‘Humanness’:
Across Contexts and Experiences

By Amy Bower

Portfolio for the Professional Doctorate in Counselling Psychology

Department of Psychology

City, University of London

September 2023

Table of Contents

List of Tables and Figures

Tables

Figures

Acknowledgments

I would like to thank the following people for their help and support:

The nine GP trainees who gave their time to share their experiences with me, thank you for coming forward and trusting me with your stories. Your openness and the insights you have provided will be invaluable in the ongoing development of the intervention, and I'm sure will make a real difference to the experiences of future trainees.

My supervisor Dr. Fran Smith - thank you for being so incredibly supportive of this project from the start, keeping me excited about it all the way, and believing in me. In particular your support and understanding in getting everyone on board has been invaluable. I hope this is only the beginning for this project, and that I will have the privilege of continuing to work with you.

My second/third supervisors, Dr. Aylish O'Driscoll and Dr. Emma Hollywell, for being there when I needed you, your enthusiasm for the project and help with designing the study. You made a challenging time much easier to navigate.

Everyone involved in the IRPP - for giving me the fantastic opportunity to conduct this research, and for your enthusiasm and support for it from day one.

Everyone in my cohort of DPsych trainees, I couldn't have wished for a better group to share this journey with. Knowing we were in this together has made navigating the highs and lows of the last three years a lot easier (and brought a lot of much needed laughter along the way too!) I hope to stay connected with you all in this next phase of our lives and careers.

The staff on the DPsych at City, for playing such an important part in my change of career by believing in and inspiring me. Thanks in no small part to your input, even when this journey has been at its most challenging I've known I made the right choice!

Thanks should also go to my fantastically supportive family and friends for their help over these last three years, I'm so lucky to have you. I hope I can now be more able and available to start showing you all exactly what it's meant to me.

And finally: Thank you to Jimmy - you make everything better! AC - for the 'way of being'. Ian Anderson - for keeping me grounded. And my wonderful Grandma, Claris Bower (14/06/1919-16/07/2006) for teaching me the value of 'humanness' and continuing to inspire my approach to counselling psychology, and to life!

Declaration of Powers of Discretion

I grant powers of discretion to the University Librarian to allow this thesis to be copied in whole or in part without further reference to the author. This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgement.

Preface

Three components make up this portfolio: empirical research into how GP trainees make use of Reflective Practice Groups (RPGs), a publishable paper summarising the findings of the empirical research, and a combined case study and process report illustrating my clinical work with a female client who came to a parent and family counselling service presenting with low mood and anxiety. A common theme of 'humanness' connects these components.

Part I: Empirical Research

The first component consists of qualitative research conducted through semi-structured interviews with nine GP specialist trainees from one NHS Trust participating in the Interprofessional Reflective Practice Project (IRPP) through which they attend RPGs facilitated by trainee Counselling Psychologists. Using constructivist grounded theory methodology (Charmaz, 2014), an explanatory theory of the way GP trainees make use of RPGs was developed. This showed how participants used the groups to navigate the complex relationship between their 'humanness' - that is emotions, vulnerabilities, flaws, limitations, and desire for connection with others - and their sense, partly derived from ideas embedded in medical culture, training and practice, of how as Doctors they should be and behave. An inter-connected process of sharing experiences, recognising and processing emotions, and developing empathy and compassion, all the while developing understanding and skills which they integrated into their work and personal lives, enabled participants to begin to reconcile their humanness with themselves as Doctors. The counselling psychologist facilitator emerged as important in supporting this process. Findings were explored in the context of wider literature, and comparisons drawn with relevant psychological theories which offer insight into possible mechanisms underpinning these processes. Suggestions for future research were offered, and clinical implications considered, including recommendations for counselling psychology practice.

Part II: Publishable Paper

The second component is a paper written for submission to the journal *'Medical Education'*. This includes a conceptualisation of the core category and all identified major categories of the emergent theory, and presents the findings in the context of wider literature and relevant theory to demonstrate where these make a significant contribution. This journal was chosen due to its high impact in the field of education for healthcare professionals, and the importance of disseminating these findings to medical educators and students/trainees. The journal's inclusion of papers relating to postgraduate training and interprofessional education fits well with this study. It is hoped that the impact factor of this journal (6.0 in 2022) will mean the findings reach trainees and educators not just from a GP/GP training background, but from a range of disciplines.

Part III: Clinical Piece

The final component is a combined case study and process report demonstrating an integrative piece of work, the assimilative integration of a person-centred host model with systemic ideas, which I carried out with a biracial female client named Lisa (pseudonym) who was referred to the School-based parent and family counselling service following a meeting in relation to her son Tom (pseudonym) where she reported low mood and anxiety which she related to Tom's behaviour towards her at home. My work with Lisa revealed that as a child she had introjected the belief that showing emotion means making a fuss, and experienced her mother's love and acceptance as conditional upon being emotionally unexpressive, performing domestic tasks and caring for younger siblings. The escalation of Lisa's difficulties, when as a Mother herself she began to struggle with Tom's behaviour, were a result of the incongruence between what Rogers (1961) termed her organismic self (which needed support) and her presentational self (which rejects support), leaving her feeling increasingly frustrated and powerless. Systemic issues of difference, including race, gender, and socioeconomic background, Lisa's family relationships and experiences of professional services also contributed to her feelings of powerlessness. The clinical piece highlights how I brought the core conditions (Rogers, 1957), particularly empathy, to my work with Lisa, to allow her to begin to understand herself and reach a greater self-acceptance, and emphasises the importance of the therapeutic alliance in facilitating change. By bringing my 'humanness' to the relationship with Lisa, I was able to communicate my empathic understanding of her. However, I was focused on Lisa's lack of outward expressions of emotion during sessions, which when I named with her elicited the response that, for her, she *was* being emotional. This helped me to recognise my own expectations and become aware of when I was assuming it would be helpful for Lisa to be more emotional, or turning this into a therapeutic 'goal 'for her. Considerations of difference helped me to shift my therapeutic approach to one where empathic behaviour took precedence over responses designating feelings (Brodley, 1996). In turn, this supported Lisa to recognise when her responses were simply reflective of who she was, and when she was' making light 'of her emotions because she felt these did not matter. As Lisa began to value herself and her emotions more highly, and acknowledge her need for these to be validated, she experienced an alleviation of her difficulties.

'Humanness' as the Common Theme

The idea of 'humanness', developed from participant accounts to include emotions, vulnerabilities, limitations, imperfections and need for connection, runs through this portfolio.

GP trainees in the empirical research appeared to experience a conflict between aspects of their humanness and how they felt they *should* be as Doctors. Ingrained ideas from medical culture

(Crowe & Brugha, 2018), and environmental and contextual factors such as pressures on time and resources, impacted on this. For some this led to self-criticism and imposter feelings. Others experienced despondency, emotional exhaustion, and symptoms of burnout. The findings showed how through the sharing of difficult experiences, creating an openness to vulnerability and a sense of greater connection and belonging, recognising and processing the emotions that arose, their own and others', developing empathy and compassion, including self-compassion, and skills which supported them to bring their 'humanness' to their communications with others, including colleagues and patients, participants were able to navigate this complex relationship between humanness and being a doctor.

The clinical piece shows how Lisa had introjected a belief that showing her 'humanness' (expressing emotions, admitting she is struggling/needs help) would make her unworthy of love or lead to rejection, and values associated with working above and beyond her limitations and putting others first. This stimulated later conflict between her need for support and for her feelings to be heard and valued, and her instinctive rejection of support and belief that her feelings did not matter. Alongside her early experiences, Lisa had assimilated ideas and expectations from her environment about how she should behave, which conflicted with her inherent humanness. Understanding and accepting this 'humanness' was an important aspect of Lisa beginning to accept herself.

Implicit within the 'human' need for connection is the idea of sharing experiences. Group discussions supported GP trainees to recognise a common 'humanness', which united them all, and challenged their sense that their experiences were individual and personal, or meant they were a 'failure' as a doctor. Through sharing her experiences in therapy, Lisa developed a greater sense that her feelings were valid and began to value herself more highly. And through 'being with' Lisa in this, I developed an understanding of how she experienced and expressed her feelings and how I could bring my own 'humanness 'to the therapeutic relationship to support a deeper exploration of this.

For myself, the idea that sharing experiences facilitates self- and other-understanding and acceptance feels intuitive. For the GP trainees and for Lisa, however, this was both unfamiliar and potentially uncomfortable as it challenged those ways they had learned to present in order to 'survive 'in their world, or 'play the game' (Brosnan, 2010) which were in conflict with their 'humanness'.

The idea of 'humanness' seems to fit well not just with my own approach to therapy, but with the ethos of counselling psychology in general. It implies a non-pathologising stance, recognising our difficulties and challenges as human experiences. It could also be said to go some way towards creating greater equality and lessening the power imbalance inherent in professional relationships, where instead of seeing ourselves in terms of 'therapist and client', or in the case of GP trainees,

'doctor and patient', we recognise and are congruent of our own and our clients' humanness first. The idea of humanness not only allows for but makes imperative vital considerations of difference, and the recognition of the individual histories, experiences and identities which we, our clients and colleagues bring to our relationships. It brings to mind a respectful, non-judgmental, accepting approach to understanding and working with people which goes to the heart of counselling psychology.

Insights from this portfolio have resulted in an increased awareness that recognising the differences in the way we all experience and conceptualise aspects of our humanness can be crucial in finding the most helpful ways to facilitate client self-exploration, which I bring to my counselling psychology practice.

My Relationship with the Theme of Humanness

It was difficult at first to see how these very different pieces, empirical research with GP trainees and clinical work with a parent in an inner-city School-based counselling service, were related. But as the common theme of 'humanness' began to emerge, it gave me cause to reflect on my own relationship with this.

As a career changer, in my previous career within a highly competitive culture, which valued emotional toughness and could feel very isolating, I found myself at odds with particular aspects of my humanness in attempting to meet my own and others', expectations of what I should be. My sense of my 'humanness' as frustrating my pursuit of my goals led me to hide my emotions and struggles, caused increased anxiety and self-criticism, and made the job exhausting and unrewarding. It was only by beginning to talk about these experiences that I was able to recognise that I was not failing or not competent, everyone experienced emotional responses to demanding situations, and no one was perfect. This made it feel safer to admit I was unhappy and wanted to make a change. Changing paths, culminating in my arriving at this point, has been a process of coming to understand myself better. I have come not just to feel more comfortable with and accepting of my own 'humanness', but to value it. As a counselling psychologist, my understanding and recognition of my own humanness is important in my therapeutic relationships. I have always been inspired by the idea that just being human with clients can go a long way towards supporting them to greater self-understanding and acceptance. At this point I feel more comfortable with my own humanness than I ever have, and this training experience has played an important part in that. Through personal therapy, supervision, and experiences on placement I have been supported to explore aspects of myself and my humanness, develop my professional identity, and align this with my personal identity. Going through this journey with my cohort of counselling psychologist trainees has given me a sense of connection and belonging and, crucially, allowed for sharing experiences.

I have found this experience transformative, and the changes I have noticed, in my openness to showing vulnerability, sitting with doubt and uncertainty, experiencing an emotional reaction to my therapeutic work, and recognising my own limitations and boundaries, will support me as I go on into my career. I fully anticipate continuing to learn and grow in these areas.

I hope this portfolio will inspire others to reflect on their own humanness, their relationships with this, and the impact of early experiences and systemic factors on their responses to and the meanings they attach to it. In navigating our humanness, in whatever we do, we begin to find ways of aligning who we *want* to be, and our sense of who, and what, we *should* be, with who we are, and talking to one another about our experiences is a good starting point for this. I hope that insights from this portfolio will inform the work of other practitioners, whether that be with groups or individuals, therapeutic work or the facilitation of reflective practice.

References

Brodley, B. T. (1996). Empathic understanding and feelings in client-centred therapy. *The Person Centred Journal, 3*(1), 22-30. https://www.adpca.org/wp-content/uploads/2020/11/Brodley-Empathic-PCJ-3_1.pdf

Brosnan, C. (2010). Making sense of differences between medical schools through Bourdieu's concept of 'field'. *Medical Education, 44*(7), 645-652. https://doi.org/10.1111/j.1365-2923.2010.03680.x

Charmaz, K. (2014). *Constructing grounded theory* (2nd ed). SAGE Publications Ltd.

Crowe, S. & Brugha, R. (2018). “We’ve all had patients who’ve died…” Narratives of emotion and ideals of competence among junior doctors. *Social Science & Medicine (1982), 215*, 152-159. https://doi.org/10.1016/j.socscimed.2018.08.03

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*(2), 95–103. https://doi.org/10.1037/h0045357.

Rogers, C.R. (1961). *On becoming a person.* Houghton Mifflin.

Part I: Empirical Research

"It's like… here's a space to be human about it" – or: How do GP Trainees Make Use of Reflective Practice Groups? A Grounded Theory Investigation

Abstract

Reflective practice, an important aspect of counselling psychology training and increasingly important in healthcare training and practice, has been shown to have a number of benefits, including the reduction of burnout. Given the reported high levels of burnout in doctors and need for interventions to support their emotional wellbeing, reflective practice interventions could have an important role to play in this. One such intervention, the Interprofessional Reflective Practice Project (IRPP), provides reflective practice groups for GP trainees, facilitated by trainee Counselling Psychologists. Although recent research has highlighted the potential of psychologist-facilitated reflective practice in healthcare, research actually examining interprofessional reflective practice between medical and counselling psychology professionals is still extremely limited. This constructivist grounded theory study, therefore, aimed to understand more about how participants make use of this form of interprofessional reflective practice, via semi-structured interviews with nine GP trainees involved in the IRPP. Five major categories emerged from the analysis. One core category: 'Navigating the relationship between 'humanness' and being a Doctor' , encompassed all of these, revealing how participants' 'human' emotions, vulnerabilities, limitations and struggles conflicted with ideas that Doctors should be strong, emotionally resilient and able to 'do it all'. An emergent theory was developed that attempts to explain how participants used the groups to navigate this, through the processes of 'Sharing experiences', 'Recognising and Processing Emotions', 'Developing Insight and Compassion', 'Developing Understanding and Skills', and 'Integrating' these 'into Work - and Beyond'. These categories were complex and linked to one another, and the facilitator emerged as an important contributor across each. These findings are explored in the context of relevant theory and wider literature. Their clinical and wider implications are discussed, including recommendations for counselling psychology practice. Strengths and limitations are identified, with suggestions for future research to continue the exploration of this important subject.

Chapter One: Introduction

1.1 Overview

The primary focus of this chapter will be to synthesise and provide a critical overview of all of the literature relevant to the current study. It will begin by providing an overview of the research into reflective practice (RP) in healthcare, including definitions and categories. It will examine research relating to the role and impact of the RP facilitator, and the relatively limited research base in relation to interprofessional RP involving healthcare and psychology trainees and practitioners. The impact of RP engagement will also be explored, including both positive and potentially negative or detrimental effects of this. Attention will be paid to findings which might suggest a role for counselling psychologists in the facilitation of RP. In the following sections it will go on to provide an overview of research relevant to the context of the current study, that is GP and medical training, including research concerning GP emotional wellbeing, the role of medical culture in this, and the prevalence of burnout and related phenomena impacting on medical trainees. It will briefly examine research findings concerning interventions aimed at remediating this, and highlight those which suggest a role for RP. 'Humanness', as it relates to the current study, will then be explored, including definitions and critical reflections from academic research and iterature. Gaps in the literature will be identified, with an explanation of how the current study fits into the existing literature and addresses these gaps. This chapter will conclude by setting out the rationale for the current study, its aims and relevance to counselling psychology.

1.2 Reflective Practice

The British Psychological Society (BPS, 2019) place an emphasis on RP in counselling psychology (CoP) training and practice, and posit that CoPs should *'embody the identity of the Reflective Practitioner'* (p12). RP is also recognised as being of increasing importance in healthcare training and practice (Mann et al, 2009). In medicine, reflective capacity is seen as an essential characteristic of competent professional practice (Wald & Reis, 2010; Johnson & Bird, 2006) and important in the development of professional behaviours (Roberts & Stark, 2008). The Royal College of GPs training curriculum describes RP as *'integral to fitness to practice and ethical working'* (Rutherford et al, 2017, p158). Sandars (2009) asserted that the knowledge of one's values and beliefs, as developed through the process of reflection, is important for a doctor to develop therapeutic relationships with patients. And Howe et al (2009) found that reflecting on practice and developing self-awareness were important mechanisms of resilience in the face of a demanding profession.

1.2.1 Definitions of Reflective Practice

Reflective Practice is difficult to define (Richard et al, 2019). Early definitions came from the field of education. Dewey, an American philosopher and educator, provided what is thought to be the first definition of RP in his 1933 work *'How we think'.* Dewey (1933) suggested a reflective process inspired by the scientific method, which has five stages: 1) identifying the problem; 2) defining the problem; 3) identifying hypotheses and possible solutions; 4) analysis and assessment, and 5) testing in action. This process is intended to move the enquirer as close to certainty as possible, however has been criticised on the basis that it does not allow for reflection *and* action to happen at the same time (Herbert, 2015).

Since then, the definition of RP has undergone a number of developments. Arguably the most significant dervies from Schon, in his works *'The reflective practitioner'* (1983) and *'Educating the reflective practitioner'* (1987). Schon (1983, p49) stressed that often professionals have to be spontaneous and are not able to engage in a process of reflection before acting, and argued that due to their knowledge from experience, reflective practitioners can reflect *and* act at the same time. He identified two processes: reflection-in-action, which occurs at the time of action, and reflection-on-action, which occurs after the event with the benefit of an opportunity to think about what has happened.

Lavender (2003) developed Schon's work for the clinical psychology field, to include reflection about impact on others, which reflects the interpersonal context and can involve seeking feedback from the other on their feelings about the communication, and reflection about the self, where personal experiences directly impacting on client work are examined. It is arguable that Lavender's developments have relevance for all healthcare professionals whose role and context are inherently relational and interpersonal. Lafortune (in Richard et al 2019, p424) further developed Lavender's (2003) work to include a critical and ethical element, arguing that RP must *'go beyond the level of impression and reach a more critical, metacognitive, and ethical order'*. And Nguyen et al (2014) included in their model of RP both the trigger for reflection, that is the experience, and the context, including the timing, of reflection.

In the context of health and social care, Mamede and Schmidt (2004) refer to the action of thinking critically and consciously about practice, so as to reduce the risk of non-conscious habitual practice which can lead to compromised patient care and safety. Richard et al (2019) asserted that RP so defined is an application of critical thinking to professional practice with a view to improving the latter. And in the context of psychology, the BPS (2017, p11) frame RP as *'psychologists… having a complex understanding of self in the context of others'.*

It is clear then that difficulties exist in coming to a precise definition of RP. As such a broad definition will be adopted for the purposes of this study, reflective of Richard et al (2019, p2)'s description of RP as a *'deliberate and conscious reflective process, supported by a rigorous approach, and involving a critical dimension'.*

1.2.2 Categories of Reflective Practice

RP is a relatively heterogenous area, covering a range of methods and categorised in a number of ways.

The literature differentiates between summative methods, including reflective diaries and portfolios, and formative methods, such as supervision and reflective groups (Norrie et al, 2012).

Miraglia and Asselin (2015) proposed further categorisations of reflection. First, individual reflection, which includes reflective writing and Launer's (2020a) idea of 'inner dialogue', or talking to oneself about an issue or challenge (Launer, 2011) versus group reflection, which includes such interventions as group supervision, Balint Groups[1] (see Nandagopal, 2022), and Schwartz Rounds[2]. Quilty and Murphy (2022) posed a challenge group-based RP. Whilst asserting where it is *'resourced and facilitated expertly and related to external benchmarks, the potential benefits are extensive '* (p2), they raised a concern that where this is not the case, group-based RP may reflect a purely internal perspective, and may, inadvertently or intentionally, homogenise thinking to a single group view, subvert self-analysis, and inhibit individual growth. However, Carroll and Gilbert (2011) and Priddis and Rogers' (2018) assert that reflecting with peers provides more objective views and an 'outsider's perspective', which can help reduce the influence of personal biases. And Launer (2016) argued that reflecting in groups can help doctors to learn that there is rarely a single way of looking at any clinical case, nor any single correct way of managing it.

A further category of reflection, identified by Miraglia and Asselin (2015), is structured versus unstructured reflection. Structured reflection refers to RP using a particular format, such as a 'reflecting team', where a presenter brings a situation and poses a question to the group, then sits 'aside' while the group discuss it (Andersen, 1987; Launer, 2016). By contrast, in unstructured reflection a case presenter brings a situation and the process of reflection is facilitated only by the use of reflective questioning.

Many RP interventions involve the use of lived experience accounts. One approach, 'telling stories' involves participants talking about problematic situations they have experienced (see Petersson et al, 2009). Other similar approaches involve presenting accounts of truthful interactions between professionals and patients (see Vatne et al, 2009). Some of these approaches involve reference to actual clinical cases, but others focus on sharing situations experienced in the course of team discussions (Nancarrow et al, 2014).

The heterogeneity in the definitions, categorisations and methods of RP has made researching its impact and effectiveness challenging.

[1] 'A Balint Group is a group of clinicians… who meet regularly to present clinical cases in order to improve and to better understand the clinician-patient relationship' (https://www.americanbalintsociety.org/content.aspx?page_id=22&club_id=445043&module_id=406070)

[2] 'Schwartz Rounds are group reflective practice forums giving staff from all disciplines an opportunity to reflect on the emotional and social aspects of working in healthcare' (https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/reflective-practice/schwartz-rounds)

1.2.3 Interprofessional Reflective Practice

A further category of RP is that involving participants from different professional disciplines. Critical reflection is considered by the World Health Organisation to be one of the main interprofessional learning domains (Richard et al, 2019), and research suggests that interprofessional approaches can be beneficial to trainees during training (Launer, 2018; Buring et al, 2009; Freeth, 2013). Launer (2015) drew attention to research from a number of countries indicating that GP participation in interprofessional collaborative learning groups can bring about significant changes in engagement with patients, performance in psychological approaches to treatment, and levels of burnout (Siegel Sommers & Launer, 2013). He urged managers and educators to consider setting up and funding these groups.

Richard et al (2019) in their review of studies in this area, the first of its kind, found that regardless of their quality, all studies generally supported the effectiveness of integrating RP into interprofessional continuing education and practice. Drynan and Murphy (2013) argued for the value of group reflection focusing on interprofessional communication, and Clark (2009), Kinsella (2010), and Kuipers et al (2014) identified RP as useful in challenging situations containing multiple dimensions. Richard et al (2019) concluded that RP makes a valuable and necessary contribution to interprofessional collaboration. Whilst only six studies were reviewed, three demonstrated an improvement in attitude and greater openness to collaboration, and results were reported in all studies in relation to the acquisition of knowledge and skills, particularly communication skills (Vatne et al, 2009). And three articles (Benson, 2010; Vatne et al, 2009; Nancarrow et al, 2014) provided results in relation to changes that were subsequently translated into the individual's practice. Richard et al (2019) highlight the reliability of these findings due to the varied cross-referenced measurements on which they were based.

Again, the characteristics of RP interventions varied widely across the studies reviewed, with only three using approaches involving lived experience accounts (Benson, 2010; Vatne et al, 2009; and Nancarrow et al, 2014). This suggests the heterogeneity of RP research extends to interprofessional RP. Across all reviewed articles, four characteristics were identified as being of key importance: the use of clinical situations, the use of theory to improve clinical practice, the inclusion of a reflective theory or a rigorous and explicit reflective process, and having a facilitator for group discussions (Richard et al, 2019). The importance of the facilitator will be explored further in 1.1.4.

In this area, it is also worth considering interprofessional supervision. Launer (2018) highlighted the potential benefits of this, but recognised that some doctors may experience fear or uncertainty about it. He described running interprofessional supervision workshops in which participants brought narratives of encounters at work that were bothering them and had a chance to practise supervision in a pair or small group with someone from another profession. One of the benefits identified was getting entirely new perspectives on one's work. Launer (2018) suggested that someone from outside the medical profession may be more likely to ask questions a doctor had

not even considered, and in so doing stimulate new thinking. His findings echo those of previous research into interprofessional supervision: that it enables the acquisition of skills and knowledge from other disciplines, a greater awareness of the underlying assumptions of your own practice generally and thinking more critically about these, and a better understanding and appreciation of the different contributions, perspectives and roles of others (Davys & Beddoe, 2015).

The BPS (2019, p7) include the promotion of *'psychological mindedness and skills in other health, educational and social care professionals'* as a necessary standard for the accreditation of CoP doctoral programmes. However, research relating to CoPs involvement in interprofessional RP or supervision was extremely limited. Two recent studies examined the impact for healthcare professionals of participating in clinical psychologist (CP)-facilitated RPGs: Ingram et al (2020; trainee doctors) and O'Neil et al (2019; psychiatric nurses). These were both small studies, and neither examined whether any objective changes occurred as a result of attending groups, but they do support the idea of psychologist facilitators in interprofessional RP. Launer's (2018) assertion that it is more important for supervisors, and arguably the same could be said to be true of facilitators, to have *'human skills like empathy, an open mind and a capacity to invite reflection'* than technical knowledge of the field in question arguably strengthens the case for CoP-facilitated RP, as these traits are central to the ethos, training and practice of counselling psychology. As such, the next section will examine whether research findings in relation to RP facilitators is suggestive of a role for or indicates potential strengths of CoPs in this.

1.2.4 Facilitators in RP and IPE: A role for Counselling Psychology?

Although there is very little research explictly looking at CoPs as facilitators of reflective groups, the literature does identify particular facilitator traits and practices which seem to have resonance with the ethos of counselling psychology.

Richard et al (2019, p433) found that RPG facilitators *'played a key role in the successful implementation and effectiveness of the* [RP] *interventions'.* Across four studies, the facilitator's contribution was considered supportive (Benson, 2010; Dobson et al, 2009; Nancarrow et al, 2014; Vatne et al, 2009). This echoes findings by Knight et al (2010), who identified that the potency of RPG facilitation significantly predicted levels of perceived value and distress in participants. Consistent with this, Lyons et al (2019, p76) described the RPG facilitator as *'a significant contributor to the reflective process'*, and asserted that: *'it is crucial for… facilitators to foster an environment of safety and openness when emotions surface'* (p80). Creating a safe and containing space for the experience and exploration of emotions is an important aspect of CoP training and practice, and could point to a possible strength of CoPs in RP facilitation.

Richard et al (2019, p433) asserted that facilitators are regarded as pivotal in the IPE literature, describing them as *'the guardians of the intervention structure, orienting the process in line with identified theory and evidence, fostering the establishment and maintenance of healthy*

collaboration, and supporting the reflective dimension of the process'. RP is built into counselling psychology training and practice, and with the profession's emphasis on reflexivity, self-reflection, and openness to a collaborative approach, CoPs are arguably well-placed to bring these elements.

There is very little research into the efficacy of facilitation models (Chaffey et al, 2012) and Lyons et al (2019) pointed out, echoing Knight et al (2010), that there is very little research into the perspectives of RPG facilitators.

As such, while some findings indicate potential strengths of CoPs as RP facilitators, further research is clearly needed to explore what they can bring to the process of interprofessional RP, and how this compares to research involving CP facilitators (O'Neil et al, 2019; Ingram et al, 2020).

1.2.5 What are the barriers and challenges to engagement in Reflective Practice?

Understanding the challenges to RP engagement is important to the research area in general, but could also help to further illuminate the potential of CoP facilitators. As such, the next section will explore those barriers and challenges identified in the RP literature, whilst taking into consideration whether CoPs with their particular skills and training could play a role in mitigating them.

One common barrier identified across professional contexts is the challenging nature of RPGs. Research has found that participants can experience high levels of distress in RPGs or as a result of RP (Nancarrow et al, 2014; Benson et al, 2010; Knight et al, 2010; Vatne et al, 2009, see 1.2.7). This may explain why Neilsen and Soderstrom (2012) found that workplace problems, difficult patient relationships and complaint cases were not commonly raised by GPs in supervision groups, although Lyons et al (2019) found that a majority of participants reported valuing the difficult and distressing aspects of RPGs. For healthcare professionals, the reluctance to talk about the emotional aspects of work, or explore challenges and difficulties may be reflective of the culture of medicine (see 1.3), although Sadusky and Spinks (2022) identified a similar culture in CP practice (Bearse et al, 2013) and highlighted the potential of RP engagement to help overcome this.

Lyons et al (2019) posited that the potentially distressing nature of RP highlights the importance of having a facilitator who can provide a safe space for the exploration of these more challenging aspects. This suggests a potential role for CoPs, with our skills and training in creating a safe and containing space, in order to support participants and mitigate the impact of the challenging nature of RP on engagement and attendance. It certainly makes a case for further research into RP interventions with CoP facilitators.

Another common barrier is making time for RP. Launer (2011, p505) reflected that health professionals often complain that it is 'impossible to practice reflectively' due to time constraints and their highly pressurised circumstances, and argued that RP is always possible if it is prioritised. The issue of prioritising RP has been raised in subsequent studies from across professional disciplines. Nancarrow et al (2014) found that some participants felt uncomfortable about spending time on RP which could have been spent on patient care, and Sargeant and Au-Yong (2020) found that issues

arose where groups clashed with aspects of training concerning medical care, which was viewed as deserving of priority over those with a more psychosocial focus. And this was not unique to medical trainees and practitioners. Lyons et al (2019) identified competing demands on time, leaving little room for focusing on personal and emotional responses, and a feeling that RP should not be a priority over time spent on work, as barriers for CP trainees.

One way of addressing this, making RPGs mandatory, is quite widely explored in the literature. Albanese (2006) noted that medical students were often task-focussed, with little time for reflection, and given the importance of time and motivation in facilitating reflection, it was not surprising that voluntary reflection was unlikely to occur in the medical student population (Grant et al, 2006). This may make a case for mandatory reflection, however questions have been raised about this approach. In Sargeant and Au-Yong (2020), groups were initially voluntary but mandatory groups were later introduced, and while voluntary groups were received more positively and were easier to run, an advantage of mandatory groups was that all trainees attended, and some who were initially reluctant found the process helpful. However previous research has identified that in medical groups where participation is mandatory, trainees are likely to give poorer feedback on the value of discussions (Monk et al, 2018), and facilitators in Sargeant and Au-Yong (2020) reported that some participants did not attend even when groups were mandatory. Sargeant and Au Yong (2020) suggested that this might be a result of them unconsciously protecting themselves from the anxiety associated with experiencing distress around exploring feelings about difficult experiences. If so, this would seem to reflect previous studies highlighting the distressing nature of RPGs (Knight et al, 2010), and again might suggest value in exploring what CoP facilitators could bring to this in providing a safe space and bringing their skills and training to the more emotional aspects of groups. But with so little research in this area, this can only be hypothesised on.

1.2.6 Impact of Reflective Practice Participation

One area that is relatively widely researched is the impact of RP engagement. However, again heterogeneity in terms of types of interventions, professional groups and context, including settings and stages of training and practice, makes it difficult to quantify (Mann et al, 2009). What is notable is the relative lack of resesarch into the impacts of RP for GP trainees or practitioners.

Most of the research into the impact of RP is qualitative. Exisiting quantitative studies tend to use unvalidated measures of reflection (Richard et al, 2019). For example, Knight et al (2010) developed an RPG questionnaire to explore the personal and professional impact of RPGs on CP trainees and used factor analysis to identify the underlying constructs, two of which were identified: value and distress. And Nielsen and Söderström (2012) used questionnaires to explore the impact of participating in group supervision on preventing burnout in GPs. Their findings suggested that engaging in this type of RP could play a role in preventing burnout, something that was later supported by Van Roy et al (2015), but their response rate was low. Ooi et al (2021) identified two

questionnaires to measure RP within healthcare settings, but highlighted there is no standardised tool for this. More recently, one of the few RCTs in this area, by Golaghie et al (2019), used a pre/post design to identify the effect of integrating case-based learning with RP on the outcomes of continuing nurse education. Participants were randomly allocated to two groups, and the experimental group was supported to perform a collective reflection on patient care. Participants in the experimental group recorded significantly higher post intervention scores of learning and of self-perceived competency, suggesting that this is promoted through engagement in RP. Strengths of this study were its sample size and the inclusion of follow up measures, which suggested score were maintained over time. However, it did not use a true control, and it was carried out in University hospitals only, so may not represent a wider sample of nurses. Launer (2015) pointed out that the research base into collaborative group learning was hard to quantify, in that it is difficult to compare like with like, randomisation and control groups are often not possible, and there are many confounding variables. The same could be said of RP research in general, but in particular the quantitative studies in this area.

Outside the purely quantitative research base, a mixed-methods evaluation by Gill et al (2014) of hospital-based discussion groups aimed at promoting professionalism, reflective practice and patient-centred care among trainee doctors found that participation had a positive effect on their understanding of professionalism, and highlighted the importance of having a protected space for healthcare workers to come together, narrate their experiences, learn from one another, 'dress rehearse' challenges and develop new insights into what it means to be professional. Van Roy et al's (2015) systemic review of the research into Balint groups and outcomes for healthcare professionals found that reflective participation improved participants' attitudes, possibly decreased burnout/dissatisfaction, and increased psychosocial self-efficacy. Increased psychosocial awareness and confidence to discuss psychosocial issues in clinical settings was subsequently found by Chu et al (2018) to be a benefit for medical students of engaging in reflective group dialogues. And while Mann et al (2009) raised concerns that there was no evidence linking RP engagement with increased self-awareness, a meta-synthesis review from the psychotherapy field, including ten studies, identified six distinct themes of involvement in RP, including increased self-awareness; increased interpersonal, perceptual and relational skills; and increased empathy for clients; and understanding of the discomfort associated with self-disclosure (McGillivray et al, 2015). The development of empathy and self-awareness was also identified by Wald et al (2016) in their study into the use of a workshop using mind-body medicine and interactive reflective writing to promote resiliency for senior medical students. They argued that increased self-awareness can illuminate values and what causes stress, which can lead to increased resilience. This echoes an earlier study by Howe et al (2009) which found that that reflecting on practice and developing self-awareness are important mechanisms of resilience in the face of a demanding profession.

Some of these findings were also supported by Carmichael et al (2020) in their IPA study of CPs experiences of using RP in clinical work, which identified themes relating to the development of

perspective taking ability, management of the emotional impact of work, and use of reflection as a way of containing their own thoughts and feelings in practice, which also had an impact on the building and maintaining of therapeutic relationships. This echoes Launer's (2016) assertion that participating in reflective group discussions can make doctors more at ease with clinical uncertainty and increase compassion towards complex or challenging patients. Increased compassion and self-compassion was also identified by Taylor et al (2018) as an impact of participating in Schwartz Rounds, along with reduced feelings of isolation. Engagement in RP, particularly interprofessional RP, has also been found to have an impact on professional identity (Sergeant & Au-Yong, 2020).

One critique of the RP research body is that it nearly exclusively focuses on whether clinicians, and usually trainees, find reflection helpful, but not on how they use RP, *how* they find it helpful or what benefit, if any, it has to their practice (Wigg et al., 2011). This criticism was levelled at research from the CP field, however it is notable that of the only two studies identified which examined the use of RP in practice both related to CPs. Of these, Fisher et al (2015) found that reflection helped CPs better understand both themselves and how they personally impacted their work, and helped them in understanding and engaging with clients, and Carmichael et al (2020) echoed these findings. It was difficult to find any studies relating to the ways in which healthcare professionals used RP in practice, in fact Ingram et al (2020) identified a lack of research looking at change as a result of participating in RP and highlighted a need for further research in this area.

Research from across the healthcare professions has highlighted the potential impact of RP on levels of occupational stress and burnout. As previously described, Neilsen and Soderstrom (2012) identified the potential of engaging in group supervision to prevent burnout in GPs. More recently, in their quantitative study of psychologists in Australia and other countries, Sadusky and Spinks (2022) found that elements of RP addressed factors specific to the experience of burnout such as client-related stress and enhanced self-awareness, resulting in greater attunement with clients, and asserted that access to regular reflective practices could impact burnout levels. And a mixed methods study by Ingram et al (2020) found that trainee doctors described psychologist-led RPGs as a safe space to talk about themes which contributed to the experience of burnout, including the impact of feeling alone and not talking, and the benefit of a community of support that enabled discussion of shared challenges and coping initiatives. This was a pilot study so was relatively small-scale, but it led to the adoption of regular CP-facilitated RP sessions for trainees in the Trust. A previous qualitative study of nurses attending psychology-led RPGs (O'Neil et al, 2019) had reported similar findings, with nurses perceiving a range of benefits including sharing common experiences, expressing emotions and having a safe space to have conversations with and learn from one another, with some participants reporting increased confidence and self-esteem.

While the literature discussed above goes part of the way towards answering questions posed by Mann (2009), findings have been mixed. Further research is clearly needed into the impact of RP on clinical practice. The potential of RP to reduce burnout symptoms and imposter feelings, and an exploration of the 'how' in relation to this, arguably also warrants further investigation, particularly

given the prevalence of these in the medical professions, which will be discussed further in section 1.3.

1.2.7 Potentially Harmful, Detrimental, or Negative Effects of Reflective Practice

As well as considering the positive impacts that research has identified of RP engagement, it is important also to consider the possibility that engagement in RP may have negative, detrimental, or potentially harmful effects.

Lengelle et al (2016) point out that research from several sub-domains of psychology indicates that an emphasis on reflecting can put people at risk of rumination, with its associated symptoms such as worry, anxiety, and depression. Rumination is when reflection is characterised by negative effects such as becoming blocked from taking action, loss of spontaneity, pessimism, and falling into a cycle of reflection upon reflection (Van Woerkom, 2010). Dohn (2011, in Lengelle et al, 2016, p101) raises the concern that engaging in RP activities *'can lead to rumination in the process of establishing independent secondary reflection practices with their own evaluative criteria'*, and as a result creating a frame of reference for reflection which is increasingly out of touch with the realities of practice. Dohn (2011) also raises self-delusion and an excessive preoccupation with oneself and ones practice as possible risks/harms of reflection. Several scholars view rumination as a likely side effect of RP (Tokako & Tanno, 2009; Van Seggelen-Damen & Van Dam, 2016) and claim that this accounts for studies which have found few or no positive effects of self-reflection. It is the case that definitions of reflection and rumination overlap considerably, and relationships have been found between reflection, rumination and psychological distress (Lengelle et al, 2016). Elliott and Coker (2008) who constructed the Self-Reflection and Self-Rumination Scales, found significant relationships between the two concepts and a measure for happiness, and concluded that *'self-relection may trigger self-rumination, which has detrimental consequences for happiness'* (p127). They identified that individuals with an increased capacity for or tendency towards self-reflection may find it difficult to disengage with this process in the face of *'adverse circumstances, unfavourable outcomes and negative events in their lives'* (p132). Similarly, Van Seggelen-Damen and Van Dam (2016) found a strong unidirectional relationship between reflection and rumination, and significant relationships between rumination and emotional exhaustion and job satisfaction. This is an important consideration for RP in healthcare, where the risks of emotional exhaustion and burnout are well established (see 1.3.1). Van Seggelen-Damen and Van Dam (2016) suggested that reflection can raise questions and doubts which remain with the individual and are difficult to abandon, so trying to understand themselves and reflect on challenges at work carries the risk that the individual might struggle with the issues raised and this may lead to rumination. Studies on diverse popilations and cultures showing positive outcomes of RP have found that these positive outcomes can be 'spoiled' by negative effects caused by rumination (Lengelle et al, 2016). Given the association of rumination with psychological distress, anxiety and depression (see Rood, 2011), this is an important consideration. Lengelle et al (2016, p106) suggested that if RP interventions are to prevent the

harmful effects of rumination, this requires a safe, holding space facilitated by *'a compassionate teacher or guide'*. This could be said to be suggestive of the potential of CoPs in this role, as explored above. They advocated a group format for this, as it allows for the development of a wider range of possible perspectives, has individuals see and experience that they are not alone with their struggles and provides opportunities to witness one's own growing competence through the eyes of others (Lengelle et al, 2016, p107).

Davies & Kremer (2016) identified a further possible harmful effect of RP in healthcare, which is that exploring situations at work where a mistake may have been made can feel very threatening and has the potential to lead to a fight or flight response, where doctors either defend their actions rigidly and become cemented in their position, so they miss opportunities for learning or professional growth, or where out of guilt or a desire to avoid confrontation, they accept all criticisms and entirely assume fault, which can lead to feeling disheartened, or to changes to practice which increase the risk of overwork and burnout. Both of these responses can lead to a failure to reflect, and according to Perrott & Ellison (2017), can put healthcare trainees and professionals in a vulnerable position in the event that they are called upon to demonstrate reflection as part of an investigation. Associated with this is the risk of a freeze response, where overthinking or anxiety induced by reflection makes it harder for healthcare professionals to carry out necessary aspects of their jobs (see Dohn, 2011) or where becoming more aware of their emotional responses or bringing these to their work makes the daily realities of the job more distressing for doctors. On this point, research has found that increased emotional empathy, one possible outcome of RP engagement, can be a risk factor for the development of burnout in healthcare professionals (Dowling, 2018).

The level of distress that may be experienced in RPGs has been discussed as a potential barrier to RP engagement (1.2.5) but should also be considered in the context of possible harms. Benson et al (2010) and Knight et al (2010) found that CP trainees experienced high levels of distress in RPGs. And Vatne et al (2009) found that participants experienced RPGs as 'painful', particularly when the act of reflection led to a realisation, or perception, that they may not have acted in their patients' best interests. Further, Lyons et al (2019) found that for some participants, expressing emotions in RPGs led to feelings of shame. For one participant this shame took the form of a sense that by expressing strong emotions, which she perceived as being unacceptable, in front of her peers she may have reinforced negative assumptions or stereotypes of 'the emotional woman'. The potential to experience distress in RPGs creates a risk that participants may be 'left' with these feelings of distress and has the potential to lead to rumination, as discussed above, but also risks triggering, or re-triggering, feelings of shame which may be deep-rooted or derive from societal or cultural attitudes regarding the expression of emotion and acceptability of this, either in general or in specific contexts.

These findings highlight the need for a sufficiently safe and containing space for RP, and the importance of not assuming RP is a positive thing for everyone, and of taking context into account. The context of GP and medical training is explored in the next sections.

1.3 Exploring the Emotional Wellbeing Context of GP/Medical Training

Medical and in particular GP training provides the context for the current study, and issues relating to the emotional wellbeing of GP trainees is central to it, and as such it would seem important to examine the literature in relation to the emotional wellbeing context of GP and medical training, and associated issues relevant to the current study, and to explore the possible role of RP in responding to these. Jacimonwicz and Maben (2020) argued that the importance of having a reflective space to process the challenges of work should be embedded in medical training as early as possible. And in recent years there has been a push towards a greater focus on emotional wellbeing in the training of medical students (Doherty et al, 2013). However a report by the Royal College of Physicians (2016) postulated that this will not change 'embodied experience' until employers, training bodies and senior doctors pay more attention to creating space to protect junior doctors' emotional and mental health. This was echoed in a 2018 report by the Society of Occupational Medicine (Kinman & Teoh, 2018, p3) which argued for the need to *'build a culture within medicine that explicitly recognises how the job can impact on the wellbeing of doctors and promotes mental health and self-care'* which should start from the first year of medical school. And Crowe and Brugha (2018) agreed that reforms are needed in medical culture to shift understandings of emotional competence towards a greater emphasis on reflexivity and self-care for doctors. However, wider literature highlights aspects of medical training and culture that make the establishment of this challenging.

1.3.1 GP Emotional Wellbeing

A report communicating the findings of a five-year study that examined the pressures experienced by GPs working in 177 practices across the UK concluded that general practice was in crisis (Hayes et al, 2017), with findings indicating that GPs in the UK find their job more stressful than their counterparts in other countries (Baird et al, 2016). Clarke et al (2017) highlighted how the impact of economic austerity on staffing levels and the growing demand for health services have led to heavier workloads and greater stress for doctors in the UK, as reported by the Royal College of Physicians (2016). Launer (2020b) highlighted the impact of the Covid-19 pandemic on GP burnout. And a recent study survey by the General Medical Council (2022) found that 39% of junior doctors reported experiencing burnout to a high or very high degree, an increase of 6% from the previous year, and 51% of doctors described their work as emotionally exhausting to a high or very high degree (Tonkin, 2022).

Burnout is defined by Maslach & Jackson (1981) as the experience of emotional exhaustion, depersonalisation, and the sense of a loss of personal accomplishment. It overlaps with compassion fatigue, and a key feature of both is a reduced ability to demonstrate empathy towards patients and

service users (Adams et al, 2006; O'Neil et al, 2019) which has implications for patient care (Zantinge et al, 2009). Emotional exhaustion, a feature of burnout, refers to feeling depleted and de-energised, particularly from interpersonal interactions (Sadusky & Spinks, 2022). Cheung et al (2020) asserted that burnout is not due to failings on the part of any individual, but a consequence of social, cultural and technological pressures that affect the profession as a whole (Launer, 2020b). And some scholars have suggested that medical culture may be impacting on this, particularly in the way it views doctors' emotions. For example, McNaughton (2013) suggested that the tendency in the medical profession to conceive of emotion as 'individual and private' has the potential to add to student and practitioner isolation and burnout.

In light of the suggestions in the literature that RP can help to reduce feelings of isolation (Taylor et al, 2018; Carmichael et al, 2020; Ingram et al, 2020) and prevent burnout (Nielsen & Soderstrom, 2012; O'Neil et al, 2019; Ingram et al, 2020), the next sections will explore these and related issues in more detail, in particular the role played by medical culture in perpetuating them.

1.3.2 How are emotions viewed within medical culture?

Shapiro (2017) identified that emotion regulation, self-awareness, recognition, and management are not a standard part of medical education, and Schwartz et al (2022) emphasised that medical trainees are not trained as standard in how to respond when emotions arise, their own and their patients. Related literature points to a sense in medical culture that the ability to transcend emotion is a sign of competence (Hafferty, 1988). This is explored in the next section.

1.3.2.1 The phenomena of medical and emotional socialisation

Medical socialisation refers to the process of adapting to and adopting the culture of medicine by medical trainees. Boiler et al (2018) identify this and a further process, emotional socialisation, in medical trainees undertaking specialist training. Emotional socialisation is the process in which students learn from others about emotions through direct responses to their own emotions, discussion or explicit teaching about emotions and expression or emotions by others in the social context (Boiler et al, 2018). Crowe and Brugha (2018) support this, pointing to evidence from studies which explored **h**ow emotion is implicated in the normative image of a competent doctor, and how this affects students' management of difficult emotions arising during undergraduate training (Hafferty, 1988; Smith and Kleinman, 1989).

This phenomenon is considered to have developed from 'detached concern', a goal of medical training in the US, which was said to enable doctors to do things that lay people may react to with disgust or fear, and allow them to 'apply' empathy without getting 'tangled in emotional bonds' (Lief & Fox, 1963). However, Halpern (2001; 2003) argued that detached concern was qualitatively different from empathy, which he defined as emotional attunement to patients. Halpern was critical

of the fact that emotions were not recognised as being inherently part of doctors' interaction with - and therefore their ability to care for - patients, and asserted that if acknowledged, emotions could be incorporated into training, enabling doctors to have genuinely empathic relationships with patients.

1.3.2.2 The prevalence of Imposter Syndrome and Perfectionism in Doctors

Another issue impacting on doctors' emotional wellbeing is the prevalence of imposter syndrome (IS) or imposter phenomenon[3]. According to Dyrbye and Shanafelt (2016) IS occurs across the scope of medical training and is associated with burnout. A review by Gottleib et al (2020) showed that IP is prevalent among medical trainees, with rates ranging from 22–60% in medical students and 33–44% in residents. Freeman (2022) argued that, like emotional socialisation, this may emerge from and be sustained by medical culture. However, Qureshi et al (2017) argue that studies of medical students suggest that medical training selects for personality traits of perfectionism, which predisposes to IS and is likely to be present even before exposure to medical culture.

IS was first identified in high achieving individuals. It is associated with low self-esteem (Mascarenhas et al, 2018) and with high levels of stress and perfectionism (Rohrmann et al, 2016). Gerada (2020, p393) identified perfectionism as *'one of the most pervasive of all personality traits found in doctors'* and referred to a meta-analysis of medical students over the past 27 years by Curran and Hill (2016) which showed that levels of self-oriented, socially prescribed, and professionally determined perfectionism had all increased. In their letter to the editor of the journal 'Medical Education', Ng and Isaac (2021) point out that there is often a culture of perfectionism in the medical field (Peters & King, 2012) partly due to fear of making mistakes that can lead to severe clinical consequences. However, research in the CP field has also established a positive relationship between burnout and perfectionism, which is mediated by stress levels (D'Souza et al., 2011).

While personality studies have identified an association between perfectionism and IS (Ross et al, 2001; Bernard et al, 2002), Chodoff et al (2023) drew attention to a growing acceptance in the research that IS is an affective experience rooted in a host of environmental and social contexts (Mullangi & Jagsi, 2019; Feenstra et al, 2020), and emphasised that it seems to be especially common in work cultures that prize precision and results over process, humility, and empathy (Cohen & McConnell, 2019; Slank, 2019). This echoes Morgenstern and Dallaghan (2021) who sought to reframe IS as an appropriate situational response to the near constant change, uncertainty and intellectual elitism in the medical profession. Features of IS identified by Chodoff et al (2023) include the tendency to make comparisons with others, and features of the clinical learning environment which perpetuate this. Chodoff et al (2023, p62) drew particular attention to medical culture, asserting that *'informants in our study experienced imposter thoughts and feelings in clinical learning*

[3] The abbreviation 'IS' is adopted for the purposes of this study

environments where the culture valued expertise, hierarchy, and certainty'. Whilst their study had some limitations, it does suggest an impact of medical culture which goes beyond the way emotions are viewed.

Whilst the research in this area is again wide ranging in terms of settings, methods and definitions of the relevant phenomena, the literature finds common ground in that it identifies how power in the social world of medicine leads to the hiding or suppressing of emotions, the possible development of IS, and associated risks of burnout. It also highlights a clear need for different ways of thinking about and responding to the emotional experiences of medical professionals.

In her comment on doctors' mental health and stigma, Gerada (2019) identified a lack of connectedness in the practice of medicine as a risk factor, highlighting that the structures in medicine where doctors can come together to 'train, work, play, and reflect' have been reduced, removed, or moved online, threatening doctors' ability to process their struggles. This emphasises the need for interventions which provide a space for this.

1.3.2.3 The Medical 'Habitus'

The apparent resistance in medical culture to the acknowledgment of emotions and uncertainty in training and practice, which seems to be playing a part in the development of burnout and IS, has been associated with the medical 'habitus'.

Luke (2003) showed how in the early years of postgraduate training, doctors adapt to and learn to acquire social and cultural capital in the real world of medicine, and linked this to the theory of the habitus, or the non-conscious processes through which individuals adopt the cultural traits of and adapt to the "field", defined as any arena marked by struggles for resources, or "capital" (Bourdieu, 1990; Brosnan, 2010). This was highlighted in a UK study by Lempp (2009, p79) who found that medical students could assert '*legitimate professional identity'* only when they adopted the right set of dispositions to access the social and cultural capital required to succeed as doctors. Crowe and Brugha (2018, p153) also remarked on this, asserting that *'while doctors progress from medical school to the later stages and completion of specialist training, they adopt and come to embody more easily the emotional dispositions expected in the medical field'.* Their findings indicated that the medical habitus reproduces the dichotomy of emotion and feeling against, and in conflict with, reason and thinking. This echoes Hafferty (1988) who had identified through the 'cadaver stories' of medical students in the US that emotional detachment was set in opposition to vulnerability and weakness, and asserted that this positioned those struggling *to 'adopt a medical frame of reference '*as outsiders. More recently, Psilopanagioti et al (2012) identified this in physicians in Greece, describing it as 'emotional labour', that is amplifying, suppressing or faking emotions to comply with organisationally desired rules and complex role demands. This has concerning implications. In their narrative study on burnout in medical students and residents, Fainstad et al (2022) identified a culture in which 'residents' needs are inconsequential' as a contributing factor.

Crowe & Brugha (2018) found that the denial of emotional vulnerability in order to maintain an idealised image of competence was implicated in practices of and attitudes towards self-care. And Schwartz et al (2022) argued that a fear of being seen as emotionally weak was preventing physicians from taking steps aimed at remediation and skill-building. While this issue is arguably important to address, these findings highlight the challenging nature of attempting to do so.

1.3.3 How might reflective practice interventions play a part in responding to this?

The previous sections have examined the context of the current study, in relation to Doctors' emotional wellbeing, and the context of this including traits and experiences common to medical trainees and the way these things are impacted by medical culture. In this section it felt important to examine whether, in light of the identified impacts of RP engagement (1.1.6) there may be a role for RP, and in particular interprofessional RP, in responding to these important issues.

Suggestions in the literature as to what is needed in order to better support doctors' emotional wellbeing, whilst not making specific reference to RP, do include a number of elements common to RP engagement. For example, Schwartz et al (2022) argued for the introduction of an emotions curriculum to support doctors to navigate emotions in their clinical encounters, one aspect of which should be emotional self-awareness and self-regulation, which RP has been found to promote. Ng and Isaac (2021) identify psychosocial strengthening as a necessary component in medical education to help students become more resilient and avoid maladaptive thinking when faced with challenges and failures, and thus reduce imposter feelings. This has also been found to be a potential outcome of engagement in RP (Fragkos, 2016; Chu et al; 2018), however should be considered alongside research identifying a risk that reflection can lead to rumination (Lengelle et al, 2016). And Gallagher (2019) suggested that targeted group work discussing feelings of vulnerability and critical reflection on work-based experiences, both elements of RPGs, could strengthen professional identity and reduce imposter feelings.

Further research in this area has identified other ways that RP might play a role in addressing burnout and IS, and support medical trainees to aknowledge and manage emotions. Lancaster et al (2020) identified peer support as a possible buffer of IS and posited that lessons could be learned from psychiatric peer review groups, described by participants as safe spaces to discuss complex cases and adverse events. Some studies have suggested that coaching, particularly when combined with high quality feedback and involving reflective questioning, could help to mitigate IS (Rudolph et al, 2007; Sergeant et al, 2017). Secondary outcomes of an RCT by Fainstad et al (2022) examining the potential of an online group coaching programme, focused on exploring the relationship between an individual's thoughts, feelings, and behaviors, showed a statistically significant reduction in burnout scores and improvement in self-compassion scores, and pointed to the potential of the intervention to reduce doubts about abilities and belonging. These findings are consistent with Solms et al (2021), whose much smaller study of medical residents in the Netherlands found that a

programme of face to face group coaching sessions resulted in improved personal resources and reduced burnout symptoms. Solms et al (2021) drew attention to the importance of the normalising of vulnerability in the groups. This echoes Ramsay and Spencer (2019) who found that a 3-hour group education session with the aim of normalising feelings of insecurity and self-doubt, involving participants role-playing situations where they felt out of their depth and discussing how they felt and what they would do, resulted in them feeling significantly more comfortable and more likely to admit what they don't know and to ask for help. Both of these studies seem to confirm Gallagher's (2019) view that targeted group work where vulnerability is discussed has the potential to improve professional identity and reduce IS. Arguably, participation in RPGs could have the same impact, particularly as the focus of these is on discussing challenging work situations. Again there is an interesting possible role indicated for CoP facilitators, whose training supports us to sit with vulnerability and uncertainty.

The heterogeneity of this literature, like the RP literature itself, makes it hard to draw any firm conclusions, but the interventions explored for their potential impact on IS, burnout, and the stigma around emotions in medical training and practice seemed to have important aspects in common, with one another, and with RPGs. First, they contained a reflective element. Secondly, benefits identified echoed those found in the literature relating to the impact of participating in RP. And thirdly, they were all delivered in groups. Another important feature the interventions had in common was their emphasis on psychological safety, defined by Edmondson (2018) as a climate in which individuals feel comfortable taking interpersonal risks like speaking up, asking questions, and acknowledging their own deficits without fear of being judged, shamed, or ignored. Previous studies have identified that medical trainees tend to report increased satisfaction with their training experiences when psychological safety is perceived to be high (Torralba et al, 2016; Appelbaum et al, 2018). The importance of psychological safety again could be said to point to a role for CoPs in the facilitation of these interventions, and adds weight to the assertion that this is an area that needs to be further explored.

What is clear is that medical trainees have a need for, and benefit from, structured opportunities to explore their emotional experiences in a safe space (Schwartz et al, 2022). RPGs provide opportunities for this which can be built into training and practice, and I would argue that the possible role for counselling psychologists in the facilitation of this, given the profession's emphasis on reflection and reflexivity, and the particular skills of CoPs in creating a safe and containing space, is worthy of further exploration. Particularly in light of the clear benefits of interprofessional collaboration (Launer, 2015; 2018), and the promising findings of previous studies examining psychologist-facilitated interprofessional RPGs (O'Neil et al, 2019; Ingram et al, 2020).

The next section will examine another issue found to be central to the current study, that of 'humanness', and what is meant by this.

1.4 Humanness: Definitions and Critical Reflections

Through the process of data collection and analysis, ideas about 'humanness' emerged as cenral to the current study. As such, it would seem important to consider what we mean by 'humanness' and what the research and literature tells us about this.

The dictionary definition of 'humanness' is *'the quality or condition of being human or characteristic of humans'.* It is a broad term, referring only to the quality or state of being human, not to specific characteristics associated with it (Wilson & Haslam, 2013). As such, it would be beyond the scope of this chapter to provide a definitive account or full definition of humanness. However, some of the existing definitions/models of humanness seem to have particular relevance to the current study, in that they resonate with, or raise particular considerations for, the ideas of humanness which emerged from the data (see Chapter 3/4). These are set out below.

Haslam et al (2005) proposed two ways in which people construe humanness: what humans possess that other animals lack (human uniqueness; HU) and what what distinguishes humans from objects or machines (human nature; HN). Characteristics that embody HN are seen as deep-seated, prevalent within populations, cross-culturally universal, and emotion-related (Haslam et al. 2005), and bear comparison to the Experience dimension of Gray et al (2007)'s model of mind perception, which is composed of mental states such as emotions, appetites, desires, and sentience (Haslam et al, 2013). It is this dimension of humanness which has resonance for the current study, as it has the potential to elucidate those aspects of humanness which are valued, or not valued, in the context of medicine and medical education, how this feeds into trainees' beliefs about how they should be and behave as doctors, and what aspects of humanness (in the HN sense of being human and not a robot or machine) might conflict with this.

A study by Bain et al (2009) exploring cultural understandings of what it means to be human in Australia, Italy and China found that although humanness is a category encompassing all cultures, there was significant cultural variability in the types of features seen to make us human. Findings suggested that humans are described primarily using intra-individual characteristics in all cultures, but indicated significant cultural differences in these characteristics. For example, Bain et al (2009 suggested that for people from cultures which highly esteem maturity and civility, such as China, a focus on emotions may not capture the most salient aspects of humanness, whereas people from cultures which 'essentialise' HN characteristics (including emotions) such as Australia may find it very difficult to understand why other cultures would constrain emotions. As such, while McNaughton and LeBlanc (2012) describe the experience of emotion as 'a fundamental part of every human being', something which resonates with ideas of humanness which emerged in the current study, Bain et al's (2009) findings suggest significant cultural differences in the extent to which the expression or constraint of this aspect of 'humanness' is valued. Bain et al (2009) argued that definitions of humanness should incorporate more social and cultural features, such as our interactions and relationships with others, and our embeddedness within groups. They concluded that humanness beliefs point to basic assumptions people make about human strengths and frailties,

and that when shared across cultures, these may help promote inter-cultural understanding, but when they diverge, they may perpetuate inter-cultural misunderstanding and conflict.

Park et al (2012) in their similar study examining understandings of humanness in Japan, Australia and Korea, argued that existing approaches to defining 'humanness' have focused on intra-individual characteristics (e.g., traits, emotions, values), which may be applicable mainly in Western cultures, where they were developed, however, collectivist cultures may focus more on social/cultural characteristics, such as social obligations and group attributes (Oyserma et al, 2002). They posited that collectivistic societies may emphasise interpersonal connectedness, social conformity and caring for others as aspects of humanness, compared to Western societies, such as the UK, which emphasise individualistic attributes and autonomy (Markus and Kitayama, 1991; Gardner et al*.,* 1999). Park et al (2012) found that all participants in their study, regardless of culture, tended to regard HN characteristics as part of the essence of humanity, suggesting that there are some elements of universality in basic views of what it means to be human, at least between the East and West, and that regardless of how people construe the self, traits that embody relationism, such as warmth and emotional attachment, are perceived as fundamental to human nature. This is consistent with conceptualisations of humans as relational and having a need for connection with others (Gilbert, 2014; Caciopoppo & Patrick, 2008; Baumeister & Leary, 1995). Park et al (2012) suggested that social relatedness and belonging may be universally central to humans (see Baumeister & Leary, 1995). This resonates with ideas of humanness which emerged in the current study.

CFT theory (Gilbert, 2009; 2014) also includes some useful ideas about the nature of humanness which have resonance for the current study. CFT draws from attachment theory, emphasising our relationships with others as a key aspect of being human. According to Gilbert (2014) a secure attachment base facilitates intersubjectivity, which enables us to share our thoughts and feelings with others (Trevarthen & Aitken, 2001). This also creates the capacity for 'we-ness', a sharing of experience, rather than just 'me-ness' (Gilbert, 2014). The CFT conceptualisation of humanness also includes the human capacity for anger, hatred and cruelty, which it recognises as activated in certain contexts and conditions. This idea of humanness as including human strengths and frailties also resonates with ideas which emerged in the current study.

Another useful idea from CFT in terms of defining humanness is that of a 'common humanity'. CFT is influenced by Buddhist approaches, which suggest we should focus on creating a sense of 'being all the same and thus belonging' (Dalai Lama 1995; Tsering, 2008). Nickerson (1999) argued that we are members of the same species with the same basic minds, desires, needs, and fears, who share both our minds and the nature of our being-in-the-world; we are all born, flourish, are susceptible to disease and injury, and eventually die. However, Gilbert (2014) recognised that seeing others like us opens the potential for making quite significant projection errors, and emphasised the importance of empathy and mentalising in moving outside an egocentric perspective and seeing the difference between self and 'the other'. He recognised the challenging nature of applying Western models to non-Western cultures, and acknowledged that compassion is a context-dependent

construct, influenced by group norms, cultural practices and values (Gilbert et al*.,* 2011). In relation to compassion, he suggested that while Eastern collectivist societies may value devotion and concern for others more highly than individualistic Western cultures, the collectivistic social dynamic in social cultures may inhibit self/other compassion (Montero-Marin *et al*., 2018; Steindl *et al*., 2020; Kariyawasam et al*,* 2021) due to Eastern cultural norms discouraging help-seeking behaviour, which can be viewed as failure or a source of shame (Kee, 2004). Arguably, the same challenges in terms of applying Western models to non-Western cultrues apply to ideas about humanness, particularly when moving beyond what might be considered 'common' human experiences (such as being born, dying) and looking at humanness in terms of particular traits and values. Gilbert (2014) recognised that individuals from cultures who have experienced more tragedy, pain and suffering that is outside their control may feel Western models do not apply to them. And Kariyawasam et al (2022) drew attention to the importance of paying close attention to cultural and religious influences when exploring compassion across cultures. This is arguably of equal importance in considering the cross-cultural applicability of ideas about humanness. In particular, Western-centric psychological approaches to what it means to be human, such as humanistic approaches, which emphasise personal agency, individualism and autonomy (Schneider et al, 2015), can be critiqued on this basis.

These ideas from literature and research about the nature of humanness demonstrate the difficulty in coming to a fixed definition. As such, the definition of humanness adopted in the current study is a broad one which largely emphasises HN characteristics, such as emotions, and emphasises relationalism (sociability, emotional attachment; see Park et al, 2012), the idea of humans as inherently relational (Gilbert, 2014; Caciopoppo & Patrick, 2008; Baumeister & Leary, 1995). It also acknowledges the 'common humanity' approach adopted by CFT theory (Gilbert, 2009; 2014), that is our 'common' experiences of being born and dying, of pain, fear and sadness, joys and setbacks, disappointments and difficulties (see Comninos, 2022), and recognises human vulnerability/frailty and the human capacity to be flawed, imperfect, whilst recognising the influence of early and current social context. Because it is acknowledged that the adoption of these definitions and ideas in the current study reflects the cultural context both of myself as researcher and of the research participants, their cross-cultural applicability is not assumed, and the impact of this on the emergent theory will be held in mind and explored in the proceeding chapters.

1.5 Summary of Literature Review

The literature reviewed has been wide in scope and intended to cover the issues relevant to the context of this study, including the emotional wellbeing context of GP training and the need for interventions to support this; RP across the healthcare field, the effects of this, both positive and negative, and its potential as an intervention to support medical trainee wellbeing; and interprofessional RP in medical training and practice, including the potential of psychology

professionals as facilitators. It has also examined ideas of humanness as they relate to the current study, and provided a critique of these from a cultural sensitivity perspective.

The high level of heterogeniety in the RP research makes it difficult to reach any conclusions about the efficacy of RP interventions, or the areas where future research should be focused in order to answer the questions raised by existing studies.

Qualitative studies have tended to focus on participants' lived experiences or narrative accounts of these phenomena, and form the largest part of the research pool. The comparatively small quantitative research base tends to involve the use of unvalidated questionnaires to measure concepts such as reflection and burnout, and generally lacks 'true' experimental control groups. As such, RP and its impact in the areas discussed is difficult to quantify, and it is hard to formulate testable hypotheses upon which to contribute to the quantitive research base.

Research into possible interventions for the reduction of burnout, IS, and improving emotion recognition and regulation in medical training and practice involve a range of approaches, for many of which the efficacy is equally difficult to measure. Similarly, research into RP uses a range of definitions and methods, making it difficult to establish the case for a particular intervention to target these areas.

Whilst it is important to remain mindful of the potential harms of reflection identified in the literature, research across contexts and methods of reflection has established some clear benefits to healthcare professionals of engaging in some form of RP. These include a reduction in feelings of isolation (Taylor et al, 2018; Carmichael et al, 2020; Ingram et al, 2020) and burnout symptoms (Nielsen & Soderstrom, 2012; Van Roy et al, 2015; O'Neil et al, 2019; Ingram et al, 2020), an increase in compassion (Taylor et al, 2018), strengthening of professional identity (Sargeant & Au-Yong, 2020) and reduction in imposter feelings (Gallagher et al, 2019; Chodoff et al, 2023). All of these are issues which impact on medical trainees, and which it would be of benefit to target. This combined with the clear indication that healthcare education and training needs to be more cognisant of the emotional wellbeing of trainees, and call for interventions to support this (Schwartz et al, 2022; Kinman et al, 2018) suggests a gap in the literature for further studies exploring RP interventions for medical trainees. As the existing reseach in this area is so heterogenous, it would arguably be helpful to focus on the ways in which participants use these interventions or integrate this into their clinical practice, and any change experienced as a result of engagement, in order to understand more about *how* this type of intervention might be helpful in the areas identified. It is also arguable that, due to the clear benefits of interprofessional learning and collaboration (Launer, 2015, 2018; Richard et al, 2019) and limited research base on interprofessional RP, there is a particular need for studies exploring RP interventions which include an interprofessional element. The research emphasises the role of the RP facilitator, and many of the qualities identified as important point to the potential of psychologists in this role. A couple of promising recent studies (O'Neil et al, 2019; Ingram et al, 2020) have identified benefits to medical professionals of engaging in psychologist-facilitated RP. These studies used CP facilitators, but it is arguable that with our particular ethos, training and skills,

counselling psychologists might be equally well, if not better, placed to bring the necessary qualities to this role and to mitigate potential negative effects of RP and bariers to engagement. However, further research is required to establish whether this is the case.

1.6 Research Contribution and Rationale

1.6.1 Research Context

One RP intervention which combines medical trainees and psychologist facilitators, the Interprofessional Reflective Practice Project (IRPP), provides the context for the current study. The IRPP is a collaboration between City, University of London's Professional Doctorate in Counselling Psychology (DPsych) programme and the GP Specialist Training Programme at one NHS Trust, in which GP trainees attend RPGs facilitated by year 2 and 3 CoP trainees. The IRPP was set up to support interprofessional learning, but also responds to the call for a focus on trainees' emotional wellbeing and the importance of a space to explore the emotional aspects of training and practice. The decision by the Trust to introduce an interprofessional element to the structured reflection already provided as a part of GP training came following a visit to a University in the Netherlands, who employed behavioural scientists from Psychology or Social Work backgrounds, to work alongside the programme directors and lead reflective groups for GP trainees. The decision was made to collaborate with the DPsych programme at City on the grounds that the skill and practice of reflexivity and self-reflection is at the heart of counselling psychology practice and is embedded at every level of this programme. The IRPP has been running since 2020, and from January 2021 groups have been facilitated by CoP trainees following specific training.

1.6.2 Rationale for the Research

Research is vital for the ongoing development of the IRPP, however due to the difficulties in synthesising and quantifying the research in the relevant areas, before any quantitative examination can be attempted based on testable hypotheses, it is necessary to understand more about the way this intervention is experienced by participants. As previously discussed, there is a gap in the literature for research exploring how RP interventions might be helpful in areas impacting on doctor wellbeing, and for further research into interprofessional RP for medical trainees involving psychologist facilitators. The potential of counselling psychologists as RP facilitators is clearly indicated, but this is another highly under-researched area.

By asking the question: *'how do GP trainees make use of reflective practice groups?*' this research addresses those key gaps in the literature, in relation to GP trainees experiences of interprofessional RP, and how they use or integrate this into their clinical practice, including any change experienced as a result, and the impact of CoP facilitators. It also has the potential to shed

light on the impact of psychological safety in healthcare education and practice, by exploring how GP trainees make use of a safe space to explore the non-clinical aspects of their work, with an independent facilitator who brings their counselling psychology training and ethos to this. In its focus on the 'how', the research contributes to elucidating the questions raised by Mann et al (2009), particularly in relation to whether RP alters clinical behaviour.

The aim of this study will be to create a tentative theoretical model of the way GP trainees use CoP-facilitated RPGs, on the basis of which further research can be carried out into the IRPP. It is hoped that the research will contribute to the development of this and similar interventions.

1.6.3 Contribution to Counselling Psychology

Because the key unique aspect of the IRPP is the interprofessional collaboration between CoP and GP trainees, one way this research will contribute to counselling psychology is by providing an insight into a possible role for CoPs in the facilitation of RP in healthcare. Gaining greater insight into the way GP trainees make use of RP will inform CoPs tasked with facilitating RPGs for this professional group, as part of the IRPP and on a wider scale. It will also provide much needed information about a way in which CoP trainees and GP trainees may be able to support one another's training, and a role for counselling psychology, with the profession's emphasis on reflexivity and self-reflection, in the establishment of a more psychologically safe culture within medical training.

This research also contributes to counselling psychology by shedding light on the potential impact on CoP trainees of facilitating reflective groups for GP trainees as part of their training. Launer (2015) drew attention to the well-established benefits of learning alongside other disciplines (Buring et al, 2009; Freeth, 2013) and these are likely to be felt by CoP trainees as well as GP trainees through the experience of the IRPP. Research into interprofessional learning has suggested that facilitators of IPE are also learning through the process of facilitation (Evans et al, 2016). As such, while the current study focuses on the experiences of GP trainees, it is hoped that the outcomes of this research will have relevance to CoP trainees involved in the project, and in that way could help to inform future research and theory around interprofessional learning in counselling psychology training, which could focus on CoP trainees' experiences.

An important part of counselling psychologists' training and practice is supervision, which involves many of the skills relevant to RP facilitation, in particular in relation to working with trainees and practitioners from other disciplines, discussing challenging cases and promoting a reflective approach and focus on process. As such, the insights from this study may be helpful for CoPs providing supervision to GP trainees and practitioners as well as RP, particularly in understanding more about how they use the process and integrate it into their work.

By gaining an insight into the impact on GP trainees of the challenges of their work, this study also has the potential to shed light on a wider role for counselling psychology in the provision of support for GP emotional wellbeing more generally.

Chapter Two will present the methodology used to design this study.

Chapter Two: Methodology and Methods

2.1 Overview

This chapter explores the methodology I used to design this study, provides a rationale for the choice of Constructivist Grounded Theory (CGT; Charmaz, 2006) to address the research question, and discusses the methods I used to collect and analyse the data. I begin by setting out the research question, and the theoretical paradigms which underpin the study. I then provide a detailed account of the research method, including sampling, recruitment, data collection and ethical considerations. I provide a detailed account of the GT procedures adopted, within which I explore why I adopted the abbreviated Grounded Theory (GT) procedure, as outlined by Willig (2008), rather than the full version. I give an overview of how this study sought to meet robust standards of rigor and credibility for qualitative research. Finally, reflexivity is considered, in line with the emphasis the CGT approach places on this. Personal and epistemological reflexivity, and considerations of reflexivity specific to the relevant methodological processes, are explored in detail.

2.2 Research Question

This study was designed to answer the following research question:

'How do GP trainees make use of Reflective Practice Groups?'

The formulation of the research question is an important stage in the CGT process (Birks & Mills, 2015). As discussed in Chapter 1, little is known about the way GP trainees use RP, and in particular interprofessional RP involving CoP trainees, particularly in practice. I wanted to determine whether a theoretical model could elucidate how GP trainees involved in the IRPP used RPGs, and the function the groups served for them. I hoped the insights gained would support the development of the IRPP and similar interventions intended to support the emotional wellbeing of medical trainees.

When considering the research question, it is important to recognise the following implicit assumptions:

Reflective practice exists and can be delivered in groups;
Reflective practice is something that can be used or has practical implications/application for participants;
There is a social element to reflective practice inherent in the group format;
GP trainees have active involvement/take an active role in reflective practice groups;
GP trainees seek to make use of reflective practice groups;

GP trainees make use of reflective practice groups in particular ways (specific to them as GP trainees/their profession/training);

The ways GP trainees use reflective practice groups can be expressed and represented in language;

GP trainees are willing to share their accounts as part of this study;

I (as researcher) am able to construct an interpretation of participant accounts.

2.3 Theoretical Paradigms Underpinning the Research

It is important that researchers have a reflexive awareness of our own ontological and epistemological assumptions, that is our assumptions about the nature of reality/what there is to know (ontology) and how we can come to know about it (epistemology), as these will determine the questions we ask, our choice of the most appropriate methodological approach to use in order to go about answering these questions (quantitative or qualitative, and related methods of data collection and analysis), and the assumptions which we bring to the research process, in particular the interpretation and analysis of data (Willig, 2013). The ontological and epistemological positions which underpinned the current study are set out below.

2.3.1 Ontological Position

This study assumes the critical realist ontological position (Howitt, 2010), that is that there is an external reality to know, however no one person can access it in its entirety (Willig, 2013). The assumption that the IRPP, and the associated RPGs attended by GP trainees, is a shared external reality of which we can have knowledge is built into the research question and reflected in the aims of the study. However, it is acknowledged that each participant will experience these RPGs differently, and that multiple truths and perspectives will influence the ways in which they make use of them (Willig, 2013). The critical realist position also underpins the adoption of the CGT approach (see 2.4.2/3), as while the subjectivity inherent in this methodology and in the co-construction of knowledge is acknowledged, this is held against the real world utility of the GT approach, that is the development of theories that can have real-world clinical application (Bryant, 2009).

2.3.2 Epistemological Position

This study is interested in the subjective experience of each participant, and in that sense has relativist epistemological underpinnings, in that it assumes it is possible to come to know how GP trainees make use of RPGs by asking them to tell us about their experiences. The meanings that are constructed are assumed to be influenced by individual participants' perspectives, and the lens through which they view the world (Willig, 2013). However, this study also places emphasis on the

social aspects of meaning making and the collaborative process between researcher and participant in the construction of knowledge (McNamee, 2012). As such, a social constructivist epistemological position is adopted to reflect the way meanings and realities are co-constructed through the interactive process of interviewing (Cisneros-Puebla, 2007 in Losantos et al, 2016). The knowledge created by this study will be influenced by the unique perspectives of each participant, but also by my own perspective as the researcher. This is also consistent with the CGT approach (Charmaz, 2006). The concept that all knowledge is contingent, relational and subjective is embedded into the principles and practice of Counselling Psychology (Henton, 2016) therefore there is a need for what Hanson (2004) termed epistemological flexibility in counselling psychology research, as in practice.

2.4 Research Design

2.4.1 Rationale for Qualitative Methodology

As identified in Chapter 1, the vast majority of research into RP is qualitative and examines participant experiences of RP. Although there is a clear gap in the literature for more large-scale quantitative studies to explore the effectiveness of RPGs for different professional groups, it was considered that a qualitative approach would be most appropriate for this research for a number of reasons. First, the limited research in the area of GP trainees' and practitioners' experiences of RP, and of interprofessional RP involving healthcare and counselling psychology trainees or practitioners, means it would be extremely difficult to formulate a hypothesis on which to base a quantitative study. Secondly, the early stage of the IRPP and relatively small 'pool' from which to draw an appropriate participant sample makes robust quantitative research challenging. Thirdly, the relativist/social constructivist epistemological positions underpinning the study (2.3) feel better suited to a qualitative study, as qualitative approaches reflect the view that reality is subjective and varies from person to person, and the assumption that social reality is not an ontologically objective, given reality; unlike quantitative research methods, which are underpinned by an assumption that there is an objective external reality to know (da Silva & Sagvaag, 2021). And finally, the aims of this study, that is to increase our understanding of both GP trainees' ideas, and expectations about and engagement with RP and the ways in which GP trainees make use of CoP-facilitated RP, are aligned with a qualitative research project, in that an appropriate way to go about findings these things out would seem to be to ask trainees to tell us about their experiences**.** The further aim of developing a tentative conceptual model of the way GP trainees make use of RPGs, which comprises both their experiences and explanatory factors, is particularly suited to a Grounded Theory (GT) approach, as set out below.

2.4.2 Adopting Grounded Theory

Interpretative Phenomenological Analysis (IPA) was considered, to explore the lived experiences of GP trainees participating in RPGs and the way they make sense of these (Flick, 2013). However, the primary focus of this research is not on the experience itself, that is the phenomenon of RP from the perspective of GP trainees, but on the way in which GP trainees make use of their RPG experiences. Grounded Theory (GT) was considered to be better placed to achieve this, as the intention of GT is to move beyond rich description to begin to develop an explanatory framework to understand a particular phenomenon, in this case how GP trainees make use of RPGs. Like other qualitative methods it studies people's experiences of a phenomenon, but then, unlike others, it develops a model or theory about how that process works (Willig, 2013). The rationale for the adoption of GT is further expanded upon below.

GT is an inductive approach to research (Willig, 2013) in which rather than being based on pre-existing ideas, theories or bodies of knowledge, a theory emerges directly from the data. GT has its roots in Sociology (Glaser & Strauss, 1967) but has become an increasingly popular methodology for psychological research. Charmaz and Henwood (2008) suggest that GT served to respond to the growing need for more flexible methods, which took account of context, providing a better fit between psychological theory and practice. They also suggest that it provided a challenge to the argument that qualitative methods lacked rigour and potential for real-world application.

Glaser and Strauss (1967) developed a set of procedures for collecting and analysing qualitative data, and argued that this allowed for an exploration of the dynamic nature of the phenomenon under investigation (Willig, 2008). Glaser and Strauss' initial approach was underpinned by positivist principles (Charmaz, 2000). However, while Glaser (1998; 2001) maintained these prinicples, Strauss and Corbin (1990) went on to place greater emphasis on agency and action in identifying social processes. Critiques of this approach posited that it was still too prescriptive, and argued that neither of these approaches give appropriate consideration to reflexivity (Willig, 2013). This led to the development of alternative versions of GT, including that adopted in the current study, Charmaz's (2006) constructivist grounded theory (CGT). Charmaz emphasised the important role played by the researcher in co-constructing the emergent theory with participants, and thus placed emphasis on researcher reflexivity (Willig, 2008).

Whilst definitions of GT vary, all GT approaches have some specific aspects in common, which were considered relevant to the current study. First, GT is a flexible approach which allows for a wide range of perspectives to be gathered at the data collection stage (Urquhart, 2013). Secondly, it is an appropriate methodology to use when little is known about a phenomenon, as in the case of the current study, as it is exploratory in nature and aims to construct an explanatory theory which *'uncovers a process relevant to the substantive area of enquiry'* (Tie et al, 2019, p.2). GT is appropriate for studies exploring phenomena where there is either no existing theory, or there is an existing theory but this is potentially incomplete because the information was not gathered from the group the study intends to research (Ho & Lipaecher, 2021). The latter was the case in the current study, in that while RP is a widely researched area, there is little in the way of research into GPs/GP

trainees' experience of CoP facilitated RP, and therefore it was considered that existing RP models/research are unable to fully illuminate how GP trainees make use of this form of RP. Thirdly, GT lends itself to applied knowledge, that is the development of theories with implications for real world settings, such as therapeutic settings and, in the case of the current study, healthcare (Bryant, 2009). This is in-fitting with the aims of this study, one of which is to inform the development of the IRPP which, if successful, may be rolled out to other NHS Trusts and GP training programmes. As such, GT was considered an appropriate methodology to address both the research question and the aims of this study.

2.4.3 Choice of Constructivist Grounded Theory

Questions have been raised about the appropriateness of CGT for studies which intend to generate actionable theories with clinical applicability (Bryant, 2009). This was a relevant consideration for the current study, as one of the aims was that the emergent theory could inform the development of the IRPP for future participants. However, of equal importance was the consideration of reflexivity, and my own role as the researcher. As a trainee CoP at City, University of London, at the same stage of training as the IRPP facilitators, I was conscious from the outset when developing this research project of the fact that I would be likely to bring my own personal meanings, assumptions and beliefs, including my own epistemological assumptions, to the process of data collection and analysis (Charmaz & Bryant, 2011). As such, the CGT approach (Charmaz, 2006) was considered the most suitable for this study. CGT is predicated on the idea that knowledge is built from different aspects, and as we build on our existing knowledge, 'new 'forms of knowledge are created (Charmaz, 2006; 2014). The CGT approach acknowledges that the way in which we generate theory, through the iterative analysis of data, will be influenced by who we are and our experiences, and as such recognises the researcher as an active agent in the co-construction of meanings with participants. Emphasis is placed on researcher reflexivity and transparency to ensure that the developing theory remains grounded in the data (Charmaz, 2006) and in the meanings participants attach to their experiences (Willig, 2013). I considered that the need for reflexivity and for a recognition of the developing theory as constructed, rather than discovered, was a more relevant consideration than its practical application. I would also argue that CGT is more appropriate to counselling psychology research, as it reflects the relevance of subjectivity in counselling psychology research and practice (Kasket & Gil-Rodriquez, 2011).

The procedures set out in the following sections, in particular section 6, are common to all GT approaches.

2.4.4 Ensuring Research Quality

In evaluating rigour and credibility in the current study, I was informed by Yardley's (2000) evaluative criteria. I also held in mind Charmaz's (2006) criteria for GT studies, in particular the emphasis on originality. Table '2-1' provides a summary of the relevant criteria and ways in which this study sought to meet these:

Quality Criteria	**Methodological Response**
<u>Sensitivity to Context</u> 1. What was the nature of the researcher's involvement?	1. My role as researcher is clearly set out in the methodology chapter. Made it clear that I did not have a role in the IRPP and research was exploratory not evaluative.
2. Does the researcher consider how they might have influenced the participants' actions?	2. I have engaged in personal and methodological/epistemological reflexivity throughout this study. Choice of CGT reflects emphasis on reflexivity and researcher role in co-construction of emergent theory.
3. Does the researcher consider the balance of power in a situation?	3. All ethical considerations are documented in the methodology chapter, one of which was the possibility that participants might think I was interviewing them 'on behalf' of the IRPP or that their responses would be used to evaluate the project or might have any impact on their ongoing involvement and care was taken to ensure that they were informed this was not the case (this is set out on participant information sheets, see appendix, and communicated verbally at interviews. Also considered possible conflict of interest of research supervisor and brought in a second supervisor to ensure this did not prejudice any stage of the process. Time and location of interviews considered, as was the impact of small participant pool on confidentiality. Participant population had no obvious vulnerabilities. No clear power imbalances based on participant background, relative equality between trainee GPs and trainee CoP researcher (difference, privilege). Discussed in methodology chapter ('Ethics' section). Consideration also given to balance of power when selecting quotes to use for analysis.
<u>Completeness of Data Collection, Analysis and Interpretation</u> 1. Is the size and nature (comprehensiveness) of the sample adequate to address the research question?	1. Sample size just slightly lower than standard number for small GT studies (n=10; Starks & Trinidad, 2007) and appropriate size for DPsych thesis (11 participants came forward, 2 withdrew before being interviewed, n = 9)

2. Is there transparency and sufficient detail in the author's account of methods used and analytical and interpretive choices? 3. Is every aspect of the data collection process, and the approach to coding and analysing data discussed? 4. Does the researcher present excerpts from the data so that readers can discern for themselves the patterns identified? 5. Is there coherence across the research question, philosophical perspective, method, and analysis approach?	2. Methodology chapter sets out all methods used and data analytic procedure, and provides reasons for choosing these. Interpretations are discussed in analysis chapter and covered in reflexivity/reflexive memos, and coding examples provided in methodology and appendices. 3. Data collection and analysis processes discussed in the methodology chapter. Extracts of transcripts, coding, memos are provided in methodology and analysis chapters and in appendice. Coding, memo writing and categorising discussed in supervision. 4. Links between data and analysis presented through participant quotes in analysis chapter and discussion 5. GT chosen as approach best suited to address the research question and aims, choice of CGT methodology to reflect epistemology and researcher position, approach to analysis consistent with abbreviated CGT (Willig, 2008). Documented in the methodology chapter.
<u>Reflexivity</u> Does the researcher reflect on his or her own perspective and the motivations and interests that shaped the research process?	I have engaged in personal and epistemological/methodological reflexivity throughout the research process and all are documented. Reflexive journal kept (extracts included in analysis). Reflexivity discussed with supervisor(s). Reflexivity runs through the thesis. Examples of reflexive memos, journal entries and reflexivity included in methodology and analysis chapters.
<u>Importance/Usefulness</u> Is the research important? Will it have practical and theoretical utility?	Developed core category and 5 major categories which are discussed in analysis chapter. Developed a theoretical model of the way in which GP trainees make use of RPGs which can be used to inform the development of the IRPP Identified recommendations for clinical practice for CoP trainees tasked with facilitating RP for GP trainees or otherwise working with this group.

Originality Do categories offer new insights? (Charmaz, 2006)	First study of its kind to explore how GP trainees make use of interprofessional RPGs with CoP facilitators. Categories presented in the analysis chapter provide new insight into how GP trainees make use of RP in practice. This study is among the first to examine the processes which may underpin this, and the function of these groups for participants Among the first studies to identify GP trainees use of RP in personal lives/lives outside of practice. Discussion chapter includes what this study adds to research base on interprofessional RP in healthcare and identifies implications for practice for CoPs (in practice/as facilitators)

Table 2-1: Quality Criteria and Methodological Response

2.5. Research Method

2.5.1 Sampling

In accordance with the classic GT procedure, purposive sampling (Glaser & Strauss, 1967), that is the recruitment of participants from a particular group on the basis that they had the necessary characteristics for the sample, was used for data collection.

The inclusion criteria were as follows:

* Current GP specialist trainee (ST1-ST3)
* Participating in the IRPP

It was initially considered that participants who had attended less than 50% of the IRPP RPGs should be excluded, however this criterion was removed due to concerns that it could introduce a bias to the study, in that participants who had attended 50% or above of the available sessions might hold more favourable views towards RPGs or be more likely to engage with RP. Also, valuable insights into why some participants had attended less than half of the sessions could be missed.

The possibility of excluding trainees in ST1 [first year] due to the small number of RPGs they would have had the opportunity to attend at the point of data collection was considered,

however it was decided that including GP trainees at this early stage was necessary to ensure that the broadest possible range of RPG experiences was gathered.

Consideration was given to the possibility that the sample may be relatively homogenous in terms of race, socioeconomic background, and gender. The possibility of specifically asking that participants from more diverse backgrounds come forward if this was found to be the case was discussed in supervision and was decided against at the initial recruitment stage, as at this point it was unclear who would come forward and it felt important to keep the inclusion criteria as broad as possible. It was held in mind to be the focus of potential future theoretical sampling, however the decision was then made to adopt the abbreviated GT model (Willig, 2008; see 2.6) which does not include theoretical sampling as a part of the process. I am aware that these decisions had an ongoing impact on the data gathered and the subsequent analysis and theory development, and this was held in mind throughout.

2.5.2 Recruitment Method and Procedure

The Research Supervisor had ongoing direct involvement with the IRPP. They played a role in the initial development of the project, acted as an RPG facilitator, and more recently have provided training to trainee CoP facilitators. This involvement enabled me, in my role as researcher, to access the GP training programme directors and those GP trainees participating in RPGs for the purposes of recruitment.

Recruitment commenced immediately after ethical approval was granted, on 5th April 2022 (Appendix 1). I made contact with the Programme Directors at the participating NHS Trust, who supported me with recruitment by circulating the study advertisement (Appendix 3) via email to all GP trainees involved in the IRPP, and to other staff on the GP Training programme to share with their students. All prospective participants were provided with an Information Sheet (Appendix 4) and a Consent Form (Appendix 6). Those who decided to participate were asked to sign the consent form and return a copy to the researcher. An online interview via Zoom was then arranged at a time to suit them.

It quickly became apparent that recruitment would be challenging. The busy schedules of GP trainees may have been at least partially responsible for creating a reluctance to commit the time necessary to participate in this research. When after the initial participant advertisements had been shared via email, and a video made by myself as the researcher introducing the study had been shown in a whole-group teaching session, no participants had come forward, the Programme Directors allowed me to attend in person on 24th June 2022 to share information about the study with prospective participants. This generated five expressions of interest, of which three participants went on to consent to be interviewed. Participant advertisements were re-circulated in November 2022, generating a further participant. Following this, for a long period no further participants came forward.

As the researcher I responded to this in a number of ways. Following a discussion with my supervisor, we agreed that I would identify a further date to attend in person for the purposes of recruitment and to interview any interested participants, and my supervisor contacted the Programme Directors to request an opportunity for me to be present online in advance of this, to recruit for the study and interview any interested participants who gave consent. The amendment to ethics to allow for in-person interviewing was granted by the Psychology Research Ethics Committee at City, University of London on 1st March 2023 (Appendix 2). Amendments were made to the participant information sheet to reflect the option of in-person interviews (Appendix 5). Following this, it was arranged for me to be present online during a junior Doctor strike day on 14th March 2023. Some trainees had arranged with programme directors to be online on this day, as an opportunity to ask any questions they might have in relation to the taught components of their training, and group discussions were offered on topics which commonly arose. As a part of this, the course directors allowed me to 'drop in' to one of the meetings with trainees who had come online, where they reminded the attending trainees about the study and gave them an opportunity to be interviewed while they were online that day. I was put into a separate 'Zoom room' which they could access if they wished to participate. This generated two additional participants. I also requested that facilitators share information about the study with their groups at the next RPG sessions. This yielded a further three participants, one of which agreed to be interviewed on Zoom, and two of which requested to be interviewed in person. I attended the teaching hospital on 2nd May 2023, where data collection was completed. This was later than hoped and is indicative of the challenges faced in recruitment, and, among other factors, possibly also the considerable demands on the time of GP trainees.

2.5.3 Participant Sample

The final sample for this study consisted of nine GP trainees. A tenth participant gave consent but withdrew from the study before being interviewed due to other commitments on their time, and another potential participant completed training very shortly after expressing an interest in the study, so chose not to proceed. A breakdown of the dempographic details of participants is presented at table 2-2.

Participant	**Gender**	**Ethnicity**	**Stage of Training**
Sarah	F	White American	ST2
Oliver	M	White British	ST3
Claire	F	White British/European	ST2

Caroline	F	White British	ST2
Tricia	F	White British	ST3
Jane	F	White British	ST3
Ben	M	White British	ST3
Alice	F	White British	ST3
Lucy	F	White British	ST3

Table 2-2: Demographic Details of Participants (presented in order interviews were conducted)

2.5.4 Data Collection Procedure

Data was collected through semi-structured in-depth interviews with participants. Each participant attended a single semi-structured interview. The length of these ranged from 30-90 minutes depending on the amount of information participants wanted to share about their experiences. Participants were initially informed that interviews were likely to take 60 mins, however as data collection proceeded the need to be mindful of constraints on participants' time became increasingly apparent, and the amount of information participants wished to share about their experiences and their responses to interview prompts varied in terms of detail. Although interview length impacted on the quantity of data generated, it was found to have little impact on quality, with all participant interviews generating rich data around all of the interview prompts.

Seven of the interviews were conducted and recorded online on Zoom, and two were conducted in person in a private room at the teaching hospital and recorded on an Olympus DS9000 encrypted recording device. An interview schedule was used to guide these interviews. In spite of the inductive nature of GT, Charmaz (2006) posited that constructing an interview schedule for a GT study can be helpful, but emphasised the importance of allowing for sufficient flexibility in this, and listening actively to participants. The attached interview schedule (Appendix 8) reflects this, the questions included were used as prompts, with space given for participants to raise ideas and discussion points not covered by the schedule, and for these to be explored (Urquhart, 2013). Interview schedules were modified slightly as data collection progressed to reflect the ideas emerging from participant interviews (Urquhart, 2013).

Interviews were chosen as the sole data collection method, in-fitting with qualitative methodologies and the GT approach (Urquhart, 2013). However, I am aware that this carried the risk of missing or overlooking other potentially rich sources of data. The possibility of asking participants to write reflective journals or accounts of RPGs was considered. However it was

decided that this would not be appropriate for a number of reasons. First because due to the importance of confidentiality and of participant anonymity, it was made very clear to participants that their participation in this study would not involve answering questions about the content of RPG sessions. It was considered that it might be difficult to produce written reflective diary entries with no mention of the content of discussions or reference to comments or observations from other participants, whereas in semi-structured interviews the questions or prompts will make clear that participants should talk about how they personally made use of RPGs rather than what was discussed in group sessions. Secondly, research has established that a barrier to healthcare trainees and professionals' participation in RP is their workload and sense that while they are spending time on RP they are neglecting aspects of work concerning medical/patient care (Nancarrow et al, 2014). This was also apparent in the challenges encountered in recruitment. Asking participants to provide written accounts would have increased the time and work involved in both their RP engagement and, significantly, their participation in this study, which may have dissuaded them from participating. Qualitative studies by nature involve a significant time commitment from participants (Willig, 2013) and it was not deemed appropriate to ask participants to spend additional time on something that is not an aspect of the IRPP. Further, the study is interested in how participants make use of the RPGs in this context, so adding an aspect of RP which is not a part of the IRPP, such as journalling, could change the experience in a way that makes the resulting theoretical model less useful in explanatory terms.

Focus groups were considered as an alternative to interviews, but it was decided that these would be more difficult to organise for participants who already have considerable demands on their time, and would raise additional issues of confidentiality.

Also considered was the possibility of generating real-time data by recording RPG sessions. However it was considered that it would be too difficult to get informed consent for this from all participants, and even if this were obtained, it would present challenges in relation to confidentiality which would be likely to affect the content of recorded sessions and trainees' willingness to participate in the session. This would also present an ethical challenge which would be difficult to overcome, particularly given the small participant 'pool' and likelihood, even with the safeguards already in place in relation to confidentiality, that they would be able to recognise one another from their data. A further ethical consideration of importance was the fact that GP trainees would be discussing real world cases in RPGs and although the cases presented would be anonymised, recording these sessions carried too great a risk of compromising patient confidentiality, and from the data analysis point of view it would be too complex to separate this content from content providing insight into how participants were making use of the group sessions. Following discussions around this and the adoption of interviews as the sole data collection method, care was taken to reassure participants that they would not be expected to discuss the specific content of RPG sessions in interviews.

2.5.5 Ethical Considerations

Ethical approval for this study was granted by the Psychology Research Ethics Committee at City, University of London on 5th April 2022 (Appendix 1, approval code: ETH2122-1279).An amendment to ethics to allow for in-person interviewing was granted on 1st March 2023 (Appendix 2, approval code: ETH2223-1577). This study is fully compliant with the BPS (2021) and HCPC (2016) codes of human research ethics.

2.5.5.1 Informed Consent and the Right to Withdraw

As discussed above, participants were provided with an information sheet and those who wished to proceed asked to sign a consent form. Qualitative studies require a considerable time commitment from participants, so it was extremely important that the information sheet made it clear how long interviews might take and what, if anything, would be expected in terms of ongoing participation. When providing prospective participants with this information, I invited them to raise any questions they might have. Additional consent was required for audio recording of interviews and was included in the consent form, which also included a space for participants to provide an email address if they wished to be informed of the outcomes of the study. As set out on the participant information sheet, email address details were held in a separate file from participant data to protect confidentiality and this file will be deleted permanently as soon as participants have been contacted with this information.

Participants were made aware of their right to withdraw for any reason and at any time before, or up to two weeks following their interview, after which their data would be transcribed and anonymised. At the commencement of interviews, they were reminded again of their right to stop the interview at any time, decline to answer any questions, request a short break or ask that the recording be stopped.

2.5.5.2 Possible Conflicts of Interest

a. Role of the Researcher

As the researcher, I was not at any time an IRPP facilitator, but I am a CoP trainee at City, like the RPG facilitators, some of whom were my colleagues. As such, it was of importance to communicate my role very clearly to participants to ensure they understood that when interviewing them for this study I was not there as a facilitator, or as a ‘representative’ of City, and that the purpose of the research was not to evaluate the IRPP, but to better understand how they experienced and make use of RPGs, for which purpose I acted entirely independently as researcher. Care was taken to emphasise that they were free to share their experiences and

perceptions, positive or negative, and nothing they said would have any impact on their ongoing participation in the IRPP.

b. Role of the Research Supervisor

The first research supervisor is directly involved in the IRPP as the lead professional from City. In order to mitigate any potential conflicts of interest arising from this and to support researcher reflexivity, a co-supervisor was brought in. While the second supervisor was not entirely free of bias, as they were also a Counselling Psychologist who supported the aims of the IRPP and saw a role for Counselling Psychologists as facilitators of RP in healthcare training, this was minimised by the fact that they had no involvement in the IRPP. The co-supervisor was actively involved at the stage of formulating the research question and applying for ethical approval. A third supervisor was later introduced at the start of the data collection stage. This supervisor was also a Counselling Psychologist but had no involvement in the IRPP. Due to their expertise in GT methodology they were involved in the decision to adopt an abbreviated GT approach (see 2.6 below) and also had a role in the early stages of the analysis. This helped to challenge any bias.

2.5.5.3 Confidentiality

Due to the nature of the study, participants were recruited from a very specific group creating a risk that they may be able to recognise one another. As such, confidentiality was of key importance. This was protected by ensuring that all names were changed, for which purpose participants were given a pseudonym, and all actual or potential identifying information amended or removed from interview transcripts. Where quotes are included, attention was paid to ensuring nothing in these carried the risk of participants being identifiable to one another. This was discussed with participants prior to obtaining consent, and included in the participant information sheet.

Online interviews were recorded on Zoom, and in-person interviews on the Olympus DS9000 encrypted recording device. Only the researcher has access to these recordings. On completion of interveiws, audio files were uploaded to City's encrypted One Drive and deleted from all of my devices, in accordance with relevant data protection legislation and procedures. Transcriptions of interviews were also uploaded to City's One Drive and deleted from all other devices. Data will be held securely on this platform until the viva is completed and any associated amedments made and submitted. This information was communicated to participants prior to obtaining consent.

When interviews were conducted online, it was established prior to commencement of the interview that participants were in a place where they could speak confidentially and would not be

interrupted. As the researcher, I sought participants' confirmation that there was no one else in the room with them and that they could not be overheard. All online participants were able to confirm this. Where interviews were conducted face to face, a private room was arranged for these, the location of which was communicated privately to participants, and they were able to come and go without their fellow trainees observing them or being aware that they were attending. The room was intended for private consultations, and therefore was appropriate for the purposes of interviewing and met the necessary health and safety requirements.

2.5.5.4 Interview Schedules

Due to the inductive nature of GT, adjustments and additions to the prompts on the interview schedule were made as the interviews went on. These were minor and did not substantially change the content of the interview, or require an amendment to ethics.

2.5.5.5 Psychological Distress

This was a low-risk study and no particular vulnerabilities needed accounted for in the participant population. However, previous research has found that RPGs can be very challenging, and in some cases distressing, for participants (Knight et al, 2010; Nancarrow et al, 2014), and recent reports have highlighted the impact of the challenging nature of their work, training, and associated pressures on GPs mental health and emotional wellbeing (GMC, 2022; Kinman & Teoh, 2018; Baird et al, 2016). As such there was a possibility that just the opportunity to share their experiences might cause distress for some participants, particularly as this may have been the first time some of them had had a chance to talk about these issues. As the researcher I held this in mind and used my therapeutic skills and training to contain participants within the interviews, and establish clear boundaries for ensuring they felt safe. I also identified possible avenues of further support for any participants who were experiencing distress, which were included on the debriefing information. It was made clear to participants that they could request to stop the interview, pause the recording, or take a break at any time.

2.5.5.6 Debriefing

At the end of the study, participants were provided with a Debrief sheet (Appendix 7). They were reminded of their right to be informed of the results of the study and given some idea of the possible timeframe for this. The debrief sheet also contained information about possible avenues of further support for participants who may be experiencing any psychological stress as a result of their work or their participation in this study.

2.6. Grounded Theory Procedures

Due to the practical and time considerations associated with the nature of this study, as a DPsych research project, including relevant time and word limits, and in particular in this case challenges encountered around participant recruitment, a decision was made to adopt the abbreviated GT approach to data collection and analysis (Willig, 2008). I made use of supervision to discuss and reach this decision, as at the time I was working with a supervisor who had a particular specialisation in GT research. Abbreviated GT is limited to analysing the original data only, not seeking out new informants or new data to broaden and refine the emerging theory, but instead going back into and querying the original data in relation to any questions or gaps which arise during the analytic process (Willig, 2008). Rather than data collection and analysis happening concurrently, analysis does not begin until all the data is collected, at which point it is analysed following the principles of GT, that is the process of coding and constant comparative analysis. Theoretical saturation can only be implemented within the data being analysed, however Willig (2008) points out that theoretical saturation is a goal rather than a reality, and I was conscious of the fact that time would make the achievement of this difficult whatever GT procedure I had adopted, For this reason, it felt sufficient that I reached a stage where any new ideas identified within the data set were only serving to 'flesh out' the existing theory.

The stages involved in the abbreviated GT analytic procedure are as follows:

2.6.1 Familiarisation with and immersion in the data

I transcribed each interview verbatim in order to fully immerse myself in the data. I read these transcripts several times, including alongside recorded versions to pick up on participant tone, intonation and inflection which might add meaning or emphasis to the data (Charmaz, 2006).

Following this stage, the analysis was guided by Charmaz (2006; 2014)'s analytic procedure for CGT, set out below.

2.6.2 Initial Coding

This was carried out through the process of line-by-line coding to identify what actions and processes participants were attempting to describe. These initial codes were action-based, in that they identified processes rather than descriptions. This was intended to prevent myself from beginning to interpret the data at this early stage, increase objectivity, and ensure codes remained as close as possible to the data (Charmaz, 2006).

Figure 2-1 provides an example of my initial coding from my interview with one participant, 'Sarah' (pseudonym):

Transcript:	**Initial Coding:**

I think it allowed me to feel a lot more	*Being 'allowed' to feel a lot more*
Because I'm quite a thinking person	*Recognising that I am a thinking person*
I'm very analytical I'm not a very emotional person in general	*Generally consider myself very analytical rather than emotional*
I'm usually just extremely analytical	*Emphasising I am usually an analytical person*
I think it allowed me to feel a bit more rather than just thinking the whole time	*Recognising this situation allowed me to feel a bit more rather than thinking all the time*

Figure 2-1: Example of initial coding from Sarah's interview (page 5)

2.6.3 Focused Coding

This process involved the identification and elevation of the most frequent or apparently significant initial codes to focused codes (Charmaz, 2006). Focused coding was used to combine codes or identify important parts within initial codes, which could then be compared to one another and to the data (Charmaz, 2006).

The aim of focused coding is to explain and synthesise larger sections of data and identify which codes felt the most useful for analysing and categorising the data (Birks & Mills, 2015).

An example of my initial to focused coding is presented at figure 2-2 and Appendix 9.

Transcript:	**Initial Coding:**	**Focused Coding:**
I thought 'oh my gosh these people are explaining my scenario with such empathy	*Realising/surprised that others are explaining my scenario with empathy*	**Experiencing empathy and compassion from others** (first experience of this)
And compassion for me that I don't show for myself	*Feeling compassion from others that I don't allow myself*	
I can be quite hard on myself and… yeah	*Recognising I can be hard on myself*	**Recognising that I am not always empathic/compassionate to myself**
It felt quite cathartic after – after that experience	*Finding this experience cathartic*	**Emotional experience of others' compassion/empathy**
To think 'oh I've allowed myself to feel this… like gentleness towards myself	*Realising I've allowed myself to feel gentleness towards me*	

Figure 2-2: Example of progression from initial to focused coding from Sarah's interview (page 5)

2.6.4 Memo Writing

Memo-writing was used throughout the process. Willig (2008) posits that this aids the process of defining codes, recording theory development, and tracing emerging relationships.

And Charmaz and Henwood (2008) emphasise the role of memo writing in raising the analytical potential of the emerging theory.

I kept both analytic and reflexive memos (Urquhart, 2013). Analytic memos aided the process of comparison, and demonstrate the integration of participants' perspectives with my own (Milliken & Schreiber, 2012), and reflexive memos enabled me to recognise where particular things had come up for me during interviewing and analysis, and explore what might be behind my interventions and inferences.

An example of a reflexive memo in relation to Sarah's interview, where I notice I have drawn a particular inference from what she was saying in relation to experiencing her emotions in groups, is provided in figure 2-3:

Reflexive Memo: *I was aware in the interview with Sarah that I was the one who used the word 'processing' first in relation to her account of experiencing her emotions while listening to the group discuss her case. While I used it in response to the sense I was getting from her previous response(s), it was important to consider what I added by using that particular word, which it comes naturally for me to use as a trainee CoP but would not necessarily be a word Sarah would have used herself. She responded and gave more information so this obviously resonated with her, but I'm aware of my role adding my own meanings to what she was describing.*

Figure 2-3: Example of reflexive memo written in relation to Sarah's transcript

An example of an analytic memo, which recognises something in several participants' data that suggests they have fixed ideas about what 'a normal doctor' is, how this relates to their experiences of emotion and stress at work, and the ways in which they might be finding the groups a space to explore this, is provided in figure 2-4:

Analytic Memo: *Something seems to keep coming up in these initial codes about experiencing stress at work but being unable to express it, and then going home and just blocking it out, not consciously realising that it has a cumulative effect on stress levels. This seems to be linked to the idea of 'being like a doctor' or ideas about 'a normal doctor' - keeping emotions out of practice. I don't believe Sarah is the only one who has experienced this, I got the impression that Oliver was alluding to it, and I think that Claire mentioned it too, but I need to go back and check this, and also see what they say about how experiencing stress at work impacts them/their professional identity. I get the impression that groups may offer a space to process stressful experiences where participants feel 'allowed' to do this (not the same as 'work' so able to do something they wouldn't normally do 'as a doctor'?) Also might suggest that when they are given this 'permission' they realise things have caused stress which they have not been conscious of before. Could be helpful to compare accounts on this basis.*

Figure 2-4: Example of analytic memo written in relation to Sarah, Oliver (psuedonym) and Claire (psuedonym)'s transcripts.

2.6.5 Categorising

This stage involved the Identification of categories and subcategories within and between codes (Charmaz, 2006). Memoing and diagramming aided the processes of establishing the frequency of codes, their relationships and the processes they related to. This enabled the

development of major categories and the emergence of a theoretical framework (Charmaz, 2006). An example of categorisation from Sarah's data is shown at figure 2-5:

Transcript:	**Initial Coding:**	**Focused Coding:**	**Categorisation**
Processing them rather than just letting them sort of sit in your subconscious	*Processing emotions rather than letting them sit unrecognised/unacknowledged*	**Making my emotions conscious/processing them**	
it's something we probably just don't do a lot.	*Recognising that 'we' (doctors) probably don't do this a lot*	**Not my/'doctors' usual experience**	
whether you know it or not, you know it's subconsciously affecting how you behave in all aspects of your life.	*Recognising a link (conscious or unconscious) between feelings and behaviour*	**Recognising impact of emotions on behaviour**	**Recognising and Processing Emotions** *(Unlike 'being a Doctor')*
So yeah, being able to process emotions is important for our job	*Recognising importance of processing emotions as a doctor*	**Need to be able to process emotions/a space for this**	

Figure 2-5: Categorisation Process ('Sarah', page 5).

2.6.6 Constant Comparative Analysis

Throughout this process, codes, concepts and categories were constantly compared with one other in order to remain focused on the data, and to clarify and re-evaluate the codes and categories being developed (Willig, 2013).

Because this study adopted the abbreviated GT approach, theoretical sampling was not used to seek out new or disconfirming data. Instead, the original data was re-examined, queried and explored until theoretical saturation was reached, that is the data was found to be lending support to existing codes and categories but no new codes or categories were being generated (Charmaz, 2006). However, Charmaz (2006) argues that 'saturation' is more of a goal than a realistic possibility in CGT research, because it is always possible to revise the findings. As such, while I intended to get as close to saturation as possible within the original data, the point at which I concluded the analytic process was closer to 'theoretical sufficiency' (Dey, 1999). I declared the analysis finished once no new ideas were emerging which did not relate to one of the identified major categories. However I am aware that this reflects the subjectivity of the researcher's decision making in this process, and I held this in mind when considering the emergent theory.

2.6.7 Theory Development

A theory was formed when a core category emerged which seemed to connect the major categories and the entire dataset. A conceptualisation of the emergent theory is presented in Chapter 3 at figure 3-7.

The emergent theory was then considered in the light of an extensive literature review (see Chapter 1). I had conducted a preliminary literature review, in order to explore what research existed into RP, and interprofessional RP, in healthcare, identify gaps in the data and formulate a research question (see Urquhart, 2013). However, in accordance with GT procedure, the more extensive literature review was delayed until a theoretical model had been developed, in order to minimise the impact of pre-existing knowledge in this area on the emergent theory, to ensure it remained grounded in the data (Charmaz, 2006) and to explore the model in relation to wider literature and relevant theory.

2.7. Reflexivity

I made use of supervision throughout the process of data collection and analysis. I also kept a reflexive journal as an account of my process, thoughts and experiences, to recognise how my position, views and assumptions might be playing a role in co-creating meanings with participants (Charmaz, 2006) and to reflect on my influence on the emergent theory (Charmaz, 2014). Extracts from this are presented in Chapter 3.

2.7.1 Personal Reflexivity

I am aware that my motivation for undertaking this research had the potential to influence the way I conducted it (Willig, 2013). Further, in line with the constructivist GT approach, I acknowledge that as researcher I played an active role in co-constructing meanings with participants (Charmaz, 2014). I have a particular personal interest in interprofessional working and the ways in which CoPs can bring their skills to different settings and aspects of practice, particularly healthcare settings, and the challenge of establishing CoP professional identity within the NHS (Frankland & Walsh, 2005). As such, I am conscious of the fact that my motivation for undertaking this research was in part based on a belief that if successful, the IRPP could offer an important and helpful basis for a future collaboration between CoPs and GPs. Because of this, and my particular positioning as a trainee CoP at City, I was careful to hold in mind the risk of over-seeking positive responses from participants in relation to their experiences of the IRPP.

The process of data collection and analysis raised particular considerations of reflexivity. I was conscious of the fact that my automatic assumption in relation to RP is that it is a positive and helpful thing. As a CoP trainee, RP is an integral part of my training, and something I have benefited from both personally and professionally. I was also aware that all of the participants who came forward to be interviewed for this study expressed that their experience of the IRPP

had been generally positive and as such the participant experiences I was capturing were likely to be those who shared the view that RP is a helpful and important aspect of training. It was therefore of importance to be careful that this presumption of the benefits of RP did not mean I was fully supportive of any responses in the data which reflected this, to the detriment of other possible perspectives and interpretations, and to be mindful of the possible impact of this on the resultant theory. I did ensure to ask participants about more difficult or more challenging aspects of RPGs within the interview, as well as asking whether there was anything they did not get out of the experience which they would have liked to. I also made sure to return to the data and query it in relation to this, seeking new ideas and possible new categories in relation to questioning the usefulness of RP or identifying less positive aspects and effects. Had I used the full version of GT this may have been the subject of theoretical sampling at some stage in the process, however because I was limited to the existing data set, I had to search for discomforting data within that. It was therefore of even greater importance that this was held in mind when developing the final theory.

Also necessary to hold in mind was the fact that GP trainees may have been making sense of their experiences of RPGs whilst talking to me about them, so something about the interview process itself contributed to our joint understanding of how they made use of the groups and therefore to how the theory developed. It was important to hold in mind that all of the participants in this study had attended the majority of the RPGs offered and had found something useful in that process, and so they may have been those GP trainees who were more psychologically minded, which had the potential to influence the way in which they interacted with me and the meanings that were co-constructed between us. I explored in supervision and in my reflexive journal the sense I was getting that participants may be responding to me in a particular way due to my positioning, as a trainee CoP, in that there seemed to be an overall tendency to position themselves as 'different from the usual Doctor' because they were more psychologically aware or psychologically minded. I considered the possibility that this way of framing their experience might be influenced in part by their understanding of, and possible assumptions about my professional role, and my assumptions about and responses to them. This may have influenced the language that was used in the interviews, by them and myself, and one possible impact was that there may have been more of a psychological 'tone' to the resultant theory than there might have been had this not been the case.

Being a researcher in this process but at the same time a trainee CoP is also something I was aware of, particularly in recognising the usefulness of my therapeutic skills when interviewing but remaining mindful of not acting 'as therapist', both in my language and responses where participants were recounting more challenging aspects of being a doctor. I made use of supervision to explore why I might have felt a pull to respond as a trainee CoP rather than an interviewer at certain moments, and what impact this might have had on the meanings that were

co-constructed between myself and the research participants. I also explored this in my reflexive journal when analysing transcripts.

I am also conscious of the influence of my social context as a White middle class researcher, undertaking postgraduate professional training, on the data collection, analysis and theory development. This social context is also reflected in my participant sample, and as such I wonder whether my positioning may have had an impact on recruitment, as although the participants came from a variety of professional backgrounds, they were all of a similar demographic profile and may have unconsciously felt comfortable or safe to come forward to talk about their experiences of engaging in reflective practice groups due to perceived similarities between us and in our experiences, which in turn may have influenced the way the interviews progressed and as such created a very particular social/cultural lens through which a theory developed. This may also say something about engagement with RPGs, ideas and expectations about RP more generally, possibly making it more likely that the participants who came forward would be those who had had a positive experience or viewed reflective practice as 'a good thing'. I was aware of not wanting the findings of this research to be a product of White middle class professionals sharing their experiences with one another in an insular way, however a degree of this may have been inevitable due to my own social context and the way I positioned myself and framed the research, and the way my own culture and that of participants impacted our views reflection/RP. It may have been helpful to have named this and made it more explicit that I was interested in a wider range of views and experiences, in order to attempt to mitigate one of the major ways I brought myself to the research and to create a theoretical framework applicable to a wider sociocultural group. However, I did hold this in mind and explored the impact of my social context as an aspect of my positioning as researcher both in supervision and in my reflexive journal during the analytic process.

2.7.2 Epistemological/Methodological Reflexivity

Willig (2013) emphasised the need for Counselling Psychologist and therapist reflexivity in considering the epistemological underpinnings of our preferred therapeutic approach. As such, coming into this research I was conscious of the fact that my assumptions and beliefs about the nature of reality and what it means to be a person influence my practice, and also would influence my methodological choices when conducting this research. Initially I experienced something of a tension between my naturally highly relativist positioning, that is my belief that reality consists of a range of truths and perspectives depending on the individual and the personal lens through which they see the world, and my preference for engagement in practice-based research or research with implications for real-world settings, where the existence of an external reality that can be 'known' is a necessary assumption. Over the course of my training and practice in counselling psychology, whilst my approach has continued to be based on attempting to as fully as possible understand the lived experiences and inner worlds of clients, mindfulness of the

importance of evidence-based practice has meant I have moved closer to the position of the critical realist, in my acceptance of the fact that there is an external world to know, but recognition that we will all experience this differently. In research terms, this meant that embarking on this project I wanted to integrate my desire to create a research project with helpful implications for the development of the IRPP, and of inter professional RP between CoPs and GPs more generally, with my belief that the best way to understand how participants have experienced and made use of the IRPP was to ask them to tell us about their experiences. I also wanted to accommodate a further assumption I hold, which has also strengthened over the course of train,ing which is that human beings are inherently relational, and as such there is a social aspect to meaning making. I am aware that I also brought this assumption to the analysis of data.

GT is an approach which can apply itself to research within real world settings, by developing theories with practical implications, but is sufficiently flexible to allow me a broad range of perspectives to be gathered, to allow for open-mindedness and uncertainty as to what might emerge during the research process, and also recognises my role as the researcher in co-creating meanings with participants. Recognising myself as a human being who came into the research with my own assumptions, beliefs and experiences of the world, was helpful in approaching data collection and analysis in a reflexive way and in making better use of supervision throughout this process, as it is in my practice. It allowed me to create a study which reflects my epistemological positioning, but also has clinical applicability within the context of the IRPP, and implications for counselling psychology practice more generally.

The findings of this study are presented in Chapter Three.

Chapter Three: Analysis

3.1 Overview

This chapter will present the Constructivist Grounded Theory of how GP trainees make use of RPGs, developed through my analysis of the interview transcripts. I will present the five major categories that emerged from the analysis, with participant quotes to illustrate these and the subcategories within them[4], followed by the core category with an account of how this developed from the major categories.

The intention of this chapter is to develop a tentative explanatory model of how GP trainees make use of RPGs in the context of the IRPP. Concepts appeared to be interlinked and interconnected, suggesting a dynamic aspect to trainees' use of the groups, in which as one process occurs, others are likely to emerge. I will attempt to deepen the analysis by demonstrating the way these concepts connect with and relate to one another.

Participants seemed to use the interview process as an opportunity to begin, or continue, to make sense of and understand their RPG experiences, how they had used the groups, both within and outside of the RPG space, and ways in which it might have changed them or their practice. Their accounts shed light on an area where research is limited, that is GP trainee's use of CoP-facilitated RP, and raise questions for future research in this area.

At all stages, I kept the following research question in mind:

How do GP trainees make use of Reflective Practice Groups?

By focusing on this, and the intention to uncover the processes that underpinned it, I was able to identify five major categories (table 3-1) and a core category. When constructing the theory, I engaged in continuous comparative analysis of data in order to identify recurrent themes across participant accounts, and the relationships between them. These will be outlined in the next sections.

Category One: ***Sharing Experience***	**Category Two:** ***Recognising and Processing Emotions***	**Category Three:** ***Developing insigh and compassion***	**Category Four:** ***Developing understanding and skills***	**Category Five:** ***Integrating into work – and beyond***
Reducing feelings of isolation ('I am not alone')	Noticing my emotional reactions	Experiencing empathy	'Just' listening	Talking about feelings

[4] Participant quotes are presented with the participant name followed by the page and line numbers from that participant's transcript.
(.) is used to indicate a short pause, (…) and … to indicate longer pauses or periods of silence, and […] indicates a break in the quote

Category One: ***Sharing Experience***	**Category Two:** ***Recognising and Processing Emotions***	**Category Three:** ***Developing insigh and compassion***	**Category Four:** ***Developing understanding and skills***	**Category Five:** ***Integrating into work – and beyond***
Recognising I am not the only one struggling	'My emotions are valid'	Empathising with others	Responding to case discussions without bringing 'my' scenario	Application to consultations
Help-seeking	Permission to focus on feelings	Understanding my limitations and boundaries	'Why' and 'how' rather than 'what'	Thinking about how I communicate
Offloading	Others' recognising my emotions	Being kinder to myself	Developing reflective skills	

Core Category: Navigating the Relationship between 'Humanness' and Being a Doctor

Table 3-1 Major categories of the emergent theory

A diagram to illustrate the emergent theory is presented in 3.7. at figure 3-8. The five major categories are expanded upon below.

3.2 Category 1: Sharing Experiences

Sharing experiences, through the process of bringing a case to the group, and hearing and discussing cases brought by others, came up in all participant accounts. When participants described 'sharing experiences', it was clear they were referring to challenging experiences, ones where they had struggled or experienced uncertainty. This suggests that already within the process of sharing experiences was a degree of vulnerability, and differentiated the groups from participants' other experiences of sharing with colleagues, where they may have felt a pressure to present an image of 'competence'. The subcategories: reducing feelings of isolation ('I am not alone'), recognising 'I am not the only one struggling', help-seeking and offloading, were developed from the processes participants described as emerging from sharing these difficult, more 'human' experiences with the group. Across accounts, the facilitator emerged as supporting participants to focus on these non-clinical aspects of their scenarios and feeling safe to do so.

Reflexivity: *This idea that 'sharing experiences' means sharing challenges and struggles, not situations where you feel confident or have 'done well', brought to mind my first experiences of group supervision on the DPsych, in my year 1 tutor group. Our tutor specifically said to us that when bringing cases we should not bring the ones where we had received good feedback, or things had gone well, but should bring something we were finding difficult or unsure of. She suggested that often there is a real 'pull' to bring a 'successful' case or something you are confident about, as sharing experiences in groups can create feelings of vulnerability and telling peers and supervisors about situations that feel more certain or have positive outcomes can be a way of defending against both this vulnerability and the 'threat' of hearing negative feedback, or appearing 'not competent' in front of peers or tutors. I remember being surprised by this, my first thought was 'why would I want to bring a case I felt okay about when I have the chance to ask my peers for help and feedback with something more difficult?' But then when I had my first experience of bringing a case, I realised I felt very vulnerable sharing it with colleagues and the tutor, and started to question myself about actions I had taken and wonder what others were thinking about me and my work. This proved to be an extremely helpful experience which guided me in my work with a challenging client, but it made me think again about my automatic reaction to the idea of sharing my challenges and seeking feedback, and realise I was not in fact as 'comfortable' with it as I had thought I would be, particularly at that early stage of my training. And this was an experience that was not completely new to me, I had been in similar situations before, whereas for some GP trainees this was their first experience of talking about their challenges, acknowledging when they are 'not sure' or concerned about their actions, and opening themselves up to others' opinions. Throughout my experience of supervision groups the quality of the tutor/ facilitator has made all the difference to how open to and comfortable with sharing difficult experiences I have felt, so I am mindful that I may have added my own experience to interpretations of participant accounts when it came to the role the facilitator played in creating a 'safe space' for them to show their 'human' vulnerability.*

Figure 3-1: Reflexivity (theme of sharing experiences)

3.2.1 Reducing feelings of isolation - 'I am not alone'

All participants described the isolating nature of general practice, and identified a difficulty making time for engagement with colleagues. The feelings of isolation they described came from spending whole days in their consulting room just seeing patients.

'Alice' (pseudonym), an ST3 trainee, reflected that this was one of the reasons groups felt important:

'…I think because (.) particularly for general practice because we do work so independently and so (.) kind of (.) we're in our own rooms all the time we don't have a lot of kind of chance to discuss these things' (Alice, p9, 399-401).

'Oliver' (pseudonym), an ST3 trainee, identified this as something he had become more aware of through being involved in RPGs:

"…emphasises the importance of having a group of individuals that you can de… decompress with… um… as you go through your career as… in General Practice. Reason being, um… you can easily turn up at work and leave work having only spent your time listening to other people's problems and not interacting with colleagues' (Oliver, p.14, 646-650).

He recognised not just the isolating nature of spending all day in the consulting room but the fact that the patient interactions a Doctor has are all about difficulties or 'problems' as a factor in this.

For ‘Claire’ (pseudonym), an ST2 trainee, an important aspect of the groups was that they provided an opportunity to talk to her peers. She said that one of the things that motivated her to attend the RPGs was the insight it gave her into her colleagues’ experiences and the impact this had on her feelings of isolation:

‘…So what I found is that everybody had quite similar, complex cases, or faced very similar challenges at work. Um… and… especially in GP you can sometimes feel a little bit… isolated because it is just sort of… most of the time it’s you and your patients. Obviously you’ve got some support from other colleagues but… sometimes it can feel a little bit lonely and isolating. Um… so I think having… sort of the… knowledge that other people face very similar challenges, have similar feelings and experiences at work um… from… personally makes you feel… more reassured, and makes you feel like ‘it’s not just me, other people have very similar views’. So from a personal point of view I think it’s… nice to have that reassurance and… you can sort of go away knowing that… you know you’re not totally alone and… this is something lots of people face’ (Claire, p2, 68-77).

‘Tricia’ (peusdonym), an ST3 trainee, also identified this as a positive aspect of having a space to share experiences with colleagues.

Participants also recognised an increased sense of belonging. ‘Lucy’ (pseudonym) a trainee in ST3, highlighted this, and used the same word as Oliver, ‘decompress’, to describe the process and impact of recognising that you are a part of a group of people experiencing similar things, not just one person experiencing it on your own:

‘*I suppose it just helps you just decompress that little bit more that you (.) that you know that there are other people that have exactly the same issues and that it’s not (.) it’s not just you? I think that camaraderie you get and that sense of (…) erm (…) belonging somewhere that sense of (.) you belong to a group of people who all have similar issues can be quite nice especially because GP is quite isolating.’ (Lucy, p5, 210-214)*

Claire also identified this sense of belonging:

'a*s a trainee it just… um… in a sense reassures you, or makes you feel… more as part of… the team…’ (Claire, p14, 613-614).*

Participants generally agreed that sharing experiences reduced feelings of isolation. There was also an agreement that isolation related not just to feeling isolated from colleagues, but also feeling isolated in their difficulties. Lucy identified a tendency to consider that any problem she is experiencing is ‘just you’, which leads her to question whether it is something about her that is

causing the problem. She recognised that this is reduced by hearing colleagues describe similar issues:

'*I think probably the general theme most people (.) I imagine would say the same thing (.) is that (.) that again that you don't feel (.) erm (.) isolated (.) in (.) the struggles that you have (.) or the (.) annoyances that you have or frustrations' (Lucy, p10, 461-464).*

'Caroline' (pseudonym), an ST2 trainee, spoke about associating feeling annoyed at work with feeling like a failing on her part:

'…especially if you thought (.) you got particularly annoyed or something (.) that always feels a bit like a failing at work 'cause you're supposed to be very professional.' (Caroline, p12, 555-556).

The language she uses re-emphasises how deeply ingrained participants' idea was that there are particular ways that a Doctor is supposed to be and behave, and allowing others to see your emotion is not one of them.

Feeling isolated in their work seemed to be conflicting with participants' 'human' desire for connection, and was creating a sense that they were alone in their very human struggles, including the impact of their work on their mood. Sharing experiences in groups gave them a space to be with colleagues and allowed them to recognise that their colleagues were going through the same things. All participants expressed that many of the cases that they brought and heard had similar aspects or contained relatable scenarios. One thing that emerged from this was that it was not just the clinically challenging aspects of work that they had in common, but the personally challenging ones.

Reflexive Memo: *I could relate to the trainees' sense of isolation in their work, I was mindful of one placement where I worked in an office quite separately from the rest of the team within the setting and would stay there for most of the day only seeing clients. Due to my access to supervision I was able to explore this and increase my contact and communication with my peers and colleagues in order to reduce the sense of isolation and associated feelings of sadness, anxiety or of being impacted by client cases, I feel lucky to be in a profession where this is emphasised. I'm also conscious of the fact that on these days I was only seeing four clients, and had an hour with each, whereas GPs are seeing large numbers of clients with very short times to speak to patients and very short times in between consultations, which must make processing any feelings which have come up incredibly difficult. In a past job I was expected to see far more clients a day and had a much shorter period of time to work with them, and I recognised the impact this was having when I found myself hoping that they would not raise particularly complex issues, new concerns or become distressed as I could not afford a lot of time to sit with that. This has not happened in any of my placements during the DPsych, but again I am conscious of the impact of time and resource pressures and professional expectations on space for the human experiences of empathy and emotions. I wonder if this led me to place particular emphasis on these issues in recognising a tension between humanness and being a doctor (particularly these more relational aspects)? Something to hold in mind.*

Figure 3-2: Reflexive Memo (topic of isolation)

3.2.2 Recognising 'I am not the only one struggling'

This subcategory was very closely interconnected with reducing isolation, but evolved from the fact that participants described coming to this recognition in a slightly different way. The sense they got, through sharing experiences, of 'belonging', and their recognition of the importance of this related to the challenges the isolating nature of general practice posed to their need for connection with others. Whereas the recognition that they were not alone in their struggles related more to the conflict between their very human experiences of struggling and the tendency they identified to assume others were coping better with the demands of being a doctor than they were, that is imagining that others were *not* struggling, something else they connected to the idea of how a Doctor should be.

When describing what aspect of sharing experiences in groups she had found the most impactful, Caroline observed that:

'…you get to hear what people are struggling with so you feel less like… everybody else is having a spectacularly easy time while you flounder' (Caroline, p9, 417-419).

Lucy also identified this as something she took away from the groups:

'*I think the main thing that was a recurring theme that I took from it (.) was (.) that everybody struggles with very similar things' (Lucy, p2, 78-79).*

Related to this is the tendency that some participants recognised, in themselves, but also in Doctors more generally, to find it difficult to admit that they are struggling. 'Ben' (pseudonym), an ST3 trainee, referred directly to the fact that sharing experiences meant talking about cases where he was struggling or uncertain whether he had done the right thing, and said his confidence to do this had increased over his time in the groups. He also identified an increased awareness that struggling does not necessarily mean a lack of clinical competence or knowledge, something that previously would have made him reluctant to admit to it:

'I was sort of a bit (.) perhaps you know less confident at the start erm to discuss kind of where you feel like you've struggled a bit? (.) cause I think you know as Doctors I think we find it quite difficult to own up to when things have been you know less (.) less kind of in our favour because actually what we don't want to do is kind of highlight any um issues with (.) with clinical knowledge and actually it kind of (.) it's not about that at all' (Ben, p2, 64-69).

Recognising that he was not the only one struggling helped Ben to feel both more able to talk about his difficulties and more aware that this did not mean that he was failing or not competent as a doctor. He described this as a *'rewarding part'* of the experience (Ben, p2, 70).

Other participants described this process as reassuring, and said they went away from the RPGs knowing that their struggles are something *'lots of people face'* (Claire, p2, 76-77). This suggests that recognising that 'I am not the only one struggling' helped them to reconcile their struggles with being a doctor.

Most participants seemed to make use of the experience of sharing cases in groups as a way to get this reassurance from their colleagues. Caroline described bringing a case to the group where risk management had been involved, and although she had been quite confident that she had done everything she needed to, she described feeling some guilt, and some anxiety that she may have missed something, and described hearing her colleagues discuss her case and say that they would have done the same things she did as very reassuring:

'…It was really reassuring to have (.) some people listen hopefully objectively who aren't just your friends saying 'oh no, no we're all on your side 'still saying 'we see why this happened and actually we would have done the same thing' (Caroline, p4, 145-148).

It would seem, then, that for participants another element of recognising that 'I am not the only one struggling' is recognising that they are not solely responsible for their struggles, or that they are not struggling because they have done something wrong. Caroline was aware of struggling in relation to this particular case but rather than recognise this as a 'human' reaction to the situation, her inclination was to scrutinise her actions or wonder what she might have done wrong or missed. Hearing her peers in the group express that they would have responded to the situation in the same way reassured her both that this was a situation others would have struggled with, and that her struggles were not a result of a fault on her part. She distinguished this from speaking to family or friends, whose reactions would not have been as reassuring as hearing this from fellow doctors. This suggests that hearing from other doctors that they would have struggled or reacted in the same way helped her to reconcile her struggles with being a doctor.

Hearing other doctors describe their struggles or express that they would have reacted similarly in the same situation seemed to be helpful to participants in thinking again about what it means to be a Doctor, the extent to which they are reaching or not reaching a perceived 'standard' in this, and in realising that struggling is a common 'human' experience, despite it not being widely talked about outside of their RPG experiences.

3.2.3 Help-seeking

This subcategory emerged from the sense that GP trainees use the sharing of experiences in the group to get support and feedback from their peers/colleagues, and to seek help, ideas and perspectives in challenging situations. This is closely interconnected with previous subcategories. Participants described finding the process of sharing their cases and hearing other people's helpful

in itself, particularly in providing reassurance and reducing their sense of isolation. However, participant accounts suggested that they used this process of sharing experiences to seek help in different ways, all of which related, at least in part, to managing aspects of their 'humanness' as they arose in particular cases or situations.

'Jane' (pseudonym) an ST3 trainee, reflected that when bringing a case, her inclination was to describe it and then ask the group for 'help' in a general sense. She described finding it difficult to identify a specific question or focus for the discussion, something she had never experienced prior to her involvement in IRPP, and said this was something her whole group found difficult (p10, 425-430). Jane went on to say: *'I think if you've not done it before you're kind of like 'ugh just like help me not do that again!' (p10, 434-435).*

However, she reflected that she did think that having a focus was probably more helpful, because it reduced the risk of talking around a subject without ever actually identifying or getting to the real issue or concern. For Jane, an aspect of help-seeking was hearing what her colleagues thought the issue might be where she was unclear on this.

It was apparent from participant accounts that although they all described using the space to seek help, their ideas about what this help might look like, and about what was helpful, varied.

Some participants, like Claire, having shared their experience wanted to know what their colleagues might have done differently in the same situation, or how they might have approached it. For Claire, this helped her to clarify: '*is that the best thing to do or is it not, you know, just… thinking about… er… different approaches' (p7 317-318).*

'Sarah' (pseudonym), an ST2 trainee, described asking the facilitator if in one session the group could focus on a specific topic. She explained that she did this because she was aware of a struggle within her group to find cases to bring, or a reluctance to bring a case, and was conscious of the time this took out of the eventual discussion, but also because she found it more helpful to have a specific theme or focus in mind:

'…That would allow people to maybe think a little more about and like feel a little more prepared if like next week the theme is going to be… a difficult communication scenario, or if it's going to be an issue with a colleague then people have that awareness, ahead of time they might start thinking about topics that would fit with that and I thought it might kind of generate more conversation if people had those topics' (Sarah, p2, 76-80).

Sarah felt having a specific focus to the discussion would be more helpful for her in terms of her work, unlike Jane who found it hard to identify a specific focus and found a more general discussion where she was able to clarify or crystallise the issue by hearing the ideas of others more helpful. It is worth noting, however, that for both Sarah and Jane, a part of their reason for wanting or not wanting a specific focus for discussion was related to concerns about bringing a case, Sarah because she was worried that she would not be able to think of something and neither would anyone

else, and Jane because she worried about being unable to identify exactly what she wanted to discuss. This may speak to the nature of GP training as very structured, focused, and time-conscious, and the sense that any discussion which is less than clear and focused is either unproductive or feels uncomfortable. It may also suggest that for the trainees it was difficult to identify the non-clinical issues, or that to focus on these felt very different or potentially challenging, possibly insofar as they relate to considerations of emotions, values, vulnerabilities rather than clinical considerations.

The facilitator emerged as important to the process of help-seeking. For example, Ben reported that he would ask the facilitator for their perspective on the issues discussed. He described finding sharing difficult and often emotional experiences quite challenging, and said that one of his ways of help-seeking was to consider the facilitator's psychology background and ask them for ideas or strategies for managing his emotions:

'…I find (.) the discussion part is really useful with other colleagues (.) erm (…) and how you would translate that with kind of getting a bit of support in terms of how (.) you know how to deal with that kind of specific difficult thing […] *you know like there's a Psychologist then going 'okay now what we're going to work on is these tools which you can use to help distract yourself from feeling (.) you know (.) neglected' or I don't know whatever it is… because we only have a short amount of time with these patients so we need (.) what we need is (.) is a sort of a skills set to be able to kind of disarm our own emotional responses and go 'no no it's okay' you know quite quickly (.) erm (.) you know cause we only get (.) yeah ten-twelve minutes with our patients to (.) to kind of manage all of that' (Ben, p16-17, 693-703).*

Like Sarah's want for specific topics, Ben's feeling that he would like some specific ideas and strategies to take away with him into practice following case discussions for when difficult feelings come up may be reflective of the challenges they experienced with 'sitting with' difficult emotions or uncertainty, and their desire for specific ways to 'respond' to these. This could relate to the more solution-focused, problem solving nature of 'being a doctor', or to a sense that there is something unproductive about an open discussion which explores these feelings but does not necessarily offer solutions. Ben was open in saying he sometimes found that he would experience an increased awareness of emotions following these discussions, but then would experience the same tension between wanting to accept and acknowledge them as 'his' and important, and needing to 'get on' with his work as a doctor. His consciousness of the facilitator's counselling psychology training and background seemed to provoke him to seek help with this in ways he otherwise might not have.

The wide-ranging nature of help-seeking was apparent in other interviews. Lucy reflected that although people did come up with helpful suggestions in group discussions, for her the helpful aspect was more about having colleagues there to listen, and being able to do this for them. Sarah also recognised this, and reflected that when bringing a situation she had struggled with, the group

discussion would provoke her to think differently about it, and this would alleviate her difficult feelings or sense that she may have done something wrong:

'…what I found is often people would help me to reframe it in a different way (.) and I left having processed that negative emotion into something that felt more acceptable' (Sarah, p9, 430-432).

And Caroline reflected that bringing a case and hearing others' perspectives on it made her feel like she would find it easier to manage the same situation if it came up again, which suggests that just the process of talking things through was, for some participants, as helpful as practical advice:

'…If you discuss your own case you get some different perspectives (.) maybe some clarity hopefully on something that's causing you difficultly (.) and maybe (.) you're going to find it easier next time you find something difficult to think it through' (Caroline, p9-10, 419-422).

Finding it helpful to hear different perspectives came up in other interviews. For example, Claire said that when she was struggling with something, a helpful aspect of the groups was that she could: *'get loads of different people's views and perspectives, and… learn from the experience' (Claire, p11, 560-561).*

It was clear that for all participants, help-seeking represented something different, but they were conscious of using the RPG space for this through the process of sharing experiences. For some participants, the interprofessional nature of the groups provided an opportunity to seek help in ways they might not have done, or been able to do, previously. The idea that by seeking help with these things in groups they could improve their practice or create a better experience for patients seemed to help to reconcile their 'human' need for help with their ideas of 'being a Doctor'. As Ben put it:

'…because you know a happy clinician is a happy patient right? You know we can't do our job properly you know I definitely (.) erm (.) I've definitely had consultations where because the previous consultation has gone really difficult (.) really badly (.) that I haven't been that present emotionally for my next patient (.) erm you know and I think (.) that it's good to discuss those kinds of issues' (Ben, p14, 624-628).

For most participants, group discussions were a way of seeking *'peer support, emotional support and sharing ideas' (Alice, p7, 305)* which seems to incorporate their differing ideas about what help-seeking looked like. While participants seemed to feel more comfortable seeking help in a practical, problem-solving sense than 'sitting' with uncertainty, many participants found it helpful just to have colleagues hear about their challenges and offer different perspectives.

3.2.4 Offloading

This subcategory relates to participant accounts of using groups to talk about difficult cases, 'offloading' or getting them 'off your chest'. Although it emerged as an aspect of help-seeking, it also developed as a separate subcategory as it related very specifically to bringing a case themselves, whereas for all of the other subcategories the processes seemed to occur whether they were the one bringing their case, or were hearing and discussing cases brought by others.

It became clear that all of the participants faced difficult situations at work but that their conversations about these with supervisors or colleagues were very much focused on the clinical and outcomes side of these cases, with little room for just talking in a 'human' way about how difficult they were. This may relate in part to the idea that in the context of GP training, and work as a Doctor in general, discussions that are not practical or outcomes-focused are somehow unproductive.

Oliver expressed that his first thoughts about the RPGs were that they were going to be more of the same kind of reflections as the written ones he was required to do for his portfolio, and described himself as: *'pleasantly surprised that the groups were… a chance to share cases and… more just kind of have a chance to hang out and reflect' (Oliver, p2, 62-64).* He explained that at the time of starting the RPGs he was disillusioned with his training and struggling with the responses to the Covid-19 pandemic and the impact of these on his training experience and engagement, and identified the opportunity to offload in the groups as something he needed at this point:

'… it was a chance to vent as well. Which… normally in… as in if you were quite frustrated about a case you could bring that to… others to have a chat about. I remember one particular case that I brought in that setting and that sort of just allowed me to just kind of blow my top off a little bit when I was at kind of a nadir of er… of my clinical engagements at that stage.' (Oliver, p2, 75-79).

He drew attention to the formal nature of the group setting as facilitating this:

'Um… like a release valve, or a… a chance just to have a bit of a… a bit of space to kind of to unpack, maybe, I… I think it served some… Yeah, I feel for me it served some kind of function of… of formal space to relieve frustrations and to… not necessarily to seek feedback' (Oliver, p6-7, 281-284).

The idea of the RPGs as a space to unload was also identified by 'Tricia' (pseudonym) an ST3 trainee, who recognised that in her work she does not often have an opportunity for this:

'…it can help you get a (.) situation that you're struggling with off your chest and discuss it (.) like you might not have an (.) er an environment in work to do that' (Tricia, p5, 228-230).

Lucy also described the groups as a space for this: *'I think it allows you to unload a lot of things' (Lucy, p10, 465).*

Participants' language: 'unload', 'offload', 'vent', get things 'off your chest', 'blow your top' is suggestive of a build up of emotion as a result of difficult situations, which may have been due to the fact that trainees did not have a space to share their feelings, or feel it would be appropriate, as a doctor, to do this. In this way, groups seemed to provide a space where this felt more acceptable.

Like Oliver, other participants, including Jane and Lucy, drew attention to the nature of the groups as a 'formal' space to offload. This suggests that it felt important to participants that offloading was part of a 'useful' process. Lucy expressed that for her a part of what made the process of offloading helpful was the presence of an objective facilitator who 'sits outside' of her work context:

'I think er (.) hmm (.) having an outlet I think (.) er (.) having an object- an outlet that's with somebody objective (.) somebody who's not actively involved' (Lucy, p10, 459-460).

Caroline also referred to the importance of the facilitator in making this feel more helpful than 'just venting' as she had before:

'I suppose having somebody there who's trained to kind of listen and pick out [I: Mm] the thing that they think is essential so that you don't just go rambling on about how annoying the whole thing was (.) makes it a bit more (.) more productive in a different way than just venting to your friends [I: Mm] which is the only previous experience I've really had of discussing cases in that way' (Caroline, p3, 111-115).

The fact that using the RPG space to offload felt more productive for participants and reduced their sense that they were just 'complaining' may be reflective both of the fact that 'just' offloading in their day to day lives without necessarily seeking feedback or a solution did not feel acceptable or 'fit in' with their ideas of how doctors should behave, and possibly also their reluctance to 'just offload' outside of work, either because this did not feel productive or because it felt too much like 'taking work home'. Viewing the RPGs as a structured space for sharing their personal struggles with peers, in the presence of an objective person who could 'steer' the discussion, seemed to make doing this feel more acceptable, whether participants were actively help-seeking or just offloading. In this way, participants began to navigate the challenges difficult experiences, feelings of isolation and vulnerability presented to their ideas about themselves as doctors.

Extract from Reflexive Journal: *It has come up for me that my ideas about help-seeking are likely to be formed around my own profession and background, and I may be making assumptions about the way this differed for the GP trainees. My feeling that for some, open discussions, or discussions that did not end with any offer of explicit advice or help, may have felt uncomfortable or unproductive due to the culture around being a doctor did in part come from specific language they used when talking about this. However I am conscious that it may also have come from me. That they used the process of sharing experiences to seek help from their peers and from the facilitator was to all participant interviews and it was clear that they had limited space for this outside of the groups, particularly from the 'human' side (talking about struggles or difficult emotions). What is less clear is why some more than others seemed to need this to feel 'productive'. It is important to hold in mind that participants have come to this from different positions in terms of comfort with talking about emotions/struggles and different views on whether this is helpful/should be part of being a doctor. I also need to consider my own assumption that just talking about these things is helpful in itself and does not need to be solution-focused, particularly in light of the fact that these participants were still dealing with the daily realities of being a doctor. Asking for tools and advice may not have meant they did not think just talking about their struggles was productive, rather it may just reflect a recognition of the fact that while they were changing, aspects of the environment were not, and the need to manage this day to day. In my experience as a CoP trainee, I have sometimes found that I come to client work with an idea that giving clients space, sitting with their feelings and validating these rather than being more directive in offering advice or strategies, is the most helpful approach, but then have been challenged by a client who has said 'but what next?' RPGs are very different from therapy, but I can recognise that from the GPs point of view issues around how busy they are, time constraints, and also a sense that they can let their emotions out but then they are in a position of returning to the realities of the job, might impact on the extent to which they are comfortable to 'just offload', and when they might need something that feels a bit more practical.*

Figure 3-3: Reflexive Journal Entry (topic of help-seeking/offloading)

3.3 Category 2: Recognising and Processing Emotions

Participant accounts indicate that the sharing of experiences in groups led to them experiencing emotional responses to what they were sharing and hearing from others, either current or recalled from the time, and an increased awareness of the emotions of others in the scenario. For some, this was the first time they had realised that they had particular feelings and emotions in relation to the case they were bringing. For others, in hearing their colleagues bring cases they found themselves relating both to the content and to the feelings expressed about it. Others found that they began to process emotions they had been aware of but had not had the space, or been able, to sit with prior to attending the groups, or had believed that it was somehow not acceptable to feel them. But all participants described experiencing a level of recognising and processing emotions through the sharing of experiences, and the focus on this was something most described as feeling very 'new' or different.

Again this process of becoming aware they had been affected by their work and beginning to work through it seemed to occur whether participants were sharing their own case or discussing cases brought by others, and was something that developed over time.

3.3.1 Noticing my emotional reactions

It became clear throughout the interviews and analysis that participants felt they had to 'block out' or 'put aside' their emotional reactions at work. Some participants were aware of doing this, but

for most there was a sense that because there was 'no room' for this in their workplace, and because they felt that as a doctor they 'should not' be emotional in front of patients or colleagues, they had 'lost contact' with their emotional reactions to their work, in that they had started to think of themselves as not having any, were not aware of being affected their work, or struggled to identify what the feelings they were experiencing were.

In Sarah's interview she expressed:

'…it wouldn't be normal if we were crying in front of our patients or screaming at our patients so it's built into our practice that we keep our emotions very tightly guarded' (Sarah, p5, 221-223).

The language Sarah uses, *'it wouldn't be normal'*, is suggestive of the idea that there is a 'normal' or a 'right' way to be a doctor, which showing emotions is not a part of. And her implication that if Doctors were to show emotion it would lead to 'crying in front of' or 'screaming at' patients is suggestive of a conception that for her, and possibly doctors more generally (as Sarah uses the word 'we' to denote herself as part of this group) there are only two choices: showing outbursts of emotion (crying, screaming) or no emotion at all. This seems to relate to the sense participants gave that expressing an emotion at work represented failure or incompetence, or that it is unprofessional to express emotion in their workplace, and suggests that they felt in order to 'be a doctor' they needed to shut themselves down to this.

Participants described beginning to recognise those feelings that they had shut down or been unaware of in the RPG space. Jane recalled an experience where a group member brought something they had claimed happened quite a long time ago and had expressed uncertainty that it was 'worth discussing', but then became quite emotional while talking about it:

'…sometimes we would talk about this one that (.) um (.) whoever was bringing it thought (.) you know wasn't (.) really needing to be discussed but just cause there wasn't another one um (.) then (.) the discussion would be really good and like you could (.) the person bringing the case would (.) either get quite emotional or just (.) kind of (.) go (.) you know you could tell that actually it was (.) as important and as (.) like needed to be discussed as something that had happened yesterday' (Jane, p4, 145-150).

Lucy also recognised this, expressing that the process of talking about something can lead to a realisation that you did have an emotional response to it:

'I think as well that perhaps you have a (.) an idea or a feeling about something (.) and then only when we raise it to others and you get their input that perhaps actually that (.) your perception changes of how (.) little or a lot that mattered to you or (.) your behaviour in that situation might have

(.) impacted your perception of (.) yourself or (.) your professional work or whatever it is (Lucy, p4, 175-179).

Jane described these as some of the more impactful moments in the groups for her, to which she had also had an emotional response, and identified that the facilitator played a role in this:

P: '*… it's just (.) kind of (.) a lot (.) cause a lot of the cases are very relatable so if (.) even if it's not your case you're kind of like 'oh I (.) feel like I've been in a similar situation' or you know I (…) understand how that feels (.) um (.) so I think it is (.) quite emotional I think it's also quite um (…) kind of in that (.) kind of (.) situation (.) um (.) with everyone kind of talking about your experience and what happened it is quite an emotional environment isn't it? Erm*

I: *Mm (.) Mm*

P: *And then I feel like part of that was probably also the (.) environment that our facilitator created (.) kind of (.) allowed that to happen I couldn't (.) I could see in other groups that it wouldn't (.) feel (.) you wouldn't feel as (.) able to kind of (.) express that emotion as much.'*

(Jane, p4, 159-171).

For most participants, noticing their emotional reactions seemed to come in part from hearing colleagues' accounts of situations they could relate to, and recognising their emotions in themselves. As Claire put it:

'…sort of recognising the impact it does have on you. 'Cos often you sort of go through… you have a really stressful day and you often don't… you just go home and you try to block it all out. And you don't really think about it. But then cases… times like this when you can discuss it with colleagues makes *you think about it' (Claire, p13, 570-573).*

Claire's sense of not wanting to take her emotions home so trying to 'block them out' was common across participant interviews. It is notable that she highlights the group context as 'making' her recognise not just the emotions themselves, but her tendency to do this. This is something Jane had also alluded to, but for Jane the facilitator also played a role in creating a safe environment for this.

Sitting 'outside' the group discussions after bringing a case also seemed to facilitate participants' 'noticing' their emotional reactions. Sarah said this *'allowed me to feel a lot more' (Sarah, p5, 205)*. She also recognised that it had allowed her to begin to process her feelings, which in general she tended not to do:

'Processing them rather than just letting them sort of sit in your subconscious and then like I say that comes out in how you act and how you feel, whether you know it or not, you know it's subconsciously affecting how you behave in all aspects of your life. So yeah, being able to process emotions is important for our job it's something we probably just don't do a lot' (Sarah, p5, 229-232).

Sarah's words further highlight the tendency of participants to refer to 'doctors' in general terms and place themselves in that group in relation to particular behaviours and reactions. Her assertion that processing emotions is important for a doctor suggests that again, the idea that doing this has the potential to make her better at her job helped her to align this human experience with being a doctor.

Generally, participants spoke about becoming more aware of their emotions in positive terms, however Ben reflected that it could be draining: '*I definitely think when you're (.) when you're doing it it is emotionally exhausting' (p11, 483),* and questioned whether this might make some people reluctant to do it: *'…some people might find it distressing (.) erm and (.) I know that I would find it distressing if I'd had a particularly difficult morning' (Ben, p11, 494-496).*

Jane also reflected that this emotional aspect of the groups could be quite intense. However all participants described finding something helpful about becoming more aware of their emotional responses.

3.3.2 'My emotions are valid'

This subcategory was named following Ben's interview, and relates to participants' accounts of experiencing a growing sense that their emotions were valid.

Caroline had expressed that if something annoyed her at work she was always left with a feeling of guilt or failure, and said that hearing others in the group say that they would also have felt that way in her situation helped to relieve this:

'…it's quite nice to hear that other people would have been annoyed or (.) someone helps you clarify why you were annoyed (.) and that's helpful and sort of lifts some of the (.) stress or guilt or whatever it is you have associated off the case' (Caroline, p12, 557-559).

It is notable that she also identifies others helping her understand *why* she was annoyed as supporting her sense that this feeling was valid.

For Oliver being a part of the IRPP and the VTS programme in general provided an opportunity to hear from colleagues at different stages and with different levels of experience and recognise that they were all going through or had been through similar things, which he found validating:

'I think it can give you a sense of confidence that… um… that there's always going to be uncertainty um and… have kind of validating that from… cause the nice thing about the VTS programme is it generally is people from all walks of life entering' (Oliver, p13, 583-586).

He had described himself prior to beginning the groups as *'frustrated and despondent' (Oliver, p10, 426)* and found that hearing from others helped him recognise that uncertainty is something that everyone goes through and would probably always be present, and increased his confidence that he would *'get there' (Oliver, p13, 593).* Although Oliver's experience related more to his sense of himself as a GP trainee in the context of Covid-19 than as a doctor in general, he was still conscious that the groups gave him the opportunity to process how he was feeling and a sense that his feelings were valid, and in this way helped him to acknowledge and accept his uncertainty.

Ben spoke explicitly about the groups giving him a sense that his feelings were valid, and described this as having an impact on him in his work:

'it's definitely helped me feel like (.) even after a difficult consultation that I'm not (.) you know my emotions are valid and like my sort of thoughts and feelings are valid' (Ben, p9, 408-410).

It was clear across the interviews that whether participants were aware of strong emotional reactions within the groups, or they felt more of a general sense of uncertainty, frustration or disillusionment around their experiences and themselves as a doctor, group discussions gave them some sense of validation in this. This would seem to interconnect quite closely with the sense that 'I am not alone', in that feeling they were justified in their reactions and that others were also having these helped to reconcile these 'human' experiences with being a doctor.

Reflexive Memo*: I was really conscious of wanting to relate to the GP trainees during the interviews when they brought accounts of experiencing training during Covid, so was quite impacted by Oliver's interview and his sense that his training experience was not what he had expected, and the uncertainty and doubt that can come from that. As previously mentioned, I have found interacting with colleagues the most validating part of my experience, particularly during that period although this has continued throughout my training. There is something important about realising others are experiencing the same thing and without that space to get together this can sometimes get lost and lead to a feeling of being 'alone' with your emotions, or a sense that perhaps you should not, or do not have a good reason, to be feeling that way. While I did not, as far as I can see, bring my own experiences of training during the pandemic to my responses to Oliver (in fact I was so mindful of trying not to that I perhaps did not explore this topic with him as deeply, in terms of how it impacted the way he used the groups, as I could have - and interestingly only explored this with other participants as it related to having some RPGs online, perhaps again due to a fear of bringing too much of my own 'lens') it is likely to have impacted my interpretation of these aspects of his interview. Did I over or under-emphasise the impact of covid (particularly as it impacted on feelings of isolation and the 'human' need for connection?) Hold in mind in terms of context of trainees involvement in IRPP - and therefore this study as a whole.*

Figure 3-4: Reflexive Memo (Covid-19 as context)

3.3.3. Permission to focus on feelings

Something else which came up across participant interviews was the sense that the RPGs gave them 'permission' both to feel and express their feelings about their work and life as a doctor. This sense of permission seemed to come from the positioning of groups as part of their training, but also the way the groups were conducted.

For Sarah, the purpose of the RPGs for was allowing herself the time to process emotions and difficult experiences, which was not a part of her work and she did not build into her personal life. She expressed that without protected time for this, she would struggle with competing priorities and feeling that there were other things she 'should' be doing:

'*…like actually prioritising that because it's very easy to say 'oh I could be doing… I could be studying something or I could be doing something that's more productive, um… which is often our temptation. But… actually saying no this is important time, and allowing myself to participate is a good use of time' (Sarah, p10, 464-467).*

For Sarah, this felt particularly important: *'people have to be allowed time and space to talk about how they're feeling' (Sarah, p14,670-671).* Oliver identified something similar, describing RPGs as formalising the process of exploring thoughts and feelings (his own and colleagues'), but distinguished it from compulsory reflections for his portfolio:

'…again it gives you a space to think with others who are on the same journey about what you're doing – in a formal way. It kind of forces your hand on that. But not in a way that feels like '…okay now you've got to do this thing, and you've got to put it in the portfolio', it's like… here's a space to be human about it' (Oliver, p13, 604-608).

His expression 'here's a space to be human' suggests that his perception is there is not much room for 'being human' in the medical/training context, but also alludes to a differentiation between being a doctor, or GP in training, and 'being human'. Groups allowed for more 'human' interactions and emotions, but in a way that was formalised as a part of training, so possibly felt more acceptable, or easier to align with being a doctor.

Jane also referred to this sense of RPGs as a formalised space for exploring the emotional aspects of work:

'…kind of having some time (.) to like to share things in like a slightly more formal confidential space that isn't (.) is kind of work but it isn't kind of work is helpful' (Jane, p11, 472-474).

For Jane, having the groups as a part of work/training made her feel that exploring her and others' emotions in sessions was part of being a doctor, like Oliver for whom the groups were a space for the 'human' side of his training journey.

All participants described the facilitator as playing a part in this by steering discussions away from the clinical side of cases and towards the more emotional aspects.

Tricia described the facilitator as 'pushing' her group to go more deeply into things:

'…the facilitator just makes you really push yourself into thinking and like (.) being more reflective and thinking about things a bit more rather than (.) just let everyone (.) you know (.) touch the surface' (Tricia, p3, 114-116).

Alice also noticed this, and related it back to the idea that although the discussions were about work, the RPGs were not work, so allowed for the more psychological and emotional aspects of being a doctor to emerge:

'…because this is kind of taking a step back from (.) or a step away from the working environment or (.) as you said there's that emotional or psychological side of it that we don't (.) always kind of approach in our kind of practice (.) or even have time to I guess '(Alice, p7, 301-304).

Whether it feeling 'allowed' to focus on emotions, or a sense that they 'had' to do this in groups, all participants identified this permission to focus on feelings as something outside their usual experience, and which facilitated the recognition and processing of emotions by creating a dedicated space for it and making these very 'human' experiences (as Oliver described them) feel like part of being a doctor.

3.3.4. Others recognising my feelings

This subcategory relates to participants' accounts of recognising emotions they had been unaware they had by virtue of these being identified or pointed out by colleagues or the RPG facilitator.

Tricia identified a moment which had stood out for her where the facilitator had drawn attention to a theme in what she was discussing which resonated with her:

'…she said (.) erm (…) you know (.) I'm picking up a theme that you think you're colluding with someone (.) erm (.) is that right? 'and you know 'what do you think can you expand on that a bit more? 'So (.) you know (.) it's not necessarily something you've even thought of (.) but then when she said it you think 'oh yeah I am' (Tricia, p3, 105-108).

The facilitator's identification of what was behind the aspect of Tricia's case that she was struggling with encouraged her to think about a deeper aspect of her experience and explore her feelings about it.

Caroline also identified this, and said it reminded her of conversations with someone she knew who is a Therapist:

'…*that skill of listening to you ramble for half an hour about something else and going 'I think this is what's going on' and you sort of go 'oh yeah that is what's going on* '[I: yeah that ability…] *(.) who had pinpointed that I was annoyed by the whole thing which was (.) absolutely true and oddly I hadn't really noticed (.) erm (.) and then when I came to the group (.) there was a lot of (.) I don't know I suppose it just clarified (.) I - sort of underlying the whole situation really didn't think that I'd done anything wrong' (Caroline, p3, 131-136).*

And Lucy, who described herself as having had no previous experience of counselling, identified this as the most important aspect of the facilitator's role in the process, and the one that for her had had the biggest impact:

'…sometimes the facilitator would say […] *I seem to notice that (.) you all have this feeling of X '(.) which is in (.) like almost subconscious that we don't think about so sometimes thinking about that can be quite helpful just to (.) kind of erm (…) I suppose enrich the kind of conversation and take it to a slightly different (.) level' (p12, 531-535).*

Lucy highlighted the fact that in a context where there is an expectation that it will be busy and challenging, and that this is the nature of the job, the awareness of feelings, or the lack of them, is not always there, and emphasised the importance of having another person recognise how she is feeling and point this out to her. She related this to an earlier experience of burnout, which at the time she had not recognised.

Sarah also identified this, emphasising the importance of talking to people in recognising thoughts and feelings you might be unaware of:

'…if you don't actually reflect on why you're thinking the way you are, and why that's making you feel the way you do, and why that's influencing your actions, then people can get stuck in thought patterns, like negative automatic thoughts, and things like that. And if you're not talking about it with people then you're not recognising those things' (Sarah, p3, 129-132).

Like Lucy, she highlighted the importance of the groups in facilitating this.

This is quite closely interconnected with recognising emotions as a result of hearing others talk about their experiences, and suggests that in RPGs participants were able to begin to recognise and explore their own emotions, whilst also identifying the emotions of others and having this reciprocated. The facilitator's role in this was apparent across the interviews, even where they picked up on themes participants were unsure were important, something about this served to prompt

deeper exploration. It seemed that there was a relational aspect to this, in that where participants were responding automatically, 'as doctors', rather than as people with emotion, others were able to draw their attention to this, and vice versa.

3.4 Category 3: Developing Empathy and Compassion

Sharing experiences and recognising and processing their emotions seemed to lead to the development of greater self and other awareness in participants, which supported the development of empathy and compassion, including self-compassion. Participants generally agreed that in becoming more aware of their and others' emotions in relation to the challenges they all faced as doctors, they were able to be more accepting of those aspects of themselves which did live up to their ideas about what a doctor should be, or those aspects of being a doctor which were not as they had imagined. The development of empathy and compassion extended to their colleagues and patients, which participant accounts suggested served to mediate the impact of difficult situations in their work.

This process has four elements: experiencing empathy, empathising with others, recognising limitations and boundaries, and 'being kinder to myself', which are expanded on below:

3.4.1 Experiencing empathy

This subcategory was named following Sarah's interview, where she described her experience of hearing the group discuss her case:

'…it feels quite cathartic to listen to other people, and sometimes when you hear them discussing you they're discussing it with such… with such empathy and compassion for you that you might not be giving yourself' (Sarah, p5, 195-197).

When explored further, Sarah explained that experiencing empathy from her colleagues made her realise how hard she usually was on herself:

'…*I thought 'oh my gosh these people are explaining my scenario with such empathy and compassion for me that I don't allow for myself', I can be quite hard on myself and… yeah it felt quite refreshing after - after that experience to think 'oh I've allowed myself to feel this… like gentleness towards myself or… you know - it was… I think I just felt more (Sarah, p5, 207-211).*

Jane described her experience of empathy in the groups as hearing others talk about her case and express that they understood how it felt to be in that situation. She said that for her this could be quite emotional.

Lucy also recognised experiencing empathy as an important aspect of her group experience, something she felt was as important as actually offering any suggestions when discussing cases. Lucy referred to this in the context of being able to empathise with others, and having that in return: '*you can understand other people's issues and (.) empathise* […] *um and that is reciprocated (Lucy, p11, 470-472).*

This relates very closely to the other side to experiencing empathy described by participants, that is empathising with others.

3.4.2 Empathising with others

Participants described experiencing empathy for their peers in groups, but also for colleagues and patients. Claire reflected on this:

'...It might make you feel… it might make you more aware to what other people are also going through, or… potentially… having a bit more empathy with a scenario or a colleague' (Claire, p6 277-279).

Her linking of this with awareness of what is happening for others re-emphasises the significance of the feelings of 'aloneness' participants described prior to engaging in groups, partly due to the isolating nature of GP practice, and partly due to their sense that they were the only ones struggling. There is a clear interconnection between recognising that others have challenges, developing a sense of shared experience and the development of empathy in participant accounts.

Caroline identified this but related it not just to her peers in groups empathising with her situation, but also them encouraging her the perspectives of others in the situation:

'hopefully we all have some empathy or we try (.) but you can forget it in the middle of your stress and clinical annoyance (.) and almost always when you're discussing it someone will make the point (.) if you're saying you know that they (.) 'I was finding this patient really difficult and this was happening 'they'll sort of say 'okay why do you think they were doing that?' […] *and (.) the more times that c (.) occurs to you I suppose the more likely you are in your (.) angry hungry moment to be able to hold onto it' (Caroline, p8, 345-352).*

Caroline's experiences of stress, anger and hunger are very natural 'human' experiences, but in the context of being a doctor make it harder for her to bring the empathy or compassion for the patient she feels she should be. Being encouraged to reflect on how the other person might be feeling helped her to 'hold on' to her empathy, which in turn had an impact on the level of her stress or frustration and helped her to align the personal with the clinical side of the consultation.

Tricia described her RPG experiences as having a similar impact on her:

'…in the past I've not really had a thought 'ooh they must be going through some terrible stuff if they're being that horrible or that rude 'erm but I think that (.) I continued with that kind of thought' (.) so I (.) that's a new think I've gained from doing these groups which I never really used to think about before (Tricia, p6, 247-250).

Like Caroline, she reflected that developing some empathy for what a colleague or patient might be going through, something she had never done before, helped to mitigate the emotional impact of their behaviour towards her.

Jane described this as 'taking a step back', which is suggestive of the idea that developing empathy made it easier to distance herself from situations which she had previously got caught up in and as a result was more personally affected:

'…I think I (.) try to do that a (.) or find myself doing that a bit more kind of taking a step back and thinking about 'ah like you know (.) why have they reacted like that or what's important to them in that (.) this situation?' (Jane, p5, 219-222).

Participants' increased recognition that they are having particular emotions and reactions to a situation, and that their patients and colleagues in that situation might also be experiencing particular emotions and reactions which are influencing their behaviour, seemed to result in a diffusion of their own emotional/behavioural response which was conflicting with 'being a doctor' in a given situation. Most participants had described a sense that they were 'shut down' to emotion or that if they were to acknowledge emotion at work this would be unprofessional, constitute failure or lead to emotional overwhelm which would make them unable to do their jobs. However across their accounts of experiencing and developing empathy was a clear process of beginning to recognise that there is a space for feeling emotion themselves, and acknowledging emotion in their patients, within their ideas of being a doctor. And that in fact, this can make the 'human' reactions they inevitably experience at work feel easier to manage as less impactful on their sense of themselves as doctors.

For most of the participants, experiencing their colleagues' empathy for them and empathising with colleagues who had been in similar situations seemed to lead to a greater willingness to encourage one another to think about what other people in their scenarios thoughts and feelings might have been, and a greater awareness of this in their work.

3.4.3 Understanding my limitations/boundaries

This subcategory developed from the sense I got from the participants' accounts that developing compassion for themselves meant a recognition of what they could and couldn't do and

acceptance that they were only human, not robots or machines, and could not 'do it all' as they might have felt they should be able to as doctors.

Sarah identified a tendency, which she felt was common amongst Doctors, to feel there is a certain standard she should be attaining all the time:

'…amongst Doctors um we… we very much have that way of thinking and being is that… there's a lot of like personal responsibility in… if you're not achieving as well as everyone else then there must be something you're doing wrong' (Sarah, p12, 553-555).

She also identified a tendency to compare herself unfavourably to others and feel she was not as good a doctor as them *(Sarah, p13, 611-612).* Again her use of a collective description of doctors is reflective of participants' strong sense that doctors are 'all' a particular way and need to position themselves within this.

Sarah's feeling that there is a particular standard, and level of achievement, to be met in order to feel like a real doctor, combined with a sense that 'everyone else' is reaching this, was identified by other participants.

Claire described a feeling that she had to get things 'right' or do things perfectly every time, and should be able to do it all. She reflected that participating in the groups had caused her to rethink this, which had affected her professional identity:

'…it sort of helps you recognise your limitations, or… whether you're… sort of… doing too much or trying to do too much, or… um… so I think yeah I do think it helps you… reflect on how you are as a professional, as a Doctor. Um… and it just gives you that space to think about how you might approach something differently to somebody else' (Claire, p7, 313-317).

An idea that continually emerged in participant accounts was that there is a 'right' way to be a doctor, and part of this involves not admitting to any limits on what you are able to cope with. Claire's reflection that her experiences in the groups allowed her to rethink this and consider how she might do something differently, or have different limitations, from someone else without this meaning that one approach was 'better' or more like a doctor than the other, is a reflection of her beginning to reconcile her own strengths and weaknesses with being a doctor. She went on to say:

'So I do think… so for example with the… with very complex cases where you wish you could do more, I think I now… you know I sort of now say to myself 'well I can only do what I can do, and this isn't something unique to me', so I think it… it gives me that little bit of… guidance and ability to… look in on it in practice and say 'well, I know I can't… go this… a thousand extra miles for this person so I have to do what I can do' (Claire, p8, 334-339).

Recognising not just that she could not do it all, but no one could, was important for Claire in recognising that she was only human, with limitations and differences from others, and reconciling this with being a doctor.

The sense that doctors should be able to do it all, and that trainee Doctors should not say 'no' when asked to do something, even if it was over and above, came up in other interviews. Lucy reflected on the fact that she had gained a recognition in groups of the importance of knowing and asserting her boundaries, and not letting her anxiety in relation to conflict or confrontation prevent her from doing this:

'I think having boundaries really does help you day to day and I think it does sort of set up your relationships better moving forwards because otherwise you do just end up (.) I think (.) you do reap what you sow sort of thing so if you just allow people to constantly ask you to do things that are not your job or above or (.) not that they're doing it out of any kind of malevolence but you do end up in a situation where you're just getting more and more stressed you're going to then (.) be worse off and (.) do things in a less effective manner (.) erm (.) so I have found that (.) it's made me (.) er (.) conscious that I should actually say these things' (Lucy, p7, 294-302).

Lucy reflected that in her experience, particularly in general practice, there was a question over whether it was actually okay, as a doctor, to have boundaries: '*there was a disagreement that actually it was acceptable to have professional boundaries (.) even as a trainee' (310-311)*. However, she made it clear that for her recognising her limits and having boundaries was important in enabling her to work effectively. This shift from feeling that to have 'human' limitations and put boundaries around what she was prepared to do as a doctor was indicative of being unable to meet the required standard to feeling that in fact recognising and asserting these things meant that she was actually able to work more effectively is an indicator of developing confidence in herself as a doctor.

Sarah also reflected on this, and emphasised the importance of talking openly in changing perceptions of what it means to be a doctor:

'…being open and discussing these things is the only way to kind of change… change how you feel about yourself, change your identity, or feel like you are a real Doctor, feel like, you know… you do deserve to be where you are. Um… and that only comes out if you're open and honest with other people about how you're feeling' (Sarah, p13, 615-618).

Her words further reflect how deeply ingrained ideas of what a doctor should be were amongst participants, even those who had worked has doctors for a considerable time before training as GPs. For Sarah, acknowledging feelings and recognising her limitations and boundaries, helped to mitigate the sense that being unable to do it all meant she was failing. Participants in general seemed

to be starting to recognise that however much they care, everyone has their limitations, something that in their previous experiences as a doctor had not been acknowledged.

3.4.4 Being kinder to myself

This subcategory emerged directly from participants accounts of recognising that it is possible to be a doctor and still to acknowledge, and assert, your (human) limitations and boundaries. Sarah's identification of a tendency to be hard on herself was echoed by Claire, who said that the groups had helped her to be less so:

'I think it helps, it does help to give… try not to give yourself such a hard time and um… you know… sort of um… give yourself a bit of a break, I guess' (Claire, p8, 346-347).

She had previously reflected that having the group space to discuss difficult experiences with colleagues:

'…does impact your sort of… overall wellbeing and your overall… um… sort of… er… what's the word? Er… ah, sort of self-understanding and being kind to yourself, like, you know, you're not going to get things perfect every time and… other people have the exact same thing' (Claire, p7, 301-304).

Ben also recognised a tendency to impose high standards on himself, particularly in relation to consultations, and expressed that the groups had helped him not to expect himself to be perfect:

'…you know not all (.) not all consultations are perfect and they're not meant to be even (.) even fully qualified Doctors' (Ben, p9, 415-416).

Recognising that even fully qualified doctors do not have 'the perfect consultation' every time helped him to be less hard on himself and represents something of a 'letting go' of his ideals about being a doctor.

Other participants found having their reactions in particular cases validated by colleagues on groups, or hearing colleagues express that they had similar boundaries, helped to mitigate their negative feelings about themselves as doctors. Caroline in particular identified that this alleviated her natural tendency to feel *'guilty about things… and… always assume I am at fault' (Caroline, p3, 137-138).*

For Lucy, being kinder to herself was a process of recognising when she is struggling and accepting that she might need help:

'*…it's definitely made me more conscious of (…) actually thinking about (.) the way I'm dealing with things and the way I'm feeling and (.) er (…) accepting it I suppose? And accepting that it might not be normal (Lucy, p9, 376-378).*

Although in a past experience of stress in her work, Lucy described not being conscious that this was happening, and therefore not linking it with trying to 'do it all' to meet the standards for a doctor, she did say she was aware that the very fact that she did not recognise what was happening, and in fact thought it was 'normal', was influenced by the culture in medicine of just getting on, and not questioning when something might be indicative of struggling emotionally. The sense that there is 'no space' for these conversations within being a doctor is something that for some participants reinforced their sense that they were alone with their difficulties and therefore were failing. Recognising this as more of a common or human experience seemed to help them to 'give themselves a break', acknowledge that no one can 'do it all', and recognise when they might need some support. This helped to align the fact that they were only human, had their own strengths and frailties and could not do everything perfectly all the time with their sense of themselves as doctors, and is indicative of developing self-compassion.

Reflexivity: *I can relate personally to the theme of empathy and compassion, and the important differences between the two. I have always been quite 'close' to my emotions and consider myself an empathic person. Even as a child I can recall being upset for others if I saw them in distress, and feeling personally impacted by things I could see meant a lot to others. This was a helpful thing to bring to my work prior to beginning CoP training, but also took its toll because I was working in a School and found I could be particularly impacted by hearing the distressing stories of children. While I was able to bracket this in order to be helpful to them during sessions, often afterwards their stories stayed with me, which could make it harder to manage the emotional impact of the work. When I started on the DPsych I found that through my training, supervision and access to regular personal therapy, I continued to bring my empathy to my work with clients, but this began to develop into something which felt more helpful and less personally impactful, which I now recognise as the development of compassion. When working with clients I consider it can be very helpful for them to see that what they bring has an impact on me, it can validate their feelings and facilitate a deeper connection, but I can only do this in a safe and helpful way if while feeling for them, I am not experiencing their feelings as my own. This development of compassion has made it possible to hold on to my empathic nature without it taking too great a toll on me. I have also noticed a greater willingness to give myself a break, having been quite hard on myself in the past, and this self-compassion has also helped me manage the more demanding aspects of training. I brought this personal experience into interviews with trainees so tried at all times to be aware of the impact of this on my interpretations of their accounts of developing empathy and compassion through the groups.*

Figure 3-5: Reflexivity (theme of empathy and compassion)

3.5 Category 4: Developing Understanding and Skills

This category relates to the ongoing development of understanding, including self-understanding, and new skills in the groups. This category all of the others, in that the development of understanding and skills which participants were ultimately able to integrate into their work (and beyond), was apparent in, and enhanced by, the processes of sharing experiences, recognising and processing emotions, and developing empathy and compassion over time.

3.5.1 'Just' listening

This subcategory emerged from participants' accounts of bringing a case to the group and sitting aside while others discussed it.

Sarah referred to this experience as something that did not feel 'natural' or 'normal' to her at first:

'And that… was just such a unique experience because it's… it's not natural. It's not how a conversation would go. There wouldn't ever be a time when you were just quiet for ten minutes while other people discuss what you've talked about. So that was a really unique experience of 'I'm just listening right now, I'm not… trying to think of what to say next, I'm not trying to be involved in this, I am just listening, and taking this in for ten minutes. Um… and that… that stood out to me as a just such a new experience um and something that's really helpful and helps… it really helps you to listen' (Sarah, p4, 184-191).

Sarah recognised this very new experience as something that changed her thinking and was helpful in enabling her to notice and experience her feelings more.

Tricia and Jane also identified this as completely new to them, and acknowledged their tendency to want to 'jump in' when others were discussing their cases *(Tricia, p4, 158; Jane, p3, 103)*, but both identified benefits of not being able to do this. Jane in particular identified that it had made her listen more attentively to what was being said:

'…Erm (…) but I think kind of knowing that you can't do that means that you *are more actively listening to what people are saying (.) because you know that your (…) you know (.) it's not your responsibility to reply or to (.) kind of give your point of view you are literally just there to hear what they're saying' Jane, (p3, 105-108).*

She went to say she had continued to use this skill in her conversations with people outside the groups:

'…listening (.) giving people time to like (.) finish what they want to say (.) and like (.) listening to it actively as opposed to just waiting for your next thing to say' (Jane, p6, 271-273).

Lucy also recognised that she found it difficult to *'keep my mouth shut'* (p3, 130) when listening to others in the group discuss her case, but she recognised that this was helpful for her in learning not to talk:

'I think I just (.) erm (.) I can be quite talkative [laughs] so I think sometimes it is quite good to just learn to like stop speaking' (Lucy, p3, 127-128).

Ben described the chance to develop his listening skills as one of the things he found valuable about the RPG format, and said this had developed his clinical practice:

'*I think probably (.) you know thinking about it actually sitting there and listening (.) um and not having a chance to kind of (.) you know directly comment on (.) everything that was said it actually sort of (.) I find it quite useful to be able to (.) to um (.) improve your listening skills? Because actually (.) you know er (.) if you (.) you know (.) if people kind of disagree with the way you've done something and then they (.) they say that (.) and then you (.) your immediate response is to want to defend yourself (.) um and actually that's not particularly helpful you know if you're trying to sort of (.) understand clinical practice from different points of view and how to develop your own clinical practice then better is probably to kind of sit there and listen' (Ben, p5, 188-196).*

His recognition of a lessening of the pull to defend himself if he heard different opinions on a scenario he had struggled with may be linked with a reduction in his sense that he should not be struggling or getting anything wrong, as hearing these opinions felt less challenging to his ideas of himself as a doctor.

Alice identified that by listening more closely rather than contributing she was able to more fully process what was being said:

'I think it allows you to have that time to sort of process it and really sort of listen to other people rather than (.) being involved in the discussion' (Alice, p3, 102-104).

For all participants, this represented a 'new' way of listening and being involved in a discussion. Most identified that what made it difficult was it how different it felt from the rules of 'normal' conversation. Several participants found the process somewhat uncomfortable at first, or as a daunting prospect coming into the groups, but a common theme seemed to be that it facilitated the development of a more active way of listening, which allowed for both the emergence of feelings and a deeper processing of the information they were receiving from the other.

3.5.2 Responding without bringing 'my' scenario

This subcategory is related to the development of participants' ability to 'just' listen, and was raised by most of them as a new way of approaching discussions which they developed in groups.

Most participants recognised a tendency to respond to others' scenarios with one of their own. Like the tendency to jump in when listening to others discuss his case, Oliver described this as *'quite*

normal as a human to do' (Oliver, p3, 136) highlighting again that for a lot of participants their experience in the group represented something completely different and something that did not feel natural, particularly at first.

All participants described hearing colleagues bring cases to the group that they could relate to, and for a lot of them this created the pull to share their similar scenario in response, which was something that was discouraged in the groups. Jane identified this as something which has stayed with her:

'you know even if you do relate to the story you don't tell your story because it's their *story (.) And I notice that so much now in (.) kind of (.) work conversations or just conversations with friends where someone's telling a story that they obviously want to debrief about and everyone's just like (.) piling on with their (.) you know (.) experience (.) which is (.) you know can be helpful but at times it also just distracts from (.) theirs' (Jane, p5-6, 229-234).*

Alice also reflected on the tendency to bring in your own stories when hearing a relatable scenario from a colleague, and acknowledged that it is difficult not to do this:

'I think it's difficult not to relate it to yours but (.) I think it can (.) one of the things that you know we'd always said in the groups is that (.) um we shouldn't be sort of talking about anecdotal (.) like bringing your own stories in (.) um (.) but you often find that people do just because everybody has a story that's (.) that's similar I suppose' (Alice, p3, 129-132).

Both Oliver and Tricia reflected on the role of the facilitator in pushing them, and their groups, to approach the discussions in this way. Oliver recalled:

'I think she… just kind of invited perspectives and questions that were… were just different from our own, and that kind of forced us to think. But also set some rules that were helpful in terms of… er… not sharing your experience as a answer to narrative, you know, which is kind of quite normal as a human to do, that's how I've experienced it, this is what happened with me, but… thinking more about the quality of what happened to the other person trying to share their story. I think that was useful technique. Um sort of commenting on what they're saying, what they are experiencing, what they are feeling – maybe through the lens of your own experience but not by saying 'and this is my experience' so that it distracts from what is being brought. '(Oliver, p3,133-141)

Oliver's assertion that contributing your own scenario when someone brings theirs is natural *'as a human'* to do, is interesting, in that unlike the other processes identified by participants which they described as feeling 'more' human than their other experiences as doctors and in training, the development of this particular skill, initially, felt counter-intuitive to their natural, 'human' reactions.

Ultimately, however, this skill seemed to help them to navigate their own and others' human experiences, because by listening more actively, not just waiting for their next chance to talk or responding with their own scenario, they actually heard others' experiences, and thoughts about their experience, which helped them not only to recognise they were not alone in their struggles, but to find ways to support one another.

Oliver went on to say that this allowed him to move away from bringing his own experience to a discussion and towards using this experience to identify questions or ways of responding which might prompt reflection, and drew attention to the reciprocal nature of this:

'So… and for me it helped me evolve my natural tendency to bring 'here's how I felt in my previous scenario that was similar to yours' into 'here's… I wonder… what sort of um… what open questions would help the other person think. Sort of helping them lead to points of reflection as well, as well as vice versa' (Oliver, p4, 167-170).

Tricia also highlighted the role of the facilitator in encouraging the group away from contributing just with their own scenarios, and expressed that she had noticed a difference between when this aspect of the group format was held, and when it had not been in her group the previous year:

'…all sorts of people were saying 'oh that happened to me this is my scenario' or someone else would be like 'oh yeah that happened to me this is my scenario' (.) and kind of (.) I don't (.) I don't know I think there's a term for that when people just talk about their own thing but erm (.) that was one of the rules that you couldn't do that and I think like I found that happened a lot more erm last year which could have been a combination of the fact that it was newer to all of us (.) erm but it could have been (.) erm (.) you know the facilitator managing to (.) get get us back on track' (Tricia, p2, 78-84).

She went on to confirm that her current group facilitator was more 'in control' of this, which she felt was important for the quality of discussions and development of her skills.

Reflexive Memo: *Since starting this research I have become more conscious of the tendency (in myself and others) to want to respond to others' scenarios with one of my (or their) own, and have been much more mindful of whether this is helpful or not. Sometimes it seems that hearing a similar scenario is reassuring (I have found this myself) but more often than not it does serve to take away from what is being said. In my work I still notice when a client says something very relatable, the pull to share my own experience, and I find it helpful to be congruent to this. Just recently in an assessment a client was describing work-related stress, and worked in the same field I did before changing to a career in psychology. I could relate to every aspect of what the client was saying, and while from the point of view of professional boundaries I do not make self-disclosures, and my approach to therapy is very much to remain mindful that every intervention is in service of the client and not myself, being congruent to how strongly I related to their experience helped me to bring my empathic understanding to the interaction. I have been conscious during the analysis of the fact that participants found this 'new' way of interacting counter to their natural 'human' instincts, their accounts suggested that it actually helped them to be more 'human' in their interactions, as they were more fully 'tuned in' to what someone else was saying and able to stay with that rather than making 'their' issue about 'me', or going into a default 'advice giving' or 'problem solving' response. However I need to be mindful of the extent to which I bring my approach to therapy and beliefs about 'humanness' to this interpretation.*

Figure 3-6: Reflexive Memo (topic of responding to others' experience with one's own)

3.5.3 'Why and how rather than what'

This subcategory was named following Oliver's interview, where he said the biggest difference between the RPGs and other similar groups he had attended was the focus on the why and how of cases rather than 'what happened'. For Oliver, this allowed for greater recognition and exploration of the human side of practice:

'…realistically as practitioners you're not going to go through a session where you see ten patients and have nothing to think about it as a human, or nothing integrated about what your experience was of that… those ten encounters and whatever it was that you've done. Um… it's just not how it goes your brain has to process things… Unless you're a complete robot. Um so… reflection is happening for all of us. Um… er… the… what this course provided was a space to maybe formalise that and provide some tools, and again those tools may not be apparent for people and they certainly present as if they're coming from a different perspective, which is a psychological one primarily […] *but it certainly er… you know provides new tools to… clinicians who have traditionally focused on 'right what was the reason for this'* […] *that's not what the focus of these sessions is all about. It's about the 'why' or the 'how' or the whatever, rather than the 'what'' (Oliver, p12, 526-539).*

For Oliver, the purpose of the groups was to move away from expected ways to 'be' as a doctor. He recognised that doctors are humans and not robots and need to be able to process their experience, and highlighted the role and psychological background of the facilitator in promoting this. His sense that the groups were providing 'tools' to support him is interesting in light of other participants' request for tools as an aspect of help-seeking. Oliver clearly saw the shift in focus away from the traditional 'medical' approach to 'the why and the how' as a tool in itself, though he did acknowledge that this may not be apparent for everyone.

Ben on the other hand described developing new insight through the psychological nature of discussions, but reflected that he would have liked some more explicit tools for managing his emotional responses to this:

'…a bit of (.) a bit of structure to like what you're kind of (.) you know why you (.) why someone might have had an emotional response to that and kind of like tools you know' (Ben, p8, 370-371).

For most participants, this focus on the why and how of cases rather than the clinical side represented a very different way of conceptualising challenges they encountered at work. As Sarah put it: *'…it's just about… opening up your mind to different ways of thinking' (p11, 581-582).* Ben's sense that he might benefit from some 'tools' seems to represent an attempt to align this new way of thinking with his ideas of being a Doctor, and to pre-empt the potential impact of this on him. Oliver, on the other hand, felt that focusing on these different aspects in itself helped him bring his 'humanness' to thinking about his work.

Alice reflected that in medicine, this different focus is rare *(Alice, p1, 26-27).* And for Claire the usefulness of the groups was their focus on the how and on her feelings, rather than what she should or should not have done as a doctor:

'…to help you sort of um… not… not work out what you should and shouldn't do in the circumstances but how to… how you might approach it, or how you might deal with the feelings that you get because of it' (Claire, p8, 355-357).

Focusing on the 'why and how' rather than 'what' of clinical scenarios represented something different for all of the participants, and although they varied in their responses to this, there was a general consensus that their thinking in this area developed over time.

3.5.4 Developing reflective skills

This subcategory might seem obvious considering the subject matter of this study, however it did emerge as a distinct set of skills and understanding, and most notably participants noticed a difference between this and their previous experiences of RP, in that these skills felt more 'human'.

Oliver emphasised the difference beyween the reflective skills he developed in groups and his experience of written reflections for his portfolio, which he described as feeling like an exercise in demonstrating capacity for reflection rather than a demonstration of actual reflectivity. For him, the groups provided something different and more valuable:

'…Like imagine how reflective you would be, you know if you were being generous and saying each reflection takes an hour to write down, which in many cases it does by the time you've thought about

it, written it, and gone through the process, an hour… I don't know, I don't know, 100 hours of reflecting with your colleagues, I don't know how that would make people… cause that's a more effective human skill I think. But that's just my feeling' (Oliver, p12-13, 560-565).

His description of this as a 'human' skill is again suggestive of a differentiation between being, or training as, a doctor and being 'human'. Participant accounts suggested the reflection they engaged in in groups felt less clinical and perhaps less clear cut. Oliver used the word 'human' a number of times in his interview as the biggest difference he perceived between the groups and anything he had done before as a doctor. He described the groups as helping to support his engagement in training, and in particular in RP, which written reflections had made him feel more negatively about. Caroline also talked about this and said that the large number of written reflections made it feel like tick box exercise (p11, 518) whereas the groups felt very different. Tricia also commented on the amount of reflection that is expected of GP trainees, and said the groups had enhanced her reflective skills:

'…I think that the process has helped me with my reflective skills (.) erm (.) and helped me to analyse situations (.) erm (.) and analyse myself in situations a bit more cause you know we have to do these so (.) so much reflection in our GP careers I think (.) and it's definitely enhanced that' (Tricia, p5, 192-195).

She explained that she was not sure she had become better at this in her work, but that it felt like over time the further she developed these skills, the more she would bring them to her interactions with colleagues and patients *(Tricia, p5, 200-201).*

Ben agreed with this, and reflected that for him the development of these skills may go further than his work:

'I think you know you sort of er (.) develop as a person don't you when you (.) when you develop skills […] *it's a social interaction skill isn't it you know it's sort of (.) kind of thinking about your thoughts your feelings erm how you deal with difficult situations' (Ben, p10-11, 461-470).*

His relating of developing reflective skills to *'developing as a person'* resonates with Oliver's assertion that this is a 'human' skill.

Caroline, who had also spoken about the amount of written reflections required in GP training, asserting that there is: *'a limit to how much you're really going to learn' (p2, 77)* from doing these to meet particular capabilities, as opposed to hearing different opinions in groups. She was hopeful that the reflective skills she had developed would be helpful in her career:

'…the way that you reflect on things maybe sticks so that (.) the next time you have a stressful case if you (.) you know (.) use your new skills it may change the way you feel about it I suppose (.) hopefully it would' (Caroline, p13, 565-567).

And Sarah emphasised the importance of developing these skills as early as possible, as she felt that the longer one had been working and had not done it, the harder it would be to reflect, particularly on feelings:

'…you want it to become a habit that you allow yourself reflective time, or that… that you naturally kind of reflect on things, or you naturally kind of ask people how they feel about a situation when they come to you to discuss something, you want it to just be reflexive that that's… that's how you… you think about the world and your work and relationships and the earlier you can implement it, the more natural it becomes' *(Sarah, p12, 536-541).*

All participants described developing new and existing understanding and skills through RPG participation. This occurred across categories 1-3 and also allowed for the development of different ways of thinking and practicing as doctors. The development of understanding and skills impacted on participants' sharing of experiences, recognition and processing of emotions and development of empathy and compassion, and likewise the development of these things seemed to lead to greater understanding and openness to new skills, approaches and ways of thinking.

3.6 Category 5: Integrating into work – and beyond

This slightly shorter final category, by virtue of the fact that due to the nature of the research question less time was spent on this area in participant interviews, draws together the processes identified by GP trainees as emerging from their participation in RPGs which they have integrated into their work and, for some, into their lives outside work.

Participants identified being more likely to talk about feelings or initiate conversations about this, in and outside of work, bringing their new skills and understanding to patient consultations, and being more thoughtful in their communications as ways they had integrated their group experiences into their work and lives. These three areas are discussed below.

Reflexive Memo: *When I began the analysis I got the impression that participants felt they were using the space to process their 'human' experiences (emotions, struggles, times when they have made a mistake or there are things they have not been able to do) but were not then noticing themselves implementing this practically (taking this into work/noticing any change in their practice). But it later started to become apparent that there are other ways of applying group experiences/learning practically - which participants were describing but which they may not have been consciously aware represented a change as they were less obviously 'doing something different'. For example, being more likely to recognise their feelings and talk to colleagues about these, being more likely to talk to colleagues about challenges in general, thinking about their behaviour/responses in particular situations. A related change seemed to be in the way they saw themselves as doctors and the range of behaviours/feelings/responses they accommodated within this, which seemed to be becoming less rigid through participation in groups. Where participants say they did not notice a change (for example in their patient/colleague interactions or outside of work) I have to take this at face value, but it is also important to consider what is implicit in their accounts (when what they are saying is suggestive of a change/represents something different) and the importance of these non-conscious changes/applications of group experiences to being a doctor. Harder to keep my influence out of these, but still feels important to recognise that they are there, and what they tell us about what groups may have been providing for participants in terms of personal development. Some participants did explicitly make reference to this, reflecting that although they were not conscious of particular changes, they felt instinctively that they had (or must have) changed their approaches as a result of their RPG experience.*

Figure 3-7: Reflexive Memo (theme of integrating into work – and beyond)

3.6.1 Talking about feelings

Participants gave a sense that processes that started in groups were extending into their working lives, and for some also their lives outside work. This subcategory emerged from my sense that one of the ways they had noticed this was in their increased likelihood to initiate conversations about how they were feeling.

Ben expressed that he is now being more reflective with his colleagues and patients, and in particular has felt able to express to colleagues, even more senior colleagues and supervisors, how he is feeling, for example about a difficult consultation:

'…*I now can like sort of reflect with you know my trainer and other GPs in my practice um (.) and it's allowed me to kind of receive information from them (.) erm you know and they've opened up and said 'actually you know I (.) I think you're justified in feeling that way and patients are sometimes difficult like that 'you know so it's (.) it's facilitated that discussion definitely' (Ben, p9, 416-420).*

Other participants agreed with this. Alice recalled a situation where something had upset her at work and she actively initiated a conversation with a colleague about it, something she would not have done before:

'…I think I've (.) been more sort of willing to talk to colleagues as well about difficulties like I've (.) had a recent case that I went and spoke to one of my other colleagues about (.) where it was (.) actually the patient it wasn't anything to do with the medical side of it it was the patient which (.) just upset me (.) so not (.) yeah then I went and had a conversation with my colleague about it (.) whereas I might not (.) well I don't know if I would have done that before but (.) I think maybe it's kind of

opened up that sort of (.) willingness to have those discussions or being used to doing it' (Alice, p6, 244-251).

She said that being able to be *'more willing to talk about you know the affects that (.) that these things have on you' (Alice, p6, 276)* is something she would like to take into her career going forward, which does seem to represent a shift away from the idea that this is in conflict with being a doctor, although Alice highlighted the importance of being in a supportive GP practice for this.

Sarah said she felt talking about feelings, with her patients and with friends, was something she was already doing quite a lot before coming into the groups, but that after taking some time off from work, and then participating in the IRPP, she has been more aware of it. She expressed that she had also found herself doing this to a greater degree with colleagues, and described noticing an increase in her confidence to initiate these conversations:

'…I'm kind of… finding it more natural in a practice meeting for example when a case is being discussed while everyone else might be focused on kind of the clinical outcomes I think it might come more naturally for me to say, like, 'oh but… it sounds like that was a really difficult situation for you', so… maybe having that confidence to build it into practice a little bit more' (Sarah, p6, 256-260).

Oliver reflected that although he had not noticed a big change in himself in this area, he did think that he might be more likely to speak to his partner about how he was feeling, particularly with a view to addressing his more negative feelings about his GP training:

'…certainly with my partner, talking about… my week and trying to kind of… bring cases out that are helpful in terms of creating space for maybe moving my own narrative […] *I'm trying to change that narrative, frustrated and despondent about doing this thing… this… this whole programme* […] *So the um… the reflective groups have been… maybe I've used some of those tools in those kind of settings with my wife and others to try and help myself feel a bit more positive about… chugging through this' Oliver, (p10, 424-432).*

Again, Oliver used the word 'tools', suggesting that the groups equipped him with skills he was able to apply.

Albeit in varying degrees, most participants noticed something of an increased willingness to create space for and initiate conversations about their feelings about work, whether in their practice, or in their personal lives.

3.6.2 Application to consultations

For some participants, the skills they developed came into use in their patient interactions. This seems interconnected with the willingness to initiate conversations about feelings, as Ben described finding himself more likely to ask questions of patients, but also noticed an increased willingness to 'sit' with his feelings about consultations, whether they had 'gone well' or not:

'*…it's definitely allowed me to kind of (.) erm (.) develop my (.) my sort of (.) er consultation (.) erm you know sort of skills set (.) erm and kind of would be asking questions about patients a little bit more (.) allowing myself to sit with my feelings of 'yeah that actually went really well' and kind of 'why did that go really well? And how can I use that next time' or 'that didn't go so well even though I know that patient previously and our previous conversations have gone well '(.) erm (.) so it's definitely kind of (.) yeah I would say developed erm (.) a skills set (.) er (.) that has allowed me to (.) erm to get better clinical outcomes with my patients for sure' (Ben, p10, 444-451).*

Ben's assertion that this has impacted his clinical outcomes seems related to participants' sense that the idea that bringing something more emotional and relational to their practice can actually help to make them better doctors:

'*…you can kind of work out how to manage your own emotions your own emotional responses to those difficult patient interactions and how to help (.) patients kind of get more out of (.) of consultations with you' (Ben, p13, 595-597).*

His recognition of what his patients might be feeling seems related to the development of empathy, or of perspective-taking ability, leading to greater empathy.

Tricia also felt she had become more reflective in her patient consultations, where she described herself as more likely to stop and think about what might be happening for the patient *(Tricia, p6, 243)*, something which Caroline also said she was more conscious of trying to do, describing an increased tendency to consider the circumstances of a 'difficult' patient during a consultation:

'…And you sort of think okay well they were trying to wrangle eight children and you know (.) they'd come straight from nursery and their child is sick that's probably why they were doing it' (Caroline, p8, 349-351).

This suggests a link between the development of empathy and a change in patient consultations and interactions. Even Claire, who felt she had not experienced a particular change in her interactions with patients (or colleagues) described a greater awareness of what they might be going through *(Claire, p6, 277-278*).

Although this was almost a subcategory within a subcategory, it did seem to represent a slightly different aspect of the integration of ideas from groups into participants' work, that they were not just noticing an increased willingness to talk about their own feelings, but also an increased recognition of their own and their patients' feelings, reactions and communication in consultations, reflective of an increased comfort as doctors with the more 'human' aspects of practice.

3.6.3 Thinking about how I communicate

This subcategory specifically relates to participants' accounts of becoming more thoughtful in their communication, particularly with colleagues in challenging situations.

Jane identified an increased tendency since attending the groups, to stop and think before responding:

'…maybe if you're having a discussion with someone (.) about something that's difficult or um there might be like conflicts of opinions kind of thinking like 'what is it helpful for me to say here? What is it not helpful for me to say?' (Jane, p5, 226-228).

Questioning whether her contributions might be helpful or unhelpful is reflective of the development of her communication skills, something other participants described noticing in their own practices. Lucy recognised that when it came to difficult conversations, rather than remaining silent to avoid a conflict or confrontation she was more likely to say something, but also more aware of both when and how to say it:

'…I think I've been more conscious about erm (.) not saying anything (.) at the time if somebody has done something or said something that I find (.) either unprofessional unhelpful (.) and I try (.) but I do actually now say something (.) but I don't do it at the time (.) er and I try to do it in a way that's (.) you know I'm not an (.) I'm very bad at conflict anyway (.) not I (.) I find it very stressful […]
I have found that (.) it's made me (.) er (.) conscious that I should actually say these things (.) but in a way that is (.) constructive (.) rather than (.) a kind of emotive response at the time (.) Whereas before I would sort of (.) just not have said anything ever (.) which probably wasn't very helpful' (Lucy, p7, 287-304).

Lucy said she had also taken this into her personal life. Unlike Jane, who had found herself more conscious of not jumping in and saying something before first considering whether it was helpful, Lucy had become more likely to say something when previously she might have stayed silent, but was equally conscious of pausing to consider what to say and when, rather than jumping in at the time. For both, the increased awareness of stopping and thinking before contributing was something they felt they had developed in RPGs.

This relates to not immediately sharing personal experiences in response to hearing the experience of someone else. Oliver described an ongoing mindfulness of this, reflecting that in his practice, particularly when talking to less experienced colleagues, he had developed a way to share his experience with them without taking away from theirs:

'…it was valuable to try to do it in a way that wasn't like 'oh yeah one time this happened to me' um… focusing slightly more on… a way to say it um… in… in a more kind of… um… universal way, which is kind of… er I mean… rules for life, whatever […] *Um… so… was it valuable… it's valuable in… developing different ways to share your experience as a way of teaching' (Oliver, p14, 621-628).*

This is a good example of the interconnectedness of the processes described, as Oliver found that developing the skill of sharing his experience without making the discussion about him was then helpful outside of the groups when trying to share his experience with less experienced colleagues in a way that was more 'human'.

In all three subcategories, participants recognised an increased tendency to pause and reflect, whether on their feelings or the feelings of others, or the most helpful way to respond in discussions. This is something they were not doing before, perhaps because it did not align with the ways they had learned to respond 'as doctors'. Arguably this brings a greater sense of 'humanness' to practice, in that participants were considering feelings, their own and others', more able to reflect in challenging situations rather than automatically blaming themselves or feeling they had failed, and becoming more thoughtful in their engagement with others.

In my interviews with Sarah and Lucy, they reflected on the impact on mental health of continuing with these automatic responses without stopping to consider yourself in the middle of them:

'I think the mental health of Doctors in general would be hugely improved if (.) they were in a certain way forced to engage with the way they felt about things' (Lucy, p13, 583-585).

All the processes in this category are suggestive of 'taking a step back' in situations, where they may be experiencing struggles or vulnerability, in a way that participants would not have previously.

3.7 Core Category: Navigating the relationship between 'Humanness' and Being a Doctor

From the major categories set out above, a core category of 'navigating the relationship between humanness and being a doctor' was developed. This seemed to capture all the major ways in which participants described making use of RPGs and the function they served for participants. The word 'human', came up across participant accounts, and emerged as distinct from participant

ideas of being a doctor. And all of the major categories seemed to involve participants navigating, through their RPG participation, the 'human' side of practice - their need for connection with others in the context of an isolating profession, their struggles and vulnerabilities in a challenging work environment, their emotions, and their own limitations, weaknesses and flaws, including an inability to 'do it all' in spite of feeling that they should – which challenged their ideas of what a doctor should be, and developing ways to align these human experiences with, and bring them to, their professional identity and practice as doctors.

All participants, regardless of how long they had been a doctor prior to embarking on GP training, alluded to a conflict between aspects of their 'humanness' and their sense of themselves within established ideas of what it means to be a doctor, which seemed to derive from medial culture, training and practice. When emotions or personal struggles came up for them at work, or they found themselves making mistakes or unable to 'do it all', they struggled to reconcile this with the idea that doctors should be emotionally composed, resilient in managing the challenges of work, and efficient and able to manage their workload, however demanding. Their sense of isolation in their experieces came from the sense that other doctors were able to do this where they were not. Some participants gave a sense that if they were to express their feelings or show vulnerability, they would be unable to fulfil their role. As a result, for most their response was to ignore, deny, or not acknowlegde any vulnerabilities, struggles or mistakes, and try to 'get on'. Participants described finding that there was then no room to process these things, because the need for an acceptable work/life balance meant they were unwilling to 'take them home'. But these 'human' experiences continued, and the conflict they continued to cause for participants manifested in different ways. Some participants described feeling disconnected and despondent about their training, others experienced self-criticism, shame and imposter feelings, and others described emotional exhaustion and the symptoms of burnout.

All participants described struggling with managing the expectations placed on them as trainee GPs. They described busy training schedules and practices, large amounts of admin, isolating working lives, with little time or opportunity for connection with colleagues, and an expectation that when they reached ST3 and were working in general practice they would be 'the finished product'. This was compounded by a sense that as doctors they should be pragmatic, emotionally tough, focused on clinical outcomes and able to get on with their job without being seen to be struggling, leading to a sense that their experiences of the very 'human' feelings and responses which arose within medical practice meant a lack of clinical competence or failure. All participants described the isolating nature of GP practice, which seemed to add to their sense that they were alone with these struggles. Throughout the interviews and analysis of transcripts, it seemed that the GP trainees were trying to position themselves in relation to an apparent binary between their 'human' responses and being a 'normal' or 'real' Doctor. Some participants differentiated themselves from 'most' or 'normal' Doctors in their belief that emotions, their own and others', were important, and others placed themselves in a general category of 'Doctors' or 'medics' (*'as Doctors we…')*. Some made conflicting statements about this, describing themselves early in interviews as 'practical' and 'analytical' but

then going on to position themselves as 'more emotionally aware' than 'other Doctors'. This highlights the potential complexity of navigating human experiences as a GP trainee/doctor and suggests a tension between participants 'human' selves and themselves as doctors. The tendency to compare themselves unfavourably to other trainees/doctors came up across almost all participant accounts.

For some participants, this meant they put their own feelings and experiences aside, stopped noticing or became unaware of them. For others who continued to feel that the emotional side of practice was important, they experienced challenges in bringing this into their work, and maintaining the care and compassion they wanted to bring when entering the profession, for a range of reasons including work pressures and time constraints, practicalities, established culture/practices within work settings, concerns about being seen as 'not coping', and emotional exhaustion and compassion fatigue.

Many of the participants described their RPGs experience as very different from any other aspects of their work/training. Participants felt that the positioning of it within their training and the way groups were run allowed them explore aspects of being a doctor that they did not have a space for, or feel able to, elsewhere. They described the RPGs as a space to be human about their work, and as facilitating a sense that they *were* only human, not a robot or a machine, and could not expect themselves to do it all or to be entirely unaffected by the challenges of being a doctor.

The process of navigating the relationship between this 'humanness' and being a doctor covers all the identified ways in which participants made use of RPGs. Each of the major categories which emerged developed towards a picture of how participants made use of RPGs to navigate the relationship between aspects of their humanness and being a doctor, both within and outside of the group space. Sharing experiences (category 1), in particular difficult cases and those in which they had struggled, involved an openness to exposing/exploring their human vulnerability and frailty, which challenged their sense that doctors should always be strong and resilient. Sharing these challenging experiences in groups reduced their feelings of isolation, increased their sense of connectedness and belonging, and gave them a sense of their struggles and challenges as a shared experience ('I am not alone', 'I am not the only one struggling'). Participants used the sharing of experience to seek help from one another and to offload about their struggles in a way they felt unable to do in their day to day lives as doctors. This led to the recognition and processing of emotions (category 2), their own and others' ('noticing my emotional reactions', 'others noticing my emotions') and faciliated a recognition, again distinct from their sense that doctors should be emotionally tough, that these 'human' feelings/experiences of emotion were valid. The RPG space gave participants 'permission' to focus on their feelings and to process the more emotional aspects of being a doctor. Recognising these emotions in themselves and others supported the development of empathy and compassion (category 3). Participants experienced empathy from, and were able to empathise with, one another in their shared challenges as doctors, which facilitated the development of self and other compassion through both the acknowledgment of their own and others' limitations

and imperfections, and a recognition that they were only human and should 'give themselves a break' ('being kinder to myself'). Through these processes, participants developed their understanding, of themselves and others, and skills (category 4). As well as reflective skills, participants developed their communication skills (just listening, responding to discussions without bringing my scenario) and broadened their focus when considering challenges at work, to include factors they identified as more 'human' (such as considering patient/colleague perspectives in understanding their behaviour) alongside the clinical considerations they had tended to focus on as doctors ('why and how rather than what'). This enabled them to more closely attune to one another, and to their patients and colleagues, as humans rather than as 'doctors' and 'patients', to take a step back in their work and consider what might be behind particular behavioirs they were finding challenging, to consider patient and colleague perspectives, and to align their own limitations and vulnerabilities with their sense of themselves as doctors. Participants then began to integrate these skills and this understanding (category 5) into both their practice, in patient consultations and with colleagues, and their personal lives with friends and family. In particular, participants noticed an increased openness to talking about their feelings, particularly in a work context, and a tendency to think more carefully about the way they were communicating with others. In this way, participants were able to navigate the relationship between their own and others' humanness, and being a doctor. This process of navigation was continual, both in and outside of RPGs. It was a dynamic process, with participants starting from different 'positions' in terms of their experience of practices focused on the non-clinical side of work, their understanding of the purpose and process of RPGs, and their previous work and life experience, but all describing a development and enhancement in each of the major categories over time. By using the groups to navigate the relationship between humanness and being a doctor in this way, participants began to develop different or more flexible ideas about what a doctor should be and how they should behave, which aligned with their personal identities and they brought to their work.

A diagrammatic conceptualistion of the emergent theory is presented at figure 3-8:

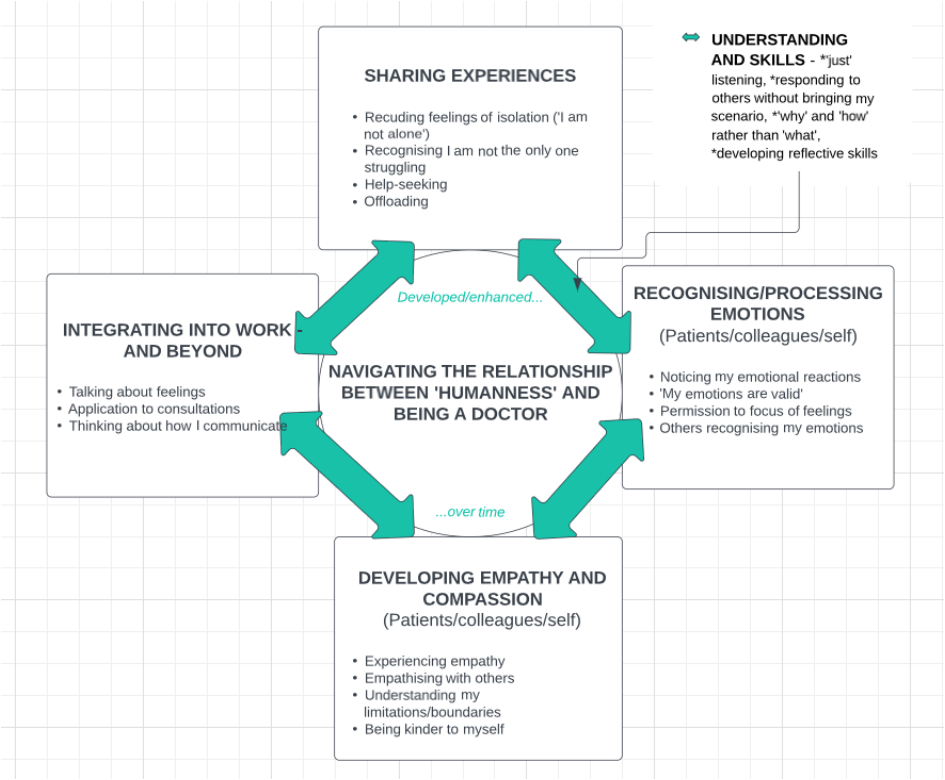


Figure 3-8: Diagrammatic conceptualisation of the emergent theory

3.8 Summary

The fact that so many of the examples participants gave of 'thinking about how I communicate' (3.7.3) involed the sharing of challenging experiences, in and outside of work, is suggestive of the interconnectedness of the processes that make up the emergent theory. In their interviews, all the trainees demonstrated fixed ideas about 'being a doctor' with which they came into the IRPP, and had developed particular responses in line with this. This seemed to be the case regardless of their level of experience, in fact for some the longer they had been a Doctor in a particular specialism, the more deeply ingrained their ideas and responses seemed to be. By making use of the groups in the defined ways, participants began to align those aspects of their 'humanness' which they had previously felt were in conflict with how they should be and behave as doctors, felt they had to hide or leave outside their work context, or worried undermined their professionalism or competence as doctors, with their developing professional identities and practice.

All of these processes were interdependent, so as one occurred, others were likely to emerge. Although all participants described a sense that navigating the relationship between humanness and being a doctor began with sharing experiences, when explored further in fact there seemed to be no set order for these processes, and participants seemed to experience them in different ways, with some carrying more importance than others at particular times depending on participants' individual contexts, histories and current circumstances. For all participants, each process seemed to interact with and facilitate others. And the RPG facilitator appeared to play an important role in all of these areas, possibly implying an influence of the interprofessional nature of groups on the way these

processes emerged, and the way trainees integrated them into their work and lives. The particular influence of the facilitator's counselling psychology training and background is explored in Chapter 4.

When asked if they would continue to engage in RPGs in the future, all participants said they thought it would be helpful, but they varied in the degrees to which they would prioritise this or considered it was possible. Sarah, Lucy, Claire, Caroline, Jane, Ben and Alice all said they definitely intended to do it, but reflected on the possible challenges to this, in particular around how they might approach the issue of the facilitator, who they felt was an important part of the process. Oliver said he thought it would be useful but was not sure what form it might take or how to build it in. Caroline said she would like to continue, but felt it would not be the same if she was just doing it with GP colleagues. Tricia told me she would definitely participate in RPGs again if it was integrated into her practice, but if not she did not think she would use her own time to do it, whereas Claire said she would consider doing it in her own time if the opportunity was available. And both Ben and Lucy identified that having some access to emotional support, whether this be in an RPG or a one-to-one, with someone external to their organisation, would be something they would benefit from. Following her reflections in relation to doctors' mental health (3.7.3) Lucy expressed a belief that a change would be needed in the culture of medical practice to support this, but she recognised the potential barriers to this.

Participants' use of the groups to navigate the complex relationship between their humanness, with all this entails, and being a doctor seemed to allow for more flexibility in their ideas about what 'a doctor' is and should be. Greater openness to showing their vulnerabilities, and to the idea that they could struggle, experience emotions, make mistakes and acknowledge their limitations and still be 'a real Doctor' - and that in fact greater awareness of these things, acknowledging them rather than denying or blocking them out, had the potential to make them 'better' doctors - supported the integration of these into their professional identities and practice. Participants' recognition of not just their own but their colleagues' 'humanness', gleaned through both greater connection with their colleagues and awareness/understanding of their experiences, also seemed to help in making 'humanness' more acceptable in being a doctor, and reduce their tendency to compare themselves negatively to 'other doctors' who they had imagined did not have these experiences.

The apparent development and enhancement of all of these processes over time is indicative of a continual process of personal and professional development for participants, which starts in the groups but continues outside this context. From participant accounts, it sounds as though this process was maintained through their ongoing involvement in IRPP, and may be reflective of the particular interprofessional nature of RPGs and participants' high level of attendance.

These findings are discussed in the context of wider literature and relevant theory in Chapter Four.

Chapter Four: Discussion

4.1 Overview

In this chapter I will review the findings of the major categories and core category of the emergent theory (illustrated in the diagrammatic conceptualisation presented at figure 3-8) in terms of theoretical themes, developing these by linking them to relevant theoretical models and existing research, and identifying areas where new insights or questions for future research have emerged. I will evaluate the strengths and limitations of the study and make suggestions for further research in this area. Finally, I will outline the clinical and wider implications of this study, including suggestions for counselling psychology practice. I hope that the findings of this research will have practical applicability for counselling psychologists tasked with facilitating RPGs for GP trainees, and in supporting GP/medical trainee wellbeing more generally.

4.2 Navigating the Relationship between 'Humanness' and Being a Doctor - The Core Category and the Emergent Theory

The aspects of 'humanness' most frequently referred to in participant accounts as being ones they struggled to reconcile with 'being a doctor' were the experience of emotion (which McNaughton and Le Blanc (2012) describe as a fundamental part of every human being); vulnerability, including doubt and uncertainty; sociability and the need for connection (consistent with Gilbert's (2014) assertion that human beings are inherently relational, and Cacioppo and Patrick (2008) and Baumeister and Leary (1995) who emphasised the human need for connection); human weakness and frailty, that is the experience of failure, mistakes, and limitations (*'I can only do what I can do'*, *Claire, p8, 335*). And values such as caring for others, which were frustrated by the 'realities' of medical training and practice, and personal factors such as exhaustion and compassion fatigue. These experiences conflicted with ideas, which participants seemed to have internalised from medical culture, that doctors are emotionally resilient, tough, pragmatic, and should not be seen to be struggling or to make mistakes (see Crowe & Brugha, 2018). Environmental and contextual factors such as pressures on time and resources, and the isolating nature of general practice, also impacted on this. It became apparent from the analysis that participants experienced a conflict between the way they were - their humanness - and how and what they felt they should be as a doctor, which they used RPGs to navigate.

This conflict is explored in the literature in relation to medical culture. Sinclair (1997) describes an inner conflict for both students and junior doctors as they attempt to integrate the scientific dimension of medicine with ideals of care and compassion, where their desire to help people clashes with and the subsequently acquired disposition of competence, or 'professional idealism'. And MacLeod (2011) explained how medical students develop their professional identities by negotiating the competing discourses of competence and caring, in which competence was found to be associated with the suppression of emotions, most importantly uncertainty and anxiety. This seems

to relate to important aspects of humanness: emotions, which are likely to arise in the challenging medical environment, and caring for others, which may have motivated participants to become a doctor, both of which had become difficult to manage and maintain due to the nature and context of their work, but also the apparent association of emotional responses with a lack of competence (MacLeod, 2011). Underman (2015) described how medical students sought to embody competence by managing their emotions in front of patients, so as to mask anxiety and discomfort, something which participants also made reference to. And Crowe and Brugha (2018, p157) described how *'taken-for-granted assumptions, including an association between emotional vulnerability and incompetence, can lead to doctors dealing with the 'emotional toll' on an individual level'.* This would seem to relate to participants' descriptions of feeling alone with their emotional responses.

Sarah, asserted that as doctors they should not show their emotion, and Caroline made reference to 'feeling like you have failed' if you get annoyed or frustrated at work. This reflects Boiler et al's (2018) assertion that medical students tend to identify with what they have been explicitly taught: that doctors should not openly express their emotions, and Schwartz et al (2022), who referred to *'a culture of denial and stoicism… and a dread of being seen as weak or inadequate by peers and mentors'* which inhibits physicians from admitting to emotional challenges. It is also reflective of de Vries et al (2016) who found that students were reluctant to talk about emotions in formal training settings, and adjusted the presentation of themselves, or their performances, according to what they believed was expected from them. Boiler et al (2018) described a dilemma for medical students in not wanting to lose too much of their emotion, as this related to caring and compassion for patients, but beginning to adopt professional norms around emotion in the process of developing their professional identities. The apparent conflict between 'humanness' and being a doctor, therefore, seems reflective of wider literature, particularly on emotions and values in medical culture.

The literature on IS and perfectionism in doctors also seems relevant to the emergent theory. Hatem et al (2019) highlighted the impact of IS on professional identity development and 'feeling like a doctor', and several participants in the current study seemed to experience this, both when they described not behaving, or achieving, 'as a doctor should', compared to others (Chodoff et al, 2023) and expecting themselves to be perfect (Quereshi et al, 2017). Chodoff et al (2023) asserted that features of the clinical learning environment perpetuate this, and stressed the ongoing impact of IS on issues of physician identity, even after the completion of training. This seems consistent with participants' sense that there is a particular standard they have to meet at all times. Sarah in particular made reference to feeling she always had to be 'achieving' at a particular level. This, again, became difficult to manage when participants were unable to maintain this standard due to their 'human' limitations, being 'only' human, not a machine, and their experiences of mistakes or failure.

Participants' accounts of the groups helping them to reconcile their 'humanness' with being a doctor is suggestive a process of the normalisation of emotions and vulnerability (Solms et al, 2021),

something which Ramsay and Spencer (2019) associated with reduced levels of burnout and IS, and Gallagher (2019) found had the potential to improve professional identity and reduce IS.

For participants in the current study, this 'normalisation' included the development of a greater openness to sharing feelings, both in and outside of work. Coming into the groups, participants' sense that their 'human' emotions and struggles were both individual and private (McNaughton, 2013) seemed to relate to both their work and personal lives, as most described not wanting to 'take their emotions home'. Perhaps this is not surprising given that a meta-analysis of 65 international studies by Lee et al (2013) found that conflict between work and personal life was the strongest predictor of emotional exhaustion among medical practitioners. It makes sense that in trying to maintain an acceptable work-life balance, doctors may not want to take their work-stress home with them, but for some participants this meant there was no space for these feelings at all. This slightly contradicts Crowe and Brugha (2018) who found that some participants processed painful emotions in relation to their work privately or with friends or family. Although some participants described 'venting' to friends or family, those who did seemed to feel this was not very productive.

In spite of this process of 'normalising' the human experiences of emotion and vulnerability, and participants' apparent increased willingness to talk about these things, they seemed to be at different stages in relation to this, with some like Ben still feeling somewhat ill-equipped to manage emotions when they came up for him at work, particularly in clinical encounters (see Schwartz et al, 2022) and feeling he would benefit from tools to help him to manage this. This is again suggestive of the idea that the process of navigating humanness and being a doctor through RPGs is a developing one, with participants at different stages and needing different things from the groups at different times.

The RPG facilitator emerged as an important contributor across categories of the emergent theory, raising important questions about whether the presence of a CoP facilitator may have enabled participants to approach these processes in particular ways which they might not have done otherwise, about what might have been underneath the development of these processes, and what this tells us about the function of the groups for participants. The emergent theory appears to be reflective of some very particular psychological theories, all of which underpin therapeutic approaches commonly delivered in groups, which suggests a possible important influence of the facilitator's counselling psychology training and background. These theories, with reference to the relevant findings and wider literature, are expanded upon below.

4.3 Findings in the Context of Relevant Theory

The findings of this study seem to suggest some possible mechanisms which may be underpinning the processes described by participants. Their ideas about what a doctor 'should' be appeared to be becoming more flexible and more aligned with their humanness, suggestive of the development of psychological flexibility. The development of compassion emerged as a major category. And participants described an increased awareness of their own and others' thoughts and

feelings, suggestive of an increased capacity for mentalisation. As such, I examined the emergent theory in relation to existing theories relating to the development of psychological flexibility, compassion and mentalising capacity, and found it to be reflective of each of these theories in potentially interesting ways, as set out in the following sections.

4.3.1 Psychological Flexibility (ACT and the Hexaflex)

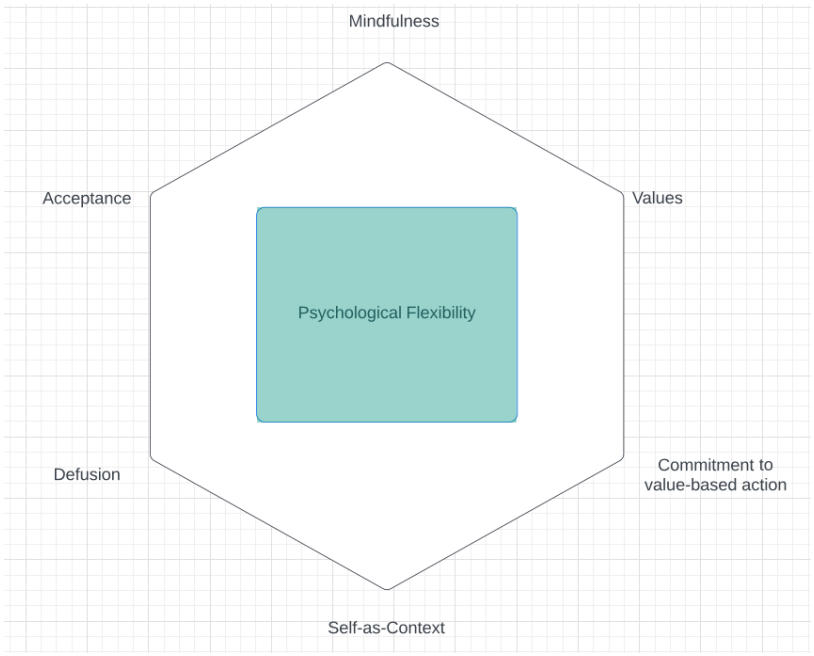


Figure 4-1: The ACT Hexaflex Model. Copyright Steven C. Hayes. Used by permission.

Findings suggest that increased psychological flexibility may have supported participants to navigate the relationship between their humanness and being a doctor. Psychological flexibility means being in contact with the present moment, aware of all emotions, thoughts and sensations, even the unpleasant ones, and adopting a pattern of behaviour based on the situation and personal values, rather than the pursuit of goals (Hayes et al, 2004). It is particularly useful when challenges arise during goal pursuit that produce distress (Doorley et al, 2020), which seemed to be the case for the trainees in the current study, whose goal of behaving and responding 'as a doctor' to a high degree at all times was inevitably frustrated by their human experiences of vulnerability, mistakes or failure, and difficult emotions, such as anxiety, anger, frustration, uncertainty or sadness, and limitations in terms of how much they were able to do. As such, I explored the emergent theory alongside the theory underpinning Acceptance and Commitment Therapy (ACT), and found it to be reflective of this theory, in particular Hayes' (2006; see also Bach & Moran, 2008) 'Hexaflex' model of psychological flexibility (figure 4-1). Like in the emergent theory, all six core processes of the Hexaflex are highly interdependent, so as one process is addressed, others are likely to emerge, and there is no correct order for addressing them, as they arise in the context of clients' different histories and experiences (Schultz, 2021). Viewing the emergent theory through this lens, it would

suggest that developing increased psychological flexibility may have supported participants to align their sense of self with their ideas about 'being a doctor'.

Findings of this study appear reflective of this. While the reduction participants described in their feelings of isolation and increased sense of belonging and recognition that they were not alone in their struggles is consistent with the wider RP literature (Taylor et al, 2018; O'Neil et al, 2019; Ingram et al, 2020) it is also consistent with the theory behind group-based ACT, where group members recognise they are not alone and can benefit from each other as collaborators, as well as their therapist, and can use groups to seek 'immediate peer support' and feedback (Nash, 2021), something which came up in participant accounts as a common aspect of help-seeking in RPGs.

All the core processes of the Hexaflex model (Bach & Moran, 2008) were reflected in participant accounts of their use of RPGs, and therefore will be considered below.

4.3.1.1 Defusion

This relates to the way we talk to ourselves. According to ACT theory, when we use a negative label we become fused with, and therefore identify with it. Cognitive defusion aims to loosen our grip on these self-labels (Schultz, 2021).

All participants in the current study demonstrated a tendency to refer to 'doctors' in general terms, in relation to particular behaviours and responses, and place themselves in that group, suggesting a close 'fusion' of their personal identity with being a doctor. Their accounts of a reduction in both imposter feelings and the impact of their negative self-labels, such as feeling 'unprofessional' or 'like a failure' if their 'humanness' impacted on their work, may have been as a result of the defusion of their sense of identity from 'being a doctor' and a reduced tendency to identify with their thoughts and experience.

One example of this is participants' increased willingness to acknowledge their struggles, and recognition that they were not alone in these. Ben described a tendency in doctors to be reluctant to admit when they are struggling, consistent with Ingram (2020), suggesting that struggling may be associated with negative self-labels such as incompetence or failure. The recognition that others faced similar struggles seemed to allow participants to loosen their grip on, or reduce the power of, these negative labels. Caroline spoke expressly about the impact of this on her sense that everyone was managing the pressures of training and practice better than she was. And Claire, Caroline and Lucy all described feeling reassured by hearing others were also struggling. Wider RP literature has suggested that a benefit of group-based RP is that participants hear about the problems others face (Launer, 2015) and can 'normalise' experiencing difficulty (Ingram et al, 2020). While findings of this study support this, they also suggest this may be due to a process of cognitive defusion, with participants starting to think again about the negative self-labels they were identifying with in relation to 'being a doctor'. Sarah, in particular, said hearing her colleagues discuss her case helped her to reframe her negative feelings about it. This feels reflective of a process of cognitive defusion, and is

also consistent with previous research which has found that RP can support participants to reframe negative thoughts and doubts about their abilities and belonging (Fainstad et al, 2022).

The way we talk to ourselves also includes self-kindness, so cognitive defusion may also partially account for the emergence of *'being kinder to myself',* and being less self-critical, as key aspects of participants' group experiences.

4.3.1.2 Self-as-Context

This refers to the ability to detach oneself from experience. An example of this is the tendency to identify ourselves with what we do, the way participants in the current study identified themselves as 'doctors'. The difficulty with this, according ACT theory, is that it creates a sense that we 'are' our thoughts and experiences (Schultz, 2021), so participants' 'human' experiences of struggles or failure were experienced as if they, personally, are a failure as a doctor. Self-as-context is a way of viewing this which focuses on the individual not as their thoughts and experience, but as the context in which these occur (Hayes et al, 2004). It appears that in RPGs participants started to recognise that they, and their training experiences, were the context in which their thoughts and experiences occurred, rather than the thoughts and experiences themselves, making them more able to 'notice' their thoughts and experiences without this immediately creating a meaning about whether they were a 'real' doctor. As Sarah put it:

'…in a way it makes me feel like more secure in my identity as… yes I'm a Doctor who can have a lot of self doubt, but that's how most Doctors feel and that's okay' (p13, 618-620).

For Sarah, this reduced her imposter feelings. This is supported by previous research, which has shown that talking more openly about feelings of insecurity and self-doubt can reduce levels of IS (Ramsay & Spencer, 2019).

4.3.1.3 Acceptance

Acceptance is conceptualised in ACT as *'embrace your demons'* (Harris, 2006). Findings suggest that participants in RPGs experienced an increased acceptance of their own limitations, imperfections and experience of difficult emotions. Coming into the groups, participants described a sense that they should be able to do it all, and unrelenting high standards for themselves. For Sarah, this involved comparing herself to others in terms of achievement. For others, such as Claire and Lucy, it related to a sense that they should always do more, or say yes to demands on them. By becoming more accepting of their imperfections, weaknesses and limitations, Claire was able to acknowledge that she could only do so much, and Lucy became more willing to assert her boundaries.

The idea of recognising limitations as an impact of engaging in RPGs is consistent with Ingram et al (2020), and particularly important given the reported culture of perfectionism in the medical field (Gerada, 2020; Ng & Isaac, 2021). However the role of acceptance in this has not previously been explored. For the current participants, a part of reconciling their humanness with being a doctor seemed to be accepting that they had limitations and could not expect themselves to be perfect, and that they would experience annoyance, frustration, uncertainty and anxiety and other emotions which they would not always be able to completely keep out of their work.

4.3.1.4 Contact with the Present Moment

ACT theory highlights the brain's tendency to go back to past mistakes or to project into the future, and increased contact with the present moment can reduce this (Schultz, 2021).

Participants seemed to be developing an increased ability to recognise and process emotions 'in the moment', particularly when sitting 'outside' of discussions and listening. For some, this involved noticing emotional reactions they had not been aware of before, in themselves and others. Readiness and openness to fully experiencing emotion is an important component of ACT (Hayes et al, 2012). Whilst developing contact with the present moment, participants are asked to keep their attention focused on the emotions, thoughts and feelings they are experiencing at a particular moment (Segal et al., 2002; Singer and Dobson, 2007) and to develop skills in 'observing' and 'noticing' these as they come up (Wojnarowska et al, 2020). It is arguable that the opportunity to be 'present' with their feelings and give them space, something several participants, including Sarah and Claire, said they were not doing elsewhere, may have arisen because the group format allowed for greater contact with the present moment, where it was not just okay but expected that participants would be open to their feelings.

Research has found that when mindfulness is applied without acceptance, it can strengthen rather than reduce negative emotional reactions (Wojnarowska et al, 2020). Participants' development of acceptance may account for the fact that, unlike in some previous research (Vatne et al, 2009; Knight et al, 2010) most participants did not describe finding this process distressing. While some, like Ben, Alice and Jane, found it draining or intense, this does not seem to have created a barrier to their engagement. Tricia, Lucy and Jane all identified the facilitator as an important factor in allowing these more emotional aspects of groups to emerge and to feel safe. This is consistent with previous RP research, which has emphasised the importance of the facilitator in creating a safe space for when emotions surface (Lyons et al, 2015; O'Neil et al, 2019).

Outside of the groups, participants' accounts of noticing a change in their patient consultations may also point to the development of greater contact with the present moment. Ben identified a greater willingness to sit with his own feelings about consultations, whether he felt they had 'gone well' or not (p10, 446-449). Tricia described herself as more likely to stop and think during her

consultations about what might be happening for the patient, and Caroline also recognised an increased tendency to do this.

It is arguable that the strengthening of their present-moment awareness helped participants to navigate their emotions, as an aspect of their humanness and being a doctor, by supporting them to notice and manage these in the moment.

4.3.1.5 Values and Committed Action

Participants also seemed to become more conscious of their values and of acting in accordance with these rather than in the pursuit of goals. Hatem et al (2019) asked 3rd year medical students to write an essay describing a time when they *'felt like a doctor'*, and found that when students were able to integrate their personal ideals with their professional values, they were able to build professional identity. The findings of this study support the importance of values in reducing imposter feelings. Coming into the groups, participants's ideas of themselves as doctors seemed to be very much goals-focused, in terms of achieving and behaving to the required standard, and competing with their peers, something Sarah referred to *(Sarah, p12, 553-555).* The conflict between humanness and being a doctor could be seen as partially related to a conflict between values and goals, in that conflicts were apparent between trainees' desire to show compassion and care for patients (reflective of their humanness) and the need to be efficient and reach required goals or targets as a doctor, and between their want to give space to their 'human' emotions and the 'goal' of being as emotionally composed as possible. Arguably, moving closer to their values may have supported participants to more closely align their 'humanness' with being a doctor, and reduced their imposter feelings, as they were less inclined compare themselves to others in terms of the attainment of goals.

Related to this is the commitment to value-based action. Participants, particularly Ben, described a sense that when they integrated their learning and experience from groups into their work, they felt better able to help their patients. Similarly, participants described an increase in empathy with patients and colleagues, also reflective of previous RP researrch (Wald et al (2016), which may have brought them more into line with the values with which they entered the profession. Commitment to value-based action is the most visible behaviour change aspect of ACT since it occurs in the external world (Schultz, 2021). Some participants described a noticeable behaviour change as a result of their group participation, and these changes seemed to be more 'human' in nature (listening more attentively, increased empathy and reflection in consultations, being more thoughtful in their communications with others) and more closely aligned with the value of providing better care for patients.

Psychological flexibility, therefore, would seem to be an important mechanism in supporting participants to navigate the relationship between their humanness and being a doctor. However,

another important aspect of the emergent theory is participants' development of compassion, which is explored in the next section.

4.3.2 Compassion (CFT and the Three Circles: Threat, Drive, Soothe)

The development of compassion, for self and others, emerged as a major category, and as such it felt important to also examine the emergent theory alongside theories underpinning the development of compassion. Processes making up the emergent theory appear to be reflective of the theory behind Compassion Focused Therapy (CFT; Gilbert, 2009; 2014), with the three circles of CFT seeming to have particular resonance. CFT defines compassion as *'being open to and moved by one's own suffering, experiencing feelings of caring and kindness toward oneself, taking an understanding, non-judgmental attitude toward one's inadequacies and failures, and recognising that one's own experience is part of the common human experience'* (Neff, 2003, p224), which seems to relate quite closely to the way participants approached their, and others', 'humanness' in groups.

'Humanness' in CFT includes our 'common' experiences of pain, fear and sadness, joys and setbacks, disappointments and difficulties (Comninos, 2022) which feels similar to participants' conceptualisation of humanness as including emotions, vulnerabilities and struggles. However, for participants, these conflicted with ingrained ideas about 'being a doctor'.

CFT theory recognises the way human brains are a product of evolution, and are particularly shaped and evolved for social processing (Gilbert, 2014). As such, it acknowledges the key influence of attachment, and of early and current social context. CFT theory posits that socially constructed hierarchies and ranks, such as oppression, have a huge impact on people's psychological wellbeing (Kraus et al, 2012; Wilkinson & Picket, 2010) and that mental health difficulties arise because of the way these rank-focused motivational systems operate in certain contexts (Johnson et al, 2012; Wilkinson & Picket, 2010). As such, it acknowledges that the context, as much as the inner motivational systems, can be problematic (Gilbert, 2014). It also recognizes that groups compete with one another which can give rise to destructive behaviours towards 'out' groups, focusing on the way in which social context, not just ingroup/outgroup motivational systems, over stimulates and perpetuates these systems (Sidanius & Pratto, 2004) leading to such atrocities that can be seen across human history as extreme cruelty, ethnic cleansing and slavery (Gilbert, 2014). Perceiving oneself to be part of an inferior, excluded or stigmatised group can be a source of fear and shame (Gilbert, 2007) and this can feed into the motivational systems, particularly threat. This recognition of the influence of the system on individuals' motivations and behaviours has considerable relevance to the emergent theory, as participants are operating within the medical field, which is one of power, with its particular hierarchies, focus on status and achievement, and competition for limited resources, where emotion and vulnerability seem to be associated with weakness or failure, and mistakes and limitations with a lack of competence. As doctors, it would

make sense to view participants' motivational systems as highly influenced by this context, rather than as something that is just within them.

These motivational or emotion regulation systems are represented by the three circles of CFT (Gilbert, 2009): threat, drive, and soothe. CFT theory posits that difficulties are caused by an overuse of the threat and drive systems, and an under use of the soothing system (Gilbert, 2014). 'Threat' creates powerfully motivating emotions such as anger, anxiety, aversion, disgust, in response to potentially threatening stimuli. 'Drive' pushes us towards the things we want or need, or believe we need, in order to prosper (Gilbert, 2014), which in the case of participants to the current study, arguably includes the goal of being a doctor. When in balance with the other two systems, drive can help keep us activated. However, it often also leads people to overcompensate for feeling bad about themselves which can lead them to pursue achievement in unrelenting and rigid ways (Gilbert, 2014). This can lead to perfectionism (identified as prevalent in the medical field, see Ng & Isaac, 2021), stress, burnout, and in some cases depression particularly when motives/goals get blocked (Taylor et al, 2011), which feels highly relevant to accounts of the mental health of doctors (see GMC, 2022). In contrast, the soothing system deactivates, and allows us to soothe ourselves and others (Gilbert, 2009). It is linked with giving and receiving care, affection, acceptance, kindness, warmth, encouragement and support (Comninos, 2022).

Prior to coming into groups, the accounts of participants in the current study suggested that they may have been spending most of their time oscillating between 'threat' and 'drive' modes (Gilbert, 2014). And because 'drive' was threat-based, this left no space for failure, as any experience of failure triggered threat via self-criticism (Longe et al., 2010). It would seem that participating in RPGs may have increased the amount of time trainees spent in 'soothe' mode, where they felt safe, and more able to step back and listen/reflect, and feel compassion and care.

Participants' growing sense that 'I am not alone' could also be said to arise from an increase in compassion, which includes the sense of belonging, being like and feeling connected to others (Baumeister & Leary, 1995; Cacioppo & Patrick, 2008). For Neff (2011) the ability to contextualise one's suffering as part of the human condition as opposed to personal, individual and alone is a key aspect of compassion, and feelings of 'aloneness' are a key focus for CFT (Gilbert, 2014). For participants who seemed to have embedded ideas from medical culture that emotion is individual and personal (Schwartz et al, 2022) this recognition of suffering as a 'human' experience may have facilitated the development of compassion.

Previous research has found developing compassion to be an impact of RP (Fainstad et al, 2022; Taylor et al, 2018; Launer, 2016). Sarah drew attention to the experience of empathy from her colleagues in the groups as helping her to recognise how hard she could be on herself, and Claire described developing increased empathy with her patients and colleagues. This increased empathy could an aspect of developing compassion. According to Gilbert (2014) once we are in contact with suffering we can have an appropriate emotional reaction, that is the ability to be emotionally connected, attuned, and affected by suffering, sometimes called emotional empathy. The differences

between empathy and compassion are worth reiterating here as they have important implications. Neuropsychological research has demonstrated the two states activate different regions of the brain (Dowling, 2018). And research has found that whilst the development of compassion is likely to be a protective factor against burnout, an increase in empathy, particularly clinical empathy, may create greater vulnerability to burnout (Dowling, 2018; Samra, 2018). This brings to mind Ben's assertion that having become more aware of his emotions in groups, he sometimes then felt 'left' with them. Research has found that where empathy for another leads to compassion, this is a protective factor against the potentially emotionally exhausting impact of empathy, as it generates more positive reactions in the brain (Dowling, 2018). The development of compassion may have mitigated the emotional impact of participants' increased empathy, allowing them to bring this aspect of their 'humanness' to their work, as studies have found that through compassion training one can continue to feel empathy, but gain the capacity to feel positive emotions rather than distress (Klimecki et al, 2013).

Gilbert (2014) also posits that engagement with suffering creates the opportunity to sit with and understand our own experiences and feelings, and that we bring an accepting, non-critical, non-judgmental approach to the process of being open to and attending to suffering. This is suggestive of an interplay between acceptance and the development of compassion for participants, and also suggests compassion may have had a role to play in participants' increased recognition and processing of their emotions. It is relevant that Ben described the groups as 'non-judgemental', and Sarah spoke about feeling a 'warmth' from the group which she was aware she did not show to herself.

In general, participant accounts seem to suggest an increase in their self-soothing capacity. All the ways in which they described integrating skills and understanding into their work involve taking a step back, which suggests an increased sense of safety, in that they were more able to approach challenging patient and colleague interactions or express their feelings without this triggering threat. Their reported tendency to be kinder to themselves may have reduced their sense that they needed to be perfect or fear of making mistakes which may previously have triggered threat. And their increased ability to activate the soothing system may have supported them to handle disappointment and difficulty in their work without spiralling into self-criticism or self-attacking (Gilbert, 2014).

Also indicative of an increase in feelings of safety and self-soothing is participants' increased openness to receiving feedback from others. Ben reflected that having to just sit and listen to others discuss his case without being able to respond had made him more open to hearing other points of view, where previously he might have been defensive or interpreted this as criticism *(Ben, p5, 188-193).* He related the reduction in his defensiveness when hearing how others might have done something differently to the development of his listening skills. However it is also possible that his increased willingness to talk about his struggles and open himself up to different points of view was as a result of an increased activation of the soothing system, reducing his sense of threat so he was more able to listen without experiencing shame or self-criticism, or this triggering imposter feelings.

Previous research has identified that an increase in compassion, including self-compassion, can be an impact of RP engagement (Taylor et al, 2018; Ingram et al, 2020) but the findings of this study shed some light on what this might mean in practice. Research has also identified the impact of increased psychological safety on levels of IS in medical trainees (Edmondson, 2018). It perhaps would seem self-evident that the presence of a psychologist-facilitator would promote an environment of greater psychological safety, however, it is possible that this may be mediated by greater activation of the soothing system, meaning that as a doctor speaking up and acknowledging limitations, expressing vulnerabilities or insecurities, all aspects of 'humanness', did not automatically trigger 'threat' mode.

Previously, the GP trainees were associating failure with not being 'up' to being a doctor. It would seem that by relating to themselves in a more compassionate way, they were less likely to be motivated by fear or their threat system. Gilbert (2014) posits that generating affiliative feelings to self and others, and knowing others feel like that to oneself, helps us to function at our optimum (Gilbert, 2014) and the idea that by accommodating their 'humanness' in their practice they could provide a better service to patients emerged as something that helped trainees to align this with 'being a doctor'.

The apparent development in RPGs of participants' ability to activate their soothing system and remain in it when presented with threat seems to be an important mechanism through which they navigated their 'humanness' and being a doctor. The techniques for cultivating compassion are commonly taught in groups, in recognition of psychological wellness as a social phenomenon (Dowling, 2018). Research into group based CFT suggests that it can result in an increase in self-compassion and compassion for others, and a reduction in fear of compassion (Asano et al, 2022), all of which seemed to occur as a result of participants' RPG participation.

While compassion is clearly an important mechanism in participants' navigation of the relationship between their humanness and being a doctor, their accounts also suggest an important development in their perspective taking ability, which is explored below.

4.3.3 Mentalisation (and MBT Theory)

Several trainees identified 'thinking about thinking' as emerging from group participation, including Sarah '*…like I say it's the thinking about thinking. Because a lot of people don't do that.' (Sarah, p6, 266*), and Ben, who referred to thinking about his own thoughts and feelings.

This idea of 'thinking about thinking' suggested that mentalisation might be another mechanism through which participants navigated their humanness and being a doctor. As such, I examined the emergent theory alongside the theory underpinning Mentalisation Based Therapy (MBT; Bateman & Fonagy, 2004), and again found it to be reflective of this. MBT focuses on improving understanding of oneself and others. Clients focus on what is going on in their minds, and

think about what might be going on in other peoples', particularly in situations which may cause strong emotional reactions or problematic behaviours.

A development in mentalising capacity could account for participants' increased recognition and consideration of their own and others' thoughts and feelings, development in perspective taking ability, enabling them to experience an increased empathy with colleagues and patients, reduced feelings of isolation, and sense of being better able to manage emotional responses. Caroline and Tricia referred to aspects of group discussions where their colleagues prompted them to consider the perspectives of others and reflected that it helped to increase their empathy and compassion for patients and colleagues. Caroline's description of considering the perspective of her patient rather than just interpreting their behaviour as 'difficult' is a clear example of mentalising. As is Ben's recognition that: *'…for them* [patients] *it's quite a difficult thing coming to speak to a GP' (p13, 599).* Tricia reflected that prior to coming to the groups, in situations where she perceived a patient or colleague was being difficult she had never reflected on what might be happening for them to make them behave that way, suggesting that mentalising had never been a part of her work as a doctor. Her description of this as helpful in mitigating the emotional impact of difficult patient and colleague encounters is consistent with previous RP research by Carmichael et al (2020), who found that participants developed their perspective taking ability to allow for a more open and curious approach, and appeared to use this to enable them to make sense of their clients' presentation and perspective. And Marathe and Sen (2021) argue that when the emotions of other participants are included, the reflective process can grow into empathic reflection, where *'the reflector, along with the focus on his/her emotions, now is able to understand and identify with the perspective of others'*, something that Farrell (2021) identified as occurring in Teacher RP. This supports the idea that mentalising capacity can develop through RP.

Participants also described an impact of their colleagues recognising their feelings. Tricia, Caroline and Lucy highlighted the importance of the group facilitator in allowing them both to better understand their own feelings and to recognise and relate to the feelings of others. This suggests they were able to benefit from their colleagues' increased mentalising capacity as well as the development of this in themselves.

Participants' sense that their struggles were individual and personal, and their consequent difficulties relating to colleagues who they viewed as coping better than they were, seemed to be exacerbating the difficulties they were experiencing. This led to imposter feelings in some cases, and feelings of failure in others when struggling with patients whose behaviour they interpreted as difficult, and feeling unable to bring the empathy and care they felt they should be. This lack of recognition of their own and others' thoughts and feelings was arguably causing them to feel very isolated in aspects of their humanness which conflicted with the way they felt doctors should be and behave. Sarah pointed out the potential risks of this *(Sarah, p3, 129-130).*

Where participants brought an increased awareness of others' thoughts and feelings to their interactions with patients and colleagues, this supported them to consider what might behind the

reactions they were interpreting as difficult, and their own struggles with this, which may have reduced their sense that these things were happening because they were not good enough as doctors. It may also have given them a greater sense of their patients' and colleagues' humanness as well as their own.

Also relevant to this are participant accounts of an increased tendency to think about how they communicate with others. Their descriptions of feeling a pull to respond to colleagues' stories with one of their own, particularly where they could relate to the situation or emotions it provoked, is consistent with Launer (2016), who found this to be common in participants first coming into discussions using reflecting teams, and emphasied the benefits of learning not to do this: *'almost everyone reported being astonished by how hard it was to follow a strict set of conversational rules like this, and yet how rewarding the results were when they did'* (p245). Participants in the current study reported finding the same, which suggests that the 'reflecting team' format of RPGs was important in supporting this development of their communication skills, and several participants emphasised the role of the facilitator in this. However, when considering what underpinned this development, consideration should be given to increased mentalising capacity, as participants were able to think about their colleague's scenario from their colleague's point of view rather than from their own, so were less likely to respond with what they did in a similar situation.

Also potentially reflective of an increased mentalising capacity is Ben, Tricia and Caroline's recognition of an increased tendency in their clinical consultations to stop and think what might be happening for the patient, and Claire's observation that although she did not think her patient interactions had changed, she was more aware of what her patients might be going through.

Participants also highlighted an increased tendency to think more carefully about their contributions to discussions. Lucy said that she was more likely to say something in difficult situations rather than stay silent for fear of conflict, but was also more conscious of pausing to consider what to say and when might be the most appropriate time to say it, something she had taken into her personal life as well as her work. Jane also reported an increased tendency to pause and think what might or might not be helpful for her to say when a conflict of opinion came up at work, rather than just jumping in. These changes suggest a development of their mentalising skills, in thinking about how any interjection they make might be received by the other person, and responding in ways which take the other's perspective into account. Previous RP research has found that participants notice a tendency to be more thoughtful in how they engage with others (O'Neil et al, 2019) and for participants in the current study, the development of an their mentalising ability seemed an important mechanism behind this.

These findings are consistent with an RCT by Ensink et al (2012), who found that training in mentalisation significantly improved the reflective function of CP trainees. More recent research from the CP field by Sandusky and Spinks (2022) associated greater attunement with clients with increased self-awareness, or self-understanding as a result of engaging in RP. The current study suggests that GP trainees also experienced this with challenging patients, but their increased self-

awareness may have been a result of an increased capacity for mentalisation. Participants seemed to be developing a greater sense that they could acknowledge aspects of humanness, their own and others', without this impacting so deeply on their sense of themselves as doctors, and could recognise where others' apparently challenging responses may be due to those people's own thoughts and feelings, rather than any 'failure' on their part.

Like ACT and CFT, MBT is also frequently delivered in groups. In group-based MBT, participants develop awareness of how they are similar to and different from other people through hearing different perspectives (Karterud, 2015). This feels similar to trainees' reflections that hearing from their colleagues' in RPGs allowed them to recognise how they might do something differently from other people without this making them any more or less of a 'real' doctor, something Claire made specific reference to (Claire, p7, 313-317). Being exposed to different perspectives also emerged as an important aspect of help-seeking in groups, with several participants describing seeking out different perspectives and, as Oliver put it, hearing from colleagues who came from different walks of life.

In the sense that it appears reflective of MBT theory, participants' navigation of their 'humanness' feels relational in nature, in that it involves a recognition of not just their own humanness, but that of others, including patients and colleagues. This could be said to account for some of the changes they integrated into their work, and beyond. Interestingly, according to CFT theory, when we are able to engage, and emotionally connect with, hold and tolerate suffering we then become capable of developing mentalising and have empathic insights; we can shift out of an egocentric perspective and take the perspective of somebody else or a different part of ourselves (Gilbert, 2014). This is suggestive of an interplay between the development of compassion and mentallisation for participants. Given that there is also an interplay between the development of acceptance and compassion, it is arguable that all the mechanisms discussed above had a role to play in supporting participants to navigate the relationship between their humanness and being a doctor.

4.3.4 What does this tell us about participants' use of RPGs?

I have examined these theories separately, and yet found that processes identified in the emergent theory are reflective of all of them, suggesting that they could all be helpful in understanding participants use of RPGs and the functions these served.

All of the mechanisms explored above are associated with psychological wellness. Recent research has pointed to the central role of psychological flexibility in healthy functioning (Doorley et al, 2020), and mentalisation and compassion have been found to be key factors in mental health (Ballespi et al, 2021; Klimecki et al, 2012). If participants are developing these in groups, this has important implications, as it points to the IRPP as a potentially useful intervention for supporting GP trainee emotional wellbeing.

An interesting aspect of all of these models is that they underpin therapeutic approaches commonly delivered in groups, thus supporting the group format of the RPGs and suggesting that the presence of a counselling psychologist facilitator may have brought a more group therapeutic dimension to the group space. The facilitator emerged as an important contributor to the development of all of these processes, and although their role was not to provide guidance and support in skills development the way it would be in group therapy, participant accounts varied in terms of how much they sought, or wanted the facilitator's particular perspective, guidance and advice, with some clearly seeing this, or wanting this to be, more of an aspect of their role than others

Another important aspect of all these theories is that they provide a possible account of how participants in RPGs might be protected from the potential harms of RP, and in particular the potential risk of bringing one aspect of their 'humanness' to their work as a doctor, that is the emotional cost of increased empathy, which can create greater vulnerability to burnout (Dowling, 2018; Samra, 2018). ACT theory would suggest that increased psychological flexibility, in particular increased acceptance, supported the trainees to manage the emotional toll of increased empathy towards patients. CFT theory would suggest that the development of participants' ability to attend to and tolerate suffering allowed their empathy to develop into compassion, which has been shown to be a protective factor against burnout (Dowling, 2018). And in terms of mentalisation, the recognition of themselves and their patients as separate people with different perspectives, thoughts and feelings, may have supported participants in not over-identifying with patients' emotions when bringing their empathy. Further, MBT has been found to enhance emotional resilience, as a deeper understanding of our emotional experiences can allow us to respond in challenging situations with greater clarity and composure (Safiye et al, 2023). Halpern (2001; 2003) argued that incorporating interventions which build compassion into medical training could be helpful in supporting doctors to bring emotions into their relationships with patients, but is arguable that an intervention which strengthens any one of these mechanisms could be equally effective. Participant accounts seem to suggest the IRPP RPGs strengthened all three.

This insight into the possible development of these mechanisms, which supported participants to navigate the relationship between their humanness and being a doctor, is distinct from previous research, which has examined the impact of RP engagement but has not explored what might be underpinning this.

All of the therapeutic models discussed above involve the development of skills, in areas such as mindfulness (ACT), activation of the soothing system (CFT) and mentalising (MBT). The development of skills and understanding was a key dimension of participants' use of RPGs. And while the skills participants described were listening, communication and reflective skills, they all seemed to involve degrees of increased psychological flexibility, including present moment awareness and acceptance, increased capacity to self-soothe, and increased mentalising capacity. For example, being more likely to talk about their feelings is suggestive of participants' increased openness to this aspect of their humanness and willingness to bring it into their role as a doctor,

which could be said to be indicative of greater psychological flexibility. It may also suggest that they were beginning to approach their work from more of a 'soothing' place, rather than from ‘threat’ or ‘drive’ mode, making them feel safer to name their emotions with colleagues. A recognition that experiencing difficult emotions is inevitable and something everyone goes through is associated with increased compassion, and an increased ability to recognise emotions in themselves and others is suggestive of an increased capacity for mentalisation. Participants would be unlikely to name these phenomena in the ways we might as counselling psychologists, but nevertheless they all seemed to be present in the way they used groups, and their accounts of skills development and integration.

Something else that feels distinct about this research is participants’ accounts of extending this to their lives outside of work. Previous research has identified some of the ways healthcare professionals use RP in their work but has not examined any change in their personal lives. Sarah highlighted that she was more prone to have conversations about how she was feeling, or ask others how they were feeling, outside of work. Oliver identified being more likely to talk to his partner and others outside of work in an attempt to re-frame his feelings of frustration and despondency about his training. And Alice described noticing in conversations with friends where she or others were responding to an account of a difficult situation with one of their own. Although some participants expressed either that they did not think they had integrated any of these ideas into their personal lives, or that they might have but had not thought about it before, the fact that even a few participants were noticing a change in their personal lives suggests that this warrants further investigation. Ben asserted that when you develop skills such as the ones he developed in the groups you *‘develop as a person’* and therefore will not just use them within that particular context, but more generally. If participants were developing increased psychological flexibility, compassion and mentalising capacity through their group participation, as well as supporting them to navigate the relationship between their humanness and being a doctor, these mechanisms have more general application, which may explain why some participants described a sense of a more personal development through the groups, rather than just the development of a set of skills to aid the process of reflection in their work.

4.3.5 What particular considerations do these theoretical perspectives raise for the emergent theoy?

Although the emergent theory is reflective of all of the existing theories set out above, CFT theory, with it’s focus on interpersonal relationships and the social context, would seem to have the greatest resonance, in that it considers the influence of the system and how particular hierarchies as well as systems of oppression can result in experiences of shame, being othered or part of an ‘out’ group, which feed into the threat system (Gilbert, 2014). Recognising the context, in this case the medical field of power, within which participants were training, working, and attending RPGs, rather than looking at purely within-person factors, is vitally important when exploring how they made use of RPGs. Participants’ apparent sense of a conflict between their humanness and being a doctor

seemed in part to be a result of established ideas from medical culture and what they had been taught about socially desirable ways a doctor should be and behave, and environmental and resource issues impacting on this were directly related to the systems and social context in which they were working. Participants used the groups to develop ways of navigating the complex relationship between their humanness and being a doctor, but the extent to which they are able to take these into their work going forward will inevitably be impacted by their context. To this end, the emergent theory would also seem to be reflective of systemic theory (Dallos & Draper), which also focuses on interpersonal relationships and locates difficulties within the system rather than the individual. However, arguably CFT theory, with its acknowledgement of the influence of evolutionary psychology, brain development and relational neuroscience, and the way these influence and are influenced by social motives and the social context (Gilbert, 2014) may have greater resonance with doctors.

Both Lucy and Alice made reference to the relevance of the system/context as influencing whether they planned to continue with RPGs. Alice reflected:

'if you're in a good (.) sort of GP practice where (.) there's a lot of contact with the other (.) the rest of the (.) the wider team then (.) yeah (.) which I'm quite hoping to be [laughs] *then yeah I think so' (Lucy, p5, 275-279).*

And Lucy suggested that if greater emphasis is to be placed on doctors' emotional wellbeing, this would require a change in NHS culture:

'…I just think there isn't that check-in process as much as everyone says there is I don't (.) I just don't think there is cause everybody's under stress and everyone's under pressure and nobody (.) it's an added (.) to me looking back now I think it (.) and I completely understand their position (.) it's like 'oh this is a problem now (.) it's a problem that I have to deal with and I have all these other things' (Lucy, p15, 669-673).

Lucy also highlighted this as one of the reasons it felt so important that the RPG facilitator was someone external to the service (consistent with previous findings by O'Neil et al, 2019). Having an external facilitator, who is separate from the social context of medical training and practice, is potentially important in mitigating the impact of the system on way participants are able to use RPGs, however a broader cultural change in medical training may be needed if there is to be a meaningful impact on doctors' emotional wellbeing.

The fact that the emergent theory appears reflective of all the theories examined could be said to reduce the usefulness of each of these in explanatory terms. This is of less consequence in practice due to the purpose of the RPGs compared to group-based ACT, CFT or MBT. While the presence of the CoP facilitator may have brought something of a group therapeutic dimension to

RPGs, these were not, and never intended to be, group therapy. While it is arguably positive that the training and background of the CoP facilitator seemed to enable the development of these more psychological processes in participants, it emerged as equally important to participants that the RPG structure was held, and that the groups did not turn into something else. As a whole, participants reported finding it helpful when the facilitator played an active role in maintaining the structure and format of groups and focus of discussions. Creating an environment which has the structure and focus of an RPG, but also allows sufficient space for these more therapeutic aspects to emerge carries a possible risk that the groups might end up achieving neither to a sufficient extent to be helpful, or could potentially cause harm in that participants may struggle when difficult emotions arise in groups to contain these outside of them, something Ben experienced when he felt he had been 'left' with his feelings following emotionally challenging group discussions, which risks leading to rumination (Lengelle et al, 2016) or difficulties in practice.

This raises questions about what these RPGs can, and should, provide. The extent to which the emergent theory reflects existing theories which underpin therapeutic approaches suggests that it would be worth considering whether an element of psychoeducation, or training in skills to support psychological flexibility or to active the soothing system (such as mindfulness) would be a helpful addition, and something the CoP facilitator would be in a position to contribute. However, this raises questions over whether this would mean departing too much from the purpose of the groups as an RP intervention. Schwartz et al (2022) argue in favour of the introduction of more interventions which equip medical trainees with the tools to manage the emotional demands of practising medicine. However Launer (2011) argues that when a reflective discussion turn into requests for advice and the offering of suggestions, this is no longer RP.

On this point, it is worth considering that Launer (2016, p245) was referring to the immediate urge to respond to colleagues' cases with advice, and take a 'problem solving' stance. This is something quite different from the provision of psychoeducation, or training in skills such as mindfulness, although these are also not consistent with 'pure' RP. It is also worth considering what is meant by 'tools'. Ben's request for this implied a desire for practical advice and strategies, whereas Oliver used the word 'tools' to refer to the different, more psychological, perspective that the facilitator supported him to develop, which he was able to take into his work. And Ben later went on to describe the reflective skills he had developed in groups as having helped him in his patient consultations. This suggests that the very different processes involved in RPGs may constitute 'tools' in themselves. For example, participant accounts of an increased tendency to pause and reflect supports Launer's (2016) suggestion that the act of reflection alone constitutes a useful tool. Similarly, the apparent development of inner dialogue may also constitute a useful tool which participants were able to take into their work. Launer (2020a, p507) asserted: *'I would like to predict that one of the next big developments in medical education, particularly at the postgraduate level, will be to make the importance of inner dialogue more explicit'* (p507). The findings of this study suggest that participants were more likely to engage in this kind of internal dialogue as a result of

participating in RPGs. Further, the apparent development of greater psychological flexibility, self-soothing and mentalising capacity could be seen as 'tools' to support participants to navigate their humanness with being a doctor, without the need for these to be explicitly named by the facilitator or to become the focus of the groups.

It is worth noting that when I asked what, in their view, was the purpose of the RPGs, all of the participants referred to having space for aspects of their 'humanness'. Sarah said: *'having that set time where I can talk about… feelings' (Sarah, p10, 458)*. Oliver, while referring to developing reflective skills, highlighted the chance to hear *'novel perspectives' (Oliver, p16, 706)*. Claire (p8, 358), Jane (p7, 321) and Alice (p7, 298) all highlighted getting peer support. Alice also raised sharing ideas and *'being able to… manage our… what's going on in our brains' (Alice, p7, 299-300)*. Caroline highlighted hearing what others are going through. For Tricia, the purpose of the groups was to *'get a (.) situation that you're struggling with off your chest' (Tricia, p5, 228-229)* but she also emphasised becoming more reflective and improving her communication skills as longer-term benefits. Ben referred to the opportunity to talk about his difficult patient interactions in a safe and non-judgmental environment and hear different opinions, while for Lucy the groups provided an outlet to talk about her struggles and feel less isolated in these *(Lucy, p10, 460-464).* As well as referring to aspects of humanness (emotions, connection with others, sharing struggles) they all refer to the supportive aspect of groups and the chance to hear different perspectives. This suggests that RPGs are able to provide some of these more group-therapeutic aspects without departing too far from the focus on RP.

4.4 Findings in the context of wider literature

The findings of this study are consistent with wider literature in relation to the impact of participating in RPGs on compassion, including self-compassion (Carmichael et al, 2018), professional identity (Sergeant & Au-Yong, 2020), feelings of isolation Taylor et al, 2018; Ingram et al, 2020; O'Neil et al, 2019) and support research which has suggested that RPGs provide a platform for exploring emotions (O'Neil et al, 2019; Vatne et al, 2009; Knight et al, 2010), have a role to play in 'normalising' vulnerability and uncertainty (Solms et al, 2021) and can reduce imposter feelings (Chodoff et al, 2023). They support previous research which has highlighted the role of the facilitator in supporting the reflective aspect of the process (Richard et al, 2019l) and in creating a safe space (O'Neil et al, 2019; Lyons et al, 2019). Where they differ is that the provide insight into the mechanisms and processes which may have underpinned participants' accounts of using the groups to navigate the relationship between their humanness and being a doctor, and in this way provide new insights into the function of RPGs, rather than just highlighting the difficulties medical trainees face and the impact of having a space to discuss these.

The findings support the benefits of interprofessional collaboration in medical education and training (Launer, 2015; 2018; Freeth, 2013) including Launer's (2015) view that it can provoke a

recognition and challenging of taken for granted assumptions, which in the current study seemed to include those about how Doctors should be and behave.

Other findings which resonate with the wider literature include participant descriptions of finding it uncomfortable when there were periods of silence while they waited for someone to bring a case to the group (O'Neil et al, 2019). However, in the current study, some participants like Jane, reported that the discussions helpful even if 'older' or 'less relevant' cases were brought to 'avoid' these periods of silence, because it transpired that either these were still impacting on the presenter, or they provoked interesting and helpful discussions which had relevance to current situations she or others were facing.

Somewhat in contrast to previous research such as Hatem et al (2019), Wald et al (2016) and Davis et al (2009) which highlight benefits of and positive trainee responses to reflective writing in medical training participants in the current study described finding the RPGs considerably more helpful in developing their reflective skills than the written reflections for their portfolios. These findings are closer to Sergeant et al (2011), where while some medical students described the use of portfolios as stimulating a deeper level of reflection, a larger number reported that they had little benefit and were, at best, a record of performance over time. Oliver described engaging in RPGs as more of a 'human' skill, suggesting a differentiation between bringing his 'humanness' to the process of reflection in the groups, and meeting the expectations required of him as a doctor in his reflective writing.

Also reflective of previous research by Fisher et al (2015) is my sense that participants were making sense of their experiences of RPGs during the interview process. This process of 'reflection on reflection' was identified by Fisher et al (2015) in CPs, who it is arguable may have had a different reflective capacity to begin with than GP trainees. However, the more 'reflective' dimension I noticed in the interview process could be suggestive of the development of participants' reflective skills in RPGs and the continued application of these outside groups. It may also be indicative of the influence of the CoP facilitator, and/or of my own positioning as researcher and CoP trainee.

4.5 Evaluation of the study

This study aimed to create a tentative explanatory model of how GP trainees made use of RPGs in the context of the IRPP, and in so doing contribute to the understanding of healthcare trainees' use of psychologist-facilitated RP, inform the development of the IRPP and the practice of counselling psychologists providing facilitating RP for doctors. The study also intended to address a gap in the literature by focusing on the 'how' of RP use (Wigg et al, 2011). As it stands, little is known about GP trainees' use of RP, in particular as it relates to interprofessional collaboration with CoP trainees, so this study had the potential to generate new knowledge.

In the next section I will discuss how this study met these aims, but also its limitations.

4.5.1 Strengths, limitations and suggestions for future research

The current study is the first of its kind to look specifically at how GP trainees use interprofessional RP, and the first to explore this in the context of GP and CoP trainees supporting one another's training. Participating in this study gave GP trainees an opportunity to reflect on their experiences and use of RPs, but also to talk about their experiences as doctors more generally, something which feels particularly important in the light of how limited doctors' opportunities seem to be to talk about their feelings in relation to their work and the challenges they face (Crowe & Brugha, 2018; Gerada, 2019). I hope that this study sheds light on the emotionally demanding nature of their work and the constant need to negotiate the relationship between their humanness and the expectations of and demands on them as doctors, as well as how they used the RPGs to navigate this.

Boiler et al (2018) identified that within the medical 'field of power', students are able to craft an emotional space to express or act upon their feelings, but for those who feel uncertain or insecure, this may be complicated. They argued that: '*students are not just passively being socialised but are able to find ways of expressing and acting upon emotion that fit their developing professional identities*' (p9) and found that some participants actively created opportunities for expressing emotions as part of their personal and professional development. These findings resonate with the current study, which suggests that participants found a space in RPGs for this. Boiler et al (2018) advocated for a supportive environment where opportunities to express emotions are offered, and it is arguable that the RPGs provided this for trainees.

In light of the similarities between the findings of this study and those of recent studies examining healthcare trainees' and practitioners experiences of psychologist-facilitated RP (O'Neil et al, 2019; Ingram et al, 2020), it is important to consider my influence, as the researcher and a trainee CoP from the same institution as the RPG facilitators. My positioning could be seen as a limitation, as it may have influenced the way participants positioned themselves in interviews, both in relation to fixed ideas of 'being a doctor', and in relation to me. On the other hand, it could be seen as a strength, insofar as it may have made them feel more comfortable to talk about the more emotional aspects of their RPG experiences. Although this may also be reflective of their increased comfort with talking about their feelings in (and outside of) RPGs in general.

The findings of this study relate to one particular intervention in one NHS Trust. As such, there was only a limited pool from which to draw participants. A majority of the participants were female (7:2) and all expressed that their positive experience of the IRPP had motivated them to volunteer for the study. Future research should seek out participants whose experiences were negative, whose attendance was not so high, who did not feel they had experienced any change, or had experienced change for the worse, as a result of their participation, in order to broaden the analysis and to challenge the assumption that participation in RP is likely to have a positive impact.

The relatively homogenous nature of the sample was something of a departure from GT protocol (Willig, 2013). Further research with a more diverse sample could provide helpful information about the impact of demographic, cultural and identity factors on the ways in which GP trainees make use of RPGs. A more equal number of male and female participants could be helpful in exploring whether there is a gender difference in terms of how participants perceive the relationship between their humanness and being a doctor, and how they used RPGs to navigate this. This could be particularly interesting in light of Crowe and Brugha (2018)'s assertion that female doctors may have to unambiguously adopt the disposition of emotional detachment in order to 'play the game', and Hafferty's (1988, p352) assertion that *'doctors who are women must try harder than men to adopt a "doctorly" way of being, since traditionally medicine has been dominated by male values, attitudes, and stereotypes'.* This is something which did not come up in the current study and would have been hard to explore due to the unequal gender balance in the sample, but it could be a useful avenue for further research. The cultural homogeneity of the sample is also a significant limitation, in that the resulting theory reflects a White Western lens which is likely to have impacted on what was understood or identified as 'humanness', what aspects of this were emphasised and valued by participants, and by myself in co-construtcing meanings with them, and the extent to which the expression of emotion, help seeking, and indeed the process of reflection itself was assumed to be desirable/positive. I have reflected upon my own influence on this as a White researcher, both in Chapter 2, and below (4.7.2), and consider that future studies which specifically explore the experiences of a more culturally diverse group of GP trainees are vital to understanding the applicability and usefulness of the emergent theory. Explicitly naming this and engaging in theoretical sampling in the current study could have provided an opportunity to actively seek out the experiences of trainees from different cultural backgrounds, and would be a good starting point for future research to develop the current study.

Also, no ST1 trainees came forward for this study. As participants' understanding of the purpose and benefits of RPGs seemed to develop over time, further research including ST1 trainees may shed light on the extent to which stage of training was a relevant factor.

For some participants, previous experiences of accessing therapy, specific experiences of burnout, or time taken out of work due to occupational stress, seemed to have impacted on their openness, coming into the groups, to look again at aspects of their 'humanness' and how these fit into their ideas of being a doctor. Previous experience of therapy might also impact on the capacity to recognise and develop psychological flexibility, compassion or mentalisation in the groups. It might be interesting for future research to examine the extent to which experiences such as this impacted on the extent, and ways in which, participants made use of the groups. It might also be of interest to examine the influence of previous career experience, as participants' sense of themselves and their professional identities seemed, at least in part, to be related to their experiences as doctors prior to commencing GP training.

Further, although the facilitator came up as having an impact across all major categories of the emergent theory, the study's focus on GP trainees means it cannot offer any further insight into the experience or impact of the RPG facilitators on the interactions and processes that occurred in groups. Future research focusing on trainee CoPs' experiences of facilitating IRPP RPGs could be of help in identifying not only this, but also the ways in which this experience impacted on their training and practice and professional identity, and in gaining insight into their perceptions of the way GP trainees used the groups. This would seem particularly important in light of the extent to which the emergent theory seems to reflect particular models underpinning therapeutic approaches commonly delivered in groups. Lyons et al (2019) pointed out that there is very little research into the perspectives of RPG facilitators. This is an important area for future research both to inform the development of the IRPP and the practice of CoPs tasked with facilitating groups for GP trainees.

The sample size of this study is only slightly smaller than the low end of standard GT studies (10 participants; Starks & Trinidad, 2007). A larger number of participants may have generated different or additional information, however, recruitment was challenging. Previous research into the barriers to healthcare professionals' engagement in RP could shed some light on why this was so. One identified barrier, which seems particularly pertinent is the time constraints and competing priorities associated with working in the medical field (Lyons et al, 2019; O'Neil et al, 2019; Sergeant and Au Yong, 2020). Lucy in particular drew attention to the fact that as trainees they are so busy it feels like they are *'always fighting fires' (p13, 562)* so they can only concentrate on what they immediately need to do, *'everything else comes second' (p13, 563).* Sarah also described always feeling there was something else she 'should' be doing (p10, 464-465). The current study involved talking about experiences and feelings in a way that, not unlike talking about and reflecting on the non-clinical side of work in groups, may have felt unproductive compared to other things trainees had to do. Launer (2011) argued that there is always time for RP if this is prioritised, something that may or may not have resonance to participating in research, however the challenges in recruitment could be said to speak to the idea that taking the time to talk about one's experiences, whatever form this takes, is not necessarily valued or emphasised in the culture and practice of medicine, or the sense that 'doctors' should be productive at all times. Arguably, a strength of the current study is that it promoted something important to the nature of RPGs, that is the value of talking about our experiences. It is worth noting that several participants expressed following interviews that they appreciated the opportunity to talk about their RPG experiences, and to explore the impact of these in different ways and, as Oliver put it, *'from different directions' (p17, 751).*

A further limitation of this study, common to qualitative research, is that it is not generalisable. Quantitative research would seem to be a vital next step in the development of the IRPP. Future research could seek to quantitatively measure the impact of engaging in RPGs on areas such as reflective capacity, levels of imposter syndrome and burnout symptoms. If as it appears participants are developing increased psychological flexibility, compassion and mentalising capacity through their engagement in groups, this suggests the IRPP has the potential to be an important intervention

in supporting their emotional wellbeing. As such, it might also be useful to use quantitative methodologies to explore the function of the groups in terms of the development of these mechanisms. It is worth noting that a strength of GT is in the clinical applicability of the emergent theory (Bryant, 2009). In this case, a better understanding of the way GP trainees make use of the RPGs, and the function of these could have helpful implications that allow for the development of the IRPP, and could inform the direction of future quantitative research.

Due to the use of abbreviated GT, some categories did not reach complete 'saturation' (Corbin & Strauss, 2008). As discussed in Chapter 2, when conducting the analysis my aim was closer to theoretical sufficiency (Dey, 1999). I do hope to engage in further research using theoretical sampling to more fully saturate the findings.

Finally, the impact of the Covid-19 pandemic on participants' training experiences and experiences of the IRPP cannot be taken out of the equation when considering the findings of this study. As a result of Covid-19 restrictions, all participants had experienced a combination of online and in-person RPGs, and expressed a preference for in-person. Some participants, like Caroline, specifically referred to the pandemic as a factor in this preference, expressing that she had become tired with doing everything online, whereas others like Alice related this preference to her personality. Interestingly, previous research has not identified any particular difference in experience or impact of engaging in online versus in-person RP (see Fainstad et al, 2022). Further research looking more closely at the extent to which the platform of group sessions makes a difference might be of help in ascertaining whether the differences felt were as a result of the pandemic context, or whether the same preference for in-person would be identified, as if so this has practical implications for the future development and delivery of the IRPP.

The sense of isolation and experience of connection and belonging in the groups described by participants may also have been influenced by the context of the pandemic, where there was a more general sense of isolation, with teaching and aspects of practice moved online. Oliver specifically identified Covid-19 as a factor in his feelings of uncertainty, frustration and despondency with training, and several participants spoke about not feeling like they 'knew' their fellow trainees, as due to Covid restrictions they had not met them in person. However, others did not mention it except in the context of engaging in a mixture of group formats. As such, while the sense of isolation described could be explained in terms of systemic and contextual factors, further research with participants from a cohort whose entire training experience post-dated the height of the pandemic might be of help in exploring the extent of the impact of this on the way they use groups. This could also illuminate whether specific aspects of the relationship between participants' humanness and being a doctor might have been influenced or exacerbated by these circumstances. I recognise that the pandemic changed the landscape for medical professionals, and as such it would be almost impossible to take it completely out of the equation, but further research with participants whose training experiences were less directly impacted by Covid-19 could still shed light on a possible factor in the way trainees used the groups.

4.5.2 Standards of rigour and credibility

I drew primarly upon Yardley's (2000) evaluative criteria to ensure this study met robust standards for qualitative research. A table showing these criteria and the methodological response is presented in Chapter 2 at table 2-1. The importance of integrating theory into practice in counselling psychology research (Morrow, 2005) is reflected in the discussion of the clinical and wider implications of this study, including suggestions for counselling psychology practice, at 4.6.

4.6 Clinical and Wider Implications and Suggestions for Counselling Psychology practice

Recently, there has been a push for medical training to place greater emphasis on trainees emotional wellbeing (Doherty et al, 2013), however Schwartz et al (2022) argue that the curricular priorities of the medical field do not pay adequate attention to this, and a recent report by the Society for Occupational Medicine (Kinman & Teoh, 2018) advocated for the establishment of a culture within medicine which promotes mental health and self-care in Doctors. The findings of this study echo recent research in relation to medical trainee and practitioner engagement in psychologist-facilitated RPGs (O'Neil et al, 2019; Ingram et el, 2020), in that participants described an increased sense of connection and belonging and reduced sense that they were alone in their struggles, an increase in compassion, and in self-compassion, and found the groups a safe space to discuss the challenges and the 'human' side of work. While RPGs in O'Neil et al (2019) and Ingram et al (2020) were facilitated by CPs rather than CoPs, this does suggest that something about the specific combination of healthcare trainees/practitioners and psychologist facilitators is a promising one, which could have implications for the reduction of IS and burnout. It might also suggest that the role could be equally effectively carried out by CPs or CoPs. However, it is arguable that counselling psychologists with our emphasis on reflexivity and self-reflection, our specific skills in creating a safe and containing space for the emergence of emotions, for individuals and groups, and the humanistic ethos of our profession, might even be better placed to fulfil this role. Launer (2015) identified as important skills for a facilitator *'empathy, an open mind and a capacity to invite reflection'*, all of which are core skills of CoPs. Further, if as it would appear, participants in the IRPP were developing increased compassion, psychological flexibility and mentalising capacity, then CoPs could have an important role to play in the promotion and facilitation of this. As explored above, this does not necessarily have to be through the provision of specific training, as participants seem to have been developing these mechanisms purely through their RPG participation. But it does raise important questions about whether there is a role for the provision of psychoeducation, and if so how this could be balanced with the need to ensure the groups maintained the RP format and did not begin to be more like group therapy. A theory such as that behind CFT might appeal to doctors as a way of understanding how their 'humanness' impacts on their ability to be and behave 'as a doctor' at all times, due to the emphasis it places on the way the brain is hard-wired to respond in particular

contexts and environments, and the impact of physiological responses to perceived threat (see Gilbert, 2014). With our training and experience in this and other models reflected in the emergent theory, Counselling Psychologists would be well placed to provide this insight. As discussed above, compassion, psychological flexibility and mentalisation are all associated with psychological wellness, so if GP trainees are developing these in groups, this suggests the IRPP could be an important intervention in supporting their emotional wellbeing, in which CoP trainees play a key role.

Attention must also be drawn to participants' accounts of what they valued in, and wanted from, the RPG facilitator. As a whole, participants reported finding it helpful when the facilitator played an active role in maintaining the structure and format of groups and focus of discussions, and when their interventions, questions and comments provoked them to deeper reflection or clarity. Some participants commented that on occasions they had felt 'chastised' by the facilitator in relation to not following the format or maintaining the focus of the discussion on the non-clinical side of work, which suggests that for CoPs tasked with facilitating these groups, there is a balance to be struck between 'holding' the structure and reflective dimension of the process, and allowing participants adequate 'leeway' to find their way in to this without making them feel like they had made a mistake if they departed from this or made contributions that were overly clinical or less relevant to the discussion. This is particularly important in light of participants' sense that as doctors they should be perfect and the conflict between this and the inevitability, as human beings, of making mistakes. Participants varied in the extent to which they wanted the facilitator to bring greater structure and focus to the groups. This suggests that again there is a balance to be struck for CoP facilitators in providing sufficient structure and focus to ensure that conversations are generated rather than shut down, whilst keeping the space open enough to allow participants to bring what feels important to them, and at the same time remaining conscious of the importance of not allowing this to become too detail-focused and surface level, and as such insufficiently reflective. Participants seemed to value the specific structure of the RPGs, suggesting that any potential inclusion of psychoeducation, or promotion of the development of mechanisms discussed above, would need to be carefully integrated into the group format so as to preserve this.

A further implication for Counselling Psychology is the insight the study provided into doctors' emotional wellbeing and the general sense they gave of a need for a space to process the challenges of their work. Two participants expressed that they thought it would be helpful to have access to something similar to the groups but on a one-to-one basis with the psychologist, as a way of checking in with themselves, and felt this would be as helpful as continuing to participate in RPGs. Although only two participants raised this, it does suggest that engaging in the groups may has the potential to make participants more open to the idea of engaging in therapy, or aware of when they might need this. This feels like an important implication for CoPs, in that it draws attention to a possible role for the profession in providing this type of support to doctors, and indicates that if it was offered, doctors would be open to taking it up, or at least those participating in RPGs might be more likely to take it up. This means CoP facilitators should be prepared to signpost to services and sources of

support, but also that if the option of additional support outside of the groups could be included, there may be a role for CoPs in the provision of this. This role would not necessarily have to be focused on the treatment of existing mental health difficulties, but rather could be more impactful in terms of the prevention of mental health issues among GP trainees, particularly as participants seemed to be developing increased psychological flexibility, compassion and self-soothing, and mentalising capacity through their group involvement, all of which are important for mental health. Involvement in training and developing core skills fits with the non-medical model encompassed by counselling psychology, rather than the medical model which treats symptoms once problems start. As such, CoPs are in a good position to promote this. Clearly, the provision of this would have cost and resource implications, but arguably these could be examined alongside the cost of working days lost due to doctors' experiences of occupational stress and burnout. It would certainly constitute a response to the calls for a greater focus on, and interventions to support, GPs emotional wellbeing, and the promotion of mental health and self-care in medical training (Kinman & Teoh, 2018).

4.7 Reflexivity

4.7.1 Epistemological/Methodological Reflexivity

Throughout the research process I kept reflexive memos and a reflexive journal in order to keep in mind how my own views and beliefs might be influencing the research. Some of these are included in Chapter 3. However, I am aware of my involvement in co-constructing the emergent theory, and the choice of CGT reflects this. The social constructivist epistemological underpinnings of this study reflect my recognition of the existence of multiple truths and realities, and the role of social processes in constructing these, and the emergent theory should be viewed as combining participants' descriptions of their use of RPGs and my interpretations of these accounts.

The fact that I was both a researcher and CoP trainee was something I was particularly conscious of when interviewing participants. I adopted a similar stance as I would in my practice, seeking to understand as fully as possible participants' experiences but also to prompt reflection on these, and I am aware of the impact on my approach to practice of my epistemic assumptions. My preferred approaches to therapy tend to have a constructivist epistemological commitment (Mahoney, 1991; Willig, 2018) in that they are more personal and reflective and start from the assumption of the subjectivity of experience and the flexibility of knowledge. I favour a collaborative approach with clients, which I am aware was also reflected in my approach to interviews with participants. My choice of a CGT methodology reflects the level of importance I place on the co-construction of knowledge and on reflexivity. While a phenomenological approach such as IPA may have provided a richer understanding of participants' lived experiences of RPGs, in fitting with the aim of this study I was keen to understand not just how participants experienced the phenomenon of CoP-facilitated RPGs, but also how they made use of it, and the function it served for them.

Adopting Charmaz's (2006) CGT enabled me to engage in the research in an open-minded way and to acknowledge and hold in mind my impact on it, which felt particularly important in light of my closeness to the subject matter. I tried to stay as close as possible to the data provided by participants' and to remain mindful of the impact of medical culture on their ideas about what a doctor 'should' be and how they positioned themselves both within this and with me. Adopting GT also allowed for the generation of the beginings of a theory with potential clinical application, which I hope will inform both the development of the IRPP, and the practice of CoPs tasked with facilitating RPGs for GPs.

The flexibility and openness of CGT was challenging when it came to analysis, and required me to sit with a high level of uncertainty and 'not knowing' whilst the theory was emerging. However this flexibility was also of benefit in enabling me to consider a range of perspectives, meanings and relationships. I hope that the emergent theory represents participants' use of RPGs in a way which they would recognise, and is clear and applicable. Adopting this approach has allowed for the generation of new insights, and provides interesting avenues for further investigation, in particular into psychological mechanisms which may support participants use of groups in the ways they identified, and which are helpful to them in their lives outside groups.

4.7.2 Personal Reflexivity

When interviewing participants, I was very conscious of my own sense that RP is a good thing, engaging in RPGs is helpful, and that I am extremely passionate about interprofessional working and the ways in which we as counselling psychologists can bring our skills and knowledge to different roles, particularly in supporting other healthcare professionals**.** I am very conscious of the fact that this may have influenced the research as early as the recruitment stage, where these assumptions, perhaps based in, my own social context, as a White British researcher from a background where help seeking and the expression of emotions was encouraged, and a postgradiuate training and professional context which emphasises the importance of reflection, may have served to encourage participants of a similar social and cultural background with similarly positive ideas and experiences of RPGs to come forward. I was careful to hold in mind throughout how this might have continued to influence the data analysis and theory development, particularly the development of the core category and definitions of humanness which emerged from participant accounts**.**

As a trainee from the same training institution as the RPG facilitators, I was mindful of the fact that this might influence the way I approached the interviews and the way participants responded to me. Something that I reflected on throughout the data collection stage, and even more so as the theory began to emerge through the process of data analysis, was the way in which my positioning as a CoP, and potential to feel qualitatively similar to participants to the RPG facilitators, may have influenced the way they responded to me. This felt relevant to the way they spoke about 'being a doctor', and where they positioned themselves in terms of the dual ideas of 'humanness' and being

a doctor. It is also relevant to the ways in which they began to reflect on their own processes of reflection during the interviews. I wonder if had I been a GP trainee-researcher rather than a CoP trainee-researcher, they may have positioned themselves differently in terms of how they related to their humanness as a doctor, and whether the dominant ideas from medical culture may have caused them to relate to me differently or provide different impressions had I also had that background. Similarly, I am aware that I feel very passionately about the benefits of engaging in counselling and therapy, and have remained congruent to the possibility that this may have caused me to draw out or emphasise some of the experiences participants brought which are relevant to this. This may also have influenced participants' willingness to identify this as something they may be more open to consider or would actively seek out as a result of engaging in the IRPP. My understanding, training in and experience of models such as CFT and ACT may also have influenced my sense that the emergent theory was reflective of these theories, although I sought at all times to hold this in mind and to remain grounded in what emerged from participant accounts.

I am highly conscious of the fact that my training experiences as a CoP had some factors in common with participants' GP training experiences, for example the impact of the Covid-19 pandemic. As a first-year trainee, all our teaching was online, and like some participants in this study, I experienced some frustration and uncertainty about my training and practice experiences, and also could relate to the sense of coming into groups, where sensitive issues were discussed, not feeling like I 'knew' my fellow trainees, as we had never met in person. As well as being congruent to the way this may have influenced my interpretation of the data, I am also aware that everyone in my cohort has experienced our training differently, and that this is different again from GP training, and as such I cannot possibly assume to understand or appreciate the experiences of training as a GP during the Covid-19 pandemic.

I am also aware that in my own career I have experienced both a sense of needing to 'do it all' and feeling like an imposter. As a career changer, I came to my CoP training with a sense of wanting, and needing, to do something that was more fulfilling and rewarding than my previous career, but still experiencing something of a sense of failure that the previous career I had been so sure I wanted had turned out not be be right for me. This gave me a sense of needing to 'get it right' this time, and also an uncertainty about making such a big decision which led to so much change in my life, causing me to question whether I was 'good enough' and doubt my own abilities. I have been fortunate enough to have access to both supervision and personal therapy during my counselling psychology training, and have used this to support me to become more tolerant of uncertainty, and to explore my imposter feelings and developing professional identity as a Counselling Psychologist. This has made me very conscious of how difficult it is to go through such a challenging training and practice experience without access to that support, particularly knowing how much I might have benefited from it in my previous career. I have endeavoured to recognise the potential impact of this personal experience when interviewing participants, and when interpreting and analysing participant accounts of struggling with doubt, uncertainty, insecurity and imposter feelings, and also to reflect

on and hold in mind the fact that everyone's circumstances and experiences are different. I hope that having had this experience supported me in bringing my empathy, something I also bring to my therapeutic work, to the interview process, but have remained mindful throughout of not allowing my personal experiences to influence too heavily either the interviews themselves or my analysis of the data.

I have experienced a lot of change since beginning this research, on top of the major transition this training has represented, that is a change of career. I have also found that at times I have been aware of a pressure in managing competing priorities, including completing this research and finding the space to be fully present with it. Having had the privilege of hearing from GP trainees who were also experiencing pressures associated with training, competing priorities and a demanding work life, I am aware of just how important taking time to hear and process these stories, reflect on their meanings and reflect on my own experiences and personal contribution is. It is something I believe there is room for all of us to do more of, and that should be recognised as a priority, and this makes me happier to have been a part of research the outcome of which might be that doctors have a built-in space for this. Taking time for this research and to immerse myself in participants' stories and reflect on my own has been, like RP itself, highly demanding but very rewarding.

4.8 Conclusion

From the first day of medical school, doctors seem to be given messages about what 'a doctor' should be. They experience conflicts between ideals of caring and compassion and the pressure to be pragmatic, efficient and outcomes-focused, and between the emotions that inevitably come up as a human being engaged in such challenging and demanding work, and established ideas of doctors as tough, resilient and emotionally composed, paired with ideas linking emotional vulnerability with a lack of competence. This is combined with a further conflict between the inevitability of mistakes, limitations, weaknesses and failure, and the sense that they should be perfect and able to 'do it all'. Further, their inherent 'human' need for connection seems to be inhibited by a busy and isolating work-life and environment. For some, this leads to feelings of disillusionment and despondency, others experience imposter feelings, and some the symptoms of emotional exhaustion and burnout. They can be reluctant to take their emotions home, due to their desire for an acceptable work-life balance, but then can be left with no space for them at all. This study has provided an understanding of how some GP trainees use CoP-facilitated RPGs to navigate this relationship between their 'humanness' (emotions, imperfections, limitations, vulnerabilities and struggles, and need for connection) and being a doctor. Participants seemed to navigate this relationship through the sharing of experiences, requiring an openness to showing vulnerability, and creating a sense of greater connection and belonging; recognising and processing the emotions that inevitably arise as a result; and developing greater compassion, including self-compassion. Throughout their group participation, they experienced the development of understanding and skills,

which they began to integrate into their work and, for some, personal lives. This development of understanding and skills applied across all the processes described, and was enhanced over time. Mechanisms of increased psychological flexibility, compassion and self-soothing, and mentalisation, all of which are associated with psychological wellness, seem to have supported the development and integration of these processes, allowing participants to more closely align their humanness with their sense of themselves as a doctor. The presence of a CoP facilitator, who emerged as important across all of these processes, seems to have influenced this. This suggests their counselling psychology training and background might bring something of a therapeutic dimension to RPGs, particularly in light of the similarity of the emergent theory to theories underpinning therapeutic approaches commonly delivered in groups.

Some participants expressed that they would be more open to accessing therapeutic support, or more likely to recognise when they might need this, as a result of their group participation, which could have important implications for counselling psychologists tasked with facilitating these groups. Interestingly whilst conducting this research I have worked with and assessed healthcare students, trainees and professionals who have described the impact on their mental health of trying to manage what seem to be aspects of their 'humanness' in the context of their demanding profession. This supports the suggestion that the mental health of healthcare practitioners is an issue that needs to be addressed. If, as it appears, participants in IRPP RPGs are developing increased psychological flexibility, compassion and mentalising capacity, this suggests the intervention has the to potential support GP trainee wellbeing and could be important for preventing the development of difficulties such as IS, emotional exhaustion and burnout. The apparent integration of these mechanisms, as well as genuinely reflective skills, into both their workplace and personal interactions is also worthy of further investigation.

I consider myself privileged that these GP trainees shared their experiences with me, and hope this research sheds light both on the challenges they face in reconciling their inherent humanness with the ideals and expectations of being a doctor, and on the IRPP as a potentially helpful intervention in supporting them to navigate this. These findings highlight the need to further understand the way GP trainees use IRPP RPGs to align their 'humanness' with their developing professional identities, the mechanisms which underpin this, and the role and influence of the CoP facilitator in this process. In particular, research is needed with a more diverse sample of GP trainees to ascertain the impact of sociocultural factors on GP trainees' use of RPGs and the way 'humanness' is defined, and navigated within groups. What is clear is that Counselling Psychology can play a large part in helping to facilitate this process for GP trainees, whilst also gaining the benefits associated with interprofessional learning in their own training experiences. The IRPP is a promising platform for this, and one which is worthy of further research to inform its development.

References

Adams, R. E., Boscarino, J. A., & Figley, C. R. (2006). Compassion fatigue and psychological distress among social workers: A validation study. *The American journal of Orthopsychiatry*, *76*(1), 103–108. https://doi.org/10.1037/0002-9432.76.1.103

Albanese, M. A. (2006). Crafting the reflective lifelong learner: Why, what and how. *Medical Education, 40*(4)*,* 288-290. https://doi.org/10.1111/j.1365-2929.2006.02470.x

Andersen T. (1987). The reflecting team: Dialogue and meta-dialogue in clinical work. *Family process*, *26*(4), 415–428. https://doi.org/10.1111/j.1545-5300.1987.00415.x

Appelbaum N. P., Santen, S. A., Aboff, B. M., Vega, R., Munoz, J. L., & Hemphill, R. R. (2018). Psychological safety and support: Assessing resident perceptions of the clinical learning environment. *Journal of Graduate Medical Education, 10*(6), 651–656. https://doi.org/10.4300/JGME-D-18-00286.1

Asano, K., Tsuchiya, M., Okamoto, Y., Ohtani, T., Sensui, T., Masuyama, A., Isato, A., Shoji, M., Shiraishi, T., Shimizu, E., Irons, C., & Gilbert, P. (2022). Benefits of group compassion-focused therapy for treatment-resistant depression: A pilot randomized controlled trial. *Frontiers in psychology, 13*, 903842. https://doi.org/10.3389/fpsyg.2022.903842

Bach, P. A., & Moran, D. J. (2008). *ACT in practice: Case conceptualization in acceptance and commitment therapy*. New Harbinger Publications.

Bain, P., Vaes, J., Kashima, Y., Haslam, N., & Guan, Y. (2012). Folk conceptions of humanness: Beliefs about distinctive and core human characteristics in Australia, Italy, and China. *Journal of Cross-Cultural Psychology*, *43*(1), 53-58. https://doi.org/10.1177/0022022111419029

Baird, B., Charles, A., Honeyman, M., Maguire, D., & Das, P. (2016). *Understanding pressures in general practice.* Kings Fund. www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Understanding-GP-pressures-Kings-Fund-May-2016.pdf

Ballespí, S., Vives, J., Sharp, C., Chanes, L., & Barrantes-Vidal, N. (2021). Self and other mentalizing polarities and dimensions of mental health: Association with types of symptoms, functioning and well-being. *Frontiers in psychology*, *12*, 566254. https://doi.org/10.3389/fpsyg.2021.566254

Bateman, A., & Fonagy, P. (2010). Mentalization based treatment for borderline personality disorder. *World Psychiatry: Official journal of the World Psychiatric Association (WPA)*, *9*(1), 11–15. https://doi.org/10.1002/j.2051-5545.2010.tb00255.x

Bateman, A. & Fonagy, P. (2004). *Psychotherapy for borderline personality disorder: Mentalization-based treatment.* Oxford University Press.

Baumeister, R. F., & Leary, M. R. (1995). The need to belong: Desire for interpersonal attachments as a fundamental human motivation. *Psychological Bulletin, 117*(3), 497–529. https://doi.org/10.1037/0033-2909.117.3.497

Bearse, J. L., McMinn, M. R., Seegobin, W., & Free, K. (2013). Barriers to psychologists seeking mental health care. *Professional Psychology, Research and Practice*, *44*(3), 150–157. https://doi.org/10.1037/a0031182

Benson, A. (2010). Creating a culture to support patient safety. The contribution of a multidisciplinary team development programme to collaborative working. *Zeitschrift fur Evidenz, Fortbildung und Qualitat im Gesundheitswesen, 104*(1), 10–17. https://doi.org/10.1016/j.zefq.2009.12.030

Bernard, N. S., Dollinger, S. J., & Ramaniah, N. V. (2002). Applying the big five personality factors to the impostor phenomenon. *Journal of Personality Assessment, 78*(2), 321– 333. https://doi.org/10.1207/S15327752JPA7802_07

Boiler, M., Doulougeri, K., de Vries, J. & Helmich, E. (2018). You put up a certain attitude: A 6-year qualitative study of emotional socialisation. *Medical Education, 52*(10), 1041-1051. https://doi.org/10.1111/medu.13650

Bourdieu, P. (1990). 3 Structures, habitus, practices. In P. Bourdeiu, (Ed.) *The logic of practice* (pp. 52-65). Stanford University Press. https://doi.org/10.1515/9781503621749-005

British Psychological Society. (2021). *BPS Code of human research ethics* (2nd ed.). BPS. https://www.bps.org.uk/news-and-policy/bps-code-human-research-ethics-2nd-edition-2014

British Psychological Society (2019). *Standards for the accreditation of doctoral programmes in counselling psychology.* BPS. https://www.bps.org.uk/sites/www.bps.org.uk/files/Accreditation/Counselling%20Accreditation%20Handbook%202019.pdf

British Psychological Society (2017). *Practice guidelines* (3rd ed.). BPS. https://explore.bps.org.uk/binary/bpsworks/7cd81b0048d10fff/b33867dfe47ba494c80dca795cc203acdf4a426630d6ab2b1835429144a575aa/inf115_2017_english.pdf

Brosnan, C. (2010). Making sense of differences between medical schools through Bourdieu's concept of 'field'. *Medical Education, 44*(7), 645-652. https://doi.org/10.1111/j.1365-2923.2010.03680.x

Bryant, A. (2009). Grounded theory and pragmatism: The curious case of Anselm Strauss. *Forum Qualitative Sozialforschung Forum: Qualitative Social Research, 10*(3). https://doi.org/10.17169/fqs-10.3.1358

Buring, S. M, Bhushan, A., Broeseker, A., Conway, S., Duncan-Hewitt, W., Hansen, L., & Westberg, S. (2009). Interprofessional education: Definitions, student competencies, and guidelines for implementation. *American Journal of Pharmaceutical Education, 73*(4), 59. https://doi.org/10.5688/aj730459

Cacioppo, J. T., & Patrick, W. (2008). *Loneliness: Human nature and the need for social connection*. Norton.

Carmichael, K., Rushworth, I., & Fisher, P. (2020). 'You're opening yourself up to new and different ideas': Clinical psychologists' understandings and experiences of using reflective practice in clinical work: An interpretative phenomenological analysis. *Reflective Practice, 21*(4), 520-533. https://doi.org/10.1080/14623943.2020.1775569

Carroll, M. & Gilbert, M. C. (2011). *On being a supervisee: Creating learning.* PsychOz Publications.

Chaffey, L. J., de Leeuw, E. J., & Finnigan, G. A. (2012). Facilitating students' reflective practice in a medical course: Literature review. *Education for Health: Change in Learning and Practice 25*(3), 198–203. https://doi.org/10.4103/1357-6283.109787

Charmaz, K. (2008). Grounded theory as an emergent method. In S. N. Hesse-Biber & P. Leavy (Eds.) *Handbook of emergent methods* (pp 155–170). The Guilford Press.

Charmaz, K. (2014). *Constructing grounded theory* (2nd ed). SAGE Publications Ltd.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis.* SAGE Publications Ltd.

Charmaz, K. (2000). *Grounded Theory: Objectivist and Constructivist Methods* (2nd ed.). SAGE Publications Ltd.

Charmaz K & Bryant A. (2011) Grounded theory and credibility. In: D. Silverman (Ed.) *Qualitative research* (pp291-309). SAGE Publications Ltd.

Charmaz, K., & Henwood, K. (2017). *Grounded Theory Methods for Qualitative Psychology*. SAGE Publications Ltd. https://doi.org/10.4135/9781526405555

Cheung, E. O., Hernandez, A., Herold, E., & Moskowitz, J. T. (2020). Positive emotion skills intervention to address burnout in critical care nurses. *AACN advanced critical care*, *31*(2), 167–178. https://doi.org/10.4037/aacnacc2020287

Chodoff, A., Conyers, L., Wright, S., & Levine, R. (2023). "I never should have been a doctor": A qualitative study of imposter phenomenon among internal medicine residents. *BMC Medical Education*, *23*(1), 57-64. https://doi.org/10.1186/s12909-022-03982-8

Chu, S., Lin, C., Lin, M., & Wen, C. (2018). Psychosocial issues discovered through reflective group dialogue between medical students. *BMC Medical Education, 18*(1), 1-9. https://doi.org/10.1186/s12909-017-1114-x

Clarke, N., Crowe, S., Humphries, N., Conroy, R., O'Hare, S., Kavanagh, P. & Brugha, R. (2017). Factors influencing trainee doctor emigration in a high income country: a mixed methods study. *Human Resources for Health, 15*, 66. https://doi.org/10.1186/s12960- 017-0239-7

Clark P. G. (2009). Reflecting on reflection in interprofessional education: Implications for theory and practice. *Journal of interprofessional care*, *23*(3), 213–223. https://doi.org/10.1080/13561820902877195

Cohen, E. D. & McConnell, W. R. (2019). Fear of fraudulence: Graduate school program environments and the impostor phenomenon. *The Sociological Quarterly, 60*(3), 457–78. https://doi.org/10.1080/00380253.2019.1580552.

Comninos, A. (2022). Your brain's 3 emotion regulation systems. *Mindfulness and Clinical Psychology Solutions.* https://mi-psych.com.au/your-brains-3-emotion-regulation-systems

Crowe, S. & Brugha, R. (2018). “We’ve all had patients who’ve died…” Narratives of emotion and ideals of competence among junior doctors. *Social Science & Medicine (1982), 215*, 152-159. https://doi.org/10.1016/j.socscimed.2018.08.03

Curran, T. & Hill, A. P. (2016). Perfectionism is increasing over time: A meta-analysis of birth cohort differences from 1989 to 2016. *Psychological Bulletin, 145*(4)*,* 410-429. https://doi.org/10.1037/bul0000138

da Silva, A. B., & Sagvaag, H. (2021 June 15). *The relationship between social constructivism and qualitative method, a revised version*. QMSH: The 5. Nordic Interdisciplinary Conference: Qualitative Methods in the Service of Health, University of Stavanger, Norway. https://www.researchgate.net/publication/352413802_The_relationship_between_social_constructivism_and_qualitative_methods_A_revised_version_By_Hildegunn_Sagvaag_and_Antonio_Barbosa_da_Silva

Dalai Lama (1995). *The power of compassion*. Harper Collins.

Dallos, R. & Draper, R. (2015). *An introduction to family therapy: Systemic theory and practice* (4th ed.). Open University Press.

Davies, M., & Kremer, D. (2016). Reflection: how to reduce the risks. *BMJ,* 353 :i3249. https://doi.org/10.1136/bmj.i3249

Davis, M. H., Ponnamperuma, G. G., & Ker, J. S. (2009). Student perceptions of a portfolio assessment process. *Medical Education, 43*(1)*,* 89-98. doi:10.1111/j.1365-2923.2008.03250.x

Davys, A. M., & Beddoe (2015). ‘Going live’: A negotiated collaborative model for live observation of practice. *Practice, 27*(3), 177-196, https://doi.org/10.1080/09503153.2015.1032234

de Vries-Erich, J. M., Dornan, T., Boerboom, T. B., Jaarsma, A. D., & Helmich, E. (2016). Dealing with emotions: medical undergraduates’ preferences in sharing their experiences. *Medical Education, 50*(8), 817–828. https://doi.org/10.1111/medu.13004

Dewey, J. (1933). *How we think: A restatement of the relation of reflective thinking to the educative process*. D.C. Heath & Co Publishers.

Dey, I. (1999). *Grounding grounded theory: Guidelines for qualitative inquiry.* Emerald.

Dobson, R. T., Stevenson, K., Busch, A., Scott, D. J., Henry, C., & Wall, P. A. (2009). A quality improvement activity to promote inter-professional collaboration among health professions students. *American Journal of Pharmaceutical Education, 73*(4), 64. https://doi.org/10.5688/ aj730464

Doherty, E.M., Cronin, P.A. & Offiah, G. (2013). Emotional intelligence assessment in a graduate entry medical school curriculum. *BMC Medical Education, 13*, 38. https://doi.org/ 10.1186/1472-6920-13-38.

Dohn N. B. (2011) On the epistemological presuppositions of reflective activities. *Educational Theory, 61,* 671–708. https://doi.org/10.1111/j.1741-5446.2011.00428.x.

Doorley, J. D., Goodman, F. R., Kelso, K. C., & Kashdan, T. B. (2020). Psychological flexibility: What we know, what we do not know, and what we think we know. *Social and Personality Psychology Compass, 14*(12), 1–11. https://doi.org/10.1111/spc3.12566

Dowling T. (2018). Compassion does not fatigue!. *The Canadian veterinary journal = La revue veterinaire canadienne*, *59*(7), 749–750.

Drynan, D., & Murphy, S. (2013). *Understanding and facilitating interprofessional education: A guide to incorporating interprofessional experiences into the practice education setting* (2nd ed.). University of British Columbia, College of Health Disciplines.

Dyrbye, L. N., West, C. P., Satele, D., Boone, S., Tan, L., & Sloan J. (2014). Burnout among U.S. medical students, residents, and early career physicians relative to the general U.S. population. *Academic Medicine, 89*(3)*,* 443–451. https://doi.org/10.1097/ACM.00000000000000134

Dyrbye, L. & Shanafelt, T. (2016). A narrative review on burnout experienced by medical students and residents. *Medical Education, 50*(1)*,* 132–149. https://doi.org/10.1111/medu.12927

D'Souza, F., Egan, S. J., & Rees, C. S. (2011). The relationship between perfectionism, stress and burnout in clinical psychologists. *Behaviour Change, 28*(1), 17-28. https://doi.org/10.1375/bech.28.1.17

Edmondson, A. (2018). *The fearless organization: Creating psychological safety in the workplace for learning, innovation, and growth*. John Wiley & Sons.

Elliott I., Coker S. (2008) Independent self-construal, self-reflection, and self-rumination: A path model for predicting happiness. *Australian Journal of Psychology*, *60,* 127–134. https://doi.org/10.1080/00049530701447368.

Ensink, K., Maheux, J., Normandin, L., Sabourin, S., Diguer, L., Berthelot, N., & Parent, K. (2013). The impact of mentalization training on the reflective function of novice therapists: A randomized controlled trial. *Psychotherapy Research*, *23*(5), 526–538. https://doi.org/10.1080/10503307.2013.800950

Evans, S., Shaw, N., Ward, C., & Hayley, A. (2016). "Refreshed…reinforced…reflective": A qualitative exploration of interprofessional education facilitators' own interprofessional learning and collaborative practice. *Journal of interprofessional care*, *30*(6), 702–709. https://doi.org/10.1080/13561820.2016.1223025

Farrell, T. S. (2022). 'I felt a sense of panic, disorientation and frustration all at the same time': The important role of emotions in reflective practice. *Reflective Practice, 23*(3), 382–393. https://doi.org/10.1080/14623943.2022.2038125

Fainstad, T., Mann, A., Suresh, K., et al. (2022). Effect of a novel online group-coaching program to reduce burnout in female resident physicians: a randomized clinical trial. *Journal of the American Medical Association Network Open, 5*(5): e2210752. https://doi.org/10.1001/jamanetworkopen.2022.10752

Feenstra, S., Begeny, C. T., Ryan, M. K., Rink, F. A., Stoker, J. I., & Jordan, J. (2020). Contextualizing the impostor "syndrome." *Frontiers in Psychology, 11,* 575024. https://doi.org/10.3389/fpsyg.2020.575024

Fisher, P., Chew, K., & Leow, Y. J. (2015). Clinical psychologists' use of reflection and reflective practice within clinical work. *Reflective Practice, 16*(6), 731-743. https://doi.org/10.1080/14623943.2015.1095724

Flick, U. (2013). *The SAGE handbook of qualitative data analysis.* SAGE Publications Ltd

Fragkos, K. C. (2016). Reflective practice in healthcare education: An umbrella review. *Education sciences, 6*(3), 27-42. https://doi.org/10.3390/eudcsci6030027

Frankland, A., & Walsh, Y. (2005). Focus on… Counselling Psychology in the NHS. *The Mental Health Review, 10*(3), 31-34.

Freeman, J. (2022). Imposter syndrome in doctors beyond training: A narrative review. *Australasian psychiatry: Bulletin of the Royal Australian and New Zealand College of Psychiatrists*, 30*(1)*, 49-54. https://doi.org/10.1177/10398562211036121

Freeth D. (2013). Interprofessional education. In T. Swanwick (Ed.). *Understanding medical education: Evidence, theory and practice* (pp 81-92). Wiley-Blackwell.

Gallagher, S., R. (2019). Professional identity and imposter syndrome. *The Clinical Teacher*, *16*(4), 426-427. https://doi.org/10.1111/tct.13042

Gardner, W. L., Gabriel, S., & Lee, A. Y. (1999). "I" value freedom, but "we" value relationships: Self-construal priming mirrors cultural differences in judgment. *Psychological Science, 10*, 321–326. https://doi.org/10.1111/1467-9280.00162.

General Medical Council (2022). The state of medical education and practice in the UK: Workplace experiences. https://www.gmc-uk.org/-/media/documents/somep-workplace-experiences-2023-full-report_pdf-101653283.pdf

Gerada C. (2019). Doctors' mental health and stigma: The tide is turning. *British Medical Journal, 366*. https://doi.org/10.1136/bmj.l4583

Gerada, C. (2020). Shame and perfectionism among Doctors. *British Medical Journal, 368*, 393. doi: https://doi.org/10.1136/bmj.m393

Gilbert, P. (2014). The origins and nature of compassion focused therapy. *The British Journal of Clinical Psychology,* 53(1), 6-41. https://doi.org/10.1111/bjc.12043

Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in Psychiatric Treatment, 15*(3), 199-208. https://doi.org/10.1192/apt.bp.107.005264

Gilbert, P. (2007). The evolution of shame as a marker for relationship security. In J. L. Tracy, R. W. Robins, & J. P. Tangney (Eds.) *The self-conscious emotions: Theory and research* (pp. 283–309). Guilford.

Gilbert, P., McEwan, K., Matos, M., & Rivis, A. (2011). Fears of compassion: Development of three self-report measures. *Psychology and Psychotherapy*, *84*(3)*,* 239–255. https://doi.org/10.1348/147608310X526511

Gill, D., Griffin, A., & Launer, J. (2014). Fostering professionalism among doctors: The role of workplace discussion groups. *Postgraduate Medical Journal, 90*(1068), 565-570. https://doi.org/10.1136/postgradmedj-2013-132165

Glaser, B. (2001). *The grounded theory perspective: Conceptualization contrasted with description.* Sociology Press.

Glaser, B. (1998). *Doing grounded theory: Issues and discussions*. Sociology Press.

Glaser, B. G. & Strauss, A. L. (1967) *The discovery of grounded theory: Strategies for qualitative research*. Aldine de Gruyter.

Golaghaie, F., Asgari, S., Khosravi, S., Ebrahimimonfared, M., Mohtarami, A., & Rafiei, F. (2019). Integrating case-based learning with collective reflection: Outcomes of inter-professional continuing education. *Reflective Practice, 20*(1), 42-55. https://doi.org/10.1080/14623943.2018.1539660

Gottlieb, M., Chung, A., Battaglioli, N., Sebok-Syer, S. S., & Kalantari, A. (2020) Impostor syndrome among physicians and physicians in training: a scoping review. *Medical Education, 54*(2):116–24. https://doi.org/10.1111/medu. 13956.

Grant, A., Kinnersley, P., Metcalf, E., Pill, R., & Houston, H. (2006) Students' views of reflective learning techniques: An efficacy study at a UK medical school. *Medical Education, 40*(4)*,* 379-388. https://doi.org/10.1111/j.1365-2929.2006.02415.x

Gray, H. M., Gray, K., & Wegner, D. M. (2007). Dimensions of mind perception. *Science (New York, N.Y.)*, *315*(5812), 619. https://doi.org/10.1126/science.1134475

Hafferty, F.W. (1988). Cadaver stories and the emotional socialization of medical students. *Journal of Health and Social Behavior, 29*(4), 344–356. https://doi.org/10.2307/2136868

Halpern, J. (2001). *From detached concern to empathy: Humanizing medical practice*. Oxford University Press.

Halpern, J. (2003). What is clinical empathy? *Journal of General Internal Medicine, 18*(8), 670–674. https://doi.org/10.1046/j.1525-1497.2003.21017.x

Harris, R. (2006). Embracing your demons: An overview of acceptance and commitment therapy. *Psychotherapy in Australia*, *12*(4), 2-8.

Haslam, N., Bain, P., Douge, L., Lee, M., & Bastian, B. (2005). More human than you: Attributing humanness to self and others. *Journal of personality and social psychology*, *89*(6), 937–950. https://doi.org/10.1037/0022-3514.89.6.937

Haslam, N., Loughnan, S., Holland, E. (2013). The Psychology of Humanness. In: S. Gervais (Ed.) *Objectification and (de)humanization*. Nebraska Symposium on Motivation (vol 60). Springer. https://doi.org/10.1007/978-1-4614-6959-9_2

Hatem, D. S., & Halpin, T. (2019). Becoming doctors: examining student narratives to understand the process of professional identity formation within a learning community. *Journal of Medical Education and Curricular Development, 6.* https://doi. org/10.1177/2382120519834546

Hayes, B., Walsh, G., Prihodova, L., Walsh, G., Doyle, F. & Doherty, S. (2017). What's up doc? A national study of wellbeing of hospital doctors in Ireland. *British Medical Journal, 7*(10), e018023. doi:10.1136/bmjopen-2017-018023

Hayes, H. (1991). A re-introduction to family therapy: clarification of three schools. *Australia and New Zealand Journal of Family Therapy, 12*(1), 27-43. https://doi.org/10.1002/j.1467-8438.1991.tb00837.x

Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: model, processes and outcomes. *Behaviour research and therapy*, *44*(1), 1–25. https://doi.org/10.1016/j.brat.2005.06.006

Hayes, S. C., Strosahl, K. D., Bunting, K., Twohig, M., & Wilson, K. G. (2004). What is acceptance and commitment therapy? In Hayes, S. C. & Strosahl, K. D. (Eds.) *A practical guide to acceptance and commitment therapy* (pp 3–29). Springer.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2012). *Acceptance and commitment therapy: The process and practice of mindful change* (2nd ed.) Guilford Press.

Health and Care Professions Council (2016). *Guidance on conduct and ethics for students.* HCPC. https://www.hcpc-uk.org/globalassets/resources/guidance/guidance-on-conduct-and-ethics-for-students.pdf

Henton, I. (2016). Engaging in research. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket, & V. Galbraith (Eds.). *Handbook of counselling psychology* (4th ed.). SAGE Publications Ltd.

Hebert, C. (2015). Knowing and/or experiencing: A critical examination of the reflective model of John Dewey and Donald Schön. *Reflective Practice, 16*(3), 361-371. https://doi.org/10.1080/14623943.2015.1023281

Ho, L., & Limpaecher, A. (2021, September 17). *The Practical Guide to Grounded Theory*. Practical Guide to Grounded Theory Research, Delve. https://delvetool.com/groundedtheory

Howe, A., Barrett, A., & Leinster, S. (2009). How medical students demonstrate their professionalism when reflecting on experience. *Medical education*, *43*(10), 942–951. https://doi.org/10.1111/j.1365-2923.2009.03456.x

Howitt, D. (2010). *Qualitative Methods in Psychology*. Pearson Education Limited.

Ingram, E., Restrick, L., & Lunn, S. (2020). 'Running on empty': understanding more about the concerns about burnout in a cohort of trainee doctors, and the value of reflective practice as an intervention. *Future Healthcare Journal, 7*(Suppl 1)*,* s96–s97. https://doi.org/10.7861/fhj.7.1.s96

Jacimowicz, S. & Maben, J. (2020). "I can't stop thinking about it": Schwartz Rounds, an intervention to support students and higher education staff with emotional, social and ethical experiences at work. *Journal of Clinical Nursing, 29*(23-24)*,* 4421-4424. https://doi.org/10.1111/jocn.15354

Johnson, C. & Bird, J. (2006). How to ...: Teach reflective practice. *Education for Primary Care, 17,* 640-642.

Johnson, S. L., Leedom, L. L., & Muhtadie, L. (2012). The dominance behavioral system and psychopathology: Evidence from self-report, observational, and biological studies. *Psychological Bulletin, 138*, 692–743. https://doi.org/10.1037/a0027503

Kariyawasam, L., Ononaiye, M., Irons, C., & Kirby, S. E. (2022). A cross-cultural exploration of compassion, and facilitators and inhibitors of compassion in UK and Sri Lankan people. *Global mental health (Cambridge, England)*, *9*, 99–110. https://doi.org/10.1017/gmh.2022.10

Karterud, S. (2015). *Mentalization-based group therapy (MBT-G): A theoretical, clinical, and research manual.* Oxford University Press. https://doi.org/10.1093/med:psych/9780198753742.001.0001

Kasket, E. and Gil-Rodriguez, E. (2011). The identity crisis in trainee counselling psychology research, *Counselling Psychology Review, 26*(4), 20-30. https://doi.org/10.53841/bpscpr.2011.26.4.20

Kee, C. H. Y. (2004). Cultural features as advantageous to therapy: a Singaporean perspective. *Journal of Systemic Therapies, 23*(4), 67–79. https://doi.org/10.1521/jsyt.23.4.67.57836

Kinman, G. & Teoh, K. (2018). *What could make a difference to the mental health of UK doctors? A review of the research evidence.* Society of Occupational Medicine. https://www.som.org.uk/sites/som.org.uk/files/What_could_make_a_difference_to_the_mental_health_of_UK_doctors_LTF_SOM.pdf

Kinsella, E. A. (2010). The art of reflective practice in health and social care: Reflections on the legacy of Donald Schön. *Reflective Practice, 11*(4), 565–575. https://doi.org/10.1080/14623943.2010.506260

Klimecki, M., Leiberg, S., Lamm, C., & Singer, T. (2012). Functional neural plasticity and associated changes in positive affect after compassion training. *Cerebral Cortex, 23*(7), 1552–1561. https://doi.org/10.1093/cercor/bhs142

Knight, K., Sperlinger, D., & Maltby, M. (2010). Exploring the personal and professional impact of reflective practice groups: A survey of 18 cohorts from a UK clinical psychology training course. *Clinical Psychology and Psychotherapy, 17*(5), 427-437. https://doi.org/10.1002/cpp.660

Kraus, M. W., Piff, P. K., Mendoza-Denton, R., Rheinschmidt, M. L., & Keltner, D. (2012). Social class, solipsism, and contextualism: How the rich are different from the poor. *Psychological Review, 119*, 546–572. https://doi.org/10.1037/a0028756

Kuipers, P., Ehrlich, C., & Brownie, S. (2014). Responding to health care complexity: Suggestions for integrated and interprofessional workplace learning. *Journal of Interprofessional Care, 28*(3), 246–248. https://doi.org/10.3109/13561820.2013.821601

Lancaster, J., Prager. S., Nash, L., & Karageorge, A. (2020). Psychiatry peer review groups in Australia: A mixed-methods exploration of structure and function. *BMJ Open, 10*(11), e040039. https://doi.org/10.1136/bmjopen-2020-040039

Launer, J. (2020a). "Why you should talk to yourself: internal dialogue and reflective practice". *Postgraduate medical journal*, *96*, 507- https://doi.org/10.1136/postgradmedj-2020-138455

Launer, J. (2020b). "Burnout in the age of Covid-19". *Postgraduate Medical Journal*, *96*(1136), 367. https://doi.org/10.1136/postgradmedj-2020-137980

Launer, J. (2018). The irresistible rise of interprofessional supervision. *Postgraduate Medical Journal, 94*(1114), 481-482. https://doi.org/10.1136/postgradmedj-2018-135988

Launer, J. (2016). Clinical case discussion: Using a reflecting team. *Postgraduate Medical Journal, 92*(1086), 245-246. https://doi.org/10.1136/postgradmedj-2016-134079

Launer, J. (2015). Collaborative learning groups. *Postgraduate Medical Journal, 91*(1078), 473-474. https://doi.org/10.1136/postgradmedj-2015-133611

Launer, J. (2011). Three kinds of reflection. *Postgraduate Medical Journal, 87*(1029), 505-506. https://doi.org/10.1136/postgradmedj-2011-130180

Lavender, T. (2003). Redressing the balance: What is the place, history and future of reflective practice in clinical training. *Clinical Psychology, 27*, 11-15. https://doi.org/10.1037/0022-0167.43.1.10

Lee, R. T., Seo, B., Hladkyj, S., Lovell, B. L., & Schwartzmann, L. (2013). Correlates of physician burnout across regions and specialties: a meta-analysis. *Human resources for health*, *11*, 48. https://doi.org/10.1186/1478-4491-11-48

Lempp, H. (2009). Medical-school culture. In: C. Brosnan, & B. S. Turner (Eds.). *Handbook of the Sociology of Medical Education* (pp 71-88). Routledge.

Lengelle, R., Luken, T., & Meijers, F. (2016). Is self-reflection dangerous? Preventing rumination in career learning. *Australian Journal of Career Development*, *25*(3), 99-109. https://doi.org/10.1177/1038416216670675

Lief, H. I., & Fox, R. C. (1963). Training for “detached concern” in medical students. In: H. I. Lief, V. F. Lief, & N. R. Lief (Eds.) *The Psychological Basis of Medical Practice* (pp 12-35). Harper & Row.

Longe, O., Maratos, F. A., Gilbert, P., Evans, G., Volker, F., Rockliffe, H., & Rippon, G. (2010). Having a word with yourself: Neural correlates of self-criticism and self-reassurance. *NeuroImage*, *49*(2), 1849–1856. https://doi.org/10.1016/j.neuroimage.2009.09.019

Losantos, M., Montoya, T., Exeni, S., Santa Cruz, M., & Loots, G. (2016). Applying social constructionist epistemology to research in psychology. *International Journal of Collaborative Practice, 6*(1), 29-42.

Luke, H. (2003). *Medical education and sociology of medical habitus: "It's not about the stethoscope!"* Kluwer Academic Publishers.

Lyons, A., Mason, B., Nutt, K., & Keville, S. (2019). Inside it was orange squash concentrate: Trainees' experiences of reflective practice groups within clinical psychology training. *Reflective Practice, 20*(1), 70-84. https://doi.org/10.1080/14623943.2018.1559804

MacLeod, A. (2011). Caring, competence and professional identities in medical education. *Advances in Health Sciences Education: Theory and Practice, 16*(3), 375–394. https://doi.org/10.1007/s10459-010-9269-9

Mahoney, M. J. (1991). *Human change processes*. Basic Books, Inc.

Mamede, S., & Schmidt, H. G. (2004). The structure of reflective practice in medicine. *Medical Education, 38*(12)*,* 1302-1308. https://doi.org/10.1111/j.1365-2929.2004.01917.x

Mann, K., Gordon, J., & MacLeod, A. (2009). Reflection and reflective practice in health professions education: A systematic review. *Advances in Health Sciences Education: Theory and Practice, 14*(4), 595-621. https://doi.org/10.1007/s10459-007-9090-2

Markus, H. R., & Kitayama, S. (1991). Culture and the self: Implications for cognition, emotion, and motivation. *Psychological Review, 98*(2), 224–253. https://doi.org/10.1037/0033-295X.98.2.224

Mascarenhas, V. R., D'Souza, D. & Bicholkar, A. (2018). Prevalence of impostor phenomenon and its association with self-esteem among medical interns in Goa, India. *International Journal of Community Medicine and Public Health, 6*(1), 355. https://doi.org/10.18203/2394-6040.ijcmph20185272

Maslach, C., Jackson, S. E., & Leiter, M. P. (1996). *Maslach burnout inventory manual* (3rd ed.). Consulting Psychologists Press.

Marathe, A., & Sen, A. (2021). Empathetic reflection: Reflecting with emotion. *Reflective Practice*, *22*(4), 566–574. https://doi.org/10.1080/14623943.2021.1927693

McGillivray, J., Gurtman, C., Boganin, C., & Sheen, J. (2015). Self-practice and self-reflection in training of psychological interventions and therapist skills development: A qualitative meta-synthesis review. *Australian Psychologist., 50*(6), 434–444. https://doi.org/10.1111/ap.12158

McNamee, S. (2012). From social construction to relational construction: Practices from the edge. *Psychological Studies, 57*(2), 150-156. https://doi.org/10.1007/s12646-011-0125-7

McNaughton, N., (2013). Discourse(s) of emotion within medical education: the ever-present absence. *Medical Education, 47*(1), 71–79. https://doi.org/10.1111/j.1365-2923. 2012.04329.x.

McNaughton, N. & LeBlanc, V. (2012) Perturbations: The central role of emotion competence in health professional training. In L. Lingard, & B. Hodges (Eds.) *The question of competence: Reconsidering medical education in the twenty-first century*. Cornell Press.

Miraglia, R. & Asselin, M. E. (2015). Reflection as an educational strategy in nursing professional development: an integrative review. *Journal of Nurses Professional Development, 31*(2), 62-72. https://doi/org/10.1097/NND.0000000000000151

Monk, A., Hind, D. & Crimlisk, H. (2018) Balint groups in undergraduate medical education: A systematic review. *Psychoanalytic Psychotherapy 32*(1), 61–86. https://doi.org/10.1080/02668734.2017.1405361

Montero-Marin, J., Kuyken, W., Crane, C., Gu, J., Baer, R., Al-Awamleh. A. A., Akutsu, S., Araya-Véliz, C., Ghorbani, N., Chen, Z. J., Kim, M., Mantzios, M., Rolim dos Santos, D. N., Serramo López, L. C., Teleb, A. A., Watson P. J., Yamaguchi, A., Yang, E., & García-Campayo, J. (2018). Self-Compassion and cultural vaues: A cross-cultural study of self-compassion using a multitrait-multimethod (MTMM) analytical procedure. *Frontiers in Psychology, 9*, Article 2638. https://doi.org/10.3389/fpsyg.2018.02638

Morgenstern, B. Z., & Dallaghan, G. B. (2021). Should medical educators help learners reframe imposterism? *Teaching and Learning in Medicine, 33*(4), 445–452. https://doi. org/10.1080/10401334.2020.1856112

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52*(2), 250–260. https://doi.org/10.1037/0022-0167.52.2.250

Mullangi, S & Jagsi, R. (2019). Imposter syndrome: treat the cause. Not the Symptom. *Journal of the American Medical Association, 322*(5), 403–404. https://doi.org/10.1001/jama.2019.9788.

Nancarrow, S. A., Smith, T., Ariss, S., & Enderby, P. M. (2014). Qualitative evaluation of the implementation of the interdisciplinary management tool: A reflective tool to enhance interdisciplinary teamwork using structured, facilitated action research for implementation. *Health & Social Care in the Community, 23*(4), 437-448. https://doi/org/10.1111/hsc.12173

Nandagopal, R. (2022). Introduction of Balint Groups as a Reflective Practice Method. *International journal of psychiatry in medicine*, *57*(6), 504–507. https://doi.org/10.1177/00912174221128642

Nash, J. (2021). *How to apply ACT in group therapy: 3 workshop activities*. https://positivepsychology.com/act-groups/#google_vignette

Neff, K. D. (2003). The Development and Validation of a Scale to Measure Self-Compassion. *Self and Identity, 2*(3)*,* 223-250. https://doi.org/10.1080/15298860309027

Ng, S. & Isaac, K. (2021). Imposter syndrome - Perspectives of final year medical students. *Medical education, 55*(9), 1110. https://doi.org/10.1111/medu.14536

Nguyen, Q.D.; Fernandez, N.; Karsenti, T., & Charlin, B. What is reflection? A conceptual analysis of major definitions and a proposal of a five-component model. *Medical Education, 48*(12), 1176–1189. https://doi.org/10.1111/medu.12583

Nickerson, R. S. (1999). How we know – and sometimes misjudge – what others know: Inputting one's own knowledge to others. *Psychological Bulletin*, *125*(6), 737–759. https://doi.org/10.1037//0033-2909.125.6.737

Nielson, H. G., & Söderström, M. (2012). Group supervision in general practice as part of continuing professional development. *Danish Medical Journal 59*(2), A4350.

O'Neil, L., Johnsone, J., & Mandela, R. (2019). Reflective practice groups: Are they useful for liaison psychiatry nurses working within the Emergency Department? *Archives of Psychiatric Nursing, 33*(1), 85-92. https://doi.org/10.1016/j.apnu.2018.11.003

Ooi, S. M., Fisher, P. & Coker, S. (2021). A systematic review of reflective practice questionnaires and scales for healthcare professionals: a narrative synthesis. *Reflective Practice, 22*(1), 1-15. https://doi.org/10.1080/14623943.2020.1801406

Oyserman, D., Coon, H. M., & Kemmelmeier, M. (2002). Rethinking individualism and collectivism: evaluation of theoretical assumptions and meta-analyses. *Psychological Bulletin*, *128*(1), 3–72.

Park, J., Haslam, N., & Kashima, J. (2012). Relational to the core: Lay theories of humanness in Australia, Japan and Korea. *Journal of Cross-Cultural Psychology, 43*(5), 774-783. https://doi.org/10.1177/0022022111414417

Perrott, V., & Ellison, K. (2017). Reflection: Realities and risks. *Medical Protection.* https://www.medicalprotection.org/uk/articles/reflection-realities-and-risks

Peters, M., & King, J. (2012). Perfectionism in doctors. *BMJ, 344*, e1674. https://doi.org/10.1136/bmj.e1674

Petersson, P., Springett, J., & Blomqvist, K. (2009). Telling stories from everyday practice, an opportunity to see a bigger picture: A participatory action research project about developing discharge planning. *Health & Social Care in the Community, 17*(6), 548–556. https://doi.org/10.1111/j.1365-2524.2009.00854.x

Priddis, L., & Rogers, S. L. (2018). Development of the reflective practice questionnaire: Preliminary findings. *Reflective Practice, 19*(1), 89–104. https://doi.org/10.1080/14623943.2017.1379384

Psilopanagioti, A., Anagnostopoulos, F. Mourtou, E., & Niakas, D. (2012). Emotional intelligence, emotional labor, and job satisfaction among physicians in Greece. *BMC Health Services Research, 12*, 463. https://doi.org/10.1186/1472-6963-12-463.

Quilty, T., & Murphy, L. (2022). Time to review reflective practice?,*International Journal for Quality in Health Care*, *34*(2), 1-2. https://doi.org/10.1093/intqhc/mzac052

Qureshi, M. A., Taj, J., Latif, M. Z., Rafique, S., Ahmed, R., & Chaudhry, M. A. (2017). Imposter syndrome among Pakistani medical students. *Annals of King Edward Medical University* 23(2), 107-111. https://doi.org/10.21649/akemu.v23i2.1647

Ramsay, J. L., & Spencer, A. L. (2019). Interns and imposter syndrome: proactively addressing resilience. *Medical Education, 53*(5), 504–505. https://doi.org/10.1111/medu.13852

Richard, A., Gagnon, M., & Careau, E. (2019). Using reflective practice in interprofessional education and practice: A realist review of its characteristics and effectiveness. *Journal of Interprofessional Care, 33*(5), 424-436. https://doi.org/10.1080/13561820.2018.1551867

Roberts, C., & Stark, P. (2008) Readiness for self-directed change in professional behaviours: Factorial validation of the self-reflection and insight scale. *Medical Education, 42*(11)*,* 1054-1063. https://doi.org/10.1111/j.1365-2923.2008.03156.x

Rohrmann, S., Bechtoldt, M. N., & Leonhardt, M. (2016). Validation of the impostor phenomenon among managers. *Frontiers in Psychology, 7,* 821. https:// doi.org/10.3389/fpsyg.2016.00821

Ross, S. R., Stewart, J., Mugge, M., & Fultz, B. (2001). The imposter phenomenon, achievement dispositions, and the five-factor model. *Personality and Individual Differences, 31*(8), 1347–1355. https://doi.org/10.1016/S0191-8869(00)00228-2

Royal College of Physicians (2016). *Being a Junior Doctor: Experiences from the Front Line of the NHS*. RCP. https://www.rcplondon.ac.uk/guidelines-policy/being-junior-doctor

Rudolph, J. W., Simon, R., Rivard, P., Dufresne, R. L., & Raemer, D. B. (2007). Debriefing with good judgment: Combining rigorous feedback with genuine inquiry. *Anesthesiology Clinics, 25*(2), 361–76. https://doi.org/10.1016/j. anclin.2007.03.007.

Ruiz-Fernandes, M. D., Ramos-Pichardo, J. D., Ibáñez-Masero, O., Cabrera-Troya, J., Inés Carmona-Rega, M., María Ortega-Galán, A. (2020). Compassion fatigue, burnout, compassion satisfaction and perceived stress in healthcare professionals during the COVID-19 health crisis in Spain. *Journal of Clinical Nursing, 29*(21-22)*,* 4321-4330. https://doi.org/10.1111/jocn.15469

Rutherford, Forde, E., Priego-Hernandez, J., Butcher, A., & Wedderburn, C. (2018). Using photography to enhance GP trainees' reflective practice and professional development. *Medical Humanities*, *44*(3), 158-164. https://doi.org/10.1136/medhum-2017-011203

Sadusky, A., & Spinks, J. (2022). Psychologists' engagement in reflective practice and experiences of burnout: a correlational analysis. *Reflective Practice, 23*(5), 593-606. https://doi.org/10.1080/14623943.2022.2090326

Safiye, T., Gutić, M., Dubljanin, J., Stojanović, T. M., Dubljanin, D., Kovačević, A., Zlatanović, M., Demirović, D. H., Nenezić, N., & Milidrag, A. (2023). Mentalizing, Resilience, and Mental Health Status among Healthcare Workers during the COVID-19 Pandemic: A Cross-Sectional

Study. *International Journal of Environmental Research and Public Health*, *20*(8), 5594. https://doi.org/10.3390/ijerph20085594

Samra R. (2018). Empathy and Burnout in medicine: Acknowledging risks and opportunities. *Journal of General Internal Medicine*, *33*(7), 991–993. https://doi.org/10.1007/s11606-018-4443-5

Sandars, J. (2009). The use of reflection in medical education: AMEE Guide No. 44. *Medical Teacher, 31*(6)*,* 685-695. https://doi.org/10.1080/01421590903050374

Sargeant, R., & Au-Yong, A. (2020). Balint groups for foundation and GP trainees. *British Journal of Psychotherapy, 36*(3), 481-496. https://doi.org/10.1111/bjp.12562

Sargeant, J., Eva, K. W., Armson, H., Chesluk, B., Dornan, T., Holmboe, E., Lockyer, J. M., Loney, E., Mann, K. V., & van der Vleuten, C. P. (2011). Features of assessment learners use to make informed self-assessments of clinical performance. *Medical Education*, *45*(6), 636–647. https://doi.org/10.1111/j.1365-2923.2010.03888.x

Schneider, K. J., Pierson, J. F., & Bugental, J. F. (2015). *The handbook of humanistic psychology: Theory, research, and practice*. SAGE Publications Inc. https://doi.org/10.4135/9781483387864

Schon, D.A. (1983) *The reflective practitioner: How professionals think in action*. Basic Books.

Schon, D. A. (1987). *Educating the reflective practitioner.* Jossey-Bass.

Schultz, J. (2021). What is ACT? The Hexaflex model and principles explained. *Positive Psychology*. https://positivepsychology.com/act-model/#google_vignette

Schwartz, R., Osterberg, L. G. & Hall, J. A. (2022). Physicians, emotion and the clinical encounter: A survey of physicians' experiences. *Patient education and counselling, 105*(7)*,* 2299-2306. https://doi.org/10.1016/j.pec.2022.03.001

Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse.* Guilford Press.

Shapiro, J. (2017). The feeling physician: educating the emotions in medical training. *European Journal for Person Centred Healthcare, 1*(2)*,* 310-316. https://doi.org/10.5750/ejpch.v1i2.664.

Sidanius, J., & Pratto, F. (2004). Social dominance theory: A new synthesis. In J. T. Jost & J. Sidanius (Eds.). *Political psychology* (pp. 315–322). Routledge.

Siegel Sommers, L., & Launer, J. (2013). *Clinical uncertainty in primary care: The challenge of collaborative engagement.* Springer Science + Business Media. https://doi.org/10.1007/978-1-4614-6812-7

Sinclair, S. (1997). *Making doctors: An institutional apprenticeship.* Routledge

Singer, A. R., & Dobson, K. S. (2007). An experimental investigation of the cognitive vulnerability to depression. *Behaviour Research and Therapy, 45*(3), 563–575. https://doi.org/10.1016/j.brat.2006.05.007

Slank, S. (2019). Rethinking the imposter phenomenon. *Ethical Theory and Moral Practice, 22*(2)*,* 205–218. https://doi.org/10.1007/s10677-019-09984-8.

Smith, A. C., & Kleinman, S. (1989). Managing emotions in medical school: Students' contacts with the living and the dead. *Social Psychology Quarterly, 52*(1), 56–69. https://doi.org/10.2307/2786904

Solms, L., vanVianen, A., Koen, J., Theeboom, T., de Pagter, A. P. J., & De Hoog, M., & Challenge & Support Research Network (2021). Turning the tide: a quasi-experimental study on a coaching intervention to reduce burn-out symptoms and foster personal resources among medical residents and specialists in the Netherlands. *BMJ Open., 11*(1), e041708. https://doi.org/10.1136/bmjopen-2020-041708

Starks, H. and Trinidad, S. B. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research, 17*(10), 1372-1380. https://doi.org/10.1177/1049732307307031

Steffen, A. M., Zeiss, A. M., & Karel, M. J. (2014). Interprofessional geriatric health care: Competencies and resources for teamwork. In N. Pachana, & K. Laidlaw (Eds.). *The Oxford Handbook of Clinical Geropsychology: International Perspectives* (pp. 733-752)*.* Oxford University Press.

Steindl, S. R., Yiu, R. X. Q., Baumann, T., & Matos, M. (2020). Comparing compassion across cultures: Similarities and differences among Australians and Singaporeans. *Australian Psychologist, 55*(3)*,* 208–219. https://doi.org/10.1111/ap.12433

Strauss, A., & Corbin, J. M. (1990). *Basics of qualitative research: Grounded theory procedures and techniques.* Sage Publications, Inc.

Takano K., Sakamoto S., Tanno Y. (2011) Ruminative and reflective forms of self-focus: Their relationships with interpersonal skills and emotional reactivity under interpersonal stress. *Personality and Individual Differences, 51*(4), 515–520. https://doi.org/10.1016/j.paid.2011.05.010.

Taylor, P., Gooding, P., Wood, A. N., & Tarrier, N. (2011). The role of defeat and entrapment in depression, anxiety and suicide. *Psychological Bulletin, 137*(3), 391–420. https://doi.org/10.1037/a0022935

Taylor, M., Maben, J., Dawson, J., C., Leamy, M., McCarthy, I., Reynolds, E.., Ross, S., Shuldham, C., Bennett, L. & Foot, C. (2018). A realist informed mixed methods evaluation of Schwartz Center Rounds in England. *Health Services and Delivery Research, 6*(37). https://doi.org/10.3310/hsdr06370.

Tie, Y. C., Birks, M. & Francis, K. (2019). Grounded theory research: A design framework for novice researchers. *SAGE Open Medicine, 7*, 2050312118822927. https://doi.org/10.1177/2050312118822927

Tonkin, T. (2022). *Burnout hits record high.* BMA. https://www.bma.org.uk/news-and-opinion/burnout-hits-record-high

Torralba, K. D., Loo, L. K., Byrne, J. M., Baz, S., Cannon, G. W., Keitz, S. A., Wicker, A. B., Henley, S. S., and Kashner, T. M. (2016). Does psychological safety impact the clinical learning environment for resident physicians? Results from the VA's Learners' perceptions survey. *Journal of Graduate Medical Education, 8*(5), 699–707. https://doi.org/10.4300/JGME-D-15-00719.1

Trevarthen, C., & Aitken, K. J. (2001). Infant intersubjectivity: research, theory, and clinical applications. *Journal of Child Psychology and Psychiatry, and Allied Disciplines*, *42*(1), 3–48.

Tsering, G. T. (2008). *The awakening mind: The foundation of Buddhist thought* (Vol. 4). Wisdom Press.

Underman, K. (2015). Playing doctor: Simulation in medical school as affective practice. *Social Science and Medicine (1982), 136–137*, 180–188. https://doi.org/10.1016/j.socscimed.2015.05.028.

Urquhart, C. (2013). *Grounded theory for qualitative research: A practical guide.* SAGE Publications Ltd.

Van Roy, K., Vanheule, S., & Inslegers, R. (2015). Research on Balint groups: A literature review. *Patient Education and Counselling, 98*(6), 685–694. https://doi.org/10.1016/j.pec.2015.01.014

Van Seggelen-Damen, I. C. M., & van Dam, K. (2016). Self-reflection as a mediator between self-efficacy and wellbeing. *Journal of Managerial Psychology*, *31,* 18–33.

Van Woerkom, M. (2010). Critical reflection as a rationalistic ideal. *Adult Education Quarterly, 60*(4), 339–356. http://doi.org/10.1177/0741713609358446.

Vatne, S., Bjornerem, H., & Hoem, E. (2009). Development of professional knowledge in action: Experiences from an action science design focusing on acknowledging communication in mental health. *Scandinavian Journal of Caring Sciences, 23*(1), 84–92. https://doi.org/10.1111/j.1471-6712.2007.00593.x

Wald, H. S., & Reis, S. P. (2010). Beyond the margins: Reflective writing and development of reflective capacity in medical education. *Journal of General Internal Medicine, 25*(7), 746-749. https://doi.org/10.1007/s11606-010-1347-4

Wald, H. S., Haramati, A., Bachner, Y. G., & Urkin, J. (2016) Promoting resiliency for interprofessional faculty and senior medical students: outcomes of a workshop using mind-body medicine and interactive reflective writing. *Medical Teacher, 38*(5)*,* 525–528. https://doi.org/10.3109/0142159X.2016.1150980

Wigg, R., Cushway, D., & Neal, A. (2011). Personal therapy for therapists and trainees: A theory of reflective practice from a review of the literature. *Reflective Practice: International and Multidisciplinary Perspective*, *12*(3), 347–359. https://doi.org/10.1080/14623943.2011.571866

Wilkinson, R., & Picket, K. (2010). *The spirit level: Why equality is better for everyone*. Penguin.

Willig, C. (2018). Ontological and epistemological reflexivity: A core skill for therapists. *Therapists and Knowledge, 19*(3), 186-194. https://doi.org/10.1002/capr.12204

Willig, C. (2013). *Introducing qualitative research in psychology* (3rd ed.). Open University Press.

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

Wilson, S., & Haslam, N. (2013). Reasoning about human enhancement: Towards a folk psychological model of humanness and human identity. In R. Luppicini (Ed.), *Handbook of research on Technoself: Identity in a technological society* (pp 175-188). https://doi.org/10.4018/978-1-4666-2211-1.ch010

Wojnarowska, A., Kobylinska, D., & Lewczuk, K. (2020). Acceptance as an emotion regulation strategy in experimental psychological research: What we know and how we can improve that knowledge. *Frontiers in Psychology, 11,* 242. https://doi.org/10.3389/fpsyg.2020.00242

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, *15*(2), 215-228. https://doi.org/10.1080/08870440008400302

Zantinge, E. M., Perhaak, F. M. V., de Bakker, D. H., van der Meer, K., & Bensing, J. M. (2009). Does burnout among doctors affect their involvement in patients' mental health problems? A study of videotaped consultations. *BMC Family Practice, 10,* 60. https://doi.org/10.1186/1471-2296-10-60

Appendices

Appendix 1: Ethics Approval

Wednesday, September 20, 2023 at 17:16:21 British Summer Time

Subject: Decision - Ethics ETH2122-1279: Ms Amy Bower (Low risk)
Date: Tuesday, 5 April 2022 at 16:44:58 British Summer Time
From: Research Manager - DO NOT REPLY
To: Bower, Amy

City, University of London

Dear Amy

Reference: ETH2122-1279

Project title: How do GP trainees make use of Reflective Practice Groups? A Grounded Theory Investigation

Start date: 5 Apr 2022

End date: 20 Oct 2023

I am writing to you to confirm that the research proposal detailed above has been granted formal approval from the Psychology low risk review. The Committee's response is based on the protocol described in the application form and supporting documentation. Approval has been given for the submitted application only and the research must be conducted accordingly. You are now free to start recruitment.

The approval was given with the following conditions:

- ...
- ...
- ...

Please ensure that you are familiar with City's Framework for Good Practice in Research and any appropriate Departmental/School guidelines, as well as applicable external relevant policies.

Please note the following:

Project amendments/extension

You will need to submit an amendment or request an extension if you wish to make any of the following changes to your research project:

- Change or add a new category of participants;

1 of 3

- Change or add researchers involved in the project, including PI and supervisor;
- Change to the sponsorship/collaboration;
- Add a new or change a territory for international projects;
- Change the procedures undertaken by participants, including any change relating to the safety or physical or mental integrity of research participants, or to the risk/benefit assessment for the project or collecting additional types of data from research participants;
- Change the design and/or methodology of the study, including changing or adding a new research method and/or research instrument;
- Change project documentation such as protocol, participant information sheets, consent forms, questionnaires, letters of invitation, information sheets for relatives or carers;
- Change to the insurance or indemnity arrangements for the project;
- Change the end date of the project.

Adverse events or untoward incidents

You will need to submit an Adverse Events or Untoward Incidents report in the event of any of the following:

a) Adverse events

b) Breaches of confidentiality

c) Safeguarding issues relating to children or vulnerable adults

d) Incidents that affect the personal safety of a participant or researcher

Issues a) and b) should be reported as soon as possible and no later than five days after the event. Issues c) and d) should be reported immediately. Where appropriate, the researcher should also report adverse events to other relevant institutions, such as the police or social services.

Should you have any further queries relating to this matter, please do not hesitate to contact me. On behalf of the Psychology low risk review, I do hope that the project meets with success.

Kind regards

[redacted]

Psychology low risk review

City, University of London

Ethics ETH2122-1279: Ms Amy Bower (Low risk)

Appendix 2: Ethics Approval (Amendment for In-Person Interviews)

Wednesday, September 20, 2023 at 17:14:36 British Summer Time

Subject: Decision - Ethics ETH2223-1577: Ms Amy Bower (Low risk)
Date: Wednesday, 1 March 2023 at 11:33:13 Greenwich Mean Time
From: Research Manager - DO NOT REPLY
To: Bower, Amy

City, University of London

Dear Amy

Reference: ETH2223-1577

Project title: How do GP trainees make use of Reflective Practice Groups? A Grounded Theory Investigation

Start date: 5 Apr 2022

End date: 20 Oct 2023

I am writing to you to confirm that the research proposal detailed above has been granted formal approval from the Psychology low risk review. The Committee's response is based on the protocol described in the application form and supporting documentation. Approval has been given for the submitted application only and the research must be conducted accordingly. You are now free to start recruitment.

The approval was given with the following conditions:

- ...
- ...
- ...

Please ensure that you are familiar with City's Framework for Good Practice in Research and any appropriate Departmental/School guidelines, as well as applicable external relevant policies.

Please note the following:

Project amendments/extension

You will need to submit an amendment or request an extension if you wish to make any of the following changes to your research project:

- Change or add a new category of participants;

1 of 3

- Change or add researchers involved in the project, including PI and supervisor;
- Change to the sponsorship/collaboration;
- Add a new or change a territory for international projects;
- Change the procedures undertaken by participants, including any change relating to the safety or physical or mental integrity of research participants, or to the risk/benefit assessment for the project or collecting additional types of data from research participants;
- Change the design and/or methodology of the study, including changing or adding a new research method and/or research instrument;
- Change project documentation such as protocol, participant information sheets, consent forms, questionnaires, letters of invitation, information sheets for relatives or carers;
- Change to the insurance or indemnity arrangements for the project;
- Change the end date of the project.

Adverse events or untoward incidents

You will need to submit an Adverse Events or Untoward Incidents report in the event of any of the following:

a) Adverse events

b) Breaches of confidentiality

c) Safeguarding issues relating to children or vulnerable adults

d) Incidents that affect the personal safety of a participant or researcher

Issues a) and b) should be reported as soon as possible and no later than five days after the event. Issues c) and d) should be reported immediately. Where appropriate, the researcher should also report adverse events to other relevant institutions, such as the police or social services.

Should you have any further queries relating to this matter, please do not hesitate to contact me. On behalf of the Psychology low risk review, I do hope that the project meets with success.

Kind regards

[redacted]

Psychology low risk review

City, University of London

Ethics ETH2223-1577: Ms Amy Bower (Low risk)

Appendix 3: Recruitment Advertisement/Flyer

CITY
UNIVERSITY OF LONDON
EST 1894

PARTICIPANTS NEEDED FOR RESEARCH INTO GPs' EXPERIENCES OF REFLECTIVE PRACTICE GROUPS

We are looking for [redacted] GP trainees involved in the Interprofessional Reflective Practice Project ('IRPP'), a collaboration between the [redacted] GP specialist training programme and the Doctorate in Counselling Psychology at City, University of London, to take part in a study into your experiences of attending Reflective Practice Groups facilitated by trainee Counselling Psychologists.

As a participant in this study, you would be asked to take part in a semi-structured interview to be conducted on Zoom, where we will be asking you questions relating to how you have made use of the Reflective Practice Groups you have attended as part of the IRPP.

Your participation would involve one interview of approximately 60-90 minutes (or two interviews of 30-45 minutes each if preferred).

Your involvement in this study will contribute to our understanding of how GP trainees use Reflective Practice, and to the development of the Interprofessional Reflective Practice Project and similar interventions.

For more information, or to volunteer for this study, please contact:

Amy Bower (Researcher), Department of Psychology, City, University of London at: [redacted]

This study is supervised by:

Dr. Aylish O'Driscoll: [redacted]

Dr. Fran Smith:

This study has been reviewed by, and received ethical clearance through the Psychology Research Ethics Committee at City, University of London.

If you would like to complain about any aspect of the study, please contact the Secretary to the Senate Research Ethics Committee on 020 7040 3040 or via email: Anna.Ramberg.1@city.ac.uk

City, University of London is the data controller for the personal data collected for this research project. If you have any data protection concerns about this research project, please contact City's Information Compliance Team at dataprotection@city.ac.uk

Appendix 4: Participant Information Sheet

How do GP Trainees Make Use of Reflective Practice Groups? A Grounded Theory Investigation.

Amy Bower (Researcher), City, University of London.

We would like to invite you to take part in a research study relating to your participation in the Inter-Professional Reflective Practice Project ('IRPP'). Before you decide whether you would like to take part, it is important that you understand why the research is being done and what it would involve for you. Please take the time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear, or if you would like more information. You will be given a copy of this information sheet to keep.

What is the purpose of the study?
This study is being conducted in partial fulfilment of the Professional Doctorate in Counselling Psychology (DPsych) at City, University of London. The aim of this study is to get a better understanding of GP trainees experiences of Reflective Practice, in particular how participants make use of Reflective Practice Groups ('RPGs'). This will support us in developing IRPP Reflective Practice Groups for future GP trainee participants and will contribute to our understanding of GP trainees' use of reflective practice more generally. Research will be carried out during the academic years 2021/22 and 2022/23 and will conclude at the earliest in October 2023, or at the latest in Summer 2024.

Why have I been invited to take part?
You have been invited to take part in this study because you are a current [redacted] GP specialist trainee who is taking part in the IRPP. If you give consent to be involved in this study you will be one of up to twelve GP trainees participating in the IRPP in total to be invited to attend an interview. It is entirely your choice whether or not to take part in this study and the decision not to take part will have no impact on your ongoing participation or future involvement in the IRPP, or on any other aspect of your current or future training.

Do I have to take part?
Participation in this study is entirely voluntary. If you choose to take part, you can withdraw your consent to be involved for any reason at any stage during the interview, and afterwards up to the point of transcription without being penalised or disadvantaged in any way. When participating in interviews, you are entitled to refuse to answer any questions you consider too personal or intrusive and this will have no effect on your involvement in this research or the IRPP. It is up to you to decide whether or not to take part. If you do decide to take part, you will be asked to sign a consent form. If you sign this form you are still free to withdraw consent at any time without giving a reason. All data that you provide will be anonymised and any identifying information changed or removed as appropriate. You can request to withdraw your data at any point up until it is anonymised, at which point it can no longer be withdrawn.

What will happen if I take part?
If you meet the inclusion criteria for this study and are interested in taking part, you will be given the opportunity to have a brief screening phone call with the researcher to address any questions you might have. If after this conversation you still wish to take part, you will be invited by the researcher to attend a single semi-structured interview of 1-1.5 hours, or two interviews of 30-45 minutes if you would prefer. Interviews will be conducted on Zoom and can be arranged at a time to suit you.

The interview questions will relate to your experiences of participating in Reflective Practice Groups as part of the IRPP, and in particular how you made use of the groups. Your responses will be analysed using an abbreviated Grounded Theory approach, and further data will be collected from new participants as themes emerge. Each participant will attend only one interview, unless you should choose to conduct the interview over two shorter sittings, you will not be asked to attend any further interviews. Grounded theory is data-led, meaning that theories arise from the responses you provide, rather than from preconceived ideas or theories, so as a participant you play a key role in constructing the eventual theoretical framework which will be developed to understand how GP trainees make use of RPGs.

What are the possible disadvantages and risks of taking part?
You will be asked to talk about your experiences of RPGs, and previous research has found that these groups can be extremely challenging, with some participants finding them distressing. The interview questions will not ask you to relate the content of discussion in the RPGs you attended, or the content of your contributions in these groups, however you may find even talking about your experiences of attending sensitive or difficult. It is also possible that you might find it difficult or sensitive to talk about issues related to professional identity. If so, you are free to refuse to answer any questions and to stop the interview at any time or take a break if you need one, without giving a reason, and will not be disadvantaged as a result. Information will be provided as to avenues of support for you in the event that you are affected by any of the topics that come up during interviews.

What are the possible benefits of taking part?
Your involvement in this research will contribute to our understanding of reflective practice in GP training and the way GP trainees make use of Reflective Practice Groups, a topic about which there is very little existing research. The insights gleaned from your responses will be invaluable in the ongoing development of the IRPP, and in shaping this project for future [redacted] trainees taking part.

Conflicts of Interest
The Inter-Professional Reflective Practice Project is a collaboration between [redacted] and City, University of London. This research is being carried out by a Researcher from the Professional Doctorate in Counselling Psychology at City, University of London as part of their DPsych thesis. Please be reassured that in conducting this research, the researcher is entirely independent of the IRPP. The researcher is not an IRPP facilitator, and is not seeking to evaluate the project,

The principal Research Supervisor is involved in the delivery of the IRPP however a co-supervisor has been appointed, currently the lead supervisor on this project, to mitigate any possible conflicts of interest and. Contact details are provided below.

What should I do if I want to take part? If you meet the inclusion criteria for this study and wish to take part please sign the consent form and return a copy to:

Amy Bower (researcher): [redacted]
You will be emailed your own copy of the signed form so do not worry if you forget to retain this.

The researcher then will contact you to set up an initial interview.

Data privacy statement
City, University of London is the sponsor and data controller of this study based in the United Kingdom. This means that we are responsible for looking after your information and using it properly. The legal basis under which your data will be processed is City's public task.

Your right to access, change or move your information are limited, as we need to manage your information in a specific way in order for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personal-identifiable information possible (for further information please see https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/lawful-basis-for-processing/public-task/).

City will use your name and contact details to contact you about the research study as necessary. If you wish to receive the results of the study, your contact details will also be kept for this purpose. The only person at City who will have access to your identifiable information will be the researcher. City will keep identifiable information about you from this study for ten years after the study has finished.

You can find out more about how City handles data by visiting https://www.city.ac.uk/about/governance/legal. If you are concerned about how we have processed your personal data, you can contact the Information Commissioner's Office (IOC) https://ico.org.uk/.

Will my participation in the study be kept confidential?
Interviews carried out with you as a part of this study will be audio recorded. Your consent for audio recording is covered in the Participant Consent Form and will be requested again at the start of the interview.

Only the researcher and research supervisor(s) will have access to the audio recordings. Interview data will be transcribed by the researcher, at which stage it will be anonymised with all names changed and identifying information changed or removed. Any quotes included in the final write-up will be anonymised with identifying information removed. Any quotes containing information which may enable participants to identify one another will also be removed or amended. Audio data and transcripts will be held by the researcher in accordance with City, University of London's data protection policies. Audio recordings will be stored on City's encrypted One Drive and will be destroyed immediately after the DPsych is completed. Transcripts will be stored on an encrypted, password protected device and retained for 10 years, after which they will be deleted.

What will happen to the results?
The results of this study will inform the ongoing development of Reflective Practice Groups for trainee GPs. As such they will be shared with City, University of London and [redacted] IRPP collaborators and colleagues, and other relevant parties including the Head of GP School and Associate Director at Health Education England South London. The study is likely to be published in health or psychological journals and may be presented at conferences. Where this is the case, anonymity will be maintained. If you would like a copy of the publication or summary of the results, please provide the researcher or research supervisor with a contact email address, this will be stored separately from all data relevant to the study, and in accordance with relevant data protection laws. Your informed consent will be required for your data to be retained for the purposes of sending you the results of the study. Results will be sent out once the study is concluded.

Who has reviewed the study?
This study has received ethical approval through the Psychology Research Ethics Committee at City, University of London. Ethics approval code: **ETH2122-1279**

What if there is a problem?
If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through City's complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is [name of project]
You can also write to the Secretary at:
[redacted] Research Integrity Manager
City, University of London, Northampton Square London, EC1V 0HB
Email: [redacted]

Insurance
City holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Further information and contact details
If you require any further information or have any further questions about this study, please contact:
Amy Bower (researcher): [redacted]

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

Appendix 5: Participant Information Sheet (amended for in-person interviews)

How do GP Trainees Make Use of Reflective Practice Groups? A Grounded Theory Investigation.

Amy Bower (Researcher), City, University of London.

We would like to invite you to take part in a research study relating to your participation in the Inter-Professional Reflective Practice Project ('IRPP'). Before you decide whether you would like to take part, it is important that you understand why the research is being done and what it would involve for you. Please take the time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear, or if you would like more information. You will be given a copy of this information sheet to keep.

What is the purpose of the study?
This study is being conducted in partial fulfilment of the Professional Doctorate in Counselling Psychology (DPsych) at City, University of London. The aim of this study is to get a better understanding of GP trainees experiences of Reflective Practice, in particular how participants make use of Reflective Practice Groups ('RPGs'). This will support us in developing IRPP Reflective Practice Groups for future GP trainee participants and will contribute to our understanding of GP trainees' use of reflective practice more generally. Research will be carried out during the academic years 2021/22 and 2022/23 and will conclude at the earliest in October 2023, or at the latest in Summer 2024.

Why have I been invited to take part?
You have been invited to take part in this study because you are a current [redacted] GP specialist trainee who is taking part in the IRPP. If you give consent to be involved in this study you will be one of up to twelve GP trainees participating in the IRPP in total to be invited to attend an interview. It is entirely your choice whether or not to take part in this study and the decision not to take part will have no impact on your ongoing participation or future involvement in the IRPP, or on any other aspect of your current or future training.

Do I have to take part?
Participation in this study is entirely voluntary. If you choose to take part, you can withdraw your consent to be involved for any reason at any stage during the interview, and afterwards up to the point of transcription without being penalised or disadvantaged in any way. When participating in interviews, you are entitled to refuse to answer any questions you consider too personal or intrusive and this will have no effect on your involvement in this research or the IRPP. It is up to you to decide whether or not to take part. If you do decide to take part, you will be asked to sign a consent form. If you sign this form you are still free to withdraw consent at any time without giving a reason. All data that you provide will be anonymised and any identifying information changed or removed as appropriate. You can request to withdraw your data at any point up until it is anonymised, at which point it can no longer be withdrawn.

What will happen if I take part?
If you meet the inclusion criteria for this study and are interested in taking part, you will be given the opportunity to have a brief screening phone call with the researcher to address any questions you might have. If after this conversation you still wish to take part, you will be invited by the researcher to attend

a single semi-structured interview of 1-1.5 hours, or two interviews of 30-45 minutes if you would prefer. Interviews will be conducted on Zoom and can be arranged at a time to suit you.

The interview questions will relate to your experiences of participating in Reflective Practice Groups as part of the IRPP, and in particular how you made use of the groups. Your responses will be analysed using an abbreviated Grounded Theory approach, and further data will be collected from new participants as themes emerge. Each participant will attend only one interview, unless you should choose to conduct the interview over two shorter sittings, you will not be asked to attend any further interviews. Grounded theory is data-led, meaning that theories arise from the responses you provide, rather than from preconceived ideas or theories, so as a participant you play a key role in constructing the eventual theoretical framework which will be developed to understand how GP trainees make use of RPGs.

What are the possible disadvantages and risks of taking part?
You will be asked to talk about your experiences of RPGs, and previous research has found that these groups can be extremely challenging, with some participants finding them distressing. The interview questions will not ask you to relate the content of discussion in the RPGs you attended, or the content of your contributions in these groups, however you may find even talking about your experiences of attending sensitive or difficult. It is also possible that you might find it difficult or sensitive to talk about issues related to professional identity. If so, you are free to refuse to answer any questions and to stop the interview at any time or take a break if you need one, without giving a reason, and will not be disadvantaged as a result. Information will be provided as to avenues of support for you in the event that you are affected by any of the topics that come up during interviews.

What are the possible benefits of taking part?
Your involvement in this research will contribute to our understanding of reflective practice in GP training and the way GP trainees make use of Reflective Practice Groups, a topic about which there is very little existing research. The insights gleaned from your responses will be invaluable in the ongoing development of the IRPP, and in shaping this project for future [redacted] trainees taking part.

Conflicts of Interest
The Inter-Professional Reflective Practice Project is a collaboration between [redacted] and City, University of London. This research is being carried out by a Researcher from the Professional Doctorate in Counselling Psychology at City, University of London as part of their DPsych thesis. Please be reassured that in conducting this research, the researcher is entirely independent of the IRPP. The researcher is not an IRPP facilitator, and is not seeking to evaluate the project,

The principal Research Supervisor is involved in the delivery of the IRPP however a co-supervisor has been appointed, currently the lead supervisor on this project, to mitigate any possible conflicts of interest and. Contact details are provided below.

What should I do if I want to take part? If you meet the inclusion criteria for this study and wish to take part please sign the consent form and return a copy to:

Amy Bower (researcher): [redacted]
You will be emailed your own copy of the signed form so do not worry if you forget to retain this.

The researcher then will contact you to set up an initial interview.

Data privacy statement
City, University of London is the sponsor and data controller of this study based in the United Kingdom. This means that we are responsible for looking after your information and using it properly. The legal basis under which your data will be processed is City's public task.

Your right to access, change or move your information are limited, as we need to manage your information in a specific way in order for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personal-identifiable information possible (for further information please

see https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/lawful-basis-for-processing/public-task/).

City will use your name and contact details to contact you about the research study as necessary. If you wish to receive the results of the study, your contact details will also be kept for this purpose. The only person at City who will have access to your identifiable information will be the researcher. City will keep identifiable information about you from this study for ten years after the study has finished.

You can find out more about how City handles data by visiting https://www.city.ac.uk/about/governance/legal. If you are concerned about how we have processed your personal data, you can contact the Information Commissioner's Office (IOC) https://ico.org.uk/.

Will my participation in the study be kept confidential?
Interviews carried out with you as a part of this study will be audio recorded. Your consent for audio recording is covered in the Participant Consent Form and will be requested again at the start of the interview.

Only the researcher and research supervisor(s) will have access to the audio recordings. Interview data will be transcribed by the researcher, at which stage it will be anonymised with all names changed and identifying information changed or removed. Any quotes included in the final write-up will be anonymised with identifying information removed. Any quotes containing information which may enable participants to identify one another will also be removed or amended. Audio data and transcripts will be held by the researcher in accordance with City, University of London's data protection policies. Audio recordings will be stored on City's encrypted One Drive and will be destroyed immediately after the DPsych is completed. Transcripts will be stored on an encrypted, password protected device and retained for 10 years, after which they will be deleted.

What will happen to the results?
The results of this study will inform the ongoing development of Reflective Practice Groups for trainee GPs. As such they will be shared with City, University of London and [redacted] IRPP collaborators and colleagues, and other relevant parties including the Head of GP School and Associate Director at Health Education England South London. The study is likely to be published in health or psychological journals and may be presented at conferences. Where this is the case, anonymity will be maintained. If you would like a copy of the publication or summary of the results, please provide the researcher or research supervisor with a contact email address, this will be stored separately from all data relevant to the study, and in accordance with relevant data protection laws. Your informed consent will be required for your data to be retained for the purposes of sending you the results of the study. Results will be sent out once the study is concluded.

Who has reviewed the study?

This study has received ethical approval through the Psychology Research Ethics Committee at City, University of London. Ethics approval code: **ETH2122-1279; ETH2223-1577**

What if there is a problem?
If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through City's complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is [name of project]
You can also write to the Secretary at:
[redacted] Research Integrity Manager
City, University of London, Northampton Square London, EC1V 0HB
Email: [redacted]

Insurance

City holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Further information and contact details
If you require any further information or have any further questions about this study, please contact:
Amy Bower (researcher): amy.bower@city.ac.uk

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

Appendix 6: Consent Form

How do GP Trainees Make Use of Reflective Practice Groups? A Grounded Theory Investigation.

Amy Bower (Researcher), City, University of London.

		Please tick or initial box
1	I confirm that I have read and understood the participant information for the above study. I have had the opportunity to consider the information and ask questions which have been answered satisfactorily.	
2	I understand that my participation is voluntary and that I am free to withdraw without giving a reason without being penalised or disadvantaged.	
3	I understand that I will be able to withdraw my data up to the time of transcription.	
4	I agree to the interview being audio recorded.	
5	I agree to City recording and processing this information about me. I understand that this information will be used only for the purpose(s) explained in the participant information sheet and my consent is conditional on City complying with its duties and obligations under the General Data Protection Regulation (GDPR).	
6	I agree to the researcher using my direct quotes as part of the final write up. I understand that any direct quotes used will be anonymised and any identifying information about myself or potentially identifying information about another participant changed or removed.	
7	I understand that the results of this study will be shared with City and GSTT collaborators on the Inter-Professional Reflective Practice Project and with the Associate Director at Health Education England South London.	
8	I agree to take part in the above study.	

As a participant in this study you are entitled to a summary of the findings once the study is completed. If you would like to receive this summary, please tick the following box and include a contact email address for us to send it to:

9	I would like to be informed of the results of this study once it has been completed, and understand that my contact email address will be retained for this purpose.	

Email address:

*Your contact email address will be stored separately from participant data and will be destroyed immediately on completion of the study, once we have sent you your summary of findings.

Appendix 7: Debrief Sheet

How do GP Trainees Make Use of Reflective Practice Groups? A Grounded Theory Investigation.

Amy Bower (Researcher), City, University of London.

DEBRIEF INFORMATION

Thank you for taking part in this study. Now that your participation has finished, we'd like to tell you a bit more about it.

The pool of research relating to healthcare trainees' experiences of reflective practice and the way in which they make use of reflective practice groups is extremely limited, and only a very small number of studies examine the possibility of inter-professional collaboration between healthcare professionals and Psychologists in reflective practice. By providing Reflective Practice Groups for GP trainees facilitated by Counselling Psychology trainees, the Inter-Professional Reflective Practice Project ('IRPP') provides us with an opportunity to conduct valuable research in these areas, and a key starting point is understanding how the GP trainees involved in this project made use of Reflective Practice Groups.

By agreeing to be interviewed about this and share your experiences, you have made an invaluable contribution to the ongoing development of the IRPP. You have contributed to the development of a theoretical framework for understanding the way trainee GPs make use of Reflective Practice Groups, which provides us with a starting point from which to develop Reflective Practice Group interventions for future GP trainee participants, in the IRPP and possibly also more generally.

We hope you found this study interesting. If you have requested a copy of the results, you will be contacted in due course using the details you provided. We anticipate the results of this study will be available at the earliest in October 2023, and no later than September 2024.

If you are experiencing any distress currently or following your participation in this study, further support can be accessed via the following channels:

The NHS Practitioner Health Service (confidential service for GPs and GP trainees in England: website: http://gphealth.nhs.uk/ email: gp.health@nhs.net phone: 0300 0303 300
The BMA Counselling Service (open to all doctors and medical students): website: https://www.bma.org.uk/advice-and-support/your-wellbeing/ phone: 0330 123 1245

If you have any other questions, please do not hesitate to contact us via the following:

Amy Bower (researcher): [redacted]

Supervised by:
Dr. Fran Smith: [redacted]

Approved by the Psychology Research Ethics Committee at City, University of London. Ethics approval code: **ETH2122-1279**

Appendix 8: Interview Schedule

Interview questions/prompts

What motivated you to come to this interview/take part in this research?

What did you think when you first heard about the groups?

Has this changed/what do you think about the groups now?

What motivates you to attend? [personal/professional]

Have you ever done anything like this before? How does it compare? [What do they relate it to?]

Can you recall a particular moment which stood out for you?

Can you recall a time when it the groups were particularly challenging?

If you have dropped out of groups/not attended/low attendance, why was this?

Have you noticed anything different about the way you work/your relationships with patients? - examples?

Have you noticed anything different about your relationships with colleagues? (GP colleagues? Others?) - examples?

Have you noticed any changes in your personal relationships/life outside work? – examples?

Are there any other practices that you are now engaging in as a result of coming to the groups? - examples?

What is your understanding of the purpose of these groups?

Do you think you will continue to engage with RPGs/something similar beyond your training? Why/why not?

Is there anything else I need to know to help me understand your experience of the Reflective Practice Groups better?

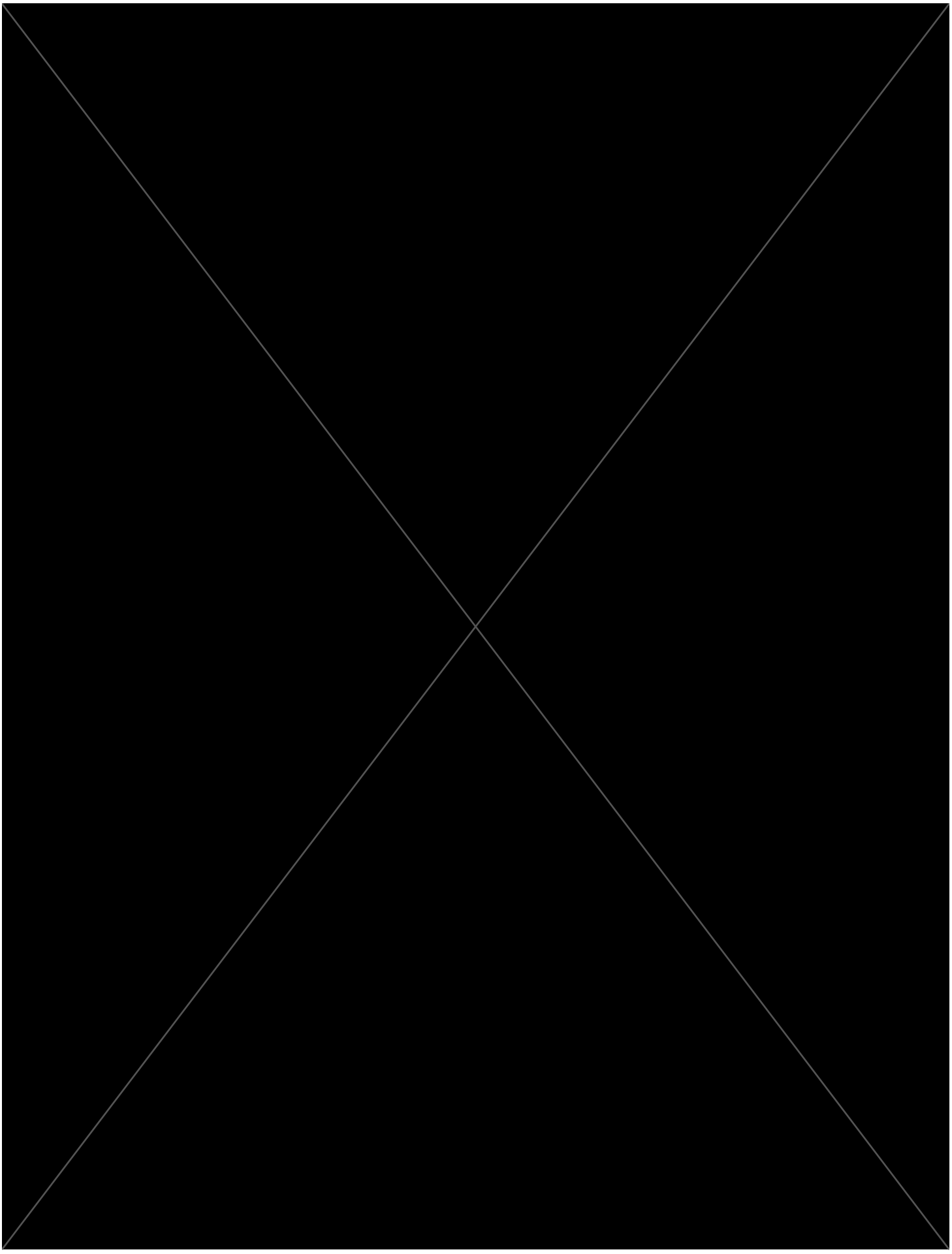
Appendix 9: Example of Transcript and Coding

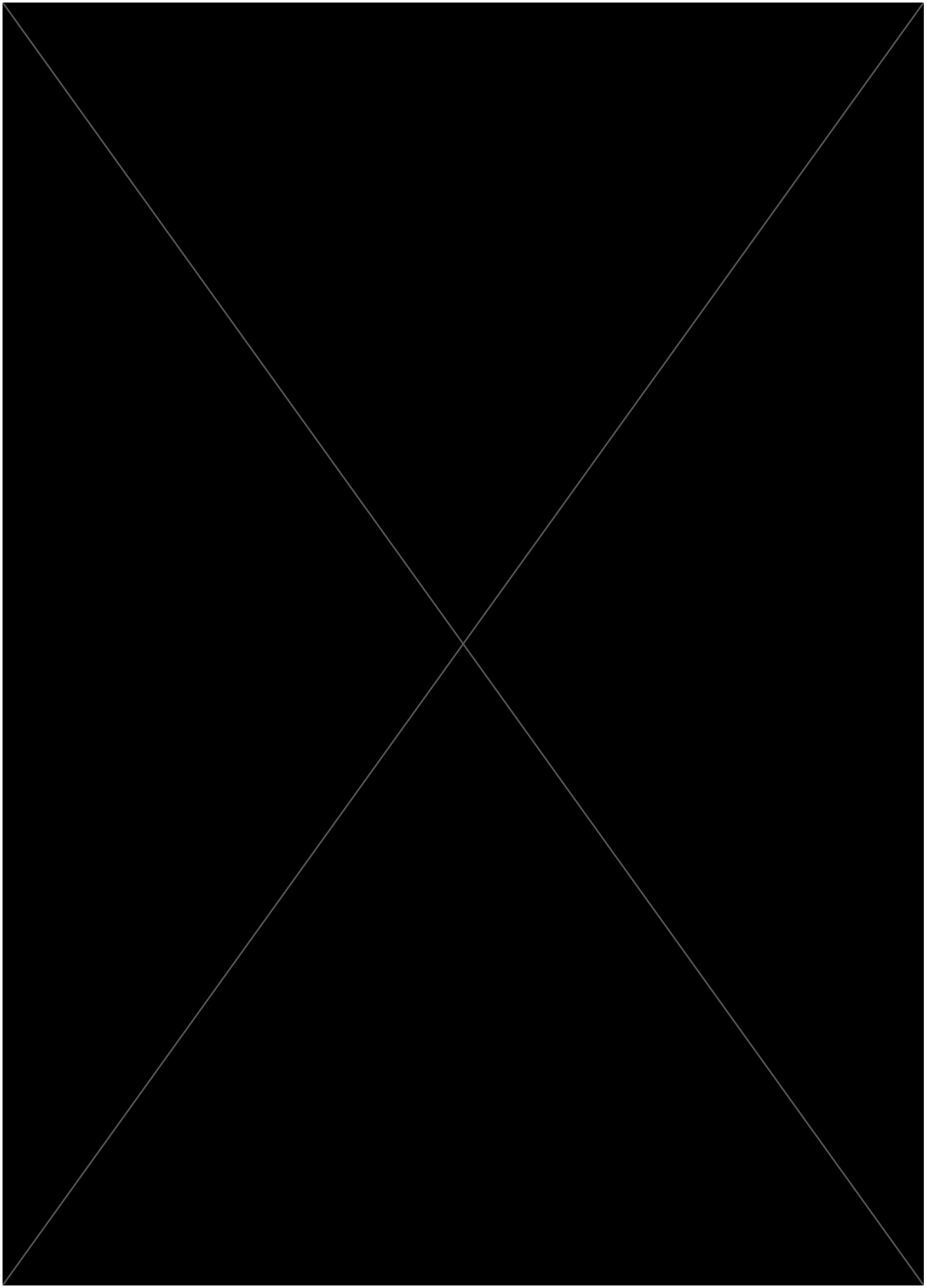
Transcript	Initial Coding	Focused Coding
P: Erm (…) Well I think I remember (…) I remember my case well [laughs] Or like my (.) I presented two (.) my two cases um (…) and (…) I think (.) I think it's just that different perspective thing like when somebody (.) kind of says something about the situation that you (.) having gone over and over and over it in your mind you just hadn't thought of that (.) um (.) so I think that stood out for me (.) from those (.) um (.) one of mine was kind of I had like a (.) slight disagreement with a Nurse and then somebody (.) kind of (.) I'd just decided that the Nurse was just being annoying [laughs] and they were like pointed out like a (.) um (.) you know a reason that they'd have a different agenda in that situation than I had and that actually if you (.) if I'd have realised that then it would have been quite different (.) erm (.) so I think that (.) and then I think (…) there was a couple of cases that (.) you know when we kind of (.) um were trying to think of one at the beginning and a lot of people would be like 'I don't really have one this week' or I (.) I've not got anything and then a few people (.) a couple of times people were like 'oh I can do one but it's from ages ago so like if anyone has one that's more (.) I guess relevant or you know they feel like they really need to discuss then that's fine' erm and then sometimes we would talk about this one that (.) um (.) whoever was bringing it thought (.) you know wasn't (.) really needing to be discussed but just cause there wasn't another one um (.) then (.) the discussion would be really good and like you could (.) the person bringing the case would (.) either get quite emotional or just (.) kind of (.) go (.) you know you could tell that actually it was (.) as important	Trying to remember a moment that stood out Remembering 'my' case well Recalling I brought two cases Recognising impact of different perspectives Hearing someone say something I hadn't thought of - about a case I had gone over and over in my mind This stood out Describing one of my cases Disagreeing with a nurse Deciding they [nurse] were 'just being annoying' Someone in the group pointing out why they might have had a different agenda from me Something I had not recognised Realising it would have made a difference if I had thought of that at the time Thinking about a couple of cases Trying to think of something to bring Recalling people saying they did not have a case, describing cases as not recent, asking if anyone had anything more relevant Suggesting that others may have something they need to discuss more Talking about cases the presenter felt did not need to be discussed Finding that the discussion was really good Seeing the person who brought the case get quite emotional Realising it was important to them/did need to be discussed Recognising that case was still relevant/present/still having an impact Realising this through talking about it	Bringing a case/cases to the group; sharing experiences; hearing different or new perspectives/perspective taking Impact of hearing other perspectives Perspective taking (encouraged by group) Thinking about how others may have been thinking; Something I had not recognised before; Impact of hearing different perspective on my thoughts/feelings Recognising others' emotions; recognising/experiencing feelings through discussions (experiencing feelings they had not recognised before); impact of sharing experiences on feelings

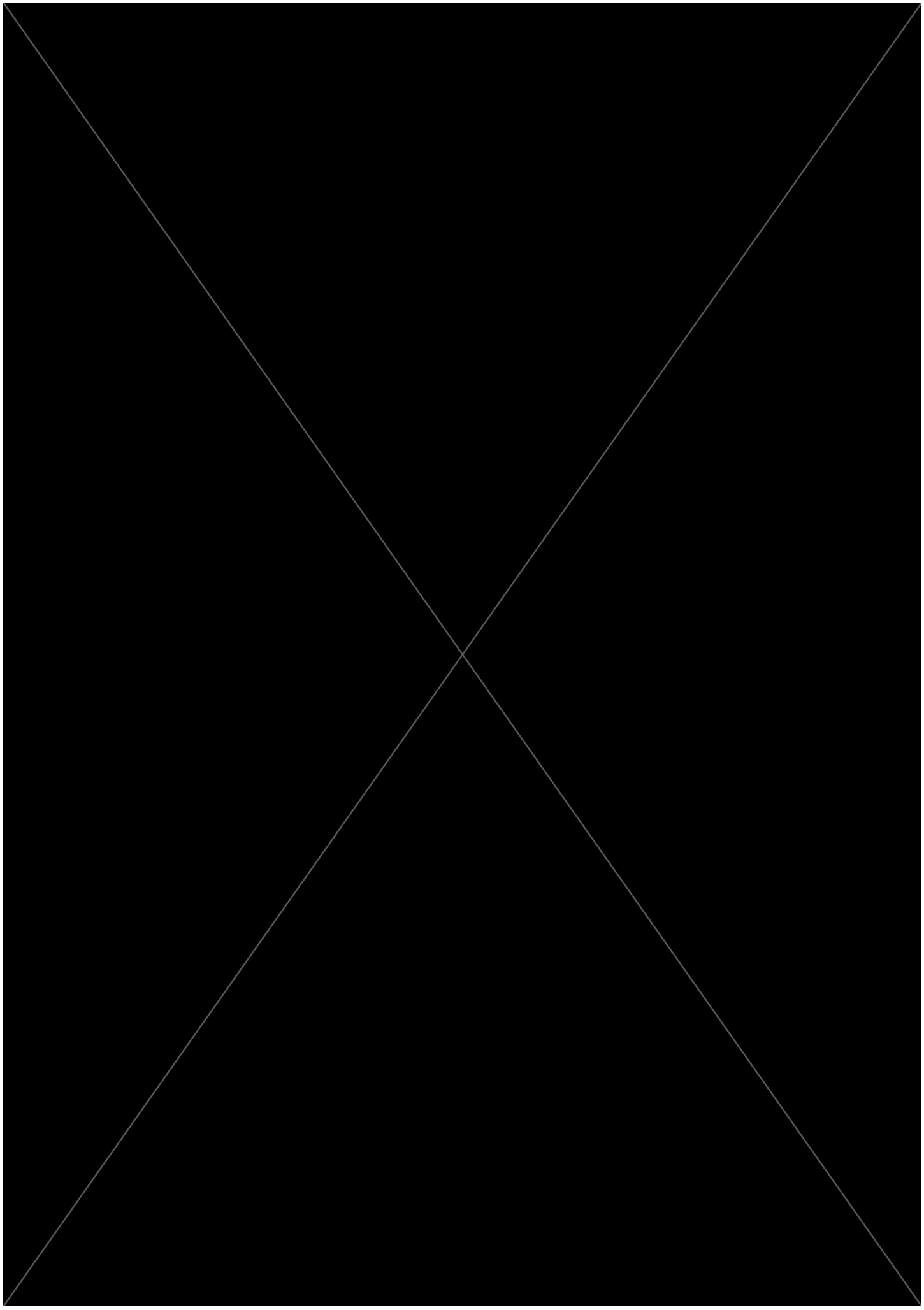
and as (.) like needed to be discussed as something that had happened yesterday (.) erm (.) so I think yeah a few of those kind of stood out **I:** Mm yeah so the discussion was helpful whether it was sort of very current or not?] **P:** Mmm] **I:** But those emotional moments how did you experience that? Did you experience an emotional impact or anything from the emotional side?	Impact of these moments/recalling they stood out	
P: (…) Yeah I think so (.) erm (…) I think a lot of it is (.) that it's just (.) kind of (.) a lot (.) cause a lot of the cases are very relatable so if (.) even if it's not your case you're kind of like 'oh I (.) feel like I've been in a similar situation' or you know I (…) understand how that feels (.) um (.) so I think it is (.) quite emotional I think it's also quite um (…) kind of in that (.) kind of (.) situation (.) um (.) with everyone kind of talking about your experience and what happened it is quite an emotional environment isn't it? Erm **I:** Mm. Mm. **P:** And then I feel like part of that was probably also the (.) environment that our facilitator created (.) kind of (.) allowed that to happen I couldn't (.) I could see in other groups that it wouldn't (.) feel (.) you wouldn't feel as (.) able to kind of (.) express that emotion as much	Experiencing an emotional impact Reflecting that it is 'a lot' (emotional side) Cases are very relatable Able to relate even if it's not my case Feeling I've been in similar situations, I understand how that feels Finding this quite emotional Hearing everyone talking about my experience and what happened Creates an emotional environment Facilitator creating this environment Allowed these discussions to happen Thinking this may not happen in other groups Wouldn't feel as able to express emotion in other groups, 'this' group environment allowed us to express emotion	Experiencing emotions; recognising others are going through similar things (I can relate) Emotional impact of hearing others discuss my experience Role of the facilitator in creating a 'space' for emotions; 'Allowed' to express/experience emotion

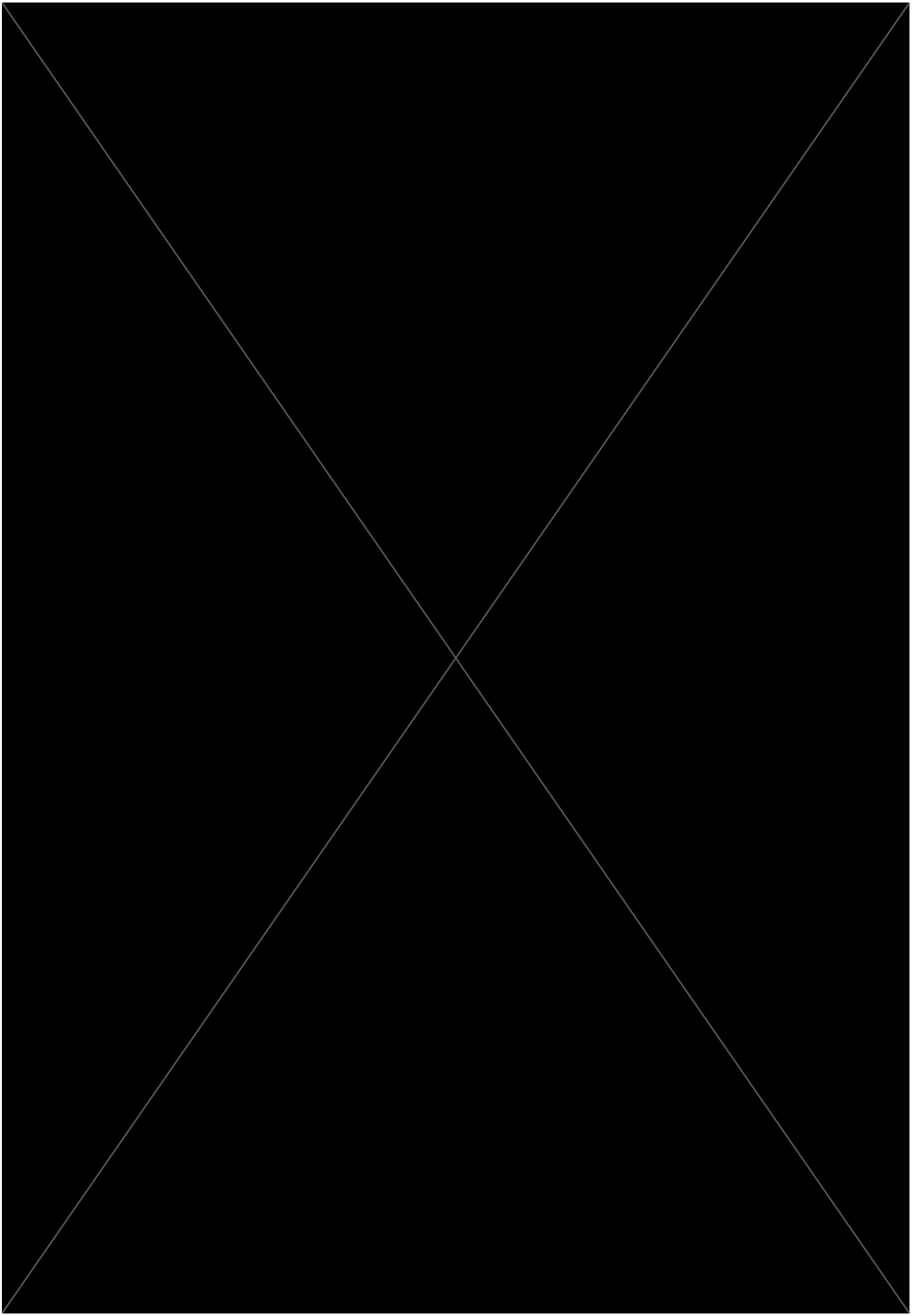
Part II: Publishable Paper

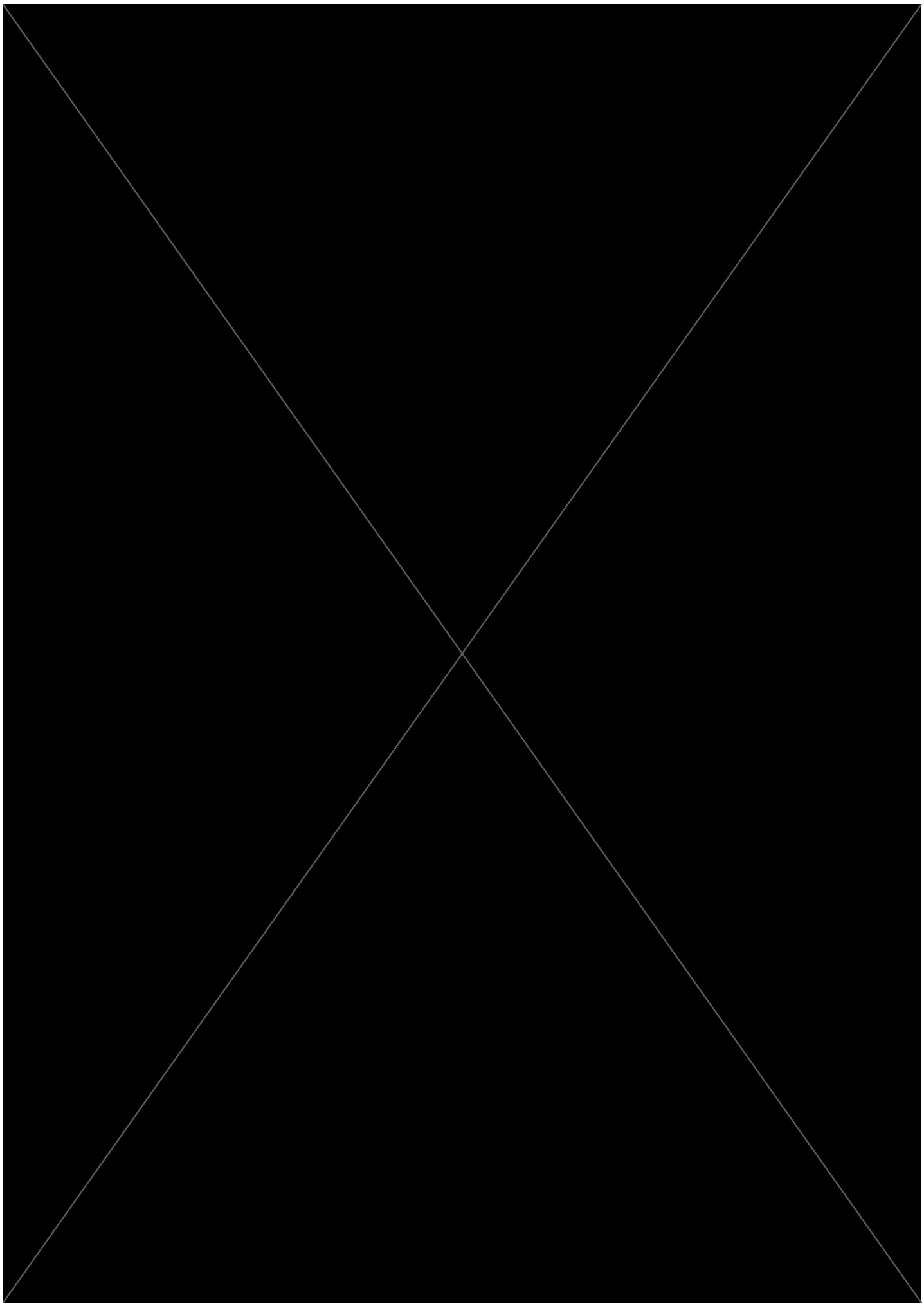
"It's like… here's a space to be human about it": A Grounded Theory Investigation into How GP Trainees Make Use of Reflective Practice Groups

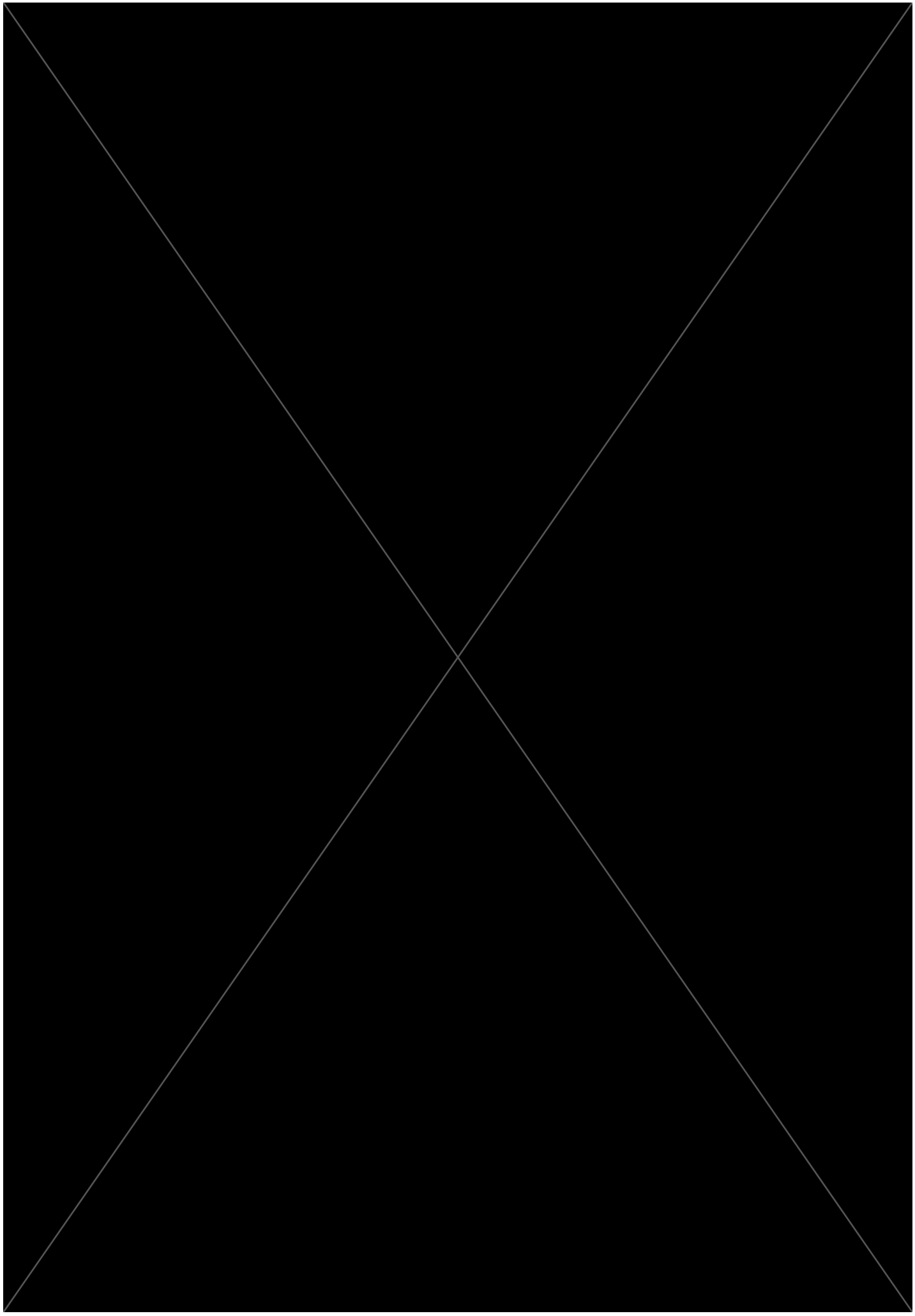


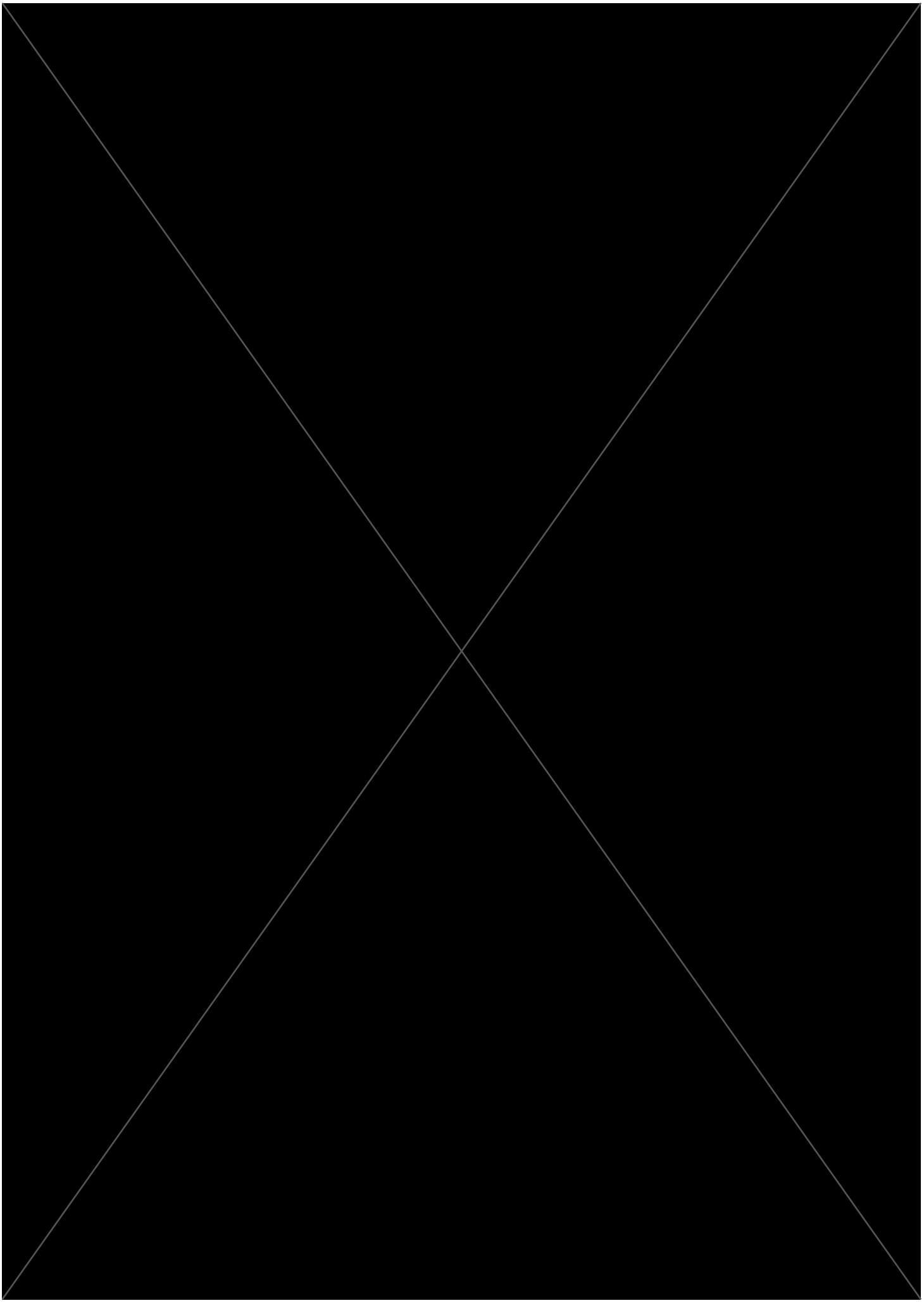


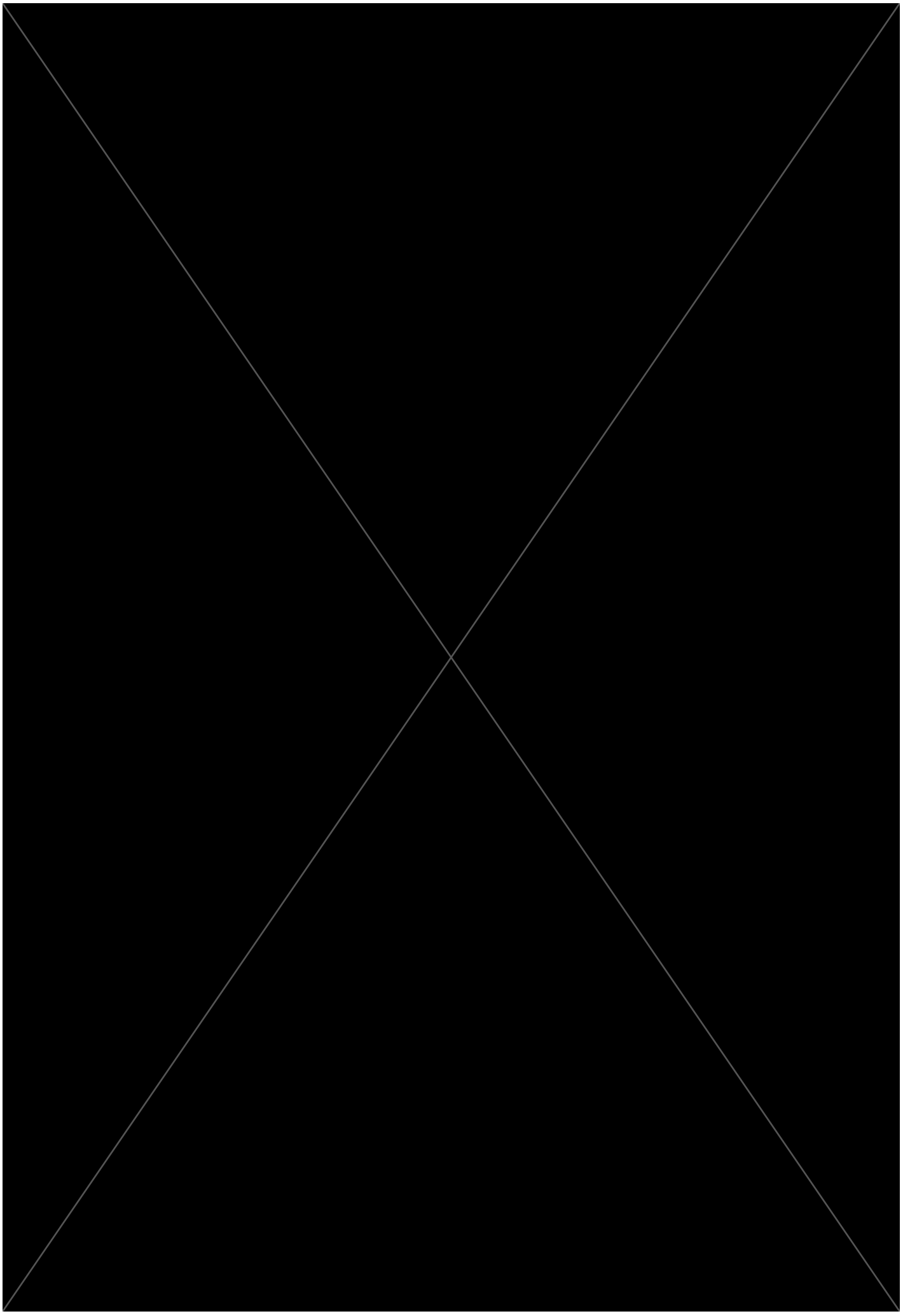


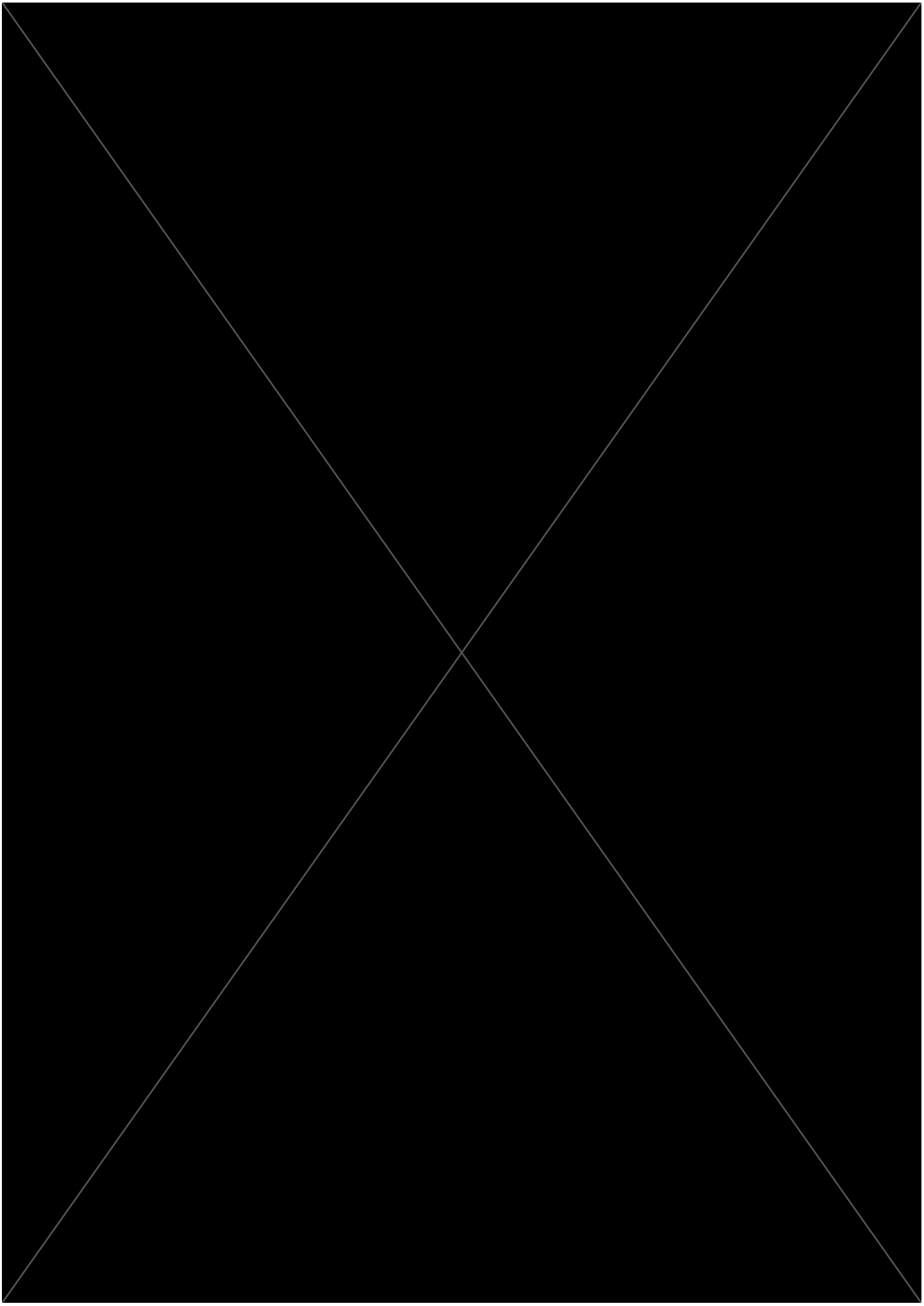


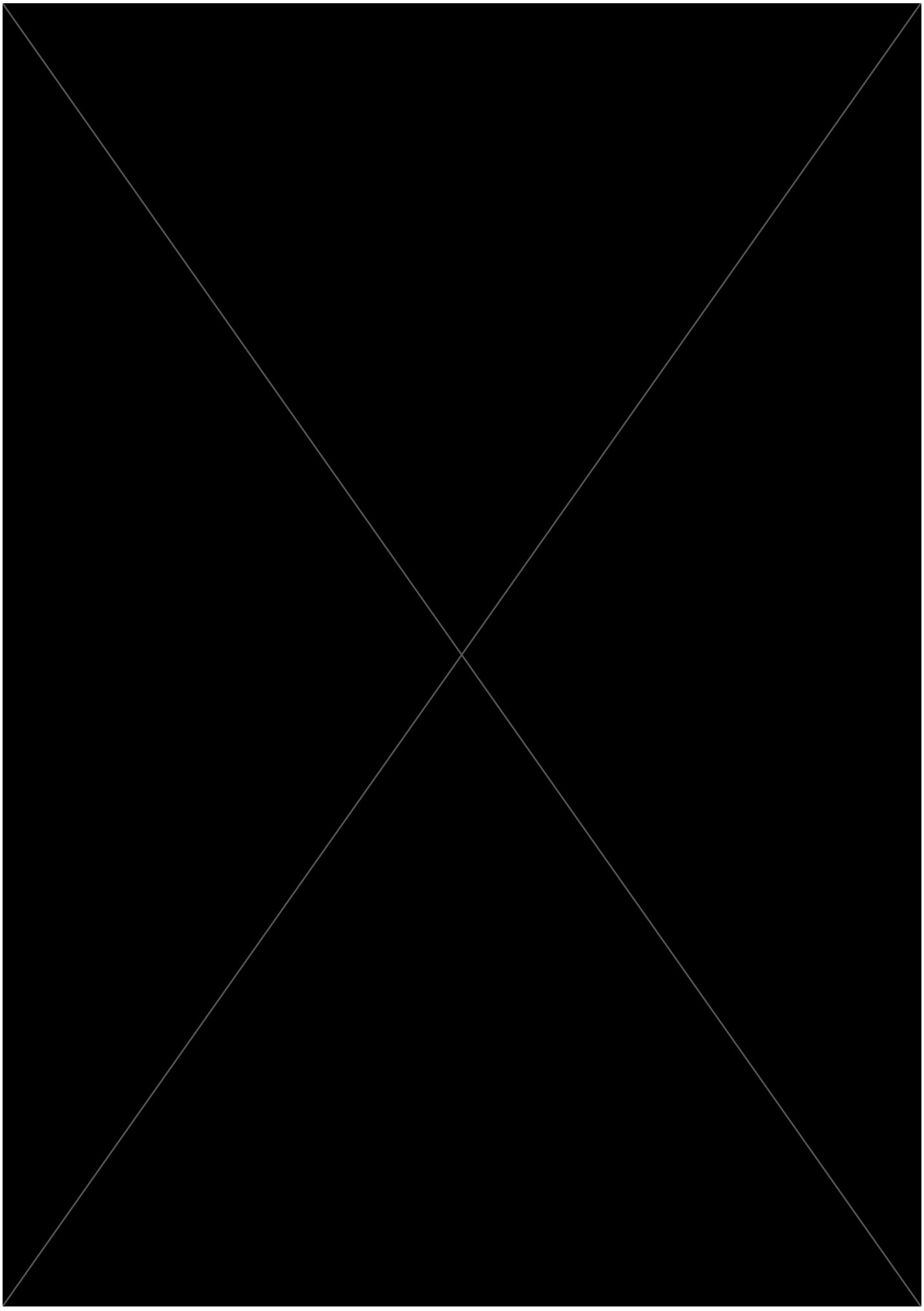


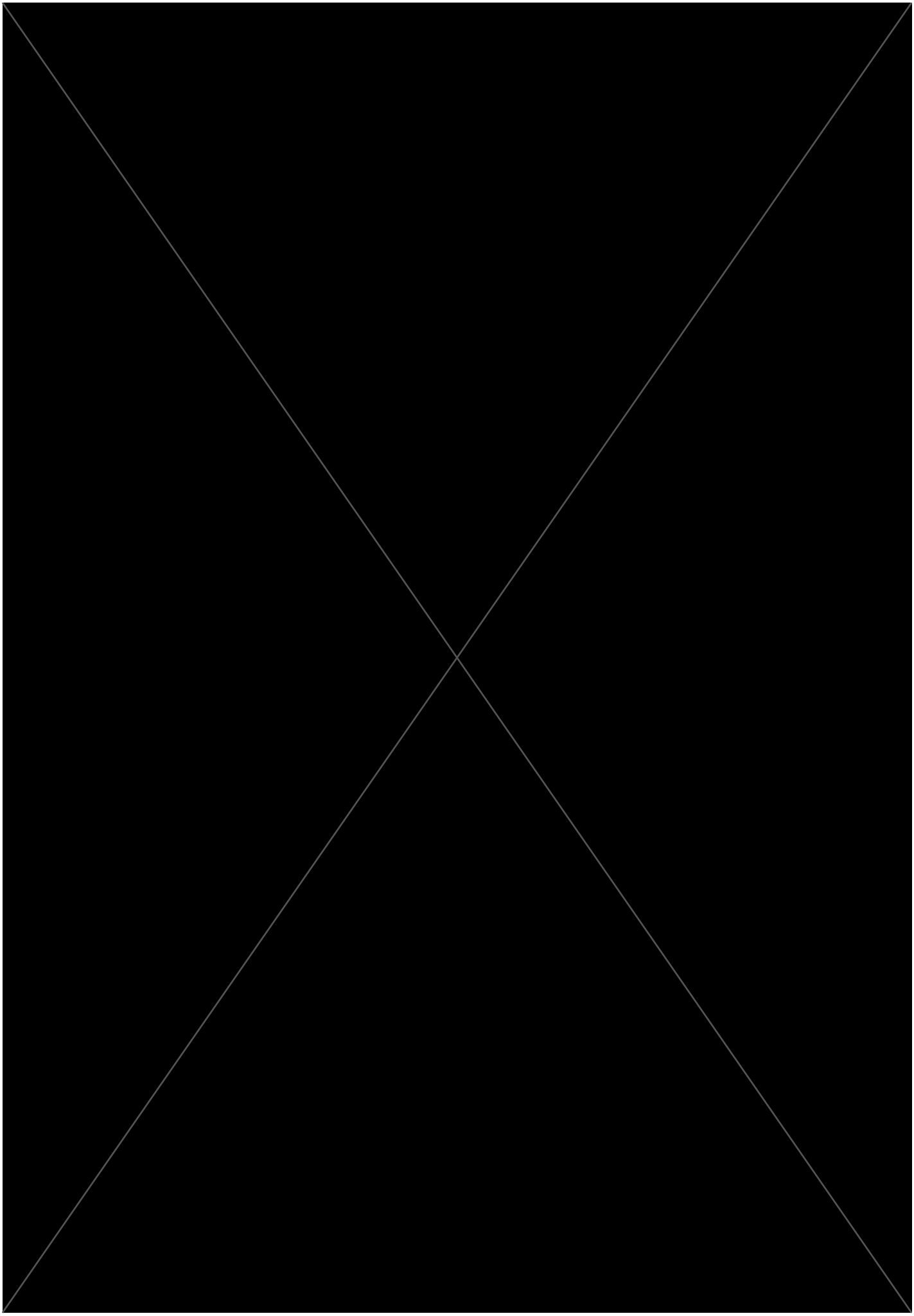


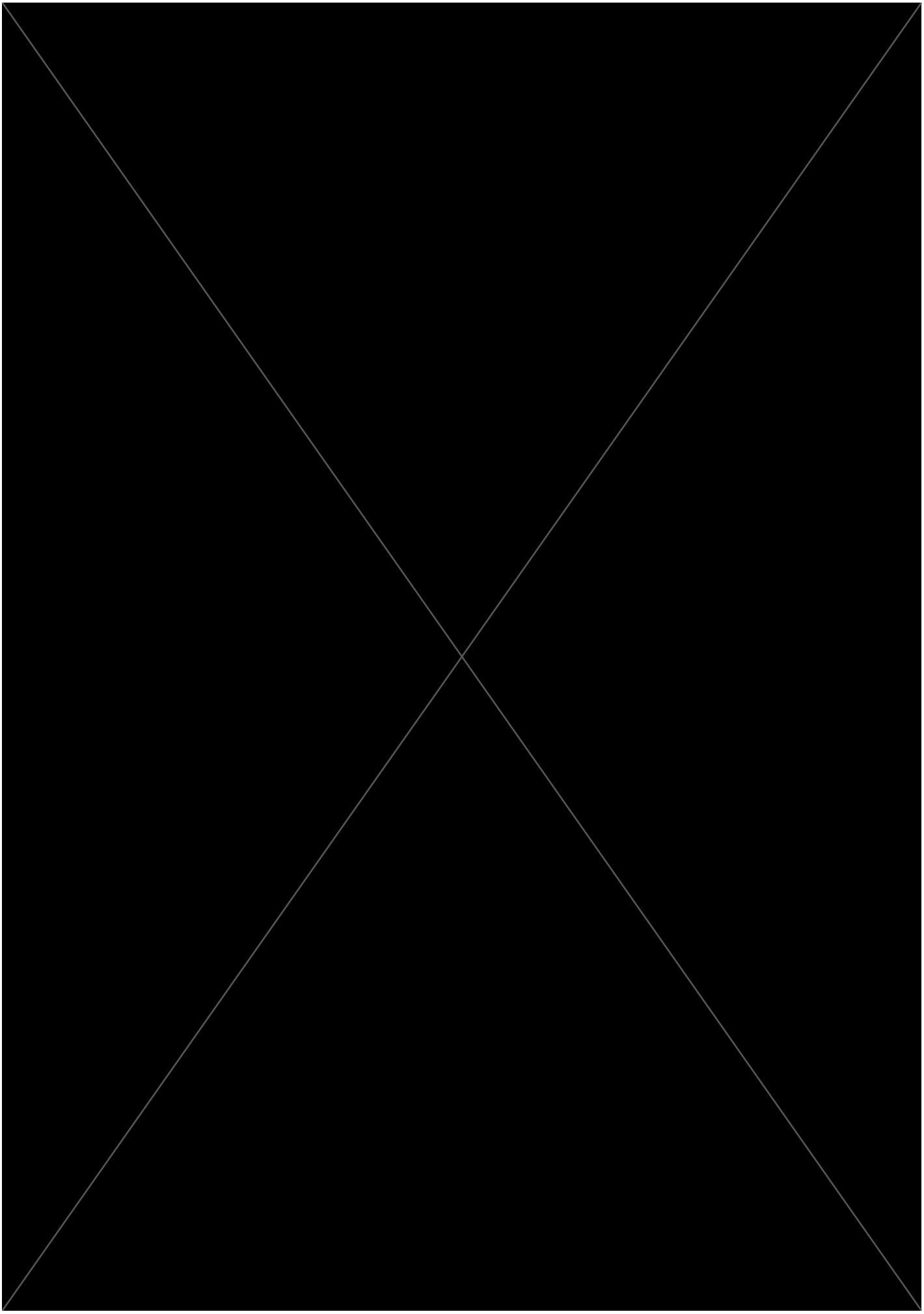


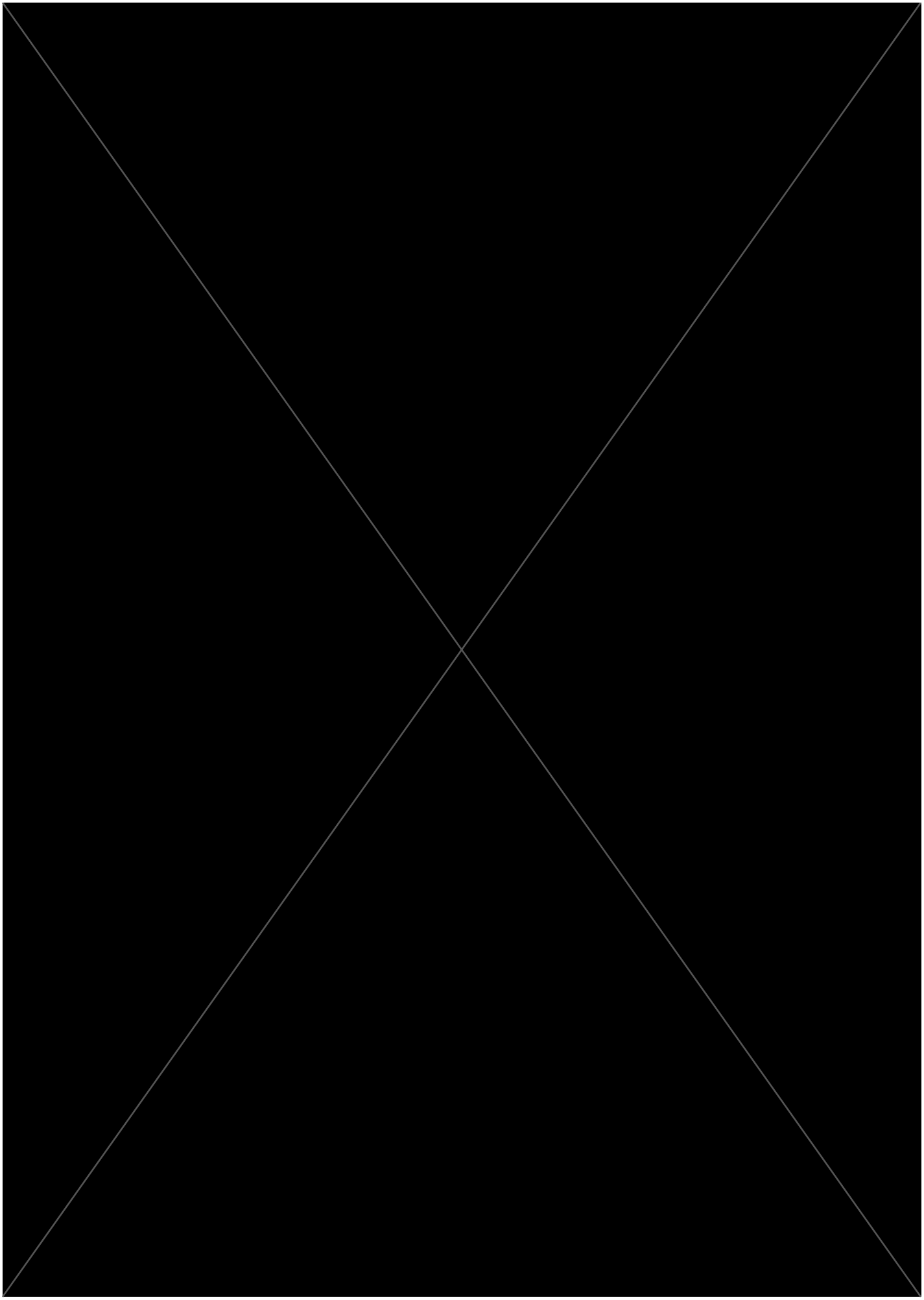


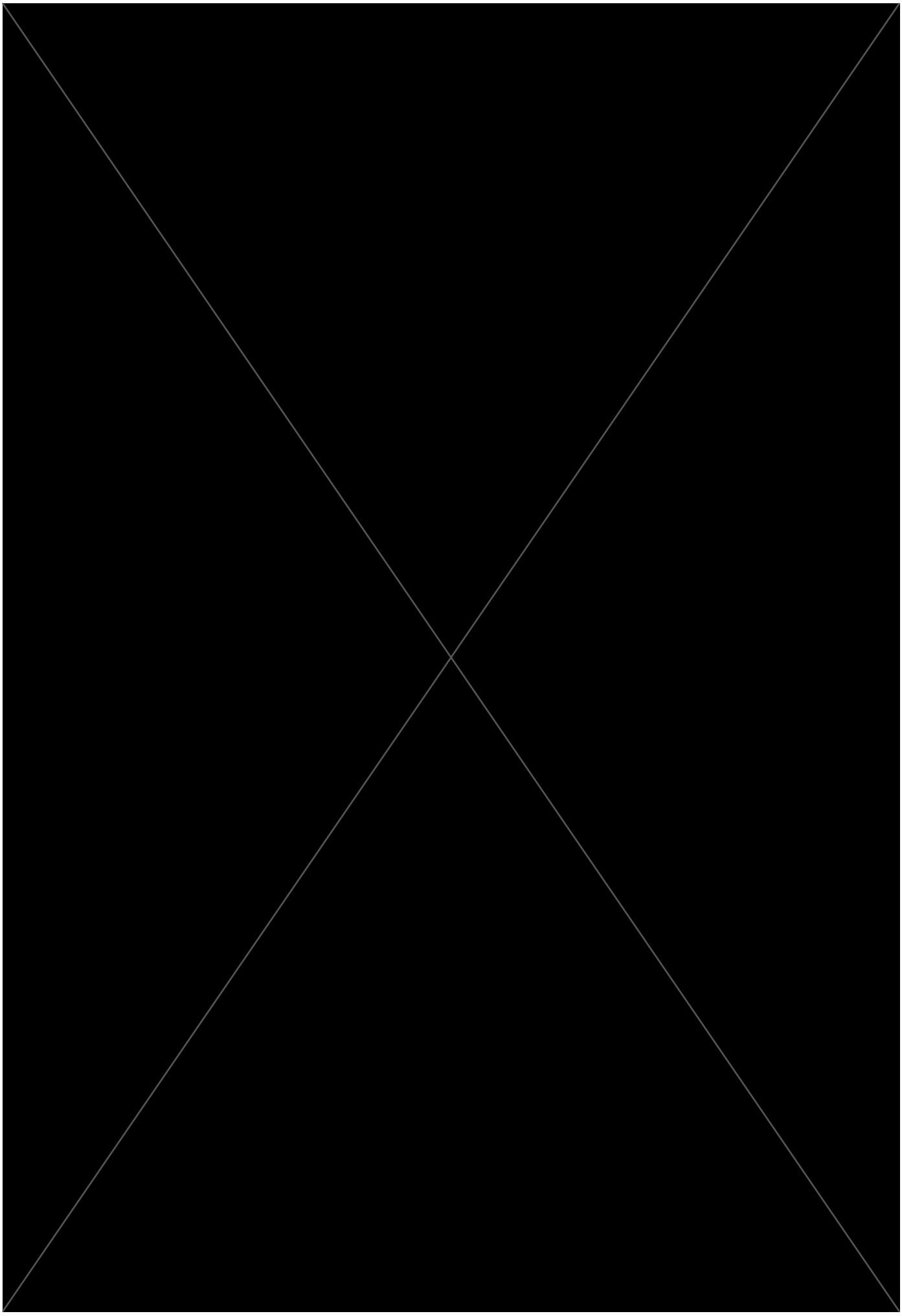


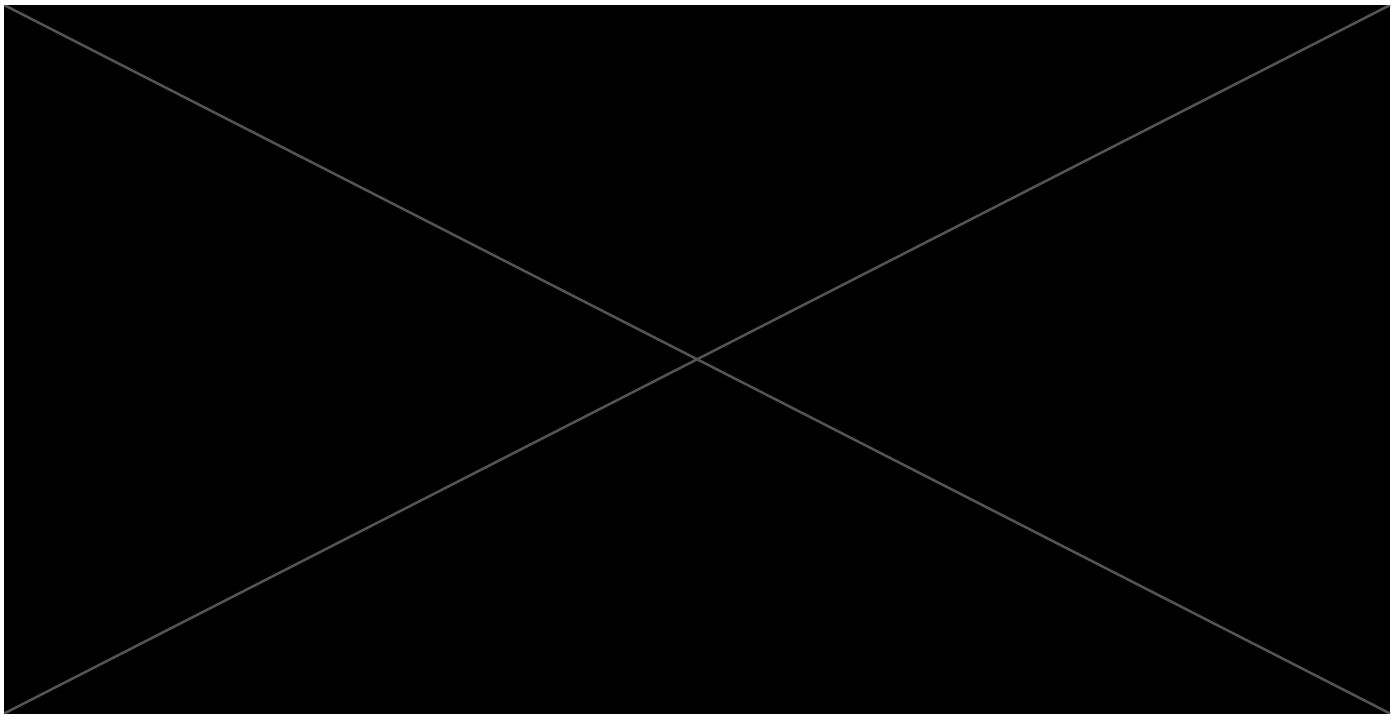


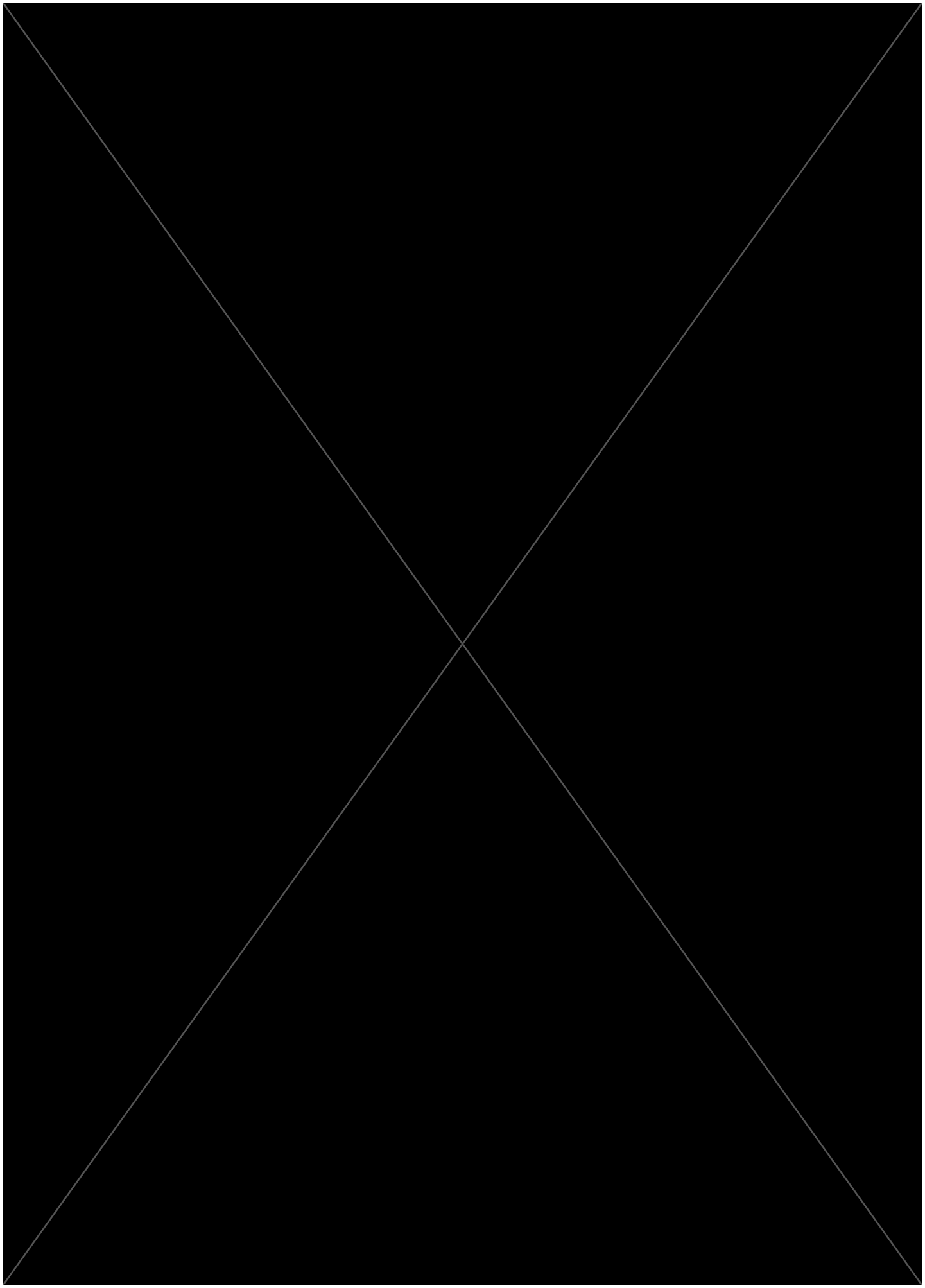


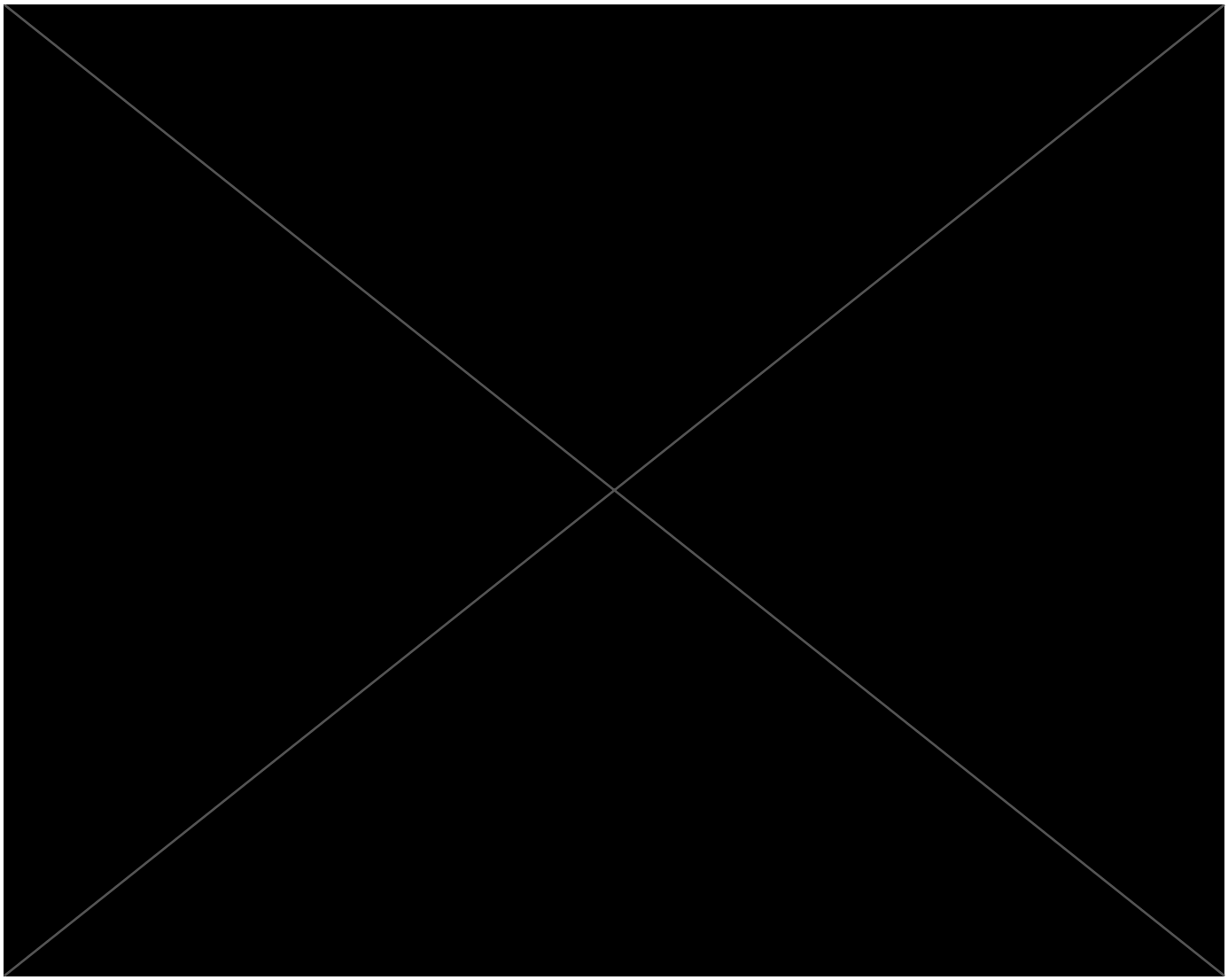












Part III: Clinical Piece

Being ‘human’ with a client and communicating empathy - The crucial need to take account of difference, in the therapeutic relationship and beyond: A Combined Integrative (Person-centred with Systemic) Case Study and Process Report