Audio-visual technology in clinical practice, supervision, and professional development

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Declaration

I confirm this work has not been submitted to any other institution or for any other qualifications.

Structure and word counts

1. Literature Review: *What is the evidence that review of video-recordings of clinical practice is associated with competence development in therapists?*

Excluding references	7,992
Including references	9,311

2. Research Report: *An exploratory interpretative phenomenological analysis of audio-visual technology in clinical supervision and professional development.*

Excluding references	11,999
Including references	13,482

Total word count

Excluding references and appendices	19,991
Including references and appendices	26,327

Thesis Abstract

Literature review: The review considers whether video review and feedback (VRF) in clinical practice promotes competence development. Thirteen articles qualified for inclusion, focussing on three domains of clinical competence; (i) communication, (ii) assessment, and (iii) supervision. There was evidence of a link between VRF and competency development, and VRF was experienced positively by participants, who found it a useful way to learn and develop. Implications for the role of VRF in training, clinical practice, and research are discussed.

Research report: The research study reports a qualitative exploration of the experience of routinely using audio-visual technology (AVT) in clinical practice. Eight Intensive Short-Term Dynamic Psychotherapy (ISTDP) practitioners participated in semi-structured interviews that were analysed using Interpretative Phenomenological Analysis. Three superordinate themes emerged from the data: *Immersion, Revelation, and Transformation.* Self-practice of therapeutic techniques, experiential learning, increased self-awareness and reflective practices appear to be integral processes in professional development. Feedback from peers and clinical supervisors is recognised to play a fundamental role in these processes. Implications for the role of AVT in training, clinical practice, and research are discussed.

Acknowledgements

I would like to thank the participants who were willing to share their experiences with me. Their enthusiasm for incorporating audio-visual recording into clinical practice is infectious, and I admire their commitment to improving patient outcome.

I could neither have begun nor completed this thesis without the support of my extremely patient supervisors. Professor Gillian Hardy has recognised not just the demands placed on me by the training and research process, but those from my personal world too. I am grateful for her understanding, support, motivation, and at times cajoling over the last few months, without which I would not have got to this point (thank you). Dr Mark Stein's input has been equally important, from recruitment to keeping me in touch with the most recent literature in the field. I am both in awe of, and grateful for, his extensive knowledge of ISTDP and his unerring attention to detail.

For going above and beyond the expectations of friendship, thank you Becky. When you could and should have been relaxing and enjoying completing training you have chosen to plough through research papers and transcripts for me, discussing themes until late at night. I could not have done it without you.

My final thanks go to Tim, Patrick, Mum and Dad. You have been my inspiration when mine has faltered, my motivation when mine has been lost and you have believed in me when I have questioned my ability to succeed. I hope I have made you proud. I look forward now to being able to focus on what's most important to me, being a mother, wife and daughter and making up for lost time.

Contents

Section one: Literature review

What is the evidence that review of video-recordings of clinical practice is associated with competence development in therapists?

Abstract

Objectives. Health professionals are required to demonstrate acquisition, maintenance and development of clinical competencies. Feedback on video-recordings of clinical practice is a way to transparently benchmark competencies. Although reviews have considered videotape review and feedback (VRF), to date, no systematic review has focussed on competency development in trainee or practitioner psychologists. This review considers research which evaluated health care professionals' competency development through VRF within a supervisory context, and extrapolates information relevant to practitioner psychologists.

Methods. Searches of PsychINFO, EMBASE, CINAHL, Medline, PsychSource and the Cochrane Library were performed. Search terms identified studies investigating competency development through video-recording review of clinical practice, and receiving feedback from supervisors.

Results. Thirteen articles were included; four controlled trials, five cohort and four qualitative studies. The studies were of poor to good quality, with most identified as moderate. Studies fell into three domains: (1) communication, (2) assessment and, (3) supervision. Communication and some assessment skills improved in the majority of studies. VRF promoted reflective practice in some areas of clinical work and was experienced positively overall. Participants found VRF to be a useful way to learn and develop.

Conclusions. There was evidence that VRF supports competency development in health care professionals. Research involving mental health practitioners is recommended.

Supervision

Supervision is an essential professional activity involving a senior practitioner mentoring/guiding an individual with the purpose of professional competence development through reflection on clinical work (Schofield & Grant, 2013; Watkins, 2012). Mental health professionals, as colleagues in other professions, rely on supervision for continued professional development (CPD) (Kanz, 2001). Supervision is integral and necessary to clinical psychology training, and a professional expectation of continued practice (British Psychological Society (BPS), 2008; Deane, Gonsalvez, Blackman, Saffiotti, & Andresen, 2015).

In addition to being essential to CPD (Bernard & Goodyear, 2009; Milne, 2003), supervision is a process through which mental health professionals can be held accountable (Schofield & Grant, 2013), and quality of performance maintained (BPS, 2008). Clinical supervision is considered an essential process through which professional competencies are developed via reflection, learning and psychological support (BPS; Schofield & Grant; Watkins, 2012). However, much of supervision depends on second-hand reporting, which may be subject to memory errors and bias (Haggerty & Hilsenroth, 2011). Video-recorded consultations provide an objective record on which to base supervision (McCullough, Bhatia, Ulvenes, Berggraf, & Osborn, 2011).

Video in Psychotherapy Supervision

Although video-recording was introduced into clinical practice and training in the early 1960s (Huhra, Yamokoski-Maynhart, & Prieto, 2008), it is common for psychologists to practice without ever being observed, or for trainees to go a year without observation (Haggerty & Hilsenroth, 2011). Haggerty and Hilsenroth's summation of literature provided rationale for increasing inclusion of video-recorded therapy sessions in training and clinical supervision. They discussed how traditional

supervision is limited in how helpful it can be if the supervisor is unable to observe the interaction, and tailor their support accordingly. The authors summarised the various means by which memory is flawed and suggested supervision based on video-recordings of therapy would be more effective.

Identification of non-verbal communications and behaviours is a potential benefit of reviewing video-recorded sessions (Abbass et al., 2011; Haggerty & Hilsenroth, 2011). McCullough et al. (2011) noted feedback on performance is becoming more prevalent in many professions as observation and practice improve performance. Video-recordings provide opportunity for objective evaluation of progress and exploration of competency development (Abbass, 2004).

Video-recordings allow therapists to focus on the patient (Briggie, Hilsenroth, Conway, Muran, & Jackson, 2016). Abbass (2004) noted the increased alliance with the patient which may subsequently occur.

Challenges, as well as advantages, have been reported when incorporating video-recordings in clinical practice. Alpert (1996), and Haggerty and Hilsenroth (2011) identified logistical issues associated with reviewing session recordings. VRF is time intensive and requires advance planning to ensure benefit from supervision is maximised. Maintaining ethical standards and patient confidentiality are of utmost importance and bring further challenges.

The focus within the literature on advantages and disadvantages is noted by Huhra et al. (2008) in their review on video technology in supervision. They applied the theory-based Integrated Developmental Model (Stoltenberg & Delworth, 1998; cited in Huhra et al., 2008) to the literature, and developed stage-based suggestions for supervisors regarding how to incorporate video-recording into practice and supervision to facilitate CPD. Suggestions included video-recording role plays with the supervisee at level one, when they are likely to be self-focussed and anxious, to encouraging the

self-review of recordings at level three, when supervisees have a balance between self and client-awareness. Huhra el al. suggested the potential of VRF to facilitate competency development.

Rationale for a Systematic Review

Despite extensive use of video-recordings in a range of psychological therapies since the early 1960s (Huhra et al., 2008), there is a paucity of empirical evidence demonstrating the value of VRF. With NHS England currently in a decade of austerity and focussed on improving value[1] in clinical practice (Alderwick, Robertson, Appleby, Dunn, & Maguire, 2015), it is important to consider the evidence for incorporating video-recordings into clinical practice.

The Current Review

This review aimed to gather and critically appraise research which investigated the video-recording of clinical practice and subsequent review within a supervisory context where feedback is offered. Due to the paucity of literature in the field of mental health and psychotherapy, the review was broadened to include healthcare practitioners. The purpose, to address three objectives: (i) to identify empirical evidence that reviewing video-recordings of clinical practice and receiving feedback within a supervisory context results was associated with development of competencies relevant to psychologists and other mental health practitioners, (ii) to provide a critical appraisal of relevant studies, and (iii) to identify training, clinical and research recommendations.

[1] Measured by the relationship between outcome and expenditure

Method

Search Strategy

Searches of PsychINFO (via OvidSP), EMBASE (via OvidSP), CINAHL (via EBSCO), Medline (via OvidSP), PsychSource (via EBSCO) and Cochrane Library (Wiley) were performed, covering the period from inception to 15th April 2016. The search terms are itemised in Table 1 (see Appendix A for comprehensive search strategy). The Boolean operators "OR" and "AND" were employed to ensure an exhaustive search. Papers were retrieved between 11th August 2015 and 15th April 2016. The references of all full-text reviewed papers were inspected to identify further relevant articles.

Table 1

Database Search Terms

Subject	Search terms
1	*video, "video recording", recordings, "video feedback", feedback
2	training, learning, *review, "professional development", competence, "competency development"
3	supervision
4	psychologist, psychotherapist, counsellor, doctor, nurse, psych*, counsel*

Five hundred and fifty six citations were identified through electronic and hand searches. Once duplicates were removed 480 unique citations remained. Their titles and abstracts were screened for relevance to this review using specific inclusion and exclusion criteria, documented below. Studies unrelated to competence development following VRF within the health professions were excluded. Studies concerned with

physical examination/medical technical skills were excluded. Full-texts of 45 citations were obtained. A further eight citations were selected for full text evaluation following reference reviews. Application of the inclusion criteria to 53 papers resulted in the exclusion of 40 from the review. Figure 1 documents reasons for exclusion.

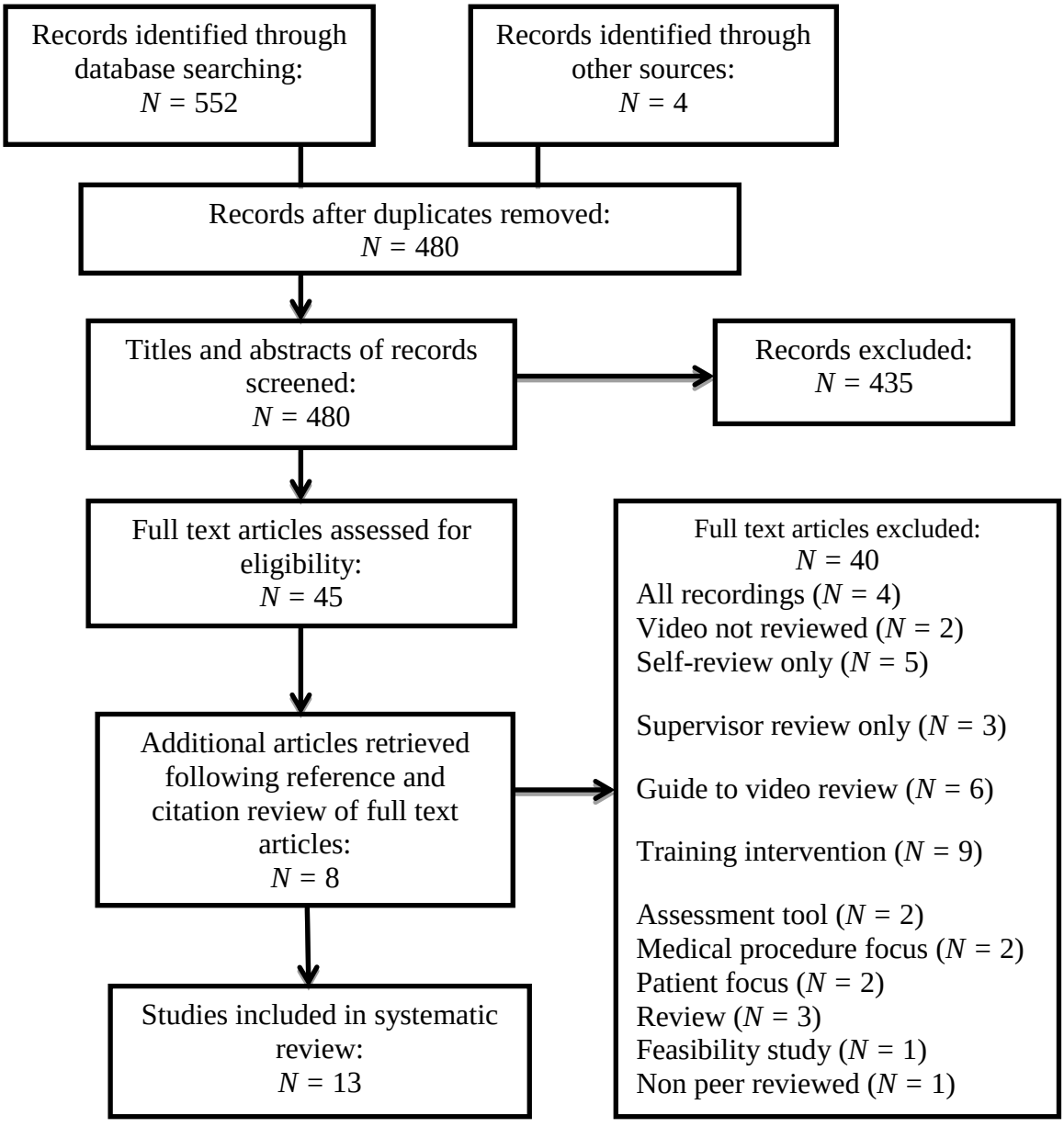

Figure 1. Flow chart of the literature search process.

Inclusion Criteria

Studies were included if they met the following criteria: (i) student or qualified physical or mental health professional who video-recorded an aspect of their practice with a real or standard/simulated patient (SP), supervisor or supervisee, (ii) the video-recording of practice was reviewed by the participant and/or their peers/supervisor[2] and feedback provided, (iii) learning, training, professional or competence development was considered, (iv) English language and (v) published in a peer-reviewed journal.

Exclusion Criteria

Studies were excluded if they met the following criteria: (i) studies concerned solely physical examination/technical medical skills and, (ii) book chapters, dissertation abstracts, conference abstracts, or unpublished studies.

Data Extraction

The data abstraction form was modified from a review of medical student learning via video review (Hammoud et al., 2012). Data was extracted for the 13 articles included in the review, and included information on author(s), publication year, country, sample size, demographic details including profession, type of encounter (the focus of the interaction in which the outcome was explored) video review and feedback context (who reviewed the video), outcome studied, analysis and summary of findings. Data were presented in "*summary of characteristics"* tables by type of methodology: controlled trial (Table 2); cohort study (Table 3); qualitative (Table 4), and summarised alphabetically.

Quality Assessment

As studies included in this review employed quantitative and qualitative methodology, a number of tools were piloted to identify which enabled comparison of

[2] For the purpose of this review the term "supervisor" will refer to an individual with seniority of position and/or experience that provided feedback based on review of performance demonstrated in the video-recording of practice.

quality. As checklists provide more useful information about the quality of a study than a numerical score (Greenhalgh & Brown, 2014), the relevant Critical Appraisal Skills Programme (CASP; 2014) checklists were employed. All CASP appraisal tools consist of three sections to assess internal validity, results and relevance to practice. Ranging in length from 10 to 12 questions the CASP toolkit enables a comparison of quality across methodologies if a consistent approach is adopted (CASP; Greenhalgh & Brown). Responses to the checklist items range from simple "yes/no and can't tell" statements to a brief summary of results and practice implications. Minor adaptations were made to the checklists to avoid repetition of information reported in data extraction tables.

Quality appraisal tables for each type of study are located in the appendices: control trials (Appendix B, Table B1), cohort studies (Appendix C, Table C1) and qualitative studies (Appendix D, Table D1). CASP checklists were designed to help the reader consider issues of quality and no specific instruction was given regarding applying a specific quality label to each paper. In order to establish guidelines for the classification of studies included in this review, the researcher met with two peers (a recently qualified clinical psychologist, and a trainee clinical psychologist). As recommended by the National Institute of Health and Care Excellence (NICE) (2012) the reviewers double assessed all papers by independently completing the relevant CASP checklist[3]. Differences between the raters occurred on two items across the 13 studies. Despite reaching a resolution through discussion, it was agreed by all reviewers that the differences on these two items did not ultimately affect the overall appraisal of the quality of the studies.

Through reflecting on the CASP checklists within the context of their own knowledge, the researcher and reviewers established criteria for assigning classification

[3] Papers were grouped alphabetically by the author's appraisal description (poor, moderate and good). Alternate papers within each group were provided to each reviewer, alongside the relevant CASP checklist.

of studies dependent on the number of "yes" responses. A score of zero to three gave a classification of "poor", a score of four to six gave a classification of "moderate" and a score of seven or above gave a classification of "good". The group were in consensus that having applied these guidelines to all studies, an accurate quality rating for each paper was generated. Further reliability checks were therefore not undertaken.

Results

Thirteen studies were included in the review. A general summary of study characteristics and quality precedes a critical appraisal of studies. The type of encounter featured in the studies fell into three domains; (i) communication, (ii) assessment, and (iii) supervision.

Study Characteristics

The 13 studies were published between 1992 and 2016. Four studies were controlled trials, with participants allocated to either intervention or control groups. Baseline and time-two measures were taken to identify the effect of intervention. Participants in three controlled trials were randomly allocated to a group. Participants and research personnel were not blinded to group allocation in any study.

Prospective cohort studies (all participants receive same intervention and are observed over a period of time to identify intervention outcomes) accounted for five studies reviewed. Four studies employed qualitative methodology, which is primarily exploratory, and used to acquire insight into the experience of participants, through a range of methods.

Studies were conducted in; Australia (n = 4), United States of America (n = 2), France (n = 1), Iran (n = 1), Korea (n = 1), Netherlands (n = 1), Norway (n = 1), Turkey (n = 1), and the United Arab Emirates (n = 1).

A total of 658 individuals participated in the studies reviewed (range 3-141, median 33). There was disparity between studies with regard to quality of demographic

data reported. All studies reported the professional group of participants. Eleven studies recruited medical students as participants, two recruited therapists, supervisor-supervisee dyads, and one recruited nurses. Only eight studies reported the age of participants. All controlled trial studies reported mean age for intervention and control group (range 20.8-46.0 years) and identified no significant differences in their sample. Only one cohort study reported age (18-33, mean 21.1 years), whilst three qualitative studies reported this data (range 22-67 years). Nine studies reported gender demographics, and females accounted for 53% of participants included in the review (range 31-100%).

As per inclusion criteria, video-recordings of practice were reviewed by all participants. Seven studies incorporated peer supervisor review and twelve studies incorporated supervisor review. Three types of encounters were identified in the studies: communication (n = 8), assessment (n = 7), and supervision ((n = 8). Five possible outcomes were explored across the studies: communication (n = 6), history-taking (n = 7), feedback (n = 4), experience (n = 9), and learning (n = 1). Participants in eight studies were video-recorded in real patient consultations, whilst three used SP. Two studies recruited real supervisor-supervisee dyads.

Studies varied in their approach to measurement of change. Three studies measured change through observation, whilst five studies based their finding on self-report. The remaining five studies incorporated both observation and self-report.

Study Quality

Using the CASP (2014) controlled trials checklist one study was categorized as good quality and three as medium. In these four studies the intervention and control groups did not differ significantly on demographic variables. Confidence intervals were reported for three studies, with two reporting significance at $p < .01$ and one at $p < .05$.

The remaining study reported statistically significant results but did not indicate at what level.

Four cohort studies were categorized as medium quality, and one as poor using CASP (2014). There was wide variation between studies with regard to minimising bias, and identifying and accounting for confounding variables, with no study addressing them all in their research design. One study out of five followed up participants beyond termination of intervention, collecting data at six month follow-up.

The qualitative checklist (CASP 2014) categorized two studies as good quality, one as moderate and one as poor. A qualitative methodology was considered appropriate to the research aims. Data was collected appropriately to address the research question in all but one study. The relationship between researcher and participant was judged to have been appropriately considered in one study. Data analysis was thought to be sufficiently rigorous in two studies. Specific strengths and limitations are discussed below.

Communication. Eight studies explored the impact of VRF on developing communication skills. Two controlled studies reported that participants in the intervention group showed significantly improved communication skills following the intervention.

Noordman, van der Weijeden, and Dulman (2014) assessed communication and clinical competence via observer ratings of nurse-patient consultations using the Maastrichtse Anamnese en Advies Scorelijst (MAAS-global; van Thiel, Ram, & van Dalen, 2000, cited in Noordman et al.). The MAAS- global is a three-section validated measure which assesses communication skills pre- and post-intervention, general communication skills and adherence to practice guidelines. The ten nurses allocated to intervention group (observing and receiving feedback on two of their videotaped

Table 2

Summary of characteristics of control trial studies

Author (Year) Country	N	Reported demographics	Type of encounter			Video review setting			Outcome studied					Analysis	Findings	Quality appraisal	Change	
			C	A	S	I	P	Su	C	H	F	E	L				O	SR
Managheb et al. (2012) Iran	40	Medical students Mean age in years, 25.5 (1.7) intervention, 25.6 (1.8) control	X	X		X	X		X	X				Paired *t*- test comparison of mean scores of clinical competence on OCSE1 and OCSE2	Intervention group had significantly higher communication and history taking skills scores following video feedback	Moderate	X	
Noordman et al. (2014) Netherlands	17	Nurses 100% female Mean age in years, 40 (5.9) intervention, 46 (5.3) control	X	X	X	X		X	X	X		X		Pre-post scores on MAAS-global and BECCI, independent *t*-test, chi-square, multilevel linear and logistic regression	Nurses who received video feedback paid significantly more attention to requests for help, gave more understandable information and attended more "agenda setting and permission seeking.	Good	X	X

(Table 2 continued)

Author (Year) Country	N	Reported demographics	Type of encounter			Video review setting			Outcome studied					Analysis	Findings	Quality appraisal	Change	
			C	A	S	I	P	Su	C	H	F	E	L				O	SR
Ozcakar et al. (2009) Turkey	52	Medical students No significant difference between intervention and control for; gender (Chi^2 = 0.624, p = 0.43 > .05), mean age (p = 0.95 > .05)	X	X		X		X	X	X				Descriptive statistics, independent and dependent sampling t-test, p < .05	No significant differences between assessors scores for control and intervention group	Moderate	X	X
Parish et al. (2006) USA	128	Medical students 52.1 % female group, 50.9% female individual Mean age in years, 37 (5.9) group, 29 (5.3) individual			X	X	X	X			X	X		Chi-square, Wilcoxon two-sample test, d values reported, p < .01	No significant difference on performance measures, though mean scores in favour of individual feedback	Moderate		X

Note. N, number of participants; C, communication (to include interpersonal skills; A, assessment skills (to include history taking and interviewing skills); S, supervision, (to include learning and reflective practice); I, individual review; P, peer view; Su, supervisor review; C, communication; H, history taking skills (to include interview skills); F, feedback; E, Experience (to include reflective practice); L, learning: OCSE, objective structured clinical examination; MAAS, Maastrichtse Anamnese en Advies Scorelijst (van Thiel et al., 2000); BECCI, Behaviour Change Counselling Index, (Lane, 2002, Lane et al., 2005); O, observed improvement; SR, self-reported improvement

Table 3

Summary of characteristics of cohort studies

Author (Year) Country	N	Reported demographics	Type of encounter			Video review setting			Outcome studied					Analysis	Findings	Quality appraisal	Change	
			C	A	S	I	P	Su	C	H	F	E	L				O	SR
Bonnaud-Antignac et al. (2010) France	108	Medical students 69% female	X		X	X		X	X		X	X		Spearman's correlation, paired *t*-test, ANOVA. Fisher Exact, chi-square	Self-reported improvement on (i) memorise and implement protocol, (ii) appropriate communication techniques, and (iii) identifying own reactions. Protocol recall inadequate on formative assessment	Moderate	X	X
Bryson-Brockman & Fischbein (1995) USA	3	Residents	X	X		X		X	X	X				Multiple baseline, single-case, observation of 3 target behaviours	Increased (i) "ask patient to repeat instructions", (ii) "ask open ended questions", and (iii) positive comments on parenting behaviour	Good	X	

(Table 3 continued)

Author (Year) Country	N	Reported demographics	Type of encounter			Video review setting			Outcome studied					Analysis	Findings	Quality appraisal	Change	
			C	A	S	I	P	Su	C	H	F	E	L				O	SR
Farnhill et al. (1997) Australia	60	Medical students 43% female Mean age in years 21.1 (range 18 – 33) 60% first language English	X	X		X	X	X	X	X		X		Descriptive statistics. Repeated measures MANOVA, univariate tests	Self-reported significantly more competent after video feedback. Ratings showed significant gains inquiry skills and communication of positive attitudes	Moderate	X	X
Lee et al. (2013) Korea	33	Medical students 33.3% female		X		X	X	X		X				Video ratings by adapted ACIRS and SEGUE, Wilcoxon paired *t*-test, McNemar test	Significant improvement in "type of question", "timeline" and "positive verbal reinforcement	Moderate	X	
Paul et al. (2013) United Arab Emirates	27	Medical students		X	X	X	X	X		X	X	X		Kruskal Wallis one-way ANOVA	73% said self - observation, 80% said feedback helped develop clinical skills	Poor	X	X

Note. N, number of participants; C, communication (to include interpersonal skills); A, assessment skills (to include history taking and interviewing skills); S, supervision (to include learning and reflective practice); I, individual review; P, peer view; Su, supervisor review; C, communication; H, history taking skills (to include interview skills); F, feedback; E, Experience (to include reflective practice); L, learning; ACIRS, Arizona Clinical Rating Scale; SEGUE, set the stage, elicit information, understand the patient's perspective and end the encounter; O, observed improvement; SR, self-reported improvement

Table 4

Summary of characteristics of qualitative studies

Author (Year) Country	N	Reported demographics	Type of encounter			Video review setting			Outcome studied					Analysis	Findings	Quality appraisal	Change	
			C	A	S	I	P	Su	C	H	F	E	L				O	SR
Del Mar & Isaacs (1992) Australia	141	Medical students			X	X	X	X			X	X		Qualitative survey	Students believed skill at analysing/ evaluating consultation enhanced	Poor		X
Grant et al. (2012) Australia	16	Supervisor and supervisees Supervisors - 31% female Mean years in practice, 27.5 Supervisees - 63% female Mean years in practice, 8.8	X		X	X		X	X			X		Modified consensual qualitative research method	Supervisors managed difficulties in supervisory relationship using four approaches; relational, reflective, confrontative and avoidant	Good		X

(Table 4 continued)

Author (Year) Country	N	Reported demographics	Type of encounter			Video review setting			Outcome studied					Analysis	Findings	Quality appraisal	Change	
			C	A	S	I	P	Su	C	H	F	E	L				O	SR
Hill et al. (2016) Australia	14	Psychologists and supervisors Supervisors - 57% female Mean years in practice, 47.85 (range, 32 – 67) Supervisees - 71% female Mean years in practice, 29.32 (range, 22 – 42)	X		X	X		X	X		X	X		Braun and Clarke, thematic analysis	Themes (i) increased discussion of supervisee anxiety/ tension between autonomy and feedback, (ii) intent to alter supervisory role/ practice, (iii) identification of and reflection on parallel processes, (iv) improvements in alliance	Good		X
Nilsen et al. (2005) Norway	19	Medical students 42% female Mean age in years, 27.1			X	X	X	X				X		Coding of transcripts	Pre intervention anxiety. Process rated positively and increased self-esteem and confidence	Moderate		X

Note. N, number of participants; C, communication (to include interpersonal skills); A, assessment skills (to include history taking and interviewing skills); S, supervision (to include learning and reflective practice); I, individual review; P, peer view; S, supervisor review; C, communication; H, history taking skills (to include interview skills); F, feedback; E, Experience (to include reflective practice); L, learning; O, observed improvement; SR, self-reported improvement

consultations) paid significantly more attention to patient's requests for help, and delivered more understandable information than control group nurses.

Strengths of the study included absence of significant demographic differences between the two groups prior to the intervention. Observer inter-rater reliability was high; Kappa (0.5) and significance levels were reported at $p < 0.001$, with 95% confidence intervals. The main limitation of the study was that participants and study personnel were not blinded to the groups.

Managheb, Zamani, Shams, and Farajzadegan (2012) also reported significant improvement of communication skills for medical students allocated to VRF intervention. All students participated in a communication class, after which their communication skills were evaluated through an Objective Structured Clinical Exam (OCSE1). Communication skills were reassessed two months later, after the intervention, using OCSE2.

The intervention comprised of five sessions of VRF in groups of four students. One student role-played a patient, one a doctor, one video-recorded the "consultation" and the fourth observed. All four reviewed the video-recording and rated their communication and history-taking skills using a self-assessment checklist. This process was repeated until all members of the group experienced each role, resulting in a reported 40 video-recorded interviews.

At Time 2 (T2) significant differences were reported between the groups on measures of communications skills, with the intervention group demonstrating improvement. These results suggested an improvement in communication skills following VRF. However, the authors did not provide specific data for communication. It is only implied communication is measured by "clinical competence", as specific results are reported for this and all other competencies except communication. Caution

is warranted when interpreting the results as validity of what is being measured and reported is questionable.

Ozcakar et al. (2009) reported no significant difference in communication skills (greeting the patient, comforting and facilitating) following VRF in comparison with verbal feedback. At T1 medical students were observed, by their assessors, conducting a video-recorded interview. They were assessed against a checklist which demonstrated medium reliability (Cronbach's alpha = .77), and provided a score between zero and twelve.

The intervention group participants reviewed the video-recording with their trainer and received verbal feedback. After 15 days (T2), the interviews were repeated. Average scores of assessed competency were reported for T1 and T2. Although the intervention and control groups did not differ significantly on assessor ratings of communication skills, control group students at T2 self-reported a significant increase compared to the intervention group. As the authors did not report the number of participants included in the analysis the findings may not accurately represent the impact of the intervention.

Two cohort studies reported improvements in communication skills based on participants' subjective ratings. As part of a study investigating the impact of video-recorded SP interviews and feedback on learning a protocol (SPIKES) for delivering a "bad news" diagnosis, Bonnaud-Antignac, Campion, Pottier, and Supiot (2010), asked medical students to assess whether they met their learning objectives by responding to three questions about the value of the individual sessions (teaching, video-recorded practical, feedback). They were also asked to rate their ability to break bad news and implement communication techniques.

Participants were externally assessed by a psychologist (observation), senior physician (video-recording review) and follow-up exam against the SPIKES protocol

which showed inadequate improvement across the long-term follow up period. Half the participants rated their communication skills as improved following the teaching and video-recorded practical sessions. Interestingly, 77% reported feeling more comfortable with the techniques following VRF. They attributed this to the session helping them to recognise their own verbal and non-verbal communication. Although no objective data was collected to compare whether self-report corresponded to competence development, it appeared students' confidence in their skills increased. Conclusions should be interpreted with caution as only 32% of participants completed all rating measures.

Farnhill, Todisco, Hayes, and Bartlett (1997) reported similar findings in their study exploring whether VRF improves skills required by medical students to interview patients from non-English speaking backgrounds. Volunteer patients and participants completed evaluations of communication based skills (greeting the patient, comforting and determining the level of communication and facilitating). Eighty-five per cent of volunteers responded to nine questions evaluating student communication skills. Volunteers' confidence they would be able to explain their illness to the student was significantly predicted by two variables: (i) their capacity to understand the student and, (ii) the student's capacity to understand their feelings.

Students reported significant improvements in avoiding jargon, using simple sentences/phrases and adjusting their rate of speech to client. Although *p* values were not reported, this study also shows increased confidence in students following VRF. Limitations included failure to address a number of confounding variables, for example, 40% of the sample's first language was not English. The impact of culture and language on communication techniques are well known and may have skewed the data somewhat. Even when a language is learned, the cultural perception of the meaning may be different (Schyve, 2007), which would apply to both participants and volunteers. It is therefore advised to remain cautious with regard to these results.

The remaining three studies discussed communication as an adjunct to their main focus, and are only referred to briefly here. Further details are reported under the relevant heading for the main focus of the study. In a multiple-baseline, single participant experimental design, Bryson-Brockman and Fischbein (1995) looked to establish the impact of video feedback on three target behaviours (asking parents to repeat instructions, asking open ended questions, positive comments on parenting behaviour) which they linked to communication skills. Following intervention and at six-month follow-up all participants increased the number of times they demonstrated these target behaviours, suggesting improvements in communication skills.

Grant, Schofield, and Crawford (2012) and Hill, Crowe, and Gonsalez (2016) focussed mainly on reflective practice within the supervisor-supervisee dyad. Interpersonal process recall (Kagan et al., 1965, cited in Hill et al.), a method which uses VRF to explore the interpersonal processes of therapist, and qualitative analysis was employed in both studies. Themes associated with the importance of communication to improving supervisory alliance emerged.

Three studies identified significant improvement in communication skills through observation (Bryson-Brockman and Fischbein, 1995; Managheb et al., 2012; Noordman et al., 2014). In studies employing self-report, increased confidence in communication following VRF was indicated. However, these findings are not replicated across all studies. Taking into account the variation in findings and the methodological limitations, it is not possible to draw definitive conclusions. However, VRF may be associated with improvement in attention to patient needs (responding to patients request for help) and clarity of communication.

Assessment. Seven studies explored the impact of VRF on history-taking and interviewing skills. Five studies (three controlled trials and two cohort studies) reported significant improvements on at least one aspect of history-taking or interviewing skills.

Noordman et al. (2014) assessed motivational interviewing skills (agenda setting and permission-seeking, the why and how of change in behaviour, the whole consultation, talk about targets) via observer ratings of nurse-patient consultations. Using The Behaviour Change Counselling Index (BECCI) comprising 11 items across four domains, it was demonstrated that, nurses allocated to the intervention group paid significantly more attention to agenda-setting and permission-seeking than control group nurses. Nurses attributed improved performance to being able to observe self in practice and receiving feedback, which they then incorporated into practice. Noordman et al., was identified as a good quality paper allowing the reader to have confidence in the results.

Managheb et al. (2012) reported significantly improved mean scores on history-taking for the intervention group at T2. Whilst the results suggest that reviewing and receiving feedback on video-recorded consultations developed history-taking skills, the authors did not provide comparable data for control group participants. It is not possible to ascertain whether there is a difference between the groups, and if so, whether it is attributable to the intervention.

Ozcakar et al.'s (2009) second checklist comprised of 12 variables which measured components of taking a medical history, history of present illness (level of story, patient perspective, what has already been done) and history-taking ability (open and closed ended questions, constructing history in sequence, guiding the patients, summarizing history episodes, determining the process, ending appropriately). When combined these scores provided a total history score.

With the exception of the intervention groups' self-assessment of "components of taking a medical history", all history-taking scores improved between T1 and T2. Significant differences at the level of $p < .05$ between T1 and T2 mean scores were found for the intervention group, as rated by the assessors, in history-taking ability,

history of present illness, and total history score. The only significant assessor rated difference for the control group was for mean history-taking ability. Students' self-ratings identified significant differences in the control group between T1 and T2 scores for "other history competencies". Whilst all students improved following verbal feedback, the opportunity to observe and reflect on self-practice appeared to lead to further improvement in asking pertinent questions about medical history to inform future care. These results provide useful information with respect to the potential value of using VRF to teach clinical skills and improve reflexivity.

Lee et al. (2013) applied the modified Arizona Clinical Rating Scale (ACIRS) with two additional items from the SEGUE framework[4] to medical students video-recorded consultations with patients. Following recording of an initial consultation, four family medicine professors, two residents and one to four students reviewed the video-recordings. A discussion followed, which included the interviewers' and other student's opinion, and senior staff feedback. The following day, discussions focussed on desirable interview skills were held, before participants were video-recorded a second time. Feedback was delivered in the same way following the second recording.

The evaluation criteria, presented as a supplement to the paper, consisted of 10 items. The same four people rated all video recordings and if there was a discrepancy of two or more between their scores they reviewed the recordings again, attempting to achieve consensus. Mean item scores were compared between T1 and T2. Of nine items which showed improvement at T2, four reached significance: (i) type of question, (ii) timeline, (iii) positive verbal reinforcement, and (iv) total score. Therapeutic sequence, facilitative behaviours, pacing of interview, summarizing, lack of jargon and general improved, but not significantly at T2. The author's approach to rating video-recordings

[4] SEGUE framework (set the stage, elicit information, give information, understand the patient's perspective and end the encounter) (Makoul, 2001, cited in Lee et al., 2013)

was a strength of the study as it provided confidence in the pre-post mean scores. The authors also had insight into the limitations of their study, such as sample size and use of an adapted rating scale. They acknowledged that more methodologically rigorous research is required before conclusions can be made about whether VRF improves interviewing skills.

In a multiple-baseline, single experimental design, Bryson-Brockman and Fischbein (1995) counted the occurrence/non-occurrence of three interview-based target behaviours (asking parents to repeat instructions, asking open-ended questions, and positive comments on parenting behaviour) during 30 second intervals. The percentage of intervals which included the target behaviour was calculated. A second rater randomly assessed 25% of the recordings. The three participants were recorded three times prior to their first feedback, then on average once or twice a month over six months. A follow-up recording was collected at six months post-intervention.

The authors reported frequency of all target behaviours only increased following VRF. Graphical representations of the results were presented for all target behaviours for each participant. The absence of a baseline median makes it difficult to identify whether any meaning can be applied to the change in target behaviours, and analysis fails to consider possible autocorrelation between data points (Borckardt et al., 2008), or percentage of data exceeding the mean (Ma, 2006). It is within the rigour of employing single case methods that researchers are able to produce a methodologically sound alternative to the randomised controlled trial (Smith, 2012). The absence of these analyses limits confidence in the findings reported, despite the good quality research design and data collection process. However, the findings provided useful information about how health professionals may adapt their clinical skills. It seems that in observing self with patient, participants received feedback regarding which of their behaviours resulted in their patients' increased adherence to medical treatment. In reflecting on this

process they appeared to make decisions about what techniques to use in future consultations to improve patient outcome.

Two studies found VRF did not improve assessment skills. Despite Farnhill et al. (2009) reporting a rigorous process to ensure inter- and intra- rater reliability for their 19- item checklist, and controlling statistically for variables which impacted on total rating of competence, no significant improvements in interviewing skills (structured inquiry, facilitation of emotional expression, positivity of response, simple vocabulary/sentence structure, opening/ending) were found.

Paul at el. (1998) taught a clinical skills programme to medical students prior to video recording consultations with real patients. The video-recordings were reviewed in groups with peers and two instructors, and feedback was given. A 24-item checklist was developed based on a literature review on the concept of feedback, which was piloted by three experienced educators.

Eleven video-recordings were independently reviewed by the first three authors to evaluate clinical performance. With regard to history-taking, 91% of students were able to obtain information about the chief complaint. However, 73% of students did not take adequate social or family history, and 91% did not gather information about development/immunization. Within the domain of interviewing skills, 12% (n = 3) introduced themselves to patients. Participants demonstrated significant improvement in clarification of details and closing/summarising. Ninety-two percent of students also reported increased confidence in working with real patients. Although skill improvement was not found in all areas, students were seen to be more attentive to identifying the patient difficulty and summarising this back to the patient, suggesting a role for VRF in training.

These results provided some evidence about the role of VRF in supporting students to observe and improve their clinical assessment skills and confidence. It is not

clear whether the findings reflected the performance of all students who participated in the study as, citing time pressures, the authors chose to evaluate only 11 (44%) of the recordings made. The remaining 56% may have performed differently to those assessed, or provided further evidence to strengthen the findings reported. The ethics of collecting data which is not analysed or reported should be considered.

Five studies found significant improvement in at least one aspect of clinical assessment skills through observation (Bonnaud-Antignac et al., 2010; Lee et al., 2013; Managheb et al., 2012; Noordman et al., 2014; Ozcakar et al., 2009). These studies provide some evidence to support the role of VRF in development of assessment skills through employing learning to future history-taking and interviewing contexts.

Supervision. The role of supervisor or supervisee requires a capacity to reflect on experience and be willing to learn (BPS, 2015). Two studies explored reflective practice within the supervisory dyad. Three studies purposely investigated the experience of VRF; whilst a further three studies collected experience data as an adjunct to their primary study aim.

Both Grant et al. (2012) and Hill et al. (2016) employed the interpersonal recall method to collect data from supervisor-supervisee dyads. Grant et al. explored how 16 experienced supervisors managed problems in supervision within the supervisory relationship. Their methodology aimed to elicit a reflective practitioner stance from participants. Data collected through interviews and reviewing a video-recorded supervision session was analysed using a modified consensual qualitative, which was similar to thematic analysis. Supervisors were found to manage difficulties in supervision using four strategies; relational, reflective, confrontative and avoidant. Supervisors identified reflexivity as core to supervision and spoke of encouraging supervisees to engage in the reflective process through modelling and questioning. Supervisors also spoke of the importance of their own reflexivity within the

relationship. VRF was employed in this study to gain access to the data collected in the research, however, it also enabled the participants to reflect on the processes they observe in their interaction and consider what this meant for their future practice.

Hill et al. (2016) piloted an intervention involving reflective dialogue grounded in video-recordings of participants' (seven supervisor, seven supervisee dyads) clinical supervision. Each dyad individually reflected on their most recent videotaped session using a reflective practice protocol, which involved responding to questions about metacognitive reflections (values, intentions, cognitions, actions, reactions, and plans for future practice) before sharing their reflections in the subsequent supervision session. Braun and Clarke's (2006) thematic analysis identified four prevailing themes: (i) more discussion relating to supervisee anxiety and the conflict between autonomy and dependence, (ii) intent to adjust supervisory roles and practice, (iii) identification of, and reflection on, parallel processes, and (iv) a number of other impacts, including improvements in supervisory alliance. The study concluded that reviewing video-recordings of supervision can facilitate a reflective dialogue which is useful for both parties, providing an opportunity for the supervisor/practitioner to identify and respond to the needs of the other.

The research design and recruitment of participants, in both studies, was appropriate to the research question and data analysis was rigorous. However, Grant et al. (2012) did not provide enough participant extracts to enable the reader to assess whether the data shows what the authors claimed.

A paucity of participant extracts also applies to Nilsen and Baerheim (2005) in their exploration of medical students' experience of receiving feedback on video-recordings of real patient consultations as part of their clinical skills training. Three groups out of a possible 12 (19 out of 75 students) discussed their experience within a focus group. Their data was analysed using a phenomenological qualitative approach

and three themes emerged: (i) concerns, (ii) feedback and, (iii) process. Despite some students experiencing "emotional distress" (Nilsen & Baerheim, p. 1) prior to intervention, many eventually realised their fears were groundless. The intervention process was evaluated positively and through use of VRF self-reported confidence and self-esteem appeared to increase. This study provides initial evidence for the value of VRF in clinical skills training.

Del Mar and Isaacs (1992) explored medical students' perceptions of the process of teaching consultation skills through VRF via a qualitative survey. Students were observed, video-recorded and offered live supervision whilst carrying out a patient consultation. Their report of findings was limited as, despite collecting responses to 21 questions from 141 students, they did not quantify the percentage of responses that agree, disagree or are not sure. Instead ambiguous statements such as "only about a sixth of the group felt" were made. The information the reader is able to extrapolate from the visual presentation is also limited. It appears almost 80% of participants enjoyed the process, two thirds reported they felt "better able to analyse consultations" (Del Mar & Isaacs, p. 56) and three quarters reported they felt "better able to assess the quality of a consultation" (Del Mar & Isaacs, p. 56). The most common suggestion relating to improving VRF was to increase the number of opportunities to participate.

Del Mar and Isaacs' (1992) findings are congruent with Bonnaud-Antignac (2010) who reported an increase in understanding own reactions, and Paul et al., (1998) who reported 75% (n = 19) of participants believed feedback made them more aware of their strengths and limitations, and enhanced their skills in analysing and evaluating their consultations. Participants in Noordman et al. (2014) reflected on recognising themselves in their feedback and being able to use this in their practice. The evidence suggests VRF as a process through which health professionals are able to observe, reflect and act up on their practice.

Finally, Parish et al. (2006) employed a controlled trial methodology to assess the educational benefits of group versus individual review/feedback of standardized patient encounter. Seventy-one medical students were allocated to group and 57 to individual feedback meetings. All completed an anonymous 13-item questionnaire. Overall, 80% found VRF a positive learning experience, and 67% found it less stressful than expected. The individual review group reported significantly higher satisfaction with the amount of time for their session (91% vs. 78%), amount of feedback received (95% vs. 79%) and were more likely to choose a self-assessed poor section for review (63% vs. 49%). Eighty-four percent reported they would not have preferred to be in the other group, suggesting it is VRF which influences learning and not necessarily the context in which this occurs.

VRF was generally experienced positively by the participants in these studies, with some identifying an increase in reflective skills as a result. The studies also suggested that although associated with anxiety, participants believed that video-recording practice provided a useful medium through which to learn, develop, and respond to the needs of the other.

Discussion

There is evidence to support VRF's potential for competence development in health care professionals. However, there was insufficient good quality evidence, to conclude definitively that a causal link exists between VRF and competence development. Further research with mental health professionals may clarify the relationship between VRF and competence development in a therapeutic context.

Summary of Findings

Seven studies reported improved communication skills following VRF. Whilst the majority of evidence comes from subjective report, findings are congruent with those reported in controlled trials. Nurses and medical students were more responsive to

patient needs and communicated more clearly (Bonnaud-Antignac et al., 2010; Farnhill et at al., 1997; Grant et al., 2012; Noordman et al., 2014).

Five studies, focussed on assessment, reported significant improvements on at least one element of assessment skills. Nurses and students appeared to be more collaborative when taking history, clarifying details, summarising and feeding back to ensure accuracy of information before moving forward (Lee at al., 2013; Noordman et al., 2014; Paul et al., 1998). Reflection on self in practice and feedback appeared to lead to adaptations in practice, and increased self-awareness (Bonnaud-Antignac et al., 2010; Bryson-Brockman & Fischbein, 1995; Noordman et al; Ozcakar et al., 2009). Findings differed regarding the specific skills that improved following VRF, and two studies reported no improvement. Overall, participants found VRF a positive experience, perceiving VRF as a useful way to learn and develop competence and confidence.

These results are consistent with models which propose that therapists acquire skills and learn through experience and reflective practice (Davis, Thwaites, Freeston, & Bennett-Levy, 2014), such as Kolb's (1984, cited in Terry, 2001) Experiential Learning Model. Kolb proposed learning is based on observation, reflection, and the assimilation of new concepts which are ultimately put into practice, beginning the cycle again (Terry). Participants in some studies reported VRF provided an opportunity to observe and reflect on their practice prior to being assessed at T2, and attribute learning and improvement in competencies to this process. Reflecting on self in practice is a key element of Schön's (1973, cited in Hébert, 2015) model of reflective practice. Schön proposed reflecting on something which has passed (*on action*) provides an opportunity to consider what you might do in future (*for action*), and ultimately how you might work in the moment (*in action*). A number of participants across the studies reported the value of VRF in enabling to think about what they might do differently to improve their work.

Review Limitations

The majority of study participants were medical students, with only two studies exploring VRF in competency development of mental health practitioners. The potential to generalise the findings to psychology and mental health is limited. However, in establishing inclusion and exclusion criteria the author attempted to focus on competencies which are relevant to mental health practitioners. “Communication”, “Assessment” and “Supervision” skills would include generic competencies underpinning model specific standards outlined in the University College London Centre for Outcomes Research and Effectiveness frameworks: (i) building a therapeutic alliance, (iii) assessment, and (iii) supervision (BPS, 2015; Roth & Pilling, 2007). The overlap between review domains and generic competencies is sufficient to allow extrapolation of information relevant to mental health professionals’ clinical practice.

The identified search terms and inclusion/exclusion criteria may have limited the number of studies considered for inclusion in the review. To mitigate non-inclusion of relevant studies, the author met with a hospital-based information specialist to audit the search strategy (Boland, Beale, & Cherry, 2014). No further papers were identified, but additional databases were not searched.

Study methodological quality may also be considered a limitation. Randomised controlled trials are considered the gold standard methodology (National Institute for Health and Care Excellence, 2012), and only three were included. In addition, whilst some authors provided details of the outcome being studied, others used only generic terms to describe communication, assessment and supervision skills. Without specificity of what is being explored, it is difficult to draw conclusions about what actually changes as a result of VRF.

Training and Practice Implications

There is some evidence VRF increases health professionals' responsiveness to patients' needs, and an improved ability to communicate with them in a way which is understood and helpful. It appears that competencies develop as a result of practitioners being able to observe self in practice, reflect upon the observations and feedback, and adapt behaviour in future interactions. This is valuable information for training providers, supervisors and practitioners when considering effective ways to deliver teaching, develop competencies, and increase self-awareness and reflexivity. Incorporation of VRF in clinical practice may enhance both personal and shared learning, and thereby lead to improved patient experience and outcome.

The requirement by the HCPC (2014) and the BPS (2015) of transparent benchmarking against competency frameworks for psychologists will inevitably require training providers and supervisors to evidence assessment and progress of trainees. VRF provides a feasible alternative to extensive live observation of trainee practice.

Although incorporation of VRF in clinical training would require considerable resources and planning, training providers have a responsibility to ensure trainees meet the agreed standards of practice and competence prior to professional registration.

Research Recommendations

Research involving mental health practitioners and psychologists is warranted. Controlled trial studies exploring the impact of VRF on clinical competence development in this population would provide useful information for training providers, and employers in ascertaining its value. Larger sample sizes and measuring clearly defined competencies, with objective validated measures would increase confidence in the findings, and provide useful information about effective ways to employ VRF.

Given the importance of patient experience and outcome (Alderwick et al., 2015), future research could explore the benefits of VRF to patients. For example, does improved competence translate into improved outcomes for patients?

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* Studies included in the review

Appendix A

Detailed description of search strategy

1	*video OR “video recording”
2	feedback OR “*feedback system”
3	supervision
4	psychologist OR psychotherapist OR counsellor OR doctor OR nurse or psych* OR counsel*
5	training OR learning OR *review OR “professional development” OR competence, OR “competency development”
6	1 AND 2
7	6 AND 4
8	7 AND 3
9	8 AND 5
10	9 [Limit to: Peer reviewed]

Table B1
Controlled trials quality appraisal

	Author (Year)			
	Managheb et al. (2012).	Noordman, et al. (2014).	Ozcakar et al. (2009).	Parish et al. (2006)
Did the trial address a clearly focussed issue?	Yes	Yes	Yes	Yes
Was the assignment of patients to treatment randomised?	No	Yes	Yes	Yes
Were participants and study personnel blinded?	No	No	No	No
Were the groups similar at the start of the trial?	Yes	Yes	Yes	Yes
Aside from the experimental intervention were the groups treated equally?	Yes	Yes	Yes	Yes
Were all the participants who entered the trial properly accounted for at its conclusion?	Can't tell	Yes	Can't tell	Can't tell
How precise was the estimate of intervention effect?	Statistically significant results reported but no indication of at what level. Confidence intervals reported	*p* values considered significant at < .01. Confidence intervals reported at 95%	*p* values reported at $p < 0.05$. Confidence intervals not reported	Four of the reported *p* values significant at < .01. Confidence intervals not reported
Can the results be applied in your context?	Yes	Yes	Yes	Yes
Were all clinically important outcomes considered?	Yes	Yes	Yes	No
Quality appraisal rating	Moderate	Good	Moderate	Moderate

Note. For the purpose of establishing a quality rating the following criteria were applied based on the items which require a yes, no or can't tell response; 0 – 3 "yes" responses = weak, 4 – 6 "yes" responses = moderate and 7 – 8 "yes" responses = Good

Table C1

Cohort studies quality appraisal

	Author (Year)				
	Bonnaud-Antignac et al. (2010)	Bryson-Brockman & Fischbein (1995)	Farnhill et al. (1997)	Lee et al. (2013)	Paul et al. (1998)
Did the study address a clearly focussed issue?	Yes	Yes	Yes	Yes	Yes
Was the cohort recruited in an acceptable way?	Yes	Can't tell Did not explain why 3, or why randomly allocated from cohort of 25	Yes	No Random allocation of participants from a different group with no explanation	Yes
Was the intervention accurately measured to minimise bias?	No Variation in the difficulty of the scenarios used and time between training and videoed interviewing	No Length of baseline and intervention different for each participant	Yes	Yes	No
Have the authors identified all important confounding factors	Yes	No No demographic information regarding participants or patients.	No	No	No

(Table C1 continued)

	Bonnaud-Antignac et al. (2010)	Bryson-Brockman et al. (1995)	Farnhill et al. (1997)	Lee et al. (2013)	Paul et al. (1998)
Have they taken account of the confounding factors in the design and/ or analysis?	No Not taken into account scenario difficulty	No	No	No	No
Was the follow up of participants complete enough?	Yes Examination question on protocol at end of year	Can't tell	No Some participants did not complete data and were not followed up	No	No
Was the follow up of participants long enough?	No	Yes Six months follow up	No	No	No
How precise are the results?	Moderate	Moderate	Moderate	Moderate	Weak
Do they results of this study fit with other available evidence?	Yes	Yes	Yes	Yes	Yes
Quality appraisal rating	Moderate	Moderate	Moderate	Moderate	Weak

Note. For the purpose of establishing a quality rating the following criteria were applied based on the items which require a yes, no or can't tell response; 0 – 3 "yes" responses = weak, 4 – 6 "yes" responses = moderate and 7 – 9 "yes" responses = Good

Table D1
Qualitative studies quality appraisal

	Author (Year)			
	Del Mar & Isaacs (1992)	Grant et al. (2012)	Hill et al. (2016)	Nilsen et al. (2005)
Was there a clear statement of the aims of the research?	No	Yes	Yes	Yes
Is qualitative methodology appropriate?	Yes	Yes	Yes	Yes
Was the research design appropriate to address the aims of the research?	Yes	Yes	Yes	Yes
Was the recruitment strategy appropriate to the aims of the study?	Yes	Yes	Yes	No Not clear and only 3 groups out of a possible 12 selected with no explanation
Was the data collected in a way that addressed the research issue?	Can't tell	Yes	Yes	Yes
Has the relationship between researcher and participants been adequately considered?	No	Yes Described in method and acknowledged as a limitation	No	Can't tell
Have ethical issues been taken into consideration?	No Not acknowledged or addressed anywhere	Yes	Yes	Can't tell Although consent etc. discussed, participants were only given a few minutes to decide if they wished to participate. Ethical approval not reported
Was the data analysis sufficiently rigorous?	No	Yes	Yes	No
Is there a clear statement of findings?	No	Yes	No	No
Quality appraisal rating	Weak	Good	Good	Moderate

Note. For the purpose of establishing a quality rating the following criteria were applied based on the items which require a yes, no or can't tell response; 0 – 3 "yes" responses = weak, 4 – 6 "yes" responses = moderate and 7 – 9 "yes" responses = Good

Section 2: Research report

An exploratory interpretative phenomenological analysis of audio-visual technology in clinical supervision and continuing professional development

Abstract

Objectives. A number of models inform how therapists learn and develop clinical skills. Audio-visual technology (AVT) has been used as an instrument in psychotherapy training since the 1960s but empirical research has rarely explored the experience of those who routinely incorporate it into their clinical practice. The aim of the current study was to develop understanding of how Intensive Short-Term Dynamic Psychotherapy (ISTDP) practitioners make sense of, adapt to the challenging process of, and deal with the emotional impact associated with, routinely using AVT in supervision.

Design and Methods. Eight ISTDP therapists, mean age 47.5 years (± 15.37) participated in semi-structured interviews that were analysed using Interpretative Phenomenological Analysis.

Results. Three superordinate themes emerged from the participants accounts: (1) *Immersion*, (2) *Revelation*, and (3) *Transformation.* Each theme comprised of several subthemes: *choosing to record, engaging with the model, transition to acceptance and valuing, nowhere to hide, window to self, opening the therapy room door, liberation, containment, developing an internal supervisor, becoming a more effective therapist and, improving patient experience and outcome.*

Conclusions. Personal practice of therapeutic techniques, experiential learning, increased self-awareness and reflective practices appear to be integral processes in professional development. In exposing themselves and their work therapists gain confidence in their skills, become more effective, and feel liberated from the fear of being "found out". Feedback from peers/clinical supervisors is recognised as fundamental to facilitating these processes. Further research is indicated within other approaches, and with individuals who have discontinued recording. Objective measurement of competencies, outcome, and patient experience is also recommended.

Developing Clinical Skills

Binder (1993) described psychotherapy training as a fundamental aspect of clinical training programmes, with a range of learning methods contributing to the development of clinical skills (Gale & Schroder, 2014). Models of how therapists acquire these skills generally propose therapists learn through experience, reflective practice, or a combination of (Davis, Thwaites, Freeston, & Bennett-Levy, 2014).

Kolb (1984, cited in Atkinson & Murrell, 1988; Terry, 2001) depicted learning as a cycle comprised of four elements: (i) concrete experience, (ii) reflective observation, (iii) abstract conceptualization, and (iv) active experimentation. The essence of the model is that experience provides something to observe and reflect upon, from which concepts are assimilated and then employed. In trying out the new concept a further experience is created from which the cycle can begin again (Sugarman, 1985).

In Schön's (1973, cited in Hébert, 2015; Papell & Slovnik, 1992; Zhu, 2011) model of reflective practice two key areas of reflection were identified, *on action* and *in action*. *On action* refers to reflection which is retroactive and based on something which has already passed, where as *in action* refers to interactive action, and thinking about the event as it occurs (Hébert; Papell & Slovnik; Zhu). Bennett-Levy's (2006) declarative, procedural, and reflective (DPR) model offers a similar explanation with reflection again considered fundamental to development.

Action learning combines experiential learning and reflective practice through a continuous and collaborative process of learning and reflection supported by colleagues (McGill & Beatty, 2001; cited in McCormack, Henderson, Boomer, Collin, & Robinson, 2008). In qualitative explorations of nurses' experience of action learning McCormack et al. (2008) and McNamara et al. (2014) found learners valued the opportunity to plan, act, observe, and reflect. McCormack et al.'s study also summarised a number of evaluative papers (Dewar, Tocher, & Watson, 2003;

McCormack & Ives, 2005; O'Connell, 2003), which found action learning brings about sustainable change in the learning and development of healthcare professionals' skills.

Learning through experience and/or reflection appears central to personal and professional development for healthcare professionals. The role of AVT in facilitating/supporting this process has long been debated.

Recordings

The use of audio-visual recordings as a psychotherapy training instrument began to gain popularity in the 1960s (Huhra, Yamokoski-Maynhart, & Prieto, 2008). Since then there has been limited research undertaken exploring the use of audio-visual recordings in supervision

Huhra et al. (2008) summarised the literature and documented advantages and disadvantages associated with the use of audio-video recordings in supervision. The advantages included, but were not limited to, a catalyst to changes in trainee self-perception, a mechanism for improved self-analysis, and a way for the trainee and supervisor to re-experience therapy sessions. Disadvantages included elevated anxiety for trainees, which may inhibit their performance during therapy sessions.

Despite the anxiety reported to be associated with use of AVT in supervision, several authors have provided additional evidence for the usefulness of recording. Alpert (1996) suggested that due to the private nature of therapy the ability of therapists to objectively evaluate their work has decreased. McCullough, Bhatia, Ulvenes, Berggraf, and Osborn (2011) expanded Alpert's discussion, suggesting psychotherapy training takes place through a master-apprentice model in which traditionally the apprentice was unable to observe the master. Through audio-visual recordings the trainee has an opportunity to observe their supervisor and assess their own clinical practice against that of more experienced others.

Alpert (1996) explored the experience of recording therapy sessions from the patient and therapist perspective. He proposed that learning about behaviours and defences can be perceived as threatening by therapists, particularly when the video is shared in supervision and mistakes and omissions can be observed and evaluated. If a therapist is able to investigate, understand, and deal with their own emotional responses to the experience of video-based supervision and training it provides an effective medium through which to learn (Alpert). Aveline (1992) agreed with Alpert, but suggested it is not enough to identify how therapists feel about video recording; believing how therapists make sense of their experience of being taped also needs to be reviewed and monitored.

Using Braun and Clarke's (2006) thematic analysis, Brown, Moller, and Ramsey-Wade (2013) explored the views of five clients and 20 psychological therapists who had experienced therapy sessions being audio- or video-recorded. The authors identified five themes in the therapist data: (i) recording is beneficial to me, (ii) we never really know how it impacts on our clients or us, (iii) refusal is surprisingly infrequent, (iv) my feelings about recording sessions change during the process and, (v) technology failures get in the way. Although therapists included in the study acknowledged the use of audio-visual recordings as a learning tool for personal development, how they made sense of and understood the feelings they experienced when using audio-visual recordings was not discussed.

The literature suggests there are positive and negative opinions regarding the use of AVT in routine clinical practice and psychotherapy training. However, there remains a paucity of literature exploring how those who actively and routinely use audio-visual recording of their clinical practice within supervision, and as part of their continuing professional development, adapt to what can be a challenging process. Although AVT is

used to a degree within many approaches, it is a routine feature of training and practice in Intensive Short-Term Dynamic Psychotherapy.

Intensive Short-Term Dynamic Psychotherapy (ISTDP)

Intensive Short-Term Dynamic Psychotherapy (ISTDP) is a Short-Term Dynamic Psychotherapy (ISTDP) within the experiential dynamic therapies (EDT) (Osimo & Stein, 2012). ISTDP was developed over many years by Habib Davanloo, who was keen to accelerate the process of psychodynamic psychotherapy (Abbass, Town, & Driessen, 2013).

Davanloo used video recordings of therapy sessions to help him develop his psychotherapeutic approach. The continued use of AVT is an integral and unique component of the approach, which provides a distinctive and valuable opportunity to reflect upon the process of change and outcome (Osimo & Stein, 2012). An open learning model is applied to training, supported and enhanced through modelling the techniques using evidence from case studies, within the context of small group supervision.

Reflecting on his observations of teaching and learning ISTDP over a 14 year period, Abbass (2004) reported that trainees became defensive when they began to share video-recordings. He observed trainees to have fluctuations in emotions and anxiety, and a loss of self-esteem, which inadvertently impeded learning and development. Abbass (2004) noted that supervision could facilitate the therapist's regaining of self-esteem but the process of learning to tolerate their anxiety and challenge their defences could take anywhere between a few months and years. The use of audio-visual recordings to observe, review and re-experience patient-therapist interactions may facilitate an increase in therapists' capacity to tolerate this process and the associated emotions (Osimo & Stein, 2012).

Within ISTDP, it is accepted that the therapist can make mistakes and can miss things in session with a patient, and because they want to offer the best treatment they can, it can be helpful to review a recording of a therapy session to check if they have missed anything with the patient. Also, it can be helpful to show part of a recording of their clinical work to their supervisor and ask their opinion about what would be helpful for the patient, where the therapist is missing something, or making a mistake. The process of reviewing work is considered to be an effective means of facilitating learning and development (ten Have-de Labije, personal communication, September 17, 2013).

Rationale

The majority of research exploring the use of recordings in therapy sessions is focussed on trainee therapists and aimed at identifying the benefits associated with recording (Brown et al., 2013). Analysis of data provided by practitioners who have adapted to and generally embraced the routine practice of video-recording their clinical work with patients has rarely been studied, but may be informative to service providers and managers who seek to ensure high quality therapy provision, as well as training providers.

In addition, according to limited evidence, the use of video and recordings in therapy and supervision is associated with strong emotions and defensive behaviours, which may impact directly on self-esteem and indirectly on clinical practice. Abbass (2004) suggested trainees who learned to make sense of their experience and tolerate their emotions and anxiety are able to challenge their defensive behaviours, eventually becoming more comfortable working with video-recordings in clinical practice and supervision.

The purpose of this research is to investigate how ISTDP practitioners make sense of AVT and its uses in their supervision and continuing professional development. Through understanding how these practitioners begin to make sense of using AVT it

may be possible to learn something about the process of adaptation to routinely using this technology and recordings in psychotherapy practice and supervision. Potentially this could inform opportunities in training, clinical practice, and supervision by supporting the individual to engage with the process of integrating the routine use of AVT.

Aims

The aims of this study were:

1. To improve our understanding of how ISTDP practitioners make sense of, adapt to the challenging process of, and deal with the emotional impact associated with routinely using AVT in supervision.
2. To explore whether using AVT has impacted on therapists' continuing professional development.

Method

Design

This study employed an exploratory flexible design utilising the qualitative methods of semi-structured phenomenological interviews and Interpretative Phenomenological Analysis (IPA). IPA was founded in the theoretical underpinnings of two traditions. Firstly, Edmund Husserl's phenomenological work, which was concerned with how people make 'sense' of their lives, and secondly in hermeneutics, the theory of interpretation. Most commonly associated with the writings of Heidegger, hermeneutics is concerned with exploring how a phenomenon materialises in data and the role of the researcher in making sense of that phenomenon (Smith, Flowers, & Larkin, 2009).

IPA offers an opportunity to develop an idiographic understanding of participants and what their experience is of a specific event. It enables further exploration of what the experience of the event means to them in the context of their

social reality (Biggerstaff & Thompson, 2008). The key aim of this research was to focus on the phenomenon of using AVT in clinical practice and gain insight into the lived experience of those who routinely use it. As Smith et al.'s (2011) review provided precedence for using IPA to explore health professionals' experience, and as Ackerman and Hilsenroth (2003) noted, therapist experience may directly influence patient experience, IPA was considered an appropriate methodology for this study.

Procedure

Recruitment. The sample was recruited from the Intensive Short Term Dynamic Therapy – UK (ISTDP-UK) online therapist directory. ISTDP-UK was set up to promote practice of ISTDP in the United Kingdom through the provision of information, support of training programmes, and the organisation of seminars and conferences. An email inviting therapists to participate in the research was sent to 15 ISTDP practitioners who listed themselves openly in the directory in August 2014. Attached to the email was a research information pack which included: participant contact letter (Appendix A), participant information sheet (Appendix B), consent form (Appendix C), and expression of interest slip (Appendix D). Hard copies of all documents were made available on request.

Recipients were invited to complete and return an expression of interest form if they wished to participate in the study. Respondents were contacted by their preferred method (telephone or email) within a week of their response. Interview arrangements were made with those who met the inclusion criteria and chose to proceed.

Six participants were recruited as detailed above and a snowballing approach was employed to recruit the remaining three participants. There were no unsuitable expressions of interest received on initial screening, although one participant was later excluded (see below).

Participants. Nine participants were recruited to the study. One was later excluded when it became apparent although core trained in other experiential dynamic therapies, they were yet to complete core training in ISTDP. As such they did not meet the inclusions criteria outlined below.

Inclusion criteria. The eight participants included in this study were over 18 years of age and had completed a three-year core training in the ISTDP model. They had audio-visually recorded their clinical work with patients within the six months prior to participating and had at least six months experience of using these recordings within supervision. All participants were willing to talk in detail about their experience, and were fluent in the English language. Demographic information for the sample is in Table 1 below.

Table 1

Demographic Information of Participants (n = 8)

			Mean ± SD	Range
Age (years)			47.50 ± 15.37	31-78
Gender				
Female	2	(25%)		
Male	6	(75%)		
Experience of ISTDP (years)			7.13 ± 2.80	4-11
Interview length (minutes)			48.15 ± 8.47	35.51–59.59

Sample size and homogeneity. The purpose of IPA is to "understand the phenomena from the perspective of a particular, defined group without *de facto* claims as to the transferability of the results to a wider population" (Brooke & Horn, 2010, p.115). From a theoretical and practical perspective this lends to the recruitment of a small homogenous sample that each have experience of the specific phenomenon to be studied (Robinson, 2014). For the present study, this refers to individuals who have completed core training in ISTDP and routinely use audio-visual recordings in their clinical practice and supervision. Robinson notes that homogenous samples may limit the generalisation of a study. However, Smith et al. (2009) suggest some value may be

drawn from the findings if readers evaluate the study in the context of their own knowledge and professional experience. Smith et al. recommends a sample size of between four and ten interviews as sufficient to provide data for a professional doctorate thesis. A homogenous sample of eight participants was recruited.

Data collection. Data was collected through individual semi-structured phenomenological interviews. An interview schedule (Appendix E) was developed in collaboration with the researcher's NHS supervisor, a qualified ISTDP practitioner and clinical supervisor. The schedule comprised of 12 questions, and a series of prompts. The key areas explored included; (i) background questions on how they came to use video recordings, (ii) the experience of using video recordings in reflective practice, peer/clinical supervision, and professional development, (iii) sharing video recordings in conferences and teaching, and (iv) how perceptions of using video recordings have changed over time. The purpose of this schedule was to guide the dialogue without being prescriptive (Smith, 1995), allowing participants to provide narratives of their experiences (Chapman, Parameshwar, Jenkins, Large, & Tsui, 2007).

As the potential sample pool was small a pilot interview was conducted with a clinical psychologist in the process of completing ISTDP core training. The interview schedule was refined and amended in response to the pilot participant's feedback and reviewing the interview transcript. As Smith et al. (2009) assert, IPA is idiographic and so the schedule was used in a flexible manner. The participant's response guided the interview, resulting in variation of scripted and follow-up questions asked to each individual.

Interviews took place between December 2014 and March 2015. The interviews lasted between 35.51 and 59.59 minutes (48.15 ± 8.47) and were conducted either face to face (*n = 3*) or via Skype (*n = 5*). Skype interviews were offered at the request of some participants who advised they commonly used this in their own clinical

supervision. An exploration of the literature highlighted the increased use of video conferencing in both clinical supervision and training (Barnett, 2011; Rousmaniere, 2014). Further ethical approval was gained from The University of Sheffield Psychology Department Ethics Committee to permit data to be collected via Skype.

All interviews were digitally recorded and transcribed verbatim, by a University of Sheffield approved transcriber, to provide raw text for analysis. The transcriber read and signed a confidentiality statement (Appendix F).

Data analysis. Interpretative Phenomenological Analysis was employed to analyse the transcripts produced from the audio-recording of each interview. Comprehensive guidance on the six stages of IPA analysis (Biggerstaff & Thompson, 2008; Smith et al., 2009) was used to inform the analyses reported in this study. A full description of each stage of analysis, for each transcript, is detailed below.

Initial reading. Each recording was listened to at least twice to support familiarisation with the data. Early reflections on the recordings were noted in a reflexive diary. The transcript was then read in conjunction with the recording, after which a brief summary of the participant's account was written.

Phenomenological coding. The transcript was viewed a few lines at a time to facilitate phenomenological coding. Descriptive notes were made in the left hand margin of the transcript for both the participant and interviewer. The aim of this stage of analysis was to describe what the experience was like for the participant and what was important to them about this experience. To successfully accomplish this it was necessary not to engage critically with the data or make judgements. This process is known as "bracketing" (Biggerstaff & Thompson, 2008).

Interpretative coding. Once phenomenological coding was complete for the first transcript, the process of interpretative coding began. The transcript was re-read and key issues identified that best captured what the text revealed about the phenomenon and

what it meant to be the participant. These were recorded in the right hand margin of the transcript. The process of looking for possible connections or conflicts was the final element of this stage of the analysis.

Identifying themes. Extracts that represented the key issues noted during interpretative coding were identified. Taking each issue in turn the extracts were considered to enable the theme to be named. A short description for each theme was written. Themes were then manually organized into clusters based on commonality. The clusters formed the basis of the development of superordinate themes. As IPA is a cyclical process, on completion of analysis of the first transcript, stages one to four were repeated for subsequent transcripts.

Integrative analysis. The final stage of the process involved an integrative analysis of the themes identified in the individual transcripts. Themes from all participants were recorded in tables and shared with the university research supervisor and two peer auditors, a recently qualified Clinical Psychologist and a final year Trainee Clinical Psychologist familiar with qualitative methodology. Patterns and overarching themes were explored and organised in a way that articulated a story for the whole group, whilst preserving the idiographic nature of the individual account.

Consideration of alternative approaches. Thematic analysis (Braun & Clarke, 2006) and grounded theory (Glaser & Strauss, 1967; cited in Robson, 2002) were considered as alternates to IPA. Braun and Clarke's approach was dismissed as it has been employed a number of times to identify several themes associated with both patients and therapists working with recordings. Discussed at the start of this study the themes identified are consistent across the evidence base. It was not deemed necessary or appropriate to simply repeat existing research.

Grounded theory is recommended as an approach for investigating social situations, with the aim of developing theory (Wimpenny & Gass, 2000). The aim of the

current study was to build on the themes identified in previous research and consider how individuals understand, make sense of, and adapt to the routine use of AVT in supervision and continuing professional development. Grounded theory does not necessarily provide access to the phenomenology of experiences, and so was also excluded.

Quality control. Yardley (2000) offered four broad principles necessary for ensuring quality permeates through the research process: (i) sensitivity to context, (ii) commitment to rigour, (iii) transparency and coherence, and (iv) impact and importance. To provide the reader with the capacity to judge the validity and credibility of the current study the measures taken by the researcher in response to Yardley are outlined below.

Sensitivity to context. The literature suggests that students and therapists experience anxiety when faced with recording and sharing their work. Often this leads to them attempting to avoid recording, despite the positive outcomes associated with doing so. Audio-visually recording and sharing work in supervision is a compulsory component of training and practice in ISTDP. This study is theoretically relevant as it seeks to explore if ISTDP therapists experience anxiety in the context of audio-visually recording their work with patients, and if so, how they make sense of this experience. Sensitivity to ethical issues has been considered throughout the research process and is described in detail below.

Goldblatt, Korneili-Miller, and Neumann (2011) suggest study credibility can be enhanced through participant involvement. Participants were invited to review the transcript of their interview and make further comments. They also had final say over which extracts were included.

***Commitment to rigour*.** As part of the Doctorate in Clinical Psychology I have attended teaching in qualitative research methods. I have also attended an independent

IPA workshop to further develop data generation and analysis skills, particularly in interpretative coding.

***Transparency and coherence*.** A clear and detailed account of the research and data analysis process has been provided in this study. Direct quotations from participant transcripts have been included to validate the themes reported and transparent links made between these and theory in the discussion. The keeping of a reflective journal throughout has enabled me to incorporate reflexivity into the study (discussed in more detail below).

Credibility checks were undertaken with my university research supervisor and two independent peer auditors to ensure the above points were achieved and the account produced was credible (Morrow, 2005). Non-annotated copies of all transcripts were made available to my NHS supervisor. Four (chosen at random) non-annotated copies were made available to each independent peer auditor. Both the NHS supervisor and peer auditors were asked to read and annotate the transcripts they had been given. I met with each person individually to discuss themes and interpretations, following which I completed further analysis on the data. Peer auditors were later provided with one annotated transcript and a table of themes and asked to check the themes I had drawn from the data. As a final measure my academic research supervisor reviewed the audit trail and had access to interpretations made for all transcripts. Detailed data collection and analysis records were kept. A worked example of the analytic process can be found in Appendix G. The aim of this process was not to arrive at consensus regarding the "truth" of the interpretations but to consider alternatives and ensure the development of an account derived from and grounded in the data (Brooke & Horn, 2010; Smith et al., 2009).

***Impact and importance*.** Through the discussion of results the aim is to demonstrate the relevance of this research to theory, clinical practice, supervision, clinical training, and CPD.

Reflexivity. As a Trainee Clinical Psychologist a requirement of obtaining my Doctorate is to audio-record some therapy and supervision sessions to provide material upon which to reflect in supervision and academic case studies. It is also expected I be observed at least twice on each placement and receive feedback. Both these elements are part of the formal assessment process and I am aware they elicit thoughts in me such as "I am not good enough", and "I am a fraud and will get found out". I have also experienced anxiety and a sense of vulnerability. Shaw (2010) describes how the interviewer's experience and judgements can detract from the participant's experience during data generation, potentially leading to a loss of richness in the participant account. As my experiences associated with recording resonate with those described in the literature I was mindful of the importance of not sharing these during interviews. Instead, as recommended by Elliot, Fischer, and Rennie (1999), I continued to explore my assumptions and reactions by keeping a reflexive diary throughout the whole of the research process. Extracts from this diary can be found in Appendix H.

Ethics.

***Ethical approval*.** The University of Sheffield Psychology Department Ethics Committee provided approval for this study (Appendix I). Approval was not sought from NHS Trusts Research and Development departments as all interviews took place away from NHS property and the study did not involve patients or access to patient data.

***Ethical issues*.**

Informed consent and withdrawal. Obtaining informed consent was addressed through the participant information sheet and consent form. Participants were given an

opportunity to read these documents and discuss them with the researcher prior to giving consent. The researcher informed participants they may experience emotional reactions and anxiety. Participants were informed of their right to withdraw from the study at any time (British Psychological Society (BPS), 2009). No participant asked to withdraw from the study.

Confidentiality and data storage. To maintain confidentiality and anonymity, pseudonyms were allocated to all participants. As participants were drawn from a small sample pool, quotations included in this study may inadvertently lead to their identification (Goldblatt et al., 2011). In an attempt to minimise this risk participants were offered an opportunity to review and veto the use of any extracts. Further consent to use the extracts will be sought prior to dissemination in acknowledgement that consent is an on-going, mutually negotiated process of research (Havercamp, 2005; Thompson & Russo, 2012). Extracts were not included which may identify any third parties discussed during the interview (Havercamp, 2005) and all participants are referred to using pseudonyms.

Audio and paper copies of data were collected, transferred and stored in accordance with University of Sheffield guidelines. Anonymised copies of transcripts and consent forms will be stored securely in a University of Sheffield site file on completion of the study.

Results

Three superordinate themes comprising eleven subthemes emerged from the analysis (see Table 2). The themes will be discussed in turn and illustrated through transcript extracts.[5] Each extract's starting line number and participant's pseudonym is stated in parentheses to maintain the audit trail.

[5] "-" denotes where an extract has been collapsed to key statements without loss of meaning.

Immersion

Immersion is made up of three subthemes which illustrate the journey participants took from choosing to record their practice to accepting and identifying the value of recording: *choosing to record, engaging with the model, and, transition to acceptance and valuing.*

Table 2

Emerging themes and subthemes

Themes	**Subthemes**
Immersion	*Choosing to record*
	Engaging with the model
	Transition to acceptance and valuing
Revelation	*Nowhere to hide*
	Window to self
	Opening the therapy room door
	Liberation
Transformation	*Containment*
	Developing an internal supervisor
	Becoming a more effective therapist
	Improving patient experience and outcome

Choosing to record. The audio-visual recording of clinical practice is integral to ISTDP training and practice. Rob chose to record routinely prior to training, stating this aspect of the work made sense as it enabled him to gain more from supervision.

> "It did make a lot of sense to me to video – to get more out of the supervision so it wasn't something I felt pressured into, it just made sense straight away." (Rob, 35)

There was congruence between Rob's approach to clinical work and the model from the beginning, which was not as evident for other participants. This is likely to have helped him to embrace working more routinely with AVT. Although Paul and Grant chose to record prior to ISTDP training, they did not share Rob's initial enthusiasm for the process. Instead there seemed to be an element of doing groundwork to prepare for what was to come.

> "It took me a while to start doing it so it wasn't until I was about to start training with (name), and I knew I would have to bring videos to training so I think a couple of months before that – I got a camera and started to record all my sessions." (Paul, 27)

> "I did it before training but only because I knew I was embarking on a training so I thought. It would be good, you know practice to do that." (Grant, 68)

This approach was not employed by the remainder of the participants who identified recording as compulsory and something they approached with reluctance.

> "You can't do ISTDP without it so I had to get on with it and do it." (Frances, 45)

Furthermore, recording sessions was viewed by some as a gateway to accessing the fundamental elements of therapeutic work and credibility as a therapist. Spencer and Andrew both seemed to perceive they had lost their autonomy and were being forced to record if they wanted to pursue training in ISTDP or have credibility as an ISTDP practitioner.

> "There was no option about the use of video – if you want to retain any credibility as an ISTDP therapist, you have to bring your videoed work." (Spencer, 58)

> "We were told categorically that you can only get supervision with a video and you video all your sessions." (Andrew, 21)

Paradoxically, although perceiving he had been forced to record, Andrew described how his attendance at a conference where videotapes of therapy sessions were presented inspired him to embark on training.

> "Went to a conference – went to that, was totally blown away by what I saw, I mean it was aah, and so when somebody said, okay, would anybody be interested in training in this method I put my hand up." (Andrew, 41)

Participants' perceptions about regarding whether they chose to record or not ranged from embracing recording to it being required. It is possible that participants experienced various degrees of anxiety about recording and/or had different attitudes towards the process of learning, and experiences in learning that could have influenced their experience of choice and willingness to embrace use of AVT in clinical practice.

Engaging with the model. Following therapy sessions, participants reviewed tapes individually, within groups, and with their clinical supervisors. To maximise learning from this process, participants worked hard to prepare their data.

> "If you videotape your material, - you're committing as a therapist to basically undertaking more work than you have to undertake." (Grant, 225)

Frances and Spencer illustrated the amount of work required by describing how they prepared data for supervision.

> "I, er, download them on to my laptop and – I keep them there until I hit supervision day and then I decide which one I'm going to take to supervision, and then the one I take to supervision I transfer onto – and I put that on a disc." (Frances, 14)

> "Well always for supervision I'll transcribe an entire tape." (Spencer, 92)

To undertake the above for each patient required participants to be invested in the approach. With all participants reporting they recorded at least half of their patient sessions the work load and time demands are considerable.

"Routinely video most patients, or maybe sixty percent." (Rob, 10)

For several participants the volume of data generated by working within the ISTDP framework was a cause for concern with regard to protecting patient confidentiality. Managing the practicalities of these concerns placed increased demands on the participants as they considered safe storage of data and working within information governance policies and service guidelines.

> "There's obviously some concerns about data protection and that stuff –having to deal with different policies and – encrypt stuff." (Rob, 502)
>
> "The only thing I don't like is that you end up with a lot of material, i.e., DVDs or stuff on the hard drive and I'm more likely now to, to immediately, erm, wipe the stuff because I don't like the idea of lots of DVDs flying about in some patient's folder that can easily get lost." (Georgia, 425)

As can be seen despite some initial trepidation about recording, participants immersed themselves in the process from the beginning. The model and recording was embraced as data was explored through a range of senses.

> "You've got the verbal, you've got the visual and you've got the actual acting something out so it's on three different levels and that's a lot more intensive – it acts on all different senses." (Georgia, 234)

The intense connection with the data, particularly through role play, which often takes place in supervision, facilitated a deeper awareness and understanding of not only the patient experience but also how the model worked in practice.

> "We'll role play what we've just seen and, erm, we've had supervision sessions where I've played the patient and the supervisor has played me and I find myself, you know, in floods of tears, or I find myself overwhelmed by emotion,- you can put yourself in the place of the patient but also you can feel the power of the inter, of good intervention." (Frances, 359)

From the initial recording participants repeatedly engaged with and reflected on the data, maintaining a connection with the patient. Whilst not as explicit in his description, Dan explained how recording his supervision provided an opportunity to assimilate his experience of the intervention with feedback from his peers.

> "One of the things which we are sort of encouraged to do is record our supervision – and then re-listen to it, and of course that's a good way of again – being able to re-listen to any comments by colleagues." (Dan, 394)

Through practice and repetition participants internalised a way of working and it became implicit.

> "Has a kind of motivation that's implicit." (Grant, 807)

> "So that's quite an interesting experience because then you haven't got the camera, you're not being recorded, you've got more freedom and I find myself doing exactly the same stuff that I would do if the camera was there." (Frances, 738)

Such engagement may lead to therapists internalising the model and applying it to self as well as the patient and therapeutic process. Georgia highlighted this when she described the experience of watching herself on videotape and noticing her defences.

> "I try to do what I see, I try to do what ISTDP teaches us for, for anxiety, you monitor it and you try – well regulate the anxiety but also take it as a signal, so what is it you're frightened of? Are you frightened of the feeling, are you frightened of the people outside, or, you know, so it, it actually makes you start to internalise the model." (Georgia, 257).

There is a sense that the process of ISTDP required considerable investment and as a result it became a part of their life as well as their practice.

Transition to acceptance and valuing. Whilst engaging in the process of training and practice participants were seen to make a transition from being somewhat

reluctant and tremendously anxious when incorporating video-recordings in their work, to a position of acceptance.

> "Well, when I first started it was bloody frightening because, erm, especially knowing you were going to show the video to a group of people – so it took me a while to get comfortable enough because seeing myself on it, - that was actually the issue." (Georgia, 29)

Two areas where this was particularly apparent were in seeking consent from participants to record sessions and sharing videotapes in supervision. Several participants identified issues in asking for consent to record therapy sessions.

> "I think I found it difficult at the beginning to get permission from the patients, it felt like a bit of an intrusion." (Frances, 151)

With more experience and a deeper understanding of why they were using videotape came a greater confidence in explaining to the patient the purpose of recording sessions. The participant's acceptance of the process translated to patient acceptance, resulting in normalisation of the video-recording for both parties.

> "I found it a bit tough at first to actually ask people to be recorded. I've got no problem now, but when I look back, erm, I think just agonising." (Spencer, 204)

Presenting video-recordings to peers was also seen as challenge associated with ISTDP practice and supervision. Through exposure to, and repetition of this experience, participants habituated to the process.

> "What I attribute that to – I mean largely just down to exposure." (Dan, 787)
>
> "But after two, three, four, five supervisions it just becomes the norm." (Paul, 161)

As the participants transitioned to a place of acceptance with regard to using video-recordings their anxiety reduced. Rather than being viewed as a threat the recording was perceived as a tool they used to facilitate their work.

> "The fact that you've got something to look through afterwards and especially when you're stuck is brilliant." (Georgia, 85)

> "I'd made an independent decision to put it there you know, I was the one reviewing it, so to me it was always a helpful thing." (Grant, 158)

Several participants utilised the video as an aide memoire recognising they did not have the capacity to notice or remember everything during the session. The video-recording served as a record of the encounter which, when reviewed, offered the participant an opportunity to fill in the blanks and access both verbal and non-verbal communication.

> "I review the tapes and I see it again and I see all the different things that I missed during the therapy hour, which is really beneficial." (Paul, 48)

For a number of participants the transition process which resulted in acceptance of the role of video appeared to continue, with a number coming recognising how valuable AVT is in the provision of therapy.

> "Occasionally I will need to go to supervision and I won't be able to share my videotape for whatever reason, and it just doesn't feel like anywhere near as useful." (Dan, 747)

When relying on recordings to capture the sessions there is less pressure on the therapist to commit all aspects of the interaction to memory, as if the video-recording becomes an external working memory. Without access to the detailed sequences of interactions the recording provided, supervision was experienced as more challenging, and less useful. Referring to working with a patient who chose not to be recorded, Andrew acknowledged the impact it had on his practice.

> "She wasn't videoed, which actually made life difficult for me not being able to review sessions. I found I was actually quite handicapped." (Andrew, 266).

Revelation

Revelation comprises four subthemes which illustrate how the sense of being exposed evolves to a sense there is no need to hide: *nowhere to hide, window to self, opening the therapy room door, and liberation.*

Nowhere to hide. Exposing their work to scrutiny by others puts therapists in a position of vulnerability, both from a professional and personal perspective.

> "I felt very vulnerable because there was nowhere I could hide." (Dan, 486)

The camera provided a record of what could be seen and heard in the therapy session, which the participants shared with their peers and supervisors. Frances and Grant illustrated how sharing the recordings of clinical sessions leads individuals to sense there is nowhere to hide as they cannot modify descriptions of what happened.

> "It's very real, you know, you can write a verbatim session, but you can write whatever you want really in that verbatim, write what you said, or what you would like to have said or what you think you said but you can't get away from the reality of the tape." (Frances, 312)

The fear identified by several participants of being exposed as a fraud in front of others, is illustrated by Dan. In externalising the fear that others will discover they are imposters, the therapists fear this may be the truth is exposed, raising questions about the therapist's own introjects.

> "The first sort of experiences I remember going through when I started using this is supervision was, er, fear and anxiety, about, erm, being found out, you know the idea that, you know somehow everybody would discover that I'm this imposter and everyone else is doing therapy and what am I doing." (Dan, 219)

In addition to being exposed to self the participants are exposed to the work of their supervisors and peers throughout training and practice. Both Frances and Andrew described how comparing self to others could be associated with self-devaluing.

> "In the group supervision, er, I found it actually quite difficult. Erm, it was difficult watching other people's videos and recognising they were all much better at it than I was, it was difficult." (Andrew, 506)

Although many participants commented on the perceived vulnerability and challenge of having nowhere to hide, a few participants referred to the potential for positive feedback.

> "If I do something, you know, a nice bit of work it can also be great to watch that back and understand what was good about it." (Grant, 254).

> "There is no hiding place on that; you know the camera doesn't lie so it, you know the therapist at the end of the day confronts the good, the bad and the ugly." (Spencer, 287)

Window to self. In being unable to hide from the truth, an opportunity arose for participants to develop a greater understanding and awareness of self. Feedback was received through both self-review of the videotape and sharing with others. This provided the participant with insight to aspects of themselves about which they were previously unaware.

> "You know I wouldn't have noticed that within myself if I hadn't seen it on video, or heard it." (Rob, 151)

> "If you don't know something, then unless it's explained to you, you're never going to know it, erm, and, and that can be a crucial factor in this type of work." (Paul, 450)

> "Because through patient work you can also cast a light on maybe some of your own conflicts you hadn't previously thought about." (Grant, 726)

Although participants had mixed emotional responses to reviewing their clinical practice, they viewed it as an opportunity to learn who they are. In embracing this

process the participants also began to learn about the impact of self on their work and patients.

> "I think even now, it is anxiety provoking to a certain extent because you lay yourself bare – but you are laid bare on a tape and it can be at times a very difficult process, but like any difficult process I think it actually helps in the long run, you know you learn something from it." (Paul, 185)

> "I maybe think, I'm, erm, maybe about being more honest as a therapist, - and I mean honest in many ways, honest with erm my feelings in a personal way that I might not have been as honest you know." (Grant, 246)

Despite reviewing their work and gaining a greater degree of insight, participants, learned through supervision that blind spots remain. Peer review provided an opportunity for further learning about self.

> "When you watch it on your own it's actually quite difficult to pick up, er, problems or issues. Erm, it's perhaps like you've still got a blind spot but as soon as you've got another person with you, if it's two colleagues watching the same tape then it frees you up, and you can see some of the things that you, you know done wrong, or sort of missed something." (Georgia, 129)

> "I wasn't aware of how different I can be at times with, with people, erm, and especially when other people comment on those kind of things within supervision itself, or to, to get that feedback, to, to kind of be aware of how I'm coming across." (Rob, 140)

Occasionally participants experienced incongruence between how they experienced their session and what is fed back to them in supervision. Paul explained how being able to review the video-recording enabled him to consider alternate explanations.

> "You know, when it's on tape you can still have disagreements but for me it's far easier to take on board the, erm, the comments offered rather than going to a defensive position of saying well, if you'd been there." (Paul, 407)

Opening the therapy room door. In sharing video-recordings of clinical practice the myth of what occurs behind the door of the therapy room is dispelled and is no longer left to the imagination. As previously reported the presentation of video-recordings of clinical practice inspired Spencer and Andrew to undertake core training. Despite being experienced therapists, what they witnessed between therapist and patient in the video-recordings was a revelation, as illustrated by Andrew.

> "Well I think I have become a better therapist because of ISTDP training, of which video is an integral part so I can't separate it out really, but I think the videoing and seeing my work on video and seeing other people's work on video has actually sharpened my appreciation of what goes on in the therapy room." (Andrew, 819)

Having access to what actually happened within the therapy room was perceived to improve the quality of supervision. Several participants used the analogy of sports coaches training athletes to illustrate how it is difficult to offer advice on how to improve performance, if you are unable to observe the individual in action. Observation enabled the supervisor to offer specific targeted feedback.

> "I think it's being able to take a tape, warts and all, and for someone to actually see what happened in that session. So when I go back now and have supervision, erm didactically I'd say it's ten percent as effective because someone's actually seeing, moment to moment what's happening with the patient in the room, how I'm responding, how they're responding or non-verbal responses, the verbal responses, there's no escaping it, there's no confusion there, you may have

> different interpretations of what happens but it's not diluted through your perceptions." (Paul, 293)

Every participant referred to the perceived value of supervision based on video-recordings of therapy sessions and all indicated they intended to continue recording because of the benefits to their practice. Having integrated video-recording into their clinical practice, and adapted to the process of reviewing their recordings, participants were struck by the idea that someone might not routinely use or have been exposed to AVT in their clinical practice or professional training.

> "People who have trained for years will sometimes say to me, I, you know, I've never seen a videotape of someone doing therapy, which sort of I find mind boggling." (Dan, 527)

Liberation. The process of training strips back any pretences a participant may have, exposing them warts and all, and provides opportunities for them to become aware of and address personal issues that may be having an impact on their therapies with patients, and in their relationships with others. Potentially, once everything has been revealed and participants have accepted themselves and experienced compassion from others there is nothing left to fear. Participants no longer have the idea they need to hide and become liberated through knowing their work is good enough or shifting the position they take in relation to themselves and their work.

> "I've become less frightened of sharing my work, it's not secretive." (Georgia, 389)

> "You're sharing what you are you know, there's no room to hide, you know, and therefore there's no need to hide." (Grant, 452)

In addition to the sense of liberation with respect to sharing videos, participants experienced greater freedom within the therapy room. As a result of not being dependent on memory or the written word to capture everything that happens in the

session, the therapist was more able to focus on being present in the moment with the patient.

> "I don't have to take notes; I don't have to write stuff down, erm, because it's there on video."(Andrew, 205)
>
> "Think it's freed me up because knowing that some, something that will record my work, I can actually focus on the process, I don't have to think, you know, you have to work, you have to do this, you have to do that, you can just focus on the work and you don't have to worry to not forget one feeling or the other – just to have that knowledge has freed me up as well." (Georgia, 414)

Transformation

Transformation is made up of four subthemes which illustrate how sharing work with peers leads to personal growth and improved patient care; *containment – safety in numbers, developing an internal supervisor, becoming a better therapist, and, improving patient experience and outcomes.*

Containment. Sharing videos within group peer supervision is a core element of the ISTDP model, and one that was associated with anxiety for all participants. Members of the group sought comfort in the shared experience and showed compassion to both themselves and each other, opening up a safe space for shared learning.

> "Group supervisions are terribly, erm, supportive, they're terribly compassionate, you don't get people just putting each other down in a competitive way and criticising each other because we all find it difficult, we're all in the same boat, and we're all struggling with the same stuff." (Frances, 522)
>
> "You might go to someone after they'd been, had a supervision or someone might come to you and say, oh that looked like that was quite tough, are you okay, you know, they were able to empathise." (Dan, 358)

Participants found it useful to attend to and reflect upon not only their own work but that of their peers.

> "Seeing your colleagues – perhaps doing something different and then being able to learn from that, both when it has a positive and negative effect is a really, er is really helpful." (Dan, 368)

The peer supervision and training groups inevitably became fertile ground for shared learning and professional development, as noted by Georgia.

> "It's massively improved, er, my, my way of working because if you share that kind of stuff with your colleagues, of, of course on the one hand you know, you are vulnerable but at the same time the value you get from, actually showing something, erm, that you can look at minute by minute and you can really analyse it and I, well – I've never learned that much, you know, without, or since I shared videotapes, I've learned loads more about my practice." (Georgia, 116)

As a result of what is considered a profound training experience peer group members often appeared to form strong friendships or working relationships with each other, based on trust, respect and mutual understanding.

> "If you are training and doing it in a group, you have to, you have to value the group and their opinions and you have to feel safe, that's so key to it." (Paul, 556)

Participants' comments about peer supervision suggested what evolved as a product of the group process was a deep sense of empathy for one another based on shared experience.

Developing an internal supervisor. Reviewing and receiving feedback on recordings of their clinical practice appeared to facilitate the development of an internal

supervisor and the clinicians' capacity for reflective practice. The internal supervisor appeared to emerge in stages as the skills of the therapist increased.

First participants reflected on what they actually saw from an outsider perspective during their review of their recordings, as if supervising someone else. Practice allowed the participants to notice things more clearly and think about why they did what they did in the session.

> "It's made me better at seeing; it allows you to look at yourself as though you were supervising someone else. It allows you to have a better view of your blind spots – you hear yourself, you hear what you're saying, you hear how you're saying it and you can be like your own supervisor." (Frances, 86)
>
> "It really causes me to think about what I did and why I think I did it." (Andrew, 649)

Through consideration of their interventions and patient responses, participants began to reflect on how they could intervene in subsequent sessions.

> "I go to the next session thinking I know what to do differently to erm, at least avoid the outcome of the last session, or at best maximise therapeutic effect." (Dan, 328)

The final stage in the development of the internal supervisor was when participants begin to reflect on their practice whilst with patients.

> "It has helped me build confidence in sharing tapes and being with patients and er, kind of going with what I think in a session or an assessment, erm, being a bit clearer about what the problem is and what to really focus on." (Rob, 447)

It was a complex task for the participant to monitor what was happening directly with patients, how they were experiencing it, and what they were bringing to the interaction. This required the participant to notice what was happening, reflect on it and potentially act in the moment.

> "In any situation, if you work with a patient, then you, you're constantly looking what, what's happening, am I getting anxious about something that's happening in the room, erm, am I getting angry, what's that about,-I think the model has taught me to be more aware about it." (Georgia, 280)

> "What am I doing in this room, am I being a psychologist, are there things I'm doing which I shouldn't do, are there things I could be doing differently, are there things I'm doing well which I'd like to continue to integrate." (Dan, 668)

Becoming a better therapist. Common to all the participants was the core value of becoming a better therapist. Use of AVT in clinical work, training and supervision was seen as essential to achieving this and developing personally and professionally.

> "I think that it's er about wanting to do therapy, er as best as you can and make, er ,er the best of your time with the patient, to be the most help that you can, erm, and to learn as well." (Rob, 267)

Participants attributed continued learning and competence development to the use of video-recording within their practice.

> "If I never looked at another tape because the things that I've learned in ISTDP, you know, would be things that stay with me whether I produce a video recording again or not, in terms of my understanding of clinical practice." (Spencer, 709)

Alongside facilitated learning participants describe their clinical skills improving.

> "I could see the scope that video offered in terms of improving clinical skills." (Rob, 84)

> "Am a better therapist now than I was eleven years ago and I think that is primarily down to the models that I've learnt and the use of videotape." (Paul, 394)

Improving patient experience and outcome. Participants identified improving patient experience and outcome as one of the key reasons they chose to continue to record, even though they continued to experience anxiety. The reviewing of videotapes of their sessions fostered a greater level of intimacy and connectedness with their patient which transferred into the therapy room.

> "I suppose there's that sort of personal connection there so I'm a bit more personally connected with them." (Spencer, 353)

> "You have a more intimate relationship with them because you hear them twice potentially." (Paul, 136)

Although a one-sided process, through the review of the session recording, the participant has an opportunity to meet with the patient, should they wish between sessions, strengthening the relationship through familiarity and understanding.

Several participants also identified with the patient experience, referring to recording of their clinical work, exposure, vulnerability, and experience of anxiety, as Spencer illustrated. In putting themselves in the patient's shoes participants appeared to experience a greater level of empathy.

> "It gives you a very clear idea of what it must be like to be a patient at least initially – in terms of anxiety." (Spencer, 458)

A small number of participants observed parallel processes in action, talking about a therapeutic element of the training programme. In the process of working on the patients' difficulties participants were exposed to their own, and given an opportunity to work through them.

> "There is also a, I don't know, some kind of therapeutic aspect in the training where you have to understand your own anxiety, your own internal processes." (Spencer, 505)

> "I think the training itself feels rather like going through therapy, I certainly felt a lot of our sessions felt like a therapy session because you know in understanding where we were struggling dealing with our patients, we were touching on our own stuff." (Frances, 572)

In building a therapeutic alliance and understanding what they bring to the relationship participants inevitably improved the patient experience. Of equal importance in driving them to continue to engage with what is undoubtedly a challenging process is that the participants experience their efforts as associated with perceived and/or patient-reported improvements in outcome, and ultimately experience a sense of mastery and achievement.

> "I think there's a dead simple answer to that, er and that is result. Er, if it, I would never, ever, ever, in a month of Sundays have gone back to the next bit of training after that – if it were not for the fact that it does exactly what it says on the tin." (Spencer, 480)

Discussion

This study presented an exploration of eight ISTDP therapists' experiences of the routine use of AVT in training, clinical practice, supervision and professional development, through interpretative phenomenological analysis. Three superordinate themes emerged from the data: (i) *Immersion,* (ii) *Revelation,* and (iii) *Transformation,* comprised of 11 subthemes. The findings of this study will be discussed in the context of their contribution to the evidence base.

Anxiety was a common theme throughout the narratives, from seeking consent from the patient to record, to sharing those recordings in supervision. A sense of exposure and vulnerability permeated the transcripts. Anxiety symptoms are unpleasant and often associated with avoidant behaviour (Leahy, Holland, & McGinn, 2012), and yet the response of the therapists was to immerse themselves in the model.

One explanation for this is through *in vivo* exposure to the process the therapists become habituated to it, and learn emotions ebb and flow, and even without taking action, anxiety reduces significantly (Barlow et al., 2011). However, the current findings suggest therapists moderate their emotional response to being placed in threatening situations by employing techniques from a number of psychological models, in addition to using their own framework to reflect on their experience. In Cognitive Behavioural Therapy (CBT), and more recently Compassion Focussed Therapy (CFT) literature much has been written about "personal practice" and the role it plays in professional development (Bennett-Levy, 2014; Gale & Schroder, 2014, Gale, Schroder, & Gilbert, 2015; McGinn, 2015). Personal practice refers to the therapist's application of therapeutic techniques to the self (Bennett-Levy, Lee, Travers, Pohlman, & Hamernik, 2003). The literature suggests that personal practice facilitates experiential learning and can impact on a range of skills, including empathy, communication, understanding and self-awareness. (Bennett-Levy et al; Gale et al.).

An example of "personal practice" emerging from the data is in the use of the six core processes of Acceptance and Commitment Therapy (ACT), a third wave CBT approach which aims to promote psychological flexibility: (i) acceptance, (ii) cognitive defusion, (iii) being present, (iv) self as context, (v) values, and (vi) committed action (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). Core to the therapist's experience was a shared value of becoming a more effective therapist and improving patient experience and outcome. In order to remain congruent to their values therapists, rather than avoiding the experience, fully engaged with the model, working hard to meet all the practical, learning, and emotional demands involved. In taking committed action and recording and reviewing sessions, AVT became integrated with clinical practice, despite the range of emotional responses which occurred. A combination of having a record of the session, and acknowledging and working through their own emotional responses,

freed up the therapist to focus on the patient. As a result meta-cognitive processes ensued, such as the development of the observer self.

Being able to observe the self is core to increasing self-awareness and developing reflective practice, both of which were seen to happen as the therapists engaged with the model. Luft (1969; cited by Jack & Smith, 2007) proposed the Johari Window as a model, consisting of four quadrants, through which you could explore aspects of self. The *open area* is what is known to self and others, whilst the *blind area* relates to aspects of self for which you do not have awareness, but others do. The *hidden area* relates to what is known to self but is chosen to be hidden from others, and the *unknown area* is not available to self or others. It is proposed that by learning more about your *blind area,* the smaller the *unknown area* becomes, leading to greater self-awareness.

Jack and Smith (2007) describe how this process occurs through the sharing of self with others. By taking a risk and revealing aspects of the self to others you are able to gain personal insight from their feedback. A model of personal and professional development, Johari's Window provides a conceptual framework for a process which is visible in the narrative of the participants. Dan described an experience, common to the majority, of feeling vulnerable as a result of sharing his work, and possibly being "found out". However, in taking this risk and being open to feedback from their peers and supervisors there was an acknowledgement by Rob, Paul, and Grant that they gained access to aspects of themselves which they had no previous awareness of, a window to self. Observing the self on tape and receiving feedback was seen as an opportunity to access personal blind spots and an essential part of the learning process.

Learning to become a better therapist and increased self-awareness were key motivators in the therapists' often challenging experience of using AVT. The ways in which they learned and developed competencies were compatible with a number of

theories, Kolb's Experiential Learning Model (1984), Schön's model of reflection (1983) and Operant Conditioning (Skinner, 1948).

Two of the four learning styles identified by Kolb (1984) appear consistent with the accounts of the therapists in this study, (i) *divergers,* and (ii) *accommodators* (also called *executors*). *Divergers* prefer concrete learning situations on which they can reflect and consider from a number of perspectives, whilst *accommodators* prefer active involvement in concrete situations (Terry, 2001). AVT provides therapists with a concrete record of the session they can reflect upon and take on board multiple perspectives through supervision, before trying out new things in the next session. It may be people are drawn to ISTDP because of its congruence to their personal learning style.

Schön's reflective practitioner was evident within the therapists' narrative, as central to their use of AVT was the process of reflecting on what happened in the therapy room through the repeated viewings of tapes. Andrew and Paul described the utility of being able to watch their own and other's recordings and reflect on/receive feedback based on a recording that revealed what actually occurred between patient and therapist. They explaining it gives an opportunity to see what you did, think why you did it, and consider what you might do differently, *reflection for action*.

What was identified in this group of therapist accounts is that repeated exposure to reflection *on action*/feedback was the catalyst for developing reflection *in action,* the ability to notice and respond appropriately to what is happening in the moment (Hébert, 2015). Through noticing, or having their attention drawn to what was missed, or what might come, the therapists developed insight in the moment, the internal supervisor (Casement, 1985). Through the process of reflecting and receiving feedback, the therapists believed their competencies developed and they become more effective in their work with patients.

In addition to using AVT to identify where the practitioner might do better, a number of therapists acknowledged that reviewing recordings of sessions and taking them to supervision was useful for identifying what they did do well and receiving positive feedback. As well as supporting therapists to understand what was good about their interventions, positive feedback would reinforce the behaviour and lead to them trying to employ the techniques in future sessions, as Skinner's (1974) operant conditioning theory explains (Cardwell, Clark, & Meldrum, 1996).

In summary, therapists reported that they employed therapeutic techniques to moderate their emotional response and anxiety. In doing so, they were able to habituate to the use of video-recordings in their clinical practice, supervision, and professional development. A willingness to receive feedback from peers and supervisors, based on video-recordings of therapy sessions, led to self-reflection, learning and professional development.

Limitations of the Research

Participants were recruited via the ISTDP-UK website and subsequent snowballing. ISTDP-UK was established to promote the practice of ISTDP in the United Kingdom, and therapists who choose to list themselves on the website are therefore likely to have idealized views about the model and training process (Abbass, 2004). By recruiting from this pool the researcher inevitably introduces self-selection bias to the research, impacting on the representativeness of the sample (Costigan & Cox, 2001). The therapists interviewed were overwhelming in their support of using AVT in clinical training, practice, and supervision and as such may reflect the experience of the wider population of ISTDP therapists, those who have chosen to discontinue training/recording or practitioners within other approaches.

In addition, a number of limitations associated with data collection, analysis and presentation were identified. Firstly, the data may reflect model based perceptions of the

value of using video-recordings rather than individual thoughts on the experience of using them. It is therefore important the reader considers participants' reflections may not be entirely based on personal experience. Secondly, participants were drawn from a small sample pool and a number voiced concerns about maintaining anonymity for themselves and their patients. As a result, some extracts based on the accounts of actual experience could not be included in the analysis.

Due to the geographical location of five participants, at their request, their interviews were conducted by Skype. Although all participants were familiar with the use of Skype, the researcher was new to the software platform. Common difficulties noted in the literature (Deane, Gonsalvez, Blackman, Saffioti, & Andreson, 2015; Sorlie, Gammon, Bergvik, & Sexton, 1999), for example, talking simultaneously, delayed voice, freezing, and loss of sound were observed by the researcher. In addition to these difficulties affecting the cadence of the interview some data was lost, either as a result of the researcher's interjections, or through not being picked up by the recording. In an attempt to address loss of data, transcripts were forwarded to individual participants with the request they respond if they had anything to add or could identify the missing data.

The purpose of IPA is not to prescribe a singular true account of a phenomenon, but to ensure credibility by ensuring the themes which emerge are grounded in the data (Brocki & Wearden, 2006), and not unduly influenced by the researcher's personal experience. Being in the process of completing professional training the researcher was also recording their clinical practice for use in supervision. Their experience of, and emotional response to this process may have influenced the interpretation process. Aware of this possibility the researcher checked interpretations were grounded in the data through peer audit.

Research Recommendations

Future research should seek to include individuals who practice different approaches and/or those who have chosen to discontinue recording in order to compensate for the self-selection bias recognised in this study. In addition, whilst the therapists in this study provide anecdotal evidence that using AVT in supervision improves patient experience and outcome, there is no empirical evidence to support this. As routine use of AVT requires substantial resource investment, and as we practice in a time of austerity, future research should incorporate objective measures of patient outcome. Controlled studies could investigate the potential benefit for patient outcome and experience associated with routine use of AVT by therapists. It may also be interesting to explore the variation in outcomes for clinicians who are afforded time to review and reflect upon recordings of their clinical work, and those who do not.

Clinical Implications

The findings of the current study (taking into consideration all limitations) highlight implications for training and clinical practice. At a time when training providers are being pressed to transparently benchmark competencies (BPS, 2015; Health and Care Professions Council, 2014), and demands on supervisors continue to increase, video-recordings offer a means by which trainees[6] can be observed *in vivo*.

To demonstrate theory and technique, as well as normalising the process of video-recording and sharing clinical work, those delivering training to, or supervising, trainees should be encouraged to video-record and share their practice within teaching and supervision. Knowing what therapy really looks like appears important to trainees' development and ability to reflect on their practice. In addition, exposure to AVT may lead to habituation to, and valuing of, the process of reviewing and sharing clinical work as part of reflective practice and supervision.

[6] Refers to trainees and students of professional training programmes

Although many trainees and practitioners avoid using AVT, in order to meet the requirements of the HCPC and BPS training providers may in future require trainees to use AVT in their clinical practice. Training providers should remain sensitive to the anxiety associated with using AVT and take steps to support students to attend to and regulate their anxiety, offering a respectful and safe learning environment. This may include placing more emphasis on the reflective practice elements of the personal and professional development modules, and/or offering therapeutic practice groups.

Supervisors should also be encouraged to integrate AVT into their own clinical practice as well as supporting supervisees to video-record and share their work in supervision, as feedback has been shown to facilitate learning and development. Supervisors should also move beyond case management and provide trainees with an opportunity to explore and manage their own anxiety, as doing so has been shown to result in increased capacity to focus on the patient and improve their experience and outcome.

Conclusions

This study provides an initial exploration into how eight ISTDP therapists made sense of, adapted to the challenging process of, and dealt with the emotional impact associated with, routinely using AVT in clinical practice, supervision, and professional development. Through the interpretation of data collected, it proposes a number of processes via which the therapists are able to manage emotional responses and transition to a place of acceptance, and indeed valuing the use of AVT and their associated experiences.

Self-practice of therapeutic techniques, experiential learning, increased self-awareness and reflective practices are integral processes in professional development. In exposing themselves and their work to colleagues and supervisors therapists gain confidence in their skills, becoming more effective and feeling liberated from the fear of

being “found out”. Feedback from peers and clinical supervisors is recognised to play a fundamental role in this process.

Although based on data collected from a specialist sample of ISTDP practitioners, it is proposed these conclusions are transferable to other contexts. Participants described feeling exposed and judged by others, whilst being required to demonstrate learning and competency development. These are familiar experiences for those embarking on professional training, regardless of modality, and for many qualified practitioners. This study provides insight into how individuals and training providers might navigate this difficult process. Further research is needed within other approaches and with individuals who have chosen to discontinue recording. Research incorporating objective measurement of competencies, outcome, and patient experience is indicated.

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Appendix A

Participant contact letter

[University letterhead removed]

Dear Sir/Madam

We are currently carrying out a research project exploring how therapists working within the ISTDP model understand and/or make sense of, and adapt to the use of AVT recordings in their supervision and how this may impact on their continued professional development.

We have contacted you as you are listed as a qualified ISTDP practitioner on the ISTDP-UK website and we would like to invite you to consider participating in this research.

You are under no obligation to take part in this study.

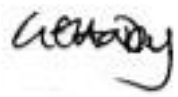
We would however be grateful if you could take some time to look at the enclosed information sheet about the research and think about whether you would be willing to take part.

If you have any questions regarding the research please contact us and we will endeavour to answer them as clearly as possible. If you decide you would like to take part, we would be obliged if you would complete the expression of interest form at the end of this letter and return it to the researcher either via email or in a Freepost envelope, which will be provided.

The researcher will contact you in the near future to discuss your participation further.

Thank you for taking time to consider taking part in this study.

Yours sincerely



Dawn Roe
Trainee Clinical Psychologist
University of Sheffield

Professor Gillian Hardy
Research Supervisor
Director of Clinical Psychology
University of Sheffield

Appendix B

Participant information sheet

[University letterhead removed]

Title of Project: AVT in supervision and continuing professional development: An exploratory interpretative phenomenological analysis of Intensive Short-Term Dynamic Psychotherapy (ISTDP) practitioners' experiences

Name of Researchers: Dawn Roe, Professor Gillian Hardy and Dr Mark Stein

We are inviting you to take part in a research study exploring your experience of using AVT (recordings) whilst working in the ISTDP model. Before you decide whether you would like to take part it is important you understand the purpose of the research and what your involvement would require. Please take time to carefully read the following information and discuss with others if you wish. Please contact us if you have any questions or would like more information. Take time to decide whether or not you wish to take part.

Thank you for taking time to read this. If you chose to take part you will be provided with a copy of this information sheet and your signed consent form.

What is the purpose of the study?

AVT and recordings are an integral component of Intensive Short-term Dynamic Psychotherapy (ISTDP), being utilised in training, self-reflection and supervision. On occasion the recordings are also shared with patients. Much has been written about people's thoughts and feelings regarding the use of "video" but there remains a paucity of literature exploring how therapists understand and make sense of the thoughts and feelings that arise as a result of the "video" and how the recordings are used. The purpose of this study is to explore ISTDP therapists' experience of using AVT in supervision and begin to understand and make sense of how they navigate this process.

Why have I been asked to take part?

You are being invited to take part in this research as you are a qualified ISTDP practitioner who works within the model and we feel that your experience can contribute to developing a greater understanding of the way therapists make sense of the use of "video" in supervision and if this work impacts on continuing professional development.

Do I have to take part?

Your participation in this research is completely voluntary. It is your choice whether you participate or not. If you do chose to participate you are free to withdraw at any point without giving a reason, and any data collected will be destroyed.

What will happen to me if I take part?

If you chose to take part in this research the researcher will meet you at a location of your choice, where you will participate in an interview which will last approximately 45 minutes to one hour (and no longer than 90 minutes). Alternatively interviews may be conducted via Skype if this is preferable. You will be asked questions about your experience of using AVT/recordings in supervision and the impact of this on CPD. Once the interview has been transcribed you will be offered an opportunity to view the transcription to confirm it is a true reflection of the interview. Approximately six months after the interview the researcher will contact you again to gain additional consent to use specific quotes from your interview. This should take no longer than one hour.

What are the possible benefits of this research?

There may be no direct benefit to you as an individual in taking part in this research. You may gain a deeper understanding of your personal experience which could translate to your clinical practice and continued development. We hope the information you share will provide further understanding to those teaching, working within and supervising those who practice in the ISTDP model. You will not be provided any incentives to take part in this research, but any associated travel expenses will be reimbursed.

Are the possible risks of taking part in this research?

We will be asking you to share personal information about your experience of working with AVT/recordings within the ISTDP model. Previous research has found that for some working with this medium may cause anxiety and other uncomfortable feelings. Talking about your experience may lead you to think about it more, and you may experience some of these feelings. You do not have to answer any questions and you can choose to end the interview at any stage, without giving your reasons.

Will I be recorded, and if so how will the recorded media be used?

The entire interview will be recorded using an encrypted digital audio recorder, which is password protected. The digital recorder will be stored in a locked filing cabinet to which only the researcher has access. Digital, password protected, audio files will also be stored in encrypted files on the researcher's laptop. The laptop will also be stored in a locked filing cabinet to which only the researcher has access. With your consent, the interview data will be transcribed by a University of Sheffield approved transcriber, who will be required to sign a confidentiality agreement. Audio files will be delivered to the transcriber via an encrypted, password protected memory stick. Pseudonyms will be used in the transcriptions, of which all paper copies will be stored in a locked filing cabinet to which only the researcher has access. Audio recordings may be shared with

the Research Supervisors to aid interpretation and reflexivity. After a period of one year, the researcher will delete all personally stored audio recordings and destroy any paper versions of data; however an anonymised copy will be stored in the research site file.

What if I change my mind?

You are free to choose to withdraw your consent to take part in this research at any time without giving your reasons. Any data collected will be destroyed.

What happens if something goes wrong?

If you have any concerns about this research please contact the researcher who will do their best to answer your questions. If they are unable to respond in an acceptable way or if you wish to make a complaint regarding the research, please contact Professor Gillian Hardy, Research Supervisor on 0114 2226571 or Ms Christie Harrison, Research Support Officer, at the University of Sheffield on 0114 2226560.

Will my participation in this research be kept confidential?

All personal information collected about you during this research will remain confidential. Your personal identifiable information will be stored separately in a locked and secure location, and destroyed on completion of the research. The Research Supervisors will have access to the audio files and transcripts, but all personal identifiers will have been removed. Prior to completion of the research you will be offered an opportunity to read the results section and request to remove any quotations you believe may lead to your possible identification.

What will happen to the results of the research?

It is the intention of the researchers to publish the results of the research in a scientific, peer reviewed journal. If you would like a summary of the results please let us know.

Who should I contact if I have a question or need more information?

Miss Dawn Roe

Clinical Psychology Department

Department of Psychology

The University of Sheffield

Western Bank

Sheffield

S10 2TN

Email: pcp12dr@sheffield.ac.uk

Alternatively, you may contact Ms Christie Harrison, Research Support Officer at the University of Sheffield on 0114 2226560.

This proposal has been reviewed and approved by the Department of Psychology, University of Sheffield Ethics Committee. The University's Research Ethics Committee monitors the application and delivery of the University's Review Procedure across the University.

Thank you for agreeing to take part in this research

Appendix C

Participant consent form

[University letterhead removed]

Title of Project: AVT in supervision and continuing professional development: An exploratory interpretative phenomenological analysis of Intensive Short-Term Dynamic Psychotherapy (ISTDP) practitioner's experiences

Name of Researchers: Dawn Roe, Professor Gillian Hardy and Dr Mark Stein

	Please initial all boxes
1. I confirm that I have read and understand the information sheet [dated 21/10/14, version 3] for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline.	☐
3. I consent to the interview being audio-recorded and the data being stored and used in the way described in the participant information sheet provided to me.	☐
4. I agree to take part in the above study.	☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

Appendix D

Expression of interest slip

[University letterhead removed]

My name is ……

I would be interested in being contacted with the view to taking part in the research "AVT in supervision and continuing professional development: An exploratory interpretative phenomenological analysis of Intensive Short-Term Dynamic Psychotherapy (ISTDP) practitioners' experiences"

I am a qualified ISTDP with a minimum of 6 months experience actively using AVT (audio-visual recordings of clinical work) within supervision.

I have used AVT within the last six months.

Profession/job title: ……

Experience of ISTDP (years): ……

Telephone number: ……

Email address: ……

Postal address ……

……

……

I would prefer to be contacted by: Telephone/email/post (delete as appropriate)

Appendix E

Interview schedule

What audio technology (AV) do you use and to what extent within your routine work as a clinical psychologist/psychotherapist?

Please describe how you came to start using AV technology within your professional role?

Possible prompts: *Was this your choice?*

What use do you make of AV technology in your professional role and can you tell me about this experience?

Possible prompts: *Can you provide specific examples? What importance/relevance do you place on this aspect of the process?*

Please tell me about how you perceived the video recorder and if this has changed over time?

Possible prompts: *What meaning do you attribute to video recording your clinical work? How do you think your client experienced it? Did it change your practice or your relationship with your client (at the time or over time)?*

Please tell me about using AV technology within your own reflective practice.

Possible prompts: *Can you describe your experience of reviewing your work on video? What is it like watching yourself? What are your thoughts/feelings? Does this change dependent on context?*

Please tell me about your experience of using AV technology within your clinical supervision

Possible prompts: *How did you experience this? How did you make sense of the process?*

Can you describe the experience of sharing your video recordings of your therapy sessions with your peers?

Possible prompts: *How did you experience/interpret comments from your peers regarding your practice?*

Have you presented recordings of your clinical work other than in peer supervision, or training, for example, at a conference, university seminar, and work based clinical meeting? If so, tell me more about your experience.

Possible prompts: *Is the experience dependent on the audience and if so how do you make sense of this?*

Tell me more about your experience of video recordings of therapy sessions in professional development.

Possible prompts: *What is your opinion of the role it plays? How were the recordings used? How have you interpreted the process?*

In what ways, if at all, has your development or practice changed as a result of video?

Possible prompts: *Do you do anything differently now? Do you think about your work differently? Given a free choice would you continue to video-record your clinical work routinely? Why?*

How, if at all, have your thoughts about video-recording your clinical work changed since you first started recording?

Possible prompts: *To what do you attribute this?*

In conclusion, is there anything we have not talked about in relation to your professional use and experience of AV technology that you think is important?

Possible prompts: *Are there any professional issues that have arisen? How did you resolve them?*

Appendix F

Transcriber confidentiality statement

Declaration

I have read the above information, as well as the Guidelines for Transcribers, and I understand that:

1. I will discuss the content of the recording only with the individual involved in the research project
2. If transcribing digital recordings – I will only accept files provided on an encrypted memory stick
3. I will keep the tapes and/or encrypted memory stick in a secure place when not in use
4. When transcribing a recording I will ensure it cannot be heard by others
5. I will treat the transcription of the recording as confidential information
6. I will adhere to the requirements detailed in the Guidelines for transcribers in relation to transcribing recordings onto a computer and transcribing digital audio files
7. If the person being interviewed on the recordings is known to me I will undertake nc further transcription work on the recording

I agree to act according to the above constraints

Your name [redacted]

Signature [redacted]

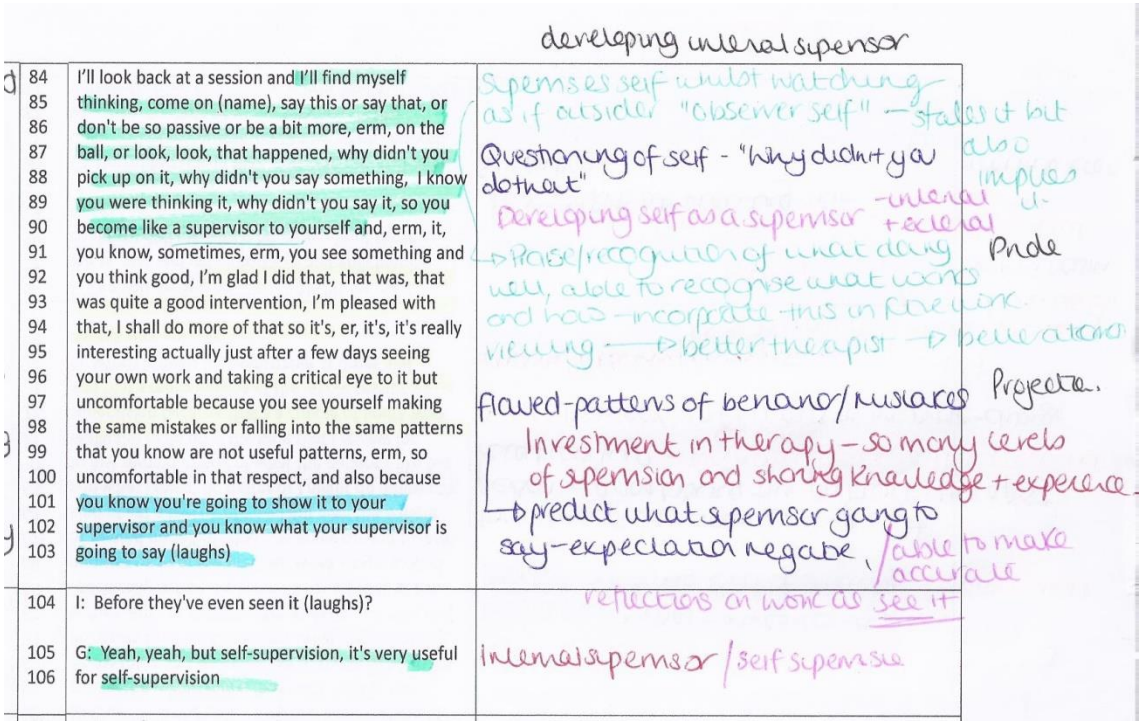
Date 12/10/14

Occasionally, the conversations on recordings can be distressing to hear. If you should find

it upsetting, please stop the transcription and raise this with the researcher as soon as possible

Appendix G

G1 – Annotated transcript



developing internal supervisor

84	I'll look back at a session and I'll find myself
85	thinking, come on (name), say this or say that, or
86	don't be so passive or be a bit more, erm, on the
87	ball, or look, look, that happened, why didn't you
88	pick up on it, why didn't you say something, I know
89	you were thinking it, why didn't you say it, so you
90	become like a supervisor to yourself and, erm, it,
91	you know, sometimes, erm, you see something and
92	you think good, I'm glad I did that, that was, that
93	was quite a good intervention, I'm pleased with
94	that, I shall do more of that so it's, er, it's, it's really
95	interesting actually just after a few days seeing
96	your own work and taking a critical eye to it but
97	uncomfortable because you see yourself making
98	the same mistakes or falling into the same patterns
99	that you know are not useful patterns, erm, so
100	uncomfortable in that respect, and also because
101	you know you're going to show it to your
102	supervisor and you know what your supervisor is
103	going to say (laughs)
104	I: Before they've even seen it (laughs)?
105	G: Yeah, yeah, but self-supervision, it's very useful
106	for self-supervision

Supervises self whilst watching as if outside "observer self" — stalls it but also implies

Questioning of self - "why didn't ya do that"

Developing self as a supervisor -internal +external

→ Praise/recognition of what doing well, able to recognise what went and has incorporate this in future work. Pride

viewing → better therapist → better outcomes

flawed-patterns of behaviour/mistakes Projector.

Investment in therapy - so many levels of supervision and sharing knowledge + experience

→ predict what supervisor going to say - expectation negative / able to make accurate

reflections on work as see it

internal supervisor / self supervise

Appendix G

G2 – Emergent themes

Practicalities	Internal supervisor
Immersion in model	Learning
Accurate feedback	Vulnerability
Beneficial for patients	I'm not good enough
Routine	Positive reinforcement
Internalised model	Remaining compassionate
Transition to acceptance	Don't need to hide
Choice	Fear of being found out
Hard work	Revelation
Being present in the moment	Self-awareness
CPD	Nowhere to hide
Self-attacking	enlightenment
Developing internal supervisor	Dependence
Accurate record	Valuing video
Filling in the blanks	Committed action
Removes blind spots	Acceptance of limitation
Video as a tool	Habituation
Clinical skills	Anxiety improves performance

Immersion	*choosing to record, engaging with the model, transition to acceptance and valuing*
Revelation	*nowhere to hide, window to self, opening the therapy room door, liberation*
Transformation	*Containment, developing an internal supervisor, becoming a more effective therapist, improving patient outcome and experience*

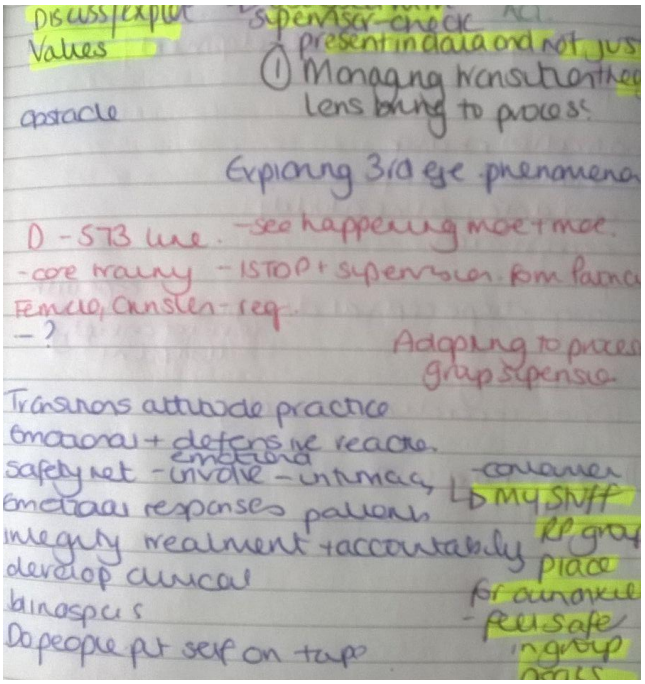
Appendix G

G3 – Excerpt from individual theme table

Main theme	Sub theme	Description	Evidence
Transformation	Developing an internal supervisor	The increase in reflective skills from reflecting on the recordings to in the session.	B:280 in any situation, if you work with a patient, then you, you're constantly looking what, what's happening, am I getting anxious about something that's happening in the room, erm, am I getting angry, what's that about, - I think the model has taught me to be more aware about it. E: 447 it has helped me build confidence in sharing tapes and being with patients and er, kind of going with what I think in a session or an assessment, erm, being a bit clearer about what the problem is and what to really focus on. H: 328 I go to the next session thinking I know what to do differently to erm, at least avoid the outcome of the last session, or at best maximise therapeutic effect. H:668 what am I doing in this room, am I being a psychologist, are there things I'm doing which I shouldn't do, are there things I could be doing differently, are there things I'm doing well which I'd like to continue to integrate. K: 649 it really causes me to think about what I did and why I think I did it.

Appendix H

Reflective diary extract



Appendix I

Ethical approval confirmation

Original Message--------
Subject: Approval of your research proposal
Date: Thu, 24 Apr 2014 11:55:33 +0100
From: Psychology Research Ethics Application Management System< no_reply@Psychology Research Ethics Application Management System>
To: G.Hardy@sheffield.ac.uk

Your submission to the Department of Psychology Ethics Sub-Committee (DESC) entitled "AVT in clinical supervision and continuing professional development: An exploratory interpretative phenomenological analysis of Intensive Short-Term Dynamic Psychotherapy (ISTDP) practitioners™ experiences " has now been reviewed. The committee believed that your methods and procedures conformed to University and BPS Guidelines.

I am therefore pleased to inform you that the ethics of your research are approved. You may now commence the empirical work.

Yours sincerely,

Prof Richard Crisp

Chair, DESC

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