“I think you’re probably given the client that...you need”

Identifying valent encounters within client/clinician interactions: An Interpretative Phenomenological Analysis

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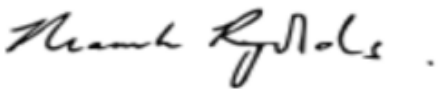
A thesis submitted to the Department of Clinical Speech and Language Studies in the School of Linguistic, Speech and Communication Sciences at Trinity College, the University of Dublin in fulfilment of the requirements of the degree of Doctor of Philosophy

2025

Declaration

I declare that this thesis has not been submitted as an exercise for a degree at this or any other university and it is entirely my own work. I agree to deposit this thesis in the University's open access institutional repository or allow the Library to do so on my behalf, subject to Irish Copyright Legislation and Trinity College Library conditions of use and acknowledgement. I consent to the examiner retaining a copy of the thesis beyond the examining period, should they so wish (EU GDPR May 2018).



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Summary

Client/clinician interactions are viewed as an integral component and facilitator of healthcare practice globally. However, there is currently a paucity of literature regarding relational aspects of healthcare practice. Of the research that does exist relating to the relational aspects of healthcare, much of the research relates to placing the clients' needs at the centre of practice, with little reference to the role of the clinician in the context of co-constructed client/clinician interactions. This research study aims to provide a further level of understanding regarding the role of the clinician in these interactions by exploring the meaning and significance of clinicians' experiences of client/clinician interactions in health and social care profession (HSCP) practice.

This study employs the use of a multiple perspective interpretative phenomenological analysis (IPA) research design to explore HSCP clinicians' understandings and experiences of client/clinician interactions. IPA affords the researcher the opportunity to access, understand and engage with the reflections of the clinician in the context of their significant lived experiences of client/clinician interactions. This engagement was achieved through the researcher's commitment to being cognisant of and adhering to the theoretical underpinnings and core principles of IPA research to include phenomenology, idiography, and hermeneutics.

Data was collected from a series of online focus groups, as a means of exploring clinicians' experiences and understandings of client/clinician interactions. Participants were recruited from five professions within social and therapeutic domains of HSCP specifically occupational therapy, physiotherapy, play therapy, social work, and speech and language therapy.

In summary, my research identified the construct of *valent encounters* within HSCP practice. The findings of my study suggest that clinicians attribute a valent quality

to particular client/clinician interactions, as described via three discrete general experiential themes (GETs) in my research study. GET I describes the *Clinician as having been elevated by the client*. This theme describes the ways in which *valent encounters* with clients have raised clinicians to a higher order of professional and personal insight. Secondly, GET II of *Clinician as having been enrooted by the client* reflects upon how *valent encounters* with clients have anchored and grounded clinicians in the context of clinical practice while also instilling a commitment to continually consider the nature, essence, and expectations of the clinical role. Finally, GET III of *Clinician as having been emboldened by the client* reflects upon how *valent encounters* with the client instil within the clinician a courage to trust and believe in the capacity of potential despite changeable conditions of clinical practice.

The findings of the study can be nestled within and extend existing concepts and theories as related to both HSCP literature and psychotherapy literature. Additionally, the findings of the research both complements and adds to existing theoretical constructs in the HSCP and psychotherapy literature base. Furthermore, potential implications of the findings for clinical practice include recognising and embracing *valent encounters* in clinical practice, increased acknowledgement of the central role of the client in healthcare practice, and the promotion of preventative education and training in undergraduate HSCP students.

The limitations and future directions of this research are also discussed. For example, the findings of the study may not be representative of all HSCP but rather relate to specific social and therapeutic domains of HSCP. Additionally, information relating to participants' years of clinical experiences and participants' place of work was not systemically collected as part of recruitment/data collection process. Meanwhile, future studies may wish to explore clients' experiences and understandings of *valent encounters*, as well as the context in which *valent encounters* are created and facilitated in clinical practice.

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List of Abbreviations

HSCP	Health and social care professions
HSCP clinician	Health and social care professions clinician
PCC	Person-centred care
PET	Personal experiential theme
GET	General experiential theme
MDT	Multidisciplinary team

Chapter 1: Introduction to Research Study

1.1. Inspiration for the Research Study

My interest in investigating this topic was inspired by many passionate and talented Speech and Language Therapists who gave of their time to enlighten and educate my peers and I during my undergraduate degree. Over the course of four years, I observed during lectures that no matter the clinician, their clinical background or the client group with whom they worked with, each clinician would reminisce and tell tales of memorable clients that they had encountered in the context of their clinical roles. The more stories and tales that I heard during lectures, the more my interest grew into exploring the significance of clinicians' experiences of interactions with clients. I subsequently undertook a research project at undergraduate level related to exploring speech and language therapy clinicians' experiences of interactions with clients. Following this preliminary research project, I was interested in exploring this topic on a larger scale to explore the meaning and significance of clinicians' experiences of client[1]/clinician[2] interactions[3] in other health and social care professions (HSCP).

1.2. Research Study Aims

This national, multi-disciplinary research study aims to explore the meaning and significance of clinicians' experiences of client/clinician interactions in HSCP practice in Ireland.

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[1] For the purposes of this study, the term 'client' refers to any individual who wishes to seek change from a HSCP clinician. The use of the term 'client' takes inspiration from the client-centred approach (Rogers, 1951) to healthcare in which both the individual and clinician are equal collaborators in the therapeutic process.

[2] The findings of the study relate to focus group interview accounts from physiotherapy, speech and language therapy, social work, play therapy and occupational therapy clinicians working in various settings in clinical practice. The term 'clinician(s)' has been chosen to reflect the universal therapeutic commonalities as presented across HSCP. Moreover, the term 'clinician' captures the specific nature of the role of the professional as one who is primarily engaged in direct clinical practice with the client, as opposed to research or laboratory-based work.

[3] For the purposes of this study, the term 'client/clinician interactions' describes a direct clinical interaction between a client who wishes to seek change from within that interaction.

Client/clinician interactions are viewed as an integral component and facilitator of healthcare practice globally. However, there is currently a paucity of literature regarding relational aspects of healthcare practice. Of the research that does exist relating to the relational aspects of healthcare, much of the research relates to placing the clients' needs at the centre of practice, with little reference to the role of the clinician in the context of co-constructed client/clinician interactions. This research study aims to provide a further level of understanding regarding the role of the clinician in these interactions by exploring the meaning and significance of clinicians' experiences of client/clinician interactions in HSCP practice.

In the everyday realities of clinical practice, the subtle and implicit nature of relational aspects of care can oftentimes go unnoticed. The subtlety of the relational aspects of care may be particularly evident in HSCP practice given that clinicians have the additional goal of incorporating therapeutic skills and techniques into their practices in order to achieve positive therapeutic outcomes for the client. Moreover, the demands and pressures of the everyday clinical environment can make it difficult for clinicians to have the opportunity to reflect upon these relational aspects of care.

However, Sylvestre and Gobeil (2020) suggest that clinicians need to be skilled and proficient in both clinical competency domains and relational competency domains of clinical practice. For example, clinical competency domains include being knowledgeable and trained in their specific areas of clinical practice. Meanwhile, relational competency domains consider clinicians possessing the necessary skills and attitudes to foster an effective therapeutic alliance with clients. Moreover, CORU (Health and Social Care Professionals Act, 2005), the statutory body responsible for the regulation of HSCP professionals in the Republic of Ireland, has published various codes of professional conduct and a code of ethics that emphasise a commitment to positive collaborative client/clinician practice (e.g., *Social Workers Registration Board – Standards of Proficiency for Social Workers*, CORU, 2019). Likewise, clients have

identified relational aspects of interactions with clinicians as being important to clients in the context of their experience of healthcare (Kornhaber et al., 2016). Given the extent to which clinicians are engaging in interactions with clients in clinical practice, I propose that it is important to explore the meaning and significance of clinicians' experiences of client/clinician interactions in HSCP practice.

1.3. Research Question

The research question for this study is: How do clinicians makes sense of their experiences of client/clinician interactions in HSCP practice?

1.4. Summary of Chapter

In summary, my research study aims to explore the meaning and significance of clinicians' experiences of client/clinician interactions in HSCP clinical practice. In the next chapter, Chapter 2, I provide an overview of the literature related to my study. In Chapters 3 and 4, I will present methodology and method chapters. Furthermore, in Chapters 5–9 inclusive, I will present the findings of the research. Meanwhile, in Chapter 10, I will discuss the theoretical contributions of the research. While finally, in Chapter 11, I will consider some of the potential implications of my findings for clinical practice. I will also propose some recommendations for clinical practice in HSCP contexts.

Chapter 2: Literature Review

2.1. Overview of Literature Review

This literature review aims to contextualise client/clinician interactions within healthcare practice. For reasons of coherence and clarity, I have divided the chapter into two sections – section one and section two.

In section one, I will reflect upon various models/approaches in healthcare that integrate elements of client/clinician interactions within their practice. I will also consider how positive client/clinician interactions may support the facilitation of such models or approaches in healthcare practice. I will also reflect upon types of client/clinician interactions, as well as the nature of these interactions in healthcare practice.

In section two, I will discuss potential factors that may contribute to understanding clinicians' experiences of client/ clinician interactions. In particular, I will briefly consider literature within the discipline of psychotherapy regarding the role of the clinician as it is the discipline which has most systematically considered the issue. I will also consider the contribution of the client to understanding clinicians' experiences of client/clinician interactions. I will also reflect upon universal traits and characteristics of clinicians that may contribute to their experiences of client/clinician interactions. Finally, I will conclude the literature review with reference to the concept of identity, reflection, and interprofessional healthcare practice.

2.2. Section One: Biopsychosocial Model

Proposed by George Engel in 1977, the biopsychosocial model recognises the dynamic and interactional nature of health and illness. Engel proposed the biopsychosocial model as an alternative model to the predominantly dualistic, reductionistic biomedical model of care that had prevailed in society since the 20th century (Borrell-Carrió et al., 2004). Engel proposed that the biopsychosocial model extended upon the biomedical model to take account of the social, psychosocial and

behavioural dimensions of an individual's experiences in the context of their overall health and illness (Engel, 1977). In essence, Engel proposed that the biopsychosocial model includes both "the patient and the illness" (p.387) whereas the biomedical predominately focused on the latter.

Engel (1977) proposed that the biomedical model did not take account of "the patient, the social context in which he lives, and the complementary system devised by society to deal with the disruptive effects of illness, that is, the physician role and the healthcare system" (p. 386). In particular, Engel reflected upon the role of the practitioner in eliciting and analysing the meaning of the patient's experience of their health and illness in the context of their psychological, cultural and social worlds (Engel, 1977). Engel expands on his comments to suggest that the "behaviour of the physician and the relationship between patient and physician powerfully influence therapeutic outcome for better or for worse" (Engel, 1977, p. 386), thus suggesting the importance of the clinician understanding the holistic experience of the client in order to provide the most meaningful care.

Moreover, Engel (1977; 1980) was cognisant of ensuring that the biopsychosocial model was based on sound scientific principles. Engel proposed that *systems theory* (von Bertalanffy, 1968), provided a suitable conceptual basis for the biopsychosocial concept. Systems theory provided a means of understanding disease and health as interrelated processes. Conceptually, systems theory treated sets of related events as a collective system that therefore extended scientific perspectives to include more holistic approaches that were more compliant to scientific conceptualisation (Engel, 1980). In the context of healthcare, Engel (1980) proposed that most healthcare encounters between doctor and patient will begin at the person level, that takes place within a two-person system, for example, the patient-doctor relationship. Taking account of the systems hierarchy, the system-orientated physician will consider person-level factors (patient's life circumstances, reactions, behaviours)

as well as other systems levels (e.g., level of the family, community) that are relevant to the patient's overall holistic presentation, to ensure the most relevant immediate and long-term care can be provided to the patient.

In his seminal paper related to the conceptualisation of the biopsychosocial model (Engel, 1977), Engel concluded that he was unsure whether the biopsychosocial model would be of any relevance to the medical profession, or indeed broader healthcare practice – "whether it is useful or not remains to be seen" (Engel, 1977, p. 394). However, twenty-five years on, Borrell-Carrió (2004) proposed that Engel's most "enduring contribution" (p. 581) was to "broaden the scope of the clinician's gaze" (p.581). In recent years, there has been a gradual shift towards the integration of the biopsychosocial model into healthcare practice (Borrell-Carrió., 2004). However, in some instances, studies have reflected upon the difficulty in conceptualising biopsychosocial considerations in clinical practice (e.g., van de Velde et al., 2017). For example, Jull (2017) suggest that the model lacks specific guidance, recommendations and restrictions for use in physiotherapy practice. Similarly, following a critical review of the literature using discourse analysis, Mescouto et al. (2022) conclude that conceptualisation of the social and interpersonal aspects of the biopsychosocial model remain limited in physiotherapy research and practice.

Furthermore, the biopsychosocial model has provided the foundation for the development of various approaches and concepts in healthcare practice, for example, person-centred care (PCC; Wade & Halligan, 2017). In the context of global healthcare practice, perhaps one of the most significant endorsements of the biopsychosocial model related to the development of the *International Classification Model of Functioning, Disability and Health* (ICF; World Health Organisation [WHO], 2001). Below, I will detail the contribution of the ICF framework and PCC to healthcare practice.

2.3. ICF Framework

ICF is an internationally recognised, multidimensional framework that is based on an integrated biopsychosocial model of human functioning, health and disability (WHO, 2001). ICF represented a radical shift from a biomedical model approach to health to place emphasis on a coherent integration of biological, individual and social perspectives of health. In essence, the ICF framework broadens the scope and meaning of diagnosis to examine the individual, environmental, social influences that may be impacting an individual's functioning and disability in the context of their lived experiences (Saleeby, 2016). At the individual level, the ICF provides a framework for assessing an individual's level of functioning and identifying relevant interventions. Additionally, the ICF provides a means of evaluating the outcomes of treatment for the individual (WHO, 2002). The ICF framework identifies three levels of functioning to include "functioning at the level of body part" (WHO, 2002, p.10), the "whole person" (p.10), and the "whole person in the social context" (p.10) in the context of body functions, activities and participation. For example, in the context of the clinical setting, the framework is commonly used to assess an individual's functioning to develop goals for intervention with the aim of supporting the individual's overall holistic health and functioning (Ferrer et al., 2014).

The framework is based on general principles closely associated with the biopsychosocial model of disability (WHO, 2002). These principles include "universality" (p.14) that relates to a means of classifying functioning and disability for all people irrespective of health condition. The second principle relates to "parity" (p.14) that refers to not differentiating disability by etiology. The third principle is described as "neutrality" (p.14) that relates to using neutral language to describe provide both positive and negative elements of each component on functioning and disability. Finally, the fourth principle emphasises the interaction between an individual's functioning and contextual factors to provide holistic insight into the lived

experience of the client that may impact an individual's overall health and functioning (WHO, 2002).

Moreover, the ICF framework is also acknowledged as the international standard for describing, classifying and measuring functioning and disability (WHO, 2001). In more recent years, Leonardi et al. (2022) reflect upon the uses and applications of the ICF model 20 years post publication. The findings of their research suggest that the framework is commonly used in clinical practice, educational training and policy development. The ICF framework is embedded in national health policy legislation, although the framework is not mandatory in the majority of countries in a global context.

In some cases, the ICF framework has been easily conceptualised in clinical practice as it has provided the foundation for the implementation of checklists, assessment instruments and procedures in clinical practice (e.g., World Health Organisation Disability Assessment Schedule 2.0 [WHODAS 2.0], (Üstün et al., 2010). However, in other instances, Prodinger et al. (2015) highlight that describing the relationship between ICF terminology and occupational therapy discipline-specific concepts is not always compatible. In light of such findings, Maritz et al. (2018) developed tables that linked occupational therapy assessments/models and ICF terminology to standardise and enhance the implementation of the ICF framework in clinical practice.

Overall, the ICF framework has been acknowledged as making a significant contribution towards a more holistic, person-centred approach to care in healthcare practice (van der Veen et al., 2023). Similarly, the biopsychosocial framework has been acknowledged as providing a foundation for a person-centred approach to care (van Dulmen et al., 2015).

2.4. Person-Centred Care (PCC)

The past two decades have represented a shift by healthcare systems towards a more holistic, person-centred approach (Lim et al., 2022). PCC is a marker of high-quality healthcare practice (Grover et al., 2022; Youssef et al., 2020). In essence, PCC views the client as an active agent in their care, by integrating a person's values and preferences into the process of decision-making to produce a care plan that is meaningful to the client (Grover et al., 2022).

From a philosophical perspective, the concept of PCC is akin to the concept of personalism, in which the person is promoted as being unique, subjective and a self-actualising entity in relation to others (Håkansson Eklund et al., 2019). Ekman et al. (2011) describe PCC as an "antithesis of reductionism" (p. 249) to take account of the client's strengths, future plans, subjectivity and integration within the context of their life environments. Furthermore, Broom (2016) describes how the concept of non-dualism has been considered and pondered in the context of PCC. In essence, PCC aims to move away from the medically dominated models of the past to embracing a broader and more holistic view of health in which the personal, social and lived experiences of an individual are recognised as intrinsically central to healthcare practice (Todres et al., 2009). PCC views the client as an active agent in their care, by integrating a person's values and preferences in the process of decision-making to produce a care plan that is meaningful to the client (Grover et al., 2022). The research suggests that healthcare systems that align with PCC principles and values that centred around the needs of the person and their communities provide more efficient and accessible services, improve client engagement, improved health and clinical outcomes, and are cost-efficient (WHO, 2015). Phelan et al. (2020) also suggest that PCC takes account of all aspects of healthcare delivery to include macro-perspective aspects of healthcare, for example, organisational and policy practices. Furthermore, PCC takes account of micro-perspective aspects of PCC to include the individual and

relational elements of care– the "compassionate, person-to-person interaction and experience of healthcare" (p. 2).

2.4.1. Definition of PCC

From my reading of the literature and to the best of my knowledge, there appears to be no one defined, globally accepted definition of PCC (Glover et al., 2021; Harding et al., 2015). In recent years there have been a myriad of terms and definitions used to encompass the concept of PCC to include person-centred care, patient centred care, patient directed care, relationship-centred care (Kogan et al., 2016; Santana et al., 2018). As a result of the lack of consensus regarding a definition of PCC[4], some commentators have reflected that confusion regarding specific components of PCC have resulted in the concept becoming ambiguous and unclear (Dewing & McCormack, 2017). For example, in both patient-centred and person-centred discourse, the care seeker is defined as an active partner in caregiving and who possesses the ability to engage in shared decision making and who is unique, and self-determining (Siouta & Olsson, 2020). The work of Håkansson Eklund et al. (2019) similarly accepts and acknowledges the overlap between the two concepts. The authors' analysis of synthesised literature identified nine themes that are common to both PCC and patient-centred care to include empathy, respect, engagement, relationship, communication, holistic focus, individualised focus and coordinated care. However, Håkansson Eklund et al. (2019) also aim to decipher the differences between person- and patient- centred care. The authors conclude that the two concepts are "*similar* at a surface level but *different* when regarded on a deeper level in light of their different goals" (Håkansson Eklund et al., 2019, p. 7). According to the authors, the goal of PCC is to live a meaningful life while the goal of patient-centred care is to live a functional

[4] For the purposes of the literature, review, I will employ the use of the term PCC to encompass collaborative practice in which the meaningful choices and preferences of the client are considered in the context of holistic healthcare practice.

life. Similar differentiations have been made in the literature in recent years. For example, Pluut (2016) defines patient-centred care in context of the people's overall life situation. In contrast, PCC emphasises the importance of viewing the caregiver as a whole person consisting of "emotions, relationships, families, traumas, experiences, stories, cultures, spiritualities and more" (Broom et al., 2019, p.415), rather than parts of a whole.

In other instances, some researchers have gravitated towards identifying components of PCC rather than explicitly defining the concept. For example, in their systematic review of the literature, Kogan et al. (2016) identified common principles as being central to person-centred practice. The six most common domains included "holistic/whole person care" (p.6) , "respect" (p.6), "value" (p.6), "dignity" (p.6), "self-determination (p.6)" and "purposeful living (p.6) ". Similarly, Harding et al. (2015) drew on international literature and research to identify three integral components of PCC. The first component included viewing PCC as a group of concepts that encompasses principles that prioritise a client's needs and circumstances to include "shared decision making" (p.9), "integrated care"(p.9), and communication between client and clinician. The second component includes viewing PCC as a "partnership" (p.9) in which there is a sharing of knowledge and expertise between client and clinician. Finally, the third component relates to emphasising personhood in PCC that encompasses recognising the whole person in the context of their lived social worlds.

2.4.2. PCC in a Global Context

Despite the lack of clarity regarding a definition of PCC, the principles and concepts informing a PCC approach to care have been widely acknowledged in global policy and healthcare practice. For example, *WHO Global Strategy on People-Centred and Integrated Health Services* (WHO, 2015) informs the implementation of person-centred and integrated health services globally. The strategy called for a significant transformation in the ways health services are managed, funded and delivered across

the world. The strategy recognises the complex nature and context of health services globally, and therefore, proposed a common set of principles and five strategic directions to ensure countries can provide a coordinated approach to care to respond to each individual's unique needs, as defined below:

> People-centred health services are an approach to care that consciously adopts the perspectives of individuals, families and communities and sees them as participants as well as beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways. People-centred care requires that people have the education and support that they need to make decisions and participate in their own care. It is organised around the health needs and expectations of people rather than diseases. (p. 7)

The strategy identifies five core principles that underpin and inform person-centred and integrated approaches to care. For example, some of these principles include healthcare systems providing care that is (i) "comprehensive" (p.11) (ii) "holistic" (p.11) – to describe focusing on the social, emotional, socioeconomic and physical well-being of people (iii) "empowering" (p.11) – to describe supporting people to make their own goal orientated decision regarding their care and outcomes of successful care, (iv) "respectful" (p.11) – to describe being respectful of peoples' social context and cultural backgrounds (v) "collaborative" (p.11) – to describe an approach to care that supports relationship building (vi) "co-produced" (p.11) – to describe developing active partnerships with people and communities at an individual and organisational level. Furthermore, the strategy outlines strategic directions to conceptualise a person-centred and integrated health service. In particular, strategic direction one – "empowering and engaging of people" (WHO, 2015, p. 8) references the principle of co-production. More specifically, co-production relates to provide health service delivery "in an equal and reciprocal relationship between clinical and

non-clinical professionals and the individuals using care services, their families, careers and communities" (WHO, 2015, p. 8). Moreover, the strategy identifies the potential benefits of a person–centred and integrated approach to care. Some of these benefits for individuals and their families may include increased collaboration between individuals and healthcare professionals relating to shared decision-making with healthcare professionals in individual care planning, stronger relationships with care providers and increased access and coordination of care.

2.4.3. PCC in the Context of the Irish Healthcare System

In light of global health initiatives and practices, there has been an evolving trend of healthcare in Ireland that aims to move away from directive and paternalistic models of care (Coulter & Oldham, 2016) to embracing a new model of PCC (Phelan et al., 2021). A person-centred approach to care was emphasised in *Committee on the Future of Healthcare Sláintecare Report (*Houses of Oireachtas, 2017*)*. The report, known as *Sláintecare,* proposed a new approach to healthcare that aims to offer universal, person-centred integrated health service where the unique choices and values of the individual are placed at the centre of healthcare delivery and practice. Within the Irish health context, the inclusion and engagement of service users in service planning and development is paramount to a person-centred, coordinated approach to healthcare (Phelan et al., 2021). For example, the Patient Narrative Project (Phelan et al., 2021) engaged with services users, service user representatives and their caregivers to co-create definition of person-centred co-ordinated in the context of the Irish healthcare system. Three main themes were identified from the focus group discussions to include "my experience of healthcare", "care that I am confident in", "my journey through healthcare" (Phelan et al., 2021, pp 5–8). In more recent times, the *Sláintecare Implementation Strategy and Action Plan 2021-2023* (Government of Ireland, 2021) outlines the health service's continued commitment to person-centred and coordinated care in Ireland.

2.4.4. Conceptualisation of PCC in Healthcare Practice

Despite the array of endorsement, international prominence and array of literature relating to PCC, there remain barriers to the full implementation of PCC to include financial educational, physical and emotional barriers (Paparella, 2016). Likewise, there is limited clinical and empirical evidence relating to how PCC is conceptualised in practice (McCormack et al, 2010; Youssef et al., 2020). Ekman et al. (2011) observe that some clinicians may underestimate the skills needed to implement PCC. Furthermore, Moore et al. (2017) identify the sceptical attitudes of some professionals towards PCC as a prominent barrier to the implementation of PCC in different healthcare contexts. For example, Sjöberg and Forsner (2020) conclude that there is more reflection and research needed to consider how PCC is implemented in daily practice in physiotherapy. Likewise, Hammell (2015) considers that although occupational therapy asserts itself as a client-centred discipline in practice, such assertions have remained largely unchallenged, leaving Hammell (2015) to suggest the need for critical reflection as a core component of person-centred practice in this area. Similarly, Moore et al. (2017) identified professional attitudes towards PCC care as a barrier to its implementation in healthcare practice. For example, some professionals believed that they were practicing PCC when in reality, this was not always the case. Moore (2017) emphasises that PCC requires "conscious effort" (p. 668) to maintain.

2.4.5. Relational Elements of PCC

As referenced previously, PCC takes account of micro-perspective aspects of PCC to include the individual and relational elements of care – the "compassionate, person-to-person interaction and experience of healthcare" (Phelan et al., 2020, p. 2). Youssef et al. (2020) suggest that the quality of the interactions between clients and clinicians was a defining aspect of PCC experiences for clients. Additionally, clients identified the ability of care teams to recognise their unique needs, as well as establish entrusting relationships with clients as integral aspects of client/clinician interaction

that moulded patient's perception of effective care. Their work concludes that PCC is "an evolving process that develops through productive patient–clinician interactions" (Youssef et al., 2020, p.7). Similarly, Kornhaber et al. (2016) conclude that the client/clinician interactions have the capacity to enrich relations between the client and clinician in clinical practice. Phelan et al. (2020) also identify the importance of "meaningful engagement" (Phelan et al., 2020, p. 3) between clinicians and clients in healthcare practice in order to promote PCC. More specifically, Hamovitch et al. (2018) suggest that "engaging a person and establishing a strong therapeutic relationship undergird a person-centred approach" (Hamovitch et al., 2018., p. 952). For example, the authors identify goal setting as "an intensely personal process" that requires the clinician having a "genuine understanding of what is meaningful to a person and the context of his or her life" (Hamovitch et al., 2018., p. 952).

Moreover, Hamovitch et al. (2018) concluded that client/clinician interactions can be both a facilitator as well as an outcome of PCC. Similarly, Grover et al. (2022) identify communication, shared decision-making, and respect as key elements that have the capacity to enhance client/clinician interactions in the context of PCC. The authors also reflected that the relationships between client and clinician "are especially important in PCC as a whole and the broader delivery of the healthcare system" (p. 1686). Similarly, Schuttner et al. (2022) acknowledge individual client/clinician interactions "as the greatest facilitators or barriers to person-centred care" (p.4189). For example, the authors describe effective communication as a key factor that has the potential to improve client engagement and provide individualised care. On the other hand, Schuttner et al. (2022) reflect that interpersonal barriers, such as clinicians being unable to ascertain a client's personal needs and values, can result in a barrier to care. The authors recommend an emphasis on continual, consistent quality client/clinician relationships to enhance trust amongst clients. Likewise, Brummel-Smith et al. (2016) identified communication that "focused on interaction

between the person and the provider" (p.17) as an effective means of implementing PCC in practice. Similarly, Moore et al. (2017) identified "communicating effectively in partnership with people" (p. 670) as a facilitator of PCC.

Likewise, clients have identified relational aspects of interactions with clinicians as being important to clients in the context of their care. For example, Kornhaber et al. (2016) conducted an integrative review using allied health, nursing and medical literature which identified person-centeredness and "therapeutic engagement" (p.543) as integral aspects of enhancing therapeutic alliances between clients and clinician in healthcare practice. Similarly, in a grounded theory study conducted by Yoessef et al.(2020), clients identified holistic care that considered the clients "whole situation" (p.6) as well as collaborative engagement with clinicians in an open and safe environment as important elements of PCC. Clients acknowledge that collaboration helped to form a strong sense of alliance between them and the care team (Youssef et al., 2020). Clients also commented that shared deliberation between client and clinician was beneficial in helping the client to understand the impact of their health needs on their social, personal and occupational worlds.

Additionally, in the context of dementia care, Kitwood and Bredin (1992) identified the interpersonal relationship based on respect, recognition and trust as an integral component of supporting and affirming an individual's personhood in a person-centred philosophy to dementia care. The authors reflect that the ability of the caregiver to create and maintain a relationship with the person with dementia can ensure and replenish an individual's sense of personhood. Similarly, Fazio et al. (2018) conclude that when examining PCC though integration of current best practice and literature as well as common decency, "it becomes clear that providing care based on knowing the person within the context of an interpersonal relationship in a way that supports individual choice and dignity is difficult to argue against" (p.18).

2.5. Summary of Client/Clinician Interactions in the Context of PCC Practice

The above research suggests that client/clinician interactions form a core and integral means of facilitating PCC in healthcare practice. Given that there seems to be a lack of conceptualisation of PCC in clinical practice, research indicates that enhanced communication between client and clinician in the context of the client/clinician interaction is a main facilitator of PCC. Moreover, research shows that further emphasises on relational components of healthcare to improve PCC in clinical practice into the future. In the following paragraphs, I will discuss the current conceptualisation of relational aspects of care in HSCP literature and practice.

2.6. Client/Clinician Interactions in Healthcare Practice

There are various terms used to describe the concept of client/clinician interactions in healthcare practice. For example, some of these terms include therapeutic relationship/therapeutic alliance/working alliance/rapport (Bright & Reeves, 2022). Despite the many definitions relating to client/clinician interactions, academics identify trust (Mechanic & Meyer, 2000; Rasiah et al., 2020, Robinson, 2016; Shore, 2003) and respect (Crits-Christoph, 2019; Rogers, 1951) as core facets that define healthcare relationships. Meanwhile, Miller and Moyers (2021) identify "compassion" (p.5) and "partnership" (p.6) as core therapeutic attitudes as possessed by clinicians in helping relationships to help enhance a client's welfare and well-being. Given the extensive use of conceptual terms related to client/clinician interactions in healthcare literature, for the purposes of my literature review, I will draw reference to the concept of *therapeutic alliance* (Bordin, 1979) due to it being one of the most commonly referenced concepts in the healthcare literature (Connery et al., 2022; Mescouto et al., 2022). Therefore the terms 'client/clinician interactions' and 'therapeutic alliance' will be used interchangeably for the remainder of the literature review.

2.6.1. Therapeutic Alliance

Stemming from the field of psychotherapy, the therapeutic alliance places emphasis on the collaborative agreement and emotional bond between client and clinician in the therapeutic interaction (Bordin, 1979). The literature recognises the therapeutic alliance as an essential construct that transcends various theoretical perspectives in psychotherapy (Bordin, 1979; Nissen-Lie et al., 2010). More specifically, Bordin (1979) specified three components that contribute to the development of a strong therapeutic alliance. These components include mutual agreement between client and clinician on therapeutic goals, agreement on therapeutic tasks and positive bonds. Many of the components relate to client and clinician engaging in collaborative practice to identify therapeutic goals, and activities that clients are willing to engage with to help facilitate change. As well as this, the concept of positive bonds relates to the development of the interpersonal relationship between client and clinician. More specifically, positive bonds involve the client building trust and confidence in the clinician to help the client to achieve their goals (Bordin, 1994). Positive bonds are built on mutual respect, respecting boundaries and listening empathetically. Similarly, the work of Edward Bordin (1979) describes how it is the "deeper bonds of trust" (p. 254) that help define the interactional and relational processes between client and clinician. Bordin (1979) further reflects on how it is "the strength rather than the kind of working alliance" (p.252) that proves to be "*the* key to the change process" (p. 252).

2.6.2. Therapeutic Alliance in the Context of HSCP

The therapeutic alliance is one of the most commonly referenced terms and concepts in the healthcare literature (Connery et al., 2022; Mescouto et al., 2022). Bordin (1979) reflected that "a working alliance between a person seeking change and a change agent can occur in many places besides the locale of psychotherapy" (p.252). HSCP have since adapted elements of the therapeutic alliance construct to HSCP practice. For example, Hansen et al. (2024) reference the importance of positive bonds

as well as collaborative agreement on goals between client and clinician to the development of a strong therapeutic alliance in the profession of speech and language therapy. Moreover, Lawton et al. (2018) reflected that Bordin's construct of alliance was highly relevant to the findings of their study, specifically in relation to positive bonds and the collaborative nature of goals in speech and language therapy.

The therapeutic alliance is deemed a fundamental component of HSCP practice. For example, the therapeutic alliance has been viewed as an integral dimension of occupational therapy practice (Cole & McLean, 2003; Finlay, 2004). Likewise, in the profession of social work, Ruch et al. (2018) suggest that it is "perhaps a truism that 'the relationship' is central to good practice in social work" (p.13). Meanwhile, the quality of the therapeutic alliance is also key factor in social work practice. Sudbery (2002) suggests that "the primary resource in this work is the social worker themselves, and their use of relationship" (p. 151). Similarly, in a child-centred approach to play therapy, the child's relationship with the therapist is integral to the likelihood of positive change (Wilson & Ryan, 2006). Likewise, research across other HSCP suggests that a strong and supportive therapeutic alliance is an important factor related to successful treatment outcomes across (Babatunde et al., 2017; Hall et al., 2010, Kinney et al., 2020).

Moreover, CORU (Irish Statute Book, 2005), the statutory body responsible for the regulation of HSCP professionals in the Republic of Ireland has published various codes of professional conduct and ethics related to regulated HSCP. For example, social work clinicians are expected to support and empower the client through collaborative practice that recognise clients as "active participants" (CORU, 2019, p.8) in their care. The recognition of clients as active participants in their care as well as empowering client to communicating their choices and preferences related to their care is similarly outlined in codes of professional conduct and ethics in speech and language therapy (e.g., *Speech and Language Therapists Registration Board –*

Standards of Proficiency for Speech and Language Therapists, CORU, 2018), occupational therapy (e.g., *Occupational Therapists Registration Board – Standards of Proficiency for Occupational Therapists*, CORU, n.d) and physiotherapy (e.g., *Physiotherapists Registration Board – Standards of Proficiency for Physiotherapists*, CORU, 2019).

2.6.3. Aspects of the Therapeutic Alliance

Furthermore, research has been undertaken related to various aspects of the therapeutic alliance construct to include fostering the therapeutic alliance in practice as well as identifying and developing methods and assessment tools related to therapeutic alliance in clinical practice. In some instances, research in HSCP has focused upon skills and the characteristics of the clinician for the development of the therapeutic alliance. For example, in the profession of physiotherapy, Miciak et al. (2018) identify being committed, genuine, receptive and present as attitudes that support the establishment and maintenance of the therapeutic alliance. While in the profession of social work, warmth and respect are considered integral skills necessary for the developing of the therapeutic alliance (Trotter, 2012). Similarly, in speech and language therapy, Fourie (2009) conceptualised a theory, namely, "restorative poise" (2009, p. 988) that identifies particular therapeutic qualities and therapeutic actions of the clinician to help foster the therapeutic alliance. The therapeutic qualities include being inspiring and understanding while the specific therapeutic actions include being empowering and practical in helping to foster a strong therapeutic alliance. Likewise, within the profession of occupational therapy, the Intentional Relationship Model (IRM; Taylor, 2008) is a conceptual framework devised to support clinicians in understanding their role within the context of the therapeutic alliance, as well as devising practical strategies and tools to support clinicians in establishing and maintaining the therapeutic alliance with clients. The framework describes four central elements of the IRM to include client interpersonal characteristics, inevitable

interpersonal events, occupation and therapist (to include the therapists' interpersonal knowledge base, therapeutic knowledge and interpersonal reasoning).

In other instances, research relating to identifying and developing methods and assessment tools related to the therapeutic alliance in clinical practice. For example, in speech and language therapy, Ebert (2017) developed and applied a set of clinician/client relationship scales to assess clinician/client relationship in paediatric speech and language therapy intervention. Moreover, Lawton et al. (2019) developed the A-STAM (aphasia and stroke therapeutic alliance measure)to measure the effectiveness of the therapeutic alliance for treatment process and outcomes. Similarly, in the profession of physiotherapy, the physiotherapy therapeutic relationship measure (P-TREM) (McCabe et al., 2022) has been specifically designed to measure the therapeutic alliance. However, in the profession of physiotherapy, in a systematic review of the literature, Gutiérrez-Sánchez et al. (2021) conclude that there have been few instruments validated to assess the theoretic relationship in physiotherapy practice.

2.6.4. Reciprocity in the Context of the Therapeutic Alliance

While the therapeutic alliance is deemed an integral component of healthcare practice, there remains questions regarding the elements of the therapeutic alliance that make the alliance significant (Priebe et al., 2011). For example, Sandhu et al. (2015) suggest further consideration of reciprocity[5] in healthcare research as a means of exploring elements that conceptualise the therapeutic alliance as significant. To the best of my knowledge, there seems to be a paucity of literature related to reciprocity

[5] The term 'reciprocal/reciprocity' seems to be used interchangeably with the term 'mutuality' in HSCP literature. From my extensive reading of the HSCP literature, I hypothesise, that authors define 'mutuality' with reference to collaborative and mutual agreement between client and clinician on therapeutic goals, agreement on therapeutic tasks and positive bonds in the context of the therapeutic interaction (Bordin, 1979). For reasons of coherence and clarity in my literature review, I will employ the use of the term 'reciprocal/reciprocity' to encompass the description of 'mutuality' as highlighted above. I will refer to Roger's (1959) use of the term 'mutuality' in a different context later in the chapter.

in HSCP practice. For example, Mescouto et al. (2022) highlights that the concept of reciprocity has not been explored within the physiotherapy literature to date. Mescouto et al. (2022) aimed to explore the ways in which reciprocity is demonstrated in clinical practice. The authors identified a number of themes that reflect upon specific processes that can foster a reciprocal environment whereby both client and clinician are engaged in collaborative practice, and mutual power-sharing practice between client and clinician. Some of these themes include accepting or blocking a patient's offer, inviting patients to make an offer and sharing personal stories as psychosocial offers. The authors conclude that reciprocity is a valuable concept that can be implemented in physiotherapy practice to help foster positive therapeutic alliances. Similarly, using inductive thematic analysis, Lawton et al. (2018) identified themes that related to strategies employed by clinicians to harness reciprocity in the therapeutic alliance. For example, "recognising personhood" (p. 554) related to clinicians recounting their personal stories and experiences to clients to foster a positive therapeutic alliance. Other themes that related to reciprocity included "sharing expectations" (p. 556) and "activating ownership" (p.556). Likewise, Hansen et al. (2024) acknowledged the reciprocity of therapeutic alliance in speech and language therapy practice.

Indeed, it can be hypothesised that research related to the concept of reciprocity suggests the co-constructed, bi-directional nature of client/clinician interactions. Furthermore, some authors have reflected upon the need for further research relating to role of the clinician in the context of co-constructed, bi-directional client/clinician interactions. For example, Cohen-Schneider et al. (2020) suggest that while the person-centred approach to care places the needs of the client at the centre of healthcare practice, the approach "does not provide enough insight into the clinician regarding his or her contribution to the therapeutic relationship" (p. 415).

Similarly, Grover et al. (2022) highlights the importance of clinician empowerment as a key element in conceptualising PCC in practice.

2.6.5. Therapeutic Alliance in the Context of Therapeutic Technique Literature

Despite therapeutic alliance being deemed a growing area of HSCP research and practice (Hansen et al., 2024; McCabe et al., 2022; Sylvestre & Gobeil, 2020), there is currently less research being undertaken regarding the therapeutic alliance in comparison to research that focuses on the application of therapeutic technique in HSCP. In their scoping review of the literature, Hansen et al. (2024) deduced that although research relating to the therapeutic alliance has grown within the last decade, in the past 50 years there have been 44 studies that have empirically investigated the therapeutic alliance in speech and language therapy. Given that much of the literature relating to the therapeutic alliance in physiotherapy literature is based on Bordin's psychotherapeutic concept, Babatunde (2017) reflects that it remains difficult to determine "if outcomes are determined by specific techniques, mechanism of action of general processes like the TA (therapeutic alliance)" (p. 2). In the context of clinical practice, Sylvestre and Gobeil (2020) suggest that clinicians need to be skilled and proficient in clinical competencies (e.g. being knowledgeable and trained in their specific areas of clinical practice). Furthermore, the authors highlight the importance of "relational competence" (p. 127) that highlights the importance of clinicians possessing the necessary skills and attitudes to foster an effective therapeutic alliance with the client. Similarly, Cohen-Schneider et al. (2020) suggest that more emphasise has been placed on the "objective" (p. 417) elements of therapeutic intervention rather than the relational aspects of speech and language therapy practice. Similarly, in recent studies conducted in the psychotherapy literature, Steindl et al. (2023) reflected upon the interplay between therapeutic technique and the therapeutic alliance. Their work concluded that applying technique without attending to the therapeutic alliance can result in ruptures if the relational impact is not monitored.

Likewise, Miller and Moyers (2021) allude to the limited attention given to the development of clinicians' therapeutic skills in the psychotherapy profession. In their final reflections in the conclusion chapter of their book, the authors acknowledge the importance of recognising "the value of both technical and relational components" (p. 174) of client/clinician interactions that will "go a long way to further improve the quality of healthcare" (p.174).

2.7. Summary of Section One

In summary, it seems that client/clinician interactions are viewed as an integral component and facilitator of HSCP practice, and healthcare practice globally. However, the literature seems to suggest the need for further emphasises on relational aspects of healthcare practice. Of the research that does exist relating to the relational components of healthcare, much of it relates to placing the clients' needs at the centre of practice, with little reference to the clinician in the context of co-constructed client/clinician interactions.

Therefore, my research aims to provide a further level of understanding regarding the role of the clinician in client/clinician interactions by exploring the meaning and significance of clinicians' experiences of client/clinician interactions in HSCP practice. The need for further exploration of therapists' experiences of relational and reciprocal experiences in HSCP literature is alluded to by Keiter Humbert et al. (2018) who conclude that many aspects of the reciprocal therapeutic alliance are not fully understood in HSCP practice.

In the following section, Section two, I will discuss potential factors that may contribute to understanding clinicians' experiences of client/ clinician interactions. In particular, I will briefly consider the role of the clinician within the context of the psychotherapy literature. I will also consider contribution of the client to understanding clinicians' experiences of client/clinician interactions. Additionally, I will reflect upon universal traits and characteristics of clinicians that may contribute to

their experiences of client/clinician interactions. Finally, I will conclude the literature review with reference to the concept of identity, reflection and interprofessional healthcare practice.

2.8. Section Two: The Concept of Mutuality in the Context of Psychotherapeutic Literature

In the context of the person-centred approach to care, the therapeutic alliance, as discussed above, consists of six necessary and sufficient conditions for therapeutic change to take place (Rogers, 1959). These include empathy, unconditional positive regard and congruence. The necessary and sufficient conditions for therapeutic change are further proposed by Rogers (1992) below:

> For constructive personality change to occur, it is necessary that these conditions exist and continue over a period of time: (1) Two persons are in psychological contact. (2) The first, whom shall be termed the client, is in a state of incongruence, being vulnerable or anxious. (3) The second person, whom shall be termed the therapist, is congruent or integrated in the relationship. (4) The therapist experiences unconditional positive regard for the client. (5) The therapist experiences an empathic understanding of the client's internal frame of reference and endeavours to communicate this experience to the client. (6) The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved. (p.827)

In essence, these six conditions are hypothesised to stimulate the process of therapy which then pave the way for the process and outcomes of change to occur (Rogers, 1959)- "if most basic element of our theory is that if the described conditions exist, then the process of therapy occurs , and the events which are called outcomes will be observed" (Rogers, 1959, p.217). Roger's process-outcome model identifies the

role of the client in the creation of a dynamic, bi-directional, reciprocal relationship. Moreover, Rogers alludes to the concept of 'mutuality' in the context of the client/ clinician interaction (Rogers, 1959):

> Assuming a minimal *mutual* willingness to be in contact and to receive the communications, we may say that the greater the communicated congruence, of experience, awareness and behaviour on the part of one individual, the more the ensuing relationship will involve a tendency towards *reciprocal* communication with the *same* qualities, *mutually* accurate understanding of the communications, improved psychological adjustment in *both* parties and functioning in *both* parties, and *mutual* satisfaction in the relationship. (p. 240)

Two years previous, in 1957, Rogers met in public dialogue at the University of Michigan with philosopher, Martin Buber. Here, both men discussed their viewpoints on the client/clinician relationship. Both Buber and Rogers agreed that mutuality can exist within the therapeutic alliance. Rogers describes how "the moments in which people do change, are perhaps the moments in which perhaps the relationship is experienced the *same on both sides*" (Cissna & Anderson, 1997, p.53). It is this "change" from the point of view of the clinician, that has received little attention in the literature within HSCP. Therefore, I wish to explore the meaning and significance of clinicians' experiences of client/clinician interactions in HSCP practice.

2.9. Contribution of the Client to Clinicians' Understanding of Client/Clinician Interactions

The work of Roter and Hall (2006) addresses the concept of reciprocity in client/clinician interactions. The authors describe the "reciprocity rule" (p.36) in which clients need to be persuaded that they are important influencers in the healthcare context. Roter and Hall (2006) similarly acknowledge that clinicians' emotions and emotional responses to clinical interactions have received less study than that of the

client, though emotions are common to both parties in equal measure. The acknowledgement of the role of the client in the context of client/clinician interactions is also referenced in the relationship-centred approach to care (Beach et al., 2006). The relationship-centred care framework recognises the quality of relationships as an integral component of effective healthcare delivery, that are built upon meaningful relationships in healthcare (Beach et al., 2006). The framework is founded upon four interrelated principles that include clinician's promotion of personhood as well as their clinical role. Moreover, the principle 2 of the framework acknowledges that client/clinician relationships "occur in the context of reciprocal influence" (Beach et al., 2006, p. 4). The principle describes how the clinician can benefit from being in interaction with the client. The principle further references the importance of "allowing a patient to have an impact on the clinician" (Beach et al., 2006, p. 4) that results in growth and development for the clinician. Soklaridis et al. (2016) suggest that the relationship-centred care framework can enhance interpersonal relationships between client and clinician to promote the humanisation of healthcare.

2.9.1. Memorable Clients in the Context of Client/Clinician Interactions

Another means of reflecting upon the contribution of the client to clinicians' understanding of client/clinician interactions is to consider the meaning and tributes that healthcare practitioners have paid to their clients in their professional roles. For example, in the practice of psychotherapy, Urban (2013, p. 525) speaks of what she has learned from her clients, that is, "the connections of emotional depth that occur out of an impelling connection for relatedness". Burges Watson et al. (2012) detail how a paramedic's identity is strongly influenced by the treatments they employ and the relationships they foster with their patients. Similarly, in his work, *the most memorable patient I never saw* (Lazarus, 2014), Dr. Arthur Lazarus acknowledges the role of the hidden curriculum and the different ways clinicians learn and recognise what it means to be a clinician – "the sense of power and powerlessness, of hope and helplessness"

(Lazarus, 2014, p.37). Lazarus reflects upon the impact of the client on his life - "I did learn, however, that caring for seriously ill patients, and those who have the potential to become seriously ill, can significantly impact our inner lives" (p.37). Moreover, de Visser (2020) provides a moving account of the memorable patients that doctors and nurses have encountered in their time as working clinicians.

In the context of HSCP, O'Dwyer and Leahy (2016, p. 164) conclude that clients attending speech and language therapy are powerful in ascribing identities to their therapist and in the co-construction of the professional identities of the speech and language therapist. Likewise, Hammond et al. (2016) acknowledge the role of patients in helping to co-construct the meaning of being a physiotherapist in intra-professional and inter-professional areas of practice. Therefore, it seems that clients have the potential to contribute to understanding clinicians' experiences of client/clinician interactions. Below, I will consider some other factors that may contribute to understanding clinicians' experiences of client/clinician interactions to include universal traits and characteristics of HSCP clinicians.

2.10. Universal Traits and Characteristics of HSCP Clinicians

Research suggests that there are some common traits and characteristics that may contribute to clinicians' experiences of client/clinician interactions. For example, some of these universal traits and characteristics include clinicians' values, emotional intelligence, empathy and communication skills.

2.10.1. Clinicians' Values

Kluckhohn and Strodtback (1951) define values as enduring convictions that both the individual and social groups consider rightful and just. Values are often deemed stable and solid in nature, making them different from opinions and attitudes (Schwartz, 2012). Schwartz further details how values are typically organised in accordance with personal importance. The work of Gecas (2000) discusses the term 'value identities' in which individuals "conceive of themselves in terms of the values

they hold" (Gecas, 2000, p.96). Research conducted by Moyo et al. (2016) identified how both personal and professional values can influence the clinical decision making of healthcare practitioners. Their construction of a single framework using the Schwartz's values model, identified the most common values held by healthcare professionals to include "altruism, equality and capability" (p. 257). Their work also emphasises how healthcare professions that hold similar values can promote compatibility, while differing values amongst healthcare professions can promote conflict between professions.

Similarly, there are common principles applied and promoted across all healthcare professions. These include avoiding harm to patients, ensuring practice is conducted in the client's best interests and that each person has equal access to healthcare (Beauchamp, 2007). Furthermore, the *International Charter for Human Values in Healthcare* (Rider et al., 2014) identified five fundamental human values that should be present in every interaction. These human values include "compassion" (p.275),"respect for persons" (p.275),"commitment to integrity and ethical practice" (p.275),"commitment to excellence" (p.275), and "justice in healthcare" (p.275). These universal and relationship-centred values were chosen as to be easily applicable across all languages and cultures to underpin high quality care.

2.10.2. Clinicians' Communication Skills

Moss (2020) describes the basic components of effective communication skills to include active listening, paraphrasing, clarifying and non-verbal body language. Moss describes how these skills are important in clinical practice though these skills alone will not facilitate effective and compassionate communication. Clinicians must strive to use their communication skills to facilitate human connection. Furthermore, Moss describes how the humility, human warmth and genuineness that "respects the common humanity that we all share" (p.7) should be employed and promoted. Moss (2020) further describes an important skill that often goes unrecognised in the

literature, that is, using our shared humanity to communicate to clients our shared humanness, vulnerability, hurt as well as our ability to be resilient and open-hearted. Nouwen (1999) describes the idea of care providers as being "wounded helpers" (p.38). Here, Nouwen describes how professionals should strive to go beyond their professional roles to embrace our common humanity to serve as a means of strength and healing when helping others.

2.10.3. Clinicians' Empathy

The concept of empathy has been described as an important concept trait in many healthcare professions (Stanley & Sethuramalingam, 2015). The concept of empathy has evolved over time. From being coined by Rogers as one of three core conditions needed to ensure the development of the therapeutic alliance in the 1950's (Rogers, 1957), the more modern-day concept of empathy encompasses the affective, cognitive and behavioural aspects of empathy (Moudatsou et al., 2020). The combination of the affective, cognitive and behavioural aspects of identity has provided a means of practicing empathy in our everyday lives. More specifically, Miller and Moyers (2021) reflect upon the term of "accurate empathy" (p. 20) in the context of helping relationships. The authors describe accurate empathy as a skill that draws upon a clinician's curiosity and empathetic listening abilities that aims to "show a deep understanding of the client's meaning" (p.21). Furthermore, the skill of accurate empathy has been widely acknowledged as the therapeutic factor that has the most "consistent relationship to positive client outcomes" (Miller & Moyles, 2021, p.29). Likewise, the role of empathy in has been widely researched in HSCP literature. For example, the work of Stanley and Sethuramalingam (2015) highlights the role of empathy in contributing to the development of the therapeutic alliance in social workers. Similarly, Murphy (2016) details the high levels of empathy often shown by physiotherapists towards clients in clinical practice. Moreover, Williams et al. (2014) view empathy as a fundamental tool in supporting the development of the therapeutic

alliance between caregiver and client as well as its link to better patient and improved patient outcomes. Meanwhile, Moudatsou et al. (2020) suggest that altruism and the therapeutic alliance are means of exploring empathy in practice. While empathy is commonly cited as being the basis of the therapeutic alliance, Thomas and Menage (2016) argue that the use of the term compassion more aptly takes accounts of interactions and the emotional responses of clinicians towards service users in occupational therapy. It seems then that concepts of empathy and compassion can differ amongst healthcare professions.

2.10.4. Clinicians' Emotional Intelligence

Goleman (1998) highlights the importance of emotional intelligence in providing quality client care. More specifically, Goleman et al. (2002) detail four domains of emotional intelligence to include "self-awareness" (p. 39), "self-management" (p. 39), "social awareness" (p.39) and "relationship management" (p. 39). High levels of emotional intelligence have been linked to lower levels of conflict, increased ability to show sensitivity towards others' needs, and the ability of the team to manage emotions to achieve a common purpose and goal (Faguy, 2012). The role of emotional intelligence across the healthcare professions has been explored to greater or lesser extents. For example, emotional intelligence has been shown to facilitate relationship building in occupational therapy practice (Andonian, 2017). To the best of my knowledge, research exploring the role of emotional intelligence in play therapy, speech and language therapy and physiotherapy is more limited.

In summary, it seems some of the universal traits and characteristics of clinicians have the potential to contribute to their experiences of client/clinician interactions. Below, I will discuss different forms of identity that may also contribute to clinicians' experiences of client/clinician interactions.

2.11. Concept of Identity

The concept of identity has been studied and explored by various scholars in different disciplines of knowledge throughout the centuries. This includes research within the fields of philosophy, physics, sociolinguistics, cultural studies, anthropology, social psychology and psychotherapy. Naturally, given the scope of these varying disciplines, identity can be a concept difficult to define. Even as far back as the 17th century, philosophers debated the concept, definition and different components of identity. John Locke, an English philosopher and physician, is often cited as a leading thinker in the modern concept of identity (Sollberger, 2013). According to Locke, identity is founded on repeated acts of consciousness and human memory. However, other philosophers of his time, namely Reid (1785/2002), questioned if identity be conceptualised on sameness if consciousness changes from minute to minute in a person's life (Reid, 1785/2002).

While the above philosophers and meta-physicists (e.g., Smart, 1963) view identity as a quantitative concept, others in the fields of sociology, describe identity in terms of the social roles of the individual (Goffman 1963). Sollberger (2013) discusses the 'missing link' between the quantitative and qualitative perspectives of identity, that is, "the aspect of being different from others but not in being different from oneself" (p.3). The concept of identity being viewed as somewhat of a 'foundation' is reflected in the work of Goffman (1963) who describes how the "general identity values of a society may be fully entrenched nowhere, and yet they can cast some kind of shadow on the encounters encountered everywhere in daily living" (p. 128–129), highlighting the influence and perhaps, limited appreciation, of identity in our everyday lives.

2.11.1. Forms of Identity

The complex nature of identity is acknowledged by many scholars in the above disciplines as both individuals and groups can be defined and characterised by multiple identities throughout the course of one's life (Rassokha, 2010). Edwards (1985) supports the notion that identity is a fluctuating concept, while Bendle (2002) describes identity as something that continues to be reconstructed during one's lifetime. Similarly, Eisenberg (2001) suggests that identity formation is a complicated phenomenon. Typically, scholars tend to categorise identity in two categories: (i) personal identity and (ii) social identity.

2.11.2. Personal Identity

Hewitt (1997) acknowledges personal identity as emphasising "a sense of individual autonomy rather than of communal involvement" (p.93). Moreover, Hitlin (2003) constitutes personal identity by having individuals reflect and focus on their "value commitments" (p.121) as "the primary phenomenon in the experience of personal identity" (p.122) helping to identify what is important to us as individuals. Cooley (1902) tended to position the 'self' as being independent of context or biography – using a defining system of self-concepts to develop an individual's constructs and concepts. However, over time, Cooley (1902) advanced his position to acknowledge the 'self' as part of a learning process in which individuals reflect and form roles, identities and attitudes as based on how the 'self' relates to others. Goffman (1959) also acknowledges the concept of the evolution of 'self' in order to navigate social processes and circumstances.

2.11.3. Social Identity

Social identity theories and self-categorisation theorists provide accounts and descriptions of how people can often define themselves as having more than one identity, that is, both personal identity and social identity representations and the relationships between them in different social contexts. Turner (1985) and Turner et

al. (1987) distinguish between personal and social identity as two different categories of self-categorisation that are equally as valid and as authentic as one another. The central hypothesis of this theory claims that as shared social identity becomes more salient, depersonalisation of personal identity occurs (Turner, 1985; Turner et al., 1987). Depersonalisation provides a means of transforming individual behaviour to intergroup behaviour. Turner et al. (1994) discusses how both personal identity and social identity are natural variations of the self and how humans can be defined by both intergroup and intragroup relations, with intergroups relations taking precedent in some social contexts. This overlap between personal and social identity is in keeping with the early work of Mead (1934/1972) who described how humans are fundamentally social beings whose identity can be contextualised within social roles and social identities.

Mead (1934/1972) furthered acknowledged the process of identity formation and reflected upon the role of language, social interaction, and social experiences to enhance the construction of an individual's identity. In the field of sociolinguistics, Foucault (1980) and Gumperz (1982) were among some of the first scholars to examine the idea of identity being constructed through discourse and interaction, providing the individual (or group) with opportunities to use language as a social agent to explore and develop their identities. Bucholtz and Hall (2005) further acknowledge language and social interaction as a tool to explore identity construction. According to Lippi-Green (1997, p.5), language is "the most salient way we have of establishing and advertising our social identities". Gumperz and Cook-Gumperz (1982, p. 7) conclude that identity is in large part "established and maintained through language". Furthermore, language has been identified by Giles and Johnson (1981) as a salient marker of social identity, particularly with the use of a 'we' code and 'they' code within a group dynamic.

2.11.4. Professional Identity

How do the above views on identity construction link with professional identity construction? As acknowledged above, defining and reflecting upon the factors that contribute to and influence the construction of identity can be a complex process. Professional identity can be defined as an individual's professional self-concept as influenced by experiences, attitudes, values and beliefs (Schein, 1978; Ibarra, 1999). There is no one accepted definition of professional identity in healthcare disciplines (Bridges, 2018), however, all individuals have their own unique insights, experiences and wisdom that have contributed to the development of their professional self. According to Franco and Tavares (2013), professional identity can be considered one of the societal identities an individual holds that can be influenced by many factors, including one's culture, ethnicity or occupation.

The relationship between one's personal identity and one's career has been well documented in the literature. Savickas' Career Construction Theory (CCT) (Savickas, 2005) takes inspiration from and builds upon the theoretical frameworks of Holland (1973). CCT aims to address the social and interpretive processes that influence one's vocational behaviour. CCT offers a comprehensive overview of how an individual chooses their profession and what they use their profession for, based on three central components – life themes, vocational personality and adaptation. Moreover, CCT details how one's career is a means of forming, examining and implementing a stable self, thus helping the individual to become who they are. For example, in healthcare practice, Hunter and Warren (2013, p.32), describe midwifery "as something someone is rather than what they do". Moreover, research concludes that occupational therapists often remained committed to the profession due to the inherent link between self-identity and professional identity (Wright, 2001). Wright suggests that many occupational therapists "had internalised the values of the profession to such an extent that they perceived being an occupational therapist to be

a significant part of their personal identity" (p.422). Similarly, Slay and Smith (2010) describe how the study of "professional identity is embedded in the study of personal identity" (p. 87), thus highlighting the overlap between personal and professional identity.

CCT also acknowledges the influence of others and social constructions on one's vocational personality. The work of Ashforth et al. (2008) emphasises the role of one's social group in helping to assign professional identity. Moreover, Dall'Alba (2009, p.42) describes how "an individual does not become a professional in isolation" highlighting the influence of others upon the professional identity of the clinician. Similarly, Dutton et al. (2010) detail the large portion of our lives spent at work and in our professional roles. This amount of time will inevitably contribute to the construct of professional identity. Moreover, healthcare practice, professional identity is believed to develop through exposure to professional behaviour and social interaction in the working world (Joynes, 2018).

2.11.5. Professional Identity in Healthcare Professionals

Despite the acknowledged benefits and the increased focus on the ways professional identities are constructed (Caza & Creary, 2016; Slay & Smith, 2010; Clarke et al., 2009), there seems to be minimal impact on how professional identities are formed in everyday practice (Joynes, 2018). The development of professional identity has been explored in other healthcare professions, particularly nursing and pharmacy (e.g., Johnson et al., 2012). However, such research remains limited in HSCP. Perhaps instead, it is important to reflect upon the challenges some professions may encounter in regards to their professional identity. In considering some healthcare professions, Jull and Moore (2013) acknowledge the difficulty that the profession of physiotherapy can encounter regarding their professional identity. Generally, many professions can be identified by the body system/function that they are most typically associated with. For example, "the profession of podiatry conjures feet, dentists –

teeth, audiologists – hearing, speech pathologists – speech, neurologists – nervous system, dermatologists – skin" (Jull & Moore, 2013, p.447). However, it is more difficult to provide such a shortly worded description or associated word description for the profession of physiotherapy.

Another profession that encounters similar challenges regarding their identity, is occupational therapy. In 1962, Mary Reilly, an American occupational therapist, stated that "the wide and gaping chasm which exists between the complexity of illness and the commonplaces of our treatment tools is, and always will be, both the pride and anguish of our profession" (Reilly, 1962, p.1) highlighting the complex nature of professional identity in some professions. While in 2002, Hooper and Wood suggested that "the profession's identity conundrum…has persisted for almost 100 years" (Hooper & Wood, 2002, p.47) . What factors may be contributing to a sense of a lack of professional identity in occupational therapy? Some suggest that the versatile nature of the profession may result in confusion regarding the nature of the profession (Macky, 2007). While on a practical level, occupational therapy clinicians often report challenges in explaining their rationale for assessment and treatment, particularly when working as part of a multi-disciplinary team (Turner & Knight, 2015). Therefore, it could be suggested that some professions encounter challenges to their identity more than others.

Overall, it is evident that identity is a complex phenomenon that can be greatly influenced by one's environment and in one's interactions with others. The following paragraphs aim to explore how reflection may help facilitate understanding of clinicians' experiences of client/clinician interactions.

2.12. Reflective Practice

From the Latin root "reflexio" and meaning 'to bend back', reflection is a concept that has been pondered and explored throughout the centuries by earlier educators and philosophers, including Aristotle and Socrates. However, it was John

Dewey (1933) who is credited as being the first to define the concept of reflection, as follows; “the active, persistent and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it and the further conclusions to which it tends” (Dewey, 1933, p. 9). This seminal definition that placed an emphasis on rational knowledge, provided a foundation for future researchers in the field. Schön (1983) aimed to build on the ideas of Dewey by placing more emphasis on practical knowledge and the use of prior experiences and intuitive feelings of practitioners to help them respond in any given situation. Schön’s ‘reflection-in-action’ principle relies on the intuitive knowledge that practitioners develop. Reflection-in-action can be described as thinking within the moment, continually assimilating, exploring and reflecting on a problem, whilst drawing on past experiences to help guide and inform new actions. The other level of reflection includes ‘reflection-on-action’ where the individual describes revisiting situations and experiences to enhance skills and future practice in the working world (Schön, 1983). Furthermore, Schön (1987) suggested that reflection is not a natural process and so practitioner may need support realising the benefit of the potential of reflective practice. Similarly, Argyris and Schön (1987) acknowledge that practitioners may not be maximining their effectiveness in practice due to following routine in their everyday practice.

2.12.1. Reflective Practice in Healthcare Practice

Although reflection is considered a cornerstone of healthcare education, the literature does not appear to provide one commonly agreed upon definition (Nguyen et al., 2014). The scientific literature suggests that research relating to reflective practice has increased in recent years (Fragkos, 2016). For example, Taylor (2010) suggests that reflection can take three forms in healthcare practice: technical, practical and emancipatory reflection. Taylor (2010) refers to technical reflections as reflection that generates and validates empirical knowledge to improve the technical aspects of one’s work. This knowledge provides the foundation for engaging in critical thinking to

support any changes to. Secondly, practical knowledge relates to reflecting upon the dynamics of human interaction to enhance communication between individuals. Finally, emancipatory reflection refers to understanding the subtle factors that may limit one's practice. Through identification of these subtle processes one can address and overcome these constraints.

2.12.2. Reflection in HSCP Practice

Moreover, reflexive practice is described as an integral component of professional development, as outlined in codes of professional conduct and ethics in HSCP. For example, in the profession of social work , clinicians are expected to "evaluate and reflect critically on own professional practice to identify learning and development goals" (CORU, 2019, p. 10). The acknowledgement of reflective practice as a core component of professional practice is also referenced in occupational therapy, speech and language therapy and physiotherapy practice (e.g., *Physiotherapists Registration Board – Standards of Proficiency for Physiotherapists*, CORU, 2019).

In their systematic review, Jayatilleke and Mackie (2012) detail how there is limited but growing literature to suggest that reflection enhances practice in health disciplines. Similarly, Mann et al. (2009) suggests viewing reflection as a learning strategy in healthcare to integrate new learning with current skills and knowledge. Paterson and Chapman (2013) highlight the importance of reflective practice in physiotherapy practice in ensuring clinicians develop and maintain clinical competencies across their professional careers. Other benefits of reflective practice may include enhanced professional development (Booth & Nelson, 2013). Furthermore, reflective practice may also result in benefits for the client in the context of the healthcare system to include enhanced clinician decision-making accuracy (Walpola & Lucas, 2020)

However, other studies have reflected upon the challenge of engaging in reflective practice in the clinical setting. For example, the findings of a mixed methods study design with occupational therapy clinicians and supervisors highlighted that reflective practice is not always consistently facilitated in supervision practice which may have implications for the development of clinicians' clinical reasoning skills and professional development (Guy et al., 2020). Other studies reference the complex psychological impact of reflective practice for some clinicians (Bannigan & Moores, 2009; Marshall et al., 2022). In examining reflective practice in particular disciplines of practice, the findings of a scoping review of forty-two publications conclude that there is a lack of transparency regarding reflective practice in the profession of speech and language therapy (Caty et al., 2014). In addition, the researchers advocate the need for more work and university-based reflective practice initiatives in speech and language therapy. This need is again echoed in the research of Hill et al. (2012) in which they conclude that a limited number of students were critical reflectors. The researchers describe how further investigation of reflective skills in speech and language therapists with previous clinical experience is advised.

2.12.3. Models and Modalities of Reflective Practice

Within current reflective practice literature, there are various reflective models that clinicians may utilised in order to provide a structure to the reflective practice process (Al- Mutawa et al., 2024). Many of the models are based on the processes of description, evaluation and critical analysis (Al- Mutawa et al., 2024). Some of the most commonly used reflective practice models in healthcare include Gibbs (1998) and Schön (1983). Moreover, in their study of speech and language clinicians' perceptions of reflective practice in the workplace, Cook et al. (2023) highlight that different reflective modalities helped to facilitate reflective practice to include verbal and written reflection methods. Moreover, Occhiuto et al. (2024) suggest the power of collective group reflective practice.

Meanwhile, in their systematic review of the literature, Chen and Forbes (2014) detail the contribution of reflective writing (i.e., journaling, blogs, diaries) to the increased empathy of all students in health occupations (e.g., nursing, pharmacy, medicine). There are also other means by which reflection can be achieved. Through narrative accounts, an individual can develop a narrative thread upon which an individual makes sense of themselves (Connelly & Clandinin, 1999) that in turn may help in establishing a professional identity. Clandinin et al. (2010) describe the contribution of narrative reflective practice as a means of developing professional identity in participants in medical residency programs. Their work concludes that professional identity is continually being developed and refined, whilst the power of narrative reflective practice lies in being able to provide a structured context in which clinicians can reflect retrospectively, while simultaneously constructing who they are becoming as health care professionals.

2.13. Interprofessional Reflective Practice

In light of global health initiatives, there is an increased emphasis on co-orientated and integrated care across healthcare professions. For example, WHO (2015) has acknowledged interprofessional practice as a core feature of person-centred care. Barrow et al (2015) reflect that the concept of interprofessional practice can oftentimes conjure ideals of practitioners seamlessly coordinating their practices to complement each other's practice to ensure the best possible outcomes for the client. However, in reality this process may be more difficult in the context of negotiating professional roles and professional scopes of practice (Goldman et al. 2010). Some authors have proposed the use of interprofessional socialisation in order to understand and development collaborative practice and relationships (Stanley et al., 2016). Similarly, Wilson et al. (2016) highlights the importance of understanding the roles and responsibilities of others in interprofessional practice. Other researchers have highlighted the importance of trust in fostering collaborative interprofessional

practice (Hellman et al., 2016). Furthermore, Flood et al. (2022) identified "openness" (p.638) to alleviating boundaries between professions, patient-centeredness and "knowing others" (p.638) as important in creating experiences of interprofessional practice. In particular, "knowing others" relates to "having an unspoken understanding, a familiarity with how the other person works" (p.638)

Within the context of Irish healthcare practice, for historical and systemic reasons, HSCP are a group of various professions have come together to highlight the potential of their workforce in the Irish healthcare context. The HSCP represent a wide range of professions. There are currently 26 HSCP that compromise 25% of the clinical workforce, and 14% of the overall health service workforce (National Health and Social Care Professions Office, 2021, 2021). HSCP represent a diverse and wide-ranging cohort of professions spanning diagnostic, social and therapeutic domains (National Health and Social Care Professions Office, 2021, 2021). *HSCP Deliver* outlines a strategic guidance framework for HSCP that emphasises the importance of harnessing the "collective potential" (p.16) of the HSCP professions. Therefore, this research study may provide further insight and understanding into the collective experiences of HSCP clinicians in the context of client/clinician interactions in HSCP practice.

2.14. Summary of Chapter

This literature review aimed to contextualise client/clinician interactions within healthcare practice. In Section one, I reflected upon various models/approaches in healthcare that integrate elements of client/clinician interactions within their practice. I also considered how positive client/clinician interactions may support the facilitation of such models/approaches in healthcare practice. I also reflected upon types of client/clinician interactions, as well as the nature of client/clinician interactions in healthcare practice. In Section two, I discussed upon potential factors that may contribute to understanding clinicians' experiences of client/ clinician interactions. In particular, I briefly considered the role of the clinician within the

context of the psychotherapy literature. I also considered contribution of the client to understanding clinicians' experiences of client/clinician interactions. I also reflected upon universal traits and characteristics of clinicians that may contribute to their experiences of client/clinician interactions. Finally, I concluded the literature review with reference to the concept of identity, reflection and interprofessional healthcare practice.

Chapter 3: Methodology

3.1. Introduction

In this chapter, I will outline the theoretical underpinnings of my research study. Firstly, I will discuss my rationale for employing my chosen methodology and secondly, I will reflect upon other possible methodologies that I considered employing in my research . I will also discuss my rationale for choosing focus groups as my method of data collection. Finally, I will conclude this chapter with reference to my reflexive approach as a researcher throughout the course of my study.

3.2. Justification for Use of Chosen Methodology

Interpretative Phenomenological Analysis (IPA; Smith et al., 2009, 2022) can provide researchers with the opportunity to examine in detail the meaning and significance of an individual's lived experience in the context of their social and personal worlds. Traditionally, IPA research studies tend to focus upon understanding complex research topics that aim to examine an individual's account of a significant experience as well as interpreting how the person makes sense of their particular experience (Smith et al., 2022). Some of these significant experiences can include "major life experiences", "health related experiences", "emotional experiences", "professional experiences" and "experiences of identity" (Smith & Nizza, 2022, p.4). Smith et al. (2022) detail how an individual's experiences can be positive, negative, expected, or unexpected, subtle or a prolonged experience, however, what all experiences have in common is the significance of the experience for the individual in the context of their lived worlds. Similarly, IPA can be particularly valuable in instances where an individual's experience is of great personal importance to them (Smith & Nizza, 2022). Therefore, I deduced that the above qualities of IPA research provided me with the opportunity to gain insight into how clinicians in various HSCP understand and make sense of their lived experiences of clinical interactions with clients.

Secondly, IPA can be particularly valuable in highlighting the ambiguity and tensions in people's reactions to their experiences (Smith & Nizza, 2022). As my research aimed to explore clinicians' understandings and experiences of clinical interactions with clients, I was confident that IPA was the most appropriate methodology to employ in my research study. IPA offered a means of furthering insights and understanding into the lived experiences of clinicians that is often currently overlooked in HSCP literature.

Additionally, IPA afforded me the opportunity to employ a multiple perspective design in my research study to help provide further understanding of the nature of clinical interactions in HSCP practice. Traditionally, standard cross-case IPA designs tend to focus upon understanding the lived experiences of a person from an individual or shared perspective on a given phenomenon. In standard IPA cross-case design, the researcher is focused on retaining a commitment to an idiographic level of analysis that is usually achieved through a relatively homogenous sample. However, in the case of my research study, I aimed to explore the lived experiences of clinicians in various HSCP that inevitability leads to encountering more than a single perspective of the phenomenon in question, therefore I chose to employ a multiple perspective IPA design in my research study.

Prior to undertaking a multiple perspective IPA design, I read various literature that specifically related to designing, undertaking and analysing multiple perspective research designs. Larkin et al. (2019) suggest that the challenge in multiple perspective design is retaining IPA's commitment to understanding each participant's lived experience (in the context of more potential variation than in traditional samples) whilst also enhancing the participants' accounts using additional perspectives. However, by examining the intersubjectivity between individuals, their interactions and the co-construction of meaning can result in gaining a deeper understanding of the phenomenon in question (Borg Xuereb, 2016). Considering the nature and aims of

my research study, I deemed IPA a particularly useful methodology to provide further insight and understanding as to the interactive nature of the lived experiences of various HSCP clinicians working in clinical practice.

Ultimately, I chose IPA as my preferred methodology as I was confident that IPA could fulfil the aims and objectives of my research study. The theoretical underpinnings, methods and flexibility in IPA ensured a coherent research design to ensure that clinicians' lived experiences of clinical interactions with clients could be richly encapsulated and understood.

3.3. Theoretical Foundations of IPA

IPA affords the researcher the ability to access, understand and engage with the reflections of the individual in the context of their significant lived experience (Smith et al., 2022). This engagement is achieved through the researcher's commitment to being cognisant of, and adhering to, the theoretical underpinnings and core principles of IPA research to include phenomenology, idiography, and hermeneutics. Below, I have detailed a brief description of each of the core principles of IPA that underpinned the theoretical foundations of my research study.

3.3.1. Phenomenology

Phenomenology is a philosophical approach that relates to the study of experience. In essence, phenomenology concerns itself with understanding the experience and the meaning of being human in the lived world (Smith et al., 2022). Various philosophers have provided significant contributions to the field of phenomenology, and from which the theoretical underpinnings of IPA have evolved. For example, Husserl (1927/1971) emphasises the role of conscious awareness and reflection in examining the human experience. Husserl (1927/1971) placed emphasises on the role of the intentional relationship between psychological processes in the consciousness and the object of one's attention in the context of the psychological process. In essence, the work of Husserl is primarily concerned with

understanding individual psychological processes to include human awareness, perception and consciousness.

Furthermore, the work of Heidegger (1927/1962) builds on the study of human experiences. More specifically, Heidegger's work is concerned with the subjective nature of one's worldly lived experiences, as described and encapsulated in the term *Dasein*. 'Dasein', as translated from the German, 'being-there' describes how the world is made meaningful to humans through relational, social and cultural processes. 'Dasein' describes how humans cannot be meaningfully detached from their pre-existing world. Similarly, 'Dasein' encompasses the concept of intersubjectivity in which one's being-in-the-world is placed in context of one's engagement within the wider world as well as one's ability to relate, communicate and to interpret other people's meaning-making activities in the wider world. The work of Heidegger is closely linked to another theoretical underpinning in IPA, namely hermeneutics, that I will briefly discuss later in this chapter.

Similarly, the work of Merleau-Ponty (1962) emphasises the interpretative nature of phenomenology that relates to one's individual perspective on the world. In the context of IPA analysis, the work of Merleau-Ponty has implications in relation to understanding another's perspectives, emotions and insights, as well as the awareness that another's experiences cannot ever be entirely captured.

Smith et al. (2022) summarises that the philosophical positions of the above philosophers and provides an understanding of the complexities, uniqueness and subjectivity of experience, that has implications for IPA research. Within IPA research design, the underpinnings of phenomenology allow researchers to derive the unique meanings of a person's relationship to the world by focusing on a particular event, relationship or process to understand the importance of the experience to the person in the context of their lived world.

3.3.2. Hermeneutics

Hermeneutics is concerned with the theory of interpretation (Smith & Nizza, 2022). The work of Heidegger (1927/1962) outlines how hermeneutics can be viewed as an interpretive activity, that in turn has significant implications for the theoretical foundations of IPA. The term *hermeneutic circle* can be used to describe the process of interpretation that examines the "dynamic relationship between the part and the whole, at a series of levels. To understand any given part, you need to look at the whole, to understand the whole, you need to look at the parts" (Smith et al., 2022, p. 22) to ensure an iterative process in IPA research. Similarly, IPA can be described in the context of a *double hermeneutic* (Smith & Osborn, 2003, p. 51) with, firstly, the participant making meaning of their life experience and secondly, the researcher attempting to "decode that meaning to make sense of the participant's meaning making" (Pietkiewicz & Smith, 2014, p. 8). The researcher aims to make sense of the participant making sense of their own life experiences, leading to a greater understanding of the person and their social realities.

In the context of multiple perspective IPA research design, Montague et al. (2020) suggests the reframing of a double hermeneutic to *multiple hermeneutics* (p. 25) to take account of the multiple participants in a multiple perspective research design. Specifically in the context of a multiple perspective design, additional participants mean "further stops" (Montague et al., 2020, p. 26) on the hermeneutic circle that can guide data analysis and interpretation in the research process to develop richer and more nuanced insights into the experience of a particular phenomenon.

3.3.3. Idiography

The underlying principle of idiography concerns itself with investigating how an individual's unique perspective of their experiences, or involvement in a particular phenomenon (Smith et al., 2022). IPA's consideration to the 'particular' encompasses two levels. On one level, the 'particular' can relate to detailed, thorough analysis, while

on another level, the 'particular' can relate to how "particular experiential phenomena (an event, process or relationship) have been understood from the perspective of particular people, in a particular context" (Smith et al., 2022, p. 24). Additionally, idiography provides the ability to remain true to the data by ensuring the individual lived experience is acknowledged and preserved during the analytic process in IPA research (Smith et al., 2009).

3.4. Alternative Methodologies

Before choosing IPA as the methodology for my research study, I considered and reflected upon the use of other methodologies to include *Reflexive Thematic Analysis (*Braun & Clarke, 2006; 2016; Braun et al., 2018); *Grounded Theory* (Glaser & Strauss, 1967/2006), and *Discourse Analysis*. Below, I will detail my rationale for choosing IPA as my chosen methodology in the context of these alternative methodologies.

3.4.1. Reflexive Thematic Analysis

Reflexive Thematic Analysis (RTA) was one of the qualitative approaches that I considered employing in my research study. RTA is similar to IPA in that it concerns itself with reporting experiences, meanings and the realities of an individual's life (Smith & Nizza, 2022). Similarly, IPA and RTA utilise "researcher subjectivity" (Braun & Clarke, 2021, p.5) as an important resource in both approaches. In line with the epistemological position of my research question, it was paramount for me to employ a methodology that was centrally concerned with understanding the experiences of HSCP clinicians at an individual case level. I understood that I needed to choose an approach that employed an idiographic focus to ensure that the personal accounts of an experience for HSCP clinicians were retained and acknowledged. Similarly, the challenge of retaining the idiographic lens is well documented in multiple perspective IPA research design (e.g., Larkin et al., 2019). Therefore, it was paramount that I employed a methodology that provided analytic methods that focused upon engaging

in in-depth analysis of each case before developing various themes across cases to ensure the idiographic focus is retained. In contrast, in RTA, all cases are deemed to be one data set from the outset. Thus, RTA is primarily concerned with coding the entire data set before themes are developed across cases, meaning that there is less in-depth focus on the unique accounts of each individual (Braun & Clarke, 2021), and therefore, tends to not be centrally focused on personal experience and sense making, as is the case in IPA.

Furthermore, IPA provides a clear set of methodological procedures throughout the research that aligned with my methodological position as a researcher. IPA is theoretically bounded to a phenomenological epistemology that can guarantee the ability to explicitly detail people's everyday experience. The focus on phenomenology ensures an in-depth, rich analysis of the accounts of HSCP clinicians in my research study. Similarly, IPA employs a double hermeneutic (or multiple hermeneutic in the context of multiple perspective research design) that can guide data analysis and interpretation in the research process to develop richer and more nuanced insights into a participant's experience of a particular phenomenon. In contrast, RTA can be described as a method in which the theoretical underpinnings, methods of data collection and sampling procedures are not explicitly defined for the researcher. In essence, thematic analysis is not confined to a pre-existing framework (Braun & Clarke, 2006; 2016; Braun et al., 2018). Given the complexity of my research design, that incorporates a multiple perspective research design, it was important to employ a methodology that could consistently align with my methodological approach and positions as a researcher to ensure the research aims and objectives of my research study could be fulfilled.

3.4.2. Discourse Analysis

Discourse analysis (DA) was another methodology that I considered employing in my research study. From my reading of the literature, it occurred to me that both

DA and IPA outline a commitment to acknowledging the principal role of language in their methodological approaches. However, the purpose of the role of language can differ between the two methodologies. For example, Gill (2000) outlines various "themes of discourse analysis" (Gill, 2000, p.174) that includes viewing DA as being solely concerned with understating the organisation and content of language used by a participant. Additionally, Gill (2000) describes how DA can view language as a "social practice" (p.175) that takes place in an interpretive context in which people "use discourse to *do* things" (p.175). On the contrary, within IPA literature, language is primarily viewed as a tool that offers participants the ability to communicate and reflect upon their thoughts, experiences and emotions in relation to how a particular experience has taken on meaning and significance for them (Smith et al., 2022). Similarly, in IPA, the tool of language provides researchers with a means of analysing and interpreting the accounts of participants' lived experiences – in terms of what is said and how it is said - to provide further insights and understanding as to how participants make sense of their experiences. Additionally, given my professional background as a Speech and Language Therapist, I tend to gravitate towards methodologies that adopt a linguistic lens in their approach. I was particularly interested in the application of language as a means of ensuring that the theoretical underpinnings that informed an IPA approach could be retained (i.e., how something is said contributes to the interpretive process). Therefore, given how my research aims to employ language as a means of understanding and interpreting participants lived experiences, rather than focusing on participants' experiences of their use of language, I justified IPA as a more fitting methodology to employ in my research study.

3.4.3. Grounded Theory

Grounded Theory (GT) is another methodology that I considered employing in my research study. Both GT and IPA can be deemed inductive approaches that are focused upon the generation of new knowledge as part of the analytic process (Smith

et al., 2009). Developed by Glaser and Strauss (1967/2006), GT seeks to collate and include data sources through the use of coding, categorisation, theoretical sampling and memos to collect and analysis data that help to construct and provide theoretical frameworks (Charmaz, 2014). While IPA details meaning through the lived experience of the individual, GT details meaning through interaction with others in social processes (Charmaz, 2014). These social processes are then used to develop a theory of basic social processes. These social processes typically have rigid, constrained structures and codes that do not take account of the unique and idiographic nature of the individual's lived experience. On the contrary, IPA strives to capture patterns of meaning within an individual's account of an experience rather than identifying reflection upon an underlying process. Particularly in the context of multiple perspective IPA research design, IPA is focused on remaining committed to identifying patterns in relation to participant's meaning-making rather than focusing on producing a model for an underlying process. Additionally, GT generally employs a larger sample size (approximately 10–60 participants) (Starks & Brown Trinidad, 2007), whereas, in the case of IPA, detailed accounts from a relatively small sample size provides further insight and reflections leading to a greater understanding of the person and their social realities (Smith & Nizza, 2022). Therefore, given how my research aims to understand clinicians' particular lived experiences of clinical interactions with clients, I deduced that IPA was a more suitable methodology to employ in my research study.

3.5. Justification for Chosen Data Collection Method

Given the multiple perspective design of my research study, I proposed the use of focus groups interviews in data collection. Pietkiewicz and Smith (2014) reflect that IPA requires a flexible approach to data collection to take account of how participants are identifying the complexities of their own worlds. Additionally, Smith et al. (2022) reflect that focus group interviews have become increasingly popular in recent years; however, the authors strike a cautionary note regarding the use of focus

group interviews in IPA research design. Smith et al. (2022) highlight the importance of ensuring that the researcher has clear rationale for undertaking focus group interviews. Therefore, it was important for me to understand and reflect upon my reasons for employing the use of focus group interviews in my research study. For me, focus group interviews provided a means of ensuring that representative insights into the intricacies and nuances of clinicians' experiences of clinical interactions with clients could be captured. Secondly, focus groups facilitated the most suitable means of incorporating key features of multiple perspective research design to ensure that a quality IPA research study could be achieved.

3.5.1. Representative Insights Into the Intricacies and Nuances of Clinicians' Experiences of Clinical Interactions with Clients

A focus group method to data collection ensured that I could gather representative insights into the intricacies and nuances of clinicians' experiences of clinical interactions with clients. I was aware that my research study examined the meaning and significance of clinicians' experiences of clinical interactions with clients across a wide range of HSCP. However, I also understood that within each profession, there existed a wide variety of sub-disciplines and areas of practice. Each participant in my research study had the opportunity to discuss the meaning of their particular experiences with other participants from within their profession. I hypothesised that hearing the accounts of participants working in different areas of clinical practice may help to spark discussion amongst focus group members. Therefore, I was confident that a representative insight of clinicians' experiences of clinical interactions with clients within each HSCP could be captured.

Additionally, as my research study aimed to explore a relatively novel area of research in HSCP, it is hypothesised that focus group interviews would provide participants with the unique opportunity to reflect and consider their experiences in relation to others. In the context of the theoretical underpinnings of multiple

hermeneutics, Tomkins and Eatough (2010) allude to the new levels of meaning and the deeper reflections that can grow and develop amongst participants in the focus group setting. Similarly, Montague et al. (2020) outline that by attending to the role of multiple hermeneutics in focus groups can offer additional insights into the cultural and social contexts in which participants' experiences exist. Therefore, I was confident that focus groups provided the most suitable means of ensuring a representative insight into clinicians' experiences of clinical interactions with clients in the HSCP context.

3.5.2. Incorporation of Key Features of Multiple Perspective Research Design

I proposed that focus group interviews would provide the most suitable means of incorporating of key features of multiple perspective research design into my research study. For example, regarding data collection, focus groups could facilitate the conceptualisation of subsamples and the employment of a "directly related groups" (Larkin et al., 2019, p. 186) design type in my research study. Similarly, regarding data analysis, focus groups provide a suitable means of analysing the multiple "units of analysis" (Tomkins & Eatough, 2010, p. 245) relating to my research data. Githaiga (2014) reflects how merging of focus groups and IPA analysis is not a simplistic combination but can be achieved through theoretically based understanding of the fundamentals of IPA and a considered explication of the procedures involved in using focus groups with IPA. Through extensive reading of the literature that specifically related to designing, undertaking, and analysing multiple perspective research designs (e.g., Reid et al., 2005; Smith, 2004; Smith et al., 2009; Smith & Nizza., 2022, Smith et al., 2022), as well as my previous experience of facilitating focus groups using IPA, I was confident that I possessed the credentials necessary to ensure a quality IPA research study could be achieved.

Regarding the theoretical underpinnings of IPA, Montague et al. (2020) suggest that there has been little attention given to multiple hermeneutics when

working with focus groups in IPA design. Love et al. (2020) similarly suggests that further consideration of multiple hermeneutics in focus groups can guide subsequent analysis to ensure that the idiographic element of IPA research design can be retained. Tomkins and Eatough (2010) suggest that a means of retaining the idiographic underpinnings of IPA in the context of multiple perspective research design is through the introduction of an "additional iterative loop" (p. 250) during data analysis to ensure rich and nuanced insights into the experience of a particular phenomenon.

3.6. My Reflexive Approach to My Research Study

The literature suggests that reflexivity can be viewed as an ambiguous concept that can often be misunderstood in qualitative literature, and particularly within the health professions (Olmos-Vega et al., 2023). For the purposes of my research study, I wish to employ a definition of reflexivity as provided by Olmos-Vega et al. (2023). I particularly liked the authors' comprehensive definition that acknowledges the continuous and multifaceted nature of reflexivity as detailed below:

> Reflexivity is a set of continuous, collaborative, and multifaceted practices through which researchers self-consciously critique, appraise, and evaluate how their subjectivity and context influence the research processes. (p. 242)

3.6.1. My Initial Understanding of the Reflexivity Process

Initially, and at the outset of my PhD journey, I had a vague understanding of the concept of reflexivity. I viewed reflexivity as a 'tick the box' exercise from a methodological standpoint. However, as I engaged more purposefully with the literature, and as I became more familiar with the principles of IPA, I began to view reflexivity as a concept to be embraced. I understood and began to view the subjectivity of IPA research as a core and integral component of the research process. The IPA literature recognises and acknowledges that the hermeneutic phenomenological underpinnings of IPA are a core component of the research process, without which the validity and quality of the research study may be undermined

(Engward & Goldspink, 2020). Therefore, for me, it was important that I embraced and did not become fearful of the reflexivity process, as ultimately, I understood that it would provide transparency and contribute to the overall quality of my research study. Similarly, Olmos-Vega et al. (2023) considers that the purpose of reflexivity is to go beyond merely acknowledging the researcher's subjectivity, but rather to explain the researcher's impact on the research study. In other terms, some contemporary researchers view subjectivity as an integral part of the data process (Koopman et al., 2020). However, I was cognisant of striking a balance between the research process and the process of reflexivity. Olmos-Vega et al. (2023) liken the process of reflexivity to being "stuck in a hall of mirrors" (p. 248) in relation to acknowledging when an adequate amount of reflexivity has been completed. Therefore, it was important for me to continually consider if there was transparency reflected between my research question, my understanding of the theoretical principles of IPA, as well as my methodological dimensions to ensure an appropriate amount of reflexivity could be achieved that resulted in a transparent and quality research design.

Below, I have adopted the use of reflexive dimensions as proposed by Walsh (2003) and Olmos-Vega et al. (2023) throughout the course of my research study. The reflexive dimensions include personal, interpersonal, contextual and methodological dimensions. These interacting and overlapping dimensions are interwoven within the findings of my research to help provide further insight and understanding as to my role as researcher within the research process.

3.6.2. Personal Reflexivity

Personal reflectivity typically involves researchers reflecting upon and clarifying their "expectations, assumptions, and conscious and unconscious reactions to contexts, participants and data" (Olmos-Vega et al., 2023, p. 244). For me, through my engagement in the reflexive process, I examined and consciously acknowledged any prior or unfounded assumptions and preconceptions that I could bring to my

research study that may impact my interpretations. I identified how my experiences as a healthcare professional, my prior experiences as a researcher, as well as my personal upbringing and background could potentially influence decisions being made throughout the course of my research study.

3.6.2.1 My Experiences as a Healthcare Professional. I am a Speech and Language Therapist with both undergraduate and professional experience working in the healthcare sector alongside other HSCP colleagues. My undergraduate training, clinical placements, and colleagues have most certainly influenced my practice and philosophies as a clinician. Given the everyday realities of clinical practice, it can be difficult to take the time to reflect and consider the preconceived assumptions and expectations of one's clinical role. Therefore, it was particularly important that I engaged in reflexive practice to ensure that I was cognisant of any conscious or unconscious assumptions and pre-existing ideas that I may have gathered and learned during my time in clinical training and in clinical practice relating to both my own profession and that of other HSCP.

3.6.2.2. My Previous Experiences as a Researcher. Secondly, I was aware that my previous experiences as a researcher may have also contributed to my expectations and experiences of my current research study. My interest in investigating my current research topic stemmed from my previous undergraduate research in which I adopted an IPA approach to my research study. I understood that my previous knowledge and assumptions were important to consider when undertaking the research at postgraduate level. For example, I was acutely aware that I had my own experiences and understanding of IPA research that I needed to explore and understood. At the outset of my PhD journey, I was privileged to be able to engage in structured team reflexive discussions with my supervisor, to discuss and consider my previous experiences of qualitative research, as well as the ways in which my previous experiences may potentially shape my current research study. As my postgraduate

supervisor was my supervisor at undergraduate level, it provided me with more opportunity to discuss in detail my personal reflections to help further clarify how my previous experiences, assumptions, and potential unconscious reactions may impact my current research study.

3.6.2.3. My Current Stage of Professional Practice. I am also aware that I am a relatively newly qualified clinician who has much to learn about my profession and practice over the course of my career. I am aware that my current stage of practice may bring with it feelings of optimism and proactivity for what my profession and other HSCP can be. Similarly, and on a personal note, I typically tend to be an optimist, who naturally sees the positive in a given situation. As considered previously, I am aware that one's interpretation of an experience is subjective, therefore, it was important for me to be aware and open to other peoples' possible perceptions and understandings of their particular experiences to ensure a balanced view of the research process in my research study.

3.6.3. Interpersonal and Contextual Reflexivity

Two other dimensions proposed by Walsh (2003) and Olmos-Vega et al. (2023) are interpersonal and cultural reflexivity. Interpersonal reflexivity refers to how "relationships surrounding the research process influence the context, people involved, and results" (Olmos-Vega., 2023, p. 244) while contextual reflexivity refers to "locating a particular project in its cultural and historical context" (Olmos-Vega., 2023, p. 245). For me, and in the context of my research study, both the interpersonal and contextual dimensions seemed to particularly overlap, given how the culture of healthcare practice is intrinsically linked to the context of the client/clinician interactions. Therefore, I amalgamated the two dimensions within my reflexive process. My reflexive process provided me with insight into two potential pre-determined cultural positions that I held, to include, the culture of healthcare practice and the culture of client/clinician interactions.

3.6.3.1. The Culture of Healthcare Practice. The work of Holmes (2020) reflects upon how being an "insider" (p.5) or "outsider" (p.5) to a culture may provide a researcher with a unique pre-determined position within a given study. I was aware that my position as a Speech and Language Therapist, and more broadly speaking, a healthcare professional, could potentially impact my interactions with participants in the research space, given both my 'insider' and 'outsider' cultural positions in the context of healthcare practice .

My professional background as a Speech and Language Therapist meant that I identified with an 'insider' position as it relates to Speech and Language Therapy participants taking part in my research study. I was aware that my pre-existing knowledge and understanding of the profession could potentially influence my interactions with participants given the assumed level of shared knowledge and understanding as it relates to the culture of the profession. As well as this, I was aware that my experience of working in a multi-disciplinary team may have also provided me with pre-conceived understandings of other HSCP. However, although I acknowledged my familiarity and previous interactions with the roles of other multi-disciplinary team members, I do not inhabit the clinical role of the other HSCP, and so, I retained an 'outsider' position to other HSCP. Therefore, I was cognisant that both my 'insider' and 'outsider' perspectives may have contributed to my interactions with participants in the research space.

3.6.3.2. The Culture of Client/ Clinician Interactions. Similarly, my previous clinical experiences provided me with the pre-determined position of being witness to the culture of client/clinician interactions in clinical practice. My pre-existing personal experience and knowledge provided me with an 'insider' cultural position of general clinical practice. However, as clinical interactions are highly individual and nuanced interactions that are responsive to context, resulted in me inhabiting an 'outsider' cultural position in relation to the nature of clinical interactions, both with my

profession as well as other HSCP. Similarly, the reflexive process encouraged me to consider how the healthcare context may impact my research study. Given the demanding nature of the clinical environment, it was important to be cognisant of participants volunteering their time to provide their own insights and reflections. Taking the time to reflect upon the implicit nature of my research question was further compounded by the busy clinic environment in which it is difficult for clinicians to take the time to understand and reflect upon their own practice as HSCP clinicians.

3.6.4. Methodological Reflexivity

I adopted a qualitative approach within an interpretative paradigm and IPA methodology. My research was underpinned by a critical realist ontology and interpretivist epistemological assumption. I was confident that my methodological considerations allowed me to explore the rich insights and understandings into clinician's experiences of their clinical interactions with clients. I was mindful of ensuring that the above methodological considerations were continually aligned throughout the course of my research process (Olmos-Vega et al., 2023).

A critical realism ontology was deemed appropriate for my research study because of its concern with capturing multiple perspective reality as interpreted by me, as the researcher, through different meanings of the individual (Grbich, 2011). A critical realism ontology works from the premise that an individual's reality is dynamic and continually susceptible to change as generated through an individual's experiences of the phenomenon in question (Cuthbertson et al., 2020). Given that my research aims to capture the complex and layered nature of HSCP clinicians' lived experiences, a critical realism ontology ensured that there was an acknowledgment of a subjective nature of reality that allowed me to explore clinicians' meanings of their multiple realities through their lived experiences.

An interpretative epistemological assumption was appropriate to gain insight into the experiences and perceptions of clinicians. I was mindful of the key assumption

that participants' insights and reflections would create multiple meanings that were elicited and interpreted in the context of my research study. In the context of IPA research, the interpretative epistemological assumption is encapsulated through the use of the double hermeneutic, in which the researcher aims to make sense of the participant making sense of their own life experiences, leading to a greater understanding of the person and their social realities (Smith et al., 2009). Or, in the context of multiple perspective research design, the interpretative epistemological assumption may be encapsulated through the use of the multiple hermeneutic that relates to the researcher attempting "to understand the participants' meaning-making who in their turn are trying to understand each other's meaning-making in a group" (Love et al., 2020, p.2). I accepted my potential influence on my research and that the findings of my research would include my own interpretations. Therefore, it was important that I engaged in reflexive practice in relation to how my personal, contextual and interpersonal factors could be considered and acknowledged in my research study.

3.7. Summary of Chapter

In this chapter, I have outlined rationale for choosing IPA as my chosen methodology. I also reflected upon other possible methodologies that I considered employing in my research study. Additionally, I discussed my rationale for choosing focus groups as my chosen method of data collection. Finally, I concluded this chapter with reference to my reflexive approach in the context of my research study.

Chapter 4: Methods

4.1. Introduction

In this chapter, I will detail the practical components of my methodology to include outlining the key features of multiple perspective IPA research designs, data collection procedures, data analysis process, ethical considerations as well as validity and quality criteria related to my research study.

4.2. Key Features of Multiple Perspective IPA Research Designs

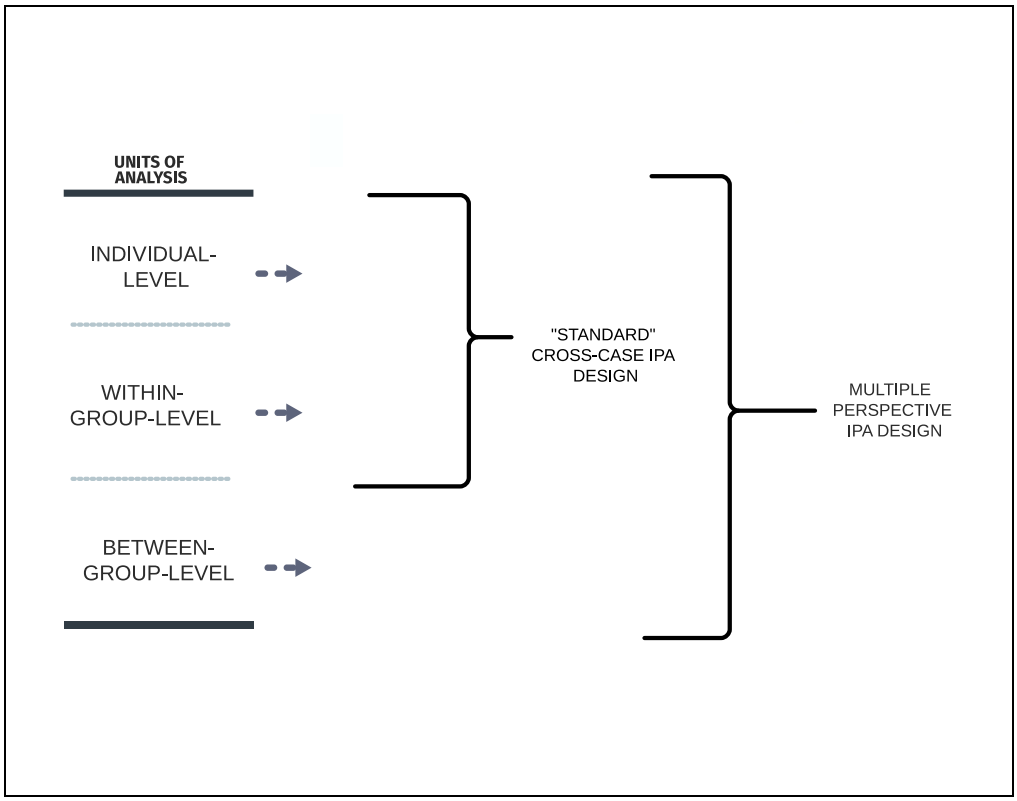
Typically, multiple perspective designs aim to understand a phenomenon from "more than one distinctive point of view" (Smith et al., 2022, p. 122). The work of Smith et al. (2022) outlines that there is "considerable complexity involved in planning and conducting multiple perspective studies" (Smith et al., 2022, p.122). Therefore, before choosing to employ a multiple perspective design, I ensured that I engaged in extensive reading of the literature to identify and consider key features of multiple perspective designs. Two of these specific features included identifying (i) units of analysis (Larkin et al., 2019), and (ii) the specific design type of multiple perspective IPA (Larkin et al., 2019, p. 186) to employ in my research study. I understood that these key features would likely have implications for the construction of data collection, data analysis, and the overall research design of my research study.

4.2.1. Feature One: Units of Analysis

Following reading of the literature (e.g., Larkin et al., 2019; Rostill-Brookes et al., 2011; Borg Xuereb et al., 2016), I proposed that my research study contained various units of analysis at the individual-level (i.e., each participant), within-group level (i.e., within each discipline group) and between-group level (between each discipline group). In Figure 4.1, I provide a visual representation of various units of analysis in standard cross-case design and multiple perspective design:

Figure 4.1.

Various Units of Analysis in Standard IPA Design and Multiple Perspective IPA Design



4.2.2. Feature Two: Specific Design Type

Another key feature of multiple perspective design involves identifying the type of design I wished to employ in my research study (Larkin et al., 2019). The various design types aim to capture a series of perspectives around a given phenomenon. As discussed in previous chapter (Section 3.5.2), I proposed that the features of "directly related groups" design type (Larkin et al., 2019, p. 186) most accurately captured my research sample as it describes how participants can be involved or immersed in the same experience or phenomenon, yet are likely to have different views of the phenomenon in question. In the context of my research study, I proposed that HSCP clinicians were immersed in the common experiences of the phenomenon of interacting with clients.

Additionally, given the complexity of conducting multiple perspective designs, Larkin et al. (2019) recommend categorising the various groups involved in a multiple perspective study into various sub-samples ,proposing various design types as a way

of rationalising the relationship between different sub-samples. Traditionally, sub-samples contain "a degree of internal coherence and homogeneity" (Smith et al., 2022, p.122). In the context of my research study, I classified potential HSCP to take part in my research study (e.g., speech and language therapy discipline group, occupational therapy discipline group) as sub-samples. Once I had cemented and clarified my research design, I was then able to begin the participant recruitment process.

4.3. Participant Recruitment

4.3.1. Overview of Recruitment Process

Having finalised my multiple perspective design type, I needed to recruit clinicians to participate in my research study. During the initial stages of data collection, I considered recruiting participants from the below healthcare professions:

(i) Occupational Therapy

(ii) Physiotherapy

(iii) Play Therapy

(iv) Psychology

(v) Radiation Therapy

(vi) Social Work

(vii) Speech and Language Therapy

(viii) Dentistry[6]

In total, there are currently 26 HSCP that compromise 25% of the clinical workforce, and 14% of the overall health service workforce (National Health and Social

[6] One of the professions considered during the initial stages of data collection was the profession of dentistry. There were two factors that ultimately influenced my decision to exclude this profession. Firstly, I received no response to my invitation to participate in the study from the professional affiliate association of dentistry. Moreover, on further reflection and reading, it became apparent that dentistry is not included in HSCP within the HSE classification, and therefore should have not have been included in the recruitment phase.

Care Professions Office, 2021). HSCP represent a diverse and wide-ranging cohort of professions spanning diagnostic, social and therapeutic domains (National Health and Social Care Professions Office, 2021). Given that my research study aimed to examine the meaning and significance of clinicians' experiences of client/clinician interactions, I deemed it most appropriate to recruit participants from the social and therapeutic domains of HSCP, due to the professions' direct and therapeutic role with the client. Additionally, considering my 'directly related groups' research design, I understood that participants from the social and therapeutic domains of HSCP were likely to be immersed in the common experience of interactions with clients, yet were likely to have different views of the experience given their varying professional training and backgrounds.

4.3.2. Inclusion and Exclusion Criteria

4.3.2.1 Inclusion Criteria. Participants were recruited from the *therapeutic* and *social* domains of HSCP only as defined in *HSCP Deliver* (National Health and Social care Professions Office, 2021) due to the professions being predominately engaged in a direct and therapeutic clinical role with the client.

4.3.2.2. Exclusion Criteria. Participants were not recruited from the *diagnostic* domains of HSCP, as defined in *HSCP Deliver* (National Health and Social care Professions Office, 2021) that includes Dietetics, Radiography and Medical Science as there was consensus between my supervisor and I that there may be a less ongoing therapeutic clinical role with the client, beyond the diagnostic phase of their intervention.

4.3.3. Participant Recruitment Process

I contacted the executive officers of affiliated professional associations to recruit eligible clinicians who might be interested in taking part in my research study (the relevant ethical approvals and considerations will be discussed in Section 4.5). The

executive officers of each of the respective professional associations acted as designated, third-party gatekeepers. Gatekeepers then notified/recruited potential participants via Participant Information Leaflets (PIL) informing them of my proposed research study. The professional organisations contacted as part of data collection for my research study are listed in Table 4.1.

In instances where I did not receive a reply from an above-mentioned professional association regarding recruitment of participants, I contacted a personal contact who agreed to fill the role of local gatekeeper. The local gatekeeper sought to recruit participants through the use of word-of- mouth and snow-ball sampling. I received interest from participants from five HSCP to include clinicians from speech and language therapy , occupational therapy , physiotherapy , social work , and play therapy. Following extensive attempts, I was unable to recruit participants from the profession of psychology and the profession of radiation therapy. Therefore, at the end of the data collection process, I had recruited participants from five HSCP to include:

(i) Occupational Therapy

(ii) Physiotherapy

(iii) Play Therapy

(iv) Social Work

(v) Speech and Language Therapy

In the context of my research study, I classified each of the HSCP as described above as sub-samples. Therefore, in total, my research comprised of five subsamples. As discussed previously, I proposed that the features of “directly related groups” design type (Larkin et al., 2019, p.186) most accurately captured my research sample as it describes how participants can be involved or immersed in the same environment or phenomenon yet are likely to have different perspectives on the phenomenon in

question. I proposed that all five HSCP were deemed to share the experience of interactions with clients.

Table 4.1

Professional Organisations Contacted as Part of Data Collection

	Professional Association	Website Address
1.	Irish Association of Speech and Language Therapists (IASLT)	https://www.iaslt.ie/
2.	Association of Occupational Therapists of Ireland (AOTI)	https://www.aoti.ie/
3.	Irish Society of Chartered Physiotherapists (ISCP)	https://www.iscp.ie/
4.	Irish Institute of Radiography and Radiation Therapy (IIRRT)	https://www.iirrt.ie/
5.	Irish Association of Social Workers (IASW)	https://www.iasw.ie/
6.	Psychological Society of Ireland (PSI)	https://www.psychologicalsociety.ie/
7.	Play Therapy Ireland	https://playtherapy.ie/
8.	Irish Dental Association (IDA)	https://www.dentist.ie/

4.3.4. Sampling

Criterion sampling was used to select participants from a group of male and female HSCP clinicians with experience working in various areas of the health care sector (e.g., hospitals, disability settings, primary care settings). Participants included qualified speech and language therapy clinicians, occupational therapy clinicians, physiotherapy clinicians, social work clinicians, play therapy clinicians. Inclusion criteria included clinicians with greater than three years' clinical experience working with clients/patients.

4.3.5. Sample Size and Composition

In light of multiple perspective IPA design, the sample was categorised into

smaller sub-samples as per participants' professions (i.e., speech and language therapy sub-sample, occupational therapy sub-sample etc). Each HSCP (i.e., sub-sample) was made up of between 2-6 participants.

4.4. Focus Group Organisation

4.4.1. Composition of Focus Groups

Data collection involved creating discipline-specific focus groups from the five HSCP. Smith et al. (2022) recommend a maximum of five participants per focus group and consider five participants a suitable number to help generate discussion amongst participants while ensuring that the focus group interview is not too difficult to manage. Similarly, Love et al. (2020) suggest that focus groups with a maximum number of five can ensure that participants can talk in-depth about their accounts of their particular lived experiences. A breakdown of the composition of each discipline-specific focus groups is detailed in Table 4.2.

4.4.2. Practical Considerations Relating to Conducting Focus Group Interviews

In relation to one of the discipline-specific focus groups (i.e., physiotherapy focus group), one participant was unsure whether they would be able to attend the focus group interviews. In the meantime, I had recruited another participant who wished to partake in the physiotherapy discipline- specific focus group interview. In the end, both participants took part in the focus group interview. Therefore, in total, the focus group comprised of six participants. Moreover, for logistical reasons, focus group discussions relating to one of the other professions (i.e., play therapy) needed to be conducted over the course of two different focus groups interviews (i.e., four participants participated in two focus groups, with two participants per focus group).

Table 4.2

Composition of Focus Group Interviews

HSCP	**Composition**
Physiotherapy	6 participants
Occupational Therapy	2 participants
Speech and Language Therapy	3 participants
Social work	5 participants
Play therapy	• Focus group 1 (2 participants) • Focus group 2 (2 participants)

4.4.3. Focus Group Interview Probes

Probes relating to each of the discipline-specific focus group interviews were informed by my own curiosity and by articles and journals that relate to client/clinician interaction and reflection. Sample probes were provided to participants approximately one week before each of the focus group interviews. A week's notice provided participants with time to consider their personal thoughts and reflections upon their experiences of clinical interactions with clients. In Table 4.3, I have provided an example of some of the prompts as used during the focus group interviews.

4.4.4. Online Focus Group Interviews

The discipline-specific focus group interviews took place via online video platforms in accordance with COVID19 public health guidelines between October 2021 and June 2022. The use of online platforms to facilitate focus group discussions expanded the geographical reach of the participants in this research study, with participants hailing from different counties and provinces across the island of Ireland.

Table 4.3.

Probes Included in Standardised Interview Schedule During Discipline-Specific Focus Group Interviews

1	Early in your career, what activity or behaviour did you do that made you think – "I'm a [e.g., physiotherapist] now!"
2	What is the best piece of advice you have received as a [e.g., social worker]?
3	What is the best piece of advice you would give as a [e.g., social worker]?
4	Can you think of a client/patient (can be multiple) who have had a profound impact on you? In what ways did they influence you? Did they encourage you, inspire you, surprise you, challenge you etc.?
5	What was it about this client/patient that has such an impact on you? For example, did they resonate with your personal experiences, previous clinical experiences, your values etc.?
6	Have there been any moments, perhaps when preparing for another client/patient, or in other clinical interactions when you have been reminded of this client? In what ways did this reflection help?
7	Can you think of any other experiences/factors that have contributed to the development of your professional identity? For example, education, family, personal healthcare experience, work environment or a culmination of these?
8	What was it about the client specifically? Were there any specific qualities that a client had that influenced you?
9	Has a client ever taught you any specific lessons, and if so what were they?
10	What inspires you to remain committed to the profession?
11	Is there anything else you would like to contribute to the focus group discussion?

If the above probes were not asked directly during the focus group interview, the researcher was confident that the probe had been addressed in the focus group/brought up by another participant in the focus group for discussion amongst the wider group of focus group participants.

4.4.5. My Role as Researcher in the Context of Focus Group Interviews

I understood that in my role of facilitator, I needed to be familiar with the dynamics of conducting focus group interviews. I researched and I read papers that

specifically considered the principles of focus group interviews (e.g., Wilkinson et al., 2004). Similarly, I had the opportunity to pilot the focus group probes with my supervisor and one of my PhD peers to ensure the probes were relevant and consistent to the aims and objectives of my research study.

The opening probes used in the focus group interviews focused on generating conversation and group discussion between participants before the key questions were introduced. I was cognisant of ensuring that participants received ample opportunity and time to air their insights and reflections. I ensured that each participant was given time to do so by providing appropriate pauses and silences between each participant's reflections as well as repeating probes from time to time. I also encouraged all participants to air their insights and reflections. Additionally, I made notes on specific dynamics and interactions within the focus group interviews. Other times, participants independently sparked discussion and illuminated each other's perspectives, and at these times, I ensured that the conversation remained relevant to the aims and objectives of my research study. Closing questions focused on any additional insights or perspectives participants wished to contribute to help conclude the discussion. On the other hand, while every effort was made to provide participants with ample opportunity and time to air their insights and reflections, I was cognisant that the participants were reflecting upon the meaning and significance of their personal lived experiences of interactions with clients. Therefore, given the personal nature of the focus group interview, some participants may not have wished to contribute to each probe as posed in the focus group discussion. I hypothesised that the structure of a focus group interview naturally lends itself towards providing participants with the opportunity to not feel obligated to contribute to each probe as posed in the focus group discussions. Instead, participants were provided with more opportunity to only contribute to the focus group discussions when they felt comfortable doing so.

4.4.6. Reflexivity With Regard to Focus Group Interviews

In Table 4.4, I have included some of my reflections as transcribed immediately following each of the discipline-specific group interviews. These reflections aim to give further insight as to the meaning of participants' experiences of clinical interactions with clients. Overall, I was struck by the passion and compassionate nature of all participants in each of the focus group interviews. Many participants reflected upon the vocational nature of their professional roles and the ways in which the role was viewed as both a privilege and a responsibility.

4.4.7. Focus Group Consideration: Multiple Perspective Focus Group Interviews

In the initial stages of my research study, I considered conducting data collection in two phases: phase one and phase two. I considered using data collected from phase one to inform discussions and ideas for phase two of data collection. As described above, phase one comprised of undertaking discipline-specific focus group interviews while phase two considered conducting a multi-disciplinary focus group interview that included participants from each of the discipline-specific focus groups. However, upon reflection of the aims and objectives of my research study and further reading of the IPA literature, it was agreed with my supervisor and that data collection would cease following the completion of phase one of data collection.

I made the decision to cease data collection following phase one to ensure my commitment to retaining the theoretical principles of IPA research design. Larkin et al. (2019) outline that the particular challenge in multi-perspective design studies relates to retaining a commitment to understanding a particular participant's insights and lived experience, while also illuminating those insights gained through inclusion of additional perspectives. Given that phase one of data collection already involved multiple perspectives both within and across HSCP, I was aware that the inclusion of another additional layer of data collection and analysis may have diluted the rich insights and in-depth accounts of clinician's experiences of clinical interactions with

clients. Therefore, to insure I was remaining committed to the principles of IPA research design, I ceased data collection following completion of the discipline-specific focus group interviews.

Table 4.4.

Researcher's Focus Group Interview Reflections

Social Work Focus Group Interview   *I noted the understanding possessed by participants regarding the nature of human suffering and the understanding of the daily challenges faced by people in our world. I also noted how acutely aware participants were of the dynamics and the complicated nature and impact of relationships in society. I was struck by the ability of participants to process, connect and create links between one's relationships and their environment, and how they interweave and intertwine.*
Play Therapy Focus Group Interview   *I was struck by how comfortable participants were in their professional roles. Many participants reflected upon the client being the reason that they choose to stay in the profession. Participants also appeared to possess an awareness of human pain and the importance of connection in helping to alleviate suffering. Moreover, participants also reflected upon the importance of trusting the process of therapeutic intervention and 'holding hope' for clients. Others reflected upon the privilege of having unique access to a person's world, and the ability to see a client's potential before other people.*
Speech and Language Therapy Focus Group Interview   *I noted the insightful, reflective nature of participants. Participants reflected upon the process of learning from challenging experiences. I was also struck by the emphasis participants placed on the importance of being a communicator and being a listener in the clinical setting.*
Occupational Therapy Focus Group Interview   *I noted participants' reflections upon encompassing the holistic nature of the client, and the importance of considering and appreciating silence in clinical practice. Participants also reflected upon their ability to see beyond the clinical presentation due to their emphasis on the environment.*
Physiotherapy Focus Group Interview   *I noted the understanding possessed by participants to identify and contextualise key components of a case/client's personal circumstances. I noted the ability of participants to succinctly describe and reflect upon the factors that may be present and contribute to client's circumstance, and how this may manifest in daily practice.*

4.5. Ethical Considerations

Ethical permission for my research study was granted by the School of Linguistic, Speech and Communication Sciences Research Ethics Committee in April 2021 (please see Appendix A). Below I will detail the various ethical factors that I considered when conducting my research study. This includes how I obtained informed consent, ensured participant confidentiality, data storage considerations, potential conflicts of interests as well as ethical considerations in the context of conducting online focus group interviews.

4.5.1. Informed Consent

Participants were provided with a Participant information Leaflet (PIL) (please see Appendix B) that provided a summary of the nature and rationale of my research study via a designated gatekeeper. If interested in taking part in my research study, potential participants from the five HSCP were asked to contact me, as the primary researcher, to confirm eligibility and to provide informed consent to participate in my research study. Participants were asked to sign a consent form (please see Appendix D) to state their agreement to participate in the research study. As the focus group interviews were being held via online platforms in line with COVID19 health guidelines, Microsoft 365 Forms was used to obtain consent from participants. Participants' responses were recorded using this form with responses being downloaded via an excel sheet as a record of consent. Participants were assured that they were entitled to withdraw from the research study at any stage without any negative consequences for the participant.

4.5.2. Confidentiality

Larkin et al. (2019) and Ummel and Achille (2016) outline additional ethical issues in multiple perspective research related to internal anonymity. To overcome this confidentiality concern, I explicitly informed participants of how their details cannot be fully anonymised due to other participants taking part in the research potentially

being able to make links to given pseudonyms of participants. As well as this, I engaged in the 'member checking process' in which participants were provided with a copy of transcripts of their focus group interview. Participants had the opportunity to delete/remove any wording/information which they may perceive as identifying them, which also helped mitigate the risk of ethical concerns regarding internal anonymity.

4.5.3. Data Storage

The focus group interviews were recorded using a Dictaphone (Sony-ICD-PX240). The interviews were also video-recorded as a means of backing-up the content of the interviews. Recordings were then downloaded and transferred to a password protected computer following completion of the interviews. Any identifying information or data obtained during the course of data collection was treated confidentially. Additionally, all data collected was compliant with General Data Protection Regulations (GDPR). Each participant was allocated a code number to protect their identity. This number could then be used in all subsequent stored data records. Only me, as researcher and my supervisor had access to the key which links code numbers to individual identities.

4.5.4. Conflicts of Interest

Given my clinical background and the respective size of the HSCP community, there existed the possibility of knowing some of the participants in my professional capacity from the clinical setting. To overcome this conflict of interest, I employed the use of a gatekeeper to recruit and gain access to potential participants. Additionally, I informed and explicitly stated to participants that my research study was unrelated to my clinical role, as stated in the PIL.

4.5.5. Online Focus Group Interview Considerations

Smith et al. (2022) reference consideration of ethical issues related to conducting online focus group interviews. Some of the ethical issues include monitoring the emotional states of participants as well as providing appropriate

support to them, which can be more difficult than in comparison to traditional face-to-face focus group interviews. To reduce the risk of such incidences in my focus group interviews, each participant was provided with a copy of the PIL, as well as a sample of some of the probes to be used in the focus group interviews before the interviews took place.

4.6. Data Analysis

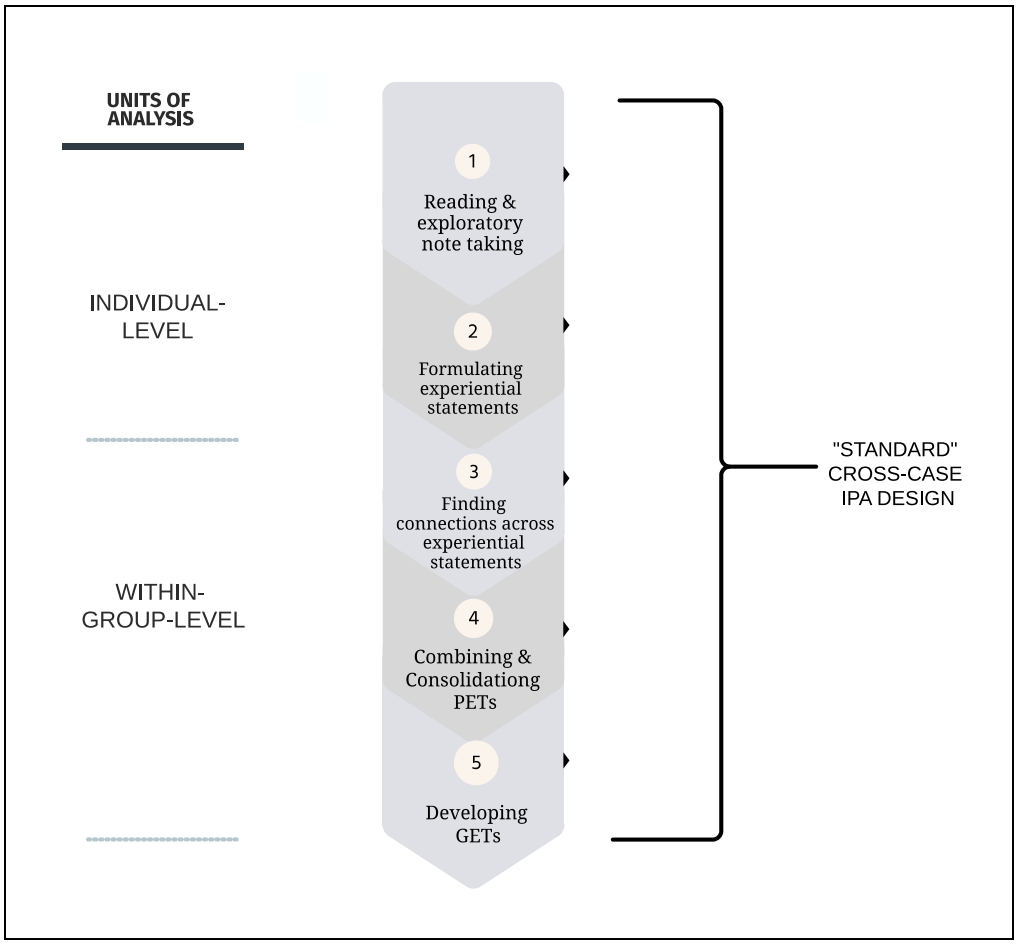
Multiple perspective data analysis typically involves employing key elements of standard cross-case IPA analysis as well as an additional analytic focus that takes account of additional conceptual and methodological considerations (Larkin et al., 2019). Given the complexity of analysis in the context of my research design, I divided the analytic process into two stages: stage one and stage two. Stage one details traditional cross-case IPA analysis, while stage two details the additional conceptual and methodological considerations specific to a multi perspective research design.

4.6.1. Stage One: *Standard IPA Cross-Case Design Analysis*

In standard IPA cross-case design, data analysis typically involves analysing the units of analysis at the (i) individual-level (i.e., each participant) and, (ii) within-group level (i.e., within each discipline-specific group). Following completion of the data analysis process, various themes are conceptualised that are typically described and captured via Personal Experiential Themes (PETs) and General Experiential Themes (GETs), respectively. In Figure 4.2, I have provided a visual representation of various steps of my analytic process in my research study in relation to the various units of analysis in standard cross-case IPA design.

Figure 4.2.

Analytic Process in Relation to the Various Units of Analysis in Standard Cross-Case IPA Design



4.6.1.1. Step One: Reading and Exploratory Note Taking. Following transcription, I listened back to the audio recordings of each of the discipline-specific focus group interviews to gain a general understanding of the data and to become familiar with the suprasegmental aspects of participants' responses (please see Appendix E for sample of discipline-specific focus group interview transcript). Smith (2004) advises researchers closely examine transcripts at least twice to assess group patterns and dynamics and to ensure idiographic accounts from participants when conducting focus group interviews. If it appears that participants can discuss their own accounts and experiences in sufficient detail within a group context, the data is deemed suitable for analysis. Next, I recorded my initial reactions to the text in one

margin, while keeping an open mind and looking for similarities and differences between segments of the text. I also looked for magnifications/contradictions in the words and sentences of participants to attempt to understand what experiences meant to participants. This phase aimed to produce a comprehensive set of notes for each participant under three different categories of exploratory notes to include descriptive, linguistic, and conceptual notes as outlined in Table 4.5. A list of the linguistic descriptions and definitions that I employed during data analysis can be found in Appendix F.

Table 4.5.

Different Categories of Exploratory Notes

Descriptive Notes	I provided a summary of what each participant explicitly said and described what is important to them. For example, this included objects, processes, locations, principles and experiences that are of significance to each participant.
Linguistic Notes	These types of comments focus on exploring the specific ways a participant used language to make a point within the data. Linguistic aspects considered particularly interesting, included repetitions, hesitations, tones, pronouns pause, laughter, metaphors and figures of speech.
Conceptual Notes	These types of comments tend to explore the data at a more conceptual and interrogative level, detailing the participant's overarching understanding of the data and its implications. These notes require reflection, consideration, and interpretation on the part of the researcher to consider a range of potential meanings for participants.

4.6.1.2. Step Two: Formulating Experiential Statements. I began by summarising the various exploratory notes of each participant to inform and reveal experiential statements. These experiential statements aimed to provide a summary of each participant's experiences through combining the processes of description and interpretation. Experiential statements need to remain both grounded in the data and conceptual in nature to ensure the psychological process and context of the participant's response is captured. At this phase of data analysis, it was important that

I remained cognisant of capturing what is fundamental at this point in the data, however, inevitably I may be influenced by the whole data set. This process draws reference to the hermeneutic circle where the part is interpreted in relation to the whole, and the whole in relation to the part.

4.6.1.3. Step Three: Finding Connections Across Experiential Statements. I gradually reviewed participant's experiential statements one by one, shifting them around and collating the most relevant experiential statements to form clusters of statements. The clusters were formed by identifying various connections between statements. At this point in my research study, the experiential statements from overlapping discipline-specific focus group interviews (e.g., two play therapy focus groups) were clustered together to provide representative data from each of the focus group interviews.

4.6.1.4. Step Four: Compiling and Consolidating PETs. Once the clustering process of experiential statements was complete, each cluster was converted into a table of PETs. PETs are comprised of highly related clusters of experiential statements (the clusters of experiential statements that can now be referred to as 'subthemes' in the context of specific PETs). Steps 1-4 were repeated for each participant in each of the discipline-specific focus groups.

4.6.1.5. Step Five: Developing and Consolidating GETs. Having developed PETs for each participant, GETS were then conceptualised for the discipline-specific focus group. GETs were developed through identifying patterns of convergence and divergence by comparing the various PETs of each participant in their respective focus groups. Developing GETs involves engaging in a higher level of analysis and can be considered a dynamic process. Thereafter, a table of GETs was then collated for the discipline-specific focus group. During this phase of data analysis, I adopted the use of various prompts as devised by Palmer et al. (2010) when undertaking focus group research, due to their specific emphasis on retaining the idiographic nature of IPA

research. An example of the prompts devised by the researchers include "what experiences are being shared?" (p.104), "what are individuals doing by sharing their experiences?" (p.104), "how are they making those things meaningful to one another" (p.104). The opportunity to reflect on the above probes ensured that I was remaining cognisant of the idiographic nature of IPA in the context of focus group interviews. Moreover, given the occurrence of multiple hermeneutics in focus groups, Tomkins and Eatough (2010) suggests that an "additional iterative loop" (p. 250) should be used to ensure the idiographic elements of the focus groups interviews are not excluded. In practice and in the context of my research study, I identified quotes/excerpts/accounts from each participant. I then checked each of the GETs against supporting quotes from relevant participants' accounts to ensure that participants' convergences and divergences in relation to the various GETs were represented.

4.6.1.6. Step Six: Repeating the Analytic Process for Each of the Discipline-Specific Groups. In the context of multiple perspective IPA design, the standard IPA analytic process was repeated for each of the discipline-specific focus groups. By this stage, a set of GETs representing each of the discipline-specific focus groups (i.e., subsamples in the context of IPA multi-perspective literature) was developed.

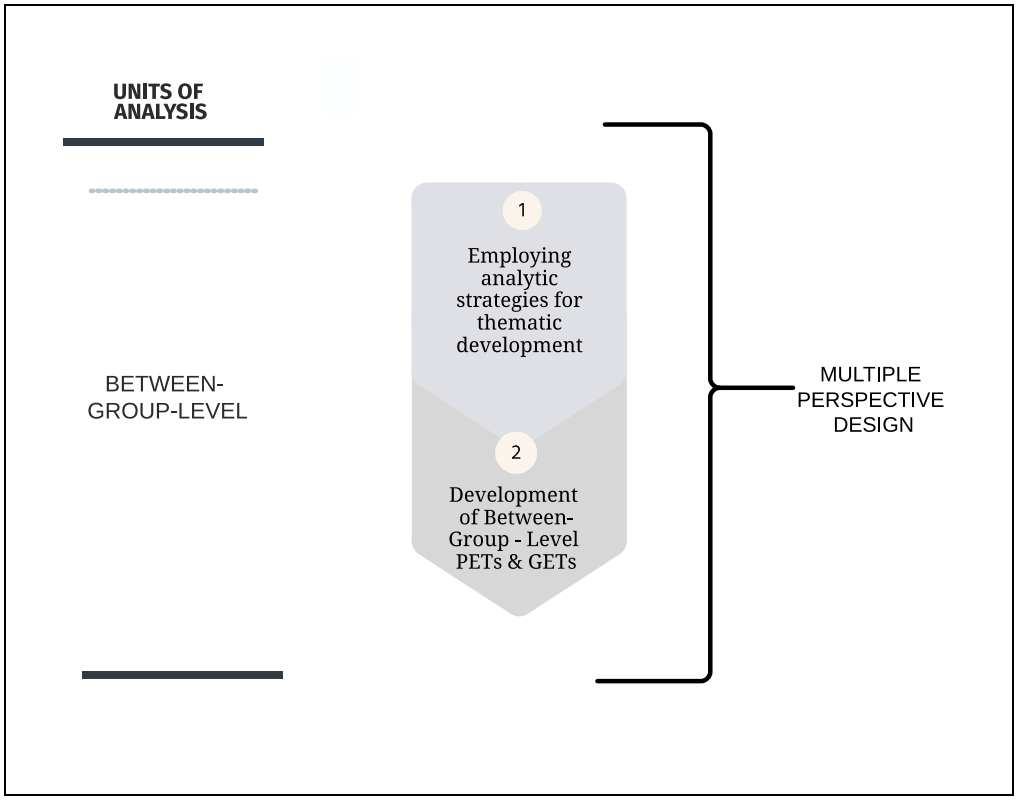
4.6.2. Stage Two: Multiple Perspective Data Analysis

As described in Stage one of data analysis, standard IPA cross- case analysis typically involves analysing units of analysis at the individual-level (i.e., each participant), and at the within-group level (i.e., within each discipline-specific group) with themes typically captured via PETs and GETs, respectively. However, in the context of multiple perspective IPA designs, there is additional analytic focus that takes account of additional conceptual and methodological considerations that aims to synthesise analysis "not only *within* a sample" but also "*between* samples" (Larkin et al., 2019, p.183) (i.e., between each discipline-specific group). Montague et al. (2020) also echo the importance of careful consideration as to how and where various themes

are identified at both individual and group levels (i.e., units of analysis) to ensure that the idiographic elements of IPA can be retained. In Figure 4.3, I provide a visual representation of various stages of the analytic process that I adopted in my multiple perspective research design in relation to various units of analysis.

Figure 4.3.

Analytic Process in Relation to the Various Units of Analysis in Multiple Perspective IPA Design



4.6.2.1. Step One: Employing Analytic Strategies for Thematic Development in the Context of Multiple Perspective Design. At this stage of the data analysis process, I had developed sets of themes representing each of the sub-samples (i.e., discipline-specific groups). Next, I employed the use of analytic strategies for thematic development (Larkin et al., 2019) to provide a coherent way of working across multiple perspectives (i.e., various sub-samples) to develop an interpretive perspective as to how participants accounts may relate, interact and overlap to each other yet also may reflect some divergences, and to consider how these differences can co-exist.

Additionally, working across the sub-samples provided me with a means of considering "the relational, intersubjective and microsocial dimensions of a given phenomenon" (Larkin et al. 2019, p. 183). I identified "conceptual overlap" (Larkin et al., 2019, p. 186) as a particularly relevant analytic strategy given that there was explicit consensus upon the extent of the impact of experiences of client/clinician interactions for participants. It was at this point that I suggested a main concept that underpinned the meaning and significance of the collective lived experiences of clinicians. The concept of will be further unpacked in Chapter 5.

4.6.2.2. Step Two: Development of Between Group-Level PETs and GETs. Regarding the analytic process, I conceptualised various PETs and associated GETs relating to the whole sample (i.e., the five discipline-specific groups). The findings of the analytic process are described and detailed in the following chapters.

4.7. Validity and Quality

Given the complex research design of my study, I was cognisant of ensuring I remained committed to incorporating validity and quality criteria in my research study. Nizza et al. (2021) provide four quality indicators that specifically relates to evaluating the quality of IPA studies. The quality markers include: (i) constructing a compelling unfolding narrative (p. 371), (ii) developing a vigorous experiential and/or existential account (p. 371) (iii) close analytic reading of participants' words (p. 371) and, (iv) attending to convergence and divergence (p.371).

4.7.1. Constructing a Compelling Unfolding Narrative

Nizza et al. (2021) reflect upon being able to tell "a persuasive and coherent story" (Nizza et al., 2021, p. 371) in data analysis and the writing process. The authors reference the researcher's consideration of the hermeneutic circle to convey a sense of narrative progression and development throughout the analysis. Within my research study, I aimed to achieve coherence and progression in my data analysis and writing process through inclusion of short quotes that were interwoven within the

extracts to help encapsulate the overall sense of a particular theme. Additionally, I included in-depth interpretations of participant's words that oftentimes made reference and connections to the experiences of other participants. At other times, my in-depth interpretation of participant's words provided me with the opportunity to introduce new ideas or insights that contributed to the development of the unfolding narrative while also remaining committed to consideration of the hermeneutic circle. Additionally, I had peers read some of my paragraphs to provide further means of ensuring clarity and coherence throughout the writing process to ensure that a rich, coherence and compelling narrative was being told. Furthermore, in the context of multiple perspective and focus group research design, I was cognisant of drawing reference to multiple hermeneutics evident in my research study. This process was achieved by including various excerpts of dialogue between at least two participants. Inclusion of such excerpts facilitated the highlighting of the additional perspectives to develop richer and more nuanced insights into clinicians' experiences of clinical interactions with clients.

4.7.2. Developing a Vigorous Experiential and/or Existential Account

Nizza et al. (2021) define this quality indicator of 'developing a vigorous experiential and/or existential account' as "focus on the important experiential and/or existential meaning of participants' accounts gives depth to the analysis" (Nizza et al., 2021, p. 371). For me as researcher, this involved me trusting my interpretations of participants' accounts that went beyond the immediacy and the context of what participants perceived as happening to them and their comments on it. I understood that I needed to consider the significance of participants' experiences as related to their sense of purpose, belonging and sense of shared humanity. I was particularly cognisant of understanding participants' experiences in the context of client/clinician interactions to ensure that my research remained committed to understanding participants' levels of experiential significance in my research.

4.7.3. Close Analytic Reading of Participant's Words

The quality indicator of "close analytic reading of participant's words" (Nizza et al., 2021, p. 375) describes the importance of analysing and interpreting quotes to provide a fuller meaning of the data as well as to capture the significance of the experience for the participant. In the context of my research study, this quality marker was achieved through detailed reading of each of the participant's quotes to identify any linguistic devices used by participants. Following identification of linguistic devices in the quotes of participants, I was then able to use the linguistic devices to help interpret the significance of the relationship between each participant and their experience. I also continually considered participant's words in the context of the wider transcript to ensure I was remaining committed to the theoretical underpinnings of IPA. As previously discussed, a list of the linguistic descriptions and definitions that I employed throughout the data analysis and writing process can be found in Appendix F.

4.7.4. Attending to Convergence and Divergence

Nizza et al. (2021) outline the importance of attending to patterns of convergence and divergence across the dataset in the data analysis process and when presenting the findings of a research study. The focus on patterns of convergence and divergence can help to highlight the unique and idiographic nature of a particular participant's experience, as well as highlighting the similarities and differences between participants. For me, I focused on attending to individual quotes in which I could compare and contrast individual accounts in the context of their personal narrative. Additionally, I developed a series of similarities and differences between participants' accounts, to highlight the interconnectedness between the experiences of participants. In other instances, I was able to build generalised cases through close attention to iterative and inductive processes to provide representative accounts of a point of view as communicated by participants.

4.8. Summary of Chapter

In this chapter I outlined the key features of multiple perspective IPA research designs, data collection procedures, ethical considerations, data analysis process, ethical considerations as well as validity and quality criteria related to my research study.

The next chapter, Chapter 5, will introduce and provide a summary of the findings of my research. I will discuss the findings of my research in further detail in later chapters.

Chapter 5: Introduction to Findings

5.1. Introduction

The following three chapters (Chapters 6–8) will present the findings of my research study. Firstly, in this chapter, I will describe and share with the reader how I came to identify the main construct identified in my research and the subsequent Personal Experiential Themes (PETs) and associated General Experiential Themes (GETs). Next, I will present a description and visual representation of the main construct as identified within the research study. Thereafter, I will introduce and present a visual summary of the findings of my study. Additionally, a description table summarising the various GETs and PETs will be presented to familiarise the reader with content to be detailed in the following chapters. Finally, I will present an extract from my research study related to the main construct identified in my research study.

5.2. My Personal Reflections Upon the Conceptualisation of the Main Construct in the Context of the Findings of My Research Study

Below, I draw on my personal reflections to describe my journey to this point and to describe how I came to identify the main construct identified in my research and the subsequent PETs, and associated GETs. I have divided my personal reflections into two phases – phase one and phase two. For the purposes of clarity and coherence, I have chosen to describe the analytic process in the context of the occupational therapy discipline-specific focus group interview, as detailed below.

5.2.1. Phase One

Having analysed the first focus group interview transcript (occupational therapy), I then compiled a comprehensive set of exploratory notes for each occupational therapy clinician. These exploratory notes aimed to inform experiential statements that captured the meaning and significance of each clinician's lived experiences of particular interactions with clients. For example, I was cognisant of describing the explicit meaning of each clinician's thoughts and experiences. However,

I was also conscious of reflecting upon and interpreting clinician's accounts at a more conceptual level to consider the potential meanings of each clinician's account. Next, I identified connections amongst the experiential statements and clustered them together. I continued this clustering process until I was confident that I had provided a set of PETs for each individual clinician. By this stage, I was satisfied that I had provided a meaningful summary of each clinician's account from within the occupational therapy focus group interview.

Next, I understood that I needed to analyse the occupational therapy focus group data more broadly to begin to identify the similarities, differences, and connections between the individual accounts of occupational therapy clinicians (i.e., identifying the similarities, differences, and connections between PETs). This parsing process resulted in the conceptualisation of GETs that represented the collective accounts of occupational therapy clinicians' lived experiences. At this stage of the analytic process, I made continual reference to the words, stories, and quotes of each individual clinician to ensure that the idiosyncratic nature of clinicians' accounts was retained in the context of the collective GETs.

I subsequently repeated the above analytic process for each of the other discipline-specific focus groups (i.e., physiotherapy, social work, play therapy, and speech and language therapy focus groups). I was now confident that I had developed a set of GETs that were representative of the collective accounts of each of the discipline-specific groups.

5.2.2. Phase Two

Following detailed reading of the literature related to designing, undertaking and analysing multiple perspective research designs, I understood that the research design requires an additional analytic focus that takes account of other conceptual and methodological considerations to synthesise analysis "not only *within* a sample" but also "*between* samples" (Larkin et al., 2019, p.183) (i.e. between each discipline-

specific group). I engaged in extensive reading relating to analytic strategies that provided a coherent way of working across the various discipline-specific focus groups.

It was at this stage that I identified "conceptual overlap" (Larkin et al., 2019, p. 186) as a particularly relevant analytic strategy, given that there was explicit consensus upon the extent of the impact of experiences for HSCP clinicians in the context of particular interactions with clients. It was at this point that I considered that the concept of [7]*valency* – to encompass the notion of value/worth – underpinned the meaning and significance of the collective lived experiences of clinicians. I believed the concept of *valency* facilitated the provision of insights and understandings into shared and overlapping thoughts and experiences of clinicians. Additionally, the concept of *valency* facilitated access to insights and understandings into the ways in which clinicians' thoughts and experiences may differ and diverge in the context of particular interactions with clients.

Additionally, through the analytic process, it occurred to me that clinicians within each of the discipline-specific focus groups reflected upon how particular interactions with clients helped facilitate, create, and provide understanding and learnings for them as both people and professionals. Therefore, I considered that *valent encounters*, as derived from the term conceptual term 'valency', described valuable encounters that encapsulate the effect of clinicians' experiences and

[7] I am aware that the term 'valence' has been employed in various other areas of research to include psychology. From my reading of the literature, there appears to be limited consensus in relation to the conceptualisation of 'valence' in psychology (Walle & Dukes, 2023). Therefore, to the best of my knowledge, the term generally refers to " the 'positive' or 'negative' character of an emotion, as well as to the 'positive' or 'negative' character of some aspect of emotion" (Colombetti, 2005, p.103). In contrast, I consider that my definition of 'valency' primarily relates to describing valuable encounters that encapsulate the effect of clinicians' experiences and responses to particular client/clinician interactions.

Additionally, italics are used in the chapter to emphasise and capture the various connotations and descriptions of the meaning of various words in the context of my research study. Italics will continue to be used throughout the remaining chapters for this purpose.

responses to particular client/clinician interactions[8], as conceptualised through various PETs and GETs within my research study.

5.3. Description of Valent Encounters

Derived from 'valency', and with its Latin origin "valentia" meaning 'strength or worth', the construct of *valent encounter*s in my research study describes valuable encounters that encapsulate the effect of clinicians' experiences and responses to particular client/clinician interactions.

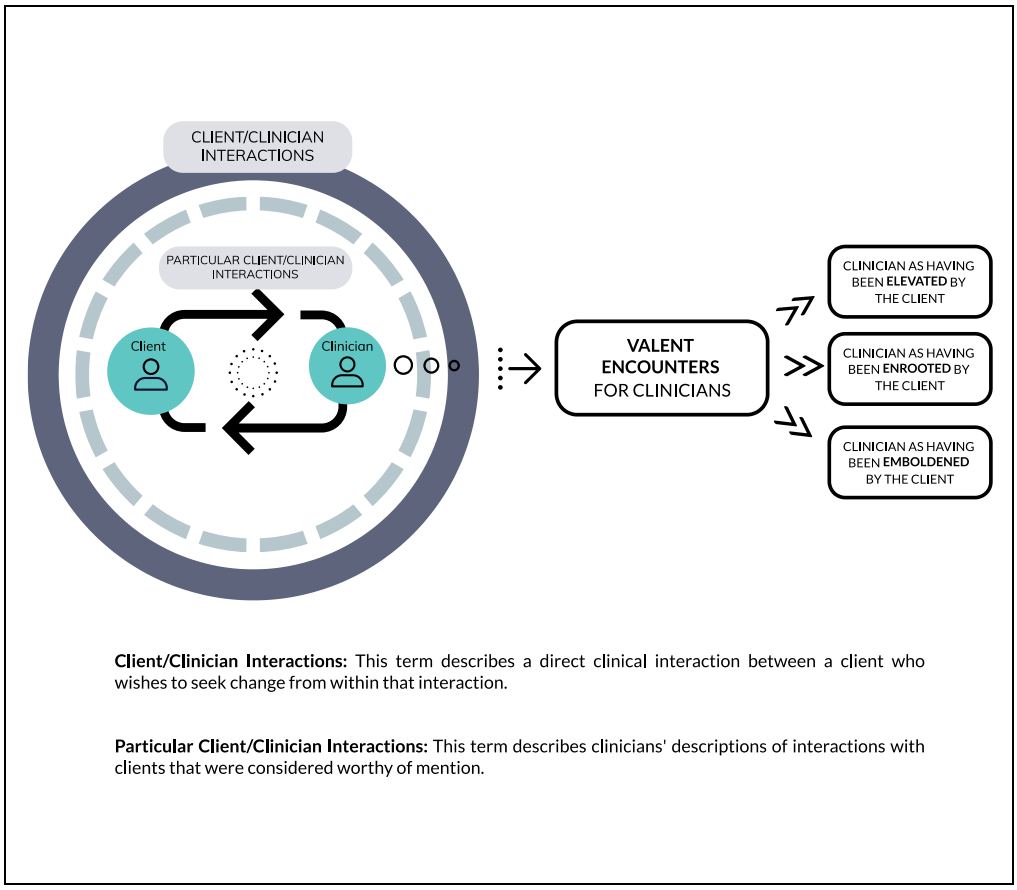
Firstly, the construct of *valent encounters* recognises the active presence and contribution of both client and clinician in the co-creation of these encounters. Secondly, the construct of *valent encounters* foregrounds clinicians' experiences with the client. Finally, the construct of *valent encounters* considers clinicians' responses to particular client/clinician interactions that in turn considers the ways in which the therapeutic, personal, and future beings of clinicians are being continually impacted and shaped.

In Figure 5.1, I present a visual representation of *valent encounters* as contextualised within other types of interactions in clinical practice. Hereafter, I will employ the use of the construct *valent encounters* in the remaining chapters of my research study.

[8] The term 'particular client/clinician interactions' describes clinicians' descriptions of interactions with clients that were considered worthy of mention.

Figure 5.1.

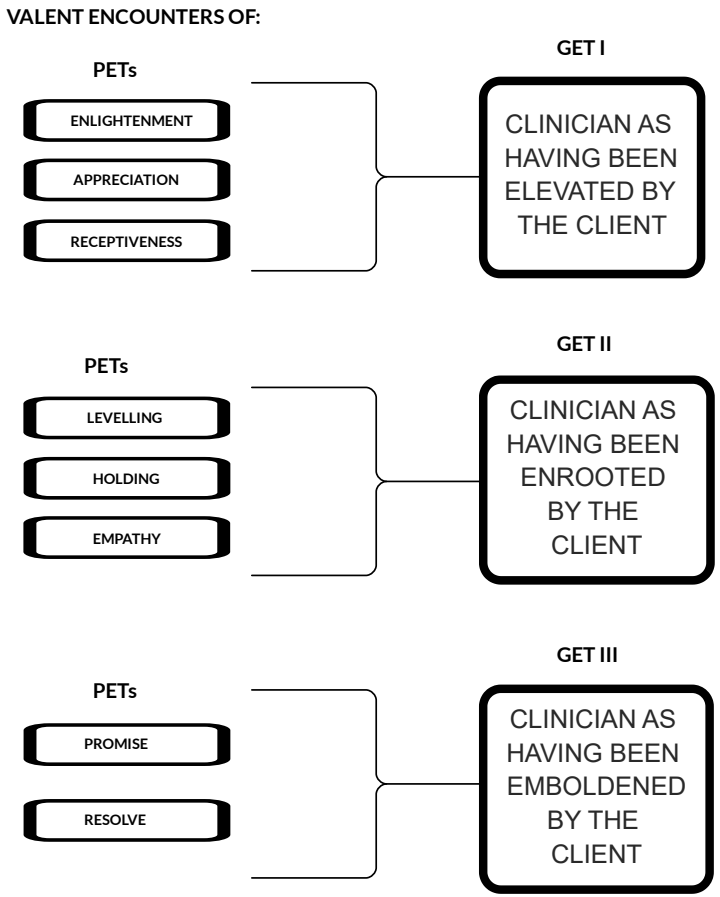
Visual Representation of 'Valent Encounters' as Contextualised Within Other Types of Interactions in Clinical Practice, and Associated GETs.



5.4. Overview of GETs and PETs in the Context of the Findings of My Research Study

Being guided by the theoretical processes of IPA, resulted in the conceptualisation of various PETs, and three main GETs. In Figure 5.2, I provide a visual summary of my research findings in the context of various PETs and GETs as identified in my research study.

Figure 5.2. *Visual Summary of Findings to Include Various PETs and Associated GETs*



5.4.1. Overview of GETs

As illustrated above, being guided by the theoretical processes of IPA allowed for the identification of experiential insights into how clinician's stories, or reflections with clients may be summarised – and it was these particular client/clinician interactions that were important for me to capture and describe. It is suggested that clinicians attribute a valent quality to these particular client/clinician interactions, as conceptualised in *valent encounters*, and that is described via three discrete GETs. The three main GETs identified in my research study include:

- *Clinician as having been elevated by the client;*
- *Clinician as having been enrooted by the client;*
- *Clinician as having been emboldened by the client.*

In Table 5.1, I define the meanings of each of the GET terms as well as a summary of the GETs in the context of my research study. Each of the following chapters (Chapters 6-8) will focus on one GET with supporting evidence from the data to support its identification. Having defined and described each GET as identified, the construct of *valent encounters* will be further explained in terms of its nature and scope in Chapter 9 – *Summary of Findings*, in light of the resulting data analysis.

5.4.2. Overview of PETs

As reflected above, each PET aims to describe the findings of this study through capturing different types of *valent encounters*. The findings will be presented by reference to extracts drawn directly from the data, that informed the development of the various PETS and associated GETS.

Table 5.1.

Definition and Summary of GETs as Identified Within My Research Study

GET I	Clinician as having been elevated by the client*	Definition of GET	Summary of GET
		The first GET to be defined is the ***Clinician as having been elevated by the client.*** This theme is defined specifically as the ways in which *valent encounters* with clients have left a positive impression on clinicians that then evokes within clinicians a desire to emulate *clients' way of being*[9] in the world in everyday practice. This GET describes the ways in which such encounters with clients have raised clinicians to a higher order of professional and personal insight.	GET I describes the ways in which *valent encounters* with clients have raised clinicians to a higher order of professional and personal insight. More specifically, in **encounters of *enlightenment***, clinicians reflect upon the richness of insight and the depth of clarity as gained by clinicians during *valent encounters* with clients, propelling clinicians to elevated states of learning and enlightenment in their clinical roles. Additionally, clinicians reflect upon cementing their growth and change through their engagement with clients in these encounters. Secondly, the theme of **encounters of *appreciation*** considers how *valent encounters* have instilled within clinicians an appreciation for the nature and context of clients' experiences and lives. Additionally, clinicians reflect upon the opportunities to look beyond the supposition of the clients' circumstances, elevating clinicians to a higher order of personal and professional insight. Finally, in the theme of **encounters of**

[9] Clients' way of being in the world refers to the clinician's desire to emulate the positive attitudes, reactions, behaviours, and emotions of clients as encountered in everyday practice.

			receptiveness, clinicians consider how *valent encounters* with clients imbue clinicians with receptiveness and an openness as it relates to the individuality, autonomy and choices of the clients, that elevate the clinician to higher orders of professional and personal insight.
GET II	**Clinician as having been enrooted by the client.**	The second GET to be defined is the ***Clinician as having been enrooted by the client***. Stemming from the concept of being rooted and fixed firmly, this theme is defined as the ability of clients to anchor and ground clinicians in the context of *valent encounters*. This theme describes how such encounters with clients have enrooted within clinicians a commitment to continually consider the nature, essence, and expectations of the clinical role.	GET II reflects upon how *valent encounters* with clients have enrooted within clinicians a commitment to continually consider the nature, essence, and expectations of the clinical role. In the PET of **encounters of *levelling***, clinicians reflect upon *valent encounters* in which clinicians' confidence in their clinical knowledge and skills was challenged and tested, enrooting within clinicians a commitment to continually consider the nature, essence, and expectations of the clinical role, a levelling of sorts. Moreover, **encounters of *holding*** considers how *valent encounters* with clients enrooted within clinicians the value of holding and embracing stillness and presence within one's clinical role. Additionally, clinicians reflect upon reappraising the fundamental principles of clinical practice in the context of *valent encounters*. Finally, in the PET **encounters of *empathy,*** clinicians reflect upon the commonalities and differences as revealed between clients and clinicians during *valent encounters*, revealing clinicians' empathy for clients.

GET III	**Clinician as having been emboldened by the client.**	The third GET to be described is the ***Clinician as having been emboldened by the client.*** This theme is defined as how *valent encounters* with clients instil within the clinician a courage to trust and believe in the capacity of potential despite changeable conditions of clinical practice.	GET III describes how *valent encounters* with clients instil within the clinician a courage to trust and believe in the capacity of potential despite changeable conditions of clinical practice. More specifically, in the PET of **encounters of *promise***, clinicians reflect upon being witness to the aptitudes, capabilities and potential within each client during *valent encounters*, emboldening within clinicians a sense of promise and higher possibilities relating to clinicians' professional and personal insights. Moreover, the PET of **encounters of *resolve***, reflects upon how *valent encounters* with clients embolden clinicians to retain their composure and belief in their skills, capabilities, and the therapeutic process, particularly during times of doubt and uncertainty.

5.5. An Extract from My Data to Illustrate the Construct of Valent Encounters

Below, I am reminded of an extract from the occupational therapy focus group which I believe describes and captures the construct of *valent encounters.* In the following example, an occupational therapy clinician (OT1) reflected upon a "magical" (OT1, line 2) encounter, evoking profound insights for the clinician that she had not considered previously within her clinical role. The clinician described meeting a gentleman who had recently moved into a long-term care facility, and was finding it difficult to settle in. The man been a very high performing pianist who had toured around the world in his younger years, however, he had not played the piano in some time, as described in the extract from Chapter 6 below:

Extract 6.2 – *"it was magical"*

> And I just remember that day, they were able to get a keyboard into the facility, which was a big deal in itself, and when he sat down at the keyboard, I started to play a few notes on my flute, his whole demeanour just changed completely. He just lit up and I was (.) he had TEARS coming out of his eyes and I was like 'don't cry don't cry, this is your placement' but that was a moment where I was just like "ah this is what occupation can do for people", it was magical". (OT1, line 2)

The clinician's use of idiom in "lit up" and the use of emphasis in "TEARS" may suggest how witnessing the client's response to the encounter had the clinician re-evaluate her previous knowledge regarding the nature of her role as an occupational therapist. Similarly, the clinician's use of self-talk "don't cry, don't cry" may suggest the unexpected nature of the learning and the clarity as evoked from this *valent encounter* for the clinician. Meanwhile, the clinician's use of the use of the exclamation "ah" may also signify the depth of understanding as gained by the clinician in relation to considering opportunities and ideas beyond the traditional parameters of

occupational therapy clinical practice, highlighting the learning and enlightenment as gained during the *valent encounter* for the clinician.

5.6. Conclusion of Introductory Chapter

In summary, in this introductory chapter I described and shared with the reader how I came to identify the construct of *valent encounters* and the subsequent PETs and associated GETs. I subsequently presented a description and visual representation of *valent encounters* as identified within the research study. Thereafter, I presented a visual summary of the findings of my study, as well as a description table summarising the various GETs and PETs. Finally, I presented an extract from my research study related to the construct of *valent encounters*.

The following chapter, Chapter 6, will focus on ***GET I – Clinician as having been elevated by the client.*** This GET will describe the ways in which *valent encounters* with clients have raised clinicians to a higher order of professional and personal insight. Chapter 7 will reflect upon ***GET II – Clinician as having been enrooted by the client***. This GET will reflect upon how *valent encounters* with clients have anchored and grounded clinicians in the context of clinical practice, while also instilling a commitment to continually consider the nature, essence, and expectations of the clinical role. Finally, Chapter 8 will present ***GET III – Clinician as having been emboldened by the client.*** This GET will consider how *valent encounters* with the client instil within the clinician a courage to trust and believe in the capacity of potential despite changeable conditions of clinical practice.

Chapter 6: GET I: Clinician as Having Been Elevated by the Client

6.1. Overview of GET I

The first GET to be defined is the *Clinician as having been elevated by the client.* This theme is defined specifically as the ways in which valent encounters with clients have left a positive impression on clinicians that then evokes within clinicians a desire to emulate *clients' way of being* in the world in everyday practice. This GET describes the ways in which valent encounters with clients have raised clinicians to a higher order of professional and personal insight.

More specifically, in encounters of *enlightenment*, clinicians reflect upon the richness of insight and the depth of clarity as gained by clinicians during valent encounters with clients, propelling clinicians to elevated states of learning and enlightenment in their clinical roles. Additionally, clinicians reflect upon cementing their growth and change through their engagement with clients in these encounters. Secondly, the theme of encounters of *appreciation* considers how valent encounters have instilled within clinicians an appreciation for the nature and context of clients' experiences and lives. Additionally, clinicians reflect upon the opportunities to look beyond the supposition of the clients' circumstances, elevating clinicians to a higher order of personal and professional insight. Finally, in the theme of encounters of *receptiveness,* clinicians consider how valent encounters with clients imbue clinicians with receptiveness and an openness as it relates to the individuality, autonomy and choices of clients, elevating clinicians to higher orders of professional and personal insight. A visual representation and description of each of the PETs associated with GET I are detailed in Figure 6.1 and Table 6.1:

Figure 6.1.

GET I: 'Clinician as Having Been Elevated by the Client' and Associated PETs

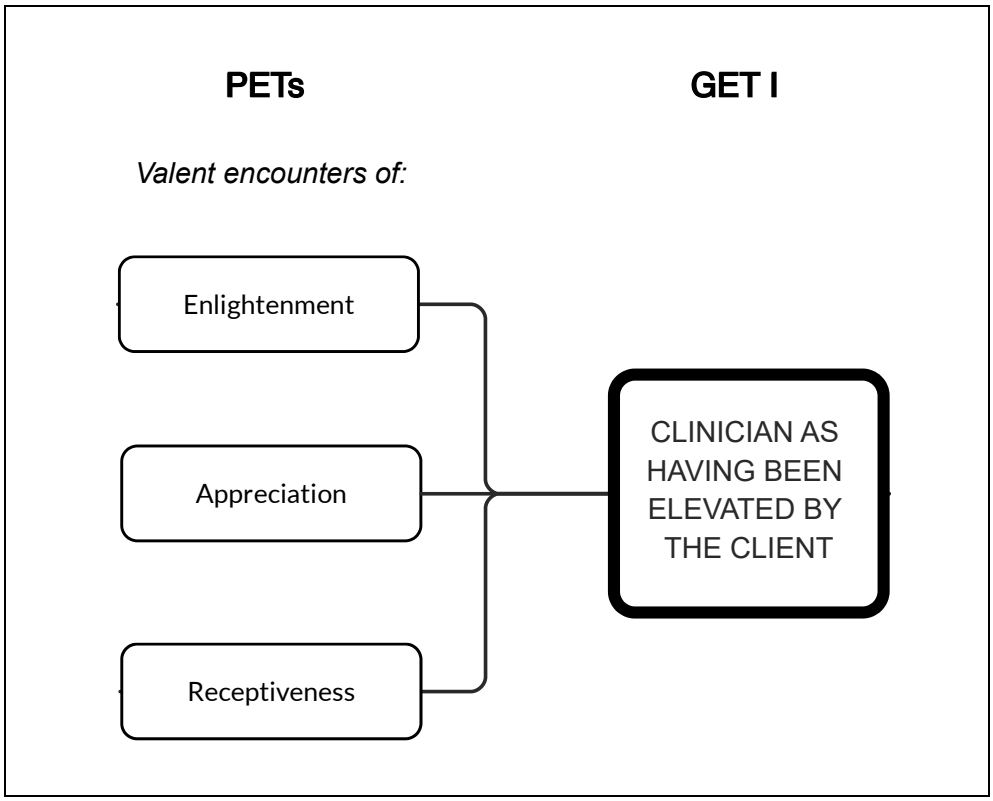


Table 6.1.

Description of PETs Associated with GET I: Clinician as Having Been Elevated by the Client

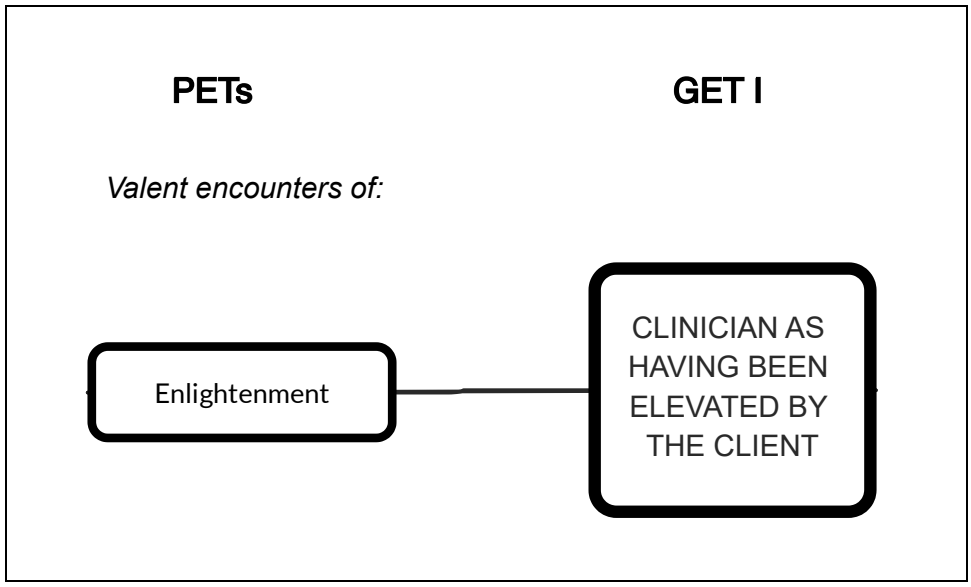
Encounters of *enlightenment*	This theme reflects upon how valent encounters with clients propel clinicians to elevated states of learning and enlightenment in their clinical roles. More specifically, the theme considers the richness of insight and the depth of clarity as gained by clinicians during valent encounters with clients. Moreover, clinicians reflect upon cementing their growth and change through their engagement with clients in these encounters.
Encounters of *appreciation*	This theme reflects upon how valent encounters with clients instil within clinicians an appreciation for the nature and context of clients' experiences and lives. Additionally, clinicians reflect upon the opportunities to look beyond the supposition of the client's circumstances, elevating clinicians to a higher order of personal and professional insight.
Encounters of *receptiveness*	This theme reflects upon how valent encounters with clients imbue clinicians with receptiveness and an openness as it relates to the individuality, autonomy and choices of clients, elevating clinicians to higher orders of professional and personal insight.

6.2. PET 1: Encounters of *Enlightenment*

The PET of encounters of *enlightenment* reflects upon how valent encounters with clients propel clinicians to elevated states of learning and enlightenment in their clinical roles. More specifically, the theme considers the richness of insight and the depth of clarity as gained by clinicians during valent encounters with clients. Moreover, clinicians reflect upon cementing their growth and change through their engagement with clients in such encounters. A visual representation of the PET encounters of *enlightenment* is detailed in Figure 6.2:

Figure 6.2.

GET I: 'Clinician as Having Been Elevated by the Client' and Associated PET 1: 'Encounters of Enlightenment'



The theme of encounters of *enlightenment* features prominently amongst the profession of play therapy in the data. For example, in the following extract (Extract 6.1), a play therapy clinician (PT2) reflected upon valent encounters with clients as "lightbulb moments", as described in the below extract:

Extract 6.1. – *"lightbulb moment"*

> And there's loads and loads of other examples where I've said like "wow, ok, that's it" – it's a lightbulb moment and I don't NEED a book or a piece of

> research or another professional to tell me that even in supervision. This child is actually giving me the answers themselves. They just need somebody to listen to them and really hear them. (PT2, line 27, FG1)

In the above extract, the words of the client may have provided the clinician with answers and learning. Meanwhile, the clinician's use of the idiom "lightbulb" may also signify the immediacy of the learning as gained by the clinician during valent encounters with clients. Further, the idiom "a lightbulb moment" may also signify the richness of the insights as acquired by the clinician during such encounters with clients. Similarly, the clinician's use of contrast between the knowledge as gained from the client in comparison to supervision sessions may also signify the extent of the profound clarity as evoked during such encounters for the clinician. Additionally, the clinician's use of the intensifier "really" suggests the significance of the active engagement of the clinician within such encounters as well as the clinician's ability to be fully present and willing to engage and learn from such encounters.

In another instance, the same play therapy clinician described a valent encounter with a young 11-year-old girl whose parents were reportedly in deep conflict. The clinician recounted a session in which the young girl, who, with her "beautiful brown eyes" (PT2, line 27, FG1) looked up at the clinician and said [PT2],"I've done nothing wrong. I was just born". The clinician remembered thinking "oh my God that's it. Like you know for children in these certain situations, they're just born. They don't ask for this to happen but yet they're the ones in therapy" (PT2, line 27, FG1). The incidental details with which the clinician recounts the colour of the young girl's eyes may suggest the memorable nature of the encounter that is etched in the memory of the clinician, perhaps emphasising how the clinician continues to revisit the profound learnings and insights as gained from this encounter. Similarly, the clinician's use of the exclamative form in "oh my God" suggests the high degree of wisdom as

gained by the clinician in relation to the extent of the child's helplessness within the context of her home environment and upbringing. Additionally, the clinician's use of contrast between the innocence of the child having to suffer the consequences of her difficult home environment evokes within the clinician a depth of clarity and understanding in relation to the child's circumstances that the clinician may not have considered previously. Likewise, another play therapy clinician (PT4) considered how the client has brought the clinician to "new depths" (PT4, line 28, FG2) in her practice. The clinician's use of metaphor of "new depths" may encapsulate the magnitude of learning for the clinician as well as the sense of burgeoning, evolving and maturing within one's clinical role, as evoked through valent encounters.

Similarly, an occupational therapy clinician (OT1) reflected upon a "magical" (OT1, line 2) encounter, evoking profound insights for the clinician that she had not considered previously within her clinical role. The clinician described meeting a gentleman who had recently moved into a long-term care facility, and was finding it difficult to settle in. The man had been a very high performing pianist who had toured around the world in his younger years, however, he had not played the piano in some time, as described in the extract below:

Extract 6.2 – *"it was magical"*

> And I just remember that day, they were able to get a keyboard into the facility, which was a big deal in itself, and when he sat down at the keyboard, I started to play a few notes on my flute, his whole demeanour just changed completely. He just lit up and I was (.) he had TEARS coming out of his eyes and I was like 'don't cry, don't cry this is your placement' but that was a moment where I was just like "ah this is what occupation can do for people", it was magical". (OT1, line 2)

The clinician's use of idiom in "lit up" and the use of emphasis in "TEARS" may suggest how witnessing the client's response to the encounter had the clinician re-evaluate her previous knowledge regarding the nature of her role as an occupational therapist. Similarly, the clinician's use of self-talk "don't cry, don't cry" may suggest the unexpected nature of the learning and the clarity as evoked from this valent encounter for the clinician. Additionally, the clinician's use of the use of the exclamation "ah" may also signify the depth of understanding as gained by the clinician in relation to considering opportunities and ideas beyond the traditional parameters of occupational therapy clinical practice, highlighting the learning and enlightenment as gained through the valent encounter for the clinician.

In another instance of encounters of *enlightenment*, a speech and language therapy clinician (SLT3) reflected upon a valent encounter with a young girl with significant needs in a service for people with intellectual disability. The clinician recounted how she was "very focused" (SLT3, line 16) on what the young girl *could not do* in terms of language skills. However, the child's mother had been told by another clinician that the child was more advanced in her understanding of language than the clinician believed the child was. In the below extract, the clinician reflected upon the richness of insight and the depth of clarity as gained from the encounter:

Extract 6.3. – *"it really taught me"*

> My understanding was that she was understanding at single word level and it caused a lot of distress for mum and I think it really taught me in how to deliver information and how to focus on more of a strength based approach, rather than, because I think in a way in our training sometimes we're used to looking for things that are wrong and this did not help this Mum at all. I think she was still grieving, and she was still processing the needs of her child. I think had I presented the information in a different way it would've seemed (.) it would have been perceived in a different way. (SLT3, line 16)

The clinician's reference to "a lot of distress" may highlight how the mother's reaction the clinician's words may have provided the clinician with a deep realisation regarding the impact and power of her words and feedback for the mother. Moreover, the clinician's reference to her clinical training may signify the clinician's recognition regarding the delivery and communication of learning and knowledge to others, and how such knowledge and feedback may need to be adapted to ensure it can serve the best interests of the client. Further, the clinician's use of pausing may again emphasise and capture the clinician's reaction to the profoundness of the learning and insights as gained from the valent encounter for the clinician.

Similarly, a social work clinician (SW6) reflected upon the levels of learning and knowledge as evoked for her in the context of encounters of *enlightenment*, as suggested in the below extract:

Extract 6.4. – *"what was I thinking there"*

> Now that I'm in the disability sector, it's kinda hitting home a bit how vulnerable kids can be, and that sounds a little bit silly but just like when you, when there is a really small little baby em (.) you know coming home from hospital, or maybe with additional needs [xxx] just the extent of what's actually needed there in terms of day to day care, really practical things (.) and sometimes I think back to kids that I had that I had maybe at home on safety plans or child protection plans [X] and it just makes me think "God what was I thinking there or what were we thinking there" in believing that the child's needs were going to be fully and appropriately met in the environment that they were in…I just wish I had the experience and the knowledge that I have now in those situations and whether I'd feel the same way as I do now== (SW6, line 61)

The clinician's use of comparison when reflecting upon her previous clinical decision- making processes in comparison to her current processes, suggests the value and wisdom of past experiences in elevating the clinician to higher orders of enlightenment. Likewise, the clinician's use of exclamation in "God" may signify the clinician's shock regarding her perceived limited extent of knowledge at the time that resulted in her making clinical decisions that she would not make again. Moreover, the clinician's use of exclamation may again signify the depth of knowledge subsequently gained by the clinician that highlights the clinician's growth and change through her engagement with clients in these encounters. Similarly, another social work clinician (SW1) recounted the learning and knowledge as gained in the context of encounters of *enlightenment*. The clinician reflected upon her time working in reunification programmes with mothers who gave up their children for adoption in Ireland during the 1940s/1950s– "coming forward all these years later where people may not have known they have a child and want to know how they're doing…they could have been 15 when they had the child and now they're 70, and it's just to know that if you really want something go forward and try and do it (SW1, line 55). The clinician's reference to the length of time that may have passed in the life of the client, suggests the extent of the insight as gained by the clinician from these valent encounters in relation to continuing to persevere with one personal's ambitions and dreams within the context of one's life.

Additionally, an occupational therapy clinician (OT1) employs the use of the term "turning point" that again may signify the clinician's insight in relation to the trajectory of development and growth within one's clinical role, cementing the clinician's learning and change through her engagement with the client in an encounter of *enlightenment*, as suggested in the below extract:

Extract 6.5. – *"that was a turning point"*

> Yeah I felt like that was a turning point in my career where it was like I had two different clients (.) so like the first time I was like "I don't know what I'm doing" but the second time around I was like "oh I've seen this before I know what to do now". And the longer that I'm an OT, the more I have those moments and it's lovely actually. (OT1, line 44)

The clinician's use of self-reflection may highlight the preciousness and richness of the learning as gained from the valent encounter that remains with the clinician as she progressed and developed within her clinical role. Additionally, the clinician's use of contrast in her examples of self-talk (i.e. " I don't know"/ "I know") may signify the clinician's growth and change within her clinical role, from a clinician who potentially somewhat feared not having enough knowledge, to a clinician who became more comfortable and confident in her clinical role.

Despite the profession of physiotherapy featuring less prominently than other professions in this PET, a clinician (P1) suggests the trajectory of growth and development as a clinician in the context of encounters of *enlightenment*– "I'm on a very strong learning curve here [laughter] which NEVER ends and that's good too that we're always learning" (P1, line 4). The clinician's reference to "learning curve" may suggest the rate and richness of learning as gained by the clinician in the context of valent encounters. Further, the clinician's use of laughter may allude to the periods of highs and lows in the context of growth and learning for the clinician. Moreover, the clinician's emphatic use of 'never' in "NEVER ends" may signify the incessant and perpetual nature of learning, as evoked through encounters of *enlightenment.*

Finally, the prominence of the theme amongst the profession of play therapy is again highlighted by a clinician (PT1) who reflected upon the precious nature, and

perhaps the celestial elements of a valent encounter that provided the clinician with profound learning and enlightenment, as suggested in the extract below:

Extract 6.6. – *"a very POWERFUL first session"*

> It was a very POWERFUL first session. I was lucky, I think in the client that came to me, I think you're probably given the client that you know, that you need at a specific time maybe (.) and she was, it was just powerful. When she left, I just went "oh my God I can't believe it, I can't believe how lucky I am". I was SO HAPPY, you know, such a lovely moment, I suppose, lovely for a first session so (.) I was delighted with that. (PT1, line 8, FG1)

The clinician's use of repetition and emphasis of the word "POWERFUL" may encapsulate the extraordinarily significant meaning of the encounter for the clinician in relation to her navigating, negotiating and cementing her values, ideologies and convictions as a clinician. Additionally, the clinician's choice of word "need" may perhaps suggest the alchemy of the encounter that promoted development and change for the clinician in ways that the clinician never conceived possible. Further, the clinician's repetition of the word "lovely" may suggest the clinician's gratitude for the experience of this valent encounter, propelling the clinician to a higher order of learning and enlightenment.

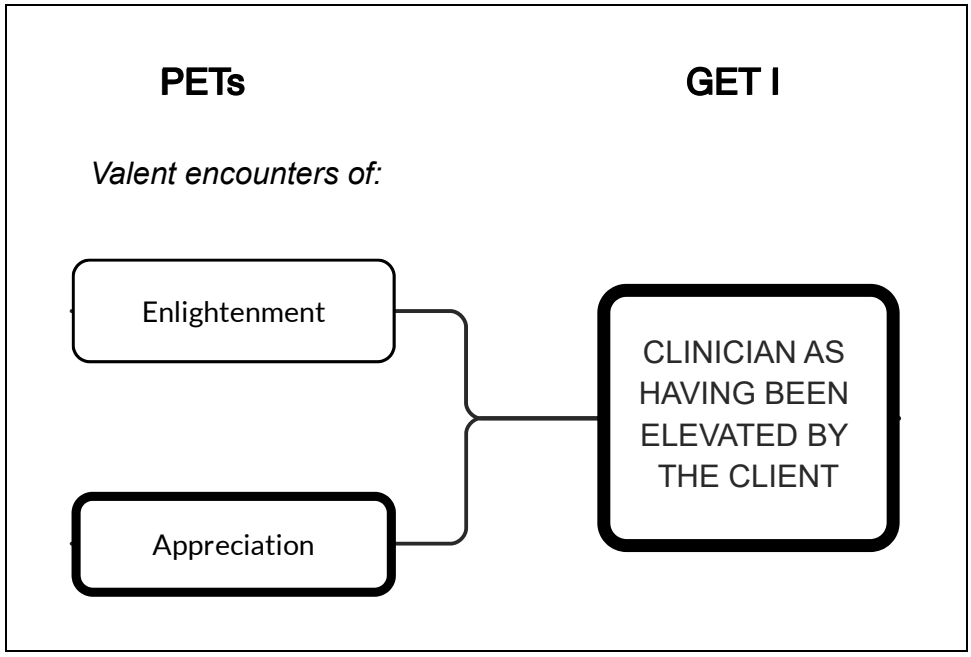
In summary, the PET encounters of *enlightenment* consider how valent encounters with clients have elevated clinicians to higher orders of learning and enlightenment in their clinical roles. Clinicians also reflect upon the richness of insight and the depth of clarity as gained by clinicians during valent encounters with clients. Moreover, clinicians reflect upon cementing their growth and change through their engagement with clients in such encounters.

6.3. PET 2: Encounters of *Appreciation*

In the theme encounters of *appreciation*, clinicians reflect upon how valent encounters with clients instil within clinicians an appreciation for the nature and context of clients' experiences and lives. Additionally, clinicians reflect upon the opportunities to look beyond the supposition of the client's circumstances, elevating clinicians to a higher order of personal and professional insight. A visual representation of the PET encounters of *appreciation* is detailed in Figure 6.3:

Figure 6.3.

GET I: 'Clinician as Having Been Elevated by the Client' and Associated PET 2: 'Encounters of Appreciation'



For example, in the PET of encounters of *appreciation*, one social work clinician (SW3) recounted one of her first cases as a newly qualified social worker. The clinician was working with a teenager who was going to be taken into care. The clinician described walking into the home of a teenager in which there was "cement floor and there was very little furniture". The clinician recalled how exposure to the teenager's home environment instilled the clinician with a recognition as to the reality and hardships of peoples' lives, as suggested in Extract 6.7 below:

Extract 6.7. – *"that cement floor"*

> I thought I was kind of (.) of the world or something…And I thought like I just knew things, street smart, but like when I walked into her house, and it was a cement floor and there was very little furniture, I realised in these reports we write and things that can't assume anything, it kind of like made me double back a bit- like I can't assume the child is fed- I can't assume she's been fed today, I can't assume those clothes aren't her only clothes. And it REALLY like (.) just was a moment (.) like REALLY early in my career, I think like the third week or something, where I was like "OKAY like that's taught you a lesson, like, you now, absolutely everything you do, like, don't make assumptions about any client because everyone is coming from a COMPLETELY different place than where you came from" but I think if I didn't learn that lesson, I would've just assumed these simplistic things. And I always think of that cement floor, and I don't know why [laughter]. I think it's just that I had never seen anything like that before, you know, NOT in Ireland, not in Dublin (.) if that makes sense? (SW3, line 59)

The image of the cement floor perhaps encapsulates how the clinician's exposure to such an environment can make one re-evaluate their own thoughts, beliefs, thinking patterns and perspectives. Moreover, the precise verb selection in "double back" suggests the clinician's shock at the reality of the teenager's living conditions that the clinician felt compelled to see again due to the overwhelming nature of the poverty. Moreover, in this encounter of *appreciation*, the clinician's reflections upon having never witnessed such challenging circumstances, despite having lived in the same city as the client, may also allude to the clinician's sense of disbelief at the extent of the adverse nature of the client's circumstances that is far removed from the clinician's daily reality.

Similarly, the sense of disparity between the clinician's lived world versus that of the client's world is highlighted by a play therapy clinician (PT3) during an encounter of *appreciation* in which "you step through into the playroom and it's like another world" (PT3, line 63, FG2). Likewise, an occupational therapy clinician (OT2) reflected upon how "people let you into their lives at a horrible time and they trust you with the most awful stories and the impact of that awful story on them" (OT2, line 28). Both clinician's precise choice of verbs "step through" and "let you in" suggests entering a hidden and vulnerable part of a client's life that is far removed from the clinicians' personal experiences and understanding of the world. The clinicians' precise choice of verbs above may also suggest the challenge for the clinicians in being able to access this part of a client's world, instilling within the clinicians an appreciation for the nature of the circumstances and the intricacies of their clients' experiences.

The prominence of the theme amongst the profession of play therapy in the data is highlighted by a clinician (PT4) who reflected upon the efforts of accessing the elusive parts of a child's world, as suggested in the below extract:

Extract 6.8. – *"they're only a little person who's has an awful time"*

> And I think sometimes that can happen in clinic work that people might have an interpretation of a child and they're only a little person who's has an awful time and they mightn't have been able to meet the child in their world and that's ok because they might have had a different idea or a different, you know, a piece of work or something else going on but I think in MDT like I think it's dissipating. I think it's still there whenever I get referrals from systems, they'll tell me how hard and what the story is as supposed to the child. (PT4, line 68, FG2)

The clinician's reference to meeting "the child in their world" may highlight the clinician's appreciation as to the disconnect between the clinician's experience of a

client's lived reality and the scripted speculation of the client's life by other professionals (i.e., 'they're only a little person who's has an awful time'). Similarly, the clinician's use of contrast between the team's understanding of a client compared to that of the clinician's understanding, may capture the clinician's keenness to ensure other professionals gain an appreciation for the inner world and place of the client. Additionally, the clinician's use of "story" may highlight the clinician's opportunity to view and see the client's circumstances from a different perspective, which may coincide with clinicians' remarks during the focus group interview regarding the possibility of building and strengthening the professional identity of the profession of play therapy.

Similarly, an occupational therapy clinician (OT2) reflected upon an encounter of *appreciation* in which she acknowledges the patterns of predictability in the context of generational trauma. However, the clinician reflected upon making the conscious decision to choose to see beyond the immediacy of the client's current context and circumstances, as suggested in the below extract:

Extract 6.9. – *"to solve or to ease the pain of the past"*

> When the client comes into us you're not just seeing the client – you're seeing generations past and generations to come and what you do in this moment here has the ability to solve or to ease the pain of the past and potentially mitigate some of the pain of the future and essentially that's actually a very powerful position to be in. (OT2, line 57)

The clinician's repetition of the word "pain" and use of the term "powerful position" perhaps highlights the clinician's opportunity to deviate from expected cycles of behaviour and societally expected outcomes for some clients. Further, the clinician's choice of the word "powerful" may also evoke a sense of the clinician being empowered within her clinical role to have the opportunity to positively influence a

client's life trajectory, encouraging the clinician to look beyond the supposition of the clients' circumstances.

On the other hand, a play therapy clinician (PT2) reflected upon an encounter of *appreciation* that highlighted for the clinician the extent of the challenge of attempting to alleviate and digress from the sense of a pre-destined life trajectory for some clients in the context of generational trauma, as suggested in the below extract:

Extract 6.10. – *"here comes the next generation"*

> He's even as we speak on my mind like cause I can see it, you say like, "God I'm going to read about him in the paper in the future" or you know(.) so because I've worked with that, the other end of it when they've been teenagers 16, 17, 18, I'm ALWAYS reminded (.) when those little people come in and dare I say it, I'm embarrassed to say it, sometimes I'm seeing maybe CHILDREN of the people that I've worked with, you know, or RELATIONS, you know [laughter]. And I've gone "oh my God" and I know (.) I know what's going on my head is here comes the next generation. Here we have generational trauma now playing out, you know (.) so yeah that would be VERY VERY evident to me. (PT2, line 40, FG1)

The clinician's use of the image of the newspaper may allude to the sense of a lack of control and the sense of inevitability the clinician may come up against in relation to psychosocial aspects of a client's circumstances. Additionally, the clinician's use of laughter suggests the clinician's acute understanding of the sheer challenge of continually attempting to withstand the relentless nature and the power of generational patterns and cycles of behaviour as the trauma continues for the young people she is working with. The clinician's use of repetition of "I know" and the particular use of pausing again may capture the wisdom of the clinician's clinical

insight, as well as the daunting nature of attempting to challenge the power of generational patterns and cycles of behaviour for the clinician.

Likewise, a speech and language therapy clinician (SLT2) reflected upon how valent encounters with clients have instilled within her an appreciation for the nature of the circumstances and the intricacies of clients' experiences. The clinician reflected upon the extent of the nature of clients' presentations in the acute setting, as suggested in the below extract:

Extract 6.11. – *"such a fine line"*

> You see quite random [xxx] strokes, road traffic accidents, traumatic brain injuries things that are just, you know, even hearing the self-harm piece and that kind of stuff and ending up in ICU. It always kind of strikes me sometimes as like, there's such a fine line between being well and being in acute care, you know what I mean. Most of the time we're just lucky we're not [laughter]. So when you realise that lack of mobility [xxx] that there's an element of thanks and respect for the person that you're treating, giving thanks that you are well or respecting the person you're treating because these random cancers appear out of seemingly nowhere and can cause such impairment if you will…My patients through their experiences have taught me that like we are so fragile and you know every day is to be purposeful. (SLT 2, line 26)

The clinician's use of listing of various clients' presentations may highlight the clinician's awareness regarding the nature and prevalence of the various types of circumstances clients encounter in the context of their lives. Further, the clinician's use of laughter may highlight the clinician's perceived precariousness regarding the relatable nature of the client's circumstances, as well as providing the clinician with a sense of gratitude and perspective, as evoked through valent encounters.

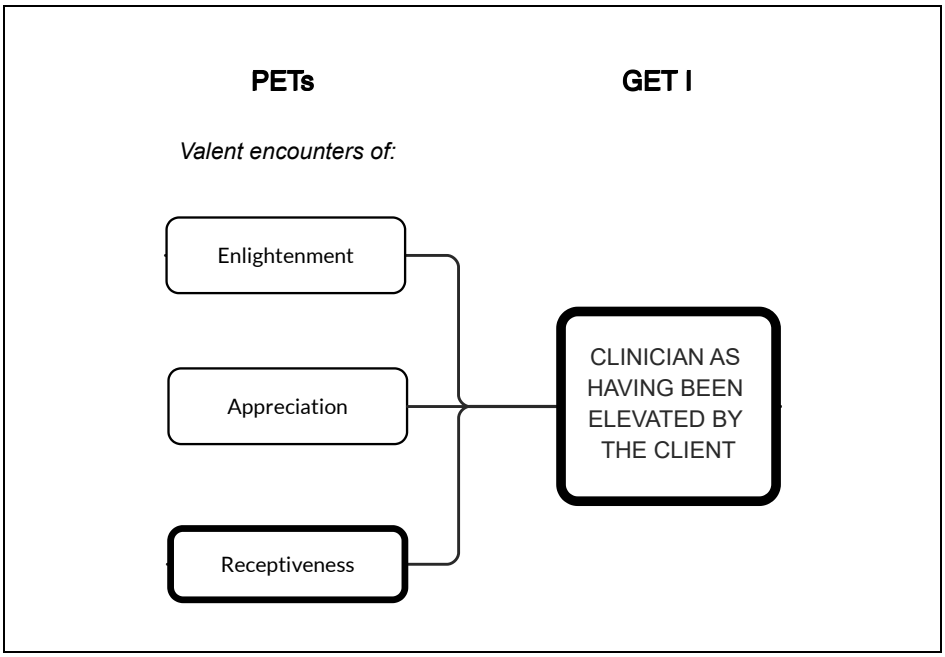
In summary, in the PET encounters of *appreciation*, clinicians reflect upon how valent encounters with clients instil within clinicians an appreciation for the nature and context of clients' experiences and lives. Additionally, clinicians reflect upon the opportunities to look beyond the supposition of the client's circumstances, elevating clinicians to a higher order of personal and professional insight.

6.4. PET 3: Encounters of *Receptiveness*

This theme, encounters of *receptiveness,* reflects upon how valent encounters with clients imbue clinicians with receptiveness and an openness as it relates to the individuality, autonomy and choices of the clients, elevating clinicians to higher orders of professional and personal insight. A visual representation of the PET encounters of *receptiveness* is detailed in Figure 6.4:

Figure 6.4.

GET I: 'Clinician as Having Been Elevated by the Client' and the Associated PET 3: 'Encounters of Receptiveness'



In one instance, a play therapy clinician (PT1) reflected upon how a valent encounter with a client cultivated within the clinician a receptiveness as it relates to understanding the uniqueness of each client's therapeutic journey. The clinician (PT1)

reminisced upon her time working with a boy with autism as represented by the symbol of “shoes”. The clinician described how this particular client had no means of communicating with others, either verbally or non-verbally. Instead, the young client would stand at the stair gate in his room “and just wait for someone to come and get him” (PT1, line 25, FG1). The clinician continued in the extract below:

Extract 6.12. – *“he started bringing his shoes”*

> He couldn’t call out for or ask for help. He just stood there and waited until somebody came to get him so, you know, he started bringing his shoes to me because he wanted to go out. Like, he couldn’t go from his front door to the car without lying down on the ground when I first started working with him- to think, he progressed to bringing me his shoes to say I want to go out, you know, and then further and further started communicating in different ways. (PT1, line 25, FG1)

The clinician’s step-by-step reflection as it relates to the client’s navigation of the therapeutic process suggests the clinician’s commitment to being open to honouring the client’s unique and nuanced therapeutic process. Similarly, the clinician’s reference to the “shoes” as symbolic suggests the clinician’s openness as it relates to understanding the distinctive nature of the client’s individual therapeutic journey, as evoked through this encounter of *receptiveness*.

Similarly, another play therapy clinician (PT2) reflected upon an encounter of *receptiveness* that encapsulates the idiosyncratic and subtle nature of the client’s navigation of the therapeutic process. The clinician described a “very rigid girl, very very strict, rigid, tight in herself, very anxious” (PT2, line 10, FG1). The clinician reflected upon their initial sessions together, during which the young person would colour “in between the lines” (PT2, line 10, FG1) during sessions. However, before a review meeting with the young person’s parents, the child started to make “this mess

inside of the bucket" (PT2, line 10, FG1) that she was playing with during sessions. The clinician remarked how she "had to contain it, there was so much mess". The clinician wondered if this "mess" could be representative of a shift in therapy. The image of the client's bucket overflowing whilst the clinician is attempting to simultaneously contain the "mess", suggests the complexity of the clinician's role in being open and receptive to seeking a balance between aspiring to shifts within the therapeutic process yet wanting to ensure such shifts can be managed and generalised, as suggested by the clinician in the below extract:

Extract 6.13. – *"the mess was overflowing"*

> She's starting to loosen up and free herself up a little bit, and the mess was overflowing, I remember thinking "oh my God, this is her, she's letting it all go", a bit like [PT1]'s you know, it was coming out of the bucket and her parents were saying she's playing with water at home and she's getting her dress all wet- sure they were over the moon…so it's a bit like the jigsaw was coming together and I was thinking is this what they're going to say? Which is what they said, they were very pleased, and I remember going away going "this is what it's all about (.) this is what play therapy is all about (.) SUCCESS! [laughter]. (PT2, line 10, FG1)

Moreover, the clinician's reference to "mess" may highlight the clinician's priviness to identifying the subtle yet significant changes within the client's therapeutic process. Further, the analogy of the "jigsaw" may highlight the skill of the clinician in piecing together the intricate and complex elements of the client's therapeutic process to facilitate the client's growth and development, as highlighted in this valent encounter.

In another instance, a physiotherapy clinician (P4) reflected upon how valent encounters with young clients imbued the clinician with a receptiveness for the individuality and choices of the client, as suggested in the below extract:

Extract 6.14. – *"getting distracted looking outside the window"*

> So I work in paediatrics now, and I love the kids who come in and the parents are like "oh yeah, they're useless at this, they're terrible at that, they can't play football, they can't play hockey, they can barely walk in a straight line", and I'll look at the kid and see them using toys in a way that no other child has used them like inventing and doing all of these interesting and peculiar things and getting distracted looking outside the window. (P4, line 57)

The clinician's use of contrast between how parents may view the skills of their children in comparison to how the clinician views the capabilities of the child may highlight the clinician's ability to celebrate the uniqueness of each client and allowing the client to live life on their own terms. Also, the clinician's use of present participle verbs in "inventing" and "getting" may capture the clinician's acceptance and recognition of the child's preferences and choices. Likewise, another physiotherapy clinician (P3) considered the importance of "understanding the individual and without actually recognising the resilience, and how they cope and what's bringing them through the whole experience" (P3, line 32), suggesting the power of the clinician's receptiveness to supporting and building upon the strengths and capabilities of clients.

Similar to the profession of play therapy, the theme of encounters of *receptiveness* features prominently amongst the profession of social work in the data. For example, a social work clinician (SW2) acknowledged how a valent encounter with a young client imbued within the clinician a receptiveness and respect for the autonomy and choices of the client. In the below extract, the clinician reflected upon

his time working with a young person, whom the clinician was told would need a certain and specific scripted course of intervention. The clinician described how "all the professionals around him looked at his life history and were like 'counselling, trauma, needs that therapeutic intervention, MUST have it' " (SW2, line 43). When the young client came into care, the clinician felt obliged to have a conversation with him regarding potential supports he may wish to avail of, as described in the extract below:

Extract 6.15. – *"I don't need it"*

> That was something that when he came into care, that I had put to him, and I put it to him a few times and set it up for him and he was like "I don't need it" and em (.) I would go back and tell people "he doesn't want to access it" and they were like "in time he will, he's not ready, in time". And then (.) we ended up fostering him, living with him and there was none. And there was no need. (SW2, line 43)

The clinician's use of comparison between what may benefit the young person in theory versus the reality of the young person's current life, suggests the power of the clinician's receptiveness to supporting the client's choices and decision-making processes as it relates to their care. Furthermore, the same social work clinician (SW2) also reflected upon not relating to people you are working with as "problems or as people who have problems that need to be solved and you're the person who's going to solve them. If you're relating to them like that, there's already, there's already a distance going up between you and them" (SW2, line 10). The clinician's selection of the verb "solve" may suggest the clinician's receptiveness to respecting the preferences and wishes of the client to help facilitate the client's growth and development.

Moreover, another social work clinician (SW3) reflected upon receptiveness and openness as it relates to the autonomy and choices of the clients, when she reflected

on how "'you can't help someone who doesn't want help'– that's always stuck with me" (SW3, line 12). Here, the clinician's precise choice of the verb "stuck" may suggest the clinician's consideration and openness as it relates to the individuality, autonomy and choices of clients. Moreover, the word "stuck" may also allude to the wisdom and cherished nature of the advice that the clinician continues to recount and remember in clinical practice, as evoked though valent encounters.

Additionally, the sense of respect and consideration for the client's choices is acknowledged by an occupational therapy clinician (OT1), as suggested in the below extract:

Extract 6.16. – "*what do you like to do?*"

> The problem doesn't lie within that person necessarily, the problem is within the environment and we can ignore problems altogether and just start at "what do you like to do?" let's start there and no other profession gets to do that and I just think that it's amazing that we can have fun with people and that's our job [laughter]. (OT1, line 61)

The clinician's use of questions in the above extract suggests the clinician's emphasis and focus as it relates to valuing the opinions, ideas and suggestions of clients. Further, the clinician's use of contrast when describing her profession of OT in the context of other professions, suggests the emphasis and consideration of valuing the client's choices and preferences from the outset of the therapeutic process in the profession of occupational therapy. The use of contrast may also highlight the potential of the profession of occupational therapy to begin intervention from a different starting point, alluding to a means of further facilitating the individuality and autonomy of the client. Likewise, reflection upon the potential of the profession of occupational therapy is again acknowledged by another occupational therapy clinician (OT2) when reflecting upon how "OTs have so much to offer (.) clients of the world"

(OT2, line 57). The same clinician continues to recount how "occupational therapy actually has the capacity to change the entire world by changing the path for this one person" (OT2, line 57). Here, the clinician's choice of the metaphor "path" may suggest the clinician's and the profession's emphasis on being cognisant of the individuality and choices of clients, as evoked through encounters of *receptiveness*.

Similarly, a play therapy clinician (PT4) reflected upon how the profession tends to lend itself towards being open and receptive to the individuality, autonomy and choices of clients, as suggested in the below extract:

Extract 6.17. – ***"Some of our work is SO non-directive"***

> Some of our work is SO non-directive and it's led by the client. We're not structuring or leading or directing at times, there are times we are! To help this child gain something but trusting that they are, like that, self-actualisation that they are going towards their greatest potential within this therapeutic relationship. (PT4, line 3, FG2)

The clinician's use of emphasis in the above extract (i.e., 'our work is SO non-directive)' may suggest the clinician's emphasis, and potentially, the profession's emphasis on the importance of empowerment and respecting the choices of clients. Additionally, the clinician's choice of verbs such as "structuring" "leading" and "directing" when describing what the profession strives against, suggests the importance of shared collaboration and joint partnership in clinical practice.

In summary, the PET of encounters of *receptiveness,* reflects upon how valent encounters with clients imbue clinicians with receptiveness and an openness as it relates to the individuality, autonomy and choices of clients, elevating clinicians to higher orders of professional and personal insight.

6.5. Summary of GET I

This chapter presented the GET of *Clinician as having been elevated by the client*. This experiential theme described the ways in which valent encounters with clients have left a positive impression on clinicians that then evokes within clinicians a desire to emulate *clients' way of being* in the world in everyday practice. This GET described the ways in which valent encounters with clients have raised clinicians to a higher order of professional and personal insight. More specifically, in encounters of *enlightenment*, clinicians reflected upon the richness of insight and the depth of clarity as gained by clinicians within valent encounters with clients, propelling clinicians to elevated states of learning and enlightenment in their clinical roles. Additionally, clinicians reflected upon cementing their growth and change through their engagement with clients in these encounters. Secondly, the theme of encounters of *appreciation* reflected upon how valent encounters instil within clinicians an appreciation for the nature and context of client's experiences and lives. Additionally, clinicians reflected upon the opportunities to look beyond the supposition of the client's circumstances, elevating clinicians to a higher order of personal and professional insight. Finally, in the theme of encounters of *receptiveness,* clinicians reflected upon how valent encounters with clients imbue clinicians with receptiveness and an openness as it relates to the individuality, autonomy and choices of clients, elevating clinicians to higher orders of professional and personal insight.

Chapter 7: GET II: Clinician as Having Been Enrooted by the Client

7.1. Overview of GET II

The second GET to be defined is the *Clinician as having been enrooted by the client.* Stemming from the concept of being rooted and fixed firmly, this theme is defined as the ability of clients to anchor and ground clinicians in the context of valent encounters. This theme reflects upon how encounters with clients have enrooted within clinicians a commitment to continually consider the nature, essence, and expectations of the clinical role.

In the PET of encounters of *levelling*, clinicians reflect upon valent encounters in which clinicians' confidence in their clinical knowledge and skills was challenged and tested, enrooting within clinicians a commitment to continually consider the nature, essence, and expectations of the clinical role, a levelling of sorts. Moreover, encounters of *holding* considers how valent encounters with clients enrooted within clinicians the value of holding and embracing stillness and presence within one's clinical role. Additionally, clinicians reflect upon reappraising the fundamental principles of clinical practice in the context of valent encounters. Finally, in the PET encounters of *empathy,* clinicians reflect upon the commonalities and differences as revealed between clients and clinicians during valent encounters, revealing clinicians' empathy for clients. A visual representation and description of each of the PETs associated with GET II are detailed in Figure 7.1 and Table 7.1:

Figure 7.1

GET II 'Clinician as Having Been Enrooted by the Client' and Associated PETs

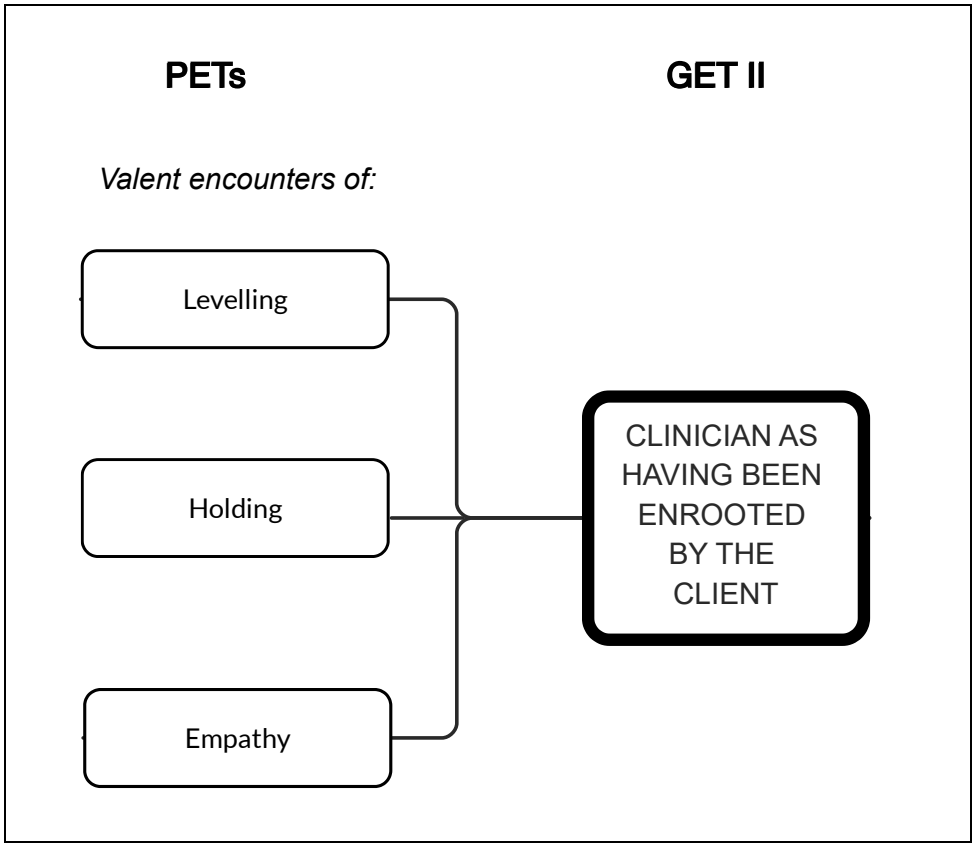


Table 7.1.

Description of PETs Associated with GET II: Clinician as Having Been Enrooted by the Client

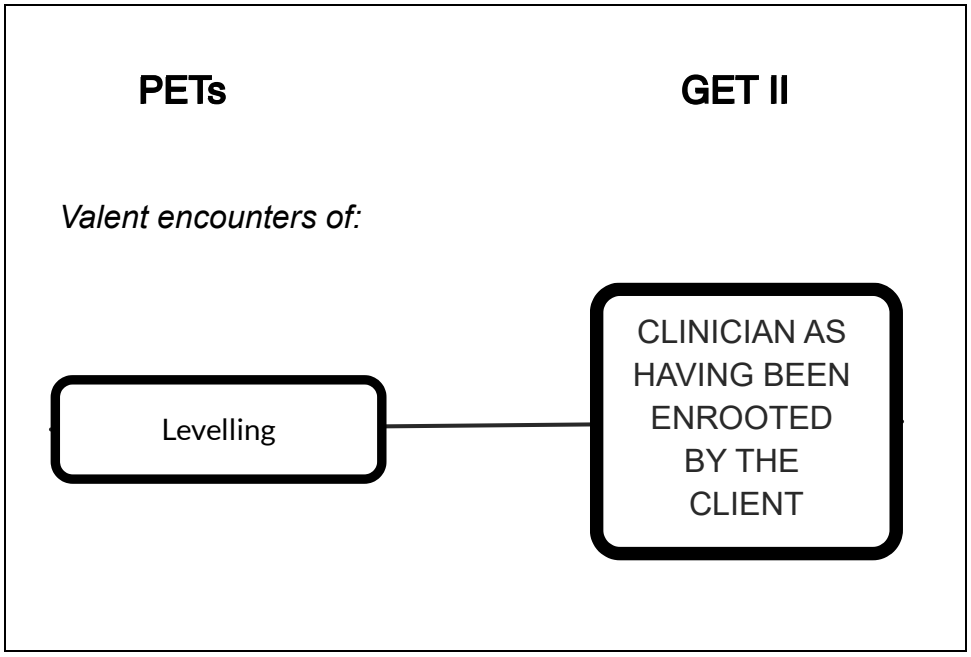
Encounters of levelling	This theme reflects upon valent encounters with clients in which clinicians' confidence in their clinical knowledge and skills were challenged and tested, enrooting within clinicians a commitment to continually consider the nature, essence, and expectations of the clinical role, a levelling of sorts.
Encounters of holding	This theme reflects upon how valent encounters with clients enrooted within clinicians the value of holding and embracing stillness and presence within one's clinical role. Additionally, clinicians reflect upon reappraising the fundamental principles of clinical practice in the context of valent encounters with clients.
Encounters of empathy	In this theme, clinicians reflect upon the commonalities and differences as revealed between clients and clinicians during valent encounters, revealing clinicians' empathy for clients.

7.2. PET 1: Encounters of *Levelling*

The PET of encounters of *levelling* reflects upon valent encounters in which clinicians' confidence in their clinical knowledge and skills was challenged and tested, enrooting within clinicians a commitment to continually consider the nature, essence, and expectations of the clinical role, a levelling of sorts. A visual representation of the PET encounters of *levelling* is detailed in Figure 7.2:

Figure 7.2.

GET II: 'Clinician as Having Been Enrooted by the Client' and Associated PET 1: 'Encounters of Levelling'



The theme of encounters of *levelling* features prominently amongst the profession of physiotherapy in the data. For example, in the following extract (Extract 7.1), a physiotherapy clinician (P2) recounted how a valent encounter with a client prompted the clinician to reevaluate his level of clinical skills and abilities at a particular point in time in clinical practice. The clinician reflected upon meeting a client whose clinical presentation the clinician had not encountered previously in his career, as described in the below extract:

Extract 7.1. – *"got my heart racing a bit"*

> I think somebody came in with something very very strongly neuropathic (.) and my whole idea up to then had been very purely musculoskeletal and I was like "CRAP!" this guy's spine is messed up but obviously it was fine but that just kinda got my heart racing a bit and made me actually think that I didn't know as much as I thought I did. (P2, line 8)

The clinician's use of emphasis in 'CRAP' may capture the clinician's heightened sense of panic regarding the novel nature of the clinical presentation that the clinician had not encountered previously. Furthermore, the clinician's use of the idiom "heart racing" may capture the clinician's apprehensiveness at having to identify and manage the case, enrooting within the clinician a commitment to continually consider the nature, essence, and expectations of the clinical role.

Additionally, another physiotherapy clinician (P5) reflected upon a valent encounter with a client that prompted her to reevaluate her competences and capabilities as a clinician. The clinician described having to tell a client that their functioning may be more limited following an accident. The clinician discussed how she found it difficult to have this particular conversation with the client- "the first time I ACTUALLY told someone you're NOT going to be able to do A,B,C, D was a difficult time for me as a physio because I thought we get people right, you know, you "FIX" people" (P5, line 48). The clinician's use of emphasis in "FIX" suggests how this encounter prompted the clinician to reconsider her expectations of her clinical role, from being a clinician who provided solutions to a clinician, to a clinician who provided supports to clients in the context of their therapeutic journey. Likewise, the clinician's use of emphasis may suggest how the encounter may have fostered within the clinician a commitment to reconsider the potential limitations and the purpose of her clinical role. Meanwhile, later in the focus group, the same clinician later acknowledged her

role in managing expectations in the context of recovery, when describing how "I do think some of our role is actually just getting people to as good as they can be and actually physically and mentally" (P5, line 50). The clinician's use of "just" may highlight the clinician's acceptance regarding the limitations of her role, that enroots within the clinician a commitment to re-evaluate her expectations regarding clinical outcomes, as evoked through encounters of *levelling*.

Moreover, a social work clinician (SW2) reflected upon an encounter of *levelling* that tested the clinician's limits and capabilities within the context of his clinical role. The clinician was working with a mother as part of a reunification plan to have her children return home to the family home. The clinician reflected upon the challenging nature of the case that resulted in it being difficult to make progress with the family, as described in the below extract:

Extract 7.2. – *"CAPITAL C CHALLENGING"*

> I was doing these weekly meetings with her, trying to put in the safety for the children to go back home and she was CAPITAL C CHALLENGING. There was a lot going on for her, there was a lot going on for the situation…but anyway she was very, very difficult to make progress with em (.) but I can remember thinking at the very end of it I NEVER got sucked into the ups and downs of it, of the obstructiveness sometimes, the lack of containment all of that sort of stuff. I can remember being like, "I was able to deal with it without coming part of it and that", that was one of those moments, I actually felt like "oh my God I've arrived" that I can go in there, not be anxious about going in there, know that I'm not going to get sucked into it and be able to leave and put it behind me, and be like 'okay, that meeting's over'. (SW2, line 43)

The clinician's use of emphasis in- "she was CAPITAL C CHALLENGING" may capture the demanding and testing nature of the encounter for the clinician.

Additionally, the clinician's use of emphasis in 'NEVER' , and the clinician's use of the intensifier "oh my God I've arrived" may highlight how this valent encounter signified to the clinician that he was able to remain boundaried throughout the course of his engagement with this particular client, instilling a confidence within the clinician regarding his clinical skills and capabilities.

Furthermore, an occupational therapy clinician (OT1) reflected upon encounters that prompted the clinician to engage in additional reflective practice to further understand the meaning and expectations of her clinical role, as suggested in the below extract:

Extract 7.3. – *"the ones that challenge me"*

> The clients that stick with me are probably the more challenging, the ones that challenge me more because I'm still learning quite a lot because I'm NEW and I suppose I walk away from those challenging clients with wanting to do a lot of reflection [laughter] which when I was a student, I was like "reflection is stupid" whereas now I really need that because otherwise it will just play over and over in my head. (OT1, line 17)

The clinician's use of laughter may capture the extent of the impact of the encounter for the clinician in relation to her confidence levels and belief in her clinical skills and abilities. Further, the clinician's reference to "over and over in my head" may allude to the clinician feeling compelled to engage in additional reflective practice to ensure that she could continue to consider and evaluate consider the nature, essence, and expectations of the clinical role.

Similarly, a play therapy clinician (PT2) reflected upon a 'challenging' client who taught her so much –"oh my God really like he's SO challenging, but I've learned SO much from him" (PT2, line 27, FG1). Here, the clinician's use of repetition and emphasis of "SO" suggests the arduous and testing nature of the encounter for the

clinician. Moreover, the clinician's reference to the long-term insights as evoked from the encounter may suggest the clinician's gratefulness for the experience despite the challenging and demanding nature of the valent encounter.

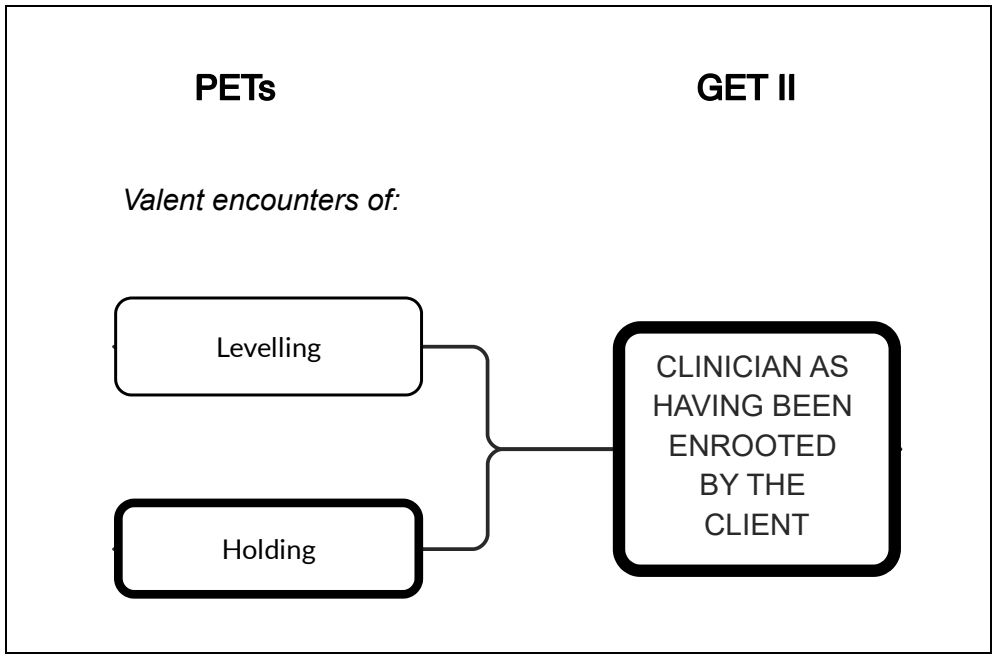
In summary, the PET of encounters of *levelling* reflects upon valent encounters with clients in which clinicians' confidence in their clinical knowledge and skills was challenged and tested, enrooting within clinicians a commitment to continually consider the nature, essence, and expectations of the clinical role, a levelling of sorts.

7.3. PET 2: Encounters of *Holding*

The PET *encounters of holding* reflects upon how valent encounters with clients enrooted within clinicians the value of holding and embracing stillness and presence within one's clinical role. Additionally, clinicians reflect upon reappraising the fundamental principles of clinical practice in the context of valent encounters with clients. A visual representation of the PET encounters of *holding* is detailed in Figure 7.3:

Figure 7.3.

GET II: 'Clinician as Having Been Enrooted by the Client' and Associated PET 2: 'Encounters of Holding'



In some instances, *encounters of holding* reflect upon how valent encounters with clients enrooted within clinicians the value of holding and embracing stillness and presence within one's clinical role. For example, the theme featured prominently amongst the profession of occupational therapy in the data. In one instance, an occupational therapy clinician (OT1) described a valent encounter with a client who continued to attend sessions every week despite the client not having any specified goals to target during sessions. The clinician reflected that despite the limited targets identified in sessions at this particular time, the client continued to attend, as detailed in the below extract:

Extract 7.4. – *"she just kept turning up"*

> I didn't even know what goals we were working on most of the time but she just kept turning up every week so I was like "well maybe that's a sign that whatever we're doing, which I didn't really know, is working" because she keeps coming whereas when she worked with other disciplines maybe she wouldn't turn up or she'd kinda fall off. (OT1, line 17).

The contrast between the client's lack of specified goals and the client's wish to continue to attend sessions suggests the clinician's willingness to not always being fixated upon striving to achieve specified targets, but instead, to help support and sustain the client's engagement and motivation within their therapeutic process. Moreover, the clinician's use of self-talk may highlight the clinician's contentment in her role and clinical abilities to consider the benefits of their sessions together despite the uncertainty of the client's intervention plan and care pathway at that time. Similarly, the use of self-talk may signify to the clinician how clients and clinicians may perceive differently the meaning and purpose of their sessions together, as evoked through this valent encounter with the client.

Additionally, another occupational therapy clinician (OT2) made reference to a "lifebuoy" to describe her role as a clinician in the context of encounters of *holding*. The clinician described how at times, her role consists of being of support and assistance to clients, as suggested in the below extract:

Extract 7.5. – *"a half inflated life-buoy is better than no life-buoy"*

> Some of it as well, like I've said, I've 30 years' experience so I get complex cases referred to me and you know some of them, I've never come across before you just have to go "ok you've just got to sit with this, what other options are there?" You're not going to deny a person a service because you can't offer them some help- you know a half inflated life-buoy is better than no life-buoy (OT2, line 48).

The clinician's reference to "half-inflated lifebuoy" may encapsulate the clinician's ability to recognise the value in supporting, and keeping clients afloat despite not always being able to provide immediate answers and solutions for clients. Furthermore, the clinician's use of "lifebuoy" may also suggest the clinician's ability to be at ease with the present moment, and not always striving to achieve progress or to feel obligated to find answers for clients.

Similarly, in some encounters of *holding*, clinicians suggested a sense of being an 'accompanier' for the client at particular moments in their lives. For example, one social work clinician (SW1) was cognisant of the unique and privileged ability of the clinician to provide counsel to clients as they navigate difficult times in their lives, as highlighted in the below extract:

Extract 7.6. – *"holding their hand a bit"*

> I think no matter what social work job you're in you're going to be going through something difficult with a person-like going along that road with them and for someone to TRUST you that much to be on that road with them no

> matter how proactive they are themselves and you're just kinda guiding them a bit or just kinda holding their hand a bit it just to, well it doesn't always feel like a privilege if they're a really challenging client [laughter], but it's rewarding that someone has that trust in you…but it's just being part of someone's story in a really difficult time in their life. (SW1, line 78)

The clinician's reference to "road" and "story" may encapsulate the clinician's emphasis on supporting rather than feeling obligated to find or provide solutions for clients. Further, the clinician's reference to "road" and "story" may capture the unique nature of each client's circumstances, in which the clinician can guide and empower clients towards spotting solutions or striving to find the answers they seek themselves. Likewise, the clinician's use of the phrase "holding their hand" suggests the clinician's commitment not to feel pressurised to change the current circumstances, but rather to be with and help accompany the client thorough hard times.

Similarly, a speech and language therapy clinician (SLT2) reflected upon how "it's a great thing to (.) to be able to accompany somebody on part of their life journey when things are maybe a bit more fragile" (SLT2, line 37). The clinician's reference to "great" may suggest the clinician's comfortableness in her role in which she does not feel compelled to continually provide answers or solutions to the client. Further, the clinician's reference to "accompany" may highlight the clinician's ability to support and attend to the client, especially during vulnerable periods in the client's life journey.

Similarly, an occupational therapy clinician (OT2) reflected upon an encounter of *holding* from which she realised that she will not always "have the answers" (OT2, line 6) but will still be able to help support clients, conveying to them that "I'm here to walk with you" (OT2, line 6). Again, the clinician's use of the phrase "walk with you" may encapsulate the clinician's opportunity to be alongside a person at a particular time in life, while not always having to feel compelled, or striving to decipher solutions

within the context of the current moment. Likewise, an occupational therapy clinician suggested - through the use of metaphor – how "the human soul doesn't want to be fixed it just wants to be heard and observed and to hold space for it" (OT2, line 6). The clinician's choice of the precise verbs "heard", "observed" and "hold" again may signify the value the clinician places in holding and embracing stillness rather than striving to seek solutions within one's clinical role.

In contrast, a play therapy clinician (PT2) was mindful of her "rescuer" (PT2, line 31, FG1) role within her family unit, and how oftentimes she would be "the go-to person a lot of the times" (PT2, line 31, FG1) in her family. The clinician identified that a struggle for her in her professional capacity is rushing in "to fix situations" (PT2, line 31, FG1) that stemmed from her own upbringing. The clinician reflected upon a valent encounter in which she recounted receiving a phone call from a solicitor in which she was asked to work with a particular client because "nobody else" would (PT2, line 31, FG1). The clinician continued to describe her thought processes regarding engaging with particular cases, as described in the below extract:

Extract 7.7. – *"can I fix this, can I do this?"*

> I'll immediately go "can I fix this, can I do this?". I can see one linking in with that inner part of me that I am VERY AWARE of [laughter] but I always have to keep an eye on because that's not my job. It is not my job obviously [laughter] to rescue these families. (PT2, line 31, FG1)

The clinician's use of self-talk may highlight the clinician's struggle to step back and suppress her innate instinct to want to help ameliorate certain situations for the client. Similarly, the clinician's use of laughter may highlight the challenge for the clinician to embrace and be comfortable with providing support to the client rather than being focused on clinical outcomes.

In other instances, encounters of *holding* reflect upon clinicians reappraising the fundamental principles of clinical practice. For example, one speech and language therapy clinician (SLT3) reflected upon the importance of engaging in the practice of listening. The clinician described how "even if a person is not able to use their voice it's about being able to listen to them in the best way that they can communicate" (SLT3, line 32). The clinician's reference to "voice" may capture the clinician's commitment to identify and provide alternative means of supporting the client's skills and abilities to empower the client to find solutions to certain situations themselves.

Likewise, a social work clinician (SW5) reflected upon continuing to engage in the practice of listening in clinical practice, as suggested in the below extract:

Extract 7.8. – *"that's all it really takes"*

> The power of just listening and being present and that's all it really takes to, I feel, affect any sort of change or have an impact and I find that HUGELY rewarding being able to be maybe a safe space or a consistent in someone's life and when maybe they're in a place of chaos and be that ear to bounce things off or to maybe – the validation they might need around something. (SW5, line 76)

The clinicians use of emphasis in "HUGELY" suggests the clinician's acknowledgement regarding the role of listening and stillness in helping to affecting change for the client. Moreover, the clinician's choice of the verb "bounce" may also suggest the clinician's ability to harness the fundamental skills of clinical practice, such as active listening skills and presence, to provide support and reassurance to clients as they navigate their current circumstances.

Likewise, a play therapy clinician (PT3) reflected upon the value of taking a step-back, and embracing the basic principles of practice, especially when feeling "stuck" as a clinician, as suggested in the below extract:

Extract 7.9. – *"back to the basics"*

> I always kind of remind myself and I take that to supervision a lot it's just back to the basics, the basic principles of play therapy – just kind of reminding myself I need to be present, just you know, for the child, in the play room, and stripping everything back and coming out of my own head and I think that's always one that that's stood to me when I've kind of felt a bit stuck. (PT3, line 2, FG2)

The clinician's use of repetition of "basic/s" as well as the clinician's choice of the verb "stuck" suggests the clinician's emphasis on embracing simplicity and revisiting the familiar and fundamental principles of clinical practice. Likewise, an occupational therapy clinician reflected upon the importance of "being heard and held and being told that however difficult it's going to be, it'll be ok" (OT2, line 57). The clinician's use of alliteration ('heard and held') may encapsulate the clinician's consideration of ensuring that the client feels valued and understood in clinical practice. Moreover, the clinician's use of alliteration may highlight the clinician's emphasis upon attending to the fundamental philosophies of clinical practice.

In summary, the PET of encounters of *holding* reflects upon how valent encounters with clients enrooted within clinicians the value of holding and embracing stillness and presence within one's clinical role. Additionally, clinicians reflect upon reappraising the fundamental principles of clinical practice in the context of valent encounters with clients.

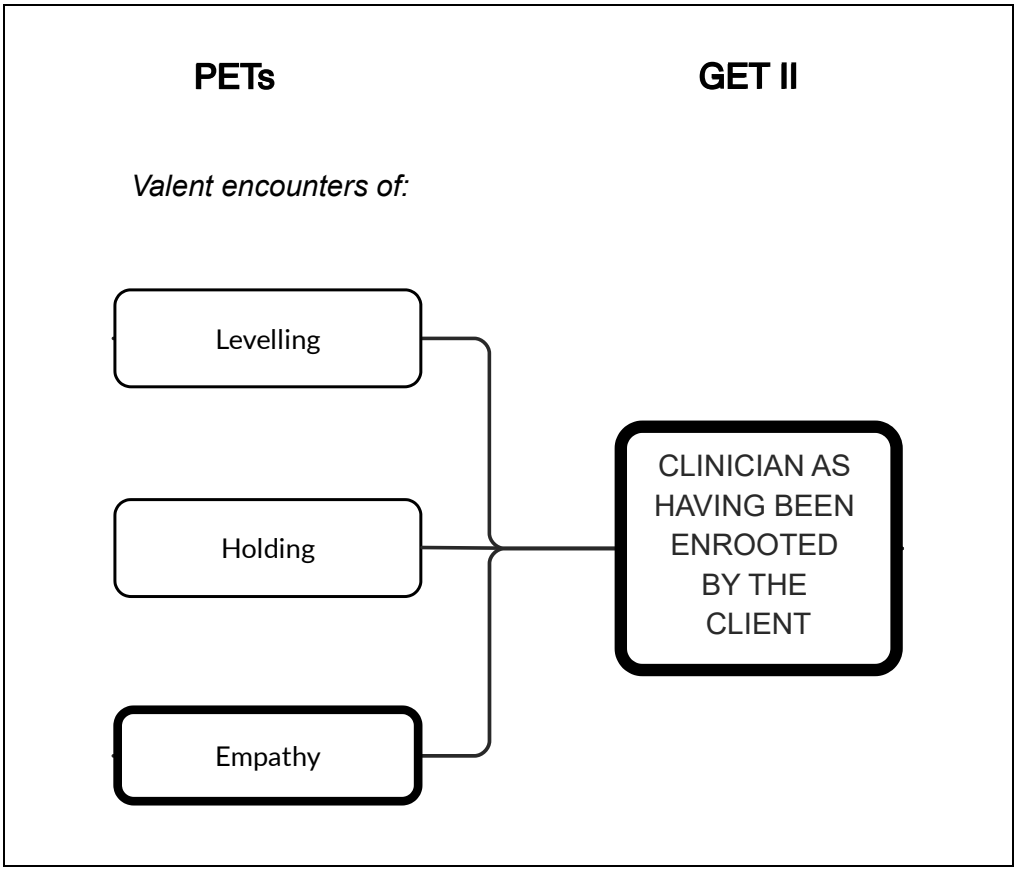
7.4. PET 3: Encounters of *Empathy*

In this PET, encounters of *empathy*, clinicians reflect upon the commonalities and differences as revealed between clients and clinicians during valent encounters,

revealing clinicians' empathy for clients. A visual representation of the PET encounters of *empathy* is detailed in Figure 7.4:

Figure 7.4.

GET II: 'Clinician as Having Been Enrooted by the Client' and Associated PET 3: 'Encounters of Empathy'



In some encounters of *empathy,* clinicians reflect upon how encounters with clients have enrooted clinicians with an understanding of the commonalities as present between clients and clinicians, revealing clinicians' empathy for clients. For example, some clinicians reflect upon discovering and identifying parallels between the clients and clinicians, as rooted in family relationships. For example, in one instance, an occupational therapy clinician (OT2) reflected upon identifying with the parents of children. More specifically, the clinician recounted relating to the sacrifices as made by parents for their children, as suggested in the below extract:

Extract 7.10. – *"I get it"*

> I'm a parent myself (.)…I mean you'd open a vein for them, you know what I mean, you'd stand in front of a speeding bus for them, like that is the reality and so I think it's parents maybe that I relate to more. The sacrifices that they'll make to make sure that they'll get to the appointment or that they'll implement the program that you've given them or they explain about their worries or their fears and I get it (.) you know I've kids myself. (OT2, line 39)

The clinician's use of imagery when describing how "you'd open a vein for them" (i.e., the client) as well as "you'd stand in front of a speeding bus for them" (i.e., the client) in relation to revealing the lengths parents go to for their children, may encapsulate the depth of the clinician's understanding regarding the nature of the sacrifices and commitment of parents for their children. Moreover, the clinician's use of imagery may also capture the shared human experiences common to both client and clinician, revealing the extent of the clinician's empathy as it relates to the experiences of being a parent.

Moreover, the theme of encounters of *empathy* features prominently amongst the profession of speech and language therapy in the data. For example, a speech and language therapy clinician (SLT1) reflected upon a valent encounter that revealed to her the common lived experiences as shared between clients and clinicians. The clinician recounted being reminded of her sister during her time working with a young boy and his family, as described in the below extract:

Extract 7.11. – *"this could be my sister"*

> "I can remember that I did a home visit with an OT to this lady and she lived in an apartment block and she was at home all day by herself with her two boys nonverbal and just feeling a real sense of sadness for her, thinking this could be my sister" (SLT1, line 20).

The clinician's reference to "a real sense of sadness" may highlight the clinician's ability to identify with the emotions and experiences of the young mother, given her similar background to her own sister. The same clinician, later in the focus group, also reflected upon being reminded of her mother when working with certain families. The clinician reflected upon how her source of empathy stems from a personal time in her past when her "my own mother never felt very listened to or heard by medical professions" (SLT1, line 30). The clinician continues and employs the use of contrast in the lines "...whereas I always try to listen to parents, particularly mothers because I do feel most of the time that they have very good inside information to give us" (SLT1, line 30). The clinician's use of contrast between her own experience and the experience that she strives to provide to others suggests the empathy of the clinician to not to have others repeat or endure the experiences of her mother.

Additionally, another speech and language therapy clinician (SLT2) reflected upon the significance of harnessing empathy and compassion for clients as well as for her a clinician, as suggested in the below extract:

Extract 7.12. ***"step into the shoes"***

> I suppose really what you'd like to convey to younger clinicians coming in now is to try and have as much empathy and step into the shoes of the adults that we're treating and the families because (.) because it's just so important and sometimes going above and beyond can be so rewarding and it gives you that extra sense of being part of a team and being, relating the patient as if, in the therapist's head, if they were one of your parents what would you need what would you like to do, how would you like to be spoken to? (SLT2, line 4)

The clinician's use of the idiom "step into the shoes" suggests the clinician's ability to identify and understand a certain situation from the point of view of the client or their family. Likewise, the use of idiom may suggest the power of such compassion and consideration that ensures the best quality care can be provided to the client, as

well as providing the clinician with a sense of purpose in her role as a clinician. Moreover, the clinician's use of rhetorical questions in "if they were one of your parents what would you need what would you like to do, how would you like to be spoken to?" suggests the clinician's ability to relate her personal experiences of family to ensure the best outcomes for the client in clinical practice.

Likewise, an occupational therapy clinician (OT1) reflected upon the engaging in the 'family test' with clients, that involved asking oneself when working with a client- "if that was your sister or your mother or aunt or uncle that you're working with, would you be happy with the service that you're providing?" (OT1, line 12). The clinician's use of rhetorical questions may emphasise the clinician's ability to utilise the family system as an emotional barometer to gauge the quality of care being provided to a client. Furthermore, the use of rhetorical questions may also suggest the clinician's ability to embrace the naturally occurring connections and parallels as revealed between clients and the clinician in the context of valent encounters.

However, in contrast, a social work clinician (SW2) reflected upon accepting, yet also being aware of the challenge of balancing common experiences and emotions in the context of encounters of *empathy*. The clinician referenced how if there is a family "in crisis doesn't mean you're in crisis" (SW2, line 10). The same clinician also acknowledged the importance of not being "reactive" (SW2, line 10) or getting "dragged in" (SW2, line 10) to family dynamics, and instead, to aim to understand the family's circumstances from "a position from outside the family because that's the most useful thing to actually ground them" (SW2, line 10). The clinician's choice of the verb "dragged" may allude to the clinician's caution at understanding his naturally occurring levels of empathy for families yet also being cognisant of one's professional roles and boundaries.

Furthermore, in other instances of encounters of *empathy*, clinicians reflect upon discovering and identifying parallels between clients and clinicians, as rooted in

terms of shared lived experiences. For example, a physiotherapy clinician (P4) reflected upon personally identifying and empathising with the lived experiences of a clients, as suggested in the below extract:

Extract 7.13. – *"I'm a bit of a mixed profile kind of a person myself"*

> I find it sweet the kids who, okay, their motor skills aren't great but sometimes they can be really good at climbing. They'll do really interesting things in the playground like climb up the outside of a tunnel slide but yes, when they walk they look funny, you know, their feet are turned in or they look awkward em (.) so I always feel very sympathetic for those kids cause I feel I'm a bit of a mixed profile kind of a person myself and I'm always trying to support the parent in accepting and celebrating the INDIVIDUAL…(P4, line 57)

The clinician's reference to being "a mixed profile kind of person myself" may capture the ease and the extent of the clinician's ability to relate to and to connect with clients who remind the clinician of herself. Further, the clinician's use of emphasis in 'INDIVIDUAL' may highlight the clinician's capacity to harness empathy to support the client further understand their personal experiences, or to communicate to others, such as parents, how their child may view or see the world.

In another example, a play therapy clinician (PT4) reflected upon her sensitivity and understanding as it relates to identifying with the personal emotions and experiences of clients. The clinician disclosed during the focus group interview that she had been adopted at birth, as further suggested in the below extract:

Extract 7.14. – *"I think it's no coincidence"*

> It's funny, the ones that have made a MASSIVE impact are the clients I'm probably going to be talking about had severe attachment disruptions and I think it's no coincidence that I'm probably working with a lot of children with

severe attachment disruptions and disorganised attachments. (PT4, line 60, FG2)

The clinician's use of emphasis in 'MASSIVE' suggests the clinician's profound sense of vulnerability and empathy to engage with the emotions, thoughts and experiences of clients who share the same attachment challenges as the clinician. Additionally, the clinician's use of self-reflection in "I think it's no coincidence" may capture the precious potency of the clinician's empathy that has the capacity to support clients and others further understand their own life experiences.

The extent to which the theme features amongst the profession of physiotherapy is highlighted by a piece of dialogue between two physiotherapy clinicians (P4; P5) who contemplate the role and effect of personality in clinical practice, as suggested in the below extract:

Extract 7.16. – ***"because I (.) got (.) on (.) better (.) with (.) them (.)"***

P5, line 58 One thing I have to say that just sort of (.) it bothered me as a student and it kinda still bothers me is that like (.) you know, I'd hate to think that I gave someone a better treatment because I (.) got (.) on (.) better (.) with (.) them (.), you know what I mean==

P4, line 59 ==yeah==

P5, line 60 == I do think sometimes that you bring your personality to an appointment and you (.), you know, and you'll ALWAYS get on better with someone, but I do think as clinicians I think like (.) you know, this, that, you know, that you'd limit your treatment because your personality wasn't the same as someone, like I'd hate to (.) I'm not expressing myself very well here now.

The clinician's (P5) use of pausing (line 58) in the above extract hints at the role of the clinician's subconscious and the bias that clinicians may hold in the context of personal/professional identity overlap. The use of emphasis in "ALWAYS" (line 60) may indicate the clinician's acceptance regarding natural human tendencies to gravitate towards clients who hold similar values and ideals. However, the clinician's use of emphasis may also highlight the clinician's levels of self- awareness to not allow the overlap to dictate or influence one's clinical practice with clients. Additionally, the clinician's (P5) use of hesitation (line 58/60) may highlight the impact and subtle nature of the inner conflict that clinicians may sometimes feel in the context of personal/professional identity overlap. The clinician's (i.e. P5) use of hesitation may also indicate that these topics that are not spoken about often in the clinical context but may permeate everyday practice. Furthermore, the agreement expressed by P4, may also suggest the broader consensus amongst clinicians relating to the role of personality in the context of clinical practice.

The clinician, P5, continues to reflect and contemplate whether a client may in fact receive better outcomes if paired with a physiotherapy clinician who is deemed a good fit with the client's personality – "if you get on better with someone is there a possibility that they will actually do better with you? And so should you match someone up with a suitable [laughter] physio?" (P5, line 63). The clinician's use of laughter may allude to the unspoken nature of some of these conversations, and may highlight the tension between the personal choices and preferences of the clinician and their professional responsibilities, as evoked through encounters of *empathy*.

Similarly, a play therapy clinician (PT3) reflected upon a valent encounter in which she reflected upon her first time empathising with the emotions and feelings of a client, as suggested in the below extract:

Extract 7.17. – *"that feeling"*

> I think it was that moment of being in the child's shoes and having that feeling for the first time. I think that's stood with me all (.) it's always been carried through probably every time I step through the playroom door with every client and just that feeling. (PT3, line 25, FG2)

The clinician's use of the idiom *"*being in the child's shoes" may suggest the clinician's attempt to deeply identify and understand the circumstances of the client. Additionally, the clinician's reference to "stood with me" may highlight the significance and value for the clinician of connecting with and understanding the emotions of clients.

In summary, the PET of encounters of *empathy*, clinicians reflect upon the commonalities and differences as revealed between clients and clinicians during valent encounters, revealing clinicians' empathy for clients.

7.5. Summary of GET II

In summary, GET II described the *Clinician as having been enrooted by the client.* Stemming from the concept of being rooted and fixed firmly, this theme is defined as the ability of clients to anchor and ground clinicians in the context of valent encounters. This theme reflected upon how encounters with clients have enrooted within clinicians a commitment to continually consider the nature, essence, and expectations of the clinical role.

In the PET of encounters of *levelling*, clinicians reflected upon valent encounters with clients in which clinicians' confidence in their clinical knowledge and skills were challenged and tested, enrooting within clinicians a commitment to continually consider the nature, essence, and expectations of the clinical role, a levelling of sorts. Moreover, encounters of *holding* considered how encounters with

clients enrooted within clinicians the value of holding and embracing stillness and presence within one's clinical role. Additionally, clinicians reflected upon reappraising the fundamental principles of clinical practice in the context of valent encounters. Finally, in the PET encounters of *empathy,* clinicians reflected upon the commonalities and differences as revealed between clients and clinicians through valent encounters, revealing clinicians' empathy for clients. In the following chapter, Chapter 8. I will present my final GET, GET III, as identified in my research study.

Chapter 8: GET III: Clinician as Having Been Emboldened by the Client

8.1. Overview of GET III

In this chapter, I will continue to present the findings of my study. The third GET to be described is the *Clinician as having been emboldened by the client.* This theme is defined as how valent encounters with clients instil within the clinician a courage to trust and believe in the capacity of potential despite the changeable conditions of clinical practice. More specifically, in the PET of encounters of *promise*, clinicians reflect upon being witness to the aptitudes, capabilities and potential within each client during valent encounters, emboldening within clinicians a sense of promise and higher possibilities relating to clinicians' professional and personal insights. Moreover, the PET of encounters of *resolve*, reflects upon how valent encounters with clients embolden clinicians to retain their composure and belief in their skills, capabilities, and the therapeutic process, particularly during times of doubt and uncertainty. A visual representation and description of each of the PETs associated with GET III are detailed in Figure 8.1 and Table 8.1:

Figure 8.1.

GET III 'Clinician as Having Been Emboldened by the Client' and Associated PETs

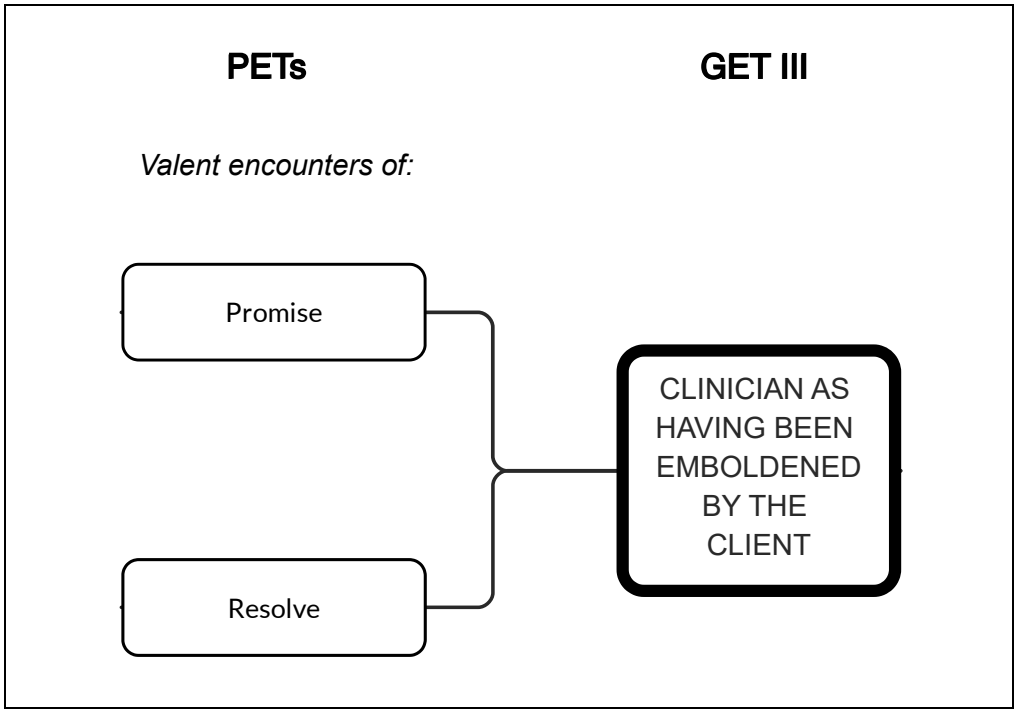


Table 8.1.

Description of PETS Associated with GET III– Clinician as Having Been Emboldened by the Client.

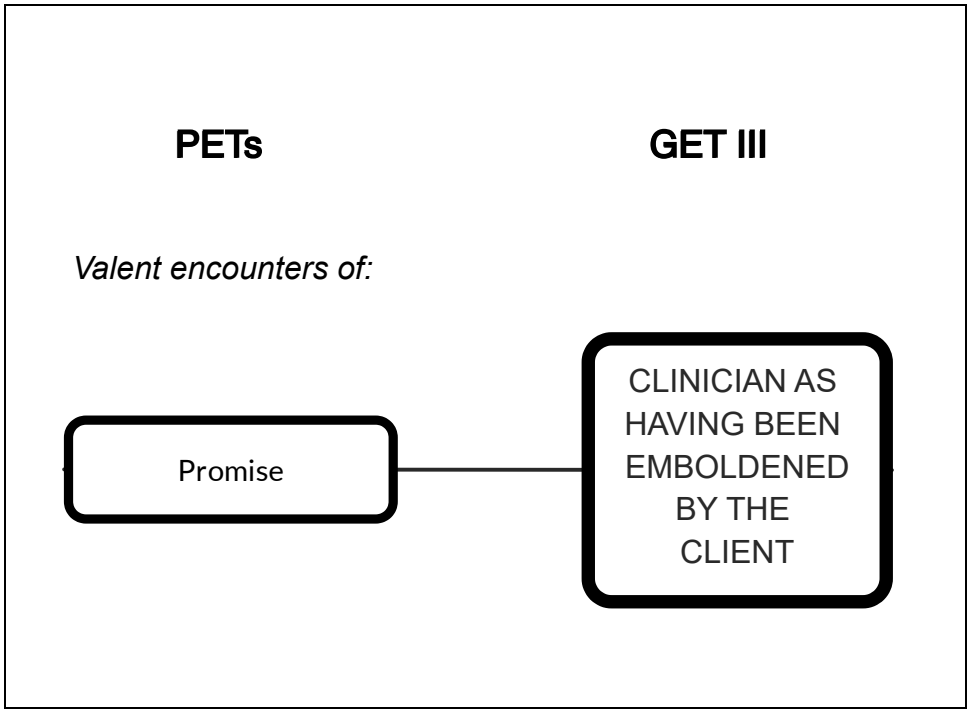
Encounters of *promise*	In this theme, clinicians reflect upon being witness to the aptitudes, capabilities and potential within each client during valent encounters, emboldening within clinicians a sense of promise and higher possibilities relating to clinicians' professional and personal insights.
Encounters of resolve	This theme reflects upon how clinicians resolve to retain belief and composure in their skills, capabilities, and the therapeutic process, particularly during times of doubt and uncertainty.

8.2. PET 1: Encounters of *Promise*

In this theme, clinicians reflect upon being witness to the aptitudes, capabilities and potential within each client during valent encounters, that emboldens clinicians with a sense of promise and higher possibilities relating to clinicians' professional and personal insights. A visual representation of the PET encounters of *promise* is detailed in Figure 8.2:

Figure 8.2.

GET I: 'Clinician as Having Been Emboldened by the Client' and the Associated PET 1: 'Encounters of Promise'



For instance, the below example represents a summary of the dialogue between two play therapy clinicians (PT3, PT4) who discussed their admiration and regard for their respective clients' determination to overcome the most adverse of personal challenges and circumstances in the context of encounters of *promise*:

Extract 8.1. – ***"two little superstars just had this DESIRE and DRIVE"***

> **PT4, line 32, FG2** Yeah, these two little superstars just had this DESIRE and DRIVE to connect and BE with people even though it was really really hard because they has so much rejection but they had SUCH a grit and determination and [laughter] they were quite playful in their relationships at times, you know. They came with a whole heap of other stuff as well BUT (.) I really admired, I know you said it straight up from the top, but their grit and determination was something that REALLY astounded me and their VULNERABILITY. That they're after you know when they're moving those coping skills, they kinda, the bravery to be vulnerable in process is such, Jesus you'd hesitate to do it at times yourself, never mind SEEING YOUR CLIENTS DOING IT, YOU'RE LIKE AHH!==
>
> **PT3, line 33, FG2** ==[laughter]==
>
> **PT4, line 34, FG2** ==so seeing that emerge in their process and in our therapeutic relationship is just astounding (.) Like [PT3], you love the work as well and you'd nearly be going, 'f*ing hell, this is incredible', you know==
>
> **PT3, line 35, FG2** ==yep==
>
> **PT4, line 36, FG2** ==and I think that's something I really admire, I'm in awe of, yeah==
>
> **PT3, line 37, FG2** ==yeah I'd be quite similar as well like when I see themselves challenging themselves and that determination, and so easy to do. You'd see other who'd just collapse and give up and just throw in the towel but there's (.) there's something within themselves that they find in the playroom when

they have that space to really push through it and it reaches that determination that again I do admire. Not anyone specifically like, but it's like just when you see that happening and that work and progress it's yeah, like yourself what you said is, in awe, is exactly how I feel as well, and like they just amaze me, how they can just push themselves to the limits like and then when you hear about them through the process and the progress and through review meetings and it's SEEN eventually by others==

PT4, line 38, FG2 ==YEAH==

PT3, line 39, FG2 ==more often than not we're the first to get that glimpse. And when you hear about it then you're like "oh my God", just (.) I don't know what the word is, it is awe. Because it's not pride, you just can't (.) like it's their pride that they feel about themselves, like but it is amazing how they can push themselves and to be able to show it outside of the playroom I think is just phenomenal.

The clinician's (PT4) use of laughter (line 32) in the above extract may highlight the clinician's disbelief and amazement at the clients' abilities to not only overcome the challenging nature of their circumstances, yet also to channel a light-hearted approach to their endeavours. Similarly, the clinician's reference to a "whole heap of other stuff" (PT4, line 32) when describing the clients' circumstances, again reinforces the clinician's admiration for the ability of the client to overcome the most adverse of circumstances. Additionally, the same clinician's (PT4) use of comparison in "you'd hesitate to do it at times yourself" (line 32) evokes a sense of wonder in relation to witnessing the extent of the clients' bravery and their ability to persevere. Thereafter, the use of laughter by PT3 (line 33) when responding to the reflections of PT4, may also suggest the clinician's agreement with the sentiment of PT4 in relation to being astonished by the character and resilience of clients. Moreover, PT3's use of echoing

in “yeah I’d be quite similar” (line 37) may also highlight the similarities in the accounts of both clinicians. Additionally, the clinician’s (PT3) use of emphasis in “SEEN” (line 37) further exemplifies the sense of promise as evoked for the clinician when clients’ abilities and qualities are eventually seen by other professionals. Further, PT3’s use of the pronoun “we’re” (line 39) may highlight the clinician’s sense of involvement in the group discussion.

Moreover, the theme of encounters of *promise* features prominently amongst the profession of occupational therapy in the data. In one instance, an occupational therapy clinician (OT1) reflected upon her amazement at clients’ abilities to rise above the most adverse of situations and circumstances. The clinician described her awe and admiration for young clients who have undergone serious surgery. The clinician recounted how some young clients “just jump out of these frames, and as soon as they’re off they’re off playing and you’re just like ‘wow’” (OT1, line 24). The use of the precise verb selection of “jump” highlights the clinician’s sense of admiration for the resilient attitudes and perseverance of young clients undertaking long-term stays in the hospital setting.

Additionally, another occupational therapy clinician (OT2) reflected upon valent encounters with young people who have experienced the most traumatic circumstances yet still have the resilience to “get up in the morning, they still have goals, they still have aspirations, they’re not beaten down by the world” (OT2, line 26). The clinician’s reference to “get up in the morning” suggests how clients continue to exemplify a sense of resilience and ambition for what they wish to achieve in life. Further, the clinician’s use of the metaphor “beaten down by the world” may allude to the strain and pressure that clients may experience yet may simultaneously highlight the determination of the clients not to become downtrodden or accepting of their circumstances, and instead to rise above them. The clinician continued and reflected “wow I don’t know that I could have had the strength that you have at seven and I’m

a lot older than that (OT2, line 26). Both clinicians' use of the exclamative "wow" in the above extracts suggests how being witness to clients' aptitudes, capabilities and potential emboldens clinicians with a sense of promise and higher possibilities as it relates to their professional and personal insights.

Further, in the following example, the same occupational therapy clinician (OT2) reflected upon an encounter of *promise* in which she describes her admiration and respect for the most "gracious" (OT2, line 21) gentleman she encountered during her time in practice, as detailed in the below extract:

Extract 8.2. – *"he was crawling"*

> And somebody had put in a level access shower at some point which he couldn't access. If he went up the stairs at night, he couldn't come downstairs to go to the bathroom because he was crawling, and he wasn't going to do that on a cold night and he was the most GRACIOUS, GRATEFUL humble man who was living in a situation I can't imagine. (OT2, line 21)

The clinician's use of imagery when describing the man crawling may capture the clinician's regard for the tenacity of the man to continue to face and overcome the everyday challenges of life. Moreover, the clinician's use of emphasis in "gracious" highlights the dignity of the man as he continued to face his circumstances with good will, that emboldens the clinician with a sense of promise related to enduring and overcoming challenging times and circumstances.

Moreover, a physiotherapy clinician (P1) reflected upon an encounter of *promise* with a young man, the same age as her, who had fallen off his motorbike. The clinician described how she continues to reflect upon this valent encounter "40 years later", as detailed in the below extract:

Extract 8.3.– *"I still think about him 40 years later"*

> He was a student, a veterinary student who came off his motorbike and it was an assigned quad [quadriplegic] injury, and I must say that he had an impact on me at the time. I still think about him 40 years later em (.) because he's (.) I suppose because we were at the same stage in our lives. He really resonated with me and em (.) and he was a very determined young man and he went on to great things and he became a Paralympian and his wife is a Paralympian and he was her coach, and he just continues to inspire me. As was mentioned earlier [i.e. in the focus group discussion], about the resilience you come across in people is just astounding, it really is. And somebody like him really makes a big impact and he's one person (.) as I say it's over 40 years ago, but I still think about him and what he has achieved and what he has come through== (P1, line 34)

The clinician's use of repetition in "40 years ago" may suggest the indelible and memorable nature of the valent encounter for the clinician who continues to remember the client four decades later. Further, the clinician's listing of the clinician's accomplishments throughout the course of his life, suggests the clinician's enduring admiration for the ability of the client to continue to overcome obstacles and to flourish in life, emboldening within the clinician a sense of promise and higher possibilities.

In another example, a social work clinician (SW1) reflected upon a valent encounter with a young client who was determined to "do well in life" (SW1, line 39) despite the lack of stability of the client's current circumstances. The clinician described how this young client had been moved from foster home to foster home after a traumatic childhood, as described in the below extract:

Extract 8.4. – *"still so resilient"*

She was still so resilient, and she wanted to do well in school and wanted to go on to college and wanted the life that her mother never had the opportunity to give her, or her older siblings had to give her. And it's just such determination in her for a 15 year old to be able to think like that, given the trauma. And I just admired her so much. There was no one stable in her life because social workers kept leaving her, foster carers kept asking her to leave, you know, and she still had such determination to do well in life. And now I'm sure she's in her 20's now and I'm like "I wonder did she go to college, I wonder does she have the job she wanted" and she's just one (.) I'll never ever forget her. (SW1, line 39)

The clinician's use of repetition of "wanted" may suggest the clinician's admiration for the ambition and perseverance of the client to continue to strive to achieve in her life despite her circumstances. The clinician's use of rhetorical questions in which the clinician ponders how the clients' life came to pass, suggests the memorable and lasting nature of the valent encounter that the clinician continues to remember and reflect upon. Likewise, the clinician's use of pausing may also signify the exceptional nature of the valent encounter that the clinician continues to fathom and process.

Additionally, another social work clinician (SW6) recalled a valent encounter with a woman who was coping with grief following the loss of her husband. The clinician described the woman's strength as she continued to cope and to support her children through this time, as highlighted in the below extract:

Extract 8.5.– *"just what she's been through"*

I've done a lot of work with her around bereavement and talking to her child around what's happened and that kind of thing and supporting her in supporting her child with the whole situation and I think just, just her strength,

being able to hold it all together and just to be able to have REALLY difficult conversations with her child and acknowledge her own pain and grief and sit with (.) like it's been a bit of a journey for her to sit with that and allow those processes to happen and I think and being able to acknowledge how sad and upsetting [xxx] around that. Just that, just what she's been through, her strength and resilience. (SW6, line 45)

The clinician's use of the metaphor "journey" suggests the clinician's regard for the ability of the woman to continue to endure the pain and hurt of loss and grief, while also remaining committed to her healing and recovery following the loss of her husband. Additionally, the clinician's use of emphasis in 'REALLY' may capture the tenacity of the woman to continue to carry and comfort her young children through this deeply sad and despairing time in their lives. Likewise, the clinician's choice of the verb "sit" may highlight the uncontrollable and unpredictable nature of loss and grief that the woman continues to experience and endure, emboldening the clinician with a sense of promise and higher possibilities.

Additionally, another social work clinician (SW4) reflected upon a valent encounter in which a mother was fleeing a domestic violence situation, as highlighted by the clinician in the below extract:

Extract 8.6. – *"I remember just being IN AWE"*

It was just really hearing how resilient this mother was, and these kids (.) and they are the most resilient people I've ever met in my life. And I do think they've had the biggest impact on me because I remember just being IN AWE of this woman, just really, even now there's just so much risk with her, but she just continued to do SO MANY good things for her children. That was definitely one that had a HUGE impact on my life (SW4, line 33)

The clinician's reference to how the mother and her children are the "most resilient people I've ever met in my life" may signify the depth of awe, and the regard with which the clinician values and views the impact of the encounter in both her professional and personal life. Additionally, the clinician's use of emphasis in "SO MANY" may again highlight the clinician's respect for the resilient attitude and perseverance of the mother to continue to choose to draw strength and positivity for her children.

Moreover, clinicians reflect upon being witness to the potential within each new client during encounters of *promise*. For example, a play therapy clinician (PT4) considers the opportunity for her, and the profession of play therapy to rediscover possibilities and potential within clients, as suggested in the extract below:

Extract 8.7. – *"this beautiful precious part"*

> I kind of love the idea that we can go back and see this beautiful precious part of a child that they've shared with us and I love when MDTs can listen to that that this child is actually really hurting, they've actually had some REALLY deep trauma that they're trying to work through and they're really can't find relationships trustful and caring so there's a lovely part where we get to share our knowledge of the child. (PT4, line 72, FG2)

The word "precious" may capture the clinician's ability to identify a quality within the client that may not always be obvious yet may be invaluable to discovering the possibilities within each client. Moreover, the precise verb selection in "go back" suggests the clinician's ability to reconsider previously overlooked and untapped potential as it relates to the client. Further, the clinician's use of "go back" may suggest the clinician's ability to provide greater understanding and insight to others regarding the overlooked aspects of a client's potential by other professions. Moreover, the clinician's use of comparison when comparing her interpretation of a child versus

others' interpretations of a child may highlight the power and potential of the profession to be heard and valued by others, which may coincide with clinicians' remarks during the focus group interview regarding the possibility of building and strengthening the professional identity of the profession of play therapy.

Moreover, an occupational therapy clinician (OT1) discusses the role of the occupational therapy clinician within the context of the multidisciplinary team, as described in the below extract:

Extract 8.8. – *"leave your sessions feeling different"*

> I think, and yeah, you do have to work alongside all of the traumas, and history and the terrible experiences that people have gone through but you get to do it in a really playful way that they leave your sessions feeling different than another kind of session that they walk out of. (OT1, line 61)

The clinician's use of "yeah" in the above extract suggests the notable ability of the clinician, and the occupational therapy profession to balance the adverse nature of the client's circumstances alongside the ideals of possibilities and believing in the potential of the client, igniting within clinicians a sense of promise and higher possibilities.

In summary, in the theme encounters of *promise*, clinicians reflect upon being witness to the aptitudes, capabilities and potential within each client during valent encounters, emboldening within clinicians a sense of promise and higher possibilities relating to clinicians' professional and personal insights.

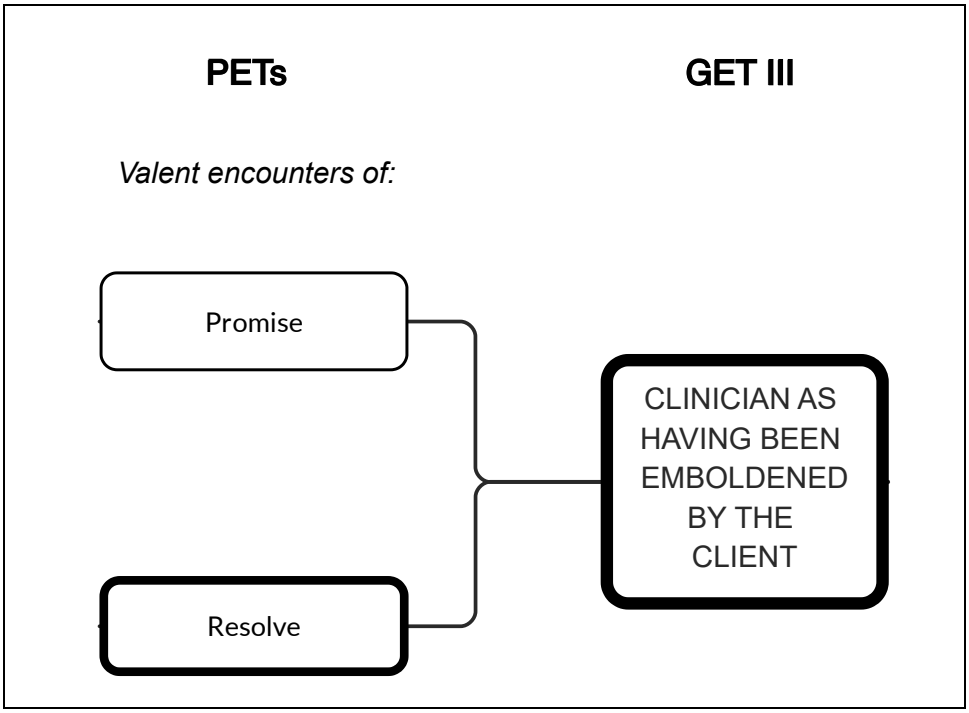
8.3. PET 2: Encounters of *Resolve*

The PET of *encounters of resolve* reflects upon how clinicians resolve to retain belief and composure in their skills, capabilities, and the therapeutic process,

particularly during times of doubt and uncertainty. A visual representation of the PET encounters of *resolve* is detailed in Figure 8.3:

Figure 8.3.

GET III: 'Clinician as Having Been Emboldened by the Client' and Associated PET 2: 'Encounters of Resolve'



In some instances, clinicians reflect upon how encounters of *resolve* embolden clinicians to trust in the wisdom and knowledge of their clinical instincts, particularly during times of doubt or uncertainty. For example, a physiotherapy clinician (P2) reflected upon a valent encounter in which the clinician suppressed his clinical philosophies and principles due to the culture and pressure of working with an elite sports team in which athletes are expected to play as many matches as possible during the competition season. The clinician recounted allowing an athlete from a professional netball team play through an Achilles tendon injury, as highlighted in the below extract:

Extract 8.9. – *"I was LETTING her play with pain"*

> I was LETTING her play with pain a lot of the time because that's what she had done and I was (.) it was my first job with a high end team so I was (.) I didn't

want to be the first person to go to the coach and say “no I’m not letting her play type thing” cause I was a little bit wary about that. But as the season went on, it got worse and she ended up having a bit of a tear in the Achilles but as a result of that, she ended up missing quite a lot of matches that were ACTUALLY A HELL OF A LOT MORE IMPORTANT than what she had been doing. (P2, line 30)

The clinician’s use of emphasis in “LETTING” may suggest the clinician’s disbelief at dismissing his clinical judgement and decision-making regarding what may have been the most appropriate intervention that was in the best interest of the client in the context of her season as a professional athlete. Furthermore, the clinician’s reference to being reluctant to tell the coach the seriousness of the client’s injury may capture the clinician’s apprehension and confliction at having to balance the needs of the individual client in the context of the goals of the collective team. Further, the clinician’s use of emphasis in “ACTUALLY A HELL OF A LOT MORE IMPORTANT” may suggest the wisdom of hindsight for the clinician as well as the clinician’s acknowledgment of believing and trusting his clinical instincts, particularly during times of doubt or uncertainty.

On the other hand, a speech and language therapy clinician (SLT3) reflected upon heeding her clinical instincts during a valent encounter with a young girl who had language needs and a diagnosis of epilepsy, as suggested in the below extract:

Extract 8.10. – *“it just didn’t feel right”*

There was a little girl who had language difficulties but actually it was due to epilepsy, and she was having absences during my interaction with her and it just didn’t feel right and I couldn’t understand what it was so I kinda did a little bit more searching for information. I spoke with Mum and you know, the nurse and we found out more that she was having absent seizures during the interactions and that meant that her medication needed to be followed up so

(.) so I think that's I guess, it's not typical speech sound difficulties for example but it did make me realise the need to be with other professionals as well and that it's not always, don't always jump to the first conclusion. (SLT3, line 6)

The clinician's refence to "it just didn't feel right" suggests the clinician being mindful and committed to following her clinical instincts that emboldened the clinician to continue to seek out more information and knowledge related to the case, despite there not being an obvious motive or rational for doing so. The clinician's use of the term "jump to the first conclusion" may highlight the clinician's commitment to continue to utilise and believe in her skills and abilities as a clinician to seek a meaningful solution for the client, rather than choosing the most convenient solution that does not consider or take account of the client's needs and best interests.

Additionally, a physiotherapy clinician (P4) reflected upon trusting in her clinical instincts, skills and abilities when working with an older client who had a severe brain injury. The clinician had recently taken over the case from a colleague. The clinician believed that "it didn't seem ethically right to use the intervention that was happening to her" (P4, line 28). The clinician describes the context of the valent encounter in the below extract:

Extract 8.11. – *"I felt that it didn't seem ethically right"*

And I felt that it didn't seem ethically right to use the intervention that was happening to her against her will, but her husband felt that it was going to get results, you know. And he was really disappointed with my suggestion of changing the status quo on how things should be and how we're intervening with this person so (.)…I researched a load of stuff around contracture prevention and contracture management and found some really interesting information... and I was able to come back to him with that information which he wasn't ready to take on board at that time, but a few months later he came

back to me once he was exhausted with doing this (which I think was a cruel regime with the woman) but anyway he came back to me and we talked it through, and at that time, a few months later, he was ready to pull back and start thinking in this different way… (P4, line 28)

The clinician's use of the term "back", as it relates to the client's family member being willing to re-engage with the advice of the clinician, may signify the clinician's composure and confidence to continue to believe in her rationale and her clinical choices until the family were ready to consider alternative means of intervention.

Similarly, an occupational therapy clinician (OT1) reflected upon trusting in her clinical rationale and judgement when making decisions that the clinician believes are in the best interests of the client, especially when her clinical choices may seem to be contrary to the therapeutic goals of the client, as suggested in the below extract:

Extract 8.12. – *"tear up your session plan"*

Every session is a lesson in patience and flexibility and being able to let them rotate on the spot if they need to so there's always that. You know, you might have plans that you're going to have a session – you're gonna start out with A,B, and C and then a kid turns up and they're completely dysregulated and you have to go find and meet them at their level and tear up your session plan sometimes – like literally. (OT1, line 32)

The contrast between the clinician listing a prescriptive set of intervention goals for a client (i.e. "you're gonna start out with A,B, and C") to then needing to "tear up your session plan" may suggest the clinician's belief and assuredness in her clinical judgement that emboldens the clinician to prioritise the immediate needs of the client

at that particular time, choosing to overlook the pre-planned goals and targets for the session, and instead to make decisions in the best interest of the client.

Furthermore, the prominence of the theme in the profession of play therapy is highlighted by a piece of dialogue between two play therapy clinicians (PT1; PT2) when discussing the challenges and struggles related to maintaining and believing in their clinical skillsets, as suggested below:

Extract 8.13. – *"my struggle is REALLY being PATIENT with their pain"*

> **PT2, line 4, FG1** I think the best advice I could give is, I suppose two (.) what comes to mind is just being patient. You have to be patient with the families, with the children, with the process. I struggle with that still all these years on, you know, are you a patient person? Can you honour their story?... I suppose the other thing that I still do all these years on is kinda create that REALLY SAFE relationship, try to I suppose, I don't always do it , but try to create that really safe relationship in the room… I can mind their feelings and that can be a very hard question… to ask of a child who hasn't trusted anybody, but that's the process then, and therein lies the patience. So, I think one kind of ties in with the other a little==
>
> **PT1, line 5, FG1** == and it's being patient with yourself isn't it? You know, and trusting the process because I keep (.) I keep having to come back to that for me (.) because I can be impatient, there's you know, there's no improvement, how is there no improvement and again as a beginner play therapist – 'what am I doing wrong, why, you know, what can I be doing better?' But being patient with yourself, being patient with the child, trusting in the process, all those kind of things==
>
> **PT2, line 6, FG1** ==really, really trusting in it and you know, I think sometimes it's (.) and I think it's, I think it's on my mind at the moment because I'm working with a child, you know you can't fix their situation, I can't like, it's, and

it's, my struggle is REALLY being PATIENT with their pain…and I've had those moments where I've just wanted to really FIX it and some situations you can't – like the loss of a parent or an illness, you just can't, and it's really HARD to, like you say, trust the process then and say "look I just have to be alongside this person, alongside them in this awful journey that they're in". When they're coming in with that really sad face every week…it's hard, but that's what patience and trust and safety I think would be the words that come to mind for me==

The clinician's (PT2) reference to "I struggle with that still all these years on" (line 4) suggests the challenge for the clinician to continually sustain her levels of belief and trust in the therapeutic process, especially when there seems to be a perceived lack of tangible outcomes in the context of the client's therapeutic process. Further, the clinician's (PT2) use of rhetorical questions in "are you a patient person? Can you honour their story?" (line 4) may suggest the clinician's fortitude and personal commitment to remain committed to trusting in her skills and abilities as a clinician. Meanwhile, PT1's use of a question in "and it's being patient with yourself isn't it?" (line 5) may highlight the clinician's commitment to engaging with the insights and reflections of PT2 in the context of the group dynamics. Moreover, PT1's use of rhetorical questions in "what am I doing wrong, why, you know, what can I be doing better?" (line 5) may capture the clinician's frustration regarding when her clinical skills and capabilities are not conceptualising in practice. Meanwhile, PT2's repetition of "trusting" (line 6) when responding to PT1 in the dialogue, may highlight the similarities and overlaps in the experiences and accounts of both clinicians. Finally, PT2's use of emphasis in "my struggle is REALLY being PATIENT with their pain" (line 6) may encapsulate the clinician's sense of self-compassion as well as the clinician's

determination to strive to believe in her skills, capabilities, and as well as the client's therapeutic process, especially during times of doubt and uncertainty .

Additionally, a speech and language therapy clinician (SLT2) described a valent encounter with a young man whom she accompanied through his life journey with motor neuron disease. The clinician detailed how she met the client prior to his diagnosis, and whom she stayed with through the rest of the journey until he passed away. The clinician recounted how the young man went home to visit his parents one Christmas. Whilst at home, his communication device stopped working on Christmas Eve, as described in the below extract:

Extract 8.14. – *"we just drove out to his house and fixed it"*

> Something has gone wrong with his communication device, and he couldn't communicate at all- and Christmas Eve so you can imagine the hospital on Christmas Eve. So I said to my manager like "we need to go out there today, it's Christmas Eve, his days are numbered, like literally numbered…he's deteriorating respiratory wise, we need to go out…so I met the [X] [i.e. name of charity organisation] there, met Mum and Dad, pulled it together and got the communication system back up and running. And on New Year's Eve, he said to his Dad through the communication system, "I think I'm coming near the end" and he died a day or two later. And I remember kind of thinking, God, to have unlocked that is just the greatest privilege and to have gone out on Christmas Eve when loads of staff would have said like "no way"…but I was so glad that I did and we just drove out to his house and fixed it and it stayed fixed until whatever week he passed away. (SLT 2, line 18)

The clinician's continual reference to "Christmas Eve" may highlight how the clinician fails to be disillusioned by the nature and context of the young man's circumstances, and instead, chooses to build upon the opportunity to apply her skillset to ensure that the client's needs can be best met. Further, the clinician's choice of the

verb “unlocked” may capture the clinician’s determination and resoluteness to apply her clinical skills to provide access for the client to his voice and identity.

Additionally, a play therapy clinician (PT1) reflected upon an encounter of *resolve* in which the clinician felt endeavoured to speak “from the heart” when working with a young person who had come into a session with “the weight of the world on her shoulders”:

Extract 8.15. – *“spoke from the heart”*

> She just came in with the weight of the world on her shoulders and she left feeling lighter. She told me she was leaving feeling lighter. And I spoke from the heart because I always worried about speaking and doing things that were right or correct throughout my training. I was always like “is this right, is this the right thing to say”, you know, so I think at that point, you know, I said “look leave those here in the sand, leave them in playroom” (i.e. the client’s troubles). She was in the sand at the time and I said to her, just leave them here within the sand and it was just lovely. (PT1, line 8, FG1)

The clinician’s use of the idiom “spoke from the heart” may signify the depth of profound realisation as evoked for the clinician as it relates to trusting and following one’s gut instinct in clinical practice. Moreover, the image of the sandpit may be representative of the clinician’s new levels of confidence and reassurance in relation to reaffirming her clinical instincts, thus cementing the clinician’s belief in her clinical skills and capabilities, as evoked through this encounter of *resolve* .

Later in the focus group, the same clinician recounted fearing that she may be “in trouble” (PT1, line 17, FG1) with her supervisor as she had been somewhat directive in her session with a client, as suggested below:

Extract 8.16. *“I’m going to get in trouble with my supervisor”*

> I was sitting on the floor cleaning with the Covid restrictions I was cleaning and disinfecting all the toys and I was thinking "oh God I'm going to get in trouble with my supervisor" because I had been a little bit directive because she needed the support, she was frozen, she was in that sort of frozen state where she couldn't decide what to play with and what to do so I just narrowed down the choices to this or this, you know, two options because she couldn't, she needed support again. (PT1, line 17, FG1)

The clinician's use of self-talk in "oh God I'm going to get in trouble with my supervisor" may suggest the clinician's strife at balancing her clinical instincts with what may be perceived as expected of her in clinical practice. Further, the clinician's repetition of the word "frozen" may highlight the nature and reality of the client's circumstances that potentially pressured the clinician to making clinical choices that were in the best interest of the client but may not have been befitting of best practice within the profession.

In summary, the PET of *encounters of resolve* reflected upon how clinicians resolve to retain belief and composure in their skills, capabilities, and the therapeutic process, particularly during times of doubt and uncertainty.

8.4. Summary of GET III

In summary, GET III described the *clinician as having been emboldened by the client*. GET III described how valent encounters with clients instil within the clinician a courage to trust and believe in the capacity of potential despite the changeable conditions of clinical practice. More specifically, in the PET of encounters of *promise*, clinicians reflected upon being witness to the aptitudes, capabilities and potential within each client during valent encounters, emboldening within clinicians a sense of promise and higher possibilities relating to clinicians' professional and personal

insights. Moreover, the PET of encounters of *resolve*, reflected upon how clinicians resolve to retain belief and composure in their skills, capabilities, and the therapeutic process, particularly during times of doubt and uncertainty. In the following chapter, Chapter 9, I will present an overall summary of my findings.

Chapter 9: Summary of Findings

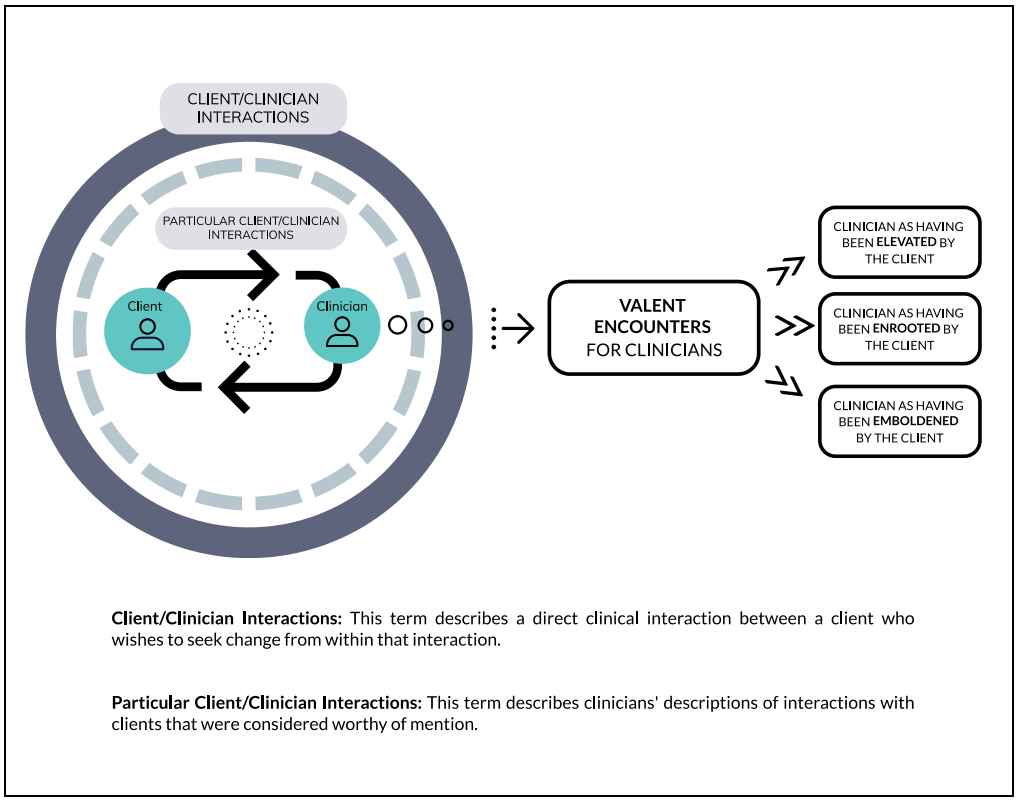
9.1. Brief Overview of Findings

In this chapter, I will provide a brief overview of my findings. Being guided by the theoretical processes of IPA as employed in my study, allowed for the identification of experiential insights into how clinician's stories, or reflections with a client may be summarised – and it was these particular client/clinician interactions that were important for me to capture and describe. The findings of my study suggest that clinicians attribute a valent quality to particular client/clinician interactions, as conceptualised in the construct of *valent encounters*, and that is described via three discrete GETs.

GET I described the ***Clinician as having been elevated by the client*.** This experiential theme described the ways in which *valent encounters* with clients have raised clinicians to a higher order of professional and personal insight. Secondly, GET II of ***Clinician as having been enrooted by the client*** reflected upon how *valent encounters* with clients have anchored and grounded clinicians in the context of clinical practice while also instilling a commitment to continually consider the nature, essence, and expectations of the clinical role. Finally, GET III of ***Clinician as having been emboldened by the client*** reflected upon how *valent encounters* with clients instil within the clinician a courage to trust and believe in the capacity of potential despite changeable conditions of clinical practice. As previously presented in Chapter 5, a visual representation of *valent encounters* as contextualised within other types of interactions in clinical practice, and associated GETs is presented in Figure 9.1:

Figure 9.1.

Visual Representation of 'Valent Encounters' as Contextualised Within Other Types of Interactions in Clinical Practice, and Associated GETs.



9.2. Overview of Valent Encounters

In the following paragraphs, I will summarise the construct of *valent encounters,* as well as describe and detail *valent encounters* in terms of its nature and scope.

9.2.1. *Valent Encounters: Construct*

Derived from 'valency', and with its Latin origin "valentia" meaning 'strength or worth', the construct of *valent encounter*s in my research study describes valuable encounters that encapsulate the effect of clinicians' experiences and responses to particular client/clinician interactions.

Firstly, the construct of *valent encounters* recognises the active presence and contribution of both client and clinician in the co-creation of these encounters. Secondly, the construct of *valent encounters* foregrounds clinicians' experiences with the client. Finally, the construct of *valent encounters* considers clinicians' responses to

particular client/clinician interactions that in turn considers the ways in which the therapeutic, personal, and future beings of clinicians are being continually impacted and shaped.

9.2.2. Valent Encounters: Nature

Firstly, the findings of my research suggest that *valent encounters* are highly personal, ever-changing, and evolving for each clinician. Each clinician has their own unique understanding of *valent encounters* that can be interpreted by them in various ways and to various extents. Although *valent encounters* are versatile, nuanced and highly individualised, *valent encounters* can be simultaneously appreciated and reflected in a universal context.

The findings of my research also suggest that *valent encounters* capture an array of positive and challenging emotions for clinicians. For example, some clinicians describe *valent encounters* that bring with them emotions of great joy and inspiration. Other clinicians reflect upon the reassurance as gained from *valent encounters* that have subsequently elevated clinicians to a higher order of professional and personal insight. Similarly, some clinicians reflect upon how *valent encounters* helps clinicians to believe in the capacity of potential in both times of success and times of challenges. On the other hand, some clinicians describe *valent encounters* that bring with them emotions of confusion and uncertainty that leaves clinicians questioning the nature, essence, and expectations of the clinical role.

Likewise, the findings of my research suggest that there is no one defined trajectory regarding the nature of change related to *valent encounters*. Some clinicians reflect upon *valent encounters* from the beginning of one's career as a newly qualified professional while in other cases, clinicians reflect upon *valent encounters* from various stages of their professional careers. Similarly, some clinicians reference how *valent encounters* may have blossomed after months, and sometimes even years of working with a client. Likewise, it can be one precise *valent encounter* or for others, an

accumulation of similar types of *valent encounters* in which these encounters gain importance for the clinician. In other cases, some clinicians reflect upon the enduring nature of some *valent encounters.*

In addition, in the findings of my study, clinicians reference the subtle and implicit nature of *valent encounters*. More specifically, clinicians reference the quiet and unassuming nature of such encounters that can further highlight the profoundness of the *valent encounter* for clinicians. In other cases, for some clinicians, the opportunity to discuss the nuanced and subtle nature of their experiences of *valent encounters* with other participants, and professional colleagues further validated their experiences and insights of the nuanced nature of *valent encounters*.

9.2.3. Valent Encounters: Scope

The findings of my research study also suggest that clinicians reflect upon how *valent encounters* have the potential to affect the therapeutic, personal and future beings of clinicians in nuanced ways. For example, some clinicians reflect upon *valent encounters* in relation to their therapeutic being in the context of the clinical setting. In other cases, some clinicians describe *valent encounters* that coincide with significant events in their personal lives which provide further insight and context for clinicians. Similarly, some clinicians reference the potential impact of *valent encounters* in relation to the clinician they will be in the future within clinical practice with future clients.

As well, it is suggested that *valent encounters* acknowledge the active presence and contribution of the client to these encounters. *Valent encounters* tend to be facilitated in the context of co-constructed, bi-directional, shared encounters between clients and clinicians. Although the client is not directly alluded to in the construct of *valent encounters*, the significance of the role of the client is based on the assumption of the existence of a bi-directional, mutual encounter between client and clinician.

Finally, it is suggested that upon airing and subsequently discussing *valent encounters* with peers that these encounters are further signified and recognised for clinicians. Some clinicians reflect upon the immediacy of understanding as gained from *valent encounters* while in other cases, the clinical clarity and personal insight as ignited from *valent encounters* flourishes long after their encounter with a client. Additionally, clinicians reflected upon the external pressures and realities of everyday practice that can make it difficult to have the opportunity to reflect upon *valent encounters* in the clinical setting. In other instances, clinicians reference the context, circumstances, and lessons as learned from reflecting upon *valent encounters*.

9.3. Interprofessional Differences and Overall Trends Within the Context of PETs and Overall GETs as Identified in the Data Analysis

All of the professions feature in the overall GETs as analysed within the data to greater or lesser extents. Table 9.1 provides a summary of the interprofessional differences and overall trends within the context of PETs and GETs as identified in the data analysis. Additionally, the themes of encounters of *appreciation* and encounters of *promise* reference the possibility of building and strengthening the professional identity of the profession of play therapy.

Table 9.1

Summary Table Relating to Interprofessional Differences and Overall Trends Within the Context of PETs and Overall GETs as Identified in the Data Analysis.

GET	PET	Theme within data analysis
I: Clinician as Having Been Elevated by the Client		
	1: Encounters of *enlightenment*	Features most prominently* in PT Features also in OT, SW, SLT and P
	2: Encounters of *appreciation*	Features most prominently in PT Features also in SW, SLT and OT Does not feature in P
	3: Encounters of *receptiveness*	Features most prominently in SW and PT Features also in OT and P Does not feature in SLT
II: **Clinician as Having Been Enrooted by the Client**		
	1: Encounters of *levelling*	Features most prominently in P Features also in SW, PT and OT Does not feature in SLT
	2: Encounters of *holding*	Features most prominently in OT Features also in SW, SLT and PT Does not feature in P
	3: Encounters of *empathy*	Features most prominently in P and SLT Features also in OT, PT and SW
III: **Clinician as Having Been Emboldened by the Client**		
	1: Encounters of *promise*	Features most prominently in OT Features also in P, SW and PT Does not feature in SLT
	2: Encounters of *resolve*	Features most prominently in PT Features also in SLT, P, and OT Does not feature in SW

Key: occupational therapy (OT); physiotherapy (P); speech and language therapy (SLT); play therapy (PT); social work (SW)

* The word 'prominently' in Table 9.1 refers to the profession/s that are most frequently represented in a given theme in the context of the data.

9.4. Summary of Chapter

In this chapter, I provided a summary of the findings of my research study. I also summarised the construct of *valent encounters*. In addition, I reflected upon the nature and scope of *valent encounters*. I also presented a summary table relating to the interprofessional differences within the context of PETs and GETs as identified in the research study. In the following chapter, Chapter 10, I aim to discuss the construct of *valent encounters*, its nature and scope in the context of existing theoretical and clinical literature to further contextualise the findings of my research study.

Chapter 10: Discussion: Theoretical Considerations

10.1. Introduction

In summary, the construct of *valent encounters* recognises the active presence and contribution of both client and clinician in the co-creation of these encounters. Secondly, the construct of *valent encounters* foregrounds clinicians' experiences with the client. Finally, the construct of *valent encounters* considers clinicians' responses to particular client/clinician interactions that in turn considers the ways in which the therapeutic, personal, and future beings of clinicians are being continually impacted and shaped.

In this chapter, I aim to discuss the construct of *valent encounters*, as well as its nature and scope in the context of existing theoretical and clinical literature to further contextualise the findings of my research study. I will relate the findings of my research to various concepts as evident in both HSCP literature and psychotherapy literature. These concepts include, *therapeutic alliance* (Bordin, 1979), *relational depth* (Mearns, 2003), *moments of meeting* (Stern et al., 1998a; Stern et al., 1998b; Stern, 2004), *therapeutic presence* (Geller & Greenberg, 2002) and *mutuality hypothesis* (Murphy et al., 2012). I propose that while my findings complement these concepts, they also add different dimensions to them, which I wish to explore in this chapter.

10.2. Contextualising Valent Encounters Within HSCP Research

The findings of my research suggests the occurrence of *valent encounters* in HSCP practice. To the best of my knowledge, the construct of *valent encounters* has not been explored within the HSCP literature to date. Traditionally, the effect of clinicians' experiences and responses to particular client/clinician interactions have largely been ignored in the literature. Instead, the HSCP literature generally tends to focus on the development of the skills, attitudes, and approaches of clinicians to create an optimum therapeutic process to subsequently facilitate and ensure positive therapeutic outcomes for the client in the context of client/clinician interactions.

Below, I relate the findings of my research to the concepts of therapeutic alliance and the 'therapeutic use of self' as commonly referenced in HSCP literature to further contextualise the findings of my research within the HSCP literature.

10.2.1. Therapeutic Alliance

As highlighted above, the construct of *valent encounters* recognises the active presence and contribution of both client and clinician in the co-creation of such encounters. In this sense, the construct of *valent encounters* resonates with the concept of the therapeutic alliance (TA; Bordin, 1979) that places emphasis on the collaborative agreement and emotional bond between client and clinician in the context of the therapeutic interaction (Bordin, 1979). Stemming from the field of psychotherapy, HSCP have since adapted elements of the TA literature to HSCP practice.

The literature recognises TA as an essential construct that transcends various theoretical perspectives in psychotherapy (Bordin, 1979; Nissen-Lei et al., 2010). More specifically, Bordin (1979) specified three components that contribute to the development of a strong TA relationship. These components include agreement between client and clinician on therapeutic goals, agreement on therapeutic tasks and positive bonds. Many of the components relate to client and clinician engaging in collaborative practice to identify therapeutic goals, and activities that clients are willing to engage with to help facilitate change. As well as this, the concept of positive bonds relates to the development of the interpersonal relationship between client and clinician. More specifically, positive bonds involve the client building trust and confidence in the clinician to help the client to achieve their goals (Bordin, 1994). Positive bonds are built on mutual respect, respecting boundaries, and listening empathetically.

However, while *valent encounters* specifically reflect upon the effect of clinicians' experiences and responses to particular client/clinician interactions, on the

other hand, TA literature tends to focus upon ways and means of recognising, constructing and establishing TA in practice. Much of the HSCP literature relates to developing the practical skills, attitudes and approaches to be adopted by therapists to help in the construction and the establishment of TA in practice to result in positive therapeutic outcomes for the client. For example, in the profession of physiotherapy, research has focused on the role of TA as a component of therapeutic outcome (Heredia-Callejón et al., 2023). Another example from the profession of occupational therapy provides a definition of TA (Restall & Egan, 2021) as well as strategies to help initiate positive client/clinician interactions (Evatt & Scanlan, 2022). Similarly, Babatunde et al. (2017) reflect upon the characteristics of TA in musculoskeletal physiotherapy and occupational therapy practice. In their research, the authors undertook a scoping review to consider both the theoretical and empirical evidence relating to how the TA is currently measured and how the construct of TA relates to adherence levels in musculoskeletal practice. Similarly, Connery et al. (2022) conclude that it is essential that the discipline of speech and language therapy places more emphasis on research relating to TA to ensure equal emphasis on clinical and relational components of speech and language therapy practice. Connery et al. (2022) also emphasise the importance of relational competence as well as the technical competence of speech and language therapy in practice.

In essence, the findings of my research study, helps to extend understanding and knowledge relating to *valent encounters* in HSCP literature and practice. The need for further exploration of relational and reciprocal experiences in HSCP literature is alluded to by Keiter Humbert et al. (2018). The authors recognise the limited research that exists within the occupational therapy literature regarding clinicians' reflections of client/clinician interactions as well as the effect of these interactions for the clinician. The findings of their research reflect upon the ways in which client/clinician interactions impacted participants as both people and professionals, reflecting upon

how such interactions “may enrich the therapist’s personal and professional life journey” (Keiter Humbert et al., 2018, p.124). The authors conclude that many aspects of reciprocal client/clinician interactions are not fully understood. Therefore, the findings of my research study help extend understanding and knowledge relating to relational experiences in HSCP literature and practice, as encompassed in the construct of *valent encounters.*

10.2.2. Therapeutic Use of Self in the Context of HSCP Practice

While the concept of ‘therapeutic use of self’– contextualises the clinician’s role within client/clinician interactions, I suggest that it does not consider the effect of clinicians’ experiences and responses to particular client/clinician interactions *per se*, as captured in the construct of *valent encounters*. ‘Therapeutic use of self’ is a concept that is viewed as integral and central to the practice, therapeutic process and therapeutic outcomes in the profession of occupational therapy (Taylor & Melton, 2009). While the concept of ‘therapeutic use of self’ stems from the psychotherapy literature, there are various understandings and definitions of the term within the occupational therapy literature (Solman & Cloustan, 2016). Punwar and Peloquin (2000) define the concept as “a practitioner’s planned use of his or her personality, insights, perceptions and judgements, as part of the therapeutic process” (p. 285). Similarly, the Intentional Relationship Model (Taylor, 2008) is a conceptual framework devised to support clinicians in understanding their role within the context of client/clinician interactions. Despite the development of the conceptual framework by Taylor in 2008, there remains little research undertaken in relation to the Intentional Relationship Model (Raber et al., 2019). Similarly, the occupational therapy literature reflects how a more defined and refined definition of the ‘therapeutic use of self’ within the profession may help provide further understanding and cohesion on the topic in occupational therapy practice (Solman & Cloustan, 2016). The authors argue that there is a discrepancy within the perceived centrality of the ‘therapeutic use of

self' to the occupational therapy profession and practice, reflecting upon a disconnect between theory and practice in relation to the concept of 'therapeutic use of self'. The authors suggest that further research related to the Intentional Relationship Model framework may help to provide understanding of the 'therapeutic use of self' in occupational therapy practice. Similarly, in the profession of speech and language therapy, Walsh (2008) reflects upon increasing clinicians' awareness of their own influence upon interactions with clients with psychiatric diagnoses.

Traditionally, the concept of 'use of self' in social work practice was viewed as a central construct related to the profession. However, during the 1960s and 1970s, emphasis on the concept began to dwindle in social work education and practice (Ruch, 2013). Instead, the profession evolved to focus upon sociological related concepts to explain human behaviour (Gordon & Dunworth, 2017). In more recent years, there has been a renewed enthusiasm for seeking to understand what the concept of 'use of self' may mean for social work practice (Gordon & Dunworth, 2017). Specifically, much of the work related to the refocus upon 'use of self' has reemerged in the context of therapeutic social work practice. Cooper (2018) describes the 'self' as a process that concerns one's ability to be aware and make sense of the impact of oneself on others, and others upon oneself. However, Cooper acknowledges that the concept of 'use of self' cannot be solely relied upon in clinical decision making and practice. Instead, Cooper reflects that the 'use of self' should be utilised in conjunction with specific professional principles and specific knowledge of the clinician.

In summary, it seems that much of the HSCP literature reflects upon the context in which client/clinician interactions occur to ensure positive therapeutic outcomes for the client. While on the other hand, the findings of my research suggest the occurrence of *valent encounters* in HSCP practice that recognises the active presence and contribution of both client and clinician in co-creating such encounters. Secondly, the construct of *valent encounters* foregrounds clinicians' experiences with

the client. Finally, the construct of *valent encounters* considers clinicians' responses to particular client/clinician interactions that in turn considers the ways in which the therapeutic, personal, and future beings of clinicians are being continually impacted and shaped.

10.3. Contextualising Valent Encounters Within Psychotherapy Research

As previously discussed, I wish to draw attention to the psychotherapy literature given the limited research related to *valent encounters* evident in HSCP literature. I wish to highlight the person-centred and psychodynamic fields of psychotherapy due to their specific reference and consideration of the concept of experiences of in-depth connectedness (Stern et al.,1998a; Stern et al.,1998b; Stern, 2004; Cooper, 2005).

10.3.1. Universal Change Process Principles in Psychotherapy

Before reflecting upon specific theoretical approaches and conceptual perspectives, I wish to acknowledge that in recent years, the field of psychotherapy has attempted to identify universal change process principles that transcend various theoretical approaches and conceptual perspectives in psychotherapeutic process research. Additionally, I wish to acknowledge my understanding of the term *therapeutic process*. The work of Knobloch-Fedders et al. (2015) summarises major goals from a psychotherapy process workshop held in 1983, regarding proposed advancements in the area of the psychotherapeutic literature at the time. Some of the recommendations as proposed at the workshop, to advance the field of therapeutic process research, included conceptualising the therapeutic change process as a "bi-directional influence and reciprocal transaction" (p.389). The need for increased research relating to the components that facilitate in-session change in psychotherapeutic practice was also recommended. Additionally, some participants stressed the importance of "macro-theories" (p.386) to consider general principles that transcend various theoretical approaches and conceptual perspectives. During

workshop discussions, it became clear to attendees that a new paradigm for psychotherapy process research was needed. The attendees considered that the dichotomy between process and outcome in the therapeutic process needed some reconsideration towards a reformulation as change events occurring within psychotherapy sessions. Knobloch-Fedders et al. (2015) reflects that although a considerable amount of time has passed since the workshop, the insights and recommendations as proposed therein, remain highly relevant to current psychotherapy practice.

10.4. Relational Depth

In keeping with the concept of universal principles of practice, the psychotherapy literature suggests that the concept of relational depth (RD) can be considered a common factor across a range of therapies and therapeutic orientations (Cooper, 2005). Stemming from a person-centred field of psychotherapy, the term RD was first coined by Mearns in 1996 (Mearns & Cooper, 2005). This term was as an extension of Roger's (1957) necessary and sufficient conditions for therapeutic change to include the therapist's empathy, congruence, and unconditional positive regard. In his earlier works, Mearns (2003) described RD as "an extraordinary depth of human contact" (p.5). Mearns and Cooper (2005) then expanded upon definition of RD as "a state of profound contact and engagement between two people, in which each person is fully real with the Other, and able to understand and value the Other's experiences at a high level" (p.xii). Moreover, Cooper (2005) acknowledges that during experiences of RD:

> one simultaneously experiences extremely high and consistent levels of empathy and acceptance towards that Other, and relates to them in a highly transparent way. In this relationship, the Other is experienced as acknowledging one's empathy and acceptance – either implicitly or explicitly – and is experienced as fully congruent and real. (p.6)

Mearns and Cooper (2005) reflect that "presence" (p.37), "affirmation" (p.43), "realness" (p.38) "client openness" (p.43), and the potential of "meeting without words" (p. 47) can also characterise the concept of RD. Although Mearns and Cooper (2005) highlight how integration of the core conditions of therapeutic change is implicit in the person-centred approach, the authors acknowledge that when the core conditions are present to a significant extent, the conditions can be encapsulated as a single variable described as RD. In more recent years, research regarding RD has focused upon empirical studies to provide further insight and understanding as to the nature and impact of RD in practice (Cooper, 2005).

Following my reading and understanding of the literature, the implicit and subtle nature of both *valent encounters* and RD is acknowledged and captured in both concepts. For example, in relation to *valent encounters*, clinicians reference the subtle, implicit and unassuming nature of such encounters that can further highlight the profoundness of the *valent encounter* for clinicians. Similarly, Cooper (2013) reflects that relational depth is "such a subtle, holistic and complex phenomenon – something that individuals find so 'hard to put into words' – that to try and analyse and present it in empirical terms would be to under-mine the very essence of what it is" (2013, p. 62). Again, Cooper (2005) suggests that experiences of in-depth connectedness with clients "is a real and distinctive occurrence within the therapeutic encounter and worthy of further empirical examination" (p.16).

In the same way, both *valent encounters* and RD have the potential to capture a range of emotions for clinicians. The findings of my research suggest that some clinicians describe *valent encounters* as bringing with them emotions of confusion and uncertainty, leaving them questioning the nature, essence, and expectations of the clinical role. Likewise, Wiggins et al. (2012) suggest that RD has the potential to be an "uncomfortable experience" (p. 140) that may not always be associated with positive emotions, highlighting the capacity and potential of *valent encounters* and RD.

Additionally, *valent encounters* and RD can be categorised in similar ways. For example, it can be one precise *valent encounter* or an accumulation of similar types of *valent encounters* in which these encounters gain importance for the clinician. Likewise, Mearns and Cooper (2005) reflect upon how RD can take two forms — lasting experiences of connection and short-lived moments of connection. The authors describe lasting experience of connection as a general quality of a relationship as "an enduring sense of contact and interconnection between two people" (p.xii) while the authors employ words such as "moments" (Mearns & Cooper, 2018, xvii) to encapsulate these more short-lived encounters characterised by a deep sense of connection.

Finally, *valent encounters* foregrounds clinicians' experiences with the client, as well as recognising the active presence and contribution of the client and clinician in the co-creation of such encounters. Likewise, the experience of RD is defined as a mutual interaction in which both client and therapist perceive the other as being understanding and genuine towards one another (Mearns & Cooper, 2005). In relation to experiencing the client/therapist relationship, clinicians reflect upon a sense of reciprocity in the therapeutic relationship (Cooper, 2005). Cooper's (2005) empirical study aimed to explore therapists' understanding and experience of the concept of in-depth connectedness during sessions. Cooper (2005) details how all participants in the research study identified at least one encounter of experiencing the client at a level of RD. More specifically, therapists' perceptions of clients during these moments of RD included experiencing clients as being articulate, transparent and communicating from a place of vulnerability within themselves. Some therapists elaborated that at moments of RD, "it was not just that they and the client experienced similar attitudes towards each other" (Cooper, 2005, p.14) but that "the client acknowledged the therapist's acknowledgement of them" (Cooper, 2005, p.14). Similarly, Cooper (2012) conducted empirical research that aimed to explore client's and therapists' perception

of intersessional connection with findings indicating a significant degree of consensus between clients' and therapists' perception of connection.

Moreover, while *valent encounters* foregrounds clinicians' experiences with the client, the construct additionally considers the effect of clinicians' responses to particular client/clinician interactions. On the other hand, although the research briefly references the impact of RD for clinicians, RD does not provide in-depth reference to the ways in which the therapeutic, personal, and future beings of clinicians are being continually impacted and shaped. For example, Cooper (2005) briefly acknowledges the impact of moments of RD for therapists. Therapists' description of these moments of RD included experiencing a deep sense of immersion in their therapeutic work, heightened feelings of acceptance, receptivity and empathy towards clients, as well as experiencing heightened levels of satisfaction and awareness in their therapeutic work. Interestingly, the findings of Cooper's (2005) research revealed that participants reflected upon being "affected", "touched", "moved", or "influenced" at times of experience of RD with clients (pp.10–11). The author provides an example in which a participant reflected: "maybe, in a way, you can say that I learnt something from them too.... [M]aybe it's a moment of change.... in me as well. I'm a bit different" (Cooper, 2005, p.11), highlighting the potential impact of meaning of moments of RD for therapists, as already acknowledged in the construct of *valent encounters*.

In summary, there appears to be both convergence and divergence within RD and *valent encounters*. Firstly, the implicit and subtle nature of both *valent encounters* and RD is acknowledged and captured. Likewise, *valent encounters* and RD can be categorised in similar ways as well as having the potential to capture a range of emotions for clinicians. Additionally, both *valent encounters* and RD acknowledge the active presence and contribution of client and clinician, as well as foregrounding clinician's experiences with the client. However, *valent encounters* additionally

considers clinicians' responses to particular client/clinician interactions that in turn considers the ways in which the therapeutic, personal, and future beings of clinicians are being continually impacted and shaped.

10.5. Moments of Meeting

Stemming from the psychodynamic field of psychotherapy, the concept of moments of meeting (MoM; Stern et al., 1998a; Stern et al., 1998b; Stern, 2004) is based on the premise of changes occurring in the shared implicit relationship between the therapist and client, creating a new dyadic state of intersubjectivity that implicates changes in the clients' "implicit procedural knowledge" (Stern, 1998a, p. 903) of being with others (Stern et al., 1998a; Stern et al., 1998b). The concept of MoM is based on the premise that both client and therapist have "contributed something unique and authentic of his or herself as an individual (not unique to their theory or technique of therapeutics) in the construction of the moment of meeting" (Stern, 1998a, p. 912). MoM can be described as "moments of intense connectedness, of openness, vulnerability, intimacy and shared humanity between patient and therapist during any therapeutic encounter that enable a spin in the therapy process" (Duarte et al., 2020, p.56).

Reflecting upon the similarities between *valent encounters* and MoM, it appears that both concepts follow similar trajectories regarding the nature and process of change. For example, the findings of my research suggest that there is no one defined trajectory regarding the nature of change related to *valent encounters*. Some clinicians reflect upon *valent encounters* from the beginning of one's career as a newly qualified professional while in other cases, clinicians reflect upon *valent* encounters from various stages of their professional careers. Similarly, some clinicians reference how *valent encounters* may have blossomed after months, and sometimes even years of working with a client. Likewise, the findings of Duarte et al. (2022) found no evidence of a linear relationship between MoM and the process of change

describing how there is not always immediate change or an accurate understanding of change in the therapeutic process but instead may acquire relevance at a later stage in the therapy process. Clinicians also describe the nature of MoM as "spontaneous, surprising and unpredictable" (p. 519). Duarte et al. (2022) also reflects upon how MoM "seem to be more a process than a single and isolated event; even though their expression is usually spontaneous and emergent, certain conditions of possibility must exist" (p.520), once again highlighting the similar trajectory between both *valent encounters* and MoM regarding the process of change.

Moreover, *valent encounters* acknowledge the active presence and contribution of both client and clinician in the co-creation of such encounters. Although the client is not directly alluded to in the construct of *valent encounters*, the significance of the role of the client is based on the assumption of the existence of a bi-directional, mutual encounter between client and clinician. Likewise, Stern (1998a) highlights how change in the psychotherapeutic process is an interactive and relational process taking place between therapist and patient, that ultimately results in a change in the patient's implicit relational knowing. Therefore, both therapist and clinician are acknowledged as actively contributing to the creation of MoM within the therapeutic encounter. Stern (1998a) describes the various stages of creation of MoM that include the "moving along" process (p.906) in which the clinician considers the traditional psychotherapeutic process principles that move towards the client's goal for therapy. The "moving along" (p. 908) process is made up of "present moments" (p.910) with the possibility of being transformed into "now moments" (p.910). 'Now moments' are described as emotionally intense moments in which the familiar intersubjective environment of the traditional therapist-client relationship becomes strained and becomes at risk at being altered, relating to changes in implicit relational knowing. 'Now moments' require both the therapist and the client to respond to the change for the now moment to be seized and in turn create a MoM.

In addition, the findings of my research suggest that while *valent encounters* are versatile, nuanced and highly individualised, *valent encounters* can be simultaneously understood and reflected in a universal context. Similarly, it appears that MoM can also be understood in a general context. Stern (1998a, p. 915) acknowledges that MoM can "only occur when something happened that was personal, shared, outside, or in addition to technique" (Stern, 1998a, p. 915). Stern (1998b) also reflected upon how MoM "cannot be an application of technique nor a habitual therapeutic move. It must be created on the spot to fit the singularity of the unexpected situation" (p.305). Stern (1998a) also acknowledges how moments of meeting "transcends but does not abrogate the 'professional' relationship and become partially freed of the transferential-counter transferential overtones" (p. 916). Additionally, the concept of MoM has been adapted to outside of the psychotherapy literature. For example, research to date has considered how MoM have been explored in dance/movement therapy (de la Parra Lopez & Panhofer, 2023). Tangerås (2022) also details instances of "now moments" and MoM for people with a digamous of mild to moderate dementia.

Reflecting upon the differences between both concepts, it is suggested that *valent encounters* consider clinicians' responses to particular client/clinician interactions that in turn considers the ways in which the therapeutic, personal being and future beings of clinicians are being continually impacted and shaped. In contrast, MoM predominately focuses upon the client's response to change to help bring about change for the client in the context of implicit relational knowledge (Stern et al., 1998a; Stern et al., 1998b). For example, Duarte et al. (2022) acknowledges the immediate changes and the long-term effects of change for the therapeutic relationship and for the client from the therapists' perspectives. Therapists reflected how MoM "give salience to the session and disrupt the regular flow, injecting vitality into the process and giving direction on how to go on" (Duarte et al., 2022, p.519). Other therapists

describe how MoM contribute to the strengthening of the therapeutic relationship between client and therapist.

However, Duarte et al. (2022) suggest an acknowledgement of the possibility of considering clinicians' responses to interactions with clients, as encapsulated in the construct of *valent encounters*. Duarte et al. (2022) acknowledge that both client and therapist were impacted in the change process. Immediate changes for the therapist included feeling relieved, and a reduction in emotional tension. As well as this, in their guidelines for future research, Duarte et al. (2022) acknowledge the possibility of future studies to consider the effect MoM on therapists and whether these MoM can be deemed therapeutic for the therapist. The researchers hypothesise that through therapists' "reminiscences and experiences we can also see a profound psychological effect on the therapist that may influence and reinforce their work and their role" (p.522), suggesting the importance of further research regarding clinicians' experiences and responses in MoM, as encapsulated in the construct of *valent encounters*.

In summary, the literature reflects upon similarities and differences as related to *valent encounters* and MoM. It appears that *valent encounters* and MoM both follow similar trajectories regarding the process of change. Likewise, both MoM and *valent encounters* acknowledge the active presence and contribution of client and clinician, while both RD and *valent encounters* can also be understood and reflected in a universal context. Conversely, MoM predominately focuses upon the client's response to change to help bring about change for the client in the context of implicit relational knowledge, whereas *valent encounters* consider clinicians' responses to particular client/clinician interactions that in turn considers the ways in which the therapeutic, personal being and future beings of clinicians are being continually impacted and shaped. However, MoM researchers acknowledge the importance of

considering clinicians' responses in MoM in future research, as acknowledged and encapsulated in the construct of *valent encounters*.

10.6. Therapeutic Presence

In relation to the findings of my research, *valent encounters* consider the active presence and contribution of both client and clinician in the co-creation of such encounters. *Valent encounters* resonates with the concept of therapeutic presence (TP) that specifically considers and emphasises the therapist's presence as an essential quality that underlies effective therapy.

Geller and Greenberg (2002) define TP as "bringing one's whole self into the encounter with the client, being completely in the moment on a multiplicity of levels, physically, emotionally, cognitively and spiritually" (pp.82-83). Geller and Greenberg (2002) continue to reflect upon the concept of TP as "the ultimate state of moment-by-moment receptivity and deep relational contact. It involves a *being* with the client rather than a *doing* to the client" (Geller & Greenberg, 2002, p.85). The authors place emphasis on the intrapersonal experience of the therapist and how the "inner receptive state of the therapist is viewed as the ultimate tool in understanding and sensitively responding to the clients' experiences and needs" (Geller, 2013, p.2). Geller and Greenberg (2002) devised a "model of therapist presence in the therapeutic relationship" (p.76) that reflects upon therapists' experiences and processes of becoming and being present in therapeutic encounters with clients. The model encompasses three categories of TP: "preparing the ground for presence", the "process of presence" and "experiencing presence" (p.76).

However, while Geller and Greenberg's (2002) model of TP provides a detailed account of therapists' experiences and responses to in-session interactions with clients, on the other hand, *valent encounters* extends upon aspects of the concept of TP to also consider the experiences and responses of clinicians in a more holistic

context regarding the ways in which therapeutic, personal, and future beings of clinicians are being continually impacted and shaped.

For example, the category of 'process of presence' in Geller and Greenberg's (2002) TP model considers the therapist's receptivity and the therapist's ability to inwardly attend to the client by utilising the "self as an instrument" (p.76), "trust" (p.76), "authenticity" (p.76) as well as the ability to return to the present moment. The "process of presence" also involves the act of "extending" (p.76) and "contact" (p.76) on the part of the therapist. Therefore, there is an expectancy on the part of the therapist to be open to embracing the client's internal world as well as the clinician being open to their own experiences of the moment to ensure access the "knowledge, professional skill and wisdom" (Geller, 2013, p.210) as embodied within the clinician. The final category in Geller and Greenberg's (2002) TP model relates to the therapists' in-session experiences of presence. There is an expectancy for the therapist be immersed within the therapeutic encounter that includes being aware, alert and focused as well as present-centred and experiencing deeply with non-attachment. Moreover, there is a sense that the therapist feels grounded and centred in themself, whilst in the experience of presence with a client. Additionally, the model reflects upon the concept of "being with and for the client" (p.76). This involves facilitating the clients' healing process rather than being focused on the outcome of the therapeutic process. The more recent work of Geller (2013) extends the concept of TP to "recognise that therapeutic presence deepens into a relational experience" (p.5). Relational therapeutic presence refers to the "deepening of the state of therapists' presence that occurs as a function of two (or more) people being fully present with one another. The relationship between creates a larger sense of spaciousness and access to wisdom and flow that is opened in relation to each other and the moment" (p.6). Moreover, the authors suggest that therapeutic presence can be deemed a foundation to RD. On the other hand, the construct of *valent encounters* extends upon

aspects of the concept of TP to also consider the experiences and responses of clinicians in a more holistic context regarding the ways in which therapeutic, personal, and future beings of clinicians may be continually impacted and shaped in the context of *valent encounters*. For example, some clinicians reflect upon *valent encounters* in relation to their therapeutic being in the context of the clinical setting. In other cases, some clinicians describe *valent encounters* that coincide with significant events in their personal lives which provide further insight and context for clinicians. Similarly, some clinicians reference the potential impact of *valent encounters* in relation to the clinician they will be in the future within clinical practice with future clients.

Furthermore, similar to *valent encounters*, therapists also reflect upon experiencing an array of emotions whilst in the experience of TP to include experiencing feelings of wonder, warmth and compassion towards clients (Geller and Greenberg, 2002). Moreover, Geller and Greenberg (2002) describe how when in therapeutic presence, the client and clinician share "a sacred space with the client and hence the feelings become shared" (Geller & Greenberg, 2002, p. 78). Therefore, in summary, although TP provides specific details regarding therapist's response to interactions with clients, TP tends to focus upon the in-session impact of these interactions for the clinician. On the other hand, the construct of *valent encounters* extends upon aspects of the concept of TP to also consider the experiences and responses of clinicians in a more holistic context that in turn considers the ways in which the therapeutic, personal, and future beings of clinicians may be continually impacted and shaped.

10.7. Mutuality Hypothesis

Stemming from Roger's (1959) process-outcome model of psychotherapy, the term mutuality extends from the person-centred literature. According to Murphy and Cramer (2014), "mutuality refers to the bi-directional, reciprocal experience of empathy, unconditional positive regard, and congruence of each person within the

dyadic relationship" (p. 652). However, the mutuality hypothesis tends to focus upon the mutual experiencing of the therapeutic relationship conditions (i.e., empathy, unconditional positive regard and congruence) for both client and therapist (Murphy & Cramer, 2014). In contrast, *valent encounters* does not relate specifically to the mutual exchange of certain therapeutic conditions. Instead, *valent encounters* captures clinicians' experiences and responses to particular client/clinician interactions that in turn considers the ways in which the therapeutic, personal, and future beings of clinicians are being continually impacted and shaped.

10.8. The Context of Valent Encounters

While the theories and concepts within the psychotherapy literature speak to the work with clients' emotions, cognitions and personal constructs, and are the primary aim of the work as such in the context of psychotherapy practice. Within HSCP, the respective professions have the goals of remaining committed to their professional clinical competence domains. For example, in occupational therapy, clinical competency goals for the client may include the client engaging in occupation domains (e.g., self-care, productivity or leisure activities), while the clinician may have the opportunity to develop their clinical competencies related to assessing the client's functioning in these occupational domains. Similarly, in speech and language therapy, clinical competency goals for the client may include engaging in activities related to supporting their language skills (e.g., developing vocabulary skills), while the clinician may have the opportunity to develop clinical competencies related to their therapeutic skills (e.g., providing appropriate prompts and cues to the client).

In the clinical setting, the subtle and implicit nature of *valent encounters* may make it challenging for clinicians to identify and conceptualise *valent encounters* in the context of other professional clinical competency goals, as highlighted previously. Similarly, in the findings of my research, clinicians reflected upon the external pressures and realities of everyday practice that can make it difficult to have the

opportunity to reflect upon *valent encounters* in the clinical setting. For some clinicians, the opportunity to discuss the nuanced and subtle nature of their experiences with other participants, and professional colleagues, further validated their experiences and insights related to *valent encounters* in the clinical setting.

10.9. Summary of My Research Findings Within the Context of HSCP Literature and Psychotherapy Literature

In summary, I suggest that the construct of *valent encounters* can be nestled within existing concepts and theories as related to both HSCP literature and psychotherapy literature. More specifically, I propose that the construct of *valent encounters* both complements and adds to existing theoretical constructs and the existing literature base relating to the effect of clinicians' experiences and responses to particular client/clinician interactions.

Below, I will now consider some of the theoretical implications of my findings related to IPA research design. More specifically, I will consider how my research has extended the body of literature related to the use of multiple perspective design. Furthermore, I will consider how my research has extended the body of literature related to using focus group interviews as a legitimate method in IPA research design.

10.10. Methodological Considerations: IPA

My research has added to the body of literature related to the use of multiple perspective design in IPA research. My research has also extended the body of literature related to the use of focus group data to inform a multiple perspective design approach to IPA research. Moreover, my research adopted the use of online focus groups in data collection, rather than interview formats. Smith et al. (2022) reference how the "innovative approaches" (p. 120) have become more popular in recent times and can be used as a "springboard" (p. 120) to help extend the possibilities of IPA studies.

10.10.1. Multiple Perspective Research Design

My research has broadened the body of research related to the integration of traditional and innovative approaches in an IPA design research study. More specifically, I employed a multiple perspective research design in my research study that aimed to understand the phenomenon in question from "more than one distinctive point of view" (Smith et al., 2022, p.122). Traditionally, standard cross-case IPA designs tend to focus upon understanding the lived experiences of a person from an individual or shared perspective on a given phenomenon. In standard IPA cross-case design, the researcher is focused on retaining a commitment to an idiographic level of analysis that is usually achieved through a relatively homogenous sample size. However, Larkin et al. (2019) suggest that multiple perspective IPA designs retain a commitment to idiography but extend the theoretical boundaries of IPA to "combine two or more focal perspectives" (p.183) that permits the researcher to consider the "relational, intersubjective and microsocial dimensions of a given phenomenon" (p.183). Therefore, Larkin et al. (2019) suggest that the challenge in multiple perspective IPA design is retaining IPA's commitment to understanding each participant's lived experience (in the context of more potential variation than in traditional samples), whilst also enhancing the participants' accounts using additional perspectives.

Prior to undertaking a multiple perspective IPA design, I read various literature that specifically related to designing, undertaking and analysing multiple perspective research designs (e.g., Reid et al., 2005; Smith, 2004; Smith et al., 2009, Smith & Nizza, 2022, Smith et al., 2022). For example, I was cognisant of incorporating key theoretical features of IPA in my study to include (i) "units of analysis" (Larkin et al., 2019, p. 190; Tomkins & Eatough, 2010, p. 245) and (ii) the specific design type of multiple perspective IPA (Larkin et al., 2019, p.186,). I understood that these key theoretical features of multiple perspective design would likely have implications for the overall

research design of my research study. I was cognisant of remaining committed to the theoretical underpinnings and principles of IPA research design to ensure a quality research study could be achieved. Therefore, it is hoped that my research study has extended the body of research related to multiple perspective design to help further expand the possibilities of IPA research.

10.10.2. Focus Group Interviews as a Legitimate Method in IPA

My research has extended the body of research related to the use of focus group interviews within multiple perspective research design. Traditionally, the use of focus groups in IPA has been met with criticisms in the context of IPA literature (Love et al., 2020). For example, some of these theoretical criticisms relate to the challenge of retaining the theoretical underpinnings and principles of idiography in the context of the shared and collective experience of focus group interviews (e.g., Palmer et al., 2010). However, in more recent times, research has addressed concerns related to the idiographic integrity of focus group designs through the development of specific protocols and strategies related to conducting and analysing IPA focus group research (e.g., Love et al. 2020; Tomkins & Eatough, 2010). Furthermore, other researchers have reflected upon the unique contribution of focus groups to retaining the commitment to idiography, while simultaneously providing the opportunity to reflect upon the co-construction of lived experience with other participants (Larkin et al., 2019; Le Boutillier et al., 2022). In the case of my research study**,** focus group interviews provided a means of encapsulating representative insights into the intricacies and nuances of clinicians' experiences of client/clinician interactions.

In more recent years, Montague et al. (2020) suggest that while much research has related to the benefits and motivations for the use of focus groups in IPA analysis, there has been less discussion regarding "the interpretation and contribution of group-based analysis"(p. 29) within the literature related to focus groups. More specifically, Montague et al. (2020) suggest that there has been little attention given to multiple

hermeneutics when working with focus groups in IPA design. Montague et al. (2020) suggest that a reframing of the double hermeneutic to a multiple hermeneutic may provide a more representative description of the theoretical underpinnings of IPA within a focus group context. Similarly Love et al. (2020) suggest that further consideration of multiple hermeneutics in focus group interviews can guide subsequent data analysis to ensure that a rich account of an individual's lived experiences can be retained.

In essence, multiple hermeneutics add to the complexity of trying to understand the idiographic lived experience of the individual as the researcher is attempting "to understand the participants' meaning-making who in their turn are trying to understand each other's meaning-making in a group" (Love et al., 2020, p.2). Following reading of the literature specifically related to attending to multiple hermeneutics in IPA design, I adopted the use of an "additional iterative loop" (Tomkins and Eatough, 2010, p. 250) during data analysis to ensure that the idiographic elements of an individual's account are not excluded within the context of multiple hermeneutics (the process of introducing an additional iterative loop was previously outlined in Chapter 4).

Furthermore, in the context of multiple perspective and focus group research design, I was cognisant of highlighting the role of multiple hermeneutics in my research study. This process was achieved by including various excerpts of dialogue between at least two participants, as well analysing the respective group interactions in the context of my finding's chapters. I hypothesised that inclusion of such excerpts enriched the interpretation of the focus group data to provide richer insights into clinicians' experiences of clinical interactions with clients.

It is important to note that focus group researchers have advised that their respective devised protocols relate to their experiences of their unique datasets that may serve as a useful means, rather than a prescriptive means, of furthering analytic

insights from focus group IPA research (Githaiga, 2014; Palmer et al., 2010; Phillips et al., 2016). Therefore, for me, another means of ensuring that the idiographic nature of IPA remained integral to my research study was through the inclusion and continual reference to the words, stories and quotes of all participants through the various stages of the analytic process. Additionally, I considered and highlighted the interprofessional differences and overall trends in the context of PETs and GETs as identified in the data analysis to ensure that the idiographic nature of IPA remained integral to my research study. I also presented a summary table relating to the interprofessional differences and overall trends within the context of PETs and GETs as identified in the research study in Table 9.1. Moreover, Githaiga (2014) reflects how merging of focus groups and IPA analysis is not a simplistic combination but can be achieved through theoretically based understanding of the fundamentals of IPA and a considered explication of the procedures involved in using focus group with IPA. Therefore, I was cognisant of engaging in extensive reading related to undertaking focus group research to take account of the various theoretical tensions in the context of the IPA literature to ensure a quality research study could be achieved. It is hoped that my research study has extended the body of research related to the use of focus groups to help further expand the possibilities of IPA research.

10.11. Summary of Chapter

In this chapter, I have reflected upon the possible theoretical contributions of my research in relation to existing literature. In summary, I suggest that *valent encounters* can be nestled within existing concepts and theories as related to both HSCP literature and psychotherapy literature. Additionally, I propose that the construct of *valent encounters* both complements and adds to existing theoretical constructs in the HSCP and psychotherapy literature base. Furthermore, I discussed some of the theoretical implications related to IPA research design. In the following chapter, I aim to outline how the construct of *valent encounters* can inform and be

implemented in the context of clinical practice. I will also propose some recommendations for clinical practice in HSCP contexts.

Chapter 11: Discussion: Clinical Implications

11.1. Introduction

In this chapter, I will consider some of the potential implications of my findings for clinical practice. I will also propose some recommendations for clinical practice in HSCP contexts. The limitations of my study as well as future directions for research will also be discussed.

11.2. Implication One: Recognising and Embracing the Construct of Valent Encounters and all its Potential in Clinical Practice

The findings of my research suggest the occurrence of *valent encounters* within HSCP practice. For example, all participants in my research study reflected upon at least one example of a *valent encounter*, suggesting the extent and prevalence of *valent encounters* in clinical practice. Therefore, I suggest the importance of recognising and embracing the construct of *valent encounters* and all its potential in clinical practice. I wish to draw reference to the concepts of compassion satisfaction and compassion fatigue in the wider literature to further contextualise the findings of my research study for the clinical setting.

11.2.1. Compassion Satisfaction

The findings of my research suggest that *valent encounters* consider the effect of clinicians' experiences and responses to particular client/clinician interactions. For example, some clinicians reflect upon the ways in which *valent encounters* with clients have left a positive impression on clinicians that then evokes within clinicians a desire to emulate clients' way of being in the world in everyday practice. Similarly, my study participants describe the ways in which *valent encounters* with clients have elevated them as clinicians to a higher order of professional and personal insight. Furthermore, clinicians describe how *valent encounters* instil within the clinician a courage to trust and believe in the capacity of potential despite changeable conditions of clinical practice. Therefore, in light of the above findings, I propose that it is important that

the positive elements and nature of one's work are cultivated and nurtured in the context of clinical practice. Following my reading and understanding of the literature, I suggest that the construct of *valent encounters* complements and aligns with existing literature related to the concept of compassion satisfaction.

Compassion satisfaction is defined as "the pleasure you derive from being able to do your work well" (Stamm, 2010, p.12). Research suggests that compassion satisfaction is viewed as a protective factor linked to clinicians' positive mental health amongst human service professionals (Harr et al., 2014). Likewise, compassion satisfaction is linked to mitigating the negative impacts of compassion fatigue (Harr et al., 2014). Radey and Figley (2007) derived a model for creating and cultivating compassion satisfaction that focuses upon identifying the factors that provide fulfilment to social work clinicians in their professional work. The model suggests that increasing "affect" (p.212), increasing "intellectual, social, and physical resources" (p.212) as well as an emphasis on high self-care amongst clinicians, results in a higher positivity-negativity ratio for clinicians to help cultivate compassion satisfaction. In the context of clinical practice, there has been an evolving trend in healthcare practice that aims to place emphasis on positive psychological factors to help promote healthcare staffs' well-being and to encourage staff to thrive in their roles despite the everyday challenges of their clinical role (Unjai et al., 2022).

Therefore, I propose that the construct of *valent encounters* may extend the ways in which the positive elements and nature of one's work are cultivated and nurtured in clinical practice to promote compassion satisfaction.

11.2.2. Compassion Fatigue

Additionally, the findings of my study suggest how *valent encounters* with clients have enrooted within clinicians (i.e., *clinicians as having been enrooted…*) a commitment to continually consider the nature, essence, and expectations of the clinical role. Following my reading and understanding of the literature, I propose that

the construct of *valent encounters* also complements and aligns with existing literature related to the concept of compassion fatigue.

One of the commonly used definitions to describe compassion fatigue includes "a state of exhaustion and dysfunction biologically, psychologically, and socially as a result of prolonged exposure to compassion stress and all it invokes" (Figley, 1995, p. 253). Figley (2002) reflected that compassion fatigue can "reduce our capacity or our interest in bearing the suffering of others" (p. 1434). Figley (2002) conceptualised eleven variables that together culminate in a causal model to predict compassion fatigue for clinicians. Some of these variables include "empathetic ability" (p.1436), "empathetic concern" (p.1436), "empathetic response" (p.1437), "exposure to the client" (p.1437), "prolonged exposure" (p.1438) and "life disruptions" (p.1438). Figley (2002) details that the model can be used to predict the onset of compassion fatigue as well as to prevent and mitigate the effects of compassion fatigue.

In relation to the findings of my research, I suggest that compassion fatigue may be an implication of not recognising and embracing the construct of *valent encounters* and its potential in clinical practice. Likewise, there has been an ongoing commitment to exploring compassion fatigue in the medical professions, in which there is common consensus that compassion fatigue is a key determinant of a clinician's quality of professional life (e.g., Abou Hashish & Ghanem, 2023). The literature also considers the effects of compassion fatigue for clinicians that include the reduced ability of clinicians to derive meaning from one's work as well as one's sense of personal achievement (Cocker & Joss, 2016). Other effects of compassion fatigue may include increased staff turnover, reduced quality of client care, and the reduced ability of the clinician to foster a therapeutic relationship with clients (Turgoose & Maddox, 2017).

Therefore, I propose that recognition of the construct of *valent encounters* can help to enhance compassion satisfaction and to prevent and mitigate the effects of

compassion fatigue in clinical practice. As highlighted previously in the work of Figley (2002), primary prevention is considered an important recommendation in helping to build an individual's resilience (Tjeltveit & Gottlieb, 2010), thus reducing the risk of compassion fatigue. Similarly, Ludick and Figley (2017) emphasise self-care as a primary protective factor for reducing the risk of compassion fatigue. However, following their systematic review of the literature, Cocker and Joss (2016) concluded that evidence in relation to the effectiveness of compassion fatigue intervention is relatively recent in HSCP. The authors recommend undertaking further research to determine the most effective means of protecting HSCP clinicians in relation to the impact of compassion fatigue. Therefore, I propose that recognition of the construct of *valent encounters* can help to enhance compassion satisfaction and to prevent and mitigate the effects of compassion fatigue in clinical practice.

In summary, the findings of my research suggest the importance of recognising and embracing the construct of *valent encounters* and all its potential to promote compassion satisfaction and to reduce the effects of compassion fatigue in clinical practice. Below, I provide some recommendations, as conceptualised from the findings of my research, that may help to recognise and embrace *valent encounters* for clinicians in the context of everyday clinical practice.

11.2.3. Recommendation: Promotion of the Role of Purposeful Reflection in Clinical Practice Related to Valent Encounters

I propose for increased promotion of the role of purposeful reflection related to the construct of *valent encounters* in clinical practice. Having been guided by the findings of my research study and readings in the wider literature, I believe that it is crucial that a culture of reflective practice is promoted and accepted in healthcare practice to ensure compassion satisfaction can be cultivated and nurtured while also helping to prevent compassion fatigue in the context of clinical practice.

With reference to the findings of my research, for some clinicians, the opportunity to discuss the nuanced and subtle nature of their experiences with other participants, and professional colleagues further validated their experiences and insights of *valent encounters*. In the context of the wider literature, Koh et al. (2023) acknowledges the importance of intentionally fostering a culture of reflective practice in healthcare. The authors highlight the importance of developing a clinicians' reflective practice skills as an integral part of an individual's professional development. The authors suggest that intentionally fostering a culture of reflective practice can result in building the personal and professional resilience of healthcare staff as well as the sustainability of the healthcare organisation. Similarly, Robertson et al. (2021) outlines how promotion and encouragement of a reflective practice culture helps build an individual's resilience as well as organisational sustainability, highlighting the effectiveness of reflective practice across healthcare services.

However, it is important to acknowledge the everyday realities of undertaking reflective practice in a demanding practice setting. Clinicians in my research study reflected upon the external pressures and realities of everyday practice that can make it difficult to engage in reflective practice in the clinical setting. However, on the other hand, the findings of my study suggest that it is upon airing and subsequently discussing *valent encounters* with peers that these encounters are further signified and recognised for clinicians. For example, in my study, clinicians were encouraged to take the time to engage in the reflective process and reflected upon the benefits of carving out space that led to novel insights and understandings for them as clinicians. It is internationally recognised that sustainable delivery of health and social care services into the future will not be achieved by simply 'more of the same' (WHO, 2016). Therefore, I propose that it is crucial that the healthcare system encourages and promotes a culture of reflective practice in which healthcare workers feel empowered

to engage in reflective practice to help bring about positive, sustainable change for the healthcare system.

Additionally, the findings of my research suggest that the subtle and implicit nature of *valent encounters* may make it challenging for clinicians to identify and conceptualise the construct of *valent encounters* in the context of clinical practice. Therefore, there may be the potential for the construct of *valent encounters* to be overlooked and to be viewed as a trivial construct that is not afforded the recognition and attention in the context of clinical practice. I suggest therefore, that the opportunity for clinicians to engage in purposeful reflective practice with guidance and supervision, will ensure promotion of compassion satisfaction and to prevent and mitigate the effects of compassion fatigue amongst HSCP clinicians.

11.2.4. Recommendation: Emphasis on the Construct of Valent Encounters in Clinical Supervision Practice

I propose an emphasis on the construct of *valent encounters* in clinical supervision practice to promote compassion satisfaction and to reduce the effects of compassion fatigue amongst HSCP clinicians. In the context of the wider literature, clinical supervision is practiced by HSCP clinicians across the globe with the practice providing benefits for clients, clinicians and health organisations (Martin et al., 2017). Similarly, Martin et al. (2021) conducted a mixed methods systematic review relating to the impact of health professionals' clinical supervision on healthcare organisational outcomes. The quantitative findings of Martin et al. (2021) study suggests that effective clinical supervision, as well as an effective clinical supervisor, were associated with reduced burnout rates amongst healthcare staff. As well as this, qualitative findings from a systematic review revealed that healthcare staff believed that adequate clinical supervision could reduce the risk of burnout and enhance the working environment (Martin et al., 2021). On the other hand, inadequate clinical supervision can lead to increased likelihood of burnout and stress amongst healthcare

staff. Martin et al. (2021) recommends that investment in high quality supervision practices is paramount if the benefits of clinical supervision are to be achieved in practice.

Therefore, I propose that it is crucial that the healthcare system encourages and promotes a culture of clinical supervision practice that facilitates the opportunity for HSCP clinicians to discuss *valent encounters* with competent clinical supervisors in clinical practice. Likewise, the importance of clinical supervision is emphasised in professional policies and documents. For example, CORU (Irish Statute Book, 2005), the statutory body responsible for the regulation of HSCP clinicians in the Republic of Ireland, has published various codes of professional conduct and ethics related to regulated HSCP (e.g., *Social Workers Registration Board – Standards of Proficiency for Social Workers*, CORU, 2019). Similarly, the *HSE/Public Health Sector Guidance Document on Supervision for Health and Social Care Professionals; Improving Performance and Supporting Employees* (Health Service Executive, 2015) outlines the importance of "sustained engagement" (p.5) in ensuring HSCP professionals maintain clarity relating to their professional roles and responsibilities, as well as "structured opportunities to discuss work, review practice and progress and plan for future development" (p.5). The document also reiterates the importance of "regular and sustained" (p.10) practice to ensure the supervisee has ample opportunity to review their role and practice. The document outlines how "it is recommended that all members of a profession at all levels avail of structured supervision" (p.14).

Therefore, I propose that it is crucial that the healthcare system encourages and promotes a culture of clinical supervision practice that facilitates the opportunity for HSCP clinicians to discuss *valent encounters* with competent clinical supervisors. The culture of supervision may help to promote compassion satisfaction and to reduce the effects of compassion fatigue amongst HSCP clinicians and to help bring about positive sustainable change for the healthcare system. Below, I propose an example of

a reflection model, as based on the findings of my research, that may be used to enrich the existing emphasises on clinical supervision and help promote awareness and understanding of *valent encounters* in HSCP clinical practice.

11.2.5. Reflection Model for HSCP Clinicians Related to Valent Encounters

As a means of integrating the various research and recommendations as highlighted above, I propose a reflection model as based on the findings of my research study. A visual representation and description of the model are provided in Figure 11.1.

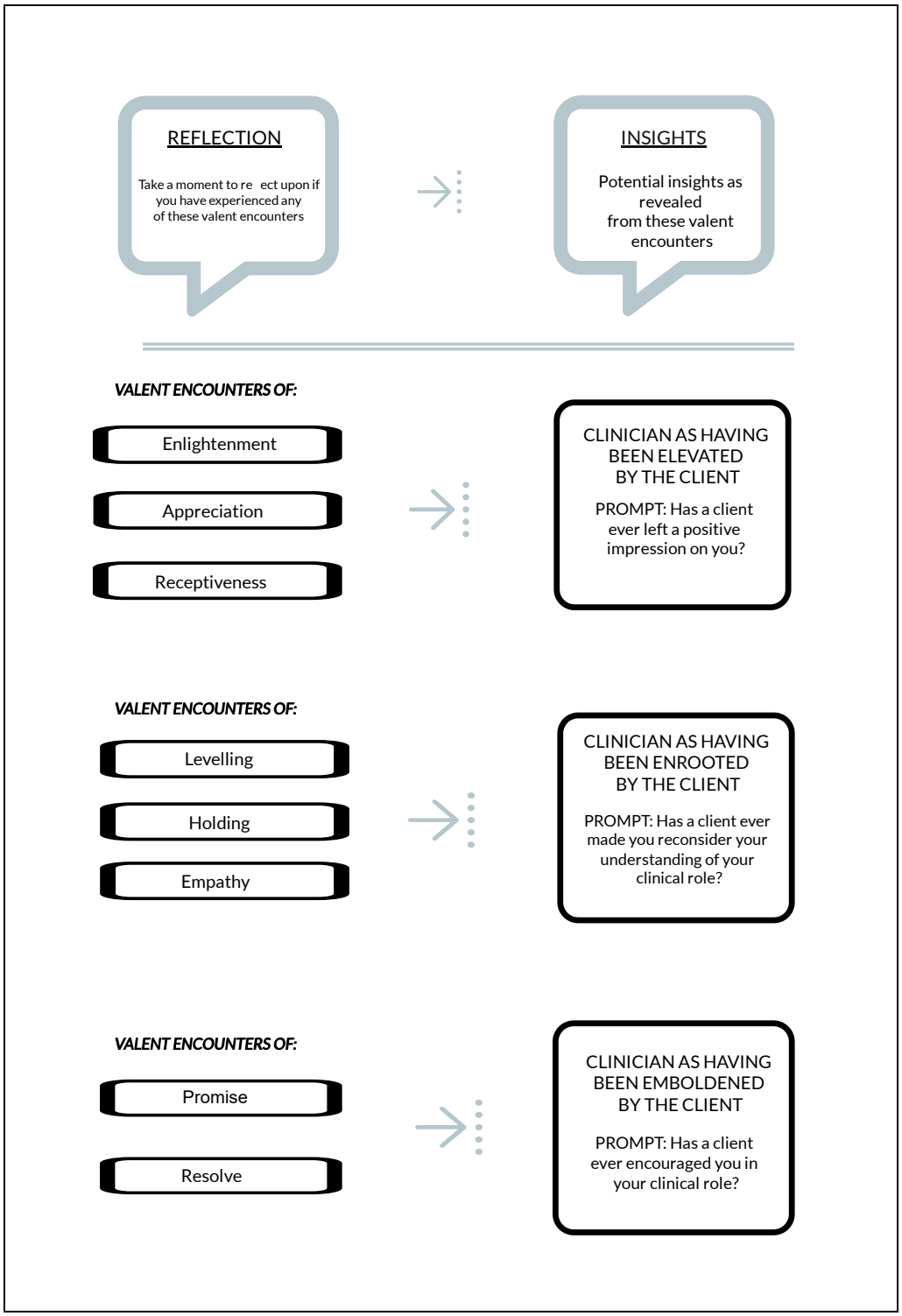
11.2.6. Description of Reflection Model for HSCP Clinicians Related to Valent Encounters

The model facilitates a practical means of reflecting upon the construct of *valent encounters* for clinicians working in the everyday realities of a demanding practice setting. Similarly, the model may help to provide structure to clinical supervision sessions, to further ensure effective supervision that provides benefit for the clinician. Furthermore, the model can be used across a range of HSCP to provide further insight into *valent encounters* for clinicians. Likewise, the model can be used across a range of clinical settings and environments.

It is important to acknowledge that the proposed reflection model may acknowledge both positive and challenging *valent encounters* for clinicians. The model helps to promote awareness of these *valent encounters* and provide an opportunity for the clinician to explicitly name these *valent encounters* in an honest and authentic way. Therefore, it is important that clinicians' reflections upon *valent encounters* are respected and can be facilitated in a safe environment unafraid of any judgement.

Figure 11.1.

Sample of Reflection Model for Use by HSCP Clinicians During Clinical Supervision/Reflective Practice



11.3. Implication Two: Preventative Education and Training in HSCP Undergraduate Students

An increased awareness of *valent encounters* can help to promote a culture of compassion satisfaction and to prevent and mitigate the effects of compassion fatigue in the context of undergraduate HSCP clinical practice placements. I suggest an increased emphasis on preventative education and training for undergraduate students to increase awareness of the construct of *valent encounters*. In the context of my research, the term 'prevention' refers to "doing something now to prevent or forestall something unpleasant or undesirable from happening in the future or doing something now that will increase desirable outcomes" (Albee & Ryan, 1998, p.441). An example of preventative education and training may include emphasis on pre-clinical reflective practice when preparing students for clinical practice placements.

The findings of my research suggest that there is no one defined trajectory regarding the nature of change related to *valent encounters*. For example, some clinicians reflected upon *valent* encounters from the beginning of one's career as a newly qualified professional while in other cases, clinicians reflect upon *valent encounters* from various stages of their professional careers. The wider literature suggests that risk factors for the development of compassion fatigue among health professionals include those of a younger age group cohort (Knight, 2010). Similarly, factors that can help mitigate the risks associated with compassion fatigue include increased levels of experience (Knight, 2010) while Tjeltveit and Gottlieb (2010) suggest primary prevention is considered an important recommendation in helping to build an individual's resilience, thus reducing the risk of compassion fatigue. Similarly, Harr et al. (2014) propose that preventative information to be incorporated into curricula on compassion fatigue, compassion satisfaction and self-care.

Therefore, the findings of my study may help to inform teaching and learning in undergraduate HSCP students. I suggest that an emphasis on pre-clinical reflective

practice when preparing students for clinical placements that promotes awareness of the construct of *valent encounters*, may cultivate a culture of compassion satisfaction and prevent compassion fatigue. Additionally, given that findings of my study emphasis how *valent encounters* tend to be facilitated in the context of co-constructed, bi-directional, shared encounters between clients and clinicians, the model may provide a means of emphasising and enriching students' appreciation for the central role of the client in healthcare practice**.**

Moreover, I propose that the use of a student specific pre-clinical reflection model related to *valent encounters* may alleviate some of the challenges currently encountered in relation to the implementation of reflective practice in third-level HSCP education. For example, the literature suggests that some educators can find it challenging to integrate reflection with the rest of the academic curriculum (Cook et al., 2019). I suggest that the student pre-clinical reflection model can be employed across a range of areas of clinical placement where students are undertaking clinical placement practice. Similarly, the model may provide a means of integrating and consolidating the learning outcomes and learning aims of theoretically based modules within the curriculum with clinical knowledge of the clinical setting.

Furthermore, promoting awareness of *valent encounters* in pre-clinical reflective practice may help inform and empower students' clinical insights and philosophies in their future clinical roles as HSCP clinicians. Below, I propose an example of a pre-clinical reflection model, as based on the findings of my research, that may promote awareness and understanding of *valent encounters* in pre-clinical reflective practice for HSCP undergraduate students.

11.3.1. Recommendation: Student Pre-Clinical Reflection Model

I propose a student specific pre-clinical reflection model that may be used as part of a student pre-placement preparation pack for HSCP students when preparing for clinical practice placements.

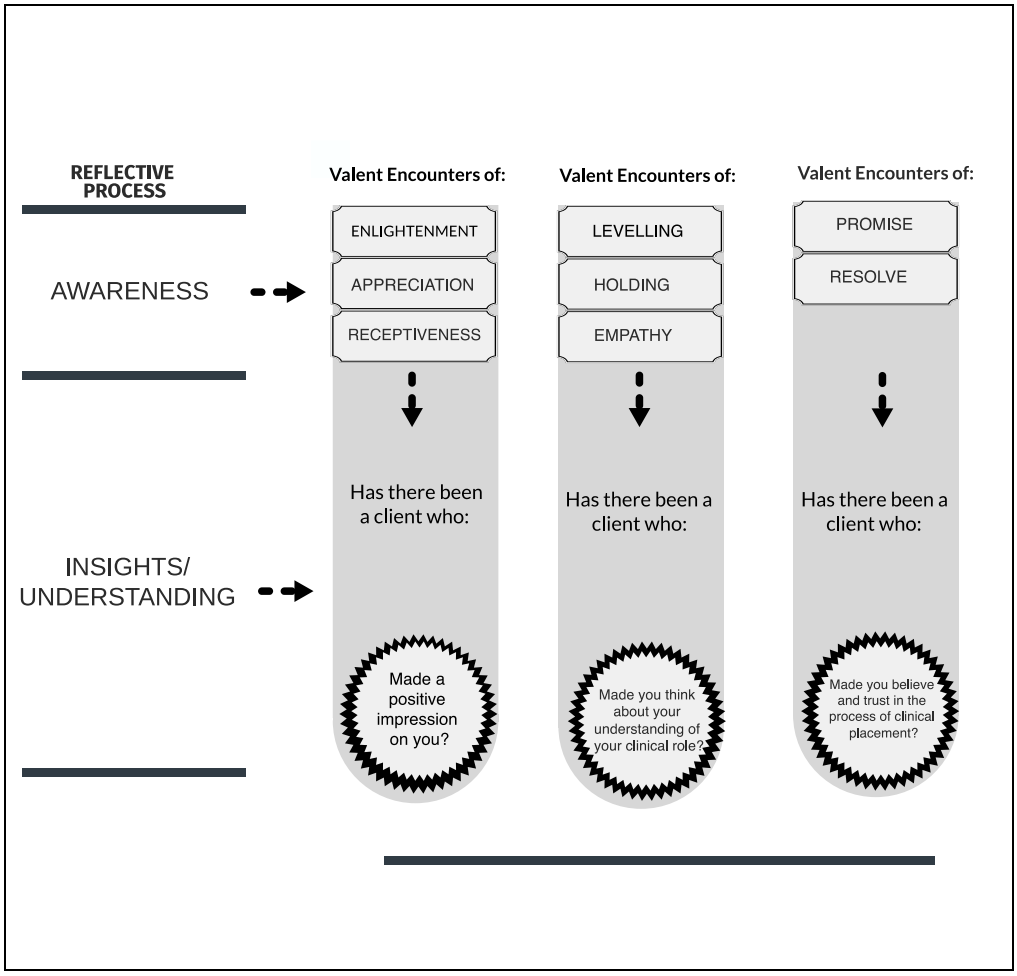
In the context of the wider literature, a type of reflection that is well-researched in the educational literature includes 'reflection-for-action' (Killion & Todnem, 1991). 'Reflection-for-action' is based on the concepts of 'reflection-in-action' (Schön, 1983) and 'reflection-on-action' (Schön, 1983) that specifically considers and helps to "guide future action" (Killion & Todnem, 1991, p.15) with the intention of enhancing one's practice. Importantly, it must be noted that students need to be guided by competent and confident trainers with experience in reflection-for- action practice due to the responsibility of combining the anticipation of what may occur in practice with traditional reflective practice on previous experiences before the knowledge can be imparted to students (Farrell, 2012). Furthermore, Rowland and Trueman (2024) aimed to enhance healthcare students' experience of clinical placement. Their work highlighted that access to student packs helped to enhance healthcare students' experiences of clinical placement. Following student feedback and collaboration with placement coordinators and clinical educators, a generic induction pack was created that included information regarding introductions from the team, information regarding the specific placement, orientation, expectations of staff and student, learning opportunities and learning resources, timetable as well as reflection models. Therefore, the literature suggests that the inclusion of reflection models can help to enhance healthcare students' experiences of clinical placement. I provide a sample and description of the pre-clinical reflection model in Figure 11.2.

11.3.2. Description of Student Pre-Clinical Reflection Model

The student pre-clinical reflection model specifically intends to increase students' awareness and understanding of *valent encounters* as may be encountered during clinical practice placement. The model provides a step-by-step process of anticipating *valent encounters*. The pack could also contain specific information related to increasing awareness of compassion satisfaction and compassion fatigue in undergraduate students.

Figure 11.2.

Sample of Student Pre-Clinical Reflection Model



11.4. Implication Three: Acknowledgment of the Central Role of the Client in Healthcare Practice

In recent years, there has been an evolving appreciation for the central role of the client in healthcare practice, as highlighted in the publication of various national policies and documents. The findings of my study support the acknowledgment of the central role of the client in healthcare practice, as conceptualised in the construct of *valent encounters* that considers the active presence and contribution of the client in the co-creation of such encounters.

In the context of the literature, one such policy, for example, is *HSCP Deliver* (National Health and Social Care Professions Office, 2021). The policy is based on the

principles of integrated and collaborative care between HSCP disciplines to provide supportive, holistic and evidence-based care to service users and their families. The commitment of HSCP to work together in collaboration to empower service users is reflected in the *Strategic Guidance Framework for Health and Social Care Professions* (National Health and Social Care Professions Office, 2021, p.9). More specifically, the framework details the commitment of HSCP clinicians to recognise clients as experts in their lived experiences, as well as identifying the goals, priorities and wishes of the service users as supported by clinicians' clinical expertise and skills. Clinicians are also committed to providing evidence based, high quality integrated care to clients, as well as being committed to empowering clients to be active partners in their care to ensure clients feel supported and understood in their healthcare journey.

Furthermore, the central role of the client in future healthcare is emphasised in *Committee on the Future of Healthcare Sláintecare Report (*Houses of Oireachtas, 2017*)*. The report, known as *Sláintecare,* envisions a single-tier, universal health and social care system based on a client's needs rather than on their ability to pay. *Sláintecare* also envisions a reorientation towards integrated care across the healthcare service (Houses of Oireachtas, 2017). The *Sláintecare Implementation Strategy* (Government of Ireland, 2018) sets out four overarching goals, ten strategic actions and eight principles to ensure the *Sláintecare* vision of a high quality, integrated, and cost-effective healthcare service can take effect. Amongst these eight principles include the principle of "patient is paramount" (p. 10). The principle ensures that appropriate planned care and pathways can be provided to clients. For example, strategic action 9 of the *Sláintecare Implementation Strategy* (Government of Ireland, 2018, p. 60) acknowledges the importance of building a resilient and sustainable workforce that is empowered to deliver the *Sláintecare* vision. The strategic action acknowledges the importance of education and training, employee health and well-being, and learning and development in supporting the recruitment, retention and

training of healthcare staff members. Similarly, *Sláintecare Implementation Strategy and Action Plan 2021-2023* (Government of Ireland, 2021) reaffirmed the commitment to engaging with front line staff as well as exploring new opportunities to continue to empower front line staff through new projects, for example, the *Sláintecare Integration Innovation Projects' Implementation and Learning Network* (p. 52).

Similarly, the *Health Services People Strategy 2019-2024* (Health Service Executive, 2019) was developed to support the implementation of *Sláintecare.* Priority 2 of the document outlines the "employee experience" (p.12) with a focus on employee wellbeing and engagement. The document proposes emphasis on an integrated focus on the employee experience to improve staff health and wellbeing. Similarly, the document outlines the commitment to evidence based and holistic health, safety and wellbeing programmes as informed by global legislation. More specifically, the psychosocial work environment (Section 2.4) emphasises prevention and early intervention in relation to stress, while the personal health resource pillar outlines collaborating with staff to encourage staff to take both personal and professional responsibility for their psychological and physical well-being through self-care practices.

11.4.1. Recommendation: Further Acknowledgement of the Impact of the Central Role of the Client in Policy Development.

The national policies and documents as highlighted above suggest an evolving emphasis on the central role of the client in healthcare practice. Ultimately, the evolving and central role of the client in healthcare is a positive precedent, however, to the best of my knowledge, it seems that, at present, policies and documents are placing much responsibility on the clinician to ensure that the above policies are implemented. For example, the *Sláintecare Implementation Strategy* (Government of Ireland, 2018) acknowledges that "the health workforce will be critical enabler of reform" (p. 60). The findings of my research suggest that clinicians are impacted by

clients in various ways, while clinicians may be further impacted as a result of increased expectation and centrality of the client in clinical practice into the future. Therefore, I recommend that there be an acknowledgement of direct client involvement in such policy development to ensure staff well-being is prioritised. Moreover, I propose a collective approach to workplace policies and development between staff and service providers to ensure that there is joint and broader responsibility for the implementation of policy development into the future.

11.5. Impact of Research Findings in the Context of Current HSCP Workforce Challenges

In essence and as described above, the findings of my research suggest the integral role of increased awareness of the construct of *valent* encounters in clinical practice. Moreover, increased purposeful reflection upon such *valent encounters* in structured supervision practice may help to promote compassion satisfaction and to prevent and mitigate the effects of compassion fatigue in HSCP clinicians. Additionally, increased promotion of preventative education and training related to *valent encounters* in undergraduate populations may help encourage a culture of compassion satisfaction and the prevention of compassion fatigue in the context of undergraduate HSCP clinical practice placements.

Therefore, I propose that the findings of my study and my proposed recommendations may help to address current workforce challenges in relation to retention of HSCP staff, and the general sustainability of the HSCP clinical workforce into the future. Further, I propose that the findings of my research may help address and facilitate the reintegration of those HSCP clinicians who have previously experienced compassion fatigue related symptoms and their effects who wish to return to their clinical roles within the HSCP workforce.

In the context of broader research, O' Brien et al. (2024) identified prevalence rates of burnout [10] at 70% amongst participants who work in the Irish healthcare system. According to the study, 16% of participants who took part in the study were employed as HSCP clinicians. The study reflects that healthcare staff are a particularly vulnerable population of workers susceptible to burnout given their exposure to an array of stressors to include exposure to significant life events, time constraint demands and staff shortages that may affect a clinician's physical and psychological well-being and overall health (O' Brien et al., 2024).

The findings of my research suggest the integral role of increased awareness of the construct of *valent encounters,* as well as purposeful reflection upon such *valent encounters* in structured supervision practice may help promote compassion satisfaction and prevention of compassion fatigue in HSCP clinicians. The findings of my research suggest the external pressures and realities of everyday practice that can make it difficult for clinicians to reflect upon *valent encounters* in the clinical setting. For some clinicians, the opportunity to discuss the nuanced and subtle nature of their experiences with other participants, and professional colleagues, further validated their experiences and insights of *valent encounters*. Given the current workforce challenges in relation to staff burnout (e.g. O' Brien et al., 2024), it is of paramount importance that staff well-being is protected and promoted to ensure the sustainability of the HSCP workforce. More specifically, I propose that the above proposed reflective models can be incorporated into established structures (e.g., established clinical supervision structures) in current healthcare practice to ensure an

[10] Definition of burnout: "a psychological syndrome with three components: emotional exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness and lack of accomplishment" (O' Brien et al., 2024, para.2)

effective and efficient means of incorporating the findings of my research into everyday practice to help promote compassion satisfaction and to help prevent and mitigate the effects of compassion fatigue in HSCP clinicians, to ensure the sustainability of the HSCP workforce.

Moreover, increased promotion of preventative education and training in relation to *valent encounters* in undergraduate populations may help enhance the sustainability of the HSCP workforce into the future. The future of the healthcare system relies on the education and training of undergraduate students; therefore, it is important that a culture of compassion satisfaction and the prevention of compassion fatigue is promoted in the context of undergraduate HSCP clinical practice placements. Further, students' awareness of such preventative education and training may result in students carrying forward their learnings, insights and reflections as gained from such education and training into their professional careers. Additionally, given that the implementation of future healthcare provisions will rely the central role of staff, as outlined various policies and documents in Section 11.4, it seems to be of paramount importance that adequate tools and resources, such as the student pre-clinical reflective model, are implemented to protect, promote and prioritise the well-being of undergraduate students, who will be the HSCP workforce of the future.

Finally, I propose that the findings of my research and proposed recommendations may help address and facilitate the reintegration of HSCP clinicians who have previously experienced compassion fatigue related symptoms and effects to return to their clinical roles. It is important that preventative and rehabilitative measures are promoted to ensure continued and consistent levels of staffing, thus helping to enhance the sustainability of the HSCP workforce into the future.

In summary, I propose that the findings of my research and the proposed recommendations consider both the current and future HSCP workforce, as well as HSCP clinicians who have previously experienced compassion fatigue related

symptoms and their effects in their clinical roles, and who wish to return to the HSCP workforce. I am confident that my findings may help address some of the workforce challenges in the healthcare service in relation to the retention of staff. Moreover, the recommendations may help to protect, promote and prioritise the well-being of current and future HSCP staff by promoting compassion satisfaction and the prevention of compassion fatigue in the workforce to ensure quality, consistent and sustainable healthcare provision can be provided to clients at present and into the future.

11.6. Study Limitations

Although every effort was made to recruit participants for my research study that represented a range of clinical experiences, backgrounds and areas of practice, the findings are drawn from a discrete collective of HSCP, specifically occupational therapy, play therapy, physiotherapy, social work and speech and language therapy. HSCP represent a diverse and wide-ranging cohort of professions spanning diagnostic, social and therapeutic domains (National Health and Social Care Professions Office, 2021). Given that my research study aimed to examine the meaning and significance of clinicians' experiences of particular interactions with clients, I deemed it most appropriate to recruit participants from the social and therapeutic domains of HSCP due to the professions direct therapeutic role with the client. Therefore, the findings of my study may not be representative of all HSCP (e.g., counselling therapy, podiatry) but rather relate to the specific disciplines of HSCP as described above. However, it is important to note that elements of findings of my research have the potential to relate and overlap with other HSCP. Furthermore, information relating to participants' years of clinical experience and participants' place of work were not systematically collected as part of the recruitment/data collection process. Such information may have provided further context as it relates to the findings of this research study.

Furthermore, as is the nature of such research with focus group participation as part of data collection, there is the potential for bias, in that some participants may have wished to take part in the research study given their specific interest in concepts related to the role of the client in clinical practice. Therefore, every effort was made to recruit participants via an independent recruitment process to ensure that clinicians working across a range of clinical backgrounds and areas of practice had the opportunity partake in my research study. For example, I contacted the executive officers of affiliated professional associations to recruit eligible clinicians who may be interested in taking part in my research study. The affiliated professional associations comprised of members who represent a wide range of clinical backgrounds and areas of practice and provided a means of ensuring that every effort was made to gather a representative sample of HSCP clinicians across various HSCP disciplines to take part in my research study.

11.7. Directions for Future Research

Future research may consider exploring clients' experiences and understanding of *valent encounters*. Can clients too experience *valent encounters*? And if so, how does it come about in the context of clinical practice? I suggest that further research related to clients' experiences of *valent encounters* can provide constructive and valuable insights into the meaning and significance of such encounters to help expand and enrich current understanding and knowledge related to *valent encounters*.

Another area for future research may include exploring the context in which *valent encounters* tend to be created and facilitated in practice. The findings of my research suggest that *valent encounters* tend to arise inherently within clinical practice. Therefore, future research may wish to explore whether there are certain features that promote *valent encounters*? What may be some factors that may prevent *valent encounters* from occurring? Future research regarding the context of *valent*

encounters may provide further insight and understanding into the current construct of *valent encounters*. I propose that the future research regarding the contextual factors related to *valent encounters* could be undertaken using IPA methodical approach, as per my research study, or perhaps, future research may wish to employ other research approaches. For example, Grounded Theory (Glaser & Strauss, 1967/2006) may identify underlying processes to develop theoretical frameworks related to the construct of *valent encounters*.

Furthermore, future research may also wish to encompass the use of multi-disciplinary focus groups in which one participant from each of the specific professions partake in focus group discussions. In light of methodological considerations as outlined in Chapter 4, I did not conduct multi-disciplinary focus group interviews. However, future research may provide valuable insight that may help to enlighten and illuminate the findings of my research study. Similarly, future studies may also wish to consider conducting research using different HSCP, as my work related specifically to five HSCP. If a future researcher wished to increase the sample size of the study, I would recommend consulting the academic literature relating to both traditional IPA design and multiple perspective IPA design to ensure the theoretical foundations and practical applications of IPA design are recognised and retained in future research.

11.8. Summary of Chapter

This chapter has outlined some of the potential implications of my research study. This chapter has also outlined some recommendations for clinical practice as well as future research. The limitations of my study were also discussed. It is hoped that the findings of my study may provide practical and pragmatic recommendations to benefit clients, prospective clinicians, and the quality and sustainability of healthcare provision into the future.

11.9. Conclusion

In summary, my research has identified the construct of *valent encounters* within HSCP practice. It is suggested that clinicians attribute a valent quality to particular client/clinician interactions, as conceptualised in *valent encounters*, and that is described via three discrete GETs as identified in my research study. Firstly, the construct of *valent encounters* recognises the active presence and contribution of both client and clinician in the co-creation of these encounters. Secondly, the construct of *valent encounters* foregrounds clinicians' experiences with the client. Finally, the construct of *valent encounters* considers clinicians' responses to particular client/clinician interactions that in turn considers the ways in which the therapeutic, personal, and future beings of clinicians are being continually impacted and shaped. The construct of *valent encounters* is further described in terms of its nature and scope within my research study.

My research study employed the use of multiple perspective interpretative phenomenological research design to explore HSCP clinicians' understandings and experiences of client/clinician interactions. IPA afforded me the opportunity to access, understand and engage with the reflections of the clinician in the context of their significant lived experiences of client/clinician interactions. From a methodological standpoint, my research study has extended the body of literature related to the use of multiple perspective design in IPA research design. My research has also extended the body of literature related to the use of focus group interviews to inform a multiple perspective design approach to IPA research.

To the best of my knowledge, the construct of *valent encounters* has not been explored within the HSCP literature to date. In summary, I suggested that *valent encounters* can be nestled within existing concepts and theories as related to both HSCP literature and psychotherapy literature. Additionally, I propose that the construct of *valent encounters* both complements and adds to existing theoretical

constructs in the HSCP and psychotherapy literature base. Furthermore, I considered some potential implications of my research for clinical practice to include recognising and embracing *valent encounters* and all its potential in clinical practice. The recognition of the construct of *valent encounters* may help to promote compassion satisfaction and help to prevent and mitigate the effects of compassion fatigue amongst HSCP clinicians. Some recommendations related to recognising *valent encounters* include (i) promoting the role of purposeful reflection in clinical practice related to *valent encounters* (ii) increased emphasis on *valent encounters* in clinical supervision practice. Additionally, I provided a sample reflection model that may provide a practical means of supporting the recognition of *valent encounters* in reflective and clinical supervision practice.

The second implication of my study related to promotion of preventative education and training in undergraduate HSCP students. I suggest that preventative education and training related to promoting awareness and recognition of *valent encounters* can encourage a culture of compassion satisfaction and help to prevent and mitigate the effects of compassion fatigue in the context of undergraduate HSCP clinical practice placements. I provided a sample student pre-clinical reflection model provided a sample reflection model that may provide a practical means of supporting the recognition of *valent encounters* in HSCP undergraduate curricula and clinical practice placements.

The third implication of my study related to the acknowledgement of the central role of the client in healthcare practice. Ultimately, the evolving and central role of the client in healthcare is a positive precedent, however, to the best of my knowledge, it seems that, at present, policies and documents are placing much responsibility on the clinician to ensure that the above policies are implemented. Therefore, I recommend that there be an acknowledgement of direct client involvement in such policy development to ensure staff well-being is prioritised.

Moreover, I propose a collective approach to workplace policies and development between staff and service providers to ensure that there is joint and broader responsibility for the implementation of policy development into the future.

Regarding the limitations of the research, the findings of my study may not be representative of all HSCP but rather relate to the specific social and therapeutic domains of HSCP to include occupational therapy, physiotherapy, play therapy, social work and speech and language therapy. Additionally, information relating to participants' years of clinical experience and participants' place of work were not systematically collected as part of the recruitment/data collection process. Such information may have provided further context as it relates to the findings of this research study.

Meanwhile, future directions of research may include exploring clients' experiences and understanding of *valent encounters* as well as exploring the context in which *valent encounters* tend to be created and facilitated in clinical practice. Furthermore, future research may also wish to encompass the use of multi-professional focus groups in which one participant from each of the specific professions partake in focus group discussions. Such research may provide valuable insights to enlighten and illuminate the findings of this research study.

11.10. Summary Reflection

As I near the end of this chapter, and the end of the writing process, I cannot help but think back to my undergraduate self who wondered and wished to further understand the reflections and insights of clinicians when describing memorable clients. I knew that the powerful and poignant stories of clinicians needed to be told. I also knew there was a collective story to be told. I just never knew if I would be able to tell that collective story, or indeed do it justice.

Fast forward some years later, and I am here summarising my thoughts of the process on these pages. In some ways, my research journey could be described and

captured via some of the various themes as described in this research. From the outset, I understood that I would need to be persistent yet patient with the research process, particularly given the abstract nature of the topic. There were some days when I wondered if I were overcomplicating a simple topic. Whilst at other times, I wondered if I was simplifying a complex topic. My contradicting thoughts throughout the process perhaps summarises and encapsulates the nuanced nature of clinical encounters with clients – maybe in some ways one can make it as simple or as complicated as one wishes it to be.

I hope this research has highlighted the power and potential of *valent encounters* within HSCP practice and perhaps has provided further insight into the nature and impact of these encounters that can permeate everyday clinical practice. I also hope that this research has provided a considered perspective on the client/clinician interaction – one that is considerate of both clients and clinicians.

Finally, what I have realised is that techniques and theories may change, yet what will always remain at the heart of all healthcare practice – and as simple or as complex as it can be – is the wonderous interplay of client and clinician working together.

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Appendices

Appendix A: Research Ethics Committee Full Approval Letter

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

Application	Academic Year 2020/21
Applicant Code	HT47
Applicant/Supervisor Name	Niamh Reynolds / Dr Irene P Walsh
Title of Research	Considering the patient/client as 'influencer': How does reflection upon experiences of the patient/client inform the construction of professional identity in health and social care professions?
Date of this letter	09/06/2021

Dear Niamh,

Your amended submission (dated 28/05/2021) for ethical approval for the research project above was considered by the Research Ethics Committee, School of Linguistic, Speech and Communication Sciences, Trinity College Dublin and has been approved in full.

Please note:
(i) On completion of research projects, applicants should complete the *End of Project Report Form* (which can be found at: https://www.tcd.ie/slscs/research/ethics/) and submit one electronic copy (to slscs@tcd.ie)
(ii) The REC requests, in particular, that you attend to your commitments regarding the storage and destruction of data arising from this research, in keeping with REC policy and General Data Protection Regulation (GDPR) guidelines.

We wish you every luck with your research.

Best wishes,

Ciarán Kenny

Dr Ciarán Kenny
Chair, Research Ethics Committee
School of Linguistic, Speech and Communication Sciences

Scoil na nEolaíochtaí Teangeolaíochta,
Urlabhra agus Cumarsáide,
Coláiste na Tríonóide,
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TRINITY COLLEGE DUBLIN
SCHOOL OF LINGUISTIC, SPEECH AND COMMUNICATION SCIENCES

Participant Information Leaflet

Discipline specific & Multidiscipline focus groups

The client/patient as 'influencer' in healthcare professional identity.

Principal Investigator(s) and Co-Investigator(s)	**Principle Researcher:** Niamh Reynolds, Speech & Language Therapist, B.Sc in Clinical Speech & Language Studies. Email: reynoln2@tcd.ie) **Principle Supervisor:** Dr. Irene P. Walsh, Director of Research, Associate Professor, Department of Clinical Speech and Language Studies, School of Linguistic, Speech & Communication Sciences, 7-9 South Leinster Street, Trinity College Dublin, Ireland. Email: ipwlash@tcd.ie **Co-supervisor**: Dr. Caroline Jagoe, Assistant Professor, Clinical Speech & Language Studies, School of Linguistic, Speech & Communication Sciences, 7-9 South Leinster Street Trinity College, Dublin, Ireland. Email: cjaogoe@tcd.ie
Study Organiser/ Funder	This research study is being funded through the privileges of Scholarship (2017) in Trinity College, Dublin.
Data Controllers	**Trinity College Dublin (for research data)**
Data Protection Officer	**Data Protection Officer** **Secretary's Office** **Trinity College Dublin** **Dublin 2**

You are being invited to take part in a research study that is being done by Niamh Reynolds at the School of Linguistic, Speech & Communication Sciences, Trinity College Dublin.

Before you decide whether or not you wish to take part, please read this information sheet carefully. You should understand the risks and benefits of taking part in this study so that you can make a decision that is right for you. You may wish to discuss it with others. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

This leaflet has five main parts:

- Part 1 – Information about the Study
- Part 2 – Information on how your data will be used and stored
- Part 3 – Information about Costs, Funding and Approval
- Part 4 – Future Research
- Part 5 – Further Information

What will happen to me if I decide to take part? What will I need to do?

If you agree to participate, you will be invited to attend two focus-group interviews with the researcher and other participants. These groups will be held through online platforms (e.g Microsoft Teams) in accordance with COVID19 guidelines.

- During the first focus group interview, you will be placed in a discipline specific focus group consisting of approximately 5- 8 people (i.e. a focus group consisting of physiotherapists etc). This will last approximately 1 hour.

- The second focus–group discussion, you will be placed in a multidisciplinary focus group of 5-8 people (i.e a focus group consisting of occupational therapists *and* physiotherapists etc) to further discussion and insights of professional identity with specific focus on the influence of the client. This will last approximately 1 hour.

In total, this research study will involve two hours of focus group discussion over the course of two different days. The first of these interviews is scheduled for **21st October 2021 via an online platform for ISCP members** (please contact Niamh Reynolds by October 14th should you wish to take part- reynoln2@tcd.ie)

Are there any benefits to taking part in this research?

Taking part in this study may have the following benefits for you and the wider healthcare system:

Individual:

- In the world health care, it can be difficult to find take the time to reflect upon, acknowledge and yield the factors and influences have shaped you to become the professional you are today. This study aims to encourage clinicians to take the time to understand and reflect on your own professional identity and how it has been shaped.

- The nature of this project will allow you the opportunity to hear and understand colleagues' experiences of the development of their professional identity- both in your discipline specific profession and in other professions.

Wider healthcare system:

- You have the opportunity to contribute, inform and provide insight and understanding around professional identity and reflective practice in the health care system. Your insights and reflections may help to support other health care workers and add new accounts to the Irish literature base regarding professional identity and reflective practice in the Irish health care system.

Are there any risks to me or others if I take part? What will happen if something goes wrong?

The reflective nature of the project may give rise to memories of your time in clinic, some positive and perhaps some negative that have influenced and rendered your outlook and perspectives as health care professionals. These memories may give rise to feelings of discomfort, stress and/or anxiety for you. The researcher will provide samples of the type of questions that will be asked during the focus group discussion to reduce any discomfort you may potentially experience. All questions provided will be general and from this, the participant will be invited to be as specific/vague as they feel comfortable. All answers provided will be acknowledged and accepted without judgement on the researcher's behalf. A list of possible support networks will be provided to you should you require any further psychological /emotional support following focus group discussions.

The risk to participants of a breach of confidentiality is considered very low. Great care will be taken to ensure the confidentiality of all data.

Will I be told the results of any assessments performed as part of this study that relate to me?

No, however, the researcher will give you a written copy of the focus group discussion and you will have the opportunity to ask the researcher to delete/remove/destroy any wording/information that you may believe identifies you.

Part 2 - Data Protection

How will my data be used?

Data from this research project may be published in future in scientific/medical/linguistic/educational journals. You will not be able to be identified in any reports or publications unless you have given your explicit consent for this. The original audio/video recordings and other stored data will only be available only to the researcher and researcher supervisors.

Pseudonymised copies of the data may be available to postgraduate, professors and researchers in national and international institutions engaged in similar research purposes. Portions of the recording may be played in linguistics classes or during conference presentations, or written transcriptions used teaching purposes or for linguistic analysis. If you agree to your data being used in future research, or in teaching your consent form will be held until the data is no longer in use.

What information about me (personal data) will be used as part of this study?
Will my medical records be accessed?

Limited personal data is required to be collected as part of this research study. Your name, email address, occupation and number of years working as a heath care professional is the only personal data that will be required from you. This data is necessary to ensure accurate collection and transcription of the focus group discussions. Each participant will be allocated a code number to protect their identities. This number can then be used in all subsequent stored data records. Only the researcher and supervisor will have access to the key which links code numbers to individual identities. Any records that identify participants (e.g. coding key) will be retained only for as long as may be needed for cross-reference during the study. Your medical records will not be accessed as part of this research study.

Who will have access my personal data? What will happen to my personal data?

- All the personal data that we collect about you during the research study will be kept strictly confidential and will only be accessible to members of the research team- the researcher and researcher supervisors. Your personal data will be stored in the Department of Clinical Speech and Language Studies, Trinity College, Dublin. Personal data will only be disclosed to the above-named individuals in the early stages of coding/collating personal data to a code number.

- If you agree to us sharing the information you provide with other researchers (e.g. by making it available in a data archive) then your personal details will not be included unless you explicitly request this. This may include national and international research institutions for the purposes of research exploring the role of professional identity in health care professions.

- Data that can identify you will be kept for a minimum of seven years from the date of completion from the date of completion of the researcher's degree and publication of the research. Anonymised data will be held for a minimum of five years. This includes recordings and transcriptions. After this time period, your personal data will be destroyed by the research supervisor, Dr. Irene. P. Walsh.

- Pseudonymised copies of the data may be available to postgraduate, professors and researchers in national and international institutions engaged in similar research purposes. Portions of the recording may be played in linguistics classes or during conference presentations, or written transcriptions used teaching purposes or for linguistic analysis. If you agree to your data being used in future research, or in teaching your consent form will be held until the data is no longer in use. If you do not consent to your personal information being used for possible future research.

Will my personal data be kept confidential? How will my data be kept safe?

Your privacy is important to us. We take many steps to make sure that we protect your confidentiality and keep your data safe. Here are some examples of how we do this:

- Any information or data which is collected during this research study which identifies you will be treated confidentially. All audio-recording/video-recording data will be stored on an encrypted external hard drive and password protected laptop/computer in the Trinity College Dublin computer network. The data will then be deleted from audio/video recording devices. The data will then be anonymised so as to hide your identity. This will be done by allocating a pseudonym to all participants.
- All original files will be transferred to an encrypted hard drive that will be stored in a locked press at the research supervisor's office and in an encrypted file in a folder on the research supervisor's computer on the Trinity College, Dublin network. Pseudonymous data will be stored on the researchers password protected computer . Only the researcher and supervisor will have access to the key which links code numbers to individual identities.
- Following this, the researcher will give you a written copy of the focus group discussion and you will have the opportunity to ask the researcher to delete/remove/destroy any wording/information which you may feel identifies you.
- Paper copies of any forms (e.g consent form with your written signature) will be kept securely in the Department of Clinical Speech and Language Studies, Trinity College, Dublin.
- All individual researchers involved in this project have been trained in data protection law and are bound by professional code to maintain confidentiality.
- Personal data, including the transfer of this personal information about you outside of the EU, will be protected in accordance with the General Data Protection Regulation.

Part 4 - Future Research

Due to the nature of this research it is very likely that other researchers may find the data collected to be useful in answering future research questions about how reflections upon experiences of the patient/client inform the construction of professional identity in health care professions. We will ask for your explicit consent for your data to be used in this way. You do not have to agree to have your data available for future research. Future research will only take place if it has research ethics approval.

Part 5 - Future Information

Who should I contact to participate or for more information?

If you wish to participate/have any questions please contact:

Niamh Reynolds. Email: reynoln2@tcd.ie by 14th October 2021.

Who should I contact if I wish to make a complaint?

Data Protection Officer, Trinity College Dublin: Data Protection Officer, Secretary's Office, Trinity College Dublin, Dublin 2, Ireland. Email: dataprotection@tcd.ie Website: www.tcd.ie/privacy
Under GDPR, if you are not satisfied with how your data is being processed, you have the right to lodge a complaint with the Office of the Data Protection Commission, 21 Fitzwilliam Square South, Dublin 2, Ireland. Website: www.dataprotection.ie

Will I be contacted again?

If you would like to take part in this study, we will contact you with the details regarding the focus-group discussion. Please email Niamh Reynolds by October 14th 2021 should you wish to take part.

Please note that focus groups will be conducted through online platforms in line with prevailing COVID19 guidelines. In this case, an online consent form will be sent to you email address for you to provide consent. Other that the arrangements for this study as described above, we will only contact you if you if you agree to be contacted again regarding future research participation.

Appendix C: Summary of Participant Information Leaflet

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

Summary of Research Project

What is this study about?
This study aims to explore the various factors and influences that have contributed to the development of a health and social care clinician's professional identity, with a specific focus on the influence of the patient/client on that identity. The reflective nature of the project may give rise to memories of your time in clinic, that have influenced and rendered your outlook and perspectives as health and social care professionals. Moreover, findings from this study may be used to help inform person-centred care and reflective practice of clinicians in the healthcare system.

Why have I been invited to take part?
You have been invited to take part because you work as a qualified clinician (speech and language therapist, occupational therapist, radiation therapist, physiotherapist, play therapist, psychologist, social worker or dentist) in the healthcare system. We are keen to understand your insights, perspectives and reflections about if, and how, your encounters with clients/patients have influenced your professional identity. We aim to have between 40-80 people participate in this study. Inclusion criteria includes clinicians with 3+ years working in a primary care, community, disability or hospital setting.

What will participating in this study involve?
You will be invited to attend two focus-group interviews with the researcher and other participants. These groups will be held through online platforms (e.g Microsoft Teams) in accordance with COVID19 guidelines.

- During the first focus group interview, you will be placed in a discipline specific focus group consisting of approximately 5- 8 people (i.e. a focus group consisting of physiotherapists). This will last approximately 1 hour.

- The second focus–group discussion, you will be placed in a multidisciplinary focus group of 5-8 people (i.e a focus group consisting of occupational therapists *and* physiotherapists etc) to further discussion and insights of professional identity with specific focus on the influence of the client. This will last approximately 1 hour.

In total, this research study will involve two hours of focus group discussion over the course of two different days. The first of these interviews is scheduled for **21st October 2021 via an online platform for ISCP members** (please contact Niamh Reynolds by October 14th should you wish to take part- reynoln2@tcd.ie)

Who is conducting this project?
This project is being conducted by Niamh Reynolds, Ph.D candidate in Trinity College, Dublin. This project is being supervised by Dr. Irene P. Walsh, Associate Professor in Speech & Language Pathology, Department of Clinical Speech and Language Studies, Trinity College, Dublin. Ethics approval for this study has been approved by the School of Linguistic, Speech and Communication Sciences, Trinity College, Dublin.

Where can I find more information/who can I contact regarding this project?
Further details regarding data protection, funding, approval, and future research and information of this study can be found below. Please contact Niamh Reynolds (email: reynoln2@tcd.ie) with any questions or if you wish to participate in this study.

Niamh Reynolds: Ph.D candidate, Department of Clinical Speech & Language Studies, TCD.
Contact: reynoln2@tcd.ie

CONSENT FORM- DISCIPLINE SPECIFIC FOCUS GROUPS

TRINITY COLLEGE DUBLIN: SCHOOL OF LINGUISTIC, SPEECH AND COMMUNICATION SCIENCES

Considering the client/patient as 'influencer': How does reflection upon experiences of the patient/client inform the construction of professional identity in health care professions.

Overview:
There are 3 sections in this form. Each section has a statement and asks you to initial if you agree. The end of this form is for the researcher to complete.
Please initial the box if you agree with the statement. Please feel free to ask any questions if there is something that you do not understand.

Section 1 ...

Data Processing

Please answer yes or no to the following questions:

1. NAME *

Enter your answer

2. I confirm I have read and understood the Information Leaflet for the above study. The information has been fully explained to me and I have been able to ask questions, all of which have been answered to my satisfaction. *

Enter your answer

3. I understand that this study is entirely voluntary, and if I decide that I do not want to take part, I can stop taking part in this study at any time without giving a reason. I understand that deciding not to take part will not affect my current or inclusion in future research projects. *

Enter your answer

4. I understand that all information will be kept private and confidential and that my name will not be disclosed. *

Enter your answer

5. I understand that I will not be paid for taking part in this study. *

Enter your answer

6. I agree to take part in this research study having been fully informed of the risks, benefits and alternatives which are set out in full in the information leaflet which I have been provided with. *

Enter your answer

7. I agree to being contacted by researchers by email as part of this research study. *

Enter your answer

8. I confirm I have read and understood the Information Leaflet for the above study. The information has been fully explained to me and I have been able to ask questions, all of which have been answered to my satisfaction. *

Enter your answer

9. I understand that this study is entirely voluntary, and if I decide that I do not want to take part, I can stop taking part in this study at any time without giving a reason. I understand that deciding not to take part will not affect my current or inclusion in future research projects. *

Enter your answer

10. I understand that all information will be kept private and confidential and that my name will not be disclosed. *

Enter your answer

11. I understand that I will not be paid for taking part in this study. *

Enter your answer

12. I agree to take part in this research study having been fully informed of the risks, benefits and alternatives which are set out in full in the information leaflet which I have been provided with. *

Enter your answer

13. I agree to being contacted by researchers by email as part of this research study. *

Enter your answer

14. I agree to allow personal information about me to be shared with third parties including; national and international hospitals, and academic research institutions for the purpose of research exploring the role of professional identity in health care professions research, as described in the information leaflet *

Enter your answer

15. I understand that personal information about me, including the transfer of this personal information about me outside of the EU, will be protected in accordance with the General Data Protection Regulation. *

Enter your answer

16. I understand that there are no direct benefits to me from participating in this study. *

Enter your answer

17. I understand that I can stop taking part in this study at any time without giving a reason and this will not affect my future ability to partake in research. *

Enter your answer

Section 2

Future Use of Information:

Please select one or more options as you see fit:

18. Question *

- [ ] OPTION 1: I give permission for my personal information to be stored for possible future research related to the current study exploring professional identity in health care professions only if consent is obtained from me at the time of the future research and the research is approved by a Research Ethics Committee.
- [ ] OPTION 2: I give permission for my personal information to be stored for possible future research related to the current study exploring professional identity in health care professions without further consent being required but only if the research is approved by a Research Ethics Committee.
- [ ] OPTION 3: I agree that future research projects into exploring professional identity in health care professionals may be carried out by researchers working for commercial companies.
- [ ] OPTION 4: I understand I will not be paid for any future use of my personal information.

Appendix E: Sample Transcript of Focus Group Interview
(other transcript copies available upon request)

Line No.		Transcription
1.	F	Thanks so much to everyone for being here today, I really appreciate it. As I say, this is a reflective space where there are no right or no wrong answers so please just chat away and I'll be here to guide discussion with some probes from time to time. So, maybe to get started with what is the best piece of advice you have received or would give as a social worker?
2.	SW1	Being told that someone's life will not fall apart if you're not there==
3.	F	==sorry [SW1] that was me (.) you were just saying that things might fall apart when you're not there==
4.	SW1	==yeah just that things will not fall apart when you're not there and then you stay in the office until about 8 or 9 o' clock at night, and then you're burning out really easily so I think if you stick to boundaries from the very start , from the very start of your career, it will guide you through the rest of it==
5.	F	==brilliant, so as you say keeping that boundary is so so important for that balance==
6.	SW1	==I wish someone told me that at the start of my career!==
7.	F	==[laughter] living and learning! Thanks for that [SW1]==
8.	SW2	==yeah I'd echo that,[F]. My very first team leader told me, well, I have two pieces of advice. My very first team leader told me when I was trying to get a piece of work done while she was leaving to go home and she said to me "[SW2], if you're chasing that feeling of having everything done, forget it"==

9.	G	== yeah [group in agreement]==
10.	SW2	== and that always stuck with me because the work to be done will never ever fit within the amount of hours you're asked to work or contracted to work. And aside from that, the BEST piece of advice I ever got was by my subsequent team leader in child protection and she said "[SW2], don't forget these are peoples' lives, these are these peoples' lives" so em (.) there was kind of a few pieces of information contained in that or I took a few pieces of information from that. One is that you, it is important not to be relating to the people you are working with as problems or as people who have problems that need to be solved and you're the person who's going to solve them. If you're relating to them like that, there's already, there's already a distance going up between you and them. And the other was that, if they're in crisis doesn't mean you're in crisis. These are CHRONIC issues. In child protection, long term child protection, there tends to be issues, going to be issues going on for years, the family has particular ways of coping. Sometimes they look from the outside as if they're in crisis and about to fall apart, but maybe this is the 12th time, the 20th time, the 25th time, the 50th time that everything has been at this point and em (.) they've pulled through, and they've pulled through without you. So the most useful piece of advice you can tell people in that situation is to be not reactive, not get dragged in, understanding it from a position from outside the family because that's the most useful thing to actually ground them==
11.	F	==brilliant [SW2], thanks so much for that, and for sharing those principles and reminders. Thanks for that==
12.	SW3	==I think the best piece of advice, I think there's two things that stuck with me as advice I suppose I'm not qualified as long as some people so it's not that long ago that I was given the advice, but that your interests in college don't have be the interests in your career. I would have been someone that was hyper-focused, thought I was going to work in child protection for a long time and I lasted one year. I had people to say "that's okay". And then I got really good advice from my first team leader ever, just like, how did she phrase it, "you can't help someone who doesn't want help"– that's always stuck with me. And she also said you know that most people just want somebody to listen to them, but I think these little snippets of information have stuck with me for some reason==
13.	F	==thanks [SW3] as you say it can be the simple things that stick with you and to have those reminders, thanks so much for that==

14.	SW4	==I think that in relation to me, probably one of the best pieces of advice I would have got, obviously finding em (.) your boundaries within child protection, so it would have been about keeping really good friendship groups within your profession that it's really important to have your breaks ,and to link in with people and get your feedback and kind of get your informal supervision that way. And she would have been, I can't even remember what she said, but it would have been very much it's always a worry for a social worker when they just sit at their desk all day at lunch and they're not linking in with other colleagues. It would have been driven home about that, yeah keep that going==
15.	F	==brilliant [SW4] as you say keep that support around you as well which is great. I don't know if anyone has other piece of advice, don't be worrying at all because I was also going to ask what's the best piece of advice you would give as a social worker? Would it be quite similar to what you've said before?
16.	SW5	Well just as everyone was talking I was like "that's a great one, that's a great one" and I kind of remembered experiencing them as I went, you know the power of taking a break with your colleagues even if you're kind of snowed under or if you feel like you have 101 other things to be doing, but that informal supervision piece is SO beneficial and so important to do. I remember just in terms of advice that was given to me, was my first practice tutor in [X]. She was a real advocator for self-care and noticing in yourself maybe when you're feeling overrun or overwhelmed and being able to clear a day and to prioritise doing certain tasks to help yourself in the long run because if we keep saying yes and keep adding to our burden and not really making time for ourselves to catch-up or to address what's kind of leaning into our anxieties or feeling overwhelmed in work, then it's going to continue and then we're in a constant state of chaos so really just honing into what's on our mind or what's putting us under the most pressure. And then outside of work, yeah, being boundaried around time because you're never going to tick that 'to-do list' at the end of the day – everything is not going to be able to get done so being able to call it a day and not do crazy hours and then minding ourselves outside of work because, yeah, I mean if we don't we burnout etc etc without, if we don't have the proper balance in terms of being active, connecting with others, time for family, using our annual leave etc etc so em (.) that was something I thought I might add there [F], [laughter]==
17.	F	==brilliant, thanks a mil [SW5], that sustainability as such to keep going. So, another question that might go back to the beginning of peoples' careers was if there was any activity or behaviour that you did that made you think "oh I'm a social worker now". So for some people it might be getting their first diary or a home visit, and there doesn't have to be, only of something stands out for anyone==

18.	SW3	==yeah being handed 16 case files in my first week in [X]=-
19.	G	==[laughter]==
20.	SW3	==with HUGE gaps, years, years of gaps==
21.	F	==aww wow==
22.	SW3	==that did it for me==
23.	F	==and having to figure out where to go from there==
24.	SW3	==yeah or oh like these are ACTUAL files, with ACTUAL people's lives. Some of the files were actually nearly as old as me, like you know, going back and just trying to muddle through them and then another file and another file. It just made it real so quickly, you know, em (.) , yeah, I'll never forget that first week, it was TERRIFYING==
25.	F	== it can be those moments that stick with you and being like "here we go, I'm out in the big bad world now"- there's so much to take in. Thanks so much for that==
26.	SW5	==I think for me it was when I was in [X], I fell into the definition of what a social worker was at the beginning, or what I thought, you know, I guess more limited (.) I think I was like social work- "real social work is [X]" [laughter], you know. And I think [xxx], I was doing home visits and I was working in a deprived area and I really felt like I was interested in it, I saw the potential in it. Again, massive files, tonnes of social workers' names that were previous to mine and I felt like (.) I just felt a real sense of (.) that even that awkward moment of getting to know a new family and introducing, you're that seventh/eighth social worker being introduced to the family that have had so many people dipping in and out of their lives. It's kind of an uncomfortable moment with the one family I'm thinking of eh (.) of, you know, being new, keen, green behind the ears and then they're just like "okay who's this next person that's joining us" and the I come in and sit in their sitting room and meet with us. And it was a real, yeah, flash complex or stuff like that, places I hadn't been before but have seen or driven past but for me that was like "wow, I'm working as a social worker now"==

27.	SW2	==the first (.) I'm trying to think [F], so I joined [X] on the, what they used to call the 'waiting list' team, so they were (it wouldn't be considered a waiting list in any other organisation but [X]!) but em (.) they were low end cases and they didn't have an allocated worker, and they were likely not going to receive an allocated worker because all the allocated workers were tied up with the more risky cases, so em (.) so in the beginning that I wasn't doing the same work as the rest of my colleagues around me because the rest of my colleagues were like going into court, you know they were at case conference after case conference. So I was a bit like, felt like I was in a bit of a 'no mans' land' there while I was working on it. As I was there, the longer I spent there, the more confident I became. And there was a time where I went to a house and a child was coming into care on a voluntary arrangement but she was living with her granny and the granny had guardianship and the granny just wanted her out of the house and I can remember going up to the child's bedroom with my colleague to talk to her because she wouldn't come out of the bedroom and granny was like "today she's leaving" and the child didn't want to leave. The child was so bright. She was 15, she was really, really intelligent and em (.) she put all these questions to us that really tested why this needed to happen or this was the likely outcome and she (.) I don't want to speak ill of my colleague who I was there, I WON'T , but he was kind of knocked for six by some of the questions. He didn't really have clear answers, and I felt that I was able to answer those questions clearly and I felt like "ok I've arrived', I understand what I'm doing" but that was a year into it==
28.	F	==brilliant [SW2] thanks for that. [SW6], I think you've just joined us there, welcome, thanks a mil. I'm just throwing a few questions out there from time to time so feel free to jump in at any stage. I think there might be a bit of reverb there if maybe people could just put themselves on mute but easily could be me so I'll put myself on mute as well! So yeah guys, I suppose if anyone could think of a client or clients who have had a profound impact on you. So maybe thinking of what ways they've influenced you, did they encourage you, inspire you, surprise you, challenge you?==
29.	SW4	==[xxx]==
30.	SW5	==[xxx]==
31.	SW4	==sorry [SW5], I'm talking!==
32.	G	==[laughter]==

33.	SW4	==one of mine that would have had the biggest impact on me would have been quite a positive case em (.) with a baby. I was very lucky to came into it kinda on the other side of it but it was a domestic violence case and the parent was separated, but it was just really hearing how resilient this mother was, and these kids (.) and they are the most resilient people I've ever met in my life. And I do think they've had the biggest impact on me because I remember just being IN AWE of this woman, just really, even now there's just so much risk with her, but she just continued to do SO MANY good things for her children. That was definitely one that had a HUGE impact on my life==
34.	F	==thanks for that [SW4], there can be some qualities of clients that can stick with you, that resilience piece to keep persevering, thanks for that==
35.	SW5	==when I think of different clients, and I'm sure there's some that (.) I think I remember the clients that challenged me the most in terms of my role in working with them or feeling like do I need to change tact or do I need to do something a little bit different here. And two in particular come to mind in my role in [X], but a different team to this one. And one was a girl who was just really difficult to engage with, to (.) to (.) to (.) understand her perspective. She'd turn up every single week to her appointments on time. And there was so much going on for her that she really struggled to be able to communicate. And for me, I had to change my style of working and there's something about her that em (.) endear- a QUALITY in me that wanted to mother her because I really wanted to get to the core of what it was and support her in every way I could. And I'm not too sure what it was about her, whether it was her (.) what it was about her that brought that out in me but (.) as time went on, and I guess we made great progress, and it was a very rewarding case to work on em (.). Lots of things came up in that in terms of cultural background, growing up in Ireland in a Muslim family, trying to challenge that, trying to repress certain things to please her father, having no mother at the time, her mother lived in another country – what that was like. And we took an approach of doing this through art rather than through talk therapy. And it was (.) I found (.) I used to go into these sessions ANXIOUS and eh (.) trying to do my very best and feeling obliged to (.) not obliged but a DESIRE to do my very best. And some sessions went fantastic and other sessions were more difficult than others but when I think (.) I often wonder where she's at now and things have gone for her or what her journey through therapy was because when I left that team there was LOTS more to cover and it was a difficult case to leave as well. So yeah, I guess, she's the person that stands out for me in my mind==
36.	F	==thanks for that [SW5]==

37.	SW3	==I had a case in the emergency department here in [X] last year. And I think she was definitely the person that inspired me the most like throughout my time here. She wasn't a young woman but she was escaping a domestic violence situation and I don't think I (.) caused this to happen. I think she presented to the department because she was suddenly ready just to make it all happen but I think like (.) just (.) she like had a profound impact on me to like further my training like in that area to like recognise the signs and everything and bringing her through the court process and just needing someone who could just tell you like a 40 year history but was just like ready to make like a MASSIVE change in their lives. So like she always comes to mind as like the most inspirational client –that and a few teenage runaways I had in [X] I'll probably never forget, that said they were also my favourites [xxx]. I think that one lady in the emergency department and just REALLY made me think "okay [SW3] you don't have the skills to like (.) see the signs of this so like you really need to take this and run with it like" and I did so like just like ALLOWING people to influence you and shape your practice and that need for continuous development like you know, like throughout your career so like, yeah, she shaped me a lot in that area==
38.	F	==thanks a mil [SW3] that's brilliant to hear==
39.	SW1	==when I was in [X], there was a 14 (.)I worked with her when she was 14-16 and I remember when I was leaving [X] and I was actually really, really upset saying goodbye to her out of everyone but em (.) she had just had such a traumatic childhood from when she was three and she'd gone from foster care home to foster care home, through different residentials and number of behavioural issues but she was still so resilient and she wanted to do well in school and wanted to go on to college and wanted the life that her mother never had the opportunity to give her or her older siblings had to give her. And it's just such determination in her for a 15 year old to be able to think like that, given the trauma. And I just admired her so much. There was no one stable in her life because social workers kept leaving her, foster carers kept asking her to leave, you know, and she still had such determination to do well in life. And now I'm sure she's in her 20's now and I'm like "I wonder did she go to college, I wonder does she have the job she wanted?" and she's just one (.) I'll never ever forget her"==
40.	F	==great, thanks for that [SW1]. I don't know if anyone had anything else that comes to mind, just off the top of their heads, don't worry if not==

41.	SW2	==well I've two and I won't make this long em (.) but one of them was a 16 year old boy that I brought into care em (.) about a year and a half ago. And I and [SW1] ended up fostering him so that was==
42.	SW1	==I knew you were going to end up talking about him==
43.	SW2	=[laughter]= It has affected our lives very profoundly em (.) and em (.) I won't speak about his situation in depth but he is an extraordinary person to have come through what he came through and to be so (.) be so eh (.) capable and able and thoughtful and it was one of those things. Actually I am talking about him a little now but it was one of those (.) one of those situations where all the professionals around him looked at his life history and were like "counselling, trauma, needs that therapeutic intervention, MUST have it" and em (.) that was something that when he came into care, that I had put to him, and I put it to him a few times and set it up for him and he was like "I don't need it" and em (.) I would go back and tell people "he doesn't want to access it" and they were like 'in time he will, he's not ready, in time'. And then (.) we ended up fostering him, living with him and there was none. And there was no need. And maybe there, maybe there is something you will benefit from talking down the line but in terms of like, the things we assess for in [X] in terms of impairment, in terms of distress, none of it is there. And that taught me a really important lesson about you can come through REALLY REALLY rough sustained periods of hardship and still be able to function so that's one thing. The other, I won't go on about this one but there was a mother I was working with at the very end of my time in [X]. The case was in court, and as part of the safety planning, as part of the reunification plan, I was doing these weekly meetings with her, trying to put in the safety for the children to go back home and she was CAPITAL C CHALLENGING. There was a lot going on for her, there was a lot going on for the situation, there was (.) like there could have been language issues, there could have been undiagnosed ASD, undiagnosed personality disorder, maybe it was diagnosed personality disorder, I can't remember, but anyway she was very, very difficult to make progress with em (.) but I can remember thinking at the very end of it I NEVER got sucked into the ups and downs of it, of the obstructiveness sometimes, the lack of containment all of that sort of stuff. I can remember being like, "I was able to deal with it without coming part of it and that", that was one of those moments, I actually felt like "oh my God I've arrived" that I can go in there, not be anxious about going in there, know that I'm not going to get sucked into it and be able to leave and put it behind me, and be like "okay, that meeting's over" ==

44.	F	==brilliant thanks for that again [SW2], about reflecting that balance and the different kinds of backgrounds and things that can stick with you, reflecting upon them and making changes for your practice as well. Brilliant guys, and something that might be linked to that – some people mentioned resilience, some people have mentioned determination as qualities that they've seen in clients they've just spoken about or maybe there were other ones, so if there were any specific qualities that a client had that influenced you and what was it about that client specifically==
45.	SW6	==I have a woman that I'm working with at the moment and they have a very challenging living situation. I work in a children's' disability service and the area I'm in would cover a direct provision centre, so she's residing in a direct provision centre and em (.) her husband died suddenly there last spring, around April/May time, and I've done a lot of work with her around bereavement and talking to her child around what's happened and that kind of thing and supporting her in supporting her child with the whole situation and I think just, just her strength, being able to hold it all together and just to be able to have REALLY difficult conversations with her child and acknowledge her own pain and grief and sit with (.) like it's been a bit of a journey for her to sit with that and allow those processes to happen and I think and being able to acknowledge how sad and upsetting [xxx] around that. Just that, just what she's been through, her strength and resilience. And I know resilience has come up again==
46.	F	==no problem==
47.	SW6	==and just that's what keeps coming up for me. Her strength of character, that despite all that's going on with her accommodation and her main application, and all these kind of things, but just, yeah just that strength that she has within her really is really remarkable for me because I don't know how I'd cope if I were in her shoes==
48.	F	==thanks for that [SW6]. I wonder if there are any other qualities that anyone's ever come across?
49.	SW5	==I guess I'm thinking here because I'm trying to think of others apart from (.) cause that sense of resilience can come across with the majority of the clients we work with but maybe determination there in terms of, you know, in a [X] service of parents regardless of what's going on for them or how difficult life is, or if they're single parents or whatever, there's a determination to access a service and prioritise their child and fight for what they know their child needs and deserves or just to understand just the kind of complications of the different services in which

		we work in. Like working in the area becomes so normal to us, but the different levels of acute services, public services, and the (.) I suppose (.) the (.) the (.) frustrations within that for parents, and their ability to just advocate for their child. I really RESPECT that and that (.) that (.) love and determination that they have despite, I guess, their knowledge and their insight into how maybe how some of their experiences of mental health or growing up, or the environment in which they're rearing their child may have impacted their child, they're able to see that and (.) and want better for their child regardless of the circumstances that they were brought up in or maybe or mistakes, or mistakes that parents perceive that they have made and trying to right some wrongs. So I really appreciate that vulnerability and admire what they show in sessions here in [X]and I think that's HUGE and can't be underestimated the vulnerability in opening up to a stranger about that==
50.	SW6	==I can definitely connect with what you're saying there around the advocacy piece. I suppose in our disability services, particularly at the moment where a lot of change is going on nationally, in terms of resources available and waiting lists for services and therapies and all that kind of thing. Like, the passion and the advocacy, the lengths that parents go to advocate for their children. And it can sometimes be challenging for practitioners and therapists and the service in general dealing with a lot of very upset and very angry parents taking off threats to go on Joe Duffy and all that kind of stuff, but like, em (.), you know, like that, the advocating and the lengths that they go to get what their children need are really challenging the norm and (.) and what's there, what's being provided and fighting so, so yeah, it's really admirable as well, so what [SW5] was saying there, it's about respect==
51.	SW3	==I think em (.) for my client that was escaping the domestic violence situation. I was just tryna think of her qualities. And I'd say, like (.) I think it was like her optimism, like, being in that situation for like 40 years, I guess, and still like just really optimistic about the future. I just like couldn't get over that em (.) you know, just the ability to like still be able to be optimistic about a future, beyond the situation. I think that like, I don't think like not everyone would be able to be that resilient in that situation. That's pretty amazing I think==
52.	F	==thanks for that [SW3]==
53.	SW2	==I think the quality that I saw across (.) my mind kind of goes to parents rather than to children when I'm asked that question em (.) but a quality that I see in parents both across [X] and [X], and it really does vary across the two services, in how clearly they articulate it, like really observable stuff but the LOVE that the parents have for their children. And in [X] and in [X] that's what you were banking on being able to try and reach to affect the change. When I'm doing sessions with the parents here, often, you know, social work gets involved when there are

		like behavioural difficulties or the anxiety is turning to aggression or you know, really emotionally dysregulated and em (.) you're doing work with the parents, you know , part of that is work around coregulation and validation and em (.) and strategies where ultimately you're trying to have them demonstrate their love for their children and em (.) get away from maybe em (.) less constructive ways of reacting to them when they're in those situations. I just work from the presumption that they love their children and they want things to be great for their children and, they'll move the earth for their children, it's like a skill deficit, or they haven't just sat with the implications of what shouting back actually will achieve or what that will mean. And em (.) I think if you work from that presumption, that's where you are most likely to get the actual change to happen and (.) so (.) even if the change is really, really minimal, banking on that is em (.) the best way forward. So you just see it there, I've never gone wrong banking on that so, I mightn't have seen the kind of change that I'd have liked to have seen, em (.) like children still came into care, but em (.) it was (.) it was (.) the best route and it was always there. [5]. Well you know what, I'm going to put one proviso, there were a couple of fathers where I would question, I would question whether there was love there but that's a proviso, mostly, vast majority of cases it was there==
54.	F	==great [SW2] thanks a mil for that. I think [SW4] is there, I think she just lost her internet but she'll be back to join us. I thinking we might keep going for another little while if that's okay with everyone? Some of these might sound repetitive but it's trying to come at it from different angles, but has a client ever taught you any specific lessons, and if so what were they?
55.	SW1	I worked in adoption for two years, which is kind of quite different from everything else we've been talking about em (.) and a lot of the mothers (.) I worked in reunification so with mothers who would have given up a child up for adoption in the 40' s and 50's in Ireland. And just the bravery they showed, coming forward all these years later where people may not have known they have a child and want to know how they're doing. And I suppose it taught me it's never too late to do something. You know, they could have been 15 when they had the child and now they're 70, and it's just to know that if you really want something go forward and try and do it. And em (.) I suppose the bravery you need to do that, that really showed me the strength, the strength, that some people can have and that, just, if you really want something don't let little things stop you or what people might, may judge you, don't let that stop you, just do it and who knows what can happen. And the bravery that that takes==
56.	F	==thanks [SW1]==

57.	SW5	==I think maybe working in this, working as a social worker gives you I suppose a view into people's LIVES and the REALITY and the DEPTH of what can really (.) the difficulties of peoples' lives and the challenges that they face daily. And I suppose it changed me. I'm trying to think if this is a lesson, I suppose it is in terms of to be grateful for em (.) to be grateful for the small things in life and to really hug my children tighter in the evenings and be grateful and present and not to sweat the small stuff because I guess I have a different view, and interact differently in the WORLD. To be honest, since my training as a social worker because and (.) and having met with and hearing such horrific and horrible and challenging things that people face, has made me just, I suppose interact differently with others in terms of how I treat them, or where I might view what might be behind certain things that people might do or say that before would have led to frustration or whatever. And then in terms of how I interact with my own family and my own children and my own husband and em (.) how I view my own challenges and difficulties in life so I guess, I don't know maybe that first kinda feels like the biggest lesson of all [laughter] when I say it like that, but I guess it's made me re-evaluate things and what's important in life and em (.) yeah really, and that yeah really when we talk about our clients' bravery and courage and determination and resilience that, you know, when we put our minds to things we can really achieve with the right support from certain people at certain times in our lives we can get where we want to be and come back and recover from different challenges or adversity or whatever that we experience (.) yeah and I guess overall to mind your mental health (.) aww I went on a ramble (.) thanks [F], I just opened up a pandora's box [laughter]==
58.	F	== you're so good to open up [SW5] and as you say sometimes it's only when you chat about them that you can think "that's affected me this way or that way" (.) so yeah thanks for that [SW5]. I don't know if anyone else has any specific lessons they feel they've learned from any of their clients or patients down the years==
59.	SW3	==the first one (.) the first teenager I took into care in [X], she really taught me not to make assumptions. And I think going into social work, especially going in to child protection, I didn't realise what a protected childhood I'd had. I thought I was kind of (.) of the world or something. Like I had worked in emergency hostels in the city centre, I, you know like, I had lived in [X] during college (no offence to anyone). And I thought like I just knew things, street smart, but like when I walked into her house, and it was a cement floor and there was very little furniture, I realised in these reports we write and things that can't assume anything, it kind of like made me double back a bit- like I can't assume the child is fed- I can't assume she's been fed today, I can't assume those clothes aren't her only clothes. And it REALLY like (.) just was a moment

		(.) like REALLY early in my career, I think like the third week or something, where I was like "OKAY like that's thought you a lesson, like, you now, absolutely everything you do, like, don't make assumptions about any client because everyone is coming from a COMPLETELY different place than where you came from" but I think if I didn't learn that lesson, I would've just assumed these simplistic things. And I always think of that cement floor and I don't know why [laughter]. I think it's just that I had never seen anything like that before, you know, NOT in Ireland, not in Dublin (.) if that makes sense?==
60.	F	== totally [SW3], what you see on paper doesn't always represent reality, thanks a mil for that==
61.	SW6	==I think for me, one thing that (.) I can't really pinpoint it but I think just over time, and particularly now that I'm in the disability sector, it's kinda hitting home a bit how vulnerable kids can be, and that sounds a little bit silly but just like when you, when there is a really small little baby em (.) you know coming home from hospital, or maybe with additional needs [xxx] just the extent of what's actually needed there in terms of day to day care, really practical things (.) and sometimes I think back to kids that I had maybe at home on safety plans or child protection plans [X] and it just makes me think "God what was I thinking there or what were we thinking there" in believing that the child's needs were going to be fully and appropriately met in the environment that they were in with the level of (.) you know, and I know there's this thing of "good enough" – what's "good enough" and that kind of thing, just when I'm now looking at REALLY FUNCTIONAL FAMILIES and a lot of families who are, you know, coping really well with the challenges that they're facing and the sense of support and what's involved in those children's' care and then just thinking how vulnerable those other children were and whether (.) whether, you know (.) there should have been more, you know, appropriate (.)I just (.)reflecting back on my time then em (.) I just wish I had the experience and the knowledge that I have now in those situations and whether I'd feel the same way as I do now==
62.	F	==thanks a mil for that [SW6]. Don't be hard on yourself, I think everyone can feel that they could have done more in certain situations so you're not on your own in that sense either, thanks a mil. So (.) kind of linked but more bringing it more generally to your professional identity as such, if you can think of any factors or experiences that you think have contributed to your professional identity- maybe your education, family, your work environment (.) all the above? If there's anything you feel has generally influenced you as a social worker?
63.	SW6	Well I sometimes joke that I became a social worker because I listened to too much Adrian Kennedy talk show and that's how I ended up being a social worker because em (.) yeah just so much exposure to the drama of that [laughter] but eh (.) but I think colleagues and work

		environments and things can be very influential on, you know, you can have very different feel of what your role is and what your profession is depending on those around you and how you're perceived by your team and all that kind of thing I think has a massive effect on what you end up actually doing as a social worker and also em (.) and your own profession, that kind of thing==
64.	F	==thanks a mil [SW6]===
65.	SW5	==I think I probably think I would say my family environment (.) being the youngest of five and having a mother who was always very interested in people and where they were at and always very present and I think (.) yeah (.) I think being from a family of five with very different personalities and characters and I always had an interest in people (.) which I think is (.)is (.)the (.) the medical, nursing side of things, were all different things I looked into but never felt like the right fit. I think, yeah, I guess the influence of my mother in terms of wondering where people are at and how they are and that kind of em (.) yeah (.) I'm just gonna say interest in people has led me to going down the social route (.) the social work path. And then possibly more in terms of mental health and the therapeutic side of things em (.) is probably where I am most fulfilled cause I get that from [X]. I get to have that space and that time with clients and explore different aspects of different peoples' lives and work with them around that, and that feels like it's the right path or the right channel to practice the way I want to practice as a social worker==
66.	F	==thanks a mil [SW5]==
67.	SW1	==when I was in secondary school, my school had quite a close link with [X], the youth groups. And I remember two particular group leaders who were linked in (.) me and my friends were in transition year and just the TIME they gave us certain evenings after school, so it was going until 5/6 o' clock in the evening and they'd sit down with us and talk to us about various things and they were just (.) well they acted so interested anyways, just listening to our stories. And I always remember them so it's like, I kinda wanted a job like THEM, to hear people's stories and do you know, to show them that I was interested , especially young people but I felt going into youth work was too boxed off and that's why I went into social work- and that's what I really enjoyed going into children in care and listening to their stories and being someone for them, to listen to them and I think it was those two youth workers that gave me that , that I wanted to give that on (.) like pay to forward in a way==

68.	G	==[pause]==
69.	F	==great thanks a mil for that [SW1]. It started very young and stayed with you [SW1]. I don't know if anyone else has any other influences they feel==
70.	SW2	==I echo what [SW5] was saying about family. And I suppose, I mean I could talk about it for ages, but I WON'T [laughter] but I could in that it's family and the family environment and I think like set me up for this and I think there was a consideration for other people that I (.) that I experienced when I was small with my parents and em (.) yeah I'm not going to go on and on about it [laughter]. I feel like I'm going to start doing it, but em (.)in fact I'm not going to go on about it, I'm going to start editing it as I speak but one part of it would have been my religious upbringing and there was a real consideration, especially on my mother's side for treating other people well and living the principles of (.) living the principles of her faith and that was something that was communicated in a really effective way by her because she just did it, like she just showed it and she was like yeah (.) she had a large part in forming me. And part of it was she was like "[SW2]" she wasn't saying this to me when I was like 3 or 4, but there was like a "[SW2], we pass through this world, we're going to return to the grave, what do you want your life to have been? Do you want it to be about accumulating things, do you want it to be about pursuing things that once you get you find they're meaningless, or do you want to do something where there's a real felt effect in other people's lives where it really improves it?" And it was orientated towards like helping, which sometimes I felt really naïve when I was in child protection but that was like (.) those were the worst days, and I think it is something that I think is (.) is (.) it definitely sent me in this direction and on the good days, I'm very thankful that I was given that perspective because on the good days I can see that I did something of use to another person, for another person, and without a doubt I wouldn't have done it==
71.	F	==thanks a mil [SW2] for being so honest and so open there, really appreciate it. I'm conscious that it's nearly 2 o' clock that if anyone needs to go, I have one more question really, if anyone needs to go now, do, please just fire ahead. I hope this isn't too deep or to broad but it's more what inspires you to remain committed to the profession?
72.	SW2	I mean I think actually seeing the change [laughter] it (.)it (.) it works, it works an amount of the time and sometimes it works and I don't think we perceive it because it's happening because it's happening at an imperceptible level and I think even if all you're doing is listening, and not doing anything beyond that – that can work and it's very hard to be able to assess exactly how effective that was. And also, when it doesn't

		work, like the thing you were hoping would happen doesn't happen em (.) like there's an understanding that 'you can't win 'em all' or that it's not, there's no silver bullet and that what you've tried, and what you've tried, if it's the considered thing to have done, it was worth trying==
73.	F	==thanks [SW2]==
74.	SW3	==I think in the [X] there's a real like, I don't know, just in my team now I'm sharing an office so they may not agree with this, but there's a real VALUE, like the value is seen in social work and I think there's more of a focus these days of a more holistic model of care and I think, not that I need someone to blow my trumpet, like every day or anything, but I think that value of the profession, you know, it keeps me going [laughter] in the acute setting. And then also, as well as that having enough positive outcomes in cases, you know, you take your wins where you can. I think the combination of the two keeps me going in this setting anyway==
75.	F	==thanks [SW3]==
76.	SW5	==yeah similarly I agree, the feeling –it's motivating, it's rewarding, the value of connecting with people and to kind of bringing one of the earlier points in that we were talking about around advice and what, you know, advice I would give going forward would be or a lesson or something I've learned to cover it all, is the power of just listening and being present and that's all it really takes to, I feel, affect any sort of change or have an impact and I find that HUGELY rewarding being able to be maybe a safe space or a consistent in someone's life and when maybe they're in a place of chaos and be that ear to bounce things off or to maybe – the validation they might need around something so I think, I can't imagine myself doing anything else other than this. I couldn't work as an accountant or something you know, NO [laughter], this is so rewarding, that connection with people==
77.	F	==great, thanks [SW5]==
78.	SW1	==I think no matter what social work job you're in you're going to be going through something difficult with a person –like going along that road with them and for someone to TRUST you that much to be on that road with them no matter how proactive they are themselves and you're just kinda guiding them a bit or just kinda holding their hand a bit it just to, well it doesn't always feel like a privilege if they're a really challenging client [laughter], but it's rewarding that someone has that trust in you, and you don't get that in office jobs. Like no offence to

		people who love their office job but it's just being part of someone's story in a really difficult time in their life. It can be quite a privileged position for us to be in as well (.) for people to give us that trust==
79.	F	==thanks [SW1]. Thanks guys I won't hold you up any longer so that's really all my questions. Thank you all so much for being so honest and so reflective and open with me as well. It's so much of a privilege for me to hear your stories- so thank you so much.

Appendix F: Linguistic Descriptions and Definitions

(Adapted from Scully & Walsh, 2015)

Linguistic Definition	Description
Alliteration	**Words used in quick succession that begin with letters belonging to the same sound group. It involves creating a repletion of similar sounds in the sentence**
Analogy	**Establishes a relationship based on similarities between two concepts or ideas**
Circumlocution	**The use of many words to convey/describe an idea**
Contrast	**Device that highlights differences between ideas etc**
Comparison	**Illustration by similitude; comparative statements**
Echoing	**Reminiscent of an object, movement, or event with shared characteristics with (of an object, movement, or event) be reminiscent of or have shared characteristic with**
Emphasis	**Special forcefulness of expression that gives importance to something singled out**
Example	**An object, movement, or event that is representative of a particular instance**
Exclamative	**An abrupt, emphatic or excited utterance**
Hesitation	**A halting in speech or delay due to uncertainty**
Idiom	**A combination of words that have a figurative meaning**
Image	**A visual depiction of a person/place/object**
Imagery	**Use of words, phrases or statements to create "mental images" for the reader**
Incidental Details	**Minor details as subordinate to something else**
Intensifier	**Modifier that aims to provide additional emotional context to the word it modifies.**
Laughter	**The act of laughing**
Listing	**List of words**

Metaphor	**Describes a subject by asserting that it is, on some point of comparison, the same as anther otherwise unrelated object**
Pausing	**A brief discontinuation in speech by an individual**
Phrase	**A unit of words that usually form part of a sentence.**
Precise verb selection	**An explicitly definite use of verb concerned particularly with subject specified**
Present participle verb	**"ing" form of a verb**
Pronoun	**Words that substitute for nouns.**
Question	**Sentence/expressions used to obtain knowledge/information**
Repetition	**The process of repeating a single word, phrase or statement**
Rhetorical question	**A question asked for a purpose other than to obtain the information the question asks**
Self-reflection	**A form of reflection in which the individual reflects upon their own self in a given context**
Self-talk	**One's constant internal conversation and anything said to oneself for encouragement, discouragement etc.**
Symbol	**Use of objects/actions/ideas to represent an abstract idea**

Appendix G: Transcription Conventions and Abbreviations

(Adapted from Grundy, 1995)

Transcription Symbol	**Meaning**
(.)	Pause equates to approximately one second
[.5]	Pause equates to more than one second
[X]	Name changed for reasons of confidentiality
==	Latching (utterance immediately follows previous)
,	Continuing sentence
.	Completed sentence
…	Ellipsis (words omitted for purposes of clarity)
[xxx]	Transcription uncertain
-	Repetition of a word
?	Participant posing a question
[laughter]	Laughter from group
WOW	Emphasis

Appendix H: Dissemination Outputs

Output 1: Conferences

I propose that my research can be disseminated at various professional conferences as well as collective HSCP conferences. Examples of some of these conferences are detailed below:

Discipline	Example of Conference
Irish Society of Chartered Physiotherapists (ISCP)	Irish Society of Chartered Physiotherapists Annual Conference
Association of Occupational Therapists of Ireland (AOTI)	Association of Occupational Therapists of Ireland Annual Conference
Irish Association of Speech and Language Therapists (IASLT)	Irish Association of Speech and Language Therapists Biennial Conference
Play Therapy Ireland	PTI/PTUK Conference
Irish Association of Social Workers (IASW)	Irish Association of Social Workers National Social Work Conference/All Ireland Social Work Research Conference
National Health and Social Care Professions Office	HSCP Annual Conference
General Healthcare	All-Ireland Conference on Integrated Care

Output 2:

Journal	Journal Homepage
Annals of International Occupational Therapy	https://journals.healio.com/journal/aiot/about-the-journal
The Irish Social Worker Journal	https://www.iasw.ie/isw-index
Journal of Allied Health	https://www.asahp.org/journal-of-allied-health
International Journal of Practice-based Learning in Health and Social Care	https://publications.coventry.ac.uk/index.php/pblh

Output 3: Continual Professional Development

I endeavour to contact the professional affiliated associations to recruit clinicians who may be interested in engaging in continual professional development as it relates to the findings of my study. The professional associations include:

Professional Association
Irish Society of Chartered Physiotherapists (ISCP)

Association of Occupational Therapists of Ireland (AOTI)
Irish Association of Speech and Language Therapists (IASLT)
Play Therapy Ireland
Irish Association of Social Workers (IASW)