A Qualitative Exploration of Resilience in Paediatric Healthcare Professionals

Angela Webber BSc (Hons), MSc

South Wales Doctoral Programme in Clinical Psychology

Cardiff University

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Supervised by: Dr Victoria Samuel and Dr Kerry-Ann Holder

Thesis submitted in partial fulfilment of the requirement for the degree of Doctor of Clinical Psychology (DClinPsy) at Cardiff University

DECLARATION

This work has not been submitted in substance for any other degree or award at this or any other university or place of learning, nor is being submitted concurrently in candidature for any degree or other award.

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This thesis is the result of my own independent work/investigation, except where otherwise stated.

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THESIS SUMMARY

This thesis explored paediatric professionals' perceptions of stress and coping whilst working within inpatient settings. Paper one outlines a systematic literature review and meta-synthesis of 13 qualitative studies regarding burnout and resilience in paediatric healthcare professionals. The studies were critically appraised using the Critical Appraisal Skills Programme (CASP, 2017), before being synthesised using meta-ethnography (Noblitt & Hare, 1988) in order to conceptualise factors relating to burnout and resilience in this group. The findings indicate that professionals felt unprepared for the emotional aspects of the work, culminating in feelings of helplessness. Professionals coped with challenges through a process of connection and disconnection, and described the role as one which provides opportunities for personal growth.

Paper two describes an empirical qualitative study of resilience in health play specialists working in inpatient paediatric settings. Ten health play specialists (HPS) from three children's hospitals were interviewed, and their responses were analysed using grounded theory methodology. A theory of resilience development in HPS was developed, resulting in one core-category: 'a unique role', and three categories describing the challenges they face: 'being misunderstood', 'being pulled in different directions', and 'being there'. Each sub-category describes the processes and conditions required to develop resilience for HPS. Findings from both papers demonstrate the importance of individual and organisational support structures to promote wellbeing for staff working within paediatric inpatient settings.

Paper three presents a critical appraisal of the research conducted. The key decisions made are discussed, alongside reflections of the strengths and limitations within each paper. This section also considers the key clinical psychology competencies developed through conducting a large-scale research project.

Resilience and Burnout in Paediatric Healthcare Professionals: a Qualitative Meta-synthesis

Angela Webber BSc (Hons), MSc

South Wales Doctoral Programme in Clinical Psychology

Cardiff University

Paper 1

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Supervisors:

Dr Victoria Samuel

Dr Kerry-Ann Holder

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(see Appendix 1.1)

ABSTRACT

Objective: To review and synthesise the qualitative evidence exploring resilience and burnout in paediatric healthcare professionals working in inpatient settings.

Methodology: Seven databases (PsycINFO, Proquest [dissertation and theses], Web of Science, PubMED, CINAHL, EMBASE and MEDLINE) were systematically searched in January 2018 for qualitative studies which explored paediatric professionals' views of the emotional demands of the job. Qualitative research meeting inclusion criteria were assessed for quality using the Critical Appraisal Skills Programme (CASP) framework and synthesised using a meta-ethnographic approach.

Results: Overall, 13 studies met the criteria for synthesis, and four constructs were identified, summarising factors relating to burnout: (1) Feeling unprepared; and (2) Feeling helpless and out of control; and resilience: (3) Dealing with emotions: 'connection and disconnection', and (4) New perspectives, growth and purpose.

Conclusions: A synthesis of qualitative evidence is presented which demonstrates the importance of supporting professionals working in paediatric settings to manage the emotional impact of the role.

Keywords: *Paediatric healthcare professionals, Nurses, Physicians, Burnout, Compassion fatigue, Coping, Stress, Resilience, Qualitative, Review, Meta-ethnography*

INTRODUCTION

The NHS workforce is under considerable pressure (NHS England, 2016; Wilkinson, 2015). High workloads, changes to working environments and a lack of perceived control have been linked to increased stress in professionals (Leka *et al*., 2003). The occurrence of occupational stress within NHS healthcare staff has been attributed to increased sickness, absenteeism and staff turnover (Bennett, Plint & Clifford, 2005; Van Wyk & Pillay-Van-Wyk, 2010; Department of Health, 2010). At a cost of £2.4 billion, staff sickness absence accounts for a considerable amount of the NHS budget (Public Health England, 2017). In addition, staff burnout has been linked to reduced quality of patient care (Clarke & Quin, 2007), adverse clinical events, poor decision making, and reduced communication with patients and colleagues (Shanafelt *et al*., 2010; Van Wyk & Pillay-Van-Wyk, 2010; Mukherjee *et al*., 2014). Therefore, at a time of austerity, increasing wellbeing within the NHS workforce is a priority in order to improve the safety and efficiency of healthcare services (Durdy & Bradshaw, 2014).

Stress in Paediatric Professionals

Paediatric professionals caring for children and young people with physical illnesses face a number of physical and emotional challenges. Witnessing children in pain, supporting families in distress, conducting invasive procedures and experiencing patient death on a regular basis have been described as key stressors in paediatric healthcare (Berger *et al*., 2015). Despite being described as rewarding (Berger *et al*., 2015), these aspects make paediatrics an emotionally vulnerable setting for professionals to work within.

There has been an increase in literature surrounding stress in healthcare professionals over the past 20 years (Jourdain & Chenevert, 2010). The terms 'compassion fatigue' (a reduced ability to empathise; Figley, 1995), 'secondary traumatic stress' (the impact of being exposed to another's trauma; Figley, 1995) and 'burnout' (characterised by emotional exhaustion, depersonalisation and a lack of accomplishment; Maslach & Jackson, 1984), are used interchangeably throughout the literature to represent the impact of workplace stress on healthcare professionals (Meadors & Lamsen, 2008). Workplace stress places staff at greater risk of emotional difficulties such as anxiety, depression (Czaja, Moss & Mealer, 2012), and post-traumatic stress (Figley, 1995), as well as physical illnesses such as hypertension and heart disease (Cora *et al*., 2012). In addition, compassion fatigue impacts the quality of patient care through decreasing empathy, increasing apathy and reducing productivity (Berger *et al*., 2015). Workplace stress has also been associated with substance use and suicide in physicians (Dyrbye & Shanafelt, 2016). Thus, preventing burnout may improve the effectiveness and safety of patient care, as well as reduce sickness and turnover (Roth *et al*., 2011).

Paediatric professionals are exposed to the pain, trauma and grief of their young patients and families on a daily basis. They have been reported to be at greater risk of compassion fatigue and burnout than their adult counterparts, with their level of exposure likened to that of trauma workers (Rourke, 2007). A study of 314 professionals within a children's hospital found that 39% were at risk of compassion fatigue, and 21% were at risk of burnout (Robins, Meltzer & Zelikovsky, 2009). Qualitative and quantitative research has considered factors associated with burnout in paediatric professionals, and has identified a lack of resources, conflict, poor support and level of experience as key sources of stress, contributing to staff leaving their jobs (Isikhan, Comez & Danis, 2004; Zander, Hutton & King, 2010). The emotional impact upon staff remains largely unexplored, although a recent number of qualitative studies have begun to link the emotional strain of the work with burnout (e.g. Maytum et al., 2004).

Coping Under Pressure: the Impact of Resilience

There is an increasing body of literature regarding factors which enable staff to continue in their jobs despite these challenges (Jackson, Firtko & Edenborough, 2007). A number of personal resources have been associated with coping in healthcare professionals, including experience and level of autonomy (Lee *et al*., 2015; Back *et al*., 2016; Beaune *et al*., 2017). Such resource is often referred to as resilience, defined as 'effective coping and adaptation when faced with loss, hardship or adversity' (Tugade & Fredrickson, 2004, p320). Resilience is associated with increased quality of life, physical wellbeing and less emotional exhaustion (Hart *et al*., 2014; Garcia & Calvo, 2012; Berger *et al*., 2015) and therefore increasing professional's resilience may help them to cope in the face of the organisational and emotional demands.

Resilience has been receiving increasing levels of attention in literature surrounding wellbeing in healthcare professionals. Qualitative research is particularly valuable for providing an in-depth insight into the complex psychological impact of work stress and the process of coping. A number of recent qualitative studies have explored coping in paediatric professionals across medical specialties and professions. For example, Zander and Hutton (2009) interviewed five paediatric oncology nurses and recommended that organisational structures be developed to support resilience, including improving working hours, mentoring and facilitating reflective practice groups.

However, only two reviews have considered qualitative studies of resilience and burnout, and both of these were conducted in oncology settings (Mukherjee, Beresford, Glaser & Sloper, 2009; Zander, Hutton & King, 2010). In a review of ten qualitative and quantitative studies in paediatric oncology professionals, Mukherjee and colleagues (2009) concluded that professionals experience unique challenges as compared to their adult counterparts, but called for an increased understanding of the development of coping strategies among all professionals due to a focus on nurses in the literature. In a further review, Zander, Hutton & King (2010) reviewed 24 quantitative and qualitative studies in both adult and paediatric oncology professionals, and found coping to be related to a supportive team, and a positive attitude, with experience bringing resources to cope with grief and loss. Stress was linked to building close relationships with patients (Cohen *et al*., 1994; Cohen & Sarter, 1992), and they described the 'balancing act' of professionals aiming to retain boundaries whilst continuing to care for patients. However, there is a lack of understanding of the process of resilience development in paediatric professionals.

However, both of these reviews included studies with adult and paediatric samples, and within oncology settings, so it is unclear whether these factors generalise to other areas of paediatric healthcare. Further consideration to whether these factors can be generalised is required. Thus, an up-to-date review of the qualitative literature into resilience and burnout in paediatric professionals working in a variety of specialties is called for.

Aims and Objectives of this Review

The process of development of resilience within paediatric professionals is unclear. It is hoped that a meta-synthesis will provide increased depth of understanding of the emotional impact of working in paediatric settings and how this is managed in order to consider organisational and individual clinical implications.

The review addresses the question: *'what are the factors related to stress and coping within paediatric healthcare professionals?'*. The review aims to (a) consider the impact of the work upon paediatric healthcare professionals and (b) to draw out specific factors which may help to buffer the impact of this work.

METHODOLOGY

Search Strategy

A scoping search was conducted in November 2017 within the database Medline in order to test the search strategy and identify further relevant keywords and index terms (e.g. Medical Subject Headings - MeSH). This identified a number of relevant qualitative studies and confirmed a lack of reviews. The Cochrane database and Prospero register were also checked in order to avoid duplication.

Searches were conducted by the author within titles, abstracts and keywords of the following databases: PsychINFO, Proquest, Web of Science, PubMED, CINAHL, EMBASE, and MEDLINE. The search of these databases took place on the 28th November 2017 and was updated on the 4th January 2018. No year limit was imposed due to no previous qualitative reviews being conducted. Keywords and subject headings can be found in Table 1.1. Boolean terms OR and AND were used to combine search terms. 'Qualitative' keywords were not included in the search strategy to increase sensitivity at the expense of specificity. A flow-chart of the search process can be found in Figure 1.1. Inclusion and exclusion criteria were set prior to searches to reduce reviewer bias, and language bias was considered through reviewing English studies only.

Table 1.1 Search terminology

Search Terminology	
Subject Headings	(MH "Hospitals, P*ediatric") OR (MH "Pediatric Units") OR (MH "Intensive Care Units, Pediatric") OR (MH "Pediatric Occupational Therapy") OR (MH "Pediatric Physical Therapy") OR (MH "Rehabilitation, Pediatric") OR (MH "Pediatric Cardiology") OR (MH "Society of Pediatric Nurses") OR (MH "Pediatric Oncology Nursing") OR (MH "Pediatric Advanced Life Support") OR (MH "Association of Pediatric Oncology Nurses") OR (MH "Pediatric Surgery") OR (MH "Pediatric Nurse Practitioners") OR " healthcare professionals OR p#ediatric OR healthcare staff OR (nurs or nurse or nursing or nurses) OR (doctor or physician or medical practitioner) OR p#ediatrician OR (allied health professional or healthcare professional) OR occupational therapist OR (Physiotherapist) OR psychologist OR child life specialist OR hospital play specialist. (MH "Stress, Occupational") OR (MH Compassion Fatigue") OR (MH "Stress, Psychological") OR "burnout OR compassion fatigue") OR (MH "stress, psychological") OR (MH "compassion fatigue") OR (MH Stress, occupational) OR burnout OR compassion Fatigue OR trauma OR stress OR emotional exhaustion OR (job stress or occupational stress or workplace stress)
Keywords and search strategy	Burnout OR stress OR compassion fatigue OR secondary trauma* OR traumatic stress OR emotional exhaustion OR posttraumatic stress disorder OR role stress OR Resilience OR coping OR psychological adjustment AND P*ediatric OR healthcare personnel OR p*ediatric nurs*, OR nursing staff OR p*ediatric hospital OR physician OR medic OR resident OR nurse OR allied health professional OR psychologist OR health practitioner OR children's nurse OR intensive care OR child life specialist OR hospital play specialist OR occupational therapist OR physiotherapist OR hospital chaplain

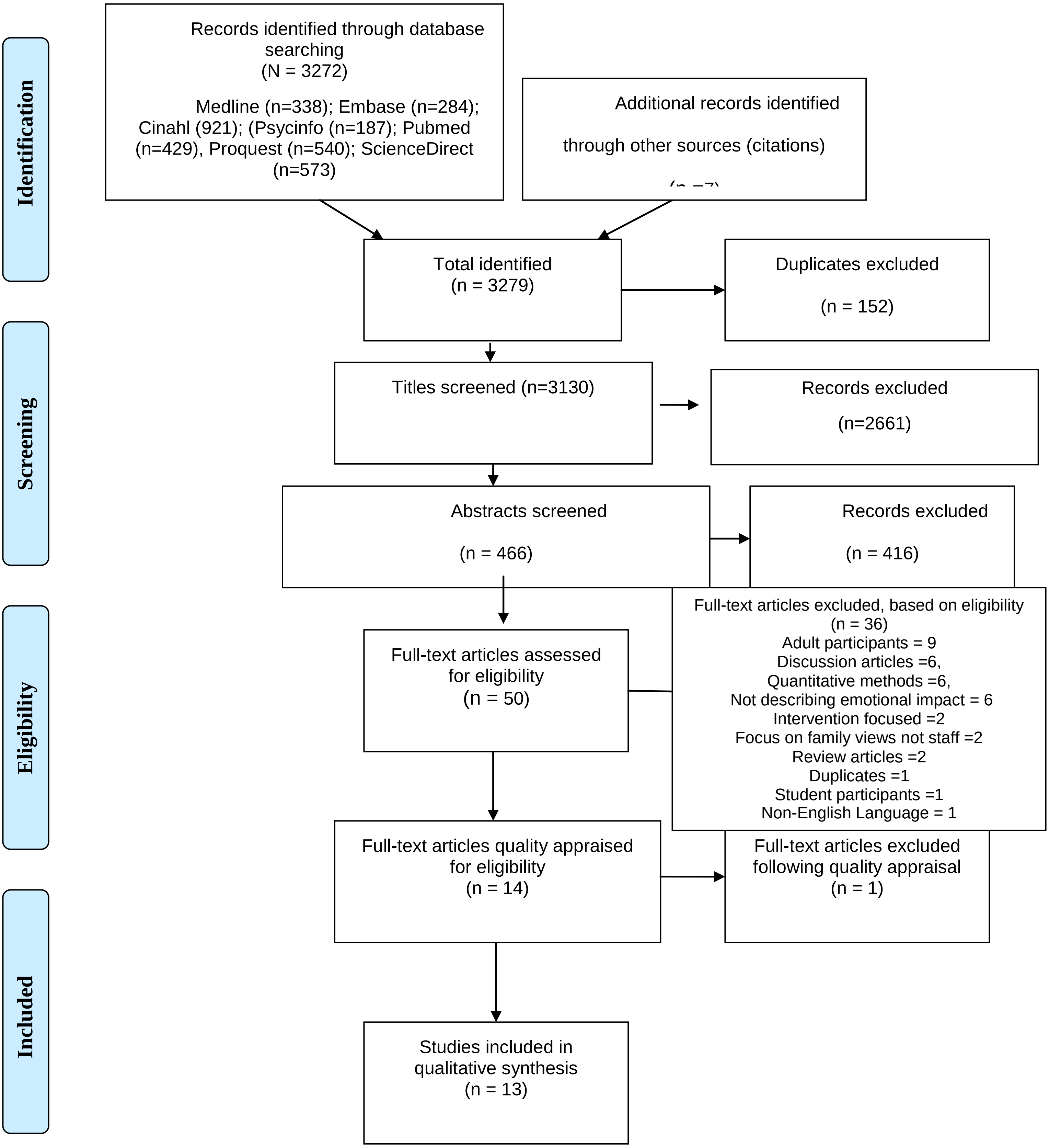
Study Selection

The selection of papers for review was guided by the below inclusion and exclusion criteria (see Table 1.2). Papers were first screened via title and abstract, and duplicate papers were removed. Full-text papers were then considered against the inclusion criteria. Further hand searches were conducted of the reference lists from all included papers in order to identify any additional literature. Please see Figure 1.1 for a flow-chart of this process.

Table 1.2. Inclusion/exclusion criteria

Inclusion criteria	**Exclusion criteria**
• Empirical research • Studies written in English • The study recruited qualified paediatric healthcare professionals working in inpatient settings • Peer-reviewed journal article • Qualitative methods including mixed-methods • Studies describing the emotional impact of the work as a main focus from the perspective of the professional	• Discussion articles or commentaries • Studies including adult samples • Quantitative articles • Studies including student and trainee samples • Professionals working in mental health settings • Studies that were conducted in neonatal settings • Researcher views - no empirical methods used • Studies exploring the perspectives of family members or patients • Intervention articles • Studies written in languages other than English

Figure 1.1 Search process and study identification.



Quality appraisal

All included studies were analysed by the author for quality using the Critical Appraisal Skills Programme (CASP, 2017) checklist for the reviewing of qualitative research. Each study was appraised for methodological rigour and conceptual validity across ten domains, with a point given for each criteria met. Each paper was therefore assigned a score of ten (see Table 1.3) to appraise the level of quality. A decision for inclusion in the review was made through discussion between the author and an independent second-rater. When discrepancies of scores arose, these were resolved via discussion and a final score was agreed. A full breakdown of scores for each paper can be found in Appendix 1.2. The decision to remove papers based on quality was discussed within this context and with the academic supervisor.

Method of Review: Meta-Ethnography

A meta-ethnographic form of meta-synthesis (Noblit & Hare, 1988), was adopted in order to develop a wider theoretical understanding of resilience and burnout. This approach was also chosen due to the capability of considering multiple methodologies in qualitative research (Barnett-Page & Thomas, 2009). The number of papers included in a meta-ethnographic review can vary considerably as searches are not advised to be exhaustive (Noblit & Hare, 1988). Meta-ethnography is widely accepted as the predominant method for synthesising qualitative information (Britten *et al.*, 2002), and the process involves seven stages (Noblitt & Hare, 1988):

1. Getting started
2. Deciding what is relevant
3. Reading the studies

4. Determining how the studies are related
5. Translating the studies into one another
6. Synthesising translations
7. Expressing the synthesis

All 13 included papers were read in depth and the main themes were identified and listed from each, known as first-order constructs. Secondly, themes from each paper were compared in order to consider similarities and differences between them, which were grouped to form 'second-order' constructs (Britten *et al*., 2002). Original wording at this stage was retained to reduce interpretive bias. Thirdly, a 'line of argument' was developed by the author to describe the relationship between the findings and to develop an overall theoretical understanding of the data, known as 'third-order constructs' (Noblit & Hare, 1988). See Appendix 1.3 for details of the components of each construct.

Reflexivity

The perspective advanced by the meta-synthesis represents the interpretation of the author, research team, the original study authors and their participants. As a Trainee Clinical Psychologist with experience in paediatric healthcare prior to training, the author has witnessed and experienced the work professionally. An awareness of the author's own beliefs has helped them to remain transparent throughout the development of third-order constructs during this review through the capturing of thoughts within a reflective journal (see extract in Appendix 1.4).

RESULTS

Systematic review

A total of 3,272 papers were identified through database searches, and seven from citation searches, as seen in Figure 1.1. A total of 152 duplicates were removed, and screening of titles removed a further 2,661. The resulting 466 abstracts were screened against inclusion/exclusion criteria which excluded a further 416 studies leaving 50 full-texts for screening. Full-text consideration against inclusion criteria screened out a further 36 studies, leaving 14 for review against the CASP quality checklist (see below). The reasons for exclusion can be seen in Figure 1 and include qualitative studies only, non-English language or the content of the paper not being relevant to the review (i.e. reflecting family experiences). Two systematic reviews were found (Mukherjee *et al*., 2009 & Zander *et al*., 2010) however were not included as they both described adult studies as well as paediatric ones.

Quality Appraisal

A total of 14 papers were critically appraised prior to the synthesis using the Critical Appraisal Skills Programme (CASP) checklist for the review of qualitative research. The quality of study included for review is important as it impacts upon the generalisability of findings and quality of implications (Boland, Cherry & Dickinson, 2017). Scores were assigned by the author and second-rater and can be seen in Table 3. Full illustration of each study's scores against the CASP checklist can be seen in Appendix 1.3. Three studies were rated of 'very high quality' (10/10; Conte, 2014; Maytum *et al*., 2004; Muskat *et al*., 2017). The majority of studies (six in total) rated as 'high quality' as 9/10 (Beaune *et al*., 2017; De Almeida-Vicente *et al*., 2016; Granek *et al*., 2016; Kellogg *et al*., 2014; Rodrigues *et al*., 2017; Zander *et al*., 2013), with one point lost across them due to lack of consideration of the researchers' reflexivity. Four studies rated as 'medium quality' with a score of 8/10 (Kpassgou & Soedje, 2017; Cook *et al*., 2012; Morrison & Morris, 2017; Papadatou *et al*., 2002), also losing points for lack of consideration of the influence of the researcher. All studies appraised considered ethical issues in recruitment of their participants. The paper by Kaplan (2000) was excluded from the meta-synthesis due to a score of 6/10. With no description of the type and process of data analysis, alongside unclear findings, this paper was thought to be inappropriate for inclusion in the meta-synthesis.

Table 1.3. Overview of appraised studies

	Beaune *et al* (2017)	**Conte (2014)**	**Cook *et al*. (2012)**	**De-Almeida Vicente *et al*. (2016)**	**Granek *et al*. (2016)**	***Kaplan (2000)*** ***(excluded)***	**Kellogg *et al*. (2014)**
Study title	The emergence of personal growth amongst healthcare professionals who care for dying children	The lived experience of work-related loss and grief among pediatric oncology nurses	Coping while caring for the dying child: nurses experiences in an acute care setting	Experienced pediatric nurses' perceptions of work-related stressors on general medical and surgical units: a qualitative study	Pediatric oncologists' coping strategies for dealing with patient death	*Delivering best care and maintaining emotional wellbeing in the intensive care unit: the perspective of experienced nurses*	The lived experience of pediatric burn nurses following patient death
Sample	9 social workers, 8 nurses, 8 physicians (n=25)	11 oncology nurses	17 nurses, 5 nurse practioners	12 nurses	21 oncologists	*15 nurses*	7 nurses
Setting	Paediatric hospital	Pediatric oncology	Cardiology unit	General medical or surgical unit	Paediatric hospital	*Paediatric hospital*	Paediatric burn unit
Data Collection	Semi-structured interviews	Semi-structured interviews	Focus groups (semi-structured interview questions)	Semi-structured interviews	Semi-structured interviews	*Semi-structured interviews*	Semi-structured interviews
Analysis	Thematic analysis	Phenomenological approach	Content analysis	Content analysis	Grounded theory	*Not described*	Phenomenological approach
Country	Canada	USA	USA	Canada	Canada	*USA*	USA
CASP rating	9/10	10/10	8/10	9/10	9/10	*6/10*	9/10

	Kpassagou & Soedje (2017)	**Maytum *et al*. (2004)**	**Morrison & Morris (2017)**	**Muskat *et al*. (2017)**	**Papadatou *et al*. (2002)**	**Rodrigues *et al*. (2017)**	**Zander *et al*. (2013)**
Study title	Heath practitioners' emotional reactions to caring for hospitilised children in Lomè, Togo: a qualitative study	Compassion fatigue and burnout in nurses who work with children with chronic conditions and their families	The practices and meanings of care for nurses working on a pediatric bone marrow transplant unit	The experiences of pediatric social workers providing end-of-life care	Greek nurse and physician grief as a result of caring for children dying of cancer	Burnout in nurses working with youth with chronic pain: a mixed-methods analysis (study 1)	Exploring resilience in paediatric oncology nursing
Sample	5 doctors, 16 nurses (n=21)	20 nurses	24 nurses	9 paediatric social workers	14 oncologists and 16 pediatric oncology nurses (n= 30)	32 nurses	5 nurses
Setting	Child oncology	Paediatric units	Bone marrow transplant unit	Paediatric acute care hospital	Pediatric oncology unit, Athens	44-bed pediatric inpatient unit	8-bed paediatric unit
Data Collection	Semi-structured interviews	Semi-structured interviews	Focus groups (semi-structured interview questions)	Semi-structured interviews	Semi-structured interviews	Focus groups	Semi-structured interviews
Analysis	Thematic analysis	Content analysis	Thematic analysis	Interpretive descriptive approach	Grounded Theory & descriptive statistics	Thematic analysis	Thematic analysis
Country	West Africa	USA	USA	Canada	Greece	USA	Australia
CASP Quality rating	8/10	10/10	8/10	10/10	8/10	9/10	9/10

Description of included papers

Included studies detailed the views of 173 nurses, 48 doctors and 18 social workers. The papers reported from a variety of countries including USA (n=6), Canada (n=4), Australia (n=1), Greece (n=1) and West Africa (n=1). All studies utilised semi-structured interviews with three employing focus groups (Cook *et al*., 2012; Morrison & Morris, 2017; Rodrigues *et al*., 2017), the remainder face-to-face individual interviews. The professionals in the papers included worked across clinical specialties, including oncology (Conte, 2014; Kpassagou & Soedje, 2017; Papadatou *et al*., 2002; Granek *et al*., 2016; Zander *et al*., 2013), burns (Kellogg *et al*., 2014), chronic conditions (Maytum *et al*., 2004), bone marrow transplant (BMT; Morrison & Morris, 2017), cardiology (Cook *et al*., 2012), chronic pain (Rodrigues *et al*., 2017), general medical and surgical (Vicente *et al*., 2016), and acute care (Muskat *et al*., 2017).

In analysing the data, the most popular method was thematic analysis (Beaune *et al*., 2017; Kpassagou & Soedje, 2017; Morrison & Morris, 2017; Rodrigues *et al*., 2017; Zander *et al*., 2013), with three using content analysis (Cook *et al*., 2012; Vicente *et al*., 2016; Maytum *et al*., 2004), two using grounded theory (Granek *et al*., 2016; Papadatou *et al*., 2002), two using phenomenological approach (Conte, 2014; Kellogg *et al*., 2014) and one interpretive descriptive approach (Muskat *et al*., 2017).

In content, the studies had varying focus, including reactions to working with dying children (Beaune *et al*., 2017; Conte, 2014; Cook *et al*., 2012; Granek *et al*., 2016; Kellogg *et al*., 2014; Muskat *et al*., 2017; Papadatou *et al*., 2002), exploring resilience (Zander *et al*., 2013), growth (Beaune *et al*., 2017), compassion fatigue and burnout (Maytum *et al*., 2004;

Rodrigues *et al*., 2017), and general challenges of the role of working in a paediatric inpatient setting (Vicente *et al*., 2016; Kpassgou & Sodedje, 2017).

Meta-ethnography

The meta-ethnography synthesised 13 qualitative studies. Four overarching concepts were developed: 1) 'feeling unprepared', 2) 'feeling helpless and out of control', 3) Dealing with emotions, 'connection and disconnection' and 4) 'new perspectives, growth and purpose'. Study partcipants' quotes are indicated by italics. Please see Appendix 4 for an outline of first and second-order constructs alongside third-order interpretations of the author. The contribution of each paper to each construct can be found in Table 1.4.

1) Feeling unprepared

Clinicians reported feeling unprepared for the emotional challenges of the work. Despite years of training, they reported a gap in education surrounding coping with death and difficult situations in the workplace, with a focus on practical domains (Cook *et al*., 2012; Kellogg *et al*., 2014; Kpassgou & Soedje, 2017; Zander *et al*., 2013):

> *"They just covered what you had to do for the patient that dies; the physical aspect of caring for the body and bringing the body to the morgue and stuff like that. The grief that you go through, not at all" (Kellogg et al., 2014, p300).*

This led to feelings of 'out of depth', especially for newly-qualified nurses: *“I saw the mother consoling the nurse. It's like who's supporting who....” (Cook* et al.*, 2012, p17).*

There was a description of the culture of pragmatism within medical training that seemed to increase distress upon losing a child. Medics felt less prepared for dealing with loss (Papadatou *et al.*, 2002). This description of un-preparedness for patient death and emotions did seem to reduce with level of experience (Zander *et al.*, 2013). Increased education was called for to prepare clinicians for these demands and to provide coping strategies to manage them (Kellogg *et al.*, 2014). However, the inclusion of reflective practice in nursing training was thought to prepare nurses for their own emotional responses in one study (Papadatou *et al.*, 2002).

2) Feeling helpless and out of control

'The kids just get sicker and sicker'

This construct encompasses the emotional impact of the work. Professionals described their feelings of sadness at seeing children deteriorate, as well as the aspects of the job they found most difficult, such as giving bad news, making difficult decisions and feeling unable to provide the best care (Papadatou *et al.*, 2002; Vicente *et al.*, 2016; Conte, 2014; Maytum *et al.*, 2015). The on-going exposure to sadness and death was a risk of the job (Maytum at al., 2015), which was compounded by feeling out of control of the outcomes for children. Professionals described intense feelings of sadness after a patient died:

> *"I sort of feel like a wave of great sadness, a feeling of great loss… when you first hear that someone died, you feel kind of like you've been hit by a truck, and you just kind of feel like wiped out and crushed." (Kellogg et al., 2014, p299).*

Exposure to the distress and pain of families had a very personal impact upon one oncologist's personal identity:

> *"Smiling was once a characteristic of my personality. Now, I experience a pressure upon my heart, a weight that does not allow me to breathe" (Papadatou et al., 2002, p351).*

Feeling powerless to help and unable to take away pain was a considerable stressor, and reduced the amount of professional successes or satisfaction gained from the job (Conte, 2014; Kellogg *et al.*, 2014; Maytum *et al.*, 2004) as *'the kids just get sicker and sicker'* (Vicente *et al.*, 2016, p222):

> *"I just remember feeling helpless to be able to help this family to be able to cope with the most horrible experience of their entire life… in not being able to fix it or make it better." (Conte, 2014, p43)*

Over time, the build up of emotional distress restricted their abilities to do their roles, with some nurses 'leaving their job entirely' (Maytum *et al.*, 2004, p174).

Feeling unable to meet expectations

Professionals spoke of the many expectations placed upon them. Carrying the expectations of parents to successfully treat their children was described as *'wearing'* (Maytum *et al.*, 2004, p175), and *'overwhelming'* (Papadatou *et al.*, 2002, p351). Professionals spoke of their own expectations of their roles in curing illness and saving lives (Granek *et al.*, 2016; Maytum *et al.*, 2004). However, due to working in areas with high patient death, these professional goals were often unfulfilled, leading to considerable stress, lack of satisfaction and feelings of 'failure' (Muskat *et al*., 2017):

> *"When you're young, or new to the profession…you're there to change the world… going to stamp out disease…after a while you realise that twenty years later, you're still losing against cancer." (Granek et al., 2016, p47).*

A lack of resources

Feeling unable to provide the best care for all patients due to feeling rushed or overworked was distressing for nurses (Maytum *et al.,* 2004; Vicente *et al*., 2017). A lack of physical and perceived resources appeared to increase the lack of control felt by some professionals, feeling unable to provide 'gold-standard' care (Vicente *et al*., 2016; Kpassgou & Soedje, 2017; Maytum *et al*., 2004; Rodrigues *et al*., 2014). A lack of time due to increasing caseloads and paperwork meant that clinicians were unable to look after themselves, leading to exhaustion and adding to risk of burnout (Vicente *et al*., 2016):

> *"We cannot provide safe care... patients aren't getting the things they need on time.'' (Vicente et al., 2016, p220).*

Within a study based in the socially-deprived country in Africa (Kpassgou & Soedje, 2017), the effects of lack of resource were even more powerful. Doctors expressed their distress at watching children die who may have otherwise been able to survive. 'Many of them reported being deeply pained, discouraged, and traumatized by seeing child who would, otherwise, have been successfully treated, suffer for long or die in their care.' (Kpassgou & Soedje, 2017, p77).

Power

Resources were described in physical terms but also in terms of power and expertise (Vicente *et al*., 2016). A lack of perceived power was expressed by nurses as stressful, compared to their more senior medical colleagues, whilst still holding a large amount of responsibility (Kellogg *et al*., 2014; Vicente *et al*., 2016; Morrison & Morris, 2017).

Professionals also felt powerlessness to prevent children from suffering (Papadatou *et al*., 2002, p348). For physicians, their sense of helplessness seemed to be amplified by an increased perception of responsibility (Papadatou *et al*., 2002). Feeling helpless led to them questioning their usefulness, their occupational identity, and therefore reduced their satisfaction from their work (Papadatou *et al*., 2002; Kpassgou; Maytum *et al*., 2004):

> *"To watch a family suffering and not be able to help them. To constantly be at that place where you walk out of work every day thinking that you didn't do a good enough job. I think that's where burnout comes in, where you just don't want to come in anymore because you're not getting any satisfaction out of your job" (Maytum et al 2015, p 176).*

The uncontrollability of emotions

Nurses also spoke of feeling a need to maintain control of their emotions 'to successfully continue through their shifts' (Conte 2014, p43) and to avoid appearing vulnerable or 'ineffective' (Kellogg *et al*., 2014). Practical strategies such as focusing on 'doing' as much as possible for children helped to buffer the impact of the loss of a child (Granek, 2015), and in order to reduce feelings of low self efficacy (Kpassgou & Soedje, 2017). However, this led to emotions building up over time:

> *"…there's clearly a built up wall inside me… I can cry on a dime…. I have to keep it together…But that comes at a cost later…maybe on the way home, maybe in two weeks… " (Muskat* et al., *2017, p 513)*

3) Dealing with emotions: connection and disconnection

Within this construct, professionals described the dichotomy of maintaining closeness and distance from patients and their emotions in order to cope with the demands of the job.

Parents and families

Connections to patients and families provided a source of comfort and reward. However, it also appeared to make losing patients more difficult, intensifying the feelings of grief (Conte *et al*., 2014, p42). Some professionals attempted to cope by beginning to withdraw from patients emotionally when they anticipated their death:

> *"When I see that a child has cancer in an advanced stage… when I expect that the child will die, my relationship with him or her is less close." (Kpassgou & Soedje, 2017, p77).*

In a study into nurses working with children with chronic pain (Rodrigues *et al*., 2017), they reported a lack of empathy and compassion for their patients' experience of suffering. They disconnected from their experience as a way of avoiding the reality of their pain, although those who were able to connect with families were described as better able to cope (Rodrigues *et al*., 2017).

Disconnecting from emotions

Many professionals reported negative feelings of guilt, sadness and anger as a result of patient death. Disconnection from their own emotional reactions seemed to enable coping at least in the short-term (Papadatou *et al*., 2002). Professionals avoided their own grief by distancing themselves physically and emotionally:

> *“Seeing somebody passing away doesn’t mean anything to me”, “I am armoured, It is a daily thing and I don’t feel anything when I see someone die.” (Kpassgou & Soedje, 2017, p78).*

It seemed that disconnecting from emotions may not serve to eradicate the feelings themselves, but possibly acted as a protective mechanism to put a boundary between what is the patient's experience and what is the professionals', in the case of oncologists:

> *"It’s difficult. You cannot forget.... you learn to compartmentalize… you can better distinguish once you become more experienced that this pain relates to this family and not to yourself" (Granek et al., 2016, p49).*

The avoidance of emotional experiences, although aimed to be protective, ultimately led to burnout. 'A few professionals who experienced high degrees of burnout used massive avoidance strategies to protect themselves from the experience of suffering and pain caused by childhood death….The motives for such conscious grief avoidance were to protect themselves from being overwhelmed by multiple deaths, from re-experiencing traumatic death experience, or from having to confront their own mortality and vulnerability' (Papadatou *et al*., 2002, p350-351):

> *"I close my pain in a little drawer. I don't let myself think, I switch off and avoid all images of what I have witnessed" (Papadatou et al., 2012, p 351)*

Work/Life Balance

Other professionals coped through physical distractions such as running and physical exercise (Muskat *et al*., 2017; Granek *et al*., 2016), vacuuming the house (Zander *et al*., 2013), or through taking breaks. In Granek's (2016) study of oncologists, taking regular breaks were described as 'essential in coping with frequent patient death. These breaks also included using research as a means of buffering the amount of loss and grief they experienced through providing distance from clinical duties. Professional and personal boundaries enabled professionals to maintain a balance between work and home life in nurses (Kellogg *et al*., 2014), with spending time with family enabling space from work and to be in the ‘here and now’ for oncologists (Granek *et al*., 2016, p53).

Connecting with emotions and others

Others tended to directly connect with their emotional experience both alone and with others, in order to process the emotional impact of the work. It was hypothesised that 'keeping it together' was important on the job but that emotions needed to be expressed eventually

(Conte, 2014). Methods of coping included venting, offloading to peers, crying privately and having rituals to mark the loss of a child (Maytum *et al*., 2004). These strategies enabled professionals to process their experiences:

> *"Sometimes I felt like I kept it together and then cried in the car". (Conte, 2014, p43)*

Organisational cultural factors also appeared to considerably impact upon professionals' emotional coping. In Papadatou's study, 'such control was also reinforced by the implicit workplace ethic that did not allow the expression of intense emotions among members of the medical team.'(Papadatou *et al*., 2002, p 350). There was an idea that emotions should not be expressed in another sample of nurses:

> *"... In the beginning I hid myself in the toilet and cried but then I said to myself, nurses do not cry" (Kpassgou & Soedje, 2017, p78).*

A culture encouraging emotional suppression seemed to increase professionals' tendency to disconnect from relationships (Granek *et al*., 2016). This appeared more pronounced in doctors, who experienced grief more privately, than nurses, who preferred to share within a team (Papadatou *et al*., 2002). 'Unlike physicians, [nurses] referred to their need to share experiences with colleagues to find an emotional outlet, receive support, and attribute meaning to the death of a child.' (Papadatou *et al*., 2002, p350).

The majority of professionals avoided talking about work at home because their families struggled to understand the unique pressures of the work (Morrison & Morris, 2017; Muskat *et al*., 2016; Granek *et al*., 2016):

> *"you can't possibly explain to them what you do in a day… no-one would ever understand it" (Morrison & Morris, 2017, p218)*

Some nurses used codes such as 'a busy day' to communicate to their partner that they have had a difficult day without revealing details (Cook *et al*., 2012; Conte, 2014). This also had the effect of isolating them from key sources of support:

> *" My family will ask me questions about things… but they really don't want to know. I never tell the stories. It upsets them too much, and then I feel bad doing that to them.." (Conte, 2014, p42)*

However, physicians were more likely to seek support from family members, but only when they were in the medical profession. As a result, professionals who did seek support, seemed to do so from their colleagues through informal conversations (Cook *et al*., 2012, Conte, 2014; Kellogg *et al*., 2014), because "*they understand the most exactly what is going on."* (Conte, 2014, p42). Those working in oncology found solace in the shared experience colleagues (Granek *et al*., 2016). Through the connections with colleagues, there was an understanding that this enabled the processing of loss and grief (Conte, 2014). When avoidance was the only strategy, processing was blocked and seemed to cause a build up of distress (Papadatou *et al*., 2002).

4) New perspectives, growth and purpose

This construct summarises the benefits of working in paediatrics which enable the professionals to keep going in the face of pain and grief. These benefits were both personal and professional (Morrison & Morris, 2017).

Making a difference

On a professional level, staff described enjoying the opportunity to 'make a difference', enabling a sense of purpose and fulfilment (Beaune *et al*., 2017, p5). Through supporting children and families, professionals gained satisfaction from being there and helping families through their darkest times. This helped social workers (Muskat *et al*., 2017) and oncologists (Granek *et al*., 2016) to cope with the difficult aspects of their work:

> *" I feel very privileged to be part of that very sacred time in a family's life " (Muskat et al., 2017, p511).*

A change in perspectives

On a personal level, the work provided professionals with a new perspective on life, and death. Professionals described the work providing a reminder of the fragility of life, and encouraged them to focus on the important things, to prioritise what is important (Conte, 2014; Zander *et al*., 2013). Professionals described feeling grateful for their families' health over a focus on material possessions (Beaune *et al*., 2017, p5). This was especially the case for professionals with their own children:

> *"I do not care about material things that I used to. I care about health... I go home, I squeeze my daughter…every day, and know every minute that she's healthy is the most important thing." (Muskat et al., 2016, p511).*

> *"My boyfriend and I really just don't fight because it's not worth that, you know, to ruin the day when this could be the last day" (Conte, 2014, p44).*

For others, a normalisation of death and illness allowed for a reduction of fear about dying (Beaune *et al*., 2017; Zander *et al*., 2013).

> *"I think there was a time where it was very, very frightening, and now… I'm not so frightened any more". (Muskat et al., 2016, p511)*

Personal and professional growth

Professionals also spoke of the their development of self-awareness over time (Muskat *et al*., 2016; Zander *et al*., 2013). This provided them with an acceptance of their emotional reactions and the ability to anticipate when a situation may impact them. This enabled them to maintain self-compassion whilst managing situations effectively (Vicente *et al*., 2016; Muskat *et al*., 2016). An acceptance of their limitations also enabled nurses to focus on what they were able to provide for families, and increased their self-efficacy (Zander *et al*., 2013). Professionally, staff described learning a lot from the strength of their patients (Beaune *et al*., 2017). Growth came from being able to focus on positive relationships with the family and being in awe of their resilience (Zander *et al*., 2013):

> *"I've learned a lot. I think I've probably learned more from my families and kids I've worked with than I have from any textbook." (Beaune et al., 2017, p5).*

It seems therefore that exposure to trauma contributed to the development of personal and professional attributes, perspective and fulfilment, enabling them to continue in the job.

Line of Argument

The findings highlight a number of factors which influence workplace stress, including feeling unprepared for patient death, witnessing patient deterioration and feeling powerless to help, as well as managing high expectations with a lack of resources. Professionals coped through withdrawing from patients, maintaining a work/life balance, and seeking peer support. Professionals varied in their level of connection with their distress, with a number describing strategies such as compartmentalising or blocking feelings, which appeared successful in the short-term to help them cope. Others chose to release their emotions by crying or talking to others. It is therefore argued that a balance between connecting and disconnecting to distress may contribute to resilience within paediatric professionals.

Table 1.4. Contribution of papers to each construct

	1.) Feeling unprepared	**2.) Helpless, feeling out of control**	**3.) Connection and disconnection**	**4.) New perspectives, growth and purpose**
Beaune *et al*., (2017)				✓
Conte (2014)		✓	✓	✓
Cook *et al*., (2012)			✓	
De Almeida Vicente *et al*., (2016)	✓	✓		✓
Granek *et al*., (2016)		✓	✓	✓
Kellogg *et al*., (2014)	✓	✓	✓	
Kpassagou & Soedje (2017)	✓	✓	✓	✓
Maytum *et al* (2004)		✓	✓	
Morrison & Morris (2017)		✓	✓	✓
Muskat *et al*., (2017)		✓	✓	✓
Papadatou *et al*., (2002)		✓	✓	✓
Rodrigues *et al*., (2017)		✓	✓	
Zander *et al*., (2013)	✓		✓	✓

DISCUSSION

This review provides the first known attempt to synthesise qualitative research into the experience of paediatric professionals working in inpatient settings, adding a breadth of understanding to an increasing body of literature into resilience in paediatric professionals (Zander, Hutton & King, 2010; McGarry *et al.*, 2013; Colville *et al.*, 2015). To our knowledge, this is the first meta-synthesis to consider results from qualitative studies within multiple specialties including burns, oncology, BMT, cardiology, PICU and surgical units, providing a broad overview of the experiences of professionals. This review advances the understanding proposed by Zander, Hutton & King (2010) that resilience represents a fluid interaction of individual and environmental factors of stress and reward.

Key sources of stress related to feeling unprepared for the emotional challenges of the role, feeling unable to control circumstances, and being exposed to patient trauma and loss (Cook *et al.*, 2012; Kellogg *et al.*, 2014; Kpassgou & Soedje, 2017; Zander *et al.*, 2013). Feeling unprepared for the emotional demands of the work suggests gaps in medical education may leave professionals vulnerable to distress. Indeed, during the first 10 years of a clinicians' career, professionals are much more likely to experience burnout (Bush, 2009), suggesting that training courses should emphasise the emotional impact of the work and provide skills to cope (Kellogg *et al.*, 2014; Beaune *et al.*, 2017). The role of experience in resilience development is currently unclear, with this review highlighting the impact of lack of experience yet also describing a relationship between exposure to distress over time. More exploration of this relationship is required.

Maytum et al., (2004) interpreted that a prolonged exposure to pain and grief over time led to an accumulation of distress for many professionals, who struggled with the emotional heaviness of losing patients under their care (Papadatou *et al*., 2002). This finding fits with research which suggests that those working in areas of high risk of patient death, such as palliative care and oncology care have higher risks of compassion fatigue than general areas (McKinley, Boland & Mahan, 2017; Abendroth & Flannery, 2006). Patient loss had an impact upon professionals both personally and professionally, with doctors in particular reporting feelings of inadequacy and failure at being powerless to save some children (Papadatou *et al*., 2002; Conte, 2014), and thus leaving their professional goals unfulfilled (Muskat *et al*., 2017; Granek *et al*., 2016). The review highlights a key difference between the responses of doctors and nurses, with nurses struggling more with the loss of the relationship over professional goals (Papadatou *et al*., 2002), although the differences between professionals' methods of coping requires further investigation.

Relationships with children and families were a source of great reward but came with the increased risk of grief and suffering (Conte, 2014). This fits with the review findings of Zander and colleagues (2010) in oncology settings, suggesting that this may be an issue across paediatrics. With increased exposure to patient distress and grief, it is thought that some professionals become overwhelmed and disconnect from patients as a way of distancing from their suffering (Berger *et al*., 2015). The importance of maintaining boundaries whilst also connecting with patients is highlighted by a number of studies into oncology professionals (Ablett & Jones, 2007; Maytum *et al*., 2004). This review highlights the importance of considering the emotional investment within all paediatric specialties. Relationships are a key aspect of providing quality care, yet leave professionals vulnerable. Thus, more research is required to consider ways of retaining connections with patients and families whilst protecting their own wellbeing.

Avoidance acted as a protective strategy by disconnecting from patients' pain (Papadatou *et al*., 2002). Avoidance took the form of blocking, heightened boundaries, physical withdrawal from patients, and using distraction techniques, which enabled them to continue doing the job (Papadatou *et al*., 2002). However, multitasking or 'keeping busy' has been thought to cause emotions to remain unprocessed (Pfifferling & Gilley, 2000), and was associated with burnout in a study of 120 PICU staff, despite being described as helpful (Colville *et al*., 2015). This highlights the importance of evaluating the helpfulness of coping strategies using multiple approaches. Indeed, the avoidance of emotions over time led to professionals feeling overwhelmed in this review (Papadatou *et al*., 2000; Conte, 2014). The concept of experiential avoidance provides some insight into how avoidance of emotional experiences increases levels of distress (Hayes *et al*., 2004). The link between experiential avoidance and distress suggests that interventions encouraging non-judgmental emotional contact through mindfulness (e.g. Mindfulness Based Stress Reduction [MBSR]; Kabat-Zinn, 1990) or acceptance-based approaches (e.g. Acceptance and Commitment Therapy; Hayes *et al*., 1999) may be helpful in enabling professionals to experience their emotions without avoiding them. For example, MBSR has been found to be helpful for healthcare professionals in a review of 10 studies (Irving *et al*., 2009) in reducing stress and increasing self-compassion. Further research into the factors enabling professionals to process the emotional impact of the role is required.

Some professionals acknowledged the importance of connecting with their emotions to process them, through talking, reflection and crying (Conte, 2014; Maytum *et al*, 2004). However, they also highlighted the need for psychological safety to be present for them to feel able to do so. Finding time to grieve has been highlighted as important in preventing burnout (Shanafelt *et al*., 2003), which was difficult for professionals in this review due to time pressures. Papadatou (2000; 2009) developed a model of processing of grief in healthcare staff. The model suggests that staff fluctuate between experiencing and avoiding grief in order to cope with the loss of a patient whilst continuing to work, similar to the dual processing model proposed by Stroebe & Shut (2010). Papadatou's (2000) model suggests that the process of connecting and disconnecting from emotions is an adaptive one, but only when this is balanced. Further application of the model with healthcare staff is needed.

Connecting with colleagues who understand the unique challenges enabled professionals to feel validated, and provided support that they felt unable to receive at home, leaving professionals potentially isolated (Morrison & Morris, 2017; Granek *et al.*, 2016). This highlights the need for an increase in organisational support (Beaune *et al.*, 2017; McConnell *et al.*, 2016). This is increasingly becoming recognised in the UK (Robert *et al.*, 2017). For example, Schwartz Rounds are facilitated multi-disciplinary forums for discussing the emotional impact of working in healthcare and have been evaluated as helpful in normalising and validating the emotional impact of caring for sick patients (Adamson *et al.*, 2018), increasing support (Deppoliti *et al.*, 2015) and reducing distress (Maben *et al.*, 2015). Schwartz Rounds have recently have been evaluated as useful in a children's hospital in the UK (Hughes, Duff & Puntis, 2018), reflecting a promising resource for paediatric professionals.

Reflective practice groups may also serve as a way for professionals to share their experiences in a safe and supportive forum, encouraging the seeking of help rather than avoiding it (Altounji & Morgan & Grover 2013, Sands, Stanley & Charon, 2008). However, it would be important for these to be facilitated in considering the power differences highlighted in the review (Kellogg *et al.*, 2014; Vicente *et al.*, 2016; Morrison & Morris, 2017). It is recognised that attending such forums may be difficult in light of time pressures, but recent NICE(2009) guidance highlights to managers the importance of prioritising staff wellbeing in order to reduce sickness and turnover. Future research should focus on the evaluation of such interventions in order to consider their effectiveness, as much of the available evidence has utilised small sample sizes.

Feeling out of control physically due to high workloads, increased pressure and lack of resources contributed to feelings of helplessness in this review (Maytum *et al*., 2015; Vicente *et al*., 2017). Burnout can be exacerbated by organisational demands, leading to reduced morale, poorer efficacy and cynicism (Bush, 2009). Thus, finding methods of coping with such reduced capacity and high workloads is important considering the current financial climate (Wilkinson, 2015). Some professionals spoke of the importance of maintaining a work-life balance, focusing on activities outside work such as exercise and family life in order to gain distance from the stress of the job (Muskat *et al*., 2017; Granek *et al*., 2016), which is supported in empirical research regarding coping in paediatric healthcare professionals (Isikahn *et al*., 2004). Paradoxically, professionals in this review identified how multiple demands restricted their ability to take part in such activities outside of work (Vicente *et al*., 2016). Therefore, promoting the use of simple self-care techniques may enable clinicians under stress to obtain some distance from the work in order to cope with the demands. The findings also emphasise however that the use of such strategies should not be used as an avoidance strategy, in order to maintain wellbeing (Hayes *et al*., 2004; Orsillo & Roemer, 2005).

Finally, the review highlighted the positive aspects taken from the work. As in Zander and colleagues' (2010) review, professionals gained satisfaction and purpose from making a difference to children and families despite the work bringing sadness and grief (Morrison & Morris, 2017; Granek *et al*., 2016; Muskat *et al*., 2017; Conte, 2014; Zander *et al*., 2013;

Beaune *et al*., 2017). This adds to evidence to suggest that whilst challenging, healthcare work can provide opportunities for personal growth, satisfaction, enrichment, meaning, perspective and reward (McCloskey & Tagard, 2010, Plante & Cyr, 2011). Finding meaning in work has been suggested to be protective against burnout in quantitative studies of healthcare professionals (Shanafelt, 2009, Pololi, Evans, & Civian *et al*., 2015; Colville *et al*., 2015), and may link to the concept of post-traumatic growth. Post-traumatic growth in healthcare professionals has been described in trauma therapists (Arnold *et al*., 2005), oncology nurses (Vishnevsky *et al*., 2015) and in paediatric palliative care with nurses, physicians and social workers (Beaune *et al*., 2017). Working with dying children created an existential shift in professionals' beliefs about life and death, and enabled them to connect with what is important to them. Defined in terms of psychological changes that occurs following the experience of negative life events (Tedeschi & Calhoun, 2004), post-traumatic growth may therefore provide further information around coping in paediatric professionals exposed to trauma and loss, but this phenomenon requires further investigation.

Limitations and further directions

This meta-synthesis represents the third-order interpretations of the studies included by the author (Sandelowski & Barroso, 2005). Although efforts have been made to maintain closeness with the original data through the use of a transparent methodology and quotations throughout, it must be noted that such interpretations are subjective and the understanding may differ from another's should it be replicated.

There was some difficulty in adequately reviewing papers due to a lack of appropriate appraisal tools for qualitative studies (Dixon-Woods & Fitzpatrick, 2001). The CASP tool provided a framework for the consideration of quality of each study, but remained a subjective measure of quality. Further rating systems are available (e.g. Duggleby *et al*., 2010) which may have aided the appraisal further. In addition, the study by Kaplan (2000) was removed due to lack of clarity of findings, although this study may have provided additional insights if it was included.

This review was deliberately broad to capture all paediatric professionals. However, doctors, nurses, and social workers are a heterogeneous group with different training pathways and experiences, and therefore drawing conclusions across groups is difficult. The breadth of studies enabled an overview of the issues across paediatric healthcare, but restricted the depth in which studies could be discussed. However, a strength of this review is that it emphasises the risk of burnout within multiple specialties, in contrast to the hypothesis of Zander *et al*., (2009) that oncology alone presents unique challenges.

Gender variation was also not reported, which could have influenced the way in which professionals chose to share, or cope with, their experiences. In addition, the review included studies from a number of different cultures (West Africa, USA, Australia, Canada and Greece), and with this comes difficulties generalising and making judgements on the importance of different coping strategies. The UK was not represented in this study, and there are risks in applying British values to other cultures. Further research is required to explore the impact of working in paediatric healthcare in the UK.

The concept of resilience has often been linked to 'hardiness' in the literature, but Ervolino-Ramirez (2007) suggests they actually represent distinct concepts. This review demonstrates the importance of considering not only the ability to 'bounce back' from adversity (i.e. hardiness), but to process negative experiences, enabling growth. Our findings suggest that a professional's resilience may change over time, depending on the organisational context and personal resources. Further research may focus on defining the concept of resilience using qualitative methods in order to fully understand its development in the context of different environments. It would be helpful to conduct longitudinal research measuring resilience and burnout in order to consider the impact of experience and exposure to distress over time.

The review also lacks the views of allied health professionals, such as chaplains, occupational therapists, physiotherapists and health play specialists who play a key role in the care of children and families in a hospital setting, as these groups have been highlighted to have equal levels of compassion fatigue than medical staff (Meadors *et al*., 2010). Considering the impact of the work across the whole healthcare team would provide a balanced account of the pressures and reward of working in paediatric healthcare.

Conclusions

This meta-synthesis of 13 studies highlights the unique stresses and rewards of paediatric healthcare among different professionals and specialties. Factors associated with stress included feeling unprepared for patient death, feeling powerless to control the outcome for patients, and a lack of resources. Resilience was most linked with striking a balance between connecting and disconnecting from emotions and patients, enabling space from the difficulties of the job whilst processing their experiences. This review also emphasises that exposure to pain and grief provides an opportunity for personal growth. The findings therefore highlight the importance of supporting professionals on an individual and organisational level in order to enable staff to cope with the emotional demands of the job.

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An Exploration of Resilience in Health Play Specialists: a Grounded Theory Study

Angela Webber BSc (Hons), MSc

South Wales Doctoral Programme in Clinical Psychology

Cardiff University

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Supervisors:

Dr Victoria Samuel

Dr Kerry-Ann Holder

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ABSTRACT

Health Play Specialists (HPS) play an integral role in the care of sick children in hospital, yet little is known about how they cope with the stress of the work. This research aimed to explore resilience in this under-researched group. Ten HPS from across three UK Children's Hospitals took part in semi-structured interviews. Their responses were analysed using constructivist grounded theory methodology.

A theory of the development of resilience is presented. The results indicate that the HPS role is unique, encompassing a number of challenges, including 'being misunderstood', 'being pulled in all directions', and 'being there'. The strategies HPS used to cope with these challenges is outlined. The findings highlight the vulnerability of HPS to experiencing distress and the theory developed outlines a number of conditions for the promotion of resilience within this group.

Keywords: *Health Play Specialist, Coping, Resilience, Constructivist Grounded Theory, Burnout, Paediatrics, Healthcare Professionals, Child Life Specialists, Hospital Play Specialist*

INTRODUCTION

The incidence of stress and burnout within healthcare professionals in the UK is increasing (Imo, 2017; Suri & Nash, 2018). The Department of Health (2010) considered workplace stress to be the predominant cause of sickness absence in the NHS in the United Kingdom (UK), at an estimated cost of £1.9 billion (The NHS staff survey, 2016). Stress also increases turnover and decreases productivity (Henderson & Madan, 2013), thus the wellbeing of the workforce directly impacts upon the efficiency of healthcare services.

Healthcare professionals are exposed to the distress and trauma of patients on a daily basis (McGarry *et al*., 2013). Over time, the accumulation of these experiences has been associated with secondary traumatic stress, (the physical and emotional response from being exposed to another's trauma; Figley, 1995; Conrad & Kellar-Guenther, 2006), compassion fatigue (the reduced ability to empathise with a patient; Figley, 1995) and burnout (characterised by emotional exhaustion, lack of accomplishment and depersonalisation; Maslach & Jackson, 1984; Imo, 2017). These phenomena restrict the level to which an individual can function at work (Palmer, Cooper & Thomas, 2004). For example, compassion fatigue and burnout have been associated with increased levels of sickness, decreased productivity in healthcare staff (Meadors *et al*., 2009), as well as increased medical errors (Hall *et al*., 2016). Therefore, increasing wellbeing and preventing burnout is a priority for healthcare providers in order to provide safe and efficient care, especially considering the current times of austerity within the UK (Boorman, 2009).

Burnout in Paediatric Healthcare Professionals

There is evidence to suggest that working in paediatric settings may incur unique challenges for staff, including witnessing the pain and distress of children, carrying out invasive procedures, experiencing children dying at an early age, and supporting parents in distress (Maytum, Heiman & Garwick, 2004; Burtson & Stichler, 2010). Indeed, Robins, Meltzer and Zelikovsky (2009) found that their level of exposure to distress was comparable to trauma workers. In a survey conducted by Berger *et al*. (2015), it was suggested that around 29% of paediatric nurses working in various departments met the criteria for burnout, and 27% had secondary traumatic stress.

There have been a number of factors linked to burnout in paediatric professionals. In Berger and colleagues' (2015) survey of 239 paediatric nurses, they found that a younger age was associated with higher levels of burnout. Recent qualitative research has indicated that high workloads, exposure to patient death and suffering, and feeling unprepared for dealing with emotions are associated with burnout in medical staff (Vicente *et al*., 2016; Kpassgou & Soedje, 2017; Maytum *et al*., 2004; Rodrigues *et al*., 2014). For example, in a study of 20 nurses working with children with chronic conditions, Maytum *et al*., (2004) found that ongoing exposure to the suffering and loss of patients was associated with a greater risk of burnout in nurses, and increased workloads led to staff feeling exhausted, increasing their intention to leave their jobs. The authors called for an increased understanding of coping strategies in order to reduce staff turnover. Despite small sample sizes limiting the generalisability of qualitative studies, they provide valuable insight into the experiences of front-line professionals.

Although the impact of working in paediatric healthcare is becoming increasingly recognised, much of this research focuses upon medical professionals. McGarry *et al*., (2013) highlights that the experiences of allied health professionals are less understood, and the limited studies available suggest that this group may be equally vulnerable. For example, Harris, Cumming & Campbell (2006) found that occupational therapists (OTs), psychologists, physiotherapists and speech and language therapists experienced similar levels of workplace stress as their medical colleagues. Equally, Taylor *et al*., (2006) discovered similar levels of stress in hospital chaplains, and Meadors *et al*., (2008) found that health play specialists were equally vulnerable to stress.

The Role of the Health Play Specialist

Health Play Specialists (HPS) play key roles in the care of children in hospital. Trained to Foundation Degree level and governed professionally through Health Play Specialist Education Trust (HPSET, 2018), HPS provide support for sick children and young people between the ages of 0-19 years (Thompson, 2018). HPS conduct tailored, individualised interventions based on the child's developmental level, personality and level of coping skills (Heiney, 1991). HPS help children to understand complex information about their care. They also promote cognitive and physical development, and prepare children for medical procedures through education, anxiety management (including desensitisation), and distraction techniques (Jun-Tai, 2008; Thompson, 2009). HPS advocate for the importance of play so that children can develop the necessary skills, confidence and resilience to cope with and undergo traumatic procedures (Jun-Tai, 2008). Additionally, HPS also support medical staff to communicate at the right developmental level for children and provide emotional support to parents and families, including support with loss and bereavement (Nutall, 2013).

Health Play Specialists and Burnout

HPS work on the 'front-line' of paediatric medicine; they witness traumatic procedures and are involved in communicating extremely difficult information to children and families (Holloway & Wallinga, 1990; Fisackerly *et al*., 2016). They are arguably equally as exposed to the stress and trauma of the sick children in their care, yet their experiences are relatively unknown in comparison to their medical colleagues (Fisackerly *et al*., 2016). HPS often work with children and families for longer periods than nurses or doctors who may have more shift-based work patterns. Thus the risk of them being further exposed to patient distress may be greater.

The emotional impact of the HPS role was recognised originally by Holloway and Wallinga (1990) who found that role ambiguity was the highest predictor of burnout in this group. More recently, Meadors *et al*. (2009) investigated secondary trauma in a multi-professional group of healthcare professionals, which included HPS (chaplains, nurses, physicians and HPS) and found burnout and compassion fatigue to affect HPS equally to other medical professionals. More recently, Fisackerly *et al*., (2016) conducted a survey of 154 HPS in the US, and suggested that HPS working in haematology and oncology had the highest risk of compassion fatigue, but called for more research to be conducted to understand the experiences of this unique profession. There is also a lack of understanding of the emotional impact of working as a HPS in the UK. Research suggests that contact with a HPS reduces the length of hospital admissions, reduces the need for general anaesthetics, improves recovery and patient satisfaction (Brooke & Janselewitz, 2012; Magrab & Bronheim, 1976). Therefore, maintaining wellbeing in this staff group has the potential to bring positive outcomes across economic and clinical domains.

Resilience: How Do Professionals Cope?

Healthcare professionals have to learn quickly how to cope with suffering, pain, grief and loss in order to continue doing their jobs (Meadors *et al.*, 2009). Resilience represents a promising concept in buffering the impact of work stress upon healthcare staff and services. Although there is no universally agreed definition of resilience (Aburn, Gott & Hoare, 2016), for the purpose of this study it is defined as the ability to adapt and cope with adversity (Windle, 2011). There has also been some debate within the literature regarding whether resilience represents a stable personality trait or something which develops over time (Luthar & Cicchetti, 2000). Acquired experience has been associated with increased coping skills in a review of studies into oncology nurses (Zander, Hutton & King, 2010), suggesting that resilience may reflect a fluid concept, although this requires further investigation. In addition, little is known about how resilience develops in healthcare staff.

A limited number of studies into resilience into paediatric professionals have suggested ways in which staff can cope with workplace pressures. Lee *et al*., (2015) investigated resilience in 1,066 staff members working in paediatric intensive care, and found the use of informal support with colleagues, taking a break, social activities and reflective practice to be associated with resilience. Most research into resilience has been quantitative, although qualitative studies are providing further depth into the phenomenon. Zander and Hutton (2012) interviewed five nurses in paediatric oncology to develop a concept of resilience. Working with families, making decisions, high workloads, invasive procedures, and witnessing deterioration and relapse were associated with distress and taking work home. Resilience was linked with gaining a realistic view of what they could do, the expression of emotion, problem solving, seeking support, having a social life outside of work, reflection, and experience. In addition, a study into coping with patient death in 21 oncologists found that strategies involving support, taking breaks and distraction were commonly used (Granek *et al*., 2016). Therefore, an awareness has recently begun to develop surrounding factors relating to resilience in paediatric professionals. However, much of the literature has focused upon the experiences of medical staff, neglecting the experiences of other key members of paediatric multi-disciplinary teams (MDTs). Considering the ongoing financial challenges to the current NHS, it is important to understand factors which may limit the impact of workplace stress for all paediatric professionals.

Resilience in Health Play Specialists

Although the topic has not been formally investigated in the UK, some insight can be gained from international studies. Findings from empirical studies suggest that peer support and supervision are important in maintaining wellbeing in US health play specialists (Munn *et al*., 1996; Seti, 2008). In a study into HPS and nurses working in a the US, Fisackerley *et al*., (2016) found that debriefing after patient death and emotional trauma significantly reduced the risk of burnout for HPS. However, to date no study has predominantly focused upon this issue in the UK, and there is no known theory of the development of resilience within this group.

Aims and Objectives

Due to the absence of research in the UK, it is unclear how HPS in this country perceive the challenges of their role. The aim of this study is to focus upon generating a theory of the development of resilience for HPS in the UK through understanding the challenges and methods used to cope, in order to provide recommendations to promote wellbeing at individual and organisational levels.

METHODOLOGY

Design

In order to generate a theory of resilience development, grounded theory methodology was thought to be most appropriate (Payne, 2007). Of the many iterations of grounded theory, (Glaser & Strauss, 1967), constructivist grounded theory (Charmaz, 2006) was considered the best fit for this study. Considering the lack of universal definition of resilience (Aburn *et al*., 2016), constructivist grounded theory was chosen in order to enable a concept of resilience to be co-constructed between the participants and the researcher, rather than from any pre-existing hypotheses (Willig, 2008). This also fits with the author's epistemological viewpoint (see reflexive bracketing section below). Further, as HPS represent an under-researched group, grounded theory provides a useful method for exploring concepts which are less understood (Charmaz, 2014).

Ethical Considerations

Ethical approval was obtained from the Cardiff University School of Psychology Research Ethics Committee, and, as the project recruited healthcare staff, the Health Research Authority (HRA) and Research Governance Wales also reviewed the study. Each NHS site Research & Development (R&D) department also conducted their own review. See Appendix 2.2 for approval documentation.

Informed Consent

Informed consent was obtained by providing a participant information sheet as part of the invitation to participate. This included details of how participants' information would be used. Participants were informed of the intention to use written quotations in the paper, and anonymity was ensured by the use of pseudonyms assigned to each participant at interview.

Participants signed a written consent form prior to taking part in the study and were informed of their right to withdraw at any time up until the write-up. All information collected was stored in line with the Data Protection Act (1998). Interviews were recorded on an encrypted dictaphone and recordings were deleted after transcription. Participants were informed of the limitations to confidentiality in line with BPS Code of Ethics and Conduct (2009), and were provided with time with the researcher after the interview for a debrief (See Appendix 2.3 for study documents).

Participants

Qualified HPS across three UK Children's Hospitals who had been working for over one year were invited via their service managers to participate in semi-structured interviews. Out of a total of approximately 30 HPS invited, 10 volunteered to participate. In line with theoretical sampling, participants were recruited alongside data analysis in order to explore emerging concepts (Charmaz, 2006). This included the sampling of varying grades of HPS, including two senior HPS and one service manager.

All participants were female which is representative of the HPS profession, and age ranges can be found in Table 1.1. The range of time qualified was 6-28 years, an average of 16.8

years (SD= 8.5). Participants worked in a range of specialities, with many working across multiple wards. Specialities included Oncology/Haematology (5), General Paediatrics (4), Surgical (3), Clinical Investigations (2), Paediatric Intensive Care (2) Renal (2) Cystic Fybrosis (1) Neurology (1) and Cardiology (1). As HPS represent a small professional group, the decision was made not to link each participant's demographic details to their pseudonym. Although this restricts the interpretation of the data somewhat through removing contextual information, the participants' right to anonymity was prioritised.

Table 2.1 Age range of participants

Age range (years)	Frequency
26-30	1
31-45	5
46-60	4

Data collection

Eight interviews were conducted in a quiet private space at the participant's place of work, and two via telephone. Interviews lasted between 25-62 minutes and were recorded via an encrypted dictaphone. Participants were introduced to the project and the aims of the research before answering a series of semi-structured interview questions. This schedule was adapted following the first four interviews based on emerging categories, and prompts were used to elaborate on participants' responses (see Appendix 2.4 for interview schedule and amendments), in line with Grounded Theory methodology (Charmaz, 2006).

Data analysis

Each interview was transcribed verbatim and analysed as soon as possible following each interview. The data was coded the using a line-by-line approach, following guidance by Charmaz (2006). Participants' own words were used where possible to ensure closeness to the data and to maintain the richness of the content (Stern & Porr, 2017). Focused coding was then conducted through a constant comparison method, noting any similarities and differences between codes. This process of comparison allowed for the development of categories and sub-categories (Evans, 2013), representing a 'higher level' understanding of the data. An example of these codes can be found in Appendix 2.5. Further theoretical sampling was engaged in following the first four interviews in order to gain a fuller understanding of the meaning of the codes.

The analytic process was supported by the use of memo writing (Charmaz, 2003) to document the thoughts and emerging concepts arising from the data, as well as considering the relationships between each category in order to develop a theory. According to Glaser (1978), it is how these codes relate to each other that builds the theory. This process was guided by recommendations by Charmaz (2006) including defining codes, processes, comparisons, questions and gaps. Validity was supported through the use of 'in-vivo' codes to provide evidence for emerging themes (Charmaz, 2006). This process aided development of the theory. See Appendix 2.6 for examples of memos. Theoretical sufficiency was aimed for, defined by the ability of new data to be added to categories without requiring adjustment (Dey, 1999).

Quality

Maintaining rigour in qualitative research is important, and care must be taken to remain close to the data and to consider reporting biases. As advised by Uquhart (2013) the full literature review was conducted after the theory was generated in order to restrict the influence of the existing literature (Glaser, 1992). Elliot *et al*, (1999) developed guidelines to monitor the quality of qualitative research. These recommendations were followed as outlined in Table 2.2.

Table 2.2. Quality assurance process

Recommendation		**Application**
1.	*Owning one's own perspective*	Methodological transparency through the use of memos, and reflective journal (see Appendices 6-7).
2.	*Situating the sample*	Description of data in the context of the sample through the use of demographic information
3.	*Grounding in examples*	Maintaining proximity to the data using quotations during write-up. Additionally, a table of categories and codes can be found in Appendix 8.
4.	*Credibility checks*	'Corroboration' process completed through the discussion of coded transcripts with the research supervisor, and the contribution of each participant to each category can be found in Appendix 9.
5.	*Coherence*	Clear presentation of the interpretations made through narrative discussion and diagrammatic representation.
6.	*Accomplishing general vs specific research tasks*	Consideration of generalisability and the overall aim of conclusions (see clinical implication section).
7.	*Resonance with readers*	The research aims to increase understanding and provide implications for clinical practice (see discussion section).

Reflexivity

The process of critical self-reflection of one's own biases and theoretical predispositions is an important aspect of building a grounded theory (Charmaz, 2006). A reflective journal was kept throughout the research process (see Appendix 2.7) in order to consider the impact of the researcher's own thoughts and feelings, encouraging self-awareness and enabling the analysis to remain a transparent process.

The researcher is writing from the perspective of a 28 year old female, working as a Trainee Clinical Psychologist who identifies with a social constructionist standpoint. The researcher has previous experience working within Paediatric Psychology setting as an Assistant Psychologist prior to beginning clinical training. During this post, the researcher worked with a number of HPS (within a different service to research study sites). The research supervisors similarly have worked alongside HPS in Paediatric Psychology teams. This experience has provided the research team with a perception of the role and challenges it may involve. In addition, the author and research team have training and experience in drawing upon Acceptance and Commitment Therapy in their work. It was important to consider the influence of this in the analysis of the data as this can influence the theory development. Taking a curious and critical stance to emerging concepts enabled the team to acknowledge and reduce the influence of assumptions based on previous experience.

RESULTS

The following section outlines the grounded theory of resilience developed throughout the ten interviews with health play specialists. The theory consists of one core-category and three sub-categories, and the relationships between categories are depicted in Figure 2.1. Each category is discussed in turn alongside qualitative quotes, followed by a summary of the grounded theory.

Core-Category: 'A Unique Role'

An overriding theme from the interviews related to the role being unique in a number of ways. The below sub-categories describe how the HPS perceived their role to differ from that of their medical colleagues, presenting a number of unique challenges: 'being misunderstood', 'feeling pulled in all directions', and 'being there'. The responses to these challenges are presented within each category.

Sub-Category 1: A Misunderstood Role

Despite being a registered profession, all participants described the HPS role as one which was unknown, even to themselves prior to their own training. The nuances of the role meant that it was very difficult for others to understand what they do, with many colleagues thinking all they do is "*gluing and sticking*" (Sarah), or "*playing all day*" (Sam). This caused considerable frustration for participants. Some participants described a lack of status within teams, and a feeling of needing to "*prove their worth*" (Becky). This was attributed to the lack of recognition as a profession, unlike physiotherapists or OTs, "*even though we're the same in our own right"* (Becky). This lack of awareness of the role meant that they were faced with sometimes unrealistic demands *"If you can't get a child to do something that the medics think you can achieve in an hour then you feel an immense amount of pressure… I don't have a magic wand"* (Sam). This appeared to be a source of pressure and strain upon some participants.

Marketing the Role

Many participants spoke of promoting the role in order to establish their place within teams. Efforts to promote the role included conducting training to junior doctors, being shadowed by student nurses, feeding back their work, speaking at conferences, publishing papers and books, writing in patient notes, and working collaboratively. The outcome of increasing the visibility was an improvement in recognition of the role, and an increased recognition as a professional:

> *"Once the doctors figure out what we can do… they know us being in the treatment room makes their job millions of times easier and quicker."* (Frankie)

Being Valued

Once established within teams, the benefits of the HPS role became clear to their colleagues, enabling the them to feel valued within teams through being consulted and being told "*we couldn't have done that without you"* (Sam). This seemed to contribute to a sense of wellbeing. Recognition on service level, through trust excellence awards was also highlighted as important: *"it's nice for the staff to be recognised for what they do.. it's good for staff morale" (Michelle),* although this was not the case for all participants:

> *"It would be good if we got bigger recognition… we're saving the Trust massive amounts of resources and costs, but no one ever acknowledges that"* (Carla).

An indirect impact of increasing awareness was rising referrals, creating a demand which was difficult to meet.

Sub-Category 2: 'Feeling Pulled in All Directions'

This varied nature of the role, often working alone on a ward with high caseloads, led a large proportion of HPS to describe feeling *"pushed and pulled in each direction"* (Sam). This was seen as 'just part of the job':

> *"It can be draining because you're there to support the staff, you're there for the child, for the parents, and if there's siblings on the ward as well you've got them to look after. Then you might be getting a bleep, it's your lunchtime, you've not had a break, there's a lot. But that's part of our day-to-day jobs"* (Sarah).

Many HPS carried 'bleeps', meaning that they could be called upon at any minute in addition to their caseloads, outpatient work and non-clinical duties. Carla attributed this to the referral system being different to other professions, such as nurses who may have an allocated caseload, leading to "*spreading ourselves too thin"*. Being short-staffed was a considerable difficulty for many, leading to restrictions in their capacity to adequately prepare children for procedures *"when they need us the most"* (Carla). Some HPS spoke of distress at not being able to provide care for everyone that needs it and spoke of the challenge in trying to prioritise the workload:

> *"Who do I offer play to?... all children should have it every day"* (Becky).

A key aspect of the pride that HPS took from their role was in providing 'gold standard care' and taking time to build relationships, so when this was not possible this caused considerable guilt and a 'trade-off' between their own wellbeing and that of their patients:

> *"I think we're constantly sacrificing a little bit of ourselves and our own needs because we're so intent on helping the next child that needs us"* (Becky).

Prioritising Workload and Knowing Own Limitations

HPS attempted to cope with increasing workloads using a number of strategies, including prioritising and asserting their own limitations, although this was something that developed with increased confidence over time, and with experience. However, as mentioned above, this had the unintended consequence of causing HPS to feel guilty at being unable to spend as much time as possible with patients. An awareness and acceptance of their own limitations seemed to be helpful in creating a more compassionate relationship with themselves, as Sam describes:

> *" I've realised you can't do everything you can't please everyone, and if you're ok with that for yourself then that makes your life a lot more easier, and now I just do as much as I can do and I try not to beat myself up about it"* (Sam).

Sub-category 3: Being There

Another unique factor of the role related to HPS being present with children 'throughout their whole journey' in hospital, which could sometimes be for many years. Jackie describes how this differs to nurses who work long shifts and may not be allocated to the same child each time:

> *"...we're the ones they see every day"* (Jackie)

In addition, not having a clinical role allowed HPS to 'do the nice things' without the pressure of doing invasive procedures for example. HPS spent time getting to know the child, their wishes and likes in order to design therapeutic input. This created a closeness and safety with families; a quality participants spoke about with pride:

> "*…you just become part of the whole family"* (Jackie)
>
> *"you sort of treat them as if they were your own child"* (Frankie)

The Risk of the Relationship

However, this closeness appeared to put some HPS at a risk of distress when children relapsed, or when bearing witness to pain and suffering. The relationship appeared to be a 'double-edged sword'; it enabled them to do their jobs well, but placed them at emotional risk:

> *"The most difficult things I think hands down is that it's my job to establish a bond with the child... and then if that child doesn't make it, it's really hard because you have to keep your professional boundaries and you have to look after yourself, but your job is to get close to that child so that they trust you "* (Sam)

Part of the role also involved being a source of support for parents during some of their darkest times. Sam described this as exhausting over time when exposed to parental distress:

> *" I've picked parents up off the ground in car parks before on my way into work… it'll happen on a day where like I've had three parents crying on me by 10 in the morning before you know because it everyone's going through a tough time and (sigh) yeah...."* (Sam)

Some participants described investing a considerable amount of themselves into the relationship with the child and family, at the expense of their own wellbeing:

> *" I would just put my whole self in… I've given them 100%. I did find that quite emotionally exhausting… because you would give them such a positive and happy experience in hospital and then a couple of weeks later unfortunately they passed away"* (Alex)

One HPS described how the impact of losing patients *" doesn't ever get easier "* (Jackie), and Sam described the effect the accumulation of grief had upon her wellbeing and home life:

> *"It's just been relapse after relapse, and death after death that'… you have to be super human at some point not to feel the effects… I'm finding it harder now to switch off after work"*

However, others spoke of the requirement to carry on despite this distress:

> *"Whatever trauma has happened… we just get on with it the best we can"* (Sarah)

Kiera spoke of the importance of developing resilience to manage the impact of the intense exposure to emotional distress:

> *"I think that over time I have built up resilience and learnt how to manage emotional situations*".

The strategies used to manage the emotional impact are outlined below.

Creating Space

Boundaries and Balance

Some participants spoke of the need to develop strong interpersonal boundaries in order to buffer the impact of the exposure to pain and distress. Professional boundaries acted as one way of maintaining wellbeing through protecting the amount of the self invested in the relationship. It seemed this developed over time with increasing experience:

> *"when I first started here; a lot of children sadly passed away, so it was quite challenging to be honest but, over the years I think as you, ... you become older and more wise… I know how to not get too involved… I think over the years of experience I still show a lot of empathy and care, but I don't give everything"* (Alex)

These boundaries provided some protection and reflect a distancing in relationships with patients and families in order to *"not get too attached and take it all home with you"* (Sarah).

Developing a boundary between work and home was another way of creating space and distance from the work. Strategies included taking part in leisure activities such as going for walks, exercising and spending time with friends. Relaxation activities such as having baths enabled some HPS to reduce the stresses of the day, and seeing family and friends allowed for connecting with people important to them, and provided perspective on the work:

> *"It makes me feel a bit more thankful really when I'm at home when I see that my children are okay and just, you know? "Well, it could be like this child here in the hospital"* (Charlie).

However, finding the time to look after themselves was difficult for some, which Becky attributed to the intensity of the job:

> *"I think we're so wrapped up with helping these children in these difficult times, to get through things that they need to do… we don't often think about what we need".*

The participants who worked part-time described it was extremely valuable for maintaining emotional wellbeing. For example, the space that part-time working provided enabled Charlie to *"come away from a situation and just have that breathing time",* and also enabled Becky to spend quality time with loved ones, with a significant positive impact upon her quality of life:

> *"I think everyone gets a bit more of me this way… definitely feel it's better for my practice, but also me as a person, my life "* (Becky).

Another way of creating space for HPS was to focus on other aspects of the work, such as cleaning toys or making resources, although the chances to do this were becoming more infrequent due to increasing workloads.

Blocking Feelings

Some participants spoke of dealing with the emotional impact of the role by blocking their emotions, which allowed them to carry on with the job:

> *"I suppose you just have to block it out at certain points, don't you? I can't say we have any particular coping techniques just try not to think about things"* (Charlie)

Distraction was a commonly cited strategy, involving drinking alcohol, exercising and watching TV, which Sam described as *'zoning out'* . Keeping 'busy' enabled Carla to keep going in work, and Jackie spoke of putting patients' needs above their own *"you have to just keep going and put all your feelings to one side"*. However, for one HPS, this caused difficulties through the build up of emotions over time, leaving Sam overwhelmed:

> *"I don't know, our patient numbers have just gone through the roof and so has our mortality rates. I've kept it away, and kept it away, and kept it away. And now I'm struggling a little bit."* (Sam)

Allowing Feelings: a Private Experience

Expressing emotions privately through seeking time out in the toilet, having a cry, or through having five-minute break was another strategy HPS described as helpful. This time to reflect and process emotions appeared helpful for some participants to continue to 'put on a happy face' for families. Most participants chose to express these emotions in private:

> *"I don't go and show it… when I've got 5 minutes on my own, I think about it or I go home and just think about it quietly, maybe sometimes have a cup of tea or coffee and then I'll go back to work"* (Alex)

Carla used a ritual after a patient passes away, through lighting a candle in order to let her family know that it has been a tough day and not to ask her about it, providing her with space to process the loss. Reflection was also discussed as a way of managing the emotional impact of the work, such as thinking through the events of the day on the way home during a commute.

Peer Support - 'In It Together'

The majority of participants expressed the value of seeking support from colleagues on the wards, through having a 'rant', or 'offloading' after a difficult day, with the best source of support being from those who *"are all in the same boat"* (Sam). Having access to support which was informal and available when needed allowed for participants to feel contained. This came from both peers and more senior colleagues. It seemed that seeking support of colleagues was preferred as opposed to seeking support of family or friends. This was attributed to family and friends not understanding the unique challenges of the role, and responses being somewhat unhelpful:

> *" I just kind of can't be bothered almost with their reaction.... to the horrible stuff that happens in work. Cos that's not what I need, I need someone to say oh my god yeah its rubbish, I don't want to be pandered "* (Sam)

However, those who had family who worked in similar areas, such as nursing, were good sources of support without having to 'explain'. One HPS also spoke of feeling the need to protect their loved ones from the trauma of their work *"because I work in this environment, I'm used to it, and I've kind of built up a resilience to it"* (Alex).

More formal structures of support included supervision from a senior HPS, line manager or Clinical Psychologist, and participants described this as helpful in having a space to discuss any difficulties in the job. However, this was not the case for everyone, with some departments receiving more input than others despite the similarities in the stressors experienced:

> *"There are colleagues in the Play team that get absolutely nothing, but they still deal with children dying it's sad seeing your colleagues struggle and knowing that we get so much support and they don't"* (Carla).

Many HPS reported being aware of staff support services such as occupational health and counselling services, and one service provided reflective practice groups. However, these *"fizzled out… [they] became another meeting to go to"* (Michelle) due to the increased pressures on staff to be on the wards. Despite this, many participants reported wanting such a space to explore work related issues.

Finding meaning and purpose

The HPS in this study spoke proudly of their jobs. It was clear that they saw the role as a privilege; a rewarding role with many benefits despite the challenges. HPS spoke of being there with families through their most difficult times as well as seeing children recover and get better. Reflecting on this enabled participants to hold onto hope for their families and provided them with a sense of fulfilment and purpose:

> *"[It] is always nice when you see them in long term follow-up, and they've got their own kids, or boyfriends, or they're buying houses and things, and they look really well. And that's what I try and focus on."* (Sam)

Making a difference was one of the main aspects of the role which HPS described as most rewarding, and these rewards enabled them to continue with the job, even when children did not recover:

> *"...just feeling that you've managed to make a small difference to a family who were going through a really rubbish time"* (Frankie)

Grounded Theory of Resilience in HPS

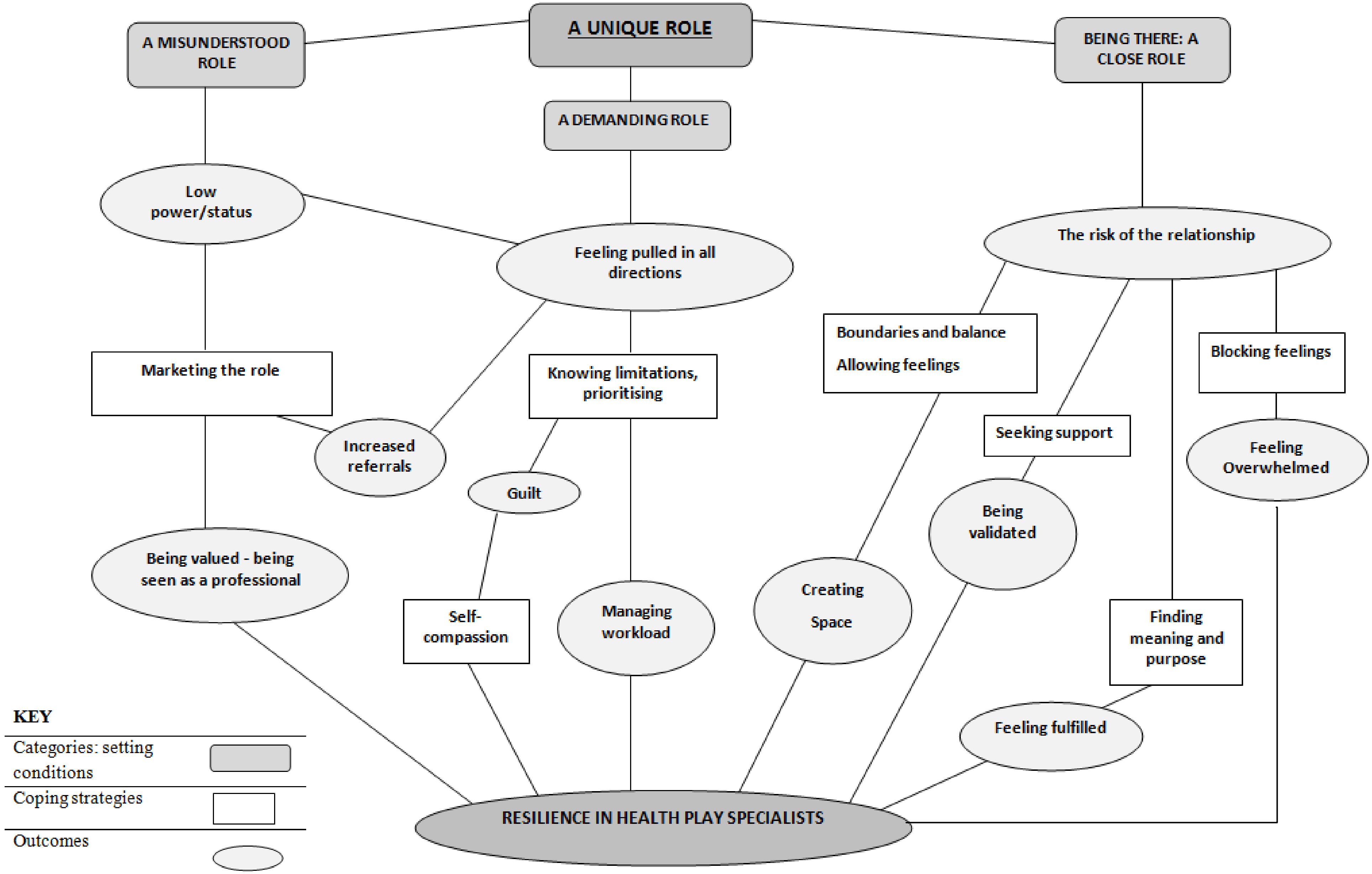
Based on the analysis of the data, theory was developed to explain the complex interplay between factors influencing distress and resilience in the HPS in our participants (see Figure 2.1). The theory describes the unique experiences of HPS and outlines the consequences of this and their individual and organisational attempts to cope. A number of 'setting factors' are described, contextual aspects of the role which may leave HPS uniquely vulnerable to distress:

In the first sub-category, HPS described feeling frustrated by the misunderstandings about the role. The lack of clarity of the role potentially leaves the HPS with reduced power and status with which to manage the demands of colleagues. Over time, efforts to promote the role has resulted in HPS becoming more integrated and recognised within ward MDTs, and this contributed to a sense of wellbeing. However, this has led to an increase in referrals which services have struggled to cope with.

In the second sub-category, the varied nature of the role means that HPS often cover more than one ward, have high caseload numbers, and are contactable at all times via bleep. As a result, some HPS felt overwhelmed by the workload, leaving them vulnerable to stress. In response, many described needing to assert their limitations and prioritise in order to manage, although this had the consequence of feeling guilty at being unable to give 'gold standard care' to everyone. A compassionate self-response to these feelings of guilt was associated with resilience.

The third sub-category relates to the emotional impact of the role. Through the unique relationships, they are present for and vulnerable to experiencing the trauma of the families in their care. HPS managed this in various ways; through keeping strong boundaries, allowing feelings, or seeking formal supervision or reflection. These aspects of coping enabled the HPS to gain space from the pain of their patients. Blocking emotions was also used in over half of the participants which enabled them to cope in the moment, but for some this lead to a build up of distress over time. For most, peer support enabled HPS to obtain validation by 'offloading' to people who 'get it'. Finally, focusing on the rewards of their work enabled meaning and purpose to be gained, enabling them to continue doing the work despite considerable exposure to stress, trauma and grief.

Figure 2.1. Grounded Theory of resilience development in Health Play Specialists



DISCUSSION

The aim of the current study was to examine the concept of resilience within UK health play specialists. The grounded theory developed supports and extends the existing literature through presenting the first known understanding of stressors and factors relating to the development of resilience within this group.

All participants perceived their role as misunderstood by other members of the MDT. This fits with the findings of Holloway and Wallinga (1990) that role ambiguity was a source of stress for HPS. However, this study further suggests that ongoing promotion of their work has increased the awareness of the profession within their services, helping to raise their profile as valued members of the MDT. However, a large stressor on the current participants was a lack of staff to meet the high referral rates. Workload has been linked to burnout in other paediatric healthcare professionals (Zander & Hutton, 2012), and this study suggests that HPS may be at further risk due to being called upon at all times. A reduced status or 'power' within teams led to some participants struggling to manage the increased expectations placed on them. Powerlessness has been associated with increased burnout risk in a qualitative study of burns nurses (Kornhaber & Wilson, 2011), and thus having a low perceived status may also place HPS at additional risk of being 'pulled in different directions'.

The study also presents a process of gaining emotional 'space' from the pain and distress of patients in order to cope. Participants described the need for developing professional boundaries in order to provide a 'buffer' from the distress. The 'blurring of boundaries' between patient and caregiver has been associated with higher burnout and compassion fatigue in paediatric professionals (Robins *et al.*, 2009), and distancing from patients has been reported to reduce the pain experienced in nurses (Kinman & Leggetter, 2016). However, the unique nature of relationships with families in HPS means that this distance may be difficult to maintain.

Other ways of creating space included a work/life balance, a strategy related to resilience in a review of 159 studies into healthcare professionals including nurses, doctors, psychologists and social workers (McCann *et al*., 2013). Spending time with family enabled study participants to gain a sense of perspective and connect with what matters to them. This relates to living in line with one's values, an aspect associated with wellbeing within the Acceptance and Commitment Therapy literature (Hayes, Strosal & Wilson, 2004). Connecting with what is important was associated resilience in the current study, especially in HPS who worked part-time. Working part-time has been associated with higher levels of resilience in a large-scale survey of 845 NHS staff (Sull, Harland & Moore, 2015), suggesting that reduced hours may enable a better work/life balance, which may reduce levels of stress. However, obtaining balance was difficult for full-time workers who sought out space in other ways through taking a quick break, or switching to non-clinical tasks. Further investigation into how space enables resilience to develop is warranted.

Another concept which emerged from the data related to how participants dealt with grief, which varied across participants. One HPS who reported blocking their emotions through 'not thinking about it', or keeping busy, reported feeling emotionally overwhelmed, an aspect also found by Berger *et al*., (2015) in other paediatric professionals. Interestingly however, the strategies reported as most helpful have been found to have the worst outcomes (Colville *et al*., 2015). The use of suppression to manage emotions is associated with higher burnout and secondary traumatic stress in paediatric nurses (Colville *et al*., 2017; McGarry *et al*., 2013).

The concept of experiential avoidance describes efforts to avoid the experience of negative emotions, and has been associated with burnout in a study of critical care nurses (Iglesias, Vallejo & Fuentes, 2010). Participants in the current study who allowed their emotional experience through taking time out, reflecting and seeking support reported this as helpful in allowing them to continue with their jobs. This indicates the presence of 'psychological flexibility' (Hayes *et al*., 2004). Defined as conscious contact with the present moment (an aspect of mindfulness practice) and the ability to adapt behaviour in order to live in line with values (Hayes, 1999), increased psychological flexibility has been associated with positive psychological functioning in the general population (Kashdan & Rottenberg, 2010) and increased quality of life in trauma survivors (Kashdan *et al*., 2008). Therefore, interventions promoting the development of psychological flexibility, such as Acceptance and Commitment Therapy (ACT; Hayes *et al*., 1999), and Mindfulness-Based Stress Reduction (MBSR; Shapiro *et al*., 2007) may be useful in buffering the effects of stress in HPS.

The finding that the HPS role provides unique opportunities for closeness in relationships with families is an important one, as this closeness also placed them at risk of distress. Experiencing the pain of others is a risk factor for developing secondary traumatic stress (Conrad & Kellar-Guenther, 2006). The current findings are consistent with studies with other paediatric healthcare professionals who develop long-lasting relationships with patients (Najjar, Davis, Beck-Coon & Carney-Doebbeling, 2009), and as HPS are faced with fear, anxiety and grief on a daily basis (Munn *et al*., 1996), they are potentially even more vulnerable.

HPS described seeking support from colleagues as helpful in managing the emotional stress of the job, supporting the findings of Munn *et al*. (1996) and (Fisackerley, 2016) within HPS, and findings from studies into other paediatric professionals (Maytum *et al.*, 2004; Zander & Hutton, 2012). A key process in gaining support for the current sample seemed to be receiving validation from those who 'understood'. HPS chose not to seek support from family and friends, as their responses were described as unhelpful, perhaps reflecting the uniqueness of working in paediatrics (Zander & Hutton, 2012).

Additionally, this study found that support of management through supervision and informal contact was important in buffering the impact of stress, in line with the quantitative findings of Fisackerley *et al.*, (2016) that debriefing after patient death reduced the risk of burnout in HPS. Containment, a concept from psychoanalysis (Krantz, 2001), relates to feeling held when experiencing emotional experiences safely, enabling regulation to occur (De Gooijer, 2009). Many participants spoke of the availability of organisational structures of support, but rarely used them, and HPS who did not have access to such avenues of support reported this as stressful. The perception of available support may be key in managing the emotional demands of the work, especially for a small profession. Managers could provide containment by promoting 'open-door policies' and the use of organisational structures such as occupational health in order to provide a 'supportive culture' (NICE, 2009).

The HPS in the current study spoke of the privilege of being there to support children and families through their darkest times. Making a difference provided them with satisfaction and purpose, in line with Meadors *et al.*, (2009) who found that HPS had the greatest satisfaction of the work in their sample of paediatric professionals. This indicates that the work provides not just challenge but an opportunity for the development of resilience.

Clinical implications

Managers may make efforts to promote the role within teams through creating posters, teaching sessions, offering shadowing to other professionals and encouraging their HPS to increase the visibility of their work through writing in patient notes, attending MDT meetings and working jointly with colleagues in order to reduce the impact of feeling misunderstood, and to increase their level of status within teams.

It would be helpful for training courses to build awareness of the unique pressures of the role, and early-career mentoring may provide an ideal opportunity for the introduction of resilience strategies. It is also recommended that qualified HPS of all levels receive regular supervision in order to provide a space for the emotional impacts of the role to be explored. It is important for managers to be aware of the pressures on staff and to provide time in job-plans to enable space to process distressing situations, despite time pressures.

Both ACT and MBSR have shown promise in early evaluations with health professionals (Jennings *et al*., 2016; Duarte, 2016). A systematic review of MBSR in healthcare professionals found improvements in burnout, stress, anxiety and depression (Lamothe *et al*., 2017). It is hypothesised that contact with the present moment through mindfulness may enable feelings to be 'allowed' rather than 'blocked', thus reducing the risk of professionals becoming overwhelmed by the build-up of their emotional experiences. Further research into this process is needed. Additionally, in considering increased pressures and lack of time to seek organisational support, it would be important for such interventions to be short. Promisingly, Guathier, Meyer, Grefe & Gold (2015) evaluated the use of a 'five-minute mindfulness' practice with 38 PICU nurses, and found decreases in stress and better coping on the job, however larger-scale research is needed to fully evaluate the effectiveness of interventions into staff wellbeing.

The process of gaining validation with colleagues who are 'in the same boat' is useful for considering effective support structures. For example, Schwartz Rounds are inter-disciplinary forums provide a space for exploring the emotional impact of the role with colleagues who are able to provide emotional support and validation (Goodrich, 2012). They may also provide opportunities to reflect on the benefits of the job, supporting the development of resilience.

Limitations

The theory developed is a detailed understanding of the process of resilience in HPS, and reflects the interpretation of the author, research team and study participants in line with constructivist grounded theory methodology (Charmaz, 2006). Although the application is limited to HPS, it is hoped that the insight into resilience development may be transferable to other areas of paediatric healthcare, this would require further theoretical investigation within varying contexts.

The sample size of ten reflects the small professional population, and recruitment utilised a heterogeneous sample of HPS in line with theoretical sampling (Charmaz, 2006). However, the participants were relatively experienced, (an average 16.8 years qualified). It may be that those who felt more confident chose to participate, thus influencing the findings. Lazarus and Folkman's (1978) transactional theory of stress and coping suggests that an imbalance between demands and perceived resources causes difficulties in coping. The participants may have perceived themselves better resourced to cope with stress with this increased experience. However, Fisackerley (2016) did not support experience as a protective factor in HPS. Further theoretical sampling with HPS earlier in their careers may help to clarify the impact of experience, and further enquiry into mechanisms underlying coping with increased workloads is required.

Conclusions

The ability to recognise factors associated with resilience has implication for staff retention, as well as in improving patient care (Kutney-Lee *et al*., 2009). The current multi-site study expands existing knowledge of resilience in healthcare professionals to HPS. The theory presented highlights a number of individual and organisational factors associated with the development of resilience. The findings highlight the importance of promoting the role and developing awareness of limitations in managing workloads, and of seeking space from the pain and trauma of patients and families in order to continue with the work. The participants in this study showed great humility, passion and dedication in their work, and the findings suggest that their unique role provides opportunity for 'not only surviving, but thriving in the workplace' (Suri and Nash 2018, p2).

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Critical Evaluation

Angela Webber BSc (Hons), MSc

South Wales Doctoral Programme in Clinical Psychology

Cardiff University

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INTRODUCTION

This paper presents a review of the research project. The aim is to provide further context into the research process and to critically reflect upon my work. This paper also summarises key decisions made at each stage of the research process, outlines further clinical and research implications, and describes plans for dissemination. The final section will reflect upon the key Clinical Psychology competencies developed.

Reflections on research project

Background

The research undertaken explored stress and resilience within paediatric professionals working in inpatient settings. As I have outlined throughout paper one and two, working in paediatric healthcare presents unique challenges for professionals. This research has highlighted the vulnerability of professionals in experiencing emotional distress, and considered the development of resilience. Understanding what underpins a professional's ability to cope with the increasing pressures and demands of working in healthcare services is therefore beneficial to increasing quality and productivity of services within a time of prudent healthcare (Welsh Government, 2014). Working within healthcare services under considerable financial pressures, I have directly experienced the pressures of working with high caseloads with limited time for interventions.

The research topic

The initial question arose from the research team's experience of working within Paediatric Psychology services throughout their respective careers. Our collective experiences of working in children's hospitals alongside a range of other healthcare professionals provided an insight into the emotional challenges of working in this area. During my post as an assistant psychologist at a children's hospital prior to beginning clinical training, I worked alongside doctors, nurses and allied health professionals to provide psychological input to children with acute and chronic health conditions, many of which would be life-long or even life-limiting. I was rewarded by hearing families' stories and being a part of their journey within the hospital, even if it was for a short period. It was also an emotional experience. The families had often experienced trauma and complex challenges as a result of having a health condition. However, one thing that struck me was the pressure the ward staff were under, especially the Health Play Specialists (HPS). I remember feeling as though their jobs put them directly in contact with children's distress and trauma; their role was to be alongside children and families during some of their most difficult moments. Although the role of clinical psychologists within hospitals could be argued to be equally or even greater exposed to emotional trauma, my sense was that ward-based staff are at higher risk due to the lack of time they have to distance themselves from the trauma of their patients. My experience of working in a paediatric psychology team was that there was a lot more time to think, reflect, and gain support for psychologists than those working on the wards. I was interested to explore how ward staff coped with this exposure. In addition, I gained a sense that the play specialist role in particular was not as recognised as their medical counterparts, which was confirmed during initial scoping searches, with a lack of published research into this group.

The concept of resilience

Researching the concept of resilience has felt like an appropriate topic for study at this point in my career. As a trainee clinical psychologist, my role is to be alongside individuals, families and teams in distress, and to support them to develop awareness and skills to manage difficult thoughts, feelings and situations. In addition, I too have experienced workplace stress throughout my career. Increasing resilience is therefore inherent to my work. I hoped that this research would enable me to better understand how healthcare staff cope with workplace stress and through this process, I feel more confident in working therapeutically with individuals and staff teams experiencing difficulties at work.

Through conducting a systematic literature review and empirical study, I have developed a broad theoretical understanding of what resilience means within this context. Throughout the writing up of this thesis I have also been able to reflect upon my own resilience strategies, highlighting a number of parallels to the research findings. I too have found myself oscillating between acceptance and avoidance of difficult feelings and, at times when life has felt very 'busy' through balancing personal life and clinical training, I have often felt overwhelmed and unable to find the time and space to take part in my own self-care. However, I have been fortunate that reflective practice is promoted within my training course, and supervision is compulsory within the profession, enabling multiple protected spaces in which to reflect upon my own responses and experiences. This has been vital for me to learn further strategies for managing my own stress. For example, exercise gives me time to myself away from work, and enables me to focus on the present moment, whilst acknowledging any difficult feelings which arise. Going for regular walks whilst writing up the thesis has had a valuable impact upon my mental wellbeing whilst under a period of stress. I feel therefore that researching the concept of resilience has increased my self-awareness and reminded me of the importance of prioritising my own resilience strategies.

Reflexivity

It has been important for me to engage in reflexivity throughout the research process in order to consider how my beliefs have influenced the research process. Whilst analysing qualitative data throughout the review and empirical project, I have remained aware of my beliefs as outlined above. I was not connected to any of the study sites, which enabled me to remain impartial. It was important for me to reflect on my own ideas about resilience, and this was aided by researching a professional group which experiences different pressures to clinical psychology (e.g. medical staff and HPS). My short time working with HPS enabled me to have a baseline awareness of their role without being overly influenced by this perception. I believe my insight into the role enabled me to develop a rapport with participants quickly without many preconceptions of what their experiences were. I was interested during the data analysis process to see the concepts emerge from the data, and through supervision I was able to remain open to considering new understandings of the concepts as the interviews progressed. I have endeavoured to stay close to the data through the use of multiple quotations during my write-up in order to separate my own beliefs from the study findings.

The process of conducting this research has enabled me to gain a wider understanding of resilience as a concept reflecting individual and systemic influences. The research highlighted the importance of the environment in contributing to stress (e.g. high pressure, workloads), and resilience (through supportive teams, supervision), but also individual factors (e.g. acceptance of limitations, self-compassion, ways of relating to feelings). Upon reflection, I will prioritise resilience during my professional role and personal life much more than I currently do.

Epistemology

My epistemological position reflects that of social constructivism. I believe that our experiences influence our view of the world, as reflected by the diverse cultures within society (Finlay, 2002). A process of co-construction between participant and researcher enabled the development of an understanding of the data in line with constructivist grounded theory (Charmaz, 2006). It is also recognised within meta-synthesis within third-order interpretations (Noblitt & Hare, 1988), therefore reflecting congruency of research methods and underlying assumptions between research methods as advocated by Willig (2008).

PAPER 1. Resilience and Burnout in Paediatric Healthcare Professionals: a Qualitative Meta-synthesis

Background and design

The initial stages of deciding upon a relevant review question involved a number of considerations. Firstly, I hoped that the review would complement the empirical study. A number of scoping searches were conducted in order to consider the literature base regarding health play specialists and other allied health professionals working in paediatrics. As this search discovered very few papers, the research team agreed that it would be appropriate for me to broaden the search to include all qualified paediatric staff members. Through this process, I became familiar with the research available. Although there were two recent quantitative reviews on the subject of staff wellbeing in paediatric oncology (Mukherjee et al., 2015; Zander, Hutton & King, 2013), there were a number of qualitative studies with staff in a number of clinical areas which had not been summarised. A qualitative meta-synthesis was therefore decided upon over a quantitative review, as it provides an opportunity to consider studies from multiple contexts (Paterson, Thorne, Canam & Jillings, 2001), as well as providing additional theoretical understandings of staff wellbeing within paediatrics, fitting in well with the research aims.

Meta-synthesis (Noblitt & Hare, 1988) is a well-known and effective approach to reviewing qualitative data (Walsh & Downe, 2004). In addition, the review aimed to interpret the qualitative information in order to develop a conceptual understanding of resilience and burnout within paediatric professionals, in comparison to a more descriptive summary offered by a meta-aggregation approach, for example (Boland et al., 2014). Meta-synthesis is used widely within healthcare research (e.g. Toye, Seers & Barker, 2017), and therefore was felt to be appropriate for reviewing resilience in a healthcare context.

The search process

A systematic search was a new experience to me, as most of my previous experiences has been in conducting narrative reviews. In particular, I was struck by the complexities in locating relevant literature due to the combinations of search terms and indexing system retrieving a number of irrelevant papers. The search process included the search of seven databases, which were selected for their focus upon issues relating to healthcare, and terms were derived through consulting relevant studies found through the scoping search, and using a thesaurus in consultation with a university librarian. Although Noblitt & Hare (1988) do not recommend a broad-based search, this approach was utilised to reduce the risk of missing papers. The search was not filtered by methodology for this reason in order to try and capture as many qualitative papers as possible. This meant that a very large amount of titles were originally sourced (3,272 papers), requiring a significant amount of time to sift through. However, this was balanced against the risk of missing potentially useful papers.

Inclusion and exclusion criteria

Papers were included which were English language only, at a risk of missing papers written in other languages with potential rich sources of data. However, it would have been difficult to effectively translate papers within such a small timescale. The search was also constricted to peer reviewed studies only. This meant that potentially valuable information may be missed from the 'grey' literature, especially considering the reduced likelihood of qualitative research being published (Gagliardi & Dobrow, 2011). However, in line with guidance from Noblitt and Hare (1988), only peer-reviewed studies were included to ensure a level of quality in the write-up.

In terms of participants, the review did not consider the views of student and trainee healthcare staff samples. This is because research suggests the impact of the work differs for staff in training than qualified staff (Dahlin & Runeson, 2007), and it was thought that this heterogeneity, in addition to including paediatric staff from across medical professions and specialities, may have made analysis more challenging. Papers relating to staff working in neonatal wards were also excluded, as the role involves the emotional support of parents more so than children. Mixed methods papers were included if they comprised a significant proportion of qualitative information, and the focus of the papers were required to include emotional impact of the role. This meant that papers which discussed 'moral dilemmas' or 'ethical decision making' (e.g. Austin et al., 2009) were excluded if the content was more focused on the process of decision making rather than the emotional impact on the clinician.

Quality assessment

In order to appraise the quality of research included for review, I chose to use the Critical Appraisal Skills Programme (CASP, 2017) because a version was available specifically for the use in qualitative reviews. My experience using the CASP checklist highlighted some limitations. With only ten criteria, this limited the depth of appraisal possible (Murphy et al., 1998). In future reviews, I would consider using a point system used by other researchers, such as Duggleby et al., (2010), allowing for further discrepancies within each dimension.

Despite the utility of quality assessment as reducing bias, I was struck by the way in which the process still required the use of subjective judgement. For this reason, I asked a second-rater to independently assess each paper. I also conducted the quality appraisal before the meta-synthesis as a quality rating cut-off was imposed. This was to ensure a level of quality within the write-up, and was balanced against the risk of missing insightful data from excluded studies. Following discussion of the pros and cons of imposing a quality cut-off, one paper (Kaplan, 2000) was removed following a low rating due to its limitations preventing a full appraisal of the analysis and results. This is despite the argument that a paper with a low rating can still be of qualitative value (Boland et al., 2016), but it was difficult to determine how the results were obtained. There is also no preferred timing for quality appraisal, and there are benefits and costs to conducting appraisal before or after the synthesis (Noyes & Lewin, 2011). Appraising quality prior to the synthesis allowed me to gain familiarity with the papers whilst not holding any preconception of its value to the review.

It is also noted that the quality ratings based on the CASP framework are based on available information from each manuscript, and thus depend on the transparency and inclusivity of the write-up. The majority of studies lost points due to a lack of acknowledgement of reflexivity. It is recognised that this does not necessarily mean that reflexivity was neglected, but that consideration of this may not have made the final manuscript. This is a challenge which I experienced during preparation of both qualitative papers, it was difficult to achieve the balance of presenting the richness of the findings and including sufficient reflection whilst still meeting tight word limits. The process of quality appraisal therefore helped me to learn which methodological processes to prioritise within my own write-up, such as consideration of reflexivity.

The process of meta-synthesis

During the process of data extraction and analysis, it was found that even with guidelines from Noblitt & Hare (1988), the process of synthesising themes from a number of studies was challenging due to the variation in reporting of the data. Some studies used more contextual data around each quote than others, and it was difficult at times to consider which professional was responsible for each quote. This restricted the amount to which this could be reported in the meta-synthesis. Ring et al. (2010) highlights the difficulties in summarising a number of studies, with the risk of losing meaning and contextual information. In addition, the studies used differing methodological approaches (e.g. content analysis, grounded theory and phenomological analysis) which made it difficult to synthesise. However, this was balanced by considering the benefits of, adding to the evidence-base and promoting the qualitative research available, as Britten et al., (2002) highlight that qualitative studies are likely to be missed unless they are summarised.

I was also required to familiarise myself with the literature during the process of writing a research proposal, and thus some pre-existing hypotheses were likely to exist. In order to counteract any confirmation bias, an open and curious approach was taken to synthesis, in line with Noblitt & Hare (1988). A process of constant comparison and consideration of differing concepts enabled for a critical approach to analysis, reducing the risk of the literature search affecting the findings. The risks of this were also reduced through the use of supervision to corroborate the findings. I aimed to remain transparent through the use of clear methodology, tables and quotations to remain close to the data throughout the write-up and to maintain quality in the review, in line with Noblitt & Hares' (1988) guidelines on reducing bias. The 'third-order' interpretation as described by Noblitt & Hare (1988) acknowledges the constructivist nature of synthesis as co-constructed between participant, original author and the person conducting the synthesis, providing transparency of analysis and increasing the quality of the results. Throughout this process I have learned the importance of considering the best method for synthesis and gained an understanding of the underlying beliefs and assumptions in order to increase the quality of the review.

Implications of the review and avenues for further research

The findings of the review agree with the view that the working environment of the modern day NHS is a vulnerable setting for the risk of burnout due to increased pressure and high workloads (Royal College of Physicians, 2015). In line with the Francis Report (2013) which recommended increasing compassionate care in order to maintain patient safety, this review demonstrates a need for the emotional impact of the work to be acknowledged within organisations. The review highlighted feelings of grief, sadness and helplessness at losing patients, which affected professionals both personal and professionally. Providing organisational support structures for paediatric professionals in particular at all stages of their careers may help to reduce the risk of burnout through increasing awareness, normalising responses and increasing peer support for staff. Zander & Hutton (2009) suggest organisational strategies for those in oncology including effective rotas to reduce fatigue, providing support at an early career stage, and providing mentoring and supervision. Perceived control has also been associated with increased resilience in paediatric healthcare professionals, including the ability to cope with higher workloads (Maytum et al., 2004). Thus, the availability of support may be just as important as accessing it. Recent NICE (2009) guidance around staff wellbeing provides information for managers regarding how best to support their teams, and evaluation of interventions is required.

The review also considered the way in which professionals managed the emotional aspects of their roles. Professionals used a combination of connecting and disconnecting from patients, emotions and colleagues in order to cope. It is perhaps unsurprising that this parallels the Stroebe & Strut (2010) dual process model of grief when considering the majority of distress was caused by patient death. Professionals both engaged in 'mourning', through seeking support with colleagues and crying, and 'moving on', through keeping busy and taking part in leisure activities such as exercise. However, it appeared that those who used only avoidance strategies were more at risk of distress than others. This fits well with the recent findings of Colville et al., (2017) who found that alcohol use, keeping busy and ignoring stress increased the risk of burnout and traumatic stress, whereas debriefing and looking for positives reduced burnout. Interestingly, exercise was also associated with reduced wellbeing, which suggests that the way in which individuals engage in these activities are more important than the activities themselves. It may be that for those professionals, exercise was used as a way of 'keeping busy' to distract from the emotional experiences, reflecting experiential avoidance which has been associated with distress (Hayes et al., 2004). Thus, interventions which encourage the use of strategies aimed at connecting with emotional experiences are likely to be most helpful, such as Acceptance and Commitment Therapy (ACT), or mindfulness-based stress reduction (MBSR; Shapiro, 2011), as discussed in paper one.

Mindfulness is defined as paying attention to the present moment, without judgement (Kabat-Zinn, 2013), and can be taught as part of a skills group or practiced individually. A psychology-led mindfulness-based intervention with 94 oncology nurses found decreases in compassion fatigue, burnout, stress, experiential avoidance and increases in mindfulness and self-compassion (Duarte, 2016). Mindfulness and acceptance based strategies are therefore promising in managing the emotional impact of the work. However, further research is required in order to further understand the effectiveness of these interventions.

Recent UK guidance based on research into factors influencing wellbeing has been released. This is known as the 'Five Ways to Wellbeing' (New Economics Foundation, 2017) and the guidance fits well with the findings of this research. Table 3.1 indicates how our findings regarding resilience in paediatric healthcare professionals fits with this guidance. It could be helpful for organisations to advertise this campaign to their staff and really promote the use of the above strategies. This could be done through wellbeing events, posters and workshops, for example.

Table 3.1. Five ways to wellbeing (New Economics Foundation, 2017)

Five Ways to Wellbeing	**Review findings**
***1.** Connect*	Connecting with colleagues (Cook et al., 2012; Conte, 2014; Kellogg et al., 2014)
***2.** Be active*	Exercise, including going for walks (Muskat et al., 2017; Granek et al., 2016)
***3.** Keep learning*	Growing personally and professionally (Muskat et al., 2016; Zander et al., 2013; Beaune et al., 2017)
***4.** Give to others*	Gaining reward through benevolence (Zander et al., 2013; Beaune et al., 2017; Muskat et al., 2017; Granek et al., 2016)
***5.** Be mindful*	Connecting with emotions (Maytum et al., 2004; Conte, 2014, p43; Granek et al., 2016)

Limitations

The inclusion of studies from multiple cultures is both a strength and a weakness of this review. Open expressions of distress is less common in British culture, whereas within African cultures, open expression (e.g. wailing) is common (Kirmayer, 1989). There are also differences in the value of community, which is less common in the UK (Wilkinson, 2015) which can create an individualistic focus of the causes and responses to distress. Further consideration of cultural norms is required in consequent reviews of qualitative research.

Due to the reasons above, papers discussing concept of moral distress was not considered as part of the review, which relates to conflict arising from situations where professionals are unable to do what they think is morally right (e.g. disagreeing on treatment options; Pye, 2013). This may have missed out potentially valuable information from the synthesis, but was considered against the possibility of analysing unrelated information.

The concept of 'resilience' has received little attention in healthcare research, with the majority of quantitative studies using concepts such as 'hardiness' and 'stoicism' to measure it (Hodges et al., 2008). However, hardiness does not encompass the flexibility and adaptation to negative events as described by resilience (Kash et al., 2000). As highlighted in this review, resilience culminates a multitude of individual and organisational factors, and more research into the concept is required in order to make meaningful recommendations.

PAPER 2: A Qualitative Exploration of Factors Relating to Resilience Within Health Play Specialists

Background and research design

Considering the lack of research into health play specialists, qualitative methodology was considered most appropriate. The use of qualitative methodology is widely accepted as a method for investigating lesser-known concepts (Fossey et al., 2002). To date there are only four known published studies into burnout in health play specialists (Holloway & Wallinga, 1990; Munn, Barber & Fritz, 1996; Meadors et al., 2008; Fisackerley et al., 2016), and none have considered resilience. In addition, the concept of resilience has not yet been universally agreed (Aburn, Gott & Hoare, 2016), thus, the research question in exploring HPS' experiences of resilience was appropriate for a qualitative study. The appropriateness of this approach was also highlighted by the aims of the research: to develop a theoretical understanding of the impact of the role of a HPS, as compared to a more descriptive account offered by approaches such as Thematic Analysis (Braun & Clarke, 2006).I hoped that grounded theory methodology would enable for a theory of resilience development to emerge from the data. I considered that this may have advantages over Interpretative Phenomenological Analysis which considers the meaning of lived experience, but does not aim to generate a theory (Smith, 2010).

Willig (2008) also proposes the importance of goodness of fit between the views of the researcher and the methodological stance. The researcher is influenced by social constructivism within their clinical work due to the collaborative nature of the therapeutic process. There is no one epistemological stance of grounded theory (Urquhart & Fernandez,

2006) and it can be influenced by a number of stances and viewpoints. Glaser's (1992) standpoint relates more to positivism (i.e. searching for an observable 'truth'), whereas Charmaz (2006) takes a constructivist view. Within constructivist grounded theory, the understanding develops through a co-construction of the views of the person and the researcher. Willig (2008) suggests that the method should align with the views of the researcher, and therefore a constructivist grounded theory approach was thought to be most appropriate and ethically salient.

Ethical considerations and approval process

Recruiting NHS staff carries a number of ethical considerations which were considered during the study set-up, including accessing NHS premises as a visitor, the possibility of participants experiencing distress, the risk of staff disclosing malpractice. The setting up of interview location was conducted with the on-site principal investigator. The risk of disclosure was managed through explaining the limits to confidentiality prior to any interview, and negotiating with principal investigator for each site a procedure for managing risk if it arose. I was able to draw upon my skills learned throughout training of active listening, containment and validation in order to manage emotional distress during the interview, and time was spent following the interview conducting a debrief.

The study was considered by multiple bodies, including the Cardiff University Psychology Ethics Committee, Research Permissions Wales, the Health Research Authority (HRA), and each local NHS Research and Development (R&D) department. Full Research Ethical Consideration (REC) was not required. This process of approval took a total of seven months and a large proportion of the research time. Obtaining ethical and site-level approval therefore took a significant amount of time during the research project, and has taught me a number of skills for managing these processes (see section 3.6 for details).

Recruitment

The inclusion criteria for participation in the study included HPS who had been qualified for one year, and worked in inpatient settings within a UK children's hospital. This decision was made in order to ensure participants had been working long enough to gain a full appreciation of the challenges of the role. Student play specialists were excluded because there appears to be differences in the experiences of novice versus experienced HPS (Kayes, 2005). However, as reflected in paper two, it may be helpful to apply the theory to newly-qualified HPS in order to consider how resilience may differ in this cohort, thus increasing heterogeneity of the theory.

Play assistants were excluded due to differences in training and role responsibilities. Interestingly, the exclusion of play assistants was subsequently queried by one of the clinical psychologists at one of the sites due to the valuable and active role they play on paediatric wards. I could understand this following my own experiences working with play assistants, but I felt it was the right decision to keep the group homogenous in terms of training background because combining experience from two job roles may have made it difficult to contextualise the data.

Initial attempts to make contact via an online forum for HPS on Facebook and via their professional agencies were unfortunately unsuccessful, resulting in delays to study commencement. However, I am grateful for the experience in navigating the NHS ethical approval process via the Integrated Research Approval System (IRAS), and as a result of this experience I would be confident in conducting further research within the NHS.

Participants were recruited from three hospitals, and around 30 play specialists were approached. With a total of 10 recruited, this yielded a response rate of 33.3%. I was hopeful that recruiting from three sites would enable recruitment to be quite straight-forward, however this was unfortunately not the case. Many of the participants described feeling busy and overwhelmed in their roles, which may have restricted participation from many. In addition, some HPS were off sick, reducing the possible pool of participants to recruit from. HPS represent a small sample group in contrast to medical staff (e.g. doctors and nurses) who represent the majority of the paediatric profession. Thus, recruiting an adequate number was always going to be more challenging. Indeed, two research sites dropped out prior to study commencement, reducing recruitment by around 30 more possible participants. This was unavoidable due to considerable service changes within these sites, but highlighted to me the importance of approaching more sites at an earlier stage of the research in future.

Recruitment may also have been difficult due to the sensitive nature of the study content, and in potentially difficult service situations, potential participants may have been reluctant to share more difficult experiences. This was hinted at during the periods post-interview when at the point that the dictaphone was switched off, I noticed several participants disclosed information which was relevant the study, which could not then be included, despite having reassured participants of the anonymisation processes.

Recruitment was conducted through an email advertisement via play service managers and presentation at team meetings. I found it important to conduct site visits and meeting managers to enable for a clear conversation about roles and responsibilities, the process of the research, aims and objectives to build relationships with the teams. I enjoyed being in the hospitals and getting to know key team members.

Grounded theory does not assign a minimum amount of participants, and the aim was to recruit until saturation, which is understood to occur between 8-24 interviews (Riley, 1996). Although saturation was not claimed, I did notice that whilst additional codes continued to emerge in interviews number 7, 8 and 9, I was creating much fewer focused codes by this point. Consistent with grounded theory methodology, the interview schedule was amended in light of emerging themes and I was able conduct theoretical sampling to focus on exploring emerging themes (Charmaz, 2006). Urquhart (2013) suggests that in academic studies, time takes priority over saturation, and it is felt that the theory considers resilience within a fairly heterogeneous group of HPS. Further theoretical sampling would have been helpful to elucidate the relationship of experience, through recruiting those with specific experiences (e.g. age, department worked within).

Demographic information was collected to provide contextual information, including the age ranges of participants, departments worked within and number of years qualified. I debated whether this information should be included alongside each quote. Whilst the inclusion of the department each HPS worked in would provide an important context to those reading the study, this was balanced with the need to protect the anonymity of the small sample of participants (who may have been aware of their colleagues taking part), who are a relatively small professional group nationwide. As a very specialist professional group, I decided that adding their department of work would leave participants vulnerable to identification and decided to provide an overview in the write-up. This also fits well with the preferences of my target journal, who stipulate that participants should not be listed as individuals with their demographic information (Qualitative Health Research; see Appendix 2.1 for author guidelines).

Interviews

The semi-structured interview questions were developed in consultation with the research team. I was interested in how HPS perceived both the stresses and rewards of their role in order to build a theory of resilience development. The questions were deliberately broad. I found that initial exploratory questions served a dual purpose, they enabled me to build a rapport with participants early on during the interview, which enabled me to explore more challenging topics. I found that the semi-structured questions were a helpful guide, and prompts enabled emotive content to emerge, without imposing rigidity upon the way in which participants responded. In line with constructivist grounded theory methodology, the interview schedule was revised after the coding of the first four interviews (Charmaz, 2014). The emerging concepts 'feeling misunderstood', and 'being there' were further explored during interviews through addition questions in order to consider the meaning of these emerging concepts (see Appendix 2.4 for interview schedule and amendments).

The interviews were the most rewarding aspect of the research process. It was a privilege to hear participants stories and sharing their experiences. I also noticed that although research interviews had a different feel to clinical sessions, I was nonetheless drawing upon skills learned in clinical training including containment, validation, active listening and use of supervision to process the feelings evoked. I was also careful to hold onto aspects of systemic therapy training with regards to holding onto positions of neutrality, hypothesising and curiosity (Selvini et al., 1980) in order to ensure I did not influence the interview responses, whilst remaining validating. Holding onto positions of neutrality throughout the interview process was difficult at times due to participants making reference to similarities between the psychologist and HPS roles. Using frequent summaries and reflections enabled for me to check understanding, and this often led to further elaboration and exploration of meanings that may not have been possible otherwise. Therefore, my professional role supported the process of interviewing, and supervision of transcripts and audio recordings enabled me to ensure I was interviewing in line with grounded theory methodology.

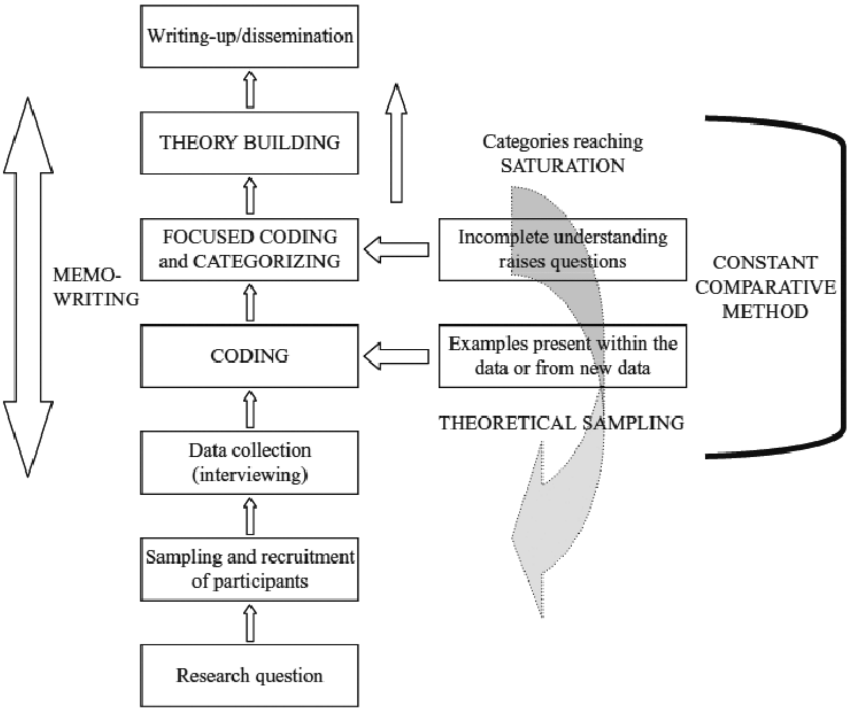
In addition to interviews I did wonder how much each participants may have scored on quantitative tools such as the Maslach Burnout Inventory (MBI; Maslach et al., 1981) and resilience questionnaires such as the Connor Davidson Resilience Scale (Connor & Davidson, 2003), and considered the benefits of this extra information in contextualising each HPS' level of resilience and/or burnout. Although the quantitative element would have limited power due to the small sample size, mixed methods studies have a number of advantages, including enabling a broader understanding of concepts (Hurmerinta-Peltomaki & Nummella, 2006; McKim, 2015). However, it is recognised that mixed-methods requires additional time for data collection and analysis (Cresswell & Plano Clark, 2011), and therefore this was considered outside of the remit of this doctorate project.

Analysis

Although I initially aimed to transcribe each interview, time pressures meant that this would not be an effective use of my limited time available. An external transcription service was utilised for 7/10 of the interviews in order to make sure I could code each transcript as soon as possible after it had been conducted, so that avenues of interest could be added to future interviews, in line with grounded theory methodology (Charmaz, 2006). I ensured quality of the transcriptions and immersed myself in the data by listening to each recording whilst coding the transcript, after which the recording was deleted. A written contract of data protection governance was provided (see Appendix 3.1) in order to ensure confidentiality was adhered to, in addition to each participant being assigned a psuedonym at the point of interview.

The process of analysis within constructivist grounded theory enabled for the development of a theory of resilience to emerge. The analysis process as described by Charmaz (2006) provided me with a framework and structure which was helpful as a novice qualitative researcher and ensured credibility of the write-up. An illustration of this can be found in Figure 3.1.

Figure 3.1. Analysis process in constructivist grounded theory (Tweed & Charmaz, 2012)



Coding

Line by line coding was conducted through attaching active gerund labels to each line of the data. As a result, these codes were descriptive and used participants' words wherever possible. Focused codes were developed through a process of constant comparison of line-by-line codes, in order to identify commonly occurring codes and to develop a conceptual understanding of the data. An example of the coding process can be found in Appendix 2.6. Through comparing instances of focused codes, similar instances were subsumed to create categories such as 'feeling misunderstood', or 'being there', and codes which did not fit were further investigated in later interviews in order to consider their relationships. The saturation of categories occurred when there was many instances of codes within that category from various participants (Urquhart, 2012). However, the research could have gone further by testing the direction of relationships between concepts through further theoretical sampling.

Theory development

In developing a theory, memos were used to track my conceptualisation of each emerging construct (Charmaz, 2006). The content of memos included my thoughts, reflections, and observations of the relationships between codes, including considerations of gaps and further questions to explore in future interviews (Urquhart, 2013). An example of this can be found in Appendix 2.6. During the memo-writing process, I found it important to draw upon my skills in managing uncertainty (Mason, 2015), as many of the categories were ambiguous during the parallel process of interviewing and analysis (Urquhart, 2013). According to Urquhart (2013), there is no 'correct' way to do grounded theory, I found this difficult when learning the methodology, but I found it very helpful to draw upon the expertise of my academic supervisor in making sure my theory was in keeping with the approach. A theory within grounded theory methodology is believed to consist of four components (Glaser, 2005):

1. A means of representation: as highlighted in Figure 2.1, and in narrative form.
2. At least one core construct: as indicated by the 'unique role' core category.
3. Statements of relationship: as indicated by Figure 2.1 and in narrative form.
4. Scope: the theory provides a framework for resilience development in HPS which can be tested using further theoretical sampling.

Theory development was also aided by considering the conditions, interactions, emotions and consequences within the data (Corbin & Strauss, 2008). This enabled for the theory to describe the process of resilience development, including the necessary conditions to enable its development (e.g. the presence of peer support, or through marketing the role and feeling valued). A diagram (see Figure 2.1) was developed to integrate the data together (Strauss, 1987). When developing the theory, care was taken to stay within the research phenomena in order to make sure the theory remained relevant to the development of resilience. This was difficult due to the richness of the data highlighting a number of possible avenues for exploration (such as the consideration of the cost-effectiveness of the play service). I felt both a responsibility to study participants to capture the richness of their interviews, but had to be mindful of my study remit and limitations of words within publications.

The theoretical coding process allowed for consideration of how concepts interrelated whilst also considering new data (Glaser, 2005). The researcher found that there was many ways of categorising the data (for example combining all elements relating to team working). However, the theory presented outlines the best fit of the current data at this time by focusing on the process of resilience development against each challenge experienced by HPS in this sample.

Evaluation of the theory

In order to maintain quality within the development of the theory, it is important to reduce the risk of bias. This was ensured through the use of reflective diaries, memo-writing and corroboration. Reflective bracketing enables the consideration of pre-existing hypothesises to be demonstrated (Ahern, 1999). A reflective diary enabled for a transparency of my own assumptions and to separate this from the study material. An example is presented below:

> *"After not interviewing for a while and with my head full of existing codes, am I trying to fit what I am hearing into what I already have constructed in my mind? I need to keep aware of this whilst I am interviewing and remain open to new information. I'm finding myself listening for quotes and not been fully present".*

Working within a social constructionist standpoint, the concept of corroboration is advised over triangulation which is thought to be more aligned to a positivist philosophy (Urquhart, 2011). Transcripts were checked by my supervisor, and codes and categories were discussed in supervision to corroborate the data. The emerging theory was developed within these meetings. At times it was difficult not to see emerging codes within the context of already existing ones (Charmaz, 2006). However, care was taken and supervision sought to retain an 'open mind' rather than an 'empty head' (Dey, 1993). It may have perhaps been easier to conduct the research considering no prior understanding of resilience, but it is widely acknowledges that the idea of the researcher as a 'blank slate' is a myth of the approach (Andrew, 2006; Urquhart, 2011). Staying close to participants' data through the use of quotations during the memo-writing process enabled me to distance myself from my own assumptions without denying them. I would also have liked to feedback the data to participants as this is thought to increase interpretation congruency (Mays & Pope, 2000), but unfortunately it wasn't feasible with the tight timescales.

Grounded theory methodology also suggests that researchers should avoid reading the literature prior to analysis (Charmaz, 2006). The literature review is thought to be guided by the emerging codes in order to assess relevance (Urquhart, 2011). Therefore, in order to complete a research proposal, a 'non-committal' literature search was conducted in order to outline the phenomenon to be researched (Martin, 2006). The use of supervision enabled me to distinguish the current findings from that of early scoping searches, as well as findings from the review which was conducted in January 2018. Then, following the generation of the theory, extensive reading of theories related to findings was undertaken in line with theoretical sensitivity (Glaser, 1978) to integrate the theory within existing literature. Through the above process, Glaser's (1978) criteria for validity was considered. See Table 3.2 for details of how this was enacted during the analysis process:

Table 3.2. Glaser's (1978) criteria for validity

Glaser (1978) criteria		**Current research**
1.	*Fit* - conceptual codes to be derived from the data, not preconceived	• Staying close to the data through the use of quotations and participant's own words • Supervision
2.	*Workability* - the theory should explain and interpret and predict future behaviour	• The theory aims to explain resilience development in HPS and can be tested through further application of the theory
3.	*Relevance* - the focus of the research should be relevant to the question	• The theory presented focuses upon the development of resilience in HPS
4.	*Modifiability* - the theory should be flexible and adaptable to new categories or ideas	• The theory can be modified to incorporate further resilience strategies

Clinical implications

The results indicate a number of implications for clinical practice. The finding that the role of a HPS may put staff members at increased risk of distress due to the proposed increased closeness in relationship suggests that this is something which should be highlighted at all stages of their career, especially in highly emotive areas. Further research is required to establish the experiences of HPS early in their careers, however the current findings suggest that experience may be key in learning strategies to cope with emotional content of the work. Management should prioritise this through considering the use of mentoring and supervision structures for HPS at all stages of their careers. Ward teams should consider the use of reflective spaces in order to prioritise staff wellbeing. Normalising the emotional impact upon staff has the benefit of validating their experiences, opening up conversations, encouraging peer support and the expression of emotions, all of which was highlighted as contributing to resilience in the current sample.

In addition, participants described finding taking space away from patients as helpful in managing the emotional load of the work, with those working part-time experiencing greater wellbeing. Although it is acknowledged that many are unable to work part-time, the same space could be achieved through providing flexible working, encouraging staff to get involved in non-clinical activities such as cleaning toys, research or developing resources, or through supporting a balanced caseload of acute and non-acute patients (Yassen, 1995; Munroe, Shay & Fisher et al., 1995), considering that research suggests that those working in areas of high risk of patient death, such as hospice workers, oncology and intensive care have higher risks of compassion fatigue than general areas (McKinley, Boland & Mahan, 2017; Aabendroth & Flannery, 2006).

Experiencing stressful events with little reward has been linked to burnout in a model known as 'effort-reward imbalance theory' (Bakker & Demerouti, 2007). Balancing this out could therefore help to reduce burnout through either decreasing demands or increasing reward (such as through recognition and praise). Indeed, this study found that recognition through Trust awards was associated with wellbeing in participants from one site.

The findings also highlight a key process in enabling HPS to manage increased workloads; accepting limitations and being compassionate to oneself. Interventions targeting harnessing a compassionate response to difficult circumstances may therefore be key to coping with this pressure. In an environment which is chaotic such as healthcare, Suri and Nash (2018) suggest that the focus be upon aspects people can control in order to cope. The principles of Acceptance and Commitment Therapy (ACT; Hayes et al., 1999) aim to increase psychological flexibility through the use of acceptance, mindfulness and leading a meaningful life. An ACT based intervention (Flaxman, Bond, Livheim & Hayes, 2013) was evaluated in a UK hospital consisting of two half day group sessions, including teaching mindfulness skills and considering personal values was evaluated with 100 healthcare staff and showed improvements in mental health, mindfulness and psychological flexibility which was maintained at three month follow up (Jennings et al., 2016), suggesting this may be helpful in increasing resilience. Accepting what cannot be changed, combined with a compassionate response, should enable HPS and other healthcare staff to continue with their work.

Clinical Psychologists can support the development of resilience in HPS through offering clinical supervision, reflective practice groups, and training. Indeed, clinical psychology support was available for some HPS within the current sample, which they described as helpful. However, the study also highlights the variation in level of organisational support offered to HPS. This study highlights the importance of support for HPS working across departments. Thus, trust-wide policy and procedures around staff wellbeing are vital in maintaining a healthy workforce. Recent NICE (2009) guidance provides a framework for organisations to consider improving the wellbeing of their staff.

Further research

The results of the empirical paper indicate a number of avenues for further research. Firstly, the prevalence of burnout in HPS is unknown in the UK and this would help to clarify the size of the issue. The theory did not consider any directions of relationship in the development of resilience, and further enquiry through theoretical sampling may enable for the direction of relationship between concepts to be tested.

Resilience in the current study is appraised as a concept that is fluid and developed over time with experience, but also when a number of conditions are present (e.g. a supportive team/management, the allowance of feelings and emotions, a work/life balance and awareness of limitations). These conditions would benefit from further research. For example, the use of marketing the role to buffer the impact of feeling misunderstood, and the use of self-compassion and acceptance in managing multiple demands. These would benefit from being further explored. Self-compassion, defined as a kind and non-judgemental response to one's experiences (Gilbert & Procter, 2016) has been linked with increased resilience (Neff, 2003; as cited in Raab, 2014). However, the consideration of compassion in resilience in healthcare staff has not been considered, and represents an interesting avenue for further research within HPS and other members of the MDT. Compassionate mind training may help HPS to manage feelings of guilt at being unable to provide care to all children who need it (Gilbert & Procter, 2006), although further research is needed to consider whether self-compassion is a viable factor in influencing resilience.

The study also highlighted the emotional risks of having a close relationship with patients, which participants described using strategies to enable distance from. It is unclear what makes this 'space' helpful, and further research is needed in order to distinguish the impact of psychological flexibility (Hayes et al., 1999) and mindfulness (Kabat-Zinn, 1990) in providing this space. Overall, there is a lack of research into HPS, and this study reflects a small proportion of the workforce. Thus, further application of the theory would enable a broader and more comprehensive understanding of resilience development in HPS.

Limitations of the research

There are several limitations to the current research. Grounded theory has been criticised for developing in-depth theory which is applicable to small populations (Urquhart, 2013). The aim of the research was not to generalise to other professional groups. Participants worked across three hospitals and a variety of hospital wards, with various levels of experience. Although this enabled a comprehensive theory to be developed, the sample size remains small. Further theoretical sampling would enable for greater heterogeneity of HPS, representing further views and allowing for a more representative theory of resilience development. This study therefore provides a helpful baseline for further research within this group.

The appraisal of the literature pertaining to HPS was limited by a lack of peer-reviewed studies available. Two international academic studies were found which consider burnout within HPS (Kayes, 2005; Isaac, 2006), both conducted in New Zealand. The decision was made to maintain quality in the write-up through not including these studies, although they may have provided a further insight into the experience of HPS in their roles. The interpretation of results in line with existing literature was also hindered by the lack of comparable studies in the UK. The role of the HPS in the US is known as a 'child life specialist' and, as much as I attempted to ensure that the role is comparable in this context, it is unknown how similar these roles are. Additionally, the lack of research into resilience in HPS restricted the interpretation further, as I was required to consider the findings in conjunction with studies into resilience within other members of the medical team, whose roles are quite different.

The ward context in which the HPS worked is important as it influences the amount to which participants were exposed to the death of patients, traumatic procedures and the closeness of the relationship (Meadors & Lamson, 2008). However, the impact of medical speciality was not interpreted due to the prioritisation of participant confidentiality. Further research considering the impact of medical specialty would be helpful in clarifying the theory in context.

PLANS FOR DISSEMINATION

The research will be disseminated through a number of avenues as outlined below, in order to ensure the research is accessible to both clinicians and researchers.

Local services

On a local level, I have been invited by all services managers from each Children's Hospital which took part in the study to present the findings of the research. These presentations are to be arranged in due course, but it is hoped that this will inform practice for Health Play Specialists. There is also the opportunity to disseminate study findings further via email to all leads of Play services within the UK, and via HPS network groups, enabling the implications to be widely shared.

Conference presentation

On a national level, the empirical paper has been accepted for presentation as a poster at the annual conference for the National Association of Health Play Specialists (NAHPS) on the 22nd June 2018 at University College London. This is to ensure that clinical implications reach HPS working across the country.

Journal publications

Paper one will be submitted for publication within the Journal of Pediatric Psychology. This paper has an impact factor of 2.4 and appeared most appropriate for the review. Other reviews have focused upon one particular department (e.g. oncology nurses; Mukherjee et al., 2009), and published in journals focusing upon this specialty. Therefore, the Journal of Pediatric Psychology was considered most appropriate within its remit of the role of psychology within healthcare settings, including recent articles focusing upon burnout in nurses (Rodrigues et al., 2018).

Paper two will be submitted to the journal of Qualitative Health Research. With an impact factor of 2.2, it was chosen for its breadth of audience, relevance to paediatrics and focus upon the experience of caregivers in their published studies (e.g. Eriksson, Starrin & Janson, 2008).

COMPETENCY DEVELOPMENT

The process of conducting this research has allowed for the development of a number of clinical and research skills over a significant proportion of doctoral clinical training. This section will focus upon the Clinical Psychology competencies developed over the course of the research process as informed by the British Psychological Society (BPS), standards for accreditation (BPS, 2015), leadership framework (BPS, 2010), and the Health and Care Professions Council standards of proficiency for practitioner psychologists (HCPC, 2010).

Research

In considering a choice for a research project, I reflected upon previous experience in conducting exclusively quantitative projects. Due to this experience, along with the dominance of quantitative research throughout the relevant literature, I was conflicted at times at the decision to explore this topic qualitatively. However, the awareness of the value of qualitative approaches has been steadily increasing over the past decade (Bondas & Hall, 2007; Ring, Ritchie, Mandava & Jepson, 2010), suggesting that the additional context and meaning provided within qualitative research (Noblitt & Hare, 1988) is increasingly welcomed. This seemed increasingly important when exploring the HPS role which is relatively unknown from an academic perspective. The opportunity to develop my skills in qualitative methodology was therefore a welcomed challenge.

Navigating the research approval process within the NHS has enabled me to develop experience in navigating complex processes and to follow the research through from conception to completion. The process of connecting with clinical teams and recruiting via NHS and relevant ethical approval processes has been a time consuming aspect of the research, but one which has enabled me to gain an understanding of the varied and complex system of obtaining approval to conduct research within the NHS. As such, I feel more prepared to continue researching when working clinically throughout my career. I am particularly interested in continuing to research the impact of working in emotionally challenging areas. Upon qualifying, I will be starting work as a clinical psychologist in a community learning disability team. I would be particularly interested in researching and supporting the emotional wellbeing of staff working in residential care settings with individuals who present with behaviours that challenge, as research suggests this is a particularly vulnerable group for burnout (Skirrow & Hatton, 2007).

Writing for publication has been a challenging yet containing process. I have at times been frustrated by the limitations of writing a qualitative paper succinctly, but I am reminded that this is something which is equally important in clinical practice when writing reports and letters, in order to retain accessibility to readers. The process of preparing manuscripts has been driven by my beliefs about the importance of disseminating research, especially considering the obligation to participants and the funding received as part of clinical psychology training. In addition, taking part in reflexive bracketing has been a welcome experience, adding to my experience of reflective practice within the training course, increasing the awareness of my own beliefs, attitudes and thoughts surrounding resilience.

Communication and collaboration

Conducting the study required me to liaise with a number of agencies, including the HRA, Research Governance Wales, three R&D departments, play service managers, and clinical psychologists. I found it helpful to meet with play service managers in person prior to conducting the research in order to introduce the study, outline what was required from them, and to develop a rapport. I found that this process helped significantly in increasing the support the manager provided in recruitment of participants, and it provided me with greater insight into the context of the service from which I was recruiting.

In approaching clinical psychologists to be principal investigator (a role which involves mostly administrative responsibility), it was important to consider what may be useful for them to receive in return. Reassurance was provided through outlining the responsibilities for the conduction of the research. I took the lead on the completion of relevant R&D paperwork and liaison with study participants to ensure the research did not take away from their clinical time.

The opportunity to publish and share findings has been a novel but exciting one. I have sought to enable the study findings to be as accessible as possible through adapting the research findings to various audiences via journal publication, presentations and posters, to audiences who may be either familiar or unfamiliar with the HPS role. In considering advertising the research project, I aimed to make information as accessible as possible to the HPS and highlighting the benefits for participation as well as for myself. This process will support me in my qualified role when working with individuals with a learning disability through making all of my resources accessible to various levels.

Leadership

The role of Clinical Psychologists within leadership roles has increased in line with the 'New Ways of Working for Applied Psychologists (Lavender & Hope, 2007). The research project has allowed for the accumulation of a number of leadership qualities (BPS, 2010), as described below.

My values of collaboration and holding a 'non-expert' stance enabled for connections to be made with a number of clinicians working in relevant areas. Firstly, key relationships were built between myself and local collaborators as described above. This involved contacting potential study sites, presenting the research aims at meetings with play service managers and contacting various external agencies (such as NAHPS). I took the lead on contacting, enquiring and liaising with all agencies, preparing relevant study paperwork, conducting risk assessments and considering ethical issues. I gained skills in coordinating other parties including research governance agencies, clinicians and through organising interviews. I was not familiar with a leadership position prior to commencing this project. At times this has been uncomfortable for me when chasing replies and approaching sites to collaborate, but I have grown in confidence as a result.

The research has enabled me to increase my skills in appraising the literature in order to consider gaps and areas for future research. Overseeing a research project has enabled for me to use and develop my organisational skills. I found that I needed to be flexible to complete the project within the specified time-frame, through offering a variety of times for interviews, and through planning my workload in order to balancing own personal responsibilities alongside the project. I sought training from the university librarians and attended short courses to develop skills in conducting the review and this experience will enable me to supervise similar research projects when qualified.

In disseminating the research, I will be promoting psychology as a profession which models and holds staff wellbeing in priority, as well as considering the service development opportunities to influence organisational structures and provisions. In future qualified posts, I aims to further develop their service development skills and leadership in taking a lead role in interventions and initiatives to improve staff wellbeing within a strategic capacity.

SUMMARY

The process of completing a large-scale research project has been an influential experience. The supervision and guidance received, as well as the challenges faced, have provided opportunities to gain a number of clinical and research skills which will be valuable throughout my career. I have been able to foster a long-standing interest in healthcare staff wellbeing and I aim to continue to promote this in my work in the NHS as a Clinical Psychologist.

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APPENDICES

Appendix 1.1 Author guidelines for the Journal of Paediatric Psychology

Instructions to Authors

The *Journal of Pediatric Psychology* is an official publication of the Society of Pediatric Psychology, Division 54 of the American Psychological Association. *JPP* publishes articles related to theory, research, and professional practice in pediatric psychology.

Author Guidelines

We would like to inform our authors that we now detect plagiarism easily. The journal to which you are submitting your manuscript employs the CrossCheck plagiarism screening system. By submitting your manuscript to this journal you accept that your manuscript may be screened for plagiarism against previously published works.

Journal of Pediatric Psychology will not consider papers that have been accepted for publication or published elsewhere. Copies of existing manuscripts with potentially overlapping or duplicative material should be submitted together with the manuscript, so that the Editors can judge suitability for publication. The Editors reserve the right to reject a paper on ethical grounds.

Organization of manuscripts

Manuscript Central will guide authors through the submission steps, including: Abstract, Keyword selection, and the Manuscript. The manuscript must contain an Introduction, Methods, Results, Discussion, Acknowledgements and Reference List.

Length of manuscript: Original research articles should not exceed 25 pages, in total, including title page, references, figures, tables, etc. Case reports should not exceed 20 pages. Review articles should not exceed 30 pages. Invited commentaries should be discussed with the Editor. The *Journal of Pediatric Psychology* no longer accepts brief reports but will accept manuscripts that are shorter in length than the 25 page manuscript. In the case of papers that report on multiple studies or those with methodologies that necessitate detailed explanation, the authors should justify longer manuscript length to the Editor in the cover letter.

Manuscripts (text, references, tables, figures, etc.) should be prepared in detailed accord with the Publication Manual of the American Psychological Association (6th ed.). There are two exceptions:

The academic degrees of authors should be placed on the title page following their names, and a structured abstract of not more than 250 words should be included. The abstract should include the following parts:

1. Objective (brief statement of the purpose of the study);
2. Methods (summary of the participants, design, measures, procedure);
3. Results (the primary findings of this work); and
4. Conclusions (statement of implications of these data).

Key words should be included, consistent with APA style. Submissions should be double-spaced throughout, with margins of at least 1 inch and font size of 12 points (or 26 lines per page, 12-15 characters per inch). Authors should remove all identifying information from the body of the manuscript so that peer reviewers will be unable to recognize the authors and their affiliations.

Informed consent and ethical treatment of study participants: Authors should indicate in the Method section of relevant manuscripts how informed consent was obtained and report the approval of the study by the appropriate Institutional Review Board(s). Authors will also be asked to sign a statement, provided by the Editor that they have complied with the American Psychological Association Ethical Principles with regard to the treatment of their sample.

Clinical relevance of the research should be incorporated into the manuscripts. There is no special section on clinical implications, but authors should integrate implications for practice, as appropriate, into papers.

Terminology should be sensitive to the individual who has a disease or disability. The Editors endorse the concept of "people first, not their disability." Terminology should reflect the "person with a disability" (e.g., children with diabetes, persons with HIV infection, families of children with cancer) rather than the condition as an adjective (e.g., diabetic children, HIV patients, cancer families). Nonsexist language should be used.

Special Instructions for Types of Manuscripts

Manuscript types include:

- Original research
- Review articles
- Topical reviews
- Systematic reviews
- Invited commentaries

Original Research

(1) Randomized controlled trials/Non-randomized trials: *JPP* is committed to enhancing the transparent reporting of all intervention studies. If you are submitting a manuscript of a randomized clinical trial (RCT) to *JPP*, you are required to submit the CONSORT checklist and a flowchart of your research showing the steps found in the Consort E-Flowchart. Both the Consort E-Flowchart and a checklist of items to be included when reporting a randomized trial can both be found here which also describes several CONSORT checklist extensions for different designs and types of data beyond two group parallel trials. At minimum, your article should report the content addressed by each item of the checklist. Meeting these basic reporting requirements will greatly improve the value of your trial report and may enhance its chances for eventual publication.

If you are submitting a non-randomized trial to *JPP*, you are required to follow the reporting elements of the TREND statement.

For each submission (original and any revisions), authors should use and submit the appropriate checklist with their manuscript. Please use this one for RCTs, and this checklist for non-randomized trials. Please clearly indicate the page numbers where each checklist item is reported in the manuscript. Please upload this checklist as supplementary material when you submit your manuscript for consideration.

All intervention studies (RCTs and non-randomized trials) will undergo an additional review for transparent reporting conducted by the *JPP* Student Editorial Liaison. Review comments will be provided on the corresponding checklist. Authors will be required to address any identified reporting issues prior to publication.

Authors are also encouraged to visit the Equator Network for additional information on transparent reporting of all manuscript types.

(2) *Single Subject Studies*: As a journal that encourages submission of intervention studies, the Journal does accept, and encourages submission of, well-conducted single subject studies (N-of-1 designs). Case studies and narrative reports of special cases that are more descriptive will not be considered for review. It is important to note that rigorous single subject designs are considered logical equivalents of Randomized Controlled Trials and include control conditions that support conclusions of causality. Previously published examples can be found in this journal including: Bernard, Cohen, & Moffett (2009); Powers et al. (2006). Authors considering submissions of case reports adopting N-of-1 methodology should consult the following sources within this journal: Cohen, Feinstein, Masuda, & Vowles (2014); Cushing, Walters, & Hoffman (2014); Rapoff & Stark (2008); Case reports that adopt formal N-of-1 methodology should not exceed 20 pages.

References:

Bernard, R. S., Cohen, L. L., & Moffett, K. (2009). A token economy for exercise adherence in pediatric cystic fibrosis: A single-subject analysis. Journal of Pediatric Psychology, 34, 354-365.

(3) Measurement development and validation articles: For additional guidance please read, Holmbeck, G. & Devine, K. (2009) Editorial: An Author's Checklist for Measure Development and Validation Manuscripts.

(4) Historical Analysis in Pediatric Psychology: This is a special series of papers devoted to the history of pediatric psychology. Authors interested in submitting a paper for this series should contact the Editor of *JPP* to discuss potential papers prior to submission. There is no deadline for these papers (they may be submitted anytime). All submissions will be peer reviewed and should comply fully with the *JPP* Instructions to Authors. Papers in this series should be tightly focused contributions that expand our understanding of the roots, evolution, and/or impact of pediatric psychology as a discipline. Manuscripts may focus on the influence of individuals, published works, organizations, conceptualizations, philosophies or approaches, or clinical and professional activities. Successful papers should articulate a clear purpose/question and develop a compelling argument for the topic. Contributions should include a breadth of coverage, such that contradictory data are included and potential biases acknowledged. Historical analysis is more than a recounting of the "facts" and should include a thoughtful and scholarly interpretation of the subject matter. Papers should rely on primary sources and must be clearly and appropriately referenced. Supplemental materials to accompany the article may be posted online.

Review articles:

(a) Topical reviews: Topical reviews summarize contemporary findings, suggest new conceptual models, or highlight noteworthy or controversial issues in pediatric psychology. They are limited to 2,000 words, contain no more than 2 tables or figures, and have an upper limit of 30 references. Supplementary online material (e.g., additional tables) may be considered on a case by case basis.

(b) Systematic reviews: Systematic reviews should not exceed 30 pages. Authors are required to attach the PRISMA checklist and flow diagram as supplementary material for each submission. Authors can find the PRISMA checklist and flow diagram in downloadable templates that can be re-used here. Authors of systematic reviews that do not include a meta-analysis must provide a clear statement in the manuscript explaining why such an analysis is not included for all or relevant portions of the report.

Please consult editorial (New Guidelines for Publishing Review Articles in *JPP*) which further describes guidelines for review articles, and the Checklist for Preparing and Evaluating Review Articles.

Appendix 1.2 Quality Appraisal

	Clear aims	Method	Design	Recruitment	Data	Relationship	Ethics	Analysis	Findings	Implications	Total /10
Beaune et al., (2017)	1	1	1	1	1	0	1	1	1	1	9
Conte (2014)	1	1	1	1	1	1	1	1	1	1	10
Cook et al., (2012)	1	1	0	1	1	0	1	1	1	1	8
De Almeida et al., (2016)	1	1	1	1	1	0	1	1	1	1	9
Granek et al., (2016)	1	1	1	1	1	0	1	1	1	1	9
Kaplan (2000)	*1*	*1*	*1*	*1*	*1*	*0*	*0*	*0*	*0*	*1*	*6*
Kellogg et al., 2014 et al., (2014)	1	1	1	1	1	0	1	1	1	1	9
Kpassagou & Soedje (2017)	1	1	1	1	1	0	1	0	1	1	8
Maytum et al (2004)	1	1	1	1	1	1	1	1	1	1	10
Morrison & Morris (2017)	1	1	0	1	1	0	1	1	1	1	9
Muskat et al., (2017)	1	1	1	1	1	1	1	1	1	1	10
Papadatou et al., 2002 et al., (2002)	1	1	1	1	1	0	0	1	1	1	8
Rodrigues et al., (2017)	1	1	1	1	1	0	1	1	1	1	9
Zander et al., (2013)	1	1	1	1	1	0	1	1	1	1	9

Appendix 1.3 Meta-synthesis process

Synthesised themes from primary data **(First-order constructs)**	**Example quotes from primary data**	**Second-Order Interpretations / Theories derived from the primary Studies (quotes directly from authors)**	**Third-order Interpretations / Reviewer's theories**
1) Feeling unprepared **(Unprepared for death; lack of training on positive coping; unprepared for emotional challenges; the role of experience)**	*”they just covered what you had to do for the patient that dies; the physical aspect of caring for the body and bringing the body to the morgue and stuff like that. The grief that you go through, not at all.”(Kellogg et al., 2014 p300)* *“I wonder if my training allows me to have a distanced view on situations entrusted to me .... Did this training enable me to go into this domain? (...). Do I have the opportunity to accompany a person to the end of his or her life? I try to do my best to relieve the patients but do I really alleviate them? (Kpassgou & Soedje, 2017, p77)* *". . .it can be very daunting for them because you don’t get much pediatric training when you’re studying... you pretty much have to learn on the job" (Zander et al, p20)*	'The proficient nurse learns from experience what to expect in certain situations and feels responsible for choosing an appropriate plan of care...The discrepancy between how participants felt and how the hospital perceived their experience level may explain the heightened levels of anxiety they described'. (De Almeida et al., 2016, p222) 'All participants expressed that they had limited education that would have enabled them to process their feelings and function effectively' (Kellogg et al., 2014, p300) 'According to the practitioners we studied, their training did not adequately prepare them for the emotional distress associated with loss of life and prolonged patient suffering' (Kpassgou & Soedje, 2017, p77)	Struggling to know what to do (with emotions) creates uncertainty in knowing how to cope

2) Feeling helpless and out of control **('They get sicker'; deterioration; dealing with death; feeling powerless; unable to provide good care; stress impeding care; maintaining control; guilt and**	*"To care for a child in pain and being unable to help makes me feel powerless. When I realize that I can do nothing but accept the child's dying process, I begin to feel helpless" (Papadatou et al., 2002, p348)* *"Smiling was once a characteristic of my personality. Now. I experience a pressure upon my heart, a weight that does not allow me to breathe" (Papadatou et al., 2002 et al., p351)* *"It is the accumulation of so many experiences over so many years. I don't laugh easily. I am not enjoying*	'Physicians grieved primarily over the loss of their professional unfulfilled goals and expectations to cure the child, whereas nurses grieved with greater frequency over the loss of a special relationship they had developed with a particular patient.' (Papadatou et al., 2002, p350) 'Participants described feeling powerless to provide quality care as a major source of work-related stress (De Almeida et al., 2016, p222) '.. maintaining control over their emotions was a vital skill... in paediatric oncology. Many of the nurses... were	Feeling out of control of patient outcome, emotions and a lack of professional status leads to a sense of helplessness.

helplessness; loss; grief; giving bad news; stress and exhaustion; compassion fatigue; moral distress; Lack of physical resources; lack of management support; poor communication; role challenges; role hierarchy conflicts; competing demands)	*myself I am no longer carefree. I feel overwhelmed. It is as if I have taken in too much" (Papadatou et al., 2002) p 351)* *"The family would blame me because their child was sick, because I wasn't there to take care of them. So, all these expectations are put on me. I have a lot of parents...dependent on me. It's wearing after a while.(Maytum et al., 2015, p175)* *To watch a family suffering and not be able to help them. To constantly be at that place where you walk out of work every day thinking that you didn't do a good enough job. I think that's where burnout comes in, where you just don't want to come in any more because you're not getting any satisfaction out of your job" (Maytum et al 2015 p 176)* *You don't feel like you can give good care because you're rushing constantly. You don't have the time to sit for 10 minutes with that parent or to hold that baby, the little things that make a difference (Maytum et al 2015 p176)* *'We are experiencing budget cuts, which cuts the number of nurses per higher patient acuity level and higher [number of] patients. . .We cannot provide safe care... patients aren't getting the things they need on time.'' (De Almeida et al., 2016, p220).* *I can count [on] one hand how many doctors have actually asked, 'what do you think the next step should*	not afforded any time to stop and process a loss they experienced while at work and therefore needed to be in control of their emotions to successfully continue through their shifts.'(Conte, 2014, p43). "Participants experienced a sense of powerlessness in working with what they perceived as inadequate resources and decision-making capabilities. Since senior nurses were responsible for supervising the wards, participants felt pressured to deal with the repercussions of reduced resources while striving to provide a sense of continuity and deliver quality care.' (De Almeida et al., 2016, p220) '... his perceived lack of collaboration made nurses feel unheard, and powerless.' (De Almeida et al., 2016, p221) 'Most participants had high self-expectations and perceived high expectations from others. Participants described feeling pressured to be an expert nurse even though they had become seniors at an earlier stage in their careers' (De Almeida et al., 2016, p221) The concern that current standards of care inhibit optimal pain management seemed to contribute both to nurses' distress about the treatment they provide and their levels of emotional exhaustion at the end of the day (Rodrigues et al., 2014, p5)	

	be?’’ (De Almeida et al., 2016, p221)		
3) Connection and disconnection **(Connectedness to patients, families and peers; 'being there'; peer support; acceptance and normalisation of death; connection to values; spirituality; engagement coping; problem-solving; regulation of emotions; self-care; connection to emotions; processing grief; processing emotions; grieving; sharing with others; keeping boundaries; disengagement; avoidance; withdrawal; suppressing emotions; compartmentalising; isolation; alienation; negative beliefs**	*I don't grieve, on the contrary, I become fully involved in life, i try to find friends, to get out. I don't mention what I have experienced at work that day. I try to think about it as little as possible"(Papadatou et al., 2002 et al., 2002 p350)* *" Everybody supports everybody else even if it’s informally." (Conte, 2014, p42).* *"I had another mother say, ‘What do you do?’ and I said, ‘I’m a pediatric oncologist.’[Her response was] ‘Oh! I’m a head-in-the-sand kind of person when it comes [to] that sort of thing.’ So I don’t know how much more direct people can be, right? I don’t want to hear about it.(Granek et al., 2016, p50)* *"I mean that’s one of the great things about pediatric oncology. It’s a relatively small world and we all work so closely together, and thus, and everybody understands the emotional challenges are a huge part of what we do and everyone goes through it." (Granek et al., 2016, p49)* *"...you have to be in control of yourself... keep a sort of private guard for your personal life and sometimes it’s quite challenging. It’s difficult. You cannot forget.... what you live on a daily basis. It remains painful … you learn to compartmentalize better that this pain, while you experience that this is painful, you can better distinguish once you become more experienced that this*	'Participants developed various coping mechanisms such as maintaining control to help themselves while providing care during emotionally difficult situations' (Conte, 2014, p44). 'Some physicians honestly admitted that their presence was an act performed out of a sense of duty, since the death of a patient caused them increased distress. By contrast, nurses considered their presence by the child's bed as a natural and integral aspect of their job.' (Papadatou et al., 2002, p349) '...Feeling a sense of connectedness to their patients and other nurses assisted them in finding meaning in their work and support in times of distress... however, these relationships also intensified the sense of loss and grief the nurses experienced when these patients were lost' (Conte, 2014, p42). 'The connectedness that these nurses established with each other provided psychological support and assisted in the processing of their reactions to the losses they encountered during their careers... and belonging to this group meant that nurses had a core group of individuals from which they could draw support and empathy.' (Conte, 2014, p42). 'When oncologists did talk to a friend or family member, it was often someone who was also a medical professional who could understand this type of work context.' (Granek	Balancing connection and disconnection to patients, families and colleagues as a way of regulating exposure to pain.

about patients)	*pain relates to this family and not to yourself, and while you regret that this family's experience…my rule is not to, not to mix it up with my own experiences" (Grane et al., 2016, p49)* *"I felt as though my co-workers were probably the best counselling that I needed because they were all with me. I felt they were in the same place as I was." (Kellogg et al., 2014 p300)* *When I see that a child has cancer in an advanced stage… when I expect that the child will die, my relationship with him or her is less close." (Kpassgou & Soedgje, 2017, p77)* *I finally began to process. Now I have a ritual that I carry out after each child's death... (Maytum et al 2015 p177)* *"…I try to run, and I don't necessarily think when I run…I go blank…it's just probably, a bit of an escape, in that way." (Muskat et al., 2017, p 513)* *"… in order for you to be helpful, you have to go, you have to leave here and go to whatever your other life is. And you have to have a life outside of here."(Muskat et al., 2017, p513)* *"… And so, we're very in tune with each other and supportive of each other. And nobody's afraid to say, "Oh, I can't deal with one more."…we don't have to be tough and strong all the time. So that's really, really*	et al., 2016, p50) 'Although this use of alienation served to protect the nurses' loved ones, it in turn removed their loved ones as available sources of support." (Conte, 2014, p42). "Another type of boundary that was described by several nurses was developed [over time'] to maintain an emotional separation and thus prevent burnout' (Cook et al., 2012, p15) Nurses discussed feeling worried that their careers in pediatric oncology had some negative consequences on their families and loved ones. One nurse shared she used to be concerned that the grief and stress she experienced early in her tenure as a pediatric oncology nurse affected her young daughter. (Conte, 2014, p42) 'using distancing as a way of self-protection when they felt the emotions of a situation were too intense. Some achieved this by emotionally distancing themselves, whereas others physically distanced themselves from the difficult situation in order to stay in control of their emotions' (Conte, 2014, p43). 'For pediatric oncologists, physical activity was an important coping strategy to 'let off steam' and to ameliorate the emotional pain of patient death'. (Granek et al., 2016, p53) 'Spending time with one's own children was described as an effective coping strategy to take their mind off from	

	helpful. And it's safe. It's a safe team to communicate how you're feeling and support each other". (Muskat et al., 2017, p 513) *"So, how do I deal with [it]? I don't think I do. I shut it down…Don't talk about it." (Muskat et al., 2017, p514)* *"I know I also feel a lot of guilt because we got into this business to make people feel better and we are sitting there judging and rolling our eyes. It's hard because that's conflicting. We as nurses want to make them feel better, but then in the back of my mind I'm like, 'Oh, you're so full of it.' I don't want to feel that way about my patients, but sometimes it's hard not to and so you try to get that." (Rodrigues et al., 2014, p5)* *". . .home and I'll vacuum the house and for me, I just feel all my stress just leaving my body and I'm happy and it's just. . . one of those things that helps me cope." (Zander et al., 2013, p21)*	work and to be in the 'here and now'. (Granek, 2016, p53) 'Participants described the impact that their work had on their personal lives and relationships. They felt that their friends and family were not able to truly comprehend the nature and impact of their work'(Muskat et al., 2017, p512) Some participants reported disengaging or avoiding emotions as a way of coping. Participants described not wanting to "deal" with their emotions, pretending like the death of a child "didn't happen" and that avoidance was a form of "self-preservation."(Muskat et al., 2017, p514) 'Nurses discussed their fears of losing, or having already lost, compassion for their patients, and they discussed actively trying to empathize and understand their patients' experience and behaviours. Although many nurses discussed losing compassion, some nurses noted maintaining empathy for their patients Nurses described being able to cope better with frustration when they were able to empathize and take the perspective of their patients or their patients' parents (Rodrigues et al., 2014, p5)	

4) New perspectives, growth and purpose **(Gaining sense of perspective; enhanced personal resources, reframing; increasing self awareness; making meaning; reflecting and growing; the privilege of the role; fond memories; benevolence; gratitude; appreciation of the strength of others; redefined priorities; personal strengths and limitations; clinical lessons learned; advocacy for children; feeling rewarded; making a difference)**	*" I feel very privileged to be part of that very sacred time in a family's life " (Muskat et al., 2017, p511)* *"I think there was a time where it was very, very frightening, and now… I'm really, really not looking forward to it, but it's not so frightening. I'm not so frightened any more". (Muskat et al., 2017, p511)* *"I feel like I have such good perspective around what's important in life. I do not care about material things that I used to. I care about health... I go home, I squeeze my daughter…every day, and know every minute that she's healthy is the most important thing." (Muskat et al., 2017 p511)* *". . .life is short, life is unpredictable, you really need to appreciate what you've got everyday" (Zander et al., 2013, p21)* *"The positives, you see the strength in people...and you see the good in people", I...get to witness the lives of some of these kids, and what they go through. It's amazing." (Zander et al., 2013, p21)* *"...in my own life... I've got really good examples of why it's not important to sweat the small stuff, and, I have perspective and I have clear, clearer priorities"* (Zander et al., 2013, p21) *"Humility is the only thing I think that's important in this as well. Realizing there are limitations to what you*	'Social workers felt honoured to be allowed to witness the strength of families at their most vulnerable times and to guide families through the process of their child's end of life' (Muskat et al., 2016, p511) '..focusing on making a difference and focusing on research were two coping strategies that allowed the oncologists to reframe some of the difficult aspects of their jobs' (Granek et al., 2016, p53) Participants described the profound impact that their work has had on their own perspectives about life. For some, witnessing illness and death on a regular basis created anxiety; they were acutely aware of the many negative things that could happen to a child (Muskat et al., 2016, p511) 'their experiences with work-related losses changed the way they viewed life and illness in other areas of their lives.' (Conte, 2014, p43) 'Social workers spoke about the evolution of their coping strategies over time. They spoke about being more comfortable with their work and with taking time for themselves when needed. They spoke of being able to better anticipate their triggers and to respond "proactively" instead of "reactively." Some spoke of granting themselves permission to be "human,"'. (Muskat et al., 2016, p515) 'Insight contributed to resilience development due to improved self-esteem, self-awareness' (Zander et al., 2013,	A sense of meaning and perspective on life provided rewards and enabled staff to cope with painful experiences.

	can do... You can think of powerlessness not necessarily as a weakness but sometimes as strength." (Zander et al., 2013, p21) *"I love that I love my job. It's definitely a job and its hard work, but I love coming to work every day. I am proud to tell people where I work and what I do and explain to people that it's not sad, it's actually really fun, and rewarding" (Zander et al., 2013, p21)* *"When you go home at the end of the day, you know that you've made a difference."(Beaune et al., 2017, p5)* *"My boyfriend and I really just don't fight because it's not worth that, you know, to ruin the day when this could be the last day." (Conte, 2014, p44).* *"So when I see that I did something good for them, they say, "Thank you for being there and for helping me," and ... that bonding with the family .. . that's something that's positive"(Beaune et al., 2017, p5)*	p22) 'They also realized that experience brought awareness of resources and confidence that helped them deal with competing roles and demands'.(De Almeida et al., 2016, p222) 'Practitioners' narratives also suggested that they coped with emotional distress by normalizing and accepting death.' (Kpassgou & Soedje, 2017, p78)	

Appendix 1.4 Reflective diary extract

"The synthesis so far is connecting with my own experiences. When I worked as an Assistant Psychologist in Paediatric Psychology, I too gained a sense of reward from making a difference to the lives of sick children, but also from witnessing their bravery and being alongside families in distress. I must be careful to remain close to the data and open to differences though as to not influence the write-up, however it is validating that the literature mirrors my experiences."

"What does resilience mean to me? Conducting this review has made me think about my own resilience and how this has changed over time. Training has increased my self-awareness, and I wonder whether this is similar to the findings of experience bringing increased resources to cope? I too have coped with challenges through avoidance strategies, as so often throughout the chaos of balancing clinical training and my personal life there has been a lack of time for 'balance'. However, this review is reminding me of the importance of prioritising my own self-care."

Appendix 2.1 Author guidelines

Author Guidelines: *Qualitative Health Research* (QHR)

Please read the guidelines below then visit the Journal's submission site http://mc.manuscriptcentral.com/qhr to upload your manuscript. Please note that manuscripts not conforming to these guidelines may be returned.
Only manuscripts of sufficient quality that meet the aims and scope of QHR will be reviewed. As part of the submission process you will be required to warrant that you are submitting your original work, that you have the rights in the work, that you are submitting the work for first publication in the Journal and that it is not being considered for publication elsewhere and has not already been published elsewhere, and that you have obtained and can supply all necessary permissions for the reproduction of any copyright works not owned by you.

1. Article types

Each issue of QHR provides readers with a wealth of information — book reviews, commentaries on conceptual, theoretical, methodological and ethical issues pertaining to qualitative inquiry as well as articles covering research, theory and methods.

1.1 What types of articles will QHR accept?

QHR asks authors to make their own decision regarding the fit of their article to the journal. Do not send query letters regarding article fit.

- Read the Mission Statement on main QHR webpage.
- Search the QHR journal for articles that address your topic. Do we publish in your area of expertise?
- Ask these questions: Does it make a meaningful and strong contribution to qualitative health research literature? Is it original? Relevant? In depth? Insightful? Significant? Is it useful to reader and/or practitioner?
- Note the sections: General articles, critical reviews, articles addressing qualitative methods, commentaries on conceptual, theoretical, methodological, and ethical issues pertaining to qualitative inquiry.
- QHR accepts qualitative methods and qualitatively-driven mixed-methods, qualitative meta-analyses, and articles addressing all qualitative methods.
- QHR is a multi-disciplinary journal and accepts articles written from a variety of perspectives including: cross-cultural health, family medicine, health psychology, health social work, medical anthropology, medical sociology, nursing, pediatric health, physical education, public health, and rehabilitation.
- Articles in QHR provide an array of timely topics such as: experiencing illness, giving care, institutionalization, substance abuse, food, feeding and nutrition, living with disabilities, milestones and maturation, monitoring health, and children's perspectives on health and illness.

Look Out for These Regular Special Features

Pearls, Pith and Provocation: This section fosters debate about significant issues, enhances communication of methodological advances and encourages the discussion of provocative ideas.
Book Review Section: *Qualitative Health Research* includes a book review section helping readers determine which publications will be most useful to them in practice, teaching and research.
Mixed Methods: This section includes qualitatively-driven mixed-methods research, and qualitative contributions to quantitative research.
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Evidence of Practice: Theoretical or empirical articles addressing research integration and the translation of qualitatively derived insights into clinical decision-making and health service policy planning.

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Teaching Matters: Articles that promote and discuss issues related to the teaching of qualitative methods and methodology.

2. Editorial policies

2.1 Peer review policy

QHR strongly endorses the value and importance of peer review in scholarly journals publishing. All papers submitted to the journal will be subject to comment and external review. All manuscripts are initially reviewed by the Editors and only those papers that meet the scientific and editorial standards of the journal, and fit within the aims and scope of the journal, will be sent for outside review.

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QHR maintains a transparent review system, meaning that all reviews, once received, are then forwarded to the author(s) as well as to ALL reviewers.

Peer review takes an average of 6–8 weeks, depending on reviewer response.

2.2 Authorship

Papers should only be submitted for consideration once consent is given by all contributing authors. Those submitting papers should carefully check that all those whose work contributed to the paper are acknowledged as contributing authors.

The list of authors should include all those who can legitimately claim authorship. This is all authors who:

(i) Made a substantial contribution to the concept and design, acquisition of data or analysis and interpretation of data,

(ii) Drafted the article or revised it critically for important intellectual content, (iii) Approved the version to be published.

Authors should meet the conditions of all of the points above. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content.

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Acquisition of funding, collection of data, or general supervision of the research group alone does not constitute authorship, although all contributors who do not meet the criteria for authorship should be listed in the Acknowledgments section.

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It is the policy of QHR to require a declaration of conflicting interests from all authors enabling a statement to be carried within the paginated pages of all published articles. Please ensure that a "'Declaration of Conflicting Interests" statement is included at the end of your manuscript, after any acknowledgements and prior to the references. If no conflict exists, please state that "The Author(s) declare(s) that there is no conflict of interest."

For guidance on conflict of interest statements, please see the ICMJE recommendations here.

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Medical research involving human subjects must be conducted according to the World Medical Association Declaration of Helsinki.

Submitted manuscripts should conform to the ICMJE Recommendations for the Conduct, Reporting, Editing, and Publication of Scholarly Work in Medical Journals, and all papers reporting animal and/or human studies must state in the methods section that the relevant Ethics Committee or Institutional Review Board provided (or waived) approval. Please ensure that you have provided the full name and institution of the review committee, in addition to the approval number.

For research articles, authors are also required to state in the methods section whether participants provided informed consent and whether the consent was written or verbal.

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QHR conforms to the ICMJE requirement that clinical trials are registered in a WHO-approved public trials registry at or before the time of first patient enrolment as a condition of consideration for publication. The trial registry name and URL, and registration number must be included at the end of the abstract.

2.8 Reporting guidelines

The relevant EQUATOR Network reporting guidelines should be followed depending on the type of study. For example, all randomized controlled trials submitted for publication should include a completed Consolidated Standards of Reporting Trials (CONSORT) flow chart as a cited figure, and a completed CONSORT checklist as a supplementary file.

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SAGE acknowledges the importance of research data availability as an integral part of the research and verification process for academic journal articles.

QHR requests all authors submitting any primary data used in their research articles alongside their article submissions to be published in the online version of the journal, or provide detailed information in their articles on how the data can be obtained. This information should include links to third-party data repositories or detailed contact information for third-party data sources. Data available only on an author-maintained website will need to be loaded onto either the journal’s platform or a third-party platform to ensure continuing accessibility. Examples of data types include but are not limited to statistical data files, replication code, text files, audio files, images, videos, appendices, and additional charts and graphs necessary to understand the original research. [The editor(s) may consider limited embargoes on proprietary data.] The editor(s) [can/will] also grant exceptions for data that cannot legally or ethically be released. All data submitted should comply with Institutional or Ethical Review Board requirements and applicable government regulations. For further information, please contact the editorial office at vshannonqhr@gmail.com.

3. Publishing Policies

3.1 Publication ethics

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- ***Methods:*** QHR readership is sophisticated; excessive details not required.
- ***Ethics:*** Include a statement of IRB approval and participant consent. Present demographics as a group, not listed as individuals. Do not link quotations to particular individuals unless essential (as in case studies) as this threatens anonymity.
- ***Results:*** Rich and descriptive; theoretical; linked to practice if possible.
- ***Discussion:*** Link your findings with research and theory in literature, including other geographical areas and quantitative research.
- ***References:*** APA format. Use pertinent references only. References should be on a separate page.

Additional Editor's Preferences:
- Please do not refer to your manuscript as a "paper;" you are submitting an "article."
- The word "data" is plural.

4.2 Word processing formats

Preferred formats for the text and tables of your manuscript are Word DOC or PDF. The text should be double-spaced throughout with standard 1 inch margins (APA formatting). Text should be standard font (i.e., Times New Roman) 12 point.

4.3 Artwork, figures and other graphics

- Figures: Should clarify text.
- Include figures, charts, and tables created in MS Word in the main text rather than at the end of the document.
- Figures, tables, and other files created outside of Word should be submitted separately. Indicate where table should be inserted within manuscript (i.e., INSERT TABLE 1 HERE).
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- TIFF, JPED, or common picture formats accepted. The preferred format for graphs and line art is EPS.
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QHR adheres to the APA reference style. Click here to review the guidelines on APA to ensure your manuscript conforms to this reference style.

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Before submitting the manuscript, authors should have their manuscript pre-reviewed using the following QHR criteria:

1. Importance of submission: Does it make a meaningful and strong contribution to qualitative health research literature? Is it original? Relevant? In depth? Insightful? Significant? Is it useful to reader and/or practitioner?

2. Theoretical orientation and evaluation: Is it theoretically clear and coherent? Is there logical progression throughout?

3. Methodological assessment: Appropriate to question and/or aims? Approach logically articulated? Clarity in design and presentation? Data adequacy and appropriateness? Evidence of rigor?

4. Ethical Concerns (Including IRB approval and consent):

5. Data analysis and findings: Does the analysis of data reflect depth and coherence? In-depth descriptive and interpretive dimensions? Creative and insightful analysis? Linked with theory? Relevant to practice/discipline?

6. Data analysis and findings: Does the analysis of data reflect depth and coherence? In-depth descriptive and interpretive dimensions? Creative and insightful analysis? Linked with theory?

7. Discussion: Results linked to literature? Contribution of research clear? Relevant to practice/discipline?

8. Manuscript style and format: Please evaluate writing style: Length (as short as possible], organization, clarity, grammar, appropriate citations, etc.); presentation of diagrams/illustrations?

5. Submitting your manuscript

5.1 How to submit your manuscript

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IMPORTANT: Please check whether you already have an account in the system before trying to create a new one. If you have reviewed or authored for the journal in the past year it is likely that you will have had an account created. For further guidance on submitting your manuscript online please visit ScholarOne.

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Please supply a title, short title, an abstract and keywords to accompany your article. The title, keywords and abstract are key to ensuring readers find your article online through online search engines such as Google. Please refer to the information and guidance on How to Help Readers Find Your Article in the SAGE Journal Author Gateway on how best to title your article, write your abstract and select your keywords.

5.3 Corresponding author contact details

Provide full contact details of the corresponding author including email, mailing address and phone number. Academic affiliations are required for all co-authors. Present these details on the title page, separate from the article main text, to facilitate anonymous peer review.

6. On acceptance and publication

6.1 Fees

There are no fees to submit or publish, unless an author chooses to publish with open-access. See "Open Access and SAGE Choice" below. Fees for color reproduction of figures *in print* may also apply.

6.2 SAGE Production

Your SAGE Production Editor will keep you informed as to your article's progress throughout the production process. Proofs will be sent by PDF to the corresponding author to make final corrections and should be returned promptly.

6.3 Access to your published article

SAGE provides authors with online access to their final article. There is no set time frame when an article will be assigned to an issue.

6.4 OnlineFirst publication

OnlineFirst allows final revision articles (completed article in queue for assignment to an upcoming issue) to be published online prior to their inclusion in a final print journal issue, which significantly reduces the lead time between submission and publication. Articles published OnlineFirst are assigned a DOI number, but no volume/issue/page number information. Articles will be searchable in PubMed but the citation will not appear with volume/page number information until officially published in an issue. For more information, please visit our OnlineFirst Fact Sheet.

6.5 Open Access and SAGE Choice

Articles accepted in QHR have the option to be published as open access after payment of an article processing charge (APC) paid by either the funder or author. Authors wishing to publish open access should contact openaccess@sagepub.com to make the request. Read SAGE Choice FAQs here.

7. Further information

Any correspondence, queries or additional requests for information on the manuscript submission process should be sent to the QHR editorial office as follows:

Vanessa Shannon, Managing Editor, vshannonqhr@gmail.com

Appendix 2.2 Evidence of Ethical Approval

Psychology Ethics Committee

Dear Angela,

The Ethics Committee has considered your revised project proposal: *An exploration of factors contributing to resilience in Hospital Play Specialists (EC.17.10.10.4957R).*

The project has now been approved.

Please note that if any changes are made to the above project then you must notify the Ethics Committee.

Best wishes,
Mark Jones

School of Psychology Research Ethics Committee

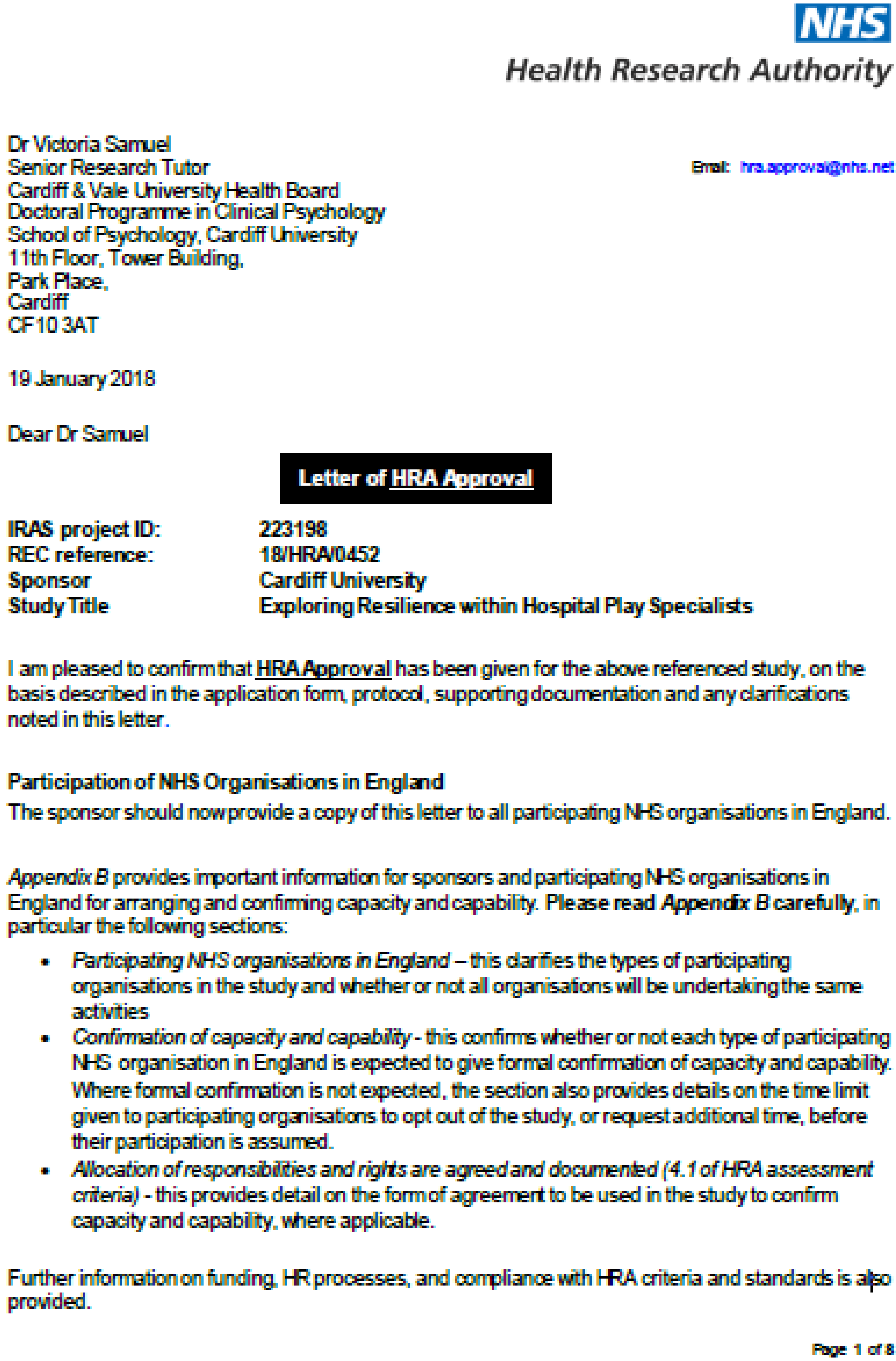
Cardiff University
Tower Building
70 Park Place
Cardiff
CF10 3AT

Tel: +44(0)29 208 70360
Email: psychethics@cardiff.ac.uk
http://psych.cf.ac.uk/aboutus/ethics.html

Prifysgol Caerdydd
Adeilad y Tŵr
70 Plas y Parc
Caerdydd
CF10 3AT

Ffôn: +44(0)29 208 70360
E-bost: psychethics@caerdydd.ac.uk

HRA Approval



Health Research Authority

Dr Victoria Samuel
Senior Research Tutor
Cardiff & Vale University Health Board
Doctoral Programme in Clinical Psychology
School of Psychology, Cardiff University
11th Floor, Tower Building,
Park Place,
Cardiff
CF10 3AT

Email: hra.approval@nhs.net

19 January 2018

Dear Dr Samuel

Letter of HRA Approval

IRAS project ID:	**223198**
REC reference:	**18/HRA/0452**
Sponsor	**Cardiff University**
Study Title	**Exploring Resilience within Hospital Play Specialists**

I am pleased to confirm that HRA Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from the HRA website.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The attached document *"After HRA Approval – guidance for sponsors and investigators"* gives detailed guidance on reporting expectations for studies with HRA Approval, including:

- Working with organisations hosting the research
- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found through IRAS.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details on the HRA website.

Research Governance Wales

UK Study-wide Governance Report

Health and Care Research Wales Permissions Service

The study-wide (global) governance review has been completed for the research study below: **IRAS Reference:**	223198
Study Title:	Exploring Resilience within Hospital Play Specialists
Study Type:	Study involving qualitative methods only
Chief Investigator:	Dr Victoria Samuel
Sponsor:	Cardiff University
Funder:	
Lead NHS R&D office location:	Wales
Lead Nation:	Wales
Review completed by:	Permissions Service - Sasha Barrate
Correspondence email address:	Research-permissions@wales.nhs.uk
Date:	15/12/2017
REC reference (if available):	
UKCRN Portfolio study (if applicable):	

Governance review

Please find below the governance criteria considered during the review of this research study and the comments associated with these criteria.

1 Application Package 1.1 IRAS project filter completed correctly	**Outcome:**	*Completed - Proceed*

All relevant signature sections within the IRAS form have been signed. The study is involving qualitative methods only. The project filter has outlined that the study is being undertaken as an educational project. The study only involves NHS staff participants therefore does not require review by REC.

2 Risk to participants 2.1 Participant information / consent documents and process	**Outcome:**	*Completed - Proceed*

The researcher has been advised to include IRAS numbers on the PIS and ICF. IRAS form A27 - A29 confirm that participants will be identified by a member of the Play Specialist Manager. The Play Specialist Manager will disseminate the information relating to the study to the Hospital Play Specialists to invite them to participate. Interested HPS can then volunteer to participate or discuss any queries about the study by contacting the researcher via the provided contact details. IRAS form A30 confirms that consent will be obtained and recorded in writing. There will be up to one week to make a decision. The PIS provides clear information on the study, research procedures, data protection, the possibility of disclosure and complaints procedure. The consent form is appropriate for the study.

3 Risk to study 3.1 Protocol assessment **Outcome:** *Completed - Proceed*

The study protocol outlines the management and organisation of the study, with an appropriate description of the procedures to be conducted at a NHS research site. This is consistent with the IRAS form and the PIS.

4 Risk to organisation 4.1 Allocation of responsibilities and rights is agreed and documented **Outcome:** *Completed - Proceed*

The protocol and IRAS form include adequate information on the allocation of responsibilities to ensure the study is conducted appropriately within an NHS Organisation.

4.2 Insurance / indemnity arrangements assessed **Outcome:** *Completed - Proceed*

The study is sponsored by Cardiff University. Insurance is provided by UMAL for the design and management of the research. This is consistent with IRAS Form A76. A copy of the insurance certificate and is in the document store. At time of this governance report, the insurance expires on 31 Jul 2018. NHS Indemnity will apply for the conduct of the study. The insurance certificate does not list any exclusions. The indemnity cover in place is GBP Â£50,000,000 any one event unlimited in the aggregate for Employers' liability and GBP Â£50,000,000 any one event and in the aggregate in respect of Products Liability and unlimited in the aggregate in respect of Public Liability

4.3 Financial management arrangements assessed **Outcome:** *Completed - Proceed*

IRAS form A65 confirms no application for external funding will be made.

5 Legal compliance 5.1 Compliance with Data Protection Act and data security issues assessed **Outcome:** *Completed - Proceed*

The process to identify, approach and obtain consent from participants is described in check 2.1 and complies with the Data Protection Act. Personal data will be collected in this study. The PIS provides clear information on data confidentiality and how personal data will be used. Consent will be obtained before any personal data is collected. IRAS Form A52 states that quotes will be used in publications and anonymity will be maintained - No identifiable information will be used. Pseudonyms will be provided alongside direct quotations in the write-up to protect identities of participants. IRAS Form A36 - A42 confirm that: This study will involve the use of audio recording devices and the publication of direct quotations from respondents. There will also be the storage of personal data on the following: Manual files, Home or personal computers and University computers. Audio recordings will be transcribed, and this data will be stored on a computer which is password protected. Manual files will be stored in a locked cabinet in Cardiff University. Any data that is transferred will be done via the use of an USB drive to maintain confidentiality. The researcher has clarified that no personal identifiable information will be held on home or personal computers. All information (i.e. names) are anonymised at the point of transcription and will not be linked with any identifiable information. These will be password protected for additional security. The original audio file will be destroyed following transcription. Transcripts and study data will be stored for 15 years in a locked cabinet in Cardiff University to maintain confidentiality as per policy for research with NHS professionals. IRAS form A43 - 45 confirm that: The researcher has clarified that all data collected will be anonymised by the use of participant numbers and pseudonyms. The only personal identifiable information held will be the name and signature on the consent form, *which will be held for 15 years at Cardiff University in a locked cabinet. Research data generated by the study will be stored for 5 years. The long term arrangements for storage of research data after the study has ended are for data to be securely stored in a locked cabinet within the South Wales Doctoral Programme in Clinical Psychology office at Cardiff University. Access will be restricted to the researcher and Academic and Clinical Supervisors of the project. There is a named data custodian.*

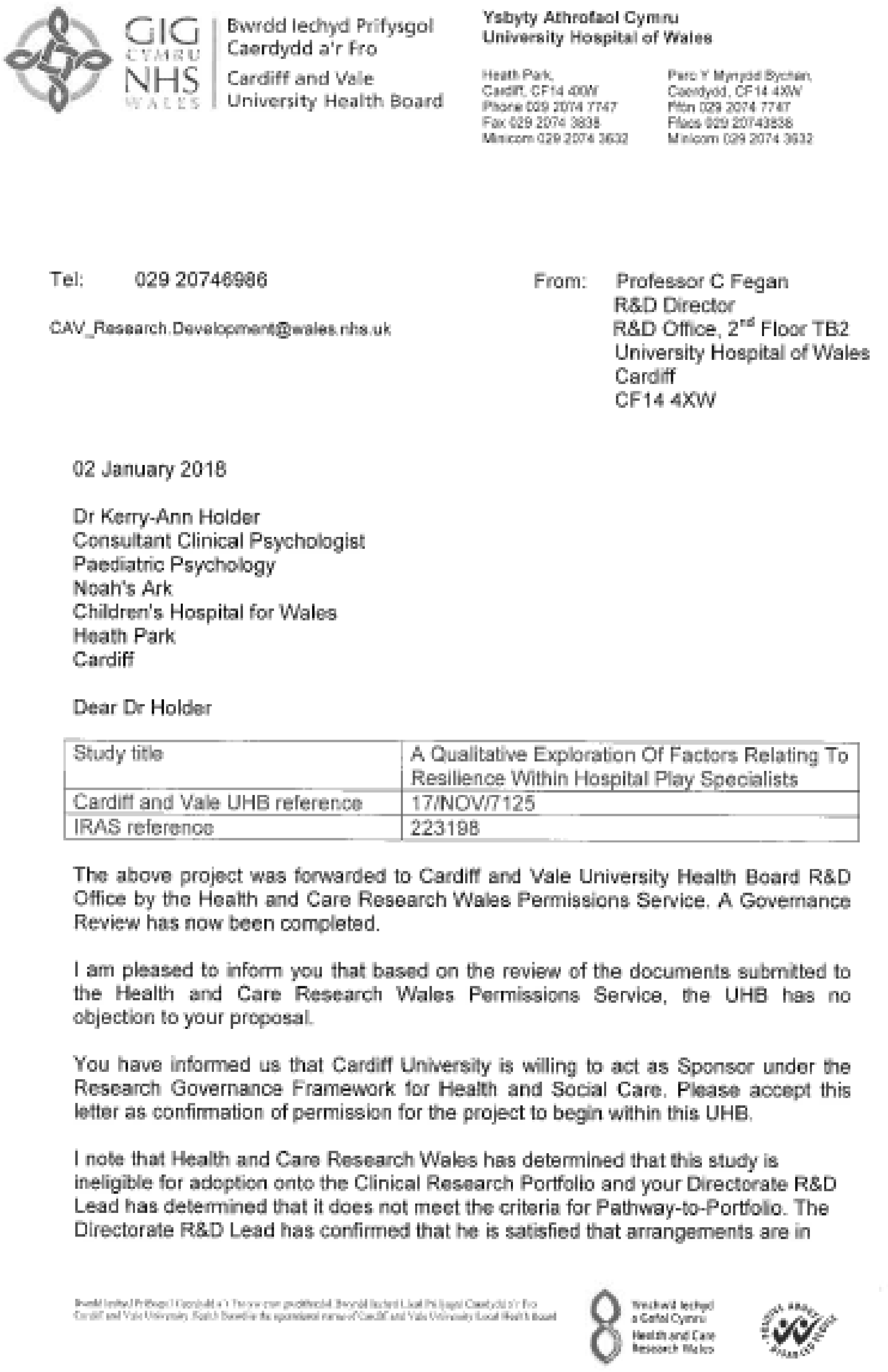
5.3 Compliance with any other applicable laws or regulations	**Outcome:**	*Completed - Proceed*

IRAS form A33-2 provides a written commitment to provide Welsh translation(s).

Approvals and authorisations 6.1 NHS Research Ethics Committee favourable opinion received for applicable studies	**Outcome:**	*Completed - Proceed*

This research study does not require review by an NHS REC because the research is limited to the involvement of staff as participants only (no involvement of patients/service users as participants).

R&D approval



GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Ysbyty Athrofaol Cymru
University Hospital of Wales

Heath Park,
Cardiff, CF14 4XW
Phone 029 2074 7747
Fax 029 2074 3838
Minicom 029 2074 3632

Parc Y Mynydd Bychan,
Caerdydd, CF14 4XW
Ffon 029 2074 7747
Ffacs 029 20743838
Minicom 029 2074 3632

Tel: 029 20746986

CAV_Research.Development@wales.nhs.uk

From: Professor C Fegan
R&D Director
R&D Office, 2nd Floor TB2
University Hospital of Wales
Cardiff
CF14 4XW

02 January 2018

Dr Kerry-Ann Holder
Consultant Clinical Psychologist
Paediatric Psychology
Noah's Ark
Children's Hospital for Wales
Heath Park
Cardiff

Dear Dr Holder

Study title	A Qualitative Exploration Of Factors Relating To Resilience Within Hospital Play Specialists
Cardiff and Vale UHB reference	17/NOV/7125
IRAS reference	223198

The above project was forwarded to Cardiff and Vale University Health Board R&D Office by the Health and Care Research Wales Permissions Service. A Governance Review has now been completed.

I am pleased to inform you that based on the review of the documents submitted to the Health and Care Research Wales Permissions Service, the UHB has no objection to your proposal.

You have informed us that Cardiff University is willing to act as Sponsor under the Research Governance Framework for Health and Social Care. Please accept this letter as confirmation of permission for the project to begin within this UHB.

I note that Health and Care Research Wales has determined that this study is ineligible for adoption onto the Clinical Research Portfolio and your Directorate R&D Lead has determined that it does not meet the criteria for Pathway-to-Portfolio. The Directorate R&D Lead has confirmed that he is satisfied that arrangements are in place for meeting any costs from outside of the R&D Activity Based Funding allocation.

May I take this opportunity to wish you success with the project and remind you that as Chief / Principal Investigator you are required to:

- Inform the Health and Care Research Wales Permissions Service and the UHB R&D Office if any external or additional funding is awarded for this project in the future
- Ensure that all study amendments are submitted to the Health and Care Research Wales Permissions Service
- Ensure the Health and Care Research Wales Permissions Service is notified of the study's closure
- Ensure that the study is conducted in accordance with all relevant policies, procedures and legislation
- Provide information on the project to the UHB R&D Office as requested from time to time.

Yours sincerely,

Professor Christopher Fegan
R&D Director / Chair of the Cardiff and Vale Research Review Service (CaRRS)

CC

R&D Lead	**Dr Philip Connor**
Chief Investigator	Dr Victoria Samuel
Sponsor Contact	Cardiff University
Student	Angela Webber
Clinical Board Assistant Head of Finance	Craig Coggins
Finance	Anthony Williams
	Rhian Thomas-Turner

SITE 2

Dear John/Victoria/ Angela

RE: IRAS 233198. Confirmation of Capacity and Capability at University Hospitals XXXX NHS Foundation Trust.

Full Study Title: ***A Qualitative Exploration of factors relating to Resilience within Hospital Play Specialists***

This email confirms that University Hospitals NHS Foundation Trust has the capacity and capability to deliver the above referenced study. Please find attached our agreed Statement of Activities as confirmation.

We agree to start this study on a date to be agreed when you as sponsor give the green light to begin. Please inform R&I of this date as well as the study team.

For all amendments, send to and the local study team for assessment.

Note to PI: Please ensure that local recruitment data is uploaded to the EDGE system and the study record is kept up-to-date. UH is measured on time taken from receipt of a full Local Information Pack from Sponsor, to the first patient recruited – the target is 70 days. Where this target is exceeded R&I department have to produce valid reasons to the NIHR. Please keep us advised of any issues or delays with recruitment.

YOUR 70 DAY TARGET:

Date site selected: **14/02/2018**	**+ 70 days =**	70 day due date*: **25/04/2018**

** Please make a note of this date in your diary and keep a record of any problems with recruitment. [Date site selected = Receipt of a full local information pack to*

and study team/PI. See guidance on the HRA website http://www.nihr.ac.uk/research-and-impact/nhs-research-performance/hra-approvals-and-nihr-metrics.htm]

As a Trust we are now required to *publish* data on the 70 day benchmark and recruitment to time and target for clinical trials. This information is published on the following page on our website:http://www..nhs.uk/research-innovation/our-research/performance/. Information about your study and any delays experienced will be included.

If you wish to discuss further, please do not hesitate to contact me.

Kind regards

Geraldine

Geraldine Salahi-Ali

Research Management Facilitator

SITE 3

Dear Mr Lowe,

This email confirms that University XXXX NHS Foundation Trust has the capacity and capability to deliver the above referenced study. Please find attached our agreed Statement of Activities as confirmation.

We agree to start this **when you as sponsor give the green light to begin.** If you have not yet been in touch with the local research team to schedule an initiation visit, please can you tell us when you expect to give the green light?

If you wish to discuss further, please do not hesitate to contact me.

Kind regards,

Heather

Mrs Heather Scott, MSc
Research Support Officer

Research Office
University NHS Foundation Trust

Appendix 2.3 Study Documents

Study Protocol

School of Psychology
Ysgol Seicoleg

South Wales Doctoral Programme in Clinical Psychology
De Cymru Rhaglen Doethuriaeth mewn Seicoleg Glinigol

Study Protocol

An exploration of factors contributing to resilience in Hospital Play Specialists

Sponsor: Cardiff University

Sponsor ref: SPON1642-17

Funder: Cardiff University Studentship

IRAS ref: 223198

Supervisors

Academic Supervisor: Dr. Victoria Samuel (Senior Research Tutor, South Wales Doctoral Programme in Clinical Psychology; Cardiff University).

Victoria.Samuel@wales.nhs.uk

Clinical Supervisor: Dr Kerry-Ann Holder (Consultant Clinical Psychologist: Noah's Ark Children's Hospital for Wales; Cardiff & Vale UHB).

Kerry-Ann.Holder@wales.nhs.uk

Student: Angela Webber (Trainee Clinical Psychologist, South Wales Doctoral Programme in Clinical Psychology; Cardiff University)

Collaborators:

XXX

XXX

XXX

Study summary

Stress and burnout is one of the most common causes of work-related sickness (Department of Health, 2010) with considerable economic implications (Audit Commission, 2011; Hendersin & Madan, 2013). Research suggests that staff working in paediatric settings experience both stress and reward in their roles within acute settings, including those working in cancer care (Mukherjee, Beresford, Glaser & Sloper, 2009; Mukherjee, Beresford & Tennant, 2014). Allied health professionals, such as Hospital Play Specialists, are a particularly un-researched group in this area, although initial research suggests they are also vulnerable (Meadors et al., 2009). Hospital Play Specialists (HPS) provide tailored psychosocial support for sick children and young people between the ages of 0-19 years, as well as providing support for siblings and family members (Thompson, 2009). HPS work on the 'front-line' of paediatric medicine; they witness traumatic procedures and are directly involved in communicating extremely difficult information to children and families (Bronson, 2012; Holloway & Wallinga, 1990). Indeed, Brinson (2012) and Fisackerly et al. (2016) found that HPS in the US experience compassion fatigue comparably to other medical professionals, and called for more research to be conducted with this group.

Aims:

It is hoped that the following study will add to the breadth of research regarding burnout within healthcare professionals. It aims to highlight the individual and environmental factors relating to resilience within hospital play specialists and to consider this in relation to psychological theory.

Population:

Sample Size: 12-15

Hospital Play Specialists working within an NHS paediatric inpatient setting for more than 1 year.

Design:

Qualitative (Grounded Theory)

Measures:

Audio-recorded semi-structured interviews lasting around 60-90 minutes will be conducted with approximately 12-15 NHS Hospital Play Specialists, inclusive of time spent reading information sheets and consent form, and debrief.

Duration of study: 8 months.

Introduction and background

Purpose of the project and academic rationale:

Stress and burnout are one of the most common causes of work-related sickness (Department of Health, 2010) with considerable economic implications (Audit Commission, 2011; Hendersin & Madan, 2013). Research suggests that staff working in paediatric settings experience both stress and reward in their roles within acute settings, including cancer care (Mukherjee, Beresford, Glaser & Sloper, 2009; Mukherjee, Beresford & Tennant, 2014). Allied health professionals, such as Hospital Play Specialists, are a particularly un-researched group in this area, although initial research suggests they are also vulnerable (Meadors et al., 2009). Hospital Play Specialists (HPS) provide tailored psychosocial support for sick children and young people between the ages of 0-19 years, as well as providing support for siblings and family members (Thompson, 2009). HPS work on the 'front-line' of paediatric medicine; they witness traumatic procedures and are directly involved in communicating extremely difficult information to children and families (Bronson, 2012; Holloway & Wallinga, 1990). Indeed, Brinson (2012) and Fisackerly et al. (2016) found that HPS in the US experience compassion fatigue comparably to other medical professionals, and called for more research to be conducted with this group.

Burnout is defined as emotional exhaustion, depersonalisation and diminished personal accomplishment (Maslach, 1992). It is associated with decreased productivity (Valent, 2002), and increased sickness, at high cost both economically and clinically in terms of patient care (Wyk & Pillay-Van Wyk, 2010). Sickness absence in healthcare staff is 46% higher than the average for all employment sectors (CIPD, 2013).

Burnout may affect health professionals' empathy for patients and increases risk of errors (Maben et al., 2012; Kings Fund, 2016). Working within emotionally challenging or traumatic environments increases the risk for the development of burnout and work-related trauma (Cunningham, 2003; Conrad & Kellar-Guenther, 2006; Figley, 1995).

Government objectives to increase a compassionate workforce across the UK (e.g. King's Fund, 2011) calls for increased understanding of the factors impacting upon burnout and resilience in healthcare professionals. The majority of available research appears to focus upon medical staff (e.g. doctors and nurses), although it is becoming increasingly apparent that Allied Health Professionals (AHPs) may be equally impacted. Harris, Cumming & Campbell (2006) found that AHPs, a professional group including Occupational Therapists, Psychologists, Physiotherapists and Speech and Language Therapists, experienced similar levels of workplace stress experienced as their medical colleagues. In Paediatric care, Hospital Play Specialists play key roles in the care of children and young people in hospital and may also be at risk of secondary trauma due to the exposure of their roles (Meadors et al.,2009).

Hospital Play Specialists (HPS) are trained extensively in child development, and provide specific psychosocial support for sick children and young people between the ages of 0-19 years of age, as well as providing support for siblings and family members (Thompson, 2009). HPS play a key role within medical teams, providing education, anxiety management, developing communication, promoting cognitive and physical development, preparation for procedures, distraction, pain management and helping children and young people to understand and process complex information about their care (Thompson, 2009). Play Specialists also support medical staff to provide the best care at the right developmental level for children and provide training and emotional support to parents and families, including support with loss and bereavement.

HPS work on the 'front-line' of paediatric medicine; they witness traumatic procedures and are often directly involved in communicating extremely difficult information to children and families (Bronson, 2012; Holloway & Wallinga, 1990). Research suggests that contact with a HPS during stays in hospital reduces length of hospital admissions, improving recovery and wellbeing among children and families (Brooke & Janselewitz, 2012). Therefore, maintaining wellbeing in this staff group has the potential to bring positive outcomes across economic and clinical domains.

Despite the information available about burnout in nursing and medical staff (e.g. Maytum, Heiman & Garwick. 2004), HPS appear to be a staff group who are under-researched considering their contact with trauma and the emotional world of acutely or critically ill children and their distressed families. Preliminary research suggested that this staff group may be equally as vulnerable to increased stress, burnout and secondary trauma as medical staff (Holloway & Wallinga,1990; Munn, Barber & Fritz, 1996; Fisackerly, Sira, Desai & McCammon, 2016), and Brinson (2012) identified that approximately 75% of HPS may be at risk of compassion fatigue.

The current research will focus upon HPS. HPS may be a particularly vulnerable group due to the intensity and duration with which they work with children and young people. HPS often work directly with families on an individual basis for long periods, their input may be more concentrated than that of medical colleagues with large caseloads and varying shifts, or more frequent than therapies teams. In addition, when a child moves between wards and medical teams (e.g. from intensive care to general wards) many staff who have worked with them, will discontinue their involvement. However, for HPS, their input is likely to remain stable across a child's admission.

Research suggests that resilience may be a factor in protecting against burnout (McDonald et al., 2013). Workplace satisfaction has been highlighted as a factor influencing resilience (Conrad & Keller-Guenther, 2006), as well as greater knowledge (Burtson & Stichler, 2010) and social support (Keene et al., 2010). It has also been suggested that social support, including supervision may protect against burnout in HPS (Brinson, 2012), and recent NICE (2009) guidance on supporting wellbeing of staff provides a framework for the development of organisational policy to support these efforts.

Aims and Objectives

Aims

To widen the current available evidence-base regarding staff wellbeing, burnout and resilience in paediatric staff

To highlight specific resilience and/or burnout risk factors within Hospital Play Specialists.

To relate this to psychological theory

Objectives

To explore the experience of Hospital Play Specialists

To identify possible factors associated with resilience

To consider findings in relation to psychological theory and existing evidence of other paediatric professionals

To provide recommendations for promoting wellbeing within this professional group at local and organisational levels.

Study Design

Qualitative (Grounded Theory)

Theoretical Framework

Grounded Theory will inform data collection and analysis. Interviews will be conducted until saturation of the data is reached, when no further information emerges (Charmaz, 2006).

Patient sample

NHS staff: 10-20 Hospital Play Specialists working in inpatient Paediatric settings across England and Wales (estimated 4 sites).

Participant selection

Participants will be recruited via purposeful sampling.

Inclusion criteria

Inclusion criteria: working as a HPS within a paediatric inpatient setting for more than 1 year.

Exclusion criteria

Exclusion criteria: working as a HPS within a paediatric setting for less than 1 year. Working in community settings only.

Setting

NHS premises.

Recruitment plans and timelines

Participants will be recruited from Play Departments across Children's Hospitals in England and Wales.

Participants will consist of Hospital Play Specialists only. Written information regarding the study rationale and protocol will be presented to each department manager. The researcher will email study information before commencement, and then attend a meeting at each site to discuss the study.

Once ethical approval and R&D approval is received, the PI from each site will email the participation information sheet to the Play Specialist Manager who will disseminate the information to HPS to invite them to participate. Interested HPS can then volunteer to participate or discuss any queries about the study by contacting the researcher via the provided contact details. Participation is voluntary and information regarding the study will be presented to each department involved. An outline of the research will be presented to participants along with a written information sheet and a consent form.

Investigations and assessments

Semi-Structured Interviews will take approximately 45-60 minutes. The researcher will ensure minimum burden to the service by offering interviews outside of working hours. The Play Department Manager has been consulted prior to the commencement to ensure minimal impact regarding recruitment and interviewing.

Study data

Access to medical records

There is no planned access to medical records for this study.

Anonymisation and access to personal data

In order to retain anonymity, participants' names will be replaced with a gender neutral pseudonym and no identifiable information will be included which could identify the participant or link them to a specific service, hospital or location.

Direct quotes will be included in the write-up but any identifiable information will be removed.

Interviews will be recorded using a portable dictaphone or telephone recording software and transcribed. These recordings will be stored securely on a computer using password protection, and will be deleted from the portable device once they have been transcribed.

Once the recording has been transcribed, the transcriptions will be kept securely for 5 years to maintain confidentiality (in line with the sponsors arrangements and systems for the management and monitoring of research at Cardiff University).

Analysis plan

Grounded Theory will inform data collection and analysis. In line with this method, responses will be transcribed and analysed after each interview to inform emerging themes (Strauss & Corbin, 1997). Anonymised verbatim quotes will be used in the study write-up with participants' consent.

Data storage & retention

Anonymised study data will be kept for a period of 15 years on a secure server of the Cardiff University network. Electronic data will be encrypted and kept on a secure server of the Cardiff University network. Identifiable paper data (consent forms) will be kept in a locked drawer in the lead supervisor’s office.

Regulatory issues

Ethical approval

Ethical approval has been obtained from Cardiff University Psychology Ethics Committee and local Research and Development departments for each site via IRAS.

Consent

Informed consent will be obtained in writing through the provision of detailed information sheets which will outline the aims of the research and what is involved in taking part, including the benefits and possible risks. It will be made clear that participation is voluntary, and participants can take up to a week to consider whether they would like to take part in order to allow for time to make the decision. If participants decide to take part, they will be provided with a consent form to sign to confirm that they understand the protocol and the research being undertaken. Participants will also be reminded of their right to withdraw their consent at any time during the research process.

Withdrawal from the study

Participants are free to withdraw from the study at any time until write-up, and their data will be removed from the analysis.

Potential risks to participants

In the interviews, participants will be invited to reflect on their experience of working in paediatric inpatient care which may bring up experiences of distress or traumatic experiences. This possible risk will be outlined to participants in the participant information sheet prior to completing the consent form. Should participants find the contents of the interview distressing, they will be offered time with the researcher who is a Trainee Clinical Psychologist to debrief following the interview. Should the participant experience distress following the interview or should the researcher become concerned about the participant's wellbeing, they will be provided with information regarding support services within each local health board or trust, such as the Employee Wellbeing Service. Participants will also be informed of their right to discontinue participation at any stage of the research. In the unlikely situation that risk (e.g. malpractice or harm) is disclosed during the interview, the researcher will inform their research clinical supervisor immediately to further assess and manage any risk which is apparent. The participant will be informed of the limitations to confidentiality prior to interview.

Interviews will take approximately 30-60 minutes, which will be informed to the participants during the consent stage. Participants will be offered home visits or the option of telephone interviews to reduce the burden to the participants and services. The Play Department manager or team leader will be informed of this during the process of recruitment, to ensure that the interviews do not place burden onto the service. As far as possible interviews will take place outside of working hours. Interviews conducted in work time will be agreed with service leads and scheduled at times of minimal service impact.

Study management

Dr Victoria Samuel is the lead supervisor will act as the Chief investigator, along with Dr Kerry-Ann Holder as co-supervisor. The supervisory team will closely supervise and support the research student to achieve the study objectives. Formal supervision between all supervisors and the student will occur on a monthly basis to monitor progress, and to plan work stages. The team will also draw on the expertise and advice of project collaborators who have agreed to support the study.

Funding

N/A

Sponsorship

Cardiff University will act as a sponsor for the study.

Confidentiality

The Chief Investigator and the research team will preserve the confidentiality of participants in accordance with the Data Protection Act 1998. Participants will be assured that their data will not be used for any purposes beyond this study.

Planned outputs

The study will be submitted in part fulfilment to a Doctorate in Clinical Psychology (DClinPsy). Additionally, the write-up will be submitted for publication in relevant journals and may also be presented at conferences and used in teaching or training.

Participant Information Sheet

School of Psychology
Ysgol Seicoleg

South Wales Doctoral Programme in Clinical Psychology
De Cymru Rhaglen Doethuriaeth mewn Seicoleg Glinigol

Participant Information Sheet

An exploration of factors contributing to resilience in Hospital Play Specialists

My name is Angela Webber and I am a second year Trainee Clinical Psychologist at the South Wales Doctoral Programme in Clinical Psychology at Cardiff University.

You are being invited to take part in a Doctorate in Clinical Psychology research study on resilience amongst Hospital Play Specialists (HPS). Before you take part it is important to understand why the research is being carried out, and what participating will involve. Please take the time to read the following information carefully If there is anything which is unclear or if you would like any further information about the study, please let me know and I will be happy to provide clarification.

What is the purpose of the study?

The research aims to explore the experience of Play Specialists working in inpatient settings, with a focus upon factors influencing resilience within the profession. It is hoped that this will add to the growing evidence-base surrounding employee wellbeing in the NHS.

How will the information I share be used?

The findings will be written up as a doctoral thesis in partial fulfilment of a Doctorate in Clinical Psychology (DClinPsy). The findings will also be submitted for publication in an academic journal to share the results more broadly. The results will also be shared with the hospital sites involved and may be presented at conferences or used within teaching or training sessions. It is hoped that the results will inform future service-development, policy guidance and/or clinical practice. The results will include anonymised quotations from the interviews conducted. Some summary demographic information will be collected, but this will not be linked to quotations to protect participants' identities.

Why have I been invited?

You have been invited because you are a Play Specialist working within a Paediatric inpatient setting.

Do I have to take part?

No, participation in the study is completely voluntary. It is your decision whether or not to take part.

If you do decide to take part, you will be asked to complete a consent form. However, you can withdraw from the study at any time without giving a reason, even if you have already been interviewed. In this case, your responses would not be included within the study.

What is involved?

If you decide to take part you will be invited to attend an interview at a convenient time and location with the researcher Angela Webber (Trainee Clinical Psychologist). It is also possible to complete the interview via telephone if preferred. It is anticipated that the interview will last around 45-60 minutes. The interview will be audio recorded so that the researcher can accurately write-up and analyse your responses but your name will be changed to a pseudonym. You will also be asked to complete a brief demographic questionnaire.

If you wish to take part please contact Angela Webber (researcher) WebberA2@cardiff.ac.uk or via text/telephone on xx to arrange a suitable time for interview.

What will happen after the interview?

Your responses will be transcribed and analysed by the researcher and supervisors to look for themes across interviews. Anonymised quotes will be used throughout the write-up to protect the identity of participants. If you would like a copy of the study write-up you can ask for this when the project is completed.

What are the possible advantages of taking part?

As well as sharing your experiences, we hope that your responses will help to support and highlight the valuable role that Play Specialists provide within UK children's hospitals, as well as increasing the limited evidence-base about wellbeing within this profession. It is hoped that the research will shape future decisions surrounding service-developments and interventions for employee wellbeing.

What are the possible disadvantages of taking part?

It is possible that discussing some of your experiences at work may bring up difficult feelings, causing distress. If at any point you feel that you would like to pause or stop the interview, or withdraw from the study, you are free to do so. The researcher will also offer some time to debrief at the end of the study. Participants can also seek support from their GP, Occupational Health and Employee Wellbeing services.

Will my participation be confidential?

All information will be treated as confidential, and your responses will not be identifiable by anyone but the researcher. However, should the researcher be made aware of any form of risk to yourself or others (e.g. malpractice or harm), then this information would be need to be shared with appropriate parties, including the researchers' supervisors.

All names will be changed following transcription to maintain anonymity. All information will be stored within a locked cabinet within the university to which only the researcher will have access, and audio content will be destroyed following transcription.

What if I have any problems?

If you have any concerns you can contact the researcher. Or, if you wish to complain about any aspect of the study or speak to somebody independent, please contact Dr Dougal Hare (Research Director; South Wales Doctorate Programme in Clinical Psychology) on 029 2087 0582 or email HareD@cardiff.ac.uk.

Who has reviewed the study?

I am conducting my dissertation along with my supervisors Dr Victoria Samuel (Clinical Psychologist and Senior Research Tutor, South Wales Doctoral Programme in Clinical Psychology) and Dr Kerry-Ann Holder (Consultant Clinical Psychologist, Noah's Ark Children's Hospital for Wales, UHW).

The study has been reviewed and given approval by Cardiff University Psychology Ethics Committee and the R&D department for the site.

Further information

If you would like to take part please contact me (Angela Webber) on the below details. If you have any questions about participating in the study or the research itself please contact on the details below.

Thank you for your time

Researcher:

Angela Webber

Trainee Clinical Psychologist

South Wales Doctoral Programme
in Clinical Psychology

11th Floor, Tower Building

Cardiff University

Park Place

CF10 3AT

Email:

Project supervisor:

Dr Victoria Samuel

Senior Research Tutor

South Wales Doctoral Programme

in Clinical Psychology

11th Floor, Tower Building

Cardiff University

Park Place

CF10 3AT

Email: Victoria.Samuel@wales.nhs.uk

The School of Psychology Cardiff University Ethics Committee

Email: psychethics@cardiff.ac.uk

Tel: 029 2087 0360

Consent Form

School of Psychology
Ysgol Seicoleg

South Wales Doctoral Programme in Clinical Psychology
De Cymru Rhaglen Doethuriaeth mewn Seicoleg Glinigol

Participant ID:

Participant Consent Form

An exploration of factors contributing to resilience in Hospital Play Specialists

Researcher: Angela Webber

If you consent to participating in the study, please initial in the box adjacent to each of the following statements, and sign the bottom of the sheet in the space provided.

Please initial:

1. I confirm that I have read and understood the participant information sheet dated 20th October 2017 (version 1). I have had the opportunity to consider the information provided, ask questions and have had these answered to my satisfaction. ☐
2. I understand that my participation in this study is entirely voluntary and that I am free to withdraw from the study at any time without giving reason. If I choose to withdraw from the study there will be no adverse consequences. ☐
3. I understand that my participation is anonymous and my responses will be recorded without any identifiable information. ☐
4. I agree to the use of anonymised verbatim quotes in publications, presentations and teaching arising from this research ☐
5. I agree to take part in the above study ☐

Name of Participant	Date	Signature
Name of researcher	Date	Signature

Debrief Form

NHS WALES GIG CYMRU

School of Psychology
Ysgol Seicoleg

South Wales Doctoral Programme in Clinical Psychology
De Cymru Rhaglen Doethuriaeth mewn Seicoleg Glinigol

CARDIFF UNIVERSITY
PRIFYSGOL CAERDYDD

Debrief Letter

Dear Sir/Madam,

Thank you for participating in the study, we really appreciate you taking the time to share your experiences with us.

The aim of the research was to explore the experience of play specialists working in inpatient settings, with a focus upon factors influencing resilience within the profession. It is hoped that your responses will add to the growing evidence-base surrounding wellbeing in the NHS. The researcher and supervisors have all worked clinically with Play Specialists and have been impressed by the valuable input provided within paediatric hospitals, and struck by the breadth of the role. We also noticed that as a professional group, little research has been carried out about the factors which influence resilience for HPS, especially considering the intensity of the work.

The study will be written up for publication in an academic journal to share the results and inform future service development, policy guidance and clinical practice. This will include anonymised quotations.

If you wish to have a copy of the results of the study please let me know and I will send you this when they become available.

Your responses will be anonymised and kept confidential. If you have any questions about the study please contact the researchers. If you remain unhappy and wish to complain formally, you can contact Cardiff University on 02920 879131 or email resgov@cardiff.ac.uk.

Yours Faithfully,	Working under supervision of:
Angela Webber	Dr Victoria Samuel
Researcher	Academic Supervisor
Email: webbera2@cardiff.ac.uk	Email: Victoria.Samuel@wales.nhs.uk
Trainee Clinical Psychologist	Senior Research Tutor

Demographic questionnaire

Demographic Questionnaire

We are collecting an overview of participants' demographic information. This information will not be linked to your responses in order to maintain anonymity.

Participant ID: ………………….

Age-range (please circle): 18-25 26-30 31-45 46-60 60+

Gender (please circle): Male Female

Job Role : ....

Number of years qualified: ....

Department (s) covered (please tick all that apply):

- ○ General Paediatrics
- ○ Oncology
- ○ Haematology
- ○ Cardiology
- ○ Diabetes
- ○ Renal
- ○ Nephrology
- ○ A&E
- ○ Neurology
- ○ Craniofacial
- ○ Burns
- ○ Cystic Fybrosis
- ○ Cleft Lip and/or Palate
- ○ Gastroenterology

Thank you very much

Appendix 2.4 Interview Schedule and Amendments

Interview Schedule

An exploration of factors contributing to resilience in Hospital Play Specialists

Questions (prompts in italics)

1. What drew you to training as a play specialist?
2. Tell me a bit about your role
    - *Where do you work? What department?*
3. How would you describe your experience as a play specialist so far?
4. What do you enjoy most about your role?
5. What makes you think 'I've done a good job?'
6. Is there anything which can be difficult about your role?
    - *When do you feel challenged by your role?*
    - *How do you manage these difficulties at work?*
    - *Do you think this has changed at all throughout your career? If so, how?*
7. What does burnout mean to you?
    - *Do you think issues like burnout are applicable to play specialists?*
8. How do work challenges impact upon your life at home, if at all?
    - *How (if at all) do other people, activities or resources outside work support you in managing the impact of your work?*
9. How do you and your colleagues experience and manage stress at work?
    - *Are there any structures or processes within your team or the wider hospital that helps buffer the impact of work challenges?*
10. If you could change one thing which would make your job easier/less stressful, what would this be?
11. Is there anything I haven't asked that you'd like to add?
12. What do you think I should ask in future interviews?

Additional questions after interview 4:

13. How do you think others perceive the HPS role (colleagues and families)?

14. How do you perceive the relationships you have with families?

Appendix 2.5 Example Transcript with Coding

Focused codes	Transcript: S	Line-by-line codes
	A. Thank you. What makes you think I've done a really good job today?	
Getting feedback	S: It's hard to put into words... what makes me feel like I've done a good job is having	*Gaining reward from feedback from colleagues*
Feeling valued; needed	feedback from the nurses who say we couldn't have done that without you.. because sometimes I think Play specialists	*Feeling needed and valued* *Being invaluable*
Feeling lower in status	put themselves down a little bit because we're not doing the life saving stuff... I think some people's attitudes towards PS is 'ah you just play that's such a nice job.. so	*HPS Putting selves down, 'not doing the lifesaving stuff'* *Perceiving others' attitudes of the job*
Being misunderstood	when other members of staff like nursing staff or doctors say 'we couldn't have done	*Being seen as just playing*
Being appreciated and recognised	that without you, or the families say we couldn't have done this without you, you know so and so won't come in and have this done without you.. that's when I think I'e done a good job. Or you know when I	*Feeling needed and respected* *The work being recognised* *Playing an integral role in care*
Being there from the beginning **Bearing witness to distress**	see a child... if I've followed a patient through and I've seen them since the beginning and they're petrified even coming in the door and then a couple of weeks later even if its a small step if you	*Being there since the beginning* *Witnessing anxiety* *Making a difference,* *Getting them to make small steps*
Being rewarded	get them to walk through the treatment room on their own.. that's when I think okay	*Acknowledging her impact*
Making a difference	I've done a good job today umm if they've achieved something then I feel like I've achieved something.	

Appendix 2.6 Excerpt from Memo Writing

Sub-category 3 - Creating Space

The strategies described to manage the difficulties of the job seemed to be summed up by a concept of physical and emotional **space** - allowing a distance from the difficulties of the job for the HPS to be able to **carry on**.

Participants are talking about ***Boundaries:***

I don't get upset in work, I don't, I never, I used to pride myself on very much, because I had to, leave my stuff at the door, but I'm finding it harder now to switch off after work. (Sam)

I think over time, these professionals learn to put up a barrier to protect themselves? **PROCESS > growing boundaries as a protective mechanism**

I think over the years of experience I still show a lot of empathy and care, but I don't give everything…. if you know what I mean… I don't get… I think we all get involved, but there's a way of getting involved just by being there to listen, to talk, to play games and encourage them to, erm, to mobilise and everything, but I think you've got to be seen like that not seen in another way of being upset, because that's… that's… you're not doing anybody any favours and it's not, you know, helping the family at all. So, I think over the years I think I've definitely, erm, got better in dealing with things. (Alex)

Sub-category 4 - Peer support; from those who understand - Feeling validated

Surprisingly, despite the difficulties in **integrating** into the MDT, Interview 1 spoke lots about receiving **support from colleagues in the MDT**. Does this relate to others **not getting it?** There seemed to be a sense of validation from gaining support and no **pressure to talk**. Support was **there if needed (accessible?). T**here seemed to be something about talking to **those who understand** rather than family - talking to family and friends was risky for the HPS and the family member as responses were often unhelpful.

Appendix 2.7 Excerpt from Reflective Diary

March 2018

Feeling very pressured and stressed at the lack of participants. Wondering whether this reflects the pressures of the staff or just a disinterest in my research? I am very much looking forward to hearing more views but running out of time to analyse and write up. I'm trying to practice my skills of managing uncertainty which have been so useful to me throughout training so far. Feeling pulled in different directions re: placement and thesis and thus struggling to manage everything. This appears to mirror participants responses and may also explain why uptake for interviews is low? Participants feel pulled too!

April 2018

After not interviewing for a while and with my head full of existing codes, am I trying to fit what I am hearing into what I already have constructed in my mind? Need to keep aware of this whilst I am interviewing and remain open to new information.

Finding myself listening for quotes and not been fully present, this isn't helped by the impending deadline! Interesting that the similar themes are coming up though.

April 2018

This participant was hard to read, seemed very stoic - wonder if this is the boundary she was telling me about? The focus was very much on practical frustrations of the job, I found it difficult to get 'underneath' to the emotion behind the work. The interview also made me think about power - HPS have no power thus no agency to change things? their relative low status compared to other professionals, despite being professionals and having a professional registration, it doesn't seem fair? Talking about reactive care - so familiar to my experience of working in the NHS settings. It's no wonder participants feel powerless to change things, but how do they keep going?

Appendix 2.8 Table of Categories and Codes

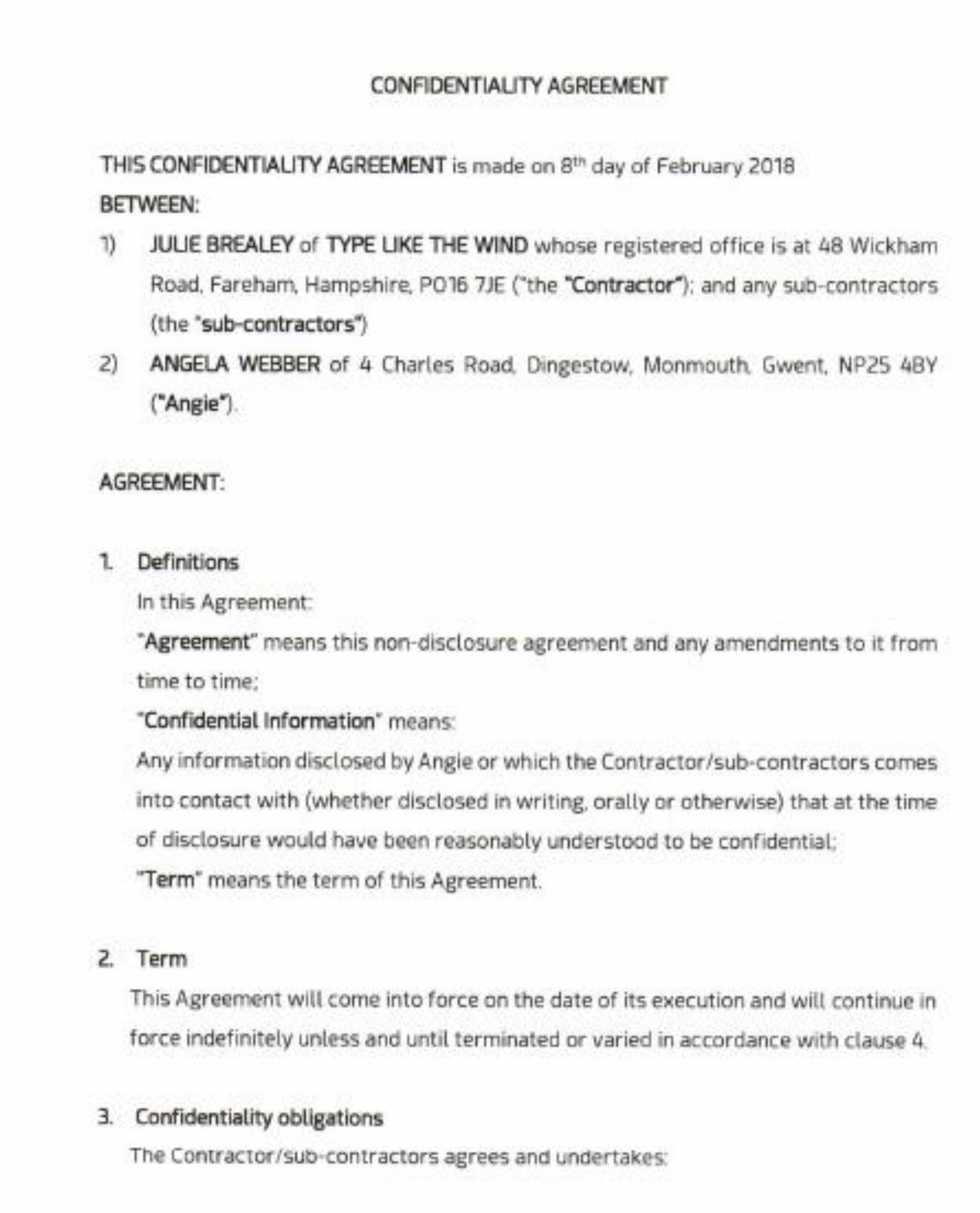
CORE-CATEGORY	**A UNIQUE ROLE**		
CATEGORY	**SUB CATEGORY**		**CODES**
Misunderstood	***Unknown role; low status***		Putting self down; unrealistic expectations; being misunderstood; an unfamiliar role; feeling isolated; a hidden role; the importance of play; being a babysitter; just doing play; working differently; lack of confidence; feeling powerless;
	Marketing		Needing to prove worth; being visible; a changing role; improving awareness; educating others; working together; providing clarity; carving out the role; raising the profile; receiving more referrals; rebranding; journalism; making relationships; modelling; advocating play;
	Being valued; a professional role		Working with children; being asked for advice; being needed; being appreciated; feeling respected; feedback; being seen as a professional; integrating into the MDT; making decisions; being consulted; getting recognised; awards
A demanding role	***Pulled in all directions***		Put under pressure; not meeting expectations; covering different areas; not enough staff; politics and paperwork; working alone; high workload; being demanded; wanting to give everything; being demanded; feeling frustrated; relying on fundraising; being restricted; reactive v proactive care; balancing multiple roles;
	Knowing limitations		The magic wand; accepting limitations; developing confidence; feeling guilty; prioritising caseload; having control over time; being backed up by manager; being productive; asserting limits; managing workload
Being there	***Like a member of the family; a unique relationship***		Being there throughout the whole treatment journey; bonding; being the safe person; not medical; being trusted; being familiar; a different relationship; doing the nice things; becoming a familiar face; providing personalised care; being on the same level; translating; being transparent; making a connection; playing the long game; being like a part of the family; conflict; being refused;
	The risk of the relationship		Supporting the family; being a soundboard; witnessing distress; being overwhelmed; exposure to pain; loss and grief; work close to home; getting attached; trade-off; questioning the shelf-life; accumulation of death; bonds as distress; holding the family; providing safety; taking work home; giving everything; being disclosed to; sharing the shock; being exhausted; high sickness;
	Creating space	***Boundaries***	Developing a thick skin; being professional; holding some of self back; experience; doing non-clinical work;
		Work/Life balance	Not taking things home; having a break; relaxing; zoning out; exercise; going for a coffee; keeping work at work; working part-time; having time to breathe; going outside; having c ode for family; pets;

		Blocking feelings	Staying strong; don't open the floodgates; getting on with it; dismissing emotions; criticising self; pull self together; putting on a mask; blocking it out; drinking wine; avoiding; putting on a brave face; distracting;
		Allowing feelings	Taking 5 minutes; reflecting; having time to self; having a cry; sitting in the toilet; releasing emotions; having space to feel;
	Support from those who 'get it' - being validated		In it together; others don't understand; sharing emotions; supervision; informal peer support; accessibility of support; speaking to those who understand; management not always there; offloading; not having to explain; debriefing; organisational support; providing support; psychology; gaining a different perspective; feeling heard; protecting family; lack of support for some areas; feeling unsupported; backing up team; holding team; holding hope for change
	Finding meaning and purpose		Providing the best possible experience; transforming the experience; professional goals; challenge and growth; the patient journey; focusing on positives; seeing children get better; relationships as rewards; holding onto hope; problem solving; seeing the smiles; the small steps; treasuring the good times; making a difference; being remembered; think of the good times;

Appendix 2. 9 Table of Participants and Categories

Core Category	**A UNIQUE ROLE**												
Categories	**MISUNDERSTOOD**			**DEMANDING ROLE**		**BEING THERE**							
Sub-category	*Unknown - Low status*	*Marketing*	*Being valued*	*Pulled in all directions*	*Knowing limitations*	*A different relationship*	*Risk of the relationship*	*Creating space*				*Peer support*	*Meaning /purpose*
								Boundaries	Balance	Block	Allow		
Sam	X	X	X	X	X	X	X			X		X	X
Alex	X	X	X		X	X	X	X	X	X	X	X	X
Charlie	X	X	X	X	X	X		X	X	X		X	X
Frankie	X	X	X	X	X	X	X	X	X	X	X	X	X
Kiera	X	X	X	X	X	X		X	X			X	X
Jackie	X	X	X	X	X	X	X	X	X	X	X	X	X
Carla	X	X	X	X	X	X		X		X		X	X
Becky	X	X	X	X	X	X		X	X		X	X	X
Michelle	X	X	X	X	X	X	X				X	X	X
Sarah	X	X	X	X		X	X	X	X	X	X	X	X

Appendix 3.1. Confidentiality Agreement, transcription service



CONFIDENTIALITY AGREEMENT

THIS CONFIDENTIALITY AGREEMENT is made on 8th day of February 2018

BETWEEN:

1) **JULIE BREALEY** of **TYPE LIKE THE WIND** whose registered office is at 48 Wickham Road, Fareham, Hampshire, PO16 7JE ("the **"Contractor"**); and any sub-contractors (the **"sub-contractors"**)

2) **ANGELA WEBBER** of 4 Charles Road, Dingestow, Monmouth, Gwent, NP25 4BY (**"Angie"**).

AGREEMENT:

1. Definitions

In this Agreement:

"Agreement" means this non-disclosure agreement and any amendments to it from time to time;

"Confidential Information" means:

Any information disclosed by Angie or which the Contractor/sub-contractors comes into contact with (whether disclosed in writing, orally or otherwise) that at the time of disclosure would have been reasonably understood to be confidential;

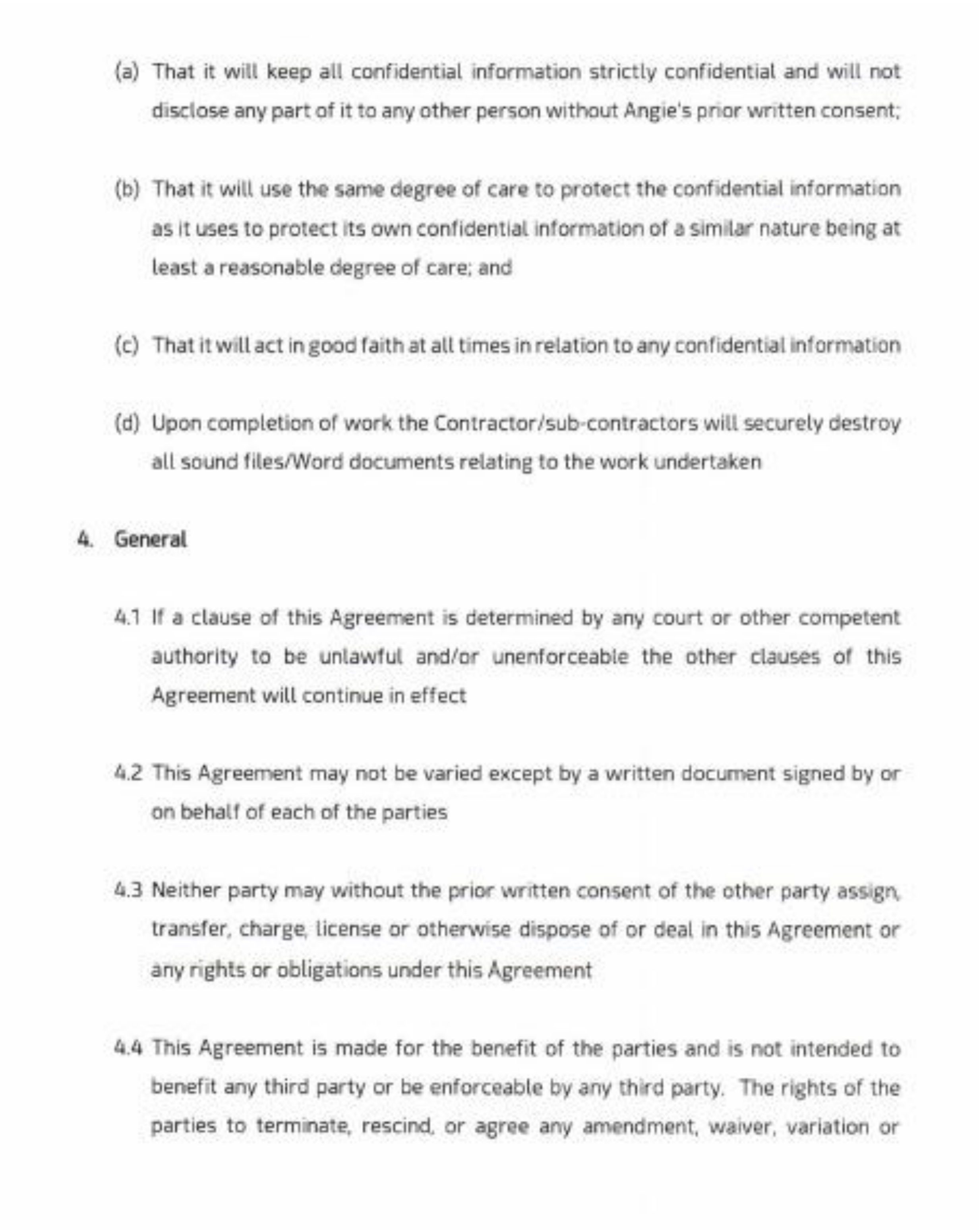
"Term" means the term of this Agreement.

2. Term

This Agreement will come into force on the date of its execution and will continue in force indefinitely unless and until terminated or varied in accordance with clause 4.

3. Confidentiality obligations

The Contractor/sub-contractors agrees and undertakes:



(a) That it will keep all confidential information strictly confidential and will not disclose any part of it to any other person without Angie's prior written consent;

(b) That it will use the same degree of care to protect the confidential information as it uses to protect its own confidential information of a similar nature being at least a reasonable degree of care; and

(c) That it will act in good faith at all times in relation to any confidential information

(d) Upon completion of work the Contractor/sub-contractors will securely destroy all sound files/Word documents relating to the work undertaken

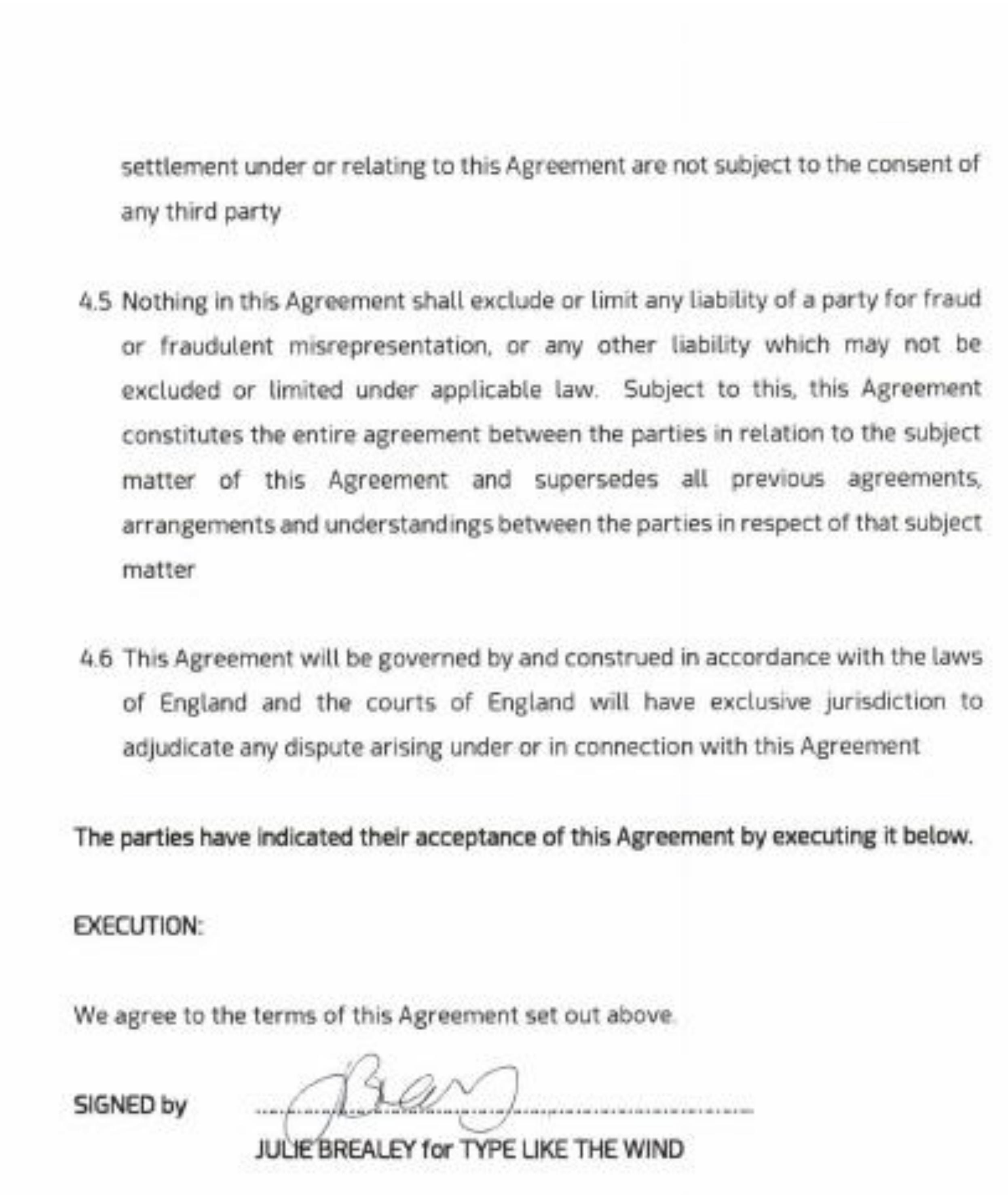
4. General

4.1 If a clause of this Agreement is determined by any court or other competent authority to be unlawful and/or unenforceable the other clauses of this Agreement will continue in effect

4.2 This Agreement may not be varied except by a written document signed by or on behalf of each of the parties

4.3 Neither party may without the prior written consent of the other party assign, transfer, charge, license or otherwise dispose of or deal in this Agreement or any rights or obligations under this Agreement

4.4 This Agreement is made for the benefit of the parties and is not intended to benefit any third party or be enforceable by any third party. The rights of the parties to terminate, rescind, or agree any amendment, waiver, variation or



settlement under or relating to this Agreement are not subject to the consent of any third party

4.5 Nothing in this Agreement shall exclude or limit any liability of a party for fraud or fraudulent misrepresentation, or any other liability which may not be excluded or limited under applicable law. Subject to this, this Agreement constitutes the entire agreement between the parties in relation to the subject matter of this Agreement and supersedes all previous agreements, arrangements and understandings between the parties in respect of that subject matter

4.6 This Agreement will be governed by and construed in accordance with the laws of England and the courts of England will have exclusive jurisdiction to adjudicate any dispute arising under or in connection with this Agreement

The parties have indicated their acceptance of this Agreement by executing it below.

EXECUTION:

We agree to the terms of this Agreement set out above.

SIGNED by ....

JULIE BREALEY for TYPE LIKE THE WIND