Background and introduction

Relationships between children's palliative care (CPC) healthcare professionals and parents are an important source of emotional support (Mooney-Doyle et al. 2017; Davies et al. 2017). Whilst these relationships can enhance care quality and job satisfaction (Klassen 2012), they carry an emotional burden; hence managing them is a challenge (Buder and Fringer, 2016; Brimble et al. 2019). Children with complex life-limiting conditions are living longer (Cooper 2017), so nurse-family relationships can span decades (Maunder 2013). Although these long-term CPC relationships have been researched (Maunder 2013; Erikson and Davies 2017), studies undertaken exclusively in children's hospices are rare. This paper outlines a doctoral research project which explored children's hospice nurses' management of emotional labour and professional integrity in long-term relationships with parents.

Research Question

How do children's nurses working in hospices manage emotional labour and professional integrity in long-term relationships with parents?

Aims

- Develop an in-depth understanding of how children's hospice nurses maintain professional integrity whilst providing long-term practical, emotional, social and spiritual care to parents.
- Explore the coping strategies and protective factors used by children's nurses to manage emotional labour whilst working in the children's hospice setting.

Concepts

Emotional labour

Hochschild's (1983) seminal definition (Box 1) was used to underpin understanding and identify when participants were alluding to emotional labour without labelling it as such.

Box 1: Hochschild's (1983) Definition of Emotional Labour

Emotional labour requires one to induce or suppress feeling in order to sustain the outward countenance that produces the proper state of mind in others- in this case, the sense of being cared for in a convivial and safe place. This kind of labour calls for a coordination of mind and feeling, and it sometimes draws on a source of self that we honour as deep and integral to our individuality

(Hochschild 1983, p.7)

Professional integrity

Although integrity relates to personal values and beliefs, in healthcare this aligns more closely to professional identity and community (Tyreman 2011). Erikson and Davies (2017) highlight that maintenance of professional integrity requires CPC nurses to successfully manage boundaries with children and families.

Methods

A narrative interpretive approach was used. This involved the collection of stories to facilitate understanding of nurses' lived experience, their thinking, actions and reactions (Ollerenshaw and Creswell 2002). This approach is well suited to exploring nurse-patient/client relationships (Joyce 2015) and enabled the principal investigator

(PI), i.e. MJB, to assemble a holistic view of the participant's world (Holloway and Jefferson 2013).

Sample

A purposive sample was recruited using the inclusion/exclusion criteria in Table 1. Table 2 presents demographic data.

Table 1: Participant inclusion and exclusion criteria

Participants	Criteria for inclusion	Criteria for exclusion
Registered children's nurses currently working in a CH setting (n=6) from across the UK. N.B. either with or without an additional specialist palliative care or related qualification, e.g. symptom control.	Have worked in the hospice environment for a minimum of four years. Have worked as a registered children's nurse in another clinical environment for at least one year prior to commencing employment in CH	Mental health or learning disability qualification (as possessing other qualifications may alter the way in which registered nurses manage their relationships with families – thus adding attributes which may not be present in those who do not have these qualifications)

Table 2: Demographic participant information

Age	Gender	No of years as a qualified children's nurse	Duration working at hospice
46-50 years	Female	17 years	8 years
41-45 years	Female	19 years	6 years
41-45 years	Female	18 years	4 years
35-40 years	Female	15 years	12 years
51-60 years	Female	34 years	32 years
51-60 years	Male	26 years	5 years

Participants were asked to discuss interactions with families they had known for three years or more, which occurred during day care or respite/short breaks but not end of life care. All were allocated gender neutral pseudonyms to maintain confidentiality.

Data collection

Audio diaries followed by telephone interviews were selected as the best fit between a robust approach to eliciting data likely to answer the research question; managing participant numbers, geographical spacing and time constraints. Audio diaries were recorded on the participants' mobile phone and securely transmitted to MJB via WhatsApp. Discussions with children's hospice health/social care stakeholders confirmed acceptability of these methods. A feasibility pilot confirmed useability (Brimble et al. 2022). Diary recordings lasted 8 - 33 minutes. Telephone interviews lasted 22 - 55 minutes.

Ethics

University and government ethical/governance requirements (HRA 2017; UK Government 2018) were followed. Approval for the pilot and subsequent main study were original granted by the University Ethics Committee in late 2017, with revisions for WhatsApp late 2018. UK children's hospices are independent, so NHS R&D requirements did not apply. However, rigour and best practice were assured via hospice ethical governance. Separate consent was obtained for audio diaries and telephone interviews. Participants were informed of their right to withdraw at any time. Audio diaries were recorded in private and deleted by participants when MJB confirmed receipt. Participants were allocated an ID number then a pseudonym. If participants became upset when discussing the emotive nature of their work, they would have been directed to hospice-based support. This was highlighted during recruitment/consent processes.

Data analysis

A paradigmatic-type narrative inquiry approach was used for analysis (Polkinghorne 1995). Polkinghorn (1995) draws on Brunner's work (1985) which identifies two types of analytical cognition: paradigmatic and pure narrative. In the paradigmatic type, stories are categorised according to the common elements within and across the datasets. In pure 'narrative' discourse is plotted to construct a new narrative known as re-storying. In keeping with the paradigmatic analysis approach, participant narratives were thematically analysed using Braun and Clarke's framework (2006). Thematic analysis was inductive, so not shaped by pre-existing theory but by the PIs' own standpoint, epistemology and disciplinary knowledge (Braun and Clarke 2013).

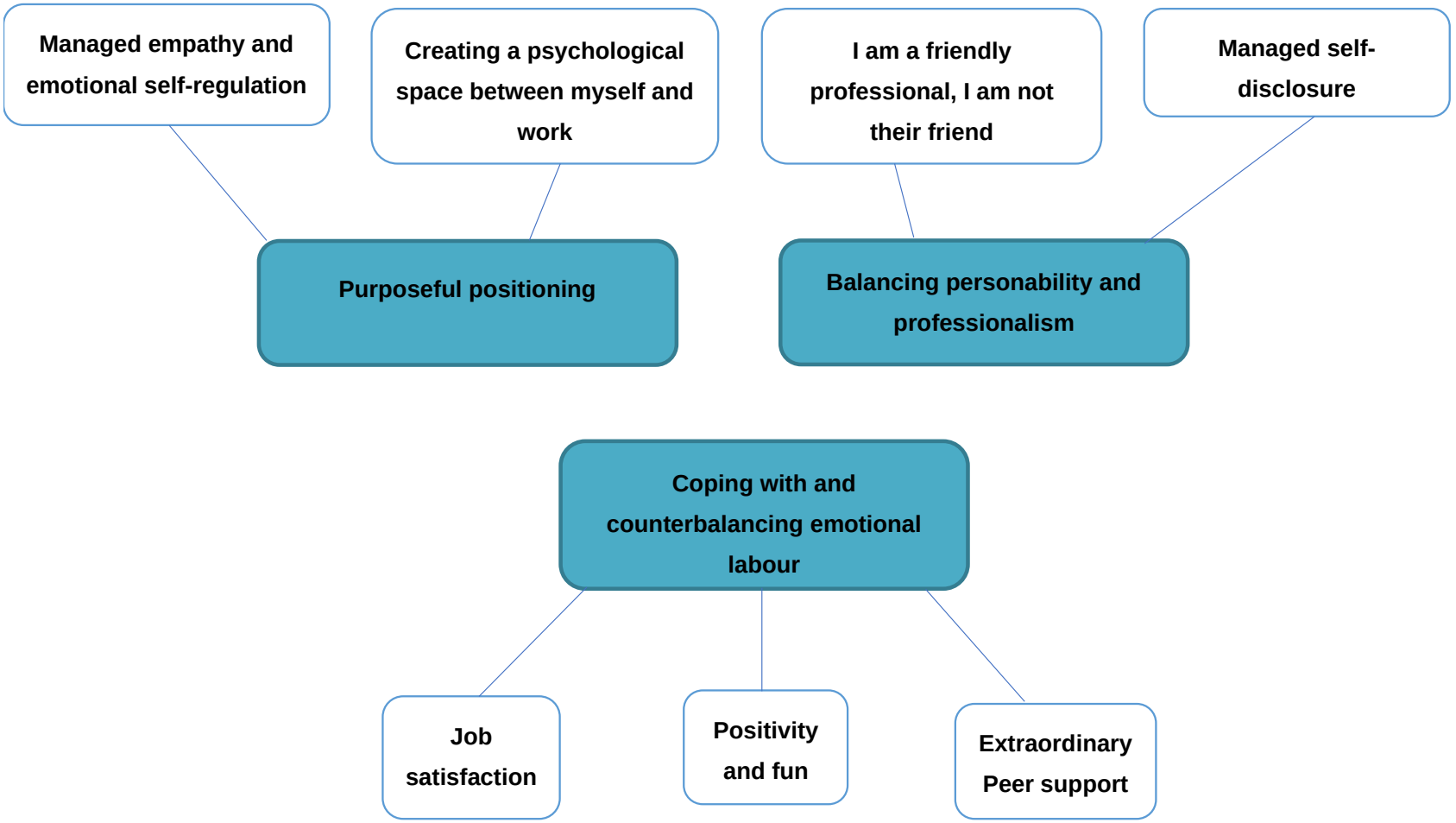
The audio diaries and telephone interviews were transcribed verbatim by MJB, thus facilitating data familiarisation. Codes were identified in each transcript, which were subsequently collated into categories. Categories were then grouped into themes for each participant. Finally, the whole data set was brought together to identify over-arching themes.

Findings

Three overarching, cross cutting themes (Figure 1) were identified:

- Purposeful positioning
- Balancing personability and professionalism
- Coping with and counterbalancing emotional labour

Figure 1: Themes and sub-themes



Purposeful Positioning

The word ‘positioning’ was used to identify this theme because although the participants often referred to emotional or professional ‘barriers’ between themselves and parents, the essence was more facilitative than a firm psychological barrier. Moreover, the word ‘barrier’ does not the possibility of movement and what participants described strongly suggested constant refinement of approach within and across relationships with parents.

Creating a psychological space between myself and work

Participants described ways in which they created psychological space between themselves and families. This occurred during the working day and afterwards. Temporal shifts which occurred at the end of the working day were sometimes accompanied by a physical action which helped to make the psychological transition from work to life outside. For example, walking to the car with colleagues after a shift, then using the drive home to mentally detach from work.

Psychological space created whilst at work was sometimes accompanied by physical action. This removed the participant from the situation and allowed for distraction or mindfulness, e.g. a walk in the hospice grounds. Longer lasting psychological space was created by extended physical distance, such as requesting that a family, who were starting to intrude on thoughts outside work, be reallocated for a few shifts. This temporal break from the emotional labour of the situation enabled participants to ‘regroup’ and return with increased objectivity.

However, creating a psychological space whilst in the workplace did not always involve a physical action. Alex used the metaphor of imagining connection via a bridge.

> *… really terrible things and situations and if you took them all on board you might crumble yourself, mighten you. So, I try and keep that sort of a bit of a bridge, you know.* (Alex, interview 2)

She elaborated by saying it helped her to visualise the space between herself and families whilst remaining connected.

Managed empathy and emotional self-regulation

The phrase 'managed empathy' was used to label participants' articulation of internal dialogue about their feelings; and how this enabled them to manage internal and external expression of emotions at work. Managed empathy differs from creating a psychological space because creating space implies a slightly defensive, self-protective separation whilst managed empathy is a more active, engaged approach to navigating emotional demands.

Participants often used the word 'empathy' to describe their response to emotive situations experienced by parents. Traditional descriptions of empathy are putting oneself in another person's position and experiencing similar feelings. However, what the participants described did not align with this. Their narratives demonstrated a more subtle, skilful approach to configuring their thoughts; enabling delivery of compassionate care without becoming immersed in the emotions of the situation.

> …we *were sort of slightly upset ourselves I suppose. Feeling a bit vulnerable but you know, at the end of the day, you've got a professional face to keep going … it's about them and not so much about us.*

Ashley, telephone interview 1)

Inducing or supressing feelings to present a countenance which reassures others is part of emotional labour, but this may be even more challenging in a children's hospice where many activities focus on having fun. So, the nurse may be required to simultaneously supress distress and induce joviality.

The undesirability and inappropriateness of displaying anything beyond becoming slightly tearful at work was highlighted by the participants. In essence this relates to the individuals' ability (or not) to self-regulate their behaviour.

Balancing Personability and Professionalism

Providing a friendly, welcoming service in a homely environment, whilst retaining a professional stance was a juxtaposition which challenged participants. They noted the need for vigilance to avoid being swept along with the informality and sociability which underpinned the service. This did not prevent them maintaining professional nurse-parent relationships, but they described it as 'different' and requiring skilful navigation.

<u>I am a friendly professional; I am not their friend</u>

Participants identified that it was often difficult to strike a balance between being sociable and personable whilst remaining professional. They were mindful of boundaries, sometimes referring to a 'line' they would not cross. Nevertheless, they felt that parents sometimes viewed them as friends, particularly those of children with complex needs whose lives were 'full' of professionals. When referring to balancing social elements of the role with professionalism, the difference between being friendly and real friendship was highlighted.

> *….have dedicated themselves to the care of these children; their only friends are other professionals … they really value those sort of social interactions, which is fine because that's part of the job … we do see it as part of our job, whereas you wouldn't be ringing up that mum a couple of weeks later asking 'are you free for coffee' whereas with one of your friends you would do.*
>
> (Ashley, interview 1 p3)

Managed self-disclosure

The nature of nurse-parent conversations was closely linked to being friendly but not a friend; and influenced by the homely, social environment. Most participants were happy to share superficial personal information with parents but noted that this required careful management. Les did not share anything, even the most tenuous commonality. The other participants highlighted that the depth of information shared (although still labelled by them as superficial) would depend on the family, circumstances and/or length of relationship.

Often sharing personal information served the purpose of making a connection, building trust and rapport.

> *…you do share some things don't you, like you might talk about perhaps my kids. I've taken the kids to a concert or something, as a way to connect, um, or you might share something which was perhaps a commonality… about a school or something.*
>
> (Alex, telephone interview 1, p17-18).

Some participants felt obligated to answer personal questions. Their reluctance to refuse was underpinned by the need to make parents feel welcome and comfortable. Further, the long-standing 'friendly' relationship with a parent of a child whose life expectancy was limited seemed to make it difficult to rebuff questions because it felt surly to do so. Although, if pressed, they felt they could usually manoeuvre the conversation to more superficial matters. In contrast one participant referred directly

to the professional role of the nurse, deflecting questions with a slightly jokey but firm rebuff.

> *Come on now, I can't be telling you that, I'm your nurse!*
>
> (Les, telephone interview, p8).

Coping with and Counterbalancing Emotional Labour

Participants identified intrinsic features of children's hospice work as things which 'off-set' emotional labour or helped them cope. These were job satisfaction, positivity and fun and exceptional peer support. Although the participants did not use the term 'counterbalance' it has been used to identify this theme, as it captures the essence of their descriptions. So, not erasing the emotional labour but acknowledging its existence whilst simultaneously enjoying and embracing positive elements of their role.

<u>Job satisfaction</u>

The standard of care which nurses were able to deliver and the opportunity to focus on one child and family was a source of immense satisfaction and motivation. There was also a sense of pride in being able to use/develop skills to provide quality care, support families and work in partnership, often over long periods. Children's hospice nursing provided the time and resources to deliver the type of care that was difficult to achieve elsewhere, due to inadequate staffing and routines.

> *For me it's the type of nursing that I love … when I worked on the wards … it was 'I'm going to be there in a minute' and I wasn't going to be there in a minute and so, as a nurse, I wasn't achieving what I want to do, and the hospice nursing gives me enough of a balance.*
>
> (Jo, telephone interview, p5)

For participants of this study, the emotional distress they felt, although intense, was not usually frequent or constant. However, high levels of job satisfaction, a somewhat milder, quieter pleasurable feeling was almost constant and therefore counterbalanced emotional labour.

Positivity and fun

Participants referred to the hospice as a hugely positive workplace. So, in the same way job satisfaction counterbalanced emotional labour, the positivity of the hospice philosophy and enjoyment nurses gained from participating in fun activities alongside families had the same effect.

> *I think it's hard to explain … to people who have never worked or had anything to do with a children's hospice … you're just making those memories and having fun and doing as much as they can.*
>
> (Jo, telephone interview, p5)

So, making memories with and for families seemed to balance the emotional labour of the role and made it highly pleasurable. In some ways this was bittersweet because the reason for focusing on memory making was a sad one, but nevertheless enjoyable and motivational. Therefore, the philosophy of 'living whilst dying', having fun and making memories, was not only delivered by participants, but they also personally benefitted.

Extraordinary peer support

Participants spoke about the value of peer support as a means of coping with emotional demands. This was at a higher level than they had experienced elsewhere. Given the nature of the speciality, this may not be surprising. However, service delivery configuration was highlighted as a facilitator, i.e. children and

families looked after on a 1:1 basis, alongside flexible routines. So,nurses had the time, as well as the inclination to support each other.

> *... being in the hospice rather than the acute hospital setting, we as a team, have got more time to be supportive of each other … be aware of each other's support needs and just vocalise your own feelings …*
>
> (Ashley, audio diary 1, p2)

The overarching impression was camaraderie, community, shared understanding and high levels of support which led to close bonds between staff. This was attributed to the uniqueness of the environment and poor understanding of the speciality by others, including other healthcare professionals.

Discussion

The themes identified in this study demonstrate that a range of factors enable children's hospice nurses to navigate the emotional demands of their work, whilst maintaining professional integrity in relationships with parents. Those discussed under the '*Purposeful Positioning'* and '*Balancing Personability and Professionalism'* themes are dependent on internal mechanisms and strategies, whereas '*Counterbalancing and Coping with Emotional Labour'* comprises sub-themes which are features of the children's hospice nurses' role that contribute to ameliorating its demands. The internal mechanisms and strategies outlined by participants represent constructs of Emotional intelligence (EI), such as self-awareness, appropriate empathy, social skills and self-regulated emotion and behaviour. Furthermore, exploration of wider literature reveals that job satisfaction (Kassim et al. 2016; Tagoe and Quarshie 2017), peer support (Saud et al. 2016) and positivity and fun (Newman 2014; Goleman 2020) all require and/or build EI. It may be unsurprising that

management of emotional labour and professional integrity requires EI, but this study provides evidence of its value outside the business leadership realm, to which it is often applied. In particular, the notion of managed empathy alongside self-awareness and self-regulation are important.

Correlation of the study findings with Goleman's work (1995 & 2017), particularly the types of empathy participants described, i.e. employing cognitive and compassionate empathy and avoiding emotional empathy (Table 3), provide insight and guidance for practitioners.

Table 3: Types of empathy

Label	Description	Desirability
Cognitive	Allows the individual to see a situation and the associated feelings from the other person's perspective. However, this type of intellectual understanding in isolation is primarily dispassionate	Basic. Useful in business meetings and negotiations.
Compassionate	Enables the individual to feel 'for' the other person and elicits a desire to help or support. Essentially a middle ground between cognitive and emotional empathy and described as the 'ideal'. The compassionate empathiser does not get 'sucked in' and take on the other persons feelings or burden; they simply understand, care and help.	Desirable. Highly suitable for care situations.
Emotional	Physically feeling alongside the other person, almost as if their emotions were contagious.	Highly undesirable in all situations but particularly care and helping relationships. Emotional empathy or empathy imbalance can lead to burnout and compassion fatigue. Professional

		behaviour can be compromised if self-regulation skills are poorly developed
From Goleman (1995 & 2017) and Cross (2019)		

Strengths and limitations

Rich data were collected using established and newly tested methods (Brimble et al. 2022), revealing complexities of participants' management of long-term relationships with parents. Participants were recruited from hospices across England, giving a broader perspective than would have been gained from one site. Data were analysed using an established framework (Braun and Clarke 2006) and the resultant themes provide a clear presentation of the findings.

Limitations of the data collection methods are lack of face-to-face researcher-participant interaction, negating body language cues. Furthermore, these methods do not reveal participants' actions, only what they say they do, allowing 'censorship' for social/professional acceptability. As is usual with qualitative studies the sample was small. It was also homogeneous. Therefore, conclusions may not necessarily be applicable to a wider heterogeneous population.

Implications for practice

It is pertinent to suggest that development of emotional intelligence (EI) in nursing students and registrants may enhance relational skills. The areas of self-awareness, self-regulation and different types of empathy are particularly noteworthy. For those who wish to integrate EI into pre or post registration education, raising awareness is essential as it is poorly understood by many nurses (Wilson 2014). Goleman (2020) states that EI, although primarily intrinsic, can be taught and therefore next steps would be to undertake assessment of EI before and after developmental activities

(Clarke 2010; Sadri 2012). In addition, EI assessment during recruitment to practice areas where emotional labour is high, may indicate suitability; or highlight requirements for targeted post recruitment training.

It is important to acknowledge the likely effect of Covid on nurses' emotional reserves and coping mechanisms (Ogueji et al. 2022). This should be considered when implementing findings of this study and complemented with other supportive well-being interventions, such as building/rebuilding resilience.

Further research

The study could be repeated to compare/contrast findings. It could also be replicated in other CPC areas, e.g. oncology, to identify similarities/differences. This would facilitate more concrete conclusions about the influence of the hospice environment, particularly perceived personability requirements and counterbalances. In addition, studies which use qualitative methods to explore the same concepts with other children's hospice staff, e.g. nursing associates, healthcare assistants and family support teams, or adult palliative care settings, would be useful.

Conclusions

This study provides an insight into the management of emotional labour and professional integrity by experienced children's hospice nurses. Although the findings, which are suggestive of emotional intelligence skills, may be transferable to other CPC settings there are elements of working in a children's hospice (highlighted in the *Coping with and Counterbalancing* theme) which may not apply elsewhere and were highlighted as satisfying and motivational. Therefore, not only would the evidence base benefit from further research in children's hospices and other CPC areas such as oncology but also those where adults receive palliative nursing care.

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