

1-10-2010

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Citation

Hilliard C, O'Neill M. Nurses' emotional experience of caring for children with burns. *Journal of Clinical Nursing*. 2010;19(19-20):2907-15.

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Nurses' emotional experience of caring for children with burns
(Nursing children with burns)

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Study design: CH, MO'N; data collection and analysis: CH; manuscript preparation: CH, MO'N.

Abstract

Aims and objectives. The aim of this phenomenological study was to explore the emotions experienced by children's nurses when caring for children with burns, in addition to ascertaining how the nurses dealt with these emotions.

Background. The nature of nursing practice is such that it inevitably generates some form of emotional response in nurses. The literature reveals that the manner in which nurses deal with their emotional experiences can impact on their nursing care.

Design: The study used Husserlian phenomenology to explore the emotional experiences of eight purposively selected children's nurses who have worked on the burns unit of an Irish paediatric hospital. Data were collected using in-depth, unstructured interviews and analysed using Colaizzi's seven stage framework.

Results. The phenomenon of participants' emotional experiences is captured within four themes: 1) Caring for children with burns, 2) Supporting parents, 3) Sustaining nurses' emotional well-being and 4) Learning to be a burns nurse. Nursing children with burns generated a myriad of emotions for participants. Burns dressing-changes, managing burn-related pain, supporting parents and the impact of busy workloads on the emotional care of children and their parents emerged as the most emotionally challenging aspects of participants' role. Participants recognised the need to manage their emotional responses and spoke of the benefits of a supportive nursing team.

Conclusions. The findings offer insights into both the rewarding and challenging aspects of nursing children with burns. Nurses in this environment must be supported to recognise and manage their emotional responses to their work.

Relevance to clinical practice. Helping nurses to manage the emotional consequences of their work will help to sustain their emotional wellbeing, enhance the care received by children and also enable nurses to support parents in their role as partners in care.

Keywords: Children's nursing, burns nursing, parents, emotions, trust, phenomenology

INTRODUCTION

Nursing practice induces a myriad of emotions in nurses which are heavily influenced by nurses' ability to meet patients' needs. Being able to positively contribute to patients' care and, in particular, relieving patients' pain, confers a sense of well-being in nurses (Allcock & Standen 2001, Papadatou *et al.* 2001, Eifried 2003, Zengerle-Levy 2004). McQueen (2004) suggests that nurses' emotional response to patients' experiences may influence their nursing practice. This paper presents the findings of a phenomenological study which explored the emotions experienced by nurses caring for children with burns, and the ways in which nurses dealt with their emotions.

BACKGROUND

Burns are amongst the most distressing injuries children may receive. Nursing these children can be emotionally challenging as nurses must care for children who are in pain, anxious, and suffering possible disfigurement, coupled with supporting the children's parents. Furthermore, nurses on burns units perform intensely painful procedures, including dressing-changes and wound debridement (Merz *et al.* 2003). A theme dominating the literature is nurses' emotional distress when they feel unable to effectively care for patients. Nurses describe feelings of helplessness, guilt and anger when unable to relieve children's pain and suffering (Papadatou *et al.* 2001, Yam *et al.* 2001, Sorlie *et al.* 2003), which may be compounded further by performing painful procedures. White *et al.* (2004) contend that patients do not suffer in solitude but that their suffering also impacts on their carers. If nurses learn to manage their emotions effectively, they are less likely to suffer long-term consequences of working in emotionally challenging situations, including stress and burnout (Maytum *et al.* 2004). Few studies have specifically explored the emotional impact of burns nursing. Zengerle-Levy (2004) examined how nurses facilitated holistic healing in children in a burns intensive care setting. Nagy (1999) and

Cronin (2001) collectively explored the experiences of nurses caring for both adults and children with burns. Thus one cannot conclude if the emotional experiences of nursing children and adults with burns are similar. However, there are aspects unique to children's nursing, for example, children's varying stages of development and the presence of parents and families, which indicate the need to explore the emotional experience of nursing children with burns.

THE STUDY

This study aimed to:

- Explore children's nurses' emotional experiences of caring for children with burns
- Identify how the nurses deal with their emotions

Design

Husserlian phenomenology was the methodology chosen for this study to describe the lived experience of nurses caring for children with burns (Johnson 2002). Husserl's 'transcendental' phenomenology requires researchers to transcend their pre-understanding and suspend or 'bracket' their beliefs of the phenomenon under investigation to ensure it is presented from participants' perspectives, rather than what is already known or pre-understood by the researcher.

As the lead researcher involved in data collection and analysis, CH acknowledges that her experience of nursing children with burns gives rise to several pre-conceptions. She followed van Heugten's (2004) example of interviewing herself to answer the research question from her lived experience, which revealed strong personal beliefs in the individual nature of children's pain. Illuminating these beliefs helped to avoid judging

participants with differing beliefs. A diary was also used as a means of bracketing by exposing the researcher's beliefs through reflecting on each stage of the study.

Ethical Considerations

Ethical approval was sought from the hospital's Research Ethics Committee. At the time of conducting this study, CH was the Clinical Facilitator on the burns unit. The Research Ethics Committee was concerned about the dual roles of researcher and Clinical Facilitator, and instead gave approval to recruit nurses with whom CH did not have a supervisory relationship and who had previously worked on the burns unit. Participants were advised in writing that participation was voluntary and that their anonymity and confidentiality would be preserved. Written consent was obtained from participants before each interview.

Study setting and sample

The study was conducted in a large paediatric teaching hospital in the Republic of Ireland, with a 17-bed burns unit caring for children from infancy to sixteen years of age. The hospital's Human Resources Manager supplied the names of ten nurses who met the inclusion criteria. A letter of invitation was sent to these nurses, eight of whom agreed to participate. Data saturation was achieved following the eighth interview and no further participants were recruited. Participants were female with 6-30 years of children's nursing experience and they had held staff nurse positions on the burns unit for 1-8 years. The burns unit has a low nursing turnover and to recruit sufficient participants, it was necessary to invite nurses who had left the unit up to eight years ago.

Data Collection and Analysis

Data were collected using in-depth, unstructured interviews. A topic guide (Robinson 2000) was used which was derived from the two themes of the research question – ‘*What emotions do nurses experience when caring for children with burns*’ and ‘*How do they deal with them?*’. The interviews, which lasted 25-70 minutes, were audiotaped and transcribed verbatim. As participants might recall upsetting experiences which they may need to discuss further, the participant information letter gave details of confidential access to a counsellor through the organisation’s Occupational Health Department. Participants were reminded of this facility before and after their interviews.

Data analysis was conducted using Colaizzi’s framework (1978). Listening to the interview tapes and reading the transcripts several times created a familiarity with the data. Significant statements were extracted from the transcripts and cross-checked with the original transcripts to formulate meaning and create a more explicit sense of the phenomenon. Common themes became evident which were organised into clusters of themes. These were carefully studied and gradually condensed to reveal four major themes common to all participants’ experiences (Table 1). Where possible, participants’ own words are used as titles for the themes.

Table 1: Major themes and theme clusters

Major theme	Theme clusters
Caring for children with burns	Nursing children with burns Nurses’ relationship with children Helping to relieve the pain Wound care
Supporting parents	Parents as partners in care Supporting the parents Not enough time to talk Parents’ experiences affect nurses
Sustaining nurses’ emotional well-being	Dealing with the emotional response Creating a sense of meaning Talking to someone who understands Being supported
Learning to be a burns nurse	Becoming a burns nurse Learning from senior nurses

The themes were then integrated into an exhaustive description of the nurses' emotional experience of nursing children with burns. To manage the large volumes of data, a framework was developed into which data was inserted at each stage of analysis (Table 2).

Table 2: Excerpt from the Data Analysis Framework

Significant Statement	Formulated meaning	Theme cluster	Major theme
<p><i>'you know each time you do a dressing, it's helping the child, it's getting the child nearer the door to go home.'</i> P7</p> <p><i>'But there were good times, to see kids getting better and going home'</i> P3</p>	<p>Helping children recover gave nurses a sense of meaning</p> <p>Nurses derived a sense of satisfaction from seeing children recover</p>	<p>Creating a sense of meaning</p>	<p>Sustaining nurses' emotional well-being</p>
<p><i>'You might be able to talk to somebody but - for them to be able to really empathise with you, [they] really need to have been in a similar situation to be able to give any kind of [help]'</i> P4</p> <p><i>'[someone] who knows that in your head you can hear them screaming before they ever scream. And only a nurse who has done that, knows that's what you're thinking without having to say it.'</i> P5</p>	<p>To support nurses requires an understanding and insight gained from similar experience</p> <p>Participants felt that only nurses would have the shared insight needed to offer support to nursing colleagues</p>	<p>Talking to someone who understands</p>	

Rigour

Lincoln & Guba's (1985) four criteria of credibility, transferability, dependability and confirmability were used to enhance the study's rigour. Credibility was supported by returning the themes to participants with examples of significant statements and formulated meanings to illustrate the origins of the themes. The participants confirmed that the themes accurately represented their experiences. Transferability is enhanced by describing the sample and study setting and including participants' own words within the findings. An audit trail clarifying the methodological choices made throughout this study enhances dependability. Confirmability is supported by the data analysis framework which shows how the findings originated from the raw data.

This was the first phenomenological study carried out by CH and was conducted under research supervision. The interview transcripts and the data analysis were reviewed by the research supervisor. CH's experience of burns nursing helped to establish a rapport with participants, which contributed to the richness of data yielded during the interviews. However, Kanuha (2000) cautions researchers against assuming that a mutual professional background confers a shared understanding of participants' experiences.

FINDINGS

The analysis revealed four main themes which reflect the emotional experiences of nursing children with burns:

- Caring for children with burns
- Supporting parents
- Sustaining nurses' emotional well-being
- Learning to be a burns nurse

Theme 1: Caring for children with burns

The participants revealed that their emotions were heavily invested in their care of the children.

Nursing children with burns

Participants described their role as '[helping] care for the child, help make things better, to help them get home' (P1). Burns are amongst the most traumatic injuries children can sustain, and participants recognised the importance of children's emotional care. However, participants described a sense of helplessness when they did not know how to offer comfort.

That's hard, when you know that really no matter what you say, they still see their scars and they know they're not normal anymore. (P4)

Participants recognised that children's emotional care was often a casualty of busy workloads. When faced with the competing demands of children's physical and emotional needs, the participants described their untenable choice of 'you can't neglect areas of physical nursing care for that child to spend extra time giving emotional support' (P4). Participants experienced considerable tension when they were unable to offer children the opportunity to talk because they did not have time to listen.

Nurses' relationship with children

Developing a trusting relationship with the children was an important facet of the participants' role. They unanimously emphasised that gaining children's trust was necessary so that children 'mightn't be afraid to ask you for things and be more comfortable around you' (P2). However, when participants were involved in changing children's wound dressings, they experienced feelings of guilt and distress arising from their perception that they were breaking children's trust.

You felt like a Judas because you would be playing with them two nights beforehand, you'd be sitting playing, having a laugh and then you – you're pulling the dressings off, as gently as you can, but they're still screaming the place down. (P6)

Helping to relieve the pain

Participants' emotions were heavily influenced by their ability to relieve children's pain and they stressed the importance of giving children sufficient analgesia prior to dressing-changes. Participants described how their experiences on the burns unit influenced their current practice by instilling a strong ethos of effective paediatric pain management.

Successfully relieving children's pain also helped alleviate some of the nurses' own anxiety when they had to perform painful dressing-changes.

Arming them with enough medication to reduce their pain also reduced my anxiety if I knew they were going to be reasonably comfortable. (P4)

Conversely, being unable to help relieve children's discomfort generated considerable anguish for participants, especially when all available measures to relieve children's discomfort were exhausted.

I think one of the most difficult parts for a nurse is the helplessness ... that sometimes when a child is crying in pain and you've run out of options, you feel so helpless. (P5)

Wound care

The children's wound care dominated participants' narratives, and was a source of considerable distress.

The dressings ... changing the dressings, having to change them a second time if they got soiled. You'd feel that sickness in the pit of your stomach. (P1)

Despite it being at least four years since the participants had worked on the burns unit, they retained vivid memories of children's wound care. For example, the characteristic smell of burn wounds still evokes anxiety for this nurse.

It's not the smell itself, it's what's behind it – that's the anxiety it brings out in you – **still**, I can **still** smell it. (P5)

Participants described feelings of guilt and helplessness arising from performing dressing-changes, knowing that these would also aggravate children's pain.

You're conscious of 'Oh God, I've inflicted more pain on this child'. But it's not intentional. You're not intentionally inflicting pain. It's because of the burn that the pain is there. (P7)

Theme 2: Supporting Parents

Participants recognised the need to support parents through their children's hospitalisation, so that they in turn could support their children.

Parents as partners in care

Participants described the importance of promoting parents' participation in children's care, so that 'the children wouldn't be as frightened of you' (P2). Parental presence during children's dressing-changes dominated participants' accounts of the parents' role. Nurses acknowledged that the parents found it difficult to witness children's wound care, and they stressed the importance of supporting parents.

It's not very nice, [parents] don't have to stay if they don't want to – I would always give them that option. (P7)

While parental presence during dressing-changes was considered beneficial for the children, participants conceded that if parents became upset, then nurses had to comfort both the parents and children in addition to completing the dressing.

I suppose it made it more difficult because you had to spend a lot more time talking to [parents] and trying to reassure them and trying to calm them down. (P6)

Supporting the parents

Participants described how supporting parents and alleviating their emotional distress, helped to reduce the children's anxiety. Parents 'needed [support] too, as well as the child. Some days they needed more emotional care than the children' (P4). Participants contended that their jobs were made easier when parents and children were more at ease.

Participants described how they could reduce parents' anxiety by making 'things better for the child because it's really out of [parents] hands' (P5). For example, if parents asked nurses to relieve children's pain and the nurses achieved this, participants described how parents became more relaxed. In contrast, if participants' failed to relieve children's pain, they sensed the parents' distress and felt that they were disappointing not just the children, but also the parents. This sense of not fulfilling parents' expectations generated considerable distress for all participants.

Not enough time to talk

Participants described how their busy workloads meant that 'Sometimes we were just too busy to sit and talk to parents' (P6). This created conflict and frustration for the nurses as they felt they were failing parents, particularly those who did not openly express their need for support.

It was only if somebody got very, very upset that you had to make a chunk of time to go in and talk with the parents. (P8)

If the nurses were busy when parents approached them to talk, the parents were informed that the nurses would come back to them. Returning promptly to the parents was considered necessary to preserve the parents' trust in nurses. However, participants

conceded that 'you may have missed the moment' (P5), which was a source of regret and frustration for nurses.

Parents' experiences affect nurses

Participants felt that the way parents coped with their child's condition also impacted on nurses' emotions. Examples were given of parents subtly criticising nurses in front of children, especially during dressing-changes, compounding nurses' distress at performing painful procedures because they felt they were being portrayed as 'the bad nurse' (P5). Participants sometimes felt that parents' distress and anger about their child's condition was directed towards nurses.

There was a lot of anger and sometimes it was directed towards you which I hated. (P6)

Participants understood that parents experience feelings of guilt and anger at the circumstances surrounding their children's burns. Without exception, the participants spoke of their empathy with the parents' distress and rationalised that parents were not angry with them as individuals but were angry at the circumstances surrounding their children's hospitalisation. Nevertheless, sometimes it was difficult to retain this empathy and participants described feeling 'angry myself because I suppose the human side of me would say, well, it's not my fault your child is burnt' (P6).

Theme 3: Sustaining nurses' emotional well-being

Participants described how they dealt with the emotional consequences of their role.

Dealing with the emotional response

The participants recognised the necessity of dealing with their emotions because 'you couldn't let it get to you either or you wouldn't survive it' (P2). Participants referred in

particular to coping with the emotional demands of dressing-changes. Nurses spoke of engaging with children, especially during dressing-changes by, for example, explaining the procedure and encouraging children to assist with their wound care. Helping children in this way generated a sense of satisfaction which helped offset some of the participants' distress at performing the dressing-change.

It gave me a sense of relief to give them an option, to give a choice as to what they wanted to do. (P6)

Participants spoke of hiding their emotions to avoid upsetting children and they referred to putting on a mask to achieve this. Participants also described shutting out, or creating a barrier, to the children's crying and focusing on the actual physical work of dressing the wounds. However, participants refuted the conventional understanding of emotional distancing and emphatically denied being immune to children's pain. They explained that the barrier was not created against the children, but was created to prevent the nurses from displaying their true emotions during dressing-changes.

When they're screaming I got to the point where I had to just cut them off ... not ... not as a person ... but literally cut the noise out and completely focus myself.
(P6)

While this barrier may have offered temporary emotional protection, it did not appear to assuage participants' sense of guilt and distress at exacerbating children's pain by performing dressing-changes.

Creating a sense of meaning

Participants unanimously described their satisfaction when children recovered and left hospital. Knowing they had helped children to heal, physically and emotionally, offered a buffer against the emotional distress of their role.

You almost felt the whole thing was worthwhile, going through that emotional stuff you went through yourself. (P6)

The participants spoke of trying to create meaning from their work by, for example, rationalising that dressing-changes helped children to recover and therefore their nursing care was in the children's best interests.

That's how you reconcile it – this is going to help, the only reason I'm doing it is to help the child get better, to get well enough to go home, and it's to stop the pain. If it's not going to help, **don't do it**. (P1)

This strategy did not make participants immune to children's pain, nor did it dispel nurses' sense of guilt and distress generated by the children's pain. Instead, it helped them make sense of their role, providing them with the 'satisfaction of seeing that you've contributed to the healing process' (P7).

Talking to someone who understands

Participants' colleagues were the most frequently used source of support. The nurses admitted that, as junior nurses, they were reluctant to express their emotions for fear of being judged. However, they unanimously agreed that when they settled into the unit, they felt comfortable discussing their experiences without fear of colleagues' judgement.

No-one ever said to you 'Oh well I didn't get that yesterday'. Everyone felt the same way. Everyone felt equal pressure. (P6)

Most participants avoided discussing their experiences with family members or counsellors, feeling these lacked the insight to understand the emotional impact of nursing children with burns. Instead, participants contended that an understanding of the contexts of their emotions is a prerequisite of anyone from whom they would seek support.

[Someone] who knows that in your head you can hear [children] screaming before they ever scream [during dressing-changes]. And only a nurse who has done that, knows that's what you're thinking without having to say it. (P5)

Being supported

Despite the busy and emotionally challenging working environment, participants unanimously enjoyed their work and described the strong supportive relationship with nursing colleagues which enabled participants to intuitively know when a colleague was upset and needed support. Examples of support included sharing workloads, rotating the care of emotionally taxing patients or simply talking about their experiences. Participants conceded that 'if you were having a bad day yourself, you probably wouldn't be supporting [colleagues] 100%, but you'd hope you'd be trying as best you can' (P2). Nevertheless, colleagues' support was highly valued and participants described its reciprocal nature.

I might've a bad day today and someone would support me. Another day someone else might be having a bad day and you'd be there for them. (P4)

Theme 4: Learning to be a burns nurse

Participants revealed how their emotional experiences of nursing children with burns were influenced by their level of knowledge and skill.

Becoming a burns nurse

None of the participants had burns nursing experience before joining the burns unit, creating an initial sense of self-doubt that their inexperience may have exacerbated the pain and trauma experienced by children.

If I had more confidence would I have been quicker at it [dressing-change] and made it, the whole experience, made it less traumatic. (P8)

Participants' knowledge and skill developed with experience, helping to offset their anxiety as junior nurses, and bestowed a sense of satisfaction that they were able to positively contribute to children's care.

If you go home at night and you know that – maybe a child was uncomfortable that day and they're now pain free and comfortable - you do feel a lot better. (P4)

Learning from senior nurses

As junior nurses, participants conceded that a fear of being judged by colleagues sometimes inhibited them from seeking support, which appears paradoxical considering their description of the unit's supportive nursing team. Once they overcame their reluctance to admit they were unsure of something, all participants without exception spoke of learning from and being 'guided by your senior colleagues' (P2). Senior nurses were perceived as valuable role models who 'certainly helped us as a group of junior nurses to pick up things and work better' (P1).

DISCUSSION

This study aimed to generate a greater understanding of nurses' emotions arising from nursing children with burns. Participants experienced a spectrum of emotions ranging from the satisfaction of contributing to children's recovery to anxiety of being unable to completely relieve children's pain. Participants' sense of helplessness due to the challenges of managing children's pain was compounded by performing dressing-changes which exacerbated this pain. Yam *et al.* (2001) described nurses' perceptions that relieving pain is a fundamental aspect of their role. Other studies similarly revealed nurses' sense of helplessness and guilt when they have been unable to effectively relieve

patients' pain (Nagy 1999, Papadatou *et al.* 2001, Yam *et al.* 2001, Eifried 2003, White *et al.* 2004). These studies do not reflect the finding of this research that participants' sense of distress was further exacerbated by their perception that they broke children's trust by performing dressing-changes. In fact, despite the importance placed by participants on creating a trusting relationship with children, the nature of this trust and how it may be broken is largely unexplored in the literature.

While the emotional challenges of their role dominated participants' accounts, they also described positive emotions they experienced, for example, the satisfaction derived from helping relieve children's pain and discomfort. The existing literature primarily reveals the negative emotions experienced by nurses (Allcock & Standen 2001, Ford & Turner 2001, Papadatou *et al.* 2001, Yam *et al.* 2001, Eifried 2003, McCarthy & Drebing 2003, White *et al.* 2004). Participants drew comfort from their positive emotions which, along with the knowledge that their nursing care helped children recover, helped offset the emotional challenges of their role. Positive patient outcomes are a key determinant of nurses' job satisfaction as nurses feel they have met patients' expectations (Collins & Long 2003, Archibald 2006).

A theme permeating this study was how busy workloads limited nurses' opportunity to emotionally support children and their parents, a situation participants found difficult to accept. While children in hospital are obviously the principal focus of children's nurses' work, parents and their emotional needs also require attention, particularly when today's healthcare environment positions parents as partners in their children's care (Coyne 2008). However, if time constraints impede nurses' opportunity to attend to parents' emotional needs, then parents' care of their children may be compromised. Board (2005) describes how children found talking with nurses to be an effective ways of dealing with their

hospital experience and reducing their anxiety. Chant *et al.* (2002) argue that using time constraints as a defense for poor communication implies that communication is a luxury in which to indulge only if time permits.

The literature describes distancing as a strategy nurses use to protect themselves from emotionally challenging situations by focusing on children's physical needs and limiting social interaction with children and parents (Nagy 1999, Yam *et al.* 2001, Sorlie *et al.* 2003). Nurses in this study described creating a barrier or using acting to suppress their emotional responses, particularly during dressing-changes. Unlike the distancing strategies described in the literature, the participants felt that creating a barrier against their emotions did not limit their interactions with the children or desensitise them to children's pain. Participants contended that controlling their emotions helped to prevent upsetting the children further. Livesley (2005) reports how nurses use the metaphor "step-back" (p.158) to describe how they hide their emotions from children. Rather than decreasing their sensitivity to the children's needs, these nurses insisted that taking this step-back prevented them getting upset and therefore made them more available to the children.

Participants' use of the words barrier, acting and mask may reflect the concept of emotional labour rather than distancing. Hochschild (1983) defined emotional labour as inducing or suppressing emotions in order to present 'a publicly observable facial and bodily display' (p.7) which promotes in others a feeling of being cared for. Emotional labour is provided by acting, which involves controlling the expression of emotions by managing one's facial expressions, gestures and behaviour (Hochschild 1983). Participants presented a façade to mask their own emotions and prevent their distress from upsetting the children. This strategy offered participants temporary emotional protection,

but did not appear to assuage their sense of guilt and distress at exacerbating children's pain by performing dressing-changes. While emotional labour may help sustain nurses' emotional well-being, Zammuner *et al.* (2003) contend that hiding one's emotions may prevent the expression of appropriate emotions, for example, sympathy. This has implications for nurses as children and parents may perceive them to be unaffected by the situation.

Participants created a sense of meaning in their work to offset the emotional impact of witnessing children's distress. Nagy (1999) describes a similar strategy of 'core role reconstruction' (p.1431), whereby nurses see dressing-changes as inevitable, despite the pain patients may experience. However, while dressing-changes are necessary for children's recovery, nurses should not accept pain as an inevitable outcome of these procedures. Laterjet (2002) acknowledges the well documented difficulties of managing burn-related pain, but insists that an ultimate aspiration of burns care must be the elimination of pain. It is significant that participants' construction of meaning did not make them immune to children's pain, nor did it dispel their feelings of guilt. Victor Frankl, a Holocaust survivor, suggested that, 'Man is not destroyed by suffering, he is destroyed by suffering without meaning' (1962, p.101). Knowing that they had helped children recover, offered nurses a defence against being 'destroyed by suffering'.

A supportive nursing team helps to reduce nurses' perceptions of job stress (Collins & Long 2003, AbuAlRub 2004). Participants relied heavily on colleagues for emotional support. However, workload commitments sometimes limited the amount of support available. Olofsson *et al.* (2003) cautions that supporting colleagues may exacerbate nurses' own emotional distress. Scheduled staff meetings may provide a forum at which nurses can share the responsibility of supporting each other. These meetings also offer an

opportunity to discuss positive nursing outcomes, rather than focusing only on negative incidents, and can be a means of facilitating clinical learning by considering how practice can be improved (Cronin 2001).

When participants started on the burns unit, they experienced an initial transition period during which they questioned their knowledge and skill. As their knowledge of burns nursing developed, participants became more confident in their ability as nurses, corroborating other studies which explored qualified nurses' transition experiences of moving to a new clinical setting (Rosser & King 2003, Fujino & Nojima 2005). However, this is an aspect of nursing which has received scant research attention.

REFLECTIONS

This study was underpinned by Husserlian phenomenology which is associated with describing a phenomenon from participants' perspectives rather than what is already known about the topic. As the analysis progressed and the findings were situated within the contexts of the literature, interpretation of some aspects of the data ensued. This enabled a greater understanding of the nurses' experiences but is contradictory to the central tenets of Husserlian phenomenology, which requires researchers to bracket their assumptions about the research topic. However, this move towards interpretation provides a greater understanding of the participants' lived experiences. On reflection, the subject matter of this study could also be examined using a research design with an interpretative approach to data analysis.

LIMITATIONS

This study used a small sample from one site, and therefore the findings are specific to that setting. The sample consisted of nurses who had left the burns unit up to eight years

ago and consequently their experiences may not reflect those of their colleagues currently nursing children with burns. Nevertheless, participants vividly recalled their experiences and described how their memories of nursing children with burns continue to live with them and influence their practice. Their experiences provide a greater understanding of the support needs of nurses currently practising in paediatric burns settings, ultimately benefiting children and their parents.

CONCLUSION

Participants in this study described how their emotional experiences were closely related to their perceptions of how effectively they contributed to the children's recovery. Helping children recover gave participants a sense of satisfaction and well-being. However, the emotional challenges of nursing children with burns dominated the findings. A key recommendation from this study is that nurses caring for children with burns must be supported to manage their emotional responses to their work and recognise how these emotions may influence their nursing practice. The role of trust between nurses and children is an area which warrants further research given the extent to which participants felt they were betraying children's trust by performing painful dressing-changes.

Parents are increasingly positioned as partners-in-care for their hospitalised children. However, parents need emotional support from nurses to help them deal with the circumstances of their child's burns. The extent to which busy workloads limited nurses' opportunity to attend to children's and parents' emotional needs generated considerable distress and tension for nurses in this study. The emotional care of children and their parents must be recognised as a legitimate role of nurses, and not relegated to a subordinate position by workload commitments.

RELEVANCE TO CLINICAL PRACTICE

Supporting nurses to not only manage the emotional consequences of their work but also to recognise how these emotions may influence their interactions with children, will help to enhance the care received by children with burns and their parents. The findings of this study can be used to inform the development of strategies to prepare and support nurses for the emotional experience of nursing children with burns.

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Nurses' emotional experience of caring for children with burns
(Nursing children with burns)

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Abstract

Aims and objectives. The aim of this phenomenological study was to explore the emotions experienced by children's nurses when caring for children with burns, in addition to ascertaining how the nurses dealt with these emotions.

Background. The nature of nursing practice is such that it inevitably generates some form of emotional response in nurses. The literature reveals that the manner in which nurses deal with their emotional experiences can impact on their nursing care.

Design: The study used Husserlian phenomenology to explore the emotional experiences of eight purposively selected children's nurses who have worked on the burns unit of an Irish paediatric hospital. Data were collected using in-depth, unstructured interviews and analysed using Colaizzi's seven stage framework.

Results. The phenomenon of participants' emotional experiences is captured within four themes: 1) Caring for children with burns, 2) Supporting parents, 3) Sustaining nurses' emotional well-being and 4) Learning to be a burns nurse. Nursing children with burns generated a myriad of emotions for participants. Burns dressing-changes, managing burn-related pain, supporting parents and the impact of busy workloads on the emotional care of children and their parents emerged as the most emotionally challenging aspects of participants' role. Participants recognised the need to manage their emotional responses and spoke of the benefits of a supportive nursing team.

Conclusions. The findings offer insights into both the rewarding and challenging aspects of nursing children with burns. Nurses in this environment must be supported to recognise and manage their emotional responses to their work.

Relevance to clinical practice. Helping nurses to manage the emotional consequences of their work will help to sustain their emotional wellbeing, enhance the care received by children and also enable nurses to support parents in their role as partners in care.

Keywords: Children's nursing, burns nursing, parents, emotions, trust, phenomenology

INTRODUCTION

Nursing practice induces a myriad of emotions in nurses which are heavily influenced by nurses' ability to meet patients' needs. Being able to positively contribute to patients' care and, in particular, relieving patients' pain, confers a sense of well-being in nurses (Allcock & Standen 2001, Papadatou *et al.* 2001, Eifried 2003, Zengerle-Levy 2004). McQueen (2004) suggests that nurses' emotional response to patients' experiences may influence their nursing practice. This paper presents the findings of a phenomenological study which explored the emotions experienced by nurses caring for children with burns, and the ways in which nurses dealt with their emotions.

BACKGROUND

Burns are amongst the most distressing injuries children may receive. Nursing these children can be emotionally challenging as nurses must care for children who are in pain, anxious, and suffering possible disfigurement, coupled with supporting the children's parents. Furthermore, nurses on burns units perform intensely painful procedures, including dressing-changes and wound debridement (Merz *et al.* 2003). A theme dominating the literature is nurses' emotional distress when they feel unable to effectively care for patients. Nurses describe feelings of helplessness, guilt and anger when unable to relieve children's pain and suffering (Papadatou *et al.* 2001, Yam *et al.* 2001, Sorlie *et al.* 2003), which may be compounded further by performing painful procedures. White *et al.* (2004) contend that patients do not suffer in solitude but that their suffering also impacts on their carers. If nurses learn to manage their emotions effectively, they are less likely to suffer long-term consequences of working in emotionally challenging situations, including stress and burnout (Maytum *et al.* 2004). Few studies have specifically explored the emotional impact of burns nursing. Zengerle-Levy (2004) examined how nurses facilitated holistic healing in children in a burns intensive care setting. Nagy (1999) and

Cronin (2001) collectively explored the experiences of nurses caring for both adults and children with burns. Thus one cannot conclude if the emotional experiences of nursing children and adults with burns are similar. However, there are aspects unique to children's nursing, for example, children's varying stages of development and the presence of parents and families, which indicate the need to explore the emotional experience of nursing children with burns.

THE STUDY

This study aimed to:

- Explore children's nurses' emotional experiences of caring for children with burns
- Identify how the nurses deal with their emotions

Design

Husserlian phenomenology was the methodology chosen for this study to describe the lived experience of nurses caring for children with burns (Johnson 2002). Husserl's 'transcendental' phenomenology requires researchers to transcend their pre-understanding and suspend or 'bracket' their beliefs of the phenomenon under investigation to ensure it is presented from participants' perspectives, rather than what is already known or pre-understood by the researcher.

As the lead researcher involved in data collection and analysis, CH acknowledges that her experience of nursing children with burns gives rise to several pre-conceptions. She followed van Heugten's (2004) example of interviewing herself to answer the research question from her lived experience, which revealed strong personal beliefs in the individual nature of children's pain. Illuminating these beliefs helped to avoid judging

participants with differing beliefs. A diary was also used as a means of bracketing by exposing the researcher's beliefs through reflecting on each stage of the study.

Ethical Considerations

Ethical approval was sought from the hospital's Research Ethics Committee. At the time of conducting this study, CH was the Clinical Facilitator on the burns unit. The Research Ethics Committee was concerned about the dual roles of researcher and Clinical Facilitator, and instead gave approval to recruit nurses with whom CH did not have a supervisory relationship and who had previously worked on the burns unit. Participants were advised in writing that participation was voluntary and that their anonymity and confidentiality would be preserved. Written consent was obtained from participants before each interview.

Study setting and sample

The study was conducted in a large paediatric teaching hospital in the Republic of Ireland, with a 17-bed burns unit caring for children from infancy to sixteen years of age. The hospital's Human Resources Manager supplied the names of ten nurses who met the inclusion criteria. A letter of invitation was sent to these nurses, eight of whom agreed to participate. Data saturation was achieved following the eighth interview and no further participants were recruited. Participants were female with 6-30 years of children's nursing experience and they had held staff nurse positions on the burns unit for 1-8 years. The burns unit has a low nursing turnover and to recruit sufficient participants, it was necessary to invite nurses who had left the unit up to eight years ago.

Data Collection and Analysis

Data were collected using in-depth, unstructured interviews. A topic guide (Robinson 2000) was used which was derived from the two themes of the research question – ‘*What emotions do nurses experience when caring for children with burns*’ and ‘*How do they deal with them?*’. The interviews, which lasted 25-70 minutes, were audiotaped and transcribed verbatim. As participants might recall upsetting experiences which they may need to discuss further, the participant information letter gave details of confidential access to a counsellor through the organisation’s Occupational Health Department. Participants were reminded of this facility before and after their interviews.

Data analysis was conducted using Colaizzi’s framework (1978). Listening to the interview tapes and reading the transcripts several times created a familiarity with the data. Significant statements were extracted from the transcripts and cross-checked with the original transcripts to formulate meaning and create a more explicit sense of the phenomenon. Common themes became evident which were organised into clusters of themes. These were carefully studied and gradually condensed to reveal four major themes common to all participants’ experiences (Table 1). Where possible, participants’ own words are used as titles for the themes.

Table 1: Major themes and theme clusters

Major theme	Theme clusters
Caring for children with burns	Nursing children with burns Nurses’ relationship with children Helping to relieve the pain Wound care
Supporting parents	Parents as partners in care Supporting the parents Not enough time to talk Parents’ experiences affect nurses
Sustaining nurses’ emotional well-being	Dealing with the emotional response Creating a sense of meaning Talking to someone who understands Being supported
Learning to be a burns nurse	Becoming a burns nurse Learning from senior nurses

The themes were then integrated into an exhaustive description of the nurses' emotional experience of nursing children with burns. To manage the large volumes of data, a framework was developed into which data was inserted at each stage of analysis (Table 2).

Table 2: Excerpt from the Data Analysis Framework

Significant Statement	Formulated meaning	Theme cluster	Major theme
<p><i>'you know each time you do a dressing, it's helping the child, it's getting the child nearer the door to go home.'</i> P7</p> <p><i>'But there were good times, to see kids getting better and going home'</i> P3</p>	<p>Helping children recover gave nurses a sense of meaning</p> <p>Nurses derived a sense of satisfaction from seeing children recover</p>	<p>Creating a sense of meaning</p>	<p>Sustaining nurses' emotional well-being</p>
<p><i>'You might be able to talk to somebody but - for them to be able to really empathise with you, [they] really need to have been in a similar situation to be able to give any kind of [help]'</i> P4</p> <p><i>'[someone] who knows that in your head you can hear them screaming before they ever scream. And only a nurse who has done that, knows that's what you're thinking without having to say it.'</i> P5</p>	<p>To support nurses requires an understanding and insight gained from similar experience</p> <p>Participants felt that only nurses would have the shared insight needed to offer support to nursing colleagues</p>	<p>Talking to someone who understands</p>	

Rigour

Lincoln & Guba's (1985) four criteria of credibility, transferability, dependability and confirmability were used to enhance the study's rigour. Credibility was supported by returning the themes to participants with examples of significant statements and formulated meanings to illustrate the origins of the themes. The participants confirmed that the themes accurately represented their experiences. Transferability is enhanced by describing the sample and study setting and including participants' own words within the findings. An audit trail clarifying the methodological choices made throughout this study enhances dependability. Confirmability is supported by the data analysis framework which shows how the findings originated from the raw data.

This was the first phenomenological study carried out by CH and was conducted under research supervision. The interview transcripts and the data analysis were reviewed by the research supervisor. CH's experience of burns nursing helped to establish a rapport with participants, which contributed to the richness of data yielded during the interviews. However, Kanuha (2000) cautions researchers against assuming that a mutual professional background confers a shared understanding of participants' experiences.

FINDINGS

The analysis revealed four main themes which reflect the emotional experiences of nursing children with burns:

- Caring for children with burns
- Supporting parents
- Sustaining nurses' emotional well-being
- Learning to be a burns nurse

Theme 1: Caring for children with burns

The participants revealed that their emotions were heavily invested in their care of the children.

Nursing children with burns

Participants described their role as '[helping] care for the child, help make things better, to help them get home' (P1). Burns are amongst the most traumatic injuries children can sustain, and participants recognised the importance of children's emotional care. However, participants described a sense of helplessness when they did not know how to offer comfort.

That's hard, when you know that really no matter what you say, they still see their scars and they know they're not normal anymore. (P4)

Participants recognised that children's emotional care was often a casualty of busy workloads. When faced with the competing demands of children's physical and emotional needs, the participants described their untenable choice of 'you can't neglect areas of physical nursing care for that child to spend extra time giving emotional support' (P4). Participants experienced considerable tension when they were unable to offer children the opportunity to talk because they did not have time to listen.

Nurses' relationship with children

Developing a trusting relationship with the children was an important facet of the participants' role. They unanimously emphasised that gaining children's trust was necessary so that children 'mightn't be afraid to ask you for things and be more comfortable around you' (P2). However, when participants were involved in changing children's wound dressings, they experienced feelings of guilt and distress arising from their perception that they were breaking children's trust.

You felt like a Judas because you would be playing with them two nights beforehand, you'd be sitting playing, having a laugh and then you – you're pulling the dressings off, as gently as you can, but they're still screaming the place down. (P6)

Helping to relieve the pain

Participants' emotions were heavily influenced by their ability to relieve children's pain and they stressed the importance of giving children sufficient analgesia prior to dressing-changes. Participants described how their experiences on the burns unit influenced their current practice by instilling a strong ethos of effective paediatric pain management.

Successfully relieving children's pain also helped alleviate some of the nurses' own anxiety when they had to perform painful dressing-changes.

Arming them with enough medication to reduce their pain also reduced my anxiety if I knew they were going to be reasonably comfortable. (P4)

Conversely, being unable to help relieve children's discomfort generated considerable anguish for participants, especially when all available measures to relieve children's discomfort were exhausted.

I think one of the most difficult parts for a nurse is the helplessness ... that sometimes when a child is crying in pain and you've run out of options, you feel so helpless. (P5)

Wound care

The children's wound care dominated participants' narratives, and was a source of considerable distress.

The dressings ... changing the dressings, having to change them a second time if they got soiled. You'd feel that sickness in the pit of your stomach. (P1)

Despite it being at least four years since the participants had worked on the burns unit, they retained vivid memories of children's wound care. For example, the characteristic smell of burn wounds still evokes anxiety for this nurse.

It's not the smell itself, it's what's behind it – that's the anxiety it brings out in you – **still**, I can **still** smell it. (P5)

Participants described feelings of guilt and helplessness arising from performing dressing-changes, knowing that these would also aggravate children's pain.

You're conscious of 'Oh God, I've inflicted more pain on this child'. But it's not intentional. You're not intentionally inflicting pain. It's because of the burn that the pain is there. (P7)

Theme 2: Supporting Parents

Participants recognised the need to support parents through their children's hospitalisation, so that they in turn could support their children.

Parents as partners in care

Participants described the importance of promoting parents' participation in children's care, so that 'the children wouldn't be as frightened of you' (P2). Parental presence during children's dressing-changes dominated participants' accounts of the parents' role. Nurses acknowledged that the parents found it difficult to witness children's wound care, and they stressed the importance of supporting parents.

It's not very nice, [parents] don't have to stay if they don't want do – I would always give them that option. (P7)

While parental presence during dressing-changes was considered beneficial for the children, participants conceded that if parents became upset, then nurses had to comfort both the parents and children in addition to completing the dressing.

I suppose it made it more difficult because you had to spend a lot more time talking to [parents] and trying to reassure them and trying to calm them down. (P6)

Supporting the parents

Participants described how supporting parents and alleviating their emotional distress, helped to reduce the children's anxiety. Parents 'needed [support] too, as well as the child. Some days they needed more emotional care than the children' (P4). Participants contended that their jobs were made easier when parents and children were more at ease.

Participants described how they could reduce parents' anxiety by making 'things better for the child because it's really out of [parents] hands' (P5). For example, if parents asked nurses to relieve children's pain and the nurses achieved this, participants described how parents became more relaxed. In contrast, if participants' failed to relieve children's pain, they sensed the parents' distress and felt that they were disappointing not just the children, but also the parents. This sense of not fulfilling parents' expectations generated considerable distress for all participants.

Not enough time to talk

Participants described how their busy workloads meant that 'Sometimes we were just too busy to sit and talk to parents' (P6). This created conflict and frustration for the nurses as they felt they were failing parents, particularly those who did not openly express their need for support.

It was only if somebody got very, very upset that you had to make a chunk of time to go in and talk with the parents. (P8)

If the nurses were busy when parents approached them to talk, the parents were informed that the nurses would come back to them. Returning promptly to the parents was considered necessary to preserve the parents' trust in nurses. However, participants

conceded that 'you may have missed the moment' (P5), which was a source of regret and frustration for nurses.

Parents' experiences affect nurses

Participants felt that the way parents coped with their child's condition also impacted on nurses' emotions. Examples were given of parents subtly criticising nurses in front of children, especially during dressing-changes, compounding nurses' distress at performing painful procedures because they felt they were being portrayed as 'the bad nurse' (P5). Participants sometimes felt that parents' distress and anger about their child's condition was directed towards nurses.

There was a lot of anger and sometimes it was directed towards you which I hated. (P6)

Participants understood that parents experience feelings of guilt and anger at the circumstances surrounding their children's burns. Without exception, the participants spoke of their empathy with the parents' distress and rationalised that parents were not angry with them as individuals but were angry at the circumstances surrounding their children's hospitalisation. Nevertheless, sometimes it was difficult to retain this empathy and participants described feeling 'angry myself because I suppose the human side of me would say, well, it's not my fault your child is burnt' (P6).

Theme 3: Sustaining nurses' emotional well-being

Participants described how they dealt with the emotional consequences of their role.

Dealing with the emotional response

The participants recognised the necessity of dealing with their emotions because 'you couldn't let it get to you either or you wouldn't survive it' (P2). Participants referred in

particular to coping with the emotional demands of dressing-changes. Nurses spoke of engaging with children, especially during dressing-changes by, for example, explaining the procedure and encouraging children to assist with their wound care. Helping children in this way generated a sense of satisfaction which helped offset some of the participants' distress at performing the dressing-change.

It gave me a sense of relief to give them an option, to give a choice as to what they wanted to do. (P6)

Participants spoke of hiding their emotions to avoid upsetting children and they referred to putting on a mask to achieve this. Participants also described shutting out, or creating a barrier, to the children's crying and focusing on the actual physical work of dressing the wounds. However, participants refuted the conventional understanding of emotional distancing and emphatically denied being immune to children's pain. They explained that the barrier was not created against the children, but was created to prevent the nurses from displaying their true emotions during dressing-changes.

When they're screaming I got to the point where I had to just cut them off ... not ... not as a person ... but literally cut the noise out and completely focus myself.
(P6)

While this barrier may have offered temporary emotional protection, it did not appear to assuage participants' sense of guilt and distress at exacerbating children's pain by performing dressing-changes.

Creating a sense of meaning

Participants unanimously described their satisfaction when children recovered and left hospital. Knowing they had helped children to heal, physically and emotionally, offered a buffer against the emotional distress of their role.

You almost felt the whole thing was worthwhile, going through that emotional stuff you went through yourself. (P6)

The participants spoke of trying to create meaning from their work by, for example, rationalising that dressing-changes helped children to recover and therefore their nursing care was in the children's best interests.

That's how you reconcile it – this is going to help, the only reason I'm doing it is to help the child get better, to get well enough to go home, and it's to stop the pain. If it's not going to help, **don't do it**. (P1)

This strategy did not make participants immune to children's pain, nor did it dispel nurses' sense of guilt and distress generated by the children's pain. Instead, it helped them make sense of their role, providing them with the 'satisfaction of seeing that you've contributed to the healing process' (P7).

Talking to someone who understands

Participants' colleagues were the most frequently used source of support. The nurses admitted that, as junior nurses, they were reluctant to express their emotions for fear of being judged. However, they unanimously agreed that when they settled into the unit, they felt comfortable discussing their experiences without fear of colleagues' judgement.

No-one ever said to you 'Oh well I didn't get that yesterday'. Everyone felt the same way. Everyone felt equal pressure. (P6)

Most participants avoided discussing their experiences with family members or counsellors, feeling these lacked the insight to understand the emotional impact of nursing children with burns. Instead, participants contended that an understanding of the contexts of their emotions is a prerequisite of anyone from whom they would seek support.

[Someone] who knows that in your head you can hear [children] screaming before they ever scream [during dressing-changes]. And only a nurse who has done that, knows that's what you're thinking without having to say it. (P5)

Being supported

Despite the busy and emotionally challenging working environment, participants unanimously enjoyed their work and described the strong supportive relationship with nursing colleagues which enabled participants to intuitively know when a colleague was upset and needed support. Examples of support included sharing workloads, rotating the care of emotionally taxing patients or simply talking about their experiences. Participants conceded that 'if you were having a bad day yourself, you probably wouldn't be supporting [colleagues] 100%, but you'd hope you'd be trying as best you can' (P2). Nevertheless, colleagues' support was highly valued and participants described its reciprocal nature.

I might've a bad day today and someone would support me. Another day someone else might be having a bad day and you'd be there for them. (P4)

Theme 4: Learning to be a burns nurse

Participants revealed how their emotional experiences of nursing children with burns were influenced by their level of knowledge and skill.

Becoming a burns nurse

None of the participants had burns nursing experience before joining the burns unit, creating an initial sense of self-doubt that their inexperience may have exacerbated the pain and trauma experienced by children.

If I had more confidence would I have been quicker at it [dressing-change] and made it, the whole experience, made it less traumatic. (P8)

Participants' knowledge and skill developed with experience, helping to offset their anxiety as junior nurses, and bestowed a sense of satisfaction that they were able to positively contribute to children's care.

If you go home at night and you know that – maybe a child was uncomfortable that day and they're now pain free and comfortable - you do feel a lot better. (P4)

Learning from senior nurses

As junior nurses, participants conceded that a fear of being judged by colleagues sometimes inhibited them from seeking support, which appears paradoxical considering their description of the unit's supportive nursing team. Once they overcame their reluctance to admit they were unsure of something, all participants without exception spoke of learning from and being 'guided by your senior colleagues' (P2). Senior nurses were perceived as valuable role models who 'certainly helped us as a group of junior nurses to pick up things and work better' (P1).

DISCUSSION

This study aimed to generate a greater understanding of nurses' emotions arising from nursing children with burns. Participants experienced a spectrum of emotions ranging from the satisfaction of contributing to children's recovery to anxiety of being unable to completely relieve children's pain. Participants' sense of helplessness due to the challenges of managing children's pain was compounded by performing dressing-changes which exacerbated this pain. Yam *et al.* (2001) described nurses' perceptions that relieving pain is a fundamental aspect of their role. Other studies similarly revealed nurses' sense of helplessness and guilt when they have been unable to effectively relieve

patients' pain (Nagy 1999, Papadatou *et al.* 2001, Yam *et al.* 2001, Eifried 2003, White *et al.* 2004). These studies do not reflect the finding of this research that participants' sense of distress was further exacerbated by their perception that they broke children's trust by performing dressing-changes. In fact, despite the importance placed by participants on creating a trusting relationship with children, the nature of this trust and how it may be broken is largely unexplored in the literature.

While the emotional challenges of their role dominated participants' accounts, they also described positive emotions they experienced, for example, the satisfaction derived from helping relieve children's pain and discomfort. The existing literature primarily reveals the negative emotions experienced by nurses (Allcock & Standen 2001, Ford & Turner 2001, Papadatou *et al.* 2001, Yam *et al.* 2001, Eifried 2003, McCarthy & Drebing 2003, White *et al.* 2004). Participants drew comfort from their positive emotions which, along with the knowledge that their nursing care helped children recover, helped offset the emotional challenges of their role. Positive patient outcomes are a key determinant of nurses' job satisfaction as nurses feel they have met patients' expectations (Collins & Long 2003, Archibald 2006).

A theme permeating this study was how busy workloads limited nurses' opportunity to emotionally support children and their parents, a situation participants found difficult to accept. While children in hospital are obviously the principal focus of children's nurses' work, parents and their emotional needs also require attention, particularly when today's healthcare environment positions parents as partners in their children's care (Coyne 2008). However, if time constraints impede nurses' opportunity to attend to parents' emotional needs, then parents' care of their children may be compromised. Board (2005) describes how children found talking with nurses to be an effective ways of dealing with their

hospital experience and reducing their anxiety. Chant *et al.* (2002) argue that using time constraints as a defense for poor communication implies that communication is a luxury in which to indulge only if time permits.

The literature describes distancing as a strategy nurses use to protect themselves from emotionally challenging situations by focusing on children's physical needs and limiting social interaction with children and parents (Nagy 1999, Yam *et al.* 2001, Sorlie *et al.* 2003). Nurses in this study described creating a barrier or using acting to suppress their emotional responses, particularly during dressing-changes. Unlike the distancing strategies described in the literature, the participants felt that creating a barrier against their emotions did not limit their interactions with the children or desensitise them to children's pain. Participants contended that controlling their emotions helped to prevent upsetting the children further. Livesley (2005) reports how nurses use the metaphor "step-back" (p.158) to describe how they hide their emotions from children. Rather than decreasing their sensitivity to the children's needs, these nurses insisted that taking this step-back prevented them getting upset and therefore made them more available to the children.

Participants' use of the words barrier, acting and mask may reflect the concept of emotional labour rather than distancing. Hochschild (1983) defined emotional labour as inducing or suppressing emotions in order to present 'a publicly observable facial and bodily display' (p.7) which promotes in others a feeling of being cared for. Emotional labour is provided by acting, which involves controlling the expression of emotions by managing one's facial expressions, gestures and behaviour (Hochschild 1983). Participants presented a façade to mask their own emotions and prevent their distress from upsetting the children. This strategy offered participants temporary emotional protection,

but did not appear to assuage their sense of guilt and distress at exacerbating children's pain by performing dressing-changes. While emotional labour may help sustain nurses' emotional well-being, Zammuner *et al.* (2003) contend that hiding one's emotions may prevent the expression of appropriate emotions, for example, sympathy. This has implications for nurses as children and parents may perceive them to be unaffected by the situation.

Participants created a sense of meaning in their work to offset the emotional impact of witnessing children's distress. Nagy (1999) describes a similar strategy of 'core role reconstruction' (p.1431), whereby nurses see dressing-changes as inevitable, despite the pain patients may experience. However, while dressing-changes are necessary for children's recovery, nurses should not accept pain as an inevitable outcome of these procedures. Laterjet (2002) acknowledges the well documented difficulties of managing burn-related pain, but insists that an ultimate aspiration of burns care must be the elimination of pain. It is significant that participants' construction of meaning did not make them immune to children's pain, nor did it dispel their feelings of guilt. Victor Frankl, a Holocaust survivor, suggested that, 'Man is not destroyed by suffering, he is destroyed by suffering without meaning' (1962, p.101). Knowing that they had helped children recover, offered nurses a defence against being 'destroyed by suffering'.

A supportive nursing team helps to reduce nurses' perceptions of job stress (Collins & Long 2003, AbuAlRub 2004). Participants relied heavily on colleagues for emotional support. However, workload commitments sometimes limited the amount of support available. Olofsson *et al.* (2003) cautions that supporting colleagues may exacerbate nurses' own emotional distress. Scheduled staff meetings may provide a forum at which nurses can share the responsibility of supporting each other. These meetings also offer an

opportunity to discuss positive nursing outcomes, rather than focusing only on negative incidents, and can be a means of facilitating clinical learning by considering how practice can be improved (Cronin 2001).

When participants started on the burns unit, they experienced an initial transition period during which they questioned their knowledge and skill. As their knowledge of burns nursing developed, participants became more confident in their ability as nurses, corroborating other studies which explored qualified nurses' transition experiences of moving to a new clinical setting (Rosser & King 2003, Fujino & Nojima 2005). However, this is an aspect of nursing which has received scant research attention.

REFLECTIONS

This study was underpinned by Husserlian phenomenology which is associated with describing a phenomenon from participants' perspectives rather than what is already known about the topic. As the analysis progressed and the findings were situated within the contexts of the literature, interpretation of some aspects of the data ensued. This enabled a greater understanding of the nurses' experiences but is contradictory to the central tenets of Husserlian phenomenology, which requires researchers to bracket their assumptions about the research topic. However, this move towards interpretation provides a greater understanding of the participants' lived experiences. On reflection, the subject matter of this study could also be examined using a research design with an interpretative approach to data analysis.

LIMITATIONS

This study used a small sample from one site, and therefore the findings are specific to that setting. The sample consisted of nurses who had left the burns unit up to eight years

ago and consequently their experiences may not reflect those of their colleagues currently nursing children with burns. Nevertheless, participants vividly recalled their experiences and described how their memories of nursing children with burns continue to live with them and influence their practice. Their experiences provide a greater understanding of the support needs of nurses currently practising in paediatric burns settings, ultimately benefiting children and their parents.

CONCLUSION

Participants in this study described how their emotional experiences were closely related to their perceptions of how effectively they contributed to the children's recovery. Helping children recover gave participants a sense of satisfaction and well-being. However, the emotional challenges of nursing children with burns dominated the findings. A key recommendation from this study is that nurses caring for children with burns must be supported to manage their emotional responses to their work and recognise how these emotions may influence their nursing practice. The role of trust between nurses and children is an area which warrants further research given the extent to which participants felt they were betraying children's trust by performing painful dressing-changes.

Parents are increasingly positioned as partners-in-care for their hospitalised children. However, parents need emotional support from nurses to help them deal with the circumstances of their child's burns. The extent to which busy workloads limited nurses' opportunity to attend to children's and parents' emotional needs generated considerable distress and tension for nurses in this study. The emotional care of children and their parents must be recognised as a legitimate role of nurses, and not relegated to a subordinate position by workload commitments.

RELEVANCE TO CLINICAL PRACTICE

Supporting nurses to not only manage the emotional consequences of their work but also to recognise how these emotions may influence their interactions with children, will help to enhance the care received by children with burns and their parents. The findings of this study can be used to inform the development of strategies to prepare and support nurses for the emotional experience of nursing children with burns.

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Nurses' emotional experience of caring for children with burns
(Nursing children with burns)

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Abstract

Aims and objectives. The aim of this phenomenological study was to explore the emotions experienced by children's nurses when caring for children with burns, in addition to ascertaining how the nurses dealt with these emotions.

Background. The nature of nursing practice is such that it inevitably generates some form of emotional response in nurses. The literature reveals that the manner in which nurses deal with their emotional experiences can impact on their nursing care.

Design: The study used Husserlian phenomenology to explore the emotional experiences of eight purposively selected children's nurses who have worked on the burns unit of an Irish paediatric hospital. Data were collected using in-depth, unstructured interviews and analysed using Colaizzi's seven stage framework.

Results. The phenomenon of participants' emotional experiences is captured within four themes: 1) Caring for children with burns, 2) Supporting parents, 3) Sustaining nurses' emotional well-being and 4) Learning to be a burns nurse. Nursing children with burns generated a myriad of emotions for participants. Burns dressing-changes, managing burn-related pain, supporting parents and the impact of busy workloads on the emotional care of children and their parents emerged as the most emotionally challenging aspects of participants' role. Participants recognised the need to manage their emotional responses and spoke of the benefits of a supportive nursing team.

Conclusions. The findings offer insights into both the rewarding and challenging aspects of nursing children with burns. Nurses in this environment must be supported to recognise and manage their emotional responses to their work.

Relevance to clinical practice. Helping nurses to manage the emotional consequences of their work will help to sustain their emotional wellbeing, enhance the care received by children and also enable nurses to support parents in their role as partners in care.

Keywords: Children's nursing, burns nursing, parents, emotions, trust, phenomenology

INTRODUCTION

Nursing practice induces a myriad of emotions in nurses which are heavily influenced by nurses' ability to meet patients' needs. Being able to positively contribute to patients' care and, in particular, relieving patients' pain, confers a sense of well-being in nurses (Allcock & Standen 2001, Papadatou *et al.* 2001, Eifried 2003, Zengerle-Levy 2004). McQueen (2004) suggests that nurses' emotional response to patients' experiences may influence their nursing practice. This paper presents the findings of a phenomenological study which explored the emotions experienced by nurses caring for children with burns, and the ways in which nurses dealt with their emotions.

BACKGROUND

Burns are amongst the most distressing injuries children may receive. Nursing these children can be emotionally challenging as nurses must care for children who are in pain, anxious, and suffering possible disfigurement, coupled with supporting the children's parents. Furthermore, nurses on burns units perform intensely painful procedures, including dressing-changes and wound debridement (Merz *et al.* 2003). A theme dominating the literature is nurses' emotional distress when they feel unable to effectively care for patients. Nurses describe feelings of helplessness, guilt and anger when unable to relieve children's pain and suffering (Papadatou *et al.* 2001, Yam *et al.* 2001, Sorlie *et al.* 2003), which may be compounded further by performing painful procedures. White *et al.* (2004) contend that patients do not suffer in solitude but that their suffering also impacts on their carers. If nurses learn to manage their emotions effectively, they are less likely to suffer long-term consequences of working in emotionally challenging situations, including stress and burnout (Maytum *et al.* 2004). Few studies have specifically explored the emotional impact of burns nursing. Zengerle-Levy (2004) examined how nurses facilitated holistic healing in children in a burns intensive care setting. Nagy (1999) and

Cronin (2001) collectively explored the experiences of nurses caring for both adults and children with burns. Thus one cannot conclude if the emotional experiences of nursing children and adults with burns are similar. However, there are aspects unique to children's nursing, for example, children's varying stages of development and the presence of parents and families, which indicate the need to explore the emotional experience of nursing children with burns.

THE STUDY

This study aimed to:

- Explore children's nurses' emotional experiences of caring for children with burns
- Identify how the nurses deal with their emotions

Design

Husserlian phenomenology was the methodology chosen for this study to describe the lived experience of nurses caring for children with burns (Johnson 2002). Husserl's 'transcendental' phenomenology requires researchers to transcend their pre-understanding and suspend or 'bracket' their beliefs of the phenomenon under investigation to ensure it is presented from participants' perspectives, rather than what is already known or pre-understood by the researcher.

As the lead researcher involved in data collection and analysis, CH acknowledges that her experience of nursing children with burns gives rise to several pre-conceptions. She followed van Heugten's (2004) example of interviewing herself to answer the research question from her lived experience, which revealed strong personal beliefs in the individual nature of children's pain. Illuminating these beliefs helped to avoid judging

participants with differing beliefs. A diary was also used as a means of bracketing by exposing the researcher's beliefs through reflecting on each stage of the study.

Ethical Considerations

Ethical approval was sought from the hospital's Research Ethics Committee. At the time of conducting this study, CH was the Clinical Facilitator on the burns unit. The Research Ethics Committee was concerned about the dual roles of researcher and Clinical Facilitator, and instead gave approval to recruit nurses with whom CH did not have a supervisory relationship and who had previously worked on the burns unit. Participants were advised in writing that participation was voluntary and that their anonymity and confidentiality would be preserved. Written consent was obtained from participants before each interview.

Study setting and sample

The study was conducted in a large paediatric teaching hospital in the Republic of Ireland, with a 17-bed burns unit caring for children from infancy to sixteen years of age. The hospital's Human Resources Manager supplied the names of ten nurses who met the inclusion criteria. A letter of invitation was sent to these nurses, eight of whom agreed to participate. Data saturation was achieved following the eighth interview and no further participants were recruited. Participants were female with 6-30 years of children's nursing experience and they had held staff nurse positions on the burns unit for 1-8 years. The burns unit has a low nursing turnover and to recruit sufficient participants, it was necessary to invite nurses who had left the unit up to eight years ago.

Data Collection and Analysis

Data were collected using in-depth, unstructured interviews. A topic guide (Robinson 2000) was used which was derived from the two themes of the research question – ‘*What emotions do nurses experience when caring for children with burns*’ and ‘*How do they deal with them?*’. The interviews, which lasted 25-70 minutes, were audiotaped and transcribed verbatim. As participants might recall upsetting experiences which they may need to discuss further, the participant information letter gave details of confidential access to a counsellor through the organisation’s Occupational Health Department. Participants were reminded of this facility before and after their interviews.

Data analysis was conducted using Colaizzi’s framework (1978). Listening to the interview tapes and reading the transcripts several times created a familiarity with the data. Significant statements were extracted from the transcripts and cross-checked with the original transcripts to formulate meaning and create a more explicit sense of the phenomenon. Common themes became evident which were organised into clusters of themes. These were carefully studied and gradually condensed to reveal four major themes common to all participants’ experiences (Table 1). Where possible, participants’ own words are used as titles for the themes.

Table 1: Major themes and theme clusters

Major theme	Theme clusters
Caring for children with burns	Nursing children with burns Nurses’ relationship with children Helping to relieve the pain Wound care
Supporting parents	Parents as partners in care Supporting the parents Not enough time to talk Parents’ experiences affect nurses
Sustaining nurses’ emotional well-being	Dealing with the emotional response Creating a sense of meaning Talking to someone who understands Being supported
Learning to be a burns nurse	Becoming a burns nurse Learning from senior nurses

The themes were then integrated into an exhaustive description of the nurses' emotional experience of nursing children with burns. To manage the large volumes of data, a framework was developed into which data was inserted at each stage of analysis (Table 2).

Table 2: Excerpt from the Data Analysis Framework

Significant Statement	Formulated meaning	Theme cluster	Major theme
<p><i>'you know each time you do a dressing, it's helping the child, it's getting the child nearer the door to go home.'</i> P7</p> <p><i>'But there were good times, to see kids getting better and going home'</i> P3</p>	<p>Helping children recover gave nurses a sense of meaning</p> <p>Nurses derived a sense of satisfaction from seeing children recover</p>	<p>Creating a sense of meaning</p>	<p>Sustaining nurses' emotional well-being</p>
<p><i>'You might be able to talk to somebody but - for them to be able to really empathise with you, [they] really need to have been in a similar situation to be able to give any kind of [help]'</i> P4</p> <p><i>'[someone] who knows that in your head you can hear them screaming before they ever scream. And only a nurse who has done that, knows that's what you're thinking without having to say it.'</i> P5</p>	<p>To support nurses requires an understanding and insight gained from similar experience</p> <p>Participants felt that only nurses would have the shared insight needed to offer support to nursing colleagues</p>	<p>Talking to someone who understands</p>	

Rigour

Lincoln & Guba's (1985) four criteria of credibility, transferability, dependability and confirmability were used to enhance the study's rigour. Credibility was supported by returning the themes to participants with examples of significant statements and formulated meanings to illustrate the origins of the themes. The participants confirmed that the themes accurately represented their experiences. Transferability is enhanced by describing the sample and study setting and including participants' own words within the findings. An audit trail clarifying the methodological choices made throughout this study enhances dependability. Confirmability is supported by the data analysis framework which shows how the findings originated from the raw data.

This was the first phenomenological study carried out by CH and was conducted under research supervision. The interview transcripts and the data analysis were reviewed by the research supervisor. CH's experience of burns nursing helped to establish a rapport with participants, which contributed to the richness of data yielded during the interviews. However, Kanuha (2000) cautions researchers against assuming that a mutual professional background confers a shared understanding of participants' experiences.

FINDINGS

The analysis revealed four main themes which reflect the emotional experiences of nursing children with burns:

- Caring for children with burns
- Supporting parents
- Sustaining nurses' emotional well-being
- Learning to be a burns nurse

Theme 1: Caring for children with burns

The participants revealed that their emotions were heavily invested in their care of the children.

Nursing children with burns

Participants described their role as '[helping] care for the child, help make things better, to help them get home' (P1). Burns are amongst the most traumatic injuries children can sustain, and participants recognised the importance of children's emotional care. However, participants described a sense of helplessness when they did not know how to offer comfort.

That's hard, when you know that really no matter what you say, they still see their scars and they know they're not normal anymore. (P4)

Participants recognised that children's emotional care was often a casualty of busy workloads. When faced with the competing demands of children's physical and emotional needs, the participants described their untenable choice of 'you can't neglect areas of physical nursing care for that child to spend extra time giving emotional support' (P4). Participants experienced considerable tension when they were unable to offer children the opportunity to talk because they did not have time to listen.

Nurses' relationship with children

Developing a trusting relationship with the children was an important facet of the participants' role. They unanimously emphasised that gaining children's trust was necessary so that children 'mightn't be afraid to ask you for things and be more comfortable around you' (P2). However, when participants were involved in changing children's wound dressings, they experienced feelings of guilt and distress arising from their perception that they were breaking children's trust.

You felt like a Judas because you would be playing with them two nights beforehand, you'd be sitting playing, having a laugh and then you – you're pulling the dressings off, as gently as you can, but they're still screaming the place down. (P6)

Helping to relieve the pain

Participants' emotions were heavily influenced by their ability to relieve children's pain and they stressed the importance of giving children sufficient analgesia prior to dressing-changes. Participants described how their experiences on the burns unit influenced their current practice by instilling a strong ethos of effective paediatric pain management.

Successfully relieving children's pain also helped alleviate some of the nurses' own anxiety when they had to perform painful dressing-changes.

Arming them with enough medication to reduce their pain also reduced my anxiety if I knew they were going to be reasonably comfortable. (P4)

Conversely, being unable to help relieve children's discomfort generated considerable anguish for participants, especially when all available measures to relieve children's discomfort were exhausted.

I think one of the most difficult parts for a nurse is the helplessness ... that sometimes when a child is crying in pain and you've run out of options, you feel so helpless. (P5)

Wound care

The children's wound care dominated participants' narratives, and was a source of considerable distress.

The dressings ... changing the dressings, having to change them a second time if they got soiled. You'd feel that sickness in the pit of your stomach. (P1)

Despite it being at least four years since the participants had worked on the burns unit, they retained vivid memories of children's wound care. For example, the characteristic smell of burn wounds still evokes anxiety for this nurse.

It's not the smell itself, it's what's behind it – that's the anxiety it brings out in you – **still**, I can **still** smell it. (P5)

Participants described feelings of guilt and helplessness arising from performing dressing-changes, knowing that these would also aggravate children's pain.

You're conscious of 'Oh God, I've inflicted more pain on this child'. But it's not intentional. You're not intentionally inflicting pain. It's because of the burn that the pain is there. (P7)

Theme 2: Supporting Parents

Participants recognised the need to support parents through their children's hospitalisation, so that they in turn could support their children.

Parents as partners in care

Participants described the importance of promoting parents' participation in children's care, so that 'the children wouldn't be as frightened of you' (P2). Parental presence during children's dressing-changes dominated participants' accounts of the parents' role. Nurses acknowledged that the parents found it difficult to witness children's wound care, and they stressed the importance of supporting parents.

It's not very nice, [parents] don't have to stay if they don't want do – I would always give them that option. (P7)

While parental presence during dressing-changes was considered beneficial for the children, participants conceded that if parents became upset, then nurses had to comfort both the parents and children in addition to completing the dressing.

I suppose it made it more difficult because you had to spend a lot more time talking to [parents] and trying to reassure them and trying to calm them down. (P6)

Supporting the parents

Participants described how supporting parents and alleviating their emotional distress, helped to reduce the children's anxiety. Parents 'needed [support] too, as well as the child. Some days they needed more emotional care than the children' (P4). Participants contended that their jobs were made easier when parents and children were more at ease.

Participants described how they could reduce parents' anxiety by making 'things better for the child because it's really out of [parents] hands' (P5). For example, if parents asked nurses to relieve children's pain and the nurses achieved this, participants described how parents became more relaxed. In contrast, if participants' failed to relieve children's pain, they sensed the parents' distress and felt that they were disappointing not just the children, but also the parents. This sense of not fulfilling parents' expectations generated considerable distress for all participants.

Not enough time to talk

Participants described how their busy workloads meant that 'Sometimes we were just too busy to sit and talk to parents' (P6). This created conflict and frustration for the nurses as they felt they were failing parents, particularly those who did not openly express their need for support.

It was only if somebody got very, very upset that you had to make a chunk of time to go in and talk with the parents. (P8)

If the nurses were busy when parents approached them to talk, the parents were informed that the nurses would come back to them. Returning promptly to the parents was considered necessary to preserve the parents' trust in nurses. However, participants

conceded that 'you may have missed the moment' (P5), which was a source of regret and frustration for nurses.

Parents' experiences affect nurses

Participants felt that the way parents coped with their child's condition also impacted on nurses' emotions. Examples were given of parents subtly criticising nurses in front of children, especially during dressing-changes, compounding nurses' distress at performing painful procedures because they felt they were being portrayed as 'the bad nurse' (P5). Participants sometimes felt that parents' distress and anger about their child's condition was directed towards nurses.

There was a lot of anger and sometimes it was directed towards you which I hated. (P6)

Participants understood that parents experience feelings of guilt and anger at the circumstances surrounding their children's burns. Without exception, the participants spoke of their empathy with the parents' distress and rationalised that parents were not angry with them as individuals but were angry at the circumstances surrounding their children's hospitalisation. Nevertheless, sometimes it was difficult to retain this empathy and participants described feeling 'angry myself because I suppose the human side of me would say, well, it's not my fault your child is burnt' (P6).

Theme 3: Sustaining nurses' emotional well-being

Participants described how they dealt with the emotional consequences of their role.

Dealing with the emotional response

The participants recognised the necessity of dealing with their emotions because 'you couldn't let it get to you either or you wouldn't survive it' (P2). Participants referred in

particular to coping with the emotional demands of dressing-changes. Nurses spoke of engaging with children, especially during dressing-changes by, for example, explaining the procedure and encouraging children to assist with their wound care. Helping children in this way generated a sense of satisfaction which helped offset some of the participants' distress at performing the dressing-change.

It gave me a sense of relief to give them an option, to give a choice as to what they wanted to do. (P6)

Participants spoke of hiding their emotions to avoid upsetting children and they referred to putting on a mask to achieve this. Participants also described shutting out, or creating a barrier, to the children's crying and focusing on the actual physical work of dressing the wounds. However, participants refuted the conventional understanding of emotional distancing and emphatically denied being immune to children's pain. They explained that the barrier was not created against the children, but was created to prevent the nurses from displaying their true emotions during dressing-changes.

When they're screaming I got to the point where I had to just cut them off ... not ... not as a person ... but literally cut the noise out and completely focus myself.
(P6)

While this barrier may have offered temporary emotional protection, it did not appear to assuage participants' sense of guilt and distress at exacerbating children's pain by performing dressing-changes.

Creating a sense of meaning

Participants unanimously described their satisfaction when children recovered and left hospital. Knowing they had helped children to heal, physically and emotionally, offered a buffer against the emotional distress of their role.

You almost felt the whole thing was worthwhile, going through that emotional stuff you went through yourself. (P6)

The participants spoke of trying to create meaning from their work by, for example, rationalising that dressing-changes helped children to recover and therefore their nursing care was in the children's best interests.

That's how you reconcile it – this is going to help, the only reason I'm doing it is to help the child get better, to get well enough to go home, and it's to stop the pain. If it's not going to help, **don't do it**. (P1)

This strategy did not make participants immune to children's pain, nor did it dispel nurses' sense of guilt and distress generated by the children's pain. Instead, it helped them make sense of their role, providing them with the 'satisfaction of seeing that you've contributed to the healing process' (P7).

Talking to someone who understands

Participants' colleagues were the most frequently used source of support. The nurses admitted that, as junior nurses, they were reluctant to express their emotions for fear of being judged. However, they unanimously agreed that when they settled into the unit, they felt comfortable discussing their experiences without fear of colleagues' judgement.

No-one ever said to you 'Oh well I didn't get that yesterday'. Everyone felt the same way. Everyone felt equal pressure. (P6)

Most participants avoided discussing their experiences with family members or counsellors, feeling these lacked the insight to understand the emotional impact of nursing children with burns. Instead, participants contended that an understanding of the contexts of their emotions is a prerequisite of anyone from whom they would seek support.

[Someone] who knows that in your head you can hear [children] screaming before they ever scream [during dressing-changes]. And only a nurse who has done that, knows that's what you're thinking without having to say it. (P5)

Being supported

Despite the busy and emotionally challenging working environment, participants unanimously enjoyed their work and described the strong supportive relationship with nursing colleagues which enabled participants to intuitively know when a colleague was upset and needed support. Examples of support included sharing workloads, rotating the care of emotionally taxing patients or simply talking about their experiences. Participants conceded that 'if you were having a bad day yourself, you probably wouldn't be supporting [colleagues] 100%, but you'd hope you'd be trying as best you can' (P2). Nevertheless, colleagues' support was highly valued and participants described its reciprocal nature.

I might've a bad day today and someone would support me. Another day someone else might be having a bad day and you'd be there for them. (P4)

Theme 4: Learning to be a burns nurse

Participants revealed how their emotional experiences of nursing children with burns were influenced by their level of knowledge and skill.

Becoming a burns nurse

None of the participants had burns nursing experience before joining the burns unit, creating an initial sense of self-doubt that their inexperience may have exacerbated the pain and trauma experienced by children.

If I had more confidence would I have been quicker at it [dressing-change] and made it, the whole experience, made it less traumatic. (P8)

Participants' knowledge and skill developed with experience, helping to offset their anxiety as junior nurses, and bestowed a sense of satisfaction that they were able to positively contribute to children's care.

If you go home at night and you know that – maybe a child was uncomfortable that day and they're now pain free and comfortable - you do feel a lot better. (P4)

Learning from senior nurses

As junior nurses, participants conceded that a fear of being judged by colleagues sometimes inhibited them from seeking support, which appears paradoxical considering their description of the unit's supportive nursing team. Once they overcame their reluctance to admit they were unsure of something, all participants without exception spoke of learning from and being 'guided by your senior colleagues' (P2). Senior nurses were perceived as valuable role models who 'certainly helped us as a group of junior nurses to pick up things and work better' (P1).

DISCUSSION

This study aimed to generate a greater understanding of nurses' emotions arising from nursing children with burns. Participants experienced a spectrum of emotions ranging from the satisfaction of contributing to children's recovery to anxiety of being unable to completely relieve children's pain. Participants' sense of helplessness due to the challenges of managing children's pain was compounded by performing dressing-changes which exacerbated this pain. Yam *et al.* (2001) described nurses' perceptions that relieving pain is a fundamental aspect of their role. Other studies similarly revealed nurses' sense of helplessness and guilt when they have been unable to effectively relieve

patients' pain (Nagy 1999, Papadatou *et al.* 2001, Yam *et al.* 2001, Eifried 2003, White *et al.* 2004). These studies do not reflect the finding of this research that participants' sense of distress was further exacerbated by their perception that they broke children's trust by performing dressing-changes. In fact, despite the importance placed by participants on creating a trusting relationship with children, the nature of this trust and how it may be broken is largely unexplored in the literature.

While the emotional challenges of their role dominated participants' accounts, they also described positive emotions they experienced, for example, the satisfaction derived from helping relieve children's pain and discomfort. The existing literature primarily reveals the negative emotions experienced by nurses (Allcock & Standen 2001, Ford & Turner 2001, Papadatou *et al.* 2001, Yam *et al.* 2001, Eifried 2003, McCarthy & Drebing 2003, White *et al.* 2004). Participants drew comfort from their positive emotions which, along with the knowledge that their nursing care helped children recover, helped offset the emotional challenges of their role. Positive patient outcomes are a key determinant of nurses' job satisfaction as nurses feel they have met patients' expectations (Collins & Long 2003, Archibald 2006).

A theme permeating this study was how busy workloads limited nurses' opportunity to emotionally support children and their parents, a situation participants found difficult to accept. While children in hospital are obviously the principal focus of children's nurses' work, parents and their emotional needs also require attention, particularly when today's healthcare environment positions parents as partners in their children's care (Coyne 2008). However, if time constraints impede nurses' opportunity to attend to parents' emotional needs, then parents' care of their children may be compromised. Board (2005) describes how children found talking with nurses to be an effective ways of dealing with their

hospital experience and reducing their anxiety. Chant *et al.* (2002) argue that using time constraints as a defense for poor communication implies that communication is a luxury in which to indulge only if time permits.

The literature describes distancing as a strategy nurses use to protect themselves from emotionally challenging situations by focusing on children's physical needs and limiting social interaction with children and parents (Nagy 1999, Yam *et al.* 2001, Sorlie *et al.* 2003). Nurses in this study described creating a barrier or using acting to suppress their emotional responses, particularly during dressing-changes. Unlike the distancing strategies described in the literature, the participants felt that creating a barrier against their emotions did not limit their interactions with the children or desensitise them to children's pain. Participants contended that controlling their emotions helped to prevent upsetting the children further. Livesley (2005) reports how nurses use the metaphor "step-back" (p.158) to describe how they hide their emotions from children. Rather than decreasing their sensitivity to the children's needs, these nurses insisted that taking this step-back prevented them getting upset and therefore made them more available to the children.

Participants' use of the words barrier, acting and mask may reflect the concept of emotional labour rather than distancing. Hochschild (1983) defined emotional labour as inducing or suppressing emotions in order to present 'a publicly observable facial and bodily display' (p.7) which promotes in others a feeling of being cared for. Emotional labour is provided by acting, which involves controlling the expression of emotions by managing one's facial expressions, gestures and behaviour (Hochschild 1983). Participants presented a façade to mask their own emotions and prevent their distress from upsetting the children. This strategy offered participants temporary emotional protection,

but did not appear to assuage their sense of guilt and distress at exacerbating children's pain by performing dressing-changes. While emotional labour may help sustain nurses' emotional well-being, Zammuner *et al.* (2003) contend that hiding one's emotions may prevent the expression of appropriate emotions, for example, sympathy. This has implications for nurses as children and parents may perceive them to be unaffected by the situation.

Participants created a sense of meaning in their work to offset the emotional impact of witnessing children's distress. Nagy (1999) describes a similar strategy of 'core role reconstruction' (p.1431), whereby nurses see dressing-changes as inevitable, despite the pain patients may experience. However, while dressing-changes are necessary for children's recovery, nurses should not accept pain as an inevitable outcome of these procedures. Laterjet (2002) acknowledges the well documented difficulties of managing burn-related pain, but insists that an ultimate aspiration of burns care must be the elimination of pain. It is significant that participants' construction of meaning did not make them immune to children's pain, nor did it dispel their feelings of guilt. Victor Frankl, a Holocaust survivor, suggested that, 'Man is not destroyed by suffering, he is destroyed by suffering without meaning' (1962, p.101). Knowing that they had helped children recover, offered nurses a defence against being 'destroyed by suffering'.

A supportive nursing team helps to reduce nurses' perceptions of job stress (Collins & Long 2003, AbuAlRub 2004). Participants relied heavily on colleagues for emotional support. However, workload commitments sometimes limited the amount of support available. Olofsson *et al.* (2003) cautions that supporting colleagues may exacerbate nurses' own emotional distress. Scheduled staff meetings may provide a forum at which nurses can share the responsibility of supporting each other. These meetings also offer an

opportunity to discuss positive nursing outcomes, rather than focusing only on negative incidents, and can be a means of facilitating clinical learning by considering how practice can be improved (Cronin 2001).

When participants started on the burns unit, they experienced an initial transition period during which they questioned their knowledge and skill. As their knowledge of burns nursing developed, participants became more confident in their ability as nurses, corroborating other studies which explored qualified nurses' transition experiences of moving to a new clinical setting (Rosser & King 2003, Fujino & Nojima 2005). However, this is an aspect of nursing which has received scant research attention.

REFLECTIONS

This study was underpinned by Husserlian phenomenology which is associated with describing a phenomenon from participants' perspectives rather than what is already known about the topic. As the analysis progressed and the findings were situated within the contexts of the literature, interpretation of some aspects of the data ensued. This enabled a greater understanding of the nurses' experiences but is contradictory to the central tenets of Husserlian phenomenology, which requires researchers to bracket their assumptions about the research topic. However, this move towards interpretation provides a greater understanding of the participants' lived experiences. On reflection, the subject matter of this study could also be examined using a research design with an interpretative approach to data analysis.

LIMITATIONS

This study used a small sample from one site, and therefore the findings are specific to that setting. The sample consisted of nurses who had left the burns unit up to eight years

ago and consequently their experiences may not reflect those of their colleagues currently nursing children with burns. Nevertheless, participants vividly recalled their experiences and described how their memories of nursing children with burns continue to live with them and influence their practice. Their experiences provide a greater understanding of the support needs of nurses currently practising in paediatric burns settings, ultimately benefiting children and their parents.

CONCLUSION

Participants in this study described how their emotional experiences were closely related to their perceptions of how effectively they contributed to the children's recovery. Helping children recover gave participants a sense of satisfaction and well-being. However, the emotional challenges of nursing children with burns dominated the findings. A key recommendation from this study is that nurses caring for children with burns must be supported to manage their emotional responses to their work and recognise how these emotions may influence their nursing practice. The role of trust between nurses and children is an area which warrants further research given the extent to which participants felt they were betraying children's trust by performing painful dressing-changes.

Parents are increasingly positioned as partners-in-care for their hospitalised children. However, parents need emotional support from nurses to help them deal with the circumstances of their child's burns. The extent to which busy workloads limited nurses' opportunity to attend to children's and parents' emotional needs generated considerable distress and tension for nurses in this study. The emotional care of children and their parents must be recognised as a legitimate role of nurses, and not relegated to a subordinate position by workload commitments.

RELEVANCE TO CLINICAL PRACTICE

Supporting nurses to not only manage the emotional consequences of their work but also to recognise how these emotions may influence their interactions with children, will help to enhance the care received by children with burns and their parents. The findings of this study can be used to inform the development of strategies to prepare and support nurses for the emotional experience of nursing children with burns.

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