HOLDING BACK THE TEARS!

An autoethnographic study of the struggles of a hospital teacher in balancing emotions, care and empathy

By

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A Research Dissertation

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Table of Contents

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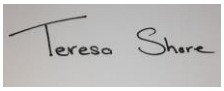
Signed: 

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Abstract

The purpose of this action research self-study was to address the challenging tensions I experienced as I embarked on a new stage of my career as a teacher in a hospital school setting. My overarching aim was to use the insights gleaned to become a more effective hospital teacher. Autoethnography as a methodology, revealed that my tensions were concerned with three integrated areas: emotions, my ontological value of care, and empathy. Upon discovering this, I refined the overarching question for the study to; *as a hospital teacher, how can I balance tensions of teaching and caring for students in an emotionally challenging environment?* The rationale behind this research approach stemmed from ethical considerations and the professional and personal challenges I encountered, following the move from mainstream teaching to hospital teaching. My practices, beliefs and values were questioned by the experiences I faced in this unusual educational setting.

A qualitative research design was chosen and autoethnography was selected as a methodology as a natural consequent to the aims of the study. To achieve these aims, it required an introspective research design, which valued 'self' as the researched. It also acknowledges vulnerabilities and emotions as valuable personal data. Significantly, students and parents were considered an extremely vulnerable cohort in this particular educational context. Therefore, I made the ethically informed decision to exclude this cohort from my research. Autoethnography facilitates their absence without damaging the richness and value of the study. As mentioned, autoethnography relies on personal data, of which the following were utilised in this study: personal memory, archived data,

reflections, reflective writing, journal, metaphor, photographs, and poetry. Validity and rigour were established by the 'outsider' perspective gained from relevant literature, my critical friend, my supervisor and interviews with four teacher participants.

This study found that emotional challenges are the greatest challenges faced in the educational setting of the hospital school. Personal responsibility is required to identify and enhance emotional intelligence competencies, specifically my self-awareness, self-regulation and empathy. The latter has a tripartite classification, with emotional well-being being negatively affected by the practice of emotional empathy, as opposed to a more favourable form—compassionate empathy. My own supressed grief and the fight to hold back my emotions was unearthed during my writing. The hospital context brought to the surface supressed grief and emotionality, my empathy for others, and my desire to care. Finally, I determined that my value of care was grounded in characteristics of empathy and maternal traits. Reflection on data retrieved from the 'outsider' resulted in my reconceptualization of care as multi-dimensional, and categorised under students, practice and self.

I can conclude from this study that I need to engage with self-care. This will involve enhancing my emotional intelligence competencies. Additionally, I need to practice emotional labour at work and deal with the emotional experiences appropriately and timely, in the correct environment. Lastly, my identity as a hospital teacher has been enhanced. The confident mainstream teacher that I once was is beginning to re-emerge in this new and challenging setting. This is due to my renewed self-awareness of my emotionality, my

understanding of empathy, and reconceptualization of my core value, care. I now go about my work with a newfound sense of confidence and pride. The cumulative learning gained from this study is life enhancing and life changing. I am now a hospital teacher who can articulate clearly and enact in my practice what it means to balance education and care.

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List of Tables

List of Figures

List of Appendices

List of Acronyms

DEIS	Delivering Equality of Education in Schools
DES	Department of Education and Skills
HOPE	Hospital Organisation of Pedagogues, Europe
COVID-19	Novel Coronavirus (2019-nCov)
HDip	Higher Diploma
NAMI	National Alliance on Mental Health
WHO	World Health Organisation
CiE	Continuity in Education
INTO	Irish National Teachers Organisation
NEARI	Network for Educational Action Research in Ireland
MT	Mainstream Teacher
HT	Hospital Teacher

Chapter 1: Introduction

'The change'

1.1 Introduction

Values underpin your life and your work (McNiff, 2014), and it is our lived experiences that have shaped and continue to shape how we behave, think, act and feel (Ruth, 2012). The interplay of values and experiences remind me of a steady pulse…working under the surface, mostly unnoticed; but this study has enabled me to take notice. For the first time in my career, I have paid attention to my values—in particular my core value of care, and to the influences behind my practice, thoughts and emotions.

I spent thirteen years teaching in an all-boys DEIS (Delivering Equality of Education in Schools) 1 school, where a high concentration of students came from socio-economically disadvantaged backgrounds. After working in this environment for such a period, I decided to fulfil my dream to teach in a hospital school. It is this 'change' to an atypical setting that necessitated this action research study. The professional transition has had a significant impact on me and therefore, an introspective study approach was utilised.

This chapter outlines the rationale, context, and aims of this study. It introduces the intervention utilised, potential contribution of the study, and a brief outline of the chapters that follow.

1.2 Rationale and Contextual Framework to this Study

With only twelve months hospital teaching experience, the original intention of the research was focused on how I could better motivate hospitalised children to learn. I had read literature and identified an intervention to put in place, when my research took a twist. A reflective and honest discussion with my supervisor following the death of a student was pivotal in shaping the future trajectory of this study. During the discussion, it became clear that the experiences encountered and emotions felt whilst working in a hospital school were having a profound effect on me. My emotionality and my confusion with regard to what I believed to be important working in a setting dedicated to sick children were paramount.

My previous confidence, beliefs, values and methods of teaching were often rendered redundant or had lost significance in this new setting. Prior to this study, I ignorantly went about my work, rarely if ever stopping to question my values or my practice. It took a 'change' for this to occur; leaving a setting in which I was comfortable and established, to fulfilling a dream of teaching in a hospital school.

The Research Context—A Hospital School

Hospital schools are schools located in the hospital setting which provide education to children during periods of hospitalisation to keep them up-to-date with their peers in their mainstream school (Uggeri et al., 2016). In Ireland, the Key Statistics National School Annual Census for 2017/2018 issued by the Department of Education and Skills ([DES], 2018) identifies nine schools catering specifically for children with medical needs. My desire to teach in a hospital school stemmed from the first time I learned of their existence

fifteen years ago. It seemed like the perfect fit to an earlier question—nursing or teaching. The 'carer' in me longed to work in a hospital setting, to make a difference to children and families during the most difficult of times…my ontological value of care exercised perpetually!

However, it is working in the uniquely challenging setting that necessitated the need for me to undertake this action research study. This study is focused on my urgent need to re-evaluate who I am as a teacher, in my context. At the core of action research is "studying your own practice with a view to improving it" (Sullivan et al., 2016: 8). This study has provided me with the opportunity to reflect on my experiences, and in doing so, discover new meaning of my values, learning and practice. Glenn et al. (2017) recognises that drawing on our own values and using them as a lens to evaluate the quality of the research is fundamental to action research. Teaching in a hospital school asked new things of me. The purpose of this study was to address my most challenging tensions working in this setting, identify them, and learn how to better myself as a result.

1.3 Methodology

In Chapter 3, I provide more detail about my choice of autoethnography as a methodology. However, put simply, it addressed my ethical concern for students and parents, and the emotional impact I was experiencing from situational experiences. In the research methodology of autoethnography, the writing process is the intervention (Ellis, 2004). Early analysis of personal data highlighted that my tensions were of a cyclical nature, an interrelated and interdependent trio of tensions, as illustrated in Figure 1.1.

Figure 1.1: A Trio of Tensions

Care, emotions, and empathy were the trio of tensions unearthed. Prior to this study, care as a value was unexamined but felt embedded in my practice. In my new setting, it felt redundant and underused, thus damaging my identity and confidence as a hospital teacher. The desire to care comprehensively for my students was expressed in my emotionality and empathic nature—the latter meaning the ability to sense other people's emotions and to imagine what someone else might be thinking or feeling. The trio of tensions each influencing the other. For example, my inability to practice my understanding of care leading to my reliance on empathy as a portrayal of care, and thus causing me to become too emotional on occasion. However, essentially my tensions are centred on my desire to care effectively for my hospitalized students. Therefore, autoethnography as a methodology

and intervention was particularly suitable as it focuses on 'self' and the changing aspects of self within a social context (Ellis, 2004; Hamilton et al., 2008).

1.4 The Purpose and Aims of the Study

As mentioned, the purpose of this study was to unearth and address the most pressing tensions I experienced while working as a hospital teacher. Overall, my aim was to explore how I can become a more effective hospital school teacher. Autoethnography as a methodology revealed that my tensions were concerned with three integrated areas: emotions, care, and empathy. This lead to the evolution of my research question; how to teach and care for students in an emotionally challenging environment. Subsequently, I framed the study on the three aforementioned tensions, and was guided by the following subsidiary questions:

1. How can I manage the **emotional weight** of working in a hospital setting?
2. How can I balance the tensions between **teaching and care** in a hospital setting?
3. How can I enhance my understanding of the **role of empathy** while working as a teacher in a hospital setting?

1.5 Potential Significance

This study was designed to examine the tensions that I was feeling in my new career as a hospital teacher. In doing so, I would gain understanding about my values, beliefs and practices in the hospital context, and learn how to care for and teach my students more effectively. The potential significance of this study is that it achieves this goal. We are our own change agents, any new understanding gained of myself, and my practice should

contribute to an improved self and improved teaching. Sullivan et al. (2016) notes possible significance residing in practical, personal and theoretical levels.

As one aspect of this study is the examination of my value of care, I hope to benefit from a new informed understanding of said value and no longer live the dilemma of experiencing myself as "living contradiction" (Whitehead, 1989). This form of improvement impacts at a practical level, influencing how and what I teach. New knowledge gained in relation to empathy and the presence of emotions in teaching may prove beneficial to me, personally and professionally. Lastly, theoretical improvement may occur through the development of new knowledge about my practice.

Indeed, new knowledge and improved practice is the goal of action research (Elliot, 1991; Sullivan et al., 2016) as it has a "participatory orientation to knowledge creation" (Bradbury, 2015: 1). During the process, it invites the opinions of others, and shares reflections with others. The significance to others begins at the outset (Sullivan et al., 2016). Indeed, the sharing of knowledge may influence colleagues practice. Furthermore, possible dissemination of findings internally within my educational establishment and externally are further outlined in Chapter 6.

1.6 Chapter Outline

Chapter 2 begins with an examination of the available literature on hospital schools that was analysed to identify its purpose and value, and the challenges and experiences encountered by hospital teachers. I then examined literature regarding emotions in

teaching—particularly grief—and cultural influences on emotions, including the practice of emotional labour. Next, I focused on 'care' as a value defined and enacted in practice. I established 'themes of care' from the literature examined. Finally, I investigated the literature on the tripartite classification of empathy. Voiced throughout the literature review is the cyclical relationship and relevance to teaching of emotion, care and empathy.

Chapter 3 documents the rationale behind the research design. A qualitative research approach was deemed most suitable as it gives voice to the researcher, is organic by nature and deals with the complexities of issues faced (Braun & Clarke, 2013). Furthermore, action research was selected as the most appropriate research method to address the aim of this research, as it is practitioner-led, wherein the practitioner gives accounts of their own experiences through the lens of their own values (McNiff & Whitehead, 2009).

The selection of autoethnography as a methodology was a natural consequent of the research aim. Significantly, autoethnography facilitates the expression of incalculable and complex feelings and emotions and places value on 'personal data' (Muncey, 2010). Most significantly, the value placed on personal data inadvertently removed the focus on the inclusion of students and parents as participants in the research, thus adhered to the ethical principal nonmaleficence—doing no harm (Cohen et al., 2011). Furthermore, their absence from the study helped me to live more closely in line with my value of care, thus enacting an ethic of care in my research.

Chapter 4 contains my 'autoethnography piece', an authentic and creative narrative telling my story, conveying feelings and emotions, previously untold. I used personal data sources:

memory, metaphors, photographs, poetry and evocative writing to convey my story. This chapter invited a personal connection and strived to create a resonance with the reader (Frank, 2000).

Chapter 5 outlines the findings of this study. Personal data and external data from interview participants, my critical friend, my supervisor and literature, were triangulated to establish rigour and validity. This was achieved by the inclusion of the outside perspective (Brookfield, 2017). The opinions of the participants provided an excellent source of data to critically reflect on and were pivotal in the shaping and reshaping of my beliefs and values. Finally, Chapter 6 discusses the findings in the context of the research question and literature. In addition, the implications, limitations and the possible dissemination of the findings are discussed.

This chapter introduced you to the rationale for, context of, and the purpose and aims of this research study. It outlined the format of this autoethnography and its potential significance. The next chapter presents the relevant literature examined in relation to emotion, care and empathy.

Chapter 2: Literature Review

'What has been said… '

2.1 Introduction

The purpose of this chapter is to analyse the available literature relevant to the three themes underpinning this thesis—emotions, care and empathy. First, I begin by drawing on the literature to discuss the purpose, history and challenges faced in this unusual context within which this research takes place—a hospital school.

2.2 Hospital School

The juxtaposition of the words 'hospital school' illustrates the unique environment in which it exists. Hospital schools were originally established as part of the benevolent efforts of religious orders managing hospitals, motivated by the desire to cater for intellectual, spiritual, humanitarian desires and to alleviate psychological distress of their patients (Kennerk, 2019). It was not until 1975 that the first hospital school was re-established and legislated under the auspices of the Department of Education and Skills.

Hospital schools provide education and the continuity of education (Keehan, 2019; Steinke et al., 2016; Shiu, 2001, Appendix A) to hospitalised students, who should not be put at educational disadvantage because of their medical needs (Kennerk, 2019; Chen et al., 2015; Government of Ireland, 1998). Gabbay et al. (2000) notes that dedicated hospital teachers are needed to deliver and implement a broad and balanced curriculum to every sick child.

Academics Shiu (2001) and Kennerk (2019) highlight the importance of hospital school beyond the realm of education. A hospital teacher may interpret their role as stretching beyond teaching the curriculum, to providing hope, normality, and routine for children during their hospitalization (Keehan, 2019), and providing 'an experience', absent from any medical treatment. Shiu (2001) and Kennerk (2019) refer to hospital school as the only place a seriously ill child can go and be something other than a patient. In congruence, Walton (1951), McKinley (1992, cited in Murphy & Ashman, 1995) and Lemke (2004) recognise that hospital 'school' is continuity of normality in a context far from the norm. Furthermore, Maor & Mitchem (2018) address the supportive role teachers play in the child's medical treatment. Their reassuring presence, along with topics taught and methods selected, provide a therapeutic role (Hen, 2020). Being more than a facilitator of learning in this particular setting has implications for teachers' emotional wellbeing as they strive to provide learning, emotional support, socialization, and escapism for their students.

The hospital school is a unique environment that enlists many challenges for the hospital teacher. These include competing with the demands of health professionals and visitors, assorted distractions, the physical and emotional state of students, and the transient population of students (Andreatta et al., 2015; Hopkins et al., 2014). Steinke et al. (2016), Lemke (2004) and Keehan (2019) identified the emotional aspect of the job as the greatest challenge faced by hospital teachers, the reality of dealing with the death or the prospect of death of their students.

Furthermore, Hen's (2020) study conducted with fifty hospital teachers identified that the majority of participants described their work positively as rewarding, challenging, satisfying, interesting, inspiring, contributing, and meaningful. However, the same participants also described their work as painful, stressful, very intuitive, intensive, overwhelming and difficult to manage. Hen (2020) notes that hospital teachers, unlike their medical counterparts, generally receive no specific training to assist them with working in an emotionally challenging environment. Hospital teachers are teaching students during an illness, (Eaton, 2012) and sadly, on occasion, the death of their students (Steinke et al., 2016) can occur. The literature review will now explore the role of emotions in being a teacher—particularly in a hospital setting.

2.3 Emotions in Teaching

Educational researchers (Hargreaves, 1994, 2001; Nias, 1996; Sutton & Wheatley, 2003; Zembylas, 2005) recognise the role of emotions in being a teacher and their importance in forming teacher identity. According to Nias (1996), teachers' have a strong 'personal' commitment towards their profession, primarily due to it being a people-based occupation. Teaching implies "human nurturance, connectedness, warmth and love" (Hargreaves, 1994: 175), and an investment of the 'self'. O'Connor (2006), Zembylas (2003), and Kelchtermans (2009) agree that the 'person' is central to teaching; furthermore, the teachers' emotionality can influence their professional practice. Zembylas (2005) perpetuates that emotions are socially activated by culture and the discourse of the experience, rather than the experience—"subjects do their emotions; emotions do not just

happen to them" (Zembylas, 2005: 938). This leads me to explore the influence of culture—particularly hospital culture—on our emotions.

2.3.1 Cultural Influence on Emotions

Put simply, culture is "the way things get done around here" (Deal & Kennedy, 1983). Culture is regarded as situationally unique (Beare et al., 1989), and is created and influenced by people and their emotions (Moody, 2020; Men, 2018). Every organisation has an emotional culture (Razzetti, 2019)—both positive and negative emotions exist in all cultures, as emotions are impossible to block (Razzetti, 2019). However, it is how they are received and responded to that shape the health of the emotional culture—"the shared affective values, norms, artefacts, and assumptions that govern which emotions people have and express at work, and which ones they are better off suppressing" (Barsade & O'Neill, 2016: para.4).

2.3.1.1 Grief

Grief is an emotion (Delaney, 2016) witnessed and experienced in hospital settings. Grief is described as acute pain that accompanies loss—not limited to the loss of people. "Grief is the conflicting feelings caused by the end of or change in a familiar pattern of behaviour" (Friedman, 2013: para.3). Grief obeys no trajectory (Nolan & Hallum, 2019; Delaney, 2016); it is highly individual and unpredictable. Grief can be put on hold, unresolved, or suppressed because of the need to cope at the time or a need to be strong for others (Moeller, 2017a). Liebenow (2015) describes metaphorically the consequence of suppressed grief:

> "Ignoring grief is like a leak in our roof. We can take care of it now, or we can wait as it seeps through the ceiling, gets into the walls, and warps the floors." (Liebenow, 2015, para.4)

The suppression or masking of emotions may result in negative consequences for our emotional well-being and general health (Moeller, 2017b). Bereavement consultant Delaney (2016) notes that grief is both difficult to experience and to witness. Additionally, witnessing a person's grief can activate our own losses. As such, hospital teachers are not immune to the grief experienced in their work environment and it may trigger their own grief experiences. Therefore, hospital teachers need to attend to their own loses if they are to work in a setting where bereavement is a real threat.

Additionally, an individual's emotional response is informed by 'emotional display rules'. These are culturally determined rules that govern emotional expression at certain times (Dzokoto et al., 2018). These rules instruct people to modify their emotional reactions to match the socially desirable reaction in a given situation (Dzokoto et al., 2018; Zembylas, 2005). A concept Hochschild's (1983) refers to as emotional labour.

2.3.2 Emotional Labour

Emotional labour is "the way in which individuals change or manage emotions to make them appropriate or consistent with a situation, a role, or an expected organisational behaviour such as those dictated by organisational culture" (Mumby & Putnam, 1993: 37). Hochschild (1983) described two important aspects related to the management of one's

emotions, deep acting and surface acting. The former, where the person modifies their personal feelings to match what is socially acceptable for a given situation. The latter, involves putting on a face so that one's outward emotional appearance is in line with what is socially accepted or expected. Emotional labour is achieved by controlling facial expressions, reactions and behaviours (Hochschild, 1983).

Isenbarger and Zembylas (2006) regard emotional labour demanded in caring professions as an effect rather than a phenomenon. Emotional labour can cause an individual to feel disengaged from their identity and can be psychologically demeaning (Härtel, 2008), negatively impacting on self-esteem and emotional well-being (Isenbarger & Zembylas 2006). However, individuals must exert a reasonable amount of emotional labour to work effectively with others (Côtê et al., 2006). According to Srinivasan (n.d.), it is not professional "to wear your emotions on your sleeve". Instead, one needs to manage their emotions (Goleman, 2011).

Hospital teachers work alongside paediatric nurses. Hilliard and O'Neill's (2010) study with said nurses identified that 'distancing' was a strategy nurses use to protect themselves from emotionally challenging situations. However, the mentioned researchers interpreted the responses of the participants to reflect the use of emotional labour. Furthermore, the participants of the study "refuted the conventional understanding of emotional distancing and emphatically denied being immune to children's pain" (Hilliard & O'Neill, 2010: 2911), and recognised was the need to manage their emotions and engage in self-care.

2.3.3 Managing Emotions

Goleman (2011) recognises the importance of understanding our emotions, controlling our reactions, and recognizing how our emotions affect our actions and others. Managing ones emotions makes them better able to cope with the challenges of their job (Bakken, 2011). According to Moody (2020), this awareness helps to relinquish the control the emotion has over us, helps to understand emotional triggers, and mitigate the negative impact they may have on our actions and reactions.

Evans and Allen (2002) and Cadman and Brewer (2001), reveal the importance of managing ones emotions as a precursor to interpreting others emotions and responding appropriately, and displaying empathy—an essential skill for any caring profession (Amplion, 2019). Furthermore, if persons in caring professions are able to deal with their own feelings, they will be better equipped to cope with others confidently, competently and safely (Stickley & Freshwater, 2004). Professionals play their part in their own emotional self-surveillance. Hen (2020) advocates that courses focused on the management and regulation of emotions should be available to hospital teachers.

2.3.4 Emotional Intelligence

Emotional intelligence involves four major abilities: to perceive emotions, to reason with emotions, to understand emotions, and to manage emotions (Cherry, 2020a). Emotionally intelligent people pay attention to how they are feeling, thus are very self-aware (Cherry, 2020a). In addition, they are empathetic, self-regulated, motivated, have great social skills, are willing to discuss feelings with others, and can correctly identify the underlying causes

of their emotions (Cherry, 2020a). In contrast, low emotional intelligence refers to the inability to perceive emotions accurately, your own and others (Cherry, 2020b). People with low emotional intelligence are described as displaying signs such as: not listening, having emotional outbursts, being oblivious to others' feelings, behaving insensitively, and having an inability to cope with emotionally charged situations (Cherry, 2020b). In order to educate the heterogeneous cohort of students that present in hospital schools, teachers are expected to possess high emotional abilities that enable them to work in distressing situations.

2.3.5 Emotional Support

In congruence, Keehan's (2019) study with hospital teachers reported collegial relationships with their immediate peers as the most beneficial source of support. Similarly, paediatric nurses in Hilliard and O'Neill's study (2010) reported that a supportive team was the most effective support, but that less experienced nurses expressed a reluctance to express their emotions to colleagues. Moreover, the participants "contended that an understanding of the contexts of their emotions is a prerequisite of anyone whom they would seek support" (Hilliard & O'Neill, 2010: 2912). They described offering support as sharing workloads, rotating difficult cases, and talking about their experiences. This implies that hospital teachers should share and express their work related emotions with their colleagues, and model such behaviour to incoming members of staff. Furthermore, emotion and the management of it in professional situations need to be examined to explore the underlying values, beliefs and attitudes that they underpin (O'Connor, 2006). As such, I will now explore the value of care in teaching and learning.

2.4 Care

The Teaching Council of Ireland is a professional standards body for the teaching profession that was established in 2006, under the Teaching Council Act 2001. The Council's function is to set, promote and regulate high professional standards for teaching and teachers (Teaching Council, 2016: 2). It explicitly states that the role of the teacher is to educate (Teaching Council, 2016: 6), and that the teacher's practice should be underpinned by the ethical foundation of the values: trust, integrity, respect, and care. The Teaching Council describe care as:

> "Teachers' practice is motivated by the best interests of the pupils/students entrusted to their care. Teachers show this through positive influence, professional judgement and empathy in practice" (2016: 6).

The Teaching Council in their definition of care proclaims the utilisation of empathy as a means of enacting care. Jeffery (2016), who states that empathy is shown in concern and care, further supports this definition. Ferguson (2015) describes care as loving others, in a non-sentimental way. However, Isenbarger and Zembylas (2006) allude that care is an 'ambiguous' term open to various interpretations and has no clear boundaries (Tronto, 2017). Interestingly, Tronto notes "it conveys both disposition and a set of actions" (2017: 31), and some entities are considered more caring than others are. Caring is considered an important aspect of education (Gilligan, 1982; Noddings, 1984, 1992).

As aforementioned, the Teaching Council (2016) names care as a fundamental value underpinning teachers' practice. Values "provide us with the basic structure of our

expectations for ourselves, and also with the overarching principles towards which we strive in our practice" (Sullivan et al., 2016: 60). According to Sullivan et al. (2016), the values we hold as practitioners permeate every action, interaction, observation and perception we make. Whitehead (1989) developed the term 'experiencing oneself as a living contradiction' to demonstrate the disharmony between how we think we are living in accordance with our values, to how we actually are.

This study was informed by philosopher of education Nel Noddings and her substantial work on the ethics of care—'a relational ethic' (Noddings, 2012). Care and relationships are fundamental aspects of education (Smith, 2002; Noddings, 2006). According to Noddings, care is:

> "Not just a warm fuzzy feeling that makes people kind and likable. Caring implies a continuous search for competence. When we care, we want to do our very best for the objects of our care…it demonstrates respect for the full range of human talents" (1995: 676).

This perspective on care places professional responsibility on the teacher to continually seek to improve their pedagogy in order to 'do their best' for their students, and advocates the holistic education of students. Keehan (2019) and Steinke et al. (2016) acknowledge the need for hospital teachers to upskill and be familiar with a diverse range of resources and programmes at all class levels. Furthermore, Hospital Organisation of Pedagogues, Europe [HOPE] (2020) advocate that hospital teachers engage with continuous training to ensure they are up to date with educational initiatives.

Care can be enacted and conveyed in multiple ways (Noddings, 1995). I have devised themes of caring in teaching and learning to include happiness, listening, fostering a sense of belonging, teacher-student relations, and child-centred learning. These were compiled from engagement with various sources of literature (Noddings, 1995, 2003a, 2007, 2012; Maslow, 1970; Garza et al., 2014; Baumeister & Leary, 1995; Goodenow, 1993; Keyes, 2019; Nias, 1996; Reeve, 2006; Hargreaves, 2000, Newberry, 2010; Hopkins et al., 2014).

2.4.1 Themes of Care

Happiness

Caring teachers promote happiness, as children learn best when they are happy (Noddings, 2003a). Happiness, described by Aristotle as "human flourishing", needs to become an "evaluative screen through which to judge everything we do" (Noddings, 2003a:5). Maslow (1970) identifies the satisfaction of psychological safety, and belonging needs in order to achieve contentment. However, these needs may not be fulfilled for hospitalised children, as Murphy and Ashman (1995) recognise that hospitalized students are often in pain, distressed, and traumatised. This further emphasises the importance of personal manifestations of care i.e. enthusiasm, as "probably more important in children's lives than any particular curriculum or pattern of pedagogy" (Noddings, 1995: 676).

Listening

Garza et al., (2014) and Noddings (2012) affirm that caring teachers listen, respond, and react to the expressed needs of their students. Noddings (2007) notes that seldom students request to learn the things we require them to learn, but caring teachers listen and respond

to their students expressed needs (Noddings, 2007). Furthermore, caring teachers acknowledge and can negotiate these expressed needs towards developing them educationally, and achieving inferred needs as set out by the teacher (Noddings, 2012). By listening, responding and addressing the expressed needs of the students, "we win students over and they become more willing to work on the needs we have identified" (Noddings, 2007: 341). In the hospital setting, effective listening informs the appropriate customisation of schoolwork so to entice a reluctant or disengaged student.

A Sense of Belonging

The need to belong has long been identified as a basic human need (Baumeister & Leary, 1995; Maslow, 1970). Therefore, creating a sense of belonging is another means of enacting care. Many authors (Baumeister & Leary, 1995; Goodenow, 1993; Ryan & Deci, 2000; Garza et al., 2014) advocate that sincere interest in students and building meaningful relationships assist in fostering a sense of belonging for students. Goodenow's (1993) seminal study defines 'classroom belonging' to mean:

> "feeling oneself to be an important part of the life and activity of the class…" (Goodenow, 1993: 25).

However, it may be difficult to foster a sense of belonging as hospital teachers teach a transient population of students, often at bedside. This compounds the need for hospital teachers to express a positive disposition towards students and provide positive verbal and non-verbal communication. Their demeanour becomes increasingly important in order to

express a disposition of welcome and warmth to the student, which contributes to fostering belonging (Garza et al., 2014).

Teacher-Student Relations

The centrality of relationships in teaching and learning is well-documented (Nias, 1996; Newberry, 2010; Russell & Loughran, 2007) and caring is fundamental to creating positive relations (Noddings, 1984, 1992, 1995). Reeve (2006) outlines four teacher characteristics that support the creation of positive teacher-student-relations. They are attunement, being sensitive to students state and adjusting lessons accordingly; relatedness, helping students feel important; supportiveness; and gentle discipline. Hospital teachers are challenged with enacting these characteristics, some of which may be challenging, as they may not know their students very well. Ikpeze (2015) recognises that a caring teacher-student relationship has positive benefits for the student, such as increased interest, self-esteem and motivation. Newberry's (2010) suggests support for teachers' by providing space and time needed to deeply reflect, converse, and plan, as teachers work on building relationships across diverse student populations. This is particularly relevant to hospital schoolteachers, who teach a heterogeneous and transient population. Hospital teachers may need to set aside time during their day focused on building relationships with students and their parents.

Child-Centeredness

Characteristics of child-centred education include directing your own learning, having different learning activities available, first-hand, practical and explorative experiences, being challenged and supported (Power et al., 2018: 578). According to Beymer and

Thomson (2015), student motivation is increased in a classroom that focusses on child-centred learning as it constructs feelings of autonomy. Hopkins et al. (2014) notes the need for feelings of autonomy and independence among young sick people who may be experiencing low self-esteem and learned helplessness. Furthermore, lessons in hospital should be of high interest and of short duration, as such factors "provide extra motivation and stimulation which are needed to maintain interest of sick children" (Murphy & Ashman, 1995: 33). I will now explore the last theme, empathy.

2.5 Empathy

Empathy is intertwined with emotions and the provision of care. According to the Teaching Council, care is portrayed in "empathy in practice" (2016: 6). Empathy is "the ability to understand and share another person's feelings and perspectives, and using that understanding and emotion to guide future action" (Jeffery; 2016: 143). Furthermore, empathy is "a social and emotional skill that helps us feel and understand the emotions, circumstances, intentions, thoughts, and needs of others, such that we can offer sensitive, perceptive, and appropriate communication and support" (McLaren, 2013).

Ekman (2003) adopts a tripartite classification of empathy to include cognitive, emotional, and compassionate—ranging from narrow to comprehensive in their understanding of empathy. This study demands analysis of the latter two. Emotional empathy involves feeling emotions as if 'their' emotions were contagious (Goleman, 2011). This type of empathy facilitates the formation of strong relationships and assists interpersonal relationships. However, the consequences of being emotionally empathetic include feeling

overwhelmed, distressed, being unhelpful and inappropriate in certain circumstances (Reiss, 2017), and even dangerous as you can saturate yourself in others suffering (Exploring Your Mind, 2020). This form of empathy can be all consuming, and can result in a loss of appropriate boundaries and burnout (Borg et al., 2014).

Compassionate empathy is the most socially desirable form of empathy (Powell & Roberts, 2017). It involves comprehending another's situation, feeling with them, and being moved to help them if needed (Goleman, 2011). This form of empathy is concerned with moving beyond understanding and hurting for others, to taking action, providing active support, affection and help (Exploring Your Mind, 2020). A person with compassionate empathy is described as knowing how to act in every given situation and providing the right kind of support. The mastering of compassionate empathy is essential in the hospital context to protect teacher well-being, as empathy is an emotional competency utilised continually.

Importantly, in order to provide empathic care for others, the importance and necessity of self-empathy and self-care for those in caring professions must be facilitated (Reiss, 2017), as being a person with compassionate empathy implies knowing when you need to receive support yourself. This denotes the need for the hospital teachers to enact compassionate empathy, first to protect themselves from burnout and being emotionally overwhelmed by other's emotions, and second to respond correctly to the needs of students, parents and colleagues. Without self-awareness, the individual can lose the 'other-perspective' and become overwhelmed. When individuals are "emotionally overloaded, overwhelmed, exploited, or burned out, the capacity for empathy declines as a result of the degree of

emotional labour extended" (Reiss, 2017: 76). Working in a context designed to care for sick children and their concerned parents, necessitates that all workers, including the hospital teacher, must be in a position to empathise appropriately.

Teaching without empathy is teaching content instead of students (Franzese, 2017). Teaching with empathy enables the teacher to recognise when students are struggling or succeeding, engaged or disengaged. To be an empathetic teacher, according to Franzese (2017), incorporates discerning how the student learns best and adapting teaching to accommodate this.

Jeffery (2016) recognises that empathy is something doctors have always struggled with, balancing their relationship with patients between connection and distance. In the medical field, a comprehensive view of empathy is advocated so to become a routine way of being (Francis, cited in Jeffery, 2016). The view one takes on empathy influences their approach to their patients and their concepts of professionalism (Jeffery, 2016). Moreover, Halpern (2012) claims that empathy elevates the work of a doctor to another level. These findings are significant for all caring professions.

Wiseman (n.d., cited in Browne, 2013) names four components of empathy: perspective-taking, non-judgement, recognising emotion, and communicating these heard emotions. Reiss (2017) recognises the essence of empathy as being heard and having ones needs responded to. This correlates with Noddings (2012) who affirms that caring teachers listen and respond to needs. It is the understanding gained from empathy that actively generates

care in action (Jeffery, 2016), as at the core of empathy lies making a connection, which involves emotionally engaging with another (Browne, 2013; Reiss, 2017; Jeffery, 2016). This illustrates the interrelatedness of the emotions, care and empathy.

2.6 Conclusion

Emotions, care and empathy have long been at the heart of hospital schools, the existence of which originates from the benevolent efforts of hospital management to care for hospitalized children (Kennerk, 2019). However, as the curriculum acknowledges, and as my autoethnography sets out to explore "effective education for children with special needs is a balance between education and care" (Department of Education and Skills, 1999: 29). Indeed, noted is the importance of the hospital school and its teachers beyond the realm of education (Lemke, 2004). Furthermore, acknowledged is the supportive role hospital teachers play to the vulnerable cohort of students in an emotional and challenging work environment.

The centrality of emotion in teaching, grief as an emotion experienced in the hospital context were explored. The influence of emotional rules as set out by the emotional culture on influencing teachers emotions is well documented (Zembylas, 2005). Furthermore, the emotional labour often demanded by the hospital culture and its negative impact on both nurse and teacher wellbeing is highlighted.

Emotions, care and empathy are intertwined. Emotions at the core of all human activity—to be caring is to be empathic, and to be empathic is to be caring (Jeffery, 2016). Indeed, an

ethic of care is fundamental to teaching and learning (Teaching Council, 2016). This literature review was heavily influenced by Noddings and interprets her substantial work alongside other relevant literature to reveal ‘themes of care’—effective ways to enact care in the hospital school setting. The literature also reveals both a ‘narrow’ and a ‘comprehensive’ view of empathy. To teach with empathy enables one to adapt and change one’s teaching to the needs of the child. The cyclical and relational nature between emotion, care and empathy is clear throughout the literature review, and furthermore, the need for teacher surveillance of their own emotional management and regulation is required for effective teaching. Thus to provide empathetic care, the need for self-care and self-awareness is paramount for teachers.

Chapter 3: Methodology

'Getting ready'

3.1 Introduction

This chapter outlines the development of the methodology for this research, from the initial research idea to the final thesis. It commences with the detailed purpose and aims of the study, and a rationale for choosing a qualitative research design is then presented. The selection of action research as a method and autoethnography as the research methodology is subsequently detailed to include the methodological tools utilised. This is followed by an explanation of how the data was managed, analysed and interpreted. A discussion on validity and ethical concerns and procedures conclude this chapter.

3.2 Purpose and Aims of the Study

As aforementioned in Chapter 1, I made the move to teach in a hospital school after thirteen years of teaching in an all-boys, DEIS 1 school. The situational 'change' was the fuel behind this research study. In my previous school setting, I was an established, confident and senior member of staff. However, in my new role as a hospital teacher, I was insecure, unsure and confused about what it meant to be a teacher where students are primarily patients in a building designed for their medical care. I originally began my research path with an interest in investigating how I can better motivate hospitalised students to learn. However, during critical discourse with my supervisor, it became clear that a more

introspective research approach was needed to address my concerns, one that values vulnerabilities (Ellis & Bochner, 2000) and emotions (Muncey, 2010).

The purpose of this study was to address my most challenging tensions working in a hospital school, with the aim of using insights gained to learn how to care for and teach students in an emotionally challenging environment. The commencement of in-depth reflective writing pinpointed a tension I was experiencing—teaching sick children and enacting my value of care. I was acutely aware that my previous held values were being challenged, some losing significance because of my new setting. It was important for me, the person and the professional, to take time to understand my value of care. The process also unearthed my emotionality and my practice of empathy as areas of tension in said environment.

Analysis of the relevant literature on hospital schools and the commencement of the reflective writing process identified pertinent research questions. The overarching aim of my study was deduced to; How do I teach and care for students in an emotionally challenging environment. This question was supplemented by the questions below.

1. How do I manage the emotional weight of working in a hospital setting?
2. How do I balance education and care in a hospital setting?
3. How can I enhance my understanding of the role of empathy while working as a teacher in a hospital setting?

3.3 Rationale for and Nature of Qualitative Research

A qualitative research design was determined as an appropriate method to understand and to accommodate unanticipated ideas that may have been lost using quantitative methods (Braun & Clarke, 2013). A qualitative approach gives a voice to the researcher to explore the issues faced, personal values, and perceptions and meanings of experiences. Qualitative research requires an interpretive approach which directs the researcher to study in their natural environment (Denzin & Lincoln, 2000) and make meaning from their experiences. The latter is important to me as I piece together my new identity as a hospital teacher. Creswell's (2003) characteristics of a qualitative study are depicted in Figure 3.1.

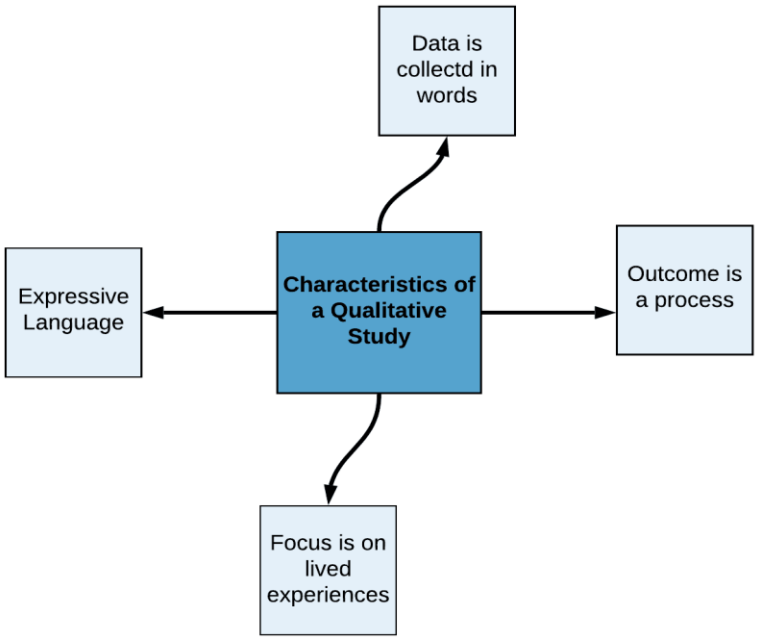


Figure 3.1: Characteristics of a Qualitative Study

Source: Adapted from Creswell (2003)

3.4 The Action Research Paradigm

Action research, also known as participatory research (Adleman, 1996), accommodates a shift away from an external researcher and addresses the practical concerns of self as the researcher. The aims of my research are contextually yielded from the challenges I have encountered during the transition from 'school' to 'hospital' teacher.

Elliott (1991) and Sullivan et al. (2016) describe the fundamental aim of action research is to improve practice, whereby the researcher "consciously and self-consciously, critically and self-critically, transforms their ways of thinking, doing and relating to the world" (Kemmis, 2009: 472). It is focused on improving your practice, generating a theory from your learning, having an educative influence on yourself and others, and leading to personal and professional development (Sullivan et al., 2016). Action research is a pragmatic approach that aims to explore and understand practice and its impact (McAteer, 2013).

Action research involves practitioners accounting their own experiences through the lens of their values, periodically reflecting on what one believes in, and how one thinks (McNiff & Whitehead, 2009). I aim to explore my understanding of care as a lived value, and the role of empathy and emotionality when teaching in a hospital setting. I believe that through critical reflection on my own practice, I will achieve great learning and transformative insights, thus improve my practice and generating new theory in the process (Glenn et al., 2017).This may have an educative influence on myself and others, leading to personal and professional development (Sullivan et al., 2016).

Fundamental to action research is the centrality of 'I' (Glenn et al., 2017). These aspects of action research are important to me considering that my concerns are personal, and I am acutely aware of being ethically sensitive in a context that is saturated with a vulnerable populace. Notably, different forms of action research address different types of problems (Kemmis, 2009), from cyclical models to more introspective forms of action research. Autoethnography was deemed most suitable for this research study.

3.5 Autoethnography

Autoethnography is a form of qualitative research that makes the researcher's life and their experiences the focus of the research (Reed-Danahay, 1997). It focuses on the "shifting aspects of self and creates ways to write about experiences in a broader social context" (Hamilton et al., 2008: 22), as depicted in Figure 3.2.

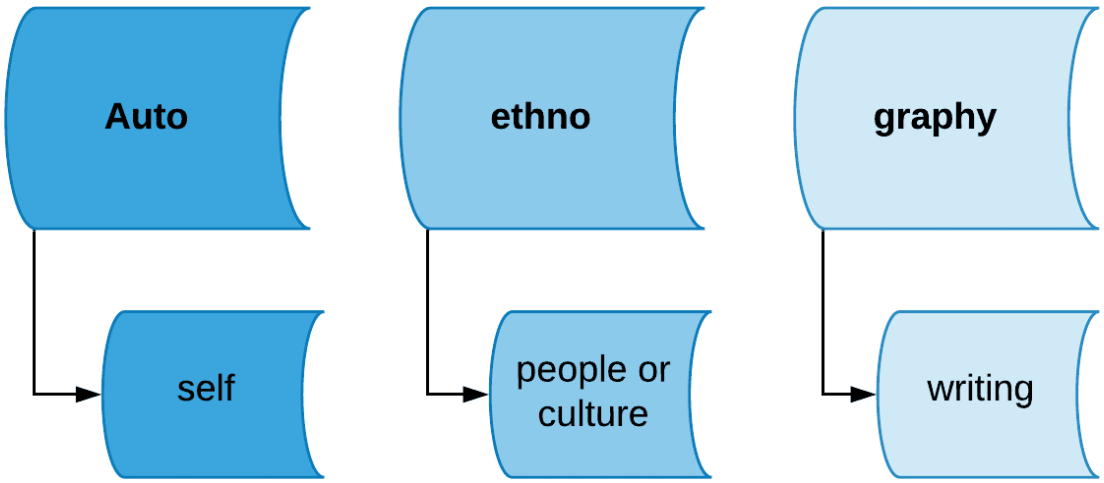


Figure 3.2: Autoethnography explained

Source: Adapted from Ellis (2004)

Figure 3.2 demonstrates that autoethnography requires the researcher to write about their lived experiences in an attempt to understand their self or an aspect of life within a social and cultural context. Ellis (2004) describes it as an autobiographical style of writing that displays multiple layers of consciousness. The researcher situates themselves in the research as an observer of their own story in its social location (Muncey, 2010). This was extremely important and relevant to me as it recognises that meaning is constructed and influenced from the social and cultural setting, and I set out to learn about my values in a new context. Crucially, this research methodology acknowledges and facilitates subjectivity, emotionality, and the researcher's influence on research (Adams et al., 2015). Figure 3.3 further illustrates the rational for the selection of autoethnography as my research methodology.

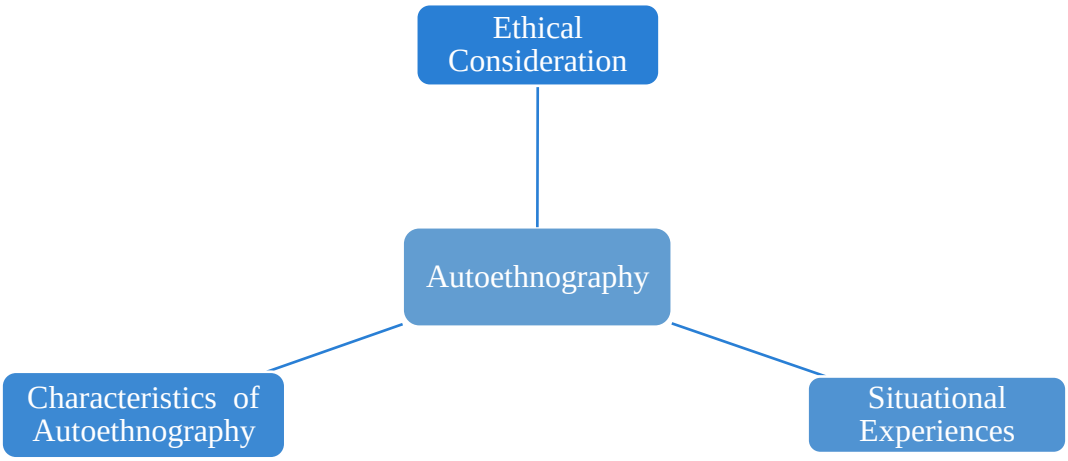


Figure 3.3: Rationale for the Selection of Autoethnography

Rationale for the Selection of Autoethnography

Firstly, ethical consideration was a leading influence in the choice of research methodology. The hospital setting brings with it greater research parameters. The cohort of students are an extremely vulnerable group and I consider it morally and ethically wrong to seek their participation in my research. Levine et al. (2004) acknowledges that vulnerable participants are people who may be susceptible to harm in some way, emotionally damaged, or offended. However, in autoethnography, the autoethnographer is both the researcher and the researched (Muncey, 2010), and thus the researcher's interpretation of the experience is the data (Ellis & Bochner, 2000). This was one of the main reasons for the selection of this research method—it facilitates the thoughtful exclusion of an extremely vulnerable cohort of students and parents from the data-gathering process. Secondly, my experiences and concerns could not be depicted in standard ways. Muncey (2010) notes that people seldom set out to do an autoethnography, but rather they turn to it as a way of conveying unquantifiable and complex feelings and emotions that cannot be depicted in typical ways, or because there are gaps in the literature that fail to echo their stories. This depicts my story. Finally, characteristics of autoethnography, as outlined in Figure 3.4, also influenced its selection.

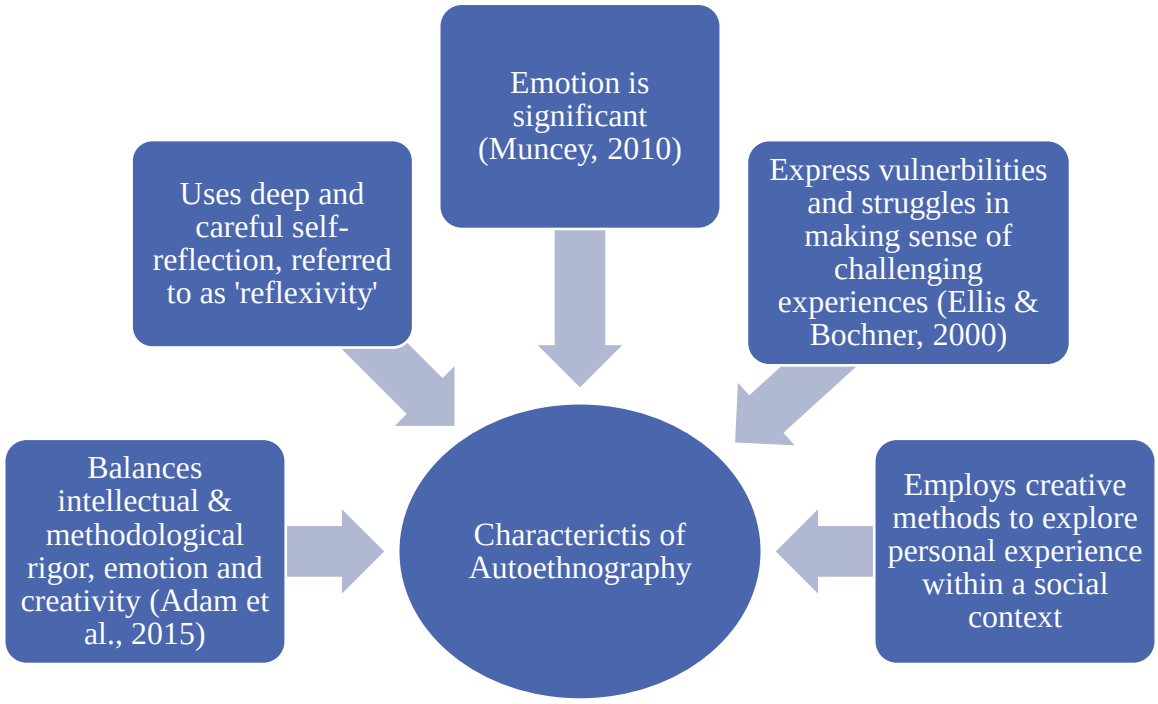


Figure 3.4: Characteristics of Autoethnography

Sources: Adapted from sources Adam et al. (2015), Muncey (2010) and Ellis and Bochner (2000)

3.6 Reflexivity

Bolton (2010) describes ‘reflexivity’ as questioning your attitudes, values, thoughts, assumptions, prejudices and habitual actions, in order to understand ourselves in relation to others. It involves having the flexibility to deliberately change deeply held ways of being (Bolton, 2010). Furthermore, O’Reilly (2009) notes that it involves thinking critically about the context, literature, writing process, research tools, and acknowledging that one is part of their own study. Remaining acutely aware of the potential for bias from the research

method adopted, reflexivity and subjectivity in this qualitative research were valued greatly (Braun & Clarke, 2013), as the researcher must be critically aware of how they are connected and implicated in every step of the research process (Walsh, 2015). A challenge I encountered was accurately interpreting memories and others' perceptions of me. For me, reflexivity involved an on-going critical reflection on every step of the research process.

3.7 Data Collection Methods

3.7.1 Triangulation

Personal data is the primary source of data for autoethnography (Chang, 2008). However, Chang et al. (2012) elaborate that different types of data from multiple sources will provide a thick description of your life and sociocultural context. The same authors support that multiple sources will also enhance the interpretation and credibility of your stories through triangulation of data sources. Triangulation can be achieved by combining personal data with outside sources, such as interviews, discussions with critical friend, supervisor, and theoretical literature. These provide additional perspectives and challenge subjectivity (Chang, 2008). Triangulation enhances accuracy, reliability and validity of the research (Robson, 2002).

3.7.2 Personal Memory and Archived Data

Autoethnography values personal memory—memories about past events, people, places, objects, behaviours, thinking, and utterances (Chang et al., 2012). Personal memory provides a wealth of insight about 'self', but can be imperfect as the researcher is selective, interpretive and distortive when retelling stories (Muncey, 2010; Chang et al., 2012). As a

result, the primary aim of personal memory work is to recall or recollect the memories that can then be reflected upon and interpreted in a new light.

Archived data such as photographs, college assignments and diaries supplement personal memory data (Chang et al., 2012), and assist in recalling, revisiting and casting light on the life being considered (Goodson & Sikes, 2001). The mentioned archived data added new details to existing data, assisted in stirring memory, and played an important role as the basis for the triangulation of data (Chang et al., 2012).

3.7.3 Reflective Practice

Reflection is defined as "deliberate and mindful thinking about one's experiences and the self-evaluation of feelings, decisions, understanding and actions, which may lead to development of professional learning for professional practice" (Hegarty, 2011: 20). An event written about, rigorously reflected upon, discussed critically and re-explored through further writings is referred to as meta-reflection. I engaged with meta-reflection throughout the research process.

Reflective writing does not guarantee a learning outcome every time, but it enhances clearer thinking, the emergence of new or additional ideas, and records thoughts that may be the foundation of future questions and learning. According to Moon (2004), reflective writing can unearth the unexpected and assist in dealing with situations that are not straightforward. Certainly, the unique setting in which I work is not straight forward, lending to unique situations and feelings. I used Moon's (2004) reflective model—

illustrated in Figure 3.5—as an evaluative screen to measure the level and depth of my reflective writing. This helped me to identify new insights about my practice and myself.

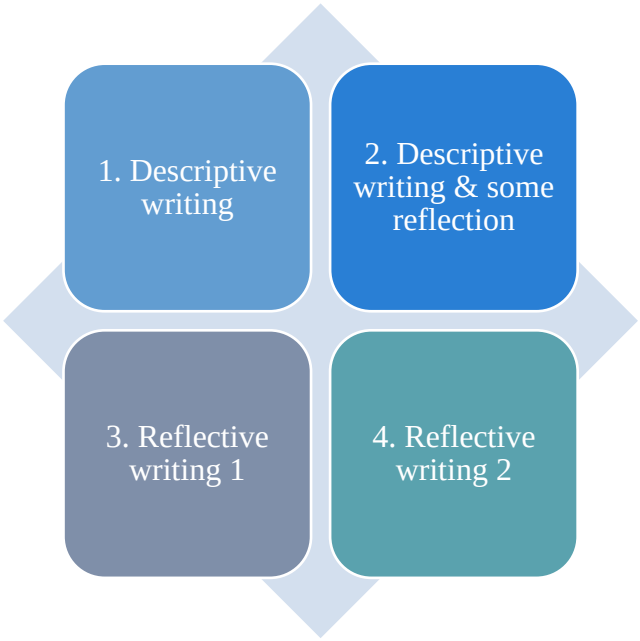


Figure 3.5: Moon's Reflective Model (2004)

Source: Adapted from Moon (2004)

Moon's (2004) model of reflective writing incorporates four levels of writing (Figure 3.5). Level four—reflective writing 2—is the most comprehensive and preferred level of reflection. It incorporates questioning self, contemplating other perspectives, standing back from the event, taking a metacognitive stance, and a preparedness to be critical of the actions of self and others. Moon's (2004) model was monumental in helping me identify my held assumption; that parents of terminally ill children were not concerned with school. This process helped me to recognise how my emotion influenced my thoughts.

Bolton & Delederfield (2018) acknowledge the difficulty in knowing the incident or event to reflect upon. The unconsidered events are often the events needing deep reflection and can be the source of the deepest reflexivity; “we need to attend to the untold” (Sharkey, 2004, cited in Bolton & Delederfield, 2018:17).

For me, reflective writing facilitates the articulation of the writers own values-in-practice; those we unwittingly live and work by, and their espoused values and that of their organisation. In this study, values, described as the ethical basis for our actions and beliefs (Bolton & Delederfield, 2018: 26), were contradictory to my actions and practice. Critical reflection helped me to identify the dissonance between held and lived values—this disharmony represented in the term a ‘living contradiction’ (Bolton & Delederfield, 2018; McNiff & Whitehead, 2009). Reflecting upon emotional incidents also assisted in discovering values-in-practice, as emotions are aroused when values are transgressed, opposed or affirmed (Bolton & Delederfield, 2018: 36). Recognising and working with emotions through reflexivity led me to transformational development, as outlined in Chapters 4 and 5.

3.7.4 Journal

The reflective journal was a vital source of rich data for me (Goodson & Sikes, 2001; Sullivan et al., 2016). It sustained thinking, recorded thoughts, maintained a focus, and created self-provided feedback (Moon, 1999). Furthermore, it facilitated an array of learning activities: metacognition, the development of theory from practice, self-

understanding, resolution of uncertainty, reaching decisions, and empowerment (Moon, 1999: 34).

Figure 3.6 outlines additional benefits of learning journals that I experienced.

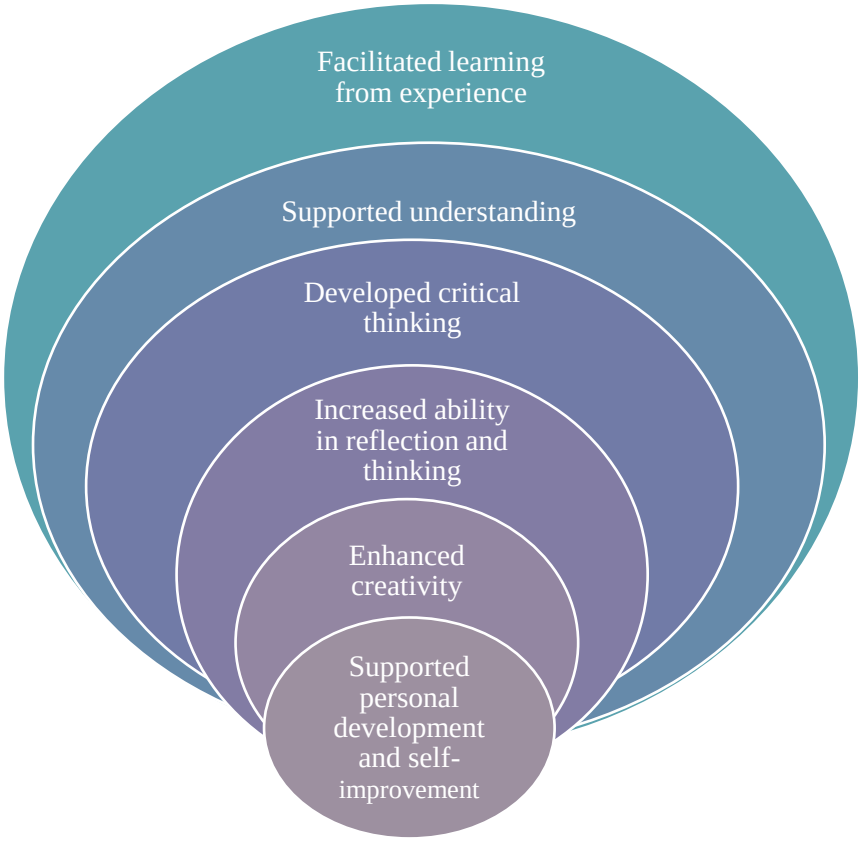


Figure 3.6: Benefits of learning journals

Source: Moon (1999: 40-42)

The journal played a vital role in recording feelings, providing a source to meta-reflection, and provided a time and place for being expressive and creative (Appendix B).

3.7.5 Metaphor

Metaphor uses images to convey meaning (Bolton, 2010; Muncey, 2010). They can be "extended and changed to provide a different way of viewing the world" (Muncy, 2010: 61), and help to gain new perspectives. The metaphor "The Mighty Oak" began as a symbol for my mother. Data retrieved from interviews encouraged me to see the teacher as the Mighty Oak—embodying maternal traits. Thus, metaphors give tangible form to a story that words alone cannot describe (Dyson, 2007), and generates lifelikeness that is powerful and pervasive in moving human beings to new levels of consciousness (Dyson, 2007). Relations with the wider world and ourselves is metaphorical, and indeed "a large part of self-understanding is the search for appropriate personal metaphors that make sense of lives" (Lakoff & Johnson, 2011) within our social and culture world (Bolton, 2010). 'The Salesperson', a metaphor doused in negative connotations, emerged as a way of seeing myself as a teacher in a health setting. The articulation of the 'salesperson' image was fundamental to understanding my role as a hospital teacher and learning how to navigate a necessary aspect of the role. The final metaphor documented in the autoethnography was COVID-19—current, relevant and inspired by the times being lived through. COVID-19 helped me to affirm my belief that health trumps education. These metaphors arrived organically from the process of reflective writing and meta-reflection. Collectively they were important in helping me to understand myself, my role as a teacher, and my value of care in a hospital setting more comprehensively.

3.7.6 Poetry

Poetry can generate new ways of thinking, “troubling the unconscious into recognising new ways of looking at and reflecting on experience” (Muncey, 2010: 59). Writing the poem entitled “The Mighty Oak” helped me to articulate the impact the loss of my mother had on me. Individual words felt inadequate to describe this experience, the technique of poetry and its rhythmic structure evoked emotion and stimulated memory, imagination, creativity, and insight. The said poem conveyed sensitivity, awareness and insight into others pain—emotional empathy.

3.7.7 Interviews

In autoethnography, interviews “provide external data that give contextual information to confirm, complement, or reject introspectively generated data” (Chang, 2008: 104). Furthermore, data gathered from interviews can stimulate memory, add to knowledge, validate personal data, and gain others perspectives (Chang, 2008). The insight provided by the participants in this study contributed to the analysis and interpretation of my practice and values.

Relatively unstructured, conversational in nature, informal in tone, semi-structured interviews were utilised due to their flexibility (Goodson & Sikes, 2001: 28). They enabled me as the interviewer, where necessary, to clarify any misunderstandings and make a true assessment of what the respondent believed (Cohen et al., 2018). This form of interview enabled me to control the order, whilst still facilitating spontaneity and the ability to press participants for complete answers on complex issues (Cohen et al., 2018).

I conducted a pilot interview with a mainstream teacher not involved in the study. This proved very useful as it helped me to identify potential ambiguities in the phrasing of questions. Furthermore, I omitted and amended questions to make them appropriate to the needs of this study (Appendix C).

Due to the restrictions in place because of COVID-19, interviews were conducted using a password-secure online platform. Apprised of the purpose and process of the research in advance, signed consent was obtained from participants and interviews were digitally recorded and transcribed verbatim. Braun and Clarke's (2006) six stages of thematic analysis, included in Appendix D, was used in the analysis and interpretation of the transcribed interviews.

Interview Participants

The use of pseudonyms is a well-established tenet of good research practice, thus adhering to anonymity and confidentiality (Saunders et al., 2015). Two sets of two teachers—mainstream (MT) and hospital (HT)—were invited to take part in the study. This was to accommodate the tensions created from the move from one educational setting to the other, and help to contextualise my held beliefs, values and practice. The four participants have witnessed my teaching and were anonymised, as presented in Appendix E.

3.7.8 Critical Friend and Supervisor

A critical friend is “a person of trust supporting another’s learning through critical questions, data and an outsider’s perspective” (Beranek & Holzinger, 2019, para. 2). My critical friend knows me since my youth and is an extremely active listener that encouraged and supported me to explore my thoughts, concerns, beliefs and values regularly. My critical friend, as Moon (1999) suggests, prompted deeper reflection and prohibited me from avoiding difficult issues.

My supervisor was an on-going supportive and thought-provoking participant throughout the research. She recognised and supported the necessity of autoethnography as a research methodology. She witnessed my journey of thought, and regularly provided candid verbal and written feedback. Her ability to ask insightful questions urged me to meta-reflect, gain new insights in to held values, and arrive at new learning.

3.8 Data Collection, Management, Analysis and Interpretation

In autoethnography, the research process is not linear. Figure 3.7 illustrates the on-going, relational process among data collection, data management, and data analysis and interpretation.

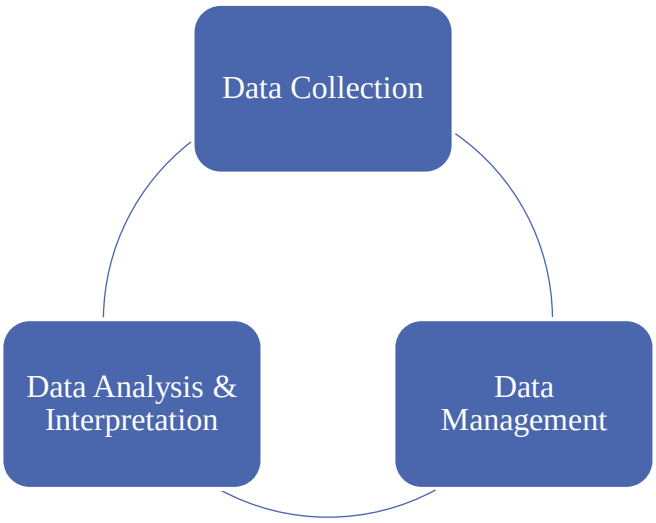


Figure 3.7: The Relational Data Process in Autoethnography

Source: Adapted from Chang (2008: 122)

Data was signed, dated, labelled, and classified with identifiers as it was collected. This involved creating ‘data sets’—"data bounded by one collection strategy within one set timeframe” (Chang, 2008:116). This process offered familiarity, refinement and expansion of sets of data (Braun & Clarke, 2006). These managed sets of data then became the grounds for analysis and interpretation.

Initial analysis and interpretation of early reflections helped to identify my tensions—care, emotions and empathy—which directed this study. From the messiness of the data collected in autoethnography, the researcher is expected to:

> "review, fracture, categorise, rearrange, probe, select, deselect, and sometimes gaze at collected data in order to comprehend how ideas, behaviours, material objects, and experiences from the data interrelate and what they really mean" (Chang, 2008: 127).

Furthermore, I needed to give cultural meaning to the data collected. Analysis required me to stay close to the data and familiarise myself with it, and interpretation involved making meaning of the data. Analysis and interpretation were on-going and interwoven processes. Rereading collected data was extremely beneficial; it challenged me to re-examine previous thoughts, enhanced familiarisation that contributed to my efficiency and effectiveness in triangulating the data. Analysis and interpretation involves a "balancing act of fracturing and connecting, between zooming in and zooming out" (2008: 128).

I 'zoomed in' on the data, dissected it and then coded it under themes that materialised. I simultaneously 'zoomed out' to draw connections across all the data sets. Strategies advised by Chang (2008: 131) were utilised as part of my data analysis and interpretation process are explained below.

1. Search for Recurring Topics, Themes, and Patterns

Informal analysis (Ryan, 2015)—keeping an eye for repeated and emerging themes—informed emotions, care and empathy as significant. This informal process occurred during discussions with my supervisor, my critical friend, and reflective writing. These themes

focused me to re-examine my data, in ‘chunks’ and holistically, giving me a broader understanding of what the data means (Chang, 2008).

2. Identify Exceptional Occurrences

Life–changing events can reveal a great deal about a person; the loss of my mother unearthed a great deal about my emotional well-being.

3. Analyse Inclusion and Omission

This type of analysis helped me to recognise the presence of the maternal role in mainstream teaching, and its absence in hospital school teaching.

4. Compare Yourself with Other People’s Cases

This process of analysis is complemented with “bringing difference and commonality to your consciousness and further understanding of self” (Chang, 2008: 136). The perspectives of others opened my eyes to new insights as discussed in the Chapter 5.

5. Contextualise Broadly

The contextualisation of data is at the crux of autoethnography research (Muncey, 2010; Ellis, 2004). I analysed data in light of the sociocultural environment in which it took place, provided by literature based on hospital school, data analysed from hospital teachers, and my situational experiences.

3.9 Validity

Validity is being true, relevant, meaningful and believable (McNiff & Whitehead, 2009: 24). The same authors advocate establishing personal and social validity. Personal validity requires your values to stand as both criteria and standards of judgement, and social validity requires testing your claim against the critical feedback of others. I used three critical lenses to establish validity—self, peers, and theory and literature (Brookfield, 2017).

Furthermore, triangulation of data strengthens rigour, validity, and enhances the accuracy of the research (Robson, 2002). Triangulation accommodates that "the flaws of one method are often the strengths of another, and by combining methods, observers can achieve the best of each, while overcoming their unique deficiencies" (Denzin, 1970: 308). Feldman (2003) developed criteria to strengthen the rigour and validity of an autoethnography study. These include clear descriptions of data, data collection, interpretation of data, and evidence that the research conducted contributed to new learning.

3.10 Criteria for Evaluating Autoethnography

Richardson's (2000) five criteria of evaluating autoethnography includes substantive contribution, aesthetic merit, reflexivity, emotional impact, lived experience. Tracey (2010) adds rich rigour, credibility, ethics and having meaningful coherence. As noted by Ellis (2004), autoethnography should be judged as valid through the concept of 'verisimilitude'. This recommends that validity be judged by whether the text evokes "lifelike, believable and possible" feelings in the reader (Muncey, 2010: 127).

3.11 Ethics

Nonmaleficence or 'doing no harm' (Cohen et al., 2011) was the guiding ethical principal that heavily influenced the research design. The Department of Children and Youth (2012) promote a commitment to the well-being and protection of participants as a core ethical principal in child-related research. I made the considered and purposeful decision to omit students and their parents from the research, as their inclusion could be considered insensitive, intrusive, and a source of unnecessary stress. In doing so, ensuring professional ethical values of care, respect, trust and integrity for human dignity (Teaching Council of Ireland, 2016) were upheld in my conduct.

Cohen at al. (2007: 70) advise that ethical protocol in relation to relevant entities needs to followed. Approval to conduct this research study was obtained from Froebel Department of Maynooth University, the schools Board of Management, and participants of the study. Consent was obtained from each participant prior to data collection (Appendix F). The ethical principal of autonomy (McLeod's, 2010) was adhered to, ensuring participants were informed, aware their participation was non-obligatory, and that they were free to withdraw from the study at any time. Furthermore, 'fidelity' in research implies the confidential and respectful nature of research and the necessity for "loyalty, reliability, dependability and action in good faith" (McLeod, 2010, 56). From the onset, participants were reassured that the recorded interviews and other sources of data shared would be treated confidentially, stored securely on a password-encrypted computer, and used only for the research outlined. Furthermore, all participants were given a pseudonym, to ensure anonymity and strict confidentiality (Cohen at al., 2007: 57).

3.12 Conclusion

This chapter outlined the methodology approach undertaken to carry out this research study. A qualitative research design was selected, autoethnography. Its suitability to the purpose and aims of the research were outlined. The personal and external sources of data utilised during the research are detailed, and the approach taken to analyse and interpret the data was comprehensively illustrated. The chapter concludes with the steps taken to ensure validity, and outlined the ethical considerations that guided the research. The research approach adopted situated me, the researcher, as the subject of investigation. The following chapter contains my autoethnography narrative. It sets out to invite the reader in to my world and share my lived-experiences.

Chapter 4: Phase One

'The Mighty Oak'

The kitchen table, no longer in its location, is now shoved beside the larger of two available windows in what is a compact apartment. It is here I sit, thirsty for air and desperate for light. The table's glass surface cruelly shares stolen glimpses of my scattered thoughts piled and penned on the floor—messy and unclear. Before me, an unstable stack of books is latched to a tablecloth of illegible pages - handwriting unrecognisable as my own and the colourful ink decorative rather than enlightening. I move my head closer to the page, hoping that the gesture alone will decipher what was so urgently needed to be put on paper. Freshly tying back my hair, in an effort to fervently and desperately detect the 'common thread' my supervisor speaks about finding - it is not easy!

Sitting at the overloaded table, the realisation sinks in that my story needs to be conveyed in what Ellis (2004) describes as a high literary and artistic manner. My 'voice' needs to be transformed into an engaging writing style to entice the reader in (Chang, 2008). It is proving to be a strenuous undertaking that I am finding particularly laborious, gruelling and thought provoking, as it unearths memories of moments, recent and more distant: *"When will you be home?"*, my eighty-seven year old dad pleaded down the phone just a few days ago. He has been living through forced isolation because of the global pandemic—COVID -19. As an older citizen, he has been particularly affected by the restrictions in place. I responded in the moment, emotionless, but his loneliness, relayed in the unspoken words,

still penetrates the room and invades my thoughts. I see him, nuzzled into the corner chair in the kitchen, longingly looking out the window, finding solace only in the sight of the ever-present oak tree. Somehow, it personifies his once strong and formidable wife, only present now in a photograph nailed proudly to the wall overhead. I am prompted to write…

The Mighty Oak

The Mighty Oak, beautiful and strong,
Ringed by its own history.
Rot sets in, but still the seasons pass.
Deciduous and selfless by nature,
Nurturing and sheltering.
Her branches engulfing a clump of tress,
Favouring none but favouring all!
Tightly nestled,
Protected.
Rooted in rich soil, a product of her own selflessness,
Nourished.

No longer stands the Mighty Oak.

There on the edge, the last to blossom,
Engraved with pain.
She must flourish in the summer sun,
Withstand the winter gales,
Like She was shown.
She glances across to the encroaching wood,
Where others stand.
Knowingly, She sees the rot,
Decaying, destroying
And She knows…
She feels it.

The act of writing the poem was tedious and painful on the mind and heart. I wrote, scribbled out, and started again…and again, and again…in search of the right words. The focus on her absence induced a tsunami of grief expressed in the shredding of paper, now scattered under head. Awakened by the sight of the neighbour sunning themselves in the May heat, I drag my gaze away, but the smell of coconut sun-cream still wafts through the window, painfully reminding me of the different canvases being worked on—mine mostly empty. My sun deprived and tired body wills to swap positions. Suddenly aware of the hoodie I am wearing, unnecessary in this weather but cosy and comforting, I pull the hood over my head, needing its shield against the emotional current bubbling inside. The outside world pulls me back. This time the sun-kissed leaves steal my attention. They are suffice to cause silent tears to form.

What is WRONG with me? Why am I so emotional?

I am an emotional person. Is it as simple as that…? I visit the fridge—icy water halts the unexpected tears before they trickle and shock the body into a new sensual awareness. I have utilised this well-seasoned strategy many times, but when cold icy water is not always available, roses work too, verified at my mother's funeral. Their sharp thorns piercing the hardened palm skin, drawing blood, succeeding momentarily at altering the source of pain, shocking the body, distracting it from what is going on—giving it a few seconds of respite.

I wonder if the current pandemic is making me feel this way. The anxiety triggered by COVID-19 is taking its toll. I am painfully aware that the deadly virus has taken 1,631 lives

in Ireland—and counting—stolen grandparents, mothers, fathers, sisters, brothers, and friends. 24,803 more people infected so far—my sister included. Hearing the numbers every evening is harrowing, but as the days and weeks have passed, I begin to wonder if 'we' have become desensitised as people? Are the large and ever growing 'numbers' making the loss of life less tangible? Perhaps a streak of detachment is needed to cope with the magnitude of what is occurring around us. COVID-19 is causing death, generating challenges and triggering emotions. Perhaps this explains my emotional turmoil. It is relevant, new and multifaceted after all. COVID-19 stirs me to identify the parallels between it and the challenge of teaching in a hospital school—where death is a 'real' and 'threatening' undercurrent. And, my transition to hospital school teaching and is therefore also relevant, new and multifaceted. My place of work is a setting dedicated to caring for large numbers of sick children, a place where you are exposed to hearing a life-changing or life-ending diagnosis, seeing children without limbs or hair because of their illness, tubes and machines sustaining life, heartbroken parents tormented by the unnatural sequence of events. The dreaded sight of a trolley on its final journey is an all-too familiar sight. Perhaps a streak of detachment is needed. I return from having taken a few minutes spent thinking about the families I have met. The sadness of one particular family sits with me, and my chest begins to tighten. I push the emotion down, topping up the emotional store within.

I am pulled into my own flashback…On a crowded bus to my first teaching job in a DEIS 1 boys' school. "*Get them in line*" for the HDip (Higher Diploma) inspection…Secure a permanent job…Attend College in the evenings… Thesis and assignments to

complete…Cycle to St. Luke's in Rathgar to visit my mum—up from the country to receive her radiotherapy (I the closest family member geographically to her), and listen silently to my best friend as she falls into depression—unbeknownst to me at the time. I was overwhelmed. I had to survive, and to survive I had to bury any distracting and unhelpful emotions. My heavy load seemingly oblivious to others, but translating to me as; No one saw my struggle. No one felt my pain. No one cared.

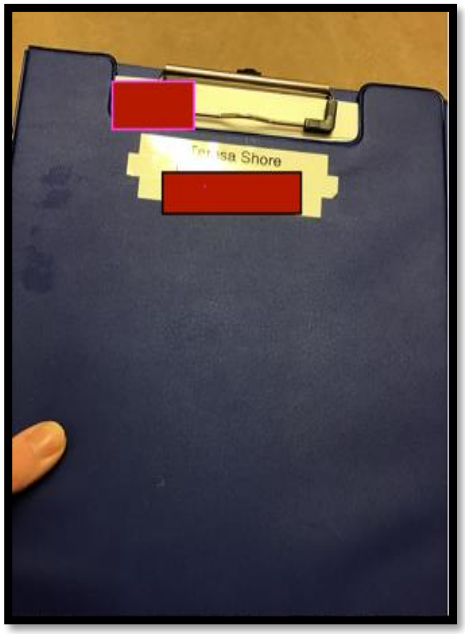
I jump from this flashback to where we are now and how we are teaching the children—not in our usual personal, face-to-face way—but remotely. It feels a little 'impersonal' and 'uncaring', as we try to get parents and children to engage in our remote service, a consequence enforced from the realities of the pandemic.

"You are being paid to teach," echoing in my head.
It is your job!"

Our responsibility to teach seems to override the reality these parents of sick children are facing—even at the expense of our genuine concern for the well-being of these children and their families? Do they feel we do not care? But, ***I*** see the struggles of the families with whom I work. ***I*** feel their pain, and ***I do*** care—***maybe too much***? The emotion inside manifests as anger and my heart races as I desperately try to type—my typing skills incapable of moving at the speed of the fuelled anger emerging inside…***health comes first!*** The parents of our ill students are worried and overwhelmed at times. Surely, school engagement is secondary to everything else for them and their sick child. The Irish

government by their actions in response to COVID-19 believes this too. School closures and economic decisions were taken to prioritise the nation's health, trumping all other aspects of society, prioritising life - ***health comes first!***

Health comes first, or 'health is all that matters' a phrase I heard repeatedly throughout my upbringing and is cemented in my core beliefs. Yet sometimes, I feel my practice does not reflect this. The photographs below of a door to a student's room and my clipboard depicts aspects of my working day: documenting all potential students and introducing myself to them.



The images combined conjure up a metaphor of me as a 'salesperson' and are steeped with negative connotations: pushy, target-driven, manipulative and self-invested.
This 'salesperson' self-image saddens me. I am acutely aware that families are not in my work environment by choice, and that the health of their child is their priority. And yet, I

tentatively knock on the door, uttering a 'sales pitch'– Lego or art? I quickly decide what I think will enthuse the student; whatever works to get them to 'buy into' school! I still hear the scream of a little girl; "No Mammy! No Mammy!" as her mum wearily tried to console her after my presence triggered an outburst of emotion. The guilt paved across my face as I gingerly retreated out the door, dejected.

An 'expectation' exists to teach at least ten students per day. I have to achieve the target. However, being a salesperson for education goes against the grain. "Canvassing" for school in this medical setting often leaves me feeling insensitive, uncaring, and oblivious to their pain. However, this truth is – ***I do feel for them***. Indeed, on occasion it upsets me terribly, and this upset happens at unpresented times. I found out yesterday that the health of one of my students was deteriorating while on our staff Zoom call (our daily means of communication since COVID-19 restrictions). Interestingly, my thoughts were immediately directed to her mum and dad, and not the student. I reflected on why it is them and not my student that I am thinking about, and perhaps like me, they are the ones that may be left behind. Awkwardly, I expanded my eyes in an effort to retract the forming tears. My efforts to mask my emotion must not have worked as I received three messages from colleagues enquiring for me, after the Zoom call. *Did anyone else struggle like this? Am I too soft to work in this setting?*

Just two days ago, I lost the ability to control my emotions when consulting with my supervisor. Where was all this coming from? Surely this is not professional behaviour from me? But then—I must acknowledge, that I can also be so strong! Less than three months in

the hospital role, I was given the responsibility (along with a colleague) to teach a palliative student.

"Maybe focus on creating keepsakes," was the advice given to me by my colleague.

No tears. No crying. I created paintings with my student, painfully aware that they would be framed and sent to her parents after her death. Later that month, I watched as she sat upright on the hospital trolley, her youthful body failing her, as she was wheeled out of hospital—to die at home. I watched from a room where I stopped momentarily from teaching fractions to a student of the same possible fate. I was interrupted by the return of his tearful mother, who opts to hug her living child there and then, clearly unhinged by the experience. I swallowed hard—no tears, no crying.

Then, there was the funeral of my student that I attended with a colleague. I repeated my mantra internally: "***Be professional****!"* I demand myself not to cry. I fight the tears. I swallow them whole. My throat stings and my palms are clammy—but I do not cry! I perform well. I watch the broken parents struggle under the white coffin that demands emotional strength, not physical. George Ezra's popular voice penetrates the air, school uniforms line up on both sides, and the 'whiteness' of the coffin, all powerful reminders to those present of the young life lost. Still—I do not cry. I had to hold it in—**be strong! Be professional!** A week later, uncontrollable tears flood my face when Ezra's song, "Shotgun" plays on the radio.

"*Will you be able for it—the hospital side of it*?" my former colleague of twelve years enquired when I announced I got the job and was leaving the school to take up the new position.

Did they see me as being too emotional? I had cried three times in my twelve years in the school. Does three times equate to being ***too*** emotional? The first occasion occurred in my first year there whilst responding to an enquiry for my mother. My crackled voice revealed that she had terminal cancer—surely that was acceptable? The second and third occasions of emotional displays with my former colleague were different and happened in my tenth and eleventh year of working there. With great emotion in my voice and printed on my face, I confronted festering issues—fairness, communication, honesty. My argument was considerably weakened (in their eyes) by tears...

*"**Will you be able for it—the hospital side of it?**"* a former colleague had enquired. Their voiced concerns filled me with self-doubt then, and still echo now—am I too emotional for the job?

I sipped the water provided—glad my blazer was dark to camouflage the moisture stinging my underarms. "What is your personal experience of loss?" was the interview question that derailed me. One of the interviewers held eye contact whilst the other two fidgeted with something—pens most likely. I did not feel their eyes. Just one pair intently awaited my answer. Ineloquently, it came cascading out; my mum. Her stroke. Teaching her to read and write. Losing her. I welled up. My face felt red and patchy and my voice crackled as I

spoke. The gesture to take a drink, to take a moment was offered. I unnervingly took a sip. The cold water returned me to the moment. To my surprise I got the job. I must be suitable for it after all and *maybe 'emotion' or 'softness' is required?*

My mind drifts back to my childhood, to a playful activity…hidden in tall grass, plucking petals from a daisy, chanting, "*He loves me. He loves me not*". Instead, now I mockingly play with petals; *"I am emotional. I am not emotional. I am emotional. I am not emotional".* The truth is it has become painfully clear how unstable my emotions are. I do not know when, where or with whom I will get upset. My increased heartbeat timely symbiotic of the ticking time bomb within. I cannot trust myself! My reactions feel unmanaged, but this process has brought greater clarity. I think I have unearthed why…

I have supressed the grief and tears I have for my mother. I have tried to deny her death, her unquantifiable loss in my life. I do not speak openly about her. I do not keep pictures of her. The day we buried her, I also tried to bury my loss and my pain. It hardened me, yet it softened me. I am strong in the most challenging moments, both physically and emotionally, and emotional in the most trivial moments. It has made me care greatly for others as my loss hurt, and I now in turn understand the hurt of others. It has made me porous and permeable to the pain of others. This autoethnography process, and the socio-cultural context of the hospital school, have highlighted me to my own repression of grief…Unexpressed grief…Mourning… Repressed tears… And loss. They have colluded and functioned as a mirror, reflecting back to me on the page or in the faces of others, the pain and emotion buried inside, the suppressed grief. I have not dealt with losing her. I have

come to understand that at unpresented times, and places, and perhaps under the falsehood of something else, the pain of losing her comes cascading out.

I wrote the poem “The Mighty Oak” during this autoethnographic process to try to acknowledge her, but by acknowledging her, I am acknowledging her absence properly for the first time in thirteen years. The poem does not do her justice, nor does it begin to convey the affects her loss had on me. The poem helped me to understand that my mother’s death, caused by the rot of cancer, made me sensitive to other people’s pain—it made me more emotionally empathic. Empathy is a desirable trait to possess but for the most part, it has proven to be disabling…and, it has taken its toll on me:

Knowingly, **I** see the rot,

Decaying, destroying,

And

I know,

I feel it.

The process of writing and reflecting, whilst difficult and painful, has begun the process of allowing me to, at the very least, acknowledge the source of my emotions and recognise the power of empathy, be it positive or negative. This combined with delving into literature and asking questions of other professionals has served to bring some resolution to my questions… Why am I emotional? How can I balance emotionality and care, and

ultimately, how can I be the best hospital teacher I can be? The next chapter presents the findings of the research study.

Chapter 5: Phase Two

'Insights gained'

5.1 Introduction

The purpose of this study was to unearth and attend to my most pressing tensions—emotions, care and empathy. My research question evolved to the following:
How can I teach and care for students in emotionally challenging environment.
Subsequently, the study was framed on the following subsidiary questions:

1. How can I manage the **emotional weight** and of working in a hospital setting?
2. How can I balance the tensions between **teaching and care** in a hospital setting?
3. How can I enhance my understanding of the **role of empathy** while working as a teacher in a hospital setting?

This chapter presents the findings of my research study. It draws on my autoethnographic piece (Chapter 4); personal data; and the external perspective from literature, my critical friend, my supervisor, and four interview participants Ellen and Cathy, mainstream teachers (MT), and Jane and Sarah, hospital school teachers (HT).

The findings that emerged are discussed under the headings below:

1. Emotionality as an on-going challenge;
2. Empathy understood and the need for self-care; and
3. My re-conceptualization of care as a core value.

5.2 Emotionality as an On-going Challenge

All participants, regardless of the educational setting, stated that aspects of their role affected their emotions. Mainstream teachers described their work as *"stressful"* (Cathy MT), *"paved with guilt… physically and emotionally demanding"* (Ellen MT). Ellen acknowledged how she finds it extremely difficult to *"shake off"* sad news about a child's background or an upsetting incident. She also acknowledged:

"I bring my passion to every aspect of the job, and I can become very emotional when my passions are denied".

In contrast, the data revealed that the greatest challenge faced by hospital teachers was the emotional aspect of the job. Sarah (HT) specifically highlighted the difficulties experienced (green) and the on-going nature of this challenge (yellow):

> "*The emotional challenge for me is the greatest difficulty. It's really hard to see children so unwell. It's really hard to see their families hurting. These people are at their most vulnerable, it can be heart-breaking to watch. Ultimately, the most difficult aspect is when a child passes away. It doesn't get any worse than that, how could it…it doesn't get any easier…"*

Importantly, the hospital teachers in this study noted that the emotional aspect caused by the death of their students, or the threat thereof, was by far the greatest challenge they faced. Their data concurs with Keehan (2019), Steinke et al. (2016), and Lemke (2004) and is depicted in Figure 5.1.

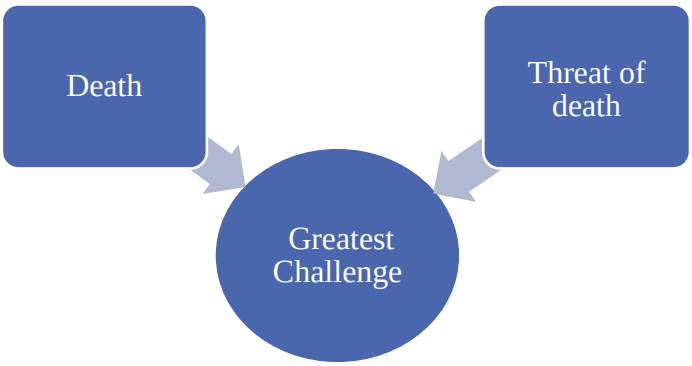


Figure 5.1: The Greatest Challenge

5.2.1 Capacity to Cope Emotionally—A Developmental Process

The questioning of my ability to cope with an emotionally-charged job was noted in Chapter 4: "*will you be able for it?"*—'it' being the emotional aspect that comes with working in a hospital setting. Similarly, Sarah (HT) shared her initial doubts about her emotional capacity, and how she has learned over time:

> *"I didn't know if I'd be able for the job—emotionally. I had to learn as I went along".*

In congruence, Jane (HT) noted how *"it took years to learn how to manage the emotional aspect of the job",* and how she is still learning, believing that sometimes she gives "too much" of herself to the job. Interestingly, Hilliard and O'Neill's (2010) study with paediatric nurses found that nurses were not immune to their patients' pain. These findings correlate with Hen's (2020) study, who found hospital teachers work to be difficult, stressful, painful, and overwhelming. *"Difficult"* and *"stressful"* were words uttered by hospital teachers Jane and Sarah, and while painful and overwhelming were not articulated,

they may be interpreted as being implied. The triangulation of data revealed that the emotional struggle of working in the hospital environment is difficult, ongoing, a shared experience and it takes time to learn to cope.

5.2.2 Impact of Emotions on Practice

All participants articulated the impact of their emotions on their practice. Sarah (HT) notes:

"We know what it's like to be affected emotionally at work, so we are quite good at minding each other when times are tough".

Additionally, Ellen states:

"Emotions will always have some impact on the decisions I make".

This amplifies Goleman's (2011) recommendation for the need to pay attention to our emotions in order to control our reactions, and recognise their impact on others and our practice. Furthermore, Zembylas (2005) and Nias' (1996) claim of the centrality of emotions in teaching and their influence on professional practice and decision-making is verified by data correlated in this study.

5.2.3 Emotional Regulation and Displaced Expression of Suppressed Grief

Supressed grief hailing from my mother's death was painfully revealed in my autoethnography. I also unearthed how the socio-cultural context of the hospital acted as a

catalyst for my grief. Grief scholar Delaney (2016) states that witnessing grief can activate our own, and can manifest as difficulty in regulating emotions. Moeller (2017a) gives the example of a garden trigging a memory of a loved one, and suddenly happy feelings lead to a place of sadness. Moeller (2017a) connects this experience to suppressed grief. My autoethnography revealed:

"This time sun-kissed leaves steal my attention. They are suffice to cause silent tears to form.

What is WRONG with me? Why am I so emotional?"

Interestingly, 'grief' was absent from the data collected from the interview participants. That said; data retrieved from the interviews revealed a shared experience—of dealing with the threat of emotional displays, something that I viewed as unique to me. Ellen (MT) noted becoming "*visibly upset*". Interestingly, Sarah (HT) acknowledged she has:

> *"The ability to be resilient and strong in the most heart-wrenching moments but then the most trivial thing can set me off—this is a sign that I need to take stock and try to manage my emotions".*

Sarah's shared insight helped me; I recalled occasions that I was extremely strong or as described in my autoethnographic piece, I "held it together". But like Sarah, I became emotional at trivial things. Sarah recognised that these moments signal the need for her to recognise and manage her emotions. In contrast, I justified them under the explanation of

being an “emotional person”. Sarah’s self-understanding was significant and insightful learning for me. It influenced me to understand my emotions, learn from them, and focus on dealing with supressed grief and enhancing my emotional intelligence. A benefit of autoethnography, as recognised by Adams and Ellis (2012), is its therapeutic possibilities and the ability to positively transform lives.

5.2.4 Emotional Intelligence—Self-awareness of my Self-regulation

Prior to this study, I failed to recognise and develop critical elements of emotional intelligence as outlined in Figure 5.2. Emotional intelligence is described as the ability to monitor your own emotions, the emotions of others, to distinguish between and label emotions correctly, and to use emotional information to influence your thinking, behaviour and that of others (Goleman, 1995; Salovey & Mayer, 1990).

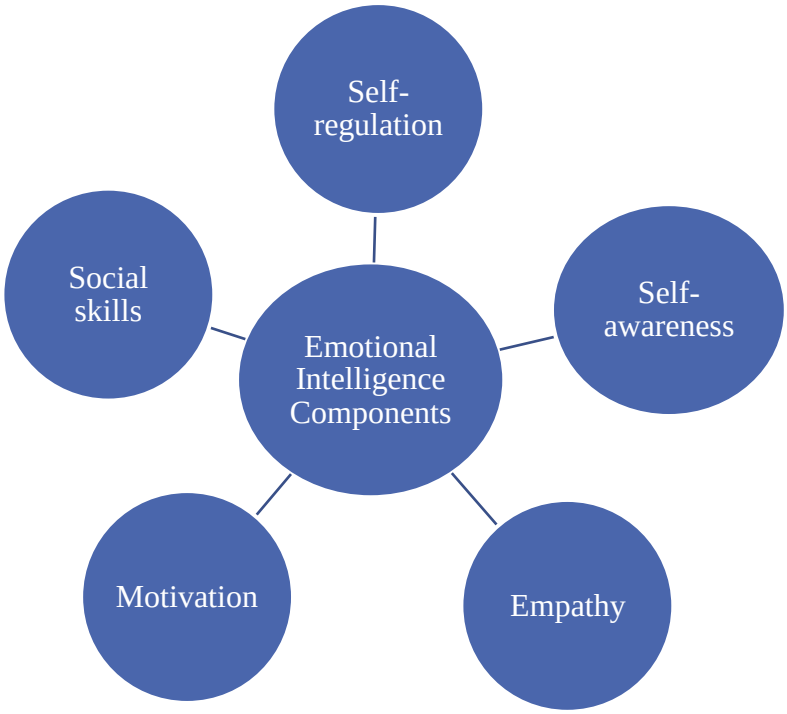


Figure 5.2: Emotional Intelligence Components

Source: Goleman (2004)

What follows next is a discussion of the relevance of two of these components in the context of this study. All interview participants articulated the need to possess high emotional capability. In particular, self-regulation was explicitly stated by Cathy (MT) and Jane (HT) as an essential emotional skill and so too was self-awareness by Sarah (HT). The latter, self-awareness, is "the ability to recognize and understand your own emotions" (Cherry, 2020a: n/d). It also encapsulates being aware of the effect your actions, moods, and emotions have on other people (Cherry, 2020a). Self-regulation, Ackerman (1996) describes, as being able to appropriately express, regulate, and manage your emotions.

Through deep reflective practice, I have discovered that on occasions, my lack of emotional regulation manifested itself in a tendency to lose control of my emotions. Furthermore, I have learned that self-regulation is not about burying one's emotions (Cherry, 2020a). Rather, it is concerned with waiting for the right moment to express them appropriately. My autoethnography revealed that I was burying my emotions, suppressing grief, which was negatively affecting my ability to self-regulate. Benefits of being self-regulated, and which are vital to working effectively in a hospital setting, include living in accordance with your values, calming oneself when upset, cheering oneself up, persisting through difficult times, remaining flexible, and adapting to situations (Cuncic, 2020).

5.2.5 Emotions and Professionalism

A significant finding for me was the varying views held by the participants about displaying emotions as a professional. Ellen's (MT) view and behaviours reflected my previous held beliefs:

> *"I bring who I am, what I consider to be right and wrong…idealistic or not to the job…they need to see who you are as a person…I feel this makes me the teacher that I am".*

She continued to describe not being able to hold back her emotions—being "*visibly upset",* noting "*if values are threatened I'm upset"*. Ziv (2020) notes that acceptability of becoming upset at work depends on the situation, frequency, audience, and the work environment.

During the process of retrieving personal data, my reflective journal reflected similar traits to Ellen:

"while listening to the teacher relay her experience, I became emotional" (Shore, 2020a).

This extract is consistent with what Reiss (2017) documents as being 'emotionally empathetic', which leads to the listener feeling overwhelmed, responding inappropriately and being unhelpful. In congruence with Ellen, my autoethnography demonstrated my inner turmoil in response to the threat to my value of care:

> "The emotion inside manifests as anger and my heart races as I desperately try to type - my typing skills incapable of moving at the speed of the fuelled anger emerging inside…***health comes first!"***

My emotionality mirrored that of Ellen—ever-present in my professional practice. Being a teacher is a values-laden profession and teachers are very heavily invested in their values and philosophies of education (Bektas & Nalcaci, 2012). Therefore, coping with challenges to one's values and philosophies requires emotional management.

Ellen's views contrasted with the other three participants, who stated the necessity to engage in "emotional labour"—the ability to mask emotions to suit the situation. According to Côtê et al. (2006), a certain amount of emotional labour is required to work professionally. The hospital teachers acknowledged that masking emotions is "part of the

job". Jane (HT) described being a witness to emotional moments, and having "*to hold herself together*", paste a smile on her face, and teach her next student. Sarah (HT) declared that she had to learn to mask emotions quickly. Sarah noted:

> *"given the setting, it is inevitable that you will become emotionally charged, and professionally it is not appropriate to get emotional when dealing with families or children. It's not fair on the family."*

Sarah acknowledged her ability to express the emotion when she is safely away from the situation:

> *"I just don't want a heart-broken family having to comfort me".*

Furthermore, like Jane (HT), she recognised the need to be there for parents in a supportive and empathic capacity. This reminded me of the unwavering significance and ever-present demand for empathy. Findings relating to empathy are addressed in the subsequent section.

5.3 Empathy Understood and the Need for Self-care

5.3.1 Empathy

Critical dialogue with my critical friend identified empathy (discussed later) as my strongest emotional intelligence competency. Engaging in autoethnographic writing revealed my experience of personal loss and empathy as my mother's parting gift—her death sensitising me to the pain of others. This was revealed at the end of my poem:

She glances across to the encroaching wood,
Where others stand.
Knowingly, She sees the rot,
Decaying, destroying
And She knows…

Prior to commencing this study, I had a basic understanding of empathy. I believed that 'feeling' the pain and hurt of another—mirroring' it—was a sign of being an empathic person. Emotion conveyed how much you cared and it depicted your ability to be empathetic. I was misguided. Ekman's (2003) tripartite classification of empathy opened my eyes to *compassionate empathy* as the most favourable form of empathy. It is characterised by the ability to be compassionate by actively listening to the other person's concerns without becoming overwhelmed. My data, informed by Reiss (2017) and Borg et al. (2014), revealed that I displayed *emotional empathy*, rather than compassionate empathy, thus becoming overwhelmed, unhelpful and often professionally inappropriate. Researchers advocate the need to practise empathy (Eyal, 2018) and expanding ones horizons through new experiences and reading extensively to develop the perspectives of others. Additionally, suggested is talking to someone new and moving beyond small talk, acquiring new information and understanding about them (Eyal, 2018). Furthermore, the Teaching Council (2016) and all four participants advocated empathic teaching; it "strengthens relationships" (Ellen), is "an important trait" (Jane), and makes you a better teacher (Ellen & Sarah).

5.3.2 Self-care

What has become clear during the analysis of data is the need to engage with self-care. Jane and Sarah acknowledged their regular emotional vulnerability. Jane shared her struggles:

> *"it's really hard but you try your best to forget about it, put it to one side, put on a happy face and go into another bedroom and introduce yourself to a new parent or child to teach for thirty minutes—after hearing some really bad news"*

The ongoing emotional challenges and the practice of emotional labour arising from the hospital context points to the need for hospital teachers to partake in self-care (Isenberger & Zembylas (2006). Furthermore, it helps one to manage emotions and practice compassionate empathy.

Self-care is about taking care of one's health and 'equipping' oneself to thrive as a teacher (Waterford, 2020). It is defined as "any action that you use to improve your health and well-being" (Waterford, 2020, para. 5). Lawless (2020) refers to the analogy of putting on your oxygen mask first, reminding us of the need to look after oneself before being equipped to support others effectively. Teachers are more effective in their role when they look after their own well-being (Lowry, 2020). Learning about and practicing self-care gives one the foundations to deal with everyday stressors and challenges (Lawless, 2020; Waterford, 2020). Mental health organisation, Jigsaw, regard self-care as having a preventative focus and a means of proactively taking steps to enhance resilience, ability to cope, and ability to handle challenging encounters (Lawless, 2020).

While the sources of stress vary from teacher to teacher, the outcomes remain the same—weakened physical and mental health (Waterford, 2020). This finding highlights the need for teachers and all professionals, including myself, to engage with self-care practice. All four participants reinforced this point but Jane (HT) noted that she would like to see it become a priority in the work place.

5.4 Re-conceptualising Care as a Core Value

In autoethnography, a purpose of interviews is to provide data that may stir contemplation and provide new insight (Chang, 2008). This was the case with the outside perspective of care. Figure 5.3 illustrates the different perspectives of care identified by both sets of teachers, in their respective setting.

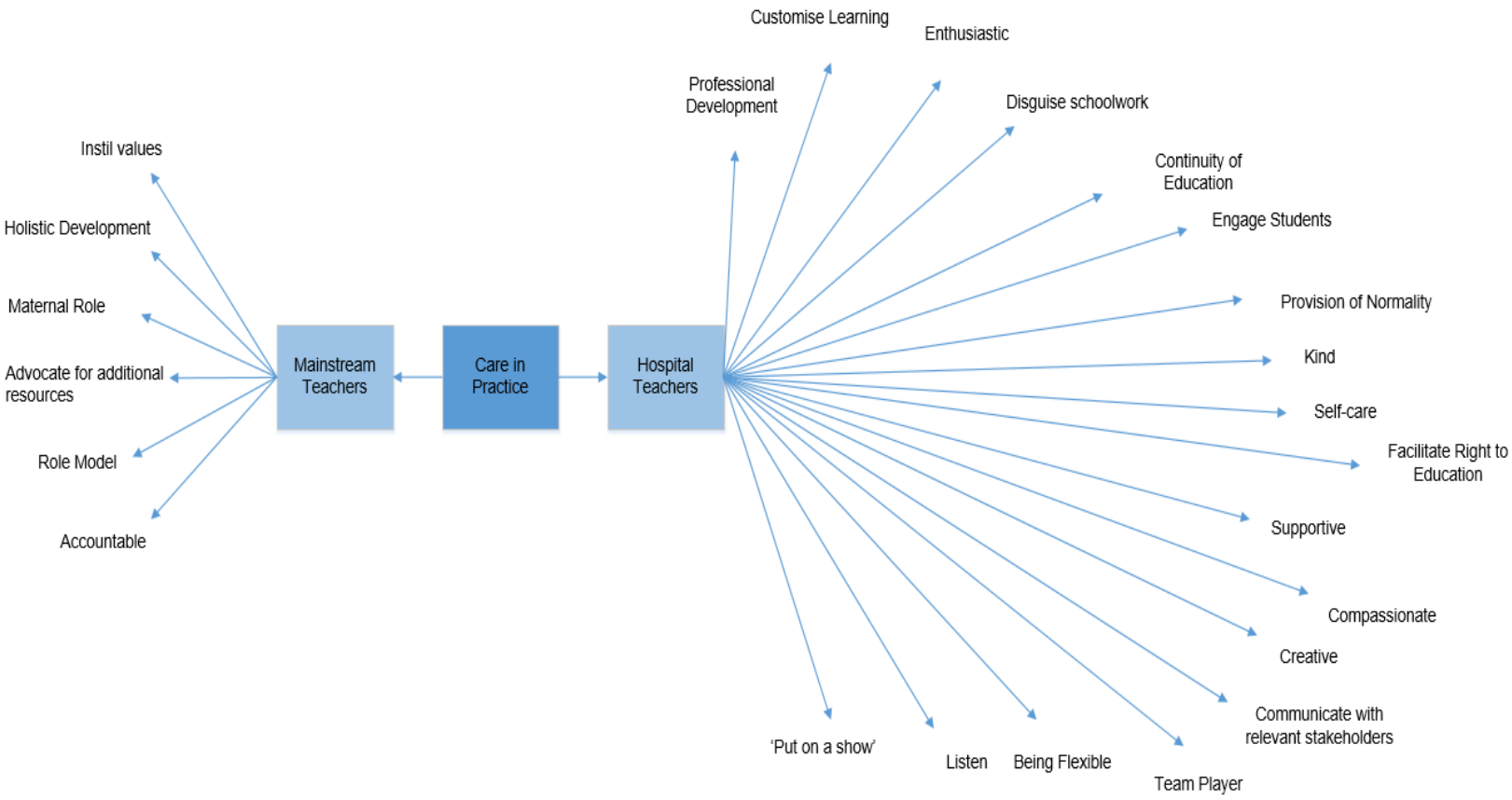


Figure 5.3: Different Perspectives of Care

The different perspectives of care, as depicted in Figure 5.3, prompted me to look deeper at my own understanding of said value. The image of myself as 'The Salesperson' in Chapter 4 highlighted the tensions I experienced with a target-driven teaching culture and my innate desire to care for the children at a deeper, more fundamental level. However, I have come to realise that this tension was fuelled by the 'narrow' view I held of care. When writing my value statement I wrote:

> *To me, care means being compassionate, empathetic, understanding, and supportive of others. Putting the child's well-being first above curriculum goals and objectives. I agree with Ferguson (2015), who describes care as loving others, in a non-sentimental way (Shore, 2019a).*

For me, care was rooted in being compassionate, understanding and supportive. According to Jeffery (2016) and Goleman (2011), these are characteristics of empathy. Furthermore, I realised that my conceptualisation of care was "narrow" and inextricably linked with empathy and emotions. The quote from my reflective journal depicts this:

> *"I have to learn to control my emotions, focus on keeping my own reactivity at bay, unhook myself from the 'situation' and therefore give more effective support. Being empathetic is a strength, but needs to be practised more effectively to prevent self-sabotage. I need to take the steps necessary to grow and develop, to learn to manage my emotions more effectively, thus enhancing my practice". (Shore, 2020a)*

Interestingly, Sarah (HT) described, *"caring enough to park my feelings".*

Additionally, the interpretation of data brought another moment of deep personal enlightenment. I also discovered that my concept of care was one based on maternal

traits. The poem entitled “The Mighty Oak” (Chapter 4)—a metaphor for my mother, symbolizes her strength and influence on traits such as selflessness, protection, nourishing, caring and loving. Meta-reflection later revealed the teacher as “The Mighty Oak”. The role of the mother and teacher merging, intertwined, and inseparable:

Her branches engulfing a clump of trees,
Favouring none but favouring all!
Tightly nestled,
Protected.

Interestingly, both mainstream teachers articulated similar views.

> “*You are like a mother figure to each child…a substitute parent…particularly for children from challenging backgrounds… you take on an increased duty of care for those children*”. (Ellen, MT)

Cathy (MT) revealed that

> “Y*ou take it on as their teacher to try and bridge any gaps that may be occurring in their care…that they are clean each morning, that they had breakfast*”.

This is also supported by Bootwala (2019), who notes the surrogate parent role played by teachers, and by Prasanna (2020) who reports the essential protecting and nurturing role of the teacher, and inadvertently being role models. Mainstream teachers Cathy and Ellen also noted the “role model” aspect of the job. Hough (2020), and indirectly Maslow (1970) and Garza et al., (2014) recognise the maternal role, with the latter pair advocating for attending to children’s psychological, safety and belonging needs.

Comparisons of data gathered helped me to realise the absence of the 'maternal role' in the hospital school setting. The absence of enacting the 'maternal role'—a caring role—had possibly contributed to me feeling that my practice felt devoid of care. Noteworthy, hospital teachers work in a context where parents are often present, in addition to nurses and carers. As identified by Andreatta et al. (2015), Hopkins et al. (2014), Jane, and Sarah, the hospital teacher is competing for time with their students against assorted contextual demands. Furthermore, they are working with a transient population of students, which further challenges their enactment of care. Jane (HT) noted the need in her role to be kind, compassionate, empathetic, flexible and creative. Sarah (HT) noted the need to "listen to and support parents". The absence of data revealed to me that the 'maternal' aspect of the teaching role is utilised less in the hospital setting. This was surprising given the particular vulnerability of the children. I had assumed this aspect of the job—nurturing, loving—would be utilised extensively, but this was not the case. This finding correlated with the loss I was experiencing of the 'maternal role' in my teaching duty, as I moved from mainstream to hospital teaching.

Interestingly, the hospital teachers' view of care included non-relational based aspects, and helped me to consider planning, curriculum selection, teaching methodologies, professional development and self-care as an integral component of care in practice. Sarah explained:

> *"Care in education for me applies to four things, caring for the children, wanting to get the best out of them, having a vested interest in providing them with opportunities. Caring about your job professionally and putting effort into being proud of your work. Caring about your colleagues and their wellbeing and caring for yourself."*

The participants' perspectives once again urged me to reflect on my conceptualisation of care. Professional dialogue with my critical friend helped me to identify three domains that encapsulate care—students, my practice, and self. However, in my opinion, certain elements of care are not restricted to one particular domain, and as such, there may be crossover, as illustrated in Table 5.1.

Students	Practice	Self
Be kind and compassionate		
Provide continuity of education		
Facilitate normality		
Advocate for additional resources		
	Communicate with stakeholders	
	Plan	
	Be a team player	
	Engage in professional development	
	Practice emotional labour	
		Develop self-care plan
Be a role model		
Engaging learning opportunities		
Students holistic development		
Build relationships		
Foster belonging		
Create a child-centred curriculum		
Cater for individual needs		
Know their interests		
Provide the right to education		
Provide a quality education		
Provide a happy and safe environment		
	Develop emotional intelligence	
	Develop compassionate empathy	
	Upskill	
Build relationships		
Listen		

Table 5.1: My Informed Conceptualisation of Care

Table 5.1 illustrates my informed conceptualisation of care. In line with the goals of action research, the researcher improves their practice (Elliot, 1991; Sullivan et al. (2016), and transforms their way of thinking (Kemmis, 2009). My new understanding

had a transformational impact on my self-esteem, identity, and the enactment of care in my practice. Significantly, my understanding of care includes the provision of the hospitalised child's right to an education, which is subsequently discussed.

5.4.1 The Right to Education as an Enactment of Care

All interview participants recognised that their main role is "to educate". As identified earlier, and significant for Steinke et al. (2016) and both hospital teachers, is their role in providing the continuity of education for hospitalised children. Sarah notes:

> *"So to ensure that children who are hospitalised are given the same opportunity to access education and ultimately the same educational outcomes as their healthy peers".*

However, personal data unearthed my struggles with this fundamental role of the teacher. "Health comes first"—a mantra embedded in my being. In Chapter 4, I revealed a conflict between my practice and my value of care.

> *"Canvassing for school in this medical setting often leaves me feeling insensitive, uncaring, and oblivious to their pain".*

The perspectives gathered from interviews and dialogue with my critical friend caused me to meta-reflect on myself as a living contradiction. The quotation below from a reflective task, revealed how my feelings towards the illness of a sick child, derailed a planned lesson.

> *"Right now I don't care about the learning outcome as long as she is enjoying the process. I just want my student to have the happiest time possible when I'm teaching her…whatever brings a smile to her face."* (Shore, 2019a)

This extract illustrates that my value of education was rapidly losing significance and negatively influencing my pedagogical thinking and practice. However, probing from my supervisor led me to reflect; "should sick children learn, or simply enjoy?" An examination of my practice showed that I was leaning towards the latter, often at the expense of the child's learning and my own professional self-image. Reflection on my practice and on Nodding's (1995) ethic of care—both of which imply a continuous search for competence—helped me to arrive at a new understanding. The hospitalised child "has a right to a quality education…and it is my job to provide it" (Shore, 2020a). I was failing to look past the illness to appreciate that care also includes facilitating a quality education to every child. So rather than seeing education as something that is compulsory, it is an entitlement that everyone can enjoy and does not have to be a chore. I need to look at the value of education differently through the lens of a sick person. Keehan's (2019) study with hospital teachers noted hospital school to have psychological benefits and the ability to instil messages of hope about their future. Furthermore, Kaffenberger (2006) recognises the importance of educational interventions for hospitalised children in helping to elevate potential decrease in motivation, self-confidence and achievement.

Additionally, critical engagement with Kelchtermans (2018) and Zembylas (2018) helped me to recognise how my tensions with 'contextual conditions' need to be overcome in order to facilitate the child's right to an education. Up to this point, I allowed structural vulnerabilities, such as the tasks of enrolling or "selling school" to

sick children, to negatively influence and impact on my professional self-understanding, as well as my teacher identity. Data shared by the hospital teachers also helped me to understand the necessity of this action in helping to ensure their continuation of education. Sarah noted:

> *"children whose education is interrupted by frequent or recurrent hospitalizations are at risk of disengaging from education…it's a role of ours to ensure that they remain connected"*

Informing and enrolling students is the first step in ensuring that children remain "connected" to education. However, Sarah advocates that in order to avoid any unnecessary distress for the child and their family, the need to "*tread carefully*" and *"empathetically*" is paramount.

My journal revealed that I had originally assumed parents of a critically ill child placed no value on education (Appendix A). However, Keehan (2019) and Walton (1951) helped me to understand that hospital education is a sign of equality with 'well children' and a means of instilling hope for their future. Sarah reminded me of the significance of providing education to a chronically ill student, "s*omething as trivial as school can mean so much to a family"*. Collectively, these influenced me to meta-reflect on my assumption. I wrote in a reflection:

> *"a distraught mother, advocating for her daughter's life mentions the teacher and the importance of hospital school in her life. I am wrong to think that health is all that matters to families; they want her to live life and part of that is school" (Shore, 2019b).*

This reflective experience has helped me to establish that I have to be alert to my held beliefs and assumptions. I must recognise how they have been influencing my practice. McNiff and Whitehead (2009) encourage periodically reflecting on, critically evaluating, and modifying ones values, if necessary. I now feel passionate about the need to sensitively advocate for a child's right to school while exerting positive influence, professional judgement and empathy (Teaching Council, 2016).

Furthermore, Craft (1984), recognises two Latin roots of the word education; "Educare" and "Educere", the two combining to balance education and care. Similarly, I now understand the symbiotic relationship between the provision of education and care in my new context. While the main role identified by the four participants is "to educate", Ellen (MT) attests that "the caring role is equally as important—if not more so". Her view helped me to recognise that while my setting is uniquely challenging, the importance of care and enactment of education is a balancing act for all teachers, in all settings.

5.5 Conclusion

The findings in this chapter illustrate my new knowledge gained from this research study. The external perspectives were invaluable in acting as a stimulus to meta-reflect on and provided new knowledge. My value of care expanded from being nestled in empathy and a maternal encasement, to incorporating a far-stretching conceptualisation that encompasses the hospitalised child's right to education. My need to participate in self-care and focus on supressed grief and developing self-awareness, self-regulation and compassionate empathy were also highlighted. This process has led to a reframing

of my identity as a hospital teacher, which will be explored in the subsequent and final chapter of this study.

Chapter 6: Conclusion

'New wings!'

"*A bird sitting on a tree is not afraid of the branch breaking, because her trust is not on the branch, but on her own wings"*

(Anon)

6.1 Introduction

This concluding chapter begins with a recap on the path taken and the challenges I encountered in this research study. It then presents a summative overview of the findings, and documents their impact on me and my hospital teacher identity. I next discuss implications, limitations and the possible dissemination of the findings. This chapter and thesis closes with a reflective conclusion.

6.2 The Path Taken…

The selection of autoethnography as a research methodology was a natural consequent for three reasons. One, it accommodates research that better enhances understanding of self, their culture and their experiences within their culture (Adams et al., 2015). Two, autoethnography provided me with the creative freedom to approach, recognise, and honour the turmoil I was feeling. Autoethnography values vulnerabilities and making senses of challenging experiences (Ellis & Bochner, 2000). It enabled me to express untold and complex feelings and emotions, and use them as 'personal data' (Muncey, 2010). Third and most importantly to me, it privileged 'self' (Ellis, 2004) and this inadvertently addressed my ethical concerns. It facilitated the omission of students and

parents—a vulnerable cohort—as participants in the research, without damaging the richness of the study.

The relief I felt as a result of their exclusion from the study blinded me to the challenges autoethnography presented; one of the most 'challenging' qualitative approaches to attempt (Wall, 2010). I was blind to the gruelling process it demands. In search for data, every old cobweb of my life was disturbed, explored and placed under the microscope. This study contains only relevant data, but the process of data retrieval was very demanding—physically and emotionally. Scavenging through my life artefacts, old boxes of treasured gifts, photos forgotten, letters and cards from loved ones no longer…my past cascaded over me…taking over my present, invading all my thoughts. The constant exposure to my past was one of the toughest challenges of autoethnography as a methodology. Additionally, autoethnography required me to invite the reader in to share in my cultural experiences (Ellis & Bochner, 2000). I had dismissed the challenge of writing in order to evoke resonance and feelings in the writer, while simultaneously being authentic and true to myself. The process was all-consuming. It erased fresh air from my life as I refused to move until paper was inked. That said, I surprised myself in my ability to endure until I scripted the right word or right phrase to echo the intended sentiment. Developing a 'grá' for narrative writing was not in any way the goal of this research, but it was a surprising finding, similar to discovering a twenty euro note in an old pair of jeans…unaware of it but excited by its presence.

6.3 Findings

The purpose of this research study was to address the challenging tensions I experienced as I embarked on a new stage of my career as a teacher in a hospital school. My research path was not predesigned, but was born organically from my contextual experiences. Autoethnography facilitated the exploration of these tensions (Ellis & Bochner, 2000) as they surfaced in the written and spoken word. Direction and clarity emerged from thematic analysis of my reflective writing and from critical discourse with my supervisor. The process unearthed my tensions, which were grounded in three inter-related areas; emotions, care, and empathy. Upon unearthing this, I refined my question: As a hospital teacher, how can I balance education and care in an emotionally challenging environment. In answering this question, the study set out to answer subsidiary questions below, that I believe it achieved.

1. How can I manage the **emotional weight** of working in a hospital setting?
2. How can I balance **teaching and care** in a hospital setting?
3. How can I enhance my understanding of the **role of empathy** while working as a teacher in a hospital setting?

6.4 Emotionality as an On-going Challenge

This research study unreservedly highlighted my emotionality—augmented by the unique educational setting of a hospital school. Findings from this study, Hen's (2020), and Keehan's (2019), identified emotional challenges as the greatest challenge encountered by hospital teachers in their working environment. This was a significant and transformational finding for me. Prior to this new knowledge, I had questioned my suitability to working with sick children. My 'emotional personality' destined me unsuitable. However, in light of shared experiences and vulnerabilities from my peers and relevant literature (Hen, 2020; Keehan 2019), I have a renewed confidence in my

ability as a hospital teacher. The once confident mainstream teacher is re-emerging in a new context. I have looked outside of 'my world' to comprehend that experiencing emotional challenges and questioning my suitability to the role are not unique or original experiences. As a hospital teacher, I will experience emotional challenges and be exposed to loss, sadness and death. However, notes that it is imperative is the need to deal with these associated emotions (Delaney, 2016). This will be an on-going and necessary endeavour for me in order to work effectively in the hospital setting, as it will be for all personnel working in such challenging environments.

One such emotion likely to arise in said context is grief. Bowlby's (1958) attachment theory recognises that we are hard wired to attach, and grief is the consequence of when we need to let go (Horst & Frank, 2011). Moeller (2017) and Delaney (2016) note that we are equally hard wired to adjust to and integrate change. Just as the physical body heals, so too can the "psychological immune system" (Delaney, 2016). However, complicated or suppressed grief is when the grieving process becomes 'stuck' (Delaney, 2016). One such consequence of complicated grief is difficulty regulating emotions (Delaney, 2016). Grief recovery (James & Friedman, 2009) is a theory for dealing with supressed grief. It recognises that time passes, but does not necessarily imply healing. It is the actions you take that determine how completely you recover. In addition, this may include identifying what you wish was more of, different, or better. These actions are unique to each individual and may involve using tools to identify the unsaid, unrealised hopes, dreams and expectations. It involves taking specific actions to heal the heart. For example, where a person is unable to listen to a loved ones favourite song, the first step might be to download the song, and progress from there. Grief recovery (James & Friedman, 2009) strives to identify what was left incomplete and emotionally

unfinished, so that it does not impact on one's quality of life moving forward. As my autoethnography acknowledged, I have no memorabilia of my mother. My first step will be to source a photograph of my mother for my apartment. Furthermore, for me, dealing with my supressed grief will involve the writing process, as I found writing this autoethnography to be therapeutic. Hooks (1994) recognises that writing is a way to label pain, and in doing so begin to heal. I will engage in conversations with family members to trigger memories and subsequently write to help articulate the areas that need healing. I expect this to be an emotional but a healing process.

Delaney (2016) notes that the grief of others can ignite personal grief and supressed grief. This has implications (Delaney, 2016) for me and others in a similar situation. Loss presents itself in various forms such as loss of life, a previous way of life, an envisaged future, or normality. Therefore, training to deal with emotional pain, one's own and others, is essential. Delaney (2016) and Neff (2020) recognise that self-compassion is a crucial part of the grieving process. Neff (2020) notes the similarities in having compassion for yourself and for others. First, you must take notice. Second, feel moved to respond. Finally, realize that suffering is a shared human experience (Neff, 2020). Practicing self-compassion means not ignoring your pain, but asking yourself "how can I comfort and care for myself in this moment? (Neff, 2020). Liebenow (2015) recognises that permission to grief fades with time. This implies dealing with experiences of grief in a timely fashion so to avail of offered support. Keehan's (2019) study with hospital teachers, and Hilliard and O'Neill's (2010) with paediatric nurses, reported that collegial support was the most effective support as, colleagues understanding was essential to those seeking support. Going forth, I believe that I, along with other staff, could debrief at the end of the day. This would be beneficial for me and

for my colleagues, as it allows us to deal timely with experiences we may have encountered that day.

Cherry (2020a) contends that to be emotionally self-regulated is not to bury ones emotions, but to deal with them appropriately. My research study has helped me to realise that much of my emotion was due to an accumulation of suppressed grief that has surfaced at unprecedented times. Thus, I was not dealing with my emotions appropriately or effectively. This new learning has shaped my future outlook and behaviour. I am aware that when I encounter challenging and emotional situations, I need to learn to deal with the emotion, in a suitable and timely manner. On a personal level, I will utilise the services within the hospital and teaching system, periodically and as required. Additionally, I plan to enrol in a course aimed at developing my emotional intelligence.

This study revealed the necessity to practice emotional labour—to mask my emotions to suit the situation. Bakken (2011) and Goleman (2011) recognise the need to manage emotions at work, and that a certain amount of emotional labour is necessary to work effectively with others (Côte et al., 2006). This is also exercised by nurses as a strategy to protect themselves from emotionally challenging situations (Hilliard & O'Neill, (2010). I believe it is not appropriate for hospital staff to be the ones needing comfort where families are trying to deal with their own worries and loss. The phrase "to care enough to park your own emotions" uttered by Sarah has stayed with me! I need to practice this strategy to protect my well-being and to remain professional. That said, the negative consequences of emotional labour can be damaging to one's general health, and can result in a weakened immune system (Moeller, 2017). Thus, this finding has

given me a greater appreciation and passion towards practicing and advocating the need for self-care.

6.5 Reinforcing the Need to Practice Empathy

This study set out to enhance my understanding of empathy, a skill continually required when working in a hospital setting. "Empathy fatigue" is particularly prevalent with health care providers and carers (Schairer, 2019). Borg et al. (2014) and Reiss (2017) recognise the consequences of frequently feeling the distress of another; it can lead to burnout, which negatively impacts on ones well-being.

In this scenario, Ekman's (2003) tripartite classification of empathy becomes significant—with *compassionate empathy* identified as the most advantageous form for both the receiver and giver. Significantly, incorporating compassion into empathy helps to prevent burnout, as "compassion and empathy employ different regions of the brain…compassion can combat empathetic distress" (Schairer, 2019). Noteworthy, compassion elevates empathy; you recognise the pain of another and you try to alleviate the person's suffering (Schairer, 2019), "without accepting the energy as your own" (Carver, 2017).

However, I contend that alleviating suffering or taking action is not always possible in a hospital setting. In support, nurses in Hilliard and O'Neill's (2010) study expressed feeling "helpless". That said, the examination of care as a value has helped me to reconceptualise it in practice, and likewise, "moving to alleviate distress" may be very simple actions to which I need to alert "my antenna".

As aforementioned, emotions are always present, positive or negative, with the latter likely to be more prevalent in the socio-cultural context of my study. Carver (2017) notes the importance of being vigilant of such emotions as they will negatively impact on your well-being. In the practice of compassionate empathy, Carver (2017) recommends practicing emotional detachment, developing awareness, choose the situations that deserve your energy, soak positivity, and to "leave it at the door". These are steps I need to develop in my practice.

Recommended further, is the need to practice compassionate empathy in order to learn to act from a place between logic and emotion (Carver, 2017). Such practice results in having a balanced perspective and not getting carried away by other people's emotions, but moving beyond logic to take action. Additionally, compassionate empathy involves making a connection with others. Reiss (2017) developed the acronym "EMPATHY" to remember the key elements involved in connecting with others: Eye gaze; Muscles of facial expression; Posture; Affect of expressed emotions; Tone of voice; Hearing the whole person; and Your response. Interestingly, Reiss (2017) recognises that in order to be best placed to be empathetic to another, one must be empathetic to oneself. This reiterates the need to be self-compassionate and to practice self-care. As a professional, particularly within the hospital context, practicing compassionate empathy is a necessity for my well-being if I am to deal effectively with the challenges encountered in my practice.

6.6 Self-care a Necessity

As aforementioned, this study has highlighted the need for engagement with self-care—amplified by contextual experiences. Self-care is a preventative measure to avoid

burnout and as a means to equipping oneself to face on-going emotional challenges, dealing with suppressed grief, and responding to the practice of emotional labour. Self-care is a term with non-exhaustive possibilities. However, as identified by Waterford (2020), self-care means different things to different people. Interestingly, the National Institute of Mental Illness (NAMI), claim there are six elements to self-care: physical, psychological, emotional, spiritual, social, and professional (Waterford, 2020). It is suggested to create a self-care plan to incorporate an activity that addresses each element, and to further identify areas that may need developing (Waterford, 2020). I intend to examine one element every fortnight, and focus on improving and forming new habits that join me on my self-care journey. Jigsaw (2020) advises being flexible in changing your self-care plan to cater for what you need in a particular time-frame. Self-care activities include: planning time to decompress, finding ways to improve your self-confidence and self-image, learning to recognise and process your emotions, and keeping a journal to reflect (Waterford, 2020).

The need to engage with self-care is increased as a result of the challenges encountered in the work environment. I believe the time required to learn and enhance self-care skills should be incorporated into the school calendar, and prioritised. I now equate the importance of self-care training with medical education training provided to hospital teachers at the commencement of each school year. I hope that the findings of this study highlight the need for self-care education and act as a catalyst for staff training in the area. Furthermore, all careers working in challenging environments should be facilitated with education on the topic.

The World Health Organisation (WHO) recognise that governments have the greatest influence on creating healthy work environments as they set standards for the way employee health and well-being is prioritised (Burton, 2010: 69). This is of particular relevance to hospital teachers as they work in an environment that encompasses two major public services—health and education. Therefore, this study speaks to the Department of Health and the Department of Education, and to the boards of managers of hospitals and schools, to prioritise and actively support employee well-being. That said, I, and all teachers are responsible for our own emotional well-being and must actively seek to identify areas for enhancement to avoid emotional burnout and be equipped to deal with work placed challenges. This study resonates with all teachers wanting to improve their practice. The need to learn about themselves is paramount to their personal and professional development, as developing one is axiomatic to developing the other (West Burnham, 2009).

6.7 The Re-conceptualisation of my Value—Care

As a result of embarking on this study, my understanding of my care as a value has transformed. Influenced by literature (Noddings, 1995; Garza et al., 2014) and the participants of my study, it evolved from 'loving' and 'caring' aspects to scaffolding my new and all-encompassing understanding of care. My new broader conceptualisation of care, as documented in Chapter 5 (Table 5.1), is categorised under three equally-weighted domains—care for: students, practice and self. Identifying less humanistic portrayals of care as an embodiment was transformational in my identity as a teacher. Furthermore, recognising and valuing 'self' has been enlightening and impactful in shaping my future behaviour.

I now understand that care and education are intertwined, and not separate and distinct. They should be enmeshed, and one should not exist without the other. However, neoliberalism has made caring more challenging (Tronto, 2017). Through a neoliberal lens, education has become more standardised and policy driven; negatively impacting creativity and individuality imposing bureaucratic demands on teachers and schools. Furthermore, neoliberalism "has come to regulate all we practice and believe" (Metcalf, 2017). Interestingly, Metcalf (2017) draws on my own self-image, 'the salesperson', and how the attitude of the salesperson—meeting targets—has become embroiled in all aspects of society. While education is the right of the child, I believe its provision should not be impersonal, not a 'ticking of the box' practice that is becoming the fabric of school life. Instead, it needs to be an enriching experience, and in the context of care, should be changeable, personalised, and cater for the needs of the child on a given day. This is supported by the Froebelian philosophy that advocates for a child-orientated and holistic approach to education (Ildiz & Ahmetoglu, 2018). This is particular relevant to hospitalised students who need to be treated with love and kindness, and the education provided to them should be determined by their interests and needs.

Interestingly, the word education, in its Latin roots, denotes two contrasting meanings: Educare and Educere (Craft, 1984). The former implying passing on of knowledge, while the latter refers to the development of inquisitive and creative thinkers, ready to take on the challenges of the future. Bass and Good (2004) note that while both are recognised, Educare is prioritised by society, while achieving a balance between the two remains the goal. This depicts my personal dilemma of balancing education and care.

6.8 Providing the Right to an Education, an Enactment of Care

As aforementioned, one domain I have identified in my broader conceptualisation of care is ensuring hospitalised children continue to access their right to education (Keehan, 2019). This would seem 'crystal clear' to perhaps society and the reader, and indeed the previous me—a mainstream teacher—but working in a hospital school populated by sick children, some terminally sick…the waters become distorted. I now understand care to incorporate servicing the "continuity" of a hospitalized child's right to a quality education. This new-found clarity has impacted my professional confidence in a medical setting. I now passionately and sensitively advocate school to those children and their parents that are medically-cleared to attend. I believe this research study may positively influence hospital teachers, who are overwhelmingly outnumbered by medical staff, to undertake a similar research into their own educational practice that may lead to enhanced professional self-worth and a reframing of their identity. As Sullivan et al. (2016) note, personal and professional development is an aim of action research.

6.9 Ongoing Professional Development, an Enactment of Care

In relation to care towards my practice, findings in this study, as supported by Noddings (1995), advocate for the continuous search for competence as an enactment of care. While not explicitly referred to as an embodiment of care, professional development is too advised by HOPE and authors in the field of hospital schools (Keehan, 2019; Hen, 2020). This manifests itself as increased time spent planning for interests of potential students that may come in to my care, staying up-to-date with mainstream initiatives and programmes, and pursuing courses to improve my practice.

New insight into my value of care has and will influence my practice and confidence as a hospital teacher. It has opened my eyes to the need for me to engage with reflective practice, literature, and professional dialogue with colleagues and peers, to further articulate and live in accordance with my espoused values. Thus, it helps me to decipher what my values mean to me as a teacher in a hospital setting, and how they are conveyed (or not) in my practice. Furthermore, unexamined values may be having a negative influence on my teaching, as I may not be living in harmony with my espoused values (Whitehead, 1989).

6.10 Limitations

The global pandemic—COVID-19—resulted in the closures of schools since 12 March, 2020. This was an unprecedented event that impacted on the amount of personal data retrieved while working in the context. However, the nature of my study was favourable to the constraints imposed by COVID-19, as student and parental participation was not a source of data. Their exclusion was an ethical decision on my part, and not determined by management in my context. I felt strongly about protecting this vulnerable cohort from my study. They already have a great deal of information to filter from medical colleagues and I formidably believe that school should not add to or enlist any potential anxiety. That said, the inclusion of the fourth lens (Brookfield, 2017); 'students perspective' would undoubtedly have enriched the data and perhaps have led to new knowledge. However, the omission of this vulnerable cohort was supported by Cohen et al. (2007) who address the ethical responsibility of nonmaleficence or doing no harm to research participants.

Due to the social gathering restrictions imposed due to COVID-19, the interviews were conducted on a secure online platform. This was a successful response to the conditions imposed; however, it perhaps impinged on the conversational style promoted by Goodson and Sikes (2001) that I would have wished. Interviews transpired more structured than I intended.

Furthermore, I limited my interview participants to four teachers, as action research is centred on the 'self' (McNiff & Whitehead, 2009), and autoethnography is not commonly associated with interviews (Chang, 2008). But, perhaps the inclusion of additional hospital teachers and mainstream teachers would have offered further additional insights and rich data to reflect on.

Muncey (2010) notes that creative work is subject to memory, and aspects of story may be disregarded, buried and left untold. However, I made every effort to be transparent about the research process and achieve standards set out by Feldman (2003) to ensure validity and rigour, clear descriptions of data, data collection methods, interpretation and evidence to indicate new learning.

6.11 Dissemination of Findings

The sharing of knowledge gained during this research study will be presented to teaching colleagues during a staff meeting. Furthermore, opportunities to present to national and international hospital teachers is facilitated though termly Teachmeets and bi-annual HOPE conferences. Continuity in Education [CiE] is an online platform aimed at expanding theory, research, knowledge and practice of effective education for young people with chronic or life threatening illnesses.

However, as articulated earlier in this chapter, the findings of my study are of relevance to all teachers, regardless of their setting. Additional domains to disseminate my findings include Irish National Teachers Organisation [INTO] magazine "In Touch", and also an online platform for action research NEARI [Network for Educational Action Research in Ireland].

6.12 Reflective Conclusion

This autoethnography study gave me the time, reason and freedom to acknowledge, place value on, and interpret my inner tensions that have surfaced as a result of moving to teach in a hospital setting. When I recall the journey this research has taken me on, every initial descriptive word oozes negative connotations about myself, my work and my practice. However, for every negative, there has been a positive. Writing my story has been soul destroying…but empowering, difficult…but rewarding, overwhelming…but insightful, crushing…but confidence-enhancing. This research study has been time-consuming and all-consuming.

I abandoned a topic selected and started to allow my deepest tensions to re-direct this study. In doing so, I followed a personal, intrusive and introspective research design. I delved into my past, my emotional experiences, particularly the loss of my mother. I have relived painful times. I have been incredibly sad, and I have wanted to quit. I have painfully revealed my struggles as a teacher, with my fundamental desire to educate. My understanding of care was limited but is now re-conceptualised providing me with more lucid clarity. I have exposed my emotional instability—in my personal and professional life, and my ignorance of the complexity of an essential skill, empathy.

But, with patience and perseverance, it has proven to be a therapeutic and enlightening experience. The trio of tensions—emotions, care and empathy—interwoven and overlapped throughout the research, but findings unearthed amalgamated and led to personal and professional self-understanding and a revitalised a new founded passion for my role as a hospital teacher. I have arrived at new knowledge about myself and my practice as a hospital teacher. These new heights of insight and knowledge have given me a revitalised purpose as a hospital teacher…and I feel ready to soar forward, with a 'new' confidence and trust in my own wings!

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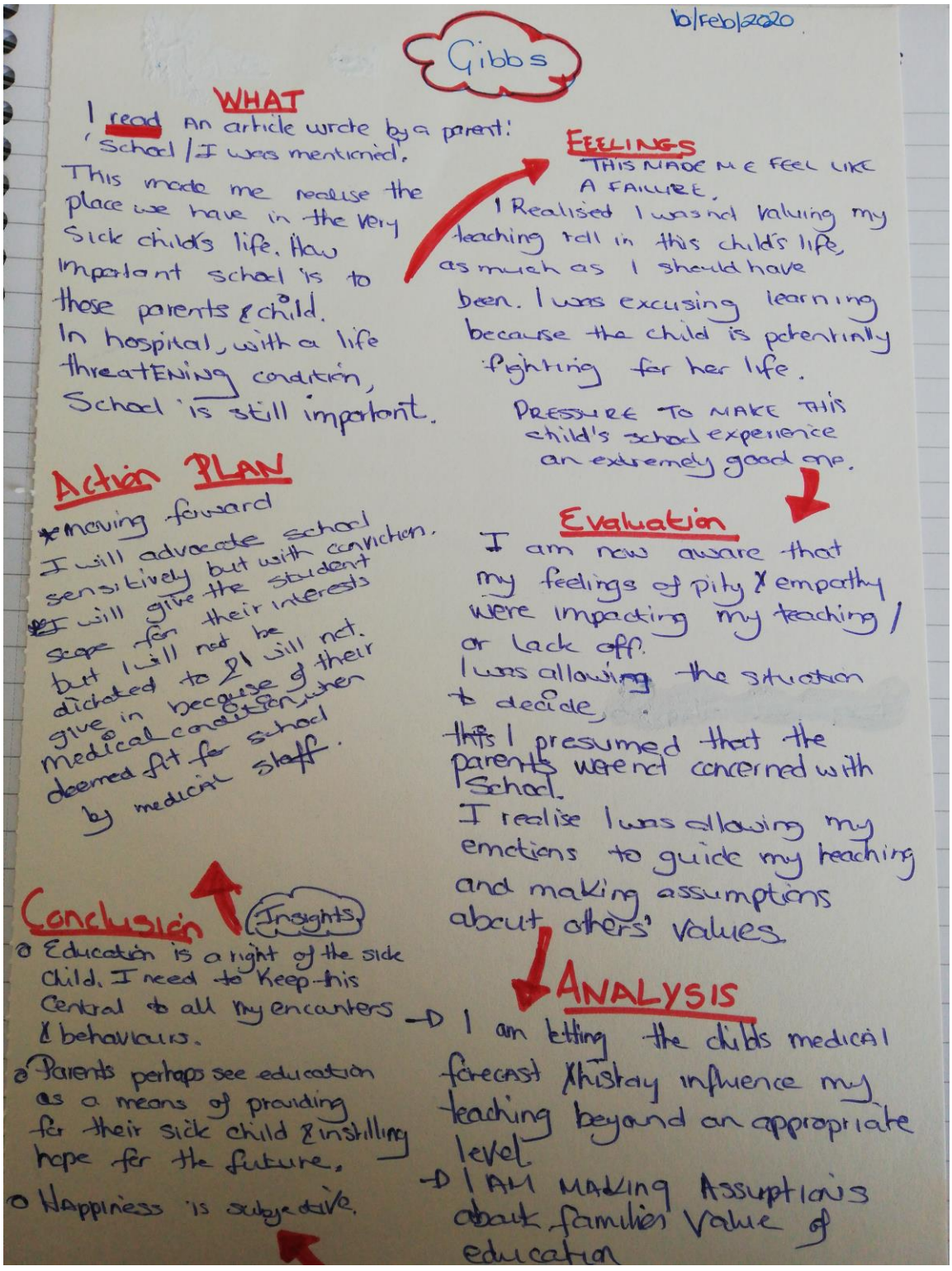
Appendices

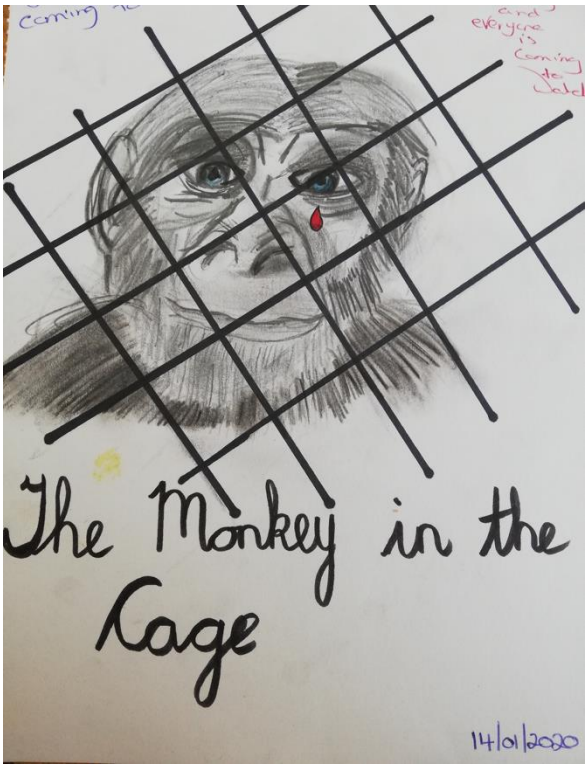
Appendix A: Adapted Hospital and School Mission Statement

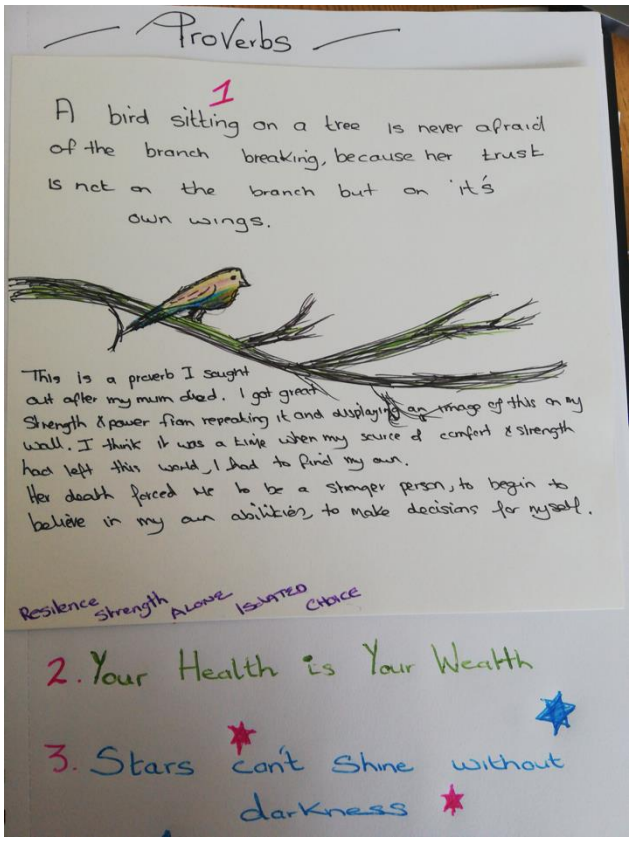
The table below is adapted from the mission statements from the hospital and school mission statements. Documented in a table below to ensure anonymity of the two entities.

	Hospital	School
Mission	Provide the highest levels of safety and excellence	Provide education
Vision	Healthier children throughout Ireland	High quality education Empower students and instil a positive attitude towards continuing their education Maximise learning opportunities
Values	Child-centred, compassionate and progressive and act with respect, excellence and integrity	Respect, integrity, care and trust

Appendix B: Journal




coming
everyone
is
coming
to
Jail
The Monkey in the Cage
14/01/2020


Proverbs
1
A bird sitting on a tree is never afraid of the branch breaking, because her trust is not on the branch but on it's own wings.
This is a proverb I sought out after my mum died. I got great strength & power from repeating it and displaying an image of this on my wall. I think it was a time when my source of comfort & strength had left this world, I had to find my own.
Her death forced me to be a stronger person, to begin to believe in my own abilities, to make decisions for myself.
Resilence
Strength
Alone
Isolated
Choice
2. Your Health is Your Wealth
3. Stars can't Shine without darkness

Appendix C: Interview Questions

1. What is your understanding of school culture? Could you describe the culture of your school?
2. How would you describe the 'role' of the teacher. Does the role of the teacher go beyond facilitating education?
3. In your opinion, what challenges do teachers encounter in your setting? What aspect of the job do you find the most challenging?
4. How would you describe working in your educational setting?
5. What aspect of the job is most rewarding?
6. Do you participate in any specific training to help assist you with teaching vulnerable children?
7. Academics (Nias, 1996; Zembylas, 2005) suggest that teachers invest the 'self' and have 'personal' commitment to their profession. Would you agree with this analysis?
8. How are emotions, both positive and negative, responded to in your work place)?
9. Emotional labour is a concept that accounts for the way in which individuals change, manage their emotions to make appropriate to a situation, to a role or an expected behaviour. Do you feel that you are required to alter your emotions to fit a situation or your role as a teacher?
10. How do you manage your emotions in particularly challenging situations?
11. Do you think you need high emotional abilities to work in your school setting? If so, what would these abilities be?
12. The Teaching Council (2016) identifies 'care' as a fundamental value in education. What is your understanding of 'care'?
13. How do you show care for your students?
14. When planning lessons for vulnerable students what considerations does a teacher need to take into account?
15. What is your understanding of empathy? How do you practice empathetic teaching?
16. Do you think there are implications for the teacher in being empathetic?
17. In order to provide empathetic care for others, the need for self-care and self-awareness is paramount for teachers. Do you think teachers practice adequate self-care?

Appendix D: Braun and Clarke (2006): Six Stages of Thematic Analysis

Six stages of Thematic Analysis
1. Familiarise yourself with the data
2. Generate initial codes
3. Search for themes
4. Review themes
5. Define and name themes
6. Produce the report

Appendix E: Interview Participants

Teacher pseudonym	Current school structure	Other types of school structures worked in
Ellen	Mainstream Teacher (MT) DEIS 1	Disadvantaged vertical school
Cathy	Mainstream Teacher (MT)	Disadvantaged vertical school
Jane	Hospital Teacher (HT)	n/a
Sarah	Hospital Teacher (HT)	Special school

Appendix F: Principal request letter, and participant information sheet and consent form

Maynooth University Froebel Department of Primary and Early Childhood Education
Roinn Froebel Don Bhun- agus Luath- Oideachas Ollscoil Mhá Nuad.

15/10/2019

Dear Chairperson,

I am writing to you to seek permission to undertake research required for my Master's in Education with Froebel in Maynooth University. The Masters requires me to conduct an action research project that examines an area of my own practice as a teacher. I have selected autoethnography as my research methodology. This is an introspective research design that privileges 'self', placing focus on personal data. The aim of this study is to learn how I can become a more effective hospital teacher.

As mentioned, this methodology places value on personal data. I will be both the researcher and the researched. Additionally, perspectives will be sought from my supervisor, my critical friend and four teacher participants—two willing participants from this setting are sought to take part in semi-structured interviews. Furthermore, I will also secure permission from all colleagues who may become collaborators in the research by way of professional dialogue, and informal discussions that may provide valuable insights.

As students and their parents could be viewed as a an extremely vulnerable group, I have made the ethical driven decision to exclude them from the research process.

I recognise that as a professional educator I should operate within an ethic of respect, care, integrity and trust while carrying out my action research. I will adhere to the ethical guidelines of Maynooth University, Froebel College, ……..School, Safeguarding Children Policies and Data Protection Guidelines.

I would be grateful if you would give your permission for this research to take place at your earliest convenience by way of signed approval below.

Yours sincerely,
Teresa Shore

Signature: _____ Position: _____

Date: _____

Maynooth University Froebel Department of Primary and Early Childhood Education

Roinn Froebel Don Bhun- agus Luath- Oideachas Ollscoil Mhá Nuad.

Dear _____,

I am a student on the Master of Education programme at Maynooth University. As part of my degree, I am doing an autoethnography action research project. The focus of my research is based on how I can enhance my practice to balance care and education in a hospital school.

In order to do this research, I require validation group participants. The role of these participants is to engage in professional dialogue in the form of semi-structured interviews in order to help me reflect accurately on my teaching. Interviews may be conducted through a video conferencing call or via a phone call. In total it will take 30-40 minutes to complete the interview. Confidentiality is of paramount importance to me and I am acutely aware of your right to privacy. For this reason, no aspect of your interview will be discussed with any other members of staff. You are under no obligation to complete the interview, or to answer all of the questions. If you come to a question you do not wish to answer, we will simply skip it.

Your name and the name of the school will not be included in the thesis that I will write at the end of the research. You are entitled to withdraw from the research process at any stage. All information will be kept confidential and information will be destroyed in a stated timeframe in accordance with the University guidelines. The correct guidelines will be complied with when carrying out this research. Ethical approval has been granted by the Froebel Department of Primary and Early Childhood Education.

I would like to invite you to give permission to take part in this project.

If you have any queries on any part of this research project, feel free to contact me by email at teresa.shore.2018@mumail.ie

Yours faithfully,

Teresa Shore

Maynooth University Froebel Department of Primary and Early Childhood Education

Roinn Froebel Don Bhun- agus Luath- Oideachas

Ollscoil Mhá Nuad

CONSENT FORM

I have read the information provided in the attached letter and all of my questions have been answered. I voluntarily agree to participate in this study. I am aware that I will receive a copy of this consent form for my information.

Signature: _____

Date: _____