

ORIGINAL RESEARCH

Impact of personal experiences on career path, clinical practice, and professional endurance among hospice nurses caring for dying children

Amy S. Porter¹, Tegan J. Reeves¹, Kristina Zalud², Jacob Applegarth³, Cameka Woods¹, Melanie Gattas¹, Emily Rutt¹, Karen Williams¹, Justin N. Baker¹, Erica C. Kaye*¹

¹St. Jude Children's Research Hospital, Memphis, TN, USA

²St. Louis Children's Hospital, Washington University School of Medicine, St. Louis, MO, USA

³Indiana University School of Medicine, Indianapolis, IN, USA

Received: September 3, 2021

Accepted: September 21, 2021

Online Published: March 14, 2022

DOI: 10.5430/jnep.v12n7p30

URL: <https://doi.org/10.5430/jnep.v12n7p30>

ABSTRACT

Context and objective: The multifaceted demands of pediatric hospice work often discourage nurses from pursuing the career route and may overwhelm nurses who choose to do the work, risking burnout. The relationship between nurses' personal experiences and their decisions to pursue this difficult work, as well as their ability to sustain it, has not been studied previously. The study objective was to explore the influences of pediatric hospice nurses' personal experiences on their career trajectories, their clinical approaches to caring for dying children, and their endurance in doing so.

Methods: From the 551 community hospice nurses in Tennessee, Mississippi, and Arkansas who completed a survey as part of a previous study, purposive sampling was used to select a cohort of 41 nurses. Semi-structured interviews were conducted, recorded, and transcribed. Content analysis of interview transcripts was performed.

Results: Nurses described three types of personal experiences that shaped their professional practice: 1) personal illness, 2) personal loss, and 3) parenthood. We identified two major themes characterizing how personal experiences influence their work: 1) leading them into the hospice field ("career trajectory") and 2) strengthening their clinical practice ("clinical approach") through four mechanisms: a) identifying tools for patient care, b) connecting with pediatric patients, c) connecting with bereaved families, and d) finding balance between competing priorities.

Conclusions: Personal experiences of illness, loss, and parenthood influence hospice nurses' career trajectories and how they care for dying children. Normalizing these influences and integrating reflection on them into hospice training may empower nurses to pursue pediatric hospice nursing, find meaning in the work, and build professional endurance.

Key Words: Pediatrics, Hospice nursing, Personal loss, Personal illness, Parenthood, Countertransference

1. INTRODUCTION

Hospice nurses caring for patients of all ages enter into families' lives in moments of staggering collective vulnerability and accompany patients and their family members through

both uncertainty and grief. The challenge is even greater when hospice nurses are tasked with caring for children, supporting parents and siblings as they face unimaginable loss. Moreover, caring for children at the end of life presents com-

*Correspondence: Erica C. Kaye; Email: erica.kaye@stjude.org; Division of Quality of Life and Palliative Care, Department of Oncology, St. Jude Children's Research Hospital, 262 Danny Thomas Place, Mail Stop 1121, Memphis, TN, 38105, USA.

plex challenges across educational, logistical, collaborative, and affective domains. Alongside balancing symptom management, communication, and care coordination for dying children,^[1] hospice clinicians carry a profound emotional burden, which may contribute to stress and moral distress.^[2,3] The multifaceted demands of pediatric hospice work often discourage nurses from pursuing the career route and may overwhelm nurses who choose to do the work, resulting in burnout and compassion fatigue.^[4-6]

Existing literature on influences of life experiences on hospice nurse careers suggests that profound loss and grief can inform strategies for building endurance and resilience.^[7] Some nurses intrinsically find meaning and build resilience while doing the challenging work of caring for dying children. Anecdotally, nurses talk about how personal experiences influence their decision and capacity to do the work; however, no formal research has been conducted on the topic. Personal experiences, such as major life events, are a core component in psychological wellness and agility.^[8]

To investigate the impact of personal experiences on pediatric hospice nurses, we conducted a qualitative, interview study exploring community hospice nurses' perceptions around caring for dying children. The aim of the current work was to examine if and how personal experiences (i.e., major life

events) may influence nurses' decisions to work in pediatric hospice and/or their approaches to caring for dying children.

2. METHODS

The current analysis focusing on pediatric hospice nurses' personal experiences is a part of a broader study of hospice nurse training and comfort in caring for children in the community. The Institutional Review Board at St. Jude Children's Research Hospital reviewed and approved this study.

2.1 Collaborative content development

A multi-site, interdisciplinary team of pediatric palliative care and hospice clinicians and researchers (Appendix 1) designed a semi-structured interview guide based on review of the literature related to provision of high quality pediatric hospice care in the community.^[9-18] Key stakeholders, including two pediatric hospice physicians and five pediatric hospice nurses, iteratively reviewed and pilot tested interview questions items for content and construct validity until consensus was achieved.^[19] The final interview guide included questions about the impact of personal and professional experiences on clinical practice as a hospice provider (see Figure 1).

Have you had any experiences in your *personal life* that have influenced the way you practice as a hospice nurse when taking care of children?

1. What was notable or significant about those experiences?
2. How did they influence the way you practice as a nurse?
3. Could you use those experiences to teach someone how to practice as a nurse?

Figure 1. Interview question targeting influences of personal experience on hospice nursing practice

2.2 Nurse selection, consent, and interview processes

Methods for the preceding population-level survey study of hospice nurse experiences and comfort with pediatric hospice care provision have been described.^[20-22] Briefly, we identified all accredited hospice organizations in a tristate region of Tennessee, Mississippi, and Arkansas that accepted referrals for pediatric patients. These three states comprise a wide catchment area for the authors' institution and have notably poor access to hospice services,^[23] and the survey study was an initial step towards improving pediatric palliative and hospice care in this underresourced region. From the 551 community hospice nurses who completed the preceding survey, purposive sampling^[24] was used to select a cohort of 41 hospice nurses representing different geographic regions and levels of comfort with providing pediatric hospice care, targeting enrollment of relatively equivalent numbers of nurses who self-identified as "very uncomfortable," "somewhat uncomfortable," "somewhat comfortable," and "very

comfortable." Nurses were randomly selected until more than 10 were enrolled from each stratum. Email invitations were sent to selected nurses, and for those who wished to participate, an audio-recorded telephone interview was conducted at their convenience by a physician with expertise in pediatric complex care and a doctoral degree in anthropology. Prior to beginning each interview, formal verbal consent was obtained from nurses in accordance with Institutional Review Board protocol. Semi-structured interviews were conducted over a period of two months between February and April 2019. Interviews were transcribed verbatim by trained medical transcriptionists.^[25]

2.3 Data analysis

Preliminary code development included transcript review and memoing.^[25] Per COREQ guidelines,^[26] four researchers used raw data to guide inductive development of codes and code definitions across serial meetings. When no new con-

cepts emerged from the transcripts and the researchers determined thematic saturation had been reached,^[27,28] the codebook was finalized. Initial coding by three researchers involved pilot-testing the codebook by applying it across a series of interview transcripts to identify areas of variance. Five researchers met to reconcile variances and achieve consensus, modifying the codebook as needed to improve dependability, confirmability, and credibility of independent codes.^[29] Final coding was performed by three analysts with significant training and experience with content analysis, each transcript coded by at least two analysts. During weekly meetings, codes were reviewed for variation and third-party adjudication to reach consensus. Consistency in code segmentation was further reviewed to ensure agreement. Patterns within and between codes were examined closely, grouped into categories, and reorganized to identify patterns and themes^[30] derived from hospice nurse responses. While member-checking was not feasible, two nurses with community-based hospice experience reviewed synthesized data (i.e. codes and examples). MAXQDA, a mixed-methods data analysis software program, was used to organize the data (VERBI Software, 2020).

The current analysis uses codes derived primarily from responses to the personal experience section of the interview guide (see Figure 1). Codes were applied across the entire transcripts. Accordingly, even as the codebook is organized based on the semi-structured interview guide probes, data emerged across the entire transcripts.

3. RESULTS

A total of 41 nurses completed interviews. Table 1 presents nurse demographics. Interview duration ranged from 20 to 60 minutes.

In describing their experiences caring for children with serious illness, nurses shared stories about how their personal experiences have influenced their career trajectories and clinical practice of pediatric palliative and hospice care. Their personal experiences of personal illness, personal loss, and parenthood influenced them in two key ways: 1) leading them into the field of hospice (“career trajectory”) and 2) strengthening their clinical practice (“clinical approach”). These influences played out through four key mechanisms: a) identifying tools for patient care, b) connecting with pediatric patients, c) connecting with bereaved families, and d) finding balance between competing priorities. Figure 2 depicts the influences of personal experiences on hospice nurse practice. The intersections of these mechanisms arise in narrative depictions of the personal experiences that influenced career trajectory and clinical approach. These narratives, elucidated below, included personal and family illness, personal

loss, and parenthood.

Table 1. Nurse demographics and clinical practice variables (N = 41)

Survey Item	Response	N (%)
Gender	Female	38 (92.7)
	Male	3 (7.3)
Race	White	39 (95.1)
	Black	1 (2.4)
	Asian/Pacific Islander	0 (0)
	Arabic/Middle Eastern	0 (0)
	Native American Indian/Alaskan Native	1 (2.4)
	Other	0 (0)
Ethnicity	Hispanic	0 (0)
	Non-hispanic	41 (100)
Age	≤ 19 years	0 (0)
	20-29 years	5 (12.2)
	30-39 years	10 (24.4)
	40-49 years	10 (24.4)
	50-59 years	12 (29.3)
	≥ 60 years	4 (9.8)
State	Arkansas	12 (29.3)
	Mississippi	10 (24.4)
	Tennessee	19 (46.3)
Years as a nurse	< 1 year	0 (0)
	1-4 years	5 (12.2)
	5-9 years	9 (22.0)
	10-19 years	9 (22.0)
	≥ 20 years	18 (43.9)
Years as a hospice nurse	< 1 year	7 (17.1)
	1-4 years	12 (29.3)
	5-9 years	11 (26.8)
	10-19 years	10 (24.4)
	≥ 20 years	1 (2.4)
Comfort level	Very uncomfortable	7 (17.1)
	Somewhat uncomfortable	13 (31.7)
	Somewhat comfortable	12 (29.3)
	Very comfortable	9 (22.0)

“In the hospital as a child”: Impact of personal and family illness experiences on hospice nurses

Hospice nurses described how past experiences as patients themselves influenced their care of dying children, both in their decisions to pursue nursing and in how they prioritize elements of care. One nurse offered reflections on how being an adolescent cancer patient and survivor led her to become a hospice nurse: “Well, I’m a second career nurse and came into the field [of nursing] to specifically come into palliative and hospice. I was diagnosed with a long-term, life-limiting condition when I was about 13 or 14, and I am a cancer survivor myself, as well, so that is kind of how I came to be here.” She directly attributed her career route into pediatric palliative and hospice nursing to her identity as a pediatric cancer survivor. Another nurse considered how her personal experience of separating from her mother as a pediatric patient has shaped her compassion in her role as a pediatric

hospice nurse: “I’ve been in the hospital as a child, a very small child, when my mother couldn’t be there because I was far away. And that was a very big experience in my life, and the nurses made me feel very comfortable. I think that can carry over to hospice. I think that’s a very important role for babies and for children to feel safe and comfortable.” She prioritizes a child’s comfort and security because of her personal experience being made to feel comfortable and safe as a hospitalized child.

Nurses also reported that strategies they found useful in caring for their own family members influenced the tools they use in caring for pediatric patients and their families. A nurse who cared for her mother-in-law at the end of life explained how learning to navigate her care in the context of dementia influenced the ways she engages with pediatric patients:

I took care of my mother-in-law who had some sort of dementia. . . She would be disturbed and cry, and you didn’t know what it was about. And so, I finally just would sometimes say I’m going to put you back together. And I would just hold her. And in the midst of that exchange, more times than not, she would settle, and she’d get back together. And so, I realized that a lot of our dementia patients – who hugs them anymore? Who holds them together? When was the last time somebody hugged them and held them and just that all-encompassing type touch. And so, taking care of her somewhat changed

some of my care of my most vulnerable patients that can’t communicate. [Now] we go to turn a patient, and I’ll ask, “Can I hold you?” And they’ll say, “yes.”

The power of physical contact as a tool for caregiving became clear when she struggled to calm her own mother-in-law and eventually realized that touch could help when other strategies fell short.

“The other side of the fence”: Influence of personal loss experiences on hospice nurses

Many nurses articulated how personal loss has affected their practice. Two nurses shared tragic stories of losing one of their own children that tremendously impacted them as pediatric caregivers. One nurse, whose 6-year-old daughter died suddenly, explained how connecting with bereaved parents helped her persevere while grieving her daughter’s death:

I’ll tell you that when I was really going through the dark days, going through the loss and the heavy grief, I was always connected to parents who had already gone through it. . . I would look at them and would say, “well, they’re still breathing and still functioning in life,” and that was encouraging to me. And so, at times when families know that I’ve gone through the death of my child, I think they look at me and say, “well, you’re still eating and breathing, and life goes on.”

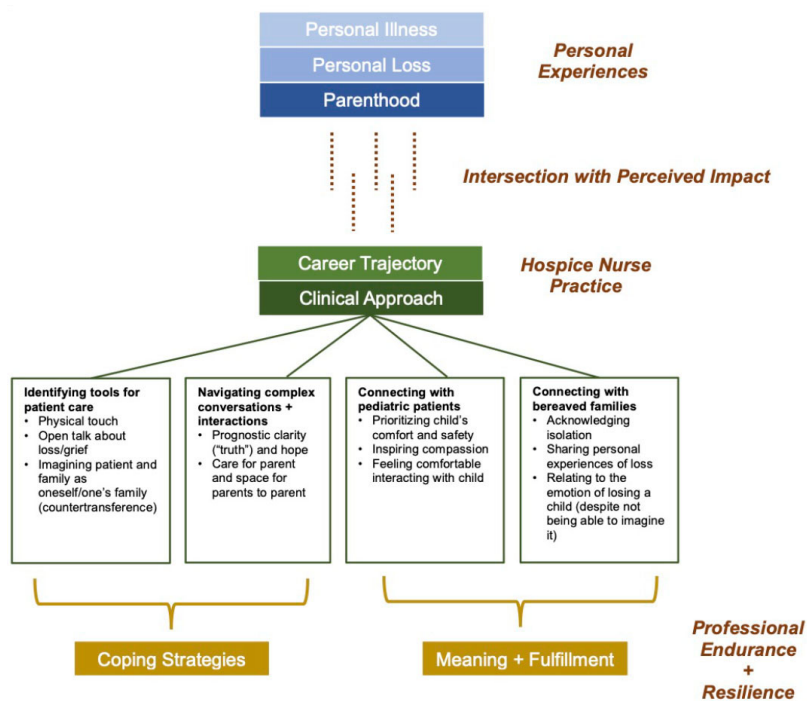


Figure 2. Impact of personal experiences on hospice nurse practice

Her personal experience of feeling supported by fellow bereaved parents while grieving for her own child has informed her strategy of connecting with bereaved parents and for supporting bereaved parents as a pediatric hospice clinician.

Nurses shared experiences with the death of friends, friends' children, classmates, cousins, or siblings during childhood and how they meaningfully impacted their practice of pediatric palliative and hospice care. One nurse explained how watching her brother die in early adulthood helped her understand how families process the death of a young family member:

My brother passed away when he was 25. And it was a sudden death; it was unexpected. But I think when you are able to as a family grieve together. . . , when you're able to sit down and talk about a loved one that passed, sometimes you cry, and sometimes you laugh, and sometimes you're upset about why does it have to be like that. I think [it helps] when you're able to grieve outwardly and it's accepted, like my family.

Seeing the way that open dialogue helped her own grieving family heal has led her to support families in talking openly about loss and grief. She went on to explain how witnessing her mother's grief upon her brother's death showed her that many bereaved parents experience a sense of isolation:

Two months after my brother had passed, my mom looked at me and she said, "You all went home." Looking back, she didn't expect us to stay there, but. . . the parent's world stops moving; it's still. Everybody else goes on, and here [the parents] are, stuck in this moment of grief, and they feel like everybody has forgotten what just happened.

Observing isolation in her own mother helped her to recognize and acknowledge it in the bereaved parents for whom she cares and thereby connect with them more effectively.

Many nurses conveyed stories about how witnessing the deaths of adult family members on hospice led them into the field: "My mother-in-law was in hospice care, and that's actually what drew me to a hospice was being in that situation on the other side of the fence, so to speak, and seeing how maybe I could assist patients and families in that time of need like we were assisted. I just wanted to help." A common theme in nurses' narration of how they came to be in the field of hospice and palliative care is that understanding what it feels like to be in a bereaved family member's position "on the other side of the fence" helped them decide to take on the

emotional challenge of caring for children at the end of life and choose this unique professional role. One nurse articulated her belief that many hospice nurses enter into the field because of personal experiences with hospice: "I had two family members who were cared for by hospice. That was a motivator to for me to start my career in hospice. I think that's true if you talk to a lot people that work in hospice, they have a personal perspective, an experience that they had that has caused them to enter that career."

"You look at them as you would your own": Impact of parenthood and countertransference on hospice nurses' pediatric care practices

When asked how personal experiences influenced them professionally, a majority of nurses mentioned parenthood – and specifically motherhood. In fact, nurses addressed the topic 50 times in the 41 interviews. In narrating how being a parent influenced her approach to caring for pediatric patients, one nurse described how thinking about her pediatric patient as her own child impacted her care of the patient:

You know I always try to put myself in the shoes of the parent - if that was my baby laying there, that was my child laying there, how would I want the nurse to respond to me and respond to my loved one? So, I try to treat everybody as if they were a family member or how I would want to be treated. . . You need to try to make that as in a bad situation make it as good as you can for them.

Her experience as a mother continues to inspire her to try to make difficult and sad situations as bearable as possible for families. Another nurse highlighted how becoming a mother changed her clinical practice because it made her more empathetic, allowing her to imagine someone caring for her own child:

I think that becoming a mother myself definitely shifted [the way I practice as a hospice nurse] because I never took care of a child before being a mother, and [now] I have a 4-year-old. Definitely, I have no doubt that when I took care of a little girl in this past year, [having a young child] deeply affected how I provided care to her because I wanted to give her the same type of care that I would want somebody to do for [my child].

Similarly, one nurse expressed compassion derived from countertransference: "Just the fact that I have children myself [influences my care of children]. Just to have a different

view of things. You look at them as you would your own, and that increases the compassion level.” For many, empathy and compassion arose via countertransference experienced by parents caring for pediatric patients.

Nurses described motherhood specifically as beneficial to their work as a pediatric caregiver: “I think that just being a mother is automatically going to affect how you take care of a child in any situation. . . for the better because if you’re familiar with children, you know how they react to certain situations it tends to make you a little bit more comfortable with being around the child.” Being a parent grants hospice nurses experience and familiarity with children and thereby helps them to feel comfortable interacting with pediatric patients.

Further, nurses offered examples of how the personal experience of parenting helps them find balance in complex circumstances. Reflecting on the importance of honest evaluation of a patient’s status and offering hope, one nurse shared, “Just knowing if I were to have a grandchild that had a chronic or life-threatening illness, what I would want - and what I would want to give to patients and families is the truth but yet still providing [a] level of hope.” For her, countertransference provided a tool for navigating prognostic communication as a child approached the end of life. Another challenge addressed in these interviews was walking the line between helping parents of dying children and leaving space for them to parent; one nurse explained that being a parent helped her balance these two goals:

I mean, just being a mother myself [influences the way I practice as a hospice nurse]. I try to think about what to say, what not to say, and also not over-stepping my bounds with parents because I know that the hair on the back of my neck would go up. Respecting that they are the parents, that’s probably the biggest [way that my parenthood influences my practice], and treating them like this is their child. I know my child better than anybody. They know their child better than anybody - letting them know that I understand that.

Both nurses reflected how their personal experiences as parents (or grandparents) helped them develop a more nuanced approach to navigating complex parental perspectives when a child is dying.

4. DISCUSSION

In this study, nurses caring for dying children shared the impact of personal experiences on their career trajectories and

approaches to clinical care. They described how personal experiences of illness, loss, and parenthood led them to decide to go into pediatric hospice nursing; helped them develop tools for patient care and navigate complex interactions and conversations; and inspired them to connect with patients and families. Hospice nurses credited personal experiences as foundational in their work, describing a sense of purpose in recognizing their “calling” and a sense of capability in navigating this challenging work.

Parenthood, in particular, emerged as a profound force affecting the clinical experiences of hospice nurses. Many nurses described a phenomenon that we interpret as countertransference, a concept originating in psychoanalytic tradition^[31] that, in part, refers to the act of imagining oneself in another’s shoes.^[32] Historically, clinical psychology and psychiatry training has discouraged countertransference, inciting clinicians to “recognize and overcome” personal emotions as mere reflections of the patient’s state.^[31] Education for health care professionals echoes warnings of the potential negative influences of countertransference.^[32]

Our findings, however, suggest that among hospice nurses, emotional connection developed through empathetic caregiving bolsters perceived interpersonal connection and meaning-making. In this study, nurses revealed the potential positive impact of countertransference, leading nurses into a pediatric hospice career and supporting their sense of efficacy and preparedness in clinical practice. This aligns with prior theory proposing that the affective attunement (i.e., emotional connection) of countertransference is a necessary component of meaningful clinical interaction.^[8] We believe that countertransference has the potential to influence pediatric palliative care clinicians in positive ways, driving personal reflection that inspires empathy, compassion, and shared meaning-making. While popular opinion recommends avoiding countertransference, our data suggest that it is not something to be overcome but rather something that has the potential to support clinical care.

Standard teaching also emphasizes the imperative for clinicians to maintain boundaries,^[33] which may preclude open reflection on how personal experiences influence our work. Nonetheless, professional boundaries may also discourage connection with patients and families, limiting the meaning-making and fulfillment that sustain clinicians who care for patients at the end of life. Adhering to strict boundaries with patients and families may result in diminished empathy, which in turn may decrease role fulfillment. Our findings suggest that hospice nurses’ reflections on their personal experiences with illness, loss, and parenthood contribute to their self-awareness and empathy.

Hospice nurses also are at risk for burnout,^[2,3] and finding mechanisms to bolster resilience is paramount to sustaining nurses in their careers.^[34,35] Current efforts to improve resilience include discouraging personal investment,^[8] yet this approach overlooks the crucial role of personal experiences and reflection in building resilience. Through countertransference, pediatric hospice nurses in this study demonstrated profound resilience, as manifested in the capacity to transform adversity into opportunity and learn from challenging situations.^[34]

Hardiness is described as one facet of clinician resilience, defined by three distinct measurable components: 1) commitment to act, 2) ability to act, and 3) perception of difficulty as a challenge to overcome.^[36] Hardiness has been shown to attenuate burnout in oncology clinicians^[37] and lower emotional exhaustion in nurses caring for seriously ill patients.^[38] Nurses in this study articulated how personal experiences led them into the field (commitment to act), provided them with important tools and strategies for approaching care for dying children (ability to act), and motivated them (reframing difficulty as worthwhile challenge to overcome). In essence, self-awareness around personal experiences profoundly shape commitment, practice, and motivation to instill nurses with hardiness, increasing resilience and protecting against burnout.

Training programs and debriefings that guide nurses in reflecting on the influences of personal experiences of illness, loss, and parenting on career paths, tools for patient care, and connection with patients may help normalize these common themes and empower hospice nurses to use their personal experiences as a foundations for developing resilience. More specifically, we recommend that theories of countertransference and hardiness should be integrated into nursing education to encourage hospice nurses to use reflection on personal experiences to build resilience. Although limited, existing literature on influences of life experiences on hospice nurse careers suggests that both loss and grief can drive the development of endurance and resilience; in this way, the act of hospice nursing may serve as a means of transformation.^[7]

This study has several limitations that present key opportunities for next steps. Sampling was specific to pediatric

hospice nurses in the tri-state area and not meant to represent all nurses nationwide. Follow-up research could explore whether there are differences in various geographic regions. Furthermore, the nurses whose stories inform our findings and recommendations may be more inclined to reflect on and share personal experiences at baseline than those who chose not to participate in interviews; accordingly, training that encourages reflection on personal experiences may be less influential to a different group of nurses. Future research exploring the impact of including reflection on personal experiences in nursing education for other nurse populations may provide further insight and distinction. Finally, the themes that arose in semi-structured, in-depth interviews should be further investigated to more clearly delineate impact. Future work may include asking nurses to explicitly weight or rank the influence of various personal experiences on career decisions, clinical care approaches, elements of hardiness, and resilience.

5. CONCLUSION

Personal experiences of illness, loss, and parenthood often influence hospice nurses' decisions to work with pediatric patients and their approaches to caring for dying children. Nurses emphasized how these personal experiences have impacted their professional practice, in terms of career trajectory, clinical approach, and professional endurance. Normalizing and reflecting on personal experiences through debriefings and trainings may empower nurses to enter into pediatric hospice nursing, find meaning in the work, and build resilience. Specifically, through novel approaches of reframing countertransference and hardiness, future interventions should formalize reflection and acknowledgement of personal experiences among hospice nurses who care for dying children to better support them in building resilience.

ACKNOWLEDGEMENTS

The authors acknowledge and thank the hospice nurses who participated in this study and shared their personal reflections and insights.

CONFLICTS OF INTEREST DISCLOSURE

The authors declare that there is no conflict of interest.

REFERENCES

- [1] Carroll JM, Santucci G, Kang TI, et al. Partners in Pediatric Palliative Care: A Program to Enhance Collaboration Between Hospital and Community Palliative Care Services. 2007. PMID:17601842 <https://doi.org/10.1177/1049909106298393>
- [2] Pearson HN. "You've only got one chance to get it right": Children's cancer nurses' experiences of providing palliative care in the

acute hospital setting. *Compr Child Adolesc Nurs.* 2013; 36(3): 188-211. PMID:23758218 <https://doi.org/10.3109/01460862.2013.797520>

- [3] McCloskey S, Taggart L. How much compassion have I left? An exploration of occupational stress among children's palliative care nurses. *Int J Palliat Nurs.* 2010; 16(5): 233-240. PMID:20679971 <https://doi.org/10.12968/ijpn.2010.16.5.48144>

- [4] Mesquita Garcia AC, Domingues Silva B, Oliveira da Silva LC, et al. Self-compassion In Hospice and Palliative Care: A Systematic Integrative Review. *J Hosp Palliat Nurs*. 2021; 23(2): 145-154. PMID:33633095 <https://doi.org/10.1097/NJH.00000000000000727>
- [5] Lehto RH, Heeter C, Forman J, et al. Hospice employees' perceptions of their work environment: A focus group perspective. *Int J Environ Res Public Health*. 2020; 17(17): 1-16. PMID:32847036 <https://doi.org/10.3390/ijerph17176147>
- [6] Barru e P, S anchez-G omez M. The emotional experience of nurses in the Home Hospitalization Unit in palliative care: A qualitative exploratory study. *Enferm Clin*. 2021.
- [7] Lea Barbato Gaydos H. The living end: Life journeys of hospice nurses. *J Hosp Palliat Nurs*. 2004.
- [8] Nathanson DL. *Knowing Feeling: Affect, Script, and Psychotherapy*. (Nathanson DL, ed.). New York, NY, US: W. W. Norton & Company; 1996.
- [9] Davies B, Sehring SA, Partridge JC, et al. Barriers to Palliative Care for Children: Perceptions of Pediatric Health Care Providers. *Pediatrics*. 2008.
- [10] J nger S, Vedder AE, Milde S, et al. Paediatric palliative home care by general paediatricians: A multimethod study on perceived barriers and incentives. *BMC Palliat Care*. 2010; 9. PMID:20525318 <https://doi.org/10.1186/1472-684X-9-11>
- [11] Knapp C, Thompson L. Factors associated with perceived barriers to pediatric palliative care: A survey of pediatricians in Florida and California. *Palliat Med*. 2012; 26(3): 268-274. PMID:21680751 <https://doi.org/10.1177/0269216311409085>
- [12] Kaye EC, Rubenstein J, Levine D, et al. Pediatric palliative care in the community. *CA Cancer J Clin*. 2015.
- [13] Claxton-Oldfield S, Marrison-Shaw H. Perceived Barriers and Enablers to Referrals to Community-Based Hospice Palliative Care Volunteer Programs in Canada. *Am J Hosp Palliat Med*. 2014; 31(8): 836-844. PMID:24037541 <https://doi.org/10.1177/1049909113504482>
- [14] Varela AMS, Deal AM, Hanson LC, et al. Barriers to Hospice for Children as Perceived by Hospice Organizations in North Carolina. *Am J Hosp Palliat Med*. 2012; 29(3): 171-176. PMID:21712308 <https://doi.org/10.1177/1049909111412580>
- [15] Friedman BT, Kay Harwood M, Shields M. Barriers and enablers to hospice referrals: An expert overview. *J Palliat Med*. 2002; 5(1): 73-80. PMID:11839229 <https://doi.org/10.1089/10966210252785033>
- [16] Dalberg T, Jacob-Files E, Carney PA, et al. Pediatric oncology providers perceptions of barriers and facilitators to early integration of pediatric palliative care. *Pediatr Blood Cancer*. 2013; 60(11): 1875-1881. PMID:23840035 <https://doi.org/10.1002/pbc.24673>
- [17] O'Brien M, Jack B. Barriers to dying at home: The impact of poor coordination of community service provision for patients with cancer. *Heal Soc Care Community*. 2010; 18(4): 337-345.
- [18] J nger S, Pastrana T, Pestinger M, et al. Barriers and needs in paediatric palliative home care in Germany: A qualitative interview study with professional experts. *BMC Palliat Care*. 2010; 9. PMID:20525166 <https://doi.org/10.1186/1472-684X-9-10>
- [19] Krippendorff K. *Content Analysis: An Introduction to Its Methodology* (Second Edition). 2004.
- [20] Kaye EC, Gattas M, Kiefer A, et al. Investigation of Modifiable Variables to Increase Hospice Nurse Comfort With Care Provision to Children and Families in the Community: A Population-Level Study Across Tennessee, Mississippi, and Arkansas. *J Pain Symptom Manage*. 2020; 60(6): 1144-1153. PMID:32622898 <https://doi.org/10.1016/j.jpainsymman.2020.06.036>
- [21] Kaye EC, Gattas M, Kiefer A, et al. Provision of Palliative and Hospice Care to Children in the Community: A Population Study of Hospice Nurses. *J Pain Symptom Manage*. 2019; 57(2): 241-250. PMID:30391654 <https://doi.org/10.1016/j.jpainsymman.2018.10.509>
- [22] Kaye EC, Applegarth J, Gattas M, et al. Hospice nurses request paediatric-specific educational resources and training programs to improve care for children and families in the community: Qualitative data analysis from a population-level survey. *Palliat Med*. 2020; 34(3): 403-412. PMID:31347446 <https://doi.org/10.1177/0269216319866576>
- [23] Carlson MDA, Bradley EH, Du Q, et al. Geographic access to hospice in the United States. *J Palliat Med*. 2010; 13(11): 1331-1338. PMID:20979524 <https://doi.org/10.1089/jpm.2010.0209>
- [24] Guest G, Bunce A, Johnson L. How Many Interviews Are Enough? *Field Methods*. 2006; 18(1): 59-82. <https://doi.org/10.1177/1525822X05279903>
- [25] Sch nfelder W. CAQDAS and Qualitative Syllogism Logic-NVivo 8 and MAXQDA 10 Compared. *Forum Qual Soc Res*. 2011; 12(1): 21.
- [26] Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *Int J Qual Heal Care*. 2007; 19(6): 349-357. PMID:17872937 <https://doi.org/10.1093/intqhc/mzm042>
- [27] Bradley EH, Curry LA, Devers KJ. Qualitative data analysis for health services research: Developing taxonomy, themes, and theory. *Health Serv Res*. 2007; 42(4): 1758-1772. PMID:17286625 <https://doi.org/10.1111/j.1475-6773.2006.00684.x>
- [28] Saunders B, Sim J, Kingstone T, et al. Saturation in qualitative research: exploring its conceptualization and operationalization. *Qual Quant*. 2018; 52(4): 1893-1907. PMID:29937585 <https://doi.org/10.1007/s11135-017-0574-8>
- [29] Korstjens I, Moser A. Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *Eur J Gen Pract*. 2018; 24(1): 120-124. PMID:29202616 <https://doi.org/10.1080/13814788.2017.1375092>
- [30] Krippendorff K. *Content Analysis: An Introduction to Its Methodology*. Newbury Park, CA: SAGE Publications; 1980.
- [31] Freud S. The origin and development of psychoanalysis. By Sigmund Freud, 1910. *Am J Psychol*. 1987; 100(3-4): 472-488.
- [32] Jones AC. Transference and countertransference. *Perspect Psychiatr Care*. 2004; 40(1): 13-19. PMID:15147048 <https://doi.org/10.1111/j.1744-6163.2004.00013.x>
- [33] Gaufberg E, Baumer N, Hinrichs M, et al. Professional boundaries: The perspective of the third year medical student in negotiating three boundary challenges. *Teach Learn Med*. 2008. PMID:18855238 <https://doi.org/10.1080/10401330802384862>
- [34] Amsrud KE, Lyberg A, Severinsson E. Development of resilience in nursing students: A systematic qualitative review and thematic synthesis. *Nurse Educ Pract*. 2019; 41. PMID:31726329 <https://doi.org/10.1016/j.nepr.2019.102621>
- [35] Henshall C, Davey Z, Jackson D. Nursing resilience interventions—A way forward in challenging healthcare territories. *J Clin Nurs*. 2020; 29(19-20): 3597-3599. <https://doi.org/10.1111/jocn.15276>
- [36] Kobasa SC, Puccetti MC. Personality and social resources in stress resistance. *J Pers Soc Psychol*. 1983; 45(4): 839-850. <https://doi.org/10.1037/0022-3514.45.4.839>
- [37] Kash KM, Holland JC, Breitbart W, et al. Stress and burnout in oncology. *Oncology*. 2000; 14(11).
- [38] Costantini A, Solano L, Di Napoli R, et al. Relationship between hardiness and risk of burnout in a sample of 92 nurses working in oncology and aids wards. *Psychother Psychosom*. 1997; 66(2): 78-82. PMID:9097334 <https://doi.org/10.1159/000289112>