Neuropsychology Supervision: Incorporating Reflective Practice

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Objective: Clinical supervision is fundamental to the training of psychologists. Neuropsychology (NP) is recognised as a distinct discipline of psychology and is an area of endorsement; however, specific training in NP supervision has received limited attention. Reflective practice is a supervisor competency required by the Psychology Board of Australia (PBA) and is one element of NP foundational competencies. Reflective practice can be described as the process of consciously analysing decision-making, and drawing upon theory and experience, in order to improve clinical practice. This discussion paper aims to improve the supervision of neuropsychologists in Australia by providing an explicit framework to incorporate reflective practice into NP supervision.

Method: As a discussion paper, the first stage is to review the NP supervision literature; and second to provide a practical supervision framework to integrate reflective practice in accordance with current research, NP-specific requirements, and the PBA.

Results: The extant literature on NP supervision is exceedingly limited. NP supervision training frameworks were based upon developmental and competency-based models and indicate that reflective practice is a core element. A practical framework for the implementation of reflective practice was effectively developed.

Conclusions: The reflective approach allows supervisees to attain core functional and foundational neuropsychological competencies, and is flexible to allow for different contexts and potentially new supervision training requirements. Importantly, the reflective practice framework supports ongoing professional development and competency throughout the neuropsychologists’ professional career span.

Key words: competency; neuropsychology; reflective practice; supervision; training.

Introduction

Competence is a defined ethical component of psychological practice (Falender & Shafranske, 2012). Supervision is the most important contributor in the development of competence (Stucky, Bush, & Donders, 2010). Providing supervision is both a challenging and time-consuming role and requires sufficient skills and knowledge, especially given increasing professional requirements. However, supervisor training is too often neglected (Gonsalvez & Milne, 2010; Stoltenberg, 2005), and poor supervision practices are relatively widespread (Falender & Shafranske, 2012; Gonsalvez & Milne, 2010). The belief that experience alone renders clinicians competent to supervise is flawed at best, and detrimental to both students and clients at worst, with some suggesting that supervision without appropriate training is unethical (Falender & Shafranske, 2012; Gonsalvez & Milne, 2010; Milne & Reiser, 2012).

There is increasing evidence that explicit training in supervision improves subsequent supervision practice (Gonsalvez & Milne, 2010), and there is collective interest in competency- and evidence-based supervision throughout the world (Falender & Shafranske, 2012; Gonsalvez & Milne, 2010; Milne & Reiser, 2012; Stucky et al., 2010). Training is therefore necessary (Falender & Shafranske, 2012), benefiting...
supervisors and supervisees, and ultimately the public, through ethical competent psychological practice. Within Australia, eligibility to practice as a supervisor of psychology interns came under the control of the national Australian Health Practitioner Regulation Agency (AHPRA) in July 2010. The Psychology Board of Australia (PBA) has established national standards for board-approved supervisor qualifications, supervisor competencies, and supervisor training.

Since that time, multiple training courses in general psychology supervision have been provided. However, neuropsychology (NP) is recognised as a distinct discipline of psychology, and as such is an endorsed “area of practice” (specialty) in Australia. As a distinct discipline, NP training is significantly reliant upon the provision of discipline-specific supervision (Schultz, Pedersen, Roper, & Rey-Casserly, 2014; Stucky et al., 2010). Discipline-specific supervision training is however often neglected with a recent survey in the USA indicating that only 27% of respondents practicing NP received specific NP supervision training, with many reporting that they feel inadequately trained (Schultz et al., 2014).

Training in NP supervision is also necessary for supervisors of psychologists who do not hold endorsement in NP but who undertake assessments in order to meet demands for NP services. A recent review of psychology services in Australia specifically suggests that in order to reduce the significant delays in access to services, the provision of NP services needs to increase (Small, Burke, & Collins, 2015). Moreover, demand for NP training and internships offering specialisation in clinical NP has more than doubled in the past 10 years in USA (Ritchie, Odland, Ritchie, & Wiley, 2012), suggesting a worldwide trend.

Accordingly, specific training in NP supervision is warranted, with appropriate training and competency being a significant ethical concern for the profession (Bush, Grote, & Johnson-Grenne, 2008). Although it is unlikely that any single supervision model will be appropriate for NP, it is crucial that discipline-specific models and training be developed (Schultz et al., 2014). In Australia, AHPRA recently approved a specialist Master Class of NP supervision for currently trained and registered supervisors.

The objective of this discussion paper is to propose a method of applying reflective practice to NP supervision so that supervisors and supervision training programmes comply with the AHPRA requirements. The PBA stipulates that Master Supervision training courses facilitate supervisors’ capacity to “reflect on their current practice and to extend their knowledge, skills and training.” Thus, this discussion paper provides an explicit practical framework for NP supervision in order to meet supervisor training requirements, and represents the first step in advancing an NP discipline-specific competency model of supervision.

NP Supervision

There is exceedingly limited research on NP supervision training (Finkelstein & Tuckman, 1997; Gonsalvez & Milne, 2010; Schultz et al., 2014; Stucky et al., 2010). For example, a thorough search of the literature provided three articles specifically concerned with NP supervision (Schultz et al., 2014; Stucky et al., 2010), including a competency model (Rey-Casserly, Roper, & Bauer, 2012) and an additional article on supervision of cognitive assessment (Finkelstein & Tuckman, 1997).

Review of the general psychology supervision literature reveals a multitude of supervision models borne largely out of research and theoretical developments in psychotherapy (Morgan & Sprenkle, 2007; Schultz et al., 2014). The principal objective of psychology supervision through clinical placements, or internships, is to assist supervisees to bridge their theoretical knowledge with functional skills and clinical practice by providing in vivo experience, so they can develop competent, ethical, and professional practice. Importantly, a review of psychology supervision models found no evidence that any one supervision model is superior to any other (Morgan & Sprenkle, 2007). Furthermore, the review identified three common dimensions: development of the competent clinician; facilitation of the process of being a clinician; and recognition of the supervision relationship (Morgan & Sprenkle, 2007), all relevant to NP supervision.

The supervised development of competency in NP assessment and diagnosis is a distinct form of supervision from the more therapeutic psychologies (Schultz et al., 2014). NP supervision has predominantly focused on instruction to develop competency and has given less emphasis than psychotherapy-based models to the development of the clinician and to the supervision relationship including considerations such as parallel processes, emotional responding and transference (Stucky et al., 2010), and ethics (Bush et al., 2008). Nonetheless, prior models of psychology supervision have been extrapolated to NP with current research, suggesting that NP supervisors incorporate aspects from several models, primarily drawing from developmental and competency-based approaches (Schultz et al., 2014; Stucky et al., 2010).

The developmental approach recognises that supervisees pass through distinct stages which must be taken into account by the supervisor by matching modelling and mentoring to the level of competency displayed by the supervisee. Supervisees at the early stage of learning need exposure to observational methods of learning, coaching, and feedback aimed at teaching new skills and enhancing competency and confidence in practice. The more experienced supervisee however may benefit from a facilitative approach to supervision (Bernard & Goodear, 2004). At all levels of development, supervisory interventions require direct observation, discussion, review, feedback, and reflection on practice. Over time, the developing supervisee gains increasing competency and maturation enabling them to manage increasing responsibilities and more complex tasks (Stoltenberg, McNeil, & Delworth, 1998). Historically, supervision of NP, more than general psychology, has relied upon formal instruction. NP supervision has focused upon supervisees developing competencies in test administration and interpretation, requiring clear and explicit instruction with performance deemed either correct or incorrect, and accuracy not determined by theoretical model or subjectivity. An early developmental model of supervision of psychological assessment involved training a novice supervisee in test administration to a level of “master assessor” with the ultimate capacity to supervise (Finkelstein & Tuckman, 1997). Similarly, supervision training ought to include long-term step-wise programmes to provide ongoing training and evaluation from basic to advanced supervision expertise (Gonsalvez & Milne, 2010).
Competency models emerged in clinical psychology and had a broader approach by considering both the application of functional and technical skills, and clinical skills (Rodolfa et al., 2005). The concept that supervision involves not only training in both skills and knowledge but also the process of being a clinician has influenced supervision practice generally and NP supervision specifically. Two competency-based supervision models have been adapted to NP supervision and integrate functional and foundational competencies (Rey-Casserly et al., 2012; Stucky et al., 2010). Functional core competencies in NP supervision are widely recognised as including specified knowledge, performance of particular skills (notably assessments and differential diagnosis), producing specific work (i.e., reports), and providing feedback and intervention (Stucky et al., 2010).

In contrast, foundational competencies involve reflective practice, relationships, interdisciplinary systems, scientific knowledge and methods, individual and cultural diversity, and ethical and legal standards (Rey-Casserly et al., 2012; Stucky et al., 2010).

Although NP supervision should also fundamentally provide for the development of foundational competencies and oversee the process of being a good NP clinician the available literature indicates that the predominant focus remains upon functional competencies (Stucky et al., 2010). Furthermore, a recent survey of NP supervision practices indicates that the most frequent topics of supervision remain assessment and reports, and the typical format of supervision is the editorial review of written reports (Schultz et al., 2014). This approach fails to provide for, or facilitate, the development of foundational competencies, including reflective practice promoting personal awareness, clinical insight, and resilience.

Rationale for Reflective Practice in NP Supervision

Reflective practice involves a critical contemplative process of evaluating one’s learning needs, understanding attitudes, beliefs and values in the context of clinical work and professional culture, and actively integrating experiential learning and knowledge to inform their clinical practice, and engage in continual self-monitoring (Mann, Gordon, & McLeod, 2009; Orchowski, Evangelista, & Probst, 2010). Reflective practice therefore offers a framework, whereby the NP learns to engage in a critical self-evaluation of their affective, cognitive, and behavioural experiences. Guided by the supervisor, this added layer of clinical investigation helps develop critical thinking, problem solving, and ethical decision-making associated with NP foundational and functional competencies.

Reflective practice is currently included in NP competency-based models (Rey-Casserly et al., 2012; Stucky et al., 2010), and stipulated in Australia by AHPRA as a core competency to be actively utilised in supervision for psychologists. However, there is little information available as to how to integrate or implement reflective practice into NP supervision.

Reflective practice is achieved by teaching the psychologist supervisee to be curious and critical of their work and has been formally defined as “purposeful critical analysis of knowledge and experience, in order to achieve deeper meaning and understanding” (Mann et al., 2009). It is a term often synonymous to self-reflection (Orchowski et al., 2010) and “self-evaluation” (Stucky et al., 2010), and is seen as both an attitude and behavioural skill. It is commonly described by learning theorists as the cyclical process of review of cognitive, affective, and behavioural experiences (Dewey, cited in Kolb, 1984; Schon, 1994; Ward, 1998) and as a means of enhancing professional practice and facilitating the professional development of psychologists by learning from experience. The value of a reflective practice orientation in supervision is that it facilitates supervisees to be introspective, to provoke reflective thinking on the clinical and supervisory experience, and to engage critical analysis of knowledge and experience (Mann et al., 2009). This process has been found to enhance both the experience of the supervision process and the effectiveness of supervision (Carroll, 2009; Neufeldt, 2000; Orchowski et al., 2010; Senediak & Bowden, 2007).

Schon (1994) delineated processes of reflection as “reflection-in-action,” “reflection-on-action,” and “reflection-for-action” so that the supervisee has critical awareness when engaged in an intervention, when engaged in analysis after the session, and when planning for future work. Reflective practice is therefore widely considered to be the cornerstone of good supervisory practice in that it facilitates psychologists to be “introspective” by systematically reviewing their work (Carroll, 2009), from both interpersonal and intrapersonal perspectives (Finkelstein & Tuckman, 1997). Thus, at a higher level, the supervisory relationship facilitates and supports students in the development of their individual clinical identity, and requires the adoption of the developmental approach (Rey-Casserly et al., 2012; Stucky et al., 2010). However, the traditional NP supervisory focus upon assessment and reports (Schultz et al., 2014; Stucky et al., 2010), has not necessarily considered the development of the clinician.

Reflective practice may therefore enable more formative approaches to supervision feedback and recognises that feedback is influenced by subjective, or stylistic factors, as well as clinical ones necessitating an adaptive flexible approach and respecting individual development. It is widely agreed that applying reflective practice involving internal examination of attention and thoughts about the clinical context “in action” (within the session), or “on action” (after the session), promotes professional practice (Carroll, 2009; Orchowski et al., 2010; Regan, 2008; Senediak, 2014). Fundamentally, supervisees who develop the capacity to be reflective upon their work with clients are thought to improve their clinical wisdom, professional judgement, and enhance ethical reasoning (Neufeldt & Karno, 1996).

By working from a reflective practice stance, the supervisee is encouraged to consider multiple perspectives of the presenting case or issue at hand allowing greater depth of conceptualisation and analysis. In the case of a neuropsychological referral question, this might involve consideration of the client’s cognitive assessment, intergenerational patterns of behaviour, health, and socio-cultural-religious factors and encourages differential diagnosis. Additionally, greater analysis may also include review of the impact that test result feedback might have upon the client and their family/carer, and on intervention outcome. Although almost 72% of NPs rate that they usually always provide feedback, providing test feedback is a much
neglected area of NP supervision (Smith, Wiggins, & Gorske, 2007). Reflective practice will significantly improve the provision of test feedback by recognising and exploring the relational elements and wider influences and the powerful potential therapeutic effect of feedback, thus shifting the focus from a test-centred approach to a client-centred one (Smith et al., 2007). Additionally, reflective practice encourages supervisees and supervisors to consider their own beliefs and attitudes towards patient populations and clinical controversies and syndromes, such as substance induced neurocognitive disorder, and possible intervention including the contentious “brain training.”

Like feedback, supervision of NP intervention has also been widely neglected despite being a key NP competency and increasingly requested by clients. For example, in the USA, less than 48% of NP respondents reported specific training in intervention (Schultz et al., 2014), and in Australia a lack of adequate training during clinical placements is reported to be the greatest barrier to implementing intervention (Wong, McKay, & Stolwyk, 2014). Reflective practice may increase a supervisee’s confidence and competency to provide intervention by asking the supervisee to consider appropriate intervention in relationship to each specific client, their condition, and situation, and not test scores. Thus, a reflective approach may complement the move towards evidence-based neuropsychological practice (EBNP) (Chelune, 2010). By developing supervisee capacity to convert referral questions into questions relevant to that particular client, tailor assessment and feedback to individual needs, and incorporate evidence-based intervention research into a meaningful “individual event” (Chelune, 2010).

Supervisors have an explicit responsibility to develop supervisee skills in self-care, so they may be protected “from the occupational hazards of psychology practice” (Pakenham, 2015). Supervision therefore needs to provide a space for NP interns to honestly assess their role related risks, as well as their own psychological needs, in order to proactively engage in their own self-care (Pakenham, 2015). By enhancing the supervisee’s awareness of self and the impact of the client/context through reflective practice, the supervisee becomes more attuned to relationship issues and boundaries within the therapeutic context, and self-care is promoted (Dennin & Ellis, 2003). Additionally, reflective practice can result in enhanced sensitivity which over time, if practiced and internalised, can minimise the sense of being “stuck” that a supervisee may experience when working clinically and providing cognitive intervention, further enhancing self-awareness and self-care (Bennett-Levy & Lee, 2014; Rhodes, Wallis, & Nge, 2008). Despite the paucity of supervision research, a study of supervisors and supervisees in geriatric-psychotherapy identified that supervisor disclosure of their own clinical experiences was helpful to supervisees (Karel, Altman, & Zeig, 2014), and we suggest such mentorship also improves self-care and the development of clinical identity.

**Integrating Reflective Practice into NP Supervision**

The first step of reflective practice is to explain the role of reflective supervision, so the supervisee understands the rationale and application for its use in supervision (Stucky et al., 2010). This is especially important within NP supervision where feedback has traditionally been educative, task focused, and directive. The application of reflective practice in NP supervision therefore represents a significant departure from previous experience. It is vitally important that the supervisee fully understands that the questioning process will develop their clinical development in order to engage fully. Given the reported benefits of supervisor disclosure in developing the clinical identity of supervisees (Karel et al., 2014), the introduction of supervisor disclosure with respect to their own clinical experiences may also need to be discussed. We additionally suggest that the supervisory relationship (or alliance), the third common component of supervision, be recognised as it is vital to the process of developing the clinician. It is well documented that supervision works best when there are clear goals and a clearly articulated contract matched to the developmental needs of the supervisee (Bernard & Goodyear, 2004).

Within the proposed NP reflective practice framework, the supervisor would apply open-ended questions (similar to those used in a counselling session) to open up discussion about the supervisee’s reactions/feelings in the clinical context. By using “counselling oriented” reflective questioning techniques, the supervisee is encouraged to be introspective about the clinical encounter. In this context, the supervisor explores supervisee reactions to their clinical work and reviews the impact of emotions (counter-transference). The focus of reflective enquiry depends on therapeutic orientation of supervisor and supervisee and the goals of supervisory discussion. A common aim is to explore new openings for different thinking outside of what is already known (Hill, Crowe, & Gonsalvez, 2015; Ladany, Friedlander, & Nelson, 2005; Senediak, 2013). In the case of NP supervision, reflective practice may examine the impact of self (e.g., past experiences, values, attitudes) in the clinical context and consider alternative ways of working with the client and his/her family.

For example, an NP supervisee may disclose they have a history of motor vehicle accident resulting in the death of a companion (“How do you make sense of your strong reaction to this case?”). In supervision, it may become clear from reflective exploration they experienced emotional issues providing NP services in similar cases (“When have you experienced similar feelings/ reactions?”). Reflective questioning can help the supervisee to understand and learn how to independently manage their concerns (“what can you do that might be helpful? What assistance can you arrange for yourself?”) and importantly how they may manage responses to ensure ethical competent practice (“How might this impact upon your clinical practice? How might you manage your responses in future?”).

Introduction of reflective practice in the first “supervisor-supervisee” meeting, or working alliance session, establishes a best practice framework for role induction and effective supervision (Senediak, 2013). The supervisor introduces a competency-based model of supervision that considers the developmental stage of the supervisee, and the goals of supervision targeting specific skills, knowledge, and attitudes consistent with high quality professional NP activities (Kaslow & Bell, 2008). This first session facilitates discussion between the supervisor and supervisee of preferred ways of working and provides the first opportunity to introduce reflective
reflective questioning. Additionally, the position of reflective practice alongside other forms of training, such as teaching, modelling, informal discussions, structured learning activities (workshops), liaison with other psychologists, and medical staff and independent learning, can be explored (Stucky et al., 2010). At this initial session, learning objectives and goal setting techniques are also established and, where necessary, contractual arrangements and financial arrangements considered (Falender & Shafranske, 2012).

The application of reflective practice to NP supervision can be facilitated through the use of the proposed framework which covers the three broad core components of NP practice: “Systems,” “NP Service Delivery” (including diagnosis, assessment, report writing, and intervention), and “Practice Standards,” presented in Table 1. The three domains provide a holistic framework for assessing the client having regard to the systemic and relational factors and best practice guidelines for NP.

The supervisor can use this framework to facilitate discussion about the client, their wider context, and important variables that may impact on decision-making and intervention planning. It allows for individual differences in context and work site (e.g., inpatient hospital, outpatient service, and community), the developmental stage of the supervisee, and other systemic and practice factors (e.g., workload, environmental factors). Whilst NP supervision most often focuses on NP Service Delivery (e.g., test administration and report writing), this framework extends the NP supervisee to consider systems issues (e.g., family of origin, the impact of cultural beliefs in recovery), in addition to opening up opportunities to reflect upon the supervisee’s reactions to the clinical material (counter-transference). Within this framework, reflective questioning is commenced early within the supervisory context to encourage the supervisee to consider ways of working, such as initiating systems level thinking and engaging family members in therapy and recovery (Hewson, 2002; Stucky et al., 2010). For example, at the completion of NP assessment, the overarching aim is to encourage the supervisee to develop a multidimensional case formulation, including test data, multiple information sources including information regarding family structure, transgenerational patterns of illness which includes genetic disease, family history of psychological illness, and learnt behaviours, and resources within the family; and how consideration of that knowledge informs the content and delivery of feedback to client and/or family. Additionally, reflective questioning encourages investigation of research and best practice, such as considering the advantages and disadvantages of written and verbal NP feedback, along with understanding how diversity issues such as culture and religion may impact upon the patient’s understanding of the feedback, and how both might impact on intervention selection and outcome. Table 2 provides examples of reflective questioning that can be applied within a neuropsychological context.

**Conclusion**

Supervision is a specific competency and formal discipline-specific training in NP supervision is overdue. A reflective framework helps to create a thinking space within the supervisory context, enabling supervisors to attend to both “supervisee’s” and “client’s” needs on multiple levels (Stucky et al., 2010). The proposed framework provides an explicit

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<th>Dimension</th>
<th>Considerations</th>
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<td>Systems</td>
<td>Development of a multi-dimensional lens for case consideration including:</td>
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<td>i. Family genogram to illustrate transgenerational patterns of illness such as dementia, alcoholism, and mental illness, and learnt behaviours, resources, belief systems that may impact diagnosis, feedback, and intervention</td>
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<td>ii. Diversity issues (cultural, religious, gender) how might it impact upon assessment and/or intervention</td>
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<td>iii. Wider systems issues (socio-economic factors, insurance, third party referrer)</td>
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<td>iv. The supervisee–client relationship (expectations, transference, counter-transference)</td>
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<td>NP services (diagnosis assessment and intervention)</td>
<td>Test selection, administration, scoring, and identification of client relevant norms</td>
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<td>Integration of diverse sources of information beyond test data—history, behavioural observations, medical reports, etc.</td>
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<td>Evidence-based differential diagnosis, awareness of base rates</td>
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<td>Case conceptualisation and theoretical models</td>
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<td>Feedback content and method, and reporting</td>
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<td>Intervention options, selection, delivery, and review of outcomes</td>
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<td>Acceptance and integration of feedback from supervisor and other health professionals</td>
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<td>Practice standards</td>
<td>Legal and ethical considerations (e.g., appropriate use of tests, identification of third party issues)</td>
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<td>Ongoing management of the case (e.g., insurance, litigation), and record keeping</td>
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<td>Management of files and client related administrative matters related to care and service delivery</td>
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<td>Evaluation of intervention outcomes</td>
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<td>Familiarity with work health and safety policies and requirements</td>
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<td>Capacity to undertake a technical review of the client encounter including:</td>
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<td></td>
<td>i. What guided my assessment and test selection?</td>
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<td>ii. Did I fulfil all relevant practice guidelines? If not, what else do I need to do?</td>
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<td>iii. What feelings do I have about the client/how I managed the client encounter?</td>
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<td>iv. What have I learnt and how might I apply this learning the next time</td>
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Table 1   NP Supervision Framework: Systems, NP Services, and Practice Standards
framework that can be used by supervisors and supervisees to facilitate reflective practice and support the development of technical skills and critical thinking, and ultimately encourages the development of personal and professional identity (Stucky et al., 2010). Additionally, it may promote a sense of mindful introspection that fosters maturity in practice over time including ethical considerations and clinical wisdom.

This shift within NP towards self-evaluative and reflective supervision approaches (Stucky et al., 2010) is aligned with the AHPRA training requirements. The proposed adoption of self-reflective practices ensures a perpetual cycle with clinicians pursuing ongoing professional development, extending their competency, and providing competency-based supervision, therefore enriching the profession and improving ethical service to clients.

Commensurate with an evidence- and competency-based approach, the proposed supervision model will require evaluation in future. A systematic review identified consistent findings regarding the utilisation and benefit of reflective practice across different health professionals and levels of learners (Mann et al., 2009). Although, the review indicated that reflective practice was difficult to evaluate and the field is relatively new, possible evaluative methods may include: self-assessment (self-report questionnaire) impact of reflective practice upon client understanding or the application of clinical skills (e.g., Sobral, 2000); review of actual clinical or simulated interventions (e.g., Miller-Kuhlmnn, O’Sullivan, & Aronson, 2016); interview how reflective practice impacts work practice/knowledge and skills (Fisher, Chew, & Leow, 2015); and formal evaluation methodologies of training such as the Kirkpatrick Model (http://www.kirkpatrick-partners.com/OurPhilosophy/TheKirkpatrickModel).

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