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Emotional Nursing Labour in the Childcare at the End-of-Life and Their Family: A Systematic Review

Paula Diogo[1], José Vilelas[2], Luiza Rodrigues[3] & Tânia Almeida[3]

Abstract

We intend to present a systematization of scientific evidence about the emotional labour of nurses in the process of childcare in the end-of-life and their family. It was performed a literature search in the databases CINAHL, Medline, Psychology and Behavioral Sciences Collection, from which we obtained nine studies for analysis and they gave response to the research questions: "How nurses perform the emotional labour inherent to nursing care provided to children in end-of-life and their family?" and "What are the nursing sensitive outcomes?". The findings highlights the focus of the emotional labour, simultaneously focused in the child and family, extolling the philosophy of family-centered care and also focused in the nurses themselves, because they are also affected by the emotional responses of clients and their need to manage these emotions in their care practice. The emotional labour is featured as part of the process of care, as key competence in caring, as a stressful experience and as regulation of their own emotions, and presents nursing sensitive outcomes. Caring for children at the end-of-life is one of the biggest emotional challenges for parents and nurses. Nurses play an emotional labour enrolled in the philosophy of holism and care relationship.

Keywords: Emotional Labour, Caring, End-of-life, Pediatric Nursing

1. Introduction

Today, the holistic approach of care, changed the relational dynamics between the nurses, the sick person and their families, in which emotional needs started to have a great importance in establishing a therapeutic relationship considered essential (Williams, 2001; McVicar, 2003).

[1] PhD, MSc, RN, Nursing Professor, Escola Superior de Enfermagem de Lisboa, UI&de, Parque de Saúde, Av. Do Brasil, nº 53-B, 1700-063 Lisbon, Portugal. Tel: (351) 217924100, Tel: (351) 217924197, Email: pmdiogo@esel.pt
[2] PhD, MSc, RN, Nursing Professor
[3] MSc, RN, Nurse Specialist

In fact Watson and Smith (2002) argue that nursing care is conceptualized on the basis of humanistic theories, such as transpersonal caring theory of Jean Watson, who emphasize the emotional involvement necessary in a human relationship. However, this involvement and proximity demand to the nurse a delivery (Phillips, 1996), and for that is required induction or suppression of feelings and emotions, to sustain an outward appearance that produces in others feelings of wellbeing and a safe environment. That is, the delivery conditions the emotions regulating its expression in the public domain - The Emotional Labour (Hochschild, 1983). This concept destined to enhance the notion of costs and benefits of a profession, in which manifestations of feelings of members of that profession are designed to influence the persons and are necessary components of professional performance. Therefore, nurses need skills in managing the wellbeing and emotional state of the person. But, in a way, is a choice dependent on the degree of emotional involvement of nurses. The research on the concept of emotional labour in nursing has been directed to understand the importance of this in care. In this sense, the concept has been explored and applied to nursing phenomena by some prominent researchers (Smith, 1992; Froggatt, 1998). Smith (2011) recognizes that it is expected that nurses apparent to be happy and know how to manage extreme feelings, inducing or repressing their own feelings, to make others feel care and safe, regardless of how the nurse feels. Another aspect of the emotional labour is the mobilization of skills that are often invisible such as support and tranquility, gentleness and kindness, sympathy, animate, using humor, be patient, relieve suffering, knowing the customer and help them solve their problems (Smith, 1992). But this, involves the management of negative feelings, in order to not become a disturbing experience (which minimizes pain) or with positive results for the individuals (James 1993).

Smith and Gray (2001) distinguished the elements of the emotional labour, which included the person, their family, the environment and the psychological elements that involved intimacy, friendship and trust in the health facility. The authors concluded that these social and psychological aspects of the emotional labour were key components in the interpersonal relationships between the nurse, the person and the family.

However, the concept of emotional labour can be seen as an aspect of human nurses, conceptualized in the theory of Watson (2005). The emotional labour involves holism and human experience (Hunter and Smith, 2007), i.e. the situational context in which the person needs care and the planning of care the person needs from nurses.

The concept recognizes the high emotional effort and the human reliability of nurses in relationships with people who care.

The nurses are aware of the demands of caring for others (McCreight, 2005), but do not recognize the consequences of their personal and professional emotional labour. The fact of the emotional labour not be recognized, and therefore undervalued by most organizations (Hunter and Smith, 2007), may contribute to understand the empirical relationship between emotional labour, emotional exhaustion and professional burnout (Mann and Cowburn, 2005; Naring et al., 2006). But gradually the emotional labour is having the proper recognition in Europe, especially through the British studies (Smith, 1992, 2011), French (Mercadier, 2004), Swedish (Rasmussen and Sandman, 2000), Dutch (Briet et al., 2005) Germans (Bussing and Glaser, 2001) and Italian (Zammunier and Galli, 2005).

For the professional of nursing, the performance the emotional labour is very complex, especially when it comes to children on end-of-life. Maunder (2008) argues that caring for a child with a bad prognosis disease and on end-of-life is one of the biggest emotional challenges for nurses. Requires an emotional labour centered on nurses, on the pretense of managing high levels of stress, and with centrality on the clients in the pretension of ensuring that their dreams, hopes and wishes are respected (Pearson, 2010), and also with the intention of positively transform the emotional experiences of clients, promoting wellbeing and alleviating suffering (Diogo, 2012). Support the child and family is only possible when it establishes a trust relationship between the triad and the multidisciplinary team (Dunlop, 2008). It is probable that the axis of this triad is the nurse who is encouraging and monitoring the child and their family to create an honest and open environment, to discuss issues related to the end-of-life and death. The child will become aware that death is approaching and may try to protect their parents, pretending not to know what's happening (Pearson, 2010). It is essential to understand the experiences of child and their family, as they run through a way of great emotional complexity. Therefore nursing interventions should include psychological support, training/empowerment, effective communication to help them experiencing this period in a healthy manner (Ewing, 2009), that is highly complex interventions which come within the nursing care.

In this sense, and concerned with the care of the child at the end-of-life, and his family, was constituted our restlessness describe and understand the emotional labour of nurses in its complexity, analyzing the factors that determine and characterize, believing that the only way you can plan and establish nursing interventions with therapeutic intent in the context of the end-of-life care. Given these assumptions, we intend to describe the emotional labour of nurses in the care process, proceeding to the systematization of scientific evidence produced in the last five years.

2. Search Method

In the formulation of research questions, definition of inclusion criteria and consequently the sample, we used the method designated as PI[C]O (Melnyk and Fineout-Overholt, 2005; Vilelas, 2009). Thus, we intend to answer the following questions: How nurses (P) perform the emotional labour (I) inherent in nursing care provided to children in the end-of-life and their family? and What are the nursing sensitive outcomes? (O).

Based on the research questions were defined criteria for inclusion and exclusion. As regards, inclusion criteria were: Nurses who provide child care in the end-of-life and their family; Nursing interventions that incorporate emotional labour; Improvement the nursing sensitive outcomes to children in the end-of-life and their family; All types of studies, qualitative and quantitative approach. For the exclusion criteria were considered: Participants who were not nurses; Care not related to emotional labour or not provided by nurses, outcomes that do not improve the care of the child at the end-of-life and their family; Studies that did not have a scientific support.

Considering the time period from 2008 to 2012, we selected 38 articles using the databases CINAHL, Medline, Psychology and Behavioral Sciences Collection, using the following keywords: [(Nurs* OR nurse-patient interaction OR nurse-patient Relationships) AND (emotional labor OR emotional labour OR emotional management OR emot*) AND (child* OR pediatrics) AND (End-of-life or bereavement or death)]. We also resorted to the LICAS, with the following keywords: Child AND Death AND Nursing, and we obtained 59 articles.

From the analysis of 97 articles, either by summary or by reading the full text, have resulted 9 articles which were included in this study.

3. Findings

Of the 9 studies that constitute the corpus of data analysis, none starts directly from the concept of emotional labour in nursing but from its definition, originating in sociology (Hochschild, 1983) which is developed and applied by Smith (1992, 2011) in nursing, and similar or associated concepts with emotional management in this field. The reason relates to the lack of articles about the emotional labour in pediatric nursing in electronic databases searched.

The analyzed studies are qualitative, using focus groups (1), the research-action (1), Phenomenology (1), the case study (1), the qualitative content analysis (4) and systematic review (1). In total, eight studies are primary and one is a secondary study. Most publications can be observed in 2010 in the United States, Ireland and Brazil, exactly the countries with the greater development of palliative care.

With the scientific evidence of the theoretical framework and the analysis of the included studies, emerge a description of the performance of the emotional labour of nurses in the care of the children at end-of-life and their families, taking into account that the focus is, simultaneously, directed to the child and family, which reaffirms the philosophy of family-centered care, currently integrated into pediatric health care. The emotional labour has also focused on nurses themselves, as they are affected by the emotional responses of the clients and need to manage these emotions in their care practice. Taking into account these three focuses (children, families, and nurses) the performance of the emotional labour is characterized as a component of the care process, as key competence in caring, as stressful experience in confronting the suffering of the client and as regulation of own emotions.

3.1 As a Component of the Care Process

The data from six studies show that nurses perform the emotional labour focused on child and family in order to transform the emotions experienced, which is anchored in the practice of care (regardless of model or guideline for practice) and has the therapeutic intent of reduce suffering.

It can be seen that the emotional labour is one component of the care process. One of the processes is the approach to the children with oncological diseases and their families through a partnership model of care as a way of mutual help, sharing and understanding of the experience in the end-of-life (Parol et al., 2008). Another perspective nursing interventions on an individual way, taking into account the biological, psychological, social and spiritual development of each child, and also encourage the participation of parents in the care, respecting the preferences of the family, providing support during this whole process of dying, giving time to accept the irreversible condition of the child and accompanying family after death. This process contributes to the wellbeing of children in the end-of-life and for his dignified death (Poles and Bousso, 2009). The opportunity for the family chooses if his son ventilated die at home or in hospital, in a context of pediatric intensive care, reveals some emotional considerations and practices (Simpson and Penrose, 2011). This process involves an appropriate environment; accept the parental choice; practical aspects that facilitate death at home; emotional aspects, monitoring the family and the reorganization of services.

Care must also privilege emotional support as a main tool when technology can do nothing for the child on end-of-life (Lee and Dupree, 2008). This study highlights the communication with the family in helping the expression of feelings, awareness through useful information for effective decision making in the accommodation/acceptance of family choices and a better emotional management. The child and their family need to feel supported by nurses in the context of pediatric intensive care. In the process of monitoring and support for parents in decision making regarding life support interventions of their premature babies before and after birth, the nurses provide emotional support, information and identify the physiological needs of parents and children (Kavanaugh et al., 2010). Nurses have a key role in the decision making of parents, watching and favoring those decisions by promoting an environment of care. This context of care (emotional support environment) enables parents to decision making. The support provided to parents is from different types: information, guidance, emotional, instrumental and financial. But it is also essential that nurses inform physicians about the wishes of the parents, because the decision should always be taken in accordance with the opinion of parents, and provide emotional support in a context where communication is essential (O'Brien et al., 2010).

In summary, the performance of nurses in the management of conflicting emotions experienced by children and families requires a process of care that embraces partnership, monitoring and communication, information, expression of feelings, such as address the uniqueness and holistic perspective of the person and also the emotional support as the main strategy in the child care at the end-of-life, which results in the qualification, mutual help, sharing, understanding, wellbeing, support and a dignified death.

3.2 As Key Competence in Caring

Nurses have a practical knowledge necessary for the performance of the emotional labour, essential for the function; skills as a knowledge in action. Le Boterf (1997) explains that competence, fits into a triangular shape for action centered on three poles: know how to act, be able to act and want to help. The ability for emotional labour, also referred by some specialists emotional competencies, is characterized as skills to meet and deal with the environment affectively and adaptive, to meet and deal with the environment of the inside feelings and manage feelings and owning them.

The competence of the emotional labour was identified in four studies. The study of Parol et al. (2008) highlights that nursing professionals, in the search for improving care of children with oncological diseases at the end-of-life, have knowledge, understanding, arrangement, active interest, affection, flexibility, responsibility, sensitivity and ability to listen facilitating the expression of feelings. Also Poles and Bousso (2009) point out that nurses during the act of caring develop an open communication, through truthful information, honest and congruent, managing emotions and promoting a dignified death for children. Already Kavanaugh et al. (2010) describe episodes in which nurses are not friendly, which leads mothers to become emotionally shocked, but there are many reports where the nurses comfort them and helping to manage emotions.

Thus, it is noted in studies of the emotional labour as competency skills: knowledge, disposition, active interest, affection, kindness, flexibility, responsibility, sensitivity, listening, open communication (through truthful information, honest and congruent) child centered care and holistic, comfort and pain relief.

Smith (1992) presents some components of the emotional labour in nursing that are in accordance with such skills: support and tranquility, gentleness and kindness, sympathy, animate, using humor, be patient, relieve suffering, knowing the clients and help solve their problems. These are intended to facilitate the expression of feelings, diminishing suffering, manage emotions and promote dignified death of the child, enrolling in the perspective of the emotional dimension of care (Mazhindu 2009).

3.3 As Stressful Experience in Confronting the Suffering of the Client

In five studies, the emotional labour arises as an intensive experience and with emotional costs for nurses associated to the exposure of the clients suffering responses, leading to an intense emotional experience, stressful and it can lead to burnout with negative impact on the caring. The study of Lee and Dupree (2008) reveals that nurses in a pediatric intensive care unit, have experiences of sadness compared to the context of care and ambiguous feelings against the use of technology, they note that this is beneficial because it provides opportunities for prolonging life, at the same time have recognized that the technology often prolongs the life beyond what is useful and desirable. They also report feelings of sadness associated with the management of the experience of caring for a child at the end-of-life and their family. Also the study of Simpson and Penrose (2011) reveals that nurses feel pleased when the child and family benefits from an environment outside of the unit, but identify sadness, because they do not follow the children at the time of death. In the study by Keene et al. (2010), nurses experience distress related to the emotional impact of the death of children in pediatric hospitals and can lead to burnout, and even the distance in the relationship with the children when the nurses repress their emotions in the exercise of their activity, and have cynical attitudes during procedures.

Also Taubman-Ben-Ari and Weintroub (2008) highlight the demands of a job very stressful for the nurses who take care of terminally ill children, so they need to develop skills in order to manage these experiences. Some professionals feel powerless over death, cease to believe in the therapeutic measures available, reflecting some inertia in caring for children with oncological diseases at end-of-life and their family (Parol et al., 2008). Rockembach et al. (2010) add that the feeling of impotence provides a weak involvement of nurses in the interaction with children in end-of-life.

On the one hand, these feelings generate indifference, understood as a defense mechanism and protection from the process of finiteness, therefore death is felt as a trivial event. On the other hand, the death process is a special situation for the health care professional, because issues related to real or potential losses, and the fear of one's own finiteness, may cause him to keep an emotional distance in their labour being, also, a protective mechanism. It stands out in these five studies the emotional costs of caring from an original conception of emotional labour from the sociologist Hochschild (1983), defining how the professional attitude imposed to deal with many emotions and negative tone that arises as a source of internal conflict and emotional exhaustion. But studies from Smith (1992) in nursing, dispute these costs for nurses because they deal with many conflicting emotions but must be taken into account their vocation, the mission of the profession, satisfaction by altruism that generates feelings of contentment and gratification. This argument is corroborated in the study analyzed by Simpson and Penrose (2011), in which nurses deny having feelings of impotence or rejection and relate the emotions of relief, satisfaction and achievement. These findings corroborate the studies of Smith (1992, 2011) that expanded the concept of emotional labour with centrality in nurses and clients, noting that this requires an internal emotional management to prevent wear and burnout.

3.4 As Regulation of Own Emotions

The problematic situation experienced by clients associated with the phenomena of health and disease, is expressed through emotions that nurses have to deal with in the course of care and in every interaction (Diogo, 2012). Thus, nurses develop an emotional labour directed at them, when they are able to process, develop and manage the emotions in their internal world, that is develop a labour on them. Nurses consciously use emotions to provide and improve care (Smith, 1992), which ensures the closeness and emotional involvement in caring without letting affect (Diogo, 2012). In six studies, nurses reveal their internal resources and personal skills of emotional management. Taubman et al. (2008), identify factors that are predictors such as optimism, professional self-esteem, level of exposure to situations of death and level of secondary traumas. The high optimism is associated with higher perception of the meaning of life, reducing burnout. In this study there is a positive correlation between the ability of caring, a sense of self-esteem and sense of life. Thus, caregivers who have a more optimistic personality, have a greater ability to deal with stress, compared to less optimistic.

High levels of self-esteem are important to mitigate the disruptive aspects of their profession, and so, manage them more effectively. Already Lee and Dupree (2008) emphasize the ability of nurses to transform the sadness when this is understood as a form of humanity and emotional availability, in the relationship and support to the child in end-of-life and their family. Rockembach et al. (2010) highlight the spirituality and practice of a religion as strategies for nurses to address pediatric death.

The same studies emphasize the importance of training programs on managing grief (Keene et al., 2010) that is intended for health professionals who care for children in end-of-life, and which aim to give emotional support and enhance management skills in the grief. The nurses in this study make an emotional labour at the level of internal regulation of their emotions, which is facilitated through this training program. Sessions are offered after every death situations and are driven by the coordinator, focusing on the emotional responses of the technicians, taking into account, the monitoring of clients and not only in the event of death itself. The evaluation results of this program show that participants increased their ability to manage the emotional experience of grief in order to persist in caring for families who need their expertise and knowledge. There are indications that this opportunity for nurses to share and reduce the emotional distress, contributes to reduce the turnover of nurses. Also in the study of Theophilos et al. (2009) are identified the practices of managing and dealing with critical incidents involving the death of children by the team of pediatric emergency department, highlighting a program of information sessions for professionals. The sessions developed focused clinical and emotional aspects, the nurses said they would like to enjoy these sessions more often, 90% of study participants refer to the need to have a program and guidelines on the labour of grief. To improve the interventions of nurses in caring for children with oncological diseases at the end-of-life, they must provide resources to enable moments in which nurses find support and security, updating their knowledge about the disease and activities in this area, and have information about the development of children who care, minimizing negative feelings, reducing uncertainties about the effectiveness of treatment, leading them to develop a more humane and emotional care (Parol et al., 2008). The study of Lee and Dupree (2008) reinforces that nurses in a pediatric intensive care unit need help to deal with their emotions in order to optimize the emotions of others.

In summary, the regulation of nurses own emotions, is achieved at the level of internal resources (high optimism and self-esteem, ability to positively transform the experience of doing a recycle of negative emotions, spirituality and religion) and also at the level of external resources (training programs, group sessions for clarification and sharing, use guidelines, receive support and security, and access to information). On the one hand, these features lead nurses to develop a humanized care and emotional. On the other hand it is essential to learn the emotions and feelings, both the caregivers and the persons cared for, is a huge source of knowledge (Collière, 2003).

4. Implications for Nursing Research and Education

This literature review revealed a gap in knowledge regarding the concept of nursing emotional labour in death situation, not only due to the reduced number of publications on the topic, but also by the lack of attention to the issue of the intended preparation/training of professionals. In fact, the concept of emotional labour is expanding lacking research in different contexts of practice and also of conceptual clarification, for what we believe in the contribution of these findings to drive that same research.

5. Conclusion and Recommendation

The performance of the emotional labour is part of the caring, being an essential component in the process of care and have nursing sensitive outcomes: promotes care partnership (Parol et al., 2008), promotes the humane care and emotional availability in relationship and child support (Lee and Dupree, 2008), favors the conditions to a child at the end-of-life, for having a dignified death at home, developing feelings of relief, satisfaction and achievement, which will reduce the emotional costs (Lee and Dupree, 2008; Poles and Bousso, 2009; Simpson and Penrose, 2011), increases the affectivity, flexibility, responsibility, sensitivity and ability to listen, facilitating the expression of feelings of the child and family (Parol et al., 2008), providing a open communication (Poles and Bousso, 2009) and consequently a more conscious decision making (Kavanaugh et al., 2010; O'Brien et al, 2010).

As strategies to improve emotional performance in nurses, highlight the spirituality and religion (Rockembach et al., 2010), optimism and professional self-esteem (Taubman Ben-Ari and Weintroub, 2008) and also regular programs of training (Parol et al., 2008; Theophilos et al., 2009; Keene et al., 2010). Provide visibility and clarify the emotional labour of nurses it was one of our concerns, enabling to raise awareness of its importance and for training in this area, and also at the level of nursing curricula.

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