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FIONA SHEDDEN BA Psychology (Hons) PGCert

**SUPPORTING STAFF IN HEALTHCARE PROFESSIONS TO
REFLECT ON THE EMOTIONAL ASPECTS OF THEIR WORK**

**Section A: What mechanisms help staff in healthcare professions
engage with reflection in reflective practice group settings: A
review of the literature**

Word Count: 8,341 (341)

**Section B: What are NHS staff members' experiences of
attending Schwartz Centre Rounds®: A grounded theory of
psychological processes**

Word Count: 8,170 (170)

Overall Word Count: 15,769 (16,511)

**A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology**

MAY 2018

**SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY**

Acknowledgements

Thank you to the participants for sharing, and trusting me, with your thoughts and experiences. A big thanks to the Schwartz Round team for your ongoing support and letting me enjoy all those lunches.

Thanks to my supervisors for your support and guidance. Thank you, Dr Melanie George, for your enthusiasm and energy for promoting staff wellbeing. A heartfelt thanks to Professor Margie Callanan for your kindness during a difficult time.

To my friends and family, I am grateful for your encouragement, support and belief in me. Mostly I want to thank my husband Sterrenberg. Ek sal jou vir altyd dankbaar wees vir die onbaatsugtige opofferings wat jy vir my gemaak het, sodat ek my kursus kon voltooi. Vir al die tye wat jy my gerus gestel het toe ek geloof in myself verloor het en gedink het ek kon nie voortgaan nie. Baie dankie ook vir die nagte wat jy my angstigheid op jou geneem het sodat ek kon slaap. Jy was my lig in die donkerte.

This work is in loving memory to my grandmother Ruby, who passed away shortly before its completion.

Summary of the Major Research Project

Section A is a literature review using a meta-ethnographic approach to synthesise qualitative studies on staff in healthcare professions' experience of reflective practice groups. This review drew out specific mechanisms which may help staff reflect on clinical practice. Findings suggest a number of key mechanisms are potentially involved with sense of security being at the core. Practice implications are considered alongside the need for further research into understanding what psychological processes are involved in reflecting on clinical practice and how this might effect staffs' perception of themselves and their work.

Section B is an empirical paper using a grounded theory approach to understanding NHS staff members' experience of attending Schwartz Center Rounds[®] and whether this type of reflective group affected the way staff perceive themselves and their work. This study explored what psychological processes may facilitate such an effect and where in the temporal process it occurred. This study is the first to explore these processes and build a theory around this. Key psychological processes of reciprocity, containment, connection, perspective taking and occupying a different space were suggested to be helpful in facilitating an effect on staffs' view of self and work. Findings are discussed in relation to practical implications and future research.

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Section A: Literature Review Paper

What mechanisms help staff in healthcare professions engage with reflection in reflective
practice group settings: A review of the literature

Word Count: 8, 341 (341)

Abstract

Background: Reflective practice continues to be an area of interest in healthcare and research has highlighted the positive benefits for staff professional development and emotional wellbeing. This review aimed to draw together the literature on staff in healthcare professions' experience of reflective practice groups. The primary aim was to identify what mechanisms might help them engage with reflection.

Method: Six electronic databases were systematically searched: ASSIA, CINAHL, Cochrane, Medline, PsycINFO and finally Web of Science.

Results: Twelve qualitative papers met the inclusion criteria set. Findings were synthesised using a meta-ethnographic approach and highlighted the underlying need for staff to feel a sense of security, before feeling able to participate in reflective practice groups. Other mechanisms were group set-up, safety, emotional containment, gaining perspective, having space, belonging and being 'confirmed'.

Discussion: This review has highlighted the importance of group facilitators being cognisant of factors which support staff reflection. The importance of group processes also emerged from the data, however this was not considered in the studies. This has important implications for staff feeling sufficiently psychologically safe to reflect. Future research could explore the psychological processes involved in reflection and its possible impact on staffs' perceptions of themselves and their work.

Keywords: healthcare staff, reflective practice, groups, staff wellbeing, group processes

Introduction

Reflective practice in healthcare settings

Since its genesis in the field of education, reflective practice has been embraced by health services, particularly nursing (Mantzoukas & Jasper, 2004). It has become something of a panacea despite a lack of robust evidence regarding its value in clinical care (Carroll et al., 2002; Nicholl & Higgins, 2004). Another area of debate is how theoretical writing has been implemented in healthcare settings (Mantzoukas & Jasper, 2004). Nevertheless, reflective practice has become part of the healthcare system; embedded within continuing professional development (e.g. Health and Care Professions Council [HCPC] (HCPC, 2017), professional revalidation (e.g. Nursing and Midwifery Council [NMC], 2017), professional practice guidelines (e.g. British Psychological Society [BPS] (BPS, 2017; NMC, 2015) and departmental policy (Department of Health [DH], 1999).

There are various forms in which staff can engage with reflective practice; keeping a reflective diary or in clinical supervision (Kennard & Hartley, 2009), or within a group setting (Sternlieb, 2015). This review will focus on reflecting in groups as it is argued sharing of experiences produces richer insights (Sternlieb, 2015; Williams & Walker, 2003), promotes and facilitates dialogue among individuals enabling increased understanding of self and other, and establishes a sense of community and care (Osterman, 1990). Groups are also thought to serve a restorative function for individuals (Rutan, Stone, & Shay, 2014; Yalom & Leszcz, 2005).

Research which has focused on exploring the outcomes of healthcare staff engaging in reflective practice suggest it increases professionalism and facilitates greater autonomy in decision making (Platzer, Blake, & Ashford, 2000b), reduces work-related stress and burnout (Peterson, Bergström, Samuelsson, Åsberg, & Nygren, 2008) and is cathartic (Haddock,

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1997). Providing staff with a space to reflect on their experiences seems particularly salient given the constant exposure to patient suffering and distress, and the likely anxiety of working in the context of ongoing changes, job uncertainty and increased workloads (Johnston & Paley, 2013).

Reflection and reflective practice: Definitions and meaning

Despite a wealth of research on ‘reflection’ and ‘reflective practice’ there remains a lack of clarity regarding these terms and their meaning. The ambiguity and difficulty in operationalising these concepts stems from variations in definitions and terminology (Atkins & Murphy, 1993; Carroll et al., 2002; Cotton, 2001). Likewise, conceptualising ‘reflective practice’ also appears problematic as it has been described as an intangible and immeasurable phenomenon (Gillmer & Marckus, 2003).

Theories of reflective practice. Within the educational domain Dewey (1933) defined reflective thought as “active, persistent, and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it and the further conclusions to which it tends” (p. 9). The work of Schön, who extended Dewey’s thinking, has been integral in highlighting the importance of reflection for moving professional practice beyond a purely scientific approach to one which can contend with the complexities and uncertainties of the human experience (Schön, 1987). Schön’s work is grounded in the tradition of learning theory arguing that reflection is the lynchpin of learning from experience (Osterman, 1990). Critics of Schön, however, note his failure to define what he means by reflective practice (Mackintosh, 1998). This lack of definition seems to have been perpetuated within the empirical and theoretical literature base.

Schön distinguished between two types of reflection namely ‘reflection-in-action’ and ‘reflection-on-action’ (Schön, 1983, 1987). The former refers to an often unconscious process where previous knowledge and experience is drawn upon in the moment to inform practice. A

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vital component of professional practice is the ability to critically reflect during moments of what Schön called ‘surprise’, where complexity and unfamiliarity are encountered. ‘Reflection-on-action’ on the other hand occurs after the event as a means to review and enhance future performance (Schön, 1983, 1987). Engaging in reflective practice is not without its dilemmas though. It challenges individuals to not only invest time but also courage, to take the personal risk of questioning values, beliefs and feelings which may be distressing (Peters, 1991).

Mentalization

‘Mentalizing’, conceptualised as reflective functioning, enables individuals to consider and understand their own mental states and the mental states of others (Fonagy, Gergely & Target, 2007). It develops in the context of secure attachment relationships (Allen, Fonagy & Bateman, 2008), where the child finds their mind in the mind of their caregiver, through the caregiver’s mirroring or making sense for the infant their own somatic and affective states (Fonagy, Gergely, Jurist, & Target, 2002).

The ability to mentalize underpins emotional regulation, control over impulses, and empathy, and is an important aspect of healthy adult functioning (Fonagy et al., 2007). Mentalizing can become compromised under conditions of stress or high arousal (Fonagy et al., 2007). For staff in healthcare professions, their ability to mentalize self and others, may be impaired when feeling stressed and/or anxious. There is an argument for strengthening the mentalizing capacity of staff and reflective practice groups (RPG) may be one way to facilitate this. The reflective functioning of individuals in a group may be enhanced through experiencing the perspectives of others and use of self (Heffron, Reynolds & Talbot, 2016).

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Group theory

Considerable research has focused on groups and their utility (e.g. Asch, 1951; Bion, 1961; Haney, Banks, & Zimbardo, 1973; Milgram, 1963; Tuckman, 1965; Yalom & Leszcz, 2005) but a comprehensive summary of group theory is beyond the scope of this review.

Therapeutic factors. The work of Yalom has helped to distil mechanisms of change within groups. In brief these ‘therapeutic factors’ are: instillation of hope, universality, imparting information, altruism, corrective recapitulation of the primary family group, development of socialising techniques, imitative behaviour, interpersonal learning, group cohesiveness, catharsis and existential factors (Yalom & Leszcz, 2005). Although not a therapy group, RPG may have a therapeutic element and sit in the gap between personal growth, support, education and therapy (Yalom & Leszcz, 2005). Thus, these factors may help illuminate the processes and outcomes of being in RPG.

Basic assumptions. Bion’s (1961) work illustrates how group behaviour may be directed towards trying to reduce members’ anxiety and internal conflicts - what he called ‘basic assumptions’ mentality. He hypothesised three ‘basic assumption groups’: dependency where group members look towards the leader for security and guidance; fight-flight where members demonstrate behaviour to gain security either through attacking or escape; and pairing where there is the coming together of two members who the group focuses on to provide solutions to managing intense feelings. Participants in RPG may avoid the task of reflecting by deferring to the facilitator for answers and guidance, avoid deeper conversations by engaging in surface level discussions, attend late or not at all, or be passive observers allowing others to talk rather than engaging with the process. Although Bion’s work is a useful frame in which to conceptualise group processes, it may be misleading to attribute resistance to reflecting to one of the ‘basic assumptions’ (Brown, 1992).

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Anti-group. Nitsun (1996) devised the term 'anti-group' to describe the destructive processes which can threaten the functioning of a group. He argues these processes stem from fear and distrust of the group process, experiencing the group as neglectful and undermining, resulting in potent feelings of shame and humiliation, and aggression between members. If the group fails to contain these feelings then the group itself is experienced as dangerous, which in turn may undermine the group's 'cohesiveness' (Nitsun, 1996). If a RPG causes considerable emotional distress for staff this could impact not only their willingness to engage in the group but also their avoidance of them.

Rationale for review

The literature on reflection, and reflective practice, has been drawn together by different studies in an attempt to provide a coherent narrative of these terms and how to conceptualise them in practice. Studies have also focused on investigating the potential outcomes of reflection and reflective practice within healthcare settings. There has not however, been a review that investigates potential mechanisms which may help staff in healthcare professions engage in reflective practice within a group setting. To ensure staff get the most benefit from these groups an understanding of these mechanisms is important.

Aim

This review aims to answer the following question:

1. What mechanisms help staff in healthcare professions engage with reflection in reflective practice group settings?

Method

Eligibility criteria

The review aimed to bring together findings about the experience of staff in healthcare professions participating in RPG as either a group participant or group facilitator. As the aim was to understand individual experiences and perspectives the review was limited to qualitative findings (Elliott, Fischer, & Rennie, 1999). The main focus was identifying particular mechanisms which may facilitate reflection within these groups. To encapsulate the different types of RPG in the literature, the review included various group formats as long as a key element included reflecting on clinical practice. Research which evaluated or described a particular theoretical model of reflection was excluded. Similarly, studies which evaluated reflective tools or instruments of reflection were also not included. The inclusion criteria are outlined in Table 1.

Table 1: *Eligibility criteria*

Criteria	Description
<i>Qualitative Data</i>	Qualitative studies including qualitative data from mixed methods studies
<i>Personal experience</i>	Limited to personal experiences of either group participants or group facilitators
<i>Mechanisms</i>	Studies which explored or discussed mechanisms, or indicators of mechanisms, which facilitated reflection
<i>Participants</i>	Limited to staff in healthcare professions in any work context. Studies of staff which included both healthcare professionals and other professionals were excluded
<i>Intervention Type</i>	Limited to studies of reflective practice groups defined as a group activity in which more than two healthcare professionals were brought together to reflect on clinical practice and experience (and not on learning processes as part of an academic module). Studies of other types of groups were included such as group supervision if reflection was described as a part of the group format.
<i>Language</i>	Studies published in English
<i>Publication Type</i>	Studies published in peer reviewed journals

Literature search

A systematic search of the literature was undertaken in January 2018 and updated in March 2018 to identify appropriate studies for this review (Figure 1). A search of six electronic databases (Table 2) was carried out using search terms for ‘healthcare professionals’ and ‘reflection’ combined with ‘group*’. The search terms are outlined in Table 3. In total, 12 studies met the criteria and were included in this review. Details of the search process are shown in Figure 1.

Table 2: *Databases searched*

Database	Articles retrieved
Applied Social Science Index and Abstracts (ASSIA)	65
Cumulative Index of Nursing and Allied Health Literature (CINAHL)	394
Cochrane Database of Systematic Reviews (EBM Reviews)	167
Medline	660
PsycINFO	62
Web of Science	156

Table 3: *Search terms*

Staff in healthcare professions	Reflection
Health Personnel OR	Reflection OR
Health Professional OR	Reflective*
Medical Professional OR	
Nurse* OR	
Mental Health Personnel OR	
Psychologist* OR	
Psychiatrist* OR	
Doctor* OR	
Physician* OR	
Staff	

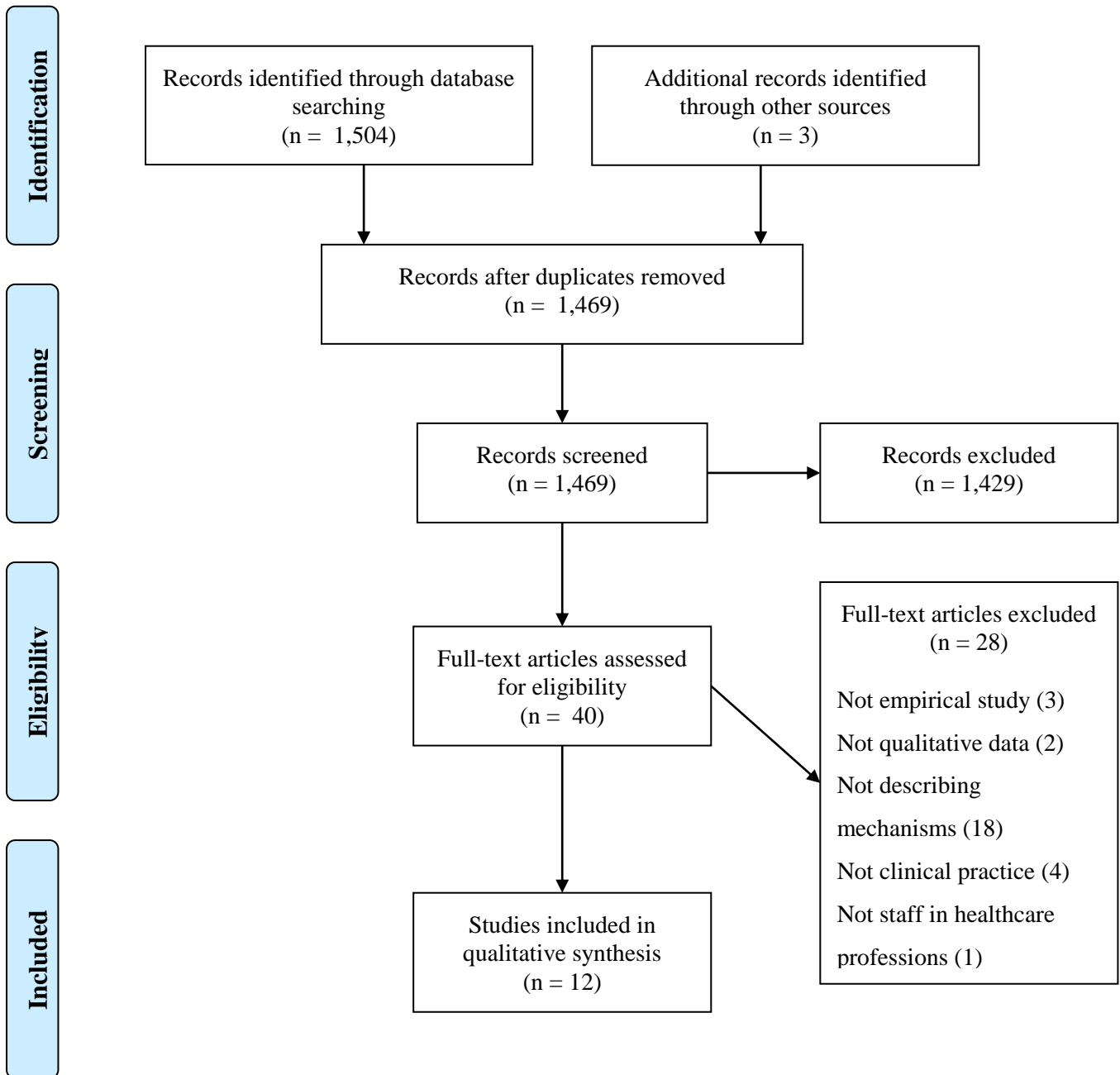


Figure 1: PRISMA flow diagram of study selection process

Review

Overview of selected studies

The included studies explore the experience of participating in groups which incorporate reflection on clinical practice. They are summarised in Table 4 and the original study themes are in Appendix A. Specific group characteristics for each study are outlined in Table 5.

Study characteristics. Of the twelve included studies, three employed mixed methodologies. Only the qualitative data from these was used in this review. These studies implemented different qualitative approaches to data collection such as focus groups (Dawber, 2013), semi-structured interviews (Heneghan, Wright, & Watson, 2014) and a survey with space for qualitative data (Gallagher et al., 2017).

Two studies combined interviews with observational data of group sessions (Platzer et al., 2000a; Taylor, 2014) and one augmented interviews with field notes (McCarthy, Cassidy & Tuohy, 2013). The authors do not explain what they mean by field notes nor do they describe how these were collected or incorporated into the analysis. Naidoo and Mtshali (2017) used focus groups and in-depth interviews to deepen the data and verify information which emerged from focus groups. These authors provide nebulous details about data collection making it hard for the reader to understand the process employed.

Studies were conducted in three continents – Africa, Australia and Europe. One study was carried out in Australia (Dawber, 2013) and South Africa (Naidoo & Mtshali, 2017) respectively. Three studies occurred in Sweden (Arvidsson, Skarsater, Oijervall, & Fridlund, 2008; Brink, Bäck-Pettersson, & Sernert, 2012; Olofsson, 2005), two in Ireland (Gallagher et al., 2017; McCarthy et al., 2013) and the remainder were conducted with UK populations.

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Facilitator experience. Three studies explored the facilitators' experience of groups. In these studies facilitators were either clinical psychologists or nurses facilitating groups in work or educational settings. The clinical psychologists were facilitating RPG in inpatient settings (Heneghan et al., 2014). McCarthy et al. (2013) explored the experience of facilitators providing RPG to nurses as part of their training and Gallagher et al. (2017) asked both facilitators and midwifery students to complete surveys and provide qualitative data about their subjective experience of reflective practice sessions.

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Table 4: *Summary of included studies*

Study	Location	Aim	Group Type	Data collection	Data analysis	Overview of findings
Platzer et al. (2000a)	UK	To evaluate the effectiveness of groups in developing reflective practice.	Unstructured reflective practice groups	Semi-structured interviews and observational data (some group sessions were audio-recorded)	Qualitative	Barriers to learning through reflective practice include: previous education and socialisation as a nurse, culture of the organisation, vulnerability and fear of exposure, commitment or resistance to shared learning by other group members, interaction between group members and facilitation styles.
Olofsson (2005)	Sweden	To evaluate reflection groups as a way of providing a chance to reflect and receive support for psychiatric staff after their involvement in the use of coercion.	Structured reflection groups	Structured interviews	Content analysis	Nurses were largely positive about participating in reflection groups feeling they gained a lot from them. They also expressed factors which effected their participation in the reflection groups and other forms of clinical supervision.

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Table 4: *Summary of included studies cont.*

Study	Location	Aim	Group Type	Data collection	Data analysis	Overview of findings
Arvidsson et al. (2008)	Sweden	To describe the variation in how nurses conceive process-oriented group supervision, implemented during nursing education, 1 year after their nursing degree.	Process-oriented group supervision	Semi-structured interviews	Phenomenographic approach	Process-oriented group supervision has a lasting influence on nurses' development and provision of high-quality care.
Manning, Cronin, Monaghan, & Rawlings-Anderson (2009)	UK	To explore the use of reflective practice groups as a means of support whilst undertaking clinical placements.	Reflective groups	Focus groups	Thematic analysis	Groups were perceived to be useful on several levels and the students identified different needs depending on their stage of training. The importance of the facilitators skills were also highlighted
Brink et al. (2012)	Sweden	To evaluate the experience of group supervision and to explore its impact on the participants' personal and professional development.	Structured group supervision	Focus groups	Content analysis	Group supervision had a positive impact on the participants' personal and professional development.

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Table 4: *Summary of included studies cont.*

Study	Location	Aim	Group Type	Data collection	Data analysis	Overview of findings
McVey & Jones (2012)	UK	To investigate the meaning of reflective practice group sessions for staff members.	Structured reflective practice groups	Semi-structured interviews	Thematic analysis	Staff reported positive experiences of these groups and viewed them as different to multidisciplinary team meetings or informal discussions.
Dawber (2013)	Australia	To measure the effect and effectiveness of reflective practice groups	Reflective practice groups	Mixed methods: Focus groups. Review includes only data from qualitative part of the study	Qualitative	Participants responded favourably to reflective practice groups, reporting a positive impact in a number of areas and the importance of facilitation style and the need to address workplace culture to enable group development and enhance the capacity for reflection.
McCarthy et al. (2013)	Ireland	To explore lecturers' experiences of facilitating guided group reflection	Structured, guided group reflection practice day	Semi-structured interviews and field notes	Thematic analysis	Different factors were central to participants' experience of facilitating groups such as knowledge and experience, personal philosophy and professional responsibility.

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Table 4: *Summary of included studies cont.*

Study	Location	Aim	Group Type	Data collection	Data analysis	Overview of findings
Heneghan et al. (2014)	UK	To explore how reflective groups are conceptualised and implemented as well as factors that facilitate or impede their implementation.	Reflective groups	Mixed methods: Semi-structured interviews. Review includes only data from qualitative part of the study	Thematic analysis	Common outcomes related to staff wellbeing, service culture and teamwork. Engagement, group dynamics and lack of management support were common challenges. Group experiences were influenced by the organisational context.
Taylor (2014)	UK	To identify the effects of a clinical supervision group on the practice of biofeedback therapists.	Structured group supervision	10 in-depth interviews, 3 semi-structured interviews and observations of 3 supervision sessions	Phenomenological approach	Group supervision provided a safe environment for practitioners to share experiences and test ideas about their practice. It increased their ability to set boundaries with clients and realise the limits of their practice
Gallagher et al. (2017)	Ireland	To evaluate structured reflective practice sessions which sought to assist midwifery students to become competent reflective practitioners.	Structured group reflective practice sessions	Mixed methods: self-completion survey with space for qualitative data. Review includes only data from qualitative part of the study	Thematic analysis	Students and facilitators reported positive experiences of the group as a form of peer support and as a catalyst for learning from clinical practice.

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Table 4: *Summary of included studies cont.*

Study	Location	Aim	Group Type	Data collection	Data analysis	Overview of findings
Naidoo & Mtshali (2017)	South Africa	To describe the shared conceptualisations of critical reflection through Communities of Practice in providing HIV nursing care	Communities of Practice (CoP)	Focus groups and in-depth interviews	Grounded theory	Nurses and midwives reported conceptualised CoP as a practice and learning community, a support network, collaborative, purposive-driven working to make a difference, and a space that fosters self-determination.

Table 5: *Group characteristics*

Study	Sample size	Participants	Setting	Group information	Group facilitator
Platzer et al. (2000a)	30	Nurses and midwives	2-year part-time post-registration Diploma in Professional Studies in Nursing Programme delivered at a college of higher education in the south of England	Groups were set up in Year 2 as part of a 36 hour reflective practice module. Participation was voluntary and was not formally assessed.	U/K

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Table 5: *Group characteristics cont.*

Study	Sample size	Participants	Setting	Group information	Group facilitator
Olofsson (2005)	21	7 registered nurses and 14 enrolled nurses	General and elderly psychiatric wards	<p>Due to logistical issues groups occurred every two weeks rather than following an occurrence of a coercive incident as originally proposed.</p> <p>A total of 11 reflection group sessions (7 sessions from the general and 4 sessions from the elderly psychiatric ward) were conducted over a period of 8 months. 23 nurses participated in the reflection groups with most only participating in one group session. Each session lasted for 1.5–2 hours and involved 2–4 nurses, in addition to the supervisor.</p>	Clinical nurse supervisor with previous experience of using coercion on patients led the groups.
Arvidsson et al. (2008)	18	6 male and 12 female nurses. Thirteen nurses had worked within health care before they began their studies.	At the time of the interview, the nurses were working in medical wards, surgical wards and primary health care	Group participation was an obligatory part of their education and offered three times per semester, for 1.5 hours. In total, they attended 18 supervision sessions. Each supervision group comprised 6-8 students. The group composition remained consistent during the 3 years.	Supervisors

MECHANISMS FOR ENGAGING WITH REFLECTION IN GROUPS

Table 5: *Group characteristics cont.*

Study	Sample size	Participants	Setting	Group information	Group facilitator
Manning et al. (2009)	U/K	Students from two cohorts (Year 1 and Year 3) of a UK Undergraduate Adult Diploma programme who were on clinical placement and who had been members of the groups for 3 months prior to the study	Two NHS Hospital Trusts	U/K	Lecturer (and part of research team)
Brink et al. (2012)	10	6 nurses and 4 Emergency Medical Technicians	Ambulance Service	Group supervision for 1 year	Supervisor

MECHANISMS FOR ENGAGING WITH REFLECTION IN GROUPS

Table 5: *Group characteristics cont.*

Study	Sample size	Participants	Setting	Group information	Group facilitator
McVey & Jones (2012)	13	12 nurse specialists and 1 occupational therapist. Participants were active members of a current reflective practice group who had attended sessions for at least six months.	Cancer, renal and neurology services in a NHS Trust	Five reflective practice groups which ran every 4 weeks and contained 3-5 participants. Groups lasted 60-90 minutes.	Clinical psychologist trained in supervision and who works in the same clinical speciality as the participants.
Dawber (2013)	U/K	Nurses and midwives	Oncology, critical care unit and midwifery nurse specialities in two hospitals	Process-focused, whole-of-group approach reflective practice groups. The oncology group had been running for 8 months and both the midwifery and critical care unit groups for over 3 years.	Consultant Liaison Psychiatry nurse and Clinical Nurse Consultant (researcher)

MECHANISMS FOR ENGAGING WITH REFLECTION IN GROUPS

Table 5: *Group characteristics cont.*

Study	Sample size	Participants	Setting	Group information	Group facilitator
McCarthy et al. (2013)	7	Lecturers (also registered nurses)	Department of nursing and midwifery at a third level institute	During the fourth year of the undergraduate nursing programmes, guided group reflection was facilitated by lecturers for six full days over an eight month period. Group membership included lecturer and 8-12 students.	Lecturers (also registered nurses)
Heneghan et al. (2014)	73 in total: 6 interviewed	Clinical psychologists	Clinical psychologists facilitated reflective groups in: forensic mental health services (4), an adult mental health recovery service (1), and an adult learning disability service (1)	U/K	Clinical psychologists
Taylor (2014)	9	6 current therapists and 3 former therapists; 8 nurses and 1 physiotherapist	Biofeedback service in a hospital setting	The nursing team sought out clinical supervision to help them cope with the demands of the role by approaching the consultant psychiatrist in psychotherapy. Weekly 1 hour group supervision which had been running continuously for 8 years	Consultant psychiatrist in psychotherapy

MECHANISMS FOR ENGAGING WITH REFLECTION IN GROUPS

Table 5: *Group characteristics cont.*

Study	Sample size	Participants	Setting	Group information	Group facilitator
Gallagher et al. (2017)	63	53 students and 10 facilitators	Two large tertiary referral teaching maternity hospitals affiliated with the third level institution providing pre and post-registration midwifery education programmes	Group reflection sessions were conducted weekly at the same time each week over one academic year. Group reflection sessions were 1 hour in duration, conducted on the same day and time each week. Midwifery students who were rostered on duty in the clinical area were encouraged to attend. Each student attended 3-4 group reflection sessions.	U/K
Naidoo & Mtshali (2017)	18	Registered nurses and midwives	Two district health hospitals	Focus group discussions in which the CoP were implemented occurred every fortnight over a 6-7 month period. They lasted 1½-2 hours each. Thirteen sessions occurred in hospital A and 15 sessions in hospital B.	Researchers (nursing background)

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Variability in groups. Although all groups included a component of reflection, they were not all called RPG. Three studies explored the experience of group supervision (Arvidsson et al., 2008; Brink et al., 2012; Taylor, 2014) and one study implemented, and examined, a Community of Practice (CoP) (Naidoo & Mtshali, 2017).

Particular theoretical orientations of the groups, or of the facilitators, were not made explicit in the studies. In the study by Heneghan et al. (2014), clinical psychologists reported drawing on psychodynamic, systemic and group theories when facilitating reflective groups. Most groups took a structured approach to reflective practice with only one study exploring the experience of an unstructured group (Platzer et al., 2000a). No information about the structure of the group was provided by Naidoo and Mtshali (2017). Nor was specific information provided about the facilitators or their training in group facilitation/reflective practice.

The frequency of RPG varied across the studies. In some settings groups occurred weekly (Gallagher et al., 2017; Taylor, 2014), fortnightly (Naidoo & Mtshali, 2017) or monthly (McVey & Jones, 2012). Others described groups running over a certain time period often associated with course structure or when groups could be organised (Arvidsson et al., 2008; McCarthy et al., 2013; Olofsson, 2005; Platzer et al., 2000a).

Groups either included nurses and/or midwives working within physical health settings (Arvidsson et al., 2008; Dawber, 2013; Gallagher et al., 2017; Manning et al., 2009; McCarthy et al., 2013; Naidoo & Mtshali, 2017; Platzer et al., 2000a) or psychiatric nurses (Olofsson, 2005). In three studies groups included nurses plus staff from different healthcare professions: emergency medical technicians (Brink et al., 2012), occupational therapists (McVey & Jones, 2012), or physiotherapists (Taylor, 2014). Six studies explored the experience of qualified staff (Brink et al., 2012; Dawber, 2013; McVey & Jones, 2012; Naidoo & Mtshali, 2017; Olofsson, 2005; Taylor, 2014) whereas four studies focused on the

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perspective of students on clinical placements (Arvidsson et al., 2008; Gallagher et al., 2017; Manning et al., 2009; Platzer et al., 2000a). However, participants in Platzer et al.'s (2000a) study were engaged in a post-registration course and Arvidsson et al. (2008) interviewed nurses about their experience of the group during their course one year after completing their nursing degree.

Effects of group participation. The studies reported on effect, or personal experience, of group participation. Seven articles evaluated the effect of the group on practice or as a mechanism of support (Brink et al., 2012; Dawber, 2013; Gallagher et al., 2017; Manning et al., 2009; Olofsson, 2005; Platzer et al., 2000a; Taylor, 2014). Four studies focused on the personal experience of attending the group (Arvidsson et al., 2008; Heneghan et al., 2014; McCarthy et al., 2013; McVey & Jones, 2012). Naidoo and Mtshali (2017) described participants shared conceptualisations of critical reflection through CoP.

Culture. Only Naidoo and Mtshali (2017) rooted their study in culture drawing on the isiZulu language, "...we call it iSisonke where we come together in this spirit of togetherness..." when conceptualising their findings. The other studies did not consider the impact of culture.

Quality assessment

Each study was critically appraised, using specific criteria for undertaking qualitative research as set out by the Critical Appraisal Skills Programme [CASP] (Public Health Research Unit, 2006). Each study was compared and scored against their criteria (Appendix B) with the intention to give weight to findings in this review based on research quality. Despite the evidence base appearing to have some key methodological flaws no study was excluded based on their score. Instead, concerns around quality and interpretation of findings will be discussed here.

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All studies explored the experience of participating in a group which incorporated reflection on clinical practice thus a qualitative approach is considered the most appropriate methodology. Each study expressed clear aims and were grounded in the extant literature and current practice.

Design. Five of the studies provided a rationale for their choice of a qualitative design to address the aims of the research (Arvidsson et al., 2008; Heneghan et al., 2014; McCarthy et al., 2013; Naidoo & Mtshali, 2017; Taylor, 2014). Two studies justified their particular method of qualitative analysis (Arvidsson et al., 2008; Naidoo & Mtshali, 2017). Failing to provide this information limits the ability of the reader to critique the methodology used and resultant findings.

Ethical issues. Most studies reported ethical approval had been sought or explained why it had not in the case of service (McVey & Jones, 2012) and educational (Gallagher et al., 2017) evaluations. One study received approval by the head of the organisation rather than from an ethics committee (Brink et al., 2012). In all cases, information was provided that participants consented to take part, although it was unclear in three studies how it was obtained and what information was given to participants in order for them to make an informed decision (Brink et al., 2012; Heneghan et al., 2014; Olofsson, 2005).

Only two of the four studies, which focused on students engaging in reflection on clinical practice within educational programmes, mentioned possible ethical issues of using participants who were also undertaking an assessed programme of study and how potential conflicts of interest were addressed. Manning et al. (2009) stated participating in the research was not dependent upon continuing to participate in the group and Gallagher et al. (2017) mentioned participating in the reflective group was not assessed as part of students' coursework. However, as the person facilitating the focus groups in Manning et al's. (2009)

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study was also a lecturer, it is questionable as to whether this poses an ethical dilemma for students feeling able to choose not to participate or feel able to honestly express themselves.

Information was lacking about the process of maintaining confidentiality during data collection, analysis and reporting in six studies (Arvidsson et al., 2008; Brink et al., 2012; Heneghan et al., 2014; Manning et al., 2009; McVey & Jones, 2012; Olofsson, 2005). Consideration of ethical issues was not mentioned by Platzer et al. (2000a) which begs the question of how much attention this issue received.

Sampling. Only four studies mentioned a particular sampling strategy, namely purposive sampling to target specific participants who had participated in the RPG (Arvidsson et al., 2008; Heneghan et al., 2014; Manning et al., 2009; Naidoo & Mtshali, 2017). The failure to describe the sampling strategy may be due to the majority of the studies evaluating specific RPG which meant potential participants could only be those who had been involved in these groups. There was no information provided about recruitment strategy or selection criteria in six of the twelve studies (Brink et al., 2012; Dawber, 2013; McVey & Jones, 2012; Olofsson, 2005; Platzer et al., 2000a; Taylor, 2014) which again could be due to most of them evaluating RPG running in health services or educational settings. Naidoo and Mtshali (2017) reported eligibility criteria but did not describe how participants were recruited. This means the reader has to make an assumption about the sampling and recruitment strategies rather than the authors making this explicit.

A limitation across all studies was the homogeneity of the sample, related to the purposive sampling strategy employed. However, Arvidsson et al. (2008) specifically recruited participants with a range of different backgrounds. There may be bias in the views expressed as all participants in the studies attended RPG either voluntarily or as a requirement of their training course. In the case of voluntary participation, the views of people who consciously chose not to attend these groups has not been explored. No information was

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provided about why people chose to take part or not. There was no mention in any of the studies whether heterogeneity or participant numbers had been met for quality and quantity of data which are important factors to report in qualitative research (Williams & Morrow, 2009).

Only five studies (Arvidsson et al., 2008; Heneghan et al., 2014; Manning et al., 2009; McCarthy et al., 2013; Naidoo & Mtshali, 2017) explicitly stated their eligibility criteria. This raises questions as to the suitability of participants to be included in these studies. The reader must make the assumption that participants were eligible to take part as they had been involved in RPG either currently or historically.

Two of the studies had a 12-month time delay between participants ending their involvement in the reflective group and participating in the study (Arvidsson et al., 2008; Gallagher et al., 2017). This raises questions as to the reliability of retrospective accounts of their experience and the potential for recall bias.

Data collection and analysis. All studies but one provided a clear account of the data collection methods. Naidoo and Mtshali (2017) do not explain how data were collected from the focus group discussions. Only four provided any justification for the methods chosen (Brink et al., 2012; Dawber, 2013; Manning et al., 2009; McCarthy et al., 2013). Of the two studies using content analysis (Brink et al., 2012; Olofsson, 2005), only one (Brink et al., 2012) provided information about what type of content, either manifest or latent, they would be focusing on which is an underlying principle of this type of analysis (Graneheim & Lundman, 2004).

All studies bar four (Gallagher et al., 2017; Olofsson, 2005; Naidoo & Mtshali, 2017; Platzer et al., 2000a) provided detailed descriptions of the analysis process, which enables the reader to consider whether the analysis was sufficiently rigorous and/or adhered to the specific methodology chosen. Two studies (Dawber, 2013; Platzer et al., 2000a) did not report what qualitative methodology was used to analyse the data which makes the reader

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unable to discern whether or not analysis adhered to the methods used. The only information provided by Platzer et al. (2000a) was that a software package was used and Dawber (2013) made reference to qualitative data being classified into emergent themes for analysis. All studies used quotes to support the generation of themes however Olofsson (2005) only used quotes for one part of their findings. They failed to provide a clear rationale for this decision which is clearly concerning in respect to grounding findings in the data.

Olofsson (2005) did not record and transcribe interviews. Instead they hand wrote participants' responses then audiotaped a summary of this written record in the presence of the interviewee. This potentially introduces researcher bias in terms of what they consider might be important and how they frame the meaning of what was said. They acknowledge this method of data collection as a potential limitation however provide no explanation as to why this might be, or what effect, it may have on the analysis and resultant findings.

Three studies collected data using focus groups (Brink et al., 2012; Dawber, 2013; Manning et al., 2009), five interviewed participants (Arvidsson et al., 2008; Heneghan et al., 2014; McCarthy et al., 2013; Olofsson, 2005; Platzer et al., 2000a), two of those combining this with group observations (Platzer et al., 2000a; Taylor, 2014) and one interviewed participants with others in their supervision group (McVey & Jones, 2012). Naidoo and Mtshali (2017) supplemented focus group discussions with interviews. Two of the studies (Dawber, 2013; Taylor, 2014) which collected data via focus groups or interviews did not provide any topic guides or interview schedules. Without these, there is no transparency about the data collection process and therefore how themes may have been derived.

Of the studies that collected data in a group format (Brink et al., 2012; Dawber, 2013; Manning et al., 2009; McVey & Jones, 2012; Naidoo & Mtshali, 2017) only two of them justified this method. It was argued that focus groups open up discussions which may not have been accessed in individual interviews (Brink et al., 2012; Manning et al., 2009). No

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thought was seemingly given to the impact of group factors or different perspectives (Sim, 1998) as potential problems in collecting data in a group format. Moreover, no consideration was given to the potential influence of being interviewed by someone from your own profession (Heneghan et al., 2014; Olofsson, 2005), by colleagues (McCarthy et al., 2013) or by a course lecturer (Manning et al., 2009). Failure to consider this may have resulted in biases going unchecked.

Data validation. Only two studies (Olofsson, 2005; Platzer et al., 2000a) omitted any form of credibility check of their data. In line with recommendations for qualitative research, most studies employed multiple reviewers and/or used an audit trail to demonstrate how a particular understanding had been arrived at or why an action had been taken (Fischer, 2009). However, the likelihood of co-researchers holding divergent views may be limited and so seeking out respondent validation may provide a better check. Only three studies used respondent validation (Dawber, 2013; Naidoo & Mtshali, 2017; Taylor, 2014). Studies by Taylor (2014) and Naidoo and Mtshali (2017) provided the most comprehensive data validation procedures incorporating various methods to establish trustworthiness.

Reflexivity. Of significance was that most studies did not report their epistemological stance or demonstrate reflexivity. It is important in qualitative research to consider the influence of the researcher's theoretical orientations and role. Heneghan et al. (2014) used a social constructionist approach to thematic analysis and provided information about the researchers' background and interests. Merely providing this information does not mediate the influence of the researcher on their analysis and resultant findings.

Findings

A meta-ethnographic approach was used to synthesise participants' perspectives and experience of RPG. Developed by Noblit and Hare (1988) it is arguably the most established method for synthesising qualitative data as it is grounded in the interpretive paradigm (Campbell et al., 2003). It aims to interpret the different findings of numerous studies rather than aggregating them. To enable transparency the synthesis process has been outlined in Table 6.

First, the relationship between studies was determined by summarising and juxtaposing the key metaphors in each paper (Noblit & Hare, 1988). A list of key metaphors related to mechanisms - and indicators of mechanisms – which staff described as facilitating reflective practice was drawn up for each of the included studies (Appendices C, D and E). Next, findings from one study were translated into another, allowing comparisons across key metaphors (Noblit & Hare, 1988). This was an iterative process where translations were continually checked against the original data and metaphors. What emerged was the similarity between the descriptions staff gave of mechanisms they perceived helped them to engage with reflection, and reference to these same mechanisms as suggestive of helping with reflection. Therefore, a decision was made to amalgamate these into the same translations where appropriate (Table 6).

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Table 6: *Translating the studies into one another*

Metaphors: mechanisms	Metaphors: indicators of mechanisms	Translation
Having time for reflection	Having time for reflection	Space for reflection (a) Holding space (b) Threats to the space
Gaining new perspectives	Gaining new perspectives	Gaining new perspectives
Security: Group set up	Security: Group set up	Security: Group set up
Security: Emotional containment	Security: Emotional containment	Security: Emotional containment
Security: Trust	Security: Feeling safe	Security: Safety (a) Feeling safe (including trust and being authentic)
Security: Feeling threatened	Security: Feeling threatened	(b) Feeling threatened (including trust and being authentic)
Security: Being authentic		
	Normative function	Normative function
Being validated	Being confirmed	Being confirmed
Commitment to the group		Belonging
	Belonging	

As the metaphors extracted fell broadly within the theme of mechanisms which may help staff engage with reflection, a ‘line of argument’ synthesis was deemed most appropriate to pursue (Noblit & Hare, 1988). The synthesis and the eight metaphors derived from the studies, is described in detail below. This is followed by an outline of how concepts were brought together to form a ‘line of argument’ synthesis. Owing to the limitations identified with the quality of the literature in this review, findings have been interpreted cautiously.

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Sense of security

All studies made reference to the basic principle that staff may need to have a sense of security in order to share and explore thoughts and feelings in the group. Broadly these findings are organised by group set up, safety and emotional containment.

Group set up. Eight studies described how the group set up may contribute to whether or not staff felt secure in the group, and therefore, prepared to share their thoughts and feelings. Factors which might contribute to this were having clear ground rules about how the group functioned and about confidentiality (Gallagher et al., 2017; Manning et al., 2009; McCarthy et al., 2013; Platzer et al., 2000a). Facilitators believed having ground rules and maintaining anonymity might provide a safe environment to help students to reflect on practice issues (McCarthy et al., 2013). This was echoed by Manning et al.'s (2009) study, "the key point was that it was stated right from the beginning that confidentiality was going to be maintained...all the students...had the confidence that whatever they discussed within the room...would be kept within and not go out" (p.180).

Four studies reported group size as a potential factor in whether staff felt a sense of security to engage with reflection. Participants in these studies perceived smaller groups made it easier to share and to be heard (Manning et al., 2009; McVey & Jones, 2012; Olofsson, 2005; Platzer et al., 2000a). Indeed, participants in one study said groups of 10 were too large to feel safe deciding a group of six was preferable and more effective (Platzer et al., 2000a).

Two studies made reference to group structure, and group atmosphere, perhaps providing a sense of security for staff to feel able to engage with reflection with others. Having a basic structure to group supervision was argued to be another element which may help create a feeling of security and participation, "...I think it was good that it was structured and that people had to think before they said anything. It is the structure that helps you express your feelings and what you have been thinking about..." (Brink et al., 2012, p. 78).

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The role of the facilitator was also proposed to be key in creating an atmosphere which encouraged open and honest dialogue. This was said to positively contribute to students' experiences of the reflective process (Gallagher et al., 2017).

Safety. Seven papers mentioned safety could be integral for engaging with reflection with some papers distinguishing between feeling safe and feeling threatened.

Feeling safe. Two authors referenced the facilitator's likely role in creating a sense of safety within the group. This included being non-judgemental towards participants and respecting everyone's views (Manning et al., 2009). Further, it was felt facilitators who treated people as equals and were inclusive, potentially fostered a feeling of safety within group members (Dawber, 2013). Settling into the group, becoming more comfortable with the process, having time to reflect (Gallagher et al., 2017; Heneghan et al., 2014), and sustained contact and familiarity with group members (Naidoo & Mtshali, 2017) were also associated with participation. Additionally, not feeling threatened or judged by group members possibly allowed participants to feel safe to admit imperfections (Naidoo & Mtshali, 2017). Not being under pressure to hold answers was also deemed helpful (Naidoo & Mtshali, 2017).

Feeling threatened. Facilitators in Gallagher et al.'s (2017, p. 11) study noticed the reluctance of students to engage in the reflective process, "The main challenge is getting the session to open, as students are reluctant/afraid to begin..." and that perhaps some students were averse to reflecting on themselves choosing instead to critique others, "Sometimes students appear to use this session to critique other professionals' practice instead of using it to personally develop" (Gallagher et al., 2017, p. 11). Group participants may have chosen not to disclose information if they felt facilitators were judging their responses, used a confrontational style or if questions felt too probing even when asked by a facilitator whose style was non-confrontational (Platzer et al., 2000a).

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If participants perceived there to be any consequences of sharing their thoughts and feelings, this seemed to inhibit reflection (Manning et al., 2009). Workplace culture, and socialisation into professional role, were associated with fear of the consequences of disclosure by two studies whose participants were nurses and midwives (Dawber, 2013; Platzer et al., 2000a). Additionally, levels of trust and cohesion within a team may have prevented group participants from being honest with their disclosures (Dawber, 2013). Participants did not seem to feel safe to make themselves vulnerable to potential criticism by exploring their practice. They may well have feared being judged by others as unprofessional, and worried they would not be respected. Interestingly, they also described a fear about their own self-judgment potentially leading to feelings of shame:

to be within the group you perhaps were going to give something that might make you look not small as a nurse but maybe the people would look on I don't know...I don't know what the word would be - certainly not see you in high esteem as a professional nurse. I think that was quite difficult... (Platzer et al., 2000a, p. 1005).

Emotional containment. The group feeling safe enough to contain emotions was referenced by seven studies. It was suggested experiencing a sense of security within the group related to support and a calm atmosphere, and helped make it possible for participants to be authentic with their selves, and with what they shared, "...I perceived that I could speak in confidence when I found things hard and ask them to help me..." (Arvidsson et al., 2008, p. 871). Feeling safe, and being in an atmosphere of respect, perhaps enabled exploration of difficult experiences and reflection (Heneghan et al., 2014; Naidoo & Mtshali, 2017; Platzer et al., 2000a). Perceiving the group as a protected space possibly enabled subconscious

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thoughts to surface (McVey & Jones, 2012) and may well provide an outlet for emotional catharsis (Dawber, 2013; Taylor, 2014).

Space for reflection

Seven authors made reference to having space for reflection, and their findings can broadly be organised into holding the space and threats to reflective space.

Holding the space. Findings from two studies illustrated how being in a group might give staff opportunities to reflect that perhaps they would not have had otherwise (Arvidsson et al., 2008; Olofsson, 2005). Participants in Arvidsson et al.'s (2008) study perceived the group as possibly providing them with a space, and protected time, to reflect. The apparent significance of having the opportunity to reflect, and on a deeper level, was highlighted by participants in Olofsson's (2005) study, "I could talk about an incident I never talked about before, an incident that was the hardest thing that had happened to me" (Olofsson, 2005, p. 263).

Other studies talked about the proposed benefit to staff of being given the space to engage in reflection. Being in RPG may provide staff with the opportunity to improve their ability to think before speaking, actively listen and reflect on discussions before responding (Brink et al., 2012). Having the time to reflect on practice, and focusing on professional development, seemed to leave staff feeling valued by their organisation (Taylor, 2014).

Threats to the space. In comparison to groups providing space to listen to others, having a dominant group member who voiced their opinion and gave unsolicited advice, seemed to silence others:

There was only really one ...quite sort of opinionated and ... if you don't go along with this then you're not all that you should be sort of thing...I

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might sort of just be quiet...I think eventually I just shut up, because I thought what's the point? (Platzer et al., 2000a, p. 1005-1006).

Two studies reported on how the organisational context and work culture of “immediacy and doing” (Heneghan et al., 2014, p. 330) might interfere with staff feeling they had the time to attend RPG, or have the mental and emotional space to step back from their work to be able to engage with reflection (Gallagher et al., 2017; Heneghan et al., 2014). Time pressures, workload and activity levels (Gallagher et al., 2017), and feeling overwhelmed by workload, might impact on creating and maintaining a space for reflection (Heneghan et al., 2014). Facilitators in Heneghan et al.'s (2014) study were mindful of this impact on staff, “It's a complete antithesis to the type of space you try and create for reflection where there's no right and wrong, and people are allowed just to talk about struggles and to explore things” (p. 330-331).

Gaining new perspectives

Three studies suggested the facilitator might have a key role in helping staff gain new perspectives through reflecting (Dawber, 2013; Manning et al., 2009; Olofsson, 2005). It was proposed the way facilitators intervened in the RPG might enhance reflective thinking, “He has a knack of getting things out of you. So you were surprised sometimes that you said what you did. Yeah, I walked out of here and just said, ‘That was really in-depth. Was it helpful? I think so’” (Dawber, 2013, p. 246).

Additionally, being in a group environment where colleagues offered different perspectives invited staff to potentially consider things differently and seemed to help them engage with reflection (Dawber, 2013; Olofsson, 2005). Participants described how reflections could bring new awareness and alternative ideas, “We could talk about how all of us are affected, sometimes in different ways, sometimes in the same way, in both cases it is

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good to talk about it” (Olofsson, 2005, p. 263). Moreover, staff perceived having a facilitator outside of their specific work context or team could be beneficial, and may possibly offer new perspectives free from the influence of team or service culture, “The supervisor was from outside the ward, s/he had other kinds of questions, saw things from another point of view, not being involved with the patient from before” (Olofsson, 2005, p. 263). The chance to work through thoughts and feelings with colleagues who might offer different perspectives, and collaborate on solutions, was seen as a likely benefit of reflecting in a group setting (Dawber, 2013).

Being confirmed

Five of the twelve studies suggested staff may feel confirmed as a result of reflecting in a group setting. This appeared to be clustered around two different areas, namely emotions and feeling valued.

Emotions. The possible importance of acknowledging and validating expressed emotions arising from working in challenging environments, with distressed patients, was highlighted by three papers (Dawber, 2013; Heneghan et al., 2014; Taylor, 2014). For staff in Taylor’s (2014) study, their feelings being validated as normal responses to clinical work, rather than seen as indicative of any professional inadequacy, was proposed to be of great importance. Recognising and affirming difficult emotions seemingly helped to manage stress for the nurses and midwives in Dawber’s (2013) study. Indeed, giving space to, and acknowledging, staffs’ feelings and concerns may precipitate their capacity to reflect on the needs of their patients (Heneghan et al., 2014).

Feeling valued. Alongside validating emotions, it seemed important to staff that their contributions in the group were valued, and considered equally as important as others’, irrespective of job role or professional hierarchy (Heneghan et al., 2014; Platzer et al., 2000a). One facilitator described, “It’s hard when people are feeling really disempowered, it seems

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important to hear that” (Heneghan et al., 2014, p. 331). Facilitators in that study hoped that RPG would flatten the hierarchy amongst the group members. Issues of hierarchy were prevalent in Platzer et al.’s (2000a) research and seemed to influence what value participants placed on what they could bring to a RPG:

...a lot of the time the midwives did talk about case histories...sometimes you sort of think ‘Oh what I’ve got to say is not quite as interesting as that it’s not quite as mind blowing, and sort of like life threatening or life-saving whatever’ you know than what they’re doing (Platzer et al., 2000a, p. 1006).

Belonging

Five authors reported how being in a RPG potentially provided staff with a sense of belonging. Being committed, or resistant, to shared learning may have been integral in whether staff shared thoughts and feelings (Platzer et al., 2000a). Specifically, Platzer et al.’s (2000a) study proposed how body language, and comments made by group members, might stop staff from sharing:

...I could have gone on and on...because it was interesting to me, but the other girls were sat there sort of like this, tapping their foot raising their eyes and you knew that they just wanted it over (Platzer et al., 2000a, p. 1005).

Working towards a common aim of cohesive functioning through commitment to resolving conflict and respecting difference (Heneghan et al., 2014), and promoting sharing and learning from each other (Manning et al., 2009), were potentially important group processes which might promote a sense of belonging amongst participants. Sharing in the

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group may foster partnership with group members, which could develop into demonstrating more care and collaboration to each other (Olofsson, 2005). Additionally, realising others' had similar experiences might promote connection amongst participants and possibly help them share in the group (Arvidsson et al., 2008), "...We were all so very happy after the supervision session and we looked forward to it...we both laughed and cried, so we became very closely united" (p. 871).

Normative function

Six papers made reference to the normative function of RPG being suggestive of a helpful mechanism for staff to engage with reflection (Dawber, 2013; Gallagher et al., 2017; Manning et al., 2009; McVey & Jones, 2012; Olofsson, 2005; Taylor, 2014). Five of these six studies described how sharing thoughts, feelings and experiences may help staff feel connected to others in their group and potentially realise they were not alone in their struggle (Gallagher et al., 2017; Manning et al., 2009; McVey & Jones, 2012; Platzer et al., 2000a; Taylor, 2014). Attending the group, "it made me feel that, ah, it's nice that it is not just me, I am not going mad, I am not suffering this alone" (Taylor, 2014, p. 28). Staff may have also come to realise they could process thoughts and emotions with the support of colleagues who had had similar experiences (Dawber, 2013).

Line of argument synthesis

What emerged from the synthesis was a range of mechanisms which staff in healthcare professions perceived as helping them to engage with reflection in a group setting. The synthesis suggested feeling a sense of security in the group could be a central feature of being able to engage with reflection. It also suggested this security might be underpinned by: how the group was set up and functioned, feeling safe to explore feelings and expose vulnerabilities, and believing the group would be able to contain these emotions. Another mechanism which might help staff engage with reflection was working within organisations

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that staff perceived as valuing and prioritising reflection, thus giving them permission to make space for noticing, thinking and feeling. Hearing different views and being invited to consider different perspectives also may contribute to staff engaging with reflection. The importance of emotions being validated and normalised, feeling valued by others and feeling connected to group members were additional mechanisms which may help staff engage with reflection. These factors and their development are outlined in Table 7. The meta-ethnography suggests these mechanisms do not appear sequential nor that all mechanisms were necessary precursors for reflection but rather that they might form part of a number of mechanisms which may help staff in healthcare professions engage with reflection (Figure 2).

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Table 7: *Line of argument synthesis*

Metaphors	Mechanism	Indicator of mechanism	Translation	Synthesising translations
Space for reflection	✓	✓	Holding the space to allow staff time to step back, notice, think and feel	Organisations valuing and prioritising reflective practice for staff to attend may allow them to step away and have space for noticing, thinking and feeling which could help them engage with reflection
	✓	✓	Threats to the space due to work culture, feeling overwhelmed and impact of others can interfere with attending reflective practice groups and being able to engage in reflection	
Gaining new perspectives	✓	✓	Being offered different perspectives and being invited, through curiosity, to consider things differently	Hearing the different perspectives of other groups members and being invited to consider things differently might help staff engage with reflection
Security: Group set up	✓	✓	A small group with identified ground rules, confidentiality clauses, a clear structure and atmosphere of honest dialogue provides a sense of security to engage in reflection	How the group is set up may influence whether staff feel secure enough to engage with reflection
Security: Emotional containment	✓	✓	A cathartic space to express emotions if the group was considered a safe space	Using the group as a space for emotional catharsis and reflection, and feeling contained by the group, likely depends upon whether staff feel a sense of security within the group

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Table 7: *Line of argument synthesis (cont.)*

Metaphors	Mechanism	Indicator of mechanism	Translation	Synthesising translations
Security: Feeling safe	✓	✓	Feeling safe enough, and trusting in the group to express authenticity in thoughts and feelings	Expressing and reflecting upon honest thoughts and emotions is possibly dependent upon staff feeling secure and safe to do so in the group
	✓	✓	Feeling exposed and vulnerable to threat due to perceived judgement and confrontation from others, possible consequences of sharing authentic thoughts and feelings, and self-criticism	
Normative function		✓	Hearing others have similar thoughts and feelings opens up opportunity to reflect on personal experience and feel connected with colleagues	Thoughts and feelings being normalised may help staff to engage with reflection
Being confirmed	✓	✓	Emotions validated, acknowledged and recognised as 'normal' rather than perceived as inadequacy	Having emotions validated and feeling valued possibly helps staff engage with reflection
	✓	✓	Feeling equal and valued regardless of professional role or seniority	
Belonging	✓	✓	Feeling connected to other participants and working towards a common aim	Feeling connected to other groups members, and a sense of cohesion in the group, might help staff to engage with reflection

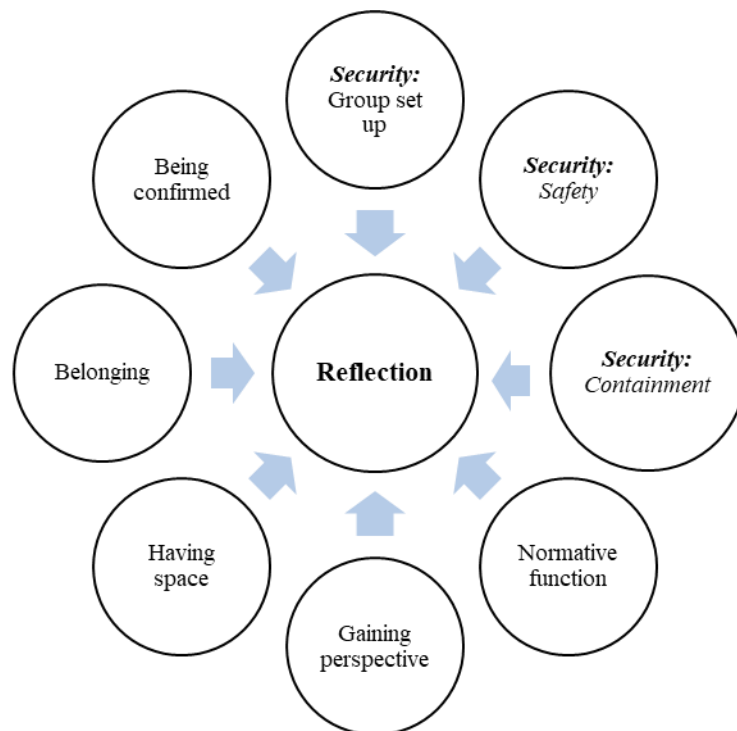


Figure 2: Line of argument synthesis model

Discussion

The purpose of this review was to draw together findings from qualitative studies exploring staff in healthcare professions' experience of participating in RPG. Primarily, this review sought to identify mechanisms which may help staff engage with reflection. This review identified eight mechanisms which helped staff reflect on their clinical practice but given the limitations with the quality of the literature these findings are tentative.

Participants across all studies emphasised the importance of having a sense of security in RPG which might help them to share and explore thoughts and feelings. This appeared a possible foundational element which might assist reflection in these groups. Participants described how this sense of security was experienced through group set up, safety and emotional containment. Within RPG, facilitators or the group itself, may provide participants with a structure paralleling that of a secure attachment relationship, providing them with the

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emotional comfort and security to explore their inner world (Bowlby, 1969; Allen et al., 2008).

Particular aspects of the group setup such as ground rules, group size and group structure seemed to help participants feel a sense of security within RPG to enable them to engage with reflection. Linking back to group theory, if staff do not trust the group process or confidentiality within it, this may affect their involvement and engagement with the group (Nitsun, 1996). It is possible then that the administrative tasks of developing a RPG may need careful consideration if staff are to be helped to reflect on clinical practice.

Safety was another suggested mechanism which may help reflection. Facilitators seemed to have a key role in this process through treating everyone equally and respecting everyone's views. Yalom and Leszcz (2005) argue the facilitator holds an important role in constructing the norms of the group, as group members need to feel comfortable to participate within an atmosphere of safety, characterised by trust and a facilitator who can sensitively manage group dynamics (Jones, 2000). Therefore, it may be important for group facilitators to remain conversant with group dynamics and group facilitation. However, in this review it is unclear as to what training, if any, the staff had undertaken to have the skills to facilitate RPG.

In addition, safety may have been fostered through increasing familiarity with the group process and group members. Fear of potential criticism and judgement were associated with feeling threatened in the group, which might make participants reluctant to engage with reflection. According to group theory feeling threatened in a group can induce group members to start to attack each other (Bion, 1961) which might further impact the reflective process as reflective functioning is affected when under high arousal (Fonagy et al., 2007).

Experiencing the group atmosphere as calm and supportive seemed to help staff feel safe enough to be authentic and share honestly. This appeared to provide containment which

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helped the expression and management of difficult emotional content. In psychoanalytic thinking, containment occurs when an individual's internal states (thinking and feeling) are taken in by another and transformed into a more tolerated experience (Leiper & Maltby, 2004). Feeling contained by the group may allow participants to explore their own mental states and potentially enhance mentalizing capacity.

Participants appeared to value having the space to reflect, and described how being in RPG permitted them to take time out of their day to notice, think and feel. Arguably, engaging with reflective practice may be enhanced if organisations allow their staff the time and space to step away from their work. This though might be constrained by the current context of under resourcing (Weinberg & Doyle, 2017) and target driven services (Bevan & Hood, 2006). Hence, the implementation and running of RPG may need the support of governmental policy or service heads, to ensure it continues to be prioritised for staff even when work pressures mount. Further, creating a culture where RPG are valued as part of self-care and professional practice may also be important. The recent shift towards recognising the importance of emotions and wellbeing in determining work-related outcomes may assist with this (Weinberg & Doyle, 2017).

Participants described how exposure to different perspectives may help expand their thinking and reflection. Heffron et al. (2016) found that hearing the perspectives of others within a group format may facilitate reflective functioning. This perhaps illustrates the additional benefit of engaging in reflection within a group setting rather than as an individual pursuit. Participants' valued skilled facilitators who seemed to enhance their reflective thinking by intervening in discussions and offering ideas to consider. It is important though that participants do not become dependent upon facilitators to do the thinking for them so as to avoid their own potentially distressing thoughts and feelings (Bion, 1961).

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Being confirmed by the group, particularly feeling valued and having emotions validated, seemed to help staff engage with reflection. Professional hierarchy seemed to influence how participants felt about contributing to reflective practice. Gilbert (2005) argues an individual's perception of their social rank influences emotions, and often results in competition and submissive behaviour. Thus, participants may need to feel a sense of parity within RPG before feeling able to fully engage with reflection.

The RPG may have also helped to foster connection with other group members and build a sense of cohesion. For Yalom, group cohesiveness is the bedrock of therapeutic factors purporting it facilitates self-disclosure and personal exploration (Yalom & Leszcz, 2005). It appeared a sense of belonging was a common experience when group members were committed to the group and to shared learning. Having thoughts and feelings normalised by the group may have also helped staff engage with reflection, supporting the idea of universality of distress (Yalom & Leszcz, 2005).

Reflective practice, and RPG, have been embraced by healthcare settings and previous research has highlighted the benefits to staff of engaging in them. This review has provided a nuanced account of mechanisms which may help staff engage with reflection in groups. Future research could helpfully explore these mechanisms further looking at specific types of RPG. Understanding the psychological processes involved in reflection, and their possible impact on staffs' perception of themselves and their work, could also be explored.

Limitations

Reflection and reflective practice is poorly defined in the literature which may make it difficult to locate studies even when using a systematic approach. Whilst none of the included studies provided definitions for these concepts, it is possible the meaning of reflective practice and how it was operationalised differed across studies, potentially impacting the robustness of comparisons. Additionally, the way specific databases index 'staff' may have

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affected the breadth of studies found. Indeed, most studies explored the experience of nurses meaning their views are overrepresented in this review. This leaves a question of bias and whether findings are transferrable across different healthcare professions.

Two other methodological concerns affected the quality of the research. The first is the lack of researcher reflexivity regarding epistemological position or views on reflective practice leaving the reader unable to evaluate possible researcher effects. The second is the research design. Most studies were service evaluations which were retrospectively evaluated. Recruitment strategy was omitted from many of these studies making it unclear how participants were recruited. Further, the sample could have been biased with participants being hand-picked from a small number of potential participants which may have resulted in positive accounts mainly being given. This was reflected in their poorer quality appraisal which ultimately affected the overall quality of the studies included in this review.

Conclusion

By drawing together existing qualitative research, this review adds to our understanding of group reflective practice. In particular it has revealed certain mechanisms which may help staff in healthcare professions reflect on their clinical practice. This hopefully will support and enhance implementation of group reflective practice. The importance of group processes has been highlighted alongside concerns about facilitators' knowledge and training in these issues. Lack of researcher reflexivity and rigorous qualitative design were limitations of this review and may affect the robustness of these findings as well as their transferability to other settings. There is a need for future research to explore what psychological processes may be present in RPG that facilitate an effect on staffs' perception of themselves and their work.

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Section B: Empirical Paper

What are NHS staff members' experiences of attending Schwartz Center Rounds®:

A grounded theory of psychological processes

For submission to Journal of Mental Health

Word Count: 8, 170 (170)

I have been the recipient of an extraordinary array of human and humane responses to my plight. These acts of kindness - the simple human touch from my caregivers - have made the unbearable bearable

- KENNETH B. SCHWARTZ

Abstract

Background. There is a continued interest around the use of Schwartz Center Rounds® (Rounds) to address the emotional impact of caring for clients. Studies indicate positive outcomes for staff and clients, yet there is a paucity of research exploring how these outcomes occur. This study aimed to understand whether attending Rounds had an impact on how staff perceived themselves and their work. Primarily, it sought to understand what psychological processes may facilitate such an effect and at what point these might occur.

Method. Eleven staff members were interviewed about their experience of attending a Round. Grounded theory methodology was used to analyse the interview data.

Results. Five key psychological processes of occupying a different space, reciprocity, containment, connection and gaining perspective were identified as facilitating an effect on staffs' perception of self and work. Processes were fostered during Rounds and seemed to continue afterwards.

Discussion. This study is the first to explore psychological processes and build a theoretical model of how Rounds work. Findings can be used to inform the continued implementation of Rounds and facilitator training programmes. Directions for future research are suggested.

Keywords: Schwartz Rounds, staff wellbeing, reflective practice, psychological processes

Introduction

The context of healthcare

The current socio-political climate seems to have created an environment within the NHS of ‘doing more with less’; an emphasis on targets, and throughput (DH, 2010; Point of Care Foundation [PCF], 2017; Weinberg & Doyle, 2017). For a workforce already faced with frequent and rapid reorganisation (Ballatt & Campling, 2011) austerity measures have potentially added to an uncertain working environment. Constant change from governmental policies, job uncertainty and increased workloads, can evoke anxiety, anger and feeling uncontained (Johnston & Paley, 2013). Indeed, stress and mental health difficulties are prevalent amongst the NHS workforce (Office of National Statistics, 2014). The potential corollary being a distressed workforce providing care to distressed clients. This is particularly concerning given the link between staff wellbeing and client wellbeing (Boorman, 2009). The events at Mid Staffordshire NHS Foundation Trust are a poignant reminder of what can happen when the work culture is “focused on doing the system’s business – not that of the clients” (Francis, 2013, p. 10).

Work-related distress

It may seem incongruent how healthcare staff, tasked with caring for the most vulnerable, could behave in ways considered cruel or uncompassionate. It may be easy to forget “the damage, the pain, the mess they encounter, the sheer stench of diseased human flesh and its waste products” (Ballatt & Campling, 2011, p. 53). Similarly, mental health professionals are continuously exposed to distressing client histories and high emotional distress. There appears a tension then between helping clients and the impact of this on the helper.

Menzies (1960) was the first to introduce the idea healthcare staff could act cruelly towards those in their care. In order to cope with the anxiety aroused by caring, she argued

nurses employ unconscious defence mechanisms which result in withdrawal from clients and depersonalisation. Menzies also highlighted how anxieties can be compounded by settings unable to contain anxiety or provide reassurances to their staff. Although the findings were considered pioneering the influence of unconscious defence mechanisms in managing anxiety has not translated into meaningful change at the individual or organisational level. There is however, a growing body of research on ‘burnout’ and ‘compassion fatigue’ illustrating the cost of caring. Over time emotionally exhausted staff can develop negative perceptions about their clients (depersonalisation) (Schaufeli, 1999) and/or lose the capacity to interact and engage with those they are caring for (Coetzee & Klopper, 2010).

Provision of care

It might be argued then that a capacity to provide care involves keeping in mind the suffering of oneself and others. Mentalizing, which involves the ability to consider and understand the thoughts, feelings and behaviours of self and others (Fonagy, Gergely & Target, 2007), may be integral to this. The ability to mentalize can assist emotional regulation, modulate impulsive behaviour, enhance empathy (Fonagy et al., 2007), and facilitate compassion (Allen, Fonagy & Bateman, 2008). Mentalizing is a dynamic trait so can be compromised by anxiety or threat, resulting in others being treated as objects (Fonagy et al., 2007). The concept of mentalizing provides a useful framework to understand how compassion may be compromised when an individual is overwhelmed by anxiety or stress.

Complex psychological processes of holding another’s suffering in mind and acting accordingly are necessary to show compassion towards others (Cole-King & Gilbert, 2011). It is important then to consider the psychology of compassion and its theoretical underpinnings. Gilbert (2005b; 2009; 2010) proposes there is an evolutionary basis for compassion and argues human nature is fundamentally social and affiliative. However, when under threat individuals experience anxiety, anger or disgust, and so will be motivated to protect

themselves through certain defensive behaviours (Gilbert, 2005b). This theory then could offer some insights into the function of staff behaviour which might be described as unkind or neglectful.

Developing interventions which target the source of anxieties in the health system, through fostering the conditions for mentalising and compassion, may prove helpful in addressing patient care and staff wellbeing. Crawford, Brown, Kvangarsnes and Gilbert (2014, p. 3595) argue “bidirectional compassion” should be integrated into service design and care. Evidence shows when organisations invest in their staffs’ health and wellbeing there are accompanying improvements in client outcomes and business performance (DH, 2011; DH, 2015b), and when staff feel valued, respected and supported compassionate care is fostered (DH, 2015a).

Reflective practice

Giving staff opportunities to reflect on practice may offset some of the stress and anxiety, and strengthen ways of coping. Reflection can help reduce work-related stress and burnout (Goodrich & Cornwell, 2012; Peterson et al., 2008), and may enhance clinical practice and skill development, as well as role satisfaction (DH, 1999; Hargreaves, 1997; Sainsbury Centre for Mental Health, 2001). Being skilled in reflection might also help sustain compassion (Baverstock & Finlay, 2016).

Engaging in reflective practice in a group setting might support learning and emotional processing (NHS England, 2014), help produce deeper insights (Sternlieb, 2015; Williams & Walker, 2003), contribute to understanding of self and others, help establish a sense of cohesion and care (Osterman, 1990), and possibly improve wellbeing (Heneghan et al., 2014). Indeed, research abounds about the influence of groups (Bion, 1961; Nitsun, 1996; Tuckman, 1965) and their restorative potential (Yalom & Leszcz, 2005). In contrast, workplace and organisational culture (Dawber, 2013; McCarthy et al., 2013; Platzer et al.,

PSYCHOLOGICAL PROCESSES IN SCHWARTZ CENTER ROUNDS®

2000a), fear of being judged and dynamics between group members (Platzer et al., 2000a), as well as facilitation style (Platzer et al., 2000a) may interfere with group members' development and the capacity to reflect.

Schwartz Center Rounds®

With the growing recognition of the symbiotic relationship between staff and client wellbeing Schwartz Center Rounds® (Rounds) have attracted increasing attention. Their implementation in NHS Trusts rose sharply following the Francis Report (Robert et al., 2017). Rounds were developed by 'The Schwartz Center for Compassionate Healthcare' in the USA. Founded by Kenneth Schwartz, a few weeks before his death, they aim to foster connection between staff and clients by providing space for staff to reflect on the emotional aspects of their work. During his illness Kenneth described how the connection between himself and his caregivers was what made the "unbearable bearable" (Schwartz, 1995, p. 1). Rounds were piloted in the NHS from 2009 - 2010 and have subsequently been introduced into over 186 sites in England (Ballatt & Campling, 2011; Goodrich, 2011; Robert et al., 2017).

Rounds last one hour and lunch is provided beforehand. They begin with a panel of three or four staff members- ideally from clinical and non-clinical backgrounds with different degrees of seniority - sharing their experience of either a particular client or theme. A trained facilitator then guides a discussion of emerging themes and invites the audience to share their thoughts and feelings about similar experiences. The ethos being "the compassion shown by staff can make all the difference to a client's experience of care, but that in order to provide compassionate care staff must, in turn, feel supported in their work" (PCF, 2015, p. 2).

Studies have demonstrated the potential link between attending Rounds and increases in compassionate care (Goodrich, 2012; Manning, Acker, Houseman, Pressman, & Goodman, 2008), stress reduction (Goodrich, 2012; Lown & Manning, 2010), validation and normalisation of feelings (Goodrich, 2012), and improvements in team work (Goodrich,

2012; Lown & Manning, 2010). To date, the majority of studies have focused on investigating outcomes of attending Rounds, with no published study examining how these outcomes might occur. This could be problematic for the future of Rounds as “if we do not understand why such an intervention works, we are unable to maximise its effectiveness” (Lloyd, Bond, & Flaxman, 2013, p. 182).

Rationale

There is a growing evidence base for the efficacy of Rounds, however there is a gap in understanding how these outcomes might occur. This study aims to understand if psychological processes facilitate an effect on the way NHS staff view themselves and their work. With improved understanding, teams responsible for implementing Rounds, as well as facilitators, may be able to capitalise on these factors for the benefit of staff and clients.

Research questions

1. Does attending Rounds affect staffs’ perceptions of themselves and their work? – and if so, what are the psychological processes that facilitate this effect?
2. If psychological processes are involved in facilitating an effect where in the temporal process might this occur – during or after attendance at Rounds?

Methodology

Design

A non-experimental qualitative design using grounded theory methodology was used to explore staff members’ experience of Rounds. As qualitative approaches attempt to understand the meaning or nature of people’s experiences (Strauss & Corbin, 1998) this design was appropriate to the study’s aim.

Grounded theory was chosen to help build a theoretical understanding of what psychological processes may facilitate an effect on how staff think about themselves and their

work. This study followed Charmaz's (2006) approach to grounded theory analysis, which holds a social constructionist epistemological position, arguing the meanings people make from an experience, and the researcher's construction of meaning from the data, are interpretations of reality influenced by previous experiences.

Eligibility criteria

Any staff member who had attended the identified Rounds as an audience member could participate. Panellists and facilitators were excluded due to their involvement in preparation meetings where panellists rehearse their stories, and facilitators help shape its re-telling, to ensure the emotional impact of the work is the focus at Rounds. As this preparatory work may alter the meaning for the panellist any psychological processes and resultant impact for both panellists and facilitators may begin prior to Rounds. Furthermore, due to their role, facilitators may engage with the stories differently to others in Rounds and so might be a step removed from the process.

Participants

Participants were recruited from five out of seven identified Rounds, delivered in a mental health Trust based in London, over a 2-month period (Table 8). The 11 participants were mostly female and from clinical backgrounds. Four participants had attended multiple Rounds. Two participants were trained facilitators but had attended Rounds as audience members (Table 9).

Recruitment setting

The Trust delivers a wide range of mental health and substance misuse services in community, inpatient and outpatient settings across nine London boroughs. They also provide specialist national services for children and adults. Around 4,600 staff are employed with the majority from nursing, midwifery and health visiting.

The Trust was one of six organisations chosen to extend Rounds into primary care, community and mental health services (Yazicilar, 2016). Rounds were first implemented in 2015, and following this first-year were rolled out to further sites, and continue to be run on a monthly basis (Power, Belton & Pettifor, n.d.).

Ethical considerations

Ethical approval was granted by Salomons Research Ethics Panel at Canterbury Christ Church University (Appendix G) and from the Health Research Authority (Appendix H) to conduct research with NHS staff. As participants were interviewed about their experience of Rounds, which focuses on the emotional impact of providing care, details of support services were included in the participant information sheet (Appendix J). They were advised if information was disclosed which suggested possible misconduct towards a client(s) this could possibly result in confidentiality being broken. They were also advised identifying information would be omitted from interview transcripts and findings. Informed consent was sought prior to interviews (Appendix K).

PSYCHOLOGICAL PROCESSES IN SCHWARTZ CENTER ROUNDS®

Table 8: *Schwartz Round characteristics*

Rounds	Location	Attendee numbers	Panellists	Researcher attended	Numbers interviewed
1	Hospital 1	40	1) Clinical Service Lead - Psychological Medicine 2) Head of Psychology 3) Ward Manager	Yes	2
2	Hospital 2	30	1) Acting Ward Manager 2) Ward Manager 3) Nurse	Yes	2
5	Hospital 4	19	1) Administration Lead 2) Patient Information Officer 3) Nurse Advisor 4) Consultant Clinical Psychologist	Yes	3
6	Hospital 1	27	1) Psychotherapist 2) Senior Clinical Nurse Specialist 3) Medical Secretary 4) Engagement Partner	No	1
7	Hospital 5	24	1) Ward Manager 2) Nurse 3) Specialist CAMHS Practitioner / Therapist	Yes	3

NB. No participants were recruited from Rounds 3 and 4

PSYCHOLOGICAL PROCESSES IN SCHWARTZ CENTER ROUNDS®

Table 9: *Participant characteristics and Rounds data*

Pseudonym	Rounds	Gender	Age	Ethnicity	Additional information	Occupational Role	Length of time in current post	Length of time employed by Trust	Number of other Rounds attended	Panellist or facilitator at other Rounds
Esme	1	Female	59	White British	-	Occupational Therapist	9 years	9 years	5	-
Chloe	1	Female	29	White British	-	Physiotherapist	18 months	18 months	-	-
Thomas	2	Male	32	White Other	-	Smoking Cessation Advisor	2 ½ years	7 years	1	-
Jess	2	Female	27	White British	Mental health difficulties / facilitator	Experience Manager	1 year	1 year	9 in total Audience = 3	Facilitator=6
Charlotte	5	Female	31	White British	-	Clinical Psychologist	5 weeks	5 weeks	-	-
Emma	5	Female	29	White British	Newly trained facilitator	Clinical Psychologist	5 months	5 months	2	-
Pippa	5	Female	43	White British	-	Smoking Cessation Advisor	10 months	10 months	-	-

PSYCHOLOGICAL PROCESSES IN SCHWARTZ CENTER ROUNDS®

Table 9: *Participant characteristics and Rounds data cont.*

Pseudonym	Rounds	Gender	Age	Ethnicity	Additional information	Occupational Role	Length of time in current post	Length of time employed by Trust	Number of other Rounds attended	Panellist or facilitator at other Rounds
Tim	6	Male	24	White British	Autism spectrum disorder	Pre-registration Pharmacist	4 months	4 months	-	-
Helen	7	Female	27	White British	Long term physical health condition	Behaviour Support Practitioner	5 months	5 months	-	-
Julie	7	Female	43	White Other	-	Administrator	4 months	3 years	-	-
Margaret	7	Female	31	Black African	Sibling has mental health difficulties	Career Coach	1 month	1 month	-	-

Procedure

Depending on availability, the researcher either attended Rounds to recruit participants or facilitators mentioned the study using a provided script. The researcher attended four of the seven Rounds used for recruitment. Before Rounds began details of the study were given, and when they finished contact details were collected, and if present the researcher answered any questions. The researcher did not stay for the Rounds so as not to unduly influence interview questions or data analysis. Following Rounds, participants were contacted to arrange interviews.

Sampling. This study adopted a narrow, purposeful sampling strategy to include only audience members as participants. To achieve heterogeneity participants could be from clinical or non-clinical backgrounds, have different professional roles, varying lengths of employment, and variation in how many Rounds they had previously attended.

Grounded theory methods suggest data collection should cease once ‘theoretical saturation’ has been achieved, that is when no new concepts or hypotheses emerge from the data (Strauss & Corbin, 1998; Willig, 2001). This study however adopted ‘theoretical sufficiency’ as it provides a more flexible and realistic approach to data collection (Glaser & Strauss, 1967). Theoretical sufficiency is met when “categories seem to cope adequately with new data without requiring continual extensions and modifications” (Dey, 1999, p.117).

Interview schedule. A semi-structured interview schedule was developed to gather as much information whilst allowing participants’ flexibility to share their subjective experience. The interview was piloted with a colleague who had attended Rounds and was consequently adapted to include participants’ descriptions of the focus of Rounds. This was to orient the researcher to the context in order to shape questions where appropriate.

Data collection. Data were collected through individual audio-recorded interviews which were then transcribed. Seven face-to-face interviews occurring at participants’ place of

work were undertaken and lasted between 43 and 91 minutes. Four interviews were conducted over Skype lasting between 63 and 71 minutes. Due to technical problems three of these were audio only. Extra attention therefore was given to active listening and responding to offset omission of non-verbal cues. Interviews occurred between 6 and 28 days following Rounds.

Data analysis

The analysis process is described in Table 10. Data collection and analysis occurred in parallel which is consistent with grounded theory.

Table 10: *Sequential data analysis process*

Step	Description
1	The first three interviews were coded line by line using ‘initial coding’ making sure to remain close to participants’ meanings by using in vivo codes.
2	The most frequent or salient codes were then used for ‘focused coding’ to explain larger segments of data. Written memos were used to postulate relationships between codes and developing categories allowing analytical distance from the data (Strauss & Corbin, 1998).
3	Further interviews were conducted and focused codes and themes were held in mind as areas to explore and/or develop. The researcher also remained open to what participants said. Exploration of these focused codes and themes occurred either organically when participants brought them up or by directly introducing the area if they did not.
4	Coding was then returned to using the early focused codes and categories alongside new initial codes through the constant comparative method. Through reviewing previous initial codes and focused codes further analytic categories and relationships were developed with the support of additional memos.
5	More interviews were carried out and analysed using focused coding and constant comparison enabling conceptual categories to be generated that began to explain the data.
6	After 11 interviews, it was deemed theoretical sufficiency had been reached.

Quality assurance

Bracketing interview. A bracketing interview exploring the researcher's view on Rounds was conducted. This occurred after the first four interviews and before analysis began (Appendix M) to identify any assumptions, interests or personal experiences that may influence how the data were viewed (Fischer, 2009).

Independent audit. Sharing assumptions and experiences of interviewing participants with a research supervisor allowed further reflexivity (Fischer, 2009). Codes, categories and theory development were discussed to allow for consideration of alternative interpretations of the data. An interview transcript was scrutinised by a research supervisor, to check for similarities and differences in analysis to ensure credibility of findings.

Reflective diary. A reflective diary was kept throughout the research process recording reflections about interviews and analysis (Appendix N).

Theory checking. The developed theory was shared with participants and their feedback integrated into the final model to ensure it represented their experience.

Results

Based on categories derived from the data, and their relationship with each other, a model outlining the experience of Rounds was developed. The model will first be discussed followed by a description of each category and their interrelationship. Five key categories: occupying a different space, reciprocity, containment, connection, and gaining perspective represented the potential psychological processes occurring in Rounds. These appeared to facilitate an effect on how staff viewed themselves and their work. They appeared dynamic and to supplement each other, meaning no singular category seemed sufficient to facilitate an effect. Two additional categories of cost and renewal were also derived from the data

bookending the psychological processes. Taken together the categories suggest there was a temporal process of change which began in Rounds.

Does attending Rounds affect staffs' perceptions of themselves and their work? – and if so, what are the psychological processes that facilitate this effect?

Cost. Participants spoke of considerable challenges encountered in the course of their work. These affected how connected they felt to their sense of self, clients, other staff, and the NHS, and therefore seemed to be a cost that participants arrived to Rounds with. The way participants spoke about Rounds seemed to represent how different this environment was to their normal work setting, but also how differently they operated within it.

Participants described the difficult landscape of the NHS, "...you're trying to do your job in a professional way, to meet your professional expectations and standards...but it's almost as if everything else is working against that ..." (Esme). Some felt disconnected from clients due to mounting work pressures, "...I think I've lost a bit of focus on what's really important in the job, what really matters. The human side of things..." (Thomas). Others felt devalued by the organisation, "...we're not actually that important except as tools to achieve an end" (Esme), and regardless of how much effort they extolled, "quite often the message that is indirectly delivered is, "you should work harder'..." (Chloe). Coupled with these pressures there was also criticism and hurt feelings, "...Do I want to spend every couple of days coming home and having exhausted myself emotionally (...) from being personally attacked (...)?" (Tim). *There was a sense of isolation and disconnection, leaving participants feeling on their own with their worries, "our work can feel quite isolating or (...) we maybe don't talk about what's going on for each of us individually"* (Emma).

Occupying a different space. Rounds were a rare opportunity for participants to get some distance from the demanding and frenetic pace of work and were described as a

“protected space” (Esme). Being in this different space facilitated and permitted participants to be themselves and enabled them to be natural with others. This ability to be different was strengthened through reciprocity, containment, connection, and gaining perspective.

Metaphorical space. Rounds provided participants with a welcome opportunity to step back, get away, and have timeout from work. This was a chance to pause, which was not necessarily something they were able to do at work, “despite something that happens with one person to immediately be able to go and be courteous and professional, and reassuring, and reassuringly competent and confident, with the next patient I see” (Tim).

Participants referred to the chance to step away from work as a “luxury” (Julie) in light of high workloads, limited resources and time pressures. This felt like a privilege, “it is quite a privilege to just have some time” (Charlotte) and participants framed this as the Trust giving them permission to attend Rounds, “it’s important to allow staff, I guess, permission to be able to stop and do something else for a short time...” (Charlotte).

It was also a space where they could reflect, “In your everyday work, you can get caught up in everyday things, and you never really have the opportunity to stand back and really think...” (Esme). Additionally, it was a space where opening up about difficult thoughts and emotions was acceptable, “In supervision I don't think my manager wants there to be anything not okay. In Schwartz Rounds I think it would be okay to say if things weren't okay” (Jess). Panellists and others who shared their experiences in Rounds were thought of by participants as honest and courageous. Seeing their colleagues in this way seemed to differ to how participants generally experienced other members of staff:

I think it's always surprising how honest people are (...) there's so much that goes on in teams and services that aren't talked about, but somehow when you get people in the room in that way (...), it frees up people to be a

bit more able to connect with some of the less surface level thoughts that they have, but actually are able to connect with their experiences from an emotional point of view. I think it takes a lot of bravery to do so. I am always surprised at how brave people are when they come to do it (Emma).

Sense of self. Occupying a different space in Rounds was perceived by participants as helping to reduce the divide between staff members. Titles and hierarchy seemed to be less commonplace in Rounds than the work setting, “less hierarchical than other spaces” (Emma). This helped participants be with other members of staff more on a person-to-person level rather than focusing on their professional titles which seemed to keep them separated:

...If I was less wrapped up with the fact ‘oh, that person’s a consultant’ (...) and try and break down the fact that actually they’re a person just go and talk to them; rather than, ‘they’re a consultant, they’re really important. I might mess up with what I’m saying’. (...) When you’re over there [Rounds] and you’re out of the work environment, it’s a lot easier to have a conversation (...) it’s just different when you’re over there... (Pippa).

Participants spoke about Rounds providing a space where they could bring more of themselves rather than just their professional persona:

I didn't necessarily have my professional hat on in the same way that I might do within the clinical team. I can be a bit more open to just kind of listening to people, and asking questions, and not being a psychologist necessarily (Charlotte).

Reciprocity. Participants did not talk about any other instances at work, apart from Rounds, where they felt valued or cared for as a person. Being able to attend Rounds, and the

experience of them, made staff feel valued by the NHS and invested in, “If you’re allowed the time to attend a reflective group, you’re being told that, you know, you’re valuable enough...” (Julie). They felt cared for and that their own needs were being recognised. This offered a sense of reciprocity for all the aforementioned costs:

The fact that the Trust will go to the effort of putting these on, and I can take time out of my day to attend, probably really contributes to feeling valued as a member of staff. And actually it’s a massive loud message that says ‘we recognise that doing this job is demanding on you as a person’, because you’re a person and not just a robot staff member (Chloe).

For participants, Rounds and particularly having lunch provided, was experienced as being nurtured and cared for, “I think they’re a space to, I suppose almost nurture staff. Obviously we feed people so we’re looking after them physically and then we try and give them a space to look after them in their selves in other ways...” (Jess). It was also seen as another sign they were valued and worthwhile:

...somebody’s taken the trouble both to order it, to pay for it, to make sure it’s going to be here. They’ve done everything, the plates, the food’s nice. It’s not just any old cheap sandwich, its nice food as well so you feel valued in a way that I don’t think we feel valued working in the NHS (Esme).

There was also a sense of reciprocity between staff members underlined by the panellists sharing their experiences and then the audience responding in kind, “I think as an audience member you feel, (...) they had shared quite a lot as a panel so it was quite reciprocal that the audience were then doing the same...” (Charlotte).

Feeling reciprocity through the experience of Rounds seemed to temper some of the costs participants' came with. Feeling that their effort was being recognised and appreciated helped foster their connection with themselves, others, and the NHS. Additionally, it enabled them to gain perspective about themselves, others and the wider system which will be discussed in detail below.

Containment. Particular aspects of Rounds which were not only fundamental to them, but also emerged from them, helped foster feelings of safety (containment). Rounds therefore provided enough containment for participants to feel able to share experiences and/or reflect on self, by reducing or eliminating a sense of uncertainty or anxiety which may have obstructed this process.

Group structure. The structure of Rounds was perceived by participants as contributing to containment. A number of elements made up this structure which included knowing the explicit purpose of the Rounds was about emotions, "...a space for people to come and just talk about their experiences and share their experience" (Margaret), panellists setting the scene, "...the panel open that up and almost set the precedent" (Chloe), which were then followed by discussions from the audience, "we're going to hear from these people, and this will happen, and then you'll be invited to speak...so I felt like I knew where I stood from the moment I was in the room rather than less structured spaces..." (Charlotte). This clear frame contributed to feelings of uncertainty and/or anxiety being alleviated.

Knowing there were no demands on them to contribute also helped participants feel at ease within Rounds:

I had been told that there wasn't an expectation that I contributed and I think that made me feel quite a bit more relaxed (...). I was told (...) you can just

listen or take part, so it certainly didn't feel pressured. It just felt... I was expecting it to be a kind of a safe place and it was (Charlotte).

Not feeling pressured to speak, and equally not feeling judged if they did not, was a noticeable difference to other groups participants had experienced:

I didn't feel pressured to contribute to discussion (...). I think that is different from general peer supervision where you almost feel a bit pressured to contribute and if you don't contribute it feels a bit awkward. I didn't experience that at all when I was there (Thomas).

...in a reflective group you are put in a position where you maybe bring a lot of yourself, and some of that is quite exposing (...). By not talking you're giving a message anyway. I think there's less of that in Schwartz Rounds. You're invited to talk if you would like to (Emma).

Additionally, having no pressure to find solutions, or provide answers also contributed to feeling contained by Rounds, "I guess there was no pressure for there to be an answer, so it's a lot less formal and less pressure" (Charlotte).

Containment was enhanced through clear statements about confidentiality which occurred from the outset. This helped participants feel Rounds were a safe space to share experiences:

P: Before the panellists started speaking, the lady who had arranged it all did mention – 'This is confidential. You can say anything here and it stays within the room' - so it was all very much in the beginning you were made to feel quite comfortable.

I: ...

P: ...from the beginning I thought ‘oh, ok, this is going to be a nice, non-judgemental environment for people to speak in’... (Pippa)

Not only did participants feel contained in Rounds, but they described how discussions themselves were contained which felt helpful. This was unlike other forums which could become uncontained, tangential or akin to ‘moaning’; “It doesn't feel like it gets uncontained” (Charlotte). Sometimes my experience in services is that once a space is given to talk about how difficult things are if that's not contained well it becomes very uncontained” (Emma).

A participant who was a newly qualified Schwartz Round facilitator offered a unique insight into the role of the facilitators in creating this containing environment:

...because I've attended the training I'm aware how hard the facilitators work to kind of keep that safe place, and keep on topic, and give everyone a chance to talk, and not feel any pressure to talk at all. I think those things make it a safe place (Emma).

Social environment. Participants explained how the response from others when someone shared an experience or reflection helped construct an environment where people did not feel judged and were accepted. This enabled people to have the courage to expose their worries and vulnerabilities:

I have this picture in my head of chat shows, and when one person talks, and then the audience claps, it makes another one feel brave enough to stand up and say something else that might be equally or as more exposing than the last person. Everyone's cheered along in some way (Emma).

Participants described Rounds as “respectful” (Julie) and “...an area where you can legitimately express frustrations without worrying about the impact that that might have on what people think of you” (Jess). Other qualities of the social environment participants spoke about were empathy, trust and being listened to.

Group atmosphere. Participants described feeling a sense of ease within Rounds: feeling “almost peace” (Esme) and that “the atmosphere was quite relaxed” (Charlotte), and “laidback” (Pippa). This experience seemed distinct to how they generally felt in their work setting related to the costs discussed above. Participants often mentioned how lunch contributed to the relaxed atmosphere:

I would just say that the lunch is important, (...) there’s that informal time at the beginning where people are just kind of milling around and chatting. (...). It plays a part in setting up the atmosphere and it's rare (Charlotte).

Connection. As participants felt contained in Rounds this allowed them to relax and not feel under pressure. This opened up opportunities to find connection with other staff and the wider system. Importantly, they had the opportunity to (re)connect with their sense of self which had been effected by the costs encountered from the work. Occupying a different space by being at Rounds facilitated this connection as it provided the space to reflect on self and others.

Connection – with self. Participants described how listening to others’ talk about their experiences helped them to (re)connect with their sense of self. They felt reminded of their values, purpose and how they wanted to engage with clients:

I remember having a realisation, a definite realisation, and thinking ‘where have you been? This is the sort of thing that used to motivate you. This is

the aspect of your job that you really enjoyed. You need to get back to that'

(Thomas).

Participants also spoke of Rounds bridging the gap between their professional and personal self, "I surprised myself with how much it made me think about my own personal life and not just professional life" (Jess). It highlighted the importance of the self - the human element - in supporting clients:

It was just a very good reminder that your being is very, very powerful (...) you should try and be aware of the way you speak, the things you do, how you present yourself (...), if I don't get that right it's going to impact the work that I'm able to do with someone (Margaret).

For some participants, who were themselves service users, being at Rounds helped them connect to that aspect of themselves, "I think it sort of helped me on a really personal level (...) I'm using it to benefit me as a professional, but also I can use it to benefit me as a patient (Helen). It also assisted in reconciling this part of themselves, "...It think it made me feel a bit better in myself (...) it made me feel more of a person again, not just a line of unhelpful behaviours or processes" (Jess).

Connection - to others. During Rounds participants became increasingly aware of the similarity of experiences across members of staff which helped to, strengthen a sense of connection, "you've got a bit of a deeper connection with the people around you through, through kind of sharing" (Jess).

Participants spoke about Rounds helping them to realise the same goals and values were shared amongst other members of staff and that they all wanted to do the best for clients, "...it's really nice to hear everyone on the same page. No matter which department they were working in. On the same page in terms of just really wanting to help people" (Chloe).

Participants also felt more connected with the wider system and described a sense of belonging, “a greater feeling of being connected with the team as a whole, in terms of Trust wide” (Chloe) which helped “build a sense of community” (Emma). This camaraderie was seen as a mechanism which would sustain them through the difficulties of the work, “...this sense of camaraderie, we're all [Trust], and we're all doing this together - at the rough and the smooth...” (Charlotte).

Gaining perspective. Experiencing reciprocity and containment within Rounds, and occupying a different space provided an opportunity to reflect upon self and others. This nurtured a greater awareness of themselves, clients and others, which helped participants feel more connected to their sense of self, others and the wider system, “Not just head down and do your job, we're going to let you reconnect with why you're doing this, perhaps, or give you a chance to think about why you're doing it and why others are doing it” (Julie).

Understanding the self. Participants spoke of gaining perspective about their professional competence, supporting clients, and holding onto their values which helped to subdue self-doubt or worry:

I: What if any has been the impact of listening to other peoples' stories and experiences on the way you think or feel about yourself?

P: That maybe I'm doing an okay job. That I still might be managing to hold onto the compassion, the empathy. I try. I still want to continue to build relationships and keep those connections even though sometimes it is just *so* difficult (Esme).

It also helped reinforce their personal choices around work, “beforehand I was like ‘oh what have I done? I've taken this job’. It was all a bit of a mess and I did leave feeling like it

will be fine because [Trust's] obviously a good place to be. I just need to get through this first uncomfortable bit" (Charlotte).

Rounds were also an opportunity where professional development came into awareness, "it was also a good opportunity for me to be in a different position to when I was in [location] the last time (...) now I'm qualified. (...). It was interesting to see the difference in me as well (Emma).

Understanding others. Participants spoke of how Rounds created a dialogic space which enabled them to better understand others. This was helpful for building relationships and offering support, "...it has helped me to empathise with the concerns that my work colleagues from different specialisms, and clients, come from, and therefore whether there's anything I can do in my practice to mitigate that, and to work with them closer" (Tim).

For participants hearing that other staff members, particularly if they had more experience or held more senior positions, also doubted themselves and were infallible helped to normalise and neutralise fears and self-criticism:

...you get quite a lot of senior staff speaking about things that they wouldn't normally talk about and I find that quite useful (...). It's really nice to hear that actually you're not the only one who is having doubts, or worries, or think you're not doing a good job (...). In some ways it's a bit more reassuring (Esme).

Renewal. Occupying a different space, which permitted and facilitated, containment, reciprocity, connection and gaining perspective, resulted in participants feeling renewed. Participants spoke of discovering their focus and purpose again, "...it helped put things into perspective for me and gave me some focus" (Helen). Similarly, they described Rounds imbuing them with increased motivation to carry on in spite of the challenges of the work and

work setting, “it reinforces to me why I work for [Trust], (...), hearing excellent people, doing excellent work, (...) it is important to be reminded why this is important and why it’s worth the struggle...” (Julie).

Participants also noticed a change in how they felt within themselves, “...I tend to come away feeling a bit more positive, and a bit more free in myself, and then I notice that it has an impact on my day (Emma). Their outlook about work also differed, “...I do feel (...) more privileged to be working here than I did...” (Charlotte), as did their perspective on engaging with clients:

I have changed the way I’ve been engaging with patients in the last few days. (...) I feel differently (...). I feel a lot more alive. I feel like I’m doing a better job. I feel more content with myself. (...) I feel like my role has a lot more purpose (Thomas).

If psychological processes are involved in facilitating an effect where in the temporal process might this occur –during or after attendance at the Rounds?

As noted above the psychological processes appeared to facilitate an effect on how participants perceived themselves and their work. The additional categories of cost and renewal help to illustrate the temporal dimension, namely that the psychological processes began in Rounds and were carried forward afterwards. How long these psychological processes are maintained is not known and was not addressed in this study as one of its aims. For one participant, the kind feelings towards herself that were fostered in Rounds had begun to dissipate due to her personal circumstances remaining unchanged:

I: ...what might have caused those warm feelings, positive thoughts, about yourself to dissipate?

P: ... basically it's my mental health condition making life a bit tricky. The impact it has on my life has just carried on. It didn't in the Schwartz Round immediately after and then you get back in the day-to-day ways of being (Jess).

An adjunct related to this research question is how through reflecting further on their experience of Rounds as part of this study, this may have consolidated the psychological processes continuing after the Rounds:

P: ...it's made me, I don't know, more mindful in a way of me...

I: Why do you think that is?...

P: ...having the space to do it. Just shutting this morning off to having the meeting with you. I don't normally give myself time, because I'm always on the Wards, or talking to staff; talking to patients...

I: Do you think it links back to taking time out (...) or is it something else...?

P: It's taking time out, it's also the questions you asked and how you've dug just deeper (...). When you're thinking it's a completely different experience as when you're saying it, because when you're saying it, it kind of cements what you're thinking (Pippa).

Grounded theory model

The model suggests psychological processes may be contained within the metaphorical space of the Rounds (Figure 3). Whilst reciprocity, containment, gaining perspective and connection

sit within separate segments these processes seemed to overlap; they appeared interdependent, and seemed neither to occur nor function separately. They are drawn individually for the sake of clarity but the lines which divide them are broken to signify these psychological processes appear to be on a spectrum. The apparent symbiotic nature of these is visually represented by the intersection within ‘occupying a different space – sense of self’. The arrow represents how these psychological processes appear to begin in Rounds and seem to continue afterwards.

Participants seemed to come to Rounds affected in some way by potential costs of working in the NHS. Rounds appeared to offer them a space, and a way of being, which might be distinct from other experiences encountered at work. Occupying this different space appeared to facilitate and permit reciprocity, containment, connection, and gaining perspective. Therefore, participants seemed to feel cared for and contained, and were willing then to open themselves up to seeing things differently, build relationships with others, felt a sense of belonging, and most importantly (re)connected to their sense of self. As a result, participants appeared to experience a renewed purpose and motivation, which helped to reinforce to them why they continued working despite the challenges.

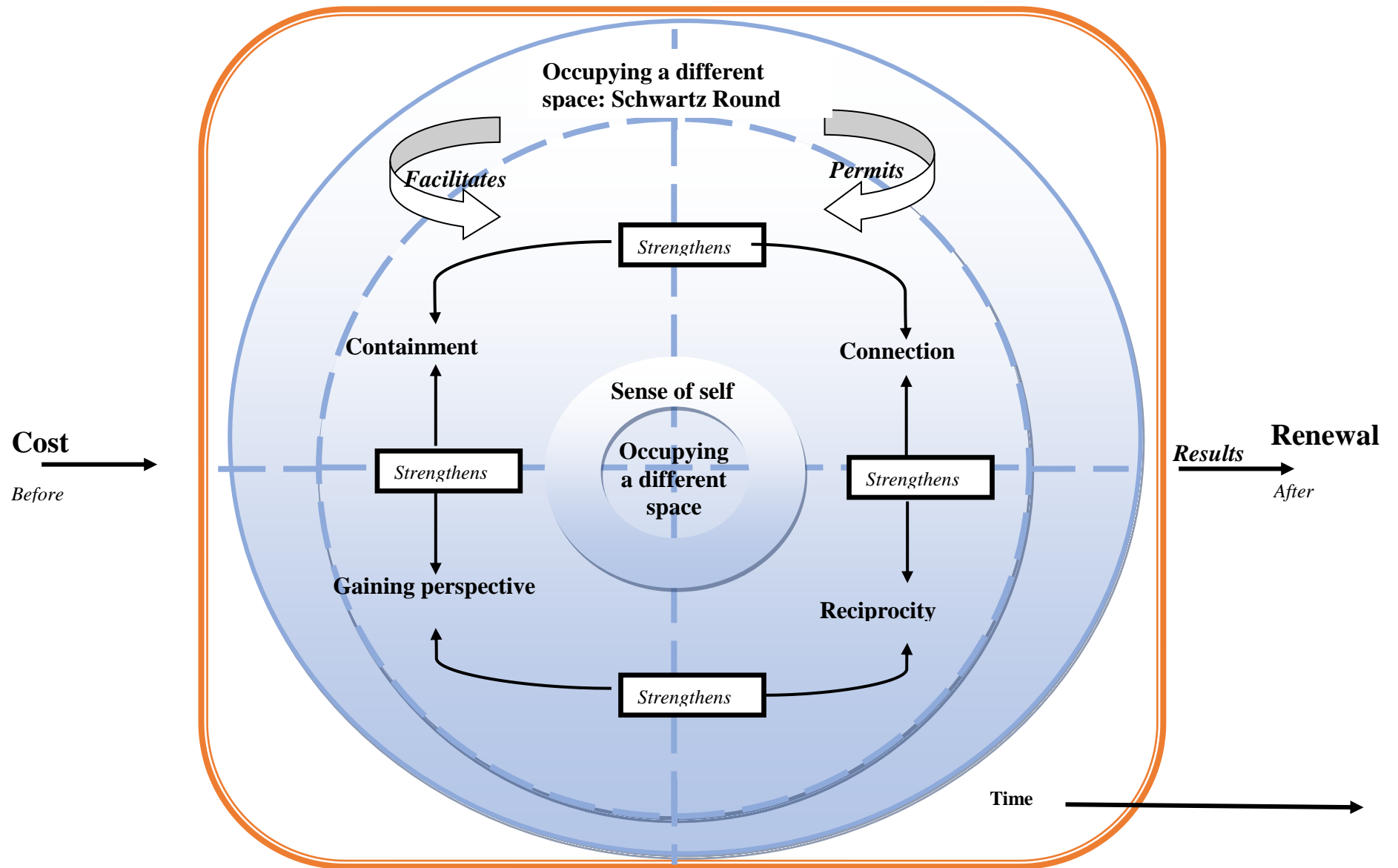


Figure 3: Model of psychological processes in Schwartz Center Rounds® effecting perceptions of self and work

Discussion

This study is the first to explore possible psychological processes which might occur in Rounds and attempt to build a theoretical framework about how they might facilitate an effect on staffs' perception of themselves and their work. Psychological processes of occupying a different space, reciprocity, containment, connection, and gaining perspective appeared to influence staffs' views. Relationship with self, and with others, appeared to be key features of most processes. An additional aim was to understand whether potential psychological processes occur during, or after, Rounds. The findings suggest psychological processes may be fostered in Rounds and maintained afterwards through a renewed sense of purpose and motivation.

Participants spoke of Rounds as a different type of space or context, which provided a distinct opportunity to not only take a physical step away from work, but also a psychological one. This space, more so than perhaps other contexts, seemed to enable participants to think about their thoughts and feelings. The ability to think about self may require disengagement from immediate experience in order to reflect on it (Ekeblad, Falkenstrom & Holmqvist, 2016).

Rounds seemed to contain participants' anxiety enabling them to share and reflect on experiences. Consistent with psychoanalytic thinking distress can be contained and transformed by the group into a more tolerable experience (Leiper & Maltby, 2004) allowing participants the opportunity to think. Feeling safe to disclose personal thoughts and experiences without fear of negative responses has been described in the literature as 'psychological safety' (Edmondson, 1999). Nevertheless, current research suggests Rounds might not provide containment to more senior staff who may feel responsible to continue to present a façade of coping in order to contain the anxieties of their team (Gallagher, in prep).

This study occurred in a different Trust, and with different facilitators, so it is difficult to hypothesise whether this finding is particular to this sample or suggestive of different psychological processes for staff with supervisory responsibilities.

Experiencing reciprocity appeared to be another important psychological mechanism. Being able to attend Rounds was perceived by participants as an indication they were being invested in and valued. Having lunch provided made participants feel nurtured and cared for. This reciprocity seemed to strengthen staffs' connection to self, clients and the organisation. This is consistent with findings which propose if an unbalanced helping relationship is perceived by staff, they start to emotionally disconnect from clients, and lose commitment to the organisation (Schaufeli, Dierendonck & Gorp, 1996).

Linking to the theory of mentalizing developed by Fonagy and colleagues (e.g. Allen et al., 2008; Fonagy et al., 2007), the capacity to think about self and others, appears to feature in a number of proposed psychological processes. As high arousal compromises this ability (Fonagy et al., 2007), feeling containment in Rounds, and having this space to step away from work demands, could have fostered the conditions for participants to engage with mentalizing.

Feeling connected with self, and to others, was another possible psychological mechanism. Participants spoke about (re)connecting with their values purpose, and personal identity. Participants felt connected to others through increasing awareness of similar experiences and goals, which gave them a sense of being part of something bigger than themselves. Consistent with mentalization theory, connectedness may have been encouraged in Rounds through participants' connection to their own mind and feelings, as well as understanding the mind and feelings of others (Fonagy & Target, 1996). Indeed, mentalizing has been linked with curiosity about self and other (Allen et al., 2008).

Participants described how Rounds appeared to help them see the perspective of others' and also consider things differently for themselves. This finding suggests Rounds might be a space which helps foster mentalization through experiencing the perspectives of others and self-exploration (Heffron, Reynolds & Talbot, 2016). Being able to understand the perspective of others is also a necessary condition for demonstrating compassion (Cole-King & Gilbert, 2011; Fonagy et al., 2007). Additionally, feeling more connected to self and wider humanity, as experienced by participants in this study, is necessary for self-compassion (Neff, 2003). Feeling compassionate towards self and others may have been fostered by feeling safe in Rounds (Gilbert, 2005a) which suggests compassion may underpin some of the psychological processes.

Limitations

A limitation of this study is the relative homogeneity of the sample. Although this study aimed to capture both clinical and non-clinical staff members' experiences of Rounds only two non-clinical staff participated meaning their views may be underrepresented. Further, whilst there was breadth of professional role, staff did not hold senior positions meaning the perspective of people in supervisory roles or with more responsibility is missing. As staff were recruited from only one NHS Trust caution is needed in the transferability of findings to other Rounds which may be implemented differently in other Trusts.

Another limitation is that the present study did not include the views of staff who had attended Rounds but not found them beneficial or possibly had a negative experience of them. The implication being that for these staff the psychological processes found in this study may not have been present. All staff who participated in the study had chosen to attend several Rounds, or if they had only attended one, were interested in attending more suggesting there might be selection-bias in this study.

Although there were attempts to minimise researcher bias through a bracketing interview, research diary and analytic memos, this may not have precluded any impact on the interviews or data analysis.

Lastly, possible research effects may be present in this study. Participating in the research, and being prompted to reflect on their experience of Rounds may have consolidated or developed the effect of the psychological processes in a way that may not have occurred otherwise.

Practice implications

This paper suggests the wider organisational context, and work-related distress, may induce anxiety and psychological states that compromise compassion and mentalizing capacity, and leave staff feeling burnt out and disconnected. Clinical psychologists are well placed to help organisations and teams understand the impact of this on staff and clients, and how Rounds might be one way to address these issues. This increased understanding may provide the impetus for organisations to continue supporting implementation of Rounds and staff taking time out to attend them.

Even though this study suggests psychological processes might continue post-Rounds questions remain about the sustainability of these processes. This is particularly if they dovetail with personal and/or organisational circumstances that might remain unchanged following attendance at Rounds. Research indicates Rounds have a cumulative effect, with increasing benefit occurring with the more Rounds that are attended (Lown & Manning, 2012). Augmenting these psychological processes with attendance at further Rounds, or consolidating them through other guided reflective forums, may help to sustain their effect and hence staff feeling re-energised and motivated for their work. Participants mentioned being part of this study, and having the opportunity for further reflection, may have

consolidated the impact of the psychological processes continuing after Rounds possibly giving some heuristic value about sustainability.

Participants described the helpfulness of panellists setting a precedent of sharing personal thoughts and feelings, and facilitators shaping conversations to focus on the emotional impact of work. As “mentalizing begets mentalizing” (Allen et al., 2008, p. 320) role modelling discussions about the emotional aspects of work by clinical leaders, supervisors, and teams, may support and encourage staff to consider their own thoughts and feelings and that of others.

This study has underlined the importance of staff feeling valued and cared for and the role reciprocity may have in enhancing connection to clients and commitment to work. As staff only attend Rounds when they can it seems important that organisations consider additional ways to demonstrate reciprocity to their staff. Accounts suggest being provided with lunch might be an important factor, which may contribute to a sense of reciprocity. Perhaps then there is an argument for the importance of lunch continuing to be provided. This may require strong leadership to advocate for this due to financial constraints currently faced by the NHS.

Considering the overlap between these findings and that of the group process literature it appears important that facilitators are trained in understanding, and working with, group dynamics. This is particularly so considering facilitators appear to have an integral role in creating a containing environment for participants. Research has found facilitators who are trained in group work are able to offer a space for participants which is safe and promotes reflection about their work and the resultant impact on them (Maben et al., 2018).

Future research

The findings from this study and subsequent limitations have highlighted important areas for future research. A further study incorporating a heterogeneous sample to include participants

from different NHS Trusts, with different professional roles and seniority levels, would be helpful to thicken and extend the findings and check the cogency of this model. Considering the different groups within Rounds – panellists and audience members - which this study did not explore, a future grounded theory study could examine the experience of panellists to discover whether the psychological processes transfer across groups. In light of the concerns about sustainability an area of further study could examine the effect of additional reflection on participants' experience of Rounds to see if this effected the impact of psychological processes.

Conclusion

This study was the first to explore psychological processes which may facilitate an effect on staffs' perception of self and their work. Staff appeared to come to Rounds feeling isolated, overwhelmed, unappreciated and disconnected from themselves, clients, colleagues, and the wider organisation. The model that emerged proposes occupying a different space, reciprocity, containment, connection, and gaining perspective may be key psychological processes. Attending Rounds seemed to contribute to a sense of renewal, and ability to persevere with work, despite its challenges. Additionally, participants felt Rounds may have helped them to feel reconnected to their personal values and purpose, and experienced a sense of community and belonging to other members of staff. These psychological processes appeared to start in Rounds and continue on afterwards. Questions however have been raised about the sustainability of these processes which cannot be answered by this study.

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Section C

Appendices and Supporting Material

Appendix A: Original themes and extracted mechanisms from included studies

Study	Key Findings	Mechanisms	Indicators of mechanisms
Platzer et al. (2000a)	Four themes found to be barriers: (i) Previous education and training; (ii) Commitment and resistance to shared learning; (iii) Vulnerability and exposure; and (iv) Structure	<p>Vulnerability and exposure: culture of the organization they worked in, and their socialization as professional nurses and midwives, made it difficult to expose themselves to potential criticism. Certain students never felt sufficiently safe to reflect on some aspects of their practice or it took a long time to develop a sense of trust whereby students felt able to explore their practice without feeling that they should have always done things according to the book. To a certain extent this reticence was a concern about confidentiality. The setting of ground rules had not convinced people that confidentiality would be kept.</p> <p>Concern was much more about feeling that they would be seen as unprofessional if they explored aspects of their practice which they were unsure about. It was not so much a feeling that others would be judgemental as this too had been addressed by most of the groups when they set up their own ground rules.</p>	

They did not feel that others would put them down or say anything negative but they did nevertheless feel that they would be judged by others and by themselves. They felt that they would be seen as unprofessional or would not be respected and that they would be ashamed.

Feelings about the way in which the groups were facilitated. Many students commented that they felt as though they were being psycho-analysed and when a confrontational style was used by one facilitator many students said this effectively stopped them from participating in the groups. However, in other groups even when the facilitation style was un-authoritarian the probing questions were experienced as quite threatening

Dominant individuals who always gave an opinion or advice could have the effect of silencing other members of the group

Feeling their contributions were not important enough in comparison to other members in the group

Group size – groups of 10 too large to feel safe. Group of 6 preferred.

Commitment and resistance to shared learning: states how the group could stop an individual from sharing but doesn't say why/how. A quote provided to support this describes feeling other people were uninterested in what they were saying based on body language which made them decided to limit what they said and not go again to the group. Also describes how an individual might have thought the session was good but then how the group says it's a waste of time impacts their views on it and participation next time

Olofsson (2005)

Psychiatric nurses' views of systematic clinical supervision and staff support: General views about clinical supervision and staff support; Specific views about staff support in relation to the use of coercion

Psychiatric nurses' experiences of participating in reflection groups focusing on the use of coercion: Positive aspects of reflection groups; Negative aspects of reflection groups

Having time for reflection: opportunity to sit down and reflect together in a deeper way, which they could not otherwise do. time given to express thoughts, feelings related to coercion; clinical supervisor allowed them time according to their individual needs

Gaining new perspectives New ideas increased the nurses' reflections and awareness. Reflections

Being confirmed Co-members and clinical supervisor confirmed their own thoughts and feelings; listening to co-members' experiences, they recognised themselves and no longer felt alone

Sharing fellowship with coworkers Shared experiences opened the way for better collaboration and more care of each other

	<p>Positive aspects of reflection groups: Having time for reflection; Being confirmed; Gaining new perspectives; Sharing fellowship with coworkers; Relating more effectively with patients</p> <p>Negative aspects of reflection groups: Not the right timing; Not the right focus; Not needed</p>	<p>brought new awareness of and other ideas and perspectives.</p> <p>Supervisor was person from outside the ward so could ask questions that stimulated new viewpoints</p>	
Arvidsson et al. (2008)	<p>Supportive actions: a sense of security, belonging and encouragement.</p> <p>Learning actions: sharing and reflecting</p> <p>Developmental actions: enabling professional identity and facilitating personal development.</p>	<p>Supportive actions: <u>a sense of security</u> Experienced a sense of security and described the importance of a supportive, calm atmosphere and the possibility to dare to be oneself and discuss everything</p> <p>Learning actions: <u>reflecting</u> Being given time to ponder over thinking and acting</p>	<p>Supportive actions: <u>belonging</u> Realising they shared experiences provided them with a special relationship which helped them to share things</p>
Manning et al. (2009)	<p>Needs: settling in; unmet need in practice; sharing experiences; expectations; competing demands; Changing needs; Differing objectives</p> <p>Confidentiality: Confidential process; Fear of disclosure; Being free to disclose; Disclosing</p>	<p>Confidentiality Having a confidential environment was imperative to be able to discuss issues freely. Consequences of saying something may stop students from disclosing information</p>	<p>Facilitator Their skills were paramount to the “success” of the group. They were non-judgemental, respected everyone’s views and were able to offer differing perspectives on situations.</p> <p>Group Processes</p>

Facilitator: Facilitator skills;
Facilitative environment

Group processes: Content of
reflection; Sharing; Being together;
Interconnected experiences

Value of sessions: Time out;
Perceived value; Relating;

Perceived value of reflection:
Resource; Coping; Learning; Sharing;
Developing

Outcome of reflection: Altered
perspectives; Options; Interpersonal
skills; Feeling valued; Application;
Support

Promoted sharing of experiences which
enabled learning from each other.

Smaller groups easier to talk in
Recognition others are having similar
experiences which make them realise
they're not on their own

Brink et al. (2012) Four main themes: (i) model structure
creates security and participation; (ii)
the collegial exchange of experience
leads to increased self-awareness and
positive professional development, (iii)
the group supervision affects
participants' values and attitudes; (iv)
the opportunity for group supervision
will be a means of developing
professional skills.

**Model structure creates security and
participation**

The basic structure used at each group
supervision session created a feeling of
security and involvement. Participants
were urged to think twice before they
had the opportunity to express their
opinion. The participants felt they had
improved their communication skills,
had become better at listening to each
other and that they had learned to focus

McVey & Jones
(2012)

Developing as a professional: Ideas and solutions; Learning psychological skills; More than practical/solution-based answers; Developing self-assurance.

Importance of group make-up: Range of professional viewpoints; Small group; Skilled facilitation.

Importance of others in the group: Helpfulness of sharing a problem; Addressing feelings of isolation

Feeling safe: Protected space; Non-threatening or non-judgemental; Feeling able to admit imperfections.

Subconscious processes: Not always knowing what to bring, but burning issues always emerging; Normally keeping issues curled up.

on what other people had to say. Moreover, an atmosphere of mutual respect in the conversations developed, where the participants were careful to let everyone have their say and have the opportunity to say what they wanted.

Feeling safe: Protected space
Felt safe in the group as the group was perceived as a protected space

Feeling safe: Non-threatening or non-judgemental
Group was non-threatening and non-judgemental which helped them open up

Feeling safe: Feeling able to admit imperfections
Feeling safe to admit things unable to do in other contexts like MDT meetings

Subconscious processes: Feeling safe, others in the group and group make-up allowed subconscious thoughts to surface and be thought about

Importance of group make-up: Small group
Smaller groups better for allowing everyone to be heard

Importance of others in the group: Helpfulness of sharing a problem
Importance of the other people in the group having gone through similar experiences and so can be empathic towards you

Importance of others in the group: Addressing feelings of isolation
Realising they're having the same feelings you're having

Dawber (2013)

Two themes and five subthemes:

- (i) Purpose/impact:** impact on practice; stress management; team building, cohesion and trust
- (ii) Process:** extra-group/contextual issues; facilitation/process issues

Purpose/impact: team building, cohesion and trust

Lack of trust and communication patterns adverse impact on reflective practice groups particularly the way in which these factors inhibit reflection

Pre-existing trust and cohesion between colleagues prevented honest disclosures

Purpose/impact: impact on practice

Able to work through thoughts and feelings with the support of colleagues, who provided associated challenges, different perspectives, and shared solutions

Purpose/impact: stress management

Stress management benefits through acknowledgment and validation and provision of a safe space to ventilate

Process: contextual issues

Role of existing workplace culture and organisational issues played in the formation and functioning of the reflective practice groups

Process: facilitation/process issues

Linked facilitation style with the development of safety within the group e.g. quotes treating people equally/inclusive; made a safe environment where nobody felt belittled

Linked facilitator interventions directly with the enhancement of reflective thinking e.g. quotes knack of getting things out of you; asking questions

Mc Carthy et al. (2013)	3 themes: (i) Being a facilitator; (ii) Facilitating reflective learning and; (iii) Creating structure.	<p>Facilitating reflective learning: When the students felt comfortable within the group it allowed for sharing within the group.</p> <p>Sharing of experience became easier when there is a feeling of safety within the group (due to ground rules and use of pseudonyms to maintain anonymity reiterated at every session)</p>	
Heneghan et al. (2014)	<p>3 themes and 7 subthemes: (i) Organisational Context: culture and leadership; power and intensity</p> <p>(ii) Emotional and Relational Understanding: Holding; containing; knowing</p> <p>(iii) Ethics: psychological contribution; values</p>	<p>Emotional and Relational Understanding: <u>Holding</u> Feeling overwhelmed by the workload impacts on creating and maintain a space for reflection</p> <p>Emotional and Relational Understanding: <u>Containing</u> An atmosphere of safety, respect for difference and a shared aim to resolve conflict and strong negative feelings is needed for a well-functioning reflective staff group</p> <p>Staff need to feel heard and have complaints acknowledged before they can begin to think about patients. It may become easier over time when trust develops and staff become familiar with the activity and its</p>	<p>Organisational Context: <u>culture and leadership</u> Dominant culture of immediacy and doing incongruent to reflective groups which try to create an opportunity to step back, notice, feel and think</p> <p>Organisational Context: <u>power and intensity</u> Being on inpatient ward is intense setting and can magnify relational power dynamics which can get played out and manifest in attendance or not at the groups. One aim of reflective staff groups – create a more level hierarchy where all group attendees could feel their contributions were valued</p>

outcomes.

Taylor (2014)

Having an outlet: Catharsis;
Exploring; Sharing with one another;
Referring the patient on.

Simplifying complexity:
Understanding the problem; Exploring
possibilities; Seeing the whole picture;
Gaining solutions.

Boundaries of self: Feeling part of a
team; Containing; Finding the balance;
Defining therapist role; Refocusing on
aims.

Developing self: Advancing
psychological insight; Increasing self-
awareness; Increasing confidence;
Promoting new ways of working.

Endorsing the service: Being valued;
Place within the organisation;
Providing feedback on outcomes

Endorsing the service: Being valued
Being given time to reflect they felt
valued

Normative function – supervision
provided a safe framework

Having an outlet: Catharsis; Sharing
with one another
Sharing of clinical difficulties and
associated emotions

Helpful to know others felt similarly
(emotions) which normalised emotions
and experience of challenging clinical
situations

Supervision provided the outlet for
feelings, thoughts, questions

Feelings were validated as recognised
their emotions were a natural
consequence of the work rather than an
indication of their inadequacy

Gallagher et al.
(2017)

**Students experiences of group
reflection:** Challenges that impacted
on attendance at group reflection;
students' preparation for the reflection

Student experiences:
**Challenges that impacted on
attendance at group reflection
sessions:** ward activity, workload and a

session; Enhancement of student learning; Role of the facilitator

Facilitators experiences of group reflection in the clinical area:

importance of group reflection sessions; Challenges encountered when facilitating group reflection sessions; Format of the group reflection session; Enhancing participation from students during the group reflection sessions; Improving facilitation of group reflection sessions

desire to spend time with their preceptor

Enhancement of student learning: value gained from sharing experiences (quote - realise not only one struggling)

Confidentiality and the freedom to speak openly about issues contributed to positive experiences and enhanced student learning/trust (discussion)

Role of the facilitator: By creating an environment that encouraged open and honest dialogue, facilitators significantly contributed to students' learning and positive experiences of the reflective process.

Facilitators experiences: Challenges encountered when facilitating group reflection sessions:

Attendance was influenced by ward/unit activity

Reluctance to participate due to being afraid (quote) or critiquing other people's practice rather than reflecting on themselves for personal development (quote)

Naidoo & Mtshali
(2017)

Four themes emerged which conceptualised the meaning of a critically reflective CoP, namely: (i) a practice and learning community, (ii) a support network, (iii) collaborative, purposive-driven working to make a difference, and (iv) a space that fosters self-determination.

A support network

Through sustained contact and familiarity among the participants, the CoP was conceptualised as a family where participants could openly reflect on emotionally charged issues in terms of the stress and emotional exhaustion of providing HIV care and treatment on a daily basis. Participants described the CoP as a supportive space where difficult experiences could be discussed openly, and comfort, advice and support were offered.

Format of the group reflection

session: students required a lot of prompting to participate in the sessions (quote – but once relaxed don't need this so much)

Enhancing participation from students during the group reflection

sessions: Facilitators felt that as the reflection sessions continued, midwifery students would become more familiar with the process, thereby enhancing engagement (quote – the more they come the more comfortable to share)

The supportive environment of the

CoP gave them the opportunity to be themselves without having the pressure of being seen as the custodian of all practice-related information

The platform for open sharing led to the CoP being conceptualised as a home where trust, support, friendship and bonds were nurtured.

CoPs were conceptualised as a safe haven, where trust and open sharing of personal and professional problems were supported

Collaborative and purpose-driven working

CoP contributed towards a collaborative and unified practice of nursing and accounted for the nurses' new way of working together to solve commonly shared HIV-related problems. Participants used the expression, "Sisonke", an isiZulu term which denotes togetherness, to refer to the shared interactions of the CoP and the bond of sisterhood which had been created in HIV nursing care.

Through critical reflection, which was fostered by working together in the

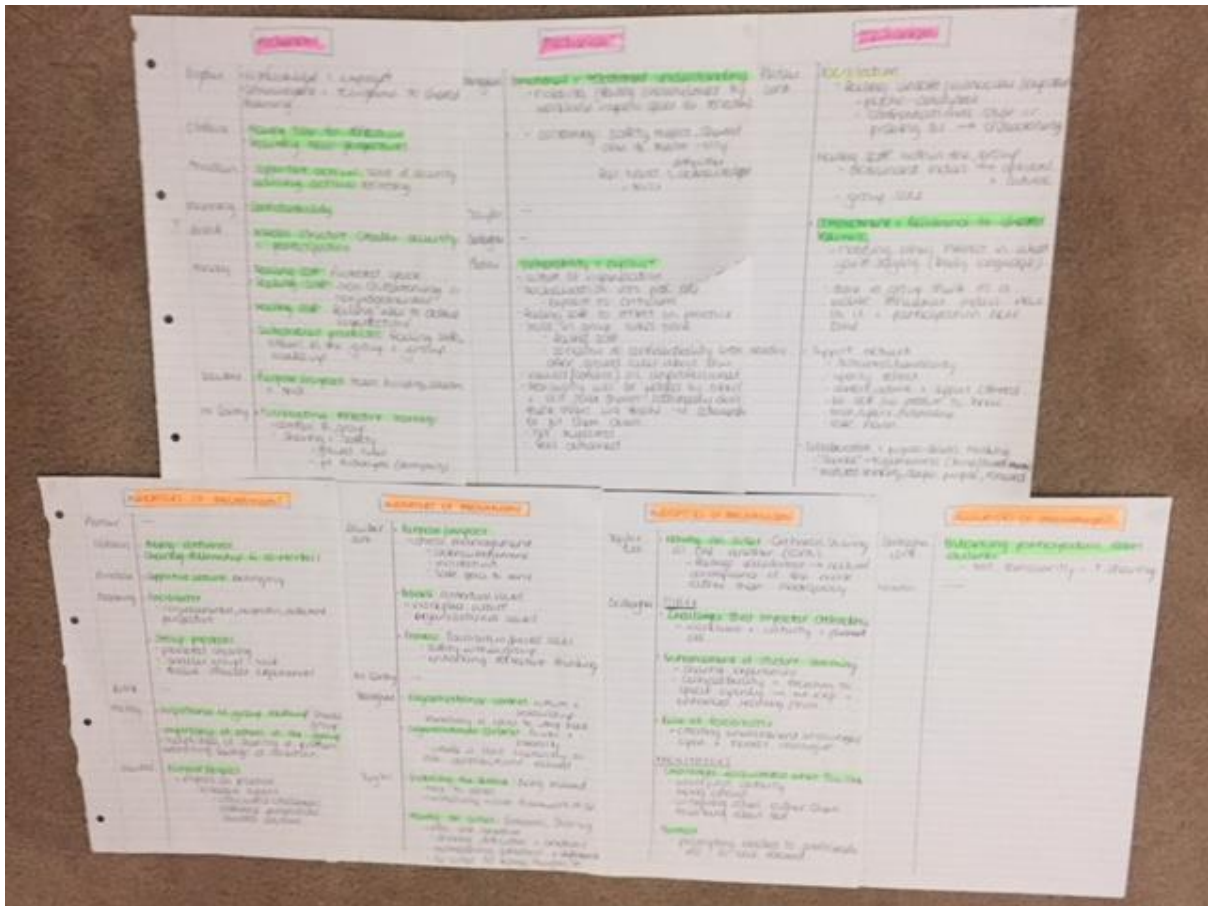
CoP, the participants matured in their thinking and found a deeper purpose and a renewed way of nursing

Appendix B: Scoring for studies included in this review

CASP Scoring Item	Platzer et al. (2000a)	Olofsson (2005)	Arvidsson et al. (2008)	Manning et al. (2009)	Brink et al. (2012)	McVey & Jones (2012)	Dawber (2013)	McCarthy et al. (2013)	Heneghan et al. (2014)	Taylor (2014)	Gallagher et al. (2017)	Naidoo & Mtshali (2017)
Clear aims	2	2	2	2	2	2	2	2	2	2	2	2
Appropriate methodology	2	2	2	2	2	2	2	2	2	2	2	2
Appropriate design	1	1	2	1	1	1	2	2	2	2	1	2
Appropriate recruitment strategy	0	1	2	1	0	0	0	2	2	0	2	1
Data collection	1	1	1	2	2	1	2	2	1	1	1	1
Relationship considered	0	0	0	0	0	0	0	0	1	0	0	0
Ethical issues considered	0	1	2	2	2	2	2	2	2	2	2	2
Data analysis	1	1	2	2	2	1	1	1	2	1	1	1
Clear findings	1	1	1	2	2	1	2	1	2	1	2	2
Valuable research	2	1	1	2	1	1	2	2	2	1	1	1
TOTAL	10	11	15	16	14	11	15	16	18	12	14	14

Note. The CASP checklist (CASP, 2013) suggests a scoring system of yes/no/can't tell. 2 points – met the criteria; 1 point – partially met the criteria; 0 points – did not meet the criteria.

Appendix C: Original metaphors from included studies



Appendix D: Key metaphors – mechanisms

Metaphors	Platzer at al. (2000a)	Olofsson (2005)	Arvidsson et al. (2008)	Manning et al. (2009)	Brink et al. (2012)	McVey & Jones (2012)	Dawber (2013)	McCarthy et al. (2013)	Heneghan et al. (2014)	Taylor (2014)	Gallagher et al. (2017)	Naidoo & Mtshali (2017)
Space for reflection	Dominant voices offering opinion and advice	Having time for reflection	Being given time to ponder		Allowing space for others and self to think; listening to others				Feeling overwhelmed by workload			
Gaining new perspectives		Listening to views of others'; outsider perspective										Matured thinking; deeper purpose
Security: Group set up	Confidentiality / ground rules; group size	Group size		Confidentiality	Structure of group			Ground rules/ anonymity				
Security: Emotional containment	Feeling safe		Supportive and calm atmosphere			Protected space; subconscious thoughts surface			Atmosphere of safety and respect			Safe haven; openly reflect
Security: Safety	Developing trust; Being analysed, probed or confronted; concern will be seen as unprofessional,			Perceived consequences of sharing		Non-threatening and non-judgemental; admitting to imperfections	Lack of trust; pre-existing trust and cohesion prevents		Time and familiarity			Sustained contact; familiarity; comfort, advice and support; be myself; no

not respected,
judged and
ashamed; dare to
be authentic self,
having honest
and free
conversation,
culture of
organisation and
socialisation into
role

honesty

pressure to
know

**Being
validated**

Contributions
valued and
equally as
important as
others'

Needing to
feel heard and
feelings
acknowledged
before being
able to reflect
on patients;
respecting
difference

**Commitment
to the group**

Being committed
or resistant to
group

Respect for
differences;
shared aim to
resolve
conflict and
negative
feelings

'Sisonke' –
togetherness;
bond

Appendix E: Key metaphors – indicators of mechanisms

Metaphors	Platzer at al. (2000a)	Olofsson (2005)	Arvidsson et al. (2008)	Manning et al. (2009)	Brink et al. (2012)	McVey & Jones (2012)	Dawber (2013)	McCarthy et al. (2013)	Heneghan et al. (2014)	Taylor (2014)	Gallagher et al. (2017)	Naidoo & Mtshali (2017)
Normative function		Thoughts and feelings confirmed by others, not alone		Realise others had similar experience, not alone		Realise others had similar experience and feelings, not alone	Processing thoughts and feelings with other with similar experience			Normative function to know others felt similarly		Realise others are also struggling
Belonging		Sense of sameness improves interactions	Shared experiences nurture special relationships	Group promoted sharing and learning from each other								
Space for reflection									Culture of immediacy/doing incongruent to stepping back, noticing, feeling and thinking	Being given time to reflect made them feel valued		Time pressure and workload interfere
Gaining new perspectives				Being offered different perspectives			Being offered different perspective and solutions, probing questions gets things out of you					

**Security:
Group set
up**

Easier to
talk in
smaller
groups

Smaller
groups
allow
space to
be heard

Confidentiality,
familiarity with
process and
creating
atmosphere of
open and
honest
dialogue

**Security:
Emotional
containment**

Safe space to
ventilate

Outlet for
difficulties,
emotions,
thoughts,
questions

**Security:
Feeling safe**

Non-
judgemental
and
respectful
interactions

Being treated as
equals, inclusive
and not belittled;
role of workplace
culture and
organisational
issues

Feeling
relaxed; being
afraid to share,
defending
against self-
reflection by
critiquing
others rather
than self-focus

**Being
confirmed**

Acknowledgement
and validation of
emotions

Feeling
equal and all
contributions
valued

Feelings
validated
as normal
rather than
indication
of
inadequacy

Appendix F: Chronology of study and approvals

25/11/2016	Salomons ethics panel approval	<u>Study</u> : What are staff members' stories about attending Schwartz Rounds? A narrative approach to understanding process
25/01/2017	HRA Approval	
	<i>Following these approvals a decision was made to change from a narrative approach to a grounded theory study</i>	
17/08/2017	Amendment approved by Salomons ethics panel	<u>Study</u> : What are NHS staff members' experiences of attending Schwartz Centre Rounds: A grounded theory of psychological processes
10/08/2017	Amendment approved by HRA	
24/08/2018	R&D Approval NHS Trust	

Appendix G: Ethics approval

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Appendix H: HRA approval

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Appendix I: Research and Development approval

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PARTICIPANT INFORMATION SHEET

What are NHS staff members' experiences of attending Schwartz Centre Rounds: A grounded theory of psychological processes

This research study is being sponsored by the Salomons Centre for Applied Psychology at Canterbury Christ Church University (CCCU)

My name is Fiona Shedden and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide if you want to participate it is important that you understand why the research is being done and what it would involve for you.

What is the purpose of the study?

This research study aims to explore the experience of attending a Schwartz Round. The study hopes to develop a greater understanding of this experience by hearing your views about attending.

Why have I been invited?

You have been invited to participate in this study as you attended the Schwartz Round on [topic] as a member of the audience and are employed at [Trust name].

Do I have to take part?

It is up to you to decide to join the study. If you agree to take part, I will then ask you to sign a consent form and you will be given a copy of this form to keep. Should you decide to participate, you are free to withdraw at any point without having to give a reason and your data will be destroyed. Your participation, or withdrawal, is completely voluntary and your rights will not be affected in any way.

What will happen to me if I take part?

Interviews

Following the Schwartz Round the researcher will contact you to arrange an individual face-to-face interview (or Skype interview) at your place of work or another Trust building. Interviews will last for approximately 45 minutes, however it could take longer, depending on how much information you share about your experience. If this is the case the researcher will look at ways to complete the interview to suit availability and time demand.

You will be asked to share your experience about attending the Schwartz Round on [topic]. The interview will cover three broad areas: (1) your expectations of Schwartz Rounds, (2) personal experience of the Schwartz Round (3) and any personal and professional development and impact from attending the Schwartz Round. The interview will be audio recorded using a digital Dictaphone.

Review of data

The researcher will then transcribe and analyse the data. Once the researcher has created a summary of the themes and ideas from all the interviews, she will then ask to meet with you either face-to-face or over the telephone to clarify any details if necessary and to check whether her interpretation of the data fits with the sense you make of your experience. It is envisaged that this might take 15 – 30 minutes. Your participation in this part of the study is completely voluntary.

Written summary

At the end of the study, the researcher will send a written summary of the developed theory and how the findings will be used in the future to all participants who indicated on the consent form that they would like to receive this. If you would prefer to receive feedback over the telephone then the researcher will provide this. Your participation in this part of the study is completely voluntary.

To participate in this research you must:

- be a staff member (of any role, both clinical and non-clinical) at [Trust 1 or 2]
- attended the Schwartz Round from start to finish
- have been an audience member at the Schwartz Round on [topic]
- be able and willing to share your experience about attending this Schwartz Round during an individual face-to-face interview (or Skype interview)
- be available for interview within four weeks of the Schwartz Round (and not earlier than five consecutive days following the Schwartz Round)

You will not be able to participate in this research if you:

- were not present from the start of the Schwartz Round
- did not stay for the entire Schwartz Round
- are not available for interview within four weeks of attending the Schwartz Round

What are the possible disadvantages and risks of taking part?

It is possible that during the interview you may find discussing your experience of attending the Schwartz Round and listening to the experience of others' distressing. Included in this information sheet are details of where you can access support if required.

What are the possible benefits of taking part?

The researcher cannot promise the study will help you personally but information gained from this study may help to enhance the running of Schwartz Rounds and to understanding more about the outcomes of attending.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to answer your questions. If you remain unhappy and wish to complain formally, you can do this by contacting Prof. Paul Camic, Research Director, Salomons Centre for

Applied Psychology, Canterbury Christ Church University at paul.camic@canterbury.ac.uk or on 01227 927 114.

Will my taking part in the study be kept confidential?

All identifying information from the audio recorded interviews will be removed, such as NHS Trust, and pseudonyms will be ascribed to participants and other people that may be mentioned within the interview. Your data will only be used for the purposes of this study and will only be discussed with my two research supervisors, Prof. Margie Callanan and Dr Melanie George.

The data will be stored on a password protected and encrypted computer and on an encrypted, password protected memory stick both of which will be kept in the researcher's home. After completion of the project the audio recordings will be destroyed. The transcripts will be stored on a password protected CD within CCCU premises in a locked cabinet in accordance with the Data Protection Act 1998 and the University's own data protection requirements. The transcripts will be in the possession of Prof. Margie Callanan for 10 years after the study is completed and after this time will be destroyed. The transcripts will be stored within CCCU premises in a locked cabinet in accordance with the Data Protection Act 1998 and the University's own data protection requirements.

If during the course of the interview you share information about yourself or another member of staff that is of concern with regard to safeguarding yourself or others, or regarding ethical practice or misconduct, discussion will take place in the first instance between the researcher and the participant about the concerns. Following this the researcher will discuss the concerns with the researcher's supervisors so that an appropriate plan of action can be undertaken. This may result in confidentiality being broken and informing the appropriate person in your Trust about these concerns.

What will happen to the results of the research study?

The researcher will write up the findings into a formal report that she will submit to CCCU as part of her Doctorate in Clinical Psychology to become a clinical psychologist. The findings will be published in an academic journal and the report will also be added to the CCCU library database called CREaTE. Additional to this a summary of the findings will be shared with the [Trust name] Research and Development department, the Schwartz Round team based in [Trust name] and the Salomons Centre for Applied Psychology ethics panel, and the Health Research Authority (HRA) ethics panel. You will not be identified in any report or publication. Anonymised quotes from your interview may be used in published reports.

Who has reviewed the study?

This study has been reviewed and given favourable opinion by the Salomons Centre for Applied Psychology Ethics Panel and the HRA.

Further information and contact details

If you would like to speak to me and find out more about the study or have questions that have not been answered by this information sheet you can contact me on a 24-hour voicemail phone line at 0122 792 7070. Please say that the message is for Fiona Shedden, the name of the study and leave a contact number so that I can get back to you as soon as possible. Alternatively, you can email me at f.shedden142@canterbury.ac.uk or write to me at:

Salomons Centre for Applied Psychology
Canterbury Christ Church University
1 Meadow Road
Tunbridge Wells
TN1 2YG

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

Best wishes,

Fiona Shedden
Trainee Clinical Psychologist

Staff Support

[Name of service]: staff can speak to a nurse advisor regarding any work related health issues. Contact the [location and telephone number removed] or the [location and telephone number removed]

[Name of service]

A confidential in-house service providing support for a broad range of difficulties.

- **[Name of service]:** Typically up to 6 sessions of counselling are offered. Staff can refer themselves by contacting the Clinical Service Lead, [name] on [telephone number].
- **[Name of service]:** Provides support, both medical and therapeutic, for staff members who have been referred to the service by Occupational Health.

Spiritual & Pastoral Care Service: facilitate multidisciplinary staff support groups, and work with individual staff.

Telephone: [telephone number]

Additional community support

[Name of service] confidential Helpline [telephone number] (staffed by counsellors and nurses)

Emergency out of hours' crisis teams: please call the **GP out of hours' service:** 111

For young men who are struggling with self-harm and/or suicidal ideation:
www.thecalmzone.net

PARTICIPANT CONSENT FORM

Title of Project: What are NHS staff members’ experiences of attending Schwartz Centre Rounds: A grounded theory of psychological processes

Name of Researcher: Fiona Shedden

Contact details:

Address: Salomons Centre for Applied Psychology
Canterbury Christ Church University
1 Meadow Road, Tunbridge Wells, TN1 2YG
Telephone: 0122 792 7070
Email: f.shedden142@canterbury.ac.uk

**Please initial
box**

- 1. I confirm that I have read the information sheet dated Version 3/29.07.17 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily
- 2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected
- 3. I consent that anonymous quotes from my interview may be used in published reports of the study findings
- 4. I consent to take part in the above study
- 5. I consent to my interview being audio recorded
- 6. I wish to receive a written summary of the developed theory and how the findings will be used in the future and consent to the researcher sending this to me

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Name of person taking consent	Date	Signature

Version 3/29.07.17

Appendix L: Interview schedule

I would like to find out about your experience of the Schwartz Round on **[date]** at **[location]** that explored **[topic]**. I wasn't present at this Round; what was this Round's intended focus?

Expectations

1. What made you want to take part in a Round?

- *Prompt: What do you think are the aims of Rounds?*

2. What made you, if anything, want to attend this particular Round on [topic]

- *Prompt: What was going on in your life either personally or professionally that might have contributed to you deciding to go to this particular Round?*

3. Tell me about your expectations of Rounds?

- *Prompt: Was it what you expected or did anything about the Round surprise you?*
- *Prompt: What did you hope to get out of attending a Round?*
- *Prompt: Did the Round you went to achieve this hope?*

4. Did the Round seem different to other reflective or supervision groups you have been to?

- *Prompt: In what way do you think Rounds differ from these other groups?*
- *Prompt: Is that good, bad or neither?*

Personal experience

5. Can you tell me about your experience of attending the Round on [topic]

- *Prompt: What was it like for you?*
- *Prompt: What was it like to listen to other peoples' stories and experiences?*
- *Prompt: If you did, what was it like for you to share your own story or experience?*

6. If there was one, could you describe the most valuable or standout experience(s) you had as a result of attending this Round

- *Prompt: What were your thoughts, feelings, or actions in response to this?*
- *Prompt: Did you notice this valuable or standout experience during the Round or afterwards? (If afterwards) How long after the Round?*
- *Prompt: What do you think contributed to this being of value to you or standing out for you?*

7. If there was one, can you describe any difficult or challenging experience(s) you had as a result of attending this Round

- *Prompt: What were your thoughts, feelings, or actions in response to this?*
- *Prompt: Did you notice this was difficult or challenging for you during the Round or afterwards? (If afterwards) How long after the Round?*
- *Prompt: What do you think contributed to this being difficult/challenging for you?*

Personal and professional development/impact

8. Has going to this Round personally impacted you? If so, in what way?

- *Prompt: What do you think contributed to this?*

- *Prompt: Did you notice this impact during the Round or afterwards? (If afterwards)*
How long after the Round?

9. Has going to this Round had an impact on your professional development? If so, in what way?

- *Prompt: What do you think contributed to this?*
- *Prompt: Did you notice this impact during the Round or afterwards? (If afterwards)*
How long after the Round?

10. What, if any, has been the impact of listening to other peoples' stories and experiences on the way you think or feel about yourself?

- *Prompt: If so, what is/was the effect, and how exactly did it do this?*
- *Prompt: What were your thoughts, feelings, or actions in response to this?*
- *Prompt: Did you notice this during the Round or afterwards? (If afterwards) How long after the Round?*

11. What, if any, has been the impact of listening to other people's stories and experiences on the way you think or feel about your work?

- *Prompt: If so, what is/was the effect, and how exactly did it do this?*
- *Prompt: What were your thoughts, feelings, or actions in response to this?*
- *Prompt: Did you notice this during the Round or afterwards? (If afterwards) How long after the Round?*

12. Now that time has passed since the Round has it had any other effect on you that we have not talked about so far today?

- *Prompt: If so, what is/was the effect, and how exactly did it do this?*
- *Prompt: What were your thoughts, feelings, or actions in response to this?*

13. Could you share any other experiences of going to this Round that we have not talked about so far today that you think are important?

Other prompts: Can you tell me more about that?, How does that happen?, What was happening? What happened next?; Why does that particular moment stand out? What qualities of this environment allow that to happen?, Does that feel important?, What makes that important? Why is that?

Appendix M: Bracketing interview excerpt

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Appendix N: Abridged reflective diary

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Appendix O: Coded transcript

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Appendix P: Theme development

(1) Initial focused codes grouped into preliminary categories

	Connecting	Disconnecting	Energy	Fatigue	Pain	Space	Being cared for
1	Unifying Supporting others Understanding others Shared experiences	Disengaging Singular focus Fractured self	Misdirected Increasing interest Authentic	Overburdened Trying hard Drive disappeared	Regret Unable to help	Relaxed Separate space	
2	Reaffirming purpose Recognising not alone Emotional connection	Dehumanising patients Survival mode Cut off Robotic	Filled up Reset Refuelled	Tiredness Draining away Emotional drain	Giving of self Devalued Self-critical	Regaining perspective Getting away Space from doing Seeing things anew Protected Safe Peace	Nourished Nurtured Thought about
3	Sharing Coming together Cohesion Commonalities			Emotional demands	No reward Feeling used Undervalued	Exposing self Trusting others Feeling safe Vulnerable	Valued

4	Connecting separate parts	Compartmentalise	Turnaround	Wavering motivation	Failure	Thinking space					
	Re-connecting		Hope	Hopeless		Ignoring emotions	Setting the frame				
	Similar experiences		Inspiring	Frustration							
	Normalising Being part of something Shared goals		Admiration Role models								
5	Remembering others	Isolated	Dynamic		Pressure	Thinking broadly					
	Integrating								stress	Providing space	
	Sharing						Lacking time to connect	Motivated		Hardship	Stepping away
	Community						Awareness of disconnection	Persevering			Time out
	Bridging the gap Camaraderie										Gaining perspective
Uniting Connecting with others Understanding others					Privilege Inclusive						
6	Collective thinking	Protection			Failing	Linking up	Looked after				
	Reconnecting with self									Open to all	Valued
	Reciprocating							Empowering		Leading the way	Showing care
Belonging		Spurred on			Honesty Bravery Freedom	Cheered on					

Comfort
 Valuing all
 Outlet
 Natural
 No pressure
 Non-
 judgemental
 Not needing
 answers
 Contained

7	Learning from others	Ignoring self	Letting go	Needing to be resilient	Facing fear	Debrief	Being given time	
	Seeing the patients	Distance		Never stopping	Crying	Seeing things differently		Prevention
	Being alongside patients Mutual respect Mutual trust Flexibility Empathy Reassuring	Pushing away		Exhaustion	Hurt Questioning self Personal attacks Sacrifices Hardship Responsibility Cost-benefit Hiding Stoicism	Permission		Validating
8	Fellowship Resonance Being human	Discomfort Division	Interest		Upset	Separate Informal Guidelines	Supportive Caring Feeling good	
	Integration of self		Focus	Helpless	Stress	Coming into awareness	Giving back	

						Intimacy Warmth
9	Connecting with feelings	Disinterest	Progression	Cost	Needing a reason	
		Ignoring	Reinforcing	Overlooked	Luxury	Feeling valuable
		Misunderstood	Worth it	Restricted	Shifting expectations	Worthwhile
	Acceptance		Admiration Enjoyment Purpose Energised Engaged		Having space Decompress	
10	Use of self Self-discovery Openness Authenticity	Guarded	Moving forward Change Evolving		Different	
11	Familiarity	Keeping safe Barrier	Passion Confidence	Self-censorship Judgement	New space Sociable	

(2) Category and code development

Connection	Impact	Change	Having space	Contained	Being cared for	Hierarchy	Miscellaneous
Shared goals between staff	Losing sense of me	Finding passion again	No solutions	Role modelling	Reciprocity	Leveller	Bravery
Normalising	Doubting my choices	Reconnecting to purpose	Person in the professional	Safe space	Being fed	Role model	Humbling
Unity	Self-protection	Shifting reality	Having permission	Sociable	Worthwhile	Role modelling	Courage
Being human	Being different	Hopeful	Stepping away	Relaxed	Nourished	Sociable	Exposing self
Being less directive with clients	Not achieving targets	Authenticity	Permission	Informal	Nurtured	Breaking down barriers	Honesty
	Not meeting expectations	Inspired	Allowed	Cheered on	Being recognised	Just like me	Open
	Overlooked	Motivated		Respect			
	Not valued	Persevering		Trust			
	Unable to help	Developing		Comfortable			
	Guilt						

(3) Final categories

Cost	Occupying a different space	Reciprocity	Containment	Connection	Gaining perspective	Renewal
Losing my way	Timeout	Sharing	Feeling safe	Shared experiences	Seeing things differently	Hope
Feeling alone	Stepping back	Nurtured	Clear structure	Sense of community	Understanding self	Motivation
Feeling disconnected from clients	Getting away	Validated	Empathy	Belonging	Understanding others	Energy
Exhaustion	Thinking space	Valued	Respect	Building relationships with others	Normalising	Re-focus
Hurt	Reducing divide	Cared for	Trust	(Re)discovering self		Purpose
Pressure Stress Pushed to do more	Openness Being yourself Protected space Permission Honesty		Peace Relaxed No demands Non-judgemental			Inspiration Reset Positive

Appendix Q: End of study/summary letter to ethics panel/HRA/R&D Department

What are NHS staff members' experiences of attending Schwartz Center Rounds®: A grounded theory of psychological processes

Dear.....,

I am writing to update you on the progress of my research study. As the recruitment and analysis phase has been completed the study has now ended.

Aims

This study explored the experience of NHS staff members' attending Schwartz Center Rounds® (Rounds). The study aimed to understand whether attending Rounds had an impact on how staff perceived themselves and their work. Primarily, it sought to understand what psychological processes may facilitate such an effect and when these processes occurred.

Method

Participants were recruited from Rounds running from October 2017 - December 2017 which occurred in different sites across the Trust. Eleven participants were interviewed and a grounded theory methodology was employed to build a theoretical model of the psychological processes.

Findings

Participants told me about how difficult it can be working in the NHS because of such things as limited resources, stress, pressure and feeling unappreciated. These had an effect on how connected participants felt to their sense of self, their clients and the organisation. Participants arrived to Rounds having experienced these 'costs' over time.

This study found five key psychological processes of occupying a different space, reciprocity, containment, connection, and gaining perspective. These effected the way participants perceived themselves and their work. The diagram below represents how these psychological processes seemed to overlap and work together.

- (1) **Occupying a different space:** Rounds were perceived as a rare opportunity for participants to get some distance from the demanding nature of work and its frenetic pace. It was considered a protected space - cocooned away - from the typical work setting. Being in this different space facilitated and permitted participants to be themselves and enable them to be natural with others. This ability to be different was strengthened through reciprocity, containment, connection, and gaining perspective.

- (2) **Reciprocity:** Rounds provided a range of validating experiences where participants felt cared for and invested in. This offered a sense of reciprocity for all their hard work and effort under stressful working conditions. Being provided lunch before Rounds played a key role in participants feeling valued and looked after.
- (3) **Containment:** Knowing the structure of Rounds and not having pressure to participate helped participants feel comfortable. Participants experienced others as non-judgmental and encouraging and felt there was a relaxed atmosphere at Rounds. All of this helped to foster a feeling of safety for participants to share experiences and/or reflect on self or others.
- (4) **Connection:** As participants felt contained in Rounds it allowed them to relax, and not feel under pressure, opening up the opportunity to find connection with other participants and the wider system. Importantly, participants were also able to (re)connect with their sense of self in terms of their purpose and how they wanted to carry out their work. These ways of being seemed to have been impacted by the pressures and uncertainty of work – the ‘costs’.
- (5) **Gaining perspective:** Experiencing reciprocity and containment within Rounds provided the conditions where participants felt able to reflect upon self and others. This nurtured a greater awareness of themselves, clients and others which helped participants feel connected to their sense of self, others and the wider system.

Participants reported Rounds re-energised, motivated, and reinforced to them why they were continuing to do the job despite its challenges. Rounds provided a feeling of ‘renewal’.

The findings also demonstrated that psychological processes started in Rounds and carried on afterwards. Feeling a sense of renewal potentially contributed to these processes remaining present after Rounds. An unexpected outcome of this study was through reflecting further on their experience of Rounds, this may have helped consolidate the impact of these processes and contributed to their continuing effect post-Rounds.

Conclusion

Participants came to Rounds feeling isolated, overwhelmed, unappreciated and disconnected from themselves, clients, colleagues and the wider organisation. The model that emerged suggests occupying a different space, reciprocity, containment, connection, and gaining perspective were key psychological processes which resulted in a change in how participants viewed themselves and their work. They felt renewed and reenergised to persevere despite the challenges of the work and the organisational context, felt reconnected to their purpose and values, and a sense of community and belonging. These psychological processes appeared to

start in Rounds and continue on afterwards. Questions remain about the sustainability of the psychological processes. Having the chance to reflect on their experience may have helped to consolidate the impact of these processes and contributed to their continuing effect post-Rounds.

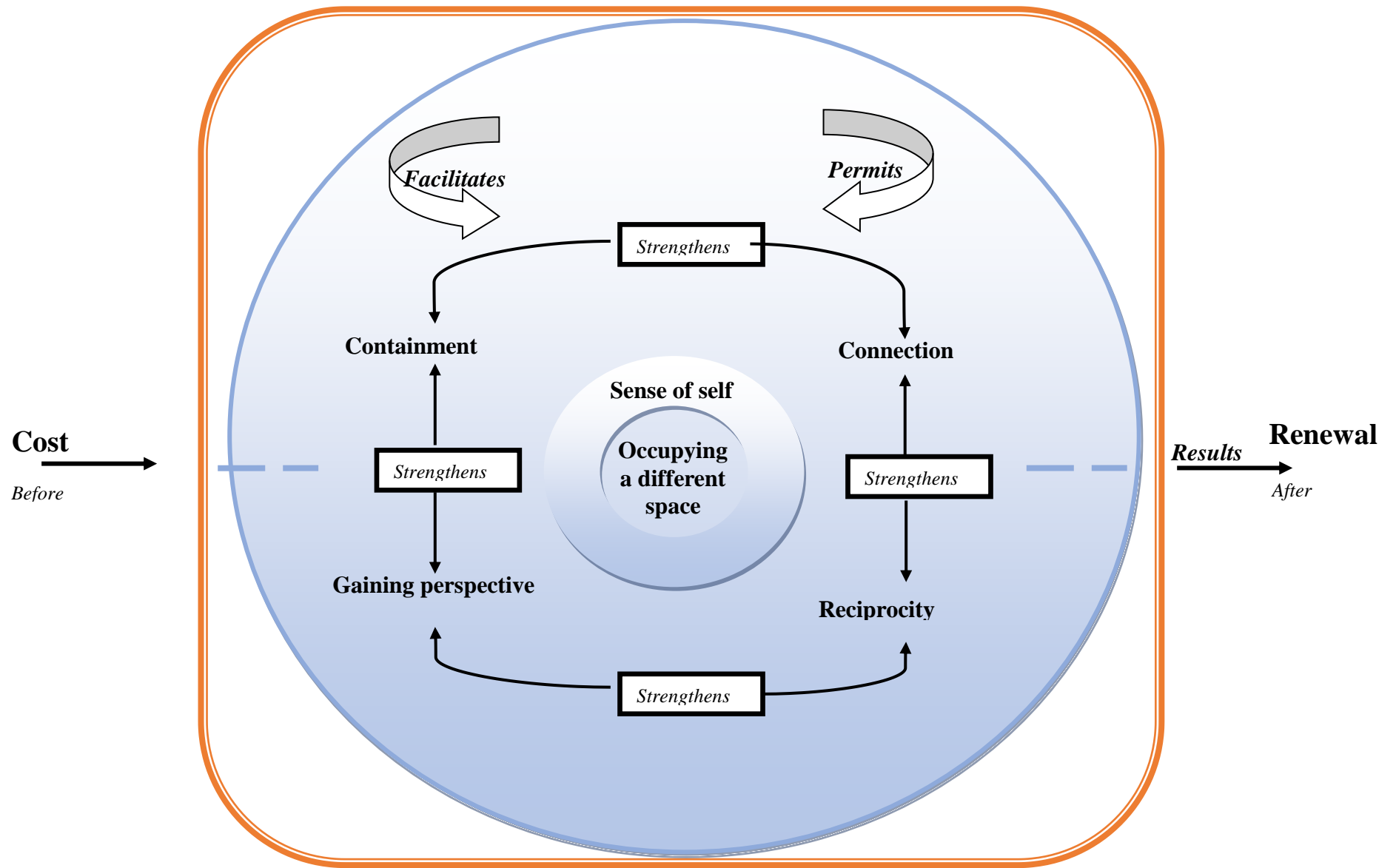
Dissemination

A written summary of the findings will be shared with all participants.

Yours sincerely,

Fiona Shedden

Trainee Clinical Psychologist
Salomons Centre for Applied Psychology
Canterbury Christ Church University



Appendix R: End of study report for participants

What are NHS staff members' experiences of attending Schwartz Center Rounds®:

A grounded theory of psychological processes

Dear Participant,

Thank you again for participating in my research study as part of my Doctorate in Clinical Psychology degree. The study is now complete. This report summarises the findings of the study.

Aims

This study aimed to explore the experience of NHS staff members' attending Schwartz Center Rounds® (Rounds). The study aimed to understand whether attending Rounds had an impact on how staff perceived themselves and their work. Primarily, it sought to understand what psychological processes may facilitate such an effect and when these occurred – during or after Rounds.

Method

Staff were recruited from Rounds running from October 2017 - December 2017. These Rounds occurred in different sites across the Trust. Eleven staff members - with different job roles and from both clinical and non-clinical backgrounds - were interviewed. Interviews were typed up and compared with each other to get an overview of what was said. After everyone had been interviewed I put together a picture to try and represent the experience of attending Rounds. I explained this picture to some of the staff who were interviewed. To them it made sense and they felt it represented their experience of Rounds.

Findings

Staff told me about how difficult it can be working in the NHS because of such things as limited resources, stress, pressure and feeling unappreciated. These had an effect on how connected staff felt to their sense of self, their clients and the organisation. These 'costs' seemed to have built up over time and so staff came to Rounds with these.

This study found there were five key psychological processes which staff experienced from attending Rounds: occupying a different space, reciprocity, containment, connection, and gaining perspective. These effected the way staff perceived themselves and their work. The diagram below represents how these psychological processes seemed to overlap and work together.

- (1) **Occupying a different space:** Rounds were seen as a rare opportunity for staff to get some distance from the demanding nature of work and its frenetic pace. It was considered a protected space - cocooned away - from the typical work setting. Being in this different space facilitated and permitted staff to be themselves and enable them to be natural with others. This ability to be different was strengthened through reciprocity, containment, connection, and gaining perspective.
- (2) **Reciprocity:** Rounds provided a range of validating experiences where staff felt cared for and invested in. This offered a sense of reciprocity for all their hard work and effort under stressful working conditions. Being provided lunch before Rounds played a key role in staff feeling valued and looked after.
- (3) **Containment:** Knowing the structure of Rounds, and not having pressure to participate, helped staff feel comfortable. Staff experienced others at Rounds as non-judgmental and encouraging and felt there was a relaxed atmosphere. All of this helped to foster a feeling of safety for staff to share experiences and/or reflect on self or others.
- (4) **Connection:** As staff felt contained in Rounds it allowed them to relax, and not feel under pressure, opening up the opportunity to find connection with other staff and the wider system. Importantly, staff were also able to (re)connect with their sense of self in terms of their purpose and how they wanted to carry out their work. These ways of being seemed to have been impacted by the pressures and uncertainty of work – the ‘costs’.
- (5) **Gaining perspective:** Feeling they were valued and cared for (reciprocity), and feeling safe (contained) within Rounds, provided the conditions where staff felt able to reflect upon self and others. This nurtured a greater awareness of themselves, clients and others, which helped staff feel connected to their sense of self, others and the wider system.

Attending Rounds resulted in staff feeling re-energised and motivated. It also reinforced to them why they were continuing to do the job despite its challenges. Rounds provided a feeling of ‘renewal’.

The findings also demonstrated that these five psychological processes started in Rounds and then carried on afterwards.

Conclusion

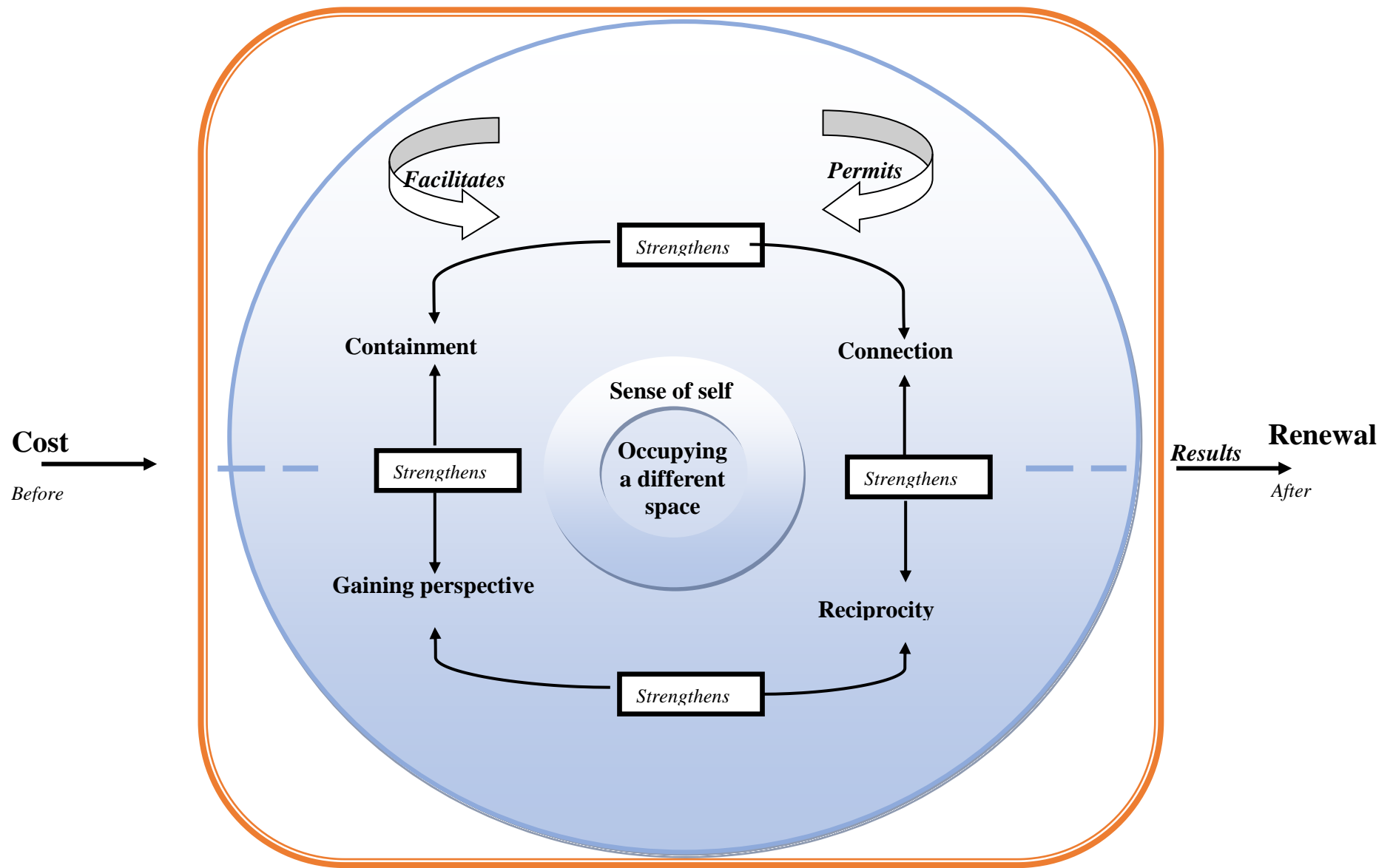
This study showed how staff came to Rounds feeling isolated, overwhelmed, unappreciated and disconnected from themselves, clients, colleagues and the wider organisation. It also showed that Rounds provide staff with a space to do things differently and be different in. In this space they experienced reciprocity, felt contained and connected with themselves and others. This space also helped them gain perspective about themselves and other people. Overall, these psychological processes resulted in a change to how staff viewed themselves and their work. Staff felt renewed and re-energised to persevere despite the challenges of the work and the organisational context, felt reconnected to their purpose and values, and a sense of community and belonging. These psychological processes appeared to start in Rounds and continue on afterwards.

I hope this summary has been of interest. I really appreciate all your support for Rounds and for this study. Thank you for sharing, and trusting me, with your thoughts and experiences.

Best wishes,

Fiona Shedden

Trainee Clinical Psychologist
Salomons Centre for Applied Psychology
Canterbury Christ Church University



Appendix S: Author guidelines for Journal of Mental Health

Preparing Your Paper

Structure

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

Word Limits

Please include a word count for your paper.

Style Guidelines

Please refer to these [quick style guidelines](#) when preparing your paper, rather than any published articles or a sample copy.

Any spelling style is acceptable so long as it is consistent within the manuscript.

Please use double quotation marks, except where “a quotation is ‘within’ a quotation”. Please note that long quotations should be indented without quotation marks.

Formatting and Templates

Papers may be submitted in Word format. Figures should be saved separately from the text.

To assist you in preparing your paper, we provide formatting template(s).

[Word templates](#) are available for this journal. Please save the template to your hard drive, ready for use.

If you are not able to use the template via the links (or if you have any other template queries) please contact authortemplate@tandf.co.uk.

References

Please use this [reference guide](#) when preparing your paper.

Checklist: What to Include

1. **Author details.** Please include all authors' full names, affiliations, postal addresses, telephone numbers and email addresses on the cover page. Where available, please also include ORCiDs and social media handles (Facebook, Twitter or LinkedIn). One author will need to be identified as the corresponding author, with their email address normally displayed in the article PDF (depending on the journal) and the online article. Authors' affiliations are the affiliations where the research was conducted. If any of the named co-authors moves affiliation during the peer-review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after your paper is accepted.
2. A structured abstract of no more than 200 words. Use the following headings: Background, Aims, Method, Results, Conclusions, Declaration of interest. The declaration of interest should acknowledge all financial support and any financial relationship that may pose a conflict of interest. Acknowledgement of individuals should be confined to those who contributed to the article's intellectual or technical content.
3. You can opt to include a video abstract with your article. Find out how these can help your work reach a wider audience, and what to think about when filming.
4. Between 3 and 8 **keywords**.

5. **Funding details.** Please supply all details required by your funding and grant-awarding bodies as follows:

For single agency grants

This work was supported by the [Funding Agency] under Grant [number xxxx].

For multiple agency grants

This work was supported by the [Funding Agency #1] under Grant [number xxxx]; [Funding Agency #2] under Grant [number xxxx]; and [Funding Agency #3] under Grant [number xxxx].

6. **Disclosure statement.** This is to acknowledge any financial interest or benefit that has arisen from the direct applications of your research.

7. **Data availability statement.** If there is a data set associated with the paper, please provide information about where the data supporting the results or analyses presented in the paper can be found. Where applicable, this should include the hyperlink, DOI or other persistent identifier associated with the data set(s). Templates are also available to support authors.

8. **Data deposition.** If you choose to share or make the data underlying the study open, please deposit your data in a recognized data prior to or at the time of submission. You will be asked to provide the DOI, pre-reserved DOI, or other persistent identifier for the data set.

9. **Supplemental online material.** Supplemental material can be a video, dataset, fileset, sound file or anything which supports (and is pertinent to) your paper. We publish supplemental material online via Figshare.

10. **Figures.** Figures should be high quality (1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour, at the correct size). Figures should be supplied in one of our preferred file formats: EPS, PS, JPEG, GIF, or Microsoft Word (DOC or DOCX).

11. **Tables.** Tables should present new information rather than duplicating what is in the text. Readers should be able to interpret the table without reference to the text. Please supply editable files.

12. **Equations.** If you are submitting your manuscript as a Word document, please ensure that equations are editable. More information about mathematical symbols and equations.

13. **Units.** Please use SI units (non-italicized).