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Doctoral Thesis

Influences on worker's role with children in residential settings: A grounded theory

Mike Heyes

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

All correspondence should be sent to:

Mike Heyes

Doctorate in Clinical Psychology

Faculty of Health and Medicine

Health Innovation One

Sir John Fisher Drive

Lancaster University

Lancaster

LA1 4AT

m.heyes@lancaster.ac.uk

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Thesis Abstract

The thesis consists of two parts aiming to focus on workers based in children's residential homes or similar settings, exploring the impact of influences on how they work within their role.

The systematic review was a narrative synthesis of 14 quantitative papers related to burnout and compassion fatigue (also referred to as secondary traumatic stress) amongst direct caregiving staff within residential settings for children. This review highlighted the prevalence of burnout, compassion fatigue and secondary traumatic stress amongst staff working in residential settings with children and young people. The review also highlighted a range of personal and work-based factors that were seen as being predictors of or protective factors against burnout or compassion fatigue. It is indicated that work-based factors such as exposure to violence, reduced job satisfaction and managerial support could make workers more susceptible to burnout or compassion fatigue. Additionally, the review highlights the personal factors associated with burnout or compassion fatigue, including age, experience and being extravert. The review suggests that potential factors associated with burnout and compassion fatigue are not standard across teams, or for workers, but does indicate that services and organisations should be aware of the wide range and to implement ways to support staff teams and minimize the risk of burnout and compassion fatigue.

The empirical paper explored the influence of personal experiences on workers' role with children in residential settings. A constructivist grounded theory approach was used, with eight participants taking part in semi-structured interviews. A model was developed from the data, which highlighted how personal experiences shape values and beliefs, which then underpin reasons for entering roles with children, and ways of working within the role. Participants also highlighted the influence of work-based factors such as training and other colleagues, as well as

the need to adhere to certain plans and procedures. These factors also influence ways of working, whilst all the influences stated then contribute to personal growth within the role.

The critical appraisal reflects on the researcher's role within the research, when considering their prior experience of working within the role of support worker with children in care.

Declaration

This thesis documents research undertaken in partial fulfilment of the Lancaster University Doctorate in Clinical Psychology. The work presented here is my own, except where due reference is made. This thesis has not been submitted for the award of a higher degree elsewhere.

Signature:

Print name: M. Heyes

Date: 21/5/2021

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Contents

	Page Number
Section One: Literature Review	**1-1**
Abstract	**1-2**
Introduction	**1-3**
Method	**1-6**
Results	**1-11**
Discussion	**1-21**
References	**1-29**
Tables and Figures	
Table 1. Key Concepts and Search Terms	**1-43**
Table 2. Summary of Peer-Reviewed Articles Included in Systematic Literature Review	**1-45**
Table 3. Study Demographics	**1-51**
Table 4. AXIS Quality Appraisal of Cross-Sectional Studies	**1-52**
Table 5. Quality Appraisal of Cohort Studies	**1-56**
Table 6. Quality Assessment Tool for Quantitative Studies	**1-57**
Figure 1. Flowchart of Systematic Literature Review	**1-59**
Figure 2. Guide for organisations to highlight potential risk factors for burnout and compassion fatigue for workers in residential setting	**1-60**
Appendices	
Appendix 1-A: Guidelines for Publication in Clinical Child Psychology and Psychiatry Journal	**1-61**
Section Two: Research Paper	**2-1**
Abstract	**2-2**

Introduction	**2-3**
Method	**2-6**
Results	**2-10**
Discussion	**2-19**
References	**2-27**
Tables and Figures	
Figure 1. Model of How Personal Experiences Influence Professionals and their Work with Children in Residential Settings	**2-35**
Table 1. Example of line by line and focused coding	**2-36**
Table 2. Example of how model was developed from quotes, codes, memos and theoretical categories	**2-42**
Table 3. Participant Details	**2-45**
Appendices	
Appendix 2-A: Topic Guide	**2-46**
Appendix 2-B: Example of Memo Writing	**2-47**
Appendix 2-C: Guidelines for Publication in the Child Psychology and Psychiatry Journal	**2-49**
Section Three: Critical Appraisal	**3-1**
Critical Appraisal	**3-2**
References	**3-13**
Table 1. Example of reflective memo writing	**3-35**
Section Four: Ethics Section	**4-1**
Ethics Application	**4-2**
Appendices	
Appendix 4-A Research Protocol and Research Materials	**4-12**

Appendix 4-B: Confirmation Letter of Ethical Approval **4-26**

Appendix 4-C: Ethics e-mail confirmation regarding consent **4-35**

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Chapter 1 : Systematic Literature Review

Burnout and Compassion Fatigue amongst Workers in Children's Residential Settings: A Systematic Literature Review

Mike Heyes

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

All correspondence should be sent to:

Mike Heyes

Doctorate in Clinical Psychology

Faculty of Health and Medicine

Health Innovation One

Sir John Fisher Drive

Lancaster University

Lancaster

LA1 4AT

m.heyeyes@lancaster.ac.uk

Abstract

This systematic literature review explored the prevalence of burnout and compassion fatigue amongst child-care workers in residential settings. The review also explored protective and predictive factors associated with levels of burnout and compassion fatigue amongst these workers. Highlighting potential factors associated with burnout or compassion fatigue amongst residential staff would be important in thinking of ways to support staff teams and enable them to provide a good standard of care.

Fourteen quantitative studies included in this review highlight the prevalence of burnout and compassion fatigue, comparable to other roles such as nursing. The literature review highlights work-based factors associated with higher levels of burnout or compassion fatigue, such as exposure to threats or violence, whilst job satisfaction, feeling supported by colleagues or management and training were associated with a reduction in burnout or compassion fatigue.

This review highlights a wide range of personal factors such as personal characteristics (age, experience in role, gender), personality traits (extraversion, agreeableness and neuroticism) and other personal factors such as sense of coherence and level of self-care as being protective or predictive factors for burnout or compassion fatigue.

This review is important in shining a light on burnout and compassion fatigue amongst workers in these settings. This review suggests organisations should be aware of the range of predictive or protective factors and keep in mind that individuals or teams may be influenced by these factors in different ways. The review highlights potential needs for supervision and training for staff teams to raise awareness of the risk of burnout, as well as allowing space for reflective practice, which can help in minimising this risk.

Introduction

Professionals supporting individuals dealing with trauma can face stress (Grant & Kinman, 2012; Kapoulitsas & Corcoran, 2015) and are susceptible to their role impacting on them psychologically, leading to physical and/or emotional exhaustion. There are different terms used to describe the cause, symptoms and impact of this. The current paper will be focusing on 'compassion fatigue' and associated terms 'secondary traumatic stress' and 'burnout.'

Compassion fatigue (Figley, 1995) is a phenomenon specifically linked to people in caring roles, and is characterised by feelings of fatigue, disillusionment within the role, feeling low (Zeidner et al., 2013) and a reduction in the ability to feel empathy for others (Elwood et al., 2011).

Secondary traumatic stress (Figley, 1995) is a term developed from the understanding that individuals can experience post-traumatic stress-like symptoms upon secondary exposure to other people's traumatic experiences (Mangoulia et al., 2015). This term has been recognised within the latest edition of the Diagnostic and Statistical Manual of mental disorders (DSM-5), which added indirect exposure to trauma to its criteria for post-traumatic stress disorder (PTSD) (American Psychiatric Association, 2013).

Burnout is another term describing the emotional and physical exhaustion of workers. Burnout is stated to be a more general phenomenon than compassion fatigue and can occur in any profession (Newell & MacNeil, 2010), with Maslach et al. (2001) indicating burnout is a psychological syndrome in response to stressors of the job. Aspects of burnout include feeling depleted of emotional and physical resources, feeling detached from the job and a lack of accomplishment (Maslach et al., 2001). Burnout can be a factor within the context of high workload or a lack of support in the work environment (Turgoose & Maddox, 2017). Research indicates feelings related to burnout have a gradual onset, developing more slowly and lasting longer than compassion fatigue (Slatten et al., 2011).

These terms are often used interchangeably within literature (Sorenson et al., 2016), due to considerable overlap of definitions (Turgoose & Maddox, 2017). Secondary traumatic stress and compassion fatigue have been used to describe the same phenomenon, with Figley (2013) suggesting compassion fatigue is a friendlier term and preferred generally by practitioners. Burnout and compassion fatigue have also been used interchangeably. Adding to confusion, compassion fatigue is described as an overarching term incorporating secondary trauma and burnout (Hannah & Woolgar, 2018).

Burnout and compassion fatigue have an impact on service delivery and those being cared for. Physical or emotional exhaustion can lead to an increased desire to leave the profession and subsequent turnover of staff and service strain (Arimon-Pagès et al., 2019; Duan et al., 2019; Lu & Gursoy, 2016; Sung et al., 2012; Zhang et al., 2018). There can be an impact when professionals do not leave their role, resulting in a reduction in productivity, motivation, and level of professional standards (Bride et al., 2007; Ebrahimi & Atazadeh, 2018; Panagioti et al., 2018).

A review by Turgoose and Maddox (2017) highlighted mental health professionals, including clinical psychologists, bereavement counsellors and mental health nurses, as being at risk of compassion fatigue. Other reviews have focused on compassion fatigue within the broader healthcare provision (Sinclair et al., 2017; Sorenson et al., 2016). Other professionals such as firefighters (Kim et al., 2020), police officers (Papazoglou et al., 2019; Turgoose et al., 2017) and specialist education teachers (Sharp Donahoo et al., 2018), amongst others, can be exposed to compassion fatigue. Burnout has been found to be prevalent amongst healthcare professionals such as nurses (Wang et al., 2020).

Individual factors associated with compassion fatigue, burnout and secondary traumatic stress.

The literature highlights individual factors associated with higher levels of compassion fatigue or burnout, including own experiences of traumatic life events (Deighton

et al., 2007; Killian, 2008; MacRitchie & Leibowitz, 2010; Rossi et al., 2012; Turgoose & Maddox, 2017). Age has been suggested as a potential predictor of burnout, with Farber (1985) highlighting younger professionals as being more susceptible, with a meta-analysis by Lim et al. (2010) also highlighting level of education, longer work hours and work setting being indicators of emotional exhaustion. Research focusing on compassion fatigue supports the idea that younger professionals are more at risk (Kelly et al., 2015; Sprang et al., 2011). However, the overall picture is mixed, with the Turgoose and Maddox (2017) review highlighting studies that found no relationship between compassion fatigue and age, or conversely, an increase in compassion fatigue for older professionals (Hatcher & Noakes, 2010). There is a similar mix of results when focusing on experience in mental health roles (Turgoose & Maddox, 2017), potentially due to experienced professionals taking on more challenging and traumatic cases. Increased hours worked during a nurse's shift has been highlighted as being a predictor for burnout (Wang et al., 2020).

The psychological impact of supporting looked after children.

Individuals working with children in care, are also susceptible to exhaustion within their role. Research has highlighted the potential for social workers to experience compassion fatigue or burnout through their work with children in care (Kapoulitsas & Corcoran, 2015; McFadden et al., 2014), due to the level of pressure placed on them to ensure the safety of children and the potential of secondary exposure to trauma. Foster carers are also at risk of secondary traumatic stress and burnout (Bridger et al., 2020; Hannah & Woolgar, 2018; Whitt-Woosley et al., 2020). Proposed reasons for this include higher exposure to secondary trauma (Whitt-Woosley et al., 2020) whilst lack of support and training can also increase the risk of secondary traumatic stress and compassion fatigue (Bridger et al., 2020).

The current review

Workers in settings such as children's residential homes are potentially exposed to the same risks around compassion fatigue and secondary traumatic stress as foster carers, as well as potential work-related factors. It is important to understand the relationship between these factors and levels of burnout, compassion fatigue and secondary traumatic stress. Organisational factors, such as low support and heavy workloads have contributed to high rates of staff turnover within residential settings (Colton & Roberts, 2007). Placement stability has been indicated as having positive short and long-term outcomes for children in care (Hicks et al., 2008; Jones et al., 2011).

The current review aims to explore the prevalence of burnout and compassion fatigue amongst staff working with children in residential settings. Due to the overlapping use of terms, compassion fatigue will also be defined as inclusive of secondary traumatic stress. The literature view will explore the predictive and protective factors related to compassion fatigue and burnout for staff working within residential or out of home care settings. Understanding these phenomena can inform the development of interventions to help prevent and reduce the effects of compassion fatigue and burnout in staff teams, which in turn has the potential for positive impacts on the children being cared for. The review will therefore synthesise data that can add to current understanding of predictive factors for burnout and compassion fatigue amongst workers in residential settings.

Method

A narrative synthesis systematic literature review of quantitative research was carried out. The review aimed to answer the following questions.

1) What is the prevalence of burnout and compassion fatigue for frontline staff working in residential settings with children?
2) What are the researched predictive and protective factors for burnout and compassion fatigue for frontline staff working in residential settings with children?

A narrative synthesis refers to the "synthesis of findings from multiple studies that relies primarily on the use of text to summarise and explain the findings" (Popay et al., 2006). This approach can involve the manipulation of statistical data, but the main feature of this synthesis is the textual approach, telling the story of included studies. There is no general consensus on what a narrative synthesis is, although attempts have been made to create guidance for researchers (Rodgers et al., 2009). The researcher adhered to this guidance, which involved summarizing the findings of each study and tabulating this information. From here the researcher organised key findings into common themes and groups to support the process of presenting and synthesizing the data via a textual approach (Dilaver et al., 2020).

A meta-analysis was considered but not possible due to the differences across studies in terms of methods used, measurement tools and what they are aiming to explore, whilst effect sizes were not shared in some papers. Furthermore, a meta-analysis was ruled out because it would have been epistemologically and ontologically inconsistent with what was being investigated. A meta-analysis assumes what is being investigated is objectively consistent, observable and measurable, whilst one of the defining features of this review is the constructs being investigated are not clearly distinct and consistent, instead overlapping and being used differently by the different researchers.

Inclusion Criteria

The following inclusion criteria were developed based on the research questions:

1) Papers reporting quantitative research.
2) Published peer-reviewed articles.
3) Included measurements specifically for burnout, compassion fatigue and/or secondary traumatic stress.

4) Focused on frontline direct care staff working with children in residential settings. Frontline direct staff refers to workers who work directly with the young people, providing everyday care, such as support workers.

Exclusion Criteria

Papers were excluded if:

1. They were unpublished papers (grey literature) or full article was not yet published.
2. Participants included other professionals working with children in care (for example social workers, teachers or child welfare workers) or foster carers. The rationale for this is, their role and involvement, particularly for social workers and teachers, will be different in terms of day-to-day provision of care. The reason for excluding foster carers is professionals supporting children in residential settings may also be exposed to different organisational factors that could contribute to the psychological impact of working within their role.
3. If they involved direct care workers in residential settings with children, but did not differentiate between professions, settings (e.g., day care centres) or supporting a different cohort of people (e.g. people with learning disabilities).
4. If they focused on general stress or other factors such as job satisfaction but did not specifically explore burnout or compassion fatigue/secondary traumatic stress were excluded as part of the selection process.

Search Strategy

To identify relevant papers, electronic searches of the following six databases were conducted between February and March 2021: PsycInfo, Academic Search Complete, Child Development and Adolescent Studies, PsycArticles, MedLine and SocIndex.

The search strategy (Table 1) was developed by establishing the different concepts involved, which included psychological impact (burnout, compassion fatigue and associated terms), role of participants (residential support worker and associated terms) and setting (children's home and other terms used). This extensive list of terms was aided by each database's thesaurus search terms to develop a comprehensive and consistent search strategy. Boolean operators, e.g., AND, OR were used when conducting the searches. The reference lists of relevant reviews and research papers were also searched by hand to identify additional papers.

Enter table 1 here.

Figure 1 demonstrates the flow diagram of studies identified and excluded at each stage of the search strategy.

Enter figure 1 here.

Data Extraction

Data relevant to the literature review's research questions were extracted from the identified articles, with the following being extracted from each article: country of research, participant characteristics, setting, study design, measurements used and relevant findings (table 2). The researcher completed this task independently.

Quality Appraisal

Three critical appraisal tools were used to evaluate the quality of the included papers. It is recommended that standardised tools be used, even if this results in multiple tools being used. Specific appraisal tools can measure appropriately aspects of a methodology or research design used (Boland et al., 2017). For the review, the appraisal tool for Cross-Sectional Studies (AXIS) Critical Appraisal (CA) was used to systematically assess ten of the

studies in the current review. This tool was developed by consensus (Downes et al., 2016) and consists of 20 questions (Table 4) covering elements such as aims, methods and results, amongst others. This tool has been extensively used in research, including in reviews looking at burnout and the psychological impact of work for professionals (Iversen & Robertson, 2020; Jackson-Koku & Grime, 2019).

A second critical appraisal tool for cohort studies was used to assess three studies (Moola S et al., 2020) (Table 5). The Quality Assessment for Quantitative Studies tool, developed by the Effective Public Health Practice Project (Thomas et al., 2004) was used to assess the final study in this review. This appraisal tool (Table 6) has been favourably compared to Cochrane Collaboration Risk of Bias Tool for inter-rater agreement (Armijo-Olivo et al., 2012).

Enter tables, 4, 5 and 6 here.

This critical appraisal highlighted strengths and limitations of studies. Most papers used validated and reliable measures as part of their procedure. When thinking of the measures exploring burnout and compassion fatigue, the Maslach Burnout Inventory (MBI) (Maslach et al., 1986) has been shown to have sound reliability and validity across professionals and differing countries (Cordes et al., 1997; Gómez García et al., 2019; Sabbah et al., 2012) and is regarded as the leading measure for burnout within the literature (Poghosyan et al., 2009). Normative samples have been developed via extensive use with a large population (Maslach et al., 1996). The Professional Quality of Life Scale (ProQOL) (Stamm, 2005), used by studies within this review, has been highlighted as a reliable and validated measure to use in research around burnout and compassion fatigue and has been used extensively in the literature. The other tools used across studies in this review, the Burnout Screening Scales (Hagemann & Geuenich, 2009) and the adapted Teacher Burnout questionnaire (Oliver Hernández, 1993), are highlighted as having internal consistency, with the BOSS also being used with large samples (Scholz et al., 2016). Although these

measures have not been used extensively, or seemingly beyond the countries or languages they were designed in, they seem appropriate tools to have been used in the studies.

Although this review does not explore extensively the other measures used by the studies, e.g., such as measures of personality or sense of coherence, most papers included information relating to these measures that indicates reliability, thus highlighting the overall validity and reliability of measures used.

The quality appraisal of the included studies indicates the standard of the papers is suitable, highlighting strengths of most studies in terms of consistency of results reporting and appropriateness of methodology used. However, there are several issues highlighted via the quality appraisal process, particularly relating to potential for bias amongst participants. All the studies use self-reporting surveys with their participants which opens them up to potential response biases, such as misinterpreting questions, subjective use of rating scales and participant ability to assess themselves accurately (Demetriou et al., 2014). There is potential for sampling bias, and questions around whether the people who complete a self-report measure are truly representative of the population. Many of the studies involved did not carry out measures to determine characteristics of the wider population, to be able to compare with those of the sample. This was recognised as an issue in some of the studies included.

Results

A total of 2,961 studies were identified as part of the search strategy. 2,422 articles remained after removal of duplicates. 2,387 articles were excluded based on title or abstract not being relevant to the current review. Thirty-five articles were assessed by reading the full text, with a total of 14 being included in the review. Reasons for articles being excluded at this stage included being qualitative studies (n=3), not differentiating residential workers from other professionals (e.g. foster carers) (n=8), not being in English (n=1), not working with

children (n=4) and not differentiating between settings (e.g., day-care) (n=4). A search of the reference lists of all included papers was conducted, resulting in no extra studies. A check of what papers had cited the included papers was completed, which yielded no further papers. Three of the 14 studies came from the same government funded project examining the efficacy of trauma-informed care in residential youth welfare institutions in Switzerland, with the initial paper being a cross-sectional study involving over 300 professional caregivers, and the succeeding papers involving 168 of the original participant pool. This will be considered in the analysis of the included papers. Authors of two further papers confirmed their studies involved the same participants, although not all of the participants in one study were included in the second study.

Study Characteristics

Taking crossover in participants across some studies into account, a total of 1,645 participants were included across the 14 articles, with participant numbers ranging from 24 to 319. The included articles were from USA (n=4), Switzerland (n=3), United Kingdom (n=2), Israel (n=1), Turkey (n=1), Spain (n=1), Saudi Arabia (n=1) and Canada (n=1).

Of the settings participants worked in, five were residential treatment centres, all being North American studies. Four studies focused on participants working in residential children's homes, with one of these studies comparing prevalence of burnout with that of care workers based in boarding schools (Zerach, 2013). Of the remaining five studies, two were in orphanages, whilst three were in welfare institutions.

Of the 14 included studies ten were cross-sectional, with three cohort studies and one randomized control trial.

Enter tables 2 and 3 here.

Tools Used to Measure Psychological Impact of Work with Children in Residential Settings.

Measures of the psychological impact of work used across the included articles included the Maslach Burnout Inventory (MBI) Maslach et al. (1986). Seven of the included 14 studies used variations of the MBI (Barford & Whelton, 2010; Çatay & Koloğlugil, 2017; Decker et al., 2002; Lakin et al., 2008; Leon et al., 2008; Sochos & Aljasas, 2020a; Winstanley & Hales, 2015).

The Professional Quality of Life (ProQOL) (Stamm, 2002, 2005, 2010) was also used. This tool measures the quality of life of healthcare professionals and measures three subscales that are relevant to the current literature review: secondary traumatic stress/compassion fatigue, burnout and compassion satisfaction. This measure was used in three of the studies included in the current review (Audin et al., 2018; Eastwood & Ecklund, 2008; Zerach, 2013).

The Burnout Screening Scale (BOSS) (Hagemann & Geuenich, 2009) was used by three studies based in Switzerland (Kind et al., 2020; Kind et al., 2018; Steinlin et al., 2017). The BOSS is a standardised and validated questionnaire that collects information related to burnout including current psychological and psychosocial symptoms in work related, personal, and interpersonal domains. The Teacher Burnout Questionnaire (Oliver Hernández, 1993) was adapted to the context of residential childcare by del Valle, López, et al. (2007). This tool provides different measures related to job satisfaction, inclusive of burnout and stress. This adapted version included 58 items scored on a Likert-type five-point scale. Steinlin et al. (2017) used an adaptation of the Questionnaire for the Assessment of Secondary Traumatic Stress.

Across the studies there is variance in referring to the terms secondary traumatic stress and compassion fatigue, particularly those that have used the ProQOL measure.

Prevalence of Burnout and Compassion Fatigue

Not all of the included studies shared scores around prevalence of burnout or compassion fatigue. Of those studies using the MBI to measure burnout and recorded

prevalence of burnout in some capacity, there is difference in terms of levels of burnout within the different dimensions (emotional exhaustion, depersonalisation and personal accomplishment). For example, in their study with 375 frontline staff from 21 residential treatment centres, Lakin et al. (2008) reported at least half of participants as having high scores for emotional exhaustion (≥27) and depersonalisation (≥10) and 35% having high levels of decreased personal accomplishment (≤33). In contrast, Decker et al. (2002), whose population also consisted of frontline staff in residential treatment centres, found that their population consisted of a smaller percentage of people recording high levels of burnout across the different dimensions (emotional exhaustion =22%, depersonalisation =19%, decreased personal accomplishment =17.2%). Barford and Whelton (2010) compared their sample of child and youth care workers against a normative sample, which consisted of 11,067 caring professionals (Maslach et al., 1996), and found that the mean score for their sample was considerably higher for emotional exhaustion, but lower for depersonalisation than the normative sample. This contrasts with other reported scores of included studies (Leon et al., 2008; Winstanley & Hales, 2015), which highlight an inconsistent range and prevalence of burnout. The scores for these studies highlight that burnout, particularly emotional exhaustion and depersonalisation, is something that needs to be considered within these roles.

Audin et al. (2018) presented a high proportion of participants self-reporting high levels of burnout (32%), secondary traumatic stress (26%) and compassion fatigue (23%), when using the cut off points developed from the normative sample (Stamm, 2010). Only one included study compared prevalence of burnout amongst residential care workers to that of another profession; care workers who worked with children in boarding schools (Zerach, 2013). When using the ProQOL, no statistical differences between the groups were found for burnout or secondary traumatic stress, but a significant difference was found between residential workers and boarding school workers for compassion satisfaction ($\beta = -1.4$, $p < .05$).

Personal Factors and their Relationship with Levels of Burnout and Compassion Fatigue

Age, Sex, Experience within Role and Level of Education. Of the papers included, six shared findings relating to age. Within their study Barford and Whelton (2010) found that younger participants reported significantly higher levels of depersonalisation when compared to older participants. However, the same study found no significant difference between ages for the other components of burnout measured by the MBI; emotional exhaustion and personal accomplishment (Barford & Whelton, 2010). del Valle, López, et al. (2007) separated participants into three different age categories (0-26 years, 26-37 years, 37+), with results showing no differences in significance for burnout-depersonalisation and burnout-personal accomplishment when using the Teacher's Burnout Questionnaire (TBQ). This slightly differs from the findings of Lakin et al. (2008) who found younger staff members reported higher levels of emotional exhaustion, as well as depersonalisation. One further study used a longitudinal design to measure differing variables relating to burnout, and associated higher levels of burnout with a younger age (Kind et al., 2018). Interestingly research by Steinlin et al. (2017), from which Kind et al. (2018) developed their longitudinal intervention study, found no correlation between age and burnout. Sochos and Aljasas (2020a) found association between younger staff age and higher scores on the MBI. The papers suggest a link between younger age and burnout, although this is inconsistent.

Five papers shared findings relating to sex of participants with differing conclusions. Audin et al. (2018) used Mann-Whitney U tests to compare difference between males and females, with no significant difference for burnout, nor for secondary traumatic stress and compassion satisfaction (all $p>.05$). No statistical difference between sexes was found in two further studies (del Valle, López, et al., 2007; Steinlin et al., 2017). In their longitudinal study Kind et al. (2020) found that male staff members self-reported higher levels of sense of coherence and self-efficacy, with both of these factors being associated with lower levels of

burnout within the results. Zerach (2013) found that male staff reported higher levels of burnout than their female counterparts.

Four studies looked at experience in role, with three finding no correlation with levels of burnout (Audin et al., 2018; Barford & Whelton, 2010; Lakin et al., 2008). One study found an association between less experience within the role and higher levels of burnout (del Valle, López, et al., 2007).

Del Valle, López, et al. (2007) explored the association between education level and burnout. Interestingly, this study found that graduates reported higher levels of burnout-personal accomplishment ($F [2,253]=4.64$, $p<.05$) than those without a university degree, whilst those without a university degree scored significantly higher on the burnout-depersonalisation scale ($F[2,253]=3.97$, $p<.05$). This contrasts with the results of Lakin et al. (2008), who found that education level did not predict burnout on any subscales when using the MBI with their sample.

The review of included papers brings focus to the variance in impact of personal factors, establishing that there can be no universal claim to predicting levels of burnout and compassion fatigue. However, the review does highlight the relevance of personal characteristics across differing organisations, countries and cultures, with the review suggesting that younger staff are potentially more susceptible to burnout

Personality. Some studies aimed to explore relationships with personality and levels of burnout or compassion fatigue. Differing measures were used to rate personality of the participants, including the Big Five Inventory and the NEO Five Factor Inventory. In their study Barford and Whelton (2010) used stepwise and hierarchical regression procedures to evaluate the relative contribution of predictor variables to emotional exhaustion, depersonalisation and personal accomplishment. For personal accomplishment, the majority of variance was explained by the neuroticism (β-.27, p=,.05), extraversion ($\beta = .27$, $p =<.05$) and conscientiousness ($\beta = .25$, $p = <.05$) factors, with the authors concluding that

participants who were emotionally stable, outgoing, determined and strong willed experienced the highest levels of personal accomplishment. Barford and Whelton (2010) also found depersonalisation to be predicted by neuroticism (β = .21, p = <.05) and agreeableness (β = -.23, p =<.05). Lakin et al. (2008) highlighted neuroticism and lower levels of extraversion as being the most consistent predictors of burnout for the sample from their research. They found that neuroticism was associated with and predicted emotional exhaustion (β =.29, $t(235)$ =3.07, p<.01). Neuroticism was found to be positively associated with depersonalisation (β=.38, $t(237)$ =5.03, p<.01) and decreased personal accomplishment (β =-.19, $t(251)$=-2.54, p<.05)). Furthermore, lower levels of extraversion were found to decrease personal accomplishment (β =-.24, t(237=3.34, p<.01) and emotional exhaustion (β=-.21, $t(235)$=2.20, p<.05).

The studies above would indicate that workers that are more neurotic, more agreeable and less extravert are potentially more susceptible to burnout and that this is potentially true across countries and organisations. This may be important to consider with these roles being unique when compared to other caregiver roles, as workers are required to bring more of themselves and their personality into the work, whilst remaining professional and boundaried.

Other Personal Factors. Other studies within the review looked at personal factors, including levels of self-care, sense of coherence and self-efficacy.

Sense of coherence, the ability to employ resources to combat stress, was a variable that was observed in terms of its relationship with burnout. Zerach (2013) used a short version of the sense of coherence scale (Antonovsky, 1993), which provides scores for the different components of sense of coherence concept (comprehensibility, manageability, and meaning), alongside the ProQOL measure to explore sense of coherence as being a factor on burnout. Using Pearson's correlation analysis the author found that sense of coherence was negatively related to secondary traumatic stress (r=-.57, p<.00) and burnout (r=-.38, p<.00), meaning high levels of sense of coherence were correlated with lower levels of

burnout (Zerach, 2013). The findings would suggest that sense of coherence is a personal protective factor against burnout. Kind et al. (2018) used the sense of coherence scale as part of their investigation into what protects youth childcare workers from burning out. This paper aimed to explore the importance of self-care and self-efficacy, meaning an individual's belief in their capacity to execute behaviours necessary to produce specific performance attainments (Bandura, 2010). The authors analysed longitudinal association between resilience and levels of burnout, with all three resilience measures being associated with reduced burnout risk (sense of coherence: $HR = 0.45$, 95% CI [−1.18, −0.49], $p < 0.001$; self-efficacy: $HR = 0.61$, 95% CI [−0.87, −0.19], $p = 0.003$; self-care: $HR = 0.68$, 95% CI [−1.12, −0.20], $p = 0.012$).

Eastwood and Ecklund (2008) found correlations between a range of self-care practices and level of burnout or compassion fatigue, including significant correlation with activities such as reading for pleasure, socialising with family, and having a hobby.

Spirituality was a variable considered by one paper (Zerach, 2013), with this being found to be negatively related to burnout ($r = -.39$, $p < .00$), suggesting that those participants with higher levels of spirituality, defined as being aligned with subjective personal beliefs (Kroenig, 2008), present with fewer symptoms of burnout.

Attachment style of care workers was another variable explored by two of the included studies (Sochos & Aljasas, 2020a; Zerach, 2013). In the research conducted by Zerach (2013) anxious attachment styles predicted secondary traumatic stress ($\beta = .32$, $p < .00$) and burnout ($\beta = .18$, $p < .00$), whilst avoidant attachment styles significantly predicted burnout ($\beta = -.32$, $p < .00$). These findings were similar to those of Sochos and Aljasas (2020a), who found carers with anxious attachment styles had higher levels of burnout, whilst those with avoidant attachment styles reported higher levels of burnout when working closely with children with their own avoidant attachment styles.

Perhaps unsurprisingly, the above research highlights self-care as being important for the involved participants. These roles can often be challenging and demanding and prioritising self-care appears to be one way to combat this demand. The included papers suggest that a sense of coherence is important in the range of roles working with young people in residential settings.

Work Environment Factors Predicting or Protecting From Burnout or Compassion Fatigue.

Several work-related variables or factors were explored in association to burnout, compassion fatigue or secondary traumatic stress, including the level of support received by the caregivers. The type of support received, and the impact of this support on burnout levels was mixed amongst the studies. For instance, Barford et al. (2010) found no significant association between supervisor support and emotional exhaustion or depersonalisation. Although using differing measures to rate levels of burnout, meaning complete comparison is difficult to achieve, Steinlin et al. (2017) found that support within the team and communication related to fewer symptoms of secondary traumatic stress ($\beta = -.32$, $p < .05$) and institutional structures and resources ($\beta = -.19$, $p < .05$).

One study aimed to explore the impact of a 20-session training and supervision support group for caregivers working at an orphanage in Istanbul (Çatay & Koloğlugil, 2017). Training provided aimed to educate staff about developmental processes of children, enabling them to provide emotional support and helping to improve the relationship with the children they care for by gaining insight into their own and the children's emotional processes. A Turkish version of the MBI was used pre and post intervention with 11 participants, with 13 carers in the control group that did not receive the training. Wilcoxon matched pair signed rank test results were carried out, with the authors reporting statistical difference between scores for emotional exhaustion pre and post intervention, with caregivers reporting lower levels of emotional exhaustion after receiving the training ($z = -2.49$, $p < .05$.). This compares to the lack of statistical difference between pre and post test

scores for the control group. These findings suggest that the support group was beneficial in supporting caregivers with exhaustion. No such statistical difference was found for the other dimensions of burnout, depersonalisation and personal accomplishment. These findings are supported by those of Lakin et al. (2008) who found staff reporting a lack of adequate training reported lower scores in the emotional exhaustion domain of the MBI measure (CE=-2.82, t(235) =-2.47, p=.015).

Job satisfaction and levels of burnout and compassion fatigue were explored in three studies (Lakin et al., 2008; Leon et al., 2008; Steinlin et al., 2017). Steinlin et al. (2017) found that having fewer work-related burnout symptoms was also related to more enjoyment of work ($\beta = -.18$, $p < .001$). Lakin et al. (2008) found that staff who had lower levels of job satisfaction had higher levels of emotional exhaustion ($\beta = -3.35$, $t(235) = -6.18$, $p < .01$), and lower levels of personal accomplishment ($\beta = 2.07$, $t(237) = 5.24$, $p < .01$), both elements of burnout. There was no significant correlation between job satisfaction and depersonalisation within this study. Leon et al. (2008) draw from the same sample as Lakin et al. (2008) and although they have slightly different statistics due to a difference in number of participants, support the findings of Lakin et al. (2008).

The current review suggests that support from peers is more effective at combating levels of burnout than support from those in managerial roles. This could potentially be due to a range of factors such as a deeper understanding of the current problem or being more readily available to offer support, and lends support to the importance of peer supervision. However, only two studies focused on this and more would need to be done to test this hypothesis further. Perhaps unsurprisingly job satisfaction has been highlighted within the review as protecting against exhaustion and positively associating with accomplishment.

Aggressive Behaviour by the Children as a Factor that Impacts on Levels of Burnout or Compassion Fatigue.

Winstanley and Hales (2015) explored the impact of children's violent or aggressive behaviour and its association with carer burnout, finding significance for higher levels of emotional exhaustion (F (2,84) 10.86, $p < 0.0005$, $\eta2 = 0.206$) and depersonalisation (F (2,84) 7.268, p — 0.001, $\eta2 = 0.222$) for those who experienced more physical assaults, as well as verbal threats, whilst there was no difference found in levels of personal accomplishment. Kind et al. (2018) also found that staff exposed to verbal aggression, and those exposed to physical aggression had scored higher levels of burnout symptoms.

One potentially unique aspect of these roles with young people is the exposure to work-based violence or threatening situations and the above studies highlight the impact of this on participants. Again, it is perhaps unsurprising to see that exposure to physical assault makes participants more susceptible to higher levels of burnout.

Discussion

Burnout and compassion fatigue in staff working in caregiving roles has been heavily researched, with several systematic literature reviews exploring the relationship between these concepts and associated factors (Adriaenssens et al., 2015; IsHak et al., 2013; Rotenstein et al., 2018). This review is the first to focus on frontline staff (i.e., staff working directly with young people on a day-to-day basis) working in residential settings and the predictors of and protective factors against burnout and compassion fatigue in this cohort. Fourteen studies were identified using a systematic search process, although some of these studies involved the same participants. There was variety across the studies, in terms of countries in which they were based, ranging across North America, Europe and Asia. A range of methods were used, including cross-section and cohort studies. Different measures were used to measure burnout or compassion fatigue, including the ProQOL, MBI, BOSS and adapted version of the TBQ.

The included studies explored a wide range of factors hypothesised as predicting or protecting against burnout and compassion fatigue. The included papers consistently

highlight the prevalence of burnout and compassion fatigue amongst participants, fitting with previous literature relating to other professionals that work with a similar cohort of children, such as social workers or child-welfare workers (Lizano & Mor Barak, 2012; McFadden et al., 2017).

Personal characteristics and their relationship with burnout and compassion fatigue were explored, including age, sex, education and time spent in role. Results across the included studies are mixed. For example, for age two studies found that younger staff scored higher levels of burnout, etc than their older colleagues (Barford & Whelton, 2010; Kind et al., 2018), whilst three studies found no statistical differences between ages (del Valle, López, et al., 2007; Lakin et al., 2008; Steinlin et al., 2017). In terms of sex, the results are more consistent, with most studies exploring this finding no difference, although Zerach (2013) found that male participants reported higher levels of burnout. Previous research around sex and burnout is mixed, with some researching suggesting females are more likely to experience burnout (Jalili et al., 2021). What this current review does indicate is that there is no universal conclusion to be made about personal characteristics and associations with burnout or compassion fatigue. This is in line with wider research for those in caregiver roles, such as nursing (Turgoose & Maddox, 2017). This inconclusiveness potentially makes it difficult to implement ways to improve workforce well-being, as there would be no strategy or method that would be appropriate for all. However, the review highlights potential personal factors for employers to be aware of, such as age and sex, and workers can be supported on a team by team or individual basis.

Sense of coherence and self-care were consistently found to be preventative factors against levels of burnout or compassion fatigue within this review (Eastwood & Ecklund, 2008; Kind et al., 2018; Zerach, 2013), supporting previous research relating to this with other cohorts of people such as hospice professionals and psychologists (George-Levi et al., 2020; Hotchkiss, 2018). This is important to consider, particularly for support workers who

are often required to work long and unsociable hours, potentially to the detriment of their own self-care.

Some included studies explored personality factors and attachment styles, again with consistent results. The findings of this review suggest that individuals who are less extravert and with higher levels of neuroticism are more likely to experience burnout when working with children in these settings (Barford & Whelton, 2010; Lakin et al., 2008), fitting with previous literature that has highlighted neuroticism as a predictor of burnout (Azeem, 2013; Goddard et al., 2004) and extraversion being related to lower levels of personal accomplishment (De la Fuente-Solana et al., 2017; Zellars et al., 2004). For attachment styles, the findings of this review showed that participants with anxious attachment styles reported higher levels of burnout (Sochos & Aljasas, 2020a; Zerach, 2013). Previous research around attachment styles highlights anxious attachment as being associated with higher levels of burnout amongst health and human service workers (West, 2015).

The importance of attachment for young people is highlighted within LAC services and for children generally, with secure attachment resulting in better outcomes for young people (Schore, 2001). Workers in these settings often implement ways of working with young people who have avoidant, insecure, ambivalent or disorganised attachment styles (Atwool, 2006; Gauthier et al., 2004), and will work in tailored ways to meet the needs of the young person. The current review highlights worker attachment styles and lends support to ideas around supporting workers individually with their own relational needs. Previous research into attachment styles of foster carers found that those with secure attachment styles were more equipped to cope with the challenges of being a carer (Caltabiano & Thorpe, 2007). Organisations could use this information to implement increased support for workers.

The studies in this review are consistent in highlighting work-based factors as being predictors of burnout or compassion fatigue and secondary traumatic stress. Participants who reported good work-based support (Barford & Whelton, 2010; Steinlin et al., 2017), and

adequate training (Çatay & Koloğlugil, 2017; Lakin et al., 2008), were found to have less symptoms of burnout, compassion fatigue or secondary traumatic stress. Interestingly peer support was viewed as having a greater impact than that from management. Wider literature indicates that individuals can benefit from peer support or supervision (Golia & McGovern, 2015; Rogers, 2017; Shilling et al., 2013). It is possible that peer support has more impact due to deeper understanding of a situation, being more readily available and workers feeling more able to vent to peers. The findings of the review support a need for peer supervision across settings.

Two studies highlighted exposure to threats, verbal aggression or physical aggression from the children as increasing likelihood of burnout, reporting similar results to those of other professionals who may be exposed to violence, such as staff of general hospitals and prison guards (Boudoukha et al., 2011; Winstanley & Whittington, 2002).

This review suggests that predicting susceptibility for burnout and compassion fatigue for staff in children's residential settings is complex. Although the review highlights a wide range of factors which organisations and staff teams would benefit from being aware of, the variation across studies and settings suggests that there is no single generalizable approach that can be implemented across different settings. Instead, organisations should be aware of their specific risk factors, but also those of the individual worker. When thinking of this, organisations could use the current review as a guide to raise awareness of factors associated with burnout and compassion fatigue. This review also highlights responsibility for reducing risk of burnout and compassion fatigue should fall predominantly on organisations, even when looking at more personal risk factors. For example, if younger staff are more susceptible to burnout, they should be given more support. As highlighted in the review staff and managerial support can help to reduce levels of burnout.

The findings support wider literature around workforce well-being generally (Mills et al., 2020). Research highlights the need to prioritise workforce well-being, viewing it as an

investment rather than a cost for services (Pronk, 2019). The current review has highlighted the importance of staff support and self-care for participants.

Limitations of the Review

There was interchangeability in the use of terms, specifically around compassion fatigue and secondary traumatic stress, amongst the included papers, and the review does little to clarify this. Although not necessarily problematic for the findings of this review, it nevertheless adds to this common issue across the literature. Distinguishing these terms has been difficult, despite attempts made to do so (Figley, 2013; Turgoose & Maddox, 2017).

Generalisability

There are certain aspects of the included studies that would suggest caution when considering generalisability of the results. For example, the residential treatment centres based in North America often have a short-term focus and involvement with the children being supported, with children often residing there to receive specific interventions and support relating to potentially different concerns. This differs in aim and structure to the residential children’s homes that are found in the UK. Children will live within these settings for a longer, often unspecified amount of time. Carers within these settings may take on more of a parental role, which potentially brings a different dynamic to the role, which can impact on burnout. Other studies focused on orphanages, with one of these involving participants working with much younger children (Çatay & Koloğlugil, 2017), which differed from the population of children in the other studies. However, the high level of contact and nature of frontline staff roles could be regarded as similar across the settings. The similarity and consistency amongst some of the results, particularly around burnout prevalence, suggests that generalisations can be made about the potential for burnout in frontline professional staff working in caring roles within these settings.

Implications of the Review

Although the findings of the studies within this review are not always consistent, fitting with the wider literature, they do highlight the relevance of personal factors and work-based influences on burnout and compassion fatigue.

The review highlights the prevalence of burnout. One heavily researched risk of burnout is the increased likelihood of individuals leaving their jobs. High levels of burnout and compassion fatigue have been found to be a determinant of turnover in staff (Kim & Stoner, 2008) and this is a concern when thinking about the detrimental effects this can have on organisations that look after children in residential settings. Turnover of staff creates challenges in a team's ability to provide consistent care and support to the children they work with. Additionally, it can result in high replacement costs, or recruitment of agency staff.

There are other implications of burnout amongst staff teams such as low motivation, employee performance and quality of care (Bride et al., 2007; Tawfik et al., 2019). Carers in these settings are often asked to provide sensitive, attuned, responsive and empathic care to children, many of whom will have experienced traumatic life events. Higher levels of burnout could lead to blocked care, where they may struggle to provide this level of responsive care, and may put barriers up to protect themselves.

In addition, burnout has also been regarded as impacting on general professional standards (Ebrahimi & Atazadeh, 2018; Panagioti et al., 2018). In alarming cases of staff abuse towards patients, burnout, specifically depersonalisation, has been associated with a high risk of abuse (Cooper et al., 2018).

What this all means for residential settings is that the children being supported are at risk of receiving a lower quality of care. This is particularly alarming as children in care, or residing in treatment centres and other associated settings, need the appropriate caring support to recover from trauma and to reach their potential.

The findings of this review highlight the need for protective factors to be put in place and that both personal and work-environment factors should be considered when thinking of ways of reducing the risk of burnout. The association of personal factors with burnout and compassion fatigue could suggest that individual caregivers have a degree of responsibility to manage this, in terms of self-care. However, it is important to highlight the role that organisations and managerial or clinical staff can have in influencing these personal factors. Organisations can implement ways to promote thinking around resilience, self and other care, and can do more to provide reflective practice, and supervision, staff support, peer support and training. Organisations could be more trauma informed in their approach, which involves being aware of the potential for trauma to play out at all levels of the system, inclusive of staff, and to actively strive to acknowledge and put things in place to reduce this, such as developing support systems.

Future Research and working

There is potential for future research or general good practice for organisations and services in involving frontline workers of children's homes in incorporating support systems. More qualitative research could be helpful in gaining more insight into what workers feel impacts them and what they feel would best support them as this can be critical in improving or maintaining staff well-being and satisfaction in role, helping to ensure that teams are equipped to provide the level of care needed by young people.

Research to explore trauma or burnout from a whole-system perspective with differing levels within services could help to gain an understanding of the complexity of staff well-being and potential service wide burnout and compassion fatigue.

The review highlights the importance of peer support. Organised peer supervision could be one way of allowing staff teams the space to reflect and share their difficulties.

Conclusions

This systematic literature review highlights the prevalence of burnout and compassion fatigue amongst child-care workers who support children in settings such as residential children's homes, alongside predictive or protective factors associated. Thus, the review points to the importance of training, support and care of staff teams and the need for further research.

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Table 1. Key Concepts and Search Terms

Key Concepts [a]	Free-text terms	Thesaurus Search Terms Examples from different databases
Concept 1 Burnout and Compassion Fatigue	(burnout OR burn-out OR "burn out" OR ((compass* OR emotion* OR psych* OR caring OR empath*) N3 (fatigu* OR exhaust*))) OR AB (burnout OR burn-out OR "burn out" OR ((compass* OR emotion* OR psych* OR caring OR empath*) N3 (fatigu* OR exhaust*))	Caregiver Burden Chronic Stress Psychological Stress Emotional Exhaustion Stress and Trauma Related Disorders Compassion Fatigue
Concept 2 Staff Role	((child-care OR childcare OR "child care" OR support OR paraprofessional Or para-professional OR care OR therap* OR residential) N3 (worker* Or staff*)) OR AB ((child-care OR childcare OR "child care" OR support OR paraprofessional Or para-professional OR care OR	Child Care Workers Paraprofessional Personnel Counselors Nonprofessional Personnel

	therap* OR residential) N3 (worker* Or staff*))	
Concept 3 Setting	((residential OR group OR childrens OR treatment) N3 (home* OR centre OR center OR setting OR faciliti*)) OR AB ((residential OR group OR childrens OR treatment) N3 (home* OR centre OR center OR setting OR faciliti*))	Orphanages Group Homes Rehabilitation Centers Residential Care Institutions Treatment Facilities

Table 2: Summary of Peer-Reviewed Articles Included in the Systematic Literature Review

Authors	Research Question	Design	Participants	Country	Key Measures	Analytic strategy	Key Findings
Audin et al. (2018)	Investigating relationship between compassion fatigue, compassion satisfaction and work engagement in residential childcare staff	Self- report survey method, correlational, within-subjects design Cross sectional	100 employees of residential childcare organisations in England, Scotland Wales (57%) Non-management 51 residential childcare workers, therapeutic care practitioners and senior care practitioners management 31 team leaders/registered managers 18 directors/senior managers	UK	Utrecht Work Engagement Scale-9 (UWES-9) Professional quality of Life (ProQOL-5)	Correlational analysis Mann-Whitney U tests Spearman's Rho	Work engagement and compassion satisfaction strongly positively correlated. Work engagement and burnout were negatively correlated (work engagement increased, burnout decreased and vice versa) No significant correlation between work engagement and secondary traumatic stress Absorption and STS mildly positively correlated. No significant correlations between years in residential childcare and burnout, STS, CS or work engagement No significant differences between males and females for work engagement, burnout, CS and STS No correlation for age and above variables Management had higher levels of work engagement than non-management. Management scored higher for CS but no differences for dedication, burnout, STS.
Barford and Whelton (2010)	Predictors of burnout amongst residential childcare workers	Self-report survey method Correlational Cross-sectional	94 residential child care workers from 8 child and youth care facilities (69.1% female)	Canada	Maslach Burnout Inventory Work Environment Scale Form The NEO Five Factor Inventory The Multidimensional Scale of Perceived Social Support	Correlational analysis Stepwise and hierarchical regression	Age was significantly correlated with depersonalisation component of burnout, but not with emotional exhaustion or personal accomplishment, with younger employees being the most distant or cynical. Significant predictors for emotional exhaustion were work pressure, clarity, involvement, neuroticism and support from a significant other. Autonomy, supervisor support, extraversion, and experience did not contribute a significant amount of variance to emotional exhaustion. Clarity, involvement found to be significant predictors of depersonalisation after variance associated with work pressure held constant.

							Neuroticism and agreeableness found to be significant predictors of depersonalisation after all work-related variance was partitioned out of regression model. Personal accomplishment – only work environment related predictor that was significant was involvement. Majority of predictors for personal accomplishment was personal factors – neuroticism, extraversion, conscientiousness.
Çatay and Koloğlugil (2017)	Examined the effectiveness of a 20-session training and supervision support group for caregivers working in orphanages	Randomized control trial	24 childcare workers (11 in intervention group) (100% female)	Turkey	General Self-Efficacy Scale (GSE) adapted to Turkish. MBI The Symptom Checklist-90-Revised	Non-parametric tests Mann-Whitney U Test	Caregivers who attended group sessions reported a significant decrease in emotional exhaustion as well as increase in self-efficacy. Both intervention and control group reported increase in job satisfaction (Hawthorn effect?)
Decker et al. (2002)		Self-report survey Cross-sectional	61 childcare workers from 6 residential treatment facilities (55% female)	US	Maslach Burnout Inventory (Turkish version)	Correlational analysis	Statistically significant correlations between lower MBI scores and protective factors such as institutional support, supervision, education and age.
del Valle, López, et al. (2007)	To determine the main sources of job stress and burnout for those working in residential care To investigate health problems most frequently experienced And to detect whether the personal and organizational variables studies are related to stress and burnout in this type of work	Self – report questionnaire Cross-sectional	257 residential workers (67% female)	Spain	Adaptation of Moreno and Oliver's CBP Teacher Burnout Questionnaire (modifying some items to fit context of residential care		Highest scores for stress related to timetables, excessive paperwork, lack of knowledge about criteria for assessing their work, exhaustion resulting from the job and lack of financial resources for fulfilling care objectives. Relationship between variables Burnout and personal variables – Age. Insecurity-conflict scale those aged over 38 and over scored significantly lower than those below 38. Youngest participants feel more insecure and perceive the environment as more conflictive. Educational level (graduates, diploma holders, no university education). Those with a degree scored significantly higher in stress, burnout-personal accomplishment and insecurity-conflict. For burnout-depersonalisation the non-university group scored significantly higher than graduates

							Job contract (infinite contract, temporary contracts and “other”). Those in other contracts scored significantly higher than indefinite contract employees in stress and burnout-depersonalisation. Years of service as a residential childcare worker. On burnout-personal accomplishment scale, the group with least number of years in profession scored significantly higher than those with experience. Changes in institution. Those who had move between three or more institutions scored significantly higher on the insecurity-conflict scale. No significant different found in relation to sex, marital status, number of children or type of children’s home.
Eastwood and Ecklund (2008)	Exploration of risk for compassion fatigue among residential childcare workers at residential treatment facilities and relationship between self-care practices and CF were explored.	Correlational	57 residential childcare workers (75% female) from one acute and one long term residential facility for distressed, traumatised and emotionally disturbed children	US	ProQOL-R III Self-care practices questionnaire (29 item 6-point Likert scale indicating frequency of staff engagement in specified self-care practices) developed by authors Demographics questionnaire	Bivariate correlational analysis Regression analysis	Burnout risk level most correlated with compassion fatigue level. Burnout and experiences of feeling stressed or overwhelmed at work were the only risk factors identified for CF. Feelings of being supported outside of work, engaging in hobby, reading for pleasure and taking trips or vacations were significant correlates or protective factors. Cs had no significant ameliorative relation to CF level, but did with burnout risk.
Kind et al. (2020)	What protects professional caregivers in youth residential childcare from burnout Measuring resilience and burnout	Longitudinal design	159 professional caregivers (57.8% women) from 14 residential welfare institutions	Switzerland	Burnout screening scale (BOSS) Sense of coherence scale Perceived self-efficacy. Self-care questionnaire Survey about work-related and personal stressors	ANOVA Bivariate Pearson’s correlation	Male p’s reported higher levels in self-efficacy. Older p’s and those with children reported higher sense of coherence and self-efficacy. The number of work-related stressors was negatively associated with self-efficacy and self-care. being in a stable relationship, employment years in current institution, work experience and personal stressors were not related to any resilience measures. Resilience and burnout – difficulties in work related, personal and interpersonal domains were negatively associated with sense of coherence and self-care. self-efficacy was only linked to difficulties in work-related and personal, not interpersonal domains.

							Lower Self-care and sense of coherence predicted burnout.
Kind et al. (2018)	Investigated the impact of verbal and physical client aggression as an indicator of chronic stress exposure and burnout	Longitudinal design	121 professional caregivers in youth residential care (62% women)	Switzerland	Survey about private stressors Survey about personal violations at the workplace Burnout screening scales (BOSS) Hair cortisol analysis	Descriptive analyses Parson's chi-square Kruskal-Wallis test ANOVA	Exposure to verbal aggression increased the risk of developing burnout symptoms (e.g., emotional exhaustion, etc). Being younger or having a longer career in youth residential care were both associated with greater burnout risk
Lakin et al. (2008)	Predictors of burnout in children's residential treatment centre staff	Self-report surveys	375 full time frontline staff within a children's residential treatment centre (62% females)	US	Demographic info form Maslach Burnout Inventory (MBI) Seven self-report items derived from Individual Reactivity Index (IRI, Davis) Emotional contagion – seven self-report items derived from the emotional empathy scale (EES, Mehrabian & Epstein, 1972) Communicative responsiveness – 5 item questionnaires Big Five Inventory (BFI) – extraversion, neuroticism, agreeableness, openness to new experience, and conscientiousness		Staff who considered that they lacked adequate training experienced increased emotional exhaustion. Experience and education did not predict burnout. Higher levels of empathic concern were associated with depersonalisation and higher levels of personal accomplishment. Higher levels of communicative responsiveness were related with higher levels of personal accomplishment but not emotional exhaustion or depersonalisation. Staff can communicate effectively with children despite being emotionally exhausted. Personal factors Age – younger staff reported higher emotional exhaustion and depersonalisation. Neuroticism and extraversion were consistent predictors for burnout. High job satisfaction associated with lower levels of emotional exhaustion and higher levels of personal accomplishment

Leon et al. (2008)	Explores whether the impact of neuroticism and extraversion with population from previous study (Lakin et al., 2008) would be moderated by the characteristics of the clients worked with		203 frontline carer staff (63.5% female)	US	Maslach Burnout Inventory (MBI) Big Five Personality Inventory (BFI Problem presentation scale adapted from the Child and Adolescent Needs and Strengths, Mental health Version (Lyons, 1999; CANS-MH)	Hierarchical ordinary least squares regressions	Staff who rated the youth population as more severe on psychosis and rated themselves as less emotionally stable had the highest level of depersonalisation. Staff who rated the children as more severe on PTSD and rated themselves as less emotionally stable had the highest levels of both emotional exhaustion and depersonalisation
Sochos and Aljasas (2020a)		Longitudinal design – 2 time points (1 year gap)	59 residential staff (84.7% female)	Saudi Arabia	Maslach Burnout Inventory Experiences in close relationships questionnaire (ECRQ) Strengths and Difficulties Questionnaire (SDQ) Security Scale Coping Strategies questionnaire (CSQ) Demographics questionnaire		Child behavioural problems correlated with staff burnout at t1 and t2. Keyworkers caring for relatively more avoidant children reported lower burnout a year later. More avoidant keyworkers experienced more burnout due to child behavioural problems a year later.
Steinlin et al. (2017)	To explore the incidence of post traumatic and secondary traumatic stress as well as burnout and to assess predictive value of sense of coherence, self-care, and job satisfaction.		319 child and youth welfare workers in residential care (61% female)	Switzerland	The Perceived Collective Efficacy (Schwarzer & Scmitz, 1999) German short version of the Sense of Coherence Scale Self-Care Questionnaire	Pearson correlations and point-biserial correlations Bonferroni alpha-error correction	Majority of workers experienced physical assault or threatening situation at work. Stronger sense of coherence associated with fewer symptoms of PTSD<STS and burnout. Self-care, especially work-related factors, were associated with fewer symptoms of burnout and PTS. Physical aspects – exercise, balanced diet was associated with fewer symptoms of STS and burnout

					Questionnaire on Job Satisfaction in Trauma Sensitive Care Impact of Event Scale-Revised The Questionnaire for the Assessment of Secondary Traumatic Stress Burnout Screening Scales (BOSS)	Linear regression analyses	Participants in established relationship tended to show more symptoms of burnout. Support from superiors, participation, and transparency associated with fewer burnout symptoms. Communication and support within the team was associated with fewer symptoms of STS, enjoyment of work associated with lower levels of burnout and institutional structures and resources were associated with fewer STS symptoms.
Winstanley and Hales (2015)	Focused on levels of burnout in staff victims of assault and threatening behaviour working within children's homes	Between-groups design, to measure differences in levels of burnout according to experiences of physical assault and threatening behaviour.	87 staff from children's homes (54% female) 65 residential support workers 16 senior support workers 6 managers	UK	Maslach Burnout Inventory Questionnaire to report frequency of physical assault and threatening behaviour within previous year.	Multivariate Analysis of Variance (MANOVA)	Physical aggression impacted upon emotional exhaustion and depersonalisation.
Zerach (2013)	Compared the levels of burnout of residential childcare workers to that of		212 direct personnel workers Of which 147 worked in residential childcare facilities (46.9% female)	Israel	ProQOL – 2nd ed Experience in close relationships scale (ECR; Brennan, Clark, & Shaver, 1998) Sense of coherence scale (SOC, Scale, Antonovsky, 1987, 1993) Daily spiritual experiences scale (DSES; Underwood & Teresi, 2002)	MANOBA Chi-square analysis T tests	Significant differences between RCWs and BCWs in CS but not in STS or BO Personality resources significantly contributed to BO; biggest contribution made by spirituality Attachment anxiety and SOC predicted ST, attachment-avoidance and spirituality predicted CS. Spirituality mitigated forms of BO. History of traumatic stress contributed to ST. Attachment avoidance positively related to BO and negatively related to CS. SOC negatively correlated to ST and BO

Table 3 Study Demographics

Variable		Number (percentage)
Country		
	USA	4
	Switzerland	3
	UK	2
	Israel	1
	Turkey	1
	Spain	1
	Saudi Arabia	1
	Canada	1
Setting		
	Residential Treatment Centre	5
	Residential Children's Home	4
	Orphanage	2
	Youth Welfare Institutions	3
Design		
	Cohort Study	3
	Cross-Sectional	10
	Randomised Control Trial	1
Range in respondents		24-319
Total respondents		1645

Table 4 AXIS Quality Appraisal of Cross-Sectional Studies

	Audin et al. (2018)	Barford and Whelton (2010)	Decker et al. (2002)	del Valle, López, et al. (2007)	Eastwood and Ecklund (2008)	Lakin et al. (2008)	Leon et al. (2008)	Steinlin et al. (2017)	Winstanley and Hales (2015)	Zerach (2013)
1. Were the aims/objectives of the study clear?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2. Was the study design appropriate for the stated aim(s)?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
3. Was the sample size justified?	N	N	N	N	N	N	N	N	Y	N
4. Was the target/reference population clearly defined? (Is it clear who the research was about?)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
5. Was the sample frame taken from an appropriate population base so that it closely represented the target/reference population under investigation?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
6. Was the selection process likely to select subjects/participants that were representative of the	N	N	N	DK	N	Y	Y	N	Y	DK

target/reference population under investigation?										
7. Were measures undertaken to address and categorise non-responders?	N	N	DK	DK	N	N	N	N	N	N
8. Were the risk factor and outcome variables measured appropriate to the aims of the study?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
9. Were the risk factor and outcome variables measured correctly using instruments/measurements that had been trialled, piloted or published previously?	Y	Y	Y	Y	Y	Y	Y	N	Y	Y
10. Is it clear what was used to determined statistical significance and/or precision estimates? (e.g., p-values, confidence intervals)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
11. Were the methods (including statistical methods) sufficiently described to enable them to be repeated?	Y	Y	N	N	Y	Y	Y	Y	Y	Y

12. Were the basic data adequately described?	Y	Y	N	Y	Y	Y	Y	Y	Y	Y
13. Does the response rate raise concerns about non-response bias?	Y	Y	DK	DK	DK	N	Y	Y	N	DK
14. If appropriate, was information about non-responders described?	No	N	N	DK	N	N	N	N	N	N
15. Were the results internally consistent?	Y	Y	DK	Y	Y	Y	Y	Y	Y	Y
16. Were the results presented for all the analyses described in the methods?	Y	Y	N	DK	Y	Y	Y	Y	Y	Y
17. Were the authors' discussions and conclusions justified by the results?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
18. Were the limitations of the study discussed?	Y	Y	N	N	N	Y	Y	Y	N	Y
19. Were there any funding sources or conflicts of interest that may affect the authors’ interpretation of the results?	Y	DK	DK	DK	DK	DK	DK	DK	DK	DK

20. Was ethical approval or consent of participants attained?	Y	Y	Y	Y	Y	Y	Y	Y	DK	Y

Table 5. Quality Appraisal of Cohort Studies

	Kind et al. (2018)	Kind et al. (2020)	Sochos and Aljasas (2020a)
1.Were the two groups similar and recruited from the same population?	Yes	Yes	Yes
2.Were the exposures measured similarly to assign people to exposed and unexposed groups?	Yes	Yes	Yes
3.Was the exposure measured in a valid and reliable way?	No	No	Yes
4.Were confounding factors identified?	Yes	No	Yes
5.Were strategies to deal with confounding factors stated?	Yes	No	Yes
6.Were the groups/participants free of the outcome at the start of the study?	No	Yes	Yes
7.Were the outcomes measured in a valid and reliable way?	Yes	Yes	Yes
8.Was the follow up time reported and sufficient to be long enough for outcomes to occur?	Yes	Yes	Yes
9.Was follow up complete, and if not, were the reasons to loss to follow up described and explored?	Yes	No	DK
10. Were strategies to address incomplete follow up utilised?	No	No	DK
11. Was appropriate statistical analysis used?	Yes	Yes	Yes

Table 6. Quality Assessment Tool for Quantitative Studies

		Çatay and Koloğlugil (2017)
Selection Bias	Are the individuals selected to participate in the study likely to be representative of the target population?	Yes
	What percentage of selected individuals agreed to participate?	Can't tell
Study Design	Indicate the study design	Non-randomised control study
Confounders	Were there important differences between groups prior to the intervention?	No
Blinding	Were the outcome assessors aware of the intervention or exposure status of participants?	Yes
	Were the study participants aware of the research question?	Can't tell
Data Collection Methods	Were data collection tools shown to be valid?	Yes
	Were data collections tools shown to be reliable?	Yes
Withdrawals and Drop-outs	Were withdrawals and drop-outs reported in terms of numbers and/or reasons per group?	Yes
	Indicate the percentage of participants completing the study.	Less than 60%
Intervention Integrity	What percentage of participants received the allocated intervention or exposure of interest?	Less than 60%

	Was the consistency of the intervention measured?	No
	Is it likely that subjects received an unintended intervention (contamination or co-intervention) that may influence results?	Yes
Analyses	Are the statistical methods appropriate for the study design?	Yes
	Is the analysis performed by intervention allocation status rather than the actual intervention received	No

Figure 1. Flowchart of systematic literature review

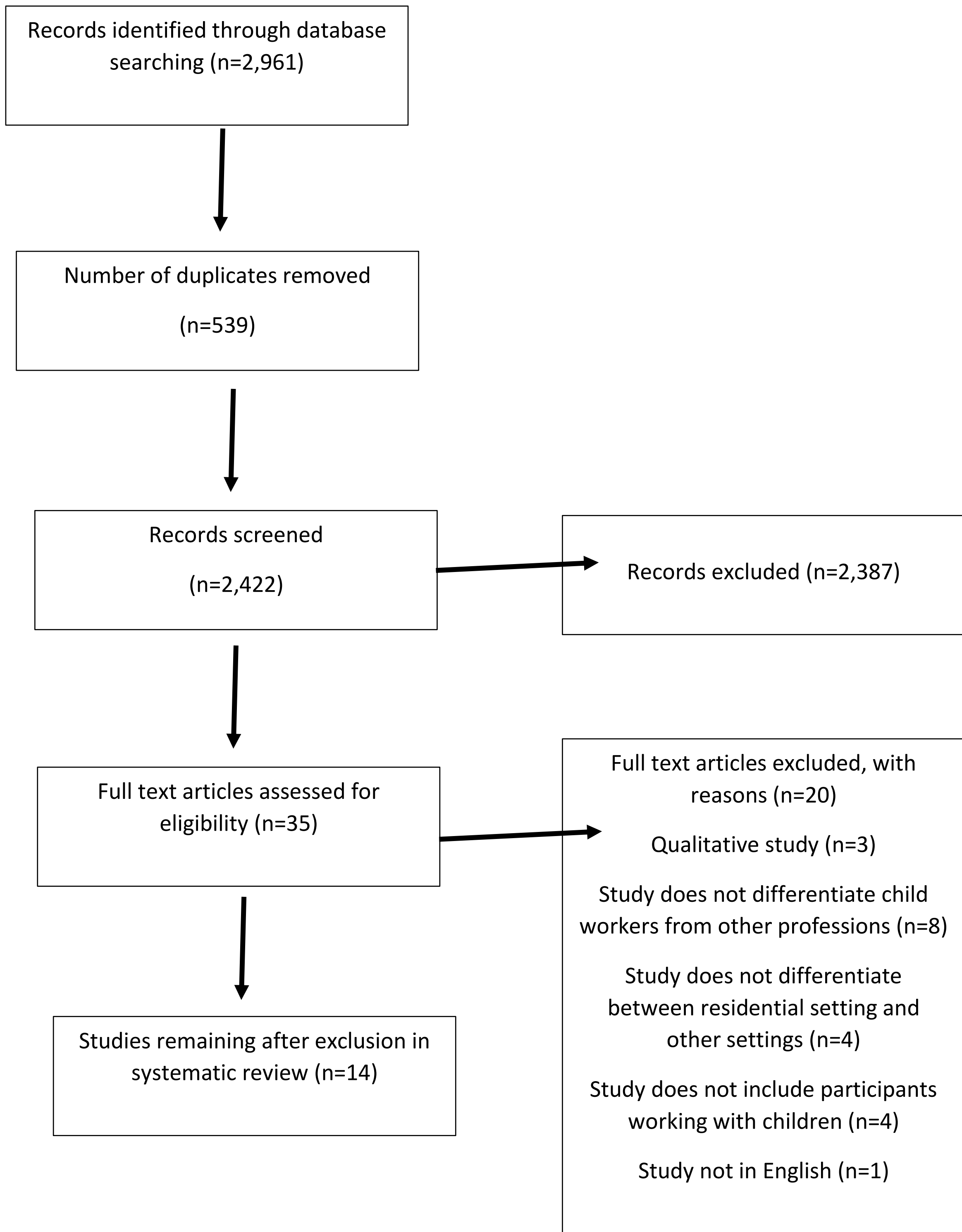

Figure 2. List of possible factors associated with burnout or compassion fatigue for workers in residential settings

Personal Factors

- Age (younger)
- Experience (less)
- Personality – more neurotic, more agreeable, less extravert
- Lower self-care
- Attachment style – anxious and avoidant

Work-based factors

- Less training
- Less support from management
- Less peer support
- Physical or verbal abuse
- Less job satisfaction

Appendix A – Guidance for Publication in the Child Psychology and Psychiatry Journal

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3. Publishing policies
   3.1 Publication ethics
   3.2 Contributor's publishing agreement
   3.3 Open access and author archiving
4. Preparing your manuscript
   4.1 Formatting
   4.2 Artwork, figures and other graphics
   4.3 Supplementary material
   4.4 Reference style
   4.5 English language editing services
5. Submitting your manuscript
   5.1 ORCID
   5.2 Information required for completing your submission
   5.3 Permissions

6. On acceptance and publication
   6.1 SAGE Production
   6.2 Online First publication
   6.3 Access to your published article
   6.4 Promoting your article
7. Further information

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Back to top

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Back to top

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Back to top

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Back to top

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Back to top

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Back to top

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Chapter 2 : Research Paper

Influences on worker's role with children in residential settings: A grounded theory

Mike Heyes

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

All correspondence should be sent to:

Mike Heyes

Doctorate in Clinical Psychology
Faculty of Health and Medicine
Health Innovation One
Sir John Fisher Drive
Lancaster University
Lancaster
LA1 4AT
m.heyeyes@lancaster.ac.uk

Abstract

Working with children in out-of-home care can be complex and require a range of personal and professional skills. The current study explored the influence of personal life experiences on staff who worked with children in out-of-home care. Eight staff members from residential or respite care were interviewed about the influence of their personal life experiences on different aspects of their role, such as choosing to enter the role and ways of working with the children they cared for.

A constructivist grounded theory approach was used to generate a model based on the reflections of participants. Participants shared their childhood experiences were key in shaping their values or qualities. Participants' values led them to want to enter caregiving roles, and they drew from these values and qualities in a predominantly unconscious way. Participants highlighted that at times they purposely drew from their own life experiences to build connections with and further understand the children they support.

Participants cited work-based influences as being important in their role, recognising their dual role as 'professionals' and 'people', as they were encouraged to bring their personal self into interactions with young people. Work-based influences such as training, and spending time with colleagues allowed participants to gain knowledge and learn new skills which they used consciously within their interactions. General experience in the role was aided by this continued development. Participants highlighted adhering to plans and policies as having a crucial influence on their role, sometimes causing frustration when working in ways that went against personal values.

This study highlights the combination of professional and personal elements for staff working with children in out-of-home care. The study includes recommendations to support staff teams around the impact of their work and their influences, as well as the need for clinical supervision, formulation and reflective practice.

Introduction

In March 2020, there were 80,080 young people, up to the age of 18 years, in care in England (Department for Education, 2021), with approximately one in ten children in care living in residential care provision (Department for Education, 2021). These residential homes are tailored to meet the needs arising from children being removed from their birth families. They are typically staffed by residential support workers, team leaders, deputy managers and home managers. Staff within these settings provide 'around the clock' care for the children they support. Research has highlighted the potential benefits of residential settings for children in care, including the value staff teams bring and the positive impact of a stable and long-term placement Holmes et al. (2018).

Outside of LAC (Looked After Children) services, children are also supported through respite care, a provision for children with complex needs including physical impairments and learning disabilities, autistic spectrum condition or other additional needs. Respite care aims to provide temporary relief to caregivers (Cooke et al., 2020), including overnight, weekly or holiday breaks at children's homes, which typically have the same staff setup as residential settings. Respite care can be provided regularly, giving children opportunities to develop relationships with staff members and other children (Robertson et al., 2011), and it has been found to alleviate stress for parents and caregivers (Cooke et al., 2020; Dyches et al., 2016) and improve marital quality (Harper et al., 2013). Respite settings can also produce positive outcomes for children, enabling them to have different experiences and develop social skills (Mcconkey et al., 2004; Robertson et al., 2011; Wilkie & Barr, 2008).

Working in Residential or Respite Care

Staff within these settings are governed by policies and procedures, ensuring the appropriate standard of care is delivered, with the Office for Standards in Education, Children's Services and Skills (Ofsted) being responsible for inspecting children's homes in England and Wales. There are a range of factors that can influence the ability of a staff

member or whole staff team to support children in care, including organisational or management factors and levels of consistency within a team (Watson, 2003). Colton and Roberts (2007) highlight staff turnover as another factor impacting on teams' ability to provide care. Lack of training has been highlighted as negatively impacting the level of care provided (Watson (2003).

In comparison to other professions or caregiver roles, there is a relative scarcity of literature related to residential children's home workers. Wider research highlights the importance of staff well-being for patient quality of care and satisfaction (Zhou et al., 2020). Workforce well-being refers to all aspects of working life, inclusive of mental and physical health. This could be inclusive of burnout, i.e. mental and physical exhaustion, whilst workers in residential settings may be exposed to secondary traumatic stress (Audin et al., 2018; Turgoose & Maddox, 2017), through their work supporting people who have a history of trauma.

When working with populations of young people with histories of developmental trauma, such as those within the care system, it is important to recognise, reflect and actively work to address the potential impact of trauma across the whole system (SAMHSA, 2014; Sweeney & Taggart, 2018). This approach is known as 'Trauma Informed Care.' The concept of 'parallel process' was first described by Bloom (2011), which articulates the complex interactions ('ripple effect') playing out across clients who are traumatised, staff who are stressed and the whole organisation which will have its own history and narrative. This can then lead to environments which hinder, rather than promote, recovery or healing. In addition, staff working in such environments often have their own histories of trauma, which may have some similarity to those of their client group (Felitti et al., 1998). Therefore, when considering the wellbeing of staff working in such settings, it is important to recognise and reflect upon the impact of working with traumatised clients, and in systems that may also be traumatised.

Research highlights prevalence of burnout in residential child care workers (Sochos & Aljasas, 2020). Burnout refers to emotional exhaustion, depersonalisation, lack of personal accomplishment, and other psychological stressors, such as compassion fatigue, i.e. emotional exhaustion leading to a diminished ability to feel compassion for others.

As the role of staff in residential care can be stressful and lead to burn out, it could be queried why staff choose to enter and stay in such roles. There is limited research exploring this, however, the author has found one study exploring the reasons why people have chosen to work within residential care settings. Moses (2000) interviewed 25 childcare workers in a large residential treatment facility and found that the reasons for choosing to work in residential settings included being influenced by their own childhood experiences, a desire to help others or work with children.

Current Study

As above, there are a wide range of contextual factors that may impact on staff teams' ability to support, and interact with, children in care. There are also suggestions personal experiences, referring to individual life experiences of staff members, can influence whether people choose to enter roles with looked after children or children in respite care. However, there has been little consideration within the literature available of the personal experiences or influences people bring into their work with children in out-of-home settings.

Knowing more about the potential influence of personal or life experiences on staff members' interactions with the children they support would have benefits for staff teams in terms of highlighting potential areas for training, support and reflective practice.

Therefore, the current study aimed to explore the influence of personal or life experiences on individuals who work in residential care settings and to understand how these personal experiences shape their ways of working and interacting with the children they support. Understanding this in greater detail can help to understand the well-being needs of workers and adapt ways of supporting them within their role.

Method

Research Question

How do personal or life experiences of workers in children's residential settings influence their ways of working and interacting with the children they support?

Design

A Constructivist Grounded Theory approach (Charmaz, 2014; Glaser & Strauss, 1973), consisting of systematic yet flexible guidelines for constructing theories from the data (Charmaz, 2017), was used. This approach is suitable for generating new and emerging theories where none are available (Charmaz, 2014), often when there is little pre-existing research, as is the case for the current research. Within grounded theory studies the focus of the research emerges during the process instead of being established prior to this (Charmaz & Thornberg, 2020). As is the case with Constructivist Grounded Theory, a subjectivist epistemological stance has been adopted by the researcher (Charmaz, 2014), with this stance acknowledging the research cannot be completely objective and takes the view that an interrelationship exists between the researcher and participants.

The process of grounded theory involves a constant comparison of analysis, which ensures any theories that are emerging are grounded in the experiences of the participants (Mills et al., 2006). A cyclical process of data collection, coding, and theoretical sampling is used with analysis starting at the early stages of the process in initial interviews. This then shapes the focus of subsequent interviews. This process is continued until theoretical saturation is accomplished.

Setting

Participants were interviewed through Microsoft Teams, with face-to-face interviewing not being possible due to COVID-19 restrictions. Participants were recruited from children's residential and respite care settings.

Participants

Eight participants were recruited. Participants needed to work directly with children in residential settings, (manager, deputy manager, team leader or support worker). Furthermore, participants must have been in their role for at least one year, which allowed for them to have more to reflect on within their work. Pseudonyms were used in this study. Anyone not meeting this criterion were excluded and this was highlighted in the information sheet shared with potential participants. Participants were recruited from both traditional residential settings and respite care settings. Despite differences in these settings (such as the length of time spent there), the children in these settings often have a similar level of complexity of needs and the staff take on a significant caregiving role. As such, the researcher felt it appropriate to recruit from both settings.

Recruitment

Purposive recruitment enabled the researcher to develop links to multiple residential services, including those within the private and charity sectors, and Local Authority provision. Information packs were shared with team managers based within different organisations, and the research was advertised via social media platforms. Potential participants were provided information related to the research, including inclusion criteria.

Participants expressed interest by directly contacting the researcher or agreeing to have their information passed on by the field supervisor. Participants were contacted by the lead researcher to arrange interviews.

During the initial round of data collection, five participants were interviewed. After initial analysis of this data, a further three participants were interviewed. Recruitment ended at a point when theoretical sufficiency was achieved, with the data gathered being sufficient to construct theory from the data.

Data collection

Semi-structured interviews were conducted between July and December 2020, ranging from 52 to 82 minutes in duration. A topic guide was used during interviews, which was developed in consultation with a staff member within a residential service. The guide was an initial framework, with opportunity for follow up questions (Belgrave & Charmaz, 2012; Charmaz, 2015). The focus of the topic guide changed during the interviewing process, with codes, memos and theoretical categories constructed from initial data shaping the questions in subsequent interviews. This is a key element of grounded theory, in which data collection and analysis happen alongside each other (Glaser & Strauss, 1973). Interviews were video recorded and stored securely before being transcribed verbatim by the lead researcher.

Information such as role and gender, amongst other characteristics was obtained during interviews. Participants were given consent forms and information sheets via e-mail prior to their interview. Participants were asked to return completed consent forms. Due to technology issues two participants confirmed their participation via e-mail after their interview, which was agreed with the ethics committee as a suitable way to confirm consent. One participant was unable to provide confirmation. However, the researcher liaised with the ethics committee, with the committee concluding the researcher had made attempts to resolve the issue and there were no consent concerns as the participant had read the information and consent sheet before being interviewed.

Data Analysis

Line by line coding was applied to interviews. Gerunds, a coding style that highlights actions, e.g. “reflecting”, either observed or conceptualised, was used (Saldana, 2012). As part of this process constant comparison of codes was carried out (Charmaz, 2014; Glaser, 2016). This involved the comparison of new data and codes with earlier codes, enabling the researcher to identify patterns within the data (Corbin & strauss, 2015; Davoudi et al., 2016).

Memo-writing is another important step within grounded theory, crucial in prompting the researcher to analyse codes and data early in the process (Lempert, 2007). Memos are the researcher's way of recording thoughts and developing concepts instantly in reaction to each stage of the research (Birks, 2011). There is no specific way in which memos must be recorded, with flexibility and freedom encouraged. It is suggested they should be more spontaneous than mechanical (Charmaz, 2014), to allow initial concepts and assumptions to be explored. The lead researcher made use of memos throughout the process, using both free hand and listed memos to enable the ability to facilitate generation of theory (Lempert, 2007). Memos were used to record initial reflections following the interview process and during coding.

Enter Table 1 here.

Reflexivity and Credibility of Analysis

A constructionist or subjectivist stance has been taken in this research (Charmaz, 2014). This perspective suggests people construct the realities in which they participate, and as a result there are multiple realities and meanings created. Consequently, it is suggested there is no objective reality (Charmaz, 2014). Based on this stance, it is important to acknowledge the researcher's interpretation of participants' realities will be influenced by their own bias and understandings and therefore cannot be objective. The lead researcher had prior experience of working in children's residential services and had potential biases related to the topic. To counter this, the researcher used supervision and reflection to continue to be aware of own biases. The lead researcher would ask supervisor's to check in with them about how the interviews related to their own experiences, which helped to raise awareness of this influence and to ensure the research remained grounded in the data, whilst also shaping potential questions to ask.

Ethical Issues

The Lancaster University Faculty of Health and Medicine Research Ethics Committee (FHMREC) approved the project. There were no requirements in terms of governance approvals required from the organisations involved in the research. In terms of ethical considerations, carrying out interviews via teams removed one dilemma of where to do interviews physically and whether I would need to go to the residential homes. This proved problematic in terms of participants being able to return completed consent forms. This issue was discussed with FHMREC and changes were made to the procedures.

Results

The research explored how personal life experiences influence staff working in residential settings. A model was developed, presenting the findings diagrammatically (Figure 1). Participants shared personal experiences shaped their individual beliefs, values and qualities, which then led them towards roles caring for children. The model also highlights influence of the professional role on ways of working, highlighting the influence of training, colleagues and experience within role, which all develop new ways of working and lead to personal growth for the participants. Participants highlighted needing to adhere to plans and procedures, which at times brought challenge due to friction and contrast to personal beliefs around ways of working. The model is a representation of the experiences and perceptions of the participants involved in the study, and is not a generalisable theory.

Enter Figure 1 here.

Personal Experiences Shape Individual Beliefs and Values.

Participants highlighted certain beliefs and values they felt were necessary to their work. Isaac stated respect he gave to others, including children he supported, was "engrained from a young age from my mum especially". Sarah also drew on long-standing values within her role, "even as a small kid, I was very much like, you know, what can I do to

help this person?", whilst Elisabeth stated "you've got to have a caring side otherwise you wouldn't want to do the job".

For many, parents were a heavily influence in how their beliefs and values were shaped;

> They raised me, supporting me to understand the importance of empowering the young people, you know, be their voice when they can't put their thoughts forward. But most importantly, ensure that they're given a choice…. So, I guess they [parents] played a big role in it (Francesca).

For some, the influence of their parents appeared to be demonstrated by parental job roles. Henry shared values around standing up for people stemmed from his parents being union representatives. Hannah highlighted her mum's role as a foster carer, whilst Elisabeth's mum was a nurse.

Alongside values developed in childhood, participants cited ongoing or newer life experiences as shaping them as individuals and within their role. For example, Francesca highlighted the impact becoming a parent had on her understanding of the importance of attachment.

Participants' decisions to enter their role were influenced by the values and qualities they held around supporting and caring for others.

> If you're a bit of a rescuer anyway in your personality, you know it's if you can connect to these kinds of families and young people. It's so meaningful that you just become part of it. (Hannah)

Isaac shared that a caring nature is a quality needed in the role, "if you haven't got genuine care, I don't know why you bother doing it". Alongside this, participants shared that life events influenced the desire to help others, as highlighted by Sarah when discussing the aftermath of a family separation;

> Seeing the effect it had on him, on the boys and on my mum really, I want to make sure that doesn't happen. I want to be part of the sort of the solution.

This event in Sarah's life contributed to a desire to support children who have experienced difficulties. For Hannah, her experience of loss drove her to "want to make a difference to people and their well-being and train in what I have trained in".

To illustrate the importance of personal values and experiences on this process, some participants highlighted previous less fulfilling roles. Benjamin felt he "needed to do something that was interesting" following a career in the sales industry, whilst Elisabeth felt that a people facing role, such as the one she has supporting children, was more rewarding than her previous office-based role:

> It's more rewarding and you can actually see the difference you make when you're working directly with people rather than just sitting in an office, doing paperwork all day.

In summary, participants highlighted wanting to work in ways that matched their personal values and beliefs, and that their role with children allowed this. Furthermore, participants highlighted childhood experiences and influences in shaping their values, with ongoing life experiences moulding values further.

Ways of Working with Children

Participants viewed bringing their own personality, values and beliefs into the role as an important element of the work they do. Benjamin stated "it's you as a person, what you could bring the team… I'm the one who brings a bit of humour", whilst sharing that staff are able to be themselves in work. Hannah shared her belief around the importance of "just being who you are with them (children) and role modelling that".

Participants spoke of "natural" or instinctive ways of drawing from personal experiences within the role, with Henry referring to it as a "muscle memory". Francesca

supported the idea that ways of working with the children are natural, stating the "type of professional that I am, is not much different to the type of parent, type of friend, type of daughter that I am".

Although drawing from personal experiences appeared to be natural, participants did share that comparing their personal experiences with those of the children helped them to provide better support. Isaac discussed understanding different behaviours of children in care through comparing them with his own experiences;

> I was brought up in a house from a really loving home, but when I work with the kids now, I think I was a good kid, but I weren't the best and I was always in trouble and stuff… so say if I was in the care system, I think I wouldn't have turned out the way I am... So, like, I understand that the pull from when they want to go out with their mates and why would they listen to me and having that kind of human thing of putting myself in their shoes.

This development of understanding was important for building relationships with children. Participants shared other, more direct, examples of having similar experiences to the children they support and how sharing these with the children helped in making connections. Sarah shared an example of how sharing her experiences with a child helped them to feel understood;

> I have that conversation with him and I'm like I miss my mum as well. I haven't seen my mum since this point. I used to see her every day and then I moved and now I don't see her, and he really relates. He seems to really relate to that because he said, well, you understand what I mean then (Sarah).

In summary, participants highlighted that being themselves is important within their role with young people, with values, beliefs and qualities underpinning ways of working in a natural way. However, there are times when participants have intentionally drawn from

personal life experiences, with the aim of understanding the young people they support and building relationships.

Ways of Working – Work-Based Influences

Despite agreement around importance of personal experiences and values for participants, work-based influences were also cited. The role of the team, training opportunities and experience over time in the role were highlighted as important in reinforcing or refining ways of working that are developed from personal experiences.

Training and Knowledge. Participants cited training as key for personal and team development. Hannah highlighted the necessity for training when stating her belief that approaches learned from her training “should be at the forefront of everything we do”.

Participants regarded training as being important in consolidating their values or ways of working or adding to their approach by developing knowledge base around working with the children they support. Benjamin highlighted receiving training as important in increasing his awareness and understanding, which then influenced his approach within his work with the children he supports. For others, training made sense to them, suggesting it fits with their way of working or approaching situations. Isaac regarded de-escalation training as “common sense”, fitting with his way of defusing challenging situations.

Experience in Role. There was recognition of the need to develop further work-specific skills and qualities and “learning on the job” (Isaac). Qualities participants spoke about needing to develop whilst in the role included resilience, boundary setting and organisational skills.

> There was never a point where I was, I felt vulnerable, so having to then come here and have things thrown at you and things kick and hit with stuff and you know pulled out pushed about… resilience has definitely been something I've had to work on (Sarah).

> You've gotta have boundaries with them and things and you've got to be able to say 'no we don't do this' and stuff, which I've sort of had to develop over time (Elisabeth).

Participants highlighted the importance of working with children and adapting their own approaches, learning when to use personal influences and when not to. This took different forms, such as curbing their own style of working or interacting and "learning from mistakes" (Benjamin). For participants, their work in the role is where they consolidate and draw from the different influences, whether this be personal influences, the team or training. As with Benjamin's example, he is drawing from his personal experiences of using humour with people to develop relationships but has learned through his experience in the role when to curb his approach and tailor it to the needs of the children he is working with. Isaac shared how working with the child and getting to know them influenced his approach;

> It might seem like a small thing to me or you, but it could be quite a sensitive subject to them. So, the longer you work with someone, the more you know what you can use, what you can say. One of the last children we [the team] worked with her for, how old is she now, probably about 16 months and by the end we [Isaac and child] had a real [pause] we understood each other and … kind of use humour a lot with her just to get simple things done.

Colleagues/Team. Participants cited colleagues as being influential on how they work. They described learning through observing other workers, particularly when starting their role. As with other work influences, there is more of a conscious decision for participants to observe, learn and put into practice other ways of working. This observing of others can be both a standard practice within the organisation, in terms of shadowing others as a new member of the team, and an informal and organic act. Francesca shared she still learned by noticing what her colleagues do, despite being the most senior person within the team as home manager; "they [other staff] do it [prepare breakfast] in a much more fun way than I do, so I'll do it like they do it". Several participants stated they learned from newer and

possibly less experienced members of the team, which highlighted how different people bring different personal skills that are useful for the role. Participants shared this went hand in hand with personal influences or ways of working rather than completely replacing it, with the influences of colleagues blending with the participant's own way of working;

> I think you learn from some of your colleagues around you and so the ones who have worked there longer and sort of see their sort of ways of dealing with situations. And obviously the first time we encounter some things, you're sort of just taking a back seat, but you kind of watch and see how they sort of respond and the ways they sort of try and get somebody sort of out of certain situations or whatever. And I think you just sort of learn from them and copy, really, I suppose, and then try and bring your own sort of slant on it and see if it works for you (Elisabeth)

Personal Growth within Role. Participants highlighted how the different influences combined to shape them as workers within their role, as illustrated by Francesca when talking about the influence of personal and work-based experiences, "the training I have and the experience I have as a parent enable me to understand a little bit better and to put into practice in and adapt the plans that we have in place".

Participants also illustrated the influence of the role on them as individuals, with it increasing awareness, changing perceptions or opening them to new ideas. Wendy, one of the more experienced participants interviewed, spoke of constant learning, stating "I don't think in this role you ever stop learning". Francesca highlighted the influence her role with children has had on her as a parent as she shared that "there is some learning from the children too, so as a parent knowing when to expect triggers and certain requests".

Adhering to Plans and Policy. A key component of work with children in residential or respite settings are the plans and procedures that need to be followed, such as those around safeguarding. These are a mixture of organisational and national procedures that are

followed, alongside plans that are individual and tailored to the specific child. This was discussed in detail by all participants who highlighted the relevance of different policies.

In many instances the plans and policies that needed to be followed accorded with participants' own personal values and beliefs around ways of supporting the children being cared for;

> I'm not acting in this way because the policies told me I have to, it's more of a I'm acting in this way because that's the logical way in my head to do it and the policies just confirm that so they're there, but they don't restrict what we do and how we do it. (Sarah)

However, there were times when the company policy conflicted with participants' personal values and preferred ways of working. When describing instances in which such conflicts occurred, participants often reflected on what would have happened in their own childhood, which differed from how they were required to approach the situation in their work role. An example of this shared by Henry, Wendy and Isaac was policy around consequences for unwanted behaviour, and how this was perceived to be not strict enough. At the other end of this spectrum participants shared examples of when they perceived individual plans to be too restrictive.

> You know we try [to provide a great service] but because of the constraints of legislation and rules, we cannot give these children a home life they would have if they were in maybe foster care or their own parents' care. You've got all these regulations of what we can and can't do. (Henry)

In agreement with Henry, Wendy shared her opinion about being unable to provide a home environment, in part due to the need to prioritise paperwork ("it is hard to give them a normal life because the system and everything has to be recorded"). It should be noted that Wendy, amongst other participants, accepted reasons for record keeping and the need to

safeguard children in care in ways that are vastly different to doing so for children not in care.

When discussing times when he disagreed with plans, Henry referred to cognitive dissonance;

> We've also got regulations that we have to follow as well that sometimes you might not agree with. So, it's getting that sort of switch in your brain saying I don't agree with this it's still got to be done. It's like cognitive dissonance.

In response to plans participants disagreed with, there was potential to challenge these cases of conflict by using the right channels, such as liaising with the home manager, social worker or other professionals, to explain why they thought the plans needed to change. However, in other instances staff accepted the lack of power they held within their role in relation to plans. When discussing his own frustrations with feeling unable to have his say on plans for a child, Isaac stated:

> Suppose just understanding that by now there's the system in place and I'm a small cog I'm there to do a very [pause] although you can do some work, it's the influence you have like in terms of decision making is very small.

Despite the frustration at times when needing to follow plans, there was an acceptance that the children being supported required a different type of care, and some plans and procedures were necessary, primarily to keep them safe.

In summary, work-based factors also are important in influencing ways of working for participants. Many of these influences, such as training and colleagues, are related to learning new skills and gaining knowledge, which participants then apply to their role with children. This is done in a more conscious way than the values-based influences. Participants highlighted elements of their role which conflicted with their personal beliefs, primarily relating to adhering to policies, and this at times led to frustration.

Satisfaction in Role.

When asked about decisions to stay within roles with children, participants spoke of the role fulfilling their desire to help others, as evidenced by Wendy stating “it’s quite rewarding when you know you’re making a difference…I always said if I could help out one that was enough”. All participants highlighted being able to make a difference as an important reason for staying. For Elisabeth, knowing the positive impact she was having in her role motivated her to continue, whilst Benjamin referred to this positive impact as rewarding. Hannah, amongst others, stated success stories in work kept her going during more difficult times.

Work-based influences were highlighted as being important when choosing to stay, with these influences marrying up with their own beliefs. An example of this was shared by Benjamin who demonstrated his beliefs around teamwork and shared how his current role and colleagues’ support him, referring to the “culture” of the organisation being key to his satisfaction.

To summarise, participants highlighted that being able to work in ways that fulfilled personal values increased satisfaction in their role. Participants highlighted the work-based influences, such as good team culture and training as also improving job satisfaction.

Discussion

Participants personal life experiences shaped their values and qualities, which they then drew from within their role with children. Participants shared that they brought themselves to their role in an unconscious and natural way, although did highlight times when they purposely referred to own life experiences to better understand and connect with children they support. Although personal values and beliefs underpinned ways of working, participants highlighted work-based influences such as training, colleagues and continued experience in role as important for gaining knowledge and learning new skills which were then implemented in their role. Participants highlighted times when they were required to

work in ways that went against personal beliefs, which was highlighted as being frustrating. The role of residential worker was seen as involving a combination of all of the aforementioned influences, as participants combined different influences to develop and refine their way of working.

How Does This Fit in the Literature?

Values and their influence. The study fits with current understanding of development of values with the influence of our surroundings, life experiences and, in early childhood, the role of family in shaping values and beliefs (Boer & Boehnke, 2016; Catlin & Epstein, 1992; Whiston & Keller, 2004). The current research is consistent with wider research in demonstrating the importance of family or primary caregivers in shaping the values of individuals. However, the current research did not highlight other influences such as societal and cultural, which are regarded as being important factors in this area (Roccas & Sagiv, 2010; Sagiv et al., 2017).

The current study highlights intrinsic and altruistic reasons for deciding to work in child-care settings. This supports the wider literature around professional caregiving roles and reasons for entering them, with a desire to help others being a key component for individuals entering other caregiving professions, such as nursing (Eley et al., 2012; ten Hoeve et al., 2017; Zamanzadeh et al., 2013) and carers working with the elderly (Hussein, 2017). People in other caregiver roles, such as nurses, share similar hardships in their role, highlighting the importance of wanting to work in ways fulfils values for professionals in this sector.

The literature around foster care indicates a desire to support and to make a difference as motivating individuals to become foster parents (De Maeyer et al., 2014; Neagoe et al., 2019; Rodger et al., 2006; Sebba, 2012). There is less research into the experiences and motivations of staff working in residential settings. One study by Moses (2000), which involved interviewing residential child care staff, found the most common

reasons cited for entering work with children in care involved a desire to be involved in socially meaningful work and the role fulfilling a preference for working within people facing roles, particularly with children. These findings mirror those of the current study as well as those of Burbidge et al. (2020) who found staff satisfaction in their role was based on making a difference for the children being supported. However, Moses (2000) highlighted personal experiences of the care system as being influential, whereas this was not the case for participants in the current study.

Influences on Ways of Working. The current study supports findings of previous research into the influence of personal values and beliefs, which can have an influence across caregiving roles in terms of working in a way that matches the individual's beliefs and standards (Farr & Cressey, 2015). The current study also highlighted work-based influences of training and colleague support as being important, which fits well with the literature relating to job retention in caregiver roles (Chênevert et al., 2019; Pia, 2007; Smith, 2005).

The findings also highlight the way in which staff bring 'themselves' into their role with children. Smith (2009) demonstrates the importance of personal qualities of the worker in building relationships with the children being supported and suggests high importance of personal qualities is unique to child-care workers because of this relationship-building aspect of their role. An interesting aspect of the current study was how staff used personal experiences to build connections and empathise with the children in their care.

The current study demonstrates how working involves a combination of personal values and work-based influences, with work-based influences often consolidating personal beliefs or developing the worker within their role. In certain situations, there is conflict between personal beliefs and what workers are being asked to do, which highlights a "dual role". Research around this with other professionals, highlights the complexity of the need to care combined with managing risk (Jacob, 2012). The wider literature refers to values-based practice frameworks which highlights the centrality of values in clinical decision making or when supporting people. Research indicates that nurses will draw from personal values

whilst also adhering to professional values when making decisions around care (Fulford, 2011; Hayes, 2017). The current research suggests that participants also draw from both professional and personal values when deciding how to approach their care of young people.

The study highlights the personal growth of the participants, drawing from all influences, life and work-based, to create their identity as a support worker and shape their communication with young people. This is an ongoing process, with experienced participants highlighting a constant development through learning within the role and how this at times influences their personal life, and vice versa. Personal growth is typically defined as being open to new experiences and to continue to develop as an individual (Ryan et al., 2008; Waterman, 2008). Research has highlighted personal growth contributing towards positive well-being. Other research focusing on nurses suggests that nurses develop personal growth through emotional connections formed with patients (Vishnevsky et al., 2015).

Clinical Implications

The study highlights the blending of professional and personal aspects of self for residential care workers within these settings. It is perhaps to be expected that there is going to be an influence of personal ways of working on the professional role with children, as the role involves personal and human interactions and relationships (Smith, 2009). When professional and personal approaches overlap in this way, there is potential for conflict in terms of preferred ways of working, as evidenced in the current study with participants highlighting frustrations around certain aspects of their role. Although not explored within the present study, there is potential for these frustrations around service procedure to lead to wider frustration and staff choosing to leave the role. This could be a potential contributor to the high levels of turnover amongst residential child care staff (Colton & Roberts, 2007). Research highlights cognitive dissonance, also known as professional dissonance, in which professionals are required to work in ways that do not sit well with their values, can impact in terms of burnout and productivity (Agarwal et al., 2020). Additionally, participants spoke of

their lack of power in decision making, highlighting a potential need for organisations to think of how they can ensure staff are able to give feedback on policies and procedures that will influence their everyday practice. This could be offered in the form of service wide reviews or opportunities to share thoughts.

Clinical psychologists, who often have an active role in providing psychological consultation into children's residential services, would be able to support staff with their frustrations by offering space for reflection and training. When thinking of participants' frustrations with policies and plans, some of these frustrations centred around the idea that children in care were treated more leniently than they themselves would have been treated in a similar situation during their own childhood. Training would be useful in providing opportunities to reflect on why traditional parenting techniques may not be appropriate for young people with complex needs, or histories of abuse and trauma. It could be helpful to think together with staff about the necessity at times to work in a different way with children in care, and how children with a history of abuse and neglect need an approach tailored to their stage of emotional and social development, often having difficulty in building trust in others and views of self as being unlovable or 'bad' (Barton et al., 2011). This is inclusive of consequences for unwanted behaviour. For example, when participants talked of more severe consequences for themselves as children, they may be doing so from a position of being a child who potentially had a more positive attachment and knew they were loved and protected by their parent handing them the punishment, thus resulting in them being more likely to accept the consequence and not feel rejected or unwanted (Barton et al., 2011). Frustrations around this could also be addressed in team formulation sessions. In formulation meetings teams can develop an understanding, not only of why the child they are supporting is behaving in the way they do, but also why certain responses they perceive as normal due to their own personal experiences may not be helpful in the situation. Space for reflection can be important for those supporting children in care, whilst also enabling the staff member to feel supported in what can be a challenging and stressful work environment

(Onions, 2018). It is important to be mindful that there may be staff members within teams who have experienced their own trauma or care history, and this could mean that it could be difficult for them to reflect upon differences between themselves and their childhood and the children they support.

As described above, staff may be impacted upon by the young people with histories of trauma that they support, they may have experienced their own difficult experiences, and they are potentially vulnerable to burnout or compassion fatigue. In addition, they also may be working in environments full of trauma, with policies and procedures that feel at odds with their values or the care that they are trying to provide. Therefore, it is important that the care provided at all levels of a system strives to be trauma-informed to improve the wellbeing of both young people and staff. Trauma informed care has a number of important principles including the embedding of a trauma-informed way of working throughout an organisation with consideration of all policies and procedures, staff training and development to build understanding, promoting safety and collaboration, taking into account the physical environment, evaluation and monitoring, and a focus upon staff wellbeing, with a recognition of the impact of supporting young people with histories of trauma on both staff and teams.

The findings of this study highlight how staff combine personal and professional elements when supporting children. Staff talked about how by sharing personal life experiences with the young people in their care, they were able to build empathy, trust and better relationships. Although participants reported this as an effective strategy, it is also important to be aware of how this could potentially leave staff feeling (emotionally) vulnerable at times or overstep professional boundaries (for example, if they later felt that they had over-shared, or the child had reacted negatively to the information). Therefore, it may be important for staff to have access to clinical supervision and reflective practice in order to think through what is useful to share, and how a young person might perceive this, and how to look after themselves and use appropriate personal boundaries. As described

above, the 'dual role' of providing care whilst also managing risk can be difficult to navigate for staff, so having a supportive space to discuss some of these dilemmas may be useful.

For many participants, the interviews were an opportunity to remind themselves of their reasons for entering the role. It is useful to think of this within the context of burnout (Maslach, 2001), vicarious trauma (McCann & Pearlman, 1990) or compassion fatigue (Figley, 1995). These terms refer to different ways in which the work environment can impact upon workers and their emotional well-being. The presence of these phenomena can lead to dissatisfaction and detachment from the job role and can lead to high levels of staff turnover. The literature highlights the risk of emotional exhaustion amongst child-care workers (Barford & Whelton, 2010; Sochos & Aljasas, 2020; Steinlin et al., 2017; Zerach, 2013). If workers are potentially losing touch with the reasons for entering their role, this could lead to the detachment described. Opportunities to keep in mind reasons for choosing to work in these roles, and how their values might fit with the overall service, may therefore be of benefit for workers.

The findings of this research inclusive of the model have been shared in a multi-agency conference for professionals working in this sector, whilst the lead researcher has referred to the model when working directly into residential staff teams.

Future Research

It would be useful to ask workers about the challenges of team working alongside their own personal values and beliefs around ways of working. Although there is crossover in broader values around wanting to make a difference, there is potential for divergence in how workers think this can be achieved. A potential downside to staff bringing different preferred ways of working is that this could lead to inconsistencies in care, which may make it more difficult to provide a secure and stable environment that is needed. Exploring challenges around this further could help in thinking of ways to implement support and training to bring a more consistent approach, whilst still ensuring workers feel they are able to work in ways

that works for them. Exploring the thoughts of children in care in terms of what they perceive as helpful in building positive relationships would be useful.

Limitations of the Study

A potential limitation of the current study is the recruitment of participants from both residential and respite care. There is similarity across these settings, such as supporting children in out-of-home care and the responsibilities and duties of workers in terms of prioritising the safety and well-being of children and building relationships. However, there are differences within each role, with residential settings being designed for children that have been removed from their family home due to their primary caregivers being unable to offer them the appropriate level of care. In contrast, children accessing respite care normally would do so on a temporary basis and would continue to live with their primary caregivers when not accessing respite care. Equally, children within respite care potentially need more medical support, as highlighted by the two participants who worked within respite settings.

Another point to highlight is the fact that this model is based on a small number of participants involved in the study and therefore is not generalisable to residential childcare as a whole.

In addition, as discussed above, the researcher has their own experiences of working within residential care and as a result will have brought their own assumptions around influences on the role, such as assumptions around the type of training offered to residential teams. This was managed through using supervision and ensuring that answers were clarified rather than assumptions being based on personal experiences. Memo writing also allowed opportunity to reflect and to shape future questions.

Conclusion

The model developed illustrates the influence of personal experiences on staff members who work with children in care, highlighting how these influences combine with work-based influences to shape how staff members interact with the children they support.

The research highlights training opportunities, as well as the importance of team formulation and space for reflective practice within children in care services.

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Figure 1. Model of How Personal Experiences Influence Professionals and their Work with Children in Residential Settings.

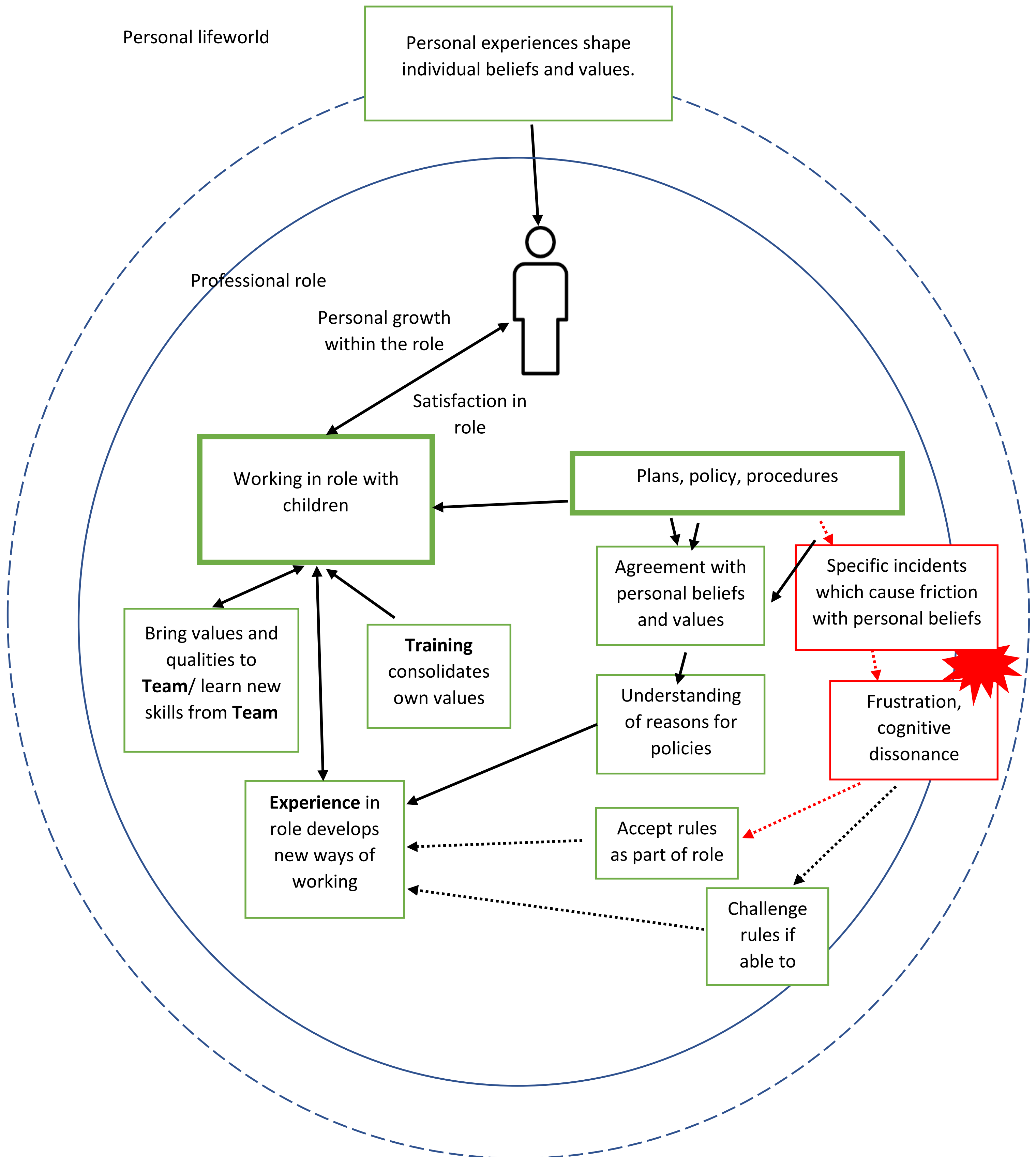

Table 1. Example of line by line and focused coding

Transcription	Line by Line Code	Focused Coding
I: so, so yeah, so yeah I don't know if you can tell me a little bit about the roles you've had and the type of children you have worked with		
P: yeah so erm my mum was a foster carer when I was really young, so she started foster caring when I was about 12.	Mum was a foster carer when I was young	
So in our house there were looked after children quite a lot of the time, erm, which was really strange at the time and I was sort of a teenager myself and I didn't, didn't really like it but then I didn't mind it	looked after children present strange to be around cic, didn't like it	Growing up with foster children in family home was part of life
and then sort of accepted it and then it became the norm.	being around LAC became the norm	
and then I went travelling when I was sort of uni age and came back and need a job.	needed a job after traveling	
And my mum being a foster carer said 'well you know they're looking for people in children's services to just spend time with young people and be a bit of a mentor role.	Mum prompted me to work within children's services	
So I was quite naïve and said 'yeah yeah I'll give it a go' and that was about 15 years ago, and it kind of went from there.	Working within area for 15 years	
So at the time my role was a support worker for foster carers who had young people erm and it was a bit of a jolly, it wasn't really anything meaningful and I remember thinking 'this doesn't feel right, like these kids should be doing something	worked as a support worker to foster carers role lacked meaning which didn't feel right	Wanting a more meaningful job with children in care

Transcript	Initial notes	Themes
education or have a bit more then me just taking them out for a jolly everyday'.	felt that the children should be doing more such as education	
Erm so I spoke to my manager about that and said this isn't for me I need to be doing something more worthwhile with them really and and direct.	wanting to do something more worthwhile within LAC	
So I joined a team where I became a family support worker which was a crisis intervention team so it was working with families directly and young people that were on the verge of being accommodated. So it was when families were saying I can't cope anymore or there was huge dysregulation or absconding, you know drug use self-harm.	joined crisis intervention team as a family support worker working with families and young people who were at risk of being removed from family supporting families who would not cope support with range of issues	Working in different ways with families in crisis in previous role
And I would go in directly to work with the parents and really throw everything we had at it to try and keep the kids at home because that fundamentally for most kids is the best place they can be.	working directly with parents to keep family together	
So that led to me being part of a lot of child protection conferences	attending child protection conferences	
and doing a lot of therapeutic work which I then went onto train as a counsellor and in CBT cos that was my interest	engaging in therapeutic work and training in counselling and CBT	
and things like attachment theory became really crucial. I I remember thinking 'all these families are kind of similar and these young people have got similar behaviours but what is it?	feeling that attachment theory became important to understand	Engaging in and valuing therapeutic approaches and theory with children in care
Why am I going into this?' and actually it was about attachment theory. And when I learned what that was I was like 'oh ok this is why this is all happening' so im really passionate that actually that is the fundamentals that all people working with	using attachment theory to understand what was happening for families	

looked after children should have and that's part of the training we do here.	feeling passionate about knowing the basics that people working with children in care should have	
So I did that for about 13 years and then I left that because I kept going back to panel and going back to the managers and saying to children's services this family needs support or this family needs more and a lot of the responses I was getting was 'just close the case', and that didn't sit right with me at the time. Erm and that was a lot a lot about resources and XXXXX	Left crisis intervention role due to frustration and having to finish cases	
Council was inadequate at that point, so everything was really In disarray really, social workers were doing their best but struggling. So I thought it's just not right for	Just closing cases did not sit right with me	Leaving crisis intervention role as it didn't fit with my way of working for children and families (values)
me, I can't not be doing something useful for the kids. so I then um went to a private organization which is called XXX child	lack of resources that contributed to general inadequacy and disarray	
care services and they are two social workers that broke away from children services and the local authority	This work isn't right for me Needing to something useful for LAC	
about 10 years ago and opened their own home. And it's had it's like 11 year as an outstanding children's home and it is amazing so. The principles of it are all	Joined a private organisation	
dyadic developmental psychotherapy based which is DDP. Don't know if you	Private organisations set up by social workers	
know that Dan Hughes? And that's the key to the kids that we look after um and XXX have got three or well three homes now and a school cause they appreciate the importance of Education and their purpose	Follow DDP principles	Working in a LAC organisation that values education and supporting of children
is to repair and young children to be able to get into a place where they can go into	Organisation appreciates importance of education	

a foster home which is what all of these kids need is that you know a foster home but they're just not available. So um I worked there for about three years and I was the lead of the therapeutic work, so I did a lot of life story work with them, which was brilliant because it was littleies that needed to make sense of where they had been and what was happening and what was coming next so did a lot of work with families and the young person.	helping children return to foster placements Kids need a foster placement Doing a lot of therapeutic work and life story work Life story work helped young children to make sense of their lives Worked with young people's families too	Work towards integrating children back to foster care Using therapy skills in work with children in residential setting
And then erm that was quite tiring because the shifts were sleep ins and I just I'm just not a sleep in kind of girl I need to go home and get to my own bed erm and actually my mum died around the same time and I just said it I just need to do what's right for me, which is going to be structure routine, have my tea go to bed. That's what I'm going to need to get through this so um, a friend of mine Kay and Gary had been running where I work now which is called Heath Lodge. So XXX started about 10 years ago. And was a B&B and Kay and Gary ran it, but at the time children services and the local authority was placing 14 year old girls here and that should not have been happening. That wasn't OK, but that's how desperate the services were and they really quickly sort of realized that these kids that were coming in couldn't just have bed and breakfast, they needed emotional support and stability.	This role was tiring due to shift patterns which do not suit me Mum passed away at this point which was important in highlighting the need to do what is right for me I need structure and routine Local B&B used by local authorities to house adolescent children in care Services desperate to accommodate children Realisation that children needed more than a bed	Needing to prioritise own needs, structure and routine in work

Transcript	Initial codes	Themes
So they gave up, XX had another job at the time and they lived here, so it's quite a big house its like a big bungalow and XX and XX lived at the back of the House with their own children who were littleies at the time and had four young people and specifically worked with children services to become semi independent.	Children needed support and stability B&B owners worked with local services to become semi independent	
So I have about 3 no about four years ago now, they moved out because their kids were getting older and that just wasn't working. Having 4 teenagers in such high needs with their teenagers in the same house um you know when the kids were missing and that was taken them away from their own kids. So they move just around the corner and they decided to take on a staff team. So that's really been what the last five years has been is getting this team, we've got a team of 13 now who are just brilliant and um me as a manager Joe he's in the background might see her here, she's also previous foster care. She's our team leader and Kay and Gary who who run the home and it's 16 teenagers. Uhm, it's a really challenging job, but it is absolutely the most needed because the teenagers we've got now are the little kids have had all of the moves and all of the really horrible family experiences. And now somehow they've gotta get ready at 18 to move move on on their own. So we have between six months	Accommodating cic with own children was difficult for owners Owners recruited staff team Larger team that I am part of as manager Challenging but needed job Working with teenagers who have had difficult family experiences	Working in a challenging role with teenagers

to two years depending on what age we get them to work with them, With the balance of working towards independence but also therapeutically around the trauma that they have experienced. So yeah, that's me in a nutshell	Work with them for up to two years Helping cic work towards independence Supporting cic therapeutically around trauma

Table 2. Example of how model was developed from quotes, codes, memos and theoretical categories

Participant	Quote	Line by line coding	Focused coding	Relevant memo	Theoretical category
Isaac	Respect was sort of ingrained from a young age especially from my mum especially, I mean manners cost nothing. Trying to ingrain that just please and thanks can get get you a long way so better when young people like yeah. Yes, but it's just from growing up,	Having respect ingrained into me from a young age from my mum Tring to ingrain respect into work with young people Respect is from growing up	Values around respect developed in childhood		Early childhood experiences and parental influences shape values and beliefs
Francesca	their parenting style impacted my parenting style. You know, if my parenting style is impacting the way I react in certain situations, I can say that you know they did a good job. I'm hoping that you know their parenting style impacted me. I come from a very caring background and my mom was a full time mum, my dad was in	Being impacted by parenting style of parents Coming from a loving background	Influence of parents in my parenting	Francesca talked about being influenced by parents. They empowered her to achieve, and she implements this in her work with the young people, trying to empower them	Parents influences shape values and beliefs

	the military so we had to travel quite a lot. But you know they were always very, um, I'm the youngest too. So I have two older sisters, so I think I had quite a lot of parenting around me. You know it was a very loving environment was all to do with positive reinforcement. You know, empowerment, you know my parents, an empowered, both myself and my sisters a lot you know, to achieve the outcomes	Being the youngest sibling so had lots of parenting around me Coming from a loving environment Positive reinforcement in childhood Feeling empowered from parents to achieve goals	Came from loving family Feeling empowered by family		
Francesca	And I think since a small age and I told my mom what happened, you know I've always been very honest, very upfront with everything an I think since a very small age I think those those values have always been there, you know	Values have been there from a young age Being honest from a young age My values have always been there	Values were there at a young age	Values around honesty developed very early Values have always been there. Is it hard to define when they developed? Do they develop unconsciously? (**These questions were asked in subsequent interviews**	Values and beliefs developed in childhood
Sarah	My parents were always very much like, you know doing things, but they were always				Childhood experiences and parental influences

	encouraging me to do things for others and be selfless and all that sort of stuff. I don't know. I don't remember a time where I really had to be sort of, reminded, or taught it. I feel like it's just been Just being there and I think The the one the desire to help people and the need like the need to help people 'cause that's more or less what is has always has always been there I think. The. Ability to sort of make anything kind of fun and follow kind of Adapt to situation came from as I said earlier, that being an only child having to sort of make sense	Being encouraged to do things for others by parents Not knowing a time when values have not been there Needing to help others Having to help others has always been there Ability to make anything fun comes from being an only child	Parents influence desire to help Values are instilled at a young age Childhood experiences develop skills	Sarah's values were developed in early childhood, with parents having a massive influence on values around wanting to care for others	shape values, beliefs and qualities

Table 3. Participant Details

	Benjamin	Hannah	Isaac	Elisabeth	Francesca	Sarah	Wendy	Henry
Gender	**Male**	**Female**	**Male**	**Female**	**Female**	**Female**	**Female**	**Male**
Role	**Team Leader**	**Manager**	**Support Worker**	**Support worker**	**Manager**	**Deputy Manager**	**Support Worker**	**Support Worker**
Setting worked in	**Respite**	**Residential**	**Residential**	**Respite**	**Residential**	**Residential**	**Residential**	**Residential**
Parent	**Yes**	**No**	**No**	**No**	**Yes**	**No**	**Yes**	**Yes**

Appendix A

Topic Guide

What is it that influenced your decision to become a residential support worker?

In your role, have you ever drawn from your own personal experiences when supporting the young people youcare for?

Could you share examples of how you have used personal experiences and applying these experiences to yoursupport of children in care?

In what ways do you interact with the children and young people you support? What style or approach do youuse?

What influences the style that you have?

What do you believe to be the benefits or downfalls of drawing from personal experiences in your role?

In what situations does your personal experiences, whether this is of being a parent, or being parented, or otherexperiences, have the most influence in your role?

Appendix B

Example of memo-writing

Interview 1

Stumbling into the role and it not being a long term ambition of mine to work in caring role with children

Drawing from personal experiences of asc and this potentially being an influence on deciding to work in role with children with asc (although driving factor was to seek a completely different career to demotivating office based team)

Being demotivated in a previous office based job and an unpleasant work atmosphere. After this experience there was a need to work in a role that was more interesting. Role with children is appealing because of the variety and fun that can be had within the role. It does not feel like a job at times, due to activities you engage (potentially due to being a 'parenting role which involves different aspects of fun, responsibility) and how it contrast with office based role. Being able to be silly within role and bring humour is a positive of the work

Staying motivated – seeing progress and development of children keeps you going within the role when facing challenges. Role brings a purpose that previous job did not

Being motivated is essential to do this role and there needs to be a level of passion in doing the role

Culture of the team and different qualities and experiences is a motivating factor in remaining in a challenging, underpaid role

The inconsistency of the role, including the different challenges keeps the role interesting

As part of role being governed by policies and procedures in carrying out tasks/duties/responsibilities. There is a focus on providing a safe environment (maybe more consciously than at home with own parents?)

Engaging in a detailed recruitment process which involved understanding individual's beliefs and previous experiences and background which highlights importance and potential influence of personal experiences

Ensuring children and their needs are first and foremost within the role and providing them with a choice and voice to input on things

Training has been important in developing ways to interact with and support children. Training is extensive (a different layer to personal experiences), training is key to developing as a person and has resonated with and challenged my own understanding, experiences and perception. In certain situations training knowledge over rides everything else in terms of influence – managing complex health issues

Managing personal struggles whilst working is part of the job, and there is a reliance on support of team to help you through that.

Interview has enabled reflection on what influences interactions and ways of working in a way that hasn't happened before

Values – it is important that individual values and beliefs marry up to those of the wider team and the service. Sharing values as a team helps to gel and work together as a unit

Bringing humour and fun to the role

Reflecting on own childhood experiences and comparing that to the experiences of children in service develops a sense of feeling humbled and grounded and shapes the way I work in ensuring needs of the children are met

Drawing from own experiences as a parent enables increased understanding and add skills needed for the role such as being patient in managing different scenarios

Nothing in particular is influential on interactions with children – a mixture of professionalism, adhering to polices, working as part of a team and bringing your own personal qualities and values to the team. A combination of these influences shape your interactions

Level of commitment needed stems from own childhood experiences and values instilled at a young age, going above and beyond in role and this being a long term value that is used or applied in the role

Appendix C – Guidance for Publication in the Child Psychology and Psychiatry Journal

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    1.1 Aims & Scope
    1.2 Article types
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2. Editorial policies
    2.1 Peer review policy
    2.2 Authorship
    2.3 Acknowledgements
    2.4 Funding
    2.5 Declaration of conflicting interests
    2.6 Research ethics and patient consent
3. Publishing policies
    3.1 Publication ethics
    3.2 Contributor's publishing agreement
    3.3 Open access and author archiving
4. Preparing your manuscript
    4.1 Formatting
    4.2 Artwork, figures and other graphics
    4.3 Supplementary material
    4.4 Reference style
    4.5 English language editing services
5. Submitting your manuscript
    5.1 ORCID

5.2 Information required for completing your submission
5.3 Permissions
6. On acceptance and publication
6.1 SAGE Production
6.2 Online First publication
6.3 Access to your published article
6.4 Promoting your article
7. Further information

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Back to top

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Back to top

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Back to top

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Back to top

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Back to top

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Back to top

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Email: dr.rkaramatali@gmail.com

Chapter 3 : Critical Appraisal

Mike Heyes

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

All correspondence should be sent to:

Mike Heyes

Doctorate in Clinical Psychology

Faculty of Health and Medicine

Health Innovation One

Sir John Fisher Drive

Lancaster University

Lancaster

LA1 4AT

m.heyeyes@lancaster.ac.uk

Critical Appraisal

The aim of this thesis was to focus on frontline workers supporting young people in settings such as residential homes and respite settings. The systematic review highlighted the prevalence of burnout and compassion fatigue amongst frontline staff. This review identified a range of factors that correlated with burnout and compassion fatigue or were seen to be predictors or protective factors. This systematic review demonstrates that people within these roles are susceptible to high levels of burnout and compassion fatigue, comparable to levels in other caring professionals, such as nurses.

The empirical paper offers a theory of how the participants' personal life experiences may influence them within their role working with children in residential settings. A grounded theory approach was used to demonstrate how personal experiences and work-based influences mix to shape their way of working. It was suggested by participants that personal experiences, whether these be childhood experiences or newer experiences such as becoming a parent, were key in developing values and beliefs that influence reasons for entering the roles and ways of working. Work-based influences, such as training, colleagues and adhering to policy, interact with those personal values and beliefs, at times consolidating individual beliefs and at other times expanding upon these to help the individual grow and develop within their role. Participants shared that they were sometimes required to work in ways that conflicted with their personal beliefs where they felt unable to change or challenge plans and policies. Although participants felt frustrated about this, they learned to accept it as part of their role.

This research highlights the need for staff support around the impact of their personal experiences and their work with children. It also highlights opportunities for reflective space and training for staff teams.

Processes of the Research - Strengths and Limitations

Participants. In the empirical paper, participants' roles ranged from support worker to manager, ensuring that professionals involved had a lot of direct involvement with the children being supported. One potential criticism of the paper is the inclusion of participants from respite settings for children with autism spectrum condition (two) as well as from residential homes with children in care (six). Although there are similarities across the settings that make the whole sample appropriate, in terms of general responsibilities, such as caring for the children, the general make up of staff teams, shift work and different challenges of the role, there are differences that need to be highlighted. For example, children's residential homes will generally consist of smaller numbers of children who live at the home, with these children often coming from a background of neglect and trauma (Narey & Owers, 2018). In comparison, although the respite services of the two participants provide care for children over a long period, the children do not live in these settings on a permanent basis, with children ultimately remaining in the care of their guardians. Although the children they support also require a high level of support, their needs may be different in terms of increased medical and health needs, which will change the role of the support worker. Staff members in these settings may work with a higher number of children as they may need support at different times. With these differences it could be said that any suggestions or recommendations specifically for one setting may not apply as fully to the other. However, the research aimed to understand influences on ways of working with the young people. In both settings, this work revolves around the core tasks of building relationships with young people, ensuring they remain safe and helping them thrive. Workers in both settings are asked to bring their personal characteristics to their role, whilst remaining professional and ensuring they meet certain standards. The decision to include respite care staff only added to the study by highlighting similar themes across different contexts and settings.

Another influence on sampling was recruiting via links that the field supervisor had made through their role as a clinical psychologist, offering formulation and training to the potentially

involved services. This is important to consider as a limitation for the study when thinking of participants representing the wider context of working with young people in these settings, as other workers in similar settings would not have this level of support or input and may have brought differing reflections. That being said the research was also shared via social media platforms to widen recruitment with three participant recruited this way.

Methodological issues. The study included only eight participants were involved, which raises the question of whether this was sufficient to achieve ‘theoretical sufficiency”, that is the point in data analysis where no new ideas or themes are emerging. In the current study the final sample size was deemed appropriate after the analysis of the second round of interviews was carried out as no new themes were emerging. However, the rigour of the research process and the validity of the findings could have been tested and further strengthened by the use of triangulation. A realistic triangulation method might have been to run a focus group of staff already interviewed after the initial collection and analysis phases.

The stressors of COVID and the impact this may have had on ways of working within children’s settings, may have added extra responsibilities to workers’ roles, thus making them less available or less inclined to engage in research. This is important to consider when thinking of representation of staff teams within the participant sample. Steps were taken to ensure that whole staff teams were targeted for recruitment, with information about the research being shared at staff meetings and via e-mail across teams and services. One way to add to this would have been for me to attend team meetings and speak in more detail about the research, and to speak to managers about allowing participants to engage within work time. Unfortunately due to COVID restrictions I was unable to attend team meetings

This study can be said to offer new insights into the ways staff members work with children in residential settings. As stated within the empirical paper itself, the current research expands on previous research (Moses, 2000) which highlighted personal experiences as being

key in support workers' decisions to work in residential care settings. The current research expands on this by exploring the influence of personal experiences whilst within the role. This paper thus fulfils the principle of originality laid out by Charmaz (2014). It should be said that this field is generally under-researched, which highlights the further potential for new, original and useful research to be undertaken.

Charmaz (2014) also refers to grounded theory research needing to have resonance, referring to how much the study is reflective of the full studied experience, and the extent to which the findings could be said to resonate with the participants themselves or with others in similar circumstances. Whilst I believe that the theory developed has resonance in that it stays close to the experiences of the individual participants, this could have been bolstered by giving participants the opportunity to reflect on the preliminary findings, allowing them an opportunity to elaborate further on their previous points, or to reflect on their experiences further. This would have helped to validate the findings and increase study resonance. I was unable to carry out second interviews due to time constraints of the thesis.

Charmaz and Thornberg (2020) refer to grounded theory research needing to be useful within the everyday worlds of the settings being studied by contributing to knowledge and offering positive solutions for the studied area. The current study has value in terms of highlighting potential areas in which support workers could benefit from support. For example, the findings highlight how important personal experiences are for workers within their role and that this has implications for workers and children and, importantly, for the organisations in which they live and work. The influence of personal experiences is something that is potentially recognised by some organisations that provide care to children in residential settings, with several participants alluding to interview processes for their role exploring and valuing their personality, beliefs and values. I am hopeful that I can refer to or draw from my research project in future clinical work, in which I will be involved in supporting staff teams from residential

settings. I have presented the results of the study at a conference attended by many children in care services, and now have a role working as a Clinical Psychologist in residential care and will be shaping the psychological support that they receive.

Reflections on COVID. During the interviews COVID naturally came into conversation, in a more general sense when talking about the impact of working in this situation. However, COVID itself was not indicated by participants as being a big influence on their role, apart from one example of adhering to plans and policy, some of which had been put in place due to COVID. It is possible that the roles of workers were impacted upon less than anticipated or less than other caregiver roles. In discussion with my supervisors I decided not to actively explore participants' experiences of working during COVID as it was felt that this would shift the focus of the research. Additionally, I wanted the potential theory or model to make sense and be relevant in a post-COVID world.

Despite these limitations, I believe that the methods used across both papers were effective in answering the questions asked. For the empirical paper, the benefit of using grounded theory was the iterative process of data collection and analysis, which helped to shape the focus of later interviews. This was key in identifying underlying values and beliefs as shaping ways of working for the participants. If another approach had been used, the transcribing and coding process may have occurred on completion of all the interviews, which might have led to important elements of the developed model being missed. For the systematic literature review, a narrative synthesis was useful to highlight the vast range of predictive factors for burnout and compassion fatigue. A more specific review process such as a meta-analysis would not have been possible due to the differences in what the papers explored and the metholodological approaches used. This literature review was effective in highlighting the potential factors that staff teams and wider organisations could consider when addressing burnout and compassion fatigue.

Why Choose to Research This Area?

I chose to carry out research around children in care and professionals supporting them, for several reasons. Primarily this is an area of interest due to experience of working within private LAC residential services, firstly as a support worker, providing therapeutic care to children within a home, and then as an assistant psychologist. The latter role involved supporting teams across different settings via training opportunities and supporting qualified psychologists in providing formulation meetings and spaces to think of how to meet the needs of the children. This work experience has been important in developing a long-term interest in LAC services and supporting young people. Through my experiences as a support worker I was able to learn more about the needs of children living in these settings, whether this be through interactions with them, training provided or consultations with clinical psychologists.

This experience as a support worker really resonated with me, in terms of fulfilling values I have around wanting to support others and supporting them to overcome challenges, achieve and be well. The work also increased my awareness of the challenges faced within these settings, both for the children and staff teams. There were many aspects of the support worker role that I have often reflected on, both positive and negative, and this has shaped my desire to carry out research that could be of benefit in these settings. Within this role I observed a number of issues that I felt ultimately had an undesirable impact for the children being supported. Unfortunately, within this role I felt that at times there were barriers to achieving this aim of supporting the children being looked after in the best way.

From a personal perspective I found that many of these barriers related to the well-being and perspectives of the staff teams. I found that the team I worked within was passionate about the well-being and care of the children they cared for, but due to, at times, a lack of support, workers became overworked and fatigued, causing a ripple effect of issues such as turnover of staff, traumatic work experiences, detachment from the role or over committing to the role to

plug gaps in staffing. These experiences shaped my beliefs around ensuring the system around children in care is looked after, as that will enable staff within that system to provide the best support to the children they care for. I also found a lack of research relating to working with children in care motivated me to be involved in research opportunities. More research can aid understanding and awareness, which can help with implementing changes and recommendations for the benefit of the whole system, inclusive of staff teams and children.

My Position within the Research and Personal Reflections

With personal experience of working in these settings, which motivated me to carry out research in this area, this was something that I needed to be mindful of in the research process. A social constructionist stance was adopted, in keeping with Charmaz's version of grounded theory (Charmaz, 2014). Constructionism as a stance suggests that the process by which the observer creates reality giving meaning to what is observed (Von Glasersfeld, 1984). This means that reality is constructed subjectively through the individual's active experience of it. Social constructionism extends this by acknowledging the influence of experiences or stories within the larger society on the individual, whilst also suggesting that knowledge and reality are created through social interactions. When thinking of social constructionism within research, this differs as an epistemological stance to other viewpoints such as positivism, in that within social constructionism the researcher is part of what is being observed rather than being an objective observer. As stated, constructivist grounded theory (Charmaz, 2014) acknowledges the researcher and their experiences as being part of the observed experience. As a stance, this is something that I have found fits with my own views on interactions and the observer's presence and views being involved in that process. This can even be said of my views of clinical work, in which although I aim to take a not knowing, non-expert position, my own experiences and my interactions will have some influence, both on what is being discussed and my interpretation of this. Using this approach, it was important that throughout the research process I acknowledged

my preconceived biases and beliefs and how they could impact on the findings. In preparation for research, whether it comes from a personal experience as in my situation or not, researchers will read the relevant literature and shape their own opinions based on this. I feel that a social constructionist stance fitted my position as a trainee clinical psychologist with prior experience in the area I was researching, as it helped bring awareness to my role in shaping the interviews and the wider research process. . Sharing my experience in residential settings was at times useful to build rapport with participants, and was useful in understanding more about what was being said by participants, particularly around role specific duties such as safeguarding or supporting family contact.

There were things that I did to attempt to minimise the impact of my interests and ensure that the findings are grounded in the data. I used memo writing for a variety of purposes (Charmaz, 2014). One way in which I used this was to reflect on my experiences and their similarity or difference to those of the participants. This helped me in ensuring that I did not make assumptions and could also ask about these experiences with other participants yet to be interviewed. I checked codes and focused codes with the data, and once the model was developed, I also compared this with the data to ensure that it was representative of participant experiences, rather than my own thoughts and beliefs, which can be seen in the appendices of the empirical paper. Other measures to help minimize the influence of biases and assumptions included discussing this with research supervisors, identifying potential biases that I had to be aware of (for example, my own assumptions around the benefit of observing colleagues). I also listened back to interviews and made a note of follow-up questions I could have asked to explore topics raised by participants in more detail and used these in later interviews, to ensure that my understanding came from the data as much as possible.

I would also like to acknowledge the emotional impact of this work in relation to my role as a father of young children. The nature of the interviews being very personal and requesting

participants to share experiences of parenting and their values around this. This did lead to some personal reflection around my own experiences of parenting, in terms of my own approaches to situations, and values that I try to hold within my role as a parent. I did reflect on how I would have potentially approached young people when I worked in my role as a support worker, and this enabled me to ask participants if they had similar experiences. For example, I thought the experiences of parenting my own children and how this has helped me to think about some of the differences in approach that children in care may need, such as a difference in boundary setting and needing to potentially focus on building trust with children in care. This reflection particularly helped with the interview I had with Francesca who had become a parent whilst in her role, and shaped some questions I asked.

Crossover Between the Systematic Literature Review and Empirical Paper

Focusing my systematic literature review on burnout and compassion fatigue of workers who supported children in residential settings was also a decision that was influenced by personal experiences and beliefs relating to this. As stated, in my role as a support worker I worked with professionals who committed themselves to their role, which at times left them feeling over committed, stretched and fatigued. I witnessed passionate members of staff teams become disenchanted with their role, and at risk of burnout.

Although the systematic literature review primarily focused on burnout and compassion fatigue, the risk of burnout is also highlighted within the empirical paper. Within my discussion I highlighted the benefit that interviews had in reminding participants of their reasons for entering the role.

It was also interesting to hear participants in the empirical paper highlight their colleagues and a positive working culture as reasons for remaining in their role. Peer support or managerial support was highlighted within the systematic literature review as being a protective

factor against burnout or compassion fatigue. Equally, I have highlighted training and support in both papers as being a potential positive influence on workers, which is supported by Çatay and Koloğlugil (2017), who highlighted training as being positive for participants in terms of reducing the risk of burnout and increasing knowledge. The empirical paper and literature review potentially provide support for a greater focus on providing training to staff teams across the country.

Future research and work

A key message that should be taken from the empirical paper and literature review in combination is the potential for dissatisfaction with work environments and burnout amongst staff. Future research, or organisations working in this sector, could look to implement training that aims to support staff teams and improve their knowledge and ability to provide good care, and use evaluation tools to measure the impact of this, both on staff well-being and that of the young people being supported.

It should also be noted that the model developed from the empirical paper is based purely on the views of just eight participants. Future work could involve sharing this model with wider organisations and asking for feedback on this, checking with staff teams if this resonates with or reflects their experiences. This can help to increase confidence in the clinical implications being suggested.

Final thoughts

Undertaking this research has reaffirmed my belief that support of staff teams, whether in this context or other settings such as NHS services or education, is pivotal in ensuring people are receiving the best care possible (Foster, 2021; Hewison et al., 2018; Sizmur & Raleigh, 2018). During my training in clinical psychology I have developed a sense of how clinical psychologists can play an important part in delivering this support, and view it as an essential

aspect of our role going forward as a profession. I appreciate the importance of psychological therapy and direct work with service users, but in many instances, particularly for groups such as looked after children, it could be stated that time would be best invested in supporting organisations and systems around children and adolescents in residential homes. For children in care, who are often faced with barriers in accessing mental health services (Shaw & De Jong, 2012; York & Jones, 2017), it could be said that influencing the environment around them is even more important. This can include providing a stable placement (Barber & Delfabbro, 2003; Carnochan et al., 2013; Vanderwill et al., 2020; Webster et al., 2000), encouraging development) and helping to recover from trauma, all of which have positive outcomes for children in care and it could be stated are more of a priority than any offer of therapy or one to one direct work from a mental health clinician. Silver, Golding, and Roberts (2015) suggest one way that psychologists can provide input is at an organisational and systemic level, with further input into training for staff and, when needed, direct therapy for the children being supported. Psychologists can support staff teams with their understanding of attachment and its implications, not only in relation to the young people, but the different needs of members of the team. Different members of teams will bring with them not only their personality and values but their own attachment styles and needs which need to be considered when thinking of support. Psychologists can play an important role in this, through supervision and liaising with teams, whilst organisations can prioritise and aim to operationalise values-based frameworks, i.e., identifying a set of values and a vision of the organisation that can then help shape recruitment and support for staff teams and individuals to work to.

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Table 1. Example of reflective memo-writing

Interview 4

Drawing from personal experiences is natural and not something that is consciously done

Resources and procedures can take precedent and dictate how we work on shift, both directly with children and in other aspects of work. risk assessments and other basic elements of routines of the day are a priority

Feeling role is fun

How you approach children is dependant on them more than you and what you bring in role

Certain qualities develop whilst in the role and learning from other colleagues. These have included being more boundaried and managing difficult situations. Leaning on each other as a staff team to bring different skills and qualities for the benefit of children, whilst also trying to remain consistent as a team. Another quality that develops in the role is patience and perseverance to keep engaging with different challenges that can be faced in the role.

This comment made me think of my own experiences as a support worker and what I needed to develop as the role progressed, including perseverance and patience. It is making me think of resilience and putting in boundaries or structure and parenting skills developed within the role. I am wondering if this is a common experience for new people in this area, particularly those who are not parents?

Adaptability is a crucial quality to working in this line of work and is something that is developed within role as you come to terms with unpredictable nature of day to day life in the service. This includes adapting to change of plans and interactions with the children.

A difference between this role and personal experiences is a need to remain professional, and having that balance between professionalism and having fun is important.

Within the role there is a need to hide own stress from the children which maybe fits with need to remain professional?

A lot of values that are important for the role are developed in childhood and how I was treated as a child. Caring nature is drawn from my experiences of being parented

Try to enable children to be empowered and have a choice and opportunities to decide what they want to do. This comes from experiences of being parented

Learning from colleagues is crucial to being effective in role as support worker and skills learned here are a part of how interactions with children occur

Comparisons between own upbringing and difficult life experiences of children enable empathy, understanding and ideas of how to provide a positive ‘home environment’ for the children

Different qualities that are brought into role – humour, team ethic, community spirit are all important in developing relationships with the children and understanding of this developed in own childhood experiences

Chapter 4 : Ethics Section

Mike Heyes

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

All correspondence should be sent to:

Mike Heyes

Doctorate in Clinical Psychology

Faculty of Health and Medicine

Health Innovation One

Sir John Fisher Drive

Lancaster University

Lancaster

LA1 4AT

m.heyes@lancaster.ac.uk

Health & Medicine | Lancaster University

Faculty of Health and Medicine Research Ethics Committee (FHMREC)
Lancaster University

Application for Ethical Approval for Research

Title of Project: Influences on support workers' approaches to caring for children in care

Name of applicant/researcher: Mike Heyes

ACP ID number (if applicable)*: **Funding source (if applicable)**

Grant code (if applicable):

***If your project has *not* been costed on ACP, you will also need to complete the Governance Checklist [link].**

Type of study

☐ Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. **Complete sections one, *two* and four of this form**

☒ Includes *direct* involvement by human subjects. **Complete sections one, *three* and four of this form**

SECTION ONE

1. Appointment/position held by applicant and Division within FHM Trainee Clinical Psychologist

2. Contact information for applicant:

E-mail: m.heyes@lancaster.ac.uk

Telephone: 0787 666 8452 (please give a number on which you

Address: Doctorate in Clinical Psychology, C16 Furness College, Lancaster University, Bailrigg, Lancaster, LA1 4YG

3. **Names and appointments of all members of the research team (including degree where applicable)**

Mr Michael Heyes - Trainee Clinical Psychologist, Studying for DClinPsy

Dr Suzanne Hodge - Lecturer in Health Research, Lancaster University

Dr Clare Dixon - Clinical Tutor, Clinical Psychology, Lancaster University

Dr Sue Knowles Consultant Clinical Psychologist and Child Family Lead, Changing Minds UK

3. If this is a student project, please indicate what type of project by marking the relevant box/deleting as appropriate: (please note that UG and taught masters projects should complete **FHMREC form UG-tPG**, following the procedures set out on the FHMREC website

PG Diploma ☐ Masters by research ☐ PhD Thesis ☐ PhD Pall. Care ☐

PhD Pub. Health ☐ PhD Org. Health & Well Being ☐ PhD Mental Health ☐ MD ☐

DClinPsy SRP ☐ [if SRP Service Evaluation, please also indicate here: ☐] DClinPsy Thesis ☒

4. Project supervisor(s), if different from applicant:
Dr Clare Dixon, Clinical Tutor, Clinical Psychology, Research Supervisor
Dr Suzanne Hodge, Lecturer in Health Research, Clinical Psychology, Research Supervisor
Dr Sue Knowles, Consultant Clinical Psychologist and Child and Family Service Lead, Field Research Supervisor

5. Appointment held by supervisor(s) and institution(s) where based (if applicable):

Dr Suzanne Hodge, Lecturer in Health Research, Lancaster University
Dr Clare Dixon, Clinical Tutor, Lancaster University
Dr Sue Knowles, Clinical Psychologist, Changing Minds UK

SECTION TWO
Complete this section if your project involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants

1. Anticipated project dates (month and year)
Start date: End date:

2. Please state the aims and objectives of the project (no more than 150 words, in lay-person's language):

Data Management
For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk

3. Please describe briefly the data or records to be studied, or the evaluation to be undertaken.

4a. How will any data or records be obtained?

4b. Will you be gathering data from websites, discussion forums and on-line 'chat-rooms'
4c. If yes, where relevant has permission / agreement been secured from the website moderator?
4d. If you are only using those sites that are open access and do not require registration, have you made your intentions clear to other site users?

4e. If no, please give your reasons

5. What plans are in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

6a. Is the secondary data you will be using in the public domain?

6b. If NO, please indicate the original purpose for which the data was collected, and comment on whether consent was gathered for additional later use of the data.

Please answer the following question *only* if you have not completed a Data Management Plan for an external funder

7a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

7b. Are there any restrictions on sharing your data?

8.**Confidentiality and Anonymity**
a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications?
b. How will the confidentiality and anonymity of participants who provided the original data be maintained?

9. What are the plans for dissemination of findings from the research?

10. What other ethical considerations (if any), not previously noted on this application, do you think there are in the proposed study? How will these issues be addressed?

SECTION THREE
Complete this section if your project includes *direct* involvement by human subjects

1. Summary of research protocol in lay terms (indicative maximum length 150 words):

The research is aiming to explore the influence of personal experiences of residential support workers on their direct work with children in care. Within this line of work residential support workers receive training, amongst other support systems such as consultation and supervision, that is aimed to shape the way they care for looked after children. However, there is little research that looks at whether personal experiences, such as being parented or being a parent, influence this.

This research will consist of semi structured interviews with residential support workers exploring what, if any, influence their personal experiences has on their work. The data from this will be analysed to explore emerging themes around participants' experiences.

2. Anticipated project dates (month and year only)

Start date: March 2020 End date August 2021

Data Collection and Management
For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk

3. Please describe the sample of participants to be studied (including maximum & minimum number, age, gender):
Participants will be residential support workers working within children's residential care provisions, supporting children in care. Participants will be of any gender and potentially any age above the age of 21. The number of participants will be between 10 and 15.

Participants will be English speaking due to the practicality of carrying out the research and limited funding. Participants will be recruited from children's residential companies based in the North West region of England, again due to practicality of carrying out the research within the required timeframe.

Participants will be included if they have been working as a residential support worker for at least one year. This is in part due to having experiences to reflect upon and discuss in interviews, and also the interview will explore what it is that drew individuals to these roles and why they have stayed in what can be described as highly

demanding and challenging roles.

4. How will participants be recruited and from where? Be as specific as possible. Ensure that you provide the *full versions* of all recruitment materials you intend to use with this application (eg adverts, flyers, posters).

Participants will be recruited directly through links with the residential companies that they are working for, which will be companies based in the North West region of England. These companies are likely to be private residential companies, as the researchers have links with staff teams within these. Leaflets will be provided to potential participants, via their team managers, as well as potential opportunities to meet staff teams on a face to face basis for recruitment purposes.

Participants will be able to confirm their participation through these face to face meetings, as well as via e-mail or telephone call directly to the researcher. This will help in maintaining confidentiality.

Participants may also be recruited in the UK through social media outlets such as Twitter and contacting social media groups for Residential Support Workers. The study will be advertised using a professional twitter account which will direct potential participants to the participant information sheet. The participant information sheet will provide potential participants with contact details including e-mail, telephone and Twitter, which they can use to discuss the project. The researcher will arrange interview dates and location with the participants.

5. Briefly describe your data collection and analysis methods, and the rationale for their use.

A qualitative approach will be used, as this proposed research is aiming to explore experiences of the participants, in this instance support workers within residential care provision for children in care. Semi structured interviews with residential support workers will be audio recorded. For those being recruited through links to residential companies in the North West of England, these interviews will take place face to face, where possible, with the option of also being by video call. For potential participants recruited via social media outlets, the interviews may take place in person, via telephone or video call.

These recordings will then be transcribed and analysed using grounded theory, from a constructivist stance (Charmaz, 2006). This approach has been used as it is an exploratory method that is aiming to generate theory from the data. This is key as there is no previous research in this area, meaning that this research project will be generating new concepts and theories, making grounded theory a relevant and appropriate method to use.

6. What plan is in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc.)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

Data will be stored within the University approved secure cloud storage. Electronic participant identifiable information will be stored under the main researcher's account on the university storage system. This will be deleted following examination of the project.

Hard copies of the consent forms will be kept by the main researcher in a secure lockable cabinet. Again, this data will be destroyed by the researcher following examination of the project. Consent forms will be scanned and stored alongside the rest of the electronic data. These forms will be saved for ten years and destroyed along with the transcripts.

Electronic data will be stored on the account of the main researcher, in the university's secure online storage system. Once the research project has been completed and examined, the encrypted transcriptions, alongside scanned consent forms, will be sent securely to the Research Coordinator who will save the files in password protected file space on the university server. The research coordinator will then delete this data after ten years, as recommended by university procedure. There will be a different process for audio recordings, highlighted below.

7. Will audio or video recording take place? ☐ **no** ☒ **audio** ☐ **video**

a. Please confirm that portable devices (laptop, USB drive etc) will be encrypted where they are used for identifiable data. If it is not possible to encrypt your portable devices, please comment on the steps you will take to protect the data.

Recordings will be uploaded directly to the University storage area as soon as possible after interviews have taken place.

There will be approximately 10 to 15 recordings, each of which will be around one hour in length. However, the data will not reach or exceed 100GB.

b What arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

Audio recordings will be stored until the research has been examined, and potentially following publication, which would be in the Summer of 2021. At this point all recordings will be deleted.

Please answer the following questions *only* if you have not completed a Data Management Plan for an external funder
8a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

Data will be stored with the research co-ordinator with restricted access post publication, subject to the conditions below

8b. Are there any restrictions on sharing your data ?

Due to the small sample size, even after full anonymization there is a small risk that participants can be identified. Therefore, supporting data will only be shared on request via repository. Access will be granted on a case bycase basis by the Faculty of Health and Medicine via the research supervisor.

9. Consent
a. Will you take all necessary steps to obtain the voluntary and informed consent of the prospective participant(s) or, in the case of individual(s) not capable of giving informed consent, the permission of a legally authorised representative in accordance with applicable law? yes

b. Detail the procedure you will use for obtaining consent?

Consent will be taken at the point of agreeing to participate via reading and signing a consent form. The potential participants will have had the opportunity to read the information sheet prior to giving their consent, as part of the initial recruiting process. As part of this initial recruiting process the main researcher will provide information to staff teams through their team managers or by attending team meetings to share participant information sheets. Those who are wanting to participate will be able to contact the researcher directly to maintain anonymity. The researcher will arrange to meet and discuss the research and gain consent before agreeing another time and date to carry out the interview.

This consent form will inform the participant that they have the right to withdraw at any point before or during the interview (and up to two weeks after), something I will remind them of during the semi structured interview. Consent will be taken by the researcher. Completed consent forms will be scanned onto the secure storage system for Lancaster University and stored until the research has been examined.

10. What discomfort (including psychological eg distressing or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks. State the timescales within which participants may withdraw from the study, noting your reasons.

As the research involves asking participants about their personal experiences this may lead to discussion of sensitive topics and/or distress. Due to this, participants will be provided with contact details of relevant services that can be contacted if required.

In addition, participants will have the option to withdraw from the study and will be informed of this as part of the information sheet. Participants are free to withdraw from the study at any time before or during the interview, and up to two weeks after the interview has taken place. Participants will only have a maximum of two weeks to withdraw after interview due to time commitments dedicated to transcribing and analysing for the researcher and the requirements to submit the project an appropriate time.

11. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, noting the support available to you; counselling considerations arising from the sensitive or distressing nature of the research/topic; details of the lone worker plan you will follow, and the steps you will

In terms of risk to the researcher, consideration will be given to time and location of the interviews taking place. Interviews will take place away from residential sites at another location such as the company head office. If this is unavailable, interviews will take place at another location such as a children's centre. Interviews may take place outside of the participant's working hours. This will result in zero contact with children in care and the potentially challenging behaviours that residential support workers face within their role. The lead research will be supplied with a Skyguard device, a personal safety service for lone workers approved by Lancaster University to protect them in case of an emergency. It will be the lead researcher's responsibility to create a Skyguard account prior to borrowing one of the devices from the Faculty of the Health & Medicine. The lead researcher will then be responsible for activating the device in case of emergency, so that relevant authorities can be alerted.

It may also not be possible to conduct interviews in person. In this instance, interviews will be carried out via safe and secure online interviewing video call. This can be done with all participants recruited, if needed. This would help in reducing some levels of risk to researcher.

In terms of the work being carried out, the main researcher will follow the guidelines set out by Lancaster University. As part of this process the researcher will leave details of the interview, such as time, location, expected duration, with a fellow trainee from the DClinPsy course. The researcher and fellow trainee will set an agreed time for the researcher to contact them, with the researcher doing so once the interview has ended. If this contact does not take place, the fellow trainee will attempt to contact the researcher via telephone, e-mail or text. At this point if there is no response the fellow trainee will alert the university and provide details of the interview, whilst also contacting the relevant authorities.

12. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.

There will not be any direct benefits to participants as a result of this research. However, participants may potentially find the process of sharing their experiences to be a positive, whilst the longer-term impact of the study could have an impact on different aspects of the role of a residential support worker working directly with children in care.

13. Details of any incentives/payments (including out-of-pocket expenses) made to participants:
None

14. Confidentiality and Anonymity
a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications?
yes
b. Please include details of how the confidentiality and anonymity of participants will be ensured, and the limits to confidentiality.

The research will not require names to be used in any public domain, whilst transcriptions of audio recordings will use pseudonyms, maintaining anonymity. Full confidentiality cannot be promised, as direct quotes may be used in future publications. However, these quotes will not be attributed to individual participants, thus they will remain anonymous.

Consideration will also be given to the fact that participants will be selected from a small pool of residential support workers. Again, this will be managed by not directly attributing quotes to individual participants and keeping these participants anonymous in any future publications. In addition the names of any residential companies that participants are employed by will not be published, with reference to the type of company and location (i.e a private residential company in the North West region).

The limits of confidentiality will be explained to each participant at the beginning of each interview and will also be addressed within the consent form. If a disclosure takes place which indicates any safeguarding or malpractice issues then confidentiality will be revisited and the interview will be terminated. This issue would then be reported to supervisors and relevant safeguarding procedures would be adhered to. Types of disclosures that could result in confidentiality being broken include harm to self or to others. If a participant was to disclose child abuse in their life or elsewhere, the interview will be terminated, and the individual participant will be made aware that the information would need to be shared with research supervisors and appropriate safeguarding professionals.

As previously established, the researcher will conduct interviews offsite. This will help in maintaining anonymity as other professionals from the team do not need to be made aware of the individual participants' involvement in the study.

Interviews will be transcribed by the main researcher, whilst supervisors will have access to transcriptions.

15. If relevant, describe the involvement of your target participant group in the *design and conduct* of your research.

I have accessed support from a former residential support worker and current deputy manager of a residential care setting. In terms of their input, they reviewed the interview schedule and gave feedback on the appropriateness of the questions asked. They also shared their interest in the research in general and stated that it sounds like a useful and relevant study.

16. What are the plans for dissemination of findings from the research? If you are a student, include here your thesis.

The raw data from this research will be seen by the research team members, comprising of the named researcher and supervisors. In terms of dissemination this piece of research will contribute to a thesis as part of the Doctorate in Clinical Psychology.

In addition, it is hoped that a summary of the project will be submitted to a peer reviewed journal for publication, with scope for presentations at training and teaching events.

Participants will also be offered a summary of the findings.

17. What particular ethical considerations, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek guidance from the FHMREC?

The researcher has previous experiences of working as a residential support worker and as such will need to be aware of their own perspectives and experiences throughout the project. This will include remaining impartial and focusing on participants' responses and experiences, and also in terms of raising potentially difficult situations and experiences for them to manage. This will be managed through use of supervision and a reflective diary.

SECTION FOUR: signature

Applicant electronic signature: Date 10/02/2020

Student applicants: please tick to confirm that your supervisor has reviewed your application, and that they are happy for the application to proceed to ethical review ☑

Project Supervisor name (if applicable): Dr Suzanne Hodge and Dr Clare Dixon Date application discussed

Submission Guidance

1. Submit your FHMREC application by email to Becky Case (fhmresearchsupport@lancaster.ac.uk) as two separate documents:

   i. FHMREC application form.
   Before submitting, ensure all guidance comments are hidden by going into 'Review' in the menu above then choosing *show markup>balloons>show all revisions in line.*

   ii. Supporting materials.
   Collate the following materials for your study, if relevant, into a single word document:

      a. Your full research proposal (background, literature review, methodology/methods, ethical considerations).
      b. Advertising materials (posters, e-mails)
      c. Letters/emails of invitation to participate
      d. Participant information sheets
      e. Consent forms
      f. Questionnaires, surveys, demographic sheets
      g. Interview schedules, interview question guides, focus group scripts
      h. Debriefing sheets, resource lists

   Please note that you DO NOT need to submit pre-existing measures or handbooks which support your work, but which cannot be amended following ethical review. These should simply be referred to in your application form.

2. Submission deadlines:

   i. Projects including direct involvement of human subjects **[section 3 of the form was completed]**.The *electronic* version of your application should be submitted to Becky Case **by the committee deadline date.** Committee meeting dates and application submission dates are listed on the FHMREC website. Prior to the FHMREC meeting you may be contacted by the lead reviewer for further clarification of your application. Please ensure you are available to attend the committee meeting (either in person or via telephone) on the day that your application is considered, if required to do so.

   ii. The following projects will normally be dealt with via chair's action, and may be submitted at any time. **[Section 3 of the form has *not* been completed, and is not required].** Those involving:

      a. existing documents/data only;
      b. the evaluation of an existing project with no direct contact with human participants;
      c. service evaluations.

3. **You must submit this application from your Lancaster University email address, and copy your supervisor in to the email in which you submit this application**

Appendix A Research Protocol and Research Materials

Influences on support workers' approach to caring for children in care

Applicant

Mike Heyes, Trainee Clinical Psychologist, Lancaster University, Lancaster, LA1 4YG

Tel: 0787 666 8452, e-mail: m.heyes@lancaster.ac.uk

Supervisors

Dr Clare Dixon, Clinical Tutor, Clinical Psychology, Lancaster University, Lancaster, LA1 4YG

Tel: 01524 593492, e-mail: c.dixon3@lancaster.ac.uk

Dr Suzanne Hodge, Lecturer in Health Research, Clinical Psychology, Lancaster University, Lancaster, LA1 4YG

e-mail: s.hodge@lancaster.ac.uk

Dr Sue Knowles, Consultant Clinical Psychologist and Child and Family Service Lead, Changing Minds UK

e-mail: sueknowles@changingmindsuk.com

Introduction

Children in care and their support networks

Children in care, also commonly referred to as looked after children (LAC), are children who are unable to live with their birth family, often due to concerns around their safety, and are in the care of the Local Authority, either voluntarily or subject to a care order. In many cases, these children have experienced traumatic early life experiences, with Narey and Owers (2018) highlighting that 65% of children in care have experienced abuse or neglect, and a further 15% have faced forms of family dysfunction. Other factors resulting in a child entering the care system include the family being in acute stress, and absent parenting. Government documents report that, as of March 2019, there were 78,150 children in care in England (Department for Education, 2019) an increase of 4% from March 2018 and nearly 20,000 from 2009.

Children in care predominantly live with foster carers. However, approximately one in ten children in care live in children's residential care provision, typically homes that are tailored to meet their needs (Department for Education, 2019) These homes are predominantly staffed by residential support workers, team leaders/deputy managers and home managers, with children living in these homes having most contact with the support workers. The number of homes that provide care provision in the UK has increased in recent times highlighting the increased demands for LAC provision. Typically, children are placed in residential care provision when foster placements have not been deemed suitable or have broken down, with a review highlighting that almost a third of children living in residential care provision have had 6 or more previous placements (Narey, 2016). Due to this use of the residential care system, many of the children living in these placements can present with higher levels of need and risk-related behaviours. Therefore, support workers in these environments play a pivotal role in supporting those children who have experienced much change in their lives, and in trying to provide a nurturing and homely environment for those that are unable to remain in families. Residential care provision comprises of team managers, deputy managers and support workers, with workers providing round the clock support and care for the children in care living in the home. As such, staff teams work on a rotational basis, meaning that children will potentially experience the care of a wider amount of people, as opposed to when placed in foster care where they would typically be cared for by one or two people.

Alongside these placements, children in care in the UK are usually supported by other professionals such as social workers, and Independent Reviewing Officers (IRO) who have responsibility for ensuring the child or young person receives appropriate care and that their human rights and well-being are protected.

In terms of mental health, children in care should be able to access Children and Adolescent Mental

Health Services (CAMHS).However, this is not always the case and there can be difficulties for children in care to access CAMHS, with Meltzer, Gatward, Corbin, Goodman, and Ford (2003) finding that only 34% of children in care with a recognised mental health difficulty had been in contact with CAMHS. There are a number of potential barriers for children in care in terms of accessing CAMHS, including waiting lists (McAuley & Young, 2006) and changes in placement resulting in delays in accessing services. Furthermore, other barriers include children in care being seen as “too complex” or services believing needs can be met within therapeutic placements. Other factors include difficulties in engaging for children in care and this potentially resulting in discharge.

Despite these barriers to CAMHS provision, more mental health professionals such as clinical psychologists are becoming directly involved in services for children in care. Silver, Golding, and Roberts (2015) suggest one way that psychologists can provide input is at an organisational and systemic level, with further input into training for staff and, when needed, direct therapy for the children within the provision. Other ways that mental health professionals are involved within these services include staff reflection and supervision, psychological consultation, team formulation, assessment and therapy.

Outcomes for current and former children in care

As established, children in care have often experienced difficult life events, which can have a wide range of impacts upon their immediate and long term mental health and well-being, alongside the previously discussed impact on stability of their family life. Sempik, Ward, and Darker (2008) found that 72% of children in care had emotional or behavioural difficulties at point of entry into care, with problems including self-harming behaviour, anxiety and depression and relationship problems, amongst others. Additionally, there is a strong evidence base that highlights that early childhood abuse or neglect can have a life-long impact (Jaffee & Christian, 2014), whilst Reeve and Batty (2011) found that one quarter of homeless people had care backgrounds.

In terms of mental health outcomes for children in the care system, there are further factors that can influence this, including the age of entry into care (Barber, Delfabbro, & Cooper, 2001) and level of trauma (Luke, Sinclair, Woolgar, & Sebba, 2018). A review of outcomes also cited placement stability and number of placements as important (Jones et al., 2011), with stable and fewer placements producing good outcomes. In terms of placement stability, this has been found to be

important in helping promote the well-being of children in care. Important factors for placement stability include how experienced foster carers are, their strong parenting skills, and opportunities for the child to develop (Rock, Michelson, Thomson, & Day, 2013). As with the broader literature about the positive impact of placement stability for children in care, Hicks, Gibbs, Weatherly, and Byford (2009) found the length of stay in residential care provision to be significantly associated with the well-being of children in care, with longer stays resulting in a positive impact.

When thinking of children in residential placements, it can be said that these children have complex emotional and behavioural needs, which has resulted in them leaving foster placements and living in residential care provision (Rich, 2009). Ford, Vostanis, Meltzer, and Goodman (2007) found that the prevalence of mental health needs and meeting of criteria for psychiatric disorders was higher in those living in residential care provision, than in those living in foster placements. Focusing on behaviour, children in residential care provision are more likely to be criminalised for their risk related behaviours (Shaw, 2016), although this could potentially be due to staff teams' higher reliance on contacting the police as a means of managing this behaviour.

What is needed to support children in care?

In terms of professional support of children in care, based on the previously described needs of the children, it is important to focus on providing security, safety, and opportunities to develop. Training, alongside psychological consultation, is often regarded as key in providing both residential support workers and foster carers with the skills and confidence to support children in care, with research highlighting its value to professionals (Watson, 2003).

Components such as training and consultation are important in applying theory to practice. It is suggested that having a theoretical base from which to develop approaches is important when caring for children in care (Tomlinson, Gonzalez, & Barton, 2011). A number of reasons for this are highlighted by Tomlinson et al. (2011), including the idea that basing approaches on theory can provide a template for managing difficult situations, whilst using evidence based theories suggest that the approach used can have a positive impact. In addition, it is also highlighted that when working as part of a team within a residential team, a theoretical base can provide consistency and reliability, two factors that are associated with placement stability. Residential care staff are often regarded as, and set up to be, “therapeutic parents” and this approach to their work is aimed to provide a safe and secure base for the children they care for. Training and continued support and consultation around the importance of providing this secure base can help with the success of establishing this. A focus on attachment is regarded is key in helping children in care develop (Dan Hughes, Golding, & Hudson, 2015).

Training and support are also important factors in managing staff levels of distress and trauma. Previous research has found that professionals can often feel a sense of hopelessness or have emotional responses to risk taking behaviours of anger and fear (Bromley & Emerson, 1995; Shea, 2015), which can subsequently impact on their approach to their work. In addition, residential support workers may also be susceptible to vicarious traumatisation, i.e. being traumatised by the stories they hear about the experiences of the children they support. With this in mind it is regarded as vital for staff teams to be supported by other professionals, such as clinical psychologists, through formulation, training and other areas of support (Furnivall & Grant, 2014).

An example of an approach highly regarded by professionals is the Parenting with PACE approach (playfulness, acceptance, curiosity and empathy), as developed by Daniel Hughes and Golding (2012). This approach has been found to have positive outcomes for children in care and is an approach delivered to staff teams, albeit not all professionals across different organisations. It is suggested that incorporating the different facets of this approach into communication and parenting can help the child to feel safe and secure, which is of importance for children in care. For example, residential support workers and foster carers are suggested to use a playful tone, rather than a lecturing one, in order to develop the relationship. Other aspects such as acceptance and empathy aim to demonstrate to the young person that the person looking after them understands their beliefs or actions, whilst a curious approach aims to explore the child's thoughts and experiences, to provide a safe space to develop trust. This can help in forming attachments, which is crucial for children.

Factors that impact on the ability of support workers to provide consistent care for children in care in residential care provision

In terms of other factors that influence the approach to care by support workers, Watson (2003) highlighted contextual factors such as management, number of occupants within a home and level of consistency in terms of rules and routines as having an impact upon the quality of care provided. For example, a wide team with different experiences and approaches would find it more difficult to provide consistent care than one or two foster carers.

In addition to this, there are other contextual factors that impact on staff teams' ability to provide a consistent and stable approach, one of which is staff turnover. The turnover of staff has been a wide-ranging problem in this area of work for a prolonged period of time (Colton & Roberts, 2007). As with other contextual factors, high turnover impacts on worker's ability to provide consistency and can impact on placement stability.

Another factor to consider is the challenge of working with children who present with need and risk related behaviours. Working in environments that can sometimes involve differing types of abuse towards residential support workers can then add further obstacles that make it harder to deliver consistent care and a secure and safe base. This can lead to the turnover in staff described in detail above. A qualitative study by Shea (2015) involving social workers suggested that professionals supporting children in care may feel a sense of hopelessness that parallels that of those they care for. As a result, professionals may start to replicate the behaviours of the children they care for, which in turn can create an unstable environment. In addition to this, often staff members can respond to the need and risk related behaviours of children in care by displaying emotions of anger, disgust, despair and fear, whilst becoming highly distressed due to difficulty in understanding the behaviour and the unpredictability of it (Bromley & Emerson, 1995). As previously discussed, these possibilities highlight the need for staff teams to be supported in being able to provide a secure base.

Why do people choose to work with children in care?

As previously discussed, working with children in care can be highly challenging, and can involve experiences of abuse and burnout. With this in mind, it is important to consider why people would choose to work within these roles.

In terms of residential support worker roles, there are several factors that can be deemed unattractive to potential candidates. in addition to previously discussed challenges of the work, these roles are often low paid and usually require working unsociable hours, two factors that may be deterrents when thinking to apply for these roles. As such, it is interesting to know more about what attracts support workers to these roles. In line with the research around social workers and foster carers, Moses (2000) found that own childhood experiences can be an important factor for many when choosing to work within these roles, amongst other reasons such as wanting to work with children and work in a caring role.

Do personal experiences influence support worker approaches to their roles?

There are other factors that could influence residential workers' approaches to their work with children in care, some of which have been described in detail above. Another factor to consider is the personal experiences of members of the staff team. Indeed, Thompson (2010) suggests that theory should not be the sole base to rely on, and should be considered as a framework from which the individual's experiences can be drawn upon, suggesting that staff teams should not solely base their approaches on theoretical knowledge.

Currently, there is a lack of research around the influence of personal experiences on approaches to practice. However, there have been studies that highlight the importance of personal experiences on deciding to work within LAC services. As previously stated, Moses (2000) found that some residential workers cited personal influences, such as own negative childhood, important factors when choosing to work within the area. Similarly, Esaki and Larkin (2013) found that a high number of people who directly worked with children in care had experienced their own adverse childhood experiences. 70% of participants had experienced at least one adverse childhood experience when using the ACE questionnaire. This percentage is seen as higher than the general public, suggesting that personal adverse experiences influence decisions to work within this field and supporting children in care. The most prevalent ACE recorded was living with a family member experiencing mental health difficulties.

Zubrzycki (1999) found that social workers considered their own experiences of being parents when supporting families, with participants highlighting that being a parent strengthened their professional skills. Interestingly, participants also indicated that their professional role also strengthened their parenting skills. This study highlighted the importance of reflective practice in the development of these professionals.

As previously established, there is a lack of literature in relation to how, if at all, personal experiences influence the practice and approaches used by residential support workers in their role. Therefore, the current study will aim to explore personal experiences of residential support workers and how these relate to and influence their approach to their work.

Relevance to Clinical Psychology

As Clinical Psychologists often provide staff support, reflective practice, consultation and supervision to support workers within residential care settings, the findings of this study will be of relevance to their ongoing practice. The findings from this study will help in developing understanding around thought processes when working with children in care. For example, knowing more about the relevance of personal experiences would be helpful in shaping reflective practice and supervision, alongside debriefs following incidents. In addition, understanding more about how actual personal experiences relate to approaches to care can shape further training programmes. Linking theoretical bases to support workers' experiences could help cement understanding and ability to apply theory to practice. This can increase the likelihood of consistency in staff team approach, and in turn provide a safe and stable environment. Further support could also be provided in helping residential support workers around the use of their own experiences, or potentially managing trauma or re-traumatisation.

Clinical Psychologists working within these organisations can play a play a pivotal role in using the information drawn from this study and putting it into practice. Indeed, Silver et al. (2015) suggest that due to their "unique skill-set", clinical psychologists can have a significant impact at many levels of organisations that support children in care. As psychologists, there would be scope to use the findings of this study and apply them to the development of training, supervision of staff, formulation meetings and consultation. If the findings of this study can influence staff support and supervision, this could help in alleviating levels of burnout. As previously stated, these roles have poor levels of retention, with Colton and Roberts (2007) identifying that the challenges of the role, alongside poor conditions of employment, contribute to difficulty in staff retention. Poor levels of retention have a detrimental impact on consistency and stability of placements, with inconsistent care being a factor of negative outcomes for children in care. If psychologists are able to understand more about beliefs and understandings of staff teams, this can then help to produce the right type of support, supervision and training.

The proposed research will aim to explore the personal experiences of residential support workers and how this relates to, or potentially influences their approach to work. As there is little previous research on the matter, it is difficult to predict what themes and discussions could come from these interviews. However, as literature has highlighted that negative experiences in childhood can influence reasons for choosing to work within these roles (Esaki & Larkin, 2013; Moses, 2000; Zubrzycki, 1999), it is possible that the experiences that have led them into these roles, will also shape the way they work within them.

Method

Design

A qualitative approach will be used, as this proposed research is aiming to explore in depth the experiences of the participants, in this instance support workers within residential care provision for children in care. Specifically, a grounded theory approach will be used. Grounded theory (Glaser, Strauss, & Strutzel, 1968; Strauss & Corbin, 1997) is a type of qualitative research that follows a systematic process to generate theoretical understanding from the data. This method is suitable for the research question as the aim is to develop a theoretical understanding of the factors that inform residential support workers' work with young people.

There are a number of approaches within grounded theory, with three considered to be the most widely used. As previously stated, the first was created by Glaser and Strauss (1967). This theory suggests that the same theories can be systematically revealed irrespective of who is analysing the

data. The second widely used approach is that of Strauss and Corbin (1990), which added a specific coding system that demonstrates a step by step approach. This approach is regarded as less flexible and more rigid in its approach and is seen as a more deductive procedure. The third version is known as constructivist grounded theory and was developed by Charmaz (2006). This approach recognises the presence of the researcher and regards the researcher's role as a co-facilitator of meaning, and thus moves away from being an objective reporter of the data.

The proposed research will use the constructivist grounded theory approach, taking into account the researcher's active role in the data. The constructivist approach to grounded theory recognises the role of the researcher, taking into consideration their perspective and values, which results in the researcher's ideas being reflected in the emerging theories. This approach is also to a degree more flexible.

Participants

Participants will be adults who work in support worker roles, supporting children and young people in looked after children services (LAC), specifically residential care provision. In terms of inclusion/exclusion criteria, support workers who have worked in this area for less than one year will not be considered. The justification for this is that this will rule out potential participants that have short-term motivations for working in these roles. In addition, staff members who have worked within their role for less than a year will not have had as much time to reflect upon the way they work.

The sample size will be approximately 10 to 15 participants. When using grounded theory, it is recommended that the number of participants is determined by when the data has reached saturation point, i.e. the point when no further themes are coming from the data. However, it is also suggested that approximately ten participants or more can be suitable for this approach (Charmaz, 2006).

Participants will be recruited via existing links with private residential companies, Local Authority and a charity that employ support workers and specialise in providing support for children in care. These links are via the field supervisor, who has direct involvement many of these organisations. Other options include recruiting through other residential companies. If these avenues are unable to recruit the required participants, social media avenues such as twitter and Facebook groups, will be used.

Materials

Participant information sheetConsent form

Sample interview schedule

Procedure

As previously stated, participants will be recruited via links to private residential companies, Local Authority and a charity that supports children in care. The researcher will distribute information sheets and contact details to home managers and staff teams. In addition to this, there will also be the option of the researcher attending team meetings to discuss the research, to increase chances of recruiting, and to answer any questions regarding the research. Following this, potential participants will be able to contact the researcher directly to confirm interest in taking part. The next stage of this process will involve the researcher meeting with potential participants to answer any questions, and if they agree to take part and consent, to arrange a time for the interview to take place.

When an individual agrees to take part in the study, a time and date will be agreed for the interview to take place. Participants will then be asked to give their written consent to participate before engaging in an audio-recorded semi structured interview. The interviews will take place away from the residential care provision, in locations such as the company's base, if there are available facilities, or at another agreed location such as a children's centre. If face to face interviewing is not possible, interviews will be carried out remotely using appropriate and secure software for interviewing purposes.

A de-brief sheet will be offered to each participant, with consideration to any difficult or traumatising topics discussed. This will include contact details for relevant support organisations. In addition, within the primary organisations targeted for recruitment, participants would have access to a clinical psychologist for additional support where needed.

As part of the grounded theory approach, the interview stage and analysis stage are intertwined, and it is standard practice for a staged approach to interviewing, transcribing and analysing. Within this approach, approximately 4 to 5 interviews will be carried out, transcribed and analysed. The theory is that as ideas emerge from early data, hypotheses will potentially shape the structure of latter interviews and guide further sampling. This is known as a constant comparative system of analysis.

There are some limitations to this approach, including generalisability, as the participants will specifically be residential support workers from the North West region of England. A social

constructivist approach to grounded theory recognises these limitations. However, if social media is to be used, participants may then be from other areas of the country.

Practical issues

It will be important to consider location and timing of interviews with participants, as support workers' primary responsibility is to support, care for and supervise the children in care they work with. in addition, staff members are usually required for several tasks throughout their working day and are expected to carry these out on site within the residential care provision. The opportunity to conduct interviews off site, at company bases will be sought, and if needed other neutral locations such as children's centres. Interviews will not take place on site at the residential care provision, due to potential risk concerns. Participants may also choose to proceed with their interview after work. Materials and recordings will need to stored securely. Recordings of interviews will be directly saved to the university server as soon as possible. Due to the nature of the discussions, there are potential confidentiality and safeguarding issues relating to Children in care. Therefore, procedures will be followed to ensure this is maintained. As the research is primarily exploring support workers' experiences, focusing on their personal influences on professional work, this minimises the need to discuss names and details of the children they care for. It will be explained within the information sheet and the interview process that specific names or details of children in care will not be required. Participants will be asked not to mention specific names, but that if any are used, these would be anonymised during the transcription phase. In addition, the main researcher will liaise with the field supervisor about safeguarding issues. Following this process, the field supervisor can liaise with any residential care provision as needed. Within the primary sites identified for recruitment, the field supervisor oversees psychology provision and is aware of safeguarding procedures.

Ethical concerns Risk to participants

As the research will draw on participants' experiences and beliefs, this has potential to raise some ethical issues, whether these are personal or work related. It is possible that participants will find the topics of conversation challenging or upsetting, as the questions may prompt participants to think about difficult and distressing personal experiences of their own. Therefore, an appropriate level of support would need to be offered in the form of a de-brief for participants, or an information sheet pointing people towards useful contacts for support. As previously stated, there is also access to psychologists for those recruited through the primary sites. Another issue that may arise relates to potential safeguarding concerns, as the participants are working with service users perceived as

being a vulnerable population. Participants would need to be made aware of the safeguarding process that would be followed within the research and my role in providing a duty of care to the service users, should these concerns arise in the interview process. In terms of myself, I would need to be aware of safeguarding procedures to follow if such incidents did arise. As previously established, the field supervisor is aware of safeguarding policies.

Risk to children in care

There will be no direct contact with children in care. However, if safeguarding issues were to arise, the standard procedures of the company will be followed.

Risk to researcher

When conducting research and lone working, the researcher will follow stand procedures set out in Lancaster University's guidance on fieldwork. As part of this process the researcher will leave details of the interview, such as time, location, expected duration, with a fellow trainee from the DClinPsy course. The researcher and fellow trainee will set an agreed time for the researcher to contact them, with the researcher doing so once the interview has ended. If this contact does not take place, the fellow trainee will attempt to contact the researcher via telephone, e-mail or text. At this point if there is no response the fellow trainee will alert the university and provide details of the interview, whilst also contacting the relevant authorities.

Timescale

February 2020: submission of ethics
April 2020: begin recruiting and interviewing participants, with concurrent analysisJune/July 2020: complete first stage of interviews, transcribe and analyse data
August/September 2020: complete second round of interviews, transcribe and analyse data

October/November 2020: if necessary complete third round of interviews, transcribe and analyse data
October-December 2020: potential follow up meetings with participants to discuss themes of the research/interviews
December 2020-March 2021: Write results and submit piece of research

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Consent Form

Study Title: Influences on support workers' approach to caring for children in care

We are asking if you would like to take part in a research project. Before you consent to participating in the study we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the principal investigator, Mike Heyes e-mail: m.heyes@lancaster.ac.uk, phone:

tick to confirm

1. I confirm that I have read the information sheet and fully understand what is expected of me within this study ☐
2. I confirm that I have had the opportunity to ask any questions and to have them answered. ☐
3. I understand that my interview will be audio recorded and then made into an anonymised written transcript. ☐
4. I understand that audio recordings will be kept until the research project has been examined. ☐
5. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐
6. I understand that once my data have been anonymised and incorporated into themes it might not be possible for it to be withdrawn, though every attempt will be made to extract my data, up to the point of publication. ☐

7. I understand that the information from my interview will be pooled with other participants' responses, anonymised and may be published; all reasonable steps will be taken to protect the anonymity of the participants involved in this project. ☐

8. I consent to information and quotations from my interview being used in reports, conferences and training events. ☐

9. I understand that the researcher will discuss data with their supervisor as needed. ☐

10. I understand that any information I give will remain confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the principal investigator will/may need to share this information with their research supervisor. ☐

11. I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has finished. ☐

12. I consent to take part in the above study. Please sign below to confirm your consent to taking part in the study. ☐

Name of Participant: Signature: Date:

Name of Researcher: Signature: Date:

Participation Information Sheet

Hello, my name is Mike Heyes and I am conducting this research as a student. The title of this study is "**Influences on support workers' approach to caring for children in care".**

The purpose of this study is to explore how staff teams approach their role in caring for children in care, and what has influenced this way of working.

Are there any requirements to taking part?

Yes. You should:

- Be a current residential support worker supporting children in care
- Have been in this role for a minimum of twelve months

Do I have to take part?

No. it is completely up to you whether you decide to take part in the project or not. Furthermore, if you decide to take part and then feel that you do not want to continue, you have the right to withdraw at any point before or during the interview. You will have up to two weeks after your interview to withdraw your participation in this study.

What will I be asked to do if I take part?

If you decide to take part you would be asked to take part in an interview with myself, which will take place at a time that suits you, either during your shift or outside of work hours. Interviews will be carried out remotely, via safe and secure online software, or face to face if possible.I will be using the interview to ask you about your experiences and how you approach your work with the children you support. The aim is that the interview will be in a relaxed environment and will last for approximately one hour. it is possible that, following this interview, I will then be in touch to ask further questions based on what we discussed. Interviews will be recorded, with these audio recordings being securely stored.

Will my data be identifiable?

The information you provide is confidential. The data collected for this study will be stored securely and only the researcher and their academic supervisors (Dr Suzanne Hodge & Dr Clare Dixon) conducting this study will have access to this data:

- Audio recordings will be destroyed once the project has been examined
- Conversations will be transcribed into an anonymized electronic form
- The files on the computer will be encrypted (that is no-one other than the researcher will be able to access them) and the computer itself password protected. All files will be deleted once the thesis has been assessed.

- The electronic copy of your interview will be made anonymous by removing any identifying information including your name. Anonymised direct quotations from your interview may be used in the reports or publications from the study, so your name will not be attached to them. All reasonable steps will be taken to protect the anonymity of the participants involved in this project.
- All your personal data will be confidential and will be kept separately from your interview responses. There are some limits to confidentiality: if what is said in the interview makes me think that you, or someone else, is at significant risk of harm, I will have to break confidentiality and speak to a member of staff about this. If possible, I will tell you if I have to do this.

What will happen to the results?

The results will be summarised and reported in a thesis and may be submitted for publication in an academic or professional journal. When, or if, your direct quotes are used within the publication, this will be anonymized.

Are there any risks?

There are no risks anticipated with participating in this study. However, if you experience any distress following participation you are encouraged to let me know. In addition, you will be provided with a de-brief sheet that will provide contact details for resources that you could access for support.

Are there any benefits to taking part?

Although you may find participating interesting, there are no direct benefits in taking part.

Who has reviewed the project?

This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

Where can I obtain further information about the study if I need it?

If you are happy to participate in this research, please contact the main researcher below by e-mail or phone to receive a consent form. If you have further questions, please contact the main researcher below or any of the other contacts displayed below.

Main researcher: Mike Heyes: m.heyes@lancaster.ac.uk, number:

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Dr Suzanne Hodge, Lecturer in Health Research Doctorate in Clinical Psychology Programme,
Faculty of Health and Medicine
Lancaster University
LancasterLA1 4YG

s.hodge@lancaster.ac.uk

If you wish to speak to someone outside of the Clinical Psychology Training Programme, you may also contact

Professor Roger Pickup
Associate Dean for Research
Email: r.pickup@lancaster.ac.uk
Tel: (01524) 593746
Faculty of Health and Medicine
(Division of Biomedical and Life Sciences)
Lancaster University
Lancaster
LA1 4YG

Thank you for taking the time to read this information sheet

Resources in the event of distress

As part of the interview, you may choose to talk about things that are difficult for you and cause distress. These feelings may go within a few minutes, hours or days. However, should you continue to feel distressed, either as a result of taking part, or in the future, the following resources may be useful:

Samaritans Helpline (emotional support)

0847 909090

Your own GP

Sample Interview Schedule

What is it that influenced your decision to become a residential support worker?

In your role, have you ever drawn from your own personal experiences when supporting the young people youcare for?

Could you share examples of how you have used personal experiences and applying these experiences to yoursupport of children in care?

In what ways do you interact with the children and young people you support? What style or approach do youuse?

What influences the style that you have?

What do you believe to be the benefits or downfalls of drawing from personal experiences in your role?

In what situations does your personal experiences, whether this is of being a parent, or being parented, or otherexperiences, have the most influence in your role?

Lancaster University

Are you a residential support worker working with children in care?
Have you worked in this role for at least 1 year?

We would love to hear from you!

I am a Trainee Clinical Psychologist at Lancaster University and I am looking to interview residential support workers about how their personal experiencesinfluence the way they support the children they care for.
If you wish to take part, and you are selected, the interview will last approximately 1 hour

For further information, please contact Mike Heyes via e-mail m.heyes@lancaster.ac.uk or telephoneon

Thank you!

Appendix B – Ethics Approval

Applicant: Mike Heyes
Supervisor: Suzanne Hodge and Clare Dixon
Department: Health Research
FHMREC Reference: FHMREC19057

06 May 2020

Dear Mike

Re: Influences on support workers' approaches to caring for children in care

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC).** The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Tel:- 01542 593987
Email:- fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

R·E·Case

Becky Case
Research Ethics Officer, Secretary to FHMREC.

Appendix C – Ethics e-mail confirmation regarding consent

Consent issue with FHM Ethics FHMREC19057 (Original application reviewed at FREC meeting 27/02/2020)

FE

FHM Research Ethics
Thu 23/12/2021 17:12
To: Heyes, Mike (Postgrad Researcher) <m.heyes@lancaster.ac.uk>
Cc: Hodge, Suzanne; Dixon, Clare (DClinPsy)

Dear Mike,

I have sought further advice from the Chair about your enquiry, please address their comments below:
Chair's comments
Please can you confirm the age of the participants.

If it is realistic for you to request a written consent form now from the three participants, please do so. I completely respect that people participating in the interview is, and of itself, implicit consent, but if it is possible to have evidence of interviewees' understanding what it means to participate then that would be particularly useful. If it isn't possible to gather written consent, please can Mike provide a brief justification.

Kind regards,

Secretary FASS & LUMS Research Ethics Committee & UREC | Research and Enterprise Services Lancaster University |
Contact me on Teams
https://www.lancaster.ac.uk/Research Ethics

HM

Heyes, Mike (Postgrad Researcher)
Mon 10/01/2022 16:55
To: FHM Research Ethics
Cc: Hodge, Suzanne; Dixon, Clare (DClinPsy)

Happy new year

I have since obtained written consent for two of the final three participants. All three participants were over 25.

For the final participant, I have evidence of sending him the consent form and him responding to emails to confirm the interview. Unfortunately at the time he was unable to send a written consent form having no access to a printer and ability to scan back. However, the participant was more than happy to proceed having read the consent form.

This is the final issue to clarify with the research so looking forward to your response. Thank you

Mi

Get Outlook for Android

...

FHM Research Ethics

Mon 24/01/2022 14:11

To: Heyes, Mike (Postgraduate Researcher); FHM Research Ethics

Cc: Hodge, Suzanne; Dixon, Clare (DClinPsy)

Hi Mike,

I have received word from the Chair that she is happy to approve the below and confirm that you have done everything you can to resolve the issue – the Chair also wanted to thank you for engaging with the REC so diligently and openly on this.

Best wishes,

Research and Enterprise Services | Lancaster University

Contact me on Microsoft Teams (for enquiries not related to REC applications)