professional training.

Rationale for systematic review

There have been a small but growing number of qualitative studies since the year 2000, coinciding with the emergence of the journal 'Reflective Practice' (Scaife, 2010) and inclusion of RP in CP and CBT training programmes (Hughes & Youngson, 2009; Lavender, 2003; McGillivray et al., 2015), exploring experiences of RP and different reflective methods within training and practice. To the author's current knowledge, the present study is the first systematic review of RP in CP training and practice. Studies of RP in both CP and CBT are considered here due to the paucity of empirical studies on RP in CP. The CBT literature is potentially relevant given that CBT training and competence is a requirement of CP training. Hence, the extent that findings from the CBT literature resonate with the CP literature will be explored. Only qualitative studies will be reviewed for the following reasons; (a) to gain insight into individual experiences of RP in order to better understand both positive and negative outcomes associated with RP, including the potential for distress and (b) there are no quantitative studies investigating RP in CP and therefore it is not possible to make

comparisons or draw connections with the very limited quantitative CBT SP/SR findings that are available.

Aim

The aim of the present systematic review is to identify, critically appraise and synthesise the qualitative findings of studies which explore experiences of RP in clinical psychology and CBT training and practice. Perceived positive and negative outcomes of RP will be explored, as well as any factors that appeared to facilitate or hinder perceived benefits. Implications for clinical practice, training and further research will be considered.

Method

Search strategy

A systematic search was conducted in February 2021 using the National Institute for Health and Care Excellence's Healthcare Databases Advanced Search facility (https://hdas.nice.org.uk). Preliminary searches revealed no relevant results within certain databases (HBE, HMIC, AMED, BNI) therefore the following databases were used: CINAHL, Medline, and PsycINFO. A further search was undertaken to identify grey literature, specifically dissertations and doctoral theses, using ProQuest (https://www.proquest.com) and Open Grey (http://www.opengrey.eu). Hand searches of the reference lists of the final studies selected for review were completed alongside key word searches using Google Scholar. Search terms included words related to reflective practice, self-practice/self-reflection and CP and CBT professions (see Appendix B for detailed description of search terms). The search was limited to English language, published from the year 2000 and qualitative studies.

Eligibility criteria

Studies were screened using the criteria detailed in Table 1.

Inclusion criteria:	**Exclusion criteria:**
• Published since year 2000 • Published in English language • Qualitative studies/ studies predominantly using qualitative methodology and analysis	• Participants from other professions • Not a primary source of data - literature review or theoretical paper or used data from another study which has already been included in the present review

• Explored experiences of reflection / RP amongst clinical psychologists or CBT therapists in professional practice or training.	• Not a clear method of RP or describes personal therapy/ group therapy. • Focused on expectations rather than experience of RP.

Table 1. Eligibility criteria

Study selection

The study selection process was primarily conducted by C.M., however supervision with H.J. was utilised to check decisions regarding inclusion where there was uncertainty, for example, where the study design diverged from the majority of other papers. The initial search identified 2343 studies. A hand search identified an additional 5 studies for review. After duplicates were removed, 1901 study titles and abstracts were screened for relevance. After screening, 45 full text articles were assessed. A total of 19 studies were eligible for review. See Figure 1 for a flow diagram of the search process.

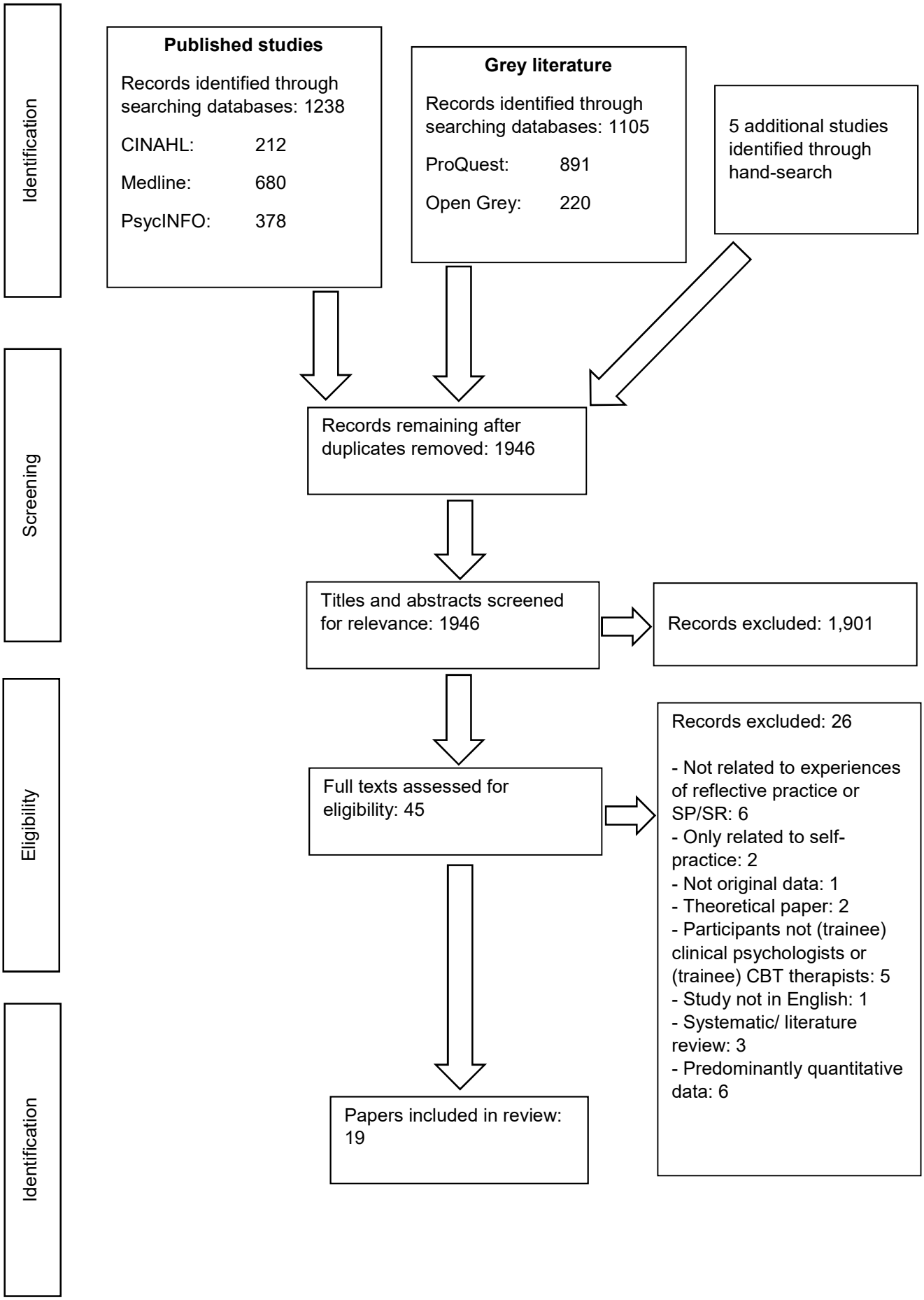

Figure 1. Flow diagram of search process

Data extraction and critical appraisal

A data extraction database was developed in order to systematically record the key features of each study (Appendix C).

The Critical Appraisal Skills Programme (CASP, 2018) Qualitative Checklist (Appendix D) was used to assess the quality and credibility of each study. Given that only qualitative findings were included in this review, it was deemed a suitable appraisal tool. Despite there being many critical appraisal tools available for assessing qualitative research, the CASP was selected because it is intuitive, comprehensive and is the most frequently used tool for the purpose of appraising qualitative evidence syntheses (Majid & Vanstone, 2018). In addition, the extent to which study findings provided explanatory insights that are transferrable to different settings was evaluated. Criteria from Noyes & Popay (2006) and Evans and colleagues (2019) were used to determine the relative richness of the description and meaning of subjective experience as well as the use of theory to generate explanations (Table 2). The richness of each study is reported in Appendix E, in relation to the contribution of each paper to the final themes reported.

In line with recent best practice recommendations (Siddaway et al., 2019), quality scores and ratings were not assigned to studies, nor were studies excluded on the basis of 'low quality'. This is due to the inherent issues with critical appraisal checklists in assigning greater or lesser weight to particular quality criteria, without clear justification (Siddaway et al., 2019). In addition, the assessment of what constitutes high or low quality is largely subjective on the part of the researcher (Valentine & Cooper, 2005). Therefore, it is deemed good practice to include all studies regardless of quality assessment, to enhance transparency and ensure all relevant findings are captured. All studies were initially appraised by the lead researcher. To increase reliability, four papers were randomly selected and analysed using the CASP (2018) by two second raters (HJ, and SG – trainee clinical psychologist). In addition, the researcher's supervisor (HJ) rated 50% of studies to assess richness. Any discrepancies were discussed until agreement was reached.

Richness	Criteria (Noyes & Popay, 2006; Evans et al., 2019)
Thick papers	• Privileges subjective experience and meanings as shown by researcher epistemological stance and immersion in the data, detailed description of participant experiences, intentions and circumstances. • Clearly describe the process by which the findings were produced, including the sample, its selection and size, with any limitations or bias noted, along with clear methods of analysis

	• Use of theory to build a developed interpretation of the data
Thin papers	• Failing to see the world as respondents saw it • Lacks clarity regarding how findings were produced • Limited/no/inappropriate use of theory, little explanatory insight and problems in generalising

Table 1. Richness criteria

Data analysis

In line with guidance by Popay and colleagues (2006), a systematic approach to data analysis was taken, involving grouping, tabulation and translation of primary themes. Studies were initially categorised based on type of RP and profession. Two groups were formed which focused on a) general reflective methods (including groups, journal writing and individual reflection) within CP training and practice and, b) self-practice and self-reflection in CBT training and CBT modules within CP training. Findings were reviewed for each study and tabulation was utilised to provide a summary of findings for each study and to begin to identify patterns across studies. The process of translation was utilised, in which conceptual overlaps and divergences between pre-existing themes were identified iteratively throughout the analysis process. An inductive thematic analysis was undertaken, given the diversity and heterogeneity within reviewed studies. Study findings were considered to be all text labelled as 'results' or 'findings' in the papers (Thomas & Harden, 2008). These were grouped according to similarities and differences in conceptual themes. Initial themes were developed and findings from subsequent studies were added into pre-existing themes. New themes were created when deemed necessary, initially within groups and then between the two analytic groups, according to the author's judgement. Negative cases were actively pursued to preserve nuanced and diverse perspectives (Appendix F illustrates analysis process). Given the remit of thematic analysis, final themes were largely descriptive. Established methods of thematic synthesis (Thomas & Harden, 2008) were considered, however declined for reasons including being beyond the scope of this initial exploratory review. The data analysis procedure resulted in a preliminary, systematic synthesis of the thematic findings from relevant published and unpublished studies.

Reflexivity

A constructivist epistemological stance was taken in relation to data analysis. It is acknowledged that qualitative research is contextual and influenced by the researcher and the context in which the phenomenon is being studied (Dodgson, 2019). A reflexive stance was taken throughout

the research process, including the bracketing of personal assumptions, to enhance credibility (see Appendix G for further details).

Results

Summary of studies

Nineteen studies were identified as eligible for the present review. A summary of each study is provided in Table 3. Studies were assigned a number and will therefore be referred to by their number within this section for brevity.

Twelve studies were conducted in the United Kingdom (3 – 5, 7, 8, 12 – 14, 16 – 19) and one study was conducted in Ireland (6). Three studies were conducted in Australia (1, 2, 15), two in New Zealand (10, 11) and one in Singapore (9).

Twelve studies were published (1, 2, 4 – 6, 8 – 10, 14 - 17) and seven were unpublished doctoral theses (3, 7, 11 – 13, 18, 19). There were ten studies which focused on RP methods within CP practice and training (3 – 5, 7, 9, 12 – 14, 18, 19). This included RPGs during CP training (7 studies) and general reflection related to clinical work/ training, such as self-reflection and reflection with supervisors or peers (4 studies). Nine studies focused on SP/SR within CBT training or CBT modules within CP training (1, 2, 6, 8, 10, 11, 15 – 17).

Across all the studies, 245 participants were recruited and of these, 165 identified as female and 54 identified as male. Participant gender was not reported in three studies (3, 15, 18). There were 75 participants who were qualified clinical psychologists, 72 were trainee clinical psychologists. Participants who were not clinical psychologists comprised 54 trainee and 44 qualified CBT therapists.

Two studies used a mixed methods design (11, 16) and 17 employed purely qualitative research methods. Of these, nine used interpretative phenomenological analysis (IPA; 3 – 5, 9, 12, 14, 17, 18, 19), six used thematic analysis (6, 8, 10, 11, 15, 16), two used grounded theory (7, 13) and the final two (1, 2) used a specific methodology drawing from a range of qualitative approaches (action research, grounded theory and practitioner researcher self-study), called the ‘technologies of participation (ToP) workshop method’ (Spencer, 1989). Studies reported a range of data collection methods including written reflections/ reflective journals, audio recorded reflections, semi-structured interviews, focus groups, and online questionnaires.

Study No.	Reference Location Publication status	Study aims	Methodology 1) Research design 2) Data collection method 3) Data analysis method	Sample characteristics	Method of reflective practice
1	Bennett-Levy, Lee, Travers, Pohlman, & Hamernik (2003) Australia Published	'To determine which therapist skills may be affected by personal experiential work, in a group of practitioners who were already working professionally as cognitive therapists.' (p. 145)	1) Qualitative 2) Group 1: Written and audio recorded reflections during SP/SR course. Group 2: Audio recorded reflections during SP/SR course and semi-structured interviews 3) Technologies of Participation (ToP) workshop method, grounded theory.	Group 1: 6 cognitive therapists (all female) Group 2: 8 practicing psychologists (7 female, 1 male)	SP/SR courses: Group 1: 5 fortnightly workshops. Co-therapy partners allocated, partners engaged in both therapist and client roles during each session. Verbal and written reflections. Group 2: practiced CT techniques on their own using a SP/SR workbook. Emailed reflections to course coordinator each week.
2	Bennett-Levy, Turner, Beaty, Smith, Paterson & Farmer (2001) Australia Published	'To map systematically the value of SP/SR in the training of cognitive therapists. Our questions of interest were: Are SP and SR perceived as useful by trainees? If so, then what are the beneficial outcomes? What processes may explain its usefulness? What are the implications and recommendations for future training courses?' (p. 205)	1) Qualitative 2) Group 1: written 1,000 word reflection assessments and audio recorded group reflections on SP/SR experience. Group 2: written SP/SR homework and semi-structured interviews with 10/12 participants. 3) Technologies of Participation (ToP) workshop method, grounded theory.	19 trainees in a postgraduate clinical psychology training program (16 female, 3 male) undertaking a one semester course in cognitive therapy. 7 were in the first year's cohort and 12 undertook the course the following year.	SP/SR as part of a cognitive therapy training course during clinical psychology training. Group 1: trainees completed a minimum of five self-practice exercises. 'Mind over mood' (Greenberger & Padesky, 1995) provided the basis for trainees' SP. Method of SR was at trainees' discretion. Group 2: SP/SR Workbook was completed. One cognitive therapy technique was covered each week. Participants were required to send weekly SP/SR homework to the course coordinator which was then anonymously disseminated to the group.

3	Biggins (2019) UK Unpublished thesis	'Does presenting clinical material within group reflective practice affect how trainee clinical psychologists think about their clients? If so, what is the nature of this impact?' (p. 32)	1) Qualitative 2) Semi-structured interview 3) IPA	5 trainee clinical psychologists – no further demographic information reported	Monthly reflective practice group during clinical training, facilitated by two clinical psychologists, where clinical cases were presented and discussed.
4	Binks, Jones, & Knight (2013) UK Published	'(1) What are facilitators' experiences and understandings regarding trainees' distress within these groups and its relationship to outcomes? (2) How do facilitators of these groups understand and make sense of their experiences of their role, including in relation to distress within the groups?' (p. 307)	1) Qualitative 2) Semi-structured interview 3) IPA	7 clinical psychologists (4 males, 3 females) who had facilitated reflective practice groups within the last 10 years at one clinical psychology training programme	RP groups during clinical psychology training. Groups were mandatory and unstructured and occurred on a fortnightly basis for all three years of training.
5	Carmichael, Rushworth & Fisher (2020) UK Published	'Clinical psychologists understandings and experiences of using reflective practice in clinical work' (p. 521)	1) Qualitative 2) Semi-structured interview 3) IPA	7 clinical psychologists (4 females, 3 males) who had qualified in the last 10 years	Experiences of reflective practice within clinical work.
6	Chigwedere, Thwaites, Fitzmaurice & Donohoe (2018) Ireland	'The utility of SP/SR as a credible alternative to PTT, using the proposed goals and mechanisms of PTT in general and in CBT as comparators for SP/SR.' (p. 2)	1) Qualitative 2) Reflective journals 3) Thematic Analysis	22 foundation and postgraduate diploma level CBT trainees and clinical supervisors/tutors (13 female, 9 male) enrolled in Trinity	SP/SR workbook (6 CBT exercises), self-reflection consisted of individual reflection after each SP exercise in the form of a personal diary and also fortnightly facilitated group reflection sessions.

	Published			College Dublin CBT courses, with 0 – 30 years of prior CBT experience.	
7	Fairhurst (2011) UK Unpublished	'The aim was to develop a preliminary, yet substantive understanding of the mechanisms through which experiences are valuable or distressing for participants who previously attended RPGs during a clinical psychology training programme in the UK' (p. 7-8).	1) Qualitative 2) Semi-structured interview 3) Grounded theory	11 qualified clinical psychologists (7 female, 4 male), who qualified in the last 2 to 21 years from the same clinical psychology training programme	RP groups during clinical psychology training. Groups were facilitated by staff external to the Course, were mandatory and held on a fortnightly basis. They were informed by a group analytic perspective.
8	Farrand, Perry & Linsley (2010) UK Published	'This small study seeks to examine the benefits and limitations of using reflective blogs to support a SP/SR approach towards CBT training.' (p. 474)	1) Qualitative 2) Focus group 3) Thematic analysis	19 (4 male, 15 female) allied health professionals who had completed a postgraduate module in CBT	SP/SR comprised of five teaching days delivered 3 weeks apart which focused on skills development in five core CBT techniques: problem level formulation, guided discovery, cognitive restructuring, behavioural experiments, and activity scheduling. Trainees were required to post at least one reflective blog for each CBT technique learnt.
9	Fisher, Chew & Leow (2015) Singapore Published	'To explore clinical psychologists' experience and use of reflective practice within their clinical role so as to address issues of practice, training and the on-going difficulties with	1) Qualitative 2) Semi-structured interview 3) IPA	6 clinical psychologists (5 female, 1 male) who had 3 to 12 years post-qualification experience	Experiences of reflective practice within clinical role.

		establishing an overarching definition or theory in this area.' (p. 733)			
10	Haarhoff, Gibson & Flett (2011) New Zealand Published	'The reflections of the intervention group on the perceived impact of the SP/SR training intervention on CC [Case Conceptualisation] competency is the focus of this paper.' (p. 326)	1) Qualitative 2) Written self-reflections 3) Thematic analysis	16 graduates from a Postgraduate diploma in CBT (6 males, 10 females)	A workbook was used for SP/SR which included exercises such as the 5 part model and thought records to develop a case conceptualisation. Participants completed SR exercises after each SP exercise. Questions were provided to prompt SR responses. Written reflections were sent to the first author.
11	Hume (2017) New Zealand Unpublished	'To explore the effects of SP/SR on six specific dimensions of CBT therapist competence: cognitive flexibility, empathy, insight, self-compassion, self-monitoring, and stress, among postgraduate CBT trainees completing the workbook, Experiencing CBT from the Inside Out: A Self-Practice/Self-Reflection Workbook for Therapists (Bennett-Levy et al., 2015) as part of their training' (p. 27)	1) Mixed methods 2) Reflective blog entries from review sessions specifically about their experience of SP/SR 3) Thematic analysis	7 CBT trainees completing a Post-graduate diploma, recruited from the same course (all female)	SP/SR workbook and reflective blog. SP/SR took the form of an 18-week program using the workbook, 'Experiencing CBT from the Inside Out: A Self-Practice/Self-Reflection Workbook for Therapists' (Bennett-Levy et al., 2015). Written reflections were completed after each module via an online blog.
12	Kiemle (2008) UK	'What is clinical psychologists' experience of reflective practice in relation to their continuing	1) Qualitative 2) Semi-structured interview	16 clinical psychologists (12 female, 4 male) who had 9 months to 24	Experiences of RP as part of professional role

	Unpublished	Professional development?' (p. 78)	3) IPA	years post-qualification experience	
13	Loveder (2017) UK Unpublished	'The study aimed to develop an explanatory theoretical model of how the social processes occurring within a reflective practice group may impact on client outcomes upon attendees' future contacts with their clients.' (p. 49)	1) Qualitative 2) Audio recordings of group sessions and follow-up semi-structured interviews 3) Grounded theory	6 trainee clinical psychologists in their second year engaging in the same RPG (4 females, 2 males).	RPG during clinical psychology training. Purpose of the group was for case discussion.
14	Lyons, Mason, Nutt & Keville (2019) UK Published	'What are trainees' experiences of RPGs within doctoral CP training?' (p. 72)	1) Qualitative 2) Semi-structured interview 3) IPA	8 practicing clinical psychologists (7 females, 1 male) who had graduated from one clinical psychology training programme within the last three to ten years	RPGs during clinical psychology training. Groups were facilitated by a group analyst, and attendance was mandatory.
15	Spafford & Haarhoff (2015) Australia Published	'(a) Does a [Self-reflective blog] enhance self-reflective experience and engagement of high-intensity CBT trainees? (b) What factors need to be considered to set up and effectively facilitate a reflective blog?' (p. 234)	1) Qualitative 2) Online questionnaire and focus group 3) Thematic analysis	7 CBT trainees in their second year of the Postgraduate Diploma of CBT course	SP/SR Workbook and blog. The SP/SR workbook, entitled 'Understanding Myself' (Haarhoff, 2008) included 17 SP/SR exercises which guided the trainee to apply CBT methods to their presenting problem, gaining an understanding of the problem and then creating a personal case conceptualisation. There was an additional SR module for final reflections. A SP/SR blog was utilised. Trainees were encouraged to complete SP/SR

					exercises over a period of 6 weeks. Reflective modules were uploaded each week along with a message from the course coordinator to encourage participation.
16	Spendelow & Butler (2016) UK Published	'SP/SR outcomes were investigated not only in terms of personal and professional outcomes (as done in previous research), but also in terms of reported negative outcomes and barriers to participation. Replication of reported outcomes is also important in novice therapists since there has been limited prior research conducted exclusively with trainee therapists.' (p. 604)	1) Mixed methods 2) Online questionnaire 3) Thematic analysis	32 trainee clinical psychologists (29 female) from years 1 and 2 of one clinical psychology training programme	SP/SR experiential exercises. Participants selected and followed a self-help book from a list of provided references, from the CBT 'Overcoming' series. Participants were put into reflective practice groups, facilitated by a member of staff (clinical psychologist). Provided written reflective accounts and discussed these together.
17	Sutton, Townend & Wright (2007) UK Published	'To research the value or otherwise of the learning journal from the students' perspective within their training as cognitive behavioural psychotherapists' (p. 389)	1) Qualitative 2) Focus groups 3) IPA	19 students (9 male, 10 female) completing a postgraduate course in CBT	A mandatory reflective learning journal which aimed to encourage students to document and reflect upon their personal and professional development.
18	Wigg (2009) UK Unpublished	'To explore the impact of using PD groups during training on clinical psychologists' practice and their role in enhancing reflective practice.' (p. 69)	1) Qualitative 2) Semi-structured interview 3) IPA	12 clinical psychologists who graduated from one clinical psychology training programme in the last 10 years.	Mandatory personal and professional development groups during clinical psychology training. Group aims were to facilitate reflection, clarify ideas for personal development, support individual and

					group change, provide support and insight into the workings of groups (including strengths and limitations)
19	Wildig (2007) UK Unpublished	'To address the gap in the research literature by building up an understanding of the experience of reflective practice from the point of view of psychologists in clinical training, and illuminating in what way this part of the training process may impact on the sense of identity of the participants.' (p. 54)	1) Qualitative 2) Semi-structured interview 3) IPA	10 trainee clinical psychologists in the second or third year from 3 different clinical psychology training programmes. All female.	Experiences of RP during clinical training - not a specific form of RP specified however participants talked about self-reflection and reflecting with others (e.g., with course staff, in supervision and with peers)

Table 3. Summary of studies

Quality appraisal

The CASP (2018) was used to assess the quality of each study by asking a series of questions (see Table 4 for overview).

Statement of Aims

The majority of studies described clear aims for the research, highlighting gaps in the literature and how their studies address these (1 – 9, 12 – 15, 17 – 19). Hume (2017) provided a statement of aims, however these only related to the quantitative analysis. It was not clear which research questions were linked to the qualitative analysis. Spendelow & Butler (2016) and Haarhoff and colleagues (2011) did not clearly describe research aims, the latter only briefly mentioning the focus of the study in the method section.

Appropriateness of Qualitative Methodology and Research Design

A qualitative or mixed methods design appeared to be appropriate and was justified for all but one study (6), for reasons such as exploring the subjective experiences of participants and 'mapping the territory' (1) due to a lack of empirical research in the area. Twelve papers gave further detail regarding why they chose specific qualitative methodology such as IPA, or grounded theory (1 – 5, 7, 9, 11 – 13, 17 – 19). Eight papers also commented on their epistemological stance to give a greater contextual understanding of the study (5 – 7, 11, 13, 14, 18, 19), whilst one paper only included this in the appendix (3).

In Chigwedere and colleagues' (2018) study it is unclear whether a qualitative design is appropriate. Study aims weren't related to the exploration of subjective experience but rather whether SP/SR is a credible alternative to 'personal training therapy' (PTT). A quantitative design comparing outcomes between the two approaches, or a qualitative methodology comparing and contrasting participant experiences of both, may be appropriate alternatives.

Despite Wigg (2009) providing a rationale for using IPA, the analysis explicitly included elements of grounded theory and a theoretical model was developed. Given the aims of the research focused on social processes, rather than idiographic experiences, a GT approach may have been more appropriate than IPA.

Quality appraisal (CASP, 2018)		1	2	3*	4	5	6	7*	8	9	10	11*	12*	13*	14	15	16	17	18*	19*
Aims, methodology and research design	Clear statement of aims?	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y	Y	N	Y	Y	Y
	Appropriate research design?	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Justified rationale for qualitative method?	Y	Y	Y	Y	Y	N	Y	N	Y	N	Y	Y	Y	N	N	N	Y	Y	Y
Recruitment and sampling	Sampling strategy reported?	N	N	Y	Y	Y	Y	Y	N	N	Y	N	Y	N	Y	N	N	N	N	N
	Opt-in rate reported?	N	N	Y	N	N	Y	Y	Y	N	N	Y	Y	Y	N	Y	Y	Y	N	Y
	Reasons for non-participation reported?	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	Y	N	N	N	N
	Sample appropriate to research aims?	N	N	Y	Y	Y	Y	N	Y	Y	N	Y	Y	Y	N	Y	N	Y	N	Y
Data collection	Clear method of data collection?	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Form of data reported?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y
	Clarity regarding who interviewer was?	N	N	Y	N	Y	N	N	N	Y	N	N	Y	Y	Y	N	N	N	Y	Y
	Development of interview schedule reported?	N	N	N	Y	Y	N	Y	Y	Y	N	N	Y	N	Y	Y	N	N	Y	Y

	Discussed modifications to interview schedule?	N	N	N	Y	N	N	Y	N	N	N	N	Y	Y	N	N	N	N	Y	N
	Setting of data collection reported?	N	N	N	Y	N	N	Y	N	N	N	N	Y	Y	Y	N	N	N	N	N
Researcher role and reflexivity	Evidence of researcher reflexivity in main text?	N	N	Y	Y	N	Y	Y	Y	Y	N	N	Y	Y	N	N	N	Y	N	Y
	Mentioned use of reflective journal/ bracketing interview?	N	N	N	Y	N	Y	Y	N	N	N	N	Y	Y	N	N	N	Y	N	Y
	Reported impact of bias on research process?	N	N	N	N	N	Y	N	N	N	N	N	Y	N	N	N	N	Y	N	N
	Critical reflection on the researcher's role in the analysis?	N	N	Y	N	N	Y	Y	N	Y	N	N	Y	Y	N	N	N	Y	Y	N
	Information regarding researcher-participant relationship?	N	N	Y	N	N	Y	Y	Y	Y	N	Y	Y	Y	N	Y	N	Y	Y	Y
Ethics	Reported ethical approval was granted?	N	N	Y	Y	Y	Y	Y	N	Y	N	N	Y	Y	Y	Y	N	Y	Y	Y
	Discussed key ethical considerations?	N	N	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	Y	Y	Y
Analysis and findings	Detailed description of analysis process?	N	N	N	Y	N	Y	Y	N	Y	N	N	Y	Y	N	N	N	N	Y	Y
	Sufficient data to support findings?	N	N	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

	Contradictory/ varied data evidenced?	N	Y	Y	Y	Y	N	Y	N	Y	Y	N	Y	N	Y	Y	Y	Y	Y	Y
	Discussion of credibility of findings?	Y	Y	Y	Y	N	Y	Y	Y	Y	N	N	Y	Y	Y	N	N	N	Y	Y
	Findings discussed in relation to research question?	Y	Y	Y	Y	Y	Y	N	N	N	Y	Y	N	N	N	Y	Y	Y	Y	Y
Value	Findings discussed in relation to theory and research?	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y
	Ideas for future research outlined?	Y	Y	Y	Y	Y	Y	Y	N	Y	N	Y	Y	Y	Y	N	Y	Y	Y	Y
	Recommendations for practice provided?	N	Y	Y	Y	Y	N	Y	Y	N	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
	Transferability of findings discussed?	Y	Y	Y	Y	N	N	Y	N	Y	N	Y	Y	Y	Y	N	Y	N	Y	N
Richness rating (Noyes & Popay, 2006; Evans et al., 2019) (Thick/ Thin)		Thick	Thin	Thick	Thick	Thick	Thin	Thin	Thin	Thick	Thin	Thin	Thick	Thick	Thick	Thin	Thin	Thin	Thick	Thin

Table 4. Overview of critical appraisal for each study. Note. * = unpublished study.

Recruitment and sampling

The degree and quality of information about the recruitment process varied across studies. Eight studies explicitly reported the sampling strategy utilised, including purposive, convenience and theoretical strategies (3 – 7, 10, 12, 14). Haarhoff and colleagues (2011) reported the use of convenience sampling, however the description of the recruitment process within the discussion indicated purposive sampling. Only seven studies explicitly commented on their inclusion/ exclusion criteria (4 – 7, 9, 13, 19). Three studies mentioned saturation (7, 12, 13) and few studies provided a rationale for the number of participants recruited (3 – 5, 7, 9, 18). Most of those that did, cited literature to justify using a small sample size for the purposes of IPA. In the Spafford & Haarhoff (2015) study, information about sample size is potentially misleading. It is stated in the abstract that there were 9 participants, but only 7 individuals completed the questionnaire and 4 participated in the focus group. Just over half the studies commented on how many participants were approached versus how many chose to participate (3, 6 – 8, 11 – 13, 15 – 17, 19), however reasons for non-participation were only reported in two studies (6, 15). Some studies reported low response rates of 6.2% and 17.2% (12, 19). It is therefore difficult to determine the nature of sampling biases.

Appropriateness of the sample to the aims of the research varied across studies. Some studies recruited participants from different training courses (1, 19), from differing professional backgrounds (1) and completing different variations of SP/SR or RP (1, 2, 19). Whilst increased heterogeneity may increase applicability of findings, it potentially compromises the depth of analysis due to variance in participant experience.

Despite research aims pertaining to the experience of cognitive therapists, three studies recruited psychologists/ trainee psychologists, without providing justification (1, 2, 16). Furthermore, four studies aimed to explore experiences during training, however recruited graduates without a clear rationale for undertaking a retrospective study (7, 10, 14, 18). Issues with memory and the potential impact of subsequent experiences of RP on participant perceptions may reduce the validity and reliability of participant accounts.

Data collection

The majority of studies used a semi-structured interview (2 – 5, 7, 9, 12 – 14, 18, 19), three studies used focus groups (8, 15, 17), three analysed self-reflective journals (6, 10, 11) and two studies were questionnaire based (15, 16). The majority collected audio-recordings only (3 – 5, 7 – 9,

12 – 14, 18, 19), four collected only written reflections (6, 10, 11, 16) and three collected written and audio-recorded data (1, 2, 15). It was clear in eight studies who conducted the interviews (3, 5, 9, 12 – 14, 18, 19) and ten studies provided information regarding how they developed the interview schedule (4, 5, 7 – 9, 12, 14, 15, 18, 19), such as being guided by the literature or pilot interviews. In addition, eleven studies provided examples of questions asked or topics covered (3 – 5, 7, 9, 11, 12, 16 – 19). Fewer studies discussed modifications made to the interview (4, 7, 12, 13, 18) and the setting in which data collection took place (4, 7, 12 – 14). Lacking such information reduces the dependability and transparency of findings. The form of data was clear in all but one study (17) which did not specify whether focus groups were audio-recorded, therefore the fidelity to participants' narrative is uncertain.

In two studies, (1, 2) methods of data collection differed between participant groups, without explanation or critical reflection. In addition, no information was provided regarding who conducted interviews, the process of developing the interview schedule or example questions. Potential for bias is therefore difficult to evaluate and replicability is reduced.

Spendelow & Butler (2016) did not provide a rationale for using an online questionnaire over an interview. The amount participants could write was capped, potentially limiting the scope and depth of data collected. Some questions appeared leading, such as providing categories for participants to comment on. This was at odds with their rationale for including a qualitative element 'to allow for identification of unanticipated findings' (Spendelow & Butler, 2016; p. 604). Similarly, Hume (2017) incorporated 'theory driven' questions to scaffold journal responses. However, it is a strength that the author acknowledged this and is in line with their post-positivist essentialist/ realist epistemological position.

Researcher role and reflexivity

Nine studies did not provide evidence of reflexivity throughout the research process, such as explicit reflection on their own biases and assumptions (1, 2, 5, 10, 11, 14 – 16, 18), reducing transparency. Two studies included this information in the appendix (7, 13). Just five studies mentioned the use of a reflective journal (7, 12, 13, 17, 19) and fewer mentioned conducting bracketing interviews (4, 6, 7, 19). There was little, if any, reflection on how any assumptions or bias may have impacted the research process, with the exception of three studies which provided more detail (6, 12, 17). Only eight studies evidenced critical reflection on the researcher's role in the

analysis (3, 6, 7, 9, 12, 13, 17, 18). The potential conflicting nature of the duality of researcher position was identified for a number of studies such as course staff and researcher (6, 8, 15), and clinical psychologists (9, 12) or trainees (7, 17 – 19) researching peers who are potential future colleagues or indeed trainees researching their own RPG during training (3, 13). Only two studies made arrangements for interviews/ focus groups to be conducted externally in order to reduce potential for positive response bias (8, 15). Meanwhile, seven studies did not provide any information as to the relationship between researcher and participant (1, 2, 4, 5, 10, 14, 16) making it difficult to evaluate potential for bias.

In general, there was a distinct lack of reflection on issues of power and ethical considerations regarding course staff conducting research in trainee populations and how this may have led to coercion in participation, bias towards reporting positive experience and potential fear/discomfort in the repercussions of reporting negative experiences. Given the role of course staff in evaluating trainee competency and gatekeeping the profession, it is conceivable that responses may have been censored. This decreases the dependability and transferability of findings.

Ethical Considerations

The majority explicitly stated that ethical approval had been granted (3 – 7, 9, 12 – 15, 17 – 19). Hume (2017) reported that ethical approval wasn't deemed necessary due to the study being identified by their supervisor and another staff member as 'low risk', without further explanation or evidence of consultation with the university ethics committee. It is therefore unclear whether ethical considerations were fully explored and accounted for. Of similar concern, four studies did not mention ethical considerations or approval (1, 2, 10, 16).

Most studies discussed issues of informed consent (3 – 9, 11 – 15, 17 – 19), whilst eleven mentioned anonymity (3 – 5, 7, 11 – 15, 17, 19), and only eight discussed confidentiality (3, 4, 7, 12 – 15, 17), with two authors commenting specifically on information storing (3, 13). Of particular concern, only three studies commented on the potential for distress (7, 14, 15). Given the emerging evidence that RP can be a distressing experience, it is surprising that this was not explicitly considered in the majority of papers. In addition, the right to withdraw was only discussed in four studies (3, 7, 13, 17). In Loveder's (2017) paper, the right to withdraw was discussed, however, it remains unclear how a participant could truly withdraw, and yet remain in the group, given group process was the focus of study.

Farrand and colleagues (2010) showed no critical reflection on ethical issues, claiming a lack of anonymity and resultant peer-pressure and scrutiny led to positive outcomes. This directly opposes findings from previous research (17) and subsequent studies which report the potential for distress (15, 16).

Data analysis and reporting findings

In depth description of the analysis process was provided in a logical and coherent way for only eight studies (4, 6, 7, 9, 12, 13, 18, 19), whilst nine briefly described the analysis process (1 – 3, 5, 10, 11, 14, 15, 17) and two provided no description at all (8, 16). Most studies provided sufficient data to support their findings (3 – 7, 9 – 19), with the exception of (1, 2, 8).

Bennett-Levy and colleagues (2003) omitted information regarding grounded theory analysis and no resultant theory was presented. Categories were presented, however the 22 subcategories were not reported. Two thirds of the overall data were obtained from the participant researchers (4 people) and differences between participant groups were not discussed. Respondent validation checks were not conducted, therefore, the representativeness of study findings to the majority of participants, or those who are less invested in SP/SR, is in question.

Similar issues of representativeness were identified in Bennett-Levy and colleagues (2001) study. Findings were illustrated by quotes only from the group of participant researchers, and member checks were not conducted for those not involved in the research project. This raises questions around possible bias in reporting which has not been acknowledged or reflected on in the paper.

The paper by Farrand and colleagues (2010) lacked detail regarding analysis procedures, reflexivity and steps to ensure rigour, therefore findings should be interpreted with caution. Themes were very briefly described with a significant amount of overlap, and a lack of illustrative quotes.

Contradictory and varied perspectives were evidenced in the findings for the majority of studies, allowing for a richer, nuanced understanding of participant experience (2 – 5, 7, 9, 10, 12, 14 – 19). In terms of credibility, three studies referred to triangulation (2, 12, 13), such as gathering data from a range of sources (2). Seven studies conducted respondent validation checks (2, 3, 6, 12, 13, 18, 19) and twelve checked findings with another analyst or during supervision (1 – 4, 6 – 9, 12, 14, 18, 19). The majority of studies related findings to their research questions (1 – 6, 10, 11, 15 – 19). Loveder (2017) and Fairhurst (2011) reflected on limitations of their studies, which led to a shift in

focus during data collection and analysis. They acknowledged that the findings did not fully address the initial aims.

Value

Most studies demonstrated their value by outlining their contribution to existing knowledge and discussing findings in relation to theory and research (1 – 7, 9, 10, 12 – 19). The majority suggested ideas for future research (1 – 7, 9, 11 – 14, 16 – 19), recommendations for practice or training (2 – 5, 7, 8, 10 – 15, 17 – 19), and described study limitations (1 – 4, 6, 7, 9, 10 – 19). The quality however differed between studies, with some offering detailed reflections and carefully considered ideas (e.g., 4, 13, 18) and others providing very brief or general comments (e.g., 6, 19) making it difficult to assess the value of the research. In addition, seven studies did not critically reflect on or consider the transferability of their findings, which is a significant area of weakness as it reduces transparency regarding which populations the findings might be applicable to (5, 6, 8, 10, 15, 17, 19).

Farrand and colleagues' (2010) study was considered to be of particularly low value. They provided little application to existing theory or recommendations for future research, and limitations were not discussed. Implications for practice were suggested without critical reflection on issues of transferability.

Chigwedere and colleagues (2018) conclude that SP/SR may be a credible and more acceptable alternative to personal therapy. However, this is unsubstantiated due to methodological limitations, which are not acknowledged by the authors. Given participants were not interviewed about their experiences of both personal therapy and SP/SR, it was not possible to compare and contrast which was most acceptable for participants. The value of this research in relation to the study aim is therefore in question.

Thematic analysis

This review identified five shared themes across the two groups of studies regarding experiences of CBT SP/SR and methods of RP in CP training and practice. The themes reflect the common factors across professions, RP methods and location. Findings from SP/SR papers will be described first, followed by the contribution from the CP literature, with areas of similarity and difference highlighted. A further theme was identified regarding 'processes in RPGs' which only

pertained to the CP literature (Table 5). Appendix E demonstrates the contribution of each study to the overall themes.

Shared themes across CBT and CP studies	Themes related to RPGs in CP
Developing experiential understanding and competence in therapeutic skills	Processes in reflective practice groups
Empathic understanding of the client	Defining the purpose of the group
Understanding the interplay between the personal and professional	Developing sufficient safety
Course-related challenges	Role of the facilitator
Challenging and distressing experiences	

Table 5. Summary of inductive thematic analysis synthesis of findings

Developing experiential understanding and competence in therapeutic skills

SP/SR Studies. Engaging in SP/SR helped therapists to move from an intellectual understanding to a deeper, emotional understanding of the CBT model (1, 2, 6, 10). This led to increased confidence in the impact of CBT through therapist experience of applying the skills to themselves (1, 2, 10). As a result, participants felt more able to sell the rationale for CBT to their clients (1, 2, 6).

Several studies also described how SP/SR helped participants to gain a greater understanding of the structural elements of CBT, such as maintenance cycles, mechanisms of change, and the importance of emotions (2, 6, 8, 10, 16). SP/SR also helped participants to refine and more flexibly utilise their skills. For example, participants reported acquiring new skills, were more thoughtful about their applicability, and believed they were more flexible in their use of techniques (1, 6, 8, 10, 16). Participants reported increased attention to and improvement in the therapeutic alliance (1, 2, 6, 10, 11). The importance of collaboration, empathy, building rapport, showing respect for courage were emphasised and some made subtle changes to their practice towards these aims (1, 2, 11). Therapist self-reflection was also seen as an important factor. In particular, reflecting in action on personal beliefs and assumptions, gaining insight into how they may impact therapeutic relationship and adjusting accordingly (1, 10).

Clinical psychology studies. Key themes from the CP literature indicated that RP also supports participants to refine and more flexibly utilise skills that are responsive to the needs of

clients, such as not sticking rigidly to therapist plans, helping the client to explore and stay with difficult emotions, and balancing being directive with stepping back (18, 19).

The experience of taking part in RPGs was perceived to facilitate new understanding about group process, systemic perspectives and relational dynamics (7, 12, 18, 19). Participants applied this learning to both client related work and professional contexts, such as providing confidence and skills to run therapeutic groups, or group supervision sessions (7).

RP also provided opportunities for reflection on the therapeutic process and the therapist's own feelings within the therapeutic relationship. This helped them to tolerate uncertainty, rather than acting on a pull to an expert position in which they have all the answers (12, 18).

Empathic understanding of the client

SP/SR studies. Taking part in SP/SR appeared to lead to a deeper understanding of the client position. The process of applying CBT techniques to participants' own personal circumstances provided an experience of being 'in the client's shoes' (2) through lived experience of using therapeutic techniques (11, 16, 17). This in turn led to the development of a greater sense of empathy for clients (2, 6, 10, 11, 16, 17). There appeared a deeper level of understanding of the possible therapeutic process, intrapsychic and practical difficulties for clients, such as a sense of exposure/ vulnerability, distress when confronted with negative beliefs and difficulty engaging in the process of psychological change, such as finding the time and motivation to complete homework (1, 2, 6, 10, 16). This in turn helped participants to develop a greater acceptance of 'where the client was at' and they adapted therapeutic strategies accordingly (1, 11).

Clinical psychology studies. Similarly within the CP literature, engagement in RP led to increased understanding and empathy for the client. Participants described a process of connecting with the client position, 'sit in the client's seat' (19) via their own experience of RP group process, through gaining an experience of distress and difficulty in examining themselves or practicing techniques on themselves (4, 19) or by sharing and exploring different perspectives, wonderings, and knowledge in relation to a case (3, 13). In addition, RP helped to increase reflection on process in therapy including transference and countertransference and the role of the therapist's own emotions and how these can inform the formulation/ understanding of client presenting difficulties (3, 9, 13). This resulted in new, compassionate understandings concerning the client and the function of their behaviour, leading to increased empathy (3, 5). Participants reported a perceived benefit to the

therapeutic relationship as a result (3, 9) and helped them to move forward in their therapeutic work (9) or helped the therapist to interact differently with the client which deepened the therapeutic relationship and improved client engagement in therapy (3).

Understanding the interplay between the personal and professional

SP/SR studies. Engaging in SP/SR helped participants to gain a greater understanding of their own thoughts, feelings and behaviours, and provided opportunity to formulate their own problems using the CBT model (2, 6, 10, 16, 17). This was seen as a helpful experience for some, particularly where self-reflections were written and could therefore be revisited and reflected upon further (17). For some, increased self-awareness led to self-acceptance, providing opportunities for self-care (10).

SP/SR also appeared to have a positive impact on personal and professional development. Participants were able to see how their own beliefs impact on their clinical practice (e.g., over-preparing for sessions, 10), and led to positive change in both their personal and professional lives (e.g., negotiating work load, 6; Managing worry better, 16; solving problems, 10; gaining more balance in life by completing an activity schedule, 11). Whilst others found aspects of applying SP/SR more challenging (e.g., completing behavioural experiments), they nonetheless learnt valuable lessons that could be applied professionally (2).

Clinical psychology studies. RP appeared to help participants gain a greater awareness of their thoughts and feelings which led to new insights about themselves (5, 7, 9, 18, 19). This increased self-awareness allowed them to accept their own fallibility (18, 19), the biases they may bring to their clinical work (19) and enabled greater choice in how they wished to respond to their emotions (5, 9). In addition, participants also became more aware about their impact on others, which helped them to feel they were making better decisions during clinical work (9).

The enhanced self-awareness experienced as a result of RP appeared to provide opportunity for emotions arising from their work to be processed and managed (5, 9, 12, 18, 19). This appeared to have a dual purpose; supporting therapist self-care and improving client work. Indeed, the ability to understand and manage emotions led to participants feeling more contained and better able to support clients (5). The studies suggest RP can help to transform therapist feelings of hopelessness, self-doubt and anxiety, leading to new solutions and positive emotions (5, 9).

In addition, RP was found to help participants to make sense of difficult emotions, preventing projection onto family members and maintaining boundaries between work and home life (5). Reflection therefore provides space to reflect on the reciprocal relationship between the personal and professional (12, 18). For some, there was disappointment that RP groups during training missed opportunities for reflection on the personal-professional interface (19). Nonetheless, RP was seen as an important aspect of their practice, part of professional identity as a psychologist (12, 18, 19) and essential for professional development (5, 12, 19), ensuring safe and ethical practice (7, 9, 12, 19).

Course-related challenges

SP/SR studies. It was difficult for some participants to make time for SP/SR, particularly given high workloads (10, 11, 15, 16). In some cases it was felt that the additional demands of SP/SR increased stress levels and therefore engagement dropped during busy periods (16). Others found the self-reflection component particularly difficult to make time for, but felt that this was an essential component in deriving personal and professional benefit (11). Some felt that the time constraints helped them to empathise with the client position, being under similar pressures when engaging in therapy (11).

There was acknowledgement that participants had differing preferences for frequency, duration and timing of group reflective sessions as part of SP/SR (16) and some completing online blogs encountered technical issues making engagement more challenging (8).

Uncertainty and confusion about the purpose of written reflection and course requirements, led to reduced motivation and engagement in the task for some (17). The compulsory nature and uncertainty regarding how subjective experience could be marked was also a barrier, leading reflection to become a forced academic exercise (15, 17). However, compulsory SP/SR was helpful for some in increasing motivation and participation (15). Ethical issues were raised concerning the lack of support and opportunity for de-briefing and further discussion, where trainee self-reflections were not followed up by course staff (17).

Clinical psychology studies. Similar themes arose from the CP literature, with time pressures, high workload and the demands of clinical training making it difficult to engage meaningfully in RP (12, 14, 19). Reflection not being valued by senior colleagues, and a subsequent lack of protected time and space, were seen as barriers to engaging in RP (12, 19). Timing of the RPG also proved to be a barrier for some. RPGs at the start of the day made it more challenging to

focus on the rest of the day's activities for some (14), whilst others felt that participating in RPGs at the end of the day/ week left them with a lack of closure and unresolved emotions (7).

The compulsory nature of RPGs in CP training was also seen as a barrier for some (7, 18) and led to participants opting out through non-participation (4, 18, 19), leading to uncomfortable 'anti-group' dynamics (4). Participants found it difficult to navigate the duality of relationships within RPGs during training. It was felt that boundaries became blurred and it was difficult to reflect on personal aspects with peers and group facilitators who could be colleagues, supervisors or line managers in the future (4, 12, 19). This led trainees to avoid talking about anything too personal and prevented them from being able to talk openly (4, 12, 19). This was particularly pronounced where there was a greater power differential, where course staff or local clinical psychologists were also group facilitators (19). Concerns about assessment led to pressure to perform, which inhibited reflection on vulnerabilities. Peer relationships and friendships within RPGs also led to concerns about confidentiality, as there was a sense that what happened in the group did not stay in the group (7).

Challenging and distressing experiences

SP/SR studies. The process of SP/SR was viewed as challenging, difficult and uncomfortable for some (6, 10), which led to a range of negative emotions such as frustration, deflation, anxiety, anger, irritation, boredom, impatience, and embarrassment (6, 10, 16). Several studies described how participants felt vulnerable and feared negative evaluation as a result of a lack of anonymity in self-disclosure (6, 10, 15 – 17). Participants were afraid of being seen as weak, flawed or incompetent and feared that confidentiality could be breached (16). Some participants reported censoring/ limiting their reflections based on who would be witness to them, such as course staff or peers (15, 17), which raises questions as to how meaningful the experience really was. Some participants feared there could be negative psychological effects as a consequence of engaging in SP/SR. These included overanalysing, rumination, becoming aware of concealed psychological issues, triggering something, or realising the severity of a pre-existing psychological problem (16).

Nonetheless, some participants were able to derive value and personal and professional growth from SP/SR, despite experiencing discomfort (10, 15). Those with previous experience of CBT as client or therapist did not appear to be as worried about negative outcomes (16). For some, the lack of anonymity helped to increase motivation, provided opportunity to learn from others (8, 15), and normalised participant experiences and difficulties within a supportive learning environment (2, 8).

Clinical psychology studies. Similar to the SP/SR literature, several studies reported that participants found RP challenging, and gave rise to difficult and sometimes overwhelming emotions (3 – 5, 7, 14, 19). RPGs can trigger personal resonances, a focus on incidents that have not gone well, and invite negative feedback from peers (19) which can lead to intense emotions which can lead to crying. Participants can then experience shame in response for expressing such strong emotions, and leave the group feeling uncontained (14, 19). As a result, participants engage in strategies to protect themselves such as stopping coming to the group, shutting down, talking about the mundane, and using humour to avoid difficult emotions (7). For some, reflection led to over-thinking and rumination which caused them to feel overwhelmed and stuck (5, 19). It was acknowledged that it can be difficult to know where reflection will lead and how to stop reflecting. However, others felt that this what part of the process and necessary for learning (19).

Similar to the SP/SR literature, participants reported concerns about how they may be perceived by others, which led them to question whether they were reflecting in the 'right' way (19), and to demonstrate how they were getting things right in their clinical practice (3). The possibility that they were getting things wrong was a source of discomfort for some participants, particularly the idea of being wrong in front of a group (3).

Similar to the SP/SR literature, there was a sense that the experience of distress could be valuable for personal and professional development. RPGs acted as a magnifying glass for other difficult experiences to be expressed, providing opportunity to be authentic in voicing discontent (14). Participants also valued the opportunity to notice and tolerate discomfort and saw this as part of the group process, which also led to increased self-awareness (7).

Group facilitators also saw distress as an inherent part of group process and believed that those who were willing to engage with their distress benefited from a deeper level of self-awareness through emotional learning (4). However, some facilitators felt anxious that the group could negatively impact trainees' emotional wellbeing, which led them to monitor levels of distress closely.

Processes in reflective practice groups

This theme relates only to studies exploring experiences of RPGs in CP training. Several subthemes were identified and pertained to group dynamics and processes.

Defining the purpose of the group. Some participants felt uncertain about the purpose of the RPG, leading to anxiety and frustration (7, 14, 18). Group members sought to negotiate and clarify

their aims, however this process was not without complication given differing expectations. Some participants expressed disappointment due to unmet expectations (18), and lack of clear aims and boundaries (14), whilst others accepted that the aims were unclear and viewed the group as an unstructured space (7). For some, the sense making process concerning the purpose of the group continued after training (7, 14) with possible benefits only realised post-qualification (7, 12, 14, 18). Meanwhile, one group appeared to successfully agree aims, a structure and clear roles and monitored adherence to these throughout each session to maintain focus (13).

Group facilitator findings appeared to mirror diverging trainee perspectives. Some believed that the unstructured nature of the RPG allowed trainees greater freedom in the range of possible uses and learning outcomes, whilst others felt that this could be perceived as intimidating for some trainees (4).

Developing sufficient safety. There was a desire for the group to feel like a safe space (3, 7, 13, 18, 19) but acknowledgement that there are degrees of safety, and therefore a need to feel safe enough in order to share (3, 4, 13). A lack of perceived safety led to avoidance of sharing personal information (7, 13, 19).

There was a sense that risk is inherent within the RPG (3, 4, 13, 19) and whilst the perception of safety does not negate risk, it allowed participants to tolerate feeling exposed, increased trust and allowed for greater vulnerability when sharing personal reflections (3, 13, 19). A process of ‘testing out the water’, sharing and monitoring group response, helped to build trust and the likelihood of sharing more where the response from group members was positive (13, 18, 19).

Two studies described how too much safety can result from group members staying within their comfort zones, keeping reflections superficial, which compromised depth of reflection and opportunity for challenge (12, 18). Finding a balance between being honest about differing perspectives whilst maintaining positive relationships and trust within the group was seen as important (3, 13). Sensitively sharing different viewpoints helped to prevent participants from feeling criticised and opened up new learning (3, 13). On the contrary, where differences became a source of conflict, this had a negative impact on the group leading to resistance, domination, distancing and splitting off (18). Feeling that conflict wasn’t being safely managed led to distress, loss of trust and avoidance of controversial topics (7, 18).

Role of the facilitator. Trainees described mixed experiences of RPG facilitators. Some found it helpful for the facilitator to be external to the course (19), whilst others struggled to develop a connection with the external facilitator. This led to participants feeling less able to speak freely (14).

The role of facilitator was experienced as important in the development of the group for some (7, 18). Desirable facilitator qualities were seen as nurturing, protecting, strong and warm (14, 18), with participants learning facilitation skills to use in their own practice (14). Unhelpful facilitator qualities were described as critical, absent and unable to protect (18). When facilitators remained quiet and weren't proactive in offering support, guidance or addressing conflict, this led to uncomfortable dynamics and trainees found it hard to contribute as a result (7, 14).

Binks and colleagues (2013) reported that facilitators experienced intense emotional reactions both during and after RPG sessions. However they also felt privileged to bear witness to trainee personal and professional development. Facilitators reported feeling aware of trainee critical evaluation of their competence, and questioned their own competency. They found supervision helpful in containing and managing their emotions and helping to build confidence in their skills.

Discussion

This systematic review aimed to identify and evaluate qualitative studies which explored experiences of RP within CP and CBT training and practice. Nineteen studies were identified and the findings were critically appraised and synthesised. The combined results represented 245 participants. A range of RP methods were explored including RPGs, self-reflection, reflection with supervisors or peers, and SP/SR. This review provides new insights into the impact of these methods on personal and professional development and factors which facilitate or hinder engagement in RP. Findings will be discussed in relation to the research aims.

Overview of critical appraisal

The findings of the present review should be interpreted according to the quality appraisal conducted. Two critical appraisal tools were used; the CASP which primarily assesses methodological quality, and a bespoke tool was developed to determine the richness, value and transferability of the research. Overall, the CASP indicated the quality of studies was good, however 10 out of 19 studies were rated as 'thin'. This disparity indicates that whilst the methodological quality may have been good, the extent to which findings provided in-depth descriptions of participant experiences and explanatory insights which could be transferred to alternative populations was limited.

Overall, the majority of studies demonstrated clear aims and an appropriate rationale for using a qualitative methodology. In most studies, participants recruited were appropriate to the aims of the research. Most studies adequately described data collection procedures and some discussed how interview schedules were created. Most studies helpfully outlined their contribution to existing knowledge and suggested ideas for future research and recommendations for practice.

There were some consistent limitations across studies. A lack of researcher reflexivity reduced the confirmability of findings. Very few studies explicitly reflected upon researcher biases and a minority of studies discussed ways of accounting for bias, such as bracketing interviews or reflective journals. There was also a wide degree of variability between studies in reporting the relationship between researcher and participants, leading to uncertainty regarding issues of power and the potential for positive response bias, particularly where researchers may be course tutors recruiting trainees. The representativeness of samples is also in question for some studies due to non-reporting of response rates and a lack of information about reasons for non-participation. In addition, many studies did not clearly describe the analysis process, making it difficult to determine fidelity to the planned analysis procedure, whilst issues of sample-sufficiency were rarely attended to.

It should be noted that papers of higher quality were often unpublished theses. Word limits imposed by journals possibly compromised the level of detail which could be included. Therefore, absence of information concerning the quality of papers may not equate to these factors being missing in practice.

Overview of findings

What are the perceived positive and negative outcomes of reflective practice?

A number of common themes were identified across studies, pertaining to different forms of RP within both CP and CBT professions. In line with findings from McGillivray and colleagues' (2015) review, RP was seen as beneficial in enhancing practice by developing knowledge and competence in therapeutic skills. SP/SR was seen to lead to a deeper understanding of the cognitive model which generated greater belief in the efficacy of CBT. Both SP/SR and RP in CP appeared to support participants to flexibly adapt therapeutic skills to the needs of the client, rather than following strict protocols and led to a greater awareness of the importance of the therapeutic relationship. This supports the proposed benefits of Bennett-Levy's (2006) DPR model and prior theorists (Ronnestad & Skovholt, 2003; Schön, 1983; Skovholt et al., 1997), hypothesising that RP is important in the

development of therapist expertise. Therapist self-reflection was seen as an important way of reflecting on their own emotions and what they bring to the therapeutic relationship. Within the CP literature, RPGs helped participants to gain a greater understanding of group process, which was perceived to support skills in facilitating therapeutic and supervision groups.

Engagement in all forms of RP across professions was thought to help participants develop a greater level of empathy for their clients. This was through a process of understanding what it is like to sit in the client's shoes by either applying therapeutic techniques to the self or gaining an experience of distress, difficulty and vulnerability in exploring the self. This helped participants to appreciate how challenging therapy can be and adapt therapeutic strategies accordingly. Within CP, engaging in RP with others helped to illuminate different perspectives on a particular case, and supported more compassionate understandings about client behaviour which led to increased empathy for the client. In turn, this was perceived to improve the quality of the therapeutic relationship and reduce stuckness in therapy.

All forms of RP appeared to support participants to gain a greater understanding of their own thoughts, feelings and behaviours, and the impact of their own beliefs on their clinical work. This provided opportunity to learn ways of managing their own difficulties, creating space to choose how to respond rather than reacting subconsciously, and served as a reminder regarding the importance of self-care. The CP literature further highlighted the interplay between the personal and professional, particularly how RP provided opportunity to process and manage difficult emotions arising from client work. This enabled participants to feel more contained and they perceived this to have a positive impact on their clinical work and also their own wellbeing and self-care. Therefore, RP was perceived to make an important contribution to safe practice and professional development.

Across SP/SR and CP studies, RP often gave rise to difficult and sometimes overwhelming emotions. Participants felt vulnerable and afraid of judgement from others, leading to the experience of shame. This led some participants to engage in protective strategies such as disengaging, limiting the depth of their reflections or using humour to avoid difficult emotions. Participants from both groups also described how reflection could lead to rumination or over-analysis of thoughts and feelings, leading them to feel overwhelmed and stuck. Despite finding RP challenging and distressing at times, both groups of studies reported that participants were able to derive value from these experiences in the form of personal and professional growth, through increased self-awareness and ability to notice

and tolerate distress. Reflection on one's own vulnerabilities is considered an essential component of training and professional practice in CP (Lavender, 2003).

What factors appear to facilitate or hinder perceived benefits?

Several themes pertaining to experiences of group processes were derived from studies exploring RPGs during CP training. Aspects of these processes appeared to either facilitate or hinder engagement in RP.

The process of trying to define the purpose of the group was experienced as challenging for some. Uncertainty regarding the aims of the group led to anxiety and frustration. Differing expectations of group members made it difficult to agree on mutual aims and led to continued confusion and disappointment due to unmet expectations. Whilst some perceived the unstructured space to allow greater opportunity for learning, others perceived it to be threatening. This ultimately acted as a barrier to meaningful engagement for some participants.

A degree of safety was deemed necessary for meaningful reflection to take place, whilst a lack of safety inhibited the disclosure of personal information. Developing sufficient safety was seen to help participants to tolerate the risk inherent in sharing vulnerable aspects of the self. There was acknowledgement that gaining a balance between conflict and safety was important. Sharing differing viewpoints was seen as helpful in generating new ideas, however when differences led to conflict which was not safely managed, group members felt distressed and therefore disengaged or avoided contentious topics.

The role of the facilitator was seen as an important factor in encouraging or hindering engagement in RP. Supervisors who were perceived as nurturing, warm and protecting helped engagement, whereas those who were perceived to be critical, absent and unable to protect led to discomfort and reluctance to contribute. There were mixed opinions concerning facilitation which was external or internal to the course in relation to how comfortable trainees felt about opening up.

Course-related factors for those in both CBT and CP training included finding it difficult to make time to reflect amidst course pressures, competing demands and time constraints. This is in line with findings from Mann and colleagues' (2009) review which highlighted time pressures as a significant barrier to RP amongst healthcare professionals. The compulsory nature of RP was also a barrier for some, making reflection feel forced. This led to disengagement, superficial engagement or hostility which created uncomfortable group dynamics. Being assessed and uncertainty about

assessment criteria hindered reflection on vulnerabilities and motivation to engage. Ethical issues were raised including lack of follow-up support from course staff (in the CBT SP/SR studies) and blurred boundaries due to dual relationships within RPGs in CP training, which led some to censor reflections and avoid discussing personal issues.

Strengths and limitations

This is the first systematic review that has integrated findings from published and grey literature across CP and CBT training and practice to gain a greater understanding of the experience of engaging in RP. Benefits and negative experiences associated with RP were identified alongside some of the processes that facilitate and hinder engagement in RP. A rigorous systematic search was completed, and a validated tool was used to systematically critique each study, alongside a bespoke tool to assess the richness of the data. The reliability and credibility of the critical appraisal was bolstered by independent raters.

The variety of methods of RP included in this review make it difficult to tease out the specific aspects of RP associated with particular benefits/ difficulties. Including studies from CBT and CP professions, and including both qualified therapists and trainees, also increased heterogeneity due to differences in training background, professional requirements, developmental stage, range of reflective practice methods and time allocated for RP due to being in training versus busy clinical contexts in qualified roles. However, care was taken to preserve contextual understanding and useful insights into the shared benefits and challenges of RP were highlighted.

Although the results are drawn from a large sample, the findings regarding group process in CP training are related to eight studies only. In addition, the final themes were not represented by all of the studies (see Appendix E). This was likely due to the wide variety of studies included, with differing research aims. It was necessary to keep inclusion criteria broad given the lack of research in this area.

Studies were mainly conducted in the UK and Ireland, with the minority conducted in Australia and New Zealand. It is therefore not known to what extent findings can be transferred to other cultures. However, as the results indicate a great deal of shared experience across a range of studies, this goes some way to increase the transferability of findings to different settings.

Another limitation is that the analysis was conducted solely by the researcher. Care was taken to bracket own assumptions and remain reflexive throughout. Results were discussed with a

supervisor familiar with the literature, who was able to comment on the goodness of fit of the themes to the data.

Implications for training, practice and research

The findings point to the perceived value of RP as a tool for practitioners to enhance clinical practice and their own self-care. There is growing evidence regarding the link between staff well-being and client outcomes (Hall et al., 2016). In often challenging and busy NHS environments, it is important for senior managers and supervisors to recognise the value of RP and support allocation of protected time for such purposes.

It is recommended that training courses put support in place, alongside follow up procedures, given evidence to suggest RP can lead to distress. The fact that it has potential to be a valuable learning experience does not guarantee it will be for every person. It is possible that experiences of RP could be harmful for some individuals (Knight et al., 2010; Binks et al., 2013). It would be helpful for courses to assign particular members of staff who are responsible for the oversight of RP course components and trainee wellbeing. Regular check-ins and reviews regarding how trainees are finding RP may be helpful, alongside giving trainees explicit permission to seek out these members of staff to de-brief following particularly challenging or distressing sessions. Further research should seek to clarify whether particular methods of RP are contraindicated for certain individuals in certain contexts.

Given RP is often mandatory during training and has the potential for distress, choice should be given to trainees regarding methods of reflection (Lavender, 2003). Youngson and Hughes (2009) caution that ‘easier’ methods could be chosen, limiting the potential benefits to personal and professional development. A compromise could be to provide opportunity to try out several different methods of RP during training.

Lack of clarity regarding the aims of RP led to anxiety and reduced meaningful engagement and depth of reflection. Courses should therefore clearly communicate the aims and demonstrate the philosophy of RP and personal learning (Smith et al., 2009). Courses should consider the potential counterproductive effects of assessment of RP, including reduction in intrinsic motivation and avoidance of reflection on personal vulnerabilities.

Within RPGs, the development of appropriate boundaries and safety were seen as challenging to achieve, yet important. Meaningful contracting processes at the start of the group may support in this endeavour. In addition, the role of the facilitator was seen as important in developing a

safe and supportive environment. Consideration should be given regarding whether external or internal facilitators may be best placed to foster a facilitative environment for trainees.

Further research is needed to explore experiences of specific and well described methods of RP in order to increase opportunities for replication of findings and nuanced perspectives regarding the benefits and negative aspects of specific practices. The findings in this review are based on the perceptions of therapists and facilitators engaging in RP. The extent to which this impacts therapist behaviour, clinical competence, the therapeutic relationship and clinical outcomes is uncertain. Whilst there is some quantitative literature regarding outcomes of SP/SR (McGillivray et al., 2015) there remains a gap within the CP literature (Lilienfeld & Basterfield, 2020). Quantitative research is therefore needed to investigate measurable outcomes of RP and to build an evidence-base to inform and justify its contribution to training programmes.

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Oxford Doctoral Course in Clinical Psychology

PAPER B

EXPLORING ISSUES OF CULTURE AND DIFFERENCE IN THE SUPERVISORY RELATIONSHIP: A GROUNDED THEORY ANALYSIS

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A thesis submitted in partial fulfilment of the requirements of the degree of Doctor of Clinical Psychology, validated by the University of Oxford

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Exploring Issues of Culture and Difference in the Supervisory Relationship: A Grounded Theory Analysis

Abstract

Background

Clinical supervision is thought to be critical to the development of cultural competence. There are several models of culturally competent supervision, however little is known about how this translates in practice. There is some evidence to suggest discrepancies between supervisor and supervisee attitudes and behaviours. There is very little research into the dyadic processes involved, with most research conducted in counselling professions in the United States.

Objectives

The present study aims to explore how supervisory dyads' perceive and explore issues of culture and difference during clinical supervision, within doctoral clinical psychology training in the UK.

Setting and participants

Five trainee clinical psychologists from one clinical psychology training programme were recruited alongside their qualified clinical psychologist supervisors (N = 5), who had provided a clinical placement.

Methods

Participants attended one individual semi-structured interview. Interviews were audio-recorded and transcribed verbatim. A constructivist grounded theory approach was used to analyse the data.

Results

The resulting model highlighted several perceptions regarding the relevance, importance and risk associated with exploring culture and difference, the need for safety within the supervisory relationship and processes involved in initiating conversation and minimising risk. Where issues of culture and difference were discussed, dyads perceived this to benefit their clinical work.

Conclusions

The model provides new insights into processes involved in exploring culture and difference within the supervisory relationship. Several implications for training, practice and future research are suggested.

Key words: grounded theory, culture, difference, supervisory relationship, clinical psychology

Public significance statement

This grounded theory study highlights how issues of culture and difference are perceived and explored within the supervisory relationship during doctoral clinical psychology training. The resulting theoretical model identifies several processes involved, and points to recommendations for training and practice to support supervisors and supervisees to further develop cultural competency within their supervisory practice.

Proposed journal: Training and Education in Professional Psychology (see Appendix H for manuscript guidelines.

Exploring Issues of Culture and Difference in the Supervisory Relationship: A Grounded Theory Analysis

Clinical supervision can be defined as a working alliance between supervisor and supervisee which aims to increase supervisee competence. Supporting supervisee reflection and providing feedback, guidance and opportunity for professional development are essential components (Proctor & Inskipp, 1988). During training, supervision is "a means of transmitting the skills, knowledge and attitudes of a particular profession to the next generation" (Bernard & Goodyear, 1998, p. 2). Supervisors evaluate skills and competence, acting as a gatekeeper for the profession (Bernard & Goodyear, 2004).

The supervisory relationship (SR) is thought to be fundamental to effective supervision (Beinart, 2014; Watkins, 2014). The development of a safe base has been shown to encourage supervisee reflection on their practice, the personal impact of their work, and their learning needs (Beinart & Clohessy, 2017). Safety in the SR has been shown to be an essential pre-condition for other aspects of the SR to take place effectively (e.g., supervisor providing a role model, reflective education and formative feedback), leading to supervisee professional development (Palomo et al., 2010; Pearce et al., 2013).

One function of the SR is to enhance the supervisee's cultural competence. Culture can be defined as a:

> "dynamic and active process of constructing shared meaning, as represented by shared ideas, beliefs, attitudes, values, norms, practices, language, spirituality, and symbols, with acknowledgement and consideration of positions of power, privilege, and oppression" (Vargas et al., 2008, p. 122).

Inherent in this definition is the assertion that all humans are cultural beings. Burnham (2012) developed the acronym *social GGRRAAACCEEESSS* to describe key aspects of

cultural diversity including gender, geography, race, religion, age, ability, appearance, culture, class, ethnicity, education, employment, sexuality, sexual orientation and spirituality. These areas are introduced in order to support practitioners in generating and integrating an awareness of a range of differences within their practice. Burnham's model has since been incorporated into clinical psychology and supervision training programmes (Divac & Heaphy, 2005; Nolte & Nel, 2012), and used as a tool for exploring intersectionality and developing therapist self-reflexivity (Butler, 2015; Totsuka, 2014). (See Appendix I - importance of developing cultural competence).

Cultural Competency in Clinical Psychology Training and Practice

Cultural competency has been specified as one of the competences trainee clinical psychologists need to develop throughout their training (British Psychological Society [BPS], 2019a). Training courses are required to integrate issues concerning the influences of society, culture and other areas of diversity throughout the academic programme. In addition, trainee clinical psychologists must work with service users from a range of backgrounds, reflecting the diversity in the population in which they are working (BPS, 2019a).

Continuing Professional Development Guidelines (BPS, 2010) state that all psychologists must continue to develop cultural competencies, actively promoting a culture of equality and universal human rights and delivering good psychological outcomes for disempowered people groups. Guidelines for psychologists working with gender, sexuality and relationship diversity (BPS, 2019b) further emphasise the importance of including such issues in education, training and personal development activities.

Models of Culturally Competent Supervision

Culturally competent supervision is thought to be key to the development of culturally competent clinical practice (Helms & Cook, 1999). There are several models which describe the main processes and factors involved.

A framework for culturally competent supervision was developed by Falender and Shafranske (2004). They outline six competencies; (a) supervisors should possess a working knowledge of the factors affecting worldview, (b) demonstrate skills in multimodal assessment of the cultural competence of supervisees, (c) continued awareness of their own identity and seek to gain an understanding of areas of supervisee and client diversity, (d) ability to develop multicultural case formulations, (e) model respect, openness and curiosity, and (f) take responsibility in initiating discussions about diversity during supervision.

A broader framework, *multicultural orientation* (MCO; Owen, 2013), has been developed which emphasises the importance of therapist attitudes and values about culture and their pertinence in the therapeutic relationship and clinical work. The MCO framework has recently been extended to provide a model for supervision (Watkins et al., 2019), in which the supervisor is responsible for modelling MCO within the SR. The model consists of three components; (a) cultural humility (supervisor openness and willingness to reflect on and understand their own cultural identity and that of their supervisees), (b) cultural comfort (supervisors working through their fear and discomfort to be able to remain calm and open in supervision) and (c) cultural opportunities (taking advantage of opportunities for discussing cultural issues and modelling how to discuss such issues for supervisee learning and implementation within clinical practice).

Jones and Branco (2020) added to this work by highlighting the importance of *broaching* in the demonstration of cultural humility. Broaching is where the supervisor initiates and engages in discussions regarding culture and difference in the supervisor-

supervisee relationship. Benefits of broaching include strengthened SRs, increased supervisee disclosure and improved self-awareness and therapeutic skills (case conceptualisation, discussion of culture and enhanced collaboration in the therapeutic relationship) (Ancis & Marshall, 2010; Jones et al., 2019; Nilsson & Duan, 2007).

A criticism of the aforementioned models is the emphasis on supervisor competencies, neglecting supervisee responsibility to also engage in reflective conversations with their supervisor. Ancis and Ladany's (2001) framework places greater emphasis on mutual responsibilities within the supervisory dyad. They identify five domains involved in culturally competent supervision: personal development (supervisor and supervisee self-exploration of personal values, biases and limitations), conceptualisation (developing a contextual understanding of client presenting difficulties, and the consideration of over and under reliance of cultural explanations), intervention (the use of flexible and culturally sensitive therapeutic interventions), process (openness and respect within the SR to facilitate the exploration of issues of power, diversity and difference), and evaluation (the assessment of supervisee competence and the supervisor's responsibility to provide appropriate opportunities for training).

Although the models discussed provide important insights into cultural competency frameworks, they are largely theoretical and offer little practical advice regarding how discussions about culture and difference can be facilitated during supervision. Patel (2004) provides specific examples regarding how these issues could be explored; (a) Supervisors and supervisees examining their own values and beliefs, (b) reflecting on and discussing their own ethnic identity development, (c) seeking further training to increase cultural knowledge, (d) seeking out and consulting BAME community groups or colleagues, (e) reflecting on their own experiences of inequality, privilege and marginalisation within their personal and professional lives, (f) supervisors and supervisees may need to identify and draw upon

support networks when reflecting on the aforementioned issues. Despite the focus on ethnicity and race, these recommendations could be applied to various other aspects of diversity.

Research Findings

The importance of culturally competent supervision has been demonstrated in the literature. Qualitative studies of predominantly supervisee experiences have found that a safe and trusting SR helps to facilitate discussion about difference. This is associated with perceived improvements in supervisee awareness of cultural issues, multicultural case conceptualisation and cultural sensitivity during clinical work, which was perceived to positively impact therapeutic outcome (Burkard et al., 2006; Tohidian & Quek, 2017; Toporek et al., 2004).

There is limited research concerning culture and difference within the supervisory relationship. It is thought that supervisory dyads often act as if culturally blind, only dealing with difference and diversity as and when it arises or becomes a problem (Beinart & Clohessy, 2017). Supervisors believe they introduce discussion of diversity and difference, however supervisees report that they are the ones who bring it up and their initiative is not always well received (Constantine & Sue, 2007; Hansen et al., 2006; Jernigan et al., 2010; Walker et al., 2007). This is associated with supervisee self-doubt and a sense of incompetence (Jernigan et al., 2010). Supervisor perspectives have received less attention in the literature. It is thought that generational differences or dominance of the supervisors' own cultural values may prevent discussion and exploration (Beinart & Clohessy, 2017). Alternatively, Patel (2004) hypothesises that supervisors may experience the request to discuss matters of diversity as an extra demand placed on them within a context of increased responsibility to provide effective supervision.

An auto-ethnographic study of one supervisory dyad during doctoral counselling training (King & Jones, 2019) highlighted the vulnerability involved in self-disclosure for both supervisor and supervisee, leading to hesitance in discussing potentially taboo subjects regarding race difference. The supervisor initially asked broad, open-ended questions, followed by more direct questions concerning their difference. It was perceived helpful for the supervisor to broach these topics early in the SR. In line with previous research, perceived benefits included a strengthened supervisory working alliance (Fuertes et al., 2002; Phillips et al., 2017) and increased supervisee self-disclosure (Hays & Chang, 2003; White-Davis et al., 2016). This work provides a useful insight into dyadic processes, however given the findings only relate to one dyad, it is not known to what extent these finding transfer to different populations.

Rationale for Present Study

Most studies within the supervision field have solely focused on either supervisor or supervisee perspectives. Given supervision is a joint exercise and discrepancies have been found between supervisee and supervisor attitudes and behaviours concerning culture and difference during supervision, a close examination of discussion of cultural issues in supervisory dyads is required.

Issues of race and ethnicity (Marshall & Wieling, 2003; Lawless et al., 2001; Gardner, 2002; Burkard et al., 2006; Constantine & Sue, 2007; Hernandez et al., 2009; White-Davis et al., 2016; King & Jones, 2019; Tohidian & Quek, 2017) have been most researched, however difference such as gender, sexual orientation, religion, spirituality, social class, education and ability/ disability have received little attention. Therefore, the present study will seek to explore perceptions and discussions of culture and difference broadly. In addition, most of the literature has been carried out in the USA, within counselling and counselling psychology

professions and therefore it is not known whether findings generalise to UK based clinical psychology SRs. Given the inclusion of cultural competence in the accreditation of clinical psychology training courses and the increasing diversity within the UK population, it will be important to explore clinical psychology trainee and supervisor perspectives in the UK.

Study Aim

The present study aims to explore the subjective experiences of supervisory dyads of discussing culture and difference during supervision, within doctoral clinical psychology training. A grounded theory approach was employed to answer the following research question: how are issues of culture and difference perceived and explored within the supervisory relationship?

Methodology

Study Design

The present study employed a qualitative, dyadic design utilising a Constructivist Grounded Theory approach (CGT; Charmaz, 2014). This was considered to be the most appropriate method due to the exploration of social processes within the supervisory relationship. A CGT approach offers a method of analysing and mapping such social processes, taking into account how the phenomena interact and identifying consequences (Charmaz, 2014; Willig, 2008). The subjective experience of the individual is privileged whilst acknowledging that the analysis and resulting theory is a constructed interpretation influenced by the researcher's preconceptions. This is managed through researcher reflexivity (Charmaz, 2014). Further details regarding the rationale for using CGT are provided in Appendix J.

Study Context

Supervisees were recruited from one clinical psychology training programme in the South of England. Clinical psychologist supervisors were employed by several NHS Trusts affiliated with the course, from a range of specialisms, providing either a 6 or 12 month placement to the recruited supervisees.

Ethical Considerations

The study was approved initially by the Oxford Doctoral Course in Clinical Psychology and ethical approval was granted from Clinical Trials and Research Governance (CTRG) at the University of Oxford. Approvals were also obtained from the Health Research Authority and the research and development departments of participating NHS Trusts. The research was sponsored by the University of Oxford CTRG. Evidence of approvals and sponsorship are provided in Appendices K – O.

Fully informed consent was gained and participants were informed of their right to withdraw. Participants were made aware about confidentiality and limits to confidentiality. To ensure anonymity, participant names and personally identifiable information were removed from interview transcripts and participant IDs were used in subsequent write up. There was potential for some participants to experience distress should they recount negative supervisory experiences. It was felt that the researcher, being a trainee clinical psychologist, had the appropriate skills to contain any distress and a debriefing sheet was provided which signposted participants to sources of support (Appendix P).

Participant Selection

Convenience sampling was used to recruit supervisees along with their supervisors. Inclusion and exclusion criteria were developed to ensure the most appropriate participants were recruited (Table 1).

Table 1

Eligibility Criteria

Inclusion Criteria	Exclusion Criteria
• Trainee Clinical Psychologists in any stage of their training, and those within their first year post-qualification who were asked to reflect on supervision during their final placement • Qualified Clinical Psychologists providing clinical supervision to the recruited supervisees, or who provided supervision to the recruited supervisees during their final year of training • Ability to recall instances where issues of culture and difference were relevant during supervision with their supervisor/ supervisee • Both supervisors and supervisees must agree to be interviewed about their experiences	• Given the researcher was a trainee clinical psychologist recruiting participants from their own clinical psychology training course, individuals who were in the researcher's cohort (2017), or who had a personal relationship with the researcher, were not included in the study.

The Course Director from the clinical psychology training programme was contacted with information about the study, alongside inclusion/ exclusion criteria (Appendix Q). Course staff disseminated this information to first and second year trainees. Permission was granted from the course for the researcher to contact those within their first year post-qualification. A total of 59 potential participants were invited to contact the researcher for further information, if interested in the study. The researcher met with 42 (first and second year) trainee clinical psychologists to discuss the project face-to-face. An information sheet was sent to those interested in taking part in the study (Appendix R). Supervisees who opted in (N = 10) were asked to contact their supervisor to let them know about the study and request their participation. An invitation letter was provided for supervisors which invited

them to make contact with the researcher if they were interested in participating in the study (Appendix S). Once both supervisee and supervisor had opted in, individual semi-structured interviews were arranged. In total, five supervisory pairs opted in to the study, therefore ten participants were recruited and interviewed in total. Reasons for non-participation included not being able to commit time to the study, supervisees not hearing back from their supervisor, and not being able to recall instances in which culture and difference were relevant during supervision.

Data Collection

Participants attended one individual semi-structured interview with the researcher (CM). Informed consent was gained at the start of the interview (Appendix T) and a demographics form was subsequently completed (Appendix U). The first interview was conducted face-to-face at a location convenient for the participant (workplace), however all subsequent interviews took place over video-conferencing software due to national lockdown because of the Covid-19 pandemic. Participants were given £10 to thank them for their time.

The interview schedule was developed according to CGT principles and in line with 'intensive interviewing' technique (Charmaz, 2014). An initial draft was developed and checked with a clinical psychologist and trainee clinical psychologist, who weren't eligible to participate in the study. One modification was made as a result; to make it clearer which questions pertained to general experience in SRs versus the experience within the specific dyads included in the study. Questions were initially open-ended and exploratory and prompts were used to elicit greater depth of understanding. Questions were informed by previous literature and gaps in the evidence base. The schedule was followed flexibly to allow participants to set the tone and pace and also to allow unexpected information to emerge. In line with theoretical sampling, theoretical directions were pursued by focusing on

particular questions or modifying the interview schedule by adding questions to pursue central ideas that had emerged in previous interviews, deemed theoretically compelling (Charmaz, 2014; see Appendix V).

Interviews lasted between 44 and 63 minutes, were audio-recorded on an encrypted audio-recorder and transcribed verbatim in Microsoft Word by CM. A reflective journal and memos were kept to record ideas and emerging themes in order to direct lines of enquiry in subsequent interviews (Appendix W and X).

Data Analysis

Data analysis followed the methodological principles of CGT (Charmaz, 2014). Interviews were listened to, transcribed and reflected on to generate initial analytic ideas between each interview, and to ensure full immersion in the data. The analytic process consisted of three main stages of coding: initial, focused and theoretical (see Appendix Y for detailed description). The resulting theoretical model was derived directly from the data (Appendix Z).

Throughout the analytic process, theoretical memo-writing aided researcher reflection and exploration of the data and allowed tentative interpretations to be made. This helped the researcher to remain grounded in the data, supported the process of exploring patterns within codes and categories, and guided the development of the theoretical model (Appendix X).

Given the relatively small sample size, it is likely that gathering further data could have revealed new information, however, after the tenth interview was analysed, it was agreed in supervision and in consultation with a grounded theory specialist that theoretical categories were robust enough to account for patterns within the data (Dey, 1999). As there weren't clear distinctions between dyads, the resulting theoretical model focused on between group (supervisor and supervisee) similarities and differences.

Reflexivity

CGT acknowledges researcher perspectives, privileges and position as an inherent part of the research process, which cannot be erased or put to one side (Charmaz, 2014). For this reason, it is essential for researchers to examine their own biases, beliefs and values to gain greater understanding of their influence on the analysis.

A bracketing interview (Ahern, 1999) prior to the formal collection of data was conducted with a peer in order to reflect on the researcher's personal and professional beliefs and assumptions (Appendix AA). Although it is not possible to fully bracket off bias, this process helped to increase awareness of how aspects of personal experience may shape the research process. In addition, a reflective journal was kept by the researcher to record the impact of both personal and professional influences on the study. Supervision was also essential in reviewing coding and exploring alternative perspectives.

Credibility

To enhance the credibility of findings, the researcher's supervisors and a grounded theory specialist reviewed excerpts of line-by-line and focused codes from four transcripts. Any discrepancies were discussed and codes were refined. This process generally validated the researcher's coding practices and no systematic changes were made. Consultation was provided by a grounded theory specialist to support the construction of categories and the development of the theoretical model. The resultant model was considered to be adequately supported by the data.

Results

Participant Characteristics

Five supervisory dyads consented to participate in the study and were predominantly female (8 females, 2 males). The majority identified as White British (N = 7), whilst three people identified as White UK (N = 1), Mixed British (N = 1), and Chinese (N = 1). Of the five supervisees, three were newly qualified clinical psychologists with 4 – 6 months post-qualification experience, and two supervisees were in their second year of training. Those who were newly qualified were reflecting on their relationship with their specialist placement supervisor during the third year of their training. One dyad remained in their SR post-qualification. The second year trainees were reflecting on their relationship with a previous placement supervisor during the second year of training. The five supervisors had been qualified for 10 to 23 years (M = 14.6, SD = 5.22). Length of SR between dyads ranged from 6 to 19 months (M = 11 months, SD = 5.39). Six participants described their therapeutic orientation to be cognitive behavioural therapy (CBT) or third wave CBT, with the remaining participants describing their orientation as attachment-focused (N = 1), systemic (N = 1), biopsychosocial/ CBT/ integrative (N = 1) or stating they don't feel oriented to any particular theoretical orientation (N = 1).

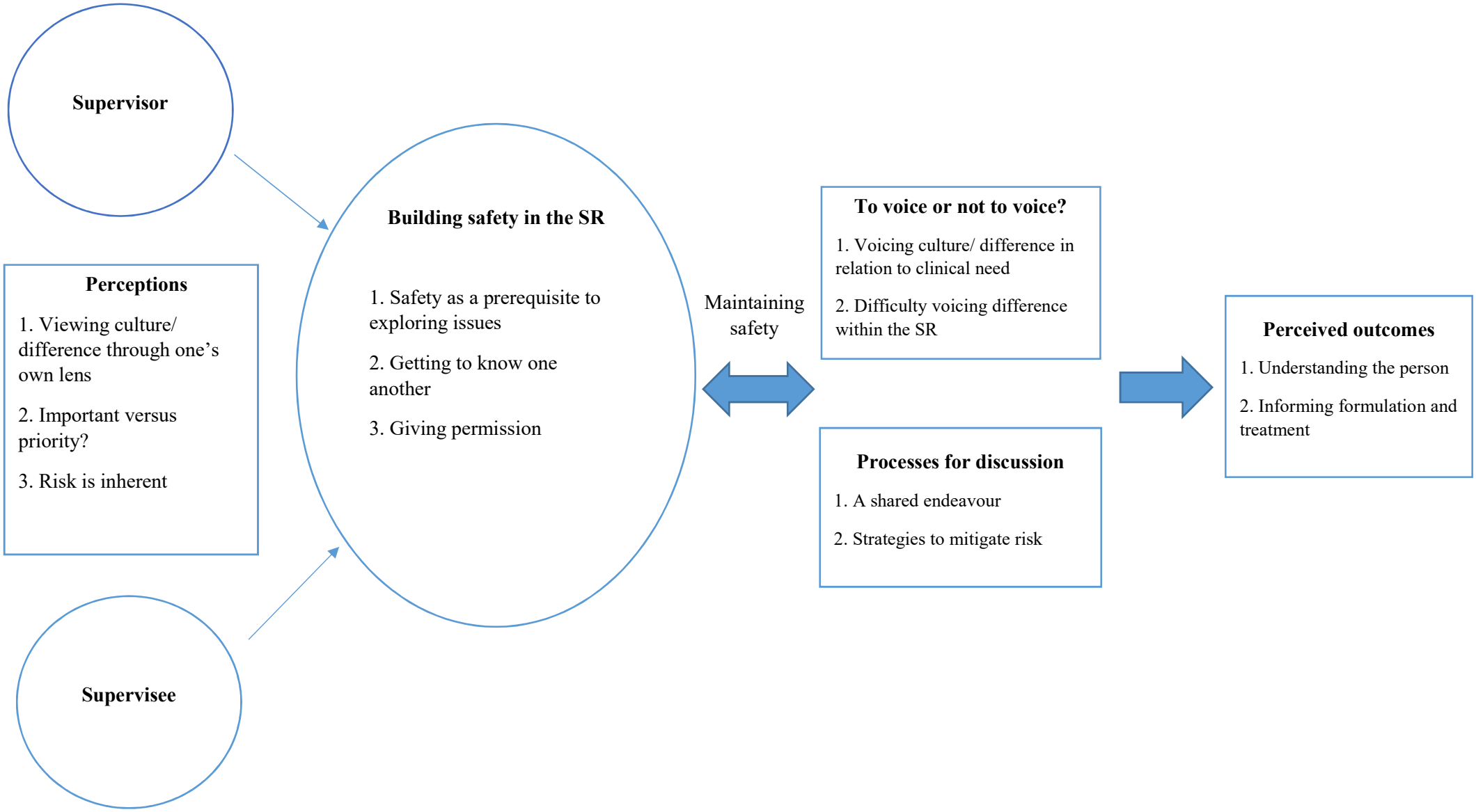
Theoretical Model

A theoretical model was developed (Figure 1) to describe how issues of culture and difference are perceived and explored within the SR. Supervisees and supervisors bring their own ideas about what culture/ difference is, and these issues are seen through their own lenses based on their background, interests, familial and wider societal norms, and service context. They weigh up the importance of these issues with what they believe should be prioritised in supervision. Both supervisors and supervisees perceive risk to be inherent in discussions of culture/ difference. This can act as a barrier if sufficient safety is not developed in the SR.

Developing a safe SR is the foundation for being able to take risks and discuss issues of culture/ difference. The process of developing safety involves getting to know one another, connecting and the supervisor self-disclosing and modelling that it is OK to discuss issues of culture and difference. In doing so, the power dynamic which may make it difficult for supervisees to take risks, becomes more balanced, leading to greater feelings of safety. The extent to which supervisees share and initiate discussion seems to be dependent on the level of safety experienced.

Once a safe enough SR is established, discussions of culture and difference can take place. These are often prompted by the supervisee encountering a clinical problem or area of stuckness, where therapist-client difference is visible, or where there are difficult personal resonances for the supervisee in relation to the client. Discussion of difference between supervisor and supervisee tends not to be voiced due to fear of conflict and a need to maintain safety in the SR.

Figure 1. *Theoretical Model*



Discussion of issues was felt to be a shared endeavour with both supervisees and supervisors raising issues at various stages in the SR. However, supervisees felt that supervisors don't always explicitly ask about issues and this was echoed in supervisors' reflections that they should be more explicit. Both supervisors and supervisees engage in strategies to minimise perceived risks, which maintains a sense of safety in the SR.

Where conversations around culture and difference do happen, supervisors and supervisees perceive it helps them to gain a greater understanding of the client through a process of understanding the person and opening up different perspectives. It also helps the dyad to incorporate aspects of culture into their understanding of client difficulties, informing formulation and treatment.

Perceptions

Supervisors and supervisees brought to the SR their own perceptions about culture and difference, which influenced the extent to which they felt able to discuss these issues in supervision.

Viewing Culture/ Difference through One's Own Lens. All but one participant defined culture and difference as a broad concept, drawing on Burnham's (2012) social GGRRAAACCEEESSS to evidence the full spectrum of difference to be considered. It was acknowledged that difference between individuals is often nuanced. Participants described seeing different layers, recognising that there is often difference within areas of similarity, and similarity within difference.

> *"Just because something's similar in one aspect it might be, it's nuanced isn't it… I think with the similarities that come up there's just this, kind of, the more you consider these kind of things the more depth or different layers um come up with it."* (Trainee 4)

"...I'm conscious of the difference there, on multiple levels...I think difference is the theme but you can also think about the similarities there, so I do know what it's like to bring up young children..." (Supervisor 3)

Despite participants describing culture/ difference broadly, they tended to privilege thinking about certain areas over others. This was due to their own interests, areas that are personally relevant, and topics being more familiar or comfortable.

"I dunno, I suppose sometimes there were elements of difference that I was drawn towards because they felt quite important to me...and I think a lot of those came from ways in which I felt different from my peers in training" (Trainee 5)

However, three supervisors and one trainee commented that they felt comfortable to discuss any area of diversity.

Wider societal events, norms and viewpoints were seen to shape what was felt relevant for exploration in the supervisory space, either facilitating or hindering discussion.

"...you can't live in the world right now without thinking about difference and belonging...I can imagine that, that does come up in bigger or smaller ways in conversations I have with others, um, professional kind of sense as well." (Supervisor 1)

"I know that there's a [societal] view...I've heard it a lot kind of with people who aren't White, um, like people saying, oh they're just jumping on the band waggon, if they raise anything and everything's racist these days..." (Trainee 2)

The service context appeared to influence which areas of culture/ difference felt relevant and therefore these were seen as a priority for consideration.

"I guess, coz it's a neuropsychology team um we've talked a lot just about ability or disability within my own family um and my beliefs around those kind of things..." (Trainee 4)

Important Versus Priority? Issues of culture and difference were perceived to be important areas to explore to enable participants to gain a greater awareness of their own background, positions and areas of bias, and the possible impact of these on their clinical work and other professional relationships.

"I think it's really important that we understand where we come from so that we know the decisions that we take when we do any of the work that we do…I think we just need to be aware of those…what our push and pulls are gonna be." (Supervisor 1)

Consideration of issues of culture/ difference was also perceived to be important in uncovering personal blind spots and assumptions made due to difference or, on the contrary, areas of similarity which meant that differences were overlooked.

"...sometimes I think...oh crap, I didn't even realise, or like I hadn't taken this into account, or um, it made me realise kind of how, kind of this big thing and how I've missed that or like what else don't I know about their lives?" (Trainee 3)

"...there might be some similarities and it's really easy to hang on to those and miss a lot of differences, and we make assumptions…" (Supervisor 4)

Despite perceiving issues of culture and difference to be important, participants described competing demands regarding how supervision should be used, which led to these issues not always being prioritised.

"I think, cultural and diversity…maybe doesn't seem quite as urgent or pressing to cover early and therefore maybe has more of a chance of being missed." (Supervisor 5)

"…and I do think I probably have a preconception that that's like really interesting and perhaps useful, but that also like we're not going to the actual problem…not perhaps as important as the other things I want to ask or brought to talk about" (Trainee 3)

This was compounded by caseload pressures and the perception that there wasn't always time and space in supervision for such discussions.

"…I really think there's a will to talk about these things and think about these things…it's just that we are all really busy and we don't always have the time to think about it." (Trainee 1)

Learning therapeutic techniques and CBT skills, clinical case and risk management were either consciously or subconsciously seen as more urgent tasks that required prioritisation over and above issues of culture and difference at times.

"I think CBT skills fell in the need to have box and cultural competency very much fell into the, it would be nice to have box and so there was a sense of…if there's time, we can chat about those things but actually, you're here to learn the nuts and bolts..." (Trainee 5)

However, others felt that exploring issues of culture and difference were of equal value to other aspects and an inherent part of the role of a psychologist.

"…if I came to supervision later today, um, and the things I wanted to talk about was like behavioural activation, if I wanted to talk about certain kind of cultural

differences with someone that would be equally, um, welcomed and worked with..." (Trainee 3)

Three supervisees and one supervisor perceived therapeutic orientation to be a factor in whether issues of culture and difference were seen as a priority for discussion during supervision. Cognitive and behavioural approaches were thought to provide little opportunity for reflection and prompting regarding the consideration of issues, or were seen to treat issues of diversity as "superfluous" (Trainee 5).

"...I'm doing CBT with her, so it's a CBT model which wouldn't um naturally lend itself to the consideration of some of these things." (Trainee 4)

Two supervisors named an assumption that there could be less room for consideration of cultural issues during CBT-based practice and more opportunity in systemic or psychodynamic work. Three participants (two supervisees and one supervisor) perceived that a systemic approach allowed a greater degree of exploration about issues of culture and difference.

"I do feel like a systemic approach lends itself very well to thinking about difference and how people's lives, life experiences have shaped them..." (Supervisor 4)

"I certainly noticed my supervisors with a slightly more systemic way of thinking were perhaps more immediately interested in factors like culture and difference." (Trainee 5)

However, three supervisors believed that consideration of issues of culture and difference should be independent of therapeutic orientation, viewing it as therapist led and the responsibility of a supervisor, regardless of their approach.

"…as a supervisor, you know, you have a responsibility to think of these things, no matter what your theoretical orientation is, um, and certainly in clinical psychology training where the training is broad." (Supervisor 2)

Where issues of culture and difference are perceived to be important, effort is made to keep them on the agenda in supervision, engaging in continued professional development activities, and seeking opportunities for learning and discussion with others.

Risk is Inherent. Both supervisors and supervisees perceived that discussing issues of culture and difference in the SR involved an element of risk, which had the potential to prevent open discussion.

"…it's not until you stop and think about it that you're like oh yeah why would I be scared about that...and there is a risk to it" (Trainee 2)

Several supervisees and one supervisor feared that they didn't have the appropriate knowledge in order to be able to confidently discuss certain areas of culture/ difference, which could lead them to either avoid discussing those areas or prompted them to seek opportunities to gain a greater understanding.

"I sometimes wonder why am I not mentioning this in terms of a formulation…I wonder generally whether there's issues that I don't know quite how to talk about, or knowing if they're relevant or not..." (Trainee 3)

Others were concerned about making incorrect assumptions about issues in relation to clients or their supervisor/ supervisee, which in some cases prevented them from asking explicitly about areas of difference.

"I suppose I don't want to make an assumption that somebody that has a more overt cultural difference would be more affected by those factors, because they might not

be…I take a stance of trying to create a supervisory relationship where those things can come up organically if they need to, rather than me explicitly regularly checking in." (Supervisor 2)

As a result, dyads felt a pressure to get it "right" in supervision and worried about getting it wrong.

"So I think the hindrance really is about not wanting to appear insensitive. Or not wanting to get it wrong..." (Supervisor 3)

This prompted them to feel worried about causing offence or discomfort.

"I think the fear of upsetting someone, offending them, saying something that felt uncomfortable or leaving someone with some emotions that they couldn't share back..." (Supervisor 4)

However, two trainees talked about how they felt it was worth taking this risk in order to aid their learning, citing personality factors such as extroversion and the ability to tolerate discomfort as helpful.

"I think some people are nervous of causing offence but that doesn't put me off particularly, so maybe something about temperament there about being extroverted and a bit... I'm willing to just take a risk for the sake of learning." (Trainee 1)

Supervisees feared their supervisor may respond negatively if they were to bring up issues of culture/ difference and worried about their negative evaluation and judgement. This was exacerbated by the evaluative nature of the SR during clinical psychology training.

"…and it can be really difficult to bring up these sorts of issues that...I don't know whether...like well how are they [supervisor] gunna take it?" (Trainee 2)

Building Safety in the SR

All participants discussed the importance of safety in the SR. This appeared to mitigate, to some extent, the perception of risk. Several processes were identified which supported the development of safety.

Safety as a Prerequisite to Exploring Issues. Supervisors commented on the need to create a safe enough SR in order for supervisees to feel able to raise issues of culture and difference.

> *"I always hope we can build up a secure enough relationship to be able to have disagreement and different views."* (Supervisor 4)

Safety appeared to develop over time, and level of felt security corresponded to the degree of supervisee self-disclosure and openness in exploring issues of culture and difference.

> *"There's a level of safety isn't there, because…I'm more than happy to talk about any of the graces quite happily. The extent to which I do that…I think is the thing that varies between them [supervisors], like depending on the level of safeness I guess."* (Trainee 4)

Safety appeared to mitigate perceived risks to a certain extent, such as fear of being judged, sharing difficult resonances and sensitive topics.

> *"…if you have a kind of safe, open relationship with somebody you can explore that together and you kind of know they're not negatively judging you."* (Trainee 2)

If sufficient safety was not developed, supervisees described a process of withholding certain sensitive information or seeking opportunities to process issues of culture and difference outside the supervisory space.

"…if your views around things like that are quite sensitive, are different to your supervisor, and you don't feel safe in that relationship then that can be really difficult...I think I probably take a lot of those thoughts out of supervision…and almost like tailor my conversation within supervision..." (Trainee 4)

The development of safety was seen as a joint endeavour, with supervisors and supervisees appreciating qualities in one another, which promoted safety. Supervisees valued supervisor warmth, openness, validation and curiosity in exploring issues further with the supervisee, which in turn conveyed their interest and support.

"I think it makes it much easier if it comes from the supervisor and setting it up as a kind of open conversation and showing an interest and showing an openness and a curiosity about those kind of issues..." (Trainee 2)

Supervisors valued supervisee openness and willingness to share relevant aspects of culture/ difference in order to create opportunities for discussion and reflection.

"…that sort of warmth, openness...um.... I guess a confidence to share things too." (Supervisor 3)

Supervisors who sensed that supervisees were uncomfortable, defensive or closed-minded about areas of culture/ difference found it difficult to pursue discussions about these issues. The perception that supervisors were not interested in the supervisee, or who were particularly didactic and focused on skills learning, meant that there was little space for supervisee reflection and exploration of issues.

"I guess that closed-ness to thinking about it, or having quite narrow minded view of what difference and culture might look like might close conversations down." (Supervisor 1)

"...just not that much interest [from supervisor] ...we didn't have that kind of relationship where we could share things...and that probably did hinder…I think supervision turned into much more of a case management." (Trainee 2)

Getting to Know One Another. Developing safety in the SR began with a process of getting to know one another; relating on a human level by having informal conversations, and beginning to gain insight into each other's viewpoints and backgrounds.

"...time with your supervisee or joint working, or being in the same team meetings and stuff. So that sense of more sort of informal relationship building, which I think adds to the sense of safety within a working relationship." (Supervisor 5)

"I think kind of having…an awareness of [supervisor]'s position and her culture and background and beliefs…I guess that helps." (Trainee 4)

In some instances, this led supervisory dyads to draw upon their shared interests or similarities in order to develop a bond with one another.

"I related to her, I guess you could say on a cultural level, despite how many differences there are between us, I experience her...I know how to communicate with [supervisor] and I feel very at ease." (Trainee 1)

Giving Permission. Participants acknowledged the imbalance of power in the SR, which had the potential to make it challenging for supervisees to raise areas of culture/ difference, particularly when they anticipated they may hold a different perspective to their supervisor.

"I think it's easier just thinking about the power dynamic as a supervisor to feel OK offering something different than it perhaps is when I was a trainee or imagining for other trainees, their experience of being able to have a different view…maybe with

this sense of, you know, does the supervisor have a better view or know more?" (Supervisor 4)

Given this power differential, all participants emphasised the importance of the supervisor taking the lead in 'giving permission' for issues of culture and difference to be discussed.

"…on paper the supervisor holds more power in the relationship…and so then there being a kind of added layer of responsibility or appropriate expectation that the supervisor should put on the table what's okay, so to de-taboo things that might otherwise be taboo." (Supervisor 5)

Supervisors disclosing relevant and appropriate personal information helped to balance power and create safety in the SR by facilitating the relationship building process. It also encouraged supervisees to then share aspects of themselves and their own backgrounds. This created a ripe environment for the exploration of issues of culture and difference.

"I think starting from a standpoint of I'm sharing information with you is, there's an expectation that we're in this two way relationship and that there's some intimacy about it...not in terms of a friendship, but as in a professional relationship." (Supervisor 4)

Where there wasn't sufficient safety in the supervisory relationship or where self-disclosure was not modelled by the supervisor, supervisees found it difficult or impossible to share personal aspects of their own background, culture or difference in supervision.

"…because we didn't necessarily get on that well, I didn't particularly want to think about things that might involve thinking about me personally…I suppose, you know, difference involves a degree of bringing yourself and I think I wasn't particularly up for that and I'm not, I'm not sold that she was up for that either..." (Trainee 5)

The importance of explicitly discussing issues of culture and difference during supervision contracting was emphasised by seven participants. It was seen as the main mechanism whereby supervisors could give permission to supervisees and acted as a springboard for further discussion.

> *"...that's something [culture and difference] that needs to be kind of talked about, like contracted, at the start of the placement... that would have probably made it feel a bit safer to talk about that kind of stuff."* (Trainee 2)

Sharing genograms at the start of the SR provided a helpful way for facilitating rich discussion about supervisor and supervisee culture and difference in relation to one another and their work, for one particular dyad.

> *"...we did a genogram, um, at the beginning of supervision and she shared hers and I shared mine and so actually, when you're talking about things of cultural difference that come up within a clinical relationship...you know that your supervisor knows the background already. You don't feel like you have to explain anything, so you're much more likely to have that conversation or bring it up."* (Trainee 4)

To Voice or Not to Voice?

Given the potential risks of discussing issues of culture and difference and a need to maintain safety in the SR, participants appeared to need a clear rationale for discussion of culture and difference in supervision, which usually related to a particular clinical need. Topics which were more readily discussed were age, gender, disability and supervisee experiences of racism during clinical work. Issues which were harder to voice or not voiced were related to sexuality, class, religion, ethnicity and race. This was particularly the case where these issues were aspects of difference within the SR. Indeed, difference between supervisee and supervisor was often not voiced during supervision and perceived to be

sometimes difficult or uncomfortable to explore. It is hypothesised that consideration of difference poses a threat to safety in the SR, due to the potential for conflict.

Voicing Culture/ Difference in Relation to Clinical Need. Both supervisors and supervisees reported that they were most likely to discuss issues of culture and difference in relation to client work. The supervisee may have a particular clinical question, problem, stuck point or area of difference between themselves and the client which is visible or obvious. This acted as a catalyst for discussing issues of culture and difference during supervision.

> *"I think differences come up more often...clinically, I think, in the context of why things aren't going as we might hope they would…what you take to supervision is more often the stuff you're stuck with, than the stuff that's going fine."* (Supervisor 5)

> *"…in supervision culture or differences…kind of only come up when prompted or when there's an obvious difference or when there's a difficulty in the relationship or in therapy."* (Trainee 3)

At times, supervisees may hold back from discussing issues of culture/ difference that aren't seen as directly relevant to their clinical work.

> *"I'm just imagining what would happen if I just went to supervision and was like...this is the thing and it didn't feel directly related to clinical stuff... I might hold back from if I…couldn't see a clinical point."* (Trainee 3)

Discussions about areas of difference in relation to client work can then lead on to consideration about the supervisees' own personal areas of difference. This is particularly the case where there are difficult resonances, both similarities and differences, with the client which may impact on the work, the therapeutic relationship or supervisee wellbeing.

"...helping think about areas of where you might identify...or not identify with a [client's] experience, because I guess that's really important when you...just have to be aware of, um, how you position yourself clinically." (Supervisor 1)

"I had much more time in supervision to kind of formulate and discuss different ideas about my clients…how I'm understanding him [client] as well, rather than just being utterly disgusted by something he said, that was my initial reaction, and I guess if I hadn't taken it to supervision I'd have probably been left with that for longer." (Trainee 2)

Difficulty Voicing Difference within the SR. Despite supervisors and supervisees identifying differences between each other, these were often not voiced during supervision and instead assumptions were made about one another.

"...there might well be lots of assumptions that I'm making where it's kind of like, well, I'm just assuming that if you're female that you, you know, just generally kind of making assumptions based on statistically what's likely and, yeah, that being a sort of a trap because it's not really giving us much space for difference." (Supervisor 5)

However, where a genogram had been completed at the start of the SR, this created space for issues of difference and similarity within the SR to be uncovered and voiced.

"...there can be lots of hidden differences [between supervisor and supervisee]...so I think the genogram has just felt like a really good space to be able to explore all of those things…and often finding out that there's a lot more differences than we might have seen." (Supervisor 4)

Both supervisors and supervisees described feeling reluctant or uncomfortable about highlighting and discussing their differences to one another. This was related to wanting to avoid the potential for conflict and to maintain safety in the SR.

"...I suppose what gets in the way of that [discussion about class difference] I think is that...I think it would be in kind of being liked less maybe." (Trainee 3)

"I think when I know that I've got a different perspective…I think it makes it more difficult [to discuss]… I think it is mostly about not wanting to somehow appear offensive." (Supervisor 3)

Participants were more at ease discussing their similarities, which contributed to bonding and feelings of safety.

"Sometimes I think when there's similarities between myself and a supervisee it can be, it can feel easier to talk about it than differences… I think there's also a time where similarities can also be quite, um, a connecting experience." (Supervisor 4)

Processes for Discussion

Exploring issues of culture and difference was seen as a shared responsibility, however the extent to which members of the supervisory dyad initiated discussion varied at different stages in the SR. Supervisory dyads engaged in strategies to mitigate perceived risk inherent in discussing issues of culture and difference, thus maintaining safety within the SR.

A Shared Endeavour. Supervisors and supervisees viewed discussing issues of culture and difference in supervision as a shared responsibility.

"It felt to me like there would have been maybe a shared conversation, not a sense of it being up to somebody or up to the other person to do it." (Supervisor 4)

It was seen as helpful for supervisors to take the lead in initiating discussion in the early stages of the SR. Supervisors then hoped to be led by the supervisee in setting the agenda for supervision, expecting they will bring relevant aspects of culture and difference.

"I know that some supervisors...they will talk about these kind of things at the beginning of your relationship...and that starts the conversation…so then it's more at the forefront of your mind." (Trainee 4)

"…what does diversity mean? What does cultural difference mean?...So I think, having those discussions at the start, um, is helpful, what I've found is that trainees and people I've supervised have varied in terms of how much that is then continued to be talked about." (Supervisor 2)

Supervisors believed it was their responsibility to prompt discussion at times, particularly if issues are not being brought to supervision by the supervisee.

"I think if it [culture and difference] doesn't exist at all in the supervisory conversations, then I guess the supervisor has to take back a bit of responsibility for asking curious questions." (Supervisor 5)

However, it was acknowledged by both supervisors and supervisees that in practice, supervisors didn't always prompt or ask explicitly about issues of culture and difference.

"Supervisors maybe didn't raise issues of diversity as often, but…of my 5 supervisors, I can't think of a time where I felt like the conversation was shut down or that the person felt uncomfortable or unprepared to talk about it." (Trainee 1)

Three supervisors questioned whether they should be more explicit in prompting and encouraging discussions.

"…how much do I explicitly ask? I feel hopeful that I create a generally open supervisory relationship where anything can be brought. But do I ask explicitly enough about culture and diversity, do I ask the right questions?" (Supervisor 2)

Strategies to Mitigate Risk. Both supervisors and supervisees engage in strategies to minimise perceived risks, which maintains a sense of safety in the SR. Supervisees bringing issues for discussion in a tentative and curious manner helped to invite discussion and minimised the perceived risk of causing offence or engendering a defensive response from the supervisor. It also made it easier for the supervisor to share a different perspective or challenge supervisee assumptions.

> *"I think there's usually a way to like just be curious about things, that doesn't make a particular clinician feel defensive."* (Trainee 1)

> *"As a supervisor, your job is to pick up on those certainties which are not certainties…and to challenge that in a helpful and constructive way, and that's always easier when the trainee brings it in a tentative manner."* (Supervisor 2)

Where a positive working alliance was established, supervisors and supervisees found the use of humour and playfulness helped them to take risks in exploring issues of culture and difference.

> *"So I think we were just having a bit of a giggle as a team around that…So I think there was, yeah, I suppose it was discussed in a playful way."* (Supervisor 3)

> *"…you could also be playful in your conversations so it didn't feel so dangerous."* (Trainee 1)

All supervisors described how they ask open-ended questions in order to invite personal reflection, which could lead to discussion of culture and difference. This appeared to mirror the supervisee approach of tentativeness and curiosity. It also allows supervisees to choose what they share, thus reducing the risk that the supervisor's questioning could cause discomfort or offence.

"I might just try some sort of gentler ways in to encourage reflection first… it might be just asking those kind of very gentle, open questions." (Supervisor 3)

Perceived Outcomes

Understanding the Person. Where conversations about culture and difference happen, supervisors and supervisees believe it helps them to gain a greater understanding of the client through a process of understanding the person of the client, rather than just the problem, and opening up different perspectives.

"If you can be thinking and understanding and interested in connecting to someone's whole self and their whole experience…that will help the engagement process." (Supervisor 4)

"I suppose I was coming from a position of, you know, being quite a young man who is not a parent, um, and it was really really helpful to have [supervisor's] perspective…having her there and bringing the perspective as a parent…" (Trainee 5)

Informing Formulation and Treatment. Participants also believed that discussions about culture and difference helped them to incorporate these issues into their understanding of client difficulties and hence informed the formulation and treatment.

"…challenges to you as a clinician in terms of how you think about incorporating the relevant factors [of culture and difference] into your formulation and your clinical work." (Supervisor 2)

"I think it was helpful [discussing client culture and difference] in the sense of helping me to kind of understand and formulate the client's difficulties more broadly and take into account wider issues." (Trainee 2)

It was acknowledged by one supervisee that the consideration of cultural factors can make client presenting problems seem more complex. This can lead to uncertainty regarding how to adapt interventions accordingly.

> *"[client cultural difference] can make me think differently about how complex the problem is...it feels easier when I know what to do with that, rather than it kind of being another uncertainty in the formulation."* (Trainee 3)

Discussion

The findings of the present study will be briefly summarised and discussed in relation to existing theory and research. Strengths and limitations are outlined and implications for practice and future research suggested.

Brief Summary of Findings

This study aimed to explore how issues of culture and difference are perceived and explored within the SR. The theoretical model developed suggests that supervisees and supervisors bring their own perceptions regarding the relevance, importance and risk associated with discussing issues of culture and difference. Given risk is perceived to be inherent, sufficient safety in the SR must be developed as a prerequisite for these discussions. Supervisors and supervisees are more likely to discuss issues of culture and difference where they are deemed clinically relevant and will engage in strategies to minimise risk in order to preserve safety in the SR. Where issues of culture and difference are discussed, supervisors and supervisees perceived this to benefit their clinical work.

Links to Existing Literature

Consistent with previous research, creating safety in the SR is essential for discussions about culture and difference to take place (Tohidian & Quek, 2017; White-Davis

et al., 2016; King & Jones, 2019; Phillips et al., 2017; Toporek et al., 2004). Valued characteristics of supervisors included warmth, openness, validation and curiosity which in turn communicated that they were interested in their supervisee. This is consistent with models of culturally competent supervision (Falendar & Shafranske, 2004; Ancis & Ladany, 2001) and research (White-Davis et al., 2016). In line with the current findings, balancing power in the SR is an important part of the development of a strong SR (Holloway, 1995).

Drawing on attachment theory, previous literature has identified that one of the most important aspects of the SR is for the creation of a *secure base* (Clohessy, 2008; Pistole & Watkins, 1995), characterised by interpersonal connection, safety, trust, honesty and openness (Clohessy, 2008). Once a sense of security is established in the SR, supervisees are more able to experiment with different approaches, or techniques (Pistole & Watkins, 1995). From a family therapy perspective, Mason (2019) argues that developing a position of safe uncertainty allows practitioners to take relational-risks, remain open to differing perspectives, and enables opportunity for different views to be expressed and acknowledged. In the present study, safety in the SR appeared to enable participants to take risks in discussing potentially sensitive or controversial areas of culture and difference, particularly in relation to their clients.

The identification and discussion of difference within the SR appeared to be avoided due to fears that it could negatively impact the SR. Supervisory dyads in the present study appeared to want to emphasise their similarities rather than differences. Given the power dynamic in the SR and in line with Tajfel's (1978) social identity theory, it could be argued that supervisees are motivated to conform to supervisor values and ideas. From an evolutionary perspective, the primitive need to belong is thought to drive humans to readily develop and maintain social relationships and actively resist the breakdown of these bonds (Baumeister & Leary, 1995). This leads to goal-directed behaviours to pursue and strengthen

relationships and avoid conflict and breakdown of social bonds. This is evidenced in the present findings by dyads seeking to maximise similarities and the adoption of strategies to mitigate risk when discussing issues of culture and difference. This may lead to missed opportunities for supervisors to model skills in cultural competence which could be replicated within the therapeutic relationship.

Findings highlighted the importance of supervisors starting the conversation about culture and difference early on in the SR. This is consistent with previous literature which suggests supervisors should initiate discussion of culture and difference during the contracting process (Beinart, 2014) and the supervisor's responsibility to broach these issues (Jones & Branco, 2020; Watkins et al., 2019). In the present study, supervisors broached issues of culture and difference by modelling and self-disclosing which created the necessary safety for supervisees to feel able to disclose and explore certain issues. Supervisor self-disclosure has been shown to strengthen trust in the SR and encourage supervisee self-disclosure (Farber, 2006; Yourman, 2003).

Culturally competent supervision is thought to encompass reflection on culture and difference in relation to the context of supervisory practice, within the SR and within therapeutic relationships (Burnham & Harris, 2002). In the present study, participants appeared to feel more comfortable, and were more likely to discuss issues of culture and difference in relation to their clients. Some participants reported that this may have been due to the predominance of a cognitive behavioural approach to supervision, in which the mastery of CBT skills are prioritised (Padesky, 1996; Reiser & Milne, 2012). This was contrasted with a systemic approach in which the therapist's self, including reflexivity regarding their own family background, culture and difference, are seen as integral (Mason, 2010; Totsuka, 2014). It could, therefore, be argued that there is less space for self-reflection and discussion about culture and difference in CBT-oriented supervision compared to a systemic approach.

Nonetheless, in recent years there has been a greater focus on culturally adapted and responsive CBT, which may prompt discussion in supervision (Beck et al., 2019; Naeem, 2019).

Issues of culture and difference were more likely to be prioritised and voiced during supervision in relation to clinical work where difference was visible and where there were stuck points in therapy. This supports the hypothesis that dyads largely deal with difference when it arises or becomes a problem (Beinart & Clohessy, 2017). Despite this, most supervisees and supervisors acknowledged they should explore culture and difference before problems arise. The hypothesis that supervisors experience supervisee requests to discuss diversity as an extra demand (Patel, 2004), was not supported by the findings.

Despite participants in the present study acknowledging the breadth of issues of culture and difference, in practice they described focusing on particular areas according to their own interests, backgrounds, and service context. This is consistent with Burnham's (2012) observations that practitioners tend to privilege areas of difference that hold meaning, are preferred or where one feels more competent. It therefore required conscious effort for supervisory dyads to explore potential blind spots. This may be easier to do when the therapeutic orientation prompts consideration of these areas.

In contrast to previous research indicating that supervisees' initiative in raising issues of culture and difference were not well received or responded to appropriately by supervisors (Constantine & Sue, 2007; Hansen et al., 2006; Jernigan et al., 2010; Walker et al., 2007), most supervisees in the current study felt satisfied with their supervisor's response and reported positive outcomes. Dyads reported that their discussions helped to inform the formulation and treatment in culturally sensitive ways. This is consistent with previous research in which culturally competent supervision was perceived to improve case

conceptualisations and supported the modification of interventions (Constantine, 2001; Soheilian et al., 2014).

Strengths and Limitations

To the author's knowledge, this is the first dyadic study exploring issues of culture and difference within clinical psychology supervision in the UK. The findings provided an in depth insight into the processes involved and were largely consistent with previous literature.

The findings of the present study are likely to be of relevance to other clinical psychology training courses in the UK. However, the transferability of findings may be impacted by the diversity of the population in the area, emphasis on different therapeutic orientations, teaching and supervisor training on cultural competence. Given the present study replicates findings from previous literature, this adds credibility and confidence in the results.

A predominantly White sample meant that differences between people from BAME backgrounds and White individuals could not be distinguished, and this was not the aim of the current research. Previous research has found that supervisees from BAME backgrounds are more likely to perceive their supervisors as culturally unresponsive compared to White supervisees (Burkard et al., 2006). Therefore, the present findings may not be transferrable to this population.

Theoretical sampling was not possible due to difficulty recruiting supervisory dyads in the necessary time frame. It is acknowledged that theoretical sampling is difficult to undertake in practice (Charmaz, 2014). However, memo-writing between each interview helped to identify tentative ideas and emerging themes in the data. This led to adaptions of the interview schedule, which allowed theory to be pursued.

The aim of the current study was to explore experiences of discussing culture and difference within supervisory dyads. It was hoped that dyadic processes specific to these SRs would be identified. However, the data collected largely pertained to general experiences of SRs, rather than experiences specific to the dyad recruited. Confidentiality agreements within SRs may have made it challenging to feel it was acceptable to share specific details, particularly negative experiences. The potentially conflicting nature of the researcher's dual role as a trainee on the same course may have exacerbated this further. Effort was taken to reassure participants about study confidentiality, however, it wasn't deemed ethical to press participants. During data analysis, clear within and between group (supervisor and supervisee) similarities and differences emerged, leading to the resultant theoretical categories. The findings highlighted important supervisory processes pertaining to participant experiences of a range of SRs.

Findings regarding favourable outcomes in therapeutic work should be treated with caution. They are perceived outcomes from the perspective of supervisor and supervisee, rather than the client perspective. Research has indicated that supervisee self-report of cultural competence diverges significantly from supervisor report, and values and beliefs regarding cultural competence do not always translate in practice (Cartwright et al., 2008; King et al., 2020). The extent to which discussions about culture and difference actually impact on supervisee behaviour, client experience and therapeutic outcome needs further investigation.

Implications for Training and Practice

Findings pointed to the importance of developing safety in the SR and the supervisor's responsibility in starting the conversation through contracting, modelling and giving permission that this is an acceptable and encouraged topic for clinical supervision. An

example of good practice from study participants was sharing and reflecting on personal genograms at the start of the SR. This has been shown to provide valuable learning opportunities within systemic and family therapy approaches (see Hardy & Laszloffy's, 1995, guidelines for using cultural genograms as a learning tool during training; Pistole, 1997), and is considered good practice within culturally adapted CBT (Beck et al., 2019). Sharing genograms within the SR provides a template for how areas of difference can be explored with clients (Aten & Hernandez, 2004). It may also provide an important opportunity for managing the emotional impact of clinical work which includes distressing experiences of overt or insidious prejudice and discrimination (BPS, 2020; Odusanya et al., 2018).

Relational processes were found to increase safety in the SR, which helped to facilitate discussions about culture and difference. It is important for supervisors to invest time in getting to know their supervisees, both formally during contracting processes and informally outside the supervisory space. This may help to convey their commitment to, and investment in the SR, which are key characteristics of effective SRs (Beinart, 2012; Clohessy, 2008).

Supervisor training should incorporate self-reflection on any intrapsychic barriers and anxieties supervisors may have about exploring issues of culture and difference, sharing any concerns and problem solving these. The use of role play in sharing genograms and developing supervision contracts which incorporate such issues may help to increase confidence and competence in initiating these conversations with supervisees. This in turn may help to alleviate their own anxiety and allow for a greater degree of openness and curiosity, in line with the principles of cultural humility and comfort within the MCO framework for supervision (Watkins et al., 2019).

Similarly for trainees, it would be helpful for clinical psychology training courses to provide opportunities to gain experience of reflecting on cultural genograms within teaching. This may help to foster confidence to reflect on these areas during supervision. Joint training for supervisors and trainees to encourage reflection on issues of culture may also be helpful.

Given busy NHS contexts and competing demands during supervision, it may be helpful for supervisory dyads to allocate protected time for broader reflection on their own areas of difference and how this may impact their clinical work. Regular supervision reviews may provide opportunity for monitoring and re-prioritising time for consideration of these issues.

Implications for Future Research

Given this is the first study to explore issues of culture and difference within clinical psychology supervision in the UK, results should be replicated in different training courses, in different regions of the UK and with culturally diverse dyads. In addition, it would be useful to evaluate the suggested implications for training on supervisor and supervisee confidence in exploring these issues within supervision, the impact on the SR and clinical practice.

Participants in the present study reported mixed ideas about the impact of therapeutic orientation in exploring issues of culture and difference during supervision. Further research is needed to explore the impact of supervisor and supervisee therapeutic orientation and for examples of good practice to be shared across modalities.

Whilst the importance of culturally competent supervision has a growing evidence base in improving the quality of the SR, there has been little research into the impact on therapist behaviours during client contact and clinical outcomes. Future research should seek to address this gap in the literature. In addition, it would be valuable to evaluate the impact

of culturally competent supervision on service user experiences of interventions and clinical outcomes.

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Appendices

Appendix A: International Journal of Practice Based Learning in Health and Social Care Manuscript Guidance

Retrieved from: https://publications.coventry.ac.uk/index.php/pblh/about/submissions

Submission Preparation Checklist

As part of the submission process, authors are required to check off their submission's compliance with all of the following items, and submissions may be returned to authors that do not adhere to these guidelines.

- The submission has not been previously published, nor is it before another journal for consideration (or an explanation has been provided in Comments to the Editor).
- The submission file is in OpenOffice, Microsoft Word, RTF, or WordPerfect document file format.
- Where available, URLs or DOIs for the references have been provided.
- The text is double-spaced; uses (primarily) a 10-point font; employs italics, rather than underlining (except with URL addresses); and all illustrations, figures, and tables are placed within the text at the appropriate points, rather than at the end.
- The text adheres to the stylistic and bibliographic requirements outlined in the Author Guidelines, which are found in About the Journal > Submissions.
- The instructions in Ensuring a Blind Review in the Author Guidelines have been followed.

- The above checkbox refers to the statement and bullet points below: In submitting this article for publication, I confirm the following:

  - That the content of the article is my own work or, where third party content is utilised, I have obtained permission from the third party to include their materials in this article and (where necessary) the third party has approved the article for publication;
  - That I agree to grant an irrevocable, royalty-free, worldwide, non-exclusive licence to Coventry University to publish this article;
  - That the article may be licensed under a creative commons licence, as detailed in the Copyright Notice;
  - That the article contains nothing that is abusive, defamatory, libellous, obscene, fraudulent or illegal;
  - That the decision to publish this article rests solely with Coventry University; and
  - That Coventry University may withdraw publication of the article at any time at its discretion without notice in the event that Coventry University becomes aware, or has reason to believe, that the author has not met any requirement(s) set out in this submission checklist.

Author Guidelines

General

- Ethical issues for any study involving human subjects should have been carefully considered in line with the Declaration of Helsinki (1964).
- Authors should refer to and conform to our **PUBLICATION ETHICS & MALPRACTICE STATEMENT** (on this website under ABOUT > Peer Review Process)

- Journal article submissions should normally not exceed the word-counts given below (Submission Types). A word count should be supplied with the submission.
- Research articles should be accompanied by between three and five keywords.
- Submissions should be compiled as follows: title, author name, affiliation, abstract, main text, acknowledgements (where relevant), references, appendices (where included).
- For all manuscripts non-discriminatory language is mandatory. Sexist or racist terms should not be used.

Submission Types

Research articles	Articles are a maximum of 5,000 words excluding references and tables. The aim of articles is to advance understanding of practice based learning by making original, conceptual or theoretical contributions to the field. While articles are typically structured in the following way – introduction, background, methods, findings, discussion, conclusions – this format is indicative only and not prescribed. Abstracts should be no more than 250 words.
Reflective papers	These papers are 1,000 words in length excluding references and tables. The aim is to provide a reflective discursive account exploring an aspect of practice.
Master Classes	Master class papers are a maximum of 4,500 words and are typically structured as follows: Introduction, background literature, methodology/principles, discussion, conclusion and key messages. Abstracts should be no more than 250 words.

Cover Page (To be uploaded as a separate file)

Author(s), affiliations, Contributions and Conflicts of Interest	* List the authors in the order they should appear in the final manuscript; * State in what ways each author contributed to this manuscript; * State whether or not each author has an interest to declare.

Corresponding author	Please provide the full correspondence address and contact email for the author who will deal with article-related correspondence before and after publication.
Funding and Acknowledgements	* Please state any relevant funding source/s; * Please provide acknowledgements if applicable.

Ensuring a Blind Review

In recent versions of MS-Word:

1. Open your submission document
2. Select 'File'
3. Select 'Check for Issues' / 'Inspect Document'
4. Select 'Inspect'
5. Against 'Document Properties and Personal Information' select 'Remove all'
6. Save the file again

Typically this takes care of the main issues with author signature on the file and in the comments and changes made during reviewing. In cases where you refer to previous publications or conferences by author(s), please ensure you refer to the publications in the third person, rather than signalling your own research, or replace essential information which would identify the authors with: '[name redacted for anonymity]'. If in doubt, please email the editors.

Formatting (Use double spacing for Peer Review)

Font	Arial
Chapter title	18 pt, bold, title case, aligned left
Author(s) and affiliations	'Author' *'University, Country'*

	'Second Author' *'University, Country'* etc. N.B. Please simply type the words 'Author', 'University' etc. in order to ensure blind review. **Ensure all author details are entered in the accompanying submission List of Contributors**
Abstract (heading)	10 pt, bold
Abstract (text)	10 pt (less than 250 words)
Keywords	10 pt (minimum, 3; maximum 5)
Level 1 subheading	11 pt, bold, title case, aligned left
Level 2 subheading	11 pt, bold, italic, sentence case, aligned left
Level 3 subheading	11 pt, italic, sentence case, aligned left
Text (including footnotes)	10 pt, left-aligned with a ragged right-hand margin. The *whole document* should be DOUBLE-SPACED for peer review.
Figure/table captions	9 pt, placed below the Figure/Table
Footnotes	10 pt
Reference text	10 pt, aligned left with hanging indent and a blank line after each entry

Language

Please consistently use **either** British English **or** American English.

Dates should be given in the form 1 January 2015.

Punctuation

Double-barrelled names contain a hyphen (-).

Number ranges and parenthetical dashes use an n-rule (–). Parenthetical dashes should be have a space on either side.

Please note: 1960s, not 1960's.

Use of italics

Italics should be used for names of publications (books, journals, newspapers etc.) and titles of films, paintings etc.

Foreign words, including Latin ones, should also be italicised.

Numbering

Numbers one to ten should be spelt out, as should any number which begins a sentence; figures should be used thereafter. Figures and spelt-out numbers should not be mixed in the same clause.

Numerals should always be used with percentages, units of measurement and in tables. Please note, there should be a space between the numeral and the unit (e.g. 5 cm).

Number ranges, including those of pages in citations and references, should be given in full and elided with an n-rule (–). For example, 123–150, not 123-50.

Quotations

Please use single quotation marks; double marks should be used within quoted material, as necessary.

Quotations longer than 30 words should be indented.

Generally, quoted material does not need to be distinguished from the rest of the text in any other way (for example, by using italics).

Referencing (Please note, that from September, 2019, this journal converted to APA-style referencing and citation - Edition 7. For previously submitted articles, either style is acceptable)

In-text citations should be in the form (Surname, year, p. n).

Number of authors	First in-text citation	Subsequent in-text citations
One or two	Forsyth & Kviz, 2006	Forsyth & Kviz, 2006
Three or more	Dillman et al., 2014	Dillman et al., 2014
Organisations	National Institute of Health Research [NIHR], 2017	NIHR, 2017

- Please note, all authors (up to 20 – see APA 7th Edition) must be listed in the full bibliographic reference.
- Multiple publications in one citation should be listed in alphabetical order and separated by semi-colons, e.g.: (Anders Ericsson, 2009, pp. 66–67; Dillman et al., 2014; Forsyth & Kviz, 2006, p. 92).

The list of references should contain full bibliographic entries for all cited material. Similarly, items appearing in the reference list must also appear in the main text. The reference entries should be compiled as follows:

- Books:

Anders Ericsson, K. (Ed.). (2009). *Development of professional expertise: Toward measurement of expert performance and design of optimal learning environments*. Cambridge University Press.

Dillman, D. A., Smyth, J. D., & Christian, L. M. (2014). *Internet, mail and mixed-mode surveys: The tailored design method* (4th ed.). John Wiley and Sons.

- An essay or article in an edited volume:

Forsyth, K., & Kviz, F. J. (2006). Survey research design. In G. Kielhofner (Ed.)*, Research in Occupational therapy: Methods of inquiry for enhancing practice* (pp. 91–109). F. A. Davis.

- Journal articles:

Aiken, F. E., Fourt, A. M., Cheng, I. K. S., & Polatajko, H. J. (2011). The meaning gap in occupational therapy: Finding meaning in our own occupation. *Canadian Journal of Occupational Therapy*, *78*, 294–302. https://doi.org/10.2182/cjot.2011.78.5.4

- Online journal articles:

Attrill, S., Lincoln, M., & McAllister, S. (2016). Supervising international students in clinical placements: Perceptions of experiences and factors influencing competency development. *BMC Medical Education*, 16, 180. https://doi.org/10.1186/s12909-016-0702-5

- Websites:

Wenger, E. (2011). *Communities of practice: A brief introduction*. https://scholarsbank.uoregon.edu/xmlui/bitstream/handle/1794/11736/A%20brief%20introduction%20to%20CoP.pdf

Figures and Tables

All figures and tables must be cited in the main text and carry captions to explain what they are (the caption appears **below** the Figure or Table).

Captions

For figures and tables, captions should be set below. In both cases, they should be numbered sequentially using Arabic numerals; tables and figures should be numbered separately.

All images, illustrations and diagrams should be referred to as 'figures'. The abbreviation 'Fig.' should be not used.

Acknowledgements and permissions

If a figure, model, image, chart or table has previously been published, its reproduction in the *International Journal of Practice-based Learning in Health and Social Care* will require copyright permission (even if minor modifications have been made). It is the responsibility of the author to secure such permission from the original publishers, for publication in both electronic and print formats. Proof of permission will need to be forwarded to the Editor. The author is also responsible for paying any permission fees associated with such materials. Any queries regarding this matter should be directed to the Editor.

Appendix B: Description of Search Terms

Given the lack of research in this area, search terms were purposefully kept as broad as possible to ensure no studies were missed.

Databases	Search terms	Limits
HDAS databases: PsycInfo, Medline, and CINAHL	reflection OR "reflective practice" OR "self-reflection" OR "self-practice" OR reflecti* OR reflexi* OR "personal development" OR "professional development" AND "clinical psycholog*" OR psychotherap* OR "cognitive therap*" OR "cognitive behavio* therap*" OR CBT	English language From the year 2000 Qualitative methodology
ProQuest	reflection OR "reflective practice" OR "self-reflection" OR "self-practice" OR reflecti* OR reflexi* OR "personal development" OR "professional development" AND "clinical psycholog*" OR psychotherap* OR "cognitive therap*" OR "cognitive behavio* therap*" OR CBT	English language From the year 2000 Dissertations and theses (there wasn't an option to set limits for qualitative methodology)
Open Grey	The following combinations were used: "reflective practice" AND psycholog* "reflective practice" AND therap*	English language (there wasn't an option to set limits for year and qualitative methodology)

	reflection AND psycholog*
	reflection AND therap*
	“self-practice” OR “self-reflection” AND therap*
	“self-practice” OR “self-reflection” AND psycholog*

Appendix C: Data Extraction Table

Authors	
Location	
Year of publication	
Journal name/ unpublished thesis	
Research aims	
Sample size and participant characteristics (including profession, in training/ qualified)	
Method of reflective practice (and brief description)	
Study design	
Method of data collection	
Method of data analysis	
Summary of results (including themes and subthemes)	

Appendix D: CASP (2018) Qualitative Checklist

CASP
Critical Appraisal Skills Programme

www.casp-uk.net
info@casp-uk.net
Summertown Pavilion, Middle Way Oxford OX2 7LG

CASP Checklist: 10 questions to help you make sense of a **Qualitative** research

How to use this appraisal tool: Three broad issues need to be considered when appraising a qualitative study:

- Are the results of the study valid? (Section A)
- What are the results? (Section B)
- Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

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CASP
Critical Appraisal Skills Programme

Paper for appraisal and reference:

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- what was the goal of the research
- why it was thought important
- its relevance

Comments:

2. Is a qualitative methodology appropriate?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Comments:

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments:

CASP
Critical Appraisal Skills Programme

4. Was the recruitment strategy appropriate to the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments:

5. Was the data collected in a way that addressed the research issue?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments:

CASP
Critical Appraisal Skills Programme

6. Has the relationship between researcher and participants been adequately considered?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments:

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments:

CASP
Critical Appraisal Skills Programme

8. Was the data analysis sufficiently rigorous?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments:

9. Is there a clear statement of findings?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments:

CASP
Critical Appraisal Skills Programme

Section C: Will the results help locally?

10. How valuable is the research?

HINT: Consider

- If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:	

Appendix E: Themes and Richness Ratings

Paper	Richness rating	Group	Developing experiential understanding & competence in therapeutic skills	Empathic understanding of the client	Personal and professional development	Course-related challenges	Challenging and distressing experiences	Processes in reflective practice groups
Bennett-Levy et al. (2003)	Thick	SP/SR	Y	Y	N	N	N	N
Bennett-Levy et al. (2001)	Thin	SP/SR	Y	Y	Y	N	Y	N
Biggins (2019)	Thick	CP	N	Y	N	N	Y	Y
Binks et al. (2013)	Thick	CP	N	Y	N	Y	Y	Y
Carmichael et al. (2020)	Thick	CP	N	Y	Y	N	Y	N
Chigwedere et al. (2018)	Thin	SP/SR	Y	Y	Y	N	Y	N
Fairhurst (2011)	Thin	CP	Y	N	Y	Y	Y	Y
Farrand et al. (2010)	Thin	SP/SR	Y	N	N	Y	Y	N
Fisher et al. (2015)	Thick	CP	N	Y	Y	N	N	N
Haarhoff et al. (2011)	Thin	SP/SR	Y	Y	Y	Y	Y	N
Hume (2017)	Thin	SP/SR	Y	Y	Y	Y	N	N
Kiemle (2008)	Thick	CP	Y	N	Y	Y	N	Y
Loveder (2017)	Thick	CP	N	Y	N	N	N	Y
Lyons et al. (2019)	Thick	CP	N	N	N	Y	Y	Y
Spafford & Haarhoff (2015)	Thin	SP/SR	N	N	N	Y	Y	N
Spendelow & Butler (2016)	Thin	SP/SR	Y	Y	Y	Y	Y	N
Sutton et al. (2007)	Thin	SP/SR	N	Y	Y	Y	Y	N
Wigg (2009)	Thick	CP	Y	N	Y	Y	N	Y
Wildig (2007)	Thin	CP	Y	Y	Y	N	Y	Y

Note. Y = study contributed towards theme, N = Study did not contribute towards theme. SP/SR = self-practice/self-reflection studies, CP = clinical psychology studies.

Appendix F: Inductive Thematic Analysis Process

Stage One

The results sections of each paper were extracted from studies and put into a table, using Excel. This data included themes and subthemes from the original papers, as well as added description from the results section regarding participants' subjective experiences. This facilitated immersion in the data and helped the researcher to begin to reflect on shared themes and patterns across studies (see Figure 1). Researcher reflexivity was essential in bracketing personal assumptions and biases during this process.

Figure 1

Excerpt from Excel spreadsheet with study information and a summary of findings

Authors	Nationality	Year	Journal	Topic	Sample	Summary of Results
Sutton, Townend, & Wright	UK	2007	Reflective Practice	Experiences of reflective learning journals by cognitive behavioural psychotherapy students	19 students (9 male, 10 female) completing a postgraduate course in cognitive behavioural psychotherapy.	**1) Benefits of the learning journal** - Thought and feeling expression - cathartic experience where thoughts and feelings can be captured. Facilitated greater awareness of their thoughts and feelings. - Client benefit and empathy - uncovering their own thoughts and feelings led to a deeper understanding of client's experiences. Practicing personal CBT techniques increased empathy for clients. - Reflection and self examination - reading and reflecting back on previously written entries. Beneficial to do so as helps to see how they have changed personally and professionally. **2) Process and content** - Form and content - students used different methods e.g., diary, positive data journalling, letters, supervision notes - each student developed own personal format and style of presentation and writing. - Frequency, amount and method - writing weekly was the most common freuqency whilst others wrote two or three monthly. For some it was mood dependent. Most were handwritten or typed. One student used a dictaphone. Varied in length from 3000 to 10,000. - Changes in structure and content - initially limited to entries about the course. Later = more personal reflections. Students reported positive changes in the structure and content of the journals as they progressed through course in terms of moving away from course content and academia to personal and client-based issues. **3) Unclear expectations and mixed messages** - Requirement and purpose uncertainty - confusion regarding purpose and requirements of the journal. Length, frequency and content. For some this reduced motivation to write reflectively. - Lecturer and course expectation - staff changes leading to increased confusion about the purpose of the journals due to differing staff expectations. - Evaluation and marking uncertainty - ambiguity regarding how journals would be evaluated and marked by tutors. How could subjective experiences in journals be objectively marked? **4) Perceptions of help and support with the learning journal** - Expressed lack of support - limited support within course to support reflective process of writing the journal. Left to deal with thoughts and feelings on their own. - Ethical issues - students asked to write expressively about personal experiences without being offered structured/ formal forum to discuss any issues/ receive support.
Spendelow & Butler	UK	2016	Psychotherapy Research	Outcomes associated with a SP/SR CBT exercise	32 trainee clinical psychologists (91% female)	**1) Personal** - Intrapersonal outcomes - **positive outcomes** - self-help skill acquisition (e.g. managing own worries), increased insight and awareness regarding own psychological processes. **Negative personal outcomes** - worried that the exercises might have negative effects e.g. overanalysing/ ruminating, might become aware of concealed psychological issues/ being triggered, hidden psychological problems might be uncovered/ severity of known problem may have been underestimated, and that the exercises wouldn't be of benefit. - Interpersonal outcomes - **feared negative outcomes** - fear of negative evaluation by others 'weak' or 'personally flawed'. Fear of unfavourable responses from others e.g., being judgemental. Feeling 'exposed' at having to make personal disclosures/ disclosing more than they would want, leading to discomfort. Discomfort of being in a group format - embarrassment/ vulnerability due to discussion of personal psychological difficulties. Breaches of confidentiality was a concern e.g. other group members disclosing to people outside of the group. **Positive attitudes** - those who had previous exposure to CBT as a client/ trainee therapist felt positive about task participation. **2) Professional** - CBT therapist skills - facilitated socialisation to therapeutic model, improved understanding of CBT techniques, enhanced ability to use these with clients. Enhanced ability to problem-solve issues that arise in therapy. More aware of potential barriers to engagement, e.g., with homework.

Stage Two

Two analytic groups were formed: 1) CBT SP/SR studies and 2) studies pertaining to reflective practices within clinical psychology training and practice. CBT SP/SR studies were analysed first and the clinical psychology studies analysed second. It was felt important to analyse these groups separately initially to acknowledge the contextual distinctions between these groups of studies (e.g., difference in professional background of the participants and methods of reflective practice).

For both analytic groups, the results sections of each paper were printed out and each theme was cut out, and labelled with the author's name and its grouping ('SP/SR' or 'Clin Psy'). In line with methodologies such as ideas webbing (as described in Popay et al., 2006), findings which were deemed conceptually similar were grouped together and tentative categories were developed. Negative cases were actively pursued throughout this process. The process of translation was also utilised. Pre-existing themes and the literal translation of words were not taken at face-value, but rather the meaning of the data was prioritised. This meant that pre-existing themes were broken down into several components in some cases, and new themes were formed which were felt to better encapsulate the meaning of the data.

Stage Three

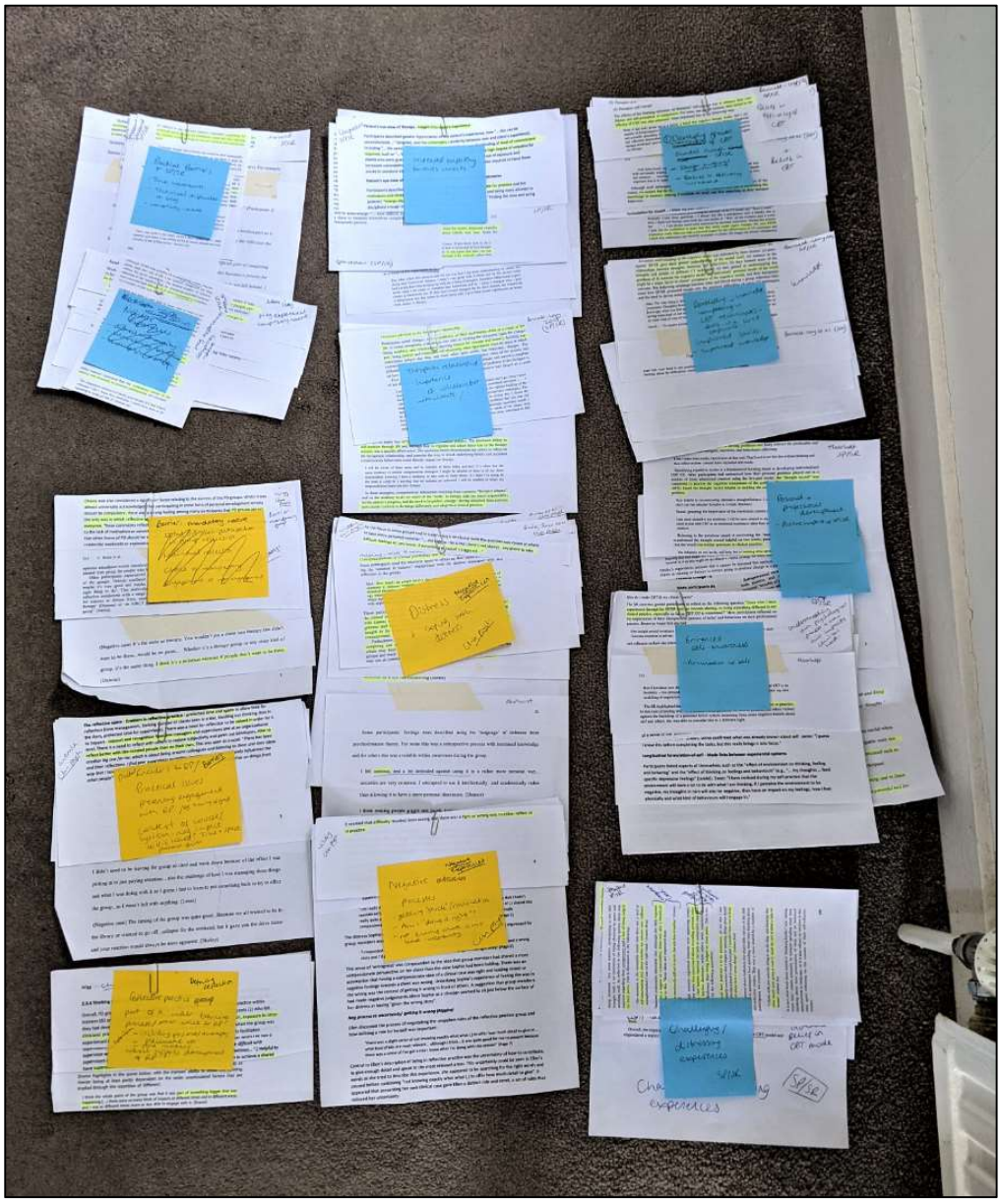
Drawing from grounded theory analysis, a similar analysis process to the constant comparison method was conducted through an inductive process of comparing findings with findings, findings with pre-existing themes, pre-existing themes with pre-existing themes, findings with analytical themes and analytical themes with analytical themes. The final themes were therefore developed and revised iteratively throughout the data analysis process, ensuring that they were grounded in the data.

In practice, descriptive themes/ categories were written onto coloured paper and sections of data were grouped below them and moved around to test out different groupings. Researcher reflexivity was essential throughout this process. The aims of the review were temporarily put to one side during this phase to ensure themes remained close to the data. The aims were then revisited once

all the descriptive themes had been identified to make sure the research questions could be answered (see Figure 2).

Figure 2

Photo to illustrate process of inductive thematic analysis to synthesise study findings



Stage Four

Overall themes for each analytic group were then inputted into a word document to summarise the findings across studies (see Figure 3 for excerpt from CBT SP/SR studies and Figure 4 for excerpt from clinical psychology studies).

Figure 3

Excerpt of themes developed from CBT SP/SR studies

5. Developing knowledge and skills in CBT techniques and therapeutic relationship

Papers which contributed: 6 – Chigwedere; Bennett-Levy, 2003; Farrand; Spendelow; Haarhoff; Bennett-Levy, 2001

CBT skills:

- Improved skills e.g. Therapeutic alliance skills, acquiring new skills/ tools, what skills to use when, flexibility in using tools (Chigwedere; Bennett-Levy, 2003; Farrand; Spendelow; Haarhoff)
- Improved knowledge e.g. maintenance cycles, limitations of model, mechanisms of the model, importance of emotions (Chigwedere; Farrand; Spendelow; Bennett-Levy, 2001; Haarhoff)

Therapeutic relationship

- Importance of collaboration, relationship skills, awareness of pull to fix but trying to listen more and talk less (Hume; Haarhoff; Bennett-Levy, 2001; Bennett-Levy, 2003)
- Reflecting on own beliefs and assumptions and how this may impact therapeutic relationship, reflecting in action during therapy sessions and adjusting (Haarhoff; Bennett-Levy, 2001; Bennett-Levy, 2003)

6. Course related barriers to SP/SR

Papers which contributed: 1 - Sutton

- Course related: uncertainty re appropriateness of marking as part of coursework (Sutton) and feeling the need to hold back/ censor reflections due to course staff marking (Sutton)
- Course related: Compulsory nature of SP/SR (Spafford) and negative emotions linked to feeling like you are being forced to reflect (Sutton)
- Course related: perceived lack of support from course which raises ethical concerns (Sutton).

7. Negative experiences (could this be split into intrapsychic barriers and negative experiences?)

Papers which contributed (7): Chigwedere, Haarhoff, Spendelow, Spafford, Sutton, Farrand, Bennett-Levy 2001.

- Experiencing negative emotions - frustration, deflation, anxiety, anger, irritation, boredom, impatience, embarrassment (Chigwedere; Haarhoff; Spendelow
- Intrapsychic barriers: Vulnerability re self-disclosure, exposing, fear of being judged and competence evaluated due to lack of anonymity, fear of negative evaluation e.g. weak or personally flawed (Chigwedere; Haarhoff; Spafford; Spendelow; Sutton)
- Intrapsychic barriers: Fear of breaches of confidentiality (Spendelow)
- Finding SP/SR challenging, difficult, uncomfortable, ambiguous, confusing re purpose and task (Chigwedere; Haarhoff; Sutton)
- Intrapsychic barriers: Fearing negative psychological effects as a consequence of engaging in exercises – e.g. overanalysing, ruminating on anxieties, becoming aware of concealed psychological issues, triggering something, uncovering psychological problem or a the severity of a pre-existing psychological problem has been underestimated (Spendelow)

Negative cases:

- Experiencing personal and professional growth despite experiencing some personal pain (Haarhoff; Spafford)

Figure 4

Excerpt of themes developed from clinical psychology studies

- **Course related barriers/ mandatory nature (4 papers)**
    - Binks – facilitators questioning mandatory nature of group – suggestion that it may not be right. Suggestion that it could remain mandatory but include choices re how trainees would like to reflect. Forced engagement led to rebellion by not contributing and staying silent/ being critical, dismissive, withdrawn, and difficult.
    - This was backed up by Wigg – agreed that reflective practice should be compulsory however there should be choice as groups may not be suitable for everyone – leading to lack of motivation and commitment from some. Process of opting out, in mind rather than body.
    - Wildig – difficulty of reflecting to command – can't force people to reflect which is what it felt like on course – then people vote with their feet and don't contribute – seen as unhelpful. Sensing that the course doesn't value reflective practice/ see it as important as it wasn't done in a way that was helpful to trainees.
    - Fairhurst – mandatory attendance unhelpful – a pointless exercise if people don't want to be there.

5. Outcomes: Benefits of RP

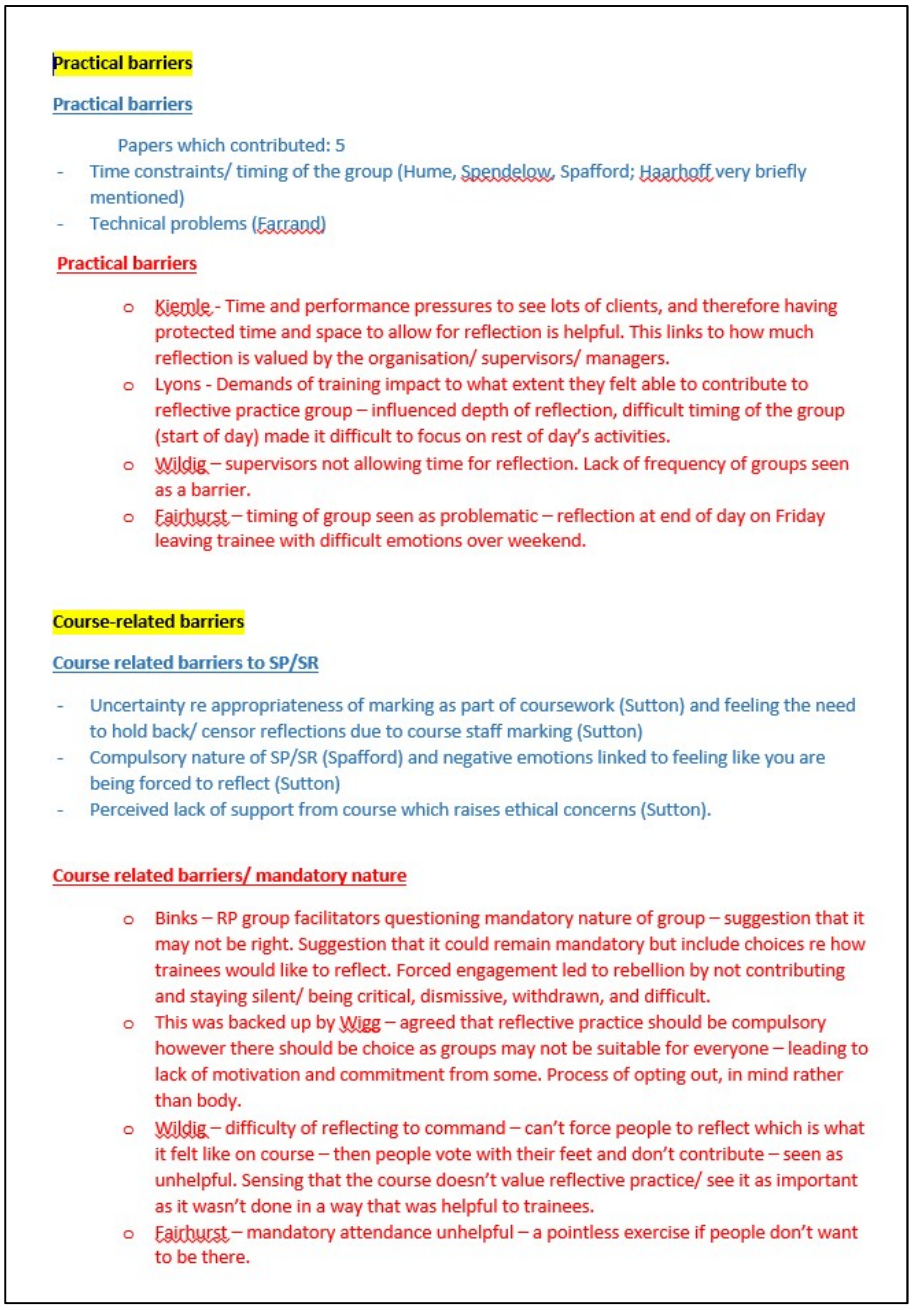
- **Increased understanding of client/ process during therapy (6 papers)**
    - Fisher – deepened understanding of client which was beneficial for the therapeutic relationship, being aware of transference and countertransference, reflection happens more regularly when they felt stuck/ client not improving, overall reflection helped them to understand client's perspective which helped them to move forward.
    - Wildig – being aware of process within therapeutic relationship, RP seen as a tool for planning next steps in clinical work, being reflexive to the needs of the client rather than sticking to plans or models, gaining experience of what it's like to be a client through RP groups.
    - Binks – RP helped trainees to connect with the client position and helped them in their therapeutic work, through gaining an experience of distress and difficulty in examining themselves – this was seen as a critical process.
    - Loveder – deepening understanding of case was the main outcome of RP group. Different perspectives of group members enrich understanding by communicating emotional reactions, sharing own perspectives, verbalising wonderings, sharing relevant knowledge, offering new understanding, suggesting practical actions
    - Carmichael – gaining new understanding and insights into clinical work, understanding the function of client behaviour. Using RP to gain empathy and understanding regarding the function of client behaviour. Felt like a containing process.
    - Biggins – Increased awareness of client's position, seeing situations from their point of view. Led to increased empathy for client and helped to adopt a more compassionate stance towards them. Gaining a different understanding of client behaviour by thinking about what they are trying to communicate – helped therapist to interact differently – deepened relationship and improved client engagement in therapy. Increased empathy and compassion for client's system – eg carers. RP helped to increase reflection on process in therapy and role of therapist own emotions and how this can inform the formulation/ understanding of client presenting difficulties and supported a greater understanding of the client.
- **Improved therapeutic skills and knowledge (4 papers)**

Stage Five

Similarities and differences between the themes of the two groups of studies were then compared and contrasted and shared themes were identified. Themes and data related to CBT SP/SR studies were coloured blue and themes and data related to clinical psychology studies were coloured red to distinguish between them during this process (see Figure 4 for excerpt which depicts this process).

Figure 4

Excerpt of document used to combine themes



Practical barriers

Practical barriers

Papers which contributed: 5

- Time constraints/ timing of the group (Hume, Spendelow, Spafford; Haarhoff very briefly mentioned)
- Technical problems (Farrand)

Practical barriers

- Kiemle - Time and performance pressures to see lots of clients, and therefore having protected time and space to allow for reflection is helpful. This links to how much reflection is valued by the organisation/ supervisors/ managers.
- Lyons - Demands of training impact to what extent they felt able to contribute to reflective practice group – influenced depth of reflection, difficult timing of the group (start of day) made it difficult to focus on rest of day's activities.
- Wildig – supervisors not allowing time for reflection. Lack of frequency of groups seen as a barrier.
- Fairhurst – timing of group seen as problematic – reflection at end of day on Friday leaving trainee with difficult emotions over weekend.

Course-related barriers

Course related barriers to SP/SR

- Uncertainty re appropriateness of marking as part of coursework (Sutton) and feeling the need to hold back/ censor reflections due to course staff marking (Sutton)
- Compulsory nature of SP/SR (Spafford) and negative emotions linked to feeling like you are being forced to reflect (Sutton)
- Perceived lack of support from course which raises ethical concerns (Sutton).

Course related barriers/ mandatory nature

- Binks – RP group facilitators questioning mandatory nature of group – suggestion that it may not be right. Suggestion that it could remain mandatory but include choices re how trainees would like to reflect. Forced engagement led to rebellion by not contributing and staying silent/ being critical, dismissive, withdrawn, and difficult.
- This was backed up by Wigg – agreed that reflective practice should be compulsory however there should be choice as groups may not be suitable for everyone – leading to lack of motivation and commitment from some. Process of opting out, in mind rather than body.
- Wildig – difficulty of reflecting to command – can't force people to reflect which is what it felt like on course – then people vote with their feet and don't contribute – seen as unhelpful. Sensing that the course doesn't value reflective practice/ see it as important as it wasn't done in a way that was helpful to trainees.
- Fairhurst – mandatory attendance unhelpful – a pointless exercise if people don't want to be there.

Appendix G: Reflexive Statement

A constructivist epistemological stance was taken to data analysis. This can be described as, "A social scientific perspective addressing how realities are made. This perspective brings subjectivity into view and assumes that people, including researchers, construct the realities in which they participate. Constructivist inquiry starts with the experience and asks how members construct it. To the best of their ability, constructivists enter the phenomenon, gain multiple views of it, and locate it in its web of connections and constraints. Constructivists acknowledge that their interpretation of the studied phenomenon is itself a construction." (Charmaz, 2014, p. 342).

It is acknowledged that all qualitative research is contextual and influenced by the researcher and the context in which the phenomenon is being studied (Dodgson, 2019). Credibility can be enhanced through researcher reflexivity. The researcher CM was a trainee clinical psychologist and completed this systematic review as part of doctoral research. CM had taken part in peer reflective practice groups, which were not facilitated, across the three years of training. CM had also engaged in various other forms of reflection, such as during clinical supervision and reflective practice groups whilst on placement. Despite finding group reflection challenging at times, CM came to value these opportunities for personal and professional development. These experiences engendered an interest in studying this area further. CM has not taken part in SP/SR before, and therefore was less familiar with this particular model of reflective practice. CM took a reflexive stance throughout the research process, using supervision to bracket personal assumptions and immersing herself in the subjective experience of participants. This helped to increase the credibility of findings.

References:

Charmaz, K. (2014). *Constructing grounded theory: A practical guide through qualitative analysis* (2nd Ed.). Sage.

Dodgson, J. E. (2019). Reflexivity in qualitative research. *Journal of Human Lactation, 35*, 220-222. https://doi.org/10.1177%2F0890334419830990

Appendix H: Training and Education in Professional Psychology Manuscript Guidance

Manuscripts

Manuscripts should be approximately 25 pages in length in total including tables and references (more pages must be strongly justified).
Each manuscript should conclude with a specific section on the implications of the research or theory presented.
Manuscripts should be written with the goal of enhancing the practice of education, training, and supervision.

Review Policy

Once *TEPP* receives a manuscript, the Editor reviews the manuscript for appropriateness for publication and competitiveness for publication in *TEPP*. If appropriate, the Editor assigns the manuscript to an Associate Editor who seeks blind review by at least two consulting editors or ad hoc reviewers.
The editorial review process takes approximately 60 to 90 days for the author to receive editorial comment about the manuscript

Manuscript Preparation

Prepare manuscripts according to the *Publication Manual of the American Psychological Association* using the 7th edition. Manuscripts may be copyedited for bias-free language (see Chapter 5 of the *Publication Manual*).
Review APA's Journal Manuscript Preparation Guidelines before submitting your article.
If your manuscript was mask reviewed, please ensure that the final version for production includes a byline and full author note for typesetting.
Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*.
Additional guidance on APA Style is available on the APA Style website.
Below are additional instructions regarding the preparation of display equations, computer code, and tables.

Display Equations

We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.
To construct your equations with MathType or Equation Editor 3.0:

- Go to the Text section of the Insert tab and select Object.
- Select MathType or Equation Editor 3.0 in the drop-down menu.

If you have an equation that has already been produced using Microsoft Word 2007 or 2010 and you have access to the full version of MathType 6.5 or later, you can convert this equation to MathType by clicking on MathType Insert Equation. Copy the equation from Microsoft Word and paste it into the MathType box. Verify that

your equation is correct, click File, and then click Update. Your equation has now been inserted into your Word file as a MathType Equation.
Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be produced as Word text using the Times or Symbol font.

Computer Code

Because altering computer code in any way (e.g., indents, line spacing, line breaks, page breaks) during the typesetting process could alter its meaning, we treat computer code differently from the rest of your article in our production process. To that end, we request separate files for computer code.

In Online Supplemental Material

We request that runnable source code be included as supplemental material to the article. For more information, visit Supplementing Your Article With Online Material.

In the Text of the Article

If you would like to include code in the text of your published manuscript, please submit a separate file with your code exactly as you want it to appear, using Courier New font with a type size of 8 points. We will make an image of each segment of code in your article that exceeds 40 characters in length. (Shorter snippets of code that appear in text will be typeset in Courier New and run in with the rest of the text.) If an appendix contains a mix of code and explanatory text, please submit a file that contains the entire appendix, with the code keyed in 8-point Courier New.

Tables

Use Word's Insert Table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

Academic Writing and English Language Editing Services

Authors who feel that their manuscript may benefit from additional academic writing or language editing support prior to submission are encouraged to seek out such services at their host institutions, engage with colleagues and subject matter experts, and/or consider several vendors that offer discounts to APA authors.
Please note that APA does not endorse or take responsibility for the service providers listed. It is strictly a referral service.
Use of such service is not mandatory for publication in an APA journal. Use of one or more of these services does not guarantee selection for peer review, manuscript acceptance, or preference for publication in any APA journal.

Submitting Supplemental Materials

APA can place supplemental materials online, available via the published article in the PsycARTICLES® database. Please see Supplementing Your Article With Online Material for more details.

Abstract and Keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

Public Significance Statements

Authors submitting manuscripts to *Training and Education in Professional Psychology* are required to provide 2–3 brief sentences regarding the public significance of the study, meta-analysis, or issues described in their paper. This description should be included within the manuscript on the abstract/keywords page. It should be written in language that is easily understood by both professionals and members of the lay public.

When an accepted paper is published, these sentences will be boxed beneath the abstract for easy accessibility. All such descriptions will also be published as part of the Table of Contents, as well as on the journal's web page. This new policy is in keeping with efforts to increase dissemination and usage by larger and diverse audiences.

Examples of these 2–3 sentences include the following:

- "This study highlights how certain therapist practices relate to the experiences of clients who are in consensually nonmonogamous (CNM) relationships. The results identify practices that are perceived as generally helpful or unhelpful, and point to the need for additional research, training, and guidelines to bridge therapists' knowledge gap regarding CNM."
- "This study suggests that nonsuicidal self-injury (NSS) among transmasculine people may be related to a combination of known risk factors for NSSI and experiences of stress from stigma due to their transgender identity. Findings highlight the need for health care providers to anticipate stressors related to transgender identity development in the context of societal stigma attached to gender minority identities and NSSI, take steps to intervene at the individual and family levels, and advocate for changes in policy to reduce stigma and facilitate gender affirmation."
- "As the Latinx population in the U.S. continues to grow, it is important to examine the consequences associated with multiple identities and interlocking systems of inequality. This intersectionality framework has the potential to advance our understanding of Latinx mental health but several theoretical, methodological, and statistical issues must be considered."
- "Inhibitory processes, particularly related to temporal attention, may play a critical role in response to exposure therapy for posttraumatic stress disorder (PTSD). The main finding that individuals with PTSD who made more clinical improvement showed faster improvement in inhibition over the course of exposure therapy supports the utility of novel therapeutic interventions that specifically target attentional inhibition and better patient-treatment matching."
- "When children participated in the enriched preschool program Head Start REDI, they were more likely to follow optimal developmental trajectories of social–emotional functioning through third grade. Ensuring that all children living in poverty have access to high-quality preschool may be one of the more effective means of reducing disparities in school readiness and increasing the likelihood of lifelong success."

To be maximally useful, these statements of public health significance should not simply be sentences lifted directly from the manuscript.

They are meant to be informative and useful to any reader. They should provide a bottom-line, take-home message that is accurate and easily understood. In addition, they should be able to be translated into media-appropriate statements for use in press releases and on social media.

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.
Examples of basic reference formats:

Journal Article

McCauley, S. M., & Christiansen, M. H. (2019). Language learning as language use: A cross-linguistic model of child language development. *Psychological Review*, *126*(1), 1–51. https://doi.org/10.1037/rev0000126

Authored Book

Brown, L. S. (2018). *Feminist therapy* (2nd ed.). American Psychological Association. https://doi.org/10.1037/0000092-000

Chapter in an Edited Book

Balsam, K. F., Martell, C. R., Jones. K. P., & Safren, S. A. (2019). Affirmative cognitive behavior therapy with sexual and gender minority people. In G. Y. Iwamasa & P. A. Hays (Eds.), *Culturally responsive cognitive behavior therapy: Practice and supervision* (2nd ed., pp. 287–314). American Psychological Association. https://doi.org/10.1037/0000119-012

Figures

Graphics files are welcome if supplied as Tiff or EPS files. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file.
The minimum line weight for line art is 0.5 point for optimal printing.
For more information about acceptable resolutions, fonts, sizing, and other figure issues, please see the general guidelines.
When possible, please place symbol legends below the figure instead of to the side.
APA offers authors the option to publish their figures online in color without the costs associated with print publication of color figures.
The same caption will appear on both the online (color) and print (black and white) versions. To ensure that the figure can be understood in both formats, authors should add alternative wording (e.g., "the red (dark gray) bars represent") as needed.
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In addition, APA Ethical Principles specify that "after research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release" (Standard 8.14).
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Authors are required to state in writing that they have complied with APA ethical standards in the treatment of their sample, human or animal, or to describe the details of treatment.

- Download Certification of Compliance With APA Ethical Principles Form (PDF, 26KB)

The APA Ethics Office provides the full Ethical Principles of Psychologists and Code of Conduct electronically on its website in HTML, PDF, and Word format. You may also request a copy by emailing or calling the APA Ethics Office (202-336-5930). You may also read "Ethical Principles," December 1992, *American Psychologist*, Vol. 47, pp. 1597–1611.

Other Information

Visit the Journals Publishing Resource Center for more resources for writing, reviewing, and editing articles for publishing in APA journals.

Appendix I: Importance of Cultural Competence

The demographic composition of the United Kingdom (UK) is becoming increasingly diverse (Rees et al., 2012). Despite decades of awareness raising regarding the need for equality in mental health provision (Department of Health, 1999; The National Service Framework for Mental Health), there remains disparity in access to mental health services across ethnic groups. In England, people experiencing mental health problems from Black Asian and Minority Ethnic (BAME) groups are less likely to access psychological therapy, achieve worse outcomes, are more likely to not complete treatment and report negative experiences during therapy (Baker, 2020; Crawford et al., 2016; Mercer et al., 2018). Members of BAME communities often only first come into contact with mental health services during crisis (Mind, 2013), leading to higher rates of psychiatric in-patient admissions (Bhui et al., 2003).

Further inequalities are evidenced amongst other vulnerable/ marginalised groups. People living in the most deprived areas in England are significantly less likely to access and engage in psychological therapy, achieving worse clinical outcomes compared to those from the least deprived areas (Baker, 2020). Those with a disability or people from certain religious backgrounds are also less likely to improve or recover following therapy (Baker, 2020). Refugees and asylum seekers experience high rates of post-traumatic stress disorder and other mental health problems, however relatively few seek support from mental health services (McCrone et al., 2005).

Public services have a duty to eliminate discrimination and actively promote equality (Equality Act, 2010). Several legislative and guidance documents have been developed in recent years to address inequalities in access, experience and outcomes for members of the BAME community and other marginalised groups (The NHS Long Term Plan, 2019; NHS

Mental Health Implementation Plan 2019/20 – 2023/24, 2019; NICE, 2018) and to support the development of culturally sensitive practice within therapy (e.g., Improving Access to Psychological Therapies BAME service user positive practice guide; Beck, Naz, Brooks, & Jankowska, 2019).

References:

Baker (2020). *Mental health statistics for England: prevalence, services and funding*. https://commonslibrary.parliament.uk/research-briefings/sn06988/

Beck, A., Naz, S., Brooks, M., & Jankowska, M. (2019). *Improving Access to Psychological Therapies BAME service user positive practice guide.* https://www.babcp.com/Portals/0/Files/About/BAME/IAPT-BAME-PPG-2019.pdf?ver=2020-06-16-004459-320

Bhui, K., Stansfeld, S., Hull, S., Priebe, S., Mole, F., & Feder, G. (2003). Ethnic variations in pathways to and use of specialist mental health services in the UK. *The British Journal of Psychiatry, 182*, 105-116. https://doi.org/10.1192/bjp.182.2.105

Crawford, M. J., Thana, L., Farquharson, L., Palmer, L., Hancock, E., Bassett, P., ... & Parry, G. D. (2016). Patient experience of negative effects of psychological treatment: results of a national survey. *The British Journal of Psychiatry, 208*, 260-265. https://doi.org/10.1192/bjp.bp.114.162628

Department of Health (1999). *National service framework for mental health*. https://www.gov.uk/government/publications/quality-standards-for-mental-health-services

Equality Act (2010). https://www.legislation.gov.uk/ukpga/2010/15

McCrone, P., Bhui, K., Craig, T., Mohamud, S., Warfa, N., Stansfeld, S. A., Thornicroft, G., & Curtis, S. (2005). Mental health needs, service use and costs among Somali refugees in the UK. *Acta Psychiatrica Scandinavica, 111*, 351-357. https://doi.org/10.1111/j.1600-0447.2004.00494.x

Mercer, L., Evans, L. J., Turton, R. & Beck, A. (2018). Psychological therapy in secondary mental health care: Access and outcomes by ethnic group. *Journal of Racial and Ethnic Health Disparities*, 1-8. https://doi.org/10.1007/s40615-018-00539-8

Mind (2013). *We still need to talk: A report on access to talking therapies*. https://www.mind.org.uk/media/494424/we-still-need-to-talk_report.pdf

NHS Mental Health Implementation Plan 2019/20 – 2023/24 (2019). https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/

NICE (2018). *Promoting health and preventing premature mortality in black, Asian and other minority ethnic groups*. https://www.nice.org.uk/guidance/qs167/chapter/Quality-statement-5-Support-for-people-with-mental-health-problems

Rees, P., Wohland, P., Norman, P., & Boden, P. (2012). Ethnic population projections for the UK, 2001–2051. *Journal of Population Research, 29*, 45-89. http://dx.doi.org/10.1007/s12546-011-9076-z

The NHS Long Term Plan (2019). https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

Appendix J: Rationale for Constructivist Grounded Theory Research Design

The design of the present study is an interview-based qualitative dyadic study of clinical psychologist supervisors and trainee clinical psychologist supervisee pairs using Constructivist Grounded Theory (Charmaz, 2014). This study's epistemological stance will be *constructivist*. It aims to develop theory from participants' experiences and the meanings they assign to such experiences. Within constructivism, social reality is believed to exist as individuals' experience it, interact with it and assign meaning to it. This understanding is created via social interaction and is a continual process (Appleton & King, 2002). Reality is therefore believed to be a constructed phenomenon in which there may be multiple 'truths'.

This viewpoint differs from a *positivist* perspective which assumes objective reality is to be found and the external world directly determines our perceptions of it (Kirk & Miller, 1986). A positivist epistemology asserts that everyone experiences reality in the same way.

Constructivism also differs from *critical realism* in which it is believed that there is objective truth to be found, however this is shaped by social structures and individual experience. A constructivist approach was felt to be most appropriate for the present study given the focus on individuals' experiences of exploring issues of culture and difference.

Constructivist grounded theory arose as an alternative to the *objectivist grounded theory approach* (e.g., Glaser & Strauss, 1967). The objectivist approach was underpinned by a positivist, empirical epistemological stance that assumed neutrality and objectivity on the part of the researcher. Charmaz (2014) argues that all data and analysis is socially created. It is therefore not possible for the researcher to be separate from the process or truly objective. The constructivist approach acknowledges that the resulting theory is a constructed interpretation based upon the researcher's perspective and stresses the importance of

reflexivity in understanding the researcher's position and how this may influence the various stages of the research process.

Constructivist grounded theory was chosen as the most appropriate method due to the exploration of social processes and identification of meanings within particular social interactions between supervisors and supervisees. A constructivist grounded theory approach offers a method of analysing and mapping such social processes, taking into account how the phenomena interact and identifying consequences (Charmaz, 2014; Willig, 2008). It was felt that other qualitative methodologies such as Interpretive Phenomenological Analysis (IPA) and Thematic Analysis (TA) would not capture these aspects and would not allow construction of theory to explore the possible complex social processes, interactions and mechanisms involved in discussions of culture and difference within the supervisory relationship.

References:

Charmaz, K. (2014). *Constructing grounded theory: A practical guide through qualitative analysis* (2nd Ed.). Sage.

Appleton, J. V., & King, L. (2002). Journeying from the philosophical contemplation of constructivism to the methodological pragmatics of health services research. *Journal of Advanced Nursing, 40*, 641-648. https://doi.org/10.1046/j.1365-2648.2002.02424.x

Kirk, J., & Miller, M. L. (1986). *Reliability and validity in qualitative research*. Sage Publications.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Weidenfeld & Nicholson.

Willig, C. (2008). *Introducing qualitative research in psychology* (2nd Ed.). Open University Press.

Appendix K: Study Approval Letter and Confirmation of Funding from the Oxford Institute of Clinical Psychology Training

Oxford Health NHS
NHS Foundation Trust

The Oxford Institute of Clinical Psychology Training

UNIVERSITY OF OXFORD

Oxford Doctoral Course in Clinical Psychology
An NHS Course validated by the University of Oxford

Isis Education Centre, Warneford Hospital, Oxford OX3 7JX
Tel: +44(0)1865 226431
Website: www.oxicpt.co.uk

4th June, 2018

To Whom It May Concern

Dear Sirs

Re: Confirmation of Funding Support – Charlotte McCann, Trainee Clinical Psychologist

I can confirm that Charlotte McCann, Trainee Clinical Psychologist, has full support for her research dissertation project. Charlotte has been allocated a budget to run her study and any costs incurred will be covered by the Oxford Institute of Clinical Psychology Training.

Please let me know if there is any further information you require.

Yours sincerely,

Myra Cooper

Dr Myra Cooper
Senior Research / Academic Tutor
and Acting Deputy Programme Director

Senior Research / Academic Tutor and Acting Deputy Programme Director:
Dr Myra Cooper, M.A. (Hons)., M.Phil., D.Phil., C.Psychol. Tel: (01865) 226375
myra.cooper@hmc.ox.ac.uk

Appendix L: Letter Confirming Central University Research Ethics Committee Approval and Email Approval of Minor Amendments

MEDICAL SCIENCES INTERDIVISIONAL RESEARCH ETHICS COMMITTEE
Research Services, University of Oxford, Wellington Square, Oxford, OX1 2JD
Tel: +44(0)1865 616577 Fax: +44(0)1865 280467
ethics@medsci.ox.ac.uk

CONFIDENTIAL

Ref: R59388/RE001

Charlotte McCann
The Oxford Institute of Clinical Psychology Training
The Isis Education Centre
Warneford Hospital
Oxford

1st October 2018

Dear Charlotte

Research Ethics Approval - CUREC 1

Study title: Exploring issues of culture and difference within the supervisory relationship: A grounded theory analyses

Short title: Culture and difference within the supervisory relationship

The above application has been considered on behalf of the Medical Sciences Interdivisional Research Ethics Committee (IDREC) in accordance with the procedures laid down by the University for Ethical Approval of all research involving human participants.

I am pleased to inform you that, on the basis of the information provided to the IDREC, the proposed research has been judged as meeting appropriate ethical standards, and approval has been granted for a period of **2 years**, commencing on **1st October 2018**. The reference number for this study is **R59388/RE001**.

This is **subject to:**

a) **it is your responsibility to comply with the requirements for administering any tests or questionnaires and, if in doubt, to contact the publisher of those tests or questionnaires.**

b) **if new research staff are engaged, the PI is responsible for ensuring they are suitably qualified by training and/or experience.**

I would like to remind you that your study may be selected for review by the MS IDREC during an annual audit.

Amendments

Should there be any subsequent changes to the study, you should submit details to the MS IDREC for consideration and approval. Details of changes must be listed on an amendment form. If your study received University Sponsorship through CTRG, then the amendment will first need to be submitted to CTRG for approval of continued Sponsorship.

Please do not hesitate to contact me if you have any queries.

Yours Sincerely

H. Barnby-Porritt

Dr. Helen Barnby-Porritt
Research Ethics Manager, Medical Sciences

Forward

MSD Ethics
Tue 05/11/2019 14:37

- Charlotte McCann;
- Helen Jenkins;
- sue.clohessy@mail.com

Dear Charlotte,

Thank you for submitting a request for an amendment to project R59388, which has been reviewed on behalf of the Medical Sciences Interdivisional Research Ethics Committee (IDREC).

I am pleased to inform you that your request to update Sue Clohessy's job role, email address, postal address and telephone number has been judged as meeting appropriate ethical standards, on the basis of the information provided to the IDREC, and approval has been granted, under reference R59388/RE002.

Please note that this email is your sole approval.

Best wishes
Helen

Dr Helen Barnby-Porritt
Research Ethics Manager (Medical Sciences) | Research Services
University of Oxford
University Offices, Wellington Square,
Oxford, OX1 2JD
T: +44 01865 (6)16577 **E:** ethics@medsci.ox.ac.uk
https://researchsupport.admin.ox.ac.uk/governance/ethics

Appendix M: Letter to Confirm HRA Approval and Email to Confirm Approval of Minor Amendments

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Mrs Charlotte McCann
The Oxford Institute of Clinical Psychology Training
The Isis Education Centre, Roosevelt Drive,
Warneford Hospital, Headington, Oxford
OX3 7JX

Email: hra.approval@nhs.net

17 October 2018

Dear Mrs McCann

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Exploring issues of culture and difference within the supervisory relationship: A grounded theory analysis**
IRAS project ID:	**248629**
Sponsor	**University of Oxford / Clinical Trials and Research Governance**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the "*summary of assessment*" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.

IRAS project ID	248629

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The attached document *"After HRA Approval – guidance for sponsors and investigators"* gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?
You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name: Oxford University Hospitals NHS Foundation Trust, Research and Development Department
Joint Research Office
Email: ouhtma@ouh.nhs.uk

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **248629**. Please quote this on all correspondence.

IRAS project ID	248629

Yours sincerely

Juliana Araujo
Assessor
Email: hra.approval@nhs.net

Copy to: *University of Oxford / Clinical Trials and Research Governance Joint Research Office*
Oxford University Hospitals NHS Foundation Trust, Research and Development Department Joint Research Office

IRAS project ID	248629

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [University of Oxford Insurance Policy]	1	04 September 2018
HRA Schedule of Events [Schedule of events v1.0 09.07.18 Validated]	1	09 July 2018
HRA Statement of Activities [Statement of activities v1.0 09.07.18 Validated]	1	09 July 2018
Interview schedules or topic guides for participants [Interview Schedule v1.0 09.07.18]	1	09 July 2018
IRAS Application Form [IRAS_Form_17092018]		17 September 2018
Letter from funder [Confirmation of funding]	1	04 June 2018
Letter from sponsor [Sponsor letter]	1	14 August 2018
Letters of invitation to participant [Supervisor invitation letter v1.0 09.07.18]	1	17 July 2018
Letters of invitation to participant [Email to course directors v1.0 09/07/18]	1	09 July 2018
Non-validated questionnaire [Demographic information sheet v1.0 09.07.18]	1	09 July 2018
Other [Participant debriefing sheet v1.0 09.07.18]	1	09 July 2018
Participant consent form [Consent Form v1.0 09.07.18]	1	09 July 2018
Participant information sheet (PIS) [Participant information sheet v1.0 09.07.18]	1	09 July 2018
Research protocol or project proposal [Research Protocol v1.0 09.07.18]	1	09 July 2018
Summary CV for Chief Investigator (CI) [CI research CV]	1	16 June 2018
Summary CV for supervisor (student research) [Sue Clohessy research CV]	1	13 September 2018
Summary CV for supervisor (student research) [Helen Jenkins research CV]	1	11 September 2018

IRAS project ID	248629

Summary of assessment

The following information provides assurance to you, the sponsor and the NHS in England and Wales that the study, as assessed for HRA and HCRW Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England and Wales to assist in assessing, arranging and confirming capacity and capability.

Assessment criteria

Section	Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	The Statement of Activities will form the agreement between the sponsor and the site(s). he Schedule of Events was submitted
4.2	Insurance/indemnity arrangements assessed	Yes	No comments
4.3	Financial arrangements assessed	Yes	The sponsor secured from funding from Oxford Institute of Clinical Psychology Training A copy of an unconditional funding award letter was received. The Statement of Activities confirms that no funds or resources will be allocated to the sites.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical	Not Applicable	No comments

IRAS project ID	248629

Section	Assessment Criteria	Compliant with Standards	Comments
	Trials Regulations assessed		
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Not Applicable	This study does not require NHS Research Ethics Committee review.
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England and Wales

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.
This is a multi-site study undertaking the same research activities; there is therefore one research type. The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England and Wales in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. Where applicable, the local LCRN contact should also be copied into this correspondence. If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England and Wales which are not provided in IRAS, the HRA or HCRW websites, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net or HCRW at Research-permissions@wales.nhs.uk. We will work with these organisations to achieve a consistent approach to information provision.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and Wales, and the minimum expectations for education, training and experience that PIs should meet (where applicable).
As per the Statement of Activities provided a Local Collaborator will be in place at each participating

IRAS project ID	248629

NHS organisation. No assistance to identify potential Collaborators is required from the participating NHS organisations.

GCP training is not a generic training expectation, in line with the HRA/HCRW/MHRA statement on training expectations.

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken
It is unlikely that letters of access or honorary research contracts will be applicable, except where external staff employed by another Trust (or University) are involved (and then it is likely that arrangements are already in place). Where arrangements are not already in place, external staff would be expected to obtain a Letter of Access based on standard DBS checks and occupational health clearance would be appropriate.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales to aid study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

hra.approval@nhs.net <noreply@harp.org.uk>
Mon 18/11/2019 10:32

- Charlotte McCann;
- CTRG Sponsorship Correspondence

Amendment Categorisation and Implementation Information

Dear Mrs McCann,

IRAS Project ID:	248629
Short Study Title:	Culture and difference within the supervisory relationship
Date complete amendment submission received:	5 November 2019
Amendment No./ Sponsor Ref:	Minor Amendment 1
Amendment Date:	22 October 2019
Amendment Type:	Non-substantial
Outcome of HRA and HCRW Assessment	**This email also constitutes HRA and HCRW Approval for the amendment,** and you should not expect anything further.
For NHS/HSC R&D Office information	
Amendment Category	**C**

Thank you for submitting an amendment to your project. We have now categorised your amendment and please find this, as well as other relevant information, in the table above.

What should I do next?

If you have participating NHS/HSC organisations in any other UK nations that are affected by this amendment **we will** forward the information to the relevant national coordinating function(s).

You should now inform participating NHS/HSC organisations of the amendment.

- For NHS organisations in England and/or Wales, this notification should include the NHS R&D Office, LCRN (where applicable) as well as the local research team.

When can I implement this amendment?

You may implement this amendment **immediately**. Please note that you may only implement changes described in the amendment notice.

Who should I contact if I have further questions about this amendment?

If you have any questions about this amendment please contact the relevant national coordinating centre for advice:

- England – hra.amendments@nhs.net
- Northern Ireland – research.gateway@hscni.net
- Scotland – nhsg.NRSPCC@nhs.net
- Wales – HCRW.amendments@wales.nhs.uk

Additional information on the management of amendments can be found in the IRAS guidance.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

Please do not hesitate to contact me if you require further information.

Kind regards

Mrs Kirsten Peck
HRA Approval Amendment Coordinator
Health Research Authority
Ground Floor | Skipton House | 80 London Road | London | SE1 6LH
E.hra.amendments@nhs.net
W. www.hra.nhs.uk

Sign up to receive our newsletter HRA Latest.

Appendix N: Research & Development Study Approval Letters

Oxford Health
NHS Foundation Trust

Professor Andrea Cipriani
Associate Director of Research & Development
Warneford Hospital
Oxford
OX3 7JX

Email: research@oxfordhealth.nhs.uk

Confirmation of Capacity and Capability

Re: Exploring issues of culture and difference within the supervisory relationship: A grounded theory analysis
Research and Development Reference: 13722
IRAS Reference: 248629
Sponsor: University of Oxford

Dear Miss Charlotte McCann,

On behalf of Oxford Health NHS Foundation Trust, I am pleased to confirm Trust Capacity and Capability for the above research as outlined in the application received.

Approved Documents

Protocol Version 2 dated 22/10/2019 is recognised as the most current to date.

The documents approved for use at this Trust are as listed in the following approval documents:

Health Research Authority Letter dated: 17/10/2018

Any subsequent, relevant amendments are additionally included to date.

Metrics and Recruitment

First Participant target	Agreed Total recruitment target
Target date: 10/02/2020	Target minimum: 5
	Recruitment Target date 01/08/2020

To comply with national research performance requirements the Trust will monitor and publish recruitment for your study:
1.Performance of the recruitment of the first participant.
2.Recruiting planned participants to time and target.

Recruitment of participants needs to be reported via the Siteline system. The R&D data manager will contact you to set this up in the coming weeks. Failure to report accruals may impact the ongoing approvals for this study.

Oxford Health
NHS Foundation Trust

Should you feel at any time that you will be unable to realistically achieve your contracted recruitment target, please get in touch with the Research Team on research@oxfordhealth.nhs.uk as soon as possible.

Conditions of Approval

The following conditions apply to this approval:

a) The study is conducted in compliance with all the relevant legislation and the relevant OHFT policies.
b) All staff working on the study have the appropriate training and experience and have responsibilities formally delegated to them.
c) Should you plan to leave your position in OHFT, you will notify R&D immediately of your plans, to enable discussions around the future of study conduct.
d) The Trust expects the named Principal Investigator to allocate regular support time to the study; this must be agreed with the research team prior to the study commencing. This may be reviewed by R&D at any time.
e) All relevant documents will be maintained and will be sent to research@oxfordhealth.nhs.uk, to facilitate compliance checks, formal audits and regulatory inspections.
f) You will notify R&D via the email above of any protocol amendments.
g) You will promptly inform R&D via the email above of the end of the study.

I wish you every success with the study.

Yours sincerely,



Professor Andrea Cipriani
Associate Director of Research & Development

SOP GE-04

NHS
Oxford University Hospitals
NHS Foundation Trust

Assignee: DR/PID13722/LoA Ref:999

Charlotte McCann
3,Frederick Place
Wokingham
Berkshire
RG41 2YB

OUH Research & Development
Joint Research Office
Second Floor, OUH Cowley
Unipart House Business Centre
Garsington Road
Oxford
OX4 2PG
Shahista.Hussain@ouh.nhs.uk
Tel: 01865 572231
Date : 03/12/2019

Dear Charlotte,

Re: Letter of access for research
Study Title: Exploring issues of culture and difference within the supervisory relationship: A grounded theory analysis
Project ID(PID) : 13722

As an existing NHS employee you do not require an additional honorary research contract with this NHS organisation. We are satisfied that the research activities that you will undertake in this NHS organisation are commensurate with the activities you undertake for your employer. Your employer is fully responsible for ensuring such checks as are necessary have been carried out. Your employer has confirmed in writing to this NHS organisation that the necessary pre-engagement check are in place in accordance with the role you plan to carry out in this organisation. This letter confirms your right of access to conduct research through **Oxford University Hospitals NHS Foundation Trust** for the purpose and on the terms and conditions set out below. This right of access commences on **25/11/2019** and ends on **30/11/2020** unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

You are considered to be a legal visitor to **Oxford University Hospitals NHS Foundation Trust** premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through **Oxford University Hospitals NHS Foundation Trust** you will remain accountable to your employer, **The Oxford Institute of Clinical Psychology** but you are required to follow the reasonable instructions of your nominated managers **Dr Sue Clohessy and Dr Helen Jenkins** in this NHS organisation or those given on her/his behalf in relation to the terms of this right of access.

NHS
Oxford University Hospitals
NHS Foundation Trust

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with **Oxford University Hospitals NHS Foundation Trust** policies and procedures, which are available to you upon request, and the UK Policy Framework for Health and Social Care Research (Nov 2017)
You are required to co-operate with **Oxford University Hospitals NHS Foundation Trust** in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on **Oxford University Hospitals NHS Foundation Trust** premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and the Trust (OUHTMA@ouh.nhs.uk) prior to commencing your research role at the Trust.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

Oxford University Hospitals NHS Foundation Trust will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

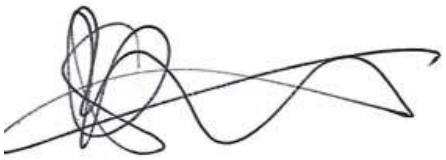
We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.

NHS
Oxford University Hospitals
NHS Foundation Trust

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or suitability to work with adults or children, or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the NHS organisation that employs you through its normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely



Shahista Hussain
Head of Research & Development Governance
Oxford University Hospitals NHS Foundation Trust

cc: tracy.mcateer@oxfordhealth.nhs.uk

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Charlotte McCann
The Oxford Institute of Clinical Psychology Training
Oxford Health NHS Foundation Trust
University of Oxford
Isis Education Centre
Warneford Hospital
Oxford , OX3 7JX

Research & Development
Psychology Department • University of Reading
Whiteknights Road • Earley • RG6 6AL
t: **0118 378 5650**
f: **0118 378 5705**
e: **research@berkshire.nhs.uk**

Date: 23/12/2019

Our Ref: 2019-39 REC Ref: 19/HRA/0387

Study title: Exploring issues of culture and difference within the supervisory relationship: A grounded theory analysis

Start date: 23/12/2019 End date: 01/10/2020

Dear Charlotte McCann,

Confirmation of Trust Management Approval

On behalf of Berkshire Healthcare NHS Foundation Trust, I am pleased to confirm Trust Management Approval for the above research on the basis described in the application, protocol and other supporting documents. Approval is **conditional on reporting up-to-date recruitment on monthly basis and the** submission of a brief final report of research findings. Trust approval will cease on the end date above. Failure to do so may result in approval being withdrawn.

It is the Trust's expectation that the study will comply with all applicable and relevant laws, such as the General Data Protection Regulation (GDPR) May 2018, the Human Tissue Act (2004), the Mental Capacity Act (2005) and adheres to the UK Policy Framework for Health and Social Care Research (2018), the principles of (ICH) Good Clinical Practice (GCP) and the NHS Confidentiality Code of Practice (Nov 2003) and if applicable the Clinical Trial regulations. You are required to submit a brief final report of research findings at the end of your project.

If there are any changes to the study protocol and/or recruitment period, the R&D Office must be informed immediately and supplied with any amended documentation as necessary, including confirmation that the amendments have been favourably reviewed by the Sponsor and the Ethics Committee.

If you have any questions about the above, or you require any other assistance, then please contact the R&D office research@berkshire.nhs.uk.

I wish you every success with the study.

Yours sincerely

Stephen Zingwe
Research and Development Manager

From the **1 July 2015 Berkshire Healthcare NHS Foundation Trust** is a **smoke free** organisation.
To help protect our staff and people who use our services from the harmful effects of tobacco smoke, please do not smoke anywhere on our sites, or during appointments when our staff are at your home. If you would like support to quit please speak to your healthcare professional or contact **Smoke Free Life Berkshire** on **0800 622 6360** or text **QUIT** to **66777**

Safe & compassionate care, every time

NHS
Buckinghamshire Healthcare
NHS Trust

Stoke Mandeville Hospital
Mandeville Road
Aylesbury
Buckinghamshire
HP21 8AL
Tel: 01296 315000
www.buckshealthcare.nhs.uk

Research Office

Date: **26th February 2020**

Dear **Charlotte McCann**

Letter of access for research

As an existing NHS employee you do not require an additional honorary research contract with this NHS organisation. We are satisfied that the research activities that you will undertake in this NHS organisation are commensurate with the activities you undertake for your employer. Your employer is fully responsible for ensuring such checks as are necessary have been carried out. Your employer has confirmed in writing to this NHS organisation that the necessary pre-engagement check are in place in accordance with the role you plan to carry out in this organisation. This letter confirms your right of access to conduct research project **'Culture and difference within the supervisory relationship''** through Bucks Healthcare for the purpose and on the terms and conditions set out below. This right of access commences on 26/02/2020 and ends on 30/11/2020 unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

You are considered to be a legal visitor to Bucks Healthcare premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through Bucks Healthcare, you will remain accountable to your employer Oxford Health NHS Foundation Trust but you are required to follow the reasonable instructions of your nominated manager, Dr Claire Daniel in this NHS organisation or those given on her behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and each participating Buckinghamshire NHS Trust prior to commencing your research role at each site.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice and the Data Protection Act 2018. Further more you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

The Buckinghamshire NHS Trust will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 2018. Any breach of the Data Protection Act 2018 may result in legal action against you and/or your substantive employer.

You must act in accordance with Bucks Healthcare policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with Bucks Healthcare in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on Bucks Healthcare premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. Where applicable, your substantive employer will initiate your Independent Safeguarding Authority (ISA) registration in-line with the phasing strategy adopted within the NHS and the applicable legislation. Once you are ISA-registered, your employer will continue to monitor your ISA registration status via the on-line ISA service. Should you cease to be ISA-registered, this letter of access is immediately terminated. Your substantive employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or ISA registration, or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the NHS organisation that employs you through its normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely



Nicola Higgins, RM&G Manager

cc: R&I office at Bucks Healthcare NHS Trust
HR department of the substantive employer (and provider of honorary clinical contract, where applicable)
HR department, Bucks Healthcare NHS Trust

Appendix O: Letter Confirming University of Oxford Sponsorship





RESEARCH SERVICES
Clinical Trials and Research Governance
Joint Research Office
Boundary Brook House
Churchill Drive
Headington, Oxford
OXON
OX3 7GB

To whom it may concern

Date: 14/08/2018

Dear Sir/Madam,

Title: Exploring issues of culture and difference within the supervisory relationship: A grounded theory analysis

PID: 13722

Protocol Date/Version: 09.07.2018 Version 1.0

The above study has been designed by Miss Charlotte McCann and colleagues at the University of Oxford and funded by The Oxford Institute of Clinical Psychology. I confirm that the University will accept the role of Research Sponsor of this Study and will comply with the requirements of the UK Policy Framework for Health and Social Care Research October 2017.

Insurance-provided indemnity arrangements are in place for the project:
Newline Underwriting Management Ltd., at Lloyd's of London.

Sponsorship is confirmed subject to the condition that the following are sent to Clinical Trials and Research Governance for review prior to submission to the Research Ethics Committee. Failure to do so may compromise insurance cover for the project.

- Any minor or substantial amendments
- Any extension to the study end date
- Addition of any new research site or patient identification centre

In addition, annual progress reports, the end of study notification and final report must be copied to Clinical Trials and Research Governance.

Lastly, where they exist, University Core SOPs must be followed by default for all clinical research sponsored by the University. Further information can be found here: https://www.admin.ox.ac.uk/researchsupport/ctrg/resources/

Any communications relating to Research Sponsorship should be directed to the undersigned, whose contact details are given in this letter.

Yours faithfully

Heather House
Head of Clinical Trials and Research Governance

Tel: +44 (0)1865 616480 Web: www.admin.ox.ac.uk/researchsupport/ctrg/
Email: Heather.house@admin.ox.ac.uk or Elaine.Chick@admin.ox.ac.uk

Appendix P: Participant Debriefing Sheet

The Oxford Institute of Clinical Psychology Training
University of Oxford

Chief Investigator: Charlotte McCann
Email: charlotte.mccann@hmc.ox.ac.uk
Tel: +44 (0)1865 226 431

Exploring issues of culture and difference within the supervisory relationship: A grounded theory analysis

DEBRIEFING SHEET

CUREC Approval Reference: R59388/RE001

Many thanks for your participation in this study.

If at any point after the interview you become distressed, you are encouraged to make use of one or more of the following sources of support.

1. Dr Sue Clohessy is a Chartered Psychologist. She can be contacted via email (sue.clohessy@mail.com) or telephone, 07580 535477.

2. Dr Helen Jenkins is a Clinical Tutor and Lead for Personal and Professional Development at the Oxford Doctoral Course in Clinical Psychology. She can be contacted via email (helen.jenkins@hmc.ox.ac.uk) or telephone, 01865 226 431.

3. Your current supervisor or line manager may also be in a position to offer support or to provide a reflective space to explore any distress.

4. You may wish to seek support from an external agency such as The Samaritans. They can be contacted via email (jo@samaritans.org) or telephone, 116 123.

If you would like any further details about the study, or to receive a summary of the results at the end of the study, please contact:

Charlotte McCann or Dr Helen Jenkins
The Oxford Institute of Clinical Psychology Training
The Isis Education Centre, Roosevelt Drive, Warneford Hospital,
Headington, Oxford, OX3 7JX.
Tel. +44 (0)1865 226 431
Email: charlotte.mccann@hmc.ox.ac.uk or helen.jenkins@hmc.ox.ac.uk

Dr Sue Clohessy
51 Southdale Road, Oxford, OX2 7SE.
Tel. 07580 535477
Email: sue.clohessy@mail.com

Appendix Q: Email to Course Director

Dear [name],

I am a third year trainee clinical psychologist on the Oxford Doctoral Course in Clinical Psychology. If possible, I would like to invite trainee clinical psychologists from the [place] course, alongside their clinical supervisors, to participate in a study entitled "Exploring issues of culture and difference within the supervisory relationship: A grounded theory analysis" which is a part of my dissertation.

Below is a brief summary of the project. I would be very grateful if you could disseminate this information to trainees, who if interested should contact me directly via email (charlotte.mccann@hmc.ox.ac.uk) for further details. If it would be helpful, I'd be very happy to visit the [place] course to discuss my project with trainees face-to-face.

This project has been approved by the University of Oxford Central University Research Ethics Committee (CUREC), CUREC Reference Number R59388/RE001. If you require any additional paperwork, then please do let me know.

Best wishes,

Charlotte McCann

Trainee Clinical Psychologist

Project summary

Title: Exploring issues of culture and difference within the supervisory relationship: A grounded theory analysis

Purpose of the research: We are interested in how supervisors and supervisees experience discussions of culture and difference within the supervisory relationship.

Inclusion criteria:

- Trainee Clinical Psychologists in any stage of their training, and those within their first year post-qualification and
- Qualified Clinical Psychologists providing clinical supervision to the recruited supervisees, or who provided supervision to the recruited supervisees during their final year of training
- Those who are able to recall instances where issues of culture and difference were relevant during supervision with their supervisor/ supervisee
- Both supervisors and supervisees must agree to be interviewed about their experiences.

Exclusion criteria: Those who are in the researcher's (Charlotte McCann) own cohort or who have a personal relationship with the researcher.

What is required? Trainees who are interested in participating will be asked to inform their clinical supervisors about the study alongside contact details for the researcher (a supervisor cover sheet

with this information will be provided). Once their supervisor has contacted the researcher and both parties are willing to participate, a single face-to-face interview will be conducted at a convenient location for each participant. The interviews will be between 45 to 60 minutes in duration and supervisor and trainee interviews will be held separately.

Appendix R: Participant Information Sheet

The Oxford Institute of Clinical Psychology
Training
University of Oxford

Chief Investigator: Charlotte McCann
Email: charlotte.mccann@hmc.ox.ac.uk
Tel: +44 (0)1865 226 431

Exploring issues of culture and difference within the supervisory relationship: A grounded theory analysis

PARTICIPANT INFORMATION SHEET

CUREC Approval Reference: R59388/RE001

We would like to invite you to take part in our research study. Before you decide to do so, we would like you to understand why the research is being done and what it would involve for you. Please take time to read this information sheet. We will be happy to answer any questions you have. You can take as much time as you need before deciding whether to take part in this study. Please ask us if there is anything that is unclear.

Thank you for reading this.

1. Background and aims of the study

Within the field of clinical psychology training, supervision is thought to be key to the development of culturally competent clinical practice. There is limited research concerning how this is experienced in practice by supervisees and their supervisors. This study aims to explore supervisor and supervisee experiences of discussing culture and difference within the supervisory relationship. It is hoped that the results of this study will help to inform supervision training and practice within the field of clinical psychology. This study is funded by the Oxford Doctoral Course in Clinical Psychology.

2. Why have I been invited to take part?

You have been asked to take part because you are either a supervisor (qualified clinical psychologist) or a supervisee (trainee clinical psychologist/ newly qualified clinical psychologist within your first year post-qualification). We want to explore your experiences of discussing culture and difference within supervision. We aim to recruit around 5 – 6 supervisory pairs (10 – 12 participants) for the study.

3. Do I have to take part?

No. Your participation is voluntary. You will have opportunity to ask any questions you may have about the study prior to deciding whether or not to participate. If you do agree to participate, you may withdraw yourself (and your data) at any point during the interview and until your data has been analysed. After this point, your data may be used in the analysis to inform any changes to the interview schedule for subsequent participants, in line with a theoretical sampling approach. You may withdraw without giving a reason and without penalty by advising the researchers of this decision.

4. What will happen in the study?

In order for you to participate in the study, both supervisor and supervisee must agree to take part in the research. Once you have both agreed to participate, an individual interview with the

researcher will be arranged at a time that is convenient for you. Supervisors and supervisees will be interviewed separately however the study procedure will be exactly the same for you both. All interviews will be recorded on an encrypted audio-recorder. You will have a chance to go through the study procedures with the investigator and will be able to ask any questions. You will then be asked to sign a consent form prior to the interview. This study consists of one semi-structured interview at a location that is convenient for you to get to. This may be in a private room at the university base of the clinical psychology course you/ your supervisee is part of, your place of work, or a private room in a local library, community building or your own home. If none of these options are convenient, it may be possible to arrange a skype call instead. In this case, we will send you a consent form via email for you to print and sign. We will then request that you scan and email back a copy of the form, which the researcher will then sign and send back to you for your records prior to arranging a time for the skype call. During the interview, we will use the record function on Skype to record the conversation and store it on a password protected computer. You should use a private room for the interview to take place.

The interview will last between 45 minutes to 1 hour and will focus on your experiences of discussing culture and difference within the supervisory relationship. At the start of the interview there will be a brief demographic questionnaire for you to complete. This should take no longer than 5 minutes and you will be asked questions concerning what year of training you are in if you are a trainee or how long you have been qualified if you are a supervisor, your gender, ethnicity and theoretical orientation.

If information about unethical or unprofessional practice is disclosed during the interviews, we will act upon this by suggesting you discuss such matters with the appropriate professionals and consult with the British Psychological Society (BPS) or the Health and Care Professions Council (HCPC). Should serious breaches of professional or ethical practice be disclosed, the concern(s) will be discussed within the research team (Charlotte McCann, Dr Sue Clohessy and Dr Helen Jenkins) to consider whether any further support, action or onward referral may be warranted.

5. Are there any potential risks in taking part?

For some individuals, exploring issues of culture and difference may be sensitive subject areas. We will be asking you to reflect on your professional experiences of exploring these areas in supervision rather than personal experiences more generally. If you do find the interview or parts of the discussion distressing, please let the researcher know. You can end the interview at any time. Information concerning appropriate sources of support will also be provided.

6. Expenses and Payments

To thank you for your participation, you will receive £10 in cash after you have completed the interview.

7. Are there any benefits in taking part?

There will be no direct benefit to you from taking part in this research, however the findings of the study are hoped to be a helpful contribution to the supervision literature which may benefit the field of clinical psychology more broadly.

8. What happens to the data provided?

The data collected during this study will be kept strictly confidential. Interviews will be recorded on an encrypted audio recorder. The recording will be deleted after it has been transferred to a password-protected computer. After the interview has been transcribed the recording will be

deleted from the computer. You will only be identified by a participant identification number and we will use a pseudonym so that data, including quotes in the final write up, cannot be linked back to you. Any person identifiable information will be omitted or removed from interview transcripts. Any paper information (such as signed consent forms) will be stored safely in lockable cabinets in a swipe-card secured building. We will keep a record of your name, contact details, pseudonym and participant identification number on an excel database, which will be saved on a password protected computer. We will delete this document upon completion of the study. Only the research team will have access to personal data. Fully anonymised data may be shared with other researchers (e.g. students and collaborators) within the Oxford Doctoral Course in Clinical Psychology. In particular a qualitative research group has been set up comprising of trainees (from the researcher's cohort) for the purposes of reflection, analysis and coding of transcripts.

All research data will be stored for a minimum retention period of three years after publication or public release of the research, in accordance with the University of Oxford's Policy on the Management of Research Data & Records.

Responsible members of the University of Oxford and regulatory authorities may be given access to data for monitoring and/or audit of the study to ensure that the research is complying with applicable regulations.

9. Will the research be published?

We hope to publish the results of this study in an academic journal. We may also present the findings at a conference and/or the Oxford Doctoral Course in Clinical Psychology website. The data will also be used in a thesis as part of Charlotte McCann's Doctorate in Clinical Psychology (DClinPsy). The University of Oxford is committed to the dissemination of its research for the benefit of society and the economy and, in support of this commitment, has established an open access online archive of research materials to increase the likely impact and use of research. The research materials from this study may be deposited in the University archives, to facilitate its use in future research. It will not be possible to identify you in any report or publication.

If you are interested, you may contact Charlotte McCann (email address below) at the end of the study for a summary of the findings.

10. Who is organising and funding the research?

This research is organised and funded by the Oxford Institute of Clinical Psychology Training.

11. Who has reviewed this study?

This study has been reviewed by, and received ethics clearance through, the University of Oxford Central University Research Ethics Committee (reference number: R59388/RE001).

12. Who do I contact if I have a concern about the study or I wish to complain?

If you have a concern about any aspect of this study, please speak to the relevant researchers Charlotte McCann (charlotte.mccann@hmc.ox.ac.uk), Principal Investigator, Dr Sue Clohessy (sue.clohessy@mail.com) or Dr Helen Jenkins (helen.jenkins@hmc.ox.ac.uk), who will do

their best to answer your query. The researcher should acknowledge your concern within 10 working days and give you an indication of how they intend to deal with it. If you remain unhappy or wish to make a formal complaint, please contact the relevant chair of the Research Ethics Committee at the University of Oxford who will seek to resolve the matter in a reasonably expeditious manner: Chair, **Medical Sciences Inter-Divisional Research Ethics Committee**; Email: ethics@medsci.ox.ac.uk; Address: Research Services, University of Oxford, Wellington Square, Oxford OX1 2JD.

13. Data Protection

We will be using information from you in order to undertake this study. Research is a task that we perform in the public interest. The University of Oxford, as sponsor, is the data controller. This means that we, as University of Oxford researchers, are responsible for looking after your information and using it properly. We will use the minimum personally-identifiable information possible. We will keep identifiable information about you for 3 months after the study has finished. We will store the anonymised research data and any research documents with personal information, such as consent forms, securely at the University of Oxford for 3 years after the end of the study.

Your rights to access, change, or move your personal information may be limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. Further information about your rights with respect to your personal data is available at http://www.admin.ox.ac.uk/councilsec/compliance/gdpr/individualrights.
You can find out more about how we use your information by contacting the CI charlotte.mccann@hmc.ox.ac.uk.

14. Contact Details

If you would like to discuss the research with someone beforehand (or if you have questions afterwards), please contact:

Charlotte McCann or Dr Helen Jenkins
The Oxford Institute of Clinical Psychology Training
The Isis Education Centre, Roosevelt Drive, Warneford Hospital, Headington, Oxford, OX3 7JX.
Tel. +44 (0)1865 226 431
Email: charlotte.mccann@hmc.ox.ac.uk
or helen.jenkins@hmc.ox.ac.uk

Dr Sue Clohessy
51 Southdale Rd Oxford OX2 7SE
Tel. 07580 535477
Email: sue.clohessy@mail.com

Appendix S: Supervisor Invitation Letter

The Oxford Institute of Clinical Psychology Training
University of Oxford

Chief Investigator: Charlotte McCann
Email: charlotte.mccann@hmc.ox.ac.uk
Tel: +44 (0)1865 226 431

Exploring issues of culture and difference within the supervisory relationship: A grounded theory analysis

Supervisor Invitation Letter

CUREC Approval Reference: R59388/RE001

We would like to invite you to take part in the above study which aims to explore supervisor and supervisee experiences of discussing culture and difference within the supervisory relationship. We have asked your supervisee (trainee/ newly qualified clinical psychologist) to pass on this invitation letter and a study participant information sheet to you. The study design requires that both you and your supervisee take part. This project has been approved by the University of Oxford Central University Research Ethics Committee (CUREC), Reference Number R59388/RE001 and is part of Charlotte McCann's doctoral thesis.

Once you have agreed to participate, a time to meet for an individual interview with the researcher will be arranged at a time and location that is convenient for you. Supervisees and supervisors will be interviewed separately about their experiences of discussing culture and difference within supervision. The study consists of one semi-structured interview and a brief demographics form. The interview will last for a maximum of 1 hour and the demograhics form should take 5 minutes to complete.

To thank you for your participation, you will receive £10 in cash after the interview.

If you are interested in taking part in this study, please contact Charlotte McCann (charlotte.mccann@hmc.ox.ac.uk). If you have any questions, please do not hesitate to make contact via email.

Many thanks for your time.

Yours sincerely,

Charlotte McCann

The Oxford Institute of Clinical Psychology Training
The Isis Education Centre, Roosevelt Drive, Warneford Hospital, Headington, Oxford, OX3 7JX.
Tel. +44 (0)1865 226 431
Email: charlotte.mccann@hmc.ox.ac.uk

Appendix T: Participant Consent Form

The Oxford Institute of Clinical Psychology Training
University of Oxford

Chief Investigator: Charlotte McCann
Email: charlotte.mccann@hmc.ox.ac.uk
Tel: +44 (0)1865 226 431

Exploring issues of culture and difference within the supervisory relationship: A grounded theory analysis

PARTICIPANT CONSENT FORM

CUREC Approval Reference: R59388/RE001

Purpose of Study: This study aims to explore supervisee and supervisor perspectives on issues of culture and difference within the supervisory relationship.

		*Please **initial** each box*
1	I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without any adverse consequences or academic penalty.	☐
3	I understand that research data collected during the study may be looked at by designated individuals from the University of Oxford and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to access my data.	☐
4	I understand that this project has been reviewed by, and received ethics clearance through, the University of Oxford Central University Research Ethics Committee.	☐
5	I understand who will have access to personal data provided, how the data will be stored and what will happen to the data at the end of the project.	☐
6	I agree to the interview being recorded on an encrypted audio recorder	☐
7	I understand how this research will be written up and published. This may include direct quotes, however all person identifiable information will be removed and pseudonyms used to protect your anonymity.	☐

8	I understand how to raise a concern or make a complaint.	☐
9	I agree to take part in the above study.	☐

Name of Participant	Date	Signature

Name of person taking consent	Date	Signature

Appendix U: Demographic Information Questionnaire

The Oxford Institute of Clinical Psychology Training
University of Oxford

Chief Investigator: Charlotte McCann
Email: charlotte.mccann@hmc.ox.ac.uk
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Exploring issues of culture and difference within the supervisory relationship: A grounded theory analysis

DEMOGRAPHIC INFORMATION QUESTIONNAIRE

CUREC Approval Reference: R59388/RE001

Participant identification number:

We would be grateful if you could complete the following demographic questions:

- How long have you been a supervisor/ supervisee to your colleague who is also participating in this study?
- What is your gender (optional)?
- What is your ethnicity (optional)?

For supervisees:

- What year of training are you in/ how many months have you been qualified?
- What placement number are you currently on?
- As a trainee clinical psychologist, how many supervisory relationships have you been part of?
- Do you feel oriented to any particular theoretical orientation/ model?

For supervisors:

- How many years have you been qualified?
- As a qualified clinical psychologist, approximately how many trainees/ staff members have you supervised?
- Do you feel oriented to a particular theoretical orientation/ model?

Appendix V: Interview Schedule

Department of Experimental Psychology
University of Oxford

Chief Investigator: Charlotte McCann
Email: charlotte.mccann@hmc.ox.ac.uk
Tel: +44 (0)1865 226 431

Exploring issues of culture and difference within the supervisory relationship: A grounded theory analysis

INTERVIEW SCHEDULE

CUREC Approval Reference: R59388/RE001

Opening questions:

Can you tell me what you understand by culture and difference in your clinical/ professional practice?

In your general experience of supervisory relationships (as a supervisor/supervisee), can you tell me about your experiences of discussing difference or culture during supervision?

- Prompt – what helps facilitate these discussions? Anything that inhibits these discussions?
- Prompt – are there any factors that you think influence these discussions?

Intermediate questions:

Modification: Thinking about the supervisory relationship we are exploring in this study, have there been certain aspects of culture or difference that you feel have been relevant, whether voiced or unvoiced?

- Can you give an example?
- **If there was a discussion** - How was the conversation initiated? How did you/ they respond? How did you feel during the conversation? How did the conversation end? Did you feel the conversation had an effect on your relationship/ work in any way? What do you think helped to facilitate discussion about it?
- **If there wasn't discussion** – how did you make sense of this not being discussed? What might have been the barriers? Do you feel this impacted on you personally/ on your work/ on your supervisory relationship?

Are there certain aspects of culture or difference that you may feel more comfortable talking about with your supervisor/ supervisee? (e.g. gender, ethnicity, social class, age, etc.)

Are there certain aspects that feel less comfortable to talk about?

Can you give me an example of the kinds of things that were discussed in supervision concerning things that felt more/ less comfortable?

- How was the conversation initiated?
- How did you/ your supervisee/ supervisor respond when the conversation was initiated?

- Can you remember how you felt during the conversation? What was going through your mind at the time?
- Was there anything that stood out to you during the conversation?
- How did this conversation end?
- What was the impact of the conversation on you? Your supervisee/ supervisor? On your supervisory relationship? On your work?

What do you feel helps to initiate/ facilitate conversations about culture, difference and diversity?

Are there any things that might hinder these conversations/ make them difficult?

In what way might these discussions be important/ helpful/ meaningful?

Modifications to interview schedule:

Have there been times where perhaps similarity (rather than difference) has been relevant in supervision? Either between you and your supervisee/ supervisor or within client work?

Do you feel that therapeutic orientation has any influence on discussions about culture and difference in supervision?

Do you feel that any of your views or practices in relation to culture and difference have changed at all over time (i.e. during training/ your career)?

Ending questions:

Reflecting on the discussion we've just had, is there anything that came up that surprised you or stood out to you?

Is there anything you might not have thought about before that occurred to you during this interview?

Is there anything else you think I should know about in order to understand your experience better?

Is there anything you would like to ask me?

Appendix W: Excerpts from Reflective Journal

4th March 2020

Ahhh I'm waiting to do my first interview. Feeling very anxious. Want to make sure I ask the right questions. Help interviewee to feel comfortable. I want to sound like I kind of know what I'm doing but I really don't. What if I struggle to concentrate on what they are saying because I'm too caught up in my head? What if I'm not validating enough? What if I don't ask good clarifying or follow up questions?

9th March 2020 – interview T1

I've just started transcribing my first interview. I can't believe how long it is taking. I'm finding it helpful to listen back to the interview and think a bit about my assumptions and biases that could have been influencing the questions I asked. For example, I realised assumptions around supervisees finding it difficult to raise issues of culture and difference (when this might not be the case) and assumptions that supervisors might not address these in a way that felt helpful to the supervisee or perhaps may have dismissed them (when this was not necessarily the case!). I also hadn't considered how someone's personal and professional background might influence the level of comfort around discussing and exploring culture and difference, e.g., the impact of prior training in social work/ the country they are from and how this shapes a person's way of thinking so much that it almost becomes an automatic response to discuss culture and difference. I had assumed that it was the level of comfort within the supervisory relationship that would have made the biggest difference – although I think this was still a factor for this particular person. I was surprised he said that he had never had trouble discussing these things in supervision though. I think I also assumed that we aren't good at thinking about culture and difference and perhaps asked slightly leading questions around this. It seemed that his experience was that his supervisors were open to exploring issues of culture and difference. It was also unexpected that he talked about his own temperament in thinking about what helps to facilitate discussions of culture and difference, i.e. being an extrovert. A theme around similarity came up – it seems that having similarities is important in forming a connection with a supervisor and also creating a safe space to explore difference. The topic of humour was also interesting – something about not

taking ourselves or these issues too seriously opens up a playfulness in exploring things and not being too concerned about getting it right or wrong perhaps/ offending?

16th March 2020 – interview T3

I'm just sitting down to transcribe the second interview. Reflecting on the interview last week, I felt it went well and I definitely felt less nervous this time and more able to go with the flow a bit, rather than feeling very wedded to the interview schedule. Themes that have stood out are around the influence of therapeutic model perhaps at times facilitating or hindering discussion around culture and difference, e.g., CBT hindering discussion as supervision is more focused on the 'problem' and therapeutic technique, which is contrasted to family therapy in which the intervention focuses more of the person including all their complexity, culture and difference. The need for supervision to feel productive and that there is a point to what you are discussing rather than reflective conversations that include general discussions. Seems like culture is mainly brought up when it is relevant to a particular client/ work context/ a particular problem and that then facilitates discussions around the supervisor/ supervisees positions. Interesting that the supervisee felt that she wanted to hear the supervisors opinions on certain subjects before deciding her position…sense of wanting to be similar and getting on personally and professionally seemed a priority but also a sense that there is a "right" position to take. Interesting that the theme of similarity came up again and the value of being aware of similarities between therapist and client as this can perhaps bias the therapist, have an emotional impact on the therapist or make them blind to differences? Perhaps this is a parallel process that plays out during supervision too – more focus on the similarity between supervisor and supervisee rather than exploration of difference in order to preserve supervisory relationship? Generally there was a sense that culture is "wooly" rather than an easily defined concept – confusion around what it really is. Overall a sense that culture and difference aren't raised unless there is a problem.

I think that the themes that this participant raised were much more in line with my own assumptions. I need to make sure I'm still remaining curious in subsequent interviews and not making too many assumptions based on my own experience. Perhaps checking with participants by reflecting back what

they have said and ensuring I've captured it accurately (including the meaning behind what they are saying) would be helpful to ensure I'm not wrongly assuming things/ missing things.

18th March 2020

I've just started coding my first transcript. It has taken me a while to figure out how I want to do this practically. I experimented with Nvivo, but I've found it too confusing as I'd like to be able to clearly see the data and my codes at the same time. I've switched over to Microsoft Word now and it's much better. Generally I'm feeling quite de-motivated at the moment, I think because I don't know if what I'm doing is "right" or not. I struggling with making all the codes action oriented and I'm concerned about being too analytical this early on, but equally not wanting to just be descriptive and basically re-write the transcript! At the moment I can't see the wood for the trees. I have no idea how I'll get to a point where it all comes together. As I'm reading through the transcript, I'm also feeling like I missed opportunities to clarify what the participant was referring to at times, and didn't direct the interview enough maybe? I think in future interviews I need to try to not rely on my own assumptions about what I think they mean as much as I may well be wrong/ have misunderstood. I need to also remember to ask more open questions, rather than perhaps putting words into people's mouths!

31st March 2020 – interview T4

Whilst transcribing my third interview I noticed I added in a question about therapeutic model and whether this influences ability to have conversations around culture and difference – this was guided by the second interview I did with a newly qualified psychologist who talked about being more likely to talk about culture and difference when using systemic/family therapy approach. I also probed a bit more around similarity between her and her supervisor and why she feels it is important/ significant in relation to her work. This is a theme that has come up in all three interviews so far. I noticed another theme arise around the use of humour and importance of personality in influencing ease around discussing culture and difference. I'm going to speak with my dissertation supervisors about adapting the schedule to include questions around orientation and similarity as these themes have come up in

each interview and so I'm wondering about how significant they are. I think I'll ask these questions later in the interviews to give a chance for the topics to come up organically first.

21st April 2020 – interview T2 transcription

Theme around it being difficult for the trainee to raise areas of difference between supervisee and supervisor due to concerns about how it might land with supervisor – what would they think of the trainee? Would it uncover trainee prejudice/ bias? Short duration of placements a factor in perhaps how safe trainees feel to bring things up? Issues of class and education very difficult for trainee to bring up as difference in the supervisory relationship due to issues of power/hierarchy? Particularly when trainee is of a higher class than supervisor?

I noticed my own bias in terms of thinking that the evaluative nature of the relationship might make it harder for trainee to take risks and discuss areas of difference. I actually said this to the participant. She didn't comment initially but came back to that point and agreed later on. I need to make sure I'm not asking leading questions and try to keep my questions as open as possible.

11th May 2020 – interview T5 transcription

Importance of contracting at start of supervisory relationship come up again and that it helps to focus conversations in supervision.

Reflection – again, I noticed I can ask quite leading questions at times e.g., would you say that was quite significant that initial contracting in terms of later conversations?....I find it really hard to think of open questions in the moment, as well as trying to ask theoretically orientated questions based on themes from previous interviews. I have tried hard to go with what people are saying as much as possible though.

29th May 2020

I've now done my first two supervisor interviews. It felt very different interviewing supervisors. I was very aware of not wanting to cast any blame or judgement particularly around issues related to what might hinder discussions about culture and difference or what may make it difficult for a supervisee to

share their experiences etc. I was aware of the power dynamic and not wanting to come across as challenging or too intrusive. It also felt odd knowing what their supervisees had said about them, but them not knowing. Also one supervisor mentioned about wanting to maintain the confidentiality of the content of supervision of her trainee and this hadn't really occurred to me that much before, but I definitely felt it during the interview – not wanting to ask detailed questions about specific conversations/ ask too many questions about the supervisory relationship. It somehow didn't feel right, even though the supervisees had consented to both parties taking part. It was also interesting to hear one supervisor say she felt anxious about what her supervisee might have told me, feeling worried that she may have not done enough to enquire about possibly relevant issues. I felt really pulled to reassure her but knew that wouldn't really be helpful given I didn't really know what the supervisee thought about that…and even if I did, it would be breaking confidentiality. It made me think that it might have been helpful to have a system in place to allow for feedback, should dyads wish. It highlighted how vulnerable supervisors may feel in this process and something I should be aware of in interviews and ensuring my questioning is sensitive to this, but equally not allowing this to completely stop me from asking curious questions.

1st July 2020

Just preparing to do my 4th supervisor interview. Noticing the familiar feeling of anxiety but reflecting on how I've actually really enjoyed the process so far. It's really interesting hearing what people have to say and I'm learning more and more to go with the flow a bit more…not being afraid to ask them to tell me a bit more or elaborate etc. The schedule has also become quite internalised now! I don't really have to look at it too much. It's feeling more natural.

6th July 2020

I'm preparing for what I hope to be my FINAL interview! I must say I'm really hoping nothing majorly new comes up so that I can officially end recruitment after all this time…so I need to be aware in the moment if I'm shutting down lines of new thought and ideas that haven't already been covered in previous interviews etc. I'm feeling nervous anticipation about what comes next….I'm not

looking forward to doing the rest of my coding as I find it so time consuming and I notice I keep second guessing myself as to whether I'm doing it "right". I feel like I have a real sense of the common themes that are coming up now and I'm worried these might get lost in the minutia? But maybe that is just part of the process? I need to trust the process!

Finally completed all the initial coding!

Oh my goodness. The initial coding has taken so unbelievably long. It's a relief to have finished but I'm now feeling really anxious about the next step – focused coding. I have read the Charmaz chapter about how to do focused coding and I'm not sure I totally understand! I think it's just that I want certainty that I'm doing things "right" at the moment but the process is subjective. There is no right or wrong, it's all about my interpretation of the data. I'm struggling to trust myself. I'm going around in circles. I think I just need to get started and see what happens.

Focused coding

I'm actually finding focused coding easier than I thought it would be. There are clear themes emerging and I'm finding it easier to condense the initial line by line codes into bigger chunks. Getting the balance between description and analysis and remaining grounded in the data has felt challenging at times. It's been really helpful to get my codes checked by my supervisor and grounded theory expert. It's definitely helped me to feel more confident that I'm on the "right" light lines.

Theoretical coding stage

I'm about to move onto theoretical coding now. I can see clear categories within the data now which is really reassuring, however it feels so daunting to know how to put it all together to generate a model! Where do I even start?! I'm finding memo writing really helpful as it's making me think about the connections between categories and I keep referring back to transcripts to make sure that the ideas are grounded in the data. At the moment it feels like a sea of ideas though.

11th December 2020 - Grounded theory supervision

I met with the grounded theory expert today and it was so helpful! We thought through all the categories I have and have started to assimilate them into higher order categories with sub-categories. I can really begin to see a model coming together now! Memo writing continues to be really helpful in organising my thinking and generating theoretical links and ideas. The next challenge is how to depict the model visually. I think I need to have a play around and see what fits my data and ideas.

Appendix X: Excerpts from Memo and Development of Theoretical Model

Focused coding – participant Trainee 1

As I'm doing focused coding for interview T1 I feel like I'm noticing an avoidance of discussing differences between the trainee and supervisor – it seems like the trainee wants to maximise the similarities within the SR and I'm wondering if this is related to what another supervisor discussed in their interview around it feeling more comfortable to discuss similarities due to attachment and building relationships. I noticed participant T1, when asked about their differences, immediately talked about their similarities. Then it seemed to feel OK for him to discuss their differences, but still focused on areas of similarity within the difference. Perhaps this is an important part of the relationship building and bonding component of a SR? But what might be the disadvantages of avoiding or not discussing difference?

I also sensed that there is a view that difference only needs to be talked about when it's an issue? I think this might be a common theme amongst participants. Perhaps the pressures of working in the NHS and lack of time mean that other more pressing things are prioritised during supervision, as T1 hinted at by saying that being busy and lack of time was a barrier.

I'm realising the power of the service context in terms of which areas of difference are seen as relevant to discuss in supervision – this seems to come up a lot in the interviews. It seems areas that are directly relevant to client contact are perhaps prioritised for more explicit discussion in supervision over other areas of possible difference, e.g., within the SR between supervisee and supervisor. Do certain areas of difference feel like more legitimate conversations to have than others? I'm wondering if this links to what others have said about therapeutic orientation. Perhaps the CBT framework means that client issues relevant to the presenting problem tend to be prioritised?

Focused coding – participant Supervisor 1

Supervisor modelling by discussing own cultural difference at the start of supervision – again seems to be a theme around supervisor taking the lead initially, due to power dynamic? Modelling it's OK to bring in the personal to supervision in the hope that then they can explore relevant aspects of trainee culture/ difference in relation to their work?

Again the idea of getting to know one another well is standing out as a really important factor – having time to find out about each other's personal lives seems to have opened up different topics of conversations around difference/ personal background etc. Does this also help to put each other at ease due to feeling safe with each other? Are they naturally talking about culture and difference without realising it?

An area that seems to come up a lot is that of supervisor modelling and giving permission that it's OK to speak about own areas of culture or difference – is this related to the power dynamic in supervision? It feels too risky for a trainee to self-disclose due to being in lower position of power or afraid that they will say wrong thing/ be judged/ negatively evaluated by supervisor?

Again there's a sense of avoidance and feeling of unsafety about discussing difference – supervisor finds it helpful when trainee is honest and open as it creates safety in SR for difference to then be discussed. I find it interesting that supervisors also feel anxious about discussing difference given they are in position of greater power. I think I assumed it would be easier for supervisors. Once again, this seems to put safety in the SR at the centre of discussions about culture and difference.

Focused coding – participant Trainee 2

Fear came up so many times with this participant – it seemed like the SR wasn't safe enough for her to be able to share or be vulnerable. Also could be related to societal views and racism

she's experienced. Sensed a lot of worry about how she might be perceived by supervisors – feels easier to not take risks/ show vulnerability. She also had lots of ideas about what would help her to feel safe enough to share. Supervisor being explicit at start about it being a safe space, giving permission to share, modelling it's OK to share personal details etc.

Focused coding – supervisor 3

Idea of modelling that it's OK to share coming up again. Implicitly inviting discussion/ reflection. She also explicitly invites discussion. I'm wondering how supervisors make the decision to be implicit or explicit. What factors impact this? Is it related to perception of trainee openness to discuss/ how comfortable the trainee seems around these issues? Later on she says that she's more likely to model when SR is young/ trainee seems hesitant. Seen as most gentle way to encourage reflection and would use this first and then perhaps be more explicit if that's not working.

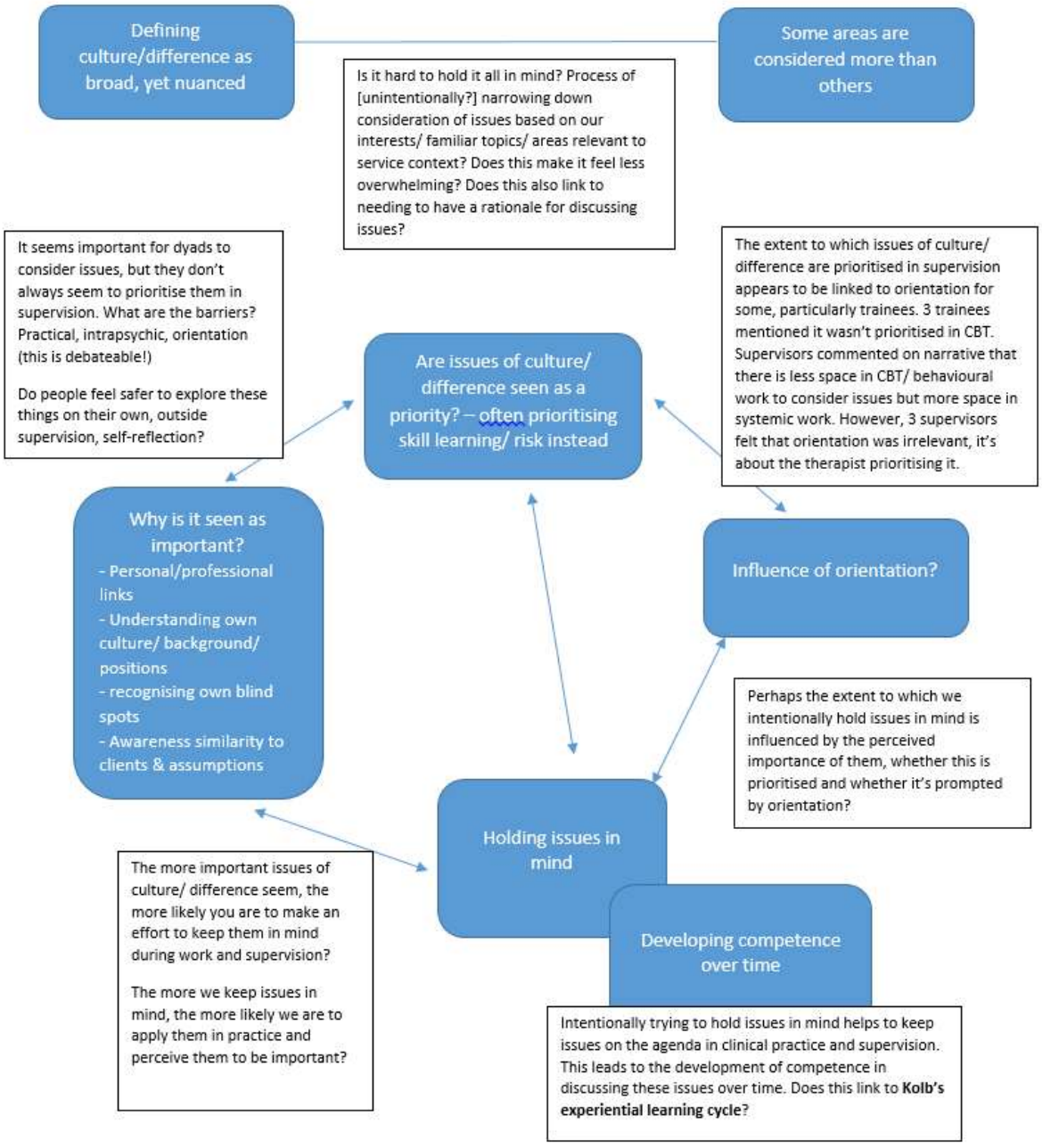
Focused coding – Trainee 5

Interesting how participant talked about the consideration of issues of culture/difference as a backup plan when usual models don't fit – there's a sense that issues aren't explored proactively but rather reactively when there is a problem in therapy. I'm wondering if this links to the extent to which issues of culture/ difference are seen as a priority by the dyad. Therapeutic orientation seems to play into this –other participants have also spoken about how in CBT there is perhaps less space to explore these things as the focus is on learning therapeutic technique/ presenting problems. Therefore issues of culture and difference may not be prioritised, even if there is a genuine wish to think about these things.

Examples of memos in the development of the theoretical model

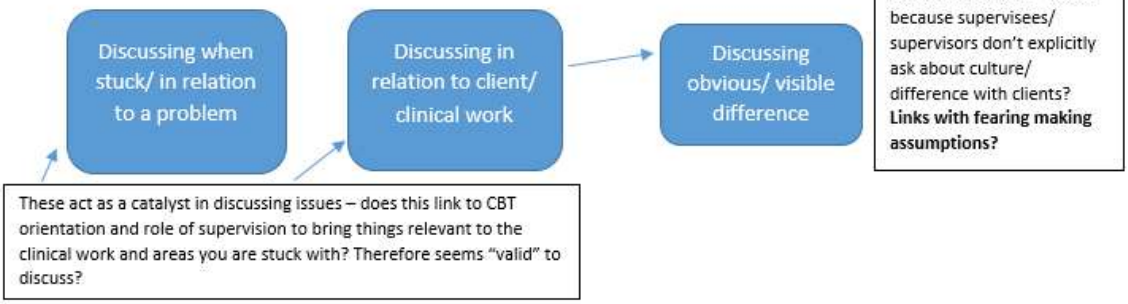
Blue boxes relate to categories formed from focused codes. Text boxes are memos detailing links between categories to begin to develop the theoretical model.

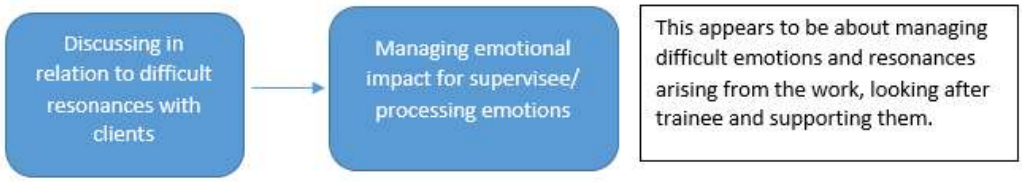
THEME 1: PERCEPTIONS OF CULTURE/ DIFFERENCE



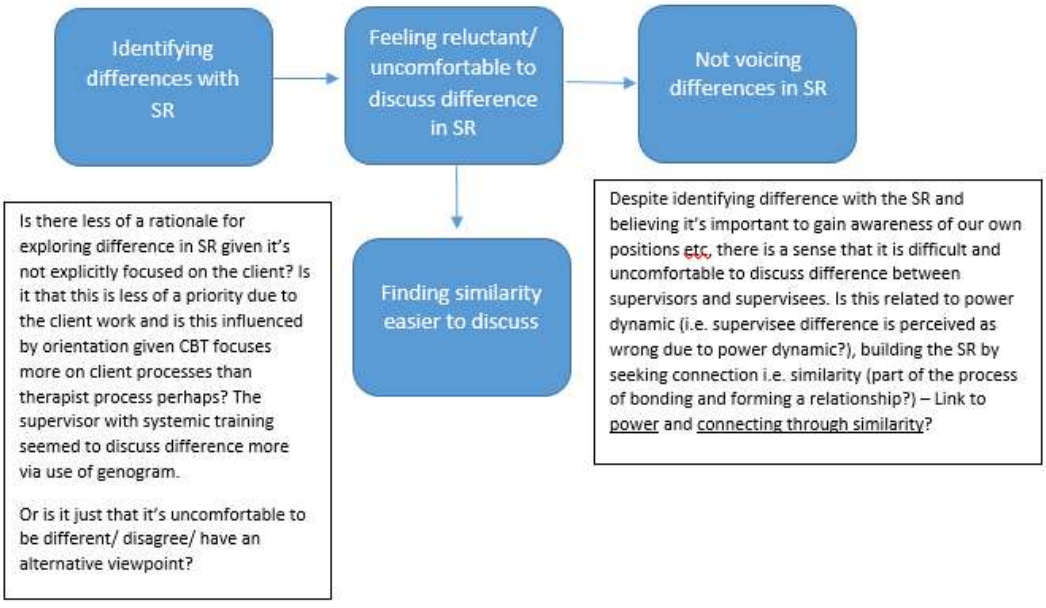
THEME 2: NEEDING A RATIONALE/ PURPOSE FOR DISCUSSING ISSUES?

When are issues of culture or difference voiced in supervision?



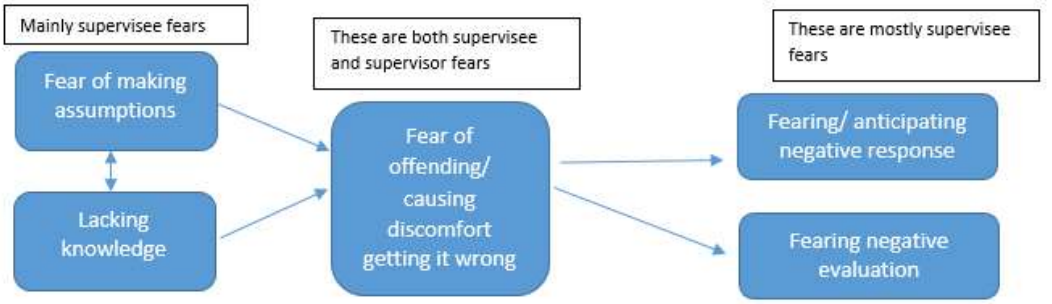


What is not voiced in supervision? Difference within the SR?



THEME 3: Perceived Barriers – this links with theme 1 about 'perceptions'

1. Intrapsychic – <u>Risk is inherent</u> – as explicitly stated by 4 trainees and one supervisor



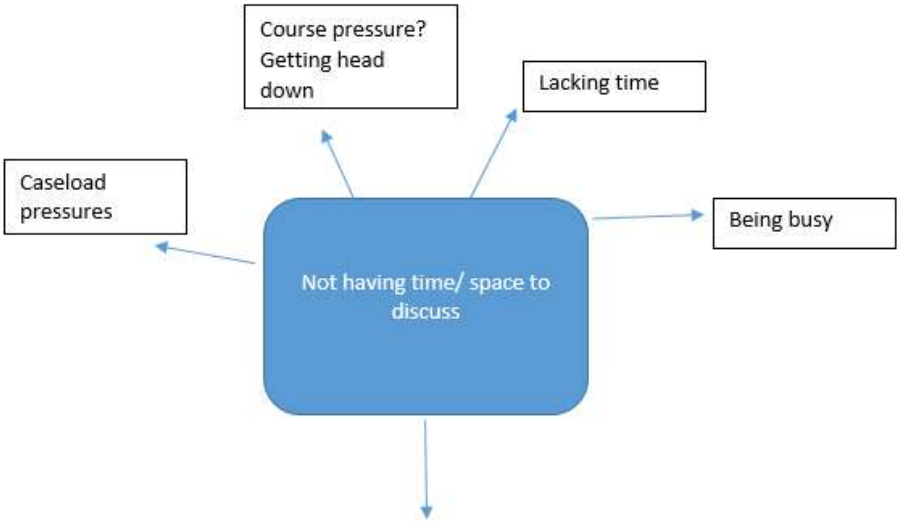
If you perceive yourself to be lacking knowledge about issues of culture/ difference are you more likely to fear that you will make false assumptions?

If you fear making assumptions, are you less likely to ask questions to seek further knowledge? Fear of making assumptions that someone's culture is relevant seems to stop people from asking curious questions?

It seems that lacking knowledge and fearing making assumptions leads both trainees and supervisors to worry they might get it wrong and offend someone. As a result, they fear that the person will respond negatively and they will be negatively evaluated by the person. This acts as a barrier to discussing issues in supervision. Trainees weighing up whether it's worth the risk to share if the supervisor response is anticipated to be negative?

Fearing negative evaluation is particularly relevant to trainees – is this due to power differential and supervisors role in evaluating trainee competence?

2. Practical barriers



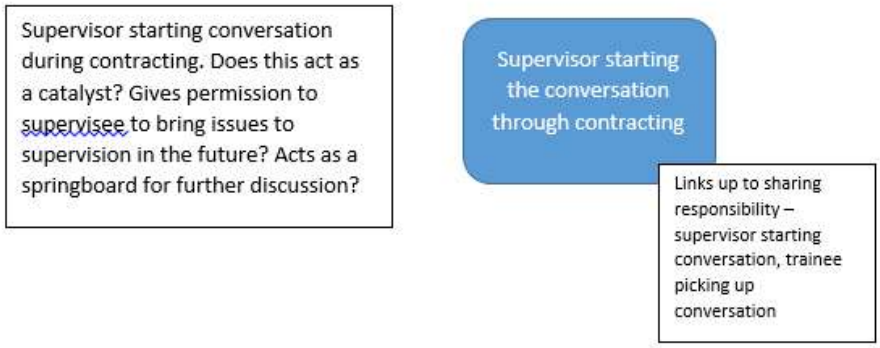
This seems to link back to prioritising in supervision. Perhaps prioritising risk/ specific therapy skills development over issues of culture and difference. Does this also link to trainee developmental stage/ CBT orientation? Need to know what to do in therapy – learning "nuts and bolts" rather than having space for more reflective discussions about culture/ difference?

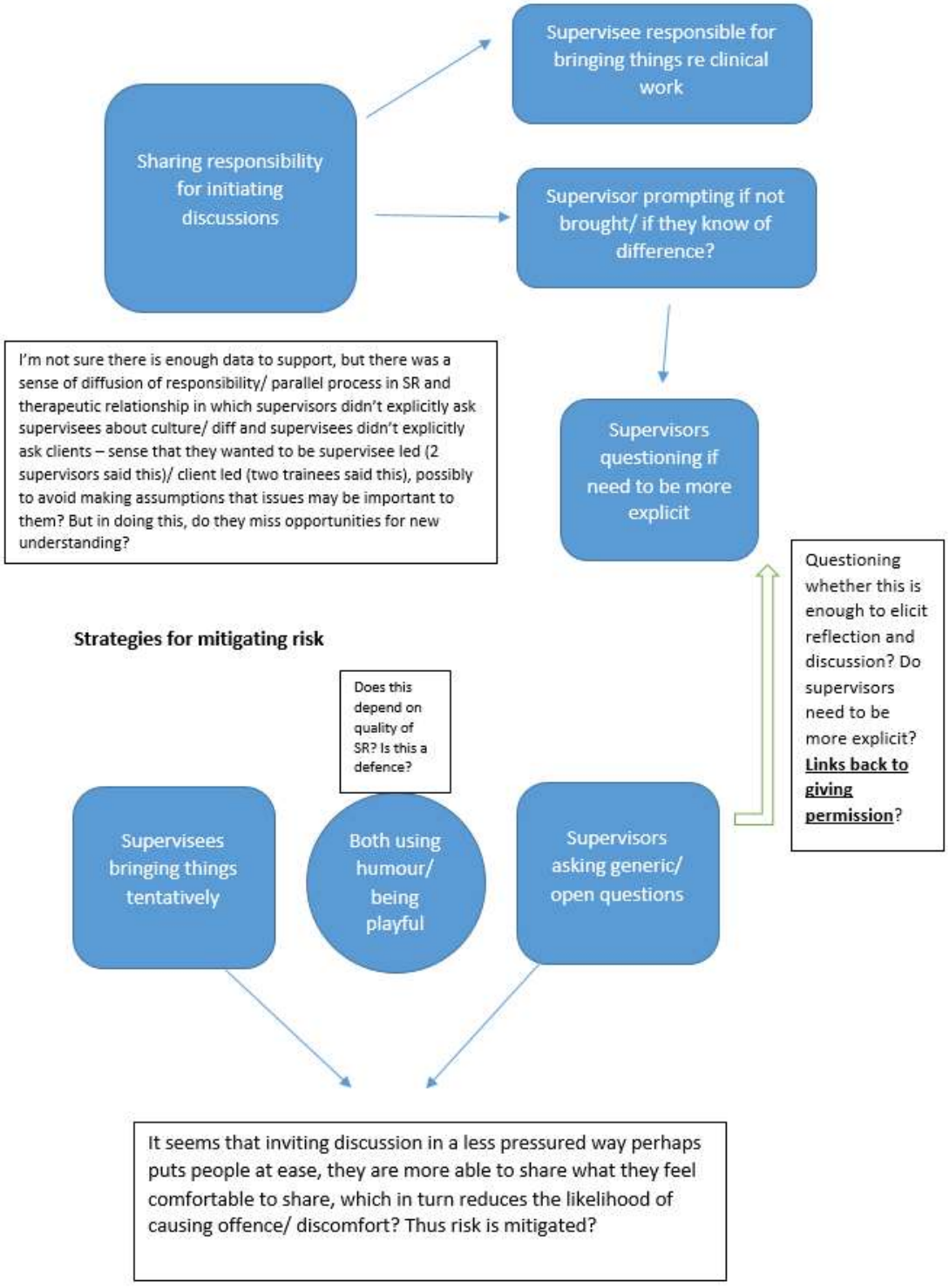
THEME 4: FEELING SAFE

Feeling safe within the supervisory relationship appears to mitigate against some of the risks mentioned above. It seems that feeling safe is the foundation for being able to discuss risky topics. The extent to which supervisees share seems to be dependent on level of safety experienced.

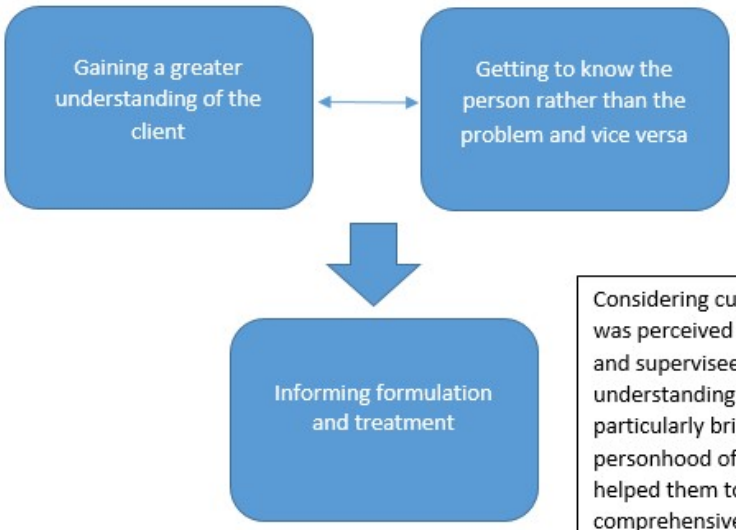


Theme 5: PROCESSES FOR DISCUSSING



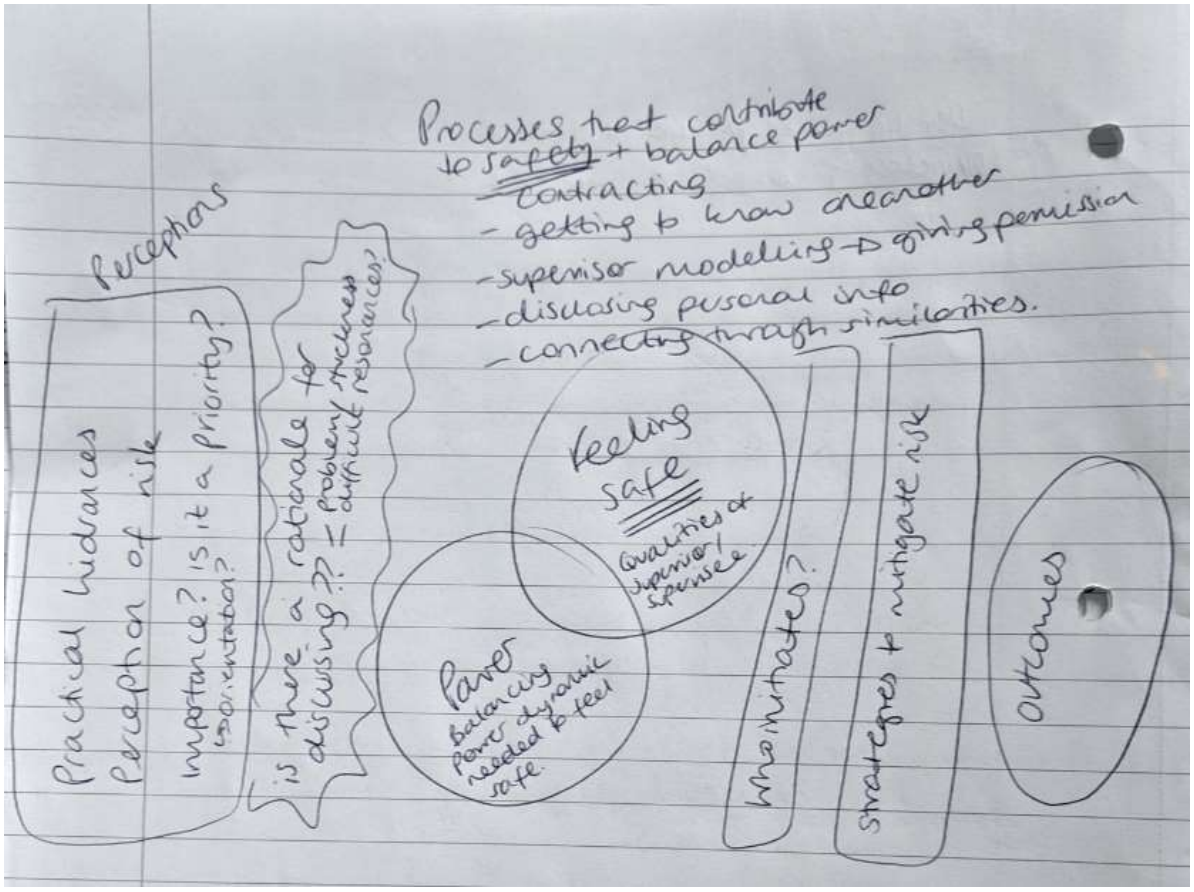

Supervisee responsible for bringing things re clinical work
Sharing responsibility for initiating discussions
Supervisor prompting if not brought/ if they know of difference?
I'm not sure there is enough data to support, but there was a sense of diffusion of responsibility/ parallel process in SR and therapeutic relationship in which supervisors didn't explicitly ask supervisees about culture/ diff and supervisees didn't explicitly ask clients – sense that they wanted to be supervisee led (2 supervisors said this)/ client led (two trainees said this), possibly to avoid making assumptions that issues may be important to them? But in doing this, do they miss opportunities for new understanding?
Supervisors questioning if need to be more explicit
Questioning whether this is enough to elicit reflection and discussion? Do supervisors need to be more explicit? Links back to giving permission?
Strategies for mitigating risk
Does this depend on quality of SR? Is this a defence?
Supervisees bringing things tentatively
Both using humour/ being playful
Supervisors asking generic/ open questions
It seems that inviting discussion in a less pressured way perhaps puts people at ease, they are more able to share what they feel comfortable to share, which in turn reduces the likelihood of causing offence/ discomfort? Thus risk is mitigated?

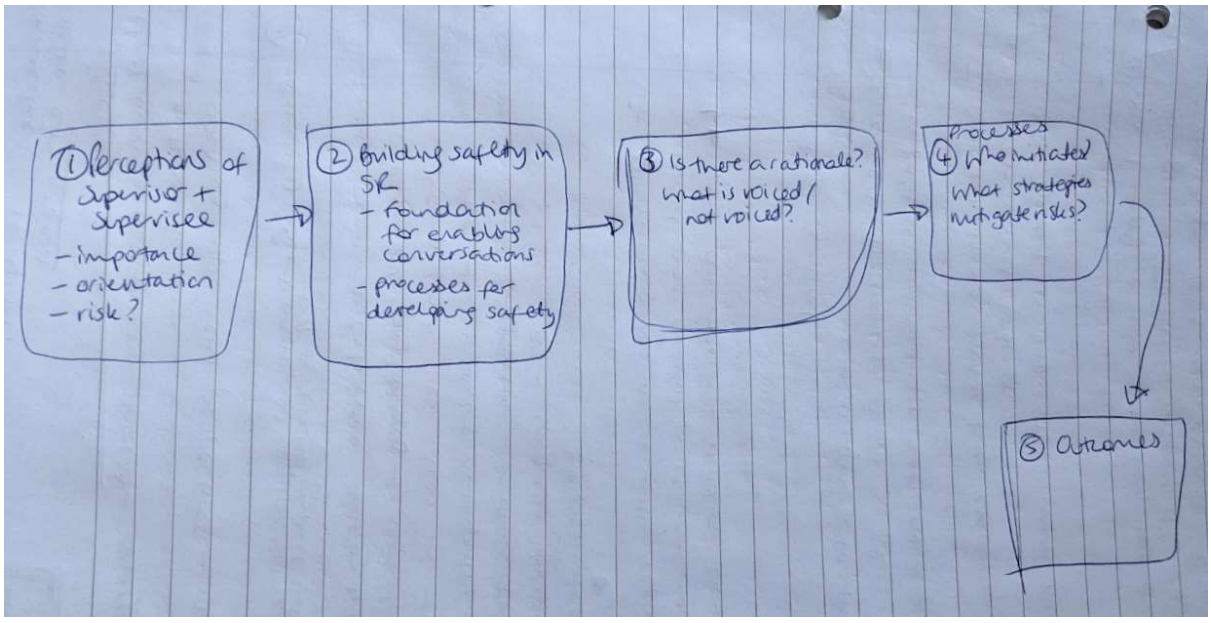
Theme 7: OUTCOMES

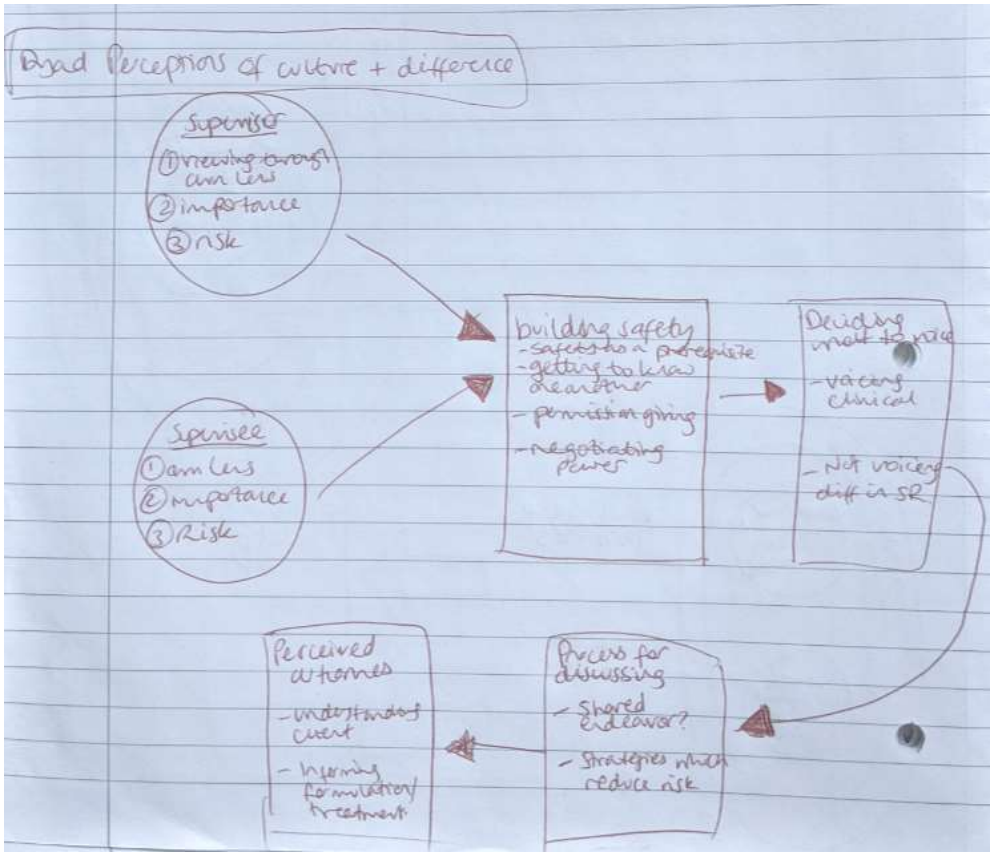


Considering culture and difference was perceived to help supervisors and supervisees to gain a greater understanding of the client, particularly bringing into focus the personhood of the client. This helped them to develop a more comprehensive formulation of presenting difficulties and also strengths (e.g. religious belief) which helped them to tailor interventions accordingly.

Visual development of theoretical model






Dyad Perceptions of culture + difference
Supervisor
① viewing through own lens
② importance
③ risk
Supervisee
① own lens
② importance
③ Risk
building safety
- safety as a prerequisite
- getting to know each other
- permission giving
- negotiating power
Deciding what to voice
- voicing clinical
- Not voicing diff in SR
Process for discussing
- Shared endeavor?
- Strategies which reduce risk
Perceived outcomes
- understanding client
- informing formulation/ treatment

Appendix Y: Analysis Procedure and Excerpt of Initial and Focused coding

Description of analysis procedure based on Charmaz (2018) guidance

Initial coding is the first stage of the analytic process and requires line by line examination of the text and an open stance to ensure codes generated remain close to the data. Data are broken down into fragments such as words, lines and incidents and coded using gerunds (verb forms serving as nouns) in order to capture meaning and action. This is believed to reduce the tendency to make conceptual leaps before the necessary analytic work has been completed. Early codes are provisional and may be adapted as analytic ideas progress. Codes may be reworded to improve their fit with the data. In vivo codes were used to preserve the language and related meanings of participant views and actions (e.g., "threw all those eggs in that one basket", Participant T1).

Focused coding is the second major stage of data analysis. During focused coding, the most frequently occurring and significant codes are identified and assimilated in order to synthesise larger sections of data into categories. This process helps to advance the emerging theory as the focused codes are more conceptual in nature, whilst still remaining grounded in the data.

Theoretical coding involves combining focused codes to form tentative analytic categories. This process allows emerging themes to be identified and is the first phase of building the theoretical model. Emergent themes are then combined to form higher-order categories and drawn together to generate a theoretical model. This was an iterative, non-linear process in which initial codes and categories were revisited and refined throughout to ensure close fit to the raw data.

Excerpts of initial and focused coding

	Initial codes	Focused codes
whereas after supervision I was like ah ok, considering everything that he's been through throughout his life I can kind of understand why he's saying these things, and it's kind of a, partly it was a kind of reactionary thing of like trying to get a reaction out of me, or saying things to kind of push the other person which kind of fitted with the rest of his experiences so it was kind of a bit more helpful to see it in that light rather than just take it as face value of he's really offensive and I really don't like working with him. I: Yeah definitely, gosh, that sounded really useful then to talk about it in supervision. And how did your supervisor react, so when you kind of told her...was it you that kind of brought it up in supervision? P: yeah	Using supervision to consider client's background Beginning to understand his views Client trying to get a reaction Client "pushing" the trainee Understanding behaviour in context of experiences Finding it helpful to see behaviour in context Not taking it as "face value" - implies without thinking/ questioning Describing initial impression of client as offensive Expressing dislike of working with client	Using supervision to formulate/ understand client
I: Right yeah, and how did they respond, so when you initially brought it up in supervision um how did they respond to you? P: Um, they were...I did feel supported by them in terms of um like my supervisor was kind of like oh you know like how can we work this through so you feel comfortable working with him? um and also kind of equally being on on my side in the sense that like that's unacceptable like that's really not OK and we need to make sure he knows that that's not OK, um, but also giving me the choice of you know, do I still want to work with him, um, but yeah I think kind of doing that initially though, I think they were really supportive in that way of just on a human level um checking in with me but then also being able to understand it in a more psychological way um kind of helped to reframe it. I: Yeah definitely, um, and how did it feel for you `to kind of raise it when you were kind of thinking oh, I dunno, I don't know if it felt like an easy decision that yeah yeah I'm just	Feeling supported by supervisor Supervisor asking how to help Supervisor being on trainee's "side" Supervisor expressing it's unacceptable Making sure client knows it's unacceptable Supervisor giving choice about working with client Supervisor being supportive Being human Checking in Understanding it from psychological perspective Helping to re-frame it	Feeling supported and validated by supervisor Relating on a human level Re-framing it

Appendix Z: Overview of Theoretical Categories and Supporting Focused Codes

Higher-order theoretical category	Second-order categories	Third-order categories	Example focused codes
Perceptions	Viewing culture/ difference through one's own lens	Defining culture/ difference as broad yet nuanced	Defining difference broadly Defining culture broadly Using social graces to define difference Describing nuances/ layers to difference Identifying similarities within the differences Recognising difference within the similarity
		Privileging aspects of difference	Being interested in areas that are personally relevant Finding it easier to discuss issues of interest Feeling at ease discussing gender, motherhood, age Finding familiar topics more comfortable Finding age in relation to clients safe topic Considering certain issues a lot due to service context Discussing injury/disability prompted by service context Integrating world events into professional discussions Being influenced by family, friends and society
	Important versus priority?	Perceived benefits of exploring culture and difference	Understanding influences from own upbringing Becoming aware of own biases/ prejudices Acknowledging own cultural biases Being aware of areas where you cannot relate to clients Gaining awareness of what you're drawn to/ what gets forgotten Understanding how personal influences professional Evaluating and managing pushes/ pulls in client work Becoming aware of blind spots
		Competing demands	Not having time to reflect on issues Having headspace to reflect Being too busy/ forgetting to discuss Describing busy NHS context hindering opportunities for reflection

			Getting caught up in immediate problem/risk – "raising our alarm bells" Prioritising risk management over culture/difference Finding it hard to prioritise culture/diff over clinical aspects Prioritising different areas to ask about
		Influence of therapeutic orientation	Finding culture/difference is treated as superfluous in CBT Viewing CBT as not lending itself towards consideration of cultural issues Identifying role of therapeutic model (CBT) in prioritising cultural issues less Finding systemic approach prompts consideration of difference Finding supervisor systemic orientation leads to more interest in issues **Negative cases:** Viewing consideration of culture/difference as a supervisor's responsibility regardless of therapeutic orientation Consideration of issues is therapist led rather than orientation led
		Holding issues in mind	Keeping issues of culture and difference on the agenda Grounding yourself in theory that is interested in difference Keeping issues in mind by writing reminders to self Staying tuned in to culture/ difference Using supervision to keep issues in mind Remembering to ask about issues Staying mindful of contextual factors Learning how to discuss culture/ difference Seeking out learning opportunities Seeking opportunities for reflection on issues Keeping lights switched on, tuning in
	Risk is inherent	Perception of risk	Seeing discussions of culture/ difference as potentially dangerous Seeing risk as inherent in having discussions about culture/difference Discussing difference is risky Finding it less risky to know supervisor views before stating own Seeing it risky to share

		Fear of lacking knowledge and getting it "wrong"	Worrying about making false assumptions Believing it's wrong to make assumptions Worrying about own lack of knowledge Avoiding discussion of areas where own knowledge/ understanding is lacking Hiding own lack of knowledge/ understanding Not wanting to get it wrong/ be insensitive Fearing getting it wrong/ using supervision inappropriately Worrying about getting things wrong
		Fear of offending	Not wanting to be insensitive Worrying about being unintentionally offensive Fearing causing offense/ upsetting Fearing upsetting someone by disagreeing Fearing upsetting/ offending/ causing discomfort Worrying about being offensive/ appearing racist
		Fearing supervisor judgement/ negative evaluation	Fearing supervisor's judgement/ negative evaluation Avoiding being judged by supervisor Feeling worried about negative evaluation from supervisor Fearing supervisor will stereotype her Being evaluated during training Fearing a negative response from supervisor Fearing supervisor's response
Developing safety in the SR	Safety as a prerequisite to exploring issues	Safety enables conversations	Building secure SR to enable disagreement/ difference to be voiced Feeling safe to discuss different beliefs/ sensitive topics Tailoring conversation based on level of safety Feeling safe in SR to take risks Creating safety in SR to discuss difference Hoping quality of supervisory relationship helped trainee to voice difference Creating safe space in SR for supervisee to raise any issue Sharing/discussing varies according to level of safety within SR Finding safety in SR helps supervisees share difficult resonances

	Valued supervisor characteristics	Seeing supervisor as a rock – strong, supportive Feeling supported by supervisor Being held in mind by supervisor Supervisor being validating, warm, curious Feeling valued by supervisor Describing supervisor's response as warm, thoughtful, interested Supervisor showing commitment to meeting trainee needs Wanting supervisor to be open, curious and interested
	Valued supervisee characteristics	Valuing supervisee honesty and openness Finding supervisee openness to share helpful Describing trainee personality as a factor – openness, willingness to initiate discussion Finding trainee openness and ease at discussing helpful Supervisees showing interest and willingness to reflect on issues Describing supervisee as reflective and thoughtful
	Unhelpful supervisee characteristics	Finding it hard to discuss difference when supervisee is forthright/ matter of fact Finding discussions difficult when supervisee is judgemental/ defensive Finding supervisee defensiveness makes discussion harder Identifying supervisee personality factors as hindering discussion – private, introverted Finding it hard to navigate conversations when others seem uncomfortable/ reluctant Sensing supervisee discomfort prevents discussion
	Unhelpful supervisor characteristics	Describing didactic supervisory style preventing reflective discussion Describing supervisor inflexibility to consider ideas outside CBT model Not showing interest in trainees personal life Not gelling with supervisor on personal level

	Getting to know one another		Relating on a human level Getting to know supervisee, their values, life experiences relevant to the work Bonding with supervisor by having fun Getting to know one another over time Understanding personal viewpoints Knowing each other's background and beliefs Getting to know each other using genogram Describing SR as a two way relationship Having informal conversations that lead to reflection re issues Having informal discussions Spending time together informally creates safety in SR Drawing on similarities Bonding with supervisor Connecting over similarities Building secure attachments and working alliances through shared views/ interests/ values/ beliefs
	Giving permission	Negotiating power	Acknowledging supervisor's power Recognising power dynamic makes it difficult for supervisee to challenge supervisor Recognising power dynamic in SR – trainees finding it harder to share different view Being aware of and balancing power differential in SR Noticing changes in power dynamics over time and across different SRs Being mindful of power dynamic in SR
		Supervisor modelling it's OK through self-disclosure	Supervisor modelling it's OK to discuss Supervisor sharing genogram first models to trainee what's OK to discuss Supervisor modelling openness to share/ disclose Modelling it's OK to share personal things that link to professional Supervisor openness about her own difference in ethnicity

			Showing feelings and vulnerabilities more leads to supervisees opening up too Modelling that it's OK to reflect from different positions Viewing it the responsibility of supervisor to model what's OK to discuss Self-disclosing helps to invite trainee self-disclosure Disclosing personal information to encourage trainee reflection Disclosing personal information to model it's OK and build relationship Finding supervisor openness/self-disclosure helpful
		Starting the conversation through contracting	Contracting as a way of starting the conversation Wanting supervisor to take lead, setting up supervision as a safe space to explore ideas Contracting consideration of culture/ difference at start of every SR Sharing genograms together at start Sharing genogram acts as springboard for further discussion Discussing difference at start creates safety to bring issues Contracting at start to reflect on issues Thinking about difference from beginning of supervisory relationships
To voice or not to voice?	Voicing culture/ difference in relation to clinical need	Clinical question, problem, stuck point	Encountering stuck points in therapy initiates discussion Discussing issues that are a problem Discussing difference when stuck Describing purpose of supervision is to bring areas you're stuck with Discussing difference at stuck points Discussing issues in supervision when problem arises Assigning importance to difference/ culture when relevant to presenting problem Discussing issues in relation to patient Discussing issues in relation to clinical question Discussions being prompted by client culture/ difference Discussing culture/diff mostly in relation to clinical work Finding only areas directly related to clinical work are discussed in supervision

		Difficult supervisee-client resonances	Supervisees occasionally discussing resonances due to client age Exploring areas where trainee identifies/ doesn't identify with clients Considering resonances/ lack of resonance with clients Being mindful of difficult resonances Using supervision to process and manage emotional reaction Supervisees reflecting on difficult/uncomfortable resonances Respecting and stepping back from areas of discomfort unless directly clinically relevant Supervisees processing emotions of working with older people and comparing to own grandparents
	Difficulty voicing difference within the SR	Not voicing difference in the SR	Being aware of but not always voicing own difference in supervision Not explicitly naming gender difference in SR Conversations being more often implicitly influenced by difference than explicitly about difference Trainees not usually raising areas of difference in SR Making assumptions about impact of trainee's religion/ family culture Remembering vague conversations rather than explicit discussions Identifying unvoiced differences in SR – personality, race, religion Making assumptions about supervisees where non visible difference isn't known/ expressed **Negative case:** Using genogram to uncover non-visible difference
		Finding difference in the SR uncomfortable to voice	Feeling unable to discuss difference in class in SR Feeling uncomfortable to talk about class in SR Feeling ambivalent about voicing difference in SR Feeling uncomfortable to ask explicitly about difference in SR Feeling reluctant to raise overt differences in SR Finding it difficult to discuss opposing beliefs within a SR Feeling uncomfortable where others' beliefs are in opposition to own Finding it hard to disagree Avoiding conflict

		Drawing on similarities in the SR	Finding it easier to discuss similarities Recognising and discussing similarities with supervisees Finding it easier to discuss areas of similarity Finding it easier to discuss similarities than differences Voicing similarity in SR more than difference Talking about similarity before difference Wanting to be seen as similar to supervisor rather than different Being similar means being liked by supervisor
Processes for discussion	A shared endeavour	Supervisors take the lead/ initiate early in the SR	Supervisor starting the conversation at the beginning of SR Explicitly encouraging discussion of culture/difference at start of SR Explicitly naming relationships where difference is relevant – SR and therapeutic relationship Discussing and clarifying trainee goals re cultural competency
		Joint responsibility to keep culture/difference on the agenda	Supervisee raising issues Trainees discussing impact of own culture/ difference Being supervisee-led in how much culture/ difference is discussed Hoping issues are raised when present [by supervisee] Being agenda led by supervisee after initial set up of SR Experiencing initiation of discussion of cultural issues as a shared endeavour Taking joint responsibility in SR to be keep in mind difference Describing shared responsibility to discuss issues Sharing responsibility to initiate discussion Supervisors prompting discussion Supervisor continuing to acknowledge and initiate discussion throughout SR Supervisor initiating conversation about impact of discussing similarity in therapy Supervisor taking responsibility initially to name and encourage discussion of issues Supervisor prompting discussion if culture/diff not brought by supervisee

		Supervisors not always explicit enough	Supervisors not raising issues of diversity but also not shutting down discussion Supervisor not explicitly asking about issues Not asking explicitly about similarity Not exploring impact of culture routinely Questioning whether she's explicit enough Not explicitly asking supervisees about own disability/ difference Worrying about not discussing explicitly enough Questioning how well she's attending to and incorporating issues in supervisory practice Questioning if she could be more explicit about making it OK for supervisees to discuss issues
	Strategies to mitigate risk	Supervisee tentativeness	Bringing items tentatively Exploring ideas versus stating beliefs Finding it easier to challenge supervisee assumptions when brought tentatively Finding trainee tentativeness/curiosity invites discussion Being curious helps to prevent offence/ defensive responses
		Supervisor asking open questions	Using general questions to invite trainee reflections and resonances Inviting trainee to share what's important to them Supervisor being curious with trainee about impact of their beliefs on their work Not putting pressure on supervisee to share Supervisor asking follow-up questions Using gentle ways to encourage reflection initially Asking gentle open questions to encourage reflection Implicitly inviting discussion Asking open questions
		Use of humour	Using humour to discuss/ name difference Being playful, sharing banter, being light-hearted together Using humour/ playfulness to take risks Using humour helps if supervisor responds negatively

		Finding humour/ playfulness helpful in discussing differences
Perceived outcomes	Understanding the person	Drawing on own positions to understand client perspectives Re-framing it – understanding client perspective Thinking about difference in client's perspective/ worldview to gain greater understanding Gaining an understanding of impact of culture/diff on the client and their beliefs/ relationships Understanding client and system and identifying needs Trying to see bigger picture by considering client's graces/ values/ culture Understanding the person and their whole experience Seeing the person rather than the problem Increasing understanding and empathy for different perspectives Holding multiple perspectives
	Informing formulation and treatment	Integrating aspects of culture and difference into formulation Understanding and formulating wider impacts on clients Acknowledging different cultural views of the problem Incorporating culture/ difference into formulation/ intervention Discussing issues to formulate early experiences Understanding culture influences intervention Integrating important areas of difference into therapy eg religion Finding ways of working with clients with opposing beliefs to you Considering cultural impact on client emotional expression and relationship to services Hypothesising and integrating issues into formulations Reviewing and improving therapy **Negative cases:** Considering issues leads to uncertainty if no clear action Seeing problem as more complex due to cultural factors

Appendix AA: Bracketing Interview and Reflexive Statement

A bracketing interview was conducted with a peer (trainee clinical psychologist) who was also conducting a grounded theory study. Questions were prepared to encourage researcher reflexivity and to elicit personal assumptions and biases which may impact the research process and analysis. The interview questions are detailed below, alongside summaries of researcher responses. This is followed by a reflexive statement, written by the researcher, to summarise the impact of personal biases and assumptions on the research process.

Bracketing Interview

How are you feeling about the dissertation process as a whole at the moment?

- Feeling ok, a lot of uncertainty, not being familiar with qualitative research and GT, at sea not knowing how. Worries about recruitment getting enough participants etc. More concerns than excitement at the moment.

What made you choose this particular topic to research?

- Importance of supervisor support to me personally
- Supervisory relationship – rely heavily on clinical supervision to learn and I value it so much, helped to shape my learning and practice. Positive experiences mostly of supervision.
- Some tricky experiences with clinical psychologists who I've looked to for advice and support. Difficulties were rooted in differences between us and communication breakdown. No discussion around what was happening between us, lots of assumptions that weren't correct, issues regarding power, hierarchy and expectations. As a result, this has made me interested in this subject area and curious as to how discussions about culture and difference can be facilitated within the supervisory relationship.

Any other experiences that might influence the research?

- Generally in supervision – supervisors have been easy to speak to about different things.
- Haven't really explored issues of culture and difference much.

- Clients I've seen haven't been very culturally diverse so it hasn't come up much.
- I feel a bit like I don't know? Do we talk about culture and difference much in supervision or between us?
- Having a male supervisor – haven't really talked much about culture and difference, often avoided
- Expectation that people might not discuss it much?

Anything that is difficult about the subject for you?

- Difference – my faith, how much to bring my religious beliefs into my work versus personal opinion
- But how much do our personal opinions affect our work, should we be talking about this in supervision or not?
- I might be drawn to discussing religious beliefs with clients and want to explore that, but equally don't want to impose any of my views on others
- Might be drawn to religious discussions over other areas of culture or difference.
- Sexuality – would find it harder to explore due to fears around my own knowledge or saying the wrong thing perhaps?
- I've been thinking more about interviewing trainees than their supervisors – nervous about dynamic between me interviewing supervisors. Will they think I'm more aligned to a trainee perspective?

How might power play out?

- Potentially harder to probe supervisors e.g. about a difficulty they have had with a trainee, due to the power differential between me and them. Worried they might feel judged. Harder to empathise with the supervisor perspective. Generally I do think supervisors want to do the best they can though for their trainees.

What do you hope to get from the research for your own professional practice?

- I want to be a really good supervisor when I qualify. What are the issues supervisors face and what are the things that trainees value? What helps discussions to take place?
- Different styles between trainee versus supervisor – how able do we feel to say that we don't agree/ that we are different and have a different style or way of approaching things?

Why did you choose grounded theory as opposed to different methods?

- I like qualitative approaches as it gives people a voice and you gain an in depth understanding of experiences.
- GT – I feel aligned to the constructivist perspective, we can't separate ourselves from the research process
- Developing theory, feel more uncertain about. Will be nice to have something concise to explain to people but not sure how I will get there.
- But I like the idea of any theory being grounded in people's experiences.

What has the literature shown you already about your subject area?

- Trainees try to bring up discussions of culture and difference and supervisors tend to shut down those discussions.
- Don't want supervisors to think I'm thinking negatively of them
- But I also think supervisors mean well and generally try to do the best for their supervisees
- Feel need to keep questions as general as possible to avoid leading questions influenced by my own biases.

Do you have any expectations of the interviews?

- Hoping the interviews will be good and productive
- Worry that people might not know how to answer questions/ haven't thought about culture and difference very much
- Worried about asking follow up questions on the spot

Is there anything you are predicting will be more difficult?

- Interviewing supervisors – power imbalance, me not wanting to come across as judgemental

Is there anything you might avoid asking in the interviews?

- Supervisors – might struggle to ask about difficult experiences with trainees, I might be drawn to focusing on more positive experiences
- Sexuality/ gender identity – I might find it hard to find words to ask questions around that as it hasn't come up much in my own supervision or clinical work.
- Worries about being politically correct, not offending anyone with a word I use etc, might be tempted to avoid asking follow up questions.

What might draw your curiosity away from the interview schedule?

- Less curious about gender differences possibly
- Religion – might be more curious due to my own religious beliefs.
- Disability – might be more curious due to having a sister with ASC
- Having children – due to life stage I'm in I might be more curious about experiences of having children

Where do you feel you belong in the power hierarchy?

- Trainee participants – I wonder if power dynamic will be quite balanced or perhaps I will hold more power as an interviewer – trainees might assign more power to me? Or would they find it easier to talk to me as an interviewer because I am a trainee and therefore may identify with their perspective?
- Interviewing supervisors – feel they hold more power than me so they may be less willing to share certain experiences? They might find it uncomfortable to share negative experiences in supervision with me as a trainee?

How do you feel about the dual role of clinician and researcher?

- Uneasy – I'm a bit worried I could go into therapy mode and validate what they say rather than focusing on getting information as part of the research, worried about keeping interviews

on topic. How boundaried should I be with sticking with interview schedule? What kind of questions are helpful for the research? When is it OK to go 'off track'?

What do you think will be most enjoyable?

- Gathering data, seeing themes in the data and starting to generate theory

What will be most challenging?

- Practicalities of arranging interviews, making sure both supervisors and supervisees agree to take part – I feel a bit worried that only trainees will opt-in and not supervisors.

Is the publication of your findings likely to cause any problems with a group of people? What are likely to be the consequences?

- If supervisors are dismissing, that could be challenging to report/ rub supervisors up the wrong way, fear that someone will look bad
- What if there are tensions between supervisors and trainees? Challenging to publish this and participants read it. Everything will be anonymised, but it could be that it's the first time they are aware of the possibility that there were issues in their supervisory relationship?

How might your own values impact on the research process?

- Balancing work and home life I think will be difficult when trying to work full time, and fitting in interviews whilst also being a parent.

What makes a good researcher or a good research process?

- Being as open and explicit as you can be about research process and findings and seeking supervision when needed to reflect on these.

How might you deal with difficulties?

- Reflecting on them, seeking supervision and asking for help.

Anything that's come up in this interview that you were surprised about, new or anything that's shifted?

- What trainees/ supervisors might think of me
- What they might be saying about each other – not knowing what was said about each other in the interview? What came up and how they could learn from it in their practice? How participants might feel afterwards?

Reflexive Statement

The researcher was a female White British trainee clinical psychologist who recruited participants from their own clinical psychology training programme. The researcher did not recruit participants from her own cohort and therefore did not have prior knowledge of the supervisory relationships explored in the present study. The reflexive methods used highlighted researcher assumptions that supervision is usually a helpful space for personal and professional development, but that issues of culture and difference are rarely explored. Underlying this was the assumption that culture and difference are uncomfortable to discuss, particularly due to fears about not being "politically correct" or creating conflict in the SR. It was noted that the researcher was more aligned to the position of supervisee, given her role as a trainee and not yet having formal supervisory responsibilities. The power imbalance between the researcher as a trainee and recruited supervisors raised the possibility that it may be difficult for the researcher to probe supervisors or discuss difficult experiences, and that supervisors may feel uncomfortable discussing negative experiences with a trainee to a trainee on the same course. It was therefore deemed essential to emphasise the importance of confidentiality during interviews.