

**THE EXPERIENCE OF NOVICE
HOSPITAL PLAY SPECIALISTS
IN THEIR EARLY MONTHS OF EMPLOYMENT**

Marianne Kayes

A thesis submitted to Auckland University of Technology
in partial fulfilment of the degree of Master of Health Science

2005

TABLE OF CONTENTS

	PAGE
TABLE OF CONTENTS.....	i
ATTESTATION OF AUTHORSHIP	v
ACKNOWLEDGEMENTS.....	vi
ABSTRACT.....	vii
 CHAPTER ONE - INTRODUCTION	
The Stories We Tell and Hear Told	
Introduction.....	1
What is a hospital play specialist?	3
What theories inform their work?.....	4
Understandings of play in hospital	5
What is meant by healthcare play and preparation?.....	7
How did hospital play programmes develop?.....	9
Volunteers and the “play lady” legacy.....	10
Becoming a profession.....	11
Hospital play specialists in New Zealand.....	12
Qualifications and professional support.....	14
Policy and regulatory frameworks.....	15
My journey from practitioner to researcher.....	16
Why this study?	18
Why hermeneutic phenomenology?	19
Overview of the thesis.....	20
 CHAPTER TWO - LITERATURE REVIEW	
The Experiencing of Now	
Introduction.....	22
Shifting understandings.....	23
Children and child development.....	23
Development and assessment.....	25
Beliefs about play.....	26
Finding a balance.....	30
Therapeutic play and early childhood education.....	30
Play, preparation and procedural support.....	31

Professional wellbeing.....	32
Workplace and resources.....	33
Inter-professional relationships.....	34
Emotional labour, stress and burnout.....	36
Professional support and development.....	39
What is missing from the literature?.....	41
Summary.....	41

CHAPTER THREE - METHODOLOGY

The Craft of Thinking

Introduction.....	43
Philosophical approach.....	43
Lived experience.....	46
Lifeworld existentials.....	46
The hermeneutic circle.....	46
Why this methodology?.....	47
Explicating my own assumptions.....	48
The research pathway.....	50
Ethical approval.....	50
Accessing participants.....	51
The participants.....	52
Protection of participants.....	52
Phenomenological interviewing.....	54
Issues arising during interviews.....	55
Working with the data.....	56
Analysis.....	57
Trustworthiness.....	59
Positioning myself.....	60
Engagement of the reader.....	61
Credibility.....	61
Reflexivity.....	62
Summary.....	63

CHAPTER FOUR – FINDINGS

Where Edges Meet

Introduction.....	64
Approaching the edge.....	65

Crossing the border.....	67
First impressions.....	67
Being guided.....	69
Being in a new world.....	72
Experiencing changed space.....	72
Experiencing changed time.....	74
Encountering others.....	77
<i>Nursing and medical staff</i>	77
<i>Children and families</i>	80
Journeying in a new role.....	82
Standing at the point of tangency.....	85
Summary.....	87

CHAPTER FIVE – FINDINGS

Struggling to Face a New World

Introduction.....	89
Experiencing vulnerability.....	90
Feeling under threat.....	90
Unsafe practice.....	92
Feeling unprepared.....	95
Unsafe environment.....	96
Being accountable.....	98
Experiencing indifference.....	100
The struggle for a place.....	103
Experiencing loss.....	106
Summary.....	109

CHAPTER SIX – FINDINGS

Learning the language of colours

Introduction.....	110
Adaptation.....	111
Showing tact.....	116
Recognition.....	119
Knowing again what is known.....	119
Recognition from others.....	121
Recognising others.....	124
Recognising self.....	126
Summary.....	131

CHAPTER SEVEN – DISCUSSION

Weaving the Threads Together

Introduction	132
Futures taking shape.....	133
Transitions in place and space.....	133
Transitions to a new world.....	134
Relationality	135
Professional identity.....	136
Temporality: From novice to competent professional.....	137
Relationship to other studies.....	139
Developmental framework.....	139
Workplace issues, role stress and relationships with others.....	140
Emotional labour and sources of support.....	141
What is new in this study's findings?.....	142
Implications of the study's findings.....	144
Selection.....	145
Orientation and communication.....	146
Interpersonal relationships and belonging.....	147
Professional development and competence.....	147
Professional recognition.....	149
Strengths and limitations of the study.....	150
Questions requiring further exploration.....	151
Concluding statement.....	152

APPENDICES

Appendix A: AUT Ethics Committee Approval.....	154
Appendix B: AUT Ethics Committee extension.....	155
Appendix C: Hospital Play Specialists Association approval.....	156
Appendix D: Service manager information letter.....	157
Appendix E: Letter of invitation to participate.....	160
Appendix F: Reminder invitation letter.....	164
Appendix G: Participant consent form.....	165
Appendix H: Transcript confidentiality agreement.....	166

REFERENCES.....	167
-----------------	-----

ATTESTATION OF AUTHORSHIP

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the qualification of any other degree or diploma of a university or other institution of higher learning, except where due acknowledgement is made in the acknowledgements.

Signed: 
Marianne Kayes

Date: 21/02/2005

ACKNOWLEDGEMENTS

I acknowledge and thank all those who have contributed in some way to this thesis:

Firstly, to the eight un-named participants, my grateful thanks for sharing your stories with me and for the time and thought you so willingly gave to the interviews. Without your participation there would be no study. Your stories are your own, and unique, yet they are bound up with the stories of the children, families and colleagues with whom you work. I would like to acknowledge, too, their contribution.

My supervisors, Clare Hocking and Ann Paddy, have been wonderful guides throughout the research process. Their knowledge, availability, patience, challenge, and feedback have been invaluable. Their encouragement and faith in me was hugely important in enabling me to complete the learning journey I undertook when I commenced this study.

My family, all of whom have been deeply immersed in their own various studies throughout much of this time, yet have been unfailingly supportive and encouraging. They are constant reminders to me of my belief that there is no real meaning or purpose to human existence outside of relationships, and I thank them for that.

My colleagues and friends who have supported my workload, cheerfully dealt with my absent-mindedness at times, sustained my sense of humour, and given me feedback.

And, finally, I acknowledge the writers, researchers and philosophers whose work I have drawn on to inform this study, and whose words and wisdom have challenged my thinking and deepened my understandings:

When he thought of the revolution of planets, the emergence of species, the balance of mathematics, he could not see that any of these was more amazing than the impertinent human wish to reach into the sea of common language and extract from it the rich dark beautiful words that could be arranged in such a way that the unsayable might be said.

Sheilds, 2000, p. 86

ABSTRACT

This study explores the day-to-day lived experience of eight novice hospital play specialists in New Zealand, during the early months following their appointment. Hospital play specialists come from a background in early childhood teaching and work as members of paediatric healthcare teams to support development and coping in hospitalised children and young people. Participants' stories were gathered in face-to-face interviews and were then analysed using an interpretive approach informed by Heideggerian hermeneutic phenomenology. Throughout the reflective process of the study, I have sought to show the vividness of the participants' unique experiences whilst revealing the *deeper understandings that lie below*.

This study shows that experiences as a novice matter to the subsequent development of professional identity as a hospital play specialist. The participants' early impressions of the world of a hospital are shown in the findings to be those of strangers arriving in a foreign country, struggling to survive and to achieve a sense of belonging. Despite initially feeling lost and vulnerable, they are revealed as resourceful in coping with change, and resilient in acquiring new skills, finding support, building relationships, and adapting their practice. Inclusion within healthcare teams, and recognition of their knowledge and skills by the participants and by their healthcare colleagues, contribute to participants' successful transitions from novice to competent practitioners.

There are implications in this study for team leaders, managers and hospital play specialists regarding recruitment and support, such as ensuring that those employed show the flexibility needed for this role and are then provided with suitable early information and induction programmes. Alongside this is the need for a focus on professional development and improved processes of communication, and inclusion of new staff members within the healthcare team.

CHAPTER ONE – INTRODUCTION AND CONTEXT

The Stories We Tell and Hear Told

Our lives are ceaselessly intertwined with narrative, with the stories we tell and hear told, those we dream or imagine or would like to tell, all of which are reworked in the story of our own lives... We live immersed in narrative, recounting and reassessing the meaning of our past actions, anticipating the outcome of our future projects, situating ourselves at the intersection of several stories not yet completed.

Brooks, 1984, cited in Epston & White, 1989, p. 46

Introduction

This study explores the experience of eight novice hospital play specialists working in New Zealand hospitals. It asks the question, “What is the meaning of their experience in their early months of employment in this role?” Hospital play specialists are allied health professionals whose role is to support the normal development, psychosocial wellbeing, and coping of infants, children and young people. They incorporate play as an integral aspect of their work, based on their understanding of play as fundamental to development, wellbeing, learning and mastery. Despite the increasing presence of hospital play specialists in many paediatric health care teams, there is very little research that is specific to this profession and none, to my knowledge, of a qualitative nature. My philosophical approach to this interpretative study is informed by hermeneutic phenomenology. There are no hypotheses or results that can be generalised. Rather, it is an approach in which I seek through thinking, writing, reflection and re-writing, to reveal a deeper understanding of each individual’s unique experience, the meaning of which might otherwise be hidden within narrative and text.

I believe that this is the first study in New Zealand to explore the lived experience of this particular professional group. The participants are eight former early childhood teachers who had been employed as hospital play specialists for between three months and two years at the time of the study. They were chosen to ensure that the study incorporated participants from a number of different hospitals and from both small and large services.

At the time of the interviews, two of the eight were no longer working as hospital play specialists. The study is important because hospital play specialists are closely involved with children, young people and families at a time of stress and vulnerability. To serve them well, hospital play specialists need to be skilled and confident yet, as former teachers, they come to aspects of their role without specific preparation. For their own wellbeing, and that of the children they work with, it matters that they have the support they need to enjoy their work and to do it competently. This study is undertaken in the hope that an exploration of the nature of hospital play specialists' early experiences may generate ideas as to how to improve the support and education given to new practitioners and thereby enhance the work they do with children.

My personal interest in this topic arises from my own career as a hospital play specialist and my involvement, more recently, in the provision of professional development support to both new and experienced hospital play specialists across New Zealand. In the course of this work, I am often privileged to talk with recently appointed play specialists about their day-to-day experiences in hospitals. The stories they tell me aroused my curiosity and started me wondering about the significance of their experiences and what meaning they might have for their professional wellbeing, for that of other new hospital play specialists, and for the profession of hospital play specialist in New Zealand. It is this curiosity that has led me to this study.

This introductory chapter provides a background to the study. It describes the work of hospital play specialists, and the theories and beliefs about working with children that underlie their role. The chapter shows how hospital play programmes have emerged over the past fifty years, shaped by widespread changes in beliefs about children and how they should be cared for. The professional context in which New Zealand hospital play programmes are developing is also explained, providing a background for a better understanding of the narratives of the participants in this study. As well, I trace my own professional journey, how it led to my interest in this area, and why I chose to approach the study from a hermeneutic phenomenological perspective. Finally, I will provide an overview of the structure of the thesis as a whole, to guide the reader in his or her journey with me as this study unfolds.

What is a hospital play specialist?

Hospital play specialists work as members of healthcare teams, with the primary aims of maintaining children's development, emotional wellbeing, and ability to master and cope with illness, hospitalisation and treatment. Involvement in play and creative activities is their primary means of engaging children and establishing trusting and supportive relationships. Their role encompasses informal assessment of children's development, learning and responses to hospitalisation, and provision of support for siblings and other family members. Hospital play specialists liaise with services outside the hospital, such as early childhood centres and schools, and help with children's transitions between home, hospital and other settings.

Hospital play specialists differ from both teachers and play therapists, yet their role incorporates teaching and their use of play draws on psychoanalytic theory and the skills used by play therapists. They work with all children and young people, rather than only those with identified problems; their goals are generally preventive and protective, rather than diagnostic. In common with other healthcare professionals, hospital play specialists also provide information and advice to families, and teaching sessions for nursing and medical students and for fellow professionals. As well, they contribute to wider aspects of paediatric care through advocacy for healthcare policies, practices and environments that minimise harm and are developmentally supportive of children and young people (Child Life Council, 2002; Francis, 1990; Hospital Play Specialists Assn of Aotearoa/New Zealand, 1999; Kayes, 1999a; Thompson & Stanford, 1981).

Most commonly, hospital play specialists are employed in paediatric hospitals or in paediatric units within general hospitals, both in inpatient wards and in areas such as outpatient clinics, intensive care and day-stay units. They may also provide services to children and young people cared for in adult units, or to children of adult patients. Sometimes they are employed in more diverse settings in the community such as respite and rehabilitation settings.

In New Zealand, hospital play specialists are a very small professional group, numbering fewer than sixty people scattered across hospitals within thirteen of the twenty-one district

health boards. Most services are quite small, although they vary from one or two person programmes to teams of ten or more. There are a number of public hospitals admitting children and young people as inpatients that do not yet have a play specialist service and, to my knowledge, none are employed in private hospitals. However, the profession is well established in the United Kingdom and parts of Europe, as well as in Canada and the United States, where comparable practitioners are known as child life specialists¹. In their gradual development as a profession, hospital play specialists have drawn on theoretical and philosophical understandings from many fields. Over time, a body of understandings has emerged that are generally believed by the profession to be fundamental to the work of hospital play specialists.

What theories inform their work?

The conceptual framework for hospital play programmes pulls together a number of strands within the theoretical and research literature. These include developmental theories, stress appraisal and coping theories, information processing and, of course, play. (Child Life Council, 2002; Gaynard et al., 1990).

Developmental theories, in which I am including understandings of learning as socially constructed, suggest that children's response to illness and hospitalisation is complex. Being unwell and in hospital may affect development by impacting on children's ability to engage in the activities necessary to maintain learning and social development. In turn, their level of development may affect how they respond to hospitalisation. Their response is also influenced by the interplay between such factors as temperament, their current and previous experiences of illness and hospitalisation, as well as family and cultural values, beliefs and expectations about the child's condition and treatment, and about healthcare more generally (Bibace & Walsh, 1980; Douglas, 1975; Gaynard et al., 1990; McIntosh, 2000; Quinton & Rutter, 1976; Rogoff, 2003). All these factors influence the likely meaning that children attach to events and also the extent to which hospitalisation may have either positive or detrimental effects on the child's development in the longer-term

¹ The terms "hospital play specialist" and "child life specialist" will both be used throughout this study, consistent with the literature or context being discussed, as will "hospital play programme" and "child life programme".

(Dahlberg, Moss, & Pence, 1999; Dockett & Fleer, 2002; McIntosh, 2000; Rogoff, 2003; Thompson & Stanford, 1981; Wong, 1999).

The basis for hospital play specialists' abilities to help children understand what is happening to them, and to engage effective coping mechanisms, is the formation of trusting, consistent and supportive relationships between hospital play specialists, children and families (Gaynard et al., 1990). Novice hospital play specialists are encouraged to facilitate communication by becoming closely attuned to children, by reflecting in language what children say and do, and by asking "open" rather than "closed" questions (Petrillo & Sanger, 1980). It is "an approach based on listening rather than speaking" (Rinaldi, 1993, cited in Dahlberg et al., 1999, p. 60). Being present with children and listening to their ideas without preconceived ideas of what is correct or valid may, for some, be rather different from their former ways of being with children as a teacher, yet I believe it is essential to engaging with children in play.

Understandings of play in hospital

Play in hospital is not the exclusive domain of any single discipline and there is a broad, multidisciplinary interest and involvement in play. However, the hospital play specialist is the person on the healthcare team with specific responsibility to implement play. This is a pivotal distinction. Providing an environment that supports children to engage in spontaneous play, and playing with children, are two key aspects of the role of the hospital play specialist.

There is a huge literature on the importance of play to children. Play is commonly believed to be a fundamental activity of childhood, essential to all aspects of the child's wellbeing and development. It is a primary means of communicating, coping, learning and adapting. It assists children in information processing, enhances understanding, and enables them to master stressful events (Azarnoff & Lindquist, 1997; Bruce, 1991; Dockett & Fleer, 2002; Golden, 1983; Linder, 1993). As well, in hospital, play is seen as a key means of coping and of ameliorating the potential ill effects of hospitalisation on wellbeing and development (Bolig, 1997; Golden, 1983; Petrillo & Sanger, 1980).

However, hospitalisation has a negative impact on children's spontaneous engagement in play. Even when play equipment and activities are available and accessible, children are less likely to engage spontaneously in play than are non-hospitalised children, and their engagement is likely to be of shorter duration. Significant differences have been found in the nature and extent of hospitalised children's engagement in play when adults are available to support play, as opposed to times when such support is not available (Adams, 1971; Noble, 1967; Thompson, 1985). Children's engagement in play has been described as a barometer of their adjustment to hospital (Bolig, Yolton, & Nissen, 1991). Children who are playing in hospital are seen as coping positively. Those who are not playing, or who for some reason cannot play, are seen as being at risk:

Play is an essential continuing report from children about their participation in the healing process. The therapeutic component of play provides cues to children's handling of illness and treatment. When play is omitted or only allowed randomly in hospitals, it is an indication that staff does *[sic]* not acknowledge its benefits and that they keep illness and passivity equated. Instead, play facilitates recuperation and emotional health. (Azarnoff & Lindquist, 1997)(p. iii)

Given the number of theoretical perspectives and the multiplicity of possible definitions of "play", the usage of the word is somewhat problematic. Rather than trying to find a single description, many definitions focus on characteristics which, when combined, contribute to a disposition of play or playfulness. Commonly, play is seen as being internally controlled, intrinsically motivated, actively engaging of the child, process rather than product oriented, internally real, pleasurable and largely free of externally imposed rules (Bruce, 1991; DelPo & Frick, 1988; Dockett & Fleer, 2002). It is helpful, I believe, to envisage play as a continuum between activities that are clearly "play", and those that are "not play", distinguished by the relative degree of control and structure exerted by children rather than adults.

Hospital play specialists incorporate play along the "play/not play" continuum depending upon circumstances and professional judgment of what is likely to serve the child's best interests at that time. For example, they may play with a child to have fun, and to build relationships and trust. They observe children's play in order to assess their response to hospitalisation and ability to cope with stress, and how best to provide for their ongoing development and any special needs they may have. They provide opportunities for

children to play with each other so as to develop friendships and social skills. They take advantage of a particular interactions or situations that arise to “scaffold” (Berk & Winsler, 1995) children’s learning, to complicate their thinking, and to implement early childhood curriculum principles and goals (Kayes, 1999a). The different kinds of play are not discrete but may coexist within a single interaction with a child. All of these activities may be more, or less, “play-full” depending upon the purpose and the way in which the adult becomes involved (DelPo & Frick, 1988). For example, engaging a child in play for the purpose of psychological preparation may be less genuinely playful than, say, engaging with a child in an unstructured activity such as water play in order to build relationships, or in healthcare play.

What is meant by healthcare play and preparation?

A particular aspect of play in hospital is the provision of opportunities for children to freely engage in medical or healthcare play (Bolíg, 1997; Harvey & Hales-Tooke, 1972; Petrillo & Sanger, 1980). “Healthcare play” is the term used for play that is focused on aspects of healthcare experiences. I have found that New Zealand hospital play specialists tend to use the term “therapeutic play” almost interchangeably with “healthcare” or “medical” play, to refer to children engaging, directly or indirectly, in play that relates to the emotional component of their illness or hospital experience. McCue (1988) defines medical play as the child’s use of their ability to play through their experience of illness and/or medical intervention in order to increase their understanding, express feelings and misconceptions, and develop more mature coping mechanisms. Direct healthcare play may involve children in re-enacting medical experiences using real or pretend medical equipment. Indirect healthcare play may be “safer” for the child in an emotional sense as it is more removed from his or her actual experience.

The adult’s role in therapeutic play is supportive and non-directive. It is akin to what Readings (1996, cited in Dahlberg et al., 1999, p. 60) calls “listening to thought”. Adults supply the environment and materials to stimulate play, ensure that children can play at their own pace without interruption, attend sensitively to the child, and reflect the child’s actions and expression of feelings. Involvement in shared activities, observation of children’s play, and listening to and talking with children, provide opportunities for

assessing children's response to being in hospital. In the course of these interactions it may become apparent that a child's understanding of events differs from the taken-for-granted understanding of adults. If so, this may suggest a need for improved communication between children, families and other members of the healthcare team in order to achieve better quality of care for children (Child Life Council, 2002; Gaynard et al., 1990; Hogg, 1990).

Hospital play specialists also use children's ability to engage in symbolic play in preparing children and young people for potentially stressful healthcare procedures or events. This is referred to in the literature as psychological preparation (Gaynard et al., 1990), although it may commonly be called, simply, preparation. It may be less playful than medical play, as the adult has particular outcomes in mind in planning his or her engagement with the child. Psychological preparation of children for procedures is a component of the hospital play specialist's role that must be acquired by novice hospital play specialists in New Zealand. Psychological preparation aims to make unfamiliar or challenging healthcare events as predictable and manageable as possible. It incorporates identification of, and planning for the situation or specific aspect of a situation that has the greatest potential to overwhelm a particular child. In addition to providing developmentally appropriate information, psychological preparation includes the selection and rehearsing of coping behaviours that enable the child to visualise "getting through it" (Child Life Council, 1997; Gaynard et al., 1990). Coping efficacy is judged by how successful the coping process is over time in preventing later emotional distress. For example, crying may be an effective coping mechanism for a young child during a distressing experience, but may be regarded as shameful, babyish or embarrassing by an adolescent, and so add to his or her distress. Successful experiences of managing stressful situations may be generalised to other potentially stressful life experiences. Conversely, repeated experiences of ineffective coping may contribute to an ingrained sense of "learned helplessness" (Seligman, 1975, cited in Gaynard et al, 1990).

How did hospital play programmes develop?

Following World War II, in a climate of increasing concern for the protection of human rights, evidence began to emerge of the harm that might be done to children through institutional care. The work of John Bowlby (1951) and James and Joyce Robertson (Robertson, 1958) focussed attention particularly on the adverse effects of hospitalisation. Their work led to the influential British Platt Report (Ministry of Health, 1959), which made a number of recommendations relating to protection of the emotional wellbeing of children in hospital. The 1960s saw the publication of numerous studies, as researchers attempted to determine the extent of the potential ill-effects of hospitalisation and to suggest initiatives that would counter any damage. Their conclusions supported the findings of Robertson, providing compelling and consistent evidence of the frequency of short-term disturbance and regression, and pointing to possible long-term detrimental effects. Children were believed to be most vulnerable between the ages of 6 months and four years, and more affected by a long stay than by a short admission (Prugh, Staub, Sands, Kirschbaum, & Lenihan, 1953; Thompson, 1985; Vernon, Schulman, & Foley, 1966).

In 1975 Douglas found an association between extended or repeated admissions of children under the age of five and disturbance into adolescence (Douglas, 1975). His findings were confirmed in a replicated study the following year (Quinton & Rutter, 1976) and changes of behaviour were also observed in a New Zealand study (Simons, 1979). More recent studies have found associations between hospitalisation and performance on cognitive tasks up to ten years later, as well as on anxiety, depression and chronic illness in adults (Gaynard et al., 1990; Lansdown, 1996; McKinlay, 1982).

The research findings led to moves to humanise healthcare for children, primarily in relation to parental presence, but also by the introduction of play (Hall & Cleary, 1988; Lansdown, 1996). Many reports were published advocating for the implementation of play programmes as a way of normalising children's development in hospital and speeding

emotional and physical recovery (Gillis, 1989; Harvey & Hales-Tooke, 1972; Thompson, 1985). A 1989 Save the Children Fund report advised:

It is imperative that adequate play provision be made available to **ALL** children admitted to hospital. Failure to do so not only constitutes a neglect of their basic developmental needs but also deprives them of the medium through which they can successfully cope with the experience. (Save the Children Fund, 1989, p. 31)

Recommendations were increasingly centred on the need not just for play, but for supervision of play programmes by trained play staff (Clatworthy, 1981; Hogg, 1990; MacCarthy, 1982; McKinlay, 1982; Organisation Mondiale pour l'Education Prescolaire, 1966; Save the Children Fund, 1989). The appointment of play staff was supported by community advocacy groups, such as the British National Association for the Welfare of Children in Hospital (later Action for Sick Children) and the Children's Health Liaison Group in New Zealand. They adopted a "children's rights" perspective in their lobbying of policy makers for hospital care to be more supportive of children's development and, particularly, for the introduction of hospital play programmes. In 1995 a "Charter for Children in Hospital" was published, linked to the United Nations Convention on the Rights of the Child (Alderson, 1993). The "Child Friendly Healthcare Initiative" launched in 2000 under the auspices of UNICEF (Southall et al., 2000), is the most recent of these developments internationally. However, while hospital authorities became more open to the implementation of play programmes, the idea of employing staff to provide play met initially with considerable resistance.

Volunteers and the "play lady" legacy

Hospital play programmes are recorded from as early as 1909, in Finland, and in the United States from 1917. However, it was not until the early 1960s that they began to proliferate, particularly in the United States and the United Kingdom (Hall & Cleary, 1988; Lansdown, 1996; McKinlay, 1982; Thompson & Stanford, 1981). The early hospital play programmes were almost always provided by volunteers, invariably women, under the auspices of a philanthropic group or, sometimes, as an adjunct to occupational therapy programmes (Hall & Cleary, 1988; Rubin, 1992). This was a time when many hospitals had strictly enforced restrictions on parental visiting. Many young children

spent long periods of time alone and distressed, and play activities were therefore most often seen primarily as a way of providing distraction and substitute mothering.

In the United States paid “play ladies” began to be employed from the mid 1940s. Care was taken to ensure that programmes assisted other disciplines to fulfil their roles and did not in any way disrupt medical treatment (Hall & Cleary, 1988). Save the Children Fund was instrumental in initiating play programmes in the United Kingdom, and their first salaried hospital play worker was employed in 1963. The 1970s saw an expansion of play programmes in Europe, the United States, Canada and the United Kingdom. Since 1991, the United Kingdom Department of Health has been advising provider hospitals to ensure that they provide play facilities and employ play specialists (Department of Health, 1991). In Sweden, employment of hospital play staff has been legislated for since 1977 (Hall & Cleary, 1988). With increasing numbers of play staff employed, a need emerged for better coordination, staff training, and consistency and quality of programme provision. Consequently, professional groups began to emerge.

Becoming a profession

The early paid play staff were given a variety of titles, ranging from play ladies or play workers to child care workers, recreation workers, play therapists and preschool activities officers. These titles reflected varying beliefs about what the role should entail, about the nature of children’s play, and about the age group of children who should be entitled to participate (Rubin, 1992). In the United States and Canada the term “child life” was adopted in 1980, in recognition that the role encompassed more than play. It was also felt that there might be some stigma associated with the volunteer and “play lady” history that might prove a barrier to professionalism. These titles were seen as feminising the profession and as being associated with lack of skills, low status and low paid work. In contrast, in Britain the title hospital play specialist was eventually chosen, as it was believed that this best reflected the “specialty” area of this profession. A situation was therefore created where the two largest professional groupings, with similar philosophical bases and programme goals, are represented by two different titles. The failure to achieve a consistent title continues today in a proliferation of names internationally to describe

essentially the same role. In Australia, for example, I am aware of at least four titles: educational play therapist, play therapist, play specialist, and play activities coordinator.

The National Association of Hospital Play Staff was formed in the United Kingdom, in 1975, and the Child Life Council, representing North American child life specialists, in 1982. The Child Life Council now has a process for certification that incorporates academic preparation to a required standard, an approved internship, and an externally moderated examination. Graduate and postgraduate courses are available in child life in the United States and Canada. (It should be noted, however, that while all child life specialists hold degrees, they are not all certified, and their degrees are in a variety of subject areas.) The first training course for British hospital play specialists was established in 1973. As yet, it is not possible to obtain a degree level qualification specific to hospital play specialists in the United Kingdom. However, British hospital play specialists are currently negotiating to become registered health professionals, which is seen as a significant step to increased recognition and professionalism.

New Zealand hospital play specialists have looked to colleagues in North America, the United Kingdom, and to some extent Europe, for guidance on the development of programmes here. A number of experts in the field have been brought to New Zealand to provide workshops and general advice, and New Zealanders have attended and presented at international conferences. The Child Life Council is by far the major international source of published resources, and the New Zealand Hospital Play Specialists Association has used these extensively in the development of professional documents and provision of training programmes.

Hospital play specialists in New Zealand

Hospital play programmes developed in New Zealand, as they did internationally, in response to concerns about the psychosocial wellbeing of children in hospital, and supported through lobbying by advocacy groups. The New Zealand Playcentre Federation was instrumental in establishing voluntary hospital playgroups, thirteen of which were operating during the 1960s (Department of Education, 1971). The 1971 report of the Committee of Inquiry into Pre-School Education urged hospital boards to “give serious

consideration to providing for the educational needs of the pre-school child in their care” (Department of Education, 1971, p. 66) and in 1974 the Department of Health provided for the establishment of positions with the title “pre-school activities officers”. The legacy of the volunteer tradition and the involvement of the early childhood section of the Department of Education was that hospital play programmes were viewed as only relevant to infants and young children. The needs of older children were presumed to be met through hospital school programmes. Although the Department of Education recommended that qualified early childhood teachers be employed, some hospitals employed staff without any qualifications, and the role was viewed in some hospitals as being an assistant to nurses and a substitute mother (McKinlay, 1982).

A comprehensive 1982 study for the Child Health Research Foundation (McKinlay, 1982) stated that “New Zealand hospitals lag behind those in most of Europe and North America in the play facilities available in children’s wards” (p. 154) and recommended:

... that trained play workers be employed in all hospital children’s departments to work with teachers and nursing staff to provide for the play and developmental needs of all children in hospital, and in the preparation of children for intervention through appropriate play therapy. (p. 155)

However, despite various reports and continuing lobbying, there was almost no change in funding or staffing levels until legislative changes to the Education Act in 1989. Subsequently, hospital early childhood education services became eligible for licensing, chartering and part-funding by the Ministry of Education. However, I know from my involvement at the time, that the goals of the programmes being provided were already changing to reflect the more comprehensive nature of programmes in North America and Britain, driven largely by the initiative of play staff themselves. Programmes began to be more therapeutic in nature, and to be inclusive of all age groups.

The debate on names took place in New Zealand, too, with “preschool activities officer” being universally seen by those who held that title as non-representative of the role. The first conference of New Zealand hospital play staff, in 1989, acknowledged that a consistent title was essential and agreed to adopt hospital play specialist, in line with the profession in the United Kingdom.

1989 marked the founding of the Australasian Association of Hospital Play Specialists. This was a significant move in terms of liaison and shared professional identity, but small numbers, lack of funding and geographic distance prevented this being a very active linking. In 1997, the Hospital Play Specialists Association of Aotearoa/New Zealand was incorporated as the professional body representing New Zealand hospital play specialists.

Qualifications and professional support

In contrast to North America and the United Kingdom, there is no qualification available in New Zealand that is specific to working as a hospital play specialist. Almost all people entering the field in this country come from early childhood education, and have not previously worked in a hospital. Most of them are qualified and registered teachers and a number have additional qualifications, for example in early intervention (Kayes, 1999a). No matter how competent and experienced the commencing hospital play specialist may be in the world of education, they are almost always newcomers to the world of illness and hospitals. They must therefore acquire new skills and knowledge “on the job”, particularly in psychological preparation of children for healthcare procedures. Working within a multidisciplinary team is not regularly a part of early childhood teaching so that, too, may require additional skills.

Because of the smallness of the profession, and of most hospital play specialist teams, responsibility for service provision, quality and development may lie with one or two people. They may be both geographically and professionally isolated from colleagues with the same professional background. The Hospital Play Specialists Association of Aotearoa/New Zealand has developed a number of documents to guide practice, including a Code of Ethics, guiding principles, and professional competencies. Certification was introduced in 2003, and more recently a comprehensive induction programme for new appointees is being trialled. Further support is provided through newsletters, a library and regular conferences. Visibility has been enhanced by the development of a website and publication of a leaflet on hospital play specialists. Since 1998 the Association has been contracted by the Ministry of Education to provide professional development support to staff in licensed and chartered hospital early childhood education services.

Policy and Regulatory Frameworks

Most New Zealand hospital play specialist services incorporate early childhood education services for children from birth to school entry age that are licensed, chartered and part-funded by the Ministry of Education. In this respect New Zealand hospital play specialist programmes are different from those provided in other countries. In order to receive funding from the Ministry of Education, hospital play specialists working in such services must abide by the relevant Education legislation (Ministry of Education, 1996). Programmes also must be consistent with the requirements of the New Zealand early childhood curriculum, *Te Whāriki* (Ministry of Education, 1996). While licensing brings significant advantages in terms of more stringent standards, external review by the Education Review Office, and additional funding, there are some drawbacks in the dual accountability to both Education and Health. In my experience of visiting services and talking with staff, the design of hospital buildings and the particular circumstances of children in hospital may cause difficulties for staff in complying with the Education Regulations. These difficulties, particularly with regard to documentation and attendance requirements, outdoor play, and playroom supervision, can be time-consuming to resolve and stressful for the staff involved.

As hospital employees, hospital play specialists work within various other guidelines and regulatory frameworks associated with health services. Hospital play specialists are not registered health professionals so are not affected by Health Practitioners' Competence Assurance Act 2003. However, their services are covered by the *New Zealand Health and Disability Sector Standards*, NZS8134:2001 (Standards NZ Ministry of Health, 2001) and the *Code of Health and Disability Services Consumers' Rights* (Health and Disability Commissioner, 1994). The Standards require that "consumers", including children, are provided with developmentally supportive facilities and services. An accompanying Audit Handbook, specific to services for children and young people, has a number of references to hospital play programmes and hospital play specialists (Standards New Zealand, 2004). *The Code of Health and Disability Services Consumers' Rights* is a statutory regulation applying to all health and disability support services in New Zealand. Under the Code, children and young people have a right to information that is given in a form, language and manner which they can understand.

Advocacy for hospital play programmes can be supported by reference to the *United Nations Convention on the Rights of the Child*, which has a number of Articles that have significance for the role of hospital play specialists. In particular, these are Article 12, the right of children to express opinions and to have these taken into account in decisions that affect them; Article 13, the right to freedom of expression, including the freedom to seek, receive and impart information and ideas; Article 28, the right to education; and Article 31, the right to leisure, play and participation in cultural and artistic activities.

My personal experience of moving from the world of early childhood education to immersion in the world of a hospital, has spanned the period during which most of these regulatory frameworks have been introduced. It is this journey that I now describe.

My journey from practitioner to researcher

There are some choices that you know are coming upon you only when they are just about to explode. But there are other choices that insinuate themselves into you and become apparent with a kind of obstinate lightness, that seem to have slowly grown within you during the happenings of your life because of a mixing of molecules and thoughts.

Malaguzzi, 1998, p. 56

In reflecting on the choices that I made in becoming a hospital play specialist, it seems they must have been of the *insinuating* kind, becoming only gradually apparent. Teaching was not my first career, it grew out of “the happenings of my life”. I was led to work with young children by the enjoyment and satisfaction I experienced from involvement in my own children’s early education within the Playcentre organisation, and from participation in a number of parent support and advocacy groups during the same period. Over time I acquired teaching and special education qualifications and worked in a number of early childhood settings. My work in hospital started in a volunteer capacity, as coordinator of the playgroup at the former Princess Mary Unit of Auckland Hospital.

In 1989 I was employed as a “pre-school activities officer”, as the job was then called, job-sharing with a colleague. At that time there was one position for 200 paediatric beds. The Starship Children’s Hospital was built, play specialist staff numbers increased, and I

subsequently became manager of the Starship play specialist team. The 1990s were a period of many exciting changes for hospital play specialists as a professional group, and I enjoyed opportunities to contribute to in the growth of the Association. Since 1999 I have been employed by the Hospital Play Specialists Association of Aotearoa/New Zealand, to provide professional development support to hospital play specialists in hospital early childhood services across New Zealand.

I vividly remember the mix of excitement and trepidation that I experienced in the days and weeks following my appointment, and the sensory impressions and unfamiliar “culture” of a hospital. I remember, too, my emotional responses to the experiences of the children and families with whom I was working. Over time I found that I was re-defining myself as a professional. I no longer saw myself as a teacher, and certainly not as a “preschool activities officer”, but neither did I feel myself to be an allied health professional in the same way I imagined that, say, a physiotherapist might. Looking back, I see that I was on a journey to a new professional identity as hospital play specialist. This role was at that time rather vaguely defined. Nevertheless it seemed to have the potential to contribute a perspective that was different from the more established professions, whilst sharing the same goals of supporting children’s healing in the broadest sense.

In my current role as a provider of professional development, I have many opportunities to hear the stories of new and experienced hospital play specialists. These stories have raised a number of questions in my mind. What impact, if any, do early experiences have on practitioners’ understanding of themselves as members of healthcare teams? In what ways, if at all, do they affect whether or not people choose to continue working in hospital settings? To what extent do their experiences parallel mine, or have there been changes of some sort in the intervening years that make these more recent experiences different from mine in ways that might be important to others? And especially, what insights might their experiences reveal to inform how new practitioners can best be provided with professional development support that is meaningful and relevant to the realities of their workplaces? Like Alice, I got “curiouser and curiouser” (Carroll, 2001a, p. 15). These questions have fostered my interest in exploring the experience of newly appointed hospital play specialists as the focus for this research study.

Why this study?

In 1998 I had the opportunity to undertake a small research project on the extent of play provision in New Zealand hospitals, as part of a Diploma in Early Intervention. The results suggested that the transition to working in a hospital setting was very challenging for many novice hospital play specialists (Káyes, 1999a). This further stimulated my interest in what influences might shape the very different experiences that participants described.

An opportunity arose for me to look at some of these ideas in more depth in papers I undertook towards my masters degree at Auckland University of Technology. Embarking on a masters degree coincided with moving into a professional development role in which I have specific responsibility for providing programmes to support professional growth and wellbeing. My own experience suggested that the early months might have a significant influence on the wellbeing of hospital play specialists. There are also suggestions in the limited literature that this period may be critical to the establishment of a unique identity within healthcare teams (Bolig, 1982). As well, I was aware that there was very little written on the professional aspects of being a hospital play specialist. It seemed therefore that the experiences of novice hospital play specialists might reveal understandings that could be useful not only for my own work, but also for the profession as a whole.

Primarily, however, the reason for this study stems from my deeply held belief that the work of hospital play specialists has potential to contribute to the wellbeing, development and recovery of children and young people who are experiencing stressful life events associated with illness, treatment and hospitalisation. A better understanding of play specialists' experiences might, therefore, ultimately benefit the children and families with whom play specialists work. It is my hope that the stories that emerge will reflect shared experiences and understandings. It is my hope, too, that this study will provide a means whereby the unique experiences of the participants will be made visible and vivid to the reader. My wish to look more deeply at the experiences of individuals so as to reveal understandings that might have meaning and value for others, has led me to use an approach to this research study that draws on both phenomenology and hermeneutics.

Why hermeneutic phenomenology?

This study is a qualitative one, its interpretive methodology informed by hermeneutic phenomenology. Hermeneutic phenomenology is founded in a philosophical tradition arising from the work of Heidegger. According to Heidegger (cited in van Manen, 1990), a phenomenological approach aims to “let that which shows itself be seen from itself in the very way in which it shows itself from itself” (p. 33). It is the search to discover, from text and narrative, the essential nature of an experience and so to describe the meaning of human experience as it is lived. In this way, as the researcher, I will endeavour to move beyond the everyday assumptions of the phenomenon being studied to show its true nature.

The decision to adopt a hermeneutic phenomenological approach was informed by my wish to have a way of uncovering the significance of lived experiences and of enabling the voice of the participants to show through. In working with adults and with children, it has been my experience that stories can illuminate everyday experiences in ways that may be surprising and thought-provoking. Even very young children can, I believe, show us through their play, art and stories the depth of meaning that may lie behind apparently insignificant events. Before I had heard the term “hermeneutic phenomenology”, I was in agreement with the Red Queen in Carroll’s story *Through the Looking Glass*, when she assures Alice that there are levels of meaning underlying every aspect of experience: “What do you suppose is the use of a child without any meaning? Even a joke should have meaning – and a child’s more important than a joke, I hope” (Carroll, 2001b, p. 171).

I was also aware as I approached this research that I have a multifaceted personal and professional involvement in the subject, and an ongoing relationship with many of the potential participants. Inevitably, my own perspectives and experiences would shape the way in which I approached the study. My sharing of a common professional background with the participants was likely to influence our relationship and the way in which they would tell, or choose not to tell, their stories. In some approaches to research, this close involvement would be seen as a bias and as presenting a barrier to objectively looking at the subject. My chosen methodology, however, allows me to “own” my own experience and requires me to recognise that I cannot step away from it. Van Manen (1990) suggests

that such shared experiences between researcher and participants may have both advantages and disadvantages. They may alert the researcher to the commonality of some aspects of the human experiences of others.

It is to the extent that **my** *[emphasis original]* experiences could be **our** *[emphasis original]* experiences that the phenomenologist wants to be reflectively aware of certain experiential meanings. To be aware of the structure of one's own experience of a phenomenon may provide the researcher with clues for orienting oneself to the phenomenon and thus to all the other stages of phenomenological research... (pp. 57-58)

Equally, however, van Manen (1990) warns that a common problem with phenomenological inquiry is "not always that we know too little about the phenomenon we wish to investigate, but that we know too much" (p. 46). In embarking on this research therefore I was aware that I must guard against the possibility that my own experiences might lead me away from the participants' narratives or that I might invest them with a significance that does not show itself from the stories. As a researcher, my duty is to continually ask myself, "What assumption am I making, that I'm not aware I'm making, that gives me what I see?" (Zander & Zander, 2000, p. 15). Just as important is to maintain an awareness of the possibility that I might ignore or minimise the significance of a story, or an aspect of a story, because it is not reflected in my own experience. Participating in a pre-suppositions interview was therefore an important part of my preparation for this study. Rather than trying to exclude my own experiences, this interview helped me to make explicit my own assumptions and expectations in order to remain open to the significance of the experiences of others. What this interview revealed about my own pre-suppositions and how these might affect my understanding of others' experiences, is looked at in greater depth in the methodology chapter, chapter three.

Overview of the thesis

The focus of this study is the experience of novice hospital play specialists in the early months following their appointment. My research seeks to understand the meaning that may be concealed beneath the everyday lived experience of the participants, and in this search for what might lie hidden I have been guided by hermeneutic phenomenology. As a researcher, and as a hospital play specialist myself, I am deeply embedded in the topic, and bring to it my own background, values, beliefs, experiences. My own history and

understandings are inevitably a part of my research journey and will therefore be acknowledged throughout.

The study unfolds over seven chapters. This introductory chapter sets the study in context. It describes the role of hospital play specialists and outlines the theoretical underpinnings of their work. It shows the connections between the development of the profession over the past fifty years and the present professional context. Chapter one also describes the methodological approach I have used, and how I came to undertake the study.

Chapter two reviews literature relevant to the study, and shows the gaps that exist. The research approach and methodology that underpin this study are shown in chapter three. The design of the study is described, including information on the participants, the interviews, and the process used for analysing the data. This chapter concludes with an examination of the trustworthiness of the study.

Chapters four, five and six contain the themes and sub-themes that emerged from the stories of the participants. The final chapter, chapter seven, brings together the significant parts of the findings, weaving them together with the literature into a whole. It is here that I discuss the implications of the study for hospital play specialists, for professional education and development, and for multidisciplinary relationships within healthcare teams. As well, I discuss the study's limitations and point to areas for further exploration. Chapter seven also contains my recommendations.

In doing research we question the world's very secrets and intimacies which are constitutive of the world, and which bring the world as world into being for us and in us. Then research is a caring act: we want to know that which is most essential to being. To care is to serve and to share our being with the one we love. We desire to truly know our loved one's very nature. And if our love is strong enough, we not only will learn much about life, we also will come face to face with its mystery.

van Manen, 1990, p. 5

CHAPTER TWO – LITERATURE REVIEW

The Experiencing of Now

For past experience does not function in the present as the discrete events that have happened in the past. These are past. What is present is the experiencing of now, and the past events have made it what it is. All the past and all the complex aspects of myself today can be involved in the experiencing of my telling the incident.

Gendlin, 1997, p. 35

Introduction

The literature review for a phenomenological study seeks to shed light on the phenomenon being explored, the experience of novice hospital play specialists in their early months of employment. It draws on other sources of understanding within the available literature in order to illuminate possible dimensions of this experience that might not otherwise be apparent. As the quotation from Gendlin suggests, the participants' "experiencing of now" can only be understood in the context of past events. This literature review therefore is closely linked to aspects of the introductory chapter that traced the history of play programmes, and to the theoretical frameworks that have guided those programmes. My search to uncover meaning in "what is present", yet hidden, in the participants' experiences is intertwined, too, with my own history and my own experience of hospital play programmes.

Hospital play programmes in New Zealand have been greatly influenced by developments in North America and the United Kingdom. It is to these two countries that I have looked, therefore, for literature most relevant to the experience of novice hospital play specialists in this country. However, there is very little published literature directly relating to hospital play specialists as a professional group and almost all of it comes from child life in North America, rather than from the United Kingdom. I have not been able to find any research that is specific to the early months of employment. Nevertheless, I hope in this chapter to provide some breadth and depth to what I believe are the significant themes underlying the experience of new hospital play specialists in New Zealand. I also hope to

show some of the changes and challenges that are shaping the philosophical understandings and the practices of hospital play specialists in the experiencing of now.

Shifting understandings

Hospital play programmes are founded on a number of beliefs about children and child development, and about the role of play in development and in helping children master stressful events. Some of these beliefs, particularly those relating to the notion of a “universal child” who progresses through sequential stages to maturity, are so widespread in the western world that they have come to be seen as “truths” (Lambert & Clyde, 2000). However these beliefs are currently the subject of widespread debate, and this debate is influencing a gradual shift in previously accepted understandings. Woodhead, (1996, cited in Dahlberg et al, 1999) throws out a challenge in suggesting that:

.... much of what counts as knowledge and expertise about children is deeply problematic right down to such fundamental ideas as ‘early childhood development programme’... Those involved in early childhood development must recognise that many of their most cherished beliefs about what is best for children, are cultural constructions. (p. 162)

It may be that these challenges to generally accepted discourses are more directly relevant to hospital play specialists in New Zealand than in other countries because of their background in teaching and their responsibility for curriculum in licensed and chartered hospital early childhood services. They have an obligation to maintain up-to-date knowledge of current issues in education, in order to fulfil their responsibilities to the Ministry of Education. It is important, therefore, to outline some of the key debates and different understandings, as these may have an impact on how the role of the play specialist is seen by families, by staff from other disciplines, and by play specialists themselves.

Children and child development

Understandings of children and childhood in the early childhood literature are shifting (Dalli, 2002; Edwards, Gandini, & Forman, 1998; Moss, Dillon, & Statham, 2000; Woodrow, 1999). These shifts are important to understanding novice hospital play

specialists' experience because they are part of the discourses of early childhood education that may not have crossed over into healthcare. They may therefore contribute to differing understandings between hospital play specialists and their colleagues of what policies and practices are in the best interests of children.

Perhaps most important is the shift from a "deficit" model, to a "credit" model in the "image of the child", the way in which we construct our understandings of children and childhood. Rather than seeing children as essentially weak and needy, there is an increasing focus on their inherent strengths and social competence, and of the importance of attending to who they are now, as well as who they will become (Dahlberg et al., 1999; Hill, 2001; Moss & Petrie, 2002). Dahlberg (Dahlberg et al., 1999) suggests that the image we have of children has a widespread yet often unacknowledged influence:

The constructions we have made of the child have enormous consequences for how we relate to children pedagogically, how we design and choreograph the milieu as well as how we relate to parents. If we have got a rich child in front of us instead of a problem child this influences everything. It functions as a language that in itself becomes productive. (p. 137)

Contemporary writers are making visible the implicit and explicit power relationships that are inherent in the assumption that children are weak and powerless, linking images of the child to adults' decisions about what is "normal" development, what is "best" for children, and what children need to know (Canella, 1997).

There are shifts in understanding, too, from seeing children's development as a staged and universal process, to what Rogoff (2003) calls "development as transformation of participation in sociocultural activity" (p. 52). Until recently, developmental psychology has dominated beliefs and expectations about children, and about the nature and quality of services for children, especially in the United States. The work of Jean Piaget, in particular has been hugely influential in the assumption that children's development is a linear movement along a biologically determined sequence of stages. More recently, Piaget's theories have been challenged and expanded to incorporate the work of Vygotsky and others (Berk & Winsler, 1995). This newer socio-cultural constructivist understanding views children as active co-constructors of knowledge and meaning, in relationship with

others, and in particular social and cultural contexts (Dahlberg et al., 1999; Dockett & Fleer, 2002; Lambert & Clyde, 2000). Dahlberg (1999) explains the argument against the universality of developmental stages, as follows:

Child development has offered, as certain and objective truth, the individual's process through universal developmental stages, a 'grand narrative' that has done much to produce the constructions of young children and early childhood institutions discussed... as well as criteria for definitions of quality in these institutions. Both the discourses of child development and of quality adopt a decontextualized approach or, at best, attempt to bring 'context' in as an explanatory variable, divorcing the child and the institution from concrete experience, everyday life, the complexities of culture, the importance of situation. (p. 100)

As a result of this shift to a constructivist framework, the concept "developmentally appropriate practice" has all but disappeared from the language of early childhood education in New Zealand, but not in the United States. The New Zealand early childhood curriculum is founded on a socio-cultural constructivist approach (Nuttall, 2003a). It emphasises:

The critical role of socially and culturally mediated learning and of reciprocal and responsive relationships for children with people, places, and things. Children learn through collaboration with adults and peers, through guided participation and observation of others, as well as through individual exploration and reflection. (Ministry of Education, 1996, p. 9)

The focus is on fostering life-long dispositions for learning, rather than particular skills (Carr, 2001; Lambert & Clyde, 2000), and this changed focus is affecting planning and assessment for children's learning.

Development and assessment

Socio-cultural constructivist understandings of children and of child development are altering assessment practices (Hill, 2001; Te One, 2003). There are moves away from quantifying achievement in terms of scores or ratings to a more dynamic and flexible process based not on what children cannot do but rather on "what they can do, independently, with assistance, and in different kinds of social contexts" (Edwards et al., 1998, p. 252). This is so for all children, including those with special needs (MacArthur, Purdue & Ballard, 2003).

Nursing and special education texts also increasingly consider individual differences and the impact of family, culture and experience. However it is still quite common in both the special education and nursing literature to see lists of prescribed abilities at particular ages (Linder, 1993; Wong, 1999). Such expectations assume previous experiences and developmental goals that may be based on a particular socio-cultural viewpoint, for example, the expectation that a child of 18 months is able to “manage a spoon without rotation” (Wong, 1999, p. 674).

It is my experience that most hospital play specialists in New Zealand, influenced by socio-constructivist understandings, resist requests to undertake formal developmental assessments of children in hospital. They are cautious about undertaking assessments of *children who are unwell* and in an unfamiliar setting, fearing that such assessment may portray children in a deficit model, creating a “label” that might be unduly influential on their future. My anecdotal views are supported by a recent qualitative study of the documentation carried out by six New Zealand hospital play specialists (Blanch, 2004). However, this is not, of course, to suggest that they do not accept the importance of assessment of children’s changed abilities following injury or illness, as a basis for planning treatment or rehabilitation.

For the hospital play specialist, differing understandings between education and health professionals about the nature of children and child development, and the purpose or methods of assessment, may be difficult to reconcile. These different understandings may carry through, too, to professionals’ attitudes to play.

Beliefs about play

As was shown in chapter one, there is general agreement in the early childhood literature about the universality and fundamental importance of play. Interestingly, the Concise Oxford Dictionary definitions of play, while numerous, do not include the definitions that might come from understandings of play as formulated by the early childhood theorists. Rather, play is defined as primarily recreational, frivolous and amusing, as well as in the sense of “playing up” or naughtiness (Allen, 1990, p. 913). These dictionary definitions arguably reflect a general public understanding of play as not serious and, therefore

perhaps, as not worthy of serious attention nor requiring involvement by adults with particular knowledge or skills. Relegation of play to an activity of childhood rather than a societal activity shared by all age groups is also believed by some writers to contribute to a view of play as “immature and childish” (Dockett & Fler, 2002, p. 107). To view play as an activity confined to childhood, that is primarily diversionary, pleasurable and free of constraints, is to ignore the power adults have in providing early childhood environments and determining when, where and how children play. Adults’ beliefs about their role in providing for children’s play and early learning, relate closely to their understandings of play and their beliefs about its value to children. These understandings are culturally constructed, yet the connections between adults’ values and practice may be hidden (Dockett & Fler, 2002; Lambert & Clyde, 2000).

Views of the adult role in early childhood education and play as quasi-parental are linked in the literature to a perception that early childhood teaching is undervalued in comparison to other areas of education (Dahlberg et al., 1999; Dalli, 2002b; Krigg, 2000; Moss & Petrie, 2002; Rubin, 1992). Even amongst early childhood teachers themselves, it seems there may not be a clearly articulated understanding of the difference between being a teacher and being a “carer” or substitute parent. A small qualitative study involving New Zealand early childhood teachers (Dalli, 2002a) suggests that, “the perceived affinity of early childhood work with mothering, and therefore also with women’s work, may be a primary reason why early childhood work has retained the status of a poor relation within the educational professions” (pp. 73-74)”. Dalli suggests that “society is not yet accustomed to the idea that early childhood teaching is a specialist area of educational work” (p. 83). In the international context, too, the “parenting” model is seen as sustaining an assumption that almost anyone can work with children with minimal preparation (Moss & Petrie, 1997; Rubin, 1992).

Somewhat ambivalent views about play show through in the development of the child life profession in North America. In 1980, the child life profession adopted the name ‘child life’ in recognition that the role encompassed more than play. A paper by Rubin (1992) explores the gender and political issues behind the decision to leave the word “play” out of the title. She relates this decision to child life specialists’ concerns at that time about the potential stigma associated with the legacy of volunteerism, the “play lady” name, and the

generally low status, lack of skills and low pay of early childhood workers. Rubin comments on the debate that ensued as follows:

... how a profession refers to itself and is referred to by others has many ramifications. How a field constructs a narrative about its own history, by using language to convey its theoretical underpinnings or its standards or practice, is a highly selective activity. Whose voices will be heard? What kinds of controversy will be welcomed? Naming provides a powerful lens through which a profession can project a self-image and establish credibility. Naming inevitably shapes social discourse about the nature of the ideas, emotions, actions, and relationships that are considered relevant to a profession. (p. 5)

Rubin raises what she sees as the contradiction implied by a profession that deeply believes play to be at the heart of their work, and yet omits play from their title and sometimes from job descriptions. By avoiding the word “play”, Rubin (1992) suggests that “child life specialists may feel as though it is imperative that they disguise a central facet of their work, paradoxically perpetuating the very invisibility that keeps child life unknown and undervalued” (p. 10). In New Zealand, I remember a similar debate, with similar concerns expressed about connotations associated with the term “play”. However, by 1993 there was general agreement to adopt the British title of hospital play specialist (Hospital Play Specialists Assn of Aotearoa/New Zealand, 2004).

Diverse views on play and its importance have been identified within New Zealand hospitals in McKinlay’s presentation (McKinlay, 1983) to the 3rd Early Childhood Convention, although this study is more than twenty years old so may or may not reflect the current situation. McKinlay described three “models” of play held by hospital staff (including hospital play staff) at that time: diversionary, educational and therapeutic. The first equated with the “substitute mother” model: staff of such programmes were not viewed as having (or needing) any professional qualifications or skills. The second equated to more of an early childhood education concept, where staff should have a relevant qualification but were not seen as having a contribution to make to healthcare outcomes for children, so were not viewed as intrinsically part of paediatric teams. McKinlay gave strong support to the third, therapeutic model, where play was seen as mediating between the child and all aspects of the healthcare experience. Professional training and an interdisciplinary approach was believed by McKinlay to be essential.

In the early 80s, the therapeutic model of hospital play was in place in only two or three New Zealand hospitals, and staffing levels made effective programme provision impossible (McKinlay, 1983). Concerns about being seen by other staff as “just a play lady” were common in my 1998 study (Kayes, 1998) and participants rated their professional knowledge and skills as the aspect of their programmes least valued by nurses and medical staff.

More fundamentally, the notion that play is universal, as conceptualised by western writers, is being challenged in contemporary early childhood writing. There are suggestions that insufficient account has been taken of cross-cultural variations in when and how children play (Dahlberg et al., 1999; Dockett & Fleer, 2002; Rogoff, 2003). Challenges are also being made to the role of adults in providing for play, and their power to influence the direction of children’s play or to take it over completely. Canella (1997) is particularly critical of what she sees as the construction of play as a Euro-American, middle-class concept, in which adults decide what is best for children:

Play has been considered a central tenet of child-centered pedagogy because it has been constructed as what is “natural” for children. The “naturalness” of play results in the perfect construct for use in education at home and school, intervention, evaluation, and therapy. We allow children to play; we encourage them; at times, we even teach them to play. We judge whether the type of play is normal for a particular age group, productive or cognitive or social growth, advanced, beneficial or even therapeutic. (Canella, 1997, p. 124)

These views clearly pose challenges for hospital play specialists, whose professional identity is closely tied to a view of play, and of adult engagement in play, as fundamentally important to all children. At the very least, they provide a basis for critical reflection and debate on practice, particularly in relation to hospital play specialists’ work with children from cultural groups where adult engagement with children in play may be unfamiliar and even, possibly, unwelcome.

Finding a balance

In providing programmes that incorporate play for diverse purposes, New Zealand hospital play specialists must balance the therapeutic aspects of their work, with curriculum requirements, and with providing more direct support for healthcare experiences. The literature suggests that finding such a balance can create tensions between competing priorities.

Therapeutic play and early childhood education

New Zealand hospital play specialists working in services that incorporate licensed and chartered early childhood centres are responsible for providing a therapeutic and comprehensive play programme for all age groups. At the same time, they are required to implement early childhood curriculum goals for children from birth to school entry age. The incorporation of curriculum goals is unique to New Zealand hospital play programmes, so far as I can ascertain. It therefore constitutes an important area of difference between programmes here and the overseas child life programmes on which New Zealand programmes have been largely modelled.

The North American Child Life Council documents and teaching resources have been used extensively to guide the New Zealand Hospital Play Specialists Association (Hospital Play Specialists Assn of Aotearoa/New Zealand, 1999). The 2002 Child Life Council documents are strongly focused on therapeutic and coping goals. An understanding of developmental theories and assessment techniques is required, and the various documents acknowledge the role of play in children's learning. However, in contrast to expectations of New Zealand hospital play specialists who also have early childhood teaching responsibilities, the Child Life Council competencies do not specifically refer to the ability to enhance children's development and learning, except in relation to healthcare-related situations (Child Life Council, 2002).

It seems possible that there might be some contradictions for New Zealand hospital play specialists in incorporating curriculum goals for children into therapeutic play programmes (Kayes, 1999a). However, the holistic nature of the New Zealand early

childhood curriculum Te Whaariki (Ministry of Education, 1996), and its socio-cultural framework, arguably means that there are fewer inherent tensions than there might be with a more traditional skills and knowledge focused curriculum. There is considerable flexibility within the document for each service to “develop its own programmes to meet the needs of its children, their families, the specific setting, and the local community” (Ministry of Education, 1996, p. 27).

Play, preparation and procedural support

Another area where a balance must be found is in determining the relative time spent involved in play as opposed to psychological preparation and procedural support (Hicks, 2003). There is currently some debate on this in child life. One of the Child Life Council (Child Life Council, 2002) values statements reads:

Play is an essential, natural part of childhood, important in its own right. Play facilitates healing, coping, mastery, self-expression, creativity, achievement and learning, and is vital to a child’s optimal growth and development. Play is an integral aspect of child life practice with infants, children and youth of all ages. (p. 3)

Despite this, a number of presentations and informal discussion at the Child Life Council Conference that I attended in 2003, raised concerns that play was being overlooked, relegated to students and volunteers rather than being a key component of child life specialists’ work. Concerns were expressed, too, about whether or not child life students were receiving sufficient undergraduate academic preparation in play. One presentation suggested that:

With the emphasis of the child life profession focusing more and more on psychological preparations, procedural support, diagnostic teaching, and bedside interactions, one of the main clinical responsibilities of the certified child life specialist – play – is often overlooked. Child life professionals are constantly being pulled in what seems like 100 different directions..... All too often, when pressed for time, the playroom falls to the bottom of the “to do” list. (Brasher & Haluska, 2003)

If child life specialists’ time is increasingly spent on preparation and procedural support, this may be in response to demands by hospital managers and funders for cost effectiveness and cost savings (Bivins & O'Brien, 2002; Brown, 2000). Kleinberg (Kleinberg, 1987) warned in 1987 of the potential implications for child life services of

what she described as a change from “service oriented” to “cost-oriented” healthcare. These activities are quantifiable and their benefits can be costed out in dollar terms. For example, the cost benefits of a young child managing radiotherapy without the need for an anaesthetic are obvious, in saved time, saved theatre costs, saved staffing, and less risk to the child. Also, the child life specialist’s role is very visible to other staff. However, the benefits of “just playing” with a child are less immediately obvious to non-play staff, and the interactions may take place out of sight of the healthcare team.

I have not found indications that obtaining this balance is such an issue for the profession in the United Kingdom, which seems to have a stronger foundation of play as the primary focus for their work. However, apart from the National Association of Hospital Play Staff Journal, there is very little published material available from hospital play specialists in the United Kingdom. Differences in healthcare systems, and public funding versus private insurance funding, may also drive differences between the United Kingdom and North America. New Zealand play programmes are unique in that they receive funding from both Health and Education. It seems that the professional wellbeing of novice hospital play specialists in New Zealand may be linked to their need to find a balance between different aspects of the role, and between the differing accountability requirements of Health and Education.

Professional wellbeing

New hospital play specialists find themselves in the unfamiliar world of a hospital, one that is both a changed physical environment as well as a different world in phenomenological terms. Leonard (1994) describes “world”, in this sense, as “the meaningful set of relationships, practices, and language that we have by virtue of being born into a culture” (p. 46). Novice play specialists have not been born, professionally, in the world of a hospital. Rather, their professional roots are in the very different world of early childhood teaching. Their transition to working in hospitals is therefore one that involves many changes. In contrast to the wealth of professional literature on hospitalisation of children, there is very little published research on professional or workplace issues affecting the wellbeing of hospital play specialists, and almost none in New Zealand. Much of the literature that does exist emanates from the 1980s, so is now

rather old. Nevertheless, it may be relevant to the present stage of development of New Zealand hospital play programmes, in view of their more recent emergence. The next section explores the available literature, which groups into four broad areas: workplace and resources; inter-professional relationships; emotional labour, stress and burnout; professional support and development.

Workplace and resources

Thompson (Thompson & Stanford, 1981), suggests a hospital is a “labyrinthine institution, as intricate in its organizational structure as in its architectural design” (p. 163). Accordingly, he suggest that the experience of child life specialists, and their ability to effect change, may be affected by organisational factors such as the type and size of hospital, and by how well resourced the service is. Thompson proposes that staff of a designated paediatric hospital can be assumed to have some paediatric training and experience, whereas there may be less awareness of the developmental needs of children by staff of small paediatric units within general hospitals. Hence, child life specialists in a small unit may find it more difficult to influence practices or to have input to the environment, especially where children are cared for in mixed adult-child units. With reference to the implementation of new child life services, Thompson suggests that some resistance by other disciplines is probably to be expected as a common response to the introduction of anything unfamiliar, and may not therefore signify any objection to child life specifically.

Workplace differences, such as those identified by Thompson (1981), and workload, are also identified as variables in a literature review of workplace stress in nursing (McVicar, 2003). With regard to workload, international standards recommend a hospital play specialist to paediatric inpatient bed ratio of between 1:10 (Hogg, 1990), and 1:15 to 1:20 (American Academy of Pediatrics, 2000), with lower ratios under particular circumstances, for example where there are large numbers of infants and toddlers, or where children are confined to bed. Additional staffing is recommended to cover areas such as outpatient clinics and emergency departments. Presumably there may be considerable variations on these recommended levels in practice. In New Zealand, ratios of hospital play specialists to inpatient beds vary enormously, from about 1:5 to 1:56

[Kayes, 1999; Paediatric Society of NZ unpublished survey, 2004]. Only one or two hospitals currently have routine weekend and evening cover. There are suggestions, too, that some New Zealand services are under-resourced and largely reliant on grants and donations from community organisations in order to obtain play resources, so fund-raising may add to workloads (Kayes, 1999a; McDonald, 2000)]. Surprisingly, however, Holloway and Wallinga (1990) found a negative correlation between workload and burnout in child life specialists, suggesting that child life specialists may simply “accept that they are unable to care for all children in the hospital” (p. 17).

In addition to workload, Hall and Cleary (1988) identify other workplace issues in a paper summarising the development of play programmes in British and European hospitals. They comment on problems associated with deficiencies in role clarification, communication, support, organisational structure, finance, continuity and proof of effectiveness. Hall and Cleary draw attention to “boundary problems as to what is in the scope, competence, and area of action of the play worker, and what belongs to others” (p. 228). They consider that support of ward staff, not only administrators, is essential if play programmes are to be any more than a “tolerated activity”. They also mention the potential for problems where tying salaries for play leaders to external organisational scales, as in education, may cause “invidious comparisons” between teaching and nursing salaries. In view of continual changes in medical and nursing personnel, they suggest that “re-education of staff into the ethos of play must be an ongoing activity and not a once and for all occasion” (Hall & Cleary, 1988, p. 229).

Inter-professional relationships

I have located only two research studies, both North American, which specifically examine the relationships between child life specialists and their colleagues. These shed further light on issues of role clarity that have been previously discussed. A rather old survey of 945 nurses, social workers, doctors and child life professionals (Gaynard, 1985, cited in Cole, Diener, Wright, & Gaynard, 2001), found a number of important differences in perceptions of the child life role. For instance, child life specialists perceived contributing to the healthcare team as a primary role, but this was barely mentioned by nurses and physicians. Nursing and medical staff mentioned amusing and entertaining

children as a primary role of child life, but child life specialists did not see themselves in this role.

A more recent, partial replication of the Gaynard study (W. Cole et al., 2001), involved 228 health care professionals from a 232-bed children's hospital with a well-established child life programme. Participants were drawn from child life, administration, social work, nursing and medicine. This study found that child life specialists were ranked highly by their colleagues in terms of their importance to the psychosocial wellbeing of patients, but low in terms of influence and power. It also found a number of discrepancies between child life specialists and healthcare team members in understanding of their role, for example, the extent of child life provision of amusement and entertainment, responsibilities for maintaining development and support for patients and families. However, there was agreement that psychological preparation for procedures was a part of child life responsibilities. The authors suggest that health care professionals' lack of knowledge about play may mean that they fail to recognise that activities are part of a planned programme to enhance development and mastery, assuming a merely entertainment function. Like Hall and Cleary (1988), they recommend that child life specialists undertake more education of other health professionals regarding the various aspects of their role.

The participants in my 1998 New Zealand study (Kayes, 1998) also felt that their role was often poorly understood by their colleagues. However, as only hospital play specialists were surveyed, and not other healthcare professionals, no data is available to verify or disprove their perceptions.

A small observational study by Gaynard, Hausslein and DeMarsh (1989) of five child life specialists in four different hospitals points to possible reasons for the findings of discrepancies between child life professionals' views of their role, and that of their healthcare colleagues. Participants were primarily engaged in direct patient interactions. They spent very little time in contact with other health professionals, primarily nurses, or in documentation of patient care. Interestingly, of the seventeen percent of administrative time spent on documentation, only one percent was spent in charting in patient notes. The authors comment:

It appears from the current study that the actual amount of documentation of child life work that takes place in hospitals, on an interdisciplinary level, is almost nonexistent (1%). This lack of communication with other health team members may significantly affect the view of child life specialists held by fellow health care professionals and the care and assessment of child patients. (p. 80)

Gaynard's study is more than a decade old and the situation may well have changed. Prior to commencing work, new hospital play specialists in New Zealand may not have had opportunities to participate in well-functioning multidisciplinary teams, even if they have worked in early childhood centres inclusive of children with disabilities (MacArthur et al., 2003). Most of the hospital play specialists I surveyed in 1998 attended interdisciplinary ward meetings but twenty percent reported that they seldom or never attended, and more than half never attended specialist team meetings or case conferences. Only a third documented frequently in patient notes and a further third said that they never documented their interventions (Kayes, 1998). My study was conducted by questionnaire, not through observation of actual practice, and its accuracy therefore relies on participants' estimates of what they do. Again, this study is now five years old and there is some evidence pointing to changed practices, at least to some extent. For instance, all the participants in Blanch's 2004 study of assessment practices by six hospital play specialists in New Zealand reported that they did regularly document in clinical notes. However, most of their documentation was retained for their own records, and not seen by others (Blanch, 2004).

New Zealand hospital play specialists are also required to document children's learning and to carry out other administrative tasks for the Ministry of Education. It seems likely that these tasks could erode the time available for documentation in patient notes. Failure to participate regularly or fully in activities that are key to interdisciplinary communication, may contribute to invisibility within the ward teams and therefore have an impact on professional wellbeing.

Emotional labour, stress and burnout

In contrast to the limited literature addressing the experiences of hospital play specialists, there is a large body of literature on professional wellbeing, stress and burnout in health

professionals and the effects of working over long periods with sick children and their families. Issues of “compassion fatigue” and “secondary traumatic stress” have been widely identified in nursing and medical staff and to some extent in other health professionals (Badger, 2001; Catlin, 2004; McVicar, 2003; Omdahl & O'Donnell, 1999; Romesberg, 2004). The “emotional labour” involved in coping with experiences of grief, fear and anxiety have also been identified by a number of writers as a threat to the professional wellbeing of child life specialists (Bolig, 1982; Holloway & Wallinga, 1990; Leff, Chan, & Walizer, 1991; Munn, Barber, & Fritz, 1996). However, the ability of professionals to show empathetic concern and communicative responsiveness has been shown to be negatively associated with burnout (Omdahl & O'Donnell, 1999).

Burnout in child life specialists has been explored by Holloway and Wallinga (1990). They undertook a study of 104 child life specialists to determine if there is a relationship between burnout in full-time child life specialists and role stress. Role stress has two components: role ambiguity, where the role occupant lacks sufficient information to adequately perform the role; and role conflict, where role demands are inconsistent with the professional's abilities, goals, values and/or beliefs. Generally, burnout was low, but this might be explained because there was a mean of only three years employment in the profession. Role ambiguity was a stronger predictor of burnout than role conflict, and organisational variables were more significant than were individual variables. Perceived adequacy of salary in relation to stress experience was a significant predictor of burnout and perceived ability to fulfil the demands of the job was a predictor for emotional exhaustion. Lack of clarity concerning work role expectation was a primary factor negatively affecting professional wellbeing. The authors comment that “there may be a lack of uniform role expectations throughout the child life programs nationally” (p. 16) and that this might contribute to child life specialists' struggle for a cohesive personal and professional identity.

Subsequent research by Munn, Barber and Fritz (1996) surveyed 156 child life specialists to test a conceptual model depicting predictors of three measures of professional wellbeing in child life specialists: burnout, job dissatisfaction and intentions to leave a job. Consistent with Holloway and Wallinga (1990), role stress, especially role ambiguity, was the best predictor of burnout and job dissatisfaction. However, role ambiguity was much

greater in the Munn study. Munn suggests this might be accounted for by changes resulting from healthcare restructuring, and consequent uncertainty about the child life role. Supervisor support was found to be particularly important for those who had been in the field for less than five years, and lack of supervisor support was the best predictor for job dissatisfaction and intentions to leave a job. The writers called for more attention to workplace stress levels, more detailed job descriptions, and the use of clinical pathways to more clearly define the responsibilities of each team member in specific situations.

In the New Zealand context, Webster (2004) describes issues in working with sick children and their families that she believes to be specific to the hospital play specialist role. Her unpublished presentation to the 2004 Hospital Play Specialists' Association conference, draws on her experience in working closely with a team of New Zealand hospital play specialists and providing them with regular team supervision. She suggests that there are aspects of the play specialists' role that distinguish them from other healthcare professionals. Hospital play specialists focus on the emotional world of children, rather than on particular tasks. They are involved in helping children manage painful or invasive procedures yet have little control over how these procedures are arranged or performed. As well, they may be asked to "fix" child distress or non-compliance that are the outcome of far wider systemic issues. Webster also draws attention to the likelihood that play specialists' previous experience will not have prepared them to understand the hospital world, yet families will expect hospital play specialists to "translate" this world for them. Power relationships, hierarchies, devaluation of their input, and unrealistic expectations of the hospital play specialist are identified in the paper as factors making it challenging for play specialists to integrate into multidisciplinary teams. Webster suggests a number of strategies to assist wellbeing: team and management acknowledgement of the intrinsic difficulties of the work; clarification of roles and boundaries within multidisciplinary teams; a team culture that enables expression of emotions; team training; cognitive strategies for dealing with irrational thinking; back up for work related risks; attention to self care; awareness of times of increased personal vulnerability; and processes and rituals for making the transition from work to home.

Webster also links the professional wellbeing of hospital play specialists to changing trends in healthcare for children (Webster, 2004). Changes in New Zealand mirror those

overseas. For example, improvements in diagnosis and treatment, and earlier discharge, may mean that children are commonly more acutely ill when they are hospitalised than was previously the case (Kleinberg, 1987; Mitchell, 2001; National Health Committee, 1998; Percival, 1999). This may have an impact on the emotional content of the work of hospital play specialists (Leff et al., 1991). Reductions in average length of stay may reduce the time available for hospital play specialists to build relationships with children and families or to provide preparation in advance of procedures. It is my experience that data on average length of stay may mask the reality that repeated admissions and/or extended admissions of several months' duration are not uncommon for young children with complex healthcare or other special needs. There may be very different lengths of stay between, say, a medical specialities unit, such as oncology, and a general medical ward, making it difficult to generalise. There are suggestions in the literature, and also anecdotally, that changes in admission patterns are leading to provision of hospital play specialist care in other settings, such as community outpatient clinics and in the home (Kleinberg, 1987).

Professional support and development

During the early 1980s, Bolig (1982) proposed a model for supporting the professional growth of child life specialists. This paper, while over 20 years old, may nevertheless have relevance to the professional growth of New Zealand hospital play specialists. She suggested that:

For child life workers, the aspects of the role that are potentially most challenging and fulfilling – working in a multidisciplinary setting, working with children of all ages and their families, working for the “whole” child – may also be the most frustrating. (p. 94)

To Bolig, lack of recognition of the needs of child life specialists, by themselves and by administrators, and lack of appropriate training and support might be significant contributors to turnover. She proposed a four-phase framework for supporting the development of child life specialists, based on models proposed by Erikson and Katz, and suggested that each phase might last around a year for a practitioner with no previous experience in hospitals. The first phase, trust, is a time when existing knowledge must be adapted and new learning acquired. Bolig saw this as a critical period for development of

professional identity, one in which child life specialists must define their own role, with the support of other child life specialists. Otherwise, “child life workers may become socialized by those in other disciplines with whom they have day-to-day contact and whose approval they need most often to carry out their tasks and responsibilities” (p. 95). Provision of specific, concrete information as well as non-critical mentoring and feedback are suggested as part of essential support. The second phase, autonomy, is characterised by a sense of competence (“I’m okay”), a focus on quality improvement, a search for recognition as professionals and inclusion in the multidisciplinary team, and a desire to share knowledge with other professionals. The third, initiative, is a time when basic skills have been mastered and child life workers may look for new challenges outside of their role within the hospital or new ways to contribute. Lastly, phase four sees the emergence of greater reflection and debate, where individuals may become engaged in research and activities such as supervision and training of others.

Bolig’s paper sets individual professional growth within a wider framework of the maturity of the programme in which child life specialists are working. She considers that programmes pass through similar stages to that of individuals, influenced by the length of time the programme has been in place, the qualifications, experience and length of employment of the staff, background of the administrators, and funding levels because funding provides evidence of institutional support. Programmes with few staff or a high turnover of staff may find it difficult to consolidate and to articulate their function and philosophy. Bolig characterises a mature programme as one that is fully integrated into the functions of the hospital, a separate department equal to others, with articulated and distinct goals. An established programme is able to address time and energy on research, advocacy, and support for other programmes.

One important source of support identified in the literature on nursing and other professional groups is the availability of mentoring or preceptoring programmes (Cooper, 1990; Mattsson & Mattsson, 1994). Bain (1996) talks of the “reality shock” for newly qualified nurses, and the need for around four months’ guidance by a preceptor to help new nurses achieve confidence. The education literature also supports the importance of ongoing supervision, professional support and critical self-reflection (Butler, 1996; Fenichel, 1992; Guskey, 2002; J. Hill, Hawk, & Taylor, 2002). New Zealand teachers

must undertake a two year supervised advice and support programme in order to become registered. However, in my experience, whilst hospital play specialists do have access to professional development support, only some are provided with preceptoring and/or professional supervision by their employing hospitals.

What is missing from the literature?

In my exploration of research relevant to the themes and sub-themes that emerge from this study, I have found a vast literature relating to play, to the importance of comprehensive play and preparation programmes for children in hospital, to professionalism, to inter-professional relationships in healthcare, to workplace stress, and to emotional contagion and burnout in healthcare professionals. There is also a growing body of writing, influenced by socio-cultural and critical perspectives, that is challenging all those involved with children to examine their professional practice in the light of the underlying assumptions *they reflect about children and childhood*.

In contrast, there is a fairly small body of research relating specifically to hospital play specialists. What does exist relates largely to the North American context, and much is twenty or more years old. I have found some studies relating specifically to professional aspects of the hospital play specialist role, but none that explore the experience of novice practitioners. I have looked in vain for published research in this area that has been undertaken elsewhere than the United States. I have also looked in vain within the published literature for the voices of hospital play specialists themselves.

Summary

In this chapter I have explored the research literature relating to the context in which participants in this study live their professional day-to-day lives. This context is a changing one. It is shaped by what has gone before, as revealed in the previous chapter. As well, it continues to be influenced by ongoing shifts in theoretical approaches, in health care practices, and in understandings about play, about children, and about ways of being a professional in relationship with children and with others.

The available literature shows some tensions for hospital play specialists in how they balance their time and their priorities between supporting free-flow play, the educational aspects of their role, and the more medically focused aspects of preparation and procedural support. Lack of clarification about the parameters of the role, together with the differing understandings of play that may be held by hospital play specialists and their healthcare colleagues, can contribute to stress. There are suggestions that hospital play specialists do not routinely participate in communication systems established in hospitals. If so, this too may contribute to misunderstandings about the contribution they make to healthcare teams.

As well as these commonalities, it seems some significant differences may be emerging between New Zealand hospital play specialists and their counterparts elsewhere. Dual accountability to both Health and Education, sets them apart from Australian programmes, their closest geographically, as well as from those in North America and the United Kingdom. Differing priorities given to play, early childhood education, and psychological preparation, between New Zealand programmes and those elsewhere may be uniquely shaping the profession in New Zealand. Alternatively, it may be that New Zealand programmes are following a similar pathway of development to those in North America, but are simply not yet as established.

Having explored the professional context of this study, the following chapter looks at the underpinning philosophical approach, the study design and the methodology.

CHAPTER THREE - METHODOLOGY

The Craft of Thinking

Everything here is the path of a responding that examines as it listens. Any path always risks going astray, leading astray. To follow such paths takes practice in going. Practice needs craft. Stay on the path, in genuine need, and learn the craft of thinking, unswerving, yet erring.

Heidegger, 1971, p. 186

Introduction

This chapter traces the research pathway that “examines as it listens”, the path I have followed in exploring the experience of novice hospital play specialists. The chapter positions me, as researcher, in relation to the study. It shows my own “practice in going” along the path to learning the craft of thinking. I describe the philosophical approach I have taken and some of the important notions that link to this approach. My own context of shared professional background and ongoing involvement with at least some of the participants, was touched on in chapter one. This chapter will focus in more depth on the presuppositions that I brought to interviewing the participants. This chapter also describes the research process itself: how the participants were accessed, how their stories were gathered and analysed, and the ethical issues involved. Finally, I explore the trustworthiness of this study.

Philosophical approach

This study is situated within the human sciences, that is, its focus is on the understanding of human experience. I have been guided in my approach to this research by hermeneutic phenomenology, informed by the work of philosophers and scholars such as Heidegger (1996), Gadamer (1989) and van Manen (1990). Phenomenology is critical of forms of objectivism that pay attention only to what is apparent and not to how this is experienced by the subject, and instead “seeks to restore the richness of the world as experienced” (Moran & Mooney, 2002, p. 2). When I ask, “What is the meaning of the experience of novice hospital play specialists in their early months of employment?” it is this richness of

experience that I trying to illustrate. I am seeking to go behind their descriptions of experience in order to better understand what it is like to “be” in the world of a hospital, what it is to “be” in a new profession.

Van Manen (1990) suggests that phenomenological research has no method, and that the important starting point for a study of this kind is the questions asked and the way that those questions are understood, rather than with the methodology itself. This study has its beginnings in my own practice as a hospital play specialist, and emerges from the questions I have asked about what this experience is like for others. My curiosity led me to seek a methodological approach that offered the possibility of plausible insights into the lived experience of others and, hence, to hermeneutic phenomenology. As van Manen (1990), puts it:

[... the author recognizes] that one’s own experiences are the possible experiences of others and also that the experiences of others are the possible experiences of oneself. Phenomenology always addresses any phenomenon as a *possible human experience*. It is in this sense that phenomenological descriptions have a universal (intersubjective) character. (pp. 57-58)

A phenomenological approach seeks to reveal the nature of the phenomenon, “to transform lived experience into a textual expression of its essence” (van Manen, 1990, p. 36). A phenomenon, according to Heidegger, is what announces itself to us through the appearance of something that is observable or somehow knowable. It signifies “that which shows itself, the manifest (Heidegger, 1962, in Moran & Mooney, 2002, p. 279). Heidegger cautions, however, that a phenomenon may make itself known by something that does not show, an example being the symptoms of an illness, where the symptoms are manifest but the illness is underlying. A study of human experience therefore seeks to uncover what may be hidden in some way, either because it is undiscovered or because it is so familiar and so much a part of our everyday lived experience, our being-in-the-world, that we do not notice it.

From a phenomenological viewpoint, each of us is essentially situated in a world that is “both constituted by and constitutive of the self” (Leonard, 1994, p. 47). We are “thrown” in Heideggerian terms, into a particular historical, cultural and familial world that is interconnected across time with our past, present and future experiences (Grenz, 1966).

Heidegger tells us that our being-in-the world is so much a part of us that we may not see the ways in which our taken-for-granted language, skills, attitudes, values and practices influence the meaning we make of experiences we have. In turn, the meaning we make of events shapes our lived reality. Another aspect of our being-in-the-world, is that particular things and activities have significance for us and matter to us. However, what we care for and what concerns us will be different depending upon our culture, language and individual experience. We interpret events in ways that make sense to us within our linguistic and cultural conditions, yet the meaning of experiences may be hidden to us. So, to understand a person, or the meaning to them of an experience, we endeavour to see that person in the context of their particular context and understandings (Leonard, 1994).

Gadamer (1989) builds on Heidegger's notions of "being-in-the-world", drawing our attention to the essentially interpretive, hermeneutic, nature of human experience. A hermeneutic phenomenological approach is both systematic and interpretive (Grenz, 1966). It challenges the idea that the researcher's own experiences should be "bracketed" or suspended in order to study the essential nature of a phenomenon, as suggested by Husserl (2002). Instead, it recognises that all understanding inevitably involves some prejudice, or pre-understanding, asserting that what should be aimed for is freedom from undisclosed prejudice (Polit, Beck, & Hungler, 2001). Gadamer tells us that "the important thing is to be aware of one's own bias, so that the text can present itself in all its otherness and thus assert its own truth against one's own fore-meanings" (Gadamer, 1989, in Moran & Mooney, 2002, p. 316). Accordingly, it is recognised that the "facts" recounted in the stories of the participants in my study will to some degree be a reflection upon their experience as it was lived at the time, filtered through their historical being. Their stories will inevitably, therefore, entail a process of interpretation (van Manen, 1990). In turn, as researcher, I cannot be "neutral" as I bring to the research my own pre-assumptions of possible meaning. I have a responsibility, therefore, to maintain a watchfulness throughout the research process, monitoring how my own understandings and experiences may influence my interpretations of the lived experiences of others.

Lived experience

The term “lived experience” is at the core of the philosophy of phenomenology. It refers to the experiences that individuals have within their own lifeworld, the world of their immediate experiences and what seems real to them. Van Manen (1990) suggests that “phenomenological human science begins in lived experience and eventually turns back to it” (p. 35). All reflection on experience involves some interpretation and the giving of meaning, although this is not a conscious act. In turn, the meaning given to past events shapes a person’s reality and their interpretation of future events. Research using a hermeneutic phenomenological approach seeks to uncover the deeper levels of understanding that may lie hidden beneath people’s day-to-day lives, or to understand their experience in a different way (Gadamer, 1989; Smythe, 1996).

Lifeworld existentials

Van Manen identifies four “existentials” that he sees as pervading the lifeworlds of all people, regardless of “historical, cultural or social situatedness” (van Manen, 1990, p. 101). They are intricately connected and cannot be separated, yet they may be differentiated. “Lived space” (spatiality) is the effect on us of the spaces we inhabit, such as our work environment, as distinguished from “mathematical space”, which is space that may be measured. “Lived body” (corporeality) refers to the ways in which we reveal ourselves to each other through our bodily responses. Examples of this can be seen in participants’ stories of working under the gaze of others. “Lived other” (relationality) is the way in which we experience our inter-personal relationships, relationships that have the power to have both a positive and negative impact. “Lived time” (temporality) refers to our experience of time, as compared with time measured on a clock or a calendar, including our temporal landscape of past, present and future. Temporality shows in the way that time seems to the participants to both speed up and slow down in the hospital setting. It shows, too, in participants’ changing understandings of their role.

The hermeneutic circle

A theme central to phenomenology is the idea of what Dilthey terms “the hermeneutic circle” (Grenz, 1966, p. 101). This idea relates to the complex weaving of the relationship

between the parts of a whole and the whole itself. In understanding the whole we must look to an understanding of the parts, and yet the parts can only be fully understood when seen together as a whole. In referring to our understanding of experiences, Gadamer says that “every experience is taken out of the continuity of life and at the same time related to the whole of one’s life” (cited in Smythe, 1996, p. 11). While the hermeneutic circle is ever-changing and stands in the way of certainty, deeper understanding may be reached by progressively moving backwards and forwards between different layers of meaning, each contributing to the next level of discovery. It is a kind of circling between presumptions and new and surprising understandings (Moran & Mooney, 2002). In this study the hermeneutic circle shows in the connectedness between historical and philosophical underpinnings of hospital play programmes, and the present-day context of hospital play specialists. It shows, too, in the links between individual stories and broader themes and sub-themes, and in the ways in which my discovery of the broader themes in turn illuminate individual stories. My own understanding, my “path of responding”, is intertwined in complex ways with the stories and with my deepening understanding of their meaning, throughout the listening, writing, reflection and re-writing process that constitutes this study.

Why this methodology?

The purpose of this study was to better understand the lived experience of novice hospital play specialists. Other researchers have provided some useful quantitative information on aspects of the work of this professional group, but their approach does not enable the reader to “see” what the experiences are like for the participants. I am not aware of other studies of hospital play specialists underpinned by phenomenology. However, a phenomenological approach is increasingly being used in similar studies seeking a better understanding of aspects of the experiences of healthcare professionals and those they work with (Paddy, 2000). As well, hospital play specialists use narrative, and narrative approaches, in assessment and in their endeavours to work more thoughtfully and responsively with children (Freeman, Epston, & Lobovits, 1997; Kayes, 1991; Kayes & Mackay, 2003; Petrillo & Sanger, 1980). In the education literature, too, there is a focus on narrative, on the experiences of both teachers and children, and on the making of meaning through enabling the voices of children and teachers to show through. This socio-

cultural constructivist approach to understanding children is founded in the critical importance of language and relationships (Carr, 2001; Hedges & Gibbs, 2001; Koch, 1998; Ministry of Education, 1996; Nuttall, 2003b). Thus, while there is no tradition of phenomenological studies within the discipline of hospital play specialists, its choice for this study is not without precedent.

A phenomenological approach was merited too by my wish to enable the individual voices of the participants in my study to emerge vividly for the reader, in the context of their work settings and day-to-day professional lives. At the same time, by exploring what mattered to them about their experiences as novice hospital play specialists, I sought to discover underlying commonalities of meaning that might provide insights for others. An interpretive methodology, informed by hermeneutic phenomenology, was therefore well suited to this study. It also fits with the wider philosophical and theoretical framework within which hospital play specialists are working (McIntosh, 2000).

Explicating my own assumptions

As previously discussed, in taking a hermeneutic phenomenological approach, it was important that I bring my own “fore-meanings” to the surface, making them visible. It was important therefore that I paid attention to my own understandings and expectations of what the stories might reveal, before I began the process of analysis of the participants’ stories. Van Manen cautions that there is a risk when undertaking phenomenological research that our everyday “common sense”, our own experiences and our professional knowledge, may prevent us from truly seeing the meaning of the experiences of others. Because it is impossible to ignore or disregard what we already know, it is better to acknowledge our presuppositions, beliefs and assumptions and bring them to the open so that they can be recognised (Husserl, 2002; van Manen, 1990).

This was a challenge for me as a researcher, in view of my shared professional background with the participants and my ongoing contact with some of them, and also in view of having done some previous research in a similar area (Kayes, 1998). Before commencing interviewing I therefore was myself interviewed about my expectations, in an attempt to help me identify when “my stories” might lead me astray and influence the

way in which I heard the stories of others and the relative influence that I attributed to them.

From my own interview it was apparent that an associated aspect of the play specialist role that I had really enjoyed in my first year or two were the opportunities at the time to be involved in lobbying for enhanced provision of play programmes throughout New Zealand. This political component occupied many of my non-working hours. It added interest and contributed to my feeling that I could make a difference beyond my direct involvement with children. This aspect continues to be important to me. In listening to others' stories I needed to be aware that the context in which they work now is very different from when I started. I needed to listen carefully, without leading the interview in particular directions, to see how the participants derived their satisfaction and how any experiences they might have, of needing to be advocates, were experienced.

In recollecting my own early experiences, I described it in the interview as "walking into a foreign country" as far as the physical environment and hospital culture was concerned. I anticipated that this might still be the case for people commencing all these years later. I experienced my own involvement with children and families as very meaningful and satisfying, and expected that these feelings might be common to others. I also expected to find some echoes of the tension that I experienced between the demands of compliance with Ministry of Education requirements relating to playroom supervision and professional decisions regarding which children were highest priority for play specialists' time.

I expressed a strong belief in the importance of play as the basis of a hospital play specialist programme. I went so far as to say "if you don't model the fundamental importance of play by actually engaging children in play and playroom experience ...then you're actually denying the whole basis of your profession." This strong belief, left unacknowledged, might well have taken me from the path of exploring others' experiences.

In my interview I also voiced my curiosity about the ways personal temperament and differences in expectations might influence new appointees' interpretation of their

experiences. I wondered about the importance of support from more experienced practitioners in the early days and weeks of employment. This was something that I had found very valuable, but is not available to all novice play specialists.

Being open to the possible influence of my own assumptions has continued to be a challenge throughout the writing up of this research. The circumstances of my continuing relationships with some of the participants provide opportunities for us to meet in situations where participants may choose to talk to me about their ongoing experiences. Sometimes they reflect on how the meaning or significance of their earlier experiences have changed with time and as the result of further experiences. I therefore needed to be mindful that I was not led astray by understandings arising through pathways other than the narratives told to me during the study. My success or otherwise in “staying on the path that listens” is addressed in the final discussion chapter.

The research pathway

This next section enables the reader to follow the steps that I took in undertaking this study, from initial approval through to the analysis of the interview transcripts. It shows how participants were accessed and interviewed, and the measures that I took in order to address my own embeddedness in the topic of the study and to safeguard participants’ privacy.

Ethical Approval

The Auckland University of Technology (AUT) Ethics Committee granted ethical approval for this study on 10 March 2003 (Appendix A). A subsequent successful application was made to extend the participant eligibility criteria from an employment period of 18 months to two years, in order to ensure sufficient numbers of potential participants. However, the study focus remained on experiences in the first 18 months. The Ethics Committee granted this amendment on 8 September 2003, for a period to 8 September 2005 (Appendix B).

I was advised by the Ministry of Health Auckland Regional Ethics Committee that its consent was not required because the study focused on professional issues, was not a health-related question, and did not require access to health records.

Because I had a professional relationship with some of the potential participants, I also sought permission to undertake this research from my employer, the Hospital Play Specialists Association of Aotearoa/New Zealand. This was granted by the President, on 3 March 2003 (Appendix C).

As a courtesy, letters were sent to the service managers responsible for hospital play programmes in all hospitals where there were hospital play specialists who met the employment criteria. These letters informed them of the project and advised that their staff might be invited to participate (Appendix D). Managers were not told whether or not a member of their staff had been approached or recruited.

Accessing participants

The criteria for this study required participants to be qualified early childhood teachers and to have been employed as hospital play specialists for between three months and two years at the time of the study. As this study sought to understand the meaning of participants' experiences, as revealed through their stories, a good command of English was also essential.

Within these broad criteria, I sought to interview between six and eight participants from a variety of hospital settings across New Zealand. Potential participants were easy to identify because I became aware of new hospital play specialist appointments in the course of my employment with the Hospital Play Specialists Association. However, the number of people who fitted the criteria was quite small. From my knowledge of recent appointments, eight people were approached who represented a range of employment circumstances, duration of employment, and age, and fitted the inclusion criteria for my study. Letters of invitation (Appendix E) were sent explaining the purpose and nature of the research and inviting their participation. I wanted to be able to schedule the interviews at some distance apart, so that I was not overwhelmed with data. For this reason, the

letters were posted out over a period of about five months. Most people responded very quickly that they were willing to participate. In two cases no response was received until a second letter was sent some four weeks after the initial letter (Appendix F), at which time they contacted me and agreed to take part.

The participants

All eight participants were qualified early childhood teachers who had previous teaching experience in early childhood centres, although some had also worked in roles where they had a broader involvement in providing services for children and families, or in special education. Three had degrees in addition to their teaching diplomas, and two of those had further post-graduate qualifications. They were drawn from a variety of hospital services across New Zealand, with staffing levels ranging from only one full-time equivalent position to departments with 10 or more hospital play specialists.

All participants were women, and most were aged between 21 and 30 years. When asked to nominate their cultural affiliation, they all wrote either “New Zealand European/pakeha”, or “New Zealander”, with no-one identifying as Maori. At the time of the study no male play specialists met the employment criteria for participation. The length of time for which they had been employed as hospital play specialists ranged from four months to two years; all except two had been employed for less than one year. At the time the interviews took place, six were still working as hospital play specialists, and two had left the field.

Protection of participants

There are approximately sixty hospital play specialists in New Zealand. Most know each other, and many are also familiar with each other’s work environments. All the potential participants for this study knew me. Because of our shared knowledge of each other there was a strong possibility that particular people or situations might be readily recognised. For these reasons, confidentiality could not be guaranteed. I was also aware that I might have multiple “hats” in terms of my relationship with potential participants: as a provider of professional support and advice, as a link to the Hospital Play Specialists Association, as a colleague and as a friend. I was therefore very aware of the importance of ensuring

that no participant felt any pressure to participate or any concern that they might be disadvantaged by refusing to participate.

I took a number of steps in order to address these concerns. Care was taken to try and maintain separation between my involvement in the research project and any current professional or other contact I might be having with the participants. The letter of invitation sent to potential participants gave an undertaking that I would not give any reminders about the request for participation, except by mail, nor would I initiate discussion of the research during any professional development visits or workshops in which they were involved (Appendix E).

The letter of invitation sent to participants acknowledged potential concerns about privacy and set out the steps that would be taken to preserve confidentiality (Appendix E). Participants were assured that they could withdraw themselves, or any information they provided, at any time prior to commencement of data analysis (Appendix G). To assist in maintaining confidentiality, they were asked not to disclose the names of any children, families, colleagues, supervisors or other employees during the interviews. An opportunity was also provided at the start of each interview for participants to discuss any concerns they might have about privacy issues. I undertook so far as possible to disguise or change any potentially identifying details in the thesis itself and in any publications or presentations that might result from it. Consequently, in writing up the study I have changed references to the physical setting of hospitals, and the exact size of the services. I have also changed information that might identify a particular child or their family, such as the child's condition, ethnicity or family size. A decision was made that participants would not be given pseudonyms in case this made it easier to track particular responses through the thesis. Instead individuals are referred to simply as "participants" or "novice play specialists".

As well, I have been vigilant to ensure that I have not subsequently identified the participants in the course of my other activities. When I presented some of the research findings to a group of hospital play specialists, I was careful not to include stories contributed by anyone who might be present, or which arose from the same workplace as any individual attending the workshop.

A further strategy to ensure participants' comfort and protection, was that they were invited to choose a place convenient to them in which to be interviewed, the provisos being that this place be private, free of interruptions, and somewhere other than their own office. Five participants chose to be interviewed in private homes and three in meeting rooms within their workplace. Where interviews were conducted within hospitals, suitable space and appropriate permission, if necessary, was obtained by the participants themselves. I pointed out that conducting interviews within hospital settings might identify the participants to their colleagues. Nevertheless, three people chose to be interviewed at their place of work and were not concerned that this might make their participation obvious to others.

In addition to protecting participants' privacy and the relationships they have with me outside of this study, steps were taken to protect participants emotionally. I anticipated that the intensity and/or nature of some of the stories related might be such that their re-telling would rekindle strong and possibly distressing emotions. Checks were therefore made with all participants prior to interview to ensure that they had avenues of support which they could access if necessary.

A confidentiality agreement was signed with a typist (Appendix H). The tapes and transcripts are stored in a locked cabinet at my home, and a copy of the transcripts is in safe keeping at AUT.

Phenomenological interviewing

Hermeneutic phenomenological interviewing serves as a way of exploring participants' stories in order to develop a richer understanding of the phenomenon experienced. The purpose of the interview is to provide the narrative that is the source material from which a deeper understanding of the phenomenon may be obtained in later analysis. It is anticipated that parts of the experience will show in the participants' stories and that parts will remain hidden. According to van Manen, the resesarcher must have an abiding, deep interest in the question, and must remain open to the possibilities for layers of meaning that lie below the surface words. He tells us that topics chosen by his own students for

phenomenological research are almost always a significant part of that student's personal or professional life (van Manen, 1984, cited in Gasquoine, 1996). This was certainly the case for me.

The interviews themselves were of a relaxed and conversational nature, as befits phenomenological inquiry. There was no sense of rush, yet I found that they came to a natural halt after about one and a half hours. Each interview was recorded, with the participants' consent, by two tape recorders so as to have backup should one malfunction. Participants were very conscious of the tape recorders at the start of each interview, but this was short-lived and their presence was soon ignored. I was careful not to turn the tape recorder off until participants had had some additional time for any further thoughts.

In order to remain as close as possible to the actual experience of each participant, it was important that I kept oriented to the subject of their early months as hospital play specialists. It was helpful to me in the first interviews to have some initial questions in my mind as a guide, but as I became more confident in the process I was able to be more relaxed and remain focused on the purpose of the interview. Participants tended to move away in their responses from the actual experience, and so I found that I needed to bring them back to the specific by asking them to tell me about their experience of particular situations or to "give me an example of a situation that...". Sometimes it was helpful to ask them to "think of another time when ..." (van Manen, 1990), or, "How did you feel when that happened?" It seemed to me that the participants welcomed these opportunities to recount stories of specific things that had happened during their early employment. There were times when I felt that the interviews served a purpose of releasing emotion. This function was not explicitly stated, yet it seemed that for some of those interviewed there was an unburdening of feelings that had stayed with the person, perhaps for many months.

Issues arising during interviews

As already noted, I have a shared professional background with the participants and already had a relationship with all of them to some extent. Because of this, there were times when participants made assumptions of shared knowledge and understandings, or

skimmed over stories which they thought I might already have heard. It was sometimes necessary to encourage them to tell me the story again, as if I had not heard it previously, or to tell it to me as though I knew nothing about their work.

As anticipated, some of the stories evoked vivid memories and strong feelings, ranging from grief at the death of a child, anger at some aspect of the workplace setting, or frustration. Where participants were clearly distressed they were given a choice about whether to continue with that story as part of the interview. No-one took up this choice, and no-one requested that an upsetting experience be omitted from the transcript.

One technical problem occurred when a participant lowered her voice in parts to the extent to which it was difficult to hear from the tape exactly what had been said. Where possible, *gaps were filled by discussing it with her by telephone and adding her additions to the transcript.* Any remaining missed phrases were not seen as essential to the meaning of the stories.

Transcripts of the interviews were returned to the participants to ensure that what had been recorded accurately reflected their understandings of what had been said. In all except one case, no changes to actual content were requested. One participant asked for some changes to a small part of the final section, which I altered as requested. Another participant telephoned to talk through with me her response to reading the transcript of her interview. She was *dismayed at recognising for the first time the strength of her angry and frustrated feelings during her early months of employment.* Previously she had not acknowledged these feelings to herself or anyone else. I was able to reassure her that many of her experiences and responses were similar to those of other respondents. To me, the strength of her emotion was related to the likelihood that this was the first opportunity she had had to tell someone how she had been feeling. After further discussion we agreed that possibly the interview had served the purpose of a de-briefing session.

Working with the data

I transcribed five of the eight tapes myself. Although this was time-consuming, I found that the stories became more familiar and more real to me through hearing and re-hearing

them as I typed. In order to capture this same familiarity with the interviews that had been transcribed by the typist, I listened to the tapes as I read the transcripts. This helped me to regain the sense of the context of the interviews and of what the participants might be revealing through emphases and hesitations that could not be seen by reading the manuscript. It was also important for me to check the accuracy of the tapes transcribed by the typist against the voice of the participant. Transcripts were returned to the participants, as I have already described, to ensure that participants were confident that what was recorded correctly expressed what they said. By reading the transcripts, and listening to the tapes over the months in which I was conducting interviews, I began to see connections and common experiences.

Each interview transcript was then read and re-read, enabling me to pull together coherent stories. Sometimes the participants had told stories that seemed pretty much complete in themselves. Just as often, however, I found that fragments of a story might be scattered through a transcript, and that the various strands needed to be pulled together in order to capture the experience. Once I had done this with all the transcripts, I found it helpful to print each participant's stories onto different coloured paper. In this way, different participants were readily distinguished and I could easily see if similar stories had been told by more than one person.

Analysis

Van Manen (1990) describes six stages to conducting hermeneutic phenomenological research, and these were a useful guide in conducting my study: *turning to a phenomenon which seriously interests us; investigating experience as it is lived; reflecting on the essential themes which characterise the phenomenon; describing the phenomenon through writing and re-writing; maintain a strong and oriented relation; and considering the parts and whole that balance the research context.* Van Manen suggests that these stages do not necessarily proceed in sequence, but may take place simultaneously or overlap each other, and this was my experience.

My focus for this study was an area of personal significance and interest, the experience of novice hospital play specialists. It was my earlier interest in this topic that brought me to

the research question in the first place and I “lived with” it (van Manen, 1990, p. 43) throughout the entire period of the research. I investigated this phenomenon by exploring, through interviews, participants’ stories of their everyday lived experiences in the early months of employment. I found that this second stage overlapped with the third stage, that of reflection on the meaning of participants’ experiences.

As I became more familiar with the stories, I searched for emerging themes and sub-themes, looking for particular words or phrases that stood out in some way or seemed to be particularly revealing of the experiences described. Three questions were helpful to me in trying to move beyond the individual’s experience to something that might have significance for others: What is the meaning of the story? What matters about this story to novice hospital play specialists? What is showing itself in the novice hospital play specialists’ first eighteen months? This search was refined throughout my writing and re-writing, a process that was ongoing through the whole period of writing this thesis. Writing is a central aspect of phenomenological research. “Writing and re-writing is the thing” (van Manen, 1990, p. 132).

I was also helped in my writing, and in my reflection on my writing, by notes that I kept along the way and by feedback from my supervisors. Talking with other students who were working on interpretive theses, and sharing my writing in AUT workshops for masters students, was also helpful. Sharing participants’ stories helped me to think more deeply about them. Sometimes others gave feedback that enabled me to think differently about some aspect of a participant’s experience. At other times, unexpectedly, helping another student reflect on his or her study prompted insights into my own.

Through a period of reflective writing and re-writing, and grouping and re-grouping of stories, three inter-connected and overlapping themes emerged. Sub-themes appeared more slowly. I found myself going back to some of the stories a number of times and interpreting their meaning differently as a result of further reflection. This in turn revealed other ways of understanding the stories and new possibilities for how they might illustrate sub-themes or connect to the broader themes. For example, a story that I first understood as showing an experience of being overwhelmed by a chaotic environment, later emerged as showing recognition by the participant of the complexity of her role.

I found that I was often pre-occupied with the research, carrying a story in my head and puzzling about its meaning. A phrase or a few lines might leap out at me from a chance conversation or from something I had read. These might be quite unrelated to my study, yet would help me to become more attentively aware of some aspect of the participants' experiences. A poem or a novel would suggest a metaphor that added richness or depth to my thinking, or illuminated a theme in a way I had not thought of. Some of these have been included at the start of chapters. This, it seems, is what van Manen describes as the fifth stage of research: maintaining a strong and oriented relation to the phenomenon.

The sixth stage was the balancing of the research study as a whole. The process of reflection on the connectedness between the overall themes and the sub-themes, and my deepening understanding of them in relation to each other, enabled me to see how the hermeneutic circle became meaningful in relation to my study. There were a number of times where I felt, as van Manen describes, "so buried in writing that one no longer knows where to go, what to do next, and how to get out of the hole that one has dug" (van Manen, 1990, p. 33). I found it helpful at these times to step back completely from the research, to move from one section to another, and to ask others who were quite *unconnected with the research to read parts and to provide me with feedback on its coherence.*

Trustworthiness

There is considerable debate around how to determine rigour or trustworthiness in studies of a qualitative nature, such as this one. The question of rigour is an important aspect of any research, yet the traditional criteria applied to positivist or quantitative research are seen as a *legacy of the scientific method* and not appropriate for use in evaluating a qualitative study (Emden, Hancock, Schubert, & Darbyshire, 2001; Koch & Harrington, 1998; Leonard, 1994; Polit et al., 2001). It seems that there is not at present any definitive answer about what constitutes a "good" qualitative study, and for this reason, the terms "credibility" and "trustworthiness" have come into use as more appropriate than "rigour" in considering qualitative studies. "Credibility" is the believability of the findings that have been established by the researcher, and refers to the truth as experienced or felt by

the participants in the study (Leininger, 1994). Hoepft (1997) tells us that qualitative researchers have a particular responsibility to the subjects of their study. It is the researcher who is responsible for discovering and interpreting the importance of what has been observed and, in turn, for showing the reader that the study is credible and that there is a believable connection between the data and the conclusions drawn.

Koch and Harrington (1998), in re-conceptualising rigour, suggest an individualised approach to qualitative research “generated within the research product itself through detailed and contextual writing and a reflexive account of the actual research process”. The work should be well-written, engaging and characterised by ongoing self-critique. Koch and Harrington tell us that if the researcher has shown how the research process has unfolded, and the signposts along the way, then readers should be able to decide for themselves whether or not the text is plausible. For my findings to be believable, I must position myself, as researcher, and show the pathway I have followed. In the following sections, therefore, I make the case for the trustworthiness of this study, through my positioning of myself, my engagement of the reader, the study’s credibility, and the reflexivity inherent in the process I have followed.

Positioning myself

This study shows my interpretation of the meaning of participants’ stories, influenced by my own history and experience. I bring to it my “practical, concerned engagement” (Leonard, 1994, p. 60). I do not claim that my interpretations are the only possible interpretations, nor that I am anything other than deeply involved in the topic of this research. It is therefore important that I show my own context in relation to this study and to its participants. Consequently, I have endeavoured throughout to maintain an awareness of my own understandings and to monitor how these might affect the research process. This was described in the introductory chapter, in this methodology chapter, and I will look again at the possible influence of my own pre-suppositions and experience in the final, discussion chapter.

Engagement of the reader

Another way of evaluating the “goodness” (Emden & Sandelowski, 1998) of a phenomenological study is through the quality of the writing. Language, and writing, are central to phenomenology. Koch and Harrington (1998) suggest that research is plausible when the work is engaging and when the final project resembles a carefully woven tapestry. It should be coherent and able to evoke the feelings and experience of the research itself (Emden et al., 2001; van Manen, 1990). For van Manen (1990), good phenomenological writing is oriented, strong, rich and deep. In my choice of participants’ stories, I looked for those that are vivid, powerful and evocative of the experiences described. I have endeavoured to capture the interest of the reader by enabling him or her to “see” the emotional content and the deeper significance that lies within them. My hope is that the study as a whole unfolds in ways that can be readily followed by a reader, and that the various strands are brought together into a plausible and believable whole.

Credibility

A credible study is one that represents the experience of the participants and where the process that has been undertaken can be easily traced. The interviews were conducted in a relaxed atmosphere, and came to a natural halt. Additional time was offered for further thought and comments, but participants seemed to have nothing more they wanted to say. Manuscripts were returned to the participants to ensure that the transcripts accurately recorded what was said, and what the participants’ intended. The changes that were made were primarily to grammar, rather than content, which reassures me that the participants felt the transcripts did represent their experiences. Themes and sub-themes were drawn from a number of stories, not merely one or two, in an endeavour to ensure that the meaning of participants’ experiences were not unduly coloured by situations specific to a particular individual.

On one occasion I presented aspects of the research to a group of seventeen hospital play specialists, for their feedback. I was careful to ensure that the stories I chose to share would not be those of anyone who might be present. Non-verbal responses, nodding agreement, indicated to me that these experiences seemed familiar to those listening. Several people told me that they knew who I was referring to in some of the stories, or that

they had heard the participant tell the story I related, but in no case was this so. I therefore assured them that what they were thinking of must have been a similar incident involving other people. Others told me very similar stories of their own experiences. I took these parallel stories as validation of the themes and their reflection of commonalities of early experience. In the months since I conducted the research I have heard many similar stories from hospital play specialists who have commenced more recently and this also gives me confidence that the meanings I have identified have a commonality.

The study shows a pathway from the reason for undertaking the research, to the research question, through the choice of methodology, the data gathering and final analysis. I have been careful throughout this research to maintain records of the process followed.

Reflexivity

As discussed in chapter one, a problem with phenomenological inquiry may be that the researcher knows too much about the subject, and may not be open to the possible meanings that show through participants' narratives. My own context of involvement in this study has already been described. I brought to this study understandings that both preceded the study and influenced my interpretations of it. As an aid to maintaining consciousness of my own pre-suppositions, I maintained a notebook in which I could reflect on my understandings, and record ideas or thoughts from others. I have also tried to ensure that there have been opportunities for voices other than my own to contribute to this text, and to deepen my own understanding and insights.

Van Manen (1990) describes some ways in which insights may be informally tested. By placing parts of the text in the open, for discussion with colleagues and others, I engaged in what he calls a "conversational relation" (p. 100) that helped me see the limits of my interpretations. Throughout the study, I met regularly with my two supervisors, who gave feedback that was challenging and that helped me in my writing, reflection and re-writing. I also participated in the interpretive thesis workshops provided for masters students at Auckland University of Technology. As well, I presented the *uncompleted study* to an Auckland University of Technology Masters of Health Science thesis seminar.

Summary

This chapter has described how I was drawn from my personal experience to this study. It has shown the connections between research question, philosophical approach and methodology, tracing in some detail the pathway I followed in exploring the participants' stories and searching for the insights hidden within them. The chapter concluded with a framework for evaluating the trustworthiness of the study.

I move now in the next three chapters to the centre of this thesis, the research findings themselves. It is in these chapters that I extract the common threads of the participants' experiences, and begin to weave them into the themes and sub-themes that will be brought together in the final chapter to form a more richly textured whole.

CHAPTER FOUR - FINDINGS

Where Edges Meet

I have always thought that the action most worth watching is not at the center of things but where edges meet. I like shorelines, weather fronts, international borders. There are interesting frictions and incongruities in these places, and often, if you stand at the point of tangency, you can see both sides better than if you were in the middle of either one.

Fadiman, 1997, p. viii

Introduction

For novice hospital play specialists, the move from early childhood education to employment in hospitals represents a professional journey from the known to the unknown. As former teachers, this move takes them from the world of education where they know they have a place, into the world of a hospital where they must find a place for themselves. In this new place, their former knowledge and experience of the world of early childhood education, together with their expectations and understandings of their new role, come up against the reality of employment within healthcare teams in the unfamiliar culture of a healthcare institution. Their memories of this early experience resonate with metaphors of journeying, of difference and of being a stranger.

The action taking place in this chapter centres on the participants' early experiences of approaching and then crossing over the border into a new world. The chapter explores *their first impressions of, and responses to, this new place and the people they meet*. It shows their anticipation of challenges and their concerns about what they bring with them. Crossing the border brings these beginning play specialists to a point of tangency. Arriving as immigrants, they see the world of a hospital from the perspective of a stranger, noticing its incongruities and sometimes experiencing the friction that arises from their unfamiliarity with how to be in this new world. They also begin to glimpse how it might be to belong.

Approaching the edge

To approach the edge is to come up to a boundary, an end or a beginning, a change of some sort. The transition may require the negotiation of steep and difficult terrain or may involve a sudden, precipitous drop (Allen, 1990). There is both excitement and danger inherent in this journey; the excitement of discovery and adventure, yet the risks of stumbling, falling or failing completely and perhaps having to return to where one came from. Just as approaching the edge is a purposeful act, the stories participants tell of how they came to apply for a hospital play specialist position are stories of journeying with intent.

Some participants recall that they had known about the work of hospital play specialists for years, for example from teachers' college. They describe how they had "always" felt that it was something they wanted to do so had invested considerable time in finding out more about the work prior to applying. One participant tells how she waited until "the time was right" and then went actively door-knocking to seek employment as a hospital play specialist. She continues:

For me, when I went into it I was scared because it was my big dream, and I thought it might not work out. I'd been working in early childhood, but I'd wanted to be a play specialist, working with children in the hospital environment, for ever, and I knew my time had come. I felt I'd had an affinity with children who were unwell since I was a teenager, but I'd never felt I could be a nurse. Not that early childhood was a second option. I just wanted to be with children. I'd just never known how to go about it. I wanted to work with children, so I went into early childhood education and loved it. I did all sorts of things including team leadership and management, and really enjoyed it. I thought that management was what I was wanting to do but it didn't give me the buzz that I'd thought it would. I didn't feel I'd arrived. I still felt that there was something more that I wanted to do and I knew that it was going back to what I'd wanted in my teens. I couldn't believe it when I got the job because I was told it might take years because it was such a small profession. And I didn't really believe in myself. I thought, oh well, there's all those other people out there, I'm sure they're not going to choose me. But then I got this job and I thought, "Oh, wow!" and that was really good. Probably two weeks after I started I remember feeling really tired and thinking maybe I should just go back to early childhood because it was easier, then the next second I was, like, no, because I was determined ... Because I knew that I'd done the right thing. And I knew that there was no way my employer would have hired someone who was going to be a danger to children! (Laughing).

This participant feels sure that she has identified a profession that she believes will give her the “buzz” and the sense of arrival that she is hoping for, yet her excitement is tempered by her fear that she is not good enough and will not be appointed. When she does achieve her goal, after pursuing it for so long, she can hardly believe that her “big dream” has come true at last. To be where she has wanted to be “for ever”, risks the discovery that it might not, after all, be what she expects. It seems the participants approach this career change with a mixture of excitement and anxiety, certain that they want the job but uncertain exactly what it entails. Whether they have known about the work for some time, or have found out about it by chance, they describe a sense of recognition. One person describes her response to seeing an advertisement:

It was a job I really wanted to do. When it came up in the paper I thought, “Yes, this is it, this is where I want to be”. I had a hugely positive feeling about it. It was, “This job has been waiting for me!”

For this new play specialist, it is almost as if the work has been calling to her, waiting for her to discover it. She feels immediately that it is “right” for her. To be so sure that this is where one wants to be, before one arrives, is risky, especially so when the path is leading to a place that one has never been before. Leaving behind a secure career in early childhood teaching and venturing into the unknown professional territory of hospital play specialist takes some professional and personal courage. Despite their enthusiasm, therefore, participants are aware that they are entering what is for them uncharted territory and some edge cautiously towards the boundaries that delineate their career change. One person tells how she hesitated about accepting a position because, as she puts it, “I didn’t really know what it is, it’s hard to know the job and it’s hard to explain it. I think it is the hardest job to explain”. Being chosen for appointment to positions as hospital play specialists provides welcome validation that is important in carrying new arrivals through any momentary doubts during their early days in new and challenging roles.

Regardless of the potential significance of the move professionally and personally, all participants describe a very real sense of excitement as they approach their first few days. They feel confident as teachers and ready to move on. They are eager to follow new pathways and explore new professional places, taking with them the knowledge and

experience they have accumulated. As one participant says, “I was ready to see what else I could do with my skills that wasn’t teaching”. The next section explores participants’ first impressions of this new workplace world.

Crossing the border

To cross a border is to enter another country. There is a point at which the traveller is on the edge of the unknown, a place that may be uncomfortable and where it may be difficult to find a sense of stability. As I have shown in the previous section, the participants in this study are aware that in accepting hospital play specialist positions they are undertaking a journey into new professional territory. They do not plan to visit briefly as tourists; rather, they are expecting to be happy and settled in this new place and to utilise the skills they bring with them. Their first impressions are important influences on their feelings about how they will settle in.

First impressions

First impressions give us clues about the nature of a place, a person or a situation. They are, by definition, ephemeral and possibly mistaken, yet paradoxically they may be deeply affecting and linger in our minds in a way that has a considerable impact on how we interpret later events. For the participants in this study, their very first impressions of the world of a hospital are positive and affirm their decision to accept the position:

I got this job and I thought, Oh wow! That was really good. I remember arriving at the hospital on my first day and I remember walking through the hospital knowing that I'd done the right thing. And that felt really good.

However, this initial sense of excitement and of being in the right place is quickly tempered for some participants by the discovery that the place in which they have arrived feels very different from anything they have known before. During interviews, they describe entering a new world or a new community, one that is full of unfamiliar people, unfamiliar languages, unfamiliar sensory experiences and unfamiliar expectations of what they will do. It seems that everything has changed:

You step into a hospital and it gets turned upside down – all the terminology, what doctor does what, what nurse does what – there’s a

whole new system to learn. I've had several years experience in early childhood, including as a supervisor, and it was very successful. We have an early childhood service here too but it's nothing like I've ever known before. Your experience on one level seems to be not useful, the things that you used to do. And taking out the 'care' aspect of it. You're not giving bottles, you're not changing nappies, you're not doing anything like that. Because of where I had come from and the fact that I was confident in my job and loved what I was doing I expected to be confident and love what I was doing here and it didn't happen. Going into that hospital environment I honestly just felt that I went back to square one. It felt like someone had pulled the rug out from under my feet. I had to step out of that previous role and step into another one and it was a bit of a loss I suppose. It was quite hard really. I felt like a swimmer that was just floundering in the water and no-one had thrown me a life-buoy. It was just awful, absolutely awful. It was horrible, absolutely horrible. There's a certain amount of assertiveness that you need when you start a new job but when you are in a completely different role and very much in a foreign environment that assertiveness just seems to sort of ebb out of your big toe and you're just left there not quite knowing how to make your way in it at all. What I've found here is that it's almost like you've been taken from one country and planted in another with a different language being spoken and that's been quite overwhelming

Rather than stepping confidently across the border as she had anticipated, this participant feels she has unexpectedly tumbled into deep and treacherous water. She no longer has the certainties of her previous role to support her, and feels she is alone, lost and floundering in this foreign place, unable to communicate or to get a handhold on anything that might enable her to regain a sense of stability. Play specialists in larger services may have opportunities to “edge into” their new roles more gently, but for others the experience may be one of abrupt falling over the edge into strange and possibly dangerous territory. What is expected to be familiar, the early childhood service, may exist in the hospital context in a form that is unrecognisable and so the security of that familiar place is missing too. The experience described is one of shock, a feeling of complete disconnection from former knowledge and skills, and from a sense of self. It seems there is nothing to hold onto from their former world that is useful as a half-way or transition point. Some new appointees have difficulty identifying any friendly stranger who can provide a welcome, a map of this new territory, or a place of shelter. Even the skills and knowledge they confidently packed in their bag to bring to this new role seem at this time to be unsuitable. Their confidence is shaken. As one participant, an experienced teacher, puts it, “When I walked into the hospital I felt like I was just a novice.”

The physical space of the buildings and the high levels of general activity are commonly mentioned as contributing to the sense of being lost or overwhelmed:

*I did feel quite overwhelmed by the busy-ness of the place. It seemed to be a **huge** job and a **huge** place. I think it was just **so** busy. It was just like getting chucked in the deep end, really. Flat out. The hospital was full. It was on red alert the whole time.*

The size and unfamiliarity of the unit merges in this new appointee's mind with the size and unfamiliarity of the workload. It is both the "mathematical space" (van Manen, 1990, p. 102)), the sheer physical size of the buildings, as well as the "felt space", the feeling of being just one person in a huge building and a huge organisation, that has such an impact. This participant also feels that she is floundering and out of her depth in her new world. Her first impressions are that an ongoing "red alert" is a part of the culture of her new workplace. It is an environment where there is a state of constant vigilance and where it seems that everyone is focused on serious issues and potential dangers, ready to take urgent action if necessary. In such a place a request for information or help may be seen as an unwarranted intrusion. The state of generalised alarm that seems to exist reinforces the differences between this world and her former workplace, where the atmosphere was more relaxed. A number of participants describe how the apparent "busy-ness" of everyone affects their confidence in approaching people and finding out where things are, or asking to have unfamiliar terminology explained. Feeling unable to seek information can feel intimidating and intensifies the sense of being an outsider, and so the new appointees reach out for people to guide and support them.

Being guided

In crossing the border into working in hospitals, the novice play specialists may feel that they are balancing precariously on the edge that marks the change between their former world of teaching and their new world in healthcare. Without support, they may feel that they will topple and fall, so they look to others to sustain them while they find their way around and learn how things are done. Where possible, they look first to more experienced hospital play specialists to guide them in negotiating their way around the new terrain. Hospital play specialist colleagues are frequently mentioned as a key means of support in the early days and weeks:

When I started, I remember the team being really supportive. I thought they were an incredible bunch of people and I was really excited about learning. I was surprised how well they worked together even though they were isolated from each other in their work on the wards. I can't remember anything negative. It was all positive.

This novice hospital play specialist experiences the warmth of relationship with “the incredible bunch of people” she worked with, who interacted so well with her and with each other. Her early experience is remembered as completely positive. A team setting such as this, where relationships are valued and new learning opportunities are available and encouraged, is experienced as very supportive. Another participant recalls that clarity of role expectations also helped, saying, “Because I had a role down there I felt like it gave me confidence – just knowing that was my place”.

Hospital play specialists starting in smaller services, or where part-time hours limit their opportunities to interact with other hospital play specialists, may have a very different experience. There may be no-one within the hospital to be their guide and it is possible for them to be in the job for several months before they meet anyone working in the same role. They may feel isolated, too, from colleagues from other disciplines, even those working on the same unit. One says, “When I first started I didn't feel like I really had a relationship with anyone. I wasn't there enough to spend much time with the staff”.

Guidance may sometimes be found from elsewhere, however. A participant in a small service tells of the importance to her of attending professional development workshops, where she would meet other novice hospital play specialists:

There is a real sense of isolation, and it doesn't help that we're confused about our role and working with these other people who are equally unsure. So it was really helpful to have someone on the end of the phone to contact. And when I went and did the first of the transition seminars, that was like taking a gulp of fresh air, seeing that there are other people and being able to talk about their experiences and things. I don't think I could have survived without that, without that support.

There is a sense from her story that she is struggling to survive, and that the courses provide a lifeline that enables her to hang on. Professional development opportunities and phone contact are like a conduit supplying her with the fresh air she needs to come to the surface and discover that there are others around to support her. Opportunities to de-brief

and to reflect on practice with other hospital play specialists reduce isolation and help new appointees to clarify their roles and evaluate for themselves the progress they are making in settling in to their new worlds.

Orientation programmes are another form of guidance, aiming to familiarise new appointees with the world of a hospital. However, the duration and nature of these vary widely, ranging from the general hospital orientation given to all new employees to comprehensive preceptor programmes designed for new hospital play specialists. One person, in a small programme with good support from hospital management, relates how she put her orientation period to good use:

I had two weeks' orientation. I went around all the different units and got to make contact with a lot of people who didn't know we had a play specialist. It was really good that they got to know me and I've kept contact since then. I ring them regularly and say hi and they let me know when they've got children and vice versa. And out of that issues arose which I've been able to deal with that I probably wouldn't have known about if I hadn't been on orientation.

This new appointee finds herself in a large, unfamiliar physical environment without a guide. However, she is less daunted by it and has less of a sense of being pulled under. Instead, she is able to see that this early period is an opportunity to build relationships and develop communication, and works from the start to influence the way in which the lived relationship (van Manen, 1990) between herself and her colleagues will develop. She is active in planning follow-up to the initial meetings and uses these later conversations to establish some understanding of her role. For others, however, well-meaning direction-giving can be overwhelming:

The first day in particular was just far too confusing. I was taken into every nook and cranny of the hospital and I was introduced to every person you could possibly come across. I met nurses from all sorts of different areas, people I didn't need to know. Half of them I never came across again. At the end of the day I didn't really know where anything was or who anybody was. It was exhausting and confusing and really it was just a waste of time. It was just complete and utter confusion really. It was quite hard.

For this person, too much is squeezed into her early days. On her first day, especially, it is as if all the inhabitants of her new country are lined up to meet her in a seemingly never-ending procession. This only reinforces her sense of being a foreigner, bombarded with

information and directions, but without any signposts to show what she really needs to know in order to begin to find her way. Instead of feeling welcomed, there is an underlying sense of anger that she is subjected to a bewildering and irrelevant whirlwind tour. A participant who later resigned, comments that her sense of not belonging on the first day stayed with her, so that “from day one I felt excluded”. This is echoed by another participant, who also subsequently resigned. Despite her “hugely positive” feeling about the job when she is appointed, she recalls that from the start she felt it “just wasn’t going to work because of personalities and politics and entrenched negativity”.

Participants’ early experiences of crossing the border are significant. Those who receive sufficient support to walk across, however tentatively, remember these early days more positively than those whose experience is more one of falling over the edge into the unknown. Whether positive or negative, these first impressions seem to stay with the newly appointed play specialists and shape their expectations of the new world they have entered.

Being in a new world

Showing throughout the stories of participants’ experiences of being in the new world of a hospital, are notions that van Manen describes as fundamental to human experience, to our “lifeworld”. These “lifeworld existentials” encompass lived space, lived body, lived time and lived other (van Manen, 1990, pp. 101-106). They are intricately connected and together make up the complexity of our experience of being in the world. The previous section has already touched on the effect on participants of how they experience the space they are in. This section reveals more of the effect of the lived space of a hospital on the participants in this study. It also shows participants’ experiences of changes in subjective time, and changes in relationality, in how they are in relation to others within the shared space of a hospital world.

Experiencing changed space

The lifeworld of the participants changes when they enter the very different space of a healthcare environment, in sharp contrast to the educational setting they have come from.

The new space is physically different, in size and layout, and is experienced differently in terms of its effect on the participants' sense of wellbeing. Most early childhood services are in ground-level buildings with easy access to the outdoors and to outdoor play activities, whereas most play specialists are working in an entirely interior environment. They may not go outside even at breaks or for lunch as they have done previously. The physical environment of a hospital seems to be a major and unanticipated part of the difference that participants experience upon starting:

I wasn't prepared for the physical environment – coming up and down stairs, with being inside. I wasn't prepared for the climate change. Here it was quite warm. It was in wintertime and the heat made me really tired. I'd been used to an environment where you could go inside and outside so the temperature was quite well controlled, a free-flow indoor-outdoor situation.

For this novice play specialist, the more natural setting of the early childhood environment has been replaced by one that is interior, man-made and outside her ability to control or make some impact on. It is difficult, if not impossible, for her to regulate aspects such as temperature or access to the outdoors. Other participants also talk about the lack of access to outdoors, and to involvement with children engaged in outdoor play. Working in the same environment all day may intensify the experiences of sensory overload that remain in the memory.

Alongside the sensory impressions, participants discover that the spaces in which they are required to operate, and their ability to access resources, are quite different from their previous employment:

Part of the thing that made me feel that it was quite overwhelming wasn't so much the families or staff, it was just trying to be organised in the space I worked in. First of all, to know where everything was I found was a real battle. Just trying to find stuff to use was really hard, because everything was in a terrible mess and I just can't work like that. Also, it was really under-resourced, especially for under-twos, and there were so many under two's. I had to try and work out a system for myself, and look at what I was given and could use, before I could actually go and do anything. And also I was quite concerned that there was no proper toy cleaning policy in place at the time and I could see what was happening with the stuff and I didn't feel very happy about that.

The lack of order and systems in this new play specialist's space add to her more general feelings of being overwhelmed, and seem to undermine her in her new role. She feels she

is battling for the most basic requirements, without which she cannot work in this new user-unfriendly space. If there has been a gap between appointments, new appointees can be faced with a playroom which has been the previous appointee's space and which may not have been staffed or properly supervised for some time. Some, like the participant above, identify practices that concern them and that may reflect negatively on them. This new world is not only foreign, the space may be under-resourced, even poverty stricken, by comparison to their previous workplace, increasing the sense of alienation. One participant recalls, "There wasn't anything that I would have called valuable educational play equipment but, being new, you don't like to get rid of things without getting reassurance it's appropriate to do it." Becoming familiar with their resources and establishing the playroom in a way that suits their way of working enables them to call upon what they know, at a time when much is unfamiliar, and to retain some sense of control. By making it their own space, the playroom provides a safe base from which they can venture out into the new aspects of the role. Without this sense of having space in order, the ability to feel a sense of belonging is likely to be diminished.

Experiencing changed time

Time changes, too, for the participants in their new roles as hospital play specialists, although the nature of this change varies with the type of unit in which they work. The pace, or tempo, of their day may be very uneven, both speeding up and slowing down in comparison with what they have previously experienced:

It's so different, your pace. You can have 18 children one day and then down to working with only five the next. Your turnover is a lot higher. That was really hard. You'd have different kids every day. I remember my first day – I'd just mastered these children and then I came in the next day and they were gone, all gone.

This participant has not anticipated the unpredictable fluctuations in numbers of children, which is yet another difference from the more stable world of early childhood. She is disconcerted to discover that no sooner has she begun to know the children than they are gone. The lack of continuity and predictability is hard at two levels. Professionally, she realises that she will need to think in different ways about how she works with children and how she will pace herself in relation to children who are with her for such a short

time, and whose numbers may vary so widely. It is also hard for her personally as the high turnover represents an ongoing loss of relationships.

The high turnover in some units means that there may be a need for these novice play specialists to form relationships quickly with children and to provide for their needs with very little background knowledge of them. For those who are used to working with children over months or years, this is a new and challenging professional situation. However, on other occasions there are also opportunities for participants to “take their time” with children:

Now I'm able to sit down and have half an hour, an hour, of one-on-one with the same child. To me that's one of the most important things you can do, to sit down in the playroom and spend time with a child. It was strange for a while, though, going from where there's 25 to one, and just that thought – is there something else I should be doing?

This participant enjoys and values one-to-one time with children, yet finds it hard to shake off the uneasy legacy that she brings with her from her previous job that this might not be seen by others as acceptable. Despite having a strong belief that attending closely to children is important and worthwhile, it may be that the participants need to give themselves permission in these early days to take the time to just fully “be” with a child without feeling guilty or apologetic.

Regardless of the pace of the work or the levels of intensity, feelings of exhaustion are common in the early stages of employment. Some of this tiredness may stem from the changed physical environment, the lack of predictability, and the demands of a new job, yet it also reflects perceived differences in the emotional component of the work in relating to others, compared with their former early childhood role. It seems, too, that time is experienced differently:

*I remember going home the first week and I was just absolutely exhausted. I got home in the evening and I went almost straight to bed. I was really, really, shattered. I remember my first day, thinking, “I've got four more days to go!” The need to keep up energy levels, just keeping something back so that you'd have enough for the next day. In early childhood you can give out a lot more because you don't need to give as much. You know, you do your best but it's different meeting their emotional needs. It was just the **emotional** tiredness. That real emotional tiredness when you've just given out all day that I wasn't used to. I'd change up to 40 nappies a*

day in daycare – physical work – but I still wouldn't go home that tired at night. I mean, I'd do that work and then go to the gym. Whereas here, it was just that different sort of tiredness. Just totally different.

For this participant, the intensity of the work seems to be greater than it was in early childhood teaching and affects how she experiences the passing of time. She is very busy, and yet her first week seems interminably slow and she can hardly imagine that she will last out to its end. Although in her former role it is likely she would have had responsibility for supporting the emotional wellbeing and social relationships of infants and very young children, she has not experienced it as the unsettling burden that she now feels. In order to survive personally and keep working, she feels that she must conserve her emotional reserves by holding back on fully “being with” the children.

The new appointees feel that they are giving more of themselves, even though the work may be less physical. Several months after appointment, one participant is still experiencing this exhaustion. She says, “I can’t take anything home. I can’t read a book. I think that’s because on an emotional level you are giving out more than you actually realise. I’m sort of waiting for the day when I feel I can actually do a bit more.” The burden of responsibility felt for the emotional wellbeing of children is experienced as heavier in the hospital setting than in their previous workplaces, perhaps because they are aware for the first time of the multiple stresses that some children and families face. Meeting children in hospital evokes in the participants a responsibility of care engendered by what van Manen terms the power of “the call of the other” (van Manen, 2003, p. 8).

However, another participant who was required to make her time constantly available after hours in her previous work, has a different perspective. She recognises that in the hospital setting she is part of a team, commenting that she feels free to leave her hospital job at the end of the day because, “there are other people there and the place will still carry on without you”. This particular participant comes to the role with an expectation, based on her previous work experience, that responsibility is shared and that she can rely on others in her absence. Understanding oneself as part of a trusted team takes time to develop. In the meantime, early encounters with colleagues, and with children and their families, create powerful impressions, as we see in the next section.

Encountering others

When we meet others we experience them initially through a certain physicality, what van Manen terms “lived body” (van Manen, 1990, p. 103). We both reveal and conceal aspects of ourselves, consciously and unconsciously, through our physical responses. We may be less natural, less our real selves, when we are aware of another’s gaze, or we may blossom under the gaze of someone we feel is admiring of us. It takes time for interpersonal relationships to develop in ways that are significant and meaningful. Meanwhile, our first impressions shape our expectations of others, of how readily we will relate to them and how they may respond to us.

For the participants in this study, entering the new world of a hospital immediately brings them face to face with many new people. Every participant has at least one significant story to tell about early encounters with hospital colleagues, children and families. One person, who was initially apprehensive about starting, is pleasantly surprised:

Everyone really wanted me here! They were saying things like, “Thank goodness, because we haven’t had anyone for a while!” And they were just so friendly and so respected me. I’d heard that I might have to fight for that kind of respect but I didn’t find that at all.

This experience of feeling welcomed and wanted establishes an immediate sense of connection and belonging for this participant. The warmth with which she is greeted is unexpected and the anxiety she has felt about whether she will be accepted dissolves and is replaced by relief. Rather than struggling to earn respect, she senses it immediately and, in turn, it is likely that she feels well-disposed to reach out to the colleagues on her unit. Early experiences such as these help establish expectations about themselves in their new role in the minds of the new appointees, and remain vivid. Some of the most memorable interactions recalled are those between the new hospital play specialists and nursing or medical colleagues.

Nursing and medical staff

Whatever the size of the play specialist team, individual hospital play specialists have a primary day-to-day working relationship with nurses and other staff working regularly on their ward. Even small gestures of friendliness are noticed and welcomed, such as being

addressed by name. The new appointees are conscious from the start that these relationships will be important to how they integrate into their new roles, so first impressions are experienced as very significant. One participant tells of an early encounter with a senior nurse, as follows:

I was told the first thing that you do in the morning is you come in and you go and check the ward list and then you go to the senior staff nurse and ask "Are there any needs on the ward at the moment, and any way that I can support you?" And I remember thinking, "Ok, I can do this", and taking a few deep breaths and going through the door and standing there. And I found where the list was and figured out what that was and figured out what this was, and then I stood there waiting patiently and she talked to everybody else and made eye contact with everybody else and I just stood there feeling quite humiliated. I didn't know how long I should sort of stand there or whether I should interrupt and say excuse me or anything. And so I just sort of skulked back to the office and felt really upset about it. So that was quite a negative experience.

This participant finds that her tentative attempts to do what she understands is expected are ignored. She is embarrassed and distressed, feeling at best invisible and, at worst, wondering if perhaps the nurse has deliberately tried to humiliate her. Either way, this experience leaves this new appointee feeling upset and intimidated. New play specialists are led to believe from job descriptions, interviews and orientation that they are a part of the ward team, and yet the behaviour of other staff may suggest this is not so. Faced with situations such as this, they may be at a loss as to how to address the issue, unwilling to believe that the other's actions are deliberate and yet having, at that stage, no other explanation. Such incidents may contribute to the sense of disequilibrium they feel as newcomers, knowing that there will be signifiers in the environment which must be learnt but which they, as foreigners, do not yet recognise or understand. On some occasions these failures to communicate are passed off by participants as mere incongruities of the new setting. At other times, they come up against different beliefs or practices in ways that cause ongoing, but often unexpressed, friction.

A possible source of friction is unanticipated for one participant who recalls a difficult early encounter with a doctor. She tells the story of what happened as a result of differing views:

There was an issue with a registrar. A decision was made to wrap a child for a procedure, which didn't need to happen, but because it was in my first week I wanted to foster good relationships with staff so I chose not to do

anything. That happened a couple of times with this doctor, and when I tried to debrief with them they just weren't interested. I didn't have the skills in conflict resolution at that stage – I didn't know how to deal with it. I felt my confidence just went way down. Although I had good support from other staff, I noticed that incident carried through to all my relations with medical staff. I didn't feel the equal of the doctor any more. I can still feel that sometimes – when they're working I get nervous.

This play specialist finds her confidence ebbing away as she works with a colleague who doesn't listen to her or respect her knowledge, consequently losing trust in all medical staff. Incidents such as this have the potential to make the new play specialists aware very early on that there are not in fact shared understandings of their role within the team. They come to the role with confidence in their ability to “read” children's abilities and coping skills, and an expectation that they will advocate for practices which in their view will minimise distress for children. However, they very quickly sense the existence of invisible professional boundaries that they feel they might violate by directly discussing options with medical staff. At this stage it seems they neither know the unwritten rules about how they might address this sort of issue, nor do they have a wider perspective that might help them appreciate the particular pressures that medical staff may be working under. Incidents that raise strong emotional responses, such as anxiety and fear, are likely to produce long-lasting loss of confidence and make it more difficult to work as an advocate for children and their families.

Another participant's experience is also surprising and somewhat challenging to her but has a more positive outcome:

*One of the first things that happened was that one of the doctors sat me down and asked me all my qualifications and why I was here. I was a bit shocked at first, but I just told him what I had and what I was planning to learn. And that made me really think, ok, why **am** I here, and that was quite good. And from that day on he respected me and asked my advice all the time.*

This participant's practice is not being questioned. She feels that she is “put on the spot”, yet is sufficiently confident to use the discussion as an opportunity to inform the doctor and to build a relationship with him. She is able to explain what she can offer, yet do this in a way that shows she is aware of gaps in her own knowledge and that she is open to new learning and to other opinions. In retrospect, she values the experience as an aid to

clarifying her own understanding of her role. It also forms the foundation for a very effective working relationship. Not all participants are able to build on the early relationships with colleagues in this way. However, they are in more familiar territory, a “known country”, in their encounters with children, and it is these very different encounters that are revealed in the next section.

Children and families

Not surprisingly, because of their past experience, establishing relationships with children and families seems generally to be one of the easiest aspects of the role for newly appointed hospital play specialists. New hospital play specialists, children and families share some characteristic of foreignness in this new territory. Despite some uncertainties about how to respond to families who are very stressed, communicating with children and families, and engaging children in activities, are skills with which participants are already familiar:

The families instantly make a difference because they see you as somebody. They don't necessarily know it's your first few days of course, so from those very early days families instantly rely on you for a bit of information, for that communication, for company, for a smile, for a direction to where they can find a cup of tea. That's happening straight away and that makes you feel as if you are part of things. And children accept you at face value if you're being honest to them. Straight away there were children there who had already been there long term and I think they make that induction process easier – if they take a liking to you they'll accept you. It's their environment and, if you respect it, that connects you to them.

By using the most basic tools of human communication, her smiles and openness, the new play specialist shows that she is friendly. Her bodily presence reveals her wish to be helpful and welcoming at the same time as it conceals her newness and uncertainty (van Manen, 1990). To be relied on by children and families provides participants, despite their newness, with some certainty in the midst of their otherwise confusing world. Being seen by others unquestioningly as a staff member helps them to see themselves as a member of the healthcare team, and invests them with a certain authority that they may not otherwise feel. Building relationships is one area where it is possible to feel confident and competent in the midst of so much that is unfamiliar.

It seems, too, that there may be an interconnectedness between the ease with which participants encounter others and the space in which they encounter others. The space of the playroom environment, containing recognisable toys and resources for play, establishes a familiar context for novice play specialists and for children and their families. It is a place of safety for them all, away from the foreignness of the new world surrounding them. In encountering each other in the playroom space, the context tells children something about the role of the play specialist. The space itself helps establish expectations, smoothes the encounter and enhances the development of relationships.

However, away from the playroom, play specialists are placed in situations when they have to show what they do and how this differs from the role of other professionals with whom children and families have contact. This is considerably more daunting, as can be seen from one participant's description of how she felt about entering children's rooms:

I found it really difficult to go into rooms at first. It took me ages. Just because often they'd have the curtain pulled, or you don't know who's in there. You don't know how many family members are there, or what family is in there. You don't know what the child is like. You don't even know what distress they're in. And just going in and sort of owning a role that you're not quite sure of yet. I mean, I didn't feel a play specialist yet and to have to go in and say "Hi, I'm ..., the play specialist", felt very foreign and also very intrusive in their bedroom because it's a child's bedroom technically and family's there. I found that quite difficult.

This play specialist is keenly aware that space and privacy within a hospital are precious commodities that deserve respect. Curtains and doors represent other kinds of boundaries, delineating space within the larger boundary of the world of a hospital. Opening the door, or going through a curtain, is moving into the unknown, in terms of relationships and of role. Moving into another's space places her under the gaze of strangers, which she finds inhibiting and hard to deal with, and which intensifies her feelings of uncertainty about her role and skills. By going through the door the play specialist is moving out of "public" space into the child's space. It is potentially a form of invasion, and needs to be negotiated with the child and family. If the family are not welcoming, but instead are distressed, angry or abusive, how will the hospital play specialist respond? In their early days the participants have not yet acquired a repertoire of responses to deal with the possible range of emotional states that they might meet in these situations. They may feel the need to show who they are and what they do at a time when they are not yet authentically a play

specialist in their own minds, yet must act in this role to children and families in order to gain their trust and acceptance. They are paradoxically both “outsiders” to themselves, and “insiders” to the children and families they work with.

Furthermore, in each new encounter, even with the same person, there is a possibility that the nature of the relationship will be different:

I went into a child who had just come up from having surgery and I walked in and she was sitting on the bed and I said to her, “Hi, I’m [name] the play specialist. I just wondered if you wanted a video. And her mum just turned around and gave me the look of death and said No! and was quite funny about it. And so I just said okay, that’s fine, and turned around and left. I went back to the office and I was fine, but I think I’m quite guilty of always feeling like it’s me who’s done something wrong. And the next time I saw the mum she was just the nicest person I’ve ever met and she was coming into the playroom, cheery and happy.

The “look of death” is unnerving. This participant interprets the mother’s physical actions and verbal response as a personal rebuke and she looks to herself as a cause of the distress. Confronted with parents’ anger or frustration, these new appointees may readily believe that it somehow reflects on their own competence or on their ability to form a supportive relationship with the family. At this early stage, it is likely that they may not have had the experience to recognise that impact of stress on the emotional wellbeing of families, and that these stresses may rebound on the play specialist through no fault of theirs. Learning to see that the world of a hospital may impact differently on others is one part of the new knowledge that is acquired during the journey across the border.

Journeying in a new role

The journey across the border takes novice hospital play specialists into a new world, the world of healthcare. It also takes them on a journey of learning, to what is for them a new profession, of hospital play specialist. As the novice hospital play specialists move forward in this professional journey, they soon notice that there are gaps in their knowledge and skills. From their reading, from talking with others and from what they see of the practice of other hospital play specialists, they recognise that new learning will be needed before they can become fully contributing citizens.

Participants' stories reveal very different experiences of their early attempts to learn aspects of the role that are new to them. All express excitement about the opportunities for new learning and new challenges, whether these are in connection with medical knowledge, working with more diverse cultures, or acquiring new professional skills. Support and feedback from more experienced play specialist colleagues is one source of learning:

I knew every week I had this meeting so I could say to her well what about this, what about that, and I could save these things up to ask and I thought that was really important, really helpful.

The certainty of knowing that she has a regular time scheduled with a colleague sustains this novice play specialist. She can hold onto her important questions and concerns until the weekly meeting. Having an experienced colleague or colleagues who can give feedback, listen to concerns, and teach new aspects of the work, such as preparing children for procedures, is something that is described as very helpful. One participant says, "I watched her preparations and I just thought it was a really wonderful way of showing children, of explaining to them what was going to happen. I found it really interesting." However, watching colleagues who seem very competent may also raise some anxieties:

I remember watching a 13 year old boy who was having quite a major operation with a lot of catheters and lots of things he was going to come out of it with. The other hospital play specialist was very onto it and knew how they all worked and how the air went up them and so on. And I'm thinking, "How am I ever going to know all that to be able to teach him and be able to talk to him about this tube going up his penis and things like that?" It made me feel quite apprehensive about whether I could do this job. And I also worried that she was only going to be with me for a week or so and how was I going to gather enough information to be able to prep that boy myself? I was feeling a bit inadequate that I wasn't going to be able to deliver to that standard.

This participant is worried, both about her ability, ever, to do the work, and also about the quality of her work. To be faced with the expectation that she will prepare an adolescent boy for procedures, especially where genitalia might be involved, is for her a very daunting prospect. Providing support for children who are undergoing complex medical treatment is very different from anything the novice play specialists are used to. Working with adolescents is also outside of the previous experience of most.

Another participant tells how opportunities to work alongside more experienced colleagues had a discouraging effect:

*I found myself working with these amazing people who were really, really good in their field. In fact, they were **legends** in the field. I don't really know if they realise that they're like this, but they just do everything right. They know just what to do and they see things that I didn't see. And I think I found that really hard. I hadn't expected to feel that I wasn't doing a good job. And even though people told me I was, I kept thinking, "Oh no, this is hard".*

This newcomer is daunted by finding she is working beside people who have “legendary”, almost God-like, status within the service. She aspires to be like them yet perceives that they can do no wrong and finds herself wanting in comparison, despite reassurance. Instead of building her confidence, the presence of experienced colleagues has the unanticipated effect of undermining it. It seems she has not yet had an opportunity to visualise the steps she will take, and the support she will receive, to enhance her own skills. As well, what she has heard about her colleagues’ abilities and experience perhaps clouds her ability to value the skills that she brings with her, and at this early stage prevents her from seeing their work as anything other than perfect.

Despite such apprehensions for some participants, others quickly identify differences between their preferred ways of working and that of their colleagues. In observing others’ practice, they are sufficiently confident to resolve that they will follow their own style. In referring to her orientation period, one participant comments, “I found being taught by her quite difficult because I wanted to question and say, ‘Well that’s not the way I would have done it’.” Opportunities to observe more than one person provide alternative models of working:

I was taught to do preparations one way, and then I saw another person who worked very differently. She made the experience much more child initiated and let the children just go the way they went rather than a pre-planned scenario which is what I had seen before that. Seeing another person do it I saw a completely different way, so I took some from one and some from another and I thought that was really helpful.

This participant is able to discover a way that seems right to her by taking some knowledge from one colleague and some from another. These novice play specialists welcome the opportunities to observe others, yet are eager to start taking on more of the

role themselves. Those in larger programmes seem to be impatient for more autonomy and for the opportunity to work with children in ways that feel authentic to them. Already at this early stage most are feeling some degree of confidence about the learning journey, and their ability to acquire the additional skills they need to undertake the new, therapeutic aspects of their role with children. This journey is less daunting if others are available to provide directions, encouragement and support, as well as a baseline against which new appointees can evaluate their own practice.

Standing at the point of tangency

Despite the pervasive sense of being a stranger that some new hospital play specialists experience, there are some advantages to seeing with an outsider's eyes. One participant describes what she calls, "doing the logical things that you'd do for any human being", even though she suspects that she has broken some unwritten rules in doing so:

Because I was so new I didn't really know what my boundaries were and I think I probably overstepped them at least a hundred times [laughs]. I'd been working with a long-stay teenager and the staff were saying she was obviously anorexic because she wouldn't eat. They wanted to get psych involved. I said, "So what are the TB drugs like to take?" And the doctor said, "Oh well, maybe they make her feel a bit sick". And I said, "Well have you ever thought about giving her some anti-nausea pills?" And the doctor said, "Oh I see what you mean". So they put her on anti-nausea pills and everything was fine. I found people just freaked and jumped to conclusions, where often it was just basic things like that.

Within the borders of the new world there may be other concealed boundaries that differentiate how people are in relation to each other, ones which this participant believes she may have overstepped on many occasions. However, taking the risk to bring her own ideas to this new world pays off. Because they are not yet fully immersed in the world of healthcare, the novice hospital play specialists can bring a wider perspective to situations such as this. This fresh viewpoint is not yet acculturated to the world of a hospital, and allows for alternative explanations for the behaviour that children and young people are showing. From this point of tangency the new hospital play specialists can see other sides. They can suggest commonsense possibilities in the first instance that may not have occurred to medical staff who are trained to seek a diagnosis.

A similar example arises from another participant's description of how she handled an acrimonious situation on the ward, one that had arisen due to differences of opinions amongst staff on how to handle the difficult and deteriorating behaviour of two girls with rheumatic fever. After several months on the ward, the nurses were increasingly impatient with them:

Staff were saying "Who do they think they are? Don't they realise there are sicker children?" There was a lot of negative stuff going on in the ward about their care. Some staff were just seeing their behaviour as naughty. It was interesting – because I was new I could stand back from it a bit and I could understand different people's points of view. So when the staff were feeling really negative about what the girls were doing I just talked to them about how these girls had been here so long and it was really their home now. And how they were going through puberty and they really needed some privacy sometimes. They were having to share rooms with five other children and other adults coming and going, and I thought if they could get their own rooms it would make a huge difference. And it did. They suddenly became human again. The staff could see it. The girls' behaviour improved when they were being treated more kindly and given some time and respect.

Being new, this play specialist is in a position where she can see multiple perspectives in situations such as these. There are real hardships associated with hospitalisation for these girls, because of their age and the length of time they have been there, and these developmental and psychosocial needs justify consideration alongside their medical condition. She is sufficiently confident even at this early stage to advocate for the girls by helping staff see the children's behaviour as a predictable reaction to the conditions of hospitalisation, rather than as wilful and deliberate bad behaviour. By acknowledging the girls' needs, their behaviour improves and this in turn has a positive impact on the way in which the ward functions. In treating the girls as truly human, their response is to behave as human beings do in relation to those who show them care and concern.

Similar situations sometimes occur with regard to parents and families. Judgments may be made about parental behaviours or responses, and at times the play specialists can see the situation through a different "lens", partly because they are new but also because they may have had the opportunity to get to know the family in a different, less formal, way. An outsider viewpoint may enable the new hospital play specialists to act as "translators" of medical jargon.

The parents are under a huge amount of stress and they nod and say yes but they have no idea what he's said and then he's gone. So sometimes I'm the go-between person, the interpreter. Yeah, just having the time to sit down with someone and go and get a book which explains it maybe, and say this is what they're planning on doing. Often you can't find your charge nurse or someone else who could help, or they just shrug their shoulders and say, "Whatever, she'll be right!"

This participant recognises that she is not the only person in foreign territory. Others, such as parents, can also be struggling with the newness of the language. Although the novice play specialists may quickly acquire knowledge of medical terminology, they are far from fully fluent in the language of the hospital. This unfamiliarity helps them to “hear” what is said from a lay perspective and perhaps to recognise when families are confused and simply acquiescing rather than really understanding. They recognise that they can create opportunities for families to have information explained to them again in a different form, or by a different person.

At the point of tangency, novice hospital play specialists may be able to see across both sides of the border. Within the new country they encounter both other staff, who are inhabitants, and children and families who are newcomers like themselves. The difference between themselves and families is that the novice play specialists plan to stay in the new world and make it theirs, whereas the families wish to leave as soon as they can. There is a tension in this situation. The new play specialists want to belong in their new world, yet at the same time there is value in their outsider viewpoint and the ability it gives them to see this world to some extent as families see it.

Summary

This chapter shows how the decision taken by the participants in this study to seek and accept positions as hospital play specialists takes them on a journey to the edge of what is effectively a new country. They set out in excited anticipation, despite their uncertainty about what lies ahead, and soon discover that in crossing the border they have entered a somewhat overwhelming world of sensory experiences, with an unfamiliar culture and language, peopled with strangers. This journey also takes them into a new professional

world, from early childhood teaching to the more therapeutic role of a hospital play specialist.

Once they have crossed the border they may find there are other unanticipated and sometimes hidden boundaries that mark out personal and professional space and influence how relationships develop. The things they brought with them, their previous experience and skills appear, at least for a brief period, to have no relevance in this foreign territory, with the result that some may feel their confidence and competence slipping away, at times creating fear and anxiety. More experienced hospital play specialists, and colleagues on their wards, can provide much wanted guidance as they try to find their way and settle in. A welcoming environment together with opportunities to see colleagues practice and to receive feedback on their own practice help participants to feel that they will in time be able to become contributing members of their new worlds. However, we have also seen from participants' stories that they cannot always find what they need. Some of the early support that is offered is overwhelming and tends to increase, rather than diminish, the sense of being different and foreign.

Paradoxically, these new play specialists discover that there are some advantages in being an outsider. While they want very much to increase their own feelings of belonging to their new communities by becoming familiar with the language and culture of a hospital, they discover that their very newness helps them to see this setting as it may seem to families. By standing at "the point of tangency", they may notice incongruities and frictions that are missed by staff members more attuned to the nature of a medical world. By glimpsing situations from both sides, neither complete "outsiders" nor fully acculturated "insiders", the new play specialists may be able to be interpreters, bringing a fresh viewpoint to how things are done in hospitals.

In the following chapter I turn to themes that show the experiences of the participants as they endeavour to become established in their roles as hospital play specialists. This next chapter reveals what happens as they attempt to find a personal and professional place in their new workplaces and discover themselves face to face with the realities of the world of a hospital.

CHAPTER FIVE - FINDINGS

Struggling to Face a New World

We must learn to be vulnerable enough to allow our world to turn upside down in order to allow the realities of others to edge themselves into our consciousness.

Delpit, 1993, cited in Canella, 1997, p. 1

Introduction

As has been shown in the previous chapter, the participants in this study approached their change in employment from early childhood teachers to hospital play specialists with excited anticipation. In stepping over the border, they quickly discover they have entered a very different world, one in which their former professional certainties may seem to have been turned upside down. It is not until they actually enter the hospital setting that they have the opportunity to survey their new professional territory and to evaluate what exists against what they had assumed it to be like. Participants tell many stories of struggling to gain a foothold. It is these experiences of facing difficulty and challenge that are revealed in this chapter.

To struggle is to make “determined efforts under difficulty” or “to have difficulty gaining recognition” (Allen, 1990, p. 1210). Struggling shows itself in a number of aspects for the novice play specialists in this study. They may struggle in their attempts to build relationships with others and to practise in an unfamiliar context and culture. They may struggle with securing a physical space for themselves and for children, and a professional place for their role within healthcare teams. Participants may also face internal personal struggles as they learn to cope emotionally with the realities of sick children and their families, and with experiences of loss. At times, striving to confront the real nature of the world of a hospital leaves them feeling exposed, anxious and unsafe, and it is to these experiences of vulnerability that I now turn.

Experiencing vulnerability

Vulnerability is experienced as feeling defenceless and at risk of harm. This may be physical harm, or it may relate to exposure to potential criticism and damage to sense of self (Allen, 1990). Participants related a number of incidents where they were involved in situations that left them feeling at risk and vulnerable, or where they felt uncertain how to proceed lest they harm others. One context in which vulnerability is apparent is in experiences of struggling to develop relationships with other staff members.

Feeling under threat

Situations where the participants feel they may be under threat in some way emerge as aspects of early experiences that are difficult to face. This may occur in early efforts to communicate, as described by a participant who tells what happens when she expresses her concerns that some equipment is too old to be safe. The background to this particular struggle is that this participant had considerable responsibility for child safety in her previous role and expects that she can make a useful contribution in this area in her new role. She understands from her charge nurse that a new pushchair can be purchased for the ward, and that she can dispose of the old one, which she does:

*As soon as I came in the door she came storming up to me in front of everyone, the receptionist, parents, everyone, and said, "Did you take that buggy? Who gave you permission? It's none of your business." She just went on and on at me and really bit my head off. It was really dreadful. I was quite shocked. I didn't know what to say. Later she came and apologised and when I said that she **had** told me I could take it away she then said, "Oh, I'm sorry, I probably did – I was having a bad day". And I just felt yucky and awful.*

To be "stormed at" in public is to be at the mercy of a verbal barrage that can only leave the recipient feeling overwhelmed by its force. The attempts of this new play specialist to show initiative and, as she understands it, to contribute to the unit and to children's safety, are met by a response that is shocking both in its unexpectedness and in its intensity. Being snapped at in front of staff and families leaves her speechless. The incident is experienced as more threatening than it might otherwise have been because the charge nurse is in a position of some power over the novice play specialist. She is left feeling angry and sickened, yet at the same time intimidated and powerless to express her sense of

indignation at the way she has been treated. Although her charge nurse apologises, this private apology does little to remedy the public humiliation experienced. The incident is likely to have quite different meanings to the nurse and to the play specialist. To the nurse, it is apparently insignificant and is lightly brushed off as just part of “a bad day”. However, to the play specialist the apparent casualness of this apology suggests either that the charge nurse has completely underestimated the impact of the verbal assault or, alternatively, that she has no concern for the impact it has had. Either way, it seems that she may now perceive the charge nurse as unpredictable and untrustworthy, and no longer feels safe. When such experiences happen to new play specialists, who may already be uncertain of their place, a heightened sense of vulnerability can be created. To feel one cannot place trust in important relationships is to experience the reality of a world turned upside down.

Vulnerability is also shown in the struggle that eventuates when a participant attempts to do what she thinks is the right thing by checking the admission book for patient information. A ward clerk whom she has not previously met challenges her.

I told her that [name of hospital play specialist colleague] said I could get useful information from the book, and she said, “I’ve never seen her look in the book”. And I said, “Well, that’s because she waits until you’re not there.” And I just thought to myself that [colleague] has developed these ways of doing things to protect herself, because it’s too hard and too big to do it on your own. But I can’t work like that. I think it’s dangerous. I think it’s unsafe.

There is a sense for this play specialist that she is unable to practice in an open, straightforward way, even where she has been told how something should be done. As a new appointee, she discovers that there are hidden barriers that she may need to circumvent in order both to do her work and also, possibly, for personal survival in her job. She realises that her colleague has discovered the existence of power relationships and has adapted to their possible impact by learning to work around them, rather than challenging them openly. However, this way of working is not one that fits readily with this participant’s values and so she struggles with how she will function without compromising her professional beliefs.

Where incidents such as these occur, they are the source of considerable disquiet and concern. They indicate the subtle and unacknowledged ways that power may be exercised in the world of a hospital, ways that must be discovered, and recognised, in order to understand the culture. The participants want to establish relationships and to belong in their new world, yet there may be tensions between what seem to be the realities of 'the way we do things here' and their preferred way of working and their understanding of safe practice.

Unsafe practice

At its most basic level, safe practice is about knowing the rules and complying with them. However, at another level, practising safely is about having confidence that one has done everything possible to fulfil professional responsibilities to others and to self. For those new to a role, this is likely to feel fundamental to their work, and concerns about practicing safely are common for some new appointees. One participant tells how the need to "get it right" was a cause of considerable anxiety in her early days:

It was just making little mistakes. Just learning the hospital policies. Little things, like maybe walking into the playroom with a drink bottle, forgetting the 'no drink' rule. Forgetting to sign things out. Learning what my boundaries were. How to talk to children who were bringing up their operations, and learning how and when to steer them in another way or when to talk to them. Learning when to say something, and when not to. Without thinking, saying things like, "You're lucky to be having an ice-block", when you know they'd rather be at home than having an ice-block. Just the whole novice feeling. Wanting to do a good job. Because, you know, you want to do everything right. For a little bit, for the first couple of days, I found myself not saying anything

Even in the relatively familiar playroom environment, where it might be expected that she would be most at home, this participant feels tentative and unsure, making her feel that she is a beginner once again. She struggles to remember and comply with the rules of the hospital world as she understands them to be, rules that require fluency in a new and different language. It seems she is vigilant in almost every aspect of her interactions with children whether this is in relation to their physical safety, for example in ensuring they do not drink prior to anaesthesia, or to their emotional wellbeing. Her concerns that she might somehow say or do the wrong thing have an inhibiting, if not almost paralysing, effect for a time. In trying to do everything right, she is constantly evaluating the appropriateness of

every action, every minute of her day, struggling with how she should be in relationship to children in hospital. Van Manen refers to this process, saying that many teachers “privately realize that everything they do with children, every minute of the day, has to do with what is appropriate or less appropriate for particular children in specific situations” (van Manen, 1994). This is a process that play specialists are accustomed to in their lives as teachers; however, in hospital there are new considerations to be evaluated and the specific situations are ones they have not come across before, so adding to the complexity of the decision making.

The hospital environment is one where there are many rules that must be learned. Some of these are overt, and available as formal policies and practices. Others are unwritten and may vary from one team to another, and between units. Some new play specialists may struggle to discover the unwritten rules, many of which may have to be “second guessed” or deduced from the behaviours and responses of others. One participant comments that she felt people were “sort of waiting to see how you are going to handle things”. It is as if they are on trial, waiting for a judgment as to whether they are doing well enough to be accepted for residency.

Feelings of vulnerability may also arise from uncertainty about role boundaries and expectations. In describing the impact of having high numbers of bureau nursing staff one participant says:

People didn't know where things were. A child might need some gas to have an injection, yet the nurse doing the job would say "Well, do we use that here? I didn't know we used it, where's it kept?" And so it's up to the hospital's play specialist to go to the maternity ward to get the gas bottle to bring it back to use, and then to say "Oh, this is the attachment and we keep it on the top of here and we plug that in to that and this is what we use for the children". And I'm thinking, "It can't be! I don't want to be responsible for that." I didn't want to be walking around the hospital getting things. I don't want to think, "I've got the wrong thing here – this is what they use for the heater, not for whatever." Strange things were happening because the hospital play specialists were the people that were there more than the nurses and they knew more of those routines.

The new play specialist is alarmed by this request. On the one hand, she wonders if she is simply expected to fetch and carry. She resents this, yet hesitates to say no because at this early stage she does not want to seem uncooperative. More importantly, she does not want

to be compromised by taking responsibility for medical equipment or for any area of knowledge that is not within her competence. In this participant's unit an expectation has developed that the play specialist is a legitimate source not only of general information but also, at times, of nursing information. To be put in this position creates a conflict between what is believed to be right and appropriate from a professional point of view, and what seems to be the unanticipated and unwelcome expectations of healthcare team colleagues. When their roles are defined by others, novice play specialists are made vulnerable and anxious at the implications and will also have less time for their assigned role. It is likely that their newness enables them to "see" what has become invisible to others and the risk involved in unacceptable practices. However, they may not at this early stage be confident in refusing to perform such tasks, especially where it seems that these are expected or have been undertaken by a previous play specialist. While concerned, they may not yet know who to approach with their concerns or how to clarify role boundaries.

Other participants struggled to fulfil what they saw as their professional responsibilities. One person who had been working with a child who was hospitalised with non-accidental injury tells of her follow up with the hospital psychologist:

I tried really hard to communicate, but there were some people who just seemed to forget that I'd been working with a child. It was really awful, and I remember thinking that it was not very safe practice. One particular psychologist would say, "Oh I'm just going to see this child", and I'd say, "Look I've spent a lot of time with her, it might be very valuable for us to sit down and share some information". I tried really hard to make sure I wasn't retaining information but she'd never come back to talk to me

This participant struggles to have her professional voice heard. She knows that she is required by hospital policies to report anything that she believes to be significant in view of the child's reason for admission. Furthermore, she also believes that what she knows about the child may be helpful to the team in enabling them to develop a fuller picture of the child's circumstances. She makes determined efforts to communicate, only to find that her input is apparently disregarded and she feels marginalised from the healthcare team. When their perspective is ignored, play specialists may feel that the safety and wellbeing of children, and their own professional safety, has been put at risk or at least compromised to some extent. They may have done all they could in abiding by the rules, yet still feel they have done less than their professional duty. It is difficult to have invisible rules to

discover, but to be treated as invisible oneself is to feel disregarded and worthless. In turn, this may leave them feeling vulnerable to future accusations that they have withheld significant information or that their own practice has been unsafe and poses a threat to others.

Feeling unprepared

Another area where participants may feel they are a threat to others is in relation to taking on aspects of the role that are new to them. As already discussed, the hospital play specialist role incorporates knowledge and practices that are not part of early childhood teaching. Foremost of these is preparation of children for procedures. For all new appointees there will be a first experience of having to prepare a child and some of the participants find themselves taking this on at a time when they do not yet feel competent to do so:

*There was a time of actually preparing a child for theatre and not **really** feeling ready for it. It's a bit like getting directions from someone who's tackled inner city Auckland a million times. They don't understand why you're feeling so scared about giving it a go yourself. They forget what it was like for them the first time they got in the car and drove. That's how I felt*

At this early stage of her employment this novice practitioner has had some basic instruction; she knows the theory of how to prepare a child, but has not had opportunities to watch others or to receive feedback on her own practice. Despite the map, her directions are vague and road signs are non-existent. She is a learner driver, yet has no warning "L" plate to signal her beginner status to others who may expect a competent operator and so make no allowances for her. She is uncertain how to proceed into this new territory that seems fraught with hazards and so she ventures out with considerable anxiety, aware that she may put innocent people at risk and do real harm. In the absence of a clearly defined "novice" period or a credentialing system, there may be no processes in place to protect new play specialists from others' expectations that they take on aspects of the role for which they do not as yet feel competent. They feel exposed both to criticism from others and to self-doubt about the adequacy of their practice.

Insufficient information may also give rise to potentially unsafe situations. One participant describes working with a family where, unknown to her, the father of the child has been issued with a protection order. In a well-meaning effort to obtain additional support for the mother, she tries to organise for the father to come into the hospital:

Things just started to fall apart. I got swept into it and I just started feeling more and more responsible for the situation and why hadn't I picked it up sooner. I was getting all sorts of conflicting stories and I wasn't sure I had the resources to deal with it. On talking it over later I realised I could have done a lot of things.

This participant feels tossed around by the different stories she is told and the mounting confusion leaves her feeling quite out of her depth and vulnerable, not knowing how to get to a safe place as her new world falls apart around her. She feels the tension of being caught up in a serious situation for which she feels responsible, yet which is beyond her ability to solve. Only in later reflection can she see what other choices she might have had. Novice play specialists are not accustomed to the enormity of the potential consequences of their involvement with children, where both they and the children they work with are vulnerable. They may take upon themselves a very personal responsibility for outcomes for individual children, fearing that any inadvertent carelessness or inappropriate intervention on their part may be catastrophic. As the following stories show, these feelings of concern may extend to their own personal safety, as well as to that of children with whom they work.

Unsafe environment

A safe environment is one which is free of danger or, at the very least, where potential dangers are guarded against in ways that make it as risk-free as possible. It seems likely the participants in this study anticipate that the hospital environment cannot be guaranteed safe and that the potential for cross-infection may be one of the realities of that world. They express concerns about the vulnerability of the children they work with and yet they may struggle to discover how to protect them:

The nurses were not putting isolation notices on the doors and I didn't have a clue what I was supposed to be doing. I got sick of asking dumb questions, trying to find out what I needed to do, and what was wrong with somebody. And no-one would tell me and no-one ever came up to me and offered any information to me, and there was no process in place.

This participant is mystified as to how to protect herself and the children she works with. She is faced with a situation where the essential information as to how to proceed is missing and no one amongst the colleagues on whom she must depend seems willing to spend the time to help her. New play specialist appointees do not know how they should be handling infection control procedures, and need accurate information. This participant goes on to say that although her concerns are supported by the unit manager, nothing seems to change, and so she decides that she will have to take more initiative in protecting herself and children.

I went and got the infectious diseases book and hunted my way through everything and found a list of paediatric requirements in the back of it and I photocopied it. So then I could find out that if a child had x, y, z, I'd wear gowns, gloves, masks or just gowns and gloves or whatever and I wouldn't have to ask any of those stupid questions any more.

By reading a manual, she is able to solve the mystery for herself, without needing to rely on those who know the answers. Effectively, she finds a way of circumventing what she believes to be the inadequate communication processes within the unit. Awareness of good hygiene and minimising cross-infection are responsibilities familiar to novice hospital play specialists from their previous early childhood roles. They are also aware that toys and playthings may be a source of contamination, so it is very frustrating to them when they are unable to find consistent information in an environment where the potential risks seem to be so much more serious. These concerns are intensified where they observe that infection control policies are not being followed, or are inconsistently applied. They expect that someone will tell them how to manage these risks, and feel very vulnerable when this does not happen or when there are inconsistencies between policy and observed practice. When those who have expert knowledge do not share their knowledge with others who need it, then novices are placed in an unsupportive environment.

While new appointees are conscious of their responsibilities to protect children, it seems they do not necessarily anticipate that their own health may be jeopardised. One person, exposed to TB, comments that, "I was quite concerned that I could catch it, and I didn't have any immunity. That was one sort of barrier, that I had to look after my own personal safety". She is taken aback at the realisation that her role requires her to work with this

infectious child in an isolation room. Initially her concern for her own safety causes her to hesitate about working with the child at all, effectively establishing a barrier between the child and any possibilities to engage in play. However, she goes on to recount how she seeks advice from medical staff and is relieved to discover that she can in fact work safely in this situation providing she follows appropriate precautions.

Another participant, who is pregnant at the time, tells of an early exposure to a contagious condition:

One of the nurses said to me, "Oh you better be careful caring for that baby because she's got CMV. It's really dangerous for you." The nurse was pretty casual about it but I was feeling like, "I don't know what this is, I don't know what it's going to do to me. I don't know what you're talking about".

This participant feels at a loss to know how to protect herself and her unborn baby from danger through her inexperience and unfamiliarity with contagious conditions. She just does not know enough. Although the nurse alerts her to a potential problem, she seems not to recognise the degree of alarm and fear of physical threat that this precipitates in someone who is not used to the hospital environment and who lacks knowledge about various infectious conditions. This participant receives reassurance from her play specialist colleagues who have a better understanding of how very vulnerable she feels. She later tells how grateful she is that they "instantly jumped on it and didn't just go, 'Oh you'll be fine'". Other health care professionals, although caring, may not recognise as well as her play specialist colleagues, who may have had similar experiences, the depth of her anxiety and stress. It seems that there is not the necessary level of care and concern, amongst those who have the expertise, for novice play specialists in situations such as this.

Being accountable

Another aspect of feeling vulnerable is in relation to new play specialists' legal accountability to the Ministry of Education for provision of curriculum, compliance with requirements for facilities, and reporting on financial matters. They tell of struggling to know how best to comply with the early childhood regulations in the hospital setting:

I brought it up with our manager and showed her that the money had come through and that we had to be absolutely clear with our processes

regarding that money. That it had to be absolutely worked out. I'm also concerned that because of the busy-ness, especially in the winter, we don't have very good processes set up for recording what's happening to children. After keeping such thorough notes for so long in my other job, I feel it's not happening as much as it could be and as I feel that it should be. I'm just not sure how to do it, the best way to do it. The Ministry's DOPs (Ministry of Education) are mandatory but what things are actually applicable to us?

The thorough accounting procedures followed in her past workplace are not visible in her new role, and this participant feels concerned that the “busy-ness” of the hospital setting will erode the time needed for something that only she seems to understand to be important. Even though this person is familiar with the Early Childhood Regulations from her previous employment, she is unsure how they are applied to hospital services. This leaves her feeling vulnerable to the possibility that her service may be non-compliant. In early childhood centres, licensees hold legal responsibility for maintaining compliance with Ministry of Education regulations. However, hospital managers who hold licensee responsibilities, and hospital accountants, may have very limited understanding of Ministry of Education requirements. New appointees sometimes struggle to impress upon them their obligations, as licensees, for service quality and financial accountability. Hospital play specialists may therefore feel very concerned at what seems to be inadequate record keeping or reporting, yet simultaneously be uncertain as to how the Ministry of Education regulations and the mandatory Desirable Objectives and Practices should be applied in the unique situation of a hospital service. They are likely to feel personally vulnerable as the person with day-to-day responsibility for the service.

Some participants also tell of more generalised experiences of feeling a lack of accountability that leave them feeling unsure that they are fulfilling the requirements of the job. One says, “It was almost like no-one was checking on you. You could do as little as you liked or as much as you liked. I sort of felt I wasn't accountable to anyone.” In the absence of any oversight, this person experiences her independence as not so much an advantage of her role but rather as a kind of limbo, where others are oblivious to how much or how little she does. It seems that these experiences may result from isolation and from unclear lines of responsibility. It may be that there is a general assumption that hospital play specialists are competent professionals who are just “getting on with the

job”. However it may also be that they stem from a certain invisibility, or from others’ indifference to their work.

Experiencing indifference

Van Manen (1990) describes indifference as the refusal to dwell together, the refusal to engage another human being in a genuine encounter or relationship. To him, “Indifference is a failure or crisis of the ‘we’” (p. 108). According to the dictionary, to experience indifference is to feel unimportant, to be someone who is of no interest to others (Allen, 1990). Participants in this study tell stories of how they struggle to belong in their healthcare teams and to have their professional knowledge and skills recognised. This experience may be challenging for hospital play specialists because they are seeking an identity within the “we” of two teams, their play specialist team and the ward team with which they work on a day-to-day basis. As shown by the narratives in chapter four, they feel warmly welcomed into their play specialist team and also receive much support from individual colleagues from other disciplines. However, they may struggle to become part of the “we” of their healthcare teams:

I found my ward really difficult to get into because my charge nurse isn't very receptive and doesn't really include a play specialist as particularly important. I don't think she means to be that way, but she is. She didn't introduce me. She didn't introduce me to the staff at all. She didn't include me in meetings that other play specialists go to, like the weekly meetings that staff have, I didn't get included in those. She didn't greet me. Not saying hello in any way. Not even talking to me in a social way; not saying 'How was your weekend?' or 'How are you?' None of that.

This new appointee commences work with an expectation that her charge nurse will be the person to help her become a part of the day-to-day life of the ward, however she discovers herself on the outside, facing a different reality. She feels excluded from even the most ordinary of social exchanges as well as from ward meetings, interpreting these experiences to mean that her charge nurse sees no need for her to be a part of the information sharing process on the ward. While she does not believe the nurse’s actions to be deliberate, she nevertheless experiences them, in van Manen’s terms, as a “refusal to dwell together” (van Manen, 1990, p. 108). Feelings of irrelevance may be heightened for this participant because she knows that other play specialist colleagues are seen differently. When such incidents happen, play specialist participants feel very isolated and excluded. They feel

their colleagues are refusing to engage in a relationship with them, but are uncertain how to respond. They do not know whether the staff members concerned are deliberately excluding them, or whether the ward culture is generally unfriendly to everyone.

Indifference is also experienced by a participant when a physiotherapist enters the playroom and, without acknowledging her at all, opens her storage cupboards and begins to take things out:

I said, "Oh can I help you?" – I'd never met this lady before – and she said, "Oh yes, I just need some balloons and some this and some that to work with the children". And I said, "Oh, don't you bring those things yourself?" She said, "Well, I didn't think I'd have to. I'm going to a children's ward – don't you have those things here?" So I said, "Well, yes we do, but asking would have been polite, and bringing your own resources would be even better". And she thought I was being dreadfully rude and I thought she was being dreadfully rude, but it was just this assumption that the playroom is here so you can help yourself to anything. And yet not for one second would it occur to me to walk into the physiotherapy room and help myself to all their balls and things without saying, "Hey, can I borrow these" or whatever. It just needs a little professional respect.

This participant has an understanding of the playroom resources as her professional tools for working with the children, and the space as her base for programme provision. To have a stranger come in and help herself to resources is experienced as not only impolite but also as indicative of lack of understanding and respect for the resources and, by inference, for her role. Opening the cupboards and taking things out, without asking or even acknowledging that the play specialist is there, overturns the play specialist's understanding of appropriate professional behaviour. She feels she is being ignored, both as a person and in terms of her work and the uses she might have for the equipment that is being taken.

When experiences such as this are repeated, it can leave novice hospital play specialists feeling that they are both personally and professionally invisible. If other staff do not "see" them, despite their physical presence, then it seems likely to them that this may equate to an invisibility and irrelevance of their role. If colleagues from other disciplines make no overtures to engage in a personal relationship with them, even at the most basic level of polite greetings, they may wonder whether it will be possible to establish a professional relationship where their contribution to children's care is noticed, let alone

valued. They may come to feel they are a source of resources, but not of expertise, and that their professional qualifications and skills count for nothing. As another says, “I felt demeaned. I felt like wearing my degree across my back and saying, ‘Hey, look, I’m not just the play lady’”. Several participants talk of battling for recognition both for themselves and for the role, and even for “why my position was even there”.

For some play specialist participants the sense of battling is ongoing, at least intermittently. One participant tells how it is for her, fifteen months into the position:

*It took a while to get to a place and some days you feel you're achieving it and others something will happen and you just suddenly feel you lost that moment. So it's still very much baby steps forward, and there comes a time when you think, I've been here for months, surely it should be different! You feel like you're fighting your way, you're fighting all the time to retain a foothold. When you're working with children and parents it's positive and you feel you're actually doing your job. But with the staff, when you're trying to find your way within the **system**, that's where the struggle happens. For a while we went out there and we were doing professional development and telling people what we did and what our role involved, but it's just a waste of time. It's better to just get on with it and hope that eventually people will see that what you are doing is actually valuable, that there's some value in the big picture.*

This participant has several years experience in teaching, yet feels she has gone back to a professional infancy where she is toddling with small and unsteady “baby steps”. More than a year into her new role she expresses a sense that there is still no strong, secure foothold for herself and her work and that gains she has made could topple over at any moment. It seems that she is making no real headway, and she feels that she might just as well withdraw from the struggle and focus on her role with children. To be always in battle mode is to be feeling defensive and subject to criticism, a frustrating and emotionally draining situation. Prolonged experiences of indifference may lead to resignations. One says, “Despite it being stressful, if I’d felt that the job was one that was valued by the hospital then I would have stayed”.

Other participants, however, seem less discouraged and able to sustain the effort needed to be pro-active in establishing themselves. Common strategies mentioned by participants are to ensure that their interventions are documented in the notes, giving feedback to other staff about how they have been involved and the outcomes of this involvement, and

joining with nursing staff at informal times such as tea breaks. One talks of the success she has once she decides to advocate for herself and “really put myself out there to be used”.

In contrast to their interactions with staff, experiences of indifference are not recalled with regard to the new play specialists’ relationships with children and families, where they tend to describe their intervention and support as recognised and, usually, as valued. As one participant explained, when she feels discouraged about her struggle to maintain a position in the team, she sustains her sense of job satisfaction from “the children, the people who are receiving the service – the grateful parent, the exhausted parent, the child where you know that a little thing, perhaps just the five minutes you spent with them, has made a difference”. Part of the difference novice play specialists can make for children is ensuring that they have access to playroom space and programmes, yet securing a place for children and for themselves may also be experienced by the participants as a struggle.

The struggle for a place

Playrooms themselves are the focus of struggle. Play specialists may struggle both to secure the playrooms as their professional space and also to ensure that they are valued and preserved as a place for children and young people. Van Manen suggests that when we want to understand a person’s world or their profession, “it is helpful to inquire into the nature of the lived space that renders that particular experience its quality of meaning” (van Manen, 1990, pp. 102-103). The hospital playroom is where play specialists spend much of their time, and it is therefore a significant space for them both personally and professionally. Hospital playrooms are their “home base”, the place where they are most able to feel at ease. For some, their administration area occupies a part of the playroom and there is nowhere else in the hospital that is not also the everyday workplace of colleagues from other disciplines. As well, as has been shown in earlier chapters, hospital playrooms are “safe spaces” for children, free of the threat of invasive procedures or treatment. They may also be licensed early childhood centres, subject to regulations established by the Ministry of Education.

In some units, playrooms may remain open when play specialists are not on duty, or they may function as a parent lounge in the evenings and weekends. Some tension may arise

between the playroom as the domain of the play specialist, the playroom as the child's space, and the playroom as a shared space within the ward. All the participants have similar stories to tell about their struggles to maintain playroom space as a safe and stimulating environment for children. All experience incidents when the playroom is used for families to sleep in, where cupboards are left unlocked in weekends, or where the room has been "trashed". Some of these experiences are very discouraging, leaving the play specialists feeling, as one said, "Oh, what's the point? What am I here for? I'm just a cleaner". However, play specialists are protective of playroom space and this seems to be an area where most are able to be assertive, as the following comments illustrate:

*I was very particular about what people did in the playroom. When I first turned up people were just treating the playroom like it was a waiting room. It was getting tagged and it was disgusting and people were ruining things and breaking into cupboards. So, what I did was to sort out a lock, and I wrote down all the reasons why it would be beneficial to have a lock for the door, and once that was done it made my job a lot easier. I felt like, by doing this, it ensured there was a space for the children to use and I think people **respected** it more. The nurses would say to the children, "You'll be excited when you get up in the morning because the playroom will be open." It became a special place for the children to go and people really looked after it and really respected it. And I think they respected the **service** better because they didn't just view the playroom as a place to get toys – they valued it as a place for children to use for therapeutic play. It was really good*

This participant is clear about how the playroom should be used and cared for, and she takes decisive action to protect it as a special place for children. In writing down why the room is important to children, she helps other staff understand the importance of play. She is gratified to subsequently find that her actions result not only in more respect for the playroom environment but also in greater understanding of and respect for the play that takes place in it and, consequently, for her service more generally. It is through being particular that she has made it a special, even exceptional, space. Another tells how she felt she had to be "overly assertive" to ensure that playrooms were available for children. She tells how she found the playroom being used by senior medical staff for a teaching session with medical students. She reminds the group that the playroom is the children's space and asks them to leave. She continues, "I think they were a little bit embarrassed, but, you know, I wouldn't take ten children into their office and take a whole lot of paint in there and let the children do what they liked in *their* space". By keeping the focus on

children's needs and right to play, some potential tensions or conflicts between staff about the use of the room are averted. The playroom is defended as the child's place to be, somewhere where children may have control, pursue activities uninterrupted, and where they are emotionally safe from potentially threatening medical interventions. This helps other staff to see that they have a shared responsibility for its availability and maintenance.

As well, however, the playroom is a special place for hospital play specialists. It is their domain, too. They enjoy the flexibility and autonomy that goes with playroom management and programme planning. As one participant says, in the playroom, "You don't have to say to someone else, 'Oh is it ok if I do this', or, 'Do you mind if I do that?'" Respect for the playroom seems to be equated by some study participants with respect for the role of the play specialist. One makes this explicit when she says, "I'm saddened that the service isn't valued enough, or seen as being important enough, to actually have an area that is physically ours without it being disturbed all the time".

Some play specialists strategise early on to ensure there is a shared sense of ownership of the playroom with nurses, in children's best interests. One person, who also experienced problems with damage to the room, encourages nurses to utilise the room and its resources. She actively discourages them from regarding it as her exclusive domain.

*One by one, I've let each nurse know exactly where things are. And I've done educational days about development and play, and they ask questions and then I see them trying out techniques I've told them about. And there's some nurses I've tapped into – one's quite artistic and she's made a lot of things and it was just so great. And another helped me paint all the furniture. And another has a husband who's a good carpenter. So that's helped them to take ownership as well. I think it's just working with your colleagues. Knowing their good points. And realising that nurses have got into paediatrics because they really like children not because they want to do mean things. So empowering them to do some of these really cool things has brought a bit of light back into **their** jobs and made **my** job a lot easier. The playroom is closed when I'm not here purely because it gets trashed. But we're starting to change that. If you're responsible, if you open it up for the children you're with and stay with them, then it can stay open. And now I have them coming to me in the morning saying they had it open for three hours and, look, it's nice and tidy and they've sorted my books out too, so that's great!*

By acknowledging the skills of her nursing colleagues, their potential to enjoy getting to know children through play, and by being inclusive of them, this participant is gradually

developing a shared understanding of the importance of the hospital playroom and a trusting relationship with her colleagues. She sees their realities and acknowledges that they, too, are in the world of a hospital because they like children and want to help them.

This theme around the struggle for a space shows two contrasting ways that people manage their work space, one way being of defending and the other of inclusion. Those play specialists who are able to engage with their colleagues and help them to better understand how they can work together, begin to establish not only a physical place for children but also a place for themselves within their healthcare teams.

Experiencing loss

Another aspect of struggling shows in the internal struggles that new hospital play specialists have in relation to the children and families with whom they work. Van Manen says that, “To care for a child is to provide for and to attend to a child in such a way that we should not be surprised that we will be burdened by worries and deeply rooted concern” (van Manen, 1990, p. 58). Where play specialists have opportunities to become close to children over extended periods of time, they may struggle with the emotions aroused by the need to let go of relationships. One participant describes her feelings, as follows:

You build up a relationship working with them and helping them manage procedures over weeks, and then they go and it's really sad sometimes. You can't really say it's upsetting, but it's definitely different from early childhood. You can't be sad about them going, because they're well. And we have such a high turnover that the next one comes along and you're busy with them. But you can't... you can't dwell on it, I guess.

Sadness is one of the emotions that this novice play specialist feels at times when children leave the hospital. Loss of relationships is another reality of the world of a hospital, yet it is something that she feels she should not indulge or dwell on because there are always new children who need attention. Becoming close to a child and then letting the child go, often with no opportunity to find out how they are managing when lost from view post discharge, may cause play specialists to struggle with mixed emotions of happiness for the child overlaid with their own sense of loss.

The emotional content of the work may lead some participants to take upon themselves a burden of care that contributes to the anxiety they experience in the early days. They may struggle to cope with their own feelings regarding the personal situations of some of the children. The experiences that are hardest to let go of are those involving children who have complex family situations of neglect or abuse:

*It's really difficult when a parent comes in and is just really tough and obviously domineering to the child and you've got to sort of sit back and say "Oh hi, how are you? I'm so-and-so". And you've got to still be really nice and take your professional role away from your emotional one. I've found those ones hard to take. I've worked with children who have been abused before, but actually having a physical child who has got physical things happening to him from being abused and then seeing **him** as a person.... I think that's been really hard. Because he's **there**. He's sitting there, and then he goes home with them. And there's.... There's nothing you can do. He goes home and that's it and you don't know what happens to him from there really.*

Situations such as these, where the participants are working both with the abused child and with the family, amongst whom may be the abuser, are experienced as particularly hard. There is no protective barrier here. Novice play specialists may struggle to be courteous and professional and to separate their emotional response from their professional role. It is very different from situations they may have come across in teaching, where it is possible to put some emotional distance between the child and the fact of the abuse, where it is unlikely they will have a relationship with the abuser, and where the abuse may be only suspected rather than confirmed. The sense of helplessness is exacerbated by the short-term nature of the contact and the likelihood they may not find out what happens to the child. As another says, "There are things you do that just stay with you. That's when I find it hard to finish at work."

Another experience that stays with the participants, is the death of a child. One participant describes her first experience of a death on the ward. It is a boy with whom she has worked for three months, and whose death was not anticipated:

*There weren't **many** times when I felt really emotional. Probably, just when that one boy died. In the time I was there, there were a lot of children who came through with physical or sexual abuse, and people would say, "How do you cope with that?" but I'm fairly open about how I feel and I'd seek out another play specialist or a nurse I was close to and just chat. But when he died, I was upset. He was getting ready for discharge, and then it*

happened so quickly. It was my first experience of watching a young person die. I remember talking with two play specialists before he died and they were really good. They were saying, "What bit are you scared of?" And I'd say, "I feel really scared about the unknown". I didn't know when it was going to happen, I didn't know what it would look like.... And I said, "What if he dies and I'm in the room?" And that sort of thing. So we really talked about it and that was great. The staff on the ward spent a lot of time talking about how we felt before he died. We had a meeting that was really useful, everyone turned up and it wasn't a hierarchy, which was really nice. They were all crying, but I found, for me, I couldn't let go. It took me a really long time. The day he died was the most emotional thing for me. I'm good friends with a nurse who was with him when he died so we had a really good chat about everything. And the charge nurse was really amazing at acknowledging people's relationships and their emotional welfare. So, even though it was an awful experience it was really amazing in pulling people together. It was incredible. The ward felt completely different afterwards.

For this new play specialist, the death of this young person is something that she struggles to deal with emotionally. Her distress is intensified by the sudden and unexpected nature of his death, and the over-turning of expectations that he would improve and go home. Despite the good support from more experienced play specialist colleagues and from her charge nurse and ward colleagues, the death is a very emotional experience which stays with her for months afterwards. Play specialists commence their work in hospital anticipating intellectually that sooner or later they will experience the death of a child. However, such an experience is likely to be more intense emotionally than anything they have previously had to deal with in teaching. They may have got to know the child and family well during their illness and feel that they have been a significant person in their lives. Unlike nursing and medical staff, who have specific cares to perform, they feel uncertain of their role as the child's condition deteriorates. They may struggle with uncertainty about how to relate to the family or to the child, or how to judge whether their continued support is welcome or an intrusion on the family's grief. As well, for some, because of their own relatively young age, they may not yet have experienced a death amongst their own family or friends. Where a child's death in hospital is the first death they have experienced, then this may contribute to the intense emotional impact. Out of a shared experience of grief and loss, through being well supported, can come a new awareness and regard for each other as individuals and a strengthened sense within a team of shared purpose and shared humanity.

Summary

In entering the new professional world of a hospital, novice hospital play specialists may experience their previous realities of the world of teaching being turned upside down by the foreign-ness of the hospital world. This chapter shows the struggles that result for the participants as they attempt to develop relationships with others and to establish a personal and professional place to be. The stories reveal participants' experiences of vulnerability, and their anxiety about how to ensure they have sufficient knowledge and skills to practice safely in the unfamiliar environment and culture of a hospital. It shows, too, their difficulties in getting to know others, and in becoming known, and how disheartening it can be to feel that they and their roles are largely invisible within their teams. The chapter also reveals the participants' experiences of coping with loss of relationships. For some, facing continuing struggles with the realities of a healthcare setting may be a regular part of their lived experience of the world of hospitals many months after commencement, leaving them feeling discouraged and frustrated. However, it seems that in allowing the process of change to happen and accepting that there will be periods of vulnerability along the way, new appointees begin to see the possibility that they may find a place to belong. The focus of the next chapter is on participants' experiences of becoming members of the hospital community.

CHAPTER SIX - FINDINGS

Learning the Language of Colours

Chameleons use their ability to change colour to both adapt to changing environments and to communicate states such as anger, fear, calm and distress. A green chameleon is peaceful, calm and serene, whereas a yellow chameleon is surrendering. It takes baby chameleons a year to learn the language of colours and to read the messages portrayed by these colours through interacting with more mature chameleons.... As with the chameleon, the ability to change *colours* is part of the learner's self-preservation repertoire to deal with the diversity of environments, settings and community, and in doing so, the learner becomes adept at being a member of multiple learning cultures and communities.

Bourke & Burns, 1998, cited in Rogoff, 2003, pp. 257-258

Introduction

Just as it takes baby chameleons a year to “learn the language of colours”, so it takes time for novice play specialists to adapt to the hospital environment. As newcomers, they want very much to belong to the multiple communities that make up a hospital, yet the previous chapter has shown that they may struggle to achieve a “self-preservation repertoire”. As has been revealed, interactions with other staff and families may intensify their feelings of being not fully prepared and vulnerable, especially where they discover that the “colours” of those around them may change in ways that are confusing and difficult to anticipate. However, we have also seen how the participants’ sense of belonging to their new profession and to the world of a hospital is enhanced where they have the support of more experienced colleagues who are themselves at home and have learnt the language of “hospital colours”. The novice play specialists’ challenge becomes one of learning to adapt and to “read the messages” in their new environment, whilst still preserving their sense of their own colour and of what they can uniquely contribute. This chapter explores experiences that reveal the ways in which participants recognise the progress they are making in becoming adept and contributing members of the new communities.

Recognition that they are adapting to their new roles is one of the signposts along their professional journeys towards becoming proficient hospital play specialists.

Adaptation

To adapt is to adjust or fit, to become acclimatised or accustomed (Allen, 1990). An adaptor is therefore someone who is able to adjust to new circumstances, to change in ways that make the person more useful or functional in a new environment. An adaptor may also be something or someone that is an aid to compatibility. In their move to a hospital setting, and their change of role from teacher to hospital play specialist, newly appointed hospital play specialists make many adaptations. As will be seen, these include adjustments to the physical environment, opportunities to extend their knowledge and skills so that these better fit their new roles, and changes in the ways in which they work.

Chapter Five revealed the impact on the participants of the physical environment of a hospital. Because play specialists are largely playroom based, adapting the playroom environment and their familiar ways of working to the hospital context is an early challenge for new appointees:

I worked at a centre where they were very much into natural things and into the outside, the sand, the sticks and stones, and those sorts of things. But it just comes down to adapting. We do the sand inside, we do the gross motor stuff that perhaps would be done outside, inside. It's just back to that adapting thing. We've got our playroom and a big corridor, so if you notice that the children are quite on the go, we can give them a ball, or a bike, and adapt like that. If they're stuck in their bed, we can give them a soft ball.

For this participant, the lived space of the hospital playroom is very different to her previous work environment. She modifies the way in which she provides activities in order to ensure that children, so far as possible, are not disadvantaged by their hospital circumstances. She shows her awareness that children in hospital may be more reliant on adults to anticipate their needs by being watchful for indications that they need additional opportunities, for example, to expend physical energy. Despite the sense of foreignness and the intense impact of their early impressions, new hospital play specialists seem to

experience little difficulty in fitting the way they work to the largely internal environment and the constraints posed by the special needs of children in isolation or confined to bed.

One participant only fully realises the extent to which she has adapted when she has an opportunity to see the playroom through a student's eyes:

I looked at the environment from the student's perspective and I thought, how grotty it looked. Makeshift furniture, nowhere decent to wash stuff, no routines. And there was just so much coming and going; parents and the children and various other people coming in and out all the time. It was absolutely amazing if you sat there and just watched. It was just like a three ring circus! But she was very enthusiastic. She seemed to really enjoy it. So we must have done something right, because she was very keen to come back. [Laughs]

The playroom is chaotic by comparison with this participant's previous setting, where she could predict which children would be there, and plan with some certainty for the day's activities. However, while she experiences some initial discomfort in relation to the student's possible response, she finds that she herself is not unduly bothered by the disorder. She discovers she is seeing the room no longer as a stranger might but, rather, as an "insider". Up till that time, she has not been consciously aware of how much she has adjusted and now realises, somewhat to her surprise, that she has become adept at working in this setting. She has developed a "self-preservation repertoire" that enables her to manage competently in the demanding and diverse role that is the reality of her new role. Furthermore, it seems from the student's response that this play specialist and her colleagues have made the playroom a place where "outsiders" feel welcome and where they enjoy themselves, despite how different it is. Standing back a little, and seeing their work as others might see it, provides novice play specialists with opportunities to re-frame what appears to be chaotic as a busy and complex workplace, a place where their skills are evident to themselves and to others.

Part of "learning the language" of hospital, is the opportunity for new appointees to adapt and extend their knowledge. The participants recognise that what they bring with them from their previous training comprises only a small part of their current role.

I guess you've got that early childhood knowledge there, and one part of this role is trying to adapt what you know to fit the needs of the children you're working with. I find myself doing a lot more work with children with

special needs than when I worked in early childhood. Parents ask me for information so I find I need to go back to research things like Downs Syndrome. Also, I do some learning about the physical aspects resulting from the treatment that the children have here, and how this affects their movements, whether or not they can get out of their wheelchair and so on. I actually enjoy that part of the role. Having to think outside the square – what can I do for this child? Just thinking, ok, what can I do here?

“Thinking outside the square” is part of the enjoyment and challenge of the work for this participant. She is not professionally threatened in any way by “not knowing”. Rather, she finds it stimulating. Requests for advice and information are welcomed as opportunities to seek further information in order both to increase participants’ own knowledge as well as to ensure that they are providing as well as they can for children. Similarly, in referring to her enjoyment of the new learning involved in her role, another participant says, “The more I read the more I find out, and the more I’m like, ‘Wow! Wow!’”

Stories emerge that show that as they gain more experience, the participants become more realistic about what they can achieve in the limited time they have. They make adjustments in their expectations and in how they prioritise their time with children:

I had to change exactly what I achieve. My outcomes are a lot smaller. When I first started I would see everybody. I was running around like a mad person really and spreading myself too thin, far too thin, because the expectation before I arrived was that the play specialist sees every child. Now I’m a lot better at prioritising. So now there are some children I just don’t get to see at all. Professionally, I found that hard because that’s not the kind of person I am. I’d like to see everyone but if children are of similar ages and have similar things happening, I’ll do it in a group, and that’s working really well.

As a new appointee, this participant set herself goals that she believed were expected of her, but that were unachievable. She felt she was spread so thinly amongst the children that needed her involvement that she was unable to be effective. Her decision to work with only some of the children is one with which she has had to wrestle as it conflicts with her view of herself as someone who provides an inclusive, quality programme. However, she has adapted her programmes in order to find a compromise that is both self-preserving and acceptable professionally. Similarly, another participant describes how she learns to fit in with the realities of time constraints and workload:

*Now I know I can go in, and even by looking at my stats I know I am getting the ones I can when I'm there. And that's something I think you just learn. Just, that's ok I can't get the ones in the weekend and I can't get the ones that went to theatre at 7 o'clock before I got to work. So I think about what else I **can** do for that child. I mightn't have managed to do the prep beforehand, but I can do something afterwards. I can also just make sure they're ok afterwards.*

In her five day week, this participant cannot be everywhere she would like to be. There are aspects of her role that she is not able to undertake for every child on the ward. However, this is not something that is a burden to her. Rather, she learns to accept what she is unable to do and focuses instead on the positive things that she can still achieve. By following up with a child she has missed, and checking on how the child has managed, she indirectly reassures herself that she, too, is “doing ok”. It seems likely that by adjusting what they are trying to achieve, and by seeing these adaptations as a necessary response to changed circumstances, novice play specialists are able to re-gain a sense of themselves as doing the best they can without unduly compromising their professional values.

Adaptation is also experienced in relation to working with parents, who are present for much of the time with their hospitalised children. Where participants' views differ from those of parents, some tension may be created:

*You're being drawn between what the parents want, and them parenting as **they** want to, and your knowledge as an early childhood teacher. But sometimes there's nothing you can do. You can't take away from a parent's wishes I don't think.*

This participant seeks a way to practice that is respectful of parents' views, but which does not unduly compromise her values as a hospital play specialist. At the same time, she accepts that in the hospital context it may be more important to uphold the family's values than to provide for the child's learning in the way that she would have hoped. Novice play specialists' commitment to valuing family expectations and ways of doing things may be challenged when their beliefs differ from those of the family:

One thing I've found quite hard around cultural stuff is where children are having painful procedures that are really upsetting to the child, but where the family just joke and laugh while it's happening. You can tell the child's used to it, but it's still hard. For me, with my background, I think “How can they sit there and laugh when that poor child's in pain?” I always thought I was really multicultural, but going into that environment it's

completely different. The first time I saw it I was kind of shocked. But when it was over, the child was sitting there laughing with everyone else. I've had to step back and look at it from other people's perspectives and I guess just accept that that is the way they do it. And this is the way I do it. I might not like their way, but that's the way it is. I've got to realise that my little bit of input is not going to change their whole values. That's all I feel I can do – have my small bit of input and tell them how I feel it should be, or the strategies I would use. Then that's it. Leave it at that.

This participant feels torn between her sympathy for a child in pain, her own beliefs about what should happen, and her intellectual commitment to respect for family and cultural practices other than her own. She is especially challenged by this experience as it requires that she re-think her view of herself as someone who is multicultural and values diversity. She takes her cues from the child's responses and is reassured by observing his ability to recover, concluding that his emotional wellbeing is not at serious risk, as she at first assumed. She adapts her responses, but her acceptance of the family's way of coping does not prevent her from sharing with them the strategies she would suggest to help the child manage with less distress. In this way, she provides the family with alternative options for future situations, yet leaves the choice to them, and in so doing she preserves her sense that she has done the best she can professionally. By recognising that their involvement is only a very small and transitory part of children's lives, novice hospital play specialists are able to be more accepting of difference and more open to the possibility that there are many ways of coping and of being a parent to a child in hospital.

One part of "learning the colours" of hospital, is becoming more aware of the pressures and stresses that are affecting other staff and families, and the impact these may have on interpersonal relationships. One tells, laughing, of how she learned to stay "a green chameleon" in the face of outbursts of distress and anger, by discovering that "It's not always **you**" who is to blame:

*People are in a really stressed environment and **anyone** who says **anything** is going to get that kind of reaction. When I first started I looked for reasons in myself and what I had done. I've got over that now! I think that's an experience thing really. You see all that those families go through and they're all different and you just learn to cope.*

Thinking about how she has been interpreting the messages portrayed by others helps this novice practitioner to see that there may be many reasons for a family's distress that do

not reflect on her. She adjusts her expectations of what is courteous in the light of her enhanced understanding of the other stresses that may cause people to act like they do. As their experience grows, the participants gain a deeper understanding of the impact on families of having a sick child, of the unique nature of each person's response, and also, perhaps, of the impact of hospital systems that may frustrate staff who are trying their best to support families. With this increased understanding, they are freed from the burden of feeling that they have a direct responsibility for how children and families manage. As has been seen, the novice play specialists begin to adapt not only to the realities of the changed physical environment and time; they also become more knowledgeable about the multiple communities that make up the world of a hospital, and more adept in interpreting the messages portrayed. In turn, this helps them to be more open and accepting of others.

Showing tact

Van Manen gives the term "pedagogic tact" (van Manen, 1990, p. 169) to actions that preserve children's space, protect those that are vulnerable from injury or hurt, enhance the unique, and sponsor personal growth and learning. Pedagogic tact may manifest itself in a number of ways, including through open-ness to a child's experience, by holding back, by demonstrating situational confidence, and by having a gift for improvisation. Pedagogic tact, in van Manen's view, is closely related to pedagogic competence. It involves "a kind of thoughtfulness, a form of praxis (thoughtful action: action full of thought and thought full of action)", actualised in real encounters between children and adults (van Manen, 1990, p. 159). Pedagogic tact seems to be similar to what participants in this study describe as "being real" or "being authentic" in their relationships to children. "The touch of tact", van Manen says, "leaves a mark on a child" (1990, p. 169). In other words, it makes a difference to a child's experiences of being in the world.

Participants in this study told me many stories of times when they felt that the opportunity to simply be with children and families during difficult times had been helpful or had made a difference, even though they had "just chatted" or had acted as "a listening ear". One participant, called to intervene with an angry and disruptive young person, recalls that she "just talked quietly" to her, and got her some things to do. From that time the young person sought her out each day in the play room, and the play specialist comments,

“Obviously, what I did on that day was just be this person that didn’t come in and put needles into her or try and get her to sit up”. It seems that by holding back, by not making any demands on the young person and by not being a part of the treatment team, this play specialist was able to use this seemingly insignificant interaction as a basis for development of a trusting relationship which could further develop with time. At the same time, by effecting a change in the young person’s behaviour, the novice play specialist is likely to have satisfied the expectations of her role held by the person making the referral.

There are times when the new play specialists are able to be emotionally or physically present for children or for their siblings when parents or family members cannot be. One hospital play specialist recalls accompanying a child to theatre, holding his hand while anaesthesia was induced, and being with him during recovery. She describes what she did as, “just being a parent replacement for that day, someone to be there who was on his side”. To this participant, the value of her accompanying the child is not in what she actively does, it is in the “being with”. As someone who has managed to develop trust with him and who is not part of the treatment team, she is able to make a difference for this child through her attentive presence at a time when his emotional needs are heightened.

The experience of showing tact reveals itself most often in stories that revolve around times of emotional intensity for children and families. It seems that relationships formed within the playroom setting can be very significant at such times, as the following story shows:

We had a family whose father had had a major accident. The mum had a newborn baby and several other children. From what I could see, the wee baby became the father in the children's play. They played in the medical corner and they pretended that the baby had the injuries of the father. I could have wept. It was an incredible thing to observe. And I didn't do anything – I just stood back and watched – and I could see and feel the value of the playroom being there and the value of having the medical corner. I couldn't help but wonder what would have happened and where those children would have been if they couldn't have come to this place. That was one of those days when you felt that your service was important and made the difference for the children.

To be part of the world of these children and to see how their father’s accident has affected them, is experienced by this new hospital play specialist as very moving. It is

enough for her simply to be present with the children and to give them the time and space they need to play through the experience of their father's accident and hospitalisation. She says that she has done nothing to support this play, yet the children's involvement shows that the environment was one in which they had both the resources and the necessary "permission" to play through the tragic situation that was so big a part of their recent and ongoing life-world. Participants demonstrate tact in situations such as this when they show by their attentive presence that they are fully available to children, yet are sufficiently confident not to intervene. They act in ways that are "thoughtful, tactful and sensitive to the child's experience" (van Manen, 1994, p 20). Their support is shown by "knowing how to listen, seeing each child as unique and different, understanding fears and vulnerabilities, encouraging success, remaining patient and supportive, and being reliable, trusted by, and available to children" (van Manen, 1994, p. 20).

In a similar story, another participant tells of how she felt she made a difference to a family by being available to children whose infant sibling has died. The child's death is the first this participant has experienced. After describing the close relationship she and her colleagues developed with the baby's brothers and sisters, and the playroom activities that were provided to help them express their feelings, she continues:

Soon after the baby died the oldest boy said, "My baby is sitting on a rainbow watching us". That was amazing. So what we did was give him a book about a Maori grandmother whose grandchildren come to visit and make a rainbow on the beach using the materials and colours they find on the beach. They get to the last colour and when they arrive the next day the sea has washed it away. It talks about how sometimes things that are precious and beautiful to us don't stay with us. And we were able to give that to the children. And there were all these little things that flowed and were just so appropriate. We went to the funeral and we felt really part of the family. We felt like we had been able to be there for them on a very important level.

It is not surprising that being closely involved with a family whose child is dying is an intensely emotional experience for a new play specialist. By being open to their experience and by finding a way to acknowledge the loss that the children and family have undergone, she feels that they have made a difference in a significant way for the family. The death of a child brings home to participants, probably more than anything else, the very different context in which they are now working. The participants' experiences in

being with children and families at such times reflect the “appeal of the other” (van Manen, 2002, p. 8). It is as if the children “burst upon” the novice play specialists in ways that leave them feeling “charged with responsibility” (van Manen, 2002, p. 10). However, it seems that recognising they can “leave a mark on a child” by acting in ways that are thought-full and tact-full ensures that such experiences are deeply satisfying. For one participant:

Sad things do happen here, but you're doing the very best you can. Seeing the best outcomes possible under the circumstances and knowing that perhaps in some way, not through any huge expertise of mine, but just through time, I've been able to help ... That's really rewarding.

Recognition

The importance of recognition to professional wellbeing is spoken about by van Manen as critical (Lecture notes, van Manen workshop, Auckland University of Technology, 9 October 2003). He describes the need to be “seen” or regarded as somebody by others, as well as the need to be a somebody in one’s own eyes. To be recognised is to have one’s existence or one’s work acknowledged and valued, or to be seen as significant in some way. According to van Manen we may recognise “who we really are” or “who we want to be” in some other person or experience. As will be shown in the next section, recognition by others or by self comes through in participants’ stories as important to their developing sense of confidence that they are “learning the language of colours”. This recognition is evidence that they are becoming adept in their new roles as hospital play specialists. There is another meaning of recognition, that is, to identify what is already known or to know it again (Allen, 1990). The stories in this first section show experiences of re-cognition.

Knowing again what is known

Previous themes have shown that during their early days and weeks in the hospital environment, participants may feel their prior knowledge and skills are irrelevant. With time, their stories reveal changes in how they see themselves and their abilities:

*I think my confidence has grown so much. Just a **huge** amount. I'm more confident in what I say and in realising that I **do** actually know what I'm talking about. I did train for three years, after all. I think when I first stepped into that environment, for a while that kind of stuff went out the*

door because I felt that there was this little bit that I did know, and this huge bit that I didn't know. But now, drawing on what I do know, sharing that with people, and being a bit more confident as I learn, plus being in the environment for a longer period and knowing more about it. Just little steps at a time I think. A little thing that happened that day. A little thing that happened this day. I told that person that and it worked. Or, I did that with so-and-so and he was able to cope.

At the start, this participant felt that what she needed to learn far outweighed the skills and knowledge that she brought with her. However, she is recognising that her previous training is relevant, after all. This new practitioner is taking small steps, but they are different from the tentative ones with which she stepped into her new role. Neither are they the “baby steps” described by the participant in Chapter Six, who felt she might totter and fall. These are confident steps, even if they are only little ones at this stage. Novice play specialists who can see that they are having some impact, no matter how small, feel that they are making progress. As they learn to “read the colours” in their new world, they are re-discovering their own strengths and gaining confidence in their ability to use them in the new context. With this increased confidence comes the ability to be open to their need for ongoing learning, at the same time knowing they can contribute as they learn.

One participant sees her previous early childhood training and experience with families in a new light:

I think that having early childhood training and valuing play in child initiated involvement, and having the theoretical knowledge and knowledge of how children interact is really important. Even though I'd not worked before with older children, I find in playing with them and talking with them, the training still comes in. Coming from early childhood education and having experience in different settings you realise that the family and community are really important and you value the family as being the first caregivers and the major influence in children's lives. I find in hospital I'm looking for what sort of intervention is needed and how well the families are coping and how much influence they have. You learn to see what the family is saying, even though they are just having a conversation. You can actually hear whether they are coping or whether they're not, or whether there are systems in place for the family.

This participant is re-discovering the relevance of what she already knew. Despite not having worked previously with children older than preschoolers, she discovers that her skills in playing and communicating with children are equally effective with older children. As well, she finds that she can readily adapt her ability, learnt in early childhood

teaching, to “read the messages” portrayed by families with regard to how they are managing in hospital and whether they may need extra support. Other participants, too, find that the knowledge of families and family dynamics that they have learnt in teaching, is very useful in the hospital setting. From her experience of working in the community, one says, “I knew the kinds of places where a lot of the families came from, the kinds of background they were in, the other stresses and strains they would have”. It is as if first impressions of hospital were so overwhelming that participants were unable to see the usefulness of their skills and knowledge. Now, they begin to know again what they knew before, and start to see that what they are doing has value. Recognition may come from within, or it may develop from knowing that others see their worth.

Recognition by others

Recognition is experienced when others demonstrate in some way that they regard the new play specialist’s involvement as useful or significant. Some participants are able to describe a particular situation that they consider to be a turning point in their relationship with others:

*Not long ago a boy came in with a chronic condition which required regular injections and blood tests. He was having real difficulties with these. For some reason the phlebotomist came and got me and together we were able to develop a coping strategy with him. By documenting that in the medical notes and by talking to the other staff, and them writing it into the handover sheet, we made it clear the steps we went through every morning to help him cope with having a blood test. And that definitely made a difference. Previously, the phlebotomist would never ever come, she wouldn't see me as an option, but after that **one** time she now calls me **all** the time to help children and support them through blood tests, which is good. It's great. It feels like you're getting somewhere. When you go to work you want to feel you've achieved something and just that small little thing, that one thing – the phlebotomist coming to get me – makes a huge difference to me in feeling like other staff can see what I've done.*

Just one opportunity to work cooperatively with the phlebotomist is seen by this participant as marking a point of decisive change in their relationship. From feeling that the phlebotomist was indifferent to her, she is now delighted to find that she is called all the time. At last she feels she is making progress, and that her contribution is being acknowledged. In working together and in sharing the planning and follow-up work, this play specialist believes that she is becoming more visible to all her colleagues, not just to

the phlebotomist. Being sought out by staff of other disciplines shows new hospital play specialists that their knowledge is valued by others and helps them find a place within multidisciplinary teams. Inclusion in a team, rather than being at the edge of one, shows acceptance and gives confidence that a corner has been turned.

In a similar vein, the following story shows another participant at a turning point for her:

Because I'd prepared him before, I knew he was really frightened about being cut open. So the next time, when he did need quite a large operation, I was able to let the team know how scared he was. Also, I knew him well enough to judge how much to tell him and how much not to tell him till he came out the other side. And that was all possible because of the nurse making sure I had the opportunity beforehand the first time. It was that whole collaboration thing.

A referral from a nurse prior to an earlier procedure, ensures that this participant is able to provide effective support to the child and useful feedback to the team. The nurse's approach is evidence to this play specialist that she values her role sufficiently to seek her out and ensure she has time to see the child. Receiving a timely referral demonstrates to participants that staff of other disciplines recognise how play specialists can contribute to children's wellbeing and recovery. To know that team planning for children's health care includes anticipating play specialist involvement helps these novice play specialists to feel that they are part of the ward teams.

Another participant describes the significance to her of being recognised, when she comments, "I was away for about a week and when I came back people said, 'Oh we missed you!' I felt I was between two teams, whereas now I feel I'm part of the ward." She no longer feels that she has to struggle to be involved. Instead, she feels her colleagues are eager to seek her out. When she returns from leave, her colleagues take time to let her know that they have noticed her absence and to make sure she knows what has been happening on the ward. While she has her play specialist team in the background to support her, it is the nursing staff on the ward who are her everyday colleagues and it is their language that she "reads" in order to assess whether she has been accepted. She attributes her increased sense of belonging to the opportunities that others have had to see her work and to "learn her colours". Successful experiences of working collaboratively with staff of other disciplines enables the work of play specialists to be seen and

understood and helps them to feel they have a place. “Belonging” may be experienced by something as simple as inclusion in the routine happenings of the ward and in day-to-day social chat.

Recognition can also come from increased visibility on the ward. One participant who described that she had previously been feeling sidelined from the team within which she worked, tells what happened as the result of making sushi with two adolescents who were on wheelchair rest:

It was so much fun! It was an extension of the boys' interests, from the day before... All the nurses poked their heads around, 'Oh, are you making sushi?' And the team leader came in – "Are you making sushi?" And I put some on the plate for the team leader and she took some down to the manager... It really helped. It helped the whole ward. It was fun, heaps of fun.

Seeing that the activity has enticed participation by a wide cross-section of the ward compensates in some way for previous occasions where she has found it difficult to involve others or to feel that she is a part of the unit. Activities such as this can involve a wide cross-section of the ward, breaking down communication barriers and hierarchies, helping children, families and staff to see each other in new ways. They provide a springboard from which new play specialists may build more positive and supportive relationships within their ward communities.

Where the novice play specialists are less available to work with other staff, this may make it more difficult to achieve recognition, as one participant describes:

Before, I could be relied upon to be available and perhaps was more visibly there and able to support children and be involved and that was really good. But because the circumstances changed I've gone back to just running the playroom and I've again become this sort of unreliable 'might be available, might not be available' person.... So I've put in the communication book that I'm available all day, approach me, and if I can't do it I'll let you know.

To be unreliable is to be someone who is erratic and inconsistent, and who may let others down. Instead of being actively involved and visible on the ward, this participant fears that she has taken what she feels to be a backwards step into the playroom. When play specialists work mostly in the playroom they may not be “seen”, both literally and

metaphorically by their colleagues. They become people whose colours keep changing and are therefore hard to read. However, it may be that the playroom setting is where they are most visible to children, and most able to “be with” them. Tensions can arise between the need to maintain a safe and stimulating playroom programme, the supervision requirements of the Ministry of Education, and the need to be available to work with other staff on the wards. Working in the playroom may seem to erect a barrier insofar as it separates play specialists from the ward communities and reduces opportunities for hospital play specialists and other staff to learn to read the messages each portrays.

Recognising others

Together with an enhanced sense of being valued by others, participants’ stories show their increasing recognition of the contribution of others. One new play specialist, commenting on her adjustment to working in a multidisciplinary team, describes how this helped her to see things from the point of view of her colleagues, saying, “It’s a whole new dynamic. Like realising that nurses have a schedule too!” The new play specialist appointees begin to see that they are not the only people who may struggle for recognition:

The social worker was also having difficulties getting referrals, and just being able to discuss things with her and know that there’s someone else in the same boat as you, who’s working alone and trying to find information ... the physio felt the same way too. That really helps.

In discovering that there are others who also feel isolated and who are having difficulties in communication, this new appointee feels far less alone and sidelined. Whereas the new play specialists may have seen themselves as outsiders in a world where everyone else belongs, they begin to see that there are different degrees of belonging. Awareness of others’ similar needs and problems takes the experience of isolation away from the individual. Another participant is looking forward to providing training sessions jointly with a newly appointed nurse educator, commenting that, “It’s going to help my profile which is good. We keep each other on each other’s toes, pointing out things to each other, and sharing different experiences. She’s a really good colleague”. This is a two-way relationship, where there are shared experiences to learn from and where both are able to challenge each other without risking a breakdown in the relationship. Rather than feeling that their experiences are unique to them or to their professional group, the new play

specialists begin to see that they have allies whom they did not previously recognise, yet who are potential sources of support. Healthcare professionals who once seemed very different from themselves are now seen as having much in common. They are appreciated in new ways, as potential allies in challenging difficulties inherent in the systems and the culture of the hospital setting. This recognition provides strength and confidence.

Not only are the novice play specialists “learning the colours” of health professionals, especially nurses, so too are health professionals learning to read the colours of the play specialists:

I've got to know the charge nurse quite well. I asked her advice of how I could support her in working together. I told her what I could offer and she was really thrilled. Just giving her a ring and saying, "Hey thanks for sending this stuff", and having a chat. That kind of thing works really well. And any positive feedback I get – because I tend to get quite a bit for other people – I'll ring and pass it on. I don't hesitate, because I think you need that in your job. And she saw me in action once or twice and thought wow, and now they've decided they'd like their own play specialist down there. So in the future that's something we'll look at.

In behaving towards other staff as she would like them to behave to her, this participant is seeing others' perspectives and recognising their mutual needs for friendship and support. Rather than relying on others to get to know what she can contribute, she is actively working at strengthening relationships through helping them understand her role and how she can support them. Where there are opportunities for the new play specialists to work respectfully and collegially with staff of other disciplines, as equals, then both can benefit from this mutual sharing of respective knowledge and skills.

At times, this sharing is stimulated by events on the ward. When describing how the ward team works together when a child dies, a participant describes how she feels able to initiate action that is supportive of families. “In working with the families, half the time I do the ringing to make sure there's a counsellor or a social worker involved, just because I'm the first person on the team'. Work done in developing trust with healthcare colleagues enables the novice play specialists to take an active role in situations such as this, without having to wonder whether they are doing the right thing or crossing professional boundaries in a way that might be seen as inappropriate.

Another new appointee comments, “We’ve got a paediatric dietician and a paediatric asthma consultant and one for diabetes and I see them fly in and out and lately I’ve been saying, ‘Hey stop and talk to me. We can work on this together’”. By actively seeking out her colleagues, she lets them know that she respects their expertise and recognises that it will help her in her own work. She is able to get more information on medical conditions and on hospital protocols, and as they get to know each other better she finds that her colleagues begin to spend time with her. This, in turn, builds confidence. As this participant says, “It ensures that I know what I’m talking about”.

The same participant tells of helping a young doctor with a developmental assessment that was a requirement of his paediatric training. She recalls how he asks for her feedback on what he did, and the next day asks to do another practice assessment with her. She suggests how he can incorporate more playful techniques and says, “From then on, I could see the difference in him. He’d be down playing on the floor and getting children doing things. He was really able to take on board what I said.” Novice play specialists’ view of themselves as beginners may be enhanced by such experiences to incorporate a view of themselves as people with knowledge that others do not have. Information-sharing begins to be seen as a two-way process in which they and their colleagues may be simultaneously both teachers and learners. In being regarded and valued by others, they are better able to value themselves.

Recognising self

External recognition is helpful to participants. However, it is not the only way by which the participants measure how well they are “learning the language of colours”. Recognition that they are adapting and becoming adept, may come from looking within themselves and reading the messages they themselves portray. For some of those interviewed, valuing of self may come as the result of a single intervention, as is evidenced by this description of a home visit:

I gave him syringes to play with and we sat on the steps and he squirted the neighbour’s fence with the water. I just talked to him in a way that he would understand, about how using these strategies would help him get through the process a lot better. I could see that what I had done to support him worked, which I was very pleased about. I felt like I’d made a really positive connection with him. The next time that I went with him to

have the injection, it was still hard. We had to really negotiate with him to lie down and to relax, but he was prepared to try, and he used the distraction throughout. It was fantastic compared with the previous experience.

This participant can see the difference she has made, without the need for any overt feedback or affirmation of her interventions. She measures the usefulness of what she has done in achievable steps, by comparing it favourably with previous similar situations rather than with a “perfect” outcome. She does not expect that the child’s difficulty with compliance will be turned around in one interaction. It is enough for her that she and the child have put some strategies in place and that he has managed better than the previous time. She goes on to say, “I was absolutely over the moon because I really felt I’d made a difference for him. I walked a few feet off the ground after that.” Realistic goals may be important in ensuring that new play specialists do not take upon themselves more responsibility for outcomes than is possible, given children’s past experiences and present circumstances. However, what is judged to be a successful intervention can be hugely affirming and encouraging.

For others of those interviewed, recognition of self may be more gradual, and is only apparent as they reflect on their early experience and the changes that have taken place. As one says, “You just slowly pick it [new knowledge and skills] up and you don’t realise it. It feels **really** good.” This gradual process is apparent in the experience of a participant who is undertaking further academic study:

*I’ve been doing a paper at college to finish my degree and it’s got me back to reading stuff I read at the beginning. For instance, I was looking at my medical play area and realised that I’d looked at it before in the first two or three weeks. But now I’ve got all the other months experience and I realise what all the things were for. And I’ve seen children use the area. And I’ve managed to redesign it and put more things in it and made it more valuable. I **know** I’ve got a more in-depth knowledge of why the area is there. For example, when I started I had a doll with a hole up its nose – well, great! And now it’s got an NG [nasogastric] tube taped onto it because I know that that’s what happens.*

In going back to the readings that she did when she began, this participant is surprised and pleased to discover the gains she has made. She looks at her playroom with fresh eyes and sees its colours very differently. Her initial practice was informed by theory, and over time

it has been modified by observation and experience of what children actually do in this setting and how they respond to what she offers. In becoming aware that they have valuable experience that complements and helps them make sense of theoretical knowledge, the participants recognise that their practice is more meaningful to children and to themselves. In turn, practical experience of working with children contributes to theoretical understandings of the role.

Accordingly, one participant evaluates her growing proficiency in the light of her increasing confidence in her ability to meet children's needs. She describes her involvement with an older boy who had had repeated admissions following a vehicle accident and who had become very withdrawn, as follows:

I had a lot to do with his care and in ensuring he got referred to other services. I know there were times when I was there that I managed to get him to do things that were very scary for him. I know that I did help because you could feel it, you could see it. Sometimes you go in and you think, oh maybe I helped a bit, but there are situations like this when you learn what helped. I got him to do what he needed to do just through persuasion and because I'd got to know him and got to know what would work for him. I got him to do it. And just by boosting his self-esteem and by being the other person – because his mum was very emotionally involved and the doctor just wanted to get on and do the procedure. That felt good. Really good. Those are the parts of the job that make you go, "Oh yeah, this is good!"

The participant is completely attuned to the child. Her focus is on the child, on his mastery of situation, and on ensuring he is able to do "what he needed to do". Her relationship with him, and her knowledge of him, enable her to demonstrate "situational confidence" (van Manen, 1990, p. 169). She judges the success of what she provides from what she can "see" and "feel" of the child's response. She later describes her role with this family as a "sort of third wheel that came in and wasn't emotionally attached but had enough knowledge of him to know what would work for him". By recognising the mother's distress and anxiety, and that these may not be helpful to the child in this situation, the hospital play specialist "contains" the anxiety of both the mother and the child, in order to enhance the child's ability to cope. The novice play specialists do not have the procedural responsibilities of the other staff members. Instead it seems they can sometimes be the "other person" who can be a support for both the child and the parent as a dyad. In this treatment situation, the participant describes providing a steadying

influence, like the third wheel on a tricycle. Sometimes it seems that the “third wheel” role enables the new play specialists to act as something of a mediator between the child and the other disciplines, to help children and families understand the colours of hospital staff and the messages they portray.

As they begin to re-claim their sense of themselves as adept and competent professionals, the participants become less tied to how they have been taught to proceed. As one person expresses it:

I know the job well enough now 'text book' that I want to adapt it to be more therapeutic or more meaningful. Now I can relate it to particular children or particular incidences. Now I want to know how I can make it better and more meaningful for that child. How I can make it more open-ended. Whereas in the beginning I probably went in and did a text book, 'Oh here's a doll and here's how the luer goes in and this is what happens and okay are you fine with that?', now I'll go in and say, 'So what would you like to know about?'

This participant is reflecting on her practice in a very conscious way, with the goal of improving the therapeutic outcomes of her work with children. She recognises that she is gaining a deeper understanding, and notices that she is now able to be more flexible and responsive in her approach. The new play specialists become aware that they are integrating their newly acquired theoretical knowledge with the practical experience they are gaining. They notice that they are becoming able to improvise and to trust their professional instincts and knowledge of individual children, rather than relying on generalisations about what should happen or how something should be done. They are developing what van Manen calls a “theory of the unique”, the ability to act in ways that are right for a particular child in a particular situation (van Manen, 1990, p. 155). It is likely that they recognise these changes as evidence of gains in competence, of their enhanced ability to work insightfully with children in the hospital setting and, consequently, of their successful transition from novice to experienced play specialists.

Stories that emerge from participants' later experiences demonstrate their increasing ease with themselves and with their own way of being with children. One tells how she endeavours to understand children's viewpoints and their concerns about treatment, but that sometimes she can do no better than guess and “Maybe I'm right, and maybe I'm

wrong, and that's fine." These changes are exemplified by another new play specialist's comments on the freedom she now feels to develop her own approach to practice:

You have your own personality, your own strengths. How I discuss things with a child is different to how the next person does. So, it's covering everything that needs to be done, using the right words, but in a way that is you. I can't go and copy someone else because they've got a whole different way of doing things, and children can see... they have a desire to see you, and to see you being real with them.

This participant begins to see the differences between her approach and that of others as a positive thing. The messages she portrays are hers uniquely and she is now more confident to "show her colours" to others. By working in ways that feel right to her, she can be more "real" or authentic with children, qualities that she believes to be essential to building a relationship.

Participants' acceptance of themselves is shown again in the following comments from a new play specialist as she looks back on her professional journey from teaching:

I think it's just trial and error, and you've just got to get in there and do it really. Sometimes I've said things and looked at the child's face and thought, "Man, that was so the wrong thing to say! [Laughs] You just think, "Oh, no! Have I scarred this child for life?" [Laughs] And then you take a few minutes to get over it. Quite often, when I say something in a prep, for instance, it'll come out and I'll think, "Oh that was so wrong", but I'll be able to go back on it and correct myself. And then other times I've tried something and it's brilliant and I've used it again. So, you have ups and downs I think, but I feel like the more I do, the more ups I'm getting

For this participant, the trial-and-error process feels like something a roller-coaster ride of high and low points. She recognises that she is still learning and making mistakes, yet there is no sense from what she says that she is daunted by this. Rather, it seems she is eager to be involved, trying out new ideas and ways of being with children and discarding those that seem to be ineffective. She is building ongoing reflection into her interactions with children, and in evaluating her practice is open to self-criticism as well as to the possibilities of "brilliance" in her work with children. She is not deterred by fear of making mistakes or discouraged by feeling that her practice with a child is less than it should have been. It seems likely that novice play specialists who are able to capture, as this participant does, a sense of excitement and a feeling that, for the most part, they are

making a difference, are showing that they have learnt to read the colours of their new professional world. It seems they are demonstrating a “self-preservation repertoire”, as learners, that will ensure they become mature and adept members of their hospital communities.

Summary

The themes of chapters four and five depicted the participants in this study as outsiders in a foreign environment and culture, and while initially excited by the difference, they may feel that they are struggling to make any headway. In order to secure a place in the world of a hospital and to be sure that they want to remain, they need to develop a “self preservation” repertoire. This chapter reveals their experiences in learning “the language of colours” and discovering how to read the messages portrayed by the members of the hospital community. The themes of this chapter also draw out the ways in which the novice play specialists are re-cognising the value of the skills and experience they brought with them, incorporating these into the new repertoire of knowledge and skills they are acquiring as they become adept hospital play specialists.

For some, an experience of recognition from colleagues can be a turning point. Feeling that they are included and are seen by other staff as part of their ward teams, included in planning for children’s care and in social events, is seen as confirmation that they belong in the world of a hospital. Opportunities to work collegially help them to see the contribution of others and the wider influences that may colour the messages portrayed. Recognition can also come from the internal satisfaction derived from “being there” for a child or family during a stressful period. It seems that the most rewarding experiences are those moments when they recognise the progress they have made not only in learning “the language of hospital colours” but in confidently displaying their own colours.

The participants trace their growing competence by evidence that they have “left a mark on a child” in some way. In other words, where they believe they are able to make a difference this in itself is deeply rewarding and confirms a developing understanding of themselves as adept in the world of a hospital.

CHAPTER SEVEN - DISCUSSION

Weaving the Threads Together

When we ponder on the meaning of the most consequential or the most trivial of human concerns, the act of interpretive writing, if done with utmost seriousness, confronts us with the dark, with the enigma of ultimate uninterpretability. And this is what it means to dwell in the space of the text, where the desire for meaningfulness leads.... the writer must enter the dark, the space of the text, in the hope of bringing back in words what cannot be captured in words – in the desire to see what cannot really be seen, hear what cannot really be heard, touch what cannot really be touched....

Van Manen, 2003, p. 11

Introduction

The purpose of this study was to better understand the meaning of the experience of novice hospital play specialists in their first months of employment. I have “dwelled in the space of the text” throughout the writing process, searching for the underlying meanings and significance of the participants’ experiences. I have brought to this process my own deep interest in the topic, my background and understandings, yet I have at all times endeavoured to ensure that the participants’ experiences were honoured and that their voices were heard more vividly.

This final chapter weaves the parts of the thesis into a whole, giving the study a form and a texture that the various threads lack when considered alone. The previous three chapters presented the participants’ narratives and my analysis to aid in understanding aspects of their experience. Each chapter centred on a particular theme that emerged from participants’ stories, but these themes are not discrete, nor do they necessarily unfold sequentially over time. Often, the themes and sub-themes co-exist, exposing paradoxes and contradictions. Early experiences of difference and foreign-ness, have a greater depth and richness when understood alongside knowing what it is like for participants to struggle as they face new professional worlds, and what it is that sustains their sense of becoming competent and of belonging. Experiences of becoming adept emerge as more

complex and more meaningful when seen in the context of the themes of newness and difficulty. Within this hermeneutic circle of interpretation, there is movement backwards and forwards through text and meaning, each spiral contributing to the next (Leonard, 1994).

Futures taking shape

The themes and sub-themes that emerged from the findings, when brought together, revealed multiple transitions. These transitions were experienced by the novice play specialists in relation to their place of work and where they fitted within this space, in learning how to be within the world of a hospital, in their relationships with others, and in their sense of who they are within their own hospital play specialist service and within health care teams. Moreover, their early experiences shaped their expectations of their workplace, their relationships, and their sense of how their identity might evolve within their own hospital play specialist service and within healthcare teams. Participants measured their progress along the journey towards belonging in the world of a hospital by the extent to which they achieved a sense of inclusion and a belief that they could make a difference.

Transitions in place and space

The first transition was that from the physical world of early childhood teaching to the very different physical world of a hospital, a world that emerged not as one homogeneous place, but many. The huge, bewildering, busy, internal place of the hospital as an institutional building, in which the participants initially felt small and lost, encompasses many different kinds of lived space. Within the space of the ward or unit on which the novice play specialist works, there are spaces that may “belong” to others, with visible or invisible boundaries, such as the space concealed behind the curtains around a child’s bed. Negotiating the boundaries and the unwritten rules could lead to uncertainty and tentativeness as the participants endeavoured to secure a place to work and a place for children to play, a place where children and adults could engage with each other. Tensions inevitably arose between the participants’ desires to delineate a space for themselves

where they had some autonomy and control, a space for children that was free of the threat of medical interventions, and a space which was valued by and accessible to all.

Transitions to a new world

The world of a hospital is not only a new physical world, it is a new cultural world, one that is constitutive of self and of others and which shapes the language, meanings, traditions and practices of those within it (Leonard, 1994). The participants in this study anticipated that there would be differences between their former world of early childhood and their new world of a hospital; these expected differences were a part of the excited anticipation with which they commenced work. However, the extent of the difference, the foreign-ness, was not anticipated and for some it was at first experienced as shocking and overwhelming. They found they were unable to generalise their knowledge and skills from the culture of their previous workplaces to the hospital culture, leaving them feeling vulnerable. Some participants felt it was so different that “nothing can really prepare you”. One describes a need to “unlearn” aspects of her past learning, in saying, “[You need to] shut that [the early childhood] door. Take your skills, but realise that you’re coming into a new profession, close the door off. Stop comparing then to now, because it’s so different.”

The ability of individuals to relate one situation to another, is commonly “supported by social interaction in which social partners suggest connections” (Rogoff, 2003, p. 258). However some participants were not able to find such partners as quickly as they needed them. The responsibility for finding out “the-way-things-are-round-here” often fell upon the new appointees, and even the most basic information was missing, “like knowing what a house surgeon is, what a registrar is”. Others were bombarded with overwhelming amounts of information, much of which was peripheral to their role. Insufficient relevant information about hospital policies and practices exacerbated participants’ feelings of isolation and their uncertainty about how to practise safely.

However, experiences varied widely, and there were many very positive recollections of being warmly welcomed and supported. Participants were helped by knowing that they would be included routinely in ward events and meetings, and that they had regular times for discussion with a more experienced hospital play specialist colleague. Those who

participated in orientation or more extended preceptoring programmes suited to their learning needs, and had opportunities for professional development, found these very helpful. The sense of being overwhelmed was quickly balanced by gaining a sense of how they might develop their own ways of working in their new roles. Experiencing opportunities to “make a difference” in some way, also provided a buffer that sustained the participants’ beliefs that they would become adept, given time.

Relationality

Experiences of lived other, relationality (van Manen, 1990), within shared interpersonal space and shared physical space, emerged as very significant to the early experiences of the new hospital play specialists in this study. Relationships with staff from other disciplines had a powerful impact on the participants’ confidence and ability to work effectively. As novices, difficulties in engaging with important others were often taken very personally, especially where others were in a position of power, such as charge nurses and unit managers. Their early attempts to seek information, or to follow what they understood to be the accepted ways of doing things, were sometimes rebuffed or ignored in ways that seemed rude or humiliating, yet their resultant distress seemed to go unnoticed. On occasions, these interchanges resembled the abusive inter-personal exchanges described in nursing studies (Blum et al., 1995; Farrell, 2001; Griffin, 2004; Taylor & Barling, 2004), and I discuss this briefly in the implications section of this chapter.

Human exchanges, according to Shotter (1978) become institutionalised through generations and are inherited in ways that ensure that the way things have been done in the past commits us to replicating certain patterns in the future, although the reasons for this are buried in institutional history. Rogoff (2003) echoes this in suggesting that habitual relationships between people become expected and incorporated within the routines of institutions. “They are often regarded as natural; their role in current activities is simply assumed and not noticed or credited (or blamed) for the processes to which they contribute” (p. 85). It is apparent from my study that, with time, some participants discerned that the negative interchanges they experienced might not be personal and,

instead, might be entrenched in the culture of the hospital. Seeing such incidents as systemic had an immunising effect and they were then less bothered by them.

Communication usually improved as the participants became more familiar with their roles, *with the roles of others, and with their workplace, and as their healthcare colleagues got to know them better.* A two-way process of mutual understanding was clearly necessary for this to occur. This finding is consistent with Wertsch (1984, cited in Rogoff, 2003) who suggests that “modifications in each participant’s perspective are necessary to accomplish things together. The modifications are a process of development; as the participants adjust to communicate and coordinate, their new perspectives involve greater understanding” (p. 285). For some, this mutual understanding came about through the processes that were established within a play specialist team or a ward. Others saw what needed to happen, and were very active in relationship building and in breaking down any potential barriers that they sensed. For some, however, negative early experiences left a long-reaching shadow for many months, so that for one participant “you never felt that you belonged”.

Professional identity

The term, “*Io chi siamo. I am who we are*” is used by New (1998, p. 219), to capture the concept of identity formation in a shared context of setting and relationships, and the potential richness stimulated by group exchange and common purpose. The phrase is useful in illustrating the themes and sub-themes of this study which, when brought together, reveal complex issues of identity, and of self in relation to the identity of others. Regardless of the size of their team, or the length of time their service had existed, it was apparent that all participants struggled to some extent for recognition within multidisciplinary teams. For some, these experiences were the cause of enormous frustration and distress, exemplified by the person who said, “I felt demeaned. I felt like wearing my degrees across my back.”

In the professional transition from teacher to hospital play specialist there is a process of re-discovery of professional self in a new role and new context. Not all of the participants came to their work as hospital play specialists directly from early childhood teaching.

Nevertheless, they brought with them an understanding of themselves as a teacher, or at least as an education professional, rather than a health professional. Their “I” was constituted in the familiar “we” of early childhood teaching, where there is a generally shared understanding of their role. In moving into work as hospital play specialists, their professional identity became much less clear to themselves. Are they “educationalists in a healthcare setting” as one participant said? Or are they something different? They were eager for the new aspects of the role, and yet they continued to have teaching responsibilities that they believed to be an essential component of their work with children and families. They did not want to be seen as “play ladies” or “just” early childhood teachers, and yet they knew very little at the beginning about the “we” of hospital play specialists. They wanted to be fully included in healthcare teams, yet they valued their “outsider”, non-medical, backgrounds and did not feel that they identified with the “we” of allied health professionals.

Regardless of how they saw themselves, their job descriptions and their nametags assigned to them a new identity, as did their colleagues and the families they worked with. Immediately they were incorporated by others into the “we” of hospital play specialists as a professional group. Some participants therefore faced a dilemma in wanting to “show their colours” to others, whilst still having to discover for themselves just what their colours were. To “change colours” completely, would be to risk losing their unique identity, and their “outsider” viewpoint, which they could see was useful. At the same time, they wanted very much to identify with the “we” of their ward team, and to have their knowledge and skills effectively understood and utilised by their healthcare colleagues.

Temporality: From novice to competent professional

Despite these complexities, it was apparent that in the context of the “we” of healthcare teams, the participants were beginning to discover a new “I”. Participants’ early experiences of undertaking aspects of the role that were new to them, such as engaging in medical play or preparation of children for procedures, were done “by the book”; they worried about getting something wrong. Feelings of uncertainty about skills may lead to self-absorption and “anxious vulnerability” (van Manen, 2003). In turn, this may mitigate

against novice play specialists being authentically available to children, which is an aspect of the role experienced as most rewarding and valuable, and one person recalled how she was so anxious about saying the wrong thing that, “At first, I said nothing”.

With time, developing competence emerged in subsequent experiences where participants showed situational confidence in response to particular children in particular circumstances. They were able to make instantaneous decisions about when to act and when to hold back, based on what they saw and understood of what was going on for that child. In thinkingly acting (van Manen, 1991) they were making intuitive decisions about what was right for an individual child. The knowledge they were developing is what van Manen (van Manen, 1999) calls non-cognitive knowing, the sort of knowing that may seem invisible, yet resides in action as lived, and is embedded in practice and in relationships.

It follows that the participants began to incorporate a new view of themselves without completely submerging their previous identity, an adding to, rather than a substitution. This new identity included a re-cognition of their skills as early childhood teachers and their transferability to the hospital setting, coupled with the new knowledge and skills they were acquiring as hospital play specialists. Simultaneously, they were also becoming more comfortable with “not knowing”. “Not knowing” does not need to be equated with “ignorance”, something to be avoided at all costs, and criticised in others. Rather:

A very different orientation to knowledge.... is that useful knowledge exists only in interaction, or in praxis. Such knowledge is mutable rather than immutable, it takes its form from the environment in which it was created. More like water than block or stone, it is endlessly transforming. (Dahlberg et al., 1999, p. 170)

While this study did not seek to evaluate the skills of novice hospital play specialists, this shift in participants’ view of self appeared to mark the transition from a novice to a competent play specialist. A kind of re-framing of situations was revealed as participants became more confident in their setting. Experiences described as difficult or challenging at the start, were seen as positive in the present time, when the interviews were conducted. The process is what van Manen (1990) refers to as reinterpreting “who I once was or who I am now. The past changes itself, because we live toward a future which we already see

taking shape” (p. 104). For instance, “getting to know a new world” was described as an exciting aspect of the job by a person who had talked about it as overwhelming in respect of her early days. The amount of new learning that seemed daunting at the start, was reappraised by another who said, on reflection, “I loved it. I *loved* all the new learning”. Their experience of the past changed when seen in the light of knowing how much knowledge they had gained. Frequently, they judged the effectiveness of their actions and interventions in terms of whether they believed they had “left a mark on a child” and their family (van Manen, 1990). As one participant said, “Feeling like you’ve made a difference is a real buzz. That’s the really big thing”.

Relationship to other studies

There are many parallels between the experiences of novice hospital play specialists, as uncovered in this study, and the limited literature that is available. This next section considers the findings of my study in the light of the literature discussed in chapter two, showing the similarities and also pointing to differences.

Developmental framework

While my study is consistent with some aspects of Bolig’s model (Bolig, 1982), my findings do not correspond well with her timeframe. For example, in my study, the need for professional recognition and inclusion, Bolig’s “autonomy” phase, was experienced very early on and emerged during the first phase even though the study participants did not yet feel fully autonomous in their new roles. One of the participants who had resigned described that she had “got to a point where I didn’t feel I was learning a lot more... it felt quite stale and a bit routine”. This situation appears to correspond to Bolig’s third, “initiative” stage, yet this person was still in her first eighteen months of employment.

In addition, the relationship between the maturity of the service, and the development of individual hospital play specialists, does not seem to be as clear-cut as Bolig proposed. Membership of a well-established, supportive, and experienced team of hospital play specialists, did not remove the need for participants to keep explaining their roles to

colleagues from other disciplines, nor eliminate experiences of invisibility and indifference within their wider healthcare teams.

On balance, it seems that the development of novice hospital play specialists is more complex and probably less universal than envisaged by Bolig's phased developmental model. Novice play specialists' own historical being, expectations of the role, their unique experiences once they are in the world of a hospital, and the meaning they make of these, influence their beliefs about the extent to which they belong and can contribute. In relating what shows through in the findings with regard to hospital play specialists' resourcefulness and resilience, their ongoing learning may be more usefully considered as development-in-context. Viewed this way, the relationship between individual, context and activities is "dynamic, negotiated, and mutually influenced, rather than static and unilateral" (New, 1998, p. 265). Seen through this socio-constructivist lens, the play specialists emerge as active in their own learning and professional growth, in relationship with others and within the particular contexts in which they find themselves.

Workplace issues, role stress and relationships with others

There are parallels in my study, too, with the child life literature on the importance of communication, organisational support, and the attitudes of ward staff (Hall & Cleary, 1988). The two participants who had resigned both related their resignations at least in part to experiences of lack of recognition by senior staff or managers, and lack of institutional support. It also seems that the hospital organisation, hierarchies and the size and nature of the unit, were influential although, as suggested above, these are probably most usefully considered as parts of a very complex intertwining of individual and contextual features.

Another area of similarity between the existing literature and this study is in relation to role confusion and role stress. The participants in my study believed that there was a lack of understanding, at times, of their role and of how they could contribute to healthcare decision-making, and is therefore consistent with Cole (Cole et al., 2001). My earlier study (Kayes, 1999a) identified frustrations amongst New Zealand hospital play specialists about been seen as a "toy lady". Both these studies suggest that play specialists

and child life specialists have very low levels of contact with some other disciplines. As well, my previous study showed that some New Zealand hospital play specialists did not routinely participate in team meetings nor document regularly in patient notes (Kayes, 1999b). Certainly some participants in the present study were having difficulty being included in ward meetings; it is not clear whether all were regularly documenting in patient notes. If not, then this is likely to contribute to lack of visibility and understanding of the play specialist role. In referring to the importance of inclusion, Cole says, "If other health care professionals do not include them in decisions or assessments of patients, child life professionals must find ways to include themselves in the health care team and perhaps educate others to their value and importance" (Cole, 1998, p. 132). If New Zealand health professionals continue to hold a model of play as primarily diversionary, as identified by McKinlay (1983) this may influence their views on the need for inclusion of hospital play specialists within team decision making.

There are strong parallels, too, between this study and United States studies which found that role stress, especially lack of clarity concerning work role expectations, negatively affected professional well-being, and that perceived ability to fulfil the demands of the role predicted emotional exhaustion (Holloway & Wallinga, 1990; Munn et al., 1996). My study also suggested a degree of exhaustion in some participants, from feeling the need, as one said, to "constantly put myself out there to explain what I did". Another longed to be somewhere where she didn't have to "keep explaining that I wasn't a volunteer, and that we were highly qualified teachers with extra training". Hall and Cleary (1988) cautioned that education of staff about play is an ongoing activity. New appointees in my study who accepted that they inevitably had an ongoing role in educating others and showing what they could offer, were perhaps less discouraged by this than those who anticipated that people would know what they did.

Emotional labour and sources of support

The emotional component of the work that has been widely acknowledged (Bolig, 1982; Holloway & Wallinga, 1990; Leff et al., 1991; Munn et al., 1996; Webster, 2004) shows through in this study, paradoxically, as both distressing to participants as well as a source of deep satisfaction. Many participants experienced a feeling of privilege at being with

families during times of intense stress, grief or loss, and described how rewarding it was to have provided some support, however small, at such a time. In contrast to nursing studies (McVicar, 2003; Omdahl & O'Donnell, 1999), but consistent with Holloway and Wallinga (1990), the emotional component of the work is not shown in my study as being associated with feelings of burnout. However, it is possible both in the Holloway and Wallinga study, and my own, that the participants had not been employed long enough for this to have developed.

Participants were helped in coping with emotional stress by regular meetings with team leaders, or with more experienced hospital play specialist colleagues. They were able to continue working in the knowledge they could “save up” their concerns until the planned meeting. Some participants also spoke highly of the support available from nursing staff at difficult times, especially their experiences of effective and inclusive processes for debriefing after distressing situations on the ward. Direct links between lack of supervisor support and intentions to leave their job, as identified by Munn, Barber and Fritz (1996), cannot be established because of the small numbers participating in my study. However, one person did link dissatisfaction with parts of her job to what she called “lack of nurturing” and lack of “sincere, genuine feedback” from her senior. Professional development opportunities available from the Hospital Play Specialists Association showed through as another avenue of valued support, which one person called a “lifeline”.

What is new in this study's findings?

The previous discussion section outlined ways in which the findings of this study support and contradict what was previously known. The findings of this study bring new understandings to the day-to-day lived experience of novice hospital play specialists. No previous study has explored the nature and meaning of this experience for New Zealand hospital play specialists, nor, to my knowledge, has such a study been undertaken elsewhere. In that sense, all of the study's findings are new in the New Zealand context.

The novice hospital play specialists in this study were revealed as resilient and committed. The study gives them a voice, and the methodology that guides it enables a depth and richness to be uncovered that is not possible from a quantitative study. Their stories

showed the overwhelming impact of the difference between the world of early childhood and the world of a hospital. They also showed participants' resourcefulness in making this transition, their enthusiasm for new learning, and the emergence of a reflective, intuitive approach to their relationships with children that enabled them to evaluate their own work, recognise their progress, and improve their practice. These qualities are not apparent from other studies.

Another finding that emerged strongly was the importance to the participants of recognition from others outside of their own profession. It seemed that recognition of their skills from fellow hospital play specialists was very welcome, but largely assumed. However, recognition from healthcare colleagues was prized as demonstrating their inclusion and their ability to be participating citizens in the world of a hospital. Those who had not achieved this recognition found it very difficult to contribute to planning and decision-making.

This study also shows the distinctive nature of New Zealand hospital play programmes, as compared with those in North America and Britain. Dual accountability to health and education requirements ensures that New Zealand hospital play specialists need to continually strive to balance their responsibilities to support children's ongoing development and learning through play, as well as *their responsibilities for preparation and procedural support*. While there is an inherent tension in this balance, it may nevertheless be a source of professional growth and strength if it results in ongoing professional debate on values, philosophy and practice.

It is also apparent from this study that considerable development has occurred in the profession in New Zealand since McKinlay's 1982 study. The participants in my study all saw *their role as incorporating both the educational and therapeutic aspects identified by McKinlay*. They had a common understanding of what their role entailed and of the new knowledge and skills they needed to acquire. It was the misunderstandings of their role by others, and their experiences of indifference, the failure of the 'we' (van Manen, 1990), that caused stress and distress.

Overall, this study provides confirmation of the challenges that Webster (2004) suggests face hospital play specialists in New Zealand, yet it also shows the satisfactions and joy that may be gained from the work. As well, it provides a basis from which to reflect on the professional needs of new members of this particular group that, until now, has not been identified.

Implications of the study's findings

In chapter one, I described my curiosity about the impact of early experiences on novice hospital play specialists. It is clear from this study that the early experiences of beginning hospital play specialists do have a significant impact on how they transition into their new roles and on their professional identity, and may influence decisions to stay or to resign.

Aspects of the participants' experience are similar to my own, as explicated in my pre-suppositions interview: the thrill of initial appointment; the foreign-ness of hospital culture; the anxiety of undertaking work in a new field, alongside the interest in learning new skills; the emotional shock at discovering what some children and families are coping with on a day-to-day basis; the experience of the relationship with children. However, there are differences. The profession is now more established and the role is more clearly defined. Consequently, it may be that the expectations placed on novice play specialists by themselves and by others are now higher than they were, giving them less leeway to edge into the role at their own pace.

This next section explores the implications of this study's findings for the selection and orientation of novice hospital play specialists, for inter-personal relationships and belonging, for professional development and competence, and for professional recognition. Hospital managers, service leaders, healthcare colleagues, hospital play specialists themselves, and their professional association, all have varying degrees of responsibility to address these issues.

Selection

This study suggests that previous experience in a healthcare setting, and previous knowledge of the role, softened the impact of the change from an early childhood setting to working in a hospital. Those responsible for the employment of new hospital play specialists should consider how they can ensure that potential new appointees are as familiar as possible with the role and the environment prior to commencement and, ideally, prior to interview. For example, opportunities to visit beforehand could facilitate self-screening by applicants who, with a greater understanding of the setting, then decide to proceed or withdraw. Interviews might usefully include questions exploring participants' expectations of the differences between early childhood and hospital settings, and previous experiences in coping with major change. Individuals considering a change of career to hospital play specialist would be well advised to find out as much as they can beforehand, and also to ask the employing hospital what will be provided by way of professional development and supervision, before accepting a position.

Personal attributes, such as flexibility, the ability to articulate their role to colleagues from a different professional background, and the confidence to seek out information and claim a place within teams, are likely to be helpful in settling into ward teams. It is hard to know from a study of this size whether qualifications beyond a diploma in teaching were helpful in carrying out the work. However, higher qualifications did seem to give participants confidence to be more assertive about their knowledge base when they were challenged by medical staff.

Team leaders and service managers need to ensure that novice hospital play specialists are aware of all potential sources of new learning and support, from both inside and outside of the hospital. In turn, the Hospital Play Specialists Association has a role to play in ensuring that service managers and new play specialist appointees receive information on professional development opportunities. Hospital managers establishing a new hospital play specialist service could find it beneficial to seek advice from the Hospital Play Specialists Association with job descriptions and selection of candidates.

Orientation and communication

The orientation provided to participants in this study was haphazard and varied considerably from one hospital to another. Some lacked information on critical issues such as infection control protocols. With no background in healthcare, new hospital play specialists need specific information very early on, both to enable them to “find their way”, literally and metaphorically, in a hospital, and also to ensure they are practising safely. For instance, they need to know the hospital’s policies on health and safety and emergency situations immediately upon commencement, and such critical information should not be withheld until hospital-wide orientation sessions that may not occur for several weeks. They also need brief basic information on things such as the role, responsibilities, and levels of authority of various personnel, for example, the difference between an intern and a registrar. If basic information was provided in written form, it could be read and re-read as needed, and this could assist new appointees to fit the pace of new learning to their own needs and learning style. No doubt these issues are addressed by team leaders in larger play specialist teams, but service managers or charge nurses need to ensure that adequate targeted orientation is provided for commencing hospital play specialists in small services.

Systems for communication within wards were also revealed as haphazard. Much of the responsibility for obtaining information seemed to fall upon the new hospital play specialists themselves. Lack of information, or inconsistent information, poses significant health and safety risks. Hospital play specialists need to know, for example, that a child is ‘nil by mouth’ or that a family member is subject to a restraining order and may not visit. Where they are uncertain about the adequacy or currency of information, they need to know who to go to. Where there are communication difficulties, ensuring that the focus of problem-solving is on the patient’s wellbeing has been identified as useful, as have shared opportunities for inter-disciplinary professional development (Headrick, Wilcock, & Batalden, 1998). Support of senior leadership of the professions involved, including play specialist senior staff, is necessary to ensure that communication systems are effective.

Interpersonal relationships and belonging

Experiences of “not belonging” and indifference were common in this study, and had a major and long-lasting impact. While examples of good processes were revealed, nurse leaders did not always recognise that their ward or particular unit was the regular workplace and professional “home” for various professionals other than nurses and medical staff. Whether or not this was deliberate, or simply the result of acculturation, the effect was to exacerbate feelings of invisibility in those who were already feeling like “outsiders”. Nurse managers and service leaders could usefully review ward processes, and informal practices, to ensure that all staff working on a ward are welcomed and included.

At worst, some units were revealed to have a culture of rudeness and humiliation that was tolerated, or even modelled, by senior and powerful people. Hospital play specialists were not necessarily the only people exposed to this; participants mentioned that others, such as social workers, shared their feelings of marginalisation and disempowerment. A systemic culture of inter-personal intimidation is, I believe, unacceptable and needs to be addressed by district health boards because of its major impact on staff wellbeing. This is particularly so in the context of the Health and Safety in Employment Act 2002, that requires employers to protect employees from harm caused by workplace stress. Some solutions identified in the nursing literature might help. Griffin (2004) suggests that identification of inter-personal intimidation as a systemic problem enables individuals to depersonalise it, and suggests cognitive rehearsal of behavioural and verbal strategies as a counter-measure. Team leaders or colleagues are potential sources of support for individuals in safely withstanding this behaviour from others. Such a culture might at least be curbed if there were clear policies of no tolerance of this behaviour at all levels of hospital hierarchies and if perpetrators were censured rather than promoted to positions of responsibility and power over others.

Professional development and competence

There is a gap for commencing hospital play specialists in New Zealand between the knowledge base of early childhood teaching, and that required of a hospital play specialist.

This gap poses a risk for the development of consistent skills across the profession and for a shared understanding of the role by play specialists themselves and by others. Effective learning opportunities shown in this study included opportunities to observe the practice of a variety of more experienced hospital play specialists, reflective discussion on practice, and participation in professional development offered through the Hospital Play Specialists Association. The nature of the support was also revealed as important: too close or too prescriptive supervision was experienced as discouraging or inhibiting by some participants. There is a need for all those involved to recognise that novices bring with them their own skills and their own ways of being with children, and that they will develop the role in their unique way.

Service managers and team leaders have a responsibility to support skill development and good practice. However, this poses challenges for small services with no experienced hospital play specialist on site. Service managers need to plan, and allocate sufficient budget, to ensure that new appointees have the opportunities they need for new learning following commencement. This may involve enabling them to spend time with a play specialist team in another hospital. The Hospital Play Specialists Association also needs to consider what else could be done to provide equitable access to professional development for members of this small and scattered professional group. The development of a qualification specific to healthcare settings might address the knowledge gap, and also help the professional credibility and confidence of hospital play specialists in their dealings with other healthcare professionals. All professional development initiatives should be researched to see that they are achieving their goals.

As well as the challenge of ensuring competency, this study also showed a need for novice practitioners to see that they had opportunities for professional growth. Finding a balance between the need to ensure that novice play specialists practice within their competence, and opportunities to feel that they have depth in their work, seems likely to be important not only to safety but also to the sustenance of personal and professional wellbeing. This, too, is a challenge for a small profession when only a very few services have senior or team leader positions. Credentialing is being introduced in some services, and this could both protect new appointees from undertaking work outside of their competence, and be another way of providing recognition for increasing skills and experience. This study was

undertaken before the Hospital Play Specialists Association introduced certification, and prior to the introduction of distance preceptoring. These various initiatives also need to be monitored to evaluate their effectiveness.

Professional recognition

The problems with recognition identified in this study are probably an inevitable stage in the development of a small and relatively new profession (Holloway & Wallinga, 1990). There was little sense from this study that participants understood themselves as strongly connected to a professional group, outside of their immediate team. This may have been a reflection of their relative newness and their consequent focus on their own new learning, or it may just be that it was not a focus for the study so did not arise. It is probable that service managers could help the development of a shared understanding of the role within healthcare teams by ensuring that the responsibilities of team members are clearly defined, and that hospital play specialists are included in clinical pathways, if they are not already (Munn et al., 1996). The Hospital Play Specialists Association also has a role in increasing understanding of the role more generally amongst professionals and public.

Individuals, too, could do much to raise their profile within their units, and the study showed a number of strategies that participants identified as successful. Given the likelihood that they will have an ongoing task of educating colleagues and families about their role, it might help new appointees to think in advance of how they are going to describe their service and the skills they bring to the work. One participant considered her colleagues were “overly reticent” about their professional base. Some new appointees may need to be more assertive about their knowledge and experience, and about claiming a place within teams.

Participation in multidisciplinary meetings and regular documentation in the clinical notes are fundamental to inter-disciplinary communication regarding children’s care. Those hospital play specialists who do not chart regularly may not be meeting their legal responsibilities, and are also missing key opportunities to show their colleagues what they do. New appointees need information on hospital policies with regard to charting. Service managers and team leaders also should ensure that new hospital play specialists know how

to access patient notes, and that they participate in inter-professional forums and in hospital-wide initiatives.

Strengths and limitations of the study

The study's strengths are that it sheds light on an area that has not been previously explored in New Zealand and that it points to ways in which hospital play specialists can be more effectively supported. It may also reduce the aloneness of new hospital play specialists by enabling them to recognise the universality of their unique experiences in the experiences of others. To van Manen (1990), the reflective thought that phenomenology sponsors can "bring us to the edge of speaking up, speaking out, or decisively acting" (p. 154). In showing the meaning underlying the participants' early experiences, this study points to action that can be taken by novice play specialists themselves, by those supporting them, and by service leaders, to help them in their transitions to their new role. I believe another strength of this study is that, as researcher, I do not come to it from a casual or temporary interest. Rather, it springs from my deep interest and personal engagement in the work of hospital play specialists: I have "lived" its questions over years (van Manen, 1990).

I believe there was a relationship of trust between the participants and myself, and that this enabled them to talk freely with me, despite our pre-existing professional relationships and my ongoing contact with most of them. They may have been more, rather than less, open with me because they anticipated I would be understanding of the issues they faced. However, it is possible that they would have told me different stories, or that I would have interpreted them differently, had I been an outsider to the profession or if we had been strangers to each other.

Along with its strengths, a study such as this one has inevitable limitations. Many stories that might have contributed to a richer understanding of sub-themes could not be explored because of constraints on time and on the length of the thesis. The participants numbered only eight, too few for generalisation yet sufficient for the methodology chosen, which does not seek to generalise findings.

One limitation related to the potential impact of culture and ethnicity on participants' experiences. The wide cultural diversity amongst children and families was one of the aspects mentioned a number of times by participants as an enjoyable aspect of working in a hospital, yet the scale of the study meant this aspect was not explored in depth. Cultural issues were also identified by some participants as they talked about how they handled differences between their own beliefs and that of some families with regard to providing support for children. However, none of the participants mentioned cultural issues in the context of their relationships with colleagues. It is possible their experiences might have been different had they been drawn from a minority cultural background, and that this would have some impact on the study's findings.

A further limitation is that all participants in the study were women, and hospital play specialists as a professional group are predominantly female. Historically, as we have seen in chapter two, play has been regarded as the province of women. The appointment of a male play specialist may well challenge any stereotypes that might exist in a healthcare setting and it is likely that gender would affect early experiences. It is unfortunate, therefore, that no male play specialists met the criteria for inclusion in this study.

Questions requiring further exploration

This research journey began with my curiosity, and many more questions arose for me along its pathway. There is tension for hospital play specialists between identity as a teacher and identity as a healthcare professional. Do novice play specialists see themselves as primarily education professionals with a different title in a hospital context, or as allied health professionals, or as something different again? If they see themselves as teachers, does this change with time, and over what period?

There is a tension too between support for child-initiated play for all age groups, the provision for young children's learning, and the more "visible" therapeutic aspects of the role. How are New Zealand hospital play specialists resolving this balance? Will they follow what seems to be the North American pathway of increasing time on preparation and procedural support? Or will their strong links with early childhood education, and to the Ministry of Education, protect their ability to simply "be with" children?

There is no New Zealand research on the understandings of healthcare professionals about the role and value of hospital play specialists. It would be useful to discover if hospital play specialists' perceptions of the differences in understanding are supported by such research, and whether the findings parallel similar studies in the United States. It would also be interesting to see the extent to which the models of play that McKinlay identified more than 20 years ago (McKinlay, 1983), are still held in New Zealand hospitals.

As well as these issues of professional identity, factors relating to retention deserve attention. Two participants resigned within their first two years, yet others continued despite their frustrations. Retention is a critical issue for a developing profession. If turnover is too high, there is a diminished pool of collective knowledge and experience to provide future leaders and mentors. It would be useful to conduct further research with people who have decided to move back to early childhood teaching and with experienced hospital play specialists who are still in the field, to explore factors contributing to their career decisions.

The study also raises questions about the extent to which the experiences of novice hospital play specialists are common to other novice healthcare professionals who belong to a small professional group. Are their experiences similar, or are the experiences of hospital play specialists *different because of their particular theoretical and philosophical backgrounds* and the "layperson" lens they bring to healthcare? Experiences of invisibility and indifference are referred to in other New Zealand studies. For example, Gasquoin (1996) and Gooder (2000) have identified this in relation to patients and families. Perhaps such experiences are widespread in the world of a hospital. If so, the experiences of the novice play specialists in this study might be revealed to have a wider meaning for how healthcare institutions are organised and for how they include new members.

Concluding statement

The experience of novice New Zealand hospital play specialists in their early months of employment has been explored in this research project. Through a process of listening, reading, writing, and reflection, many times repeated, I have sought to become more attentively attuned to aspects of the participants' lived experience that might be revealed

to have deeper meaning and significance to the participants and to others. Their stories have been like the particles in a kaleidoscope. I have carried them with me over many months, holding them to the light as I looked for glimpses of meaning. A little turn, a change in viewpoint, or a movement of one against another, showed each story reflected differently in different lights, illuminating new understandings and shifting into more complex and more interesting patterns when seen in relation to the others. Over time, I have brought together the various emerging themes and sub-themes in ways that seemed to me to capture their unique shapes and angles, and reveal the patterns of understanding they have formed. It is these patterns, these interpretations of meaning, that I offer to readers of this study. It is for the reader to decide whether the understandings shown are a trustworthy reflection of the meaning of the participants' experiences.

The novice play specialists in this study emerged as strong and competent. Within less than six months of "crossing the border" into the world of the hospital, one participant described her journey to belonging in her new world as follows:

At the start I felt a bit lost, and didn't know if I was doing the right thing, and a lot of people thought I was the play lady. I knew the job was more than that but I didn't have much confidence to do things. And now I'm just part of the team. I just get in and do what I'm supposed to do.

They were resourceful in coping with the transition from the familiar world of early childhood to the foreign world of a hospital, and resilient in their struggles to build relationships and to find a personal and professional place within their healthcare teams. They showed, too, their ability to adapt their practice to the requirements of their new role and to readily acquire new learning and skills. The study also revealed the deep satisfaction gained by the participants in recognising that they were contributing to their teams and making a difference to the lives of children and families.

But finally, when the text seems done (however incomplete or imperfect) we have to let go of it. From now on it will lead a life of its own. It will constitute a textorium, a space for others to enter – to gaze at what may reveal itself.

Van Manen, 2003, p. 14

APPENDIX A: AUT ETHICS COMMITTEE APPROVAL

MEMORANDUM

Academic Registry - Academic Services



To: Clare Hocking
From: **Madeline Banda**
Date: 14 March 2003
Subject: 03/37 The experience of novice hospital play specialist in the first eighteen months of employment

Dear Clare

Your application for ethics approval was considered by AUTEK at their meeting on 10/03/03.

Your application was approved for a period of two years until 10 March 2005.

You are required to submit the following to AUTEK:

- A brief annual progress report indicating compliance with the ethical approval given.
- A brief statement on the status of the project at the end of the period of approval or on completion of the project, whichever comes sooner.
- A request for renewal of approval if the project has not been completed by the end of the period of approval.

Please note that the Committee grants ethical approval only. If management approval from an institution/organisation is required, it is your responsibility to obtain this.

The Committee wishes you well with your research.

Please include the application number and study title in all correspondence and telephone queries.

Yours sincerely

Madeline Banda
Executive Secretary
AUTEK
Cc:

APPENDIX B: AUT ETHICS COMMITTEE EXTENSION

MEMORANDUM

Student Services Group - Academic Services



To: Clare Hocking
From: **Madeline Banda**
Date: 16 September 2003
Subject: 03/37 The experience of novice hospital play specialist in the first eighteen months of employment

Dear Clare

Your application for an amendment to your ethics approval was considered by AUTEK at their meeting on 08/09/03.

Your application was approved for a period of two years until 08/09/05.

You are required to submit the following to AUTEK:

- A brief annual progress report indicating compliance with the ethical approval given.
- A brief statement on the status of the project at the end of the period of approval or on completion of the project, whichever comes sooner.
- A request for renewal of approval if the project has not been completed by the end of the period of approval.

Please note that the Committee grants ethical approval only. If management approval from an institution/organisation is required, it is your responsibility to obtain this.

The Committee wishes you well with your research.

Please include the application number and study title in all correspondence and telephone queries.

Yours sincerely

Madeline Banda
Executive Secretary
AUTEK
Cc:
9030367 Marianne Kayes

APPENDIX C: HOSPITAL PLAY SPECIALISTS ASSOCIATION APPROVAL



HOSPITAL PLAY SPECIALISTS ASSOCIATION
OF AOTEAROA/NEW ZEALAND INC.

3 March, 2003

Marianne Kayes,
Project Director,
Professional Development,
Hospital Play Specialist Assn of Aotearoa/ New Zealand

Dear Marianne,

Master of Health Science – Thesis Research.

This letter confirms approval from the Hospital Play Specialist Association Executive as your employer for undertaking research relating to the experience of novice hospital play specialists, as partial fulfilment of the requirements for a Masters Degree in Health Science from AUT.

This letter also confirms that the ethical issues relating to the need for clear definition of roles, that of researcher and of professional development support provider have been discussed in detail and that you have our confidence and support to make the clear definition of role required for this research achievable.

The Hospital Play Specialist Association Executive confirm that you have permission to advise participants in the research that the Executive will provide support and advice should there be issues which arise for the participants in the course of the research which the Executive can help with.

You have the full support of the Executive and we await with expectation the results from the research.

Sincerely,

Carol Bolton
President

APPENDIX D: SERVICE MANAGER INFORMATION SHEET

153 Mountain Rd
Epsom
Auckland



[Date]

[Name and
Address]

SERVICE MANAGER INFORMATION SHEET

Dear

I am currently undertaking study towards a Masters degree in Health Science from Auckland University of Technology. For my thesis I plan to explore the experience of early childhood teachers who have been appointed as hospital play specialists, in the early months of employment. My interest in this area has arisen from my own experience as a hospital play specialist, as a former manager of a hospital play specialist service and, more recently, as a provider of professional development support to hospital play specialists.

Letters of invitation will be sent to hospital play specialists who have been employed within the past three months to two years. If you employ hospital play specialists who meet this criteria one or more of them may be involved in this research. I am writing, therefore, to advise you of the proposed research and to give you more information about it.

Title

The title of my thesis will be, "The experience of novice hospital play specialists in the first 18 months of employment".

Purpose of the study

The purpose of the study is to gain a better understanding of the experience of early childhood teachers who have made the transition from working as teachers in community early childhood settings to employment as hospital play specialists in healthcare settings. It aims to understand what this experience is like for practitioners in their first eighteen months of employment, as they become accustomed to this new role.

Hospital play specialists who have commenced work within the past 3 months to two years – whether or not they are still employed in a hospital - are being invited to participate. Up to eight of those who consent to participate will be interviewed. It is anticipated that interviews will take place outside of work time. If any participant wishes

to have the interview conducted during working hours they will be asked to seek approval for this from their team leader or service manager. Participants will not be interviewed in their immediate workplace. If interviews are conducted within the hospitals concerned, a meeting room or other appropriate facility will be booked for that purpose.

What are the benefits?

Participation in the research will be of benefit to participants in providing an opportunity for reflection on their experience. It is hoped that the results will provide some indications of ways in which hospitals, and the Hospital Play Specialists Association, might better support hospital play specialists during the first year or so following employment and so contribute to the professional wellbeing and retention of hospital play specialists, with the ultimate aim of enhancing the quality of programmes provided to children and families.

It is also anticipated that this qualitative research project will complement previous quantitative studies on factors affecting the well-being of hospital play specialists/child life specialists, by focusing on the actual experience of New Zealand hospital play specialists.

Confidentiality

It is recognised that hospital play specialists are a very small professional group and that participants and service managers may have concerns about confidentiality. Every effort will be made to preserve confidentiality:

1. The identity of participants will be confidential, and all identifying details will be disguised. Participants will be referred to as "a participant". Pseudonyms will not be used, so as to minimise the possibility of readers tracking individual responses.
2. Participants will be asked not to identify any colleagues, hospital staff, patients or patients' families. If they should inadvertently do so, this information will be removed from the record.
3. No information will be sought about specific aspects of services.

I recognise, too, that I may be working with some of the participants in the course of my employment as a provider of professional development support. Whether or not participants choose to participate will have no impact on their participation in professional development programmes. I will ensure that any contact for research purposes is separated from visits or other contact for the purpose of professional development. I will not initiate any discussion of this research during professional development visits or workshops.

Advice has been received from the Ministry of Health Auckland Regional Ethics committee that the research does not come within their auspices as it focuses on professional development and retention issues rather than a health-related question, and does not require access to health records. This project was approved by the Auckland University of Technology Ethics Committee on 10 March 2003, Reference number 03/37. The project also has the approval of my employer, the Hospital Play Specialists Association of Aotearoa/New Zealand.

If you would like any more information, or have any questions, you are very welcome to contact me by phone, 09 630 4158, or email mikayes@xtra.co.nz.

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Clare Hocking, tel. 09 917 9999 extn 7120, email clare.hocking@aut.ac.nz. Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEK, Madeline Banda, madeline.banda@aut.ac.nz, 09 917 9999 ext 8044.

Yours sincerely

Marianne Kayes

APPENDIX E: LETTER OF INVITATION TO PARTICIPATE

153 Mountain Rd
Epsom
Auckland



[Date]

Participant Information Sheet

Dear

As you may know, I am currently undertaking study towards a Masters degree in Health Science from Auckland University of Technology. For my thesis I plan to explore the experience of early childhood teachers who have been appointed as hospital play specialists, in the first eighteen months of employment. My interest in this area has arisen from my own experience as a hospital play specialist, as a former manager of a hospital play specialist service and, more recently, as a provider of professional development support to hospital play specialists. I am writing to ask if you would be willing to participate in this research.

Project Title

The title of my thesis will be "*The experience of novice hospital play specialists in the first 18 months of employment*".

What is the purpose of the study?

The purpose of the study is to gain a better understanding of the experience of early childhood teachers who have made the transition from working as teachers in community early childhood settings to employment as hospital play specialists in healthcare settings. It aims to understand what this experience is like for practitioners in their early months of employment as they become accustomed to this new role.

How are people chosen to be asked to be part of the study?

A number of hospital play specialists who have commenced work within the past 3 months to two years – whether or not they are still employed in a hospital – are being invited to participate. You are being invited to be part of this study because your commencement date falls within this period.

What happens in the study?

If you are agreeable to participation, I will arrange with you a convenient time and location in which to interview you. It is expected that in most cases there will be one interview, requiring about 1.5 hours of your time. There may be a follow-up phone call to clarify points made during the interview, and some participants may be asked if they are agreeable to a further brief interview at a later date in order to expand on certain areas. Interviews will be taped and later transcribed.

What are the discomforts and risks?

Participants will not be asked to do anything that puts themselves at physical risk. However, it is recognised that, for some, the early months of employment may have been a time of strong emotional responses to the nature of the work and the work environment. All participants will therefore be informed of sources of professional supervision and support available to them, should they feel they want this. If you would like to have a support person with you during the interview that would be perfectly acceptable.

I am also aware that I may be working with you during this period in my employment as a provider of professional development, or in the course of other duties which I might possibly be involved in for the Hospital Play Specialists Association, such as certification for hospital play specialists when this becomes established. Whether or not you choose to participate in the research will have no impact on your participation in professional development programmes. I will ensure that any contact for research purposes is at a different time from visits or other contact for the purpose of professional development. If interviews are conducted outside of Auckland, then the visit for interview purposes may be combined with a visit for professional development purposes. However, care will be taken to ensure a complete separation, say, by conducting the interview on a following day or out of working hours after a meal break. I will not give any verbal reminders about this request for participation, nor will I initiate discussion of the research with participants during professional development visits or workshops.

You may withdraw yourself or any information that you have provided for this project at any time up until analysis of the data commences, without being disadvantaged in any way. If you withdraw, all relevant tapes and transcripts, or parts thereof, will be destroyed.

Letters have already been sent to managers or team leaders of the various hospital play specialist services across New Zealand, informing them of the proposed research and making them aware that a member or members of their staff may be invited to participate. They have also been informed that the identity of participants is confidential.

What are the benefits?

Participation in the research may be of benefit to participants in providing an opportunity for reflection on their experience, their professional wellbeing and future professional development. It is hoped that the results will provide some indications of ways in which hospitals, and the Hospital Play Specialists Association, might better support hospital play specialists during the first year or so following employment and so contribute to the professional wellbeing and retention of hospital play specialists, with the ultimate aim of enhancing the quality of programmes provided to children and families.

It is also anticipated that this qualitative research project will complement previous quantitative studies on factors affecting the well-being of child life specialists, by focusing on the actual experience of hospital play specialists. A summary of the findings will be provided to each participant following completion of the research. I may seek to publish the research at some later date, and so make the results available to a wider readership.

How is privacy protected?

It is recognised that hospital play specialists are a very small professional group and that participants may have concerns about the possibility that their responses may be identified. Every effort will be made to preserve confidentiality:

4. All identifying details will be disguised. Participants will be referred to as “a participant” and pseudonyms will be avoided to ensure that it is difficult or impossible for readers to track individual responses.
5. Participants will be asked not to mention any colleagues, hospital staff, patients or patients’ families by name. If they should inadvertently do so, this information will be removed from the record.
6. The emphasis of the interview is on your experience. Where talking about this involves revealing things about the service you work in, this information will be disguised in the thesis and any presentation or publications, so that you are not identifiable. No information will be sought about specific aspects of your service.
7. Interviews will be recorded and the transcript of your interview will be given to you to check before it is used. At this point you will be able to decide if what has been recorded accurately reflects your views, and also whether you are happy that any potentially identifying information has been removed or disguised satisfactorily.
8. As discussed above, your participation is voluntary and you may of course decline or withdraw at any time prior to commencement of analysis of the data, without giving a reason or being disadvantaged.
9. Consent forms, tapes and transcripts will be stored securely in my office at my home while I am working on the data. On completion of the thesis, a copy of all data will be held securely at AUT for six years, and will then be destroyed.

Costs of Participating

It is not expected that there will be any cost to participants, other than the interview time. I anticipate that interviews will take place outside of your working hours. However, if you should wish to be interviewed within work time then I will ask you to seek permission for this from your service manager. Interviews will be conducted at a place convenient to you. If this is your workplace, a room will be chosen which ensures comfort and privacy. To protect participants’ privacy, interviews will not be conducted in participants’ regular office space.

Opportunity to consider invitation

I would very much appreciate your favourable consideration of this invitation to participate. If you would like any more information, or have any questions, you are very welcome to contact me by phone (09 630 4158) or email mikayes@xtra.co.nz. Alternatively, you could contact Clare Hocking, my supervisor, tel 09 917 9999 extn 7120, email clare.hocking@aut.ac.nz.

If you are willing to participate, please let me know by telephone or email. It is important that the people interviewed comprise a variety of circumstances and experiences, so at this point I will ask you a few general questions to ascertain this. We can then discuss how best to arrange for the interview. When we meet for the interview I will ask you to complete a “Consent to Participation in Research” form.

Advice has been received from the Ministry of Health Auckland Regional Ethics committee that the research does not come within their auspices as it focuses on professional development and retention issues rather than a health-related question, and does not require access to health records.

This project was approved by the Auckland University of Technology Ethics Committee on 10 March 2003, Reference number 03/37. The project also has the approval of my employer, the Hospital Play Specialists Association of Aotearoa/New Zealand.

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Clare Hocking. Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEK, Madeline Banda, madeline.banda@aut.ac.nz, 09 917 9999 ext 8044.

I look forward to hearing from you.

Yours sincerely

Marianne Kayes

Tel: 09 630 4158

Email: mikayes@xtra.co.nz

APPENDIX F: REMINDER INVITATION

153 Mountain Rd
Epsom
Auckland



[Recipient name and address]

[Date]

Dear [Name]

*Research project: The experience of novice hospital play specialists
in the first eighteen months of employment*

You will recall that I wrote to you a month ago, inviting you to participate in the above research project, which I will be conducting for my masters degree in Health Science from the Auckland University of Technology. I have not heard from you, so am writing again.

If you have decided that you do not wish to participate, then that is of course absolutely fine and I will not contact you again with regard to the research. However, if you have overlooked responding or have misplaced the original information, but would like to participate, then do please let me know by phone or email, so that we can discuss it further. I enclose a copy of the original Participant Information Sheet, for your information.

I would welcome any questions you may have about the project. Alternatively, you could contact my supervisor, Clare Hocking, tel. 09 917 999 extn 7120, email clare.hocking@aut.ac.nz.

Yours sincerely

Marianne Kayes

Tel. 09 630 4158

Email. mikayes@xtra.co.nz

APPENDIX G: PARTICIPANT CONSENT FORM

Consent to Participation in Research



Title of Project: 'The experience of novice hospital play specialists in the first 18 months of employment.'

Project Supervisor: Clare Hocking, School of Occupational Therapy

Researcher: Marianne Kayes

- I have read and understood the information provided about this research project.
- I have had an opportunity to ask questions and to have them answered.
- I understand that the interview will be audio-taped and transcribed.
- I understand that I will have an opportunity to check the transcript(s) of my interview(s) prior to analysis.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to commencement of analysis of data, without being disadvantaged in any way. If I withdraw before then, I understand that all relevant tapes and transcripts, or parts thereof, will be destroyed.
- I agree to take part in this research.

Participant signature:

Participant name:

Date:

Project Supervisor Contact Details: Clare Hocking, School of Occupational Therapy, Auckland University of Technology, tel. 09 917 9999 ext 7120, email clare.hocking@aut.ac.nz.

This research was approved by the Auckland University of Technology Ethics Committee on 10 March 2003 AUTEK Reference number 03/37.

APPENDIX H: TRANSCRIPT CONFIDENTIALITY AGREEMENT



CONFIDENTIALITY AGREEMENT

Between Marianne Kayes (researcher) and

Tania Churches

**Research topic: The experience of novice hospital play specialists
in their first 18 months of employment**

I undertake to maintain the confidentiality of all material connected with the above research topic.

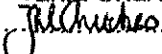
All material related to the project will be stored safely, where it is not accessible to any persons other than the transcriber.

All original data, transcriptions, and any associated material will be returned to the researcher immediately upon completion of the transcribing. All electronic files will be deleted immediately I receive Marianne's notification of receiving them.

I understand that if I have any questions I am welcome to contact the researcher on 09 630 4158.

I understand that I may raise any concerns I have about the nature of this project with the Project Supervisor, Clare Hocking, 09 917 9999 extn 7120. Any concerns about the conduct of the research may be notified to the Executive Secretary, AUTEK, Madeliné Banda, 09 917 9999 extn 8044.

Name (Transcriber): Tania Churches

Signed: 

Date: 15/5/03

Name (Researcher): Marianne Kayes

Signed: 

Date: 12/5/03

REFERENCES

- Adams, R. (1971). *The young child in hospital: His emotional reactions to short-term hospitalisation*. Unpublished reading study, University of Auckland.
- Alderson, P. (1993). European charter of children's rights. *Bulletin of Medical Ethics*, 13-15.
- Allen, R. E. E. (1990). *The concise Oxford dictionary of current English* (8th ed.). Oxford: Clarendon Press.
- American Academy of Pediatrics. (2000). Policy Statement. Child Life Services (RE9922). *Pediatrics*, 106(5), 1156-1159.
- Azarnoff, P., & Lindquist, P. (Eds.). (1997). *Psychological abuse of children in health care: The issues. Monograph No. 2* (2nd ed.). Tarzana, CA: Pediatric Projects Inc.
- Badger, J. M. (2001). Understanding secondary traumatic stress. *American Journal of Nursing*, 101(7), 26-32.
- Bain, L. (1996). Preceptorship: A review of the literature. *Journal of Advanced Nursing*, 24, 104-107.
- Berk, L. E., & Winsler, A. (1995). *Scaffolding children's learning: Vygotsky and early childhood education*. Washington, DC: National Association for the Education of Young Children.
- Bibace, R., & Walsh, M. E. (1980). Development of children's concepts of illness. *Pediatrics*, 66(6), 912-917.
- Bivins, C. M., & O'Brien, K. (2002). CL impact on market share. *Bulletin*, 19(4), 1.
- Blanch, J. (2004). *Assignment 3. Investigation report*. Unpublished assignment for BEd(Tchg), Christchurch College of Education, Christchurch.
- Blum, L. A., Hunt, D. W., Hanks, J., Nordberg, M., Goldstein, S. N., Spiro, D. C., (1995). Rude awakenings. *Emergency Medical Services*, 24(5), 31-34, 73-75, 80-85.
- Bolig, R. (1982). Child life workers: Facilitating their growth and development. *Children's Health Care*, 10(3), 94-99.
- Bolig, R. (1997). No play permitted: Indicator of psychological abuse. In P. Azarnoff & P. Lindquist (Eds.), *Psychological abuse of children in health care: The issues. Monograph No. 2* (2nd ed.). Tarzana CA: Pediatric Projects Inc.
- Bolig, R., Yolton, K., & Nissen, H. (1991). Medical play and preparation: Questions and issues. *Children's Health Care*, 20(4).

- Bowlby, J. (1951). *Maternal care and mental health. Monograph Series 2(95)*. Geneva: World Health Organisation.
- Brasher, S., & Haluska, H. (2003). *What would Emma Plank say? (Abstract)*. Paper presented at the Child Life Council 21st Annual Conference on Professional Issues, Montreal, Canada.
- Brown, C. (2000). Child life in the new millenium. *Bulletin*, 17(3), 1.
- Bruce, T. (1991). *Time to play in early childhood*. London: Hodder and Stoughton.
- Butler, J. (1996). Professional development: Practice as text, reflection as process, and self as locus. *Australian Journal of Education*, 40(3), 265-283.
- Canella, G. S. (1997). *Deconstructing early childhood education. Social justice and revolution*. New York: Peter Lang.
- Carr, M. (2001). *Assessment in early childhood settings*. London: Paul Chapman Publishing.
- Carroll, L. (2001a). *Alice's adventures in wonderland*. London: Bloomsbury Publishing.
- Carroll, L. (2001b). *Through the looking glass, and what Alice found there*. London: Bloomsbury Publishing.
- Catlin, A. (2004). Pediatric medical errors part 2: Case commentary. A source of tremendous loss. *Pediatric Nursing*, 30(4), 331-333, 335.
- Child Life Council. (1997). *Guidelines for the development of child life programs* (2nd ed.). Rockville, MD: Child Life Council.
- Child Life Council. (2002). *Official Documents* (3rd ed.). Rockville, Md: Child Life Council Inc.
- Clatworthy, S. (1981). Therapeutic play: Effects on hospitalized children. *Children's Health Care*, 9(4), 108-113.
- Cole, W., Diener, M., Wright, C., & Gaynard, L. (2001). Health care professionals' perceptions of child life specialists. *Children's Health Care*, 30(1), 1-15.
- Cole, W. S. (1998). *Reexamining child life specialists: Perceptions and value given by health care professionals*. Unpublished MSc thesis, University of Utah, Utah.
- Cooper, M. D. C. (1990). Mentorship: The key to the future of professionalism in nursing. *Journal of Perinatal Neonatal Nursing*, 4(3), 71-77.
- Dahlberg, G., Moss, P., & Pence, A. (1999). *Beyond quality in early childhood education and care. Postmodern perspectives*. London: Routledge Falmer.

- Dalli, C. (2002a). Being an early childhood teacher: Images of professional practice and professional identity during the experience of starting childcare. *New Zealand journal of educational studies*, 37(1), 73-85.
- Dalli, C. (2002b). The importance of the early years: Towards re-framing our discourse. *The first years. Nga tau tuatahi*, 4(1), 3-7.
- DelPo, E., & Frick, S. (1988). Directed and nondirected play as therapeutic modalities. *Children's Health Care*, 16(4).
- Department of Education. (1971). *Report of the committee of inquiry into pre-school education*. Wellington: Department of Education.
- Department of Health. (1991). *Welfare of children and young people in hospital* (1994 ed.). London: HMSO.
- Dockett, S., & Fleer, M. (2002). *Play and pedagogy in early childhood education. Bending the rules*. Southbank Victoria: Thomson.
- Douglas, J. (1975). Early hospital admissions and later disturbances of behavior and learning. *Developmental medicine and child neurology*, 17, 456-480.
- Edwards, C., Gandini, L., & Forman, G. (1998). *The hundred languages of children* (2nd ed.). Greenwich, CT: Ablex Publishing Corporation.
- Emden, C., Hancock, H., Schubert, S., & Darbyshire, P. (2001). A web of intrigue: The search for quality in qualitative research. *Nurse Education in Practice*, 1, 204-211.
- Emden, C., & Sandelowski, M. (1998). The good, the bad and the relative, part one: Conceptions of goodness in qualitative research. *International Journal of Nursing Practice*, 4, 206-212.
- Epston, D., & White, M. (1989). *Literate means to therapeutic ends*. Adelaide: Dulwich Centre Publications.
- Fadiman, A. (1997). *The spirit catches you and you fall down*. New York: Farrar, Straus and Giroux.
- Farrell, G. A. (2001). From tall poppies to squashed weeds: Why don't nurses pull together more? *Journal of Advanced Nursing*, 35(1).
- Fenichel, E. (Ed.). (1992). *Learning through supervision and mentorship*. Washington: Zero to Three.
- Francis, S. (1990). *Child life education series: Child life theory into practice*. Texas: Child life department, Children's Medical Center.
- Freeman, J., Epston, D., & Lobovits, D. (1997). *Playful approaches to serious problems*. New York: W.W. Norton & Company.

- Gadamer, H.-G. (1989). *Truth and Method* (J. Weinsheimer & D. G. Marshall, Trans. 2nd ed.). London: Sheed & Ward.
- Gasquoine, S. (1996). *Constant vigilance. The lived experience of mothering a hospitalised child*. Unpublished MPhil thesis, Massey University, Palmerston North.
- Gaynard, L., Hausslein, E., & DeMarsh, J. (1989). Child life specialists: Report of an observational study. *Children's Health Care*, 18(2), 75-81.
- Gaynard, L., Wolfer, J., Goldberger, J., Thompson, R., Redburn, L., & Laidley, L. (1990). *Psychosocial care of children in hospitals: A clinical practice manual from the ACCH Child Life research project*. Rockville, Md: Child Life Council Inc.
- Gendlin, E. (1997). *Experiencing and the creation of meaning*. Evanston, Illinois: Northwestern University Press.
- Gillis, A. G. (1989). The effect of play on immobilized children in hospital. *Int J Nurs Stud*, 26(3), 261-269.
- Golden, D. (1983). Play therapy for hospitalized children. In C. Schaefer & K. O'Connor (Eds.), *Handbook of play therapy*. New York: John Wiley & Sons.
- Gooder, J. (2000). *Becoming human again: Older adult's experience of rehabilitation in hospital*. Unpublished MHSc thesis, Auckland University of Technology, Auckland.
- Grenz, S. (1966). *A primer on postmodernism*. Cambridge: Eerdmans.
- Griffin, M. (2004). Teaching cognitive rehearsal as a shield for lateral violence: An intervention for newly licensed nurses. *J Continuing Education Nursing*, 35(6), 257-263.
- Guskey, R. (2002). Does it make a difference? Evaluating professional development. *Educational Leadership* (March 2002), 45-51.
- Hall, D., & Cleary, J. (1988). The development of play for children in hospitals: British and European perspectives. *Children's Health Care*, 16(3), 223-230.
- Harvey, S., & Hales-Tooke, A. (Eds.). (1972). *Play in hospital*. London: Faber & Faber.
- Headrick, L. A., Wilcock, P. M., & Batalden, P. B. (1998). *Education and debate. Interprofessional working and continuing medical education*. Retrieved 5/02/2005, from <http://bmj.bmjournals.com/archive/7133/7133ed2.htm>
- Health and Disability Commissioner. Your rights when receiving a health or disability service. Auckland: Health and Disability Commissioner.
- Hedges, H., & Gibbs, C. (2001). "It was so insanely busy all the time": Student teachers experience family life anew. *The first years: Nga tau tuatahi*, 3(2), 23-26.

- Heidegger, M. (1971). *Poetry, language, thought* (A. Hofstadter, Trans.). New York: Harper & Row.
- Heidegger, M. (1996). *Being and Time* (J. Stambaugh, Trans.). Albany: State University of New York Press.
- Hicks, M. (2003). The value of play in our practice. *Bulletin*, 21(2), 2.
- Hill, D. (2001). Passion, power and planning in the early childhood centre. *The first years. Nga tau tuatahi*, 3(2), 10-13.
- Hill, J., Hawk, K., & Taylor, K. (2002). Professional development. What makes it work? *set. Research information for teachers*(2), 12-15.
- Hoepft, M. C. (1997). Choosing qualitative research: A primer for technology education researchers. *Journal of Technology Education*, 9(1).
- Hogg, C. (1990). *Quality management for children: Play in hospital*. London: Action for Sick Children.
- Holloway, D., & Wallinga, C. (1990). Burnout in child life specialists: The relation of role stress. *Children's Health Care*, 19(1), 10-18.
- Hospital Play Specialists Assn of Aotearoa/New Zealand. (1999). *Hospital Play Specialist Core Competencies*.
- Hospital Play Specialists Assn of Aotearoa/New Zealand. (2004). *History*. Retrieved 2/12/04, from www.hospitalplay.org.nz/history
- Husserl, E. (2002). Pure phenomenology, its method and its field of investigation. In D. Moran & T. Mooney (Eds.), *The phenomenology reader*. London: Routledge.
- Kayes, M. (1991). *Making sense of it: The role of play in assisting children requiring extensive hospitalisation to understand and cope with their illness, its treatment and their hospital experience*. Paper presented at the 5th Early Childhood Convention, Dunedin, New Zealand.
- Kayes, M. (1998). *The state of play in New Zealand hospitals*. Unpublished DipEI Dissertation, Auckland College of Education, Auckland.
- Kayes, M. (1999a). *The early childhood teacher in New Zealand health care settings: changes and challenges*. Paper presented at the 7th Early Childhood Convention, Nelson, New Zealand.
- Kayes, M. (1999b). *Play in New Zealand hospitals: Still a luxury?* Paper presented at the 7th Early Childhood Convention, Nelson, New Zealand.
- Kayes, M., & Mackay, B. (2003). *"I've got a tuna in my tummy": What you need to know when a child in your centre goes to hospital*. Paper presented at the 8th Early Childhood Convention, Palmerston North.

- Kleinberg, S. (1987). Child life in the 1990s: Changing roles, changing times. *Children's Health Care*, 15(4), 240-244.
- Koch, T. (1998). Story telling: Is it really research? *Journal of Advanced Nursing*, 28(6), 1182-1190.
- Koch, T., & Harrington, A. (1998). Reconceptualizing rigour: The case for reflexivity. *Journal of Advanced Nursing*, 28(4), 882-890.
- Krigg, S. (2000). Reflections on infant dispositions. *The first years. Nga tau tuatahi*, 2(2), 13-18.
- Lambert, B., & Clyde, M. (2000). *Re thinking early childhood theory and practice*. Katoomba, NSW: Social Science Press.
- Lansdown, R. (1996). *Children in hospital. A guide for family and carers*. Oxford: Oxford University Press.
- Leff, P. T., Chan, J. M., & Walizer, E. M. (1991). Self-understanding and reaching out to sick children and their families: An ongoing professional challenge. *Children's Health Care*, 20(4), 230-239.
- Leininger, M. (1994). Evaluation criteria and critique of qualitative research studies. In J. Morse (Ed.), *Critical issues in qualitative research methods*. Thousand Oaks, CA: Sage.
- Leonard, V. W. (1994). A Heideggerian phenomenological perspective on the concept of person. In P. Benner (Ed.), *Interpretive phenomenology. Embodiment, caring, and ethics in health and illness*. Thousand Oaks: Sage Publications.
- Linder, T. W. (1993). *Transdisciplinary play-based intervention. Guidelines for developing a meaningful curriculum for young children*. Baltimore: Paul Brookes Publishing Co.
- MacArthur, J., Purdue, K., & Ballard, K. (2003). Competent and confident children? *Te Whariki* and the inclusion of children with disabilities in early childhood education. In J. Nuttall (Ed.), *Weaving Te Whariki. Aotearoa New Zealand's early childhood curriculum document in theory and practice* (pp. 131-160). Wellington: NZCER.
- MacCarthy, D. (1982). *The under-fives in hospital. The emotional well-being of children aged 0-5 years in hospital*. (3rd ed.). London: National Association for the Welfare of Children in Hospital.
- Malaguzzi, L. (1998). History, ideas and basic philosophy. In C. Edwards, Gandini, L and Forman, G (Ed.), *The hundred languages of children* (2nd ed.). Norwood, NJ: Ablex.
- Mattsson, M., & Mattsson, B. (1994). Supervision as an aid to professional development. *Physiotherapy theory and practice*, 10, 113-121.

- McCue, K. (1988). Medical play: an expanded perspective. *Children's Health Care*, 16(3).
- McDonald, S. (2000). *Unpublished assignment for MEd paper*. Auckland College of Education, Auckland.
- McIntosh, C. M. (2000). *Exploring the relationship between cultural belief systems and young children's conceptualization of illness causality*. Unpublished MEdPsych dissertation, Massey University, Palmerston North.
- McKinlay, R. (1982). *The care of children in New Zealand hospitals*. Wellington: National Children's Health Research Foundation.
- McKinlay, R. (1983). *Play for children in hospital: Luxury or necessity?* Paper presented at the Third New Zealand Early Childhood Convention.
- McVicar, A. (2003). Workplace stress in nursing: A literature review. *Advanced Nursing*, 44(6), 633-642.
- Ministry of Education. (1966b). Revised statement of desirable objectives and practices (DOPs) for chartered early childhood services in New Zealand. *Supplement to the Education Gazette*.
- Ministry of Education. (1996). *Te Whariki. He whariki matauranga mo nga mokopuna o Aotearoa. Early childhood curriculum*. Wellington: Learning Media.
- Ministry of Health (Central Health Services Council). (1959). *The welfare of children in hospital. Report of the committee (The Platt Report)*. London: HMSO
- Mitchell, L. (2001). Currents of change: Early childhood education in 2001. In I. Livingstone (Ed.), *New Zealand Annual Review of Education* (Vol. 11). Wellington: Victoria University.
- Moran, D., & Mooney, T. (2002). *The Phenomenology Reader*. London: Routledge.
- Moss, P., Dillon, J., & Statham, J. (2000). The "child in need" and "the rich child": Discourses, constructions and practice. *Critical social policy*, 20(2), 233-254.
- Moss, P., & Petrie, P. (1997). *Children's services. Time for a new approach*. London: Institute of Education, University of London.
- Moss, P., & Petrie, P. (2002). *From children's services to children's spaces. Public policy, children and childhood*. London: Routledge Falmer.
- Munn, K., Barber, C., & Fritz, J. (1996). Factors affecting the professional well-being of child life specialists. *Children's Health Care*, 25(2), 71-91.
- National Health Committee. (1998). *The social, cultural and economic determinants of health in New Zealand: Action to improve health*. Wellington: Ministry of Health.

- New, R. (1998). Theory and praxis in Reggio Emilia: They know what they are doing, and why. In C. Edwards, Gandini, L and Forman, G (Ed.), *The hundred languages of children* (2nd ed.). Greenwich, Connecticut: Ablex Publishing Corporation.
- Noble, E. (1967). *Play and the sick child*. London: Faber.
- Nuttall, J. (2003a). Exploring the role of the teacher within *Te Whariki*: Some possibilities and constraints. In J. Nuttall (Ed.), *Weaving Te Whariki. Aotearoa New Zealand's early childhood curriculum document in theory and practice*. Wellington: NZCER.
- Nuttall, J. (2003b). *Weaving Te Whariki: Aotearoa New Zealand's early childhood curriculum document in theory and practice*. Wellington: New Zealand Council for Educational Research.
- Omdahl, B. L., & O'Donnell, C. (1999). Emotional contagion, empathic concern and communicative responsiveness as variables affecting nurses' stress and occupational commitment. *Advanced Nursing*, 29(6), 1351-1359.
- Organisation Mondiale pour l'Education Prescolaire. (1966). *Play in hospital*.
- Paddy, A. (2000). *Experiencing the relationship: The client and the community occupational therapist*. Unpublished Masters of Health Science, Auckland University of Technology, Auckland.
- Percival, T. (1999). *Pacific children and young people*. Paper presented at The First Decade conference, Auckland.
- Petrillo, M., & Sanger, S. (1980). *Emotional care of hospitalized children: An environmental approach* (2nd ed.). Philadelphia: J.B. Lippincott.
- Polit, D. F., Beck, C. T., & Hungler, B. P. (2001). *Essentials of nursing research. Methods, appraisal and utilization* (5th ed.). Philadelphia: Lippincott.
- Prugh, D., Staub, E., Sands, H., Kirschbaum, R., & Lenihan, E. (1953). A study of the emotional reactions of children and families to hospitalization and illness. *American Journal of Orthopsychiatry*, 23, 70-106.
- Quinton, D., & Rutter, M. (1976). Early hospital admissions and later disturbances of behavior: An attempted replication of Douglas' findings. *Developmental medicine and child neurology*, 18, 447-459.
- Robertson, J. (1958). *Young children in hospital* (1970 ed.). London: Tavistock Institute of Human Relations.
- Rogoff, B. (2003). *The cultural nature of human development*. Oxford: Oxford University Press.
- Romesberg, T. L. (2004). Understanding grief: A component of neonatal palliative care. *Journal of Hospice and Palliative Care Nursing*, 6(3), 161-170.

- Rubin, S. (1992). What's in a name? Child Life and the play lady legacy. *Children's Health Care*, 21, 4-13.
- Save the Children Fund. (1989). *Hospital: A deprived environment for children? The case for hospital play schemes*. London: Save the Children Fund.
- Sheilds, C. (2000). *Mary Swann*. London: Fourth Estate.
- Shotter, J. (1978). The cultural context of communication studies: Theoretical and methodological issues. In E. Lock (Ed.), *Action, gesture and symbol: The emergence of language* (pp. 43-78). London: Academic Press.
- Simons, B. (1979). *Children in hospital. A descriptive study of the hospital experience of Dunedin five year olds*. Unpublished thesis, University of Otago, Dunedin.
- Smythe, L. (1996). *Evidence or understanding as the ethos of practice? A phenomenological, hermeneutic perspective*. Paper presented at the NERF Conference.
- Southall, D. P., Burr, S., Smith, R. D., Bull, D. N., Radford, A., Williams, A., et al. (2000). The child friendly healthcare initiative (CFHI): Healthcare provision in accordance with the UN Convention on the Rights of the Child. *Pediatrics*, 106(5), 1054-1064.
- Standards New Zealand. (2004). *SNZ HB 8134-4:2004. Health and disability sector standards (children and young people) audit workbook*. Wellington: Standards New Zealand.
- Standards NZ Ministry of Health. (2001). *NZS8134:2001 New Zealand Standard. Health & Disability Sector Standards*. Wellington: Standards New Zealand.
- Taylor, B., & Barling, J. (2004). Identifying sources and effects of carer fatigue and burnout for mental health nurses: A qualitative approach. *Int J Ment Health Nursing*, 13(2), 117-125.
- Te One, S. (2003). The context for *Te Whariki*: Contemporary issues of influence. In J. Nuttall (Ed.), *Weaving Te Whariki. Aotearoa New Zealand's early childhood curriculum document in theory and practice* (pp. 17-49). Wellington: NZCER.
- Thompson, R. (1985). *Psychosocial research on pediatric hospitalization and health care: A review of the literature*. Springfield: Charles C. Thomas.
- Thompson, R., & Stanford, G. (1981). *Child life in hospitals: Theory and practice*. Springfield: Charles C. Thomas.
- van Manen, M. (1990). *Researching Lived Experience*. London, Ontario: The State University of New York.
- van Manen, M. (1991). *The tact of teaching: The meaning of pedagogical thoughtfulness*. Albany, NY: SUNY Press.

- van Manen, M. (1994). *Pedagogy, virtue and narrative identity in teaching*. *Curriculum Inquiry, OISE/John Wiley (Toronto), Vol.4, No.2 (pp. 135-170)*. Retrieved 14/10/2004, from www.phenomenologyonline.com/max/virtue.htm
- van Manen, M. (1999). The practice of practice. In M. Lange, J. Olson, H. Hansen & W. Bynder (Eds.), *Changing schools/changing practices: Perspectives on educational reform and teacher professionalism*. Luvain, Belgium: Garant.
- van Manen, M. (2002). Care-as-worry, or don't worry be happy. *Qualitative Health Research: An International, Interdisciplinary Journal*, 12(2), 264-280.
- van Manen, M. (2003). Care-as-worry, or don't worry be happy. *Qualitative Health Research: An International Interdisciplinary Journal*, 12(2), 264-280.
- van Manen, M. (2003). *From hypomnesis to anamnesis. "Doing" phenomenology and the demands of writing*. Draft paper. Auckland: Auckland University of Technology.
- Vernon, D., Schulman, J., & Foley, J. (1966). Changes in children's behavior after hospitalization. *American Journal of Diseases of Children*, 111, 581-593.
- Webster, L. (2004). *What about us? Issues for staff working with sick children*. Paper presented at the Hospital Play Specialists Association of Aotearoa/NZ. 2nd Pacific Rim Conference., Auckland, New Zealand.
- Wong, D. L. (1999). *Whaley & Wong's nursing care of infants and children* (6 ed.). St Louis: Mosby.
- Woodrow, C. (1999). Revisiting images of the child in early childhood education: Reflections and considerations. *Australian Journal of Education*, 24(4), 7-12.
- Zander, R. S., & Zander, B. (2000). *The art of possibility*. Camberwell, Victoria: Penguin Books Australia Ltd.