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Reflective practice: what is it and how do I do it?

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'*An unexamined life is not worth living.*' Socrates

Abstract

Reflective practice holds importance for health and education practitioners in Australia (Mann, Gordon & MacLeod, 2009), as demonstrated by increased prominence in the new competency-based occupational standards for speech pathologists (Speech Pathology Australia [SPA], 2011). This article explores the topic of reflective practice, in the clinical context, by addressing the following questions:

- What is reflective practice?

- Why is it an important skill for speech pathologists?

- What is the evidence base for reflective practice?

- How do practitioner and students engage in the process of reflection?

In addressing the final question, four methods of facilitating reflection will be outlined: journal reflection, reflection on a critical incident, reflection following professional development, and reflection on a clinical encounter.

Introduction

As early as the 1930s, the educator Dewey stated 'there can be no true growth by mere experience alone, but only by reflecting on experience' (cited by Lincoln, Stockhausen & Maloney, 1997, p. 100). However, it was only much later in the 1980s that reflective practice (RP) started to be widely discussed following Schön's seminal books (Schön, 1983; 1987) and Boud and colleagues' widely used model of reflection described below (Boud, Keogh & Walker, 1985). There is now a growing body of literature supporting the importance of RP across a number of fields although there is only limited research in speech pathology (for example see

Freeman, 2001; Geller and Foley, 2009; Hill, Davidson, & Theodoros, 2012). This article aims to describe the evidence base and the importance of RP for speech pathologists as well as describe four different ways that students and practitioners can facilitate their own reflection throughout their lifelong learning journey.

What is Reflective Practice?

RP is 'a generic term for those intellectual and affective activities in which individuals engage to explore their experiences in order to lead to a new understanding and appreciation' (Boud et al., 1985, p. 19). Reflection involves a number of skills (such as observation, self awareness, critical thinking, self-evaluation and taking others' perspectives) and has the outcome of integrating this understanding into future planning and goal setting (Mann et al., 2009).

There are different models of reflection described in the literature which are usually iterative (a particular experience triggers reflection and results in a new understanding or decision to act differently in the future) or vertical (describing depth of reflection from a surface descriptive only level to a deeper critical synthesis level resulting in changes in behaviour) (see Mann et al., 2009 for a full description). Boud and colleagues' comprehensive model of reflection includes both dimensions (Boud et al., 1985) and this has led to its wide (for example, Chirema, 2007; Wong, Kember, Chung & Yan, 1998) including in speech pathology (Lincoln, Stockhausen & Maloney, 1997).

In Boud and colleague's model the practitioner:

- returns to a situation or event (e.g. interaction with a client, response to workshop or strong reaction to colleague);

- attends to their feelings about the experience;

- re-evaluates in light of their previous experiences (so making meaning); and

- has an outcome or resolution for the situation.

The indicators of depth of reflection are: making associations with previous experiences, knowledge or feelings; integrating the new information with current knowledge; validating the new information; changing future behaviour (appropriation); and finally, setting an outcome for the future (Boud et al., 1985).

Why is RP an important skill for speech pathologists?

The focus on developing RP has increased across teaching, nursing, medicine and allied health professions in the last twenty-five years (Mann et al., 2009). In this time the workplace has become more complex and RP is seen as a skill that enables practitioners to manage increasingly 'messy, confusing problems which defy technical solution' (Schön, 1987, p.28). Within speech pathology courses in Australia, students develop the knowledge, skills and attitudes required of an entry level speech pathologist (SPA, 2011) and RP supports the link between the curriculum and their clinical practicum experiences (Lincoln et al., 1997). Once in the workforce, a practitioner receiving appropriate supervision and professional support will continue to develop knowledge, skills and attitudes beyond entry-level (SPA, 2011) on a continuum of competency leading to expertise (King, 2009; Mann et al., 2009). New graduates as well as experienced practitioners are increasingly expected to deal with complex cases (Mann et al., 2009), and engaging in meaningful reflection enables the practitioner to learn from experience and become a more efficient, effective and skilled practitioner (King, 2009). King (2009) argues expertise is developed via working through complex cases which involve much

thinking and puzzling. 'Experts learn experientially, through engagement (deliberate practice), feedback and reflection' (King, 2009, p.186).

SPA recognised this increased focus on RP in the revised Competency Based Occupational Standards for Speech Pathology (CBOS), launched in 2011 (SPA, 2011). In CBOS a new unit of competency entitled 'Lifelong learning and reflective practice' replaces the previous unit 'Professional Development' (SPA, 2001) and states:

> Reflective practice enables the entry-level speech pathologist to consider the adequacy of their knowledge and skills in different work place and clinical contexts. Reflective practice requires the individual to take their clinical experiences and observe and reflect on them in order to modify and enhance speech pathology programs and their own clinical skills. (SPA, 2011, p.36)

Although RP was not specifically mentioned in earlier iterations of CBOS (e.g. SPA, 2001), the ability to reflect on performance is assessed as a generic competency in the Competency Assessment in Speech Pathology [COMPASS®], a nationally adopted tool for assessing students' development of competency and readiness for entry-level practice (McAllister, Lincoln, Ferguson, & McAllister, 2006). In COMPASS® it is expected that, as part of the clinical process, a student 'reflects on and evaluates performance against her/his own goals, or relevant standards of performance…identifies a range of possible responses to insights developed through reflection' (p.13) and 'monitors his/her reasoning strategies through reflection on the accuracy, reliability and validity of his/her observations and conclusions' (McAllister et al., 2006, p. 21).

There is also an increased emphasis on evidence based practice (EBP) across healthcare (SPA, 2010) and this is incorporated in the revised CBOS (SPA, 2011). Mantzoukas and Watkinson (2008) state RP and EBP supplement each other. SPA (n.d.) recommends Dollaghan's definition of EBP be used:

> the conscientious, explicit and judicious integration of 1) best available *external* evidence from systematic research, 2) best available evidence *internal* to clinical practice, and 3) best available evidence concerning the preferences of a fully informed patient.' (Dollaghan, 2007, p.2)

In order for these strands to be integrated and applied appropriately, reflection is essential.

Reflective practice, then, is claimed to be a key component of clinical reasoning (Higgs & Jones, 2008) and supervision (Driscoll, 2007); part of the process of implementing evidence based practice (Mantzoukas & Watkinson, 2008); and key to the ongoing lifelong learning journey towards the expert practitioner (King, 2009).

What is the evidence base for RP?

A systematic literature review by Mann and colleagues (2009) aimed to explore the evidence that 'reflective capacity is … an essential characteristic for {health} professional competence' (p. 596). They identified 29 research studies from a range of disciplines including nursing, medicine and physiotherapy. Although the literature base was small, there is evidence that health professionals engage in reflection. They also found a number of tools available to assess RP and evaluate the level of reflection (Mann et al., 2009). The authors highlighted the association between RP and learning approach with deep reflectors also using deep rather than surface learning approaches. Deep approaches to learning involve being interested in the subject, searching for meaning both in the task and as related to own experiences in

order to form a theory or hypothesis, whereas surface learners rely on rote memory, do not see links between parts of the subject and see the task simply as a demand to be met (see Dunn & Musolino, 2011; Leung & Kember, 2003). When compared to students, experienced practitioners were more able to reflect-in-action and tended to reflect-on-action only with new, complex or challenging situations (Mann et al., 2009). Mann and colleagues also described a variation in depth of reflection (for example descriptive, reflective or critically reflective) amongst students and practitioners with both groups experiencing difficulty achieving the deeper levels.

Supportive supervision to facilitated reflection, as did reflecting in a supportive peer group, and a positive outcome of reflection was improved relationships with colleagues (Mann et al., 2009). As a result of the systematic review, Mann and colleagues identified a need for authentic context and relevance for reflection (important for students), support for different learning styles and adequate time allowed for reflection. Finally they also concluded that RP could be taught when specific tasks and questions were given (Mann et al., 2009).

There is a need for further research in the area of reflective practice as the links between reflection and deep approaches to learning are not clearly understood, neither is the link between reflective practice and clinical reasoning (Mann et al., 2009). As yet, there is little evidence to support the idea that reflection improves self-awareness or outcomes in clinical practice or client care (Mann et al., 2009).

How do we engage in the process of reflection

Students and practitioners alike have different abilities to reflect and 'without some direction reflection can become diffuse and disparate so that conclusions or outcomes may not emerge' (Boud & Walker, 1998, p. 193). Researchers have identified that reflection is a difficult skill that needs to be explicitly taught and

modelled (Baird & Winter, 2005) and it is only possible in an environment that is safe, respectful and where confidentiality is assured (Sumsion, 2000). Students and practitioners need to know why reflection is valued, be prepared for reflection and know what to reflect on (Baird & Winter, 2005).

A number of methods of facilitating reflection, designed to support the process of reflection across a range of different contexts, have been outlined in the literature including journal writing, self-appraisal and portfolio preparation (Mann et al., 2009). Students and practitioners reflect more deeply when given specific prompts and coaching (Roberts, 2009; Russell, 2005) so the following activities have been designed to support this process.

Written reflection

Keeping a diary, journal or blog is frequently mentioned in the literature (e.g. Chirema, 2007; Hiemestra, 2001; Phipps, 2005) as a way of looking back at experiences in detail in order to learn from them and alter future behaviour accordingly. Specific prompts or cues (usually a series of questions) can support the practitioner or student to move from describing experiences to analysing, making meaning and setting goals for the future (e.g. Boud, 2001; Findlay, Dempsey & Warren-Forward, 2011; Freeman, 2001; Roberts, 2009). Chapman, Warren-Forward and Dempsey (2009) developed a checklist of cues for practitioners to use to facilitate their written reflections and to evaluate their own journal entries (shown in Figure 1). The levels and cues are based on Boud and colleagues' (1985) model of reflection.

(insert Figure 1 here)

Reflection on a critical incident

Mann and colleagues (2009) suggested experienced practitioners are more likely to reflect-in-action and so it could be suggested that experienced speech pathologists may not find processes designed to facilitate reflection-on-action, such as journal keeping, as beneficial or feasible within a busy work life. Setting aside time to reflect only on critical incidents, a situation 'that provoked surprise, concern, confusion or satisfaction' (Baird & Winter, 2005, p. 155) is more practical. Findlay and colleagues (2011) developed a number of Reflective Inventories for use by Radiotherapists which provide a set of prompts to guide the practitioner through a reflective writing. Using a Reflective Inventory resulted in a deeper level of reflection than a freeform reflection in a journal as measured by Boud and colleagues' model (Findlay et al., 2011) and one of these (Figure 2) can be used to support deep reflection following a critical incident.

(insert Figure 2 here)

Reflection following professional development

A second Reflective Inventory (Figure 3) uses reflection to support deep learning following professional development or any other kind of learning activity such as reading an article or book chapter (Findlay et al., 2011). This reflection encourages the practitioner to apply the new knowledge so encouraging deep learning as well as deeper levels of reflection (Findlay et al., 2011).

(insert Figure 3 here)

Reflection on a clinical encounter

Student practitioners are less able to reflect-in-action than more experienced practitioners (Mann et al., 2009) and need more structure to support deep reflection on their experiences. The author of this article along with speech-language pathology students developed a series of scaffolding questions (Figure 4) to support

students' ability to answer the clinical educator's question 'how did that session go?' Students use this series of questions to reflect on their clinical experiences (whether an assessment, intervention or consultation), making brief notes before then discussing with their clinical educator or peers. This tool could also be used by new graduate practitioners to support their reflections with their supervisor.

(insert Figure 4 here)

Further ideas for reflective practice

A range of other reflective practices have also been identified in the literature including telling stories or narratives (Watson & Wilcox 2000). This less structured approach to reflection often occurs in the lunch room or hallway and helps practitioners make sense of complex or challenging experiences. Discussion in a supportive small group increases the depth of reflection and therefore learning that occurs when sharing these stories (Mann and colleagues, 2009).

Another approach focuses on developing a personal statement of philosophy or code of personal ethics (Sumsion, 2000) which could be revisited each year as part of an annual appraisal. This annual reflection allows the practitioner to re-evaluate the way in which their current work practices align with their overall philosophy and ethics as a practitioner.

Creative ideas for reflection include using art, visuals (such as reflective photos), relaxation and visualisation, mind maps and drawings (Sumsion, 2000) and poetry, collage and sculpture (Newton & Plummer, 2009). These different ideas may support reflection in practitioners and students with different learning styles.

Conclusion

Reflective practice has been highlighted as an area of importance for the student, the entry level practitioner and throughout the learning journey to expert

practitioner (King, 2009). This article reviewed the literature in relation to reflective practice and the areas for further research. Some useful tools and processes that practitioners and students could use to support their reflective practice were described.

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Figure 1: Guide to Reviewing Reflective Workplace Diaries

Level of Reflection	Cue
Describing the event or experience	Recollect the experience and replay it in your mind or written format, allowing all the events and reactions, of yourself and those involved to be considered.
Defining your reaction and feelings	Acknowledge the emotions that an experience evokes. This may involve harnessing the power of positive emotions or setting in abeyance the barriers that may accompany negative emotions.
Assessing whether this varies from what you already know	Feelings or knowledge from the experience are assessed for their relationship to pre-existing knowledge and feelings of a relevant nature.
Can this new knowledge be integrated?	This involves assessing whether the feelings and knowledge are meaningful and useful to you, bringing together ideas and feelings.
Question yourself	Are the new feelings that have emerged authentic or the new knowledge accurate?
Is this going to change anything?	Describe if the new knowledge will change your practice and how. Alternatively, have the feelings and knowledge from the experience changed any of your attitudes or perspective on a topic?

Figure 2: Significant event entry

(adapted from Findlay, N., Dempsey, S. & Warren-Forward, H. (2011). Development and validation of reflective inventories: assisting radiation therapists with reflective practice. *Journal of Radiotherapy in Practice, 10*, 3-12, p.8)

- Type of event:

- Persons Present:

- Describe the event.

- Why did it happen and what was your initial reaction to the event?

- Have you ever had these feelings before?

- What is your understanding of the outcome of this experience or your feelings about it?

- Are these feelings valid and why?

- How would you approach this situation if it arose again?

Figure 3: Reflection following professional development

(adapted from Findlay, N., Dempsey, S. & Warren-Forward, H. (2011). Development and validation of reflective inventories: assisting radiation therapists with reflective practice. *Journal of Radiotherapy in Practice, 10*, 3-12, p.7)

- Who facilitated the course or workshop and what was the subject area?

- What were the three main things you learnt from the event?

- Does this differ from your previous knowledge of these areas?

- Do you see any value in the knowledge gained, is it accurate and why?

- Will this new knowledge change your practice?

- Should you take this clinical knowledge back to your department and assess

its relevance in your clinical setting?

Figure 4: Reflection after a clinical encounter

Quick summary

- Were your goals for the session achieved?

- 3 things that went well and why.

- 3 things that didn't go well and why.

Reflection in relation to your Client

- Were your goals for the session achieved?

- What improvements were built on from previous feedback?

- How would you describe the client's experience of the session?

- How would you describe the level of rapport/your relationship?

- How did the individual activities go? What did the client respond to?

- Evaluate client responses with evidence

- Steps up/down – did you need them, did you need more?

- Instructions – were they adequate, if not why not?

- How would you describe your feedback to client?

- Outcome measures – did they work?

- What do you need to find out before the next session? (information, evidence)

- What could you aim for in the next session in the light of today's performance?

Reflection in relation to your own performance

- How did you feel in the session?

- Compare your performance with clients performance and participation in

activity

- What would you improve next time?

Reflection in relation to the client's significant other – family, other stakeholders

(whether present or not)

- How did significant others engage in the session if present?

- How could significant others be engaged in the activities if not present?

- How would you summarise/represent today's session to a significant other?

- What improvements could you make for future sessions?