Exploring how nurses regulate their emotions whilst causing patients' pain during burns dressing changes

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Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signature:

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Overview

Burns can cause patients significant pain at the time of the initial injury and during consequent treatment. The personal coping strategies used by nurses when inflicting pain during treatment can be a barrier to effective pain management. This thesis therefore investigates how nurses manage their own emotions and distress whilst causing patients' pain.

Part 1 is a conceptual introduction exploring how nurses provide empathic and effective treatment to patients in pain, without becoming too distressed themselves. Research shows that witnessing other people in pain leads to an empathic response in the observer. However, for empathy to lead to prosocial behaviour (the definition of which is influenced by the wider context of nursing culture), rather than personal distress, nurses must effectively regulate their emotions.

Part 2 presents a qualitative study of the emotion regulation strategies used by nurses whilst causing patients' pain during burns dressing changes. Eight adult burns nurses completed semi-structured interviews and an empathy questionnaire. A thematic analysis yielded five themes: Emotions get in the way of being a good nurse; Pain's an inevitable and justifiable part of treatment and healing; If I'm not made aware of the pain, maybe there is no pain; The pain's due to other factors, not my actions; and Sometimes it's too much. Further research is indicated, investigating the effectiveness of the identified emotion regulation strategies for nurses and patients.

Part 3 is a critical appraisal reflecting on the process of designing, executing and writing up the research, focusing on how the researcher's views, beliefs and assumptions about the subject matter changed over time.

Impact Statement

Burns pain continues to be reported to be poorly managed, with associations between poor burns pain management and negative psychological outcomes for patients. It has been suggested that one barrier to effective pain management may be the coping strategies used by nurses whilst inflicting pain during treatment.

The conceptual introduction highlights the conflicting demands often placed upon nurses: to care for and prioritise the patient's needs, whilst remaining professional (often equated with being emotionally detached) and efficient. The emphasis on nurses being able to effectively regulate their emotions, so that their empathy leads to prosocial behaviour rather than personal distress, has important implications when considering how to improve patient care. For example, alongside teaching skills related to 'bedside manner', it may be important also to teach effective emotion regulation strategies. Furthermore, despite the identified importance of emotion regulation in the nurse-patient relationship, there is limited research, grounded in theory, exploring this.

Both the conceptual introduction and empirical paper highlight the influential role of the culture of nursing, at a broad and local level, on nursing practices. Broadly, culture and expectations can influence the value and emphasis placed on different parts of the nursing role. At a local level, the findings of the empirical paper emphasised the important role of support from colleagues in allowing burns nurses to feel justified and supported in their work, when causing patients' pain. This has clinical implications, when considering how best to support nurses' wellbeing in their work. It also has implications for research, as it demonstrates the importance of taking contextual factors into account.

The qualitative study, outlined in the empirical paper, found that burns nurses use a number of strategies to manage their emotions whilst causing patients' pain. This more in-depth understanding, linked to a major theory of emotion regulation, adds to the existing literature and could act as a foundation for important future research looking at the helpfulness of nurses' different emotion regulation strategies, for patients and nurses. This research could have significant implications for nurse wellbeing, and patient wellbeing and burn recovery.

When asked about their experience of participating in interviews focusing on their emotional experiences, the nurses reported that, although some of them were initially nervous, they had enjoyed and appreciated the experience. Whilst the helpfulness of space for nurses to reflect upon their emotional experiences cannot be commented on from the results of this study, the participants' experiences suggest they value and are open to speaking about their emotions.

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Part 1: Literature Review

How do nurses provide empathic and effective treatment to patients in pain, without becoming too distressed themselves?

Abstract

Nurses are expected to provide empathetic care, whilst often completing highly technical tasks in distressing circumstances. Whilst nurses can provide relief from pain and suffering, they can also be the cause when administering painful procedures. Both the experience and perception of pain are highly individual and subjective experiences, influenced by inter- and intra-personal processes. The areas of the brain activated when observing another person in pain overlap with those activated during the direct experience of pain. However, these experiences may be downregulated in healthcare professionals who frequently witness patients in pain. Despite medicalised cultural beliefs about remaining detached and objective when caring for patients, higher empathy has been shown to result in better outcomes for both patients and clinicians. For high empathy to lead to sympathy and prosocial behaviour, rather than personal distress, effective emotion regulation skills are required. There are multiple strategies for regulating emotions and which of them is used, at what point, is influenced by a range of factors as part of an iterative process of emotion generation and regulation. There is relatively sparse literature addressing the use of emotion regulation in healthcare settings, despite its importance in providing empathic care that is beneficial for both patients and clinicians. Further research is therefore needed to explore nurses' use of emotion regulation in healthcare.

Introduction

Witnessing, treating and causing pain are all routine parts of the nursing role. It is also known that observing other people in pain activates the same areas of the brain as when experiencing pain oneself (Lamm et al., 2011) and that empathising with others' pain can lead to personal distress (Buruck et al., 2014). Therefore, whilst being in the presence of patients in pain may be routine for nurses, this does not mean that it is without challenges. In addition to managing these challenges, nurses are expected to provide high quality technical and empathic care (Kim & Sim, 2020). Research has shown that, despite beliefs that remaining detached can free up cognitive resources to focus on the technical tasks of nursing, higher levels of empathy in clinicians can be beneficial to both patients and clinicians (Weilenmann et al., 2018).

This conceptual introduction will explore how nurses manage their own distress so that they are able to provide the care that is expected from them. It will start by outlining relevant theories of pain, and the experience (for patients and nurses) and management of pain in healthcare. The role of a nurse will then be discussed, including the implicit and explicit expectations placed upon them, before exploring empathy in more depth. Finally, the role of emotion regulation will be considered, and the resulting aims of the thesis will be outlined.

As this is a conceptual introduction, a systematic literature search was not completed. Relevant literature was found by carrying out searches related to pertinent concepts and following relevant references in existing reviews. Literature from psychological and medical fields of research was drawn upon due to the nature of the question.

Pain

Defining pain

Pain is defined by the International Association for the Study of Pain (2017) as “an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage” (Raja et al., 2020, p. 1976). This definition has been updated from the original definition, first shared in 1979, to be more inclusive of those who are not able to describe their pain verbally, and to weaken the implied association between tissue damage and pain. As pain is an individual and subjective experience, that is affected by biological, psychological and social factors, an individual’s own reporting of their pain should be seen as the primary source, whether this be through verbal or non-verbal behaviours. However, the absence of such reporting cannot necessarily be seen as the absence of pain, especially if there are difficulties with communication, and false reporting of pain is possible.

It is beyond the scope of this paper to fully describe and evaluate the mechanisms underlying the experience of pain; however, brief mention will be made of relevant theories and research.

Function of pain

Porreca and Navratilova (2017) describe pain as ‘a call to action’. The aversive nature of pain motivates a behavioural response with the aim of relieving it. These behavioural responses include stopping a behaviour and avoiding doing it again, seeking help, and resting to allow healing (Melzack & Katz, 2013). Pain therefore serves a protective function alongside other homeostatic emotions, such as hunger and thirst (Craig, 2003).

However, there are examples of where the intensity or longevity of pain can become debilitating, such as in persistent or chronic pain, and the pain itself is conceptualised as the disease, rather than the symptom (Raffaeli & Arnaudo, 2017). Evolutionary medicine proposes the ‘smoke detector principle’, which suggests that the benefits of an oversensitive pain system outweigh the costs, in regard to Darwinian fitness (Nesse & Schulkin, 2019). There are also examples where overriding the behavioural responses typically associated with pain, such as resting and avoiding the source of pain, can be essential for survival; for example, escape may be the priority for survival in warzones (Wyldbore & Aldington, 2013) and avoidance is counterproductive when requiring painful medical procedures that promote healing (e.g. Sharar et al., 2007).

How do we feel pain?

In 1965, Melzack and Wall put forward the Gate Control Theory of Pain, which acknowledged the presence of pain receptors, known as nociceptors, and proposed a series of interactions that modulate the experience of pain from the first synapse onwards. The theory suggests that following stimulation of nociceptors by noxious stimuli, nerve impulses are transmitted to the dorsal horn and onwards via the dorsal column fibres to the brain. The mechanism at the dorsal horn is likened to a gate, modulating the transmission of nerve impulses from afferent fibres subserving other senses, such as touch and temperature. These modulating properties are also influenced by descending control from brain processes, such as thoughts, emotions and expectations.

Research has shown a variety of specific factors that influence an individual’s experience of pain, including genetics (Bennett & Woods, 2014), negative emotions

(Wiech & Tracey, 2009; Yoshino, 2010), depression (Berna, et al., 2010), internalised gender stereotypes (Schwarz, et al., 2019), anticipatory anxiety (Ziv, et al., 2010), attention (Quevedo & Coghill, 2007) and cognitive appraisal (Severeijns, et al., 2001). This therefore suggests that two individuals with near identical injuries could still have vastly differing levels and experiences of pain (Ossipov, et al., 2010); and that a holistic, biopsychosocial approach to pain is required to truly begin to understand an individual's experience (Garland, 2012).

The Social Communication Model of Pain

Sole focus on the intrapersonal aspects of pain fails to address its complex social nature. The Social Communication Model of Pain proposed by Craig (2009) aims to capture both the intra- and inter-personal processes involved. Humans have evolved to exist in complex social environments, which include the way that pain is experienced, expressed and perceived. We have the capacity for sophisticated social interactions and creating institutions designed to care for those in pain, beyond what is seen in other species (Mogil, 2009). Nonetheless, humans do not always manage pain effectively in themselves or others (Craig, 2006) and the biopsychosocial approach of the Social Communication Model of Pain aims to help understand this.

The model posits that following actual or perceived tissue damage a series of events occur, each influenced by the one before it and by "reciprocal, recursive, and dynamic influences" (Craig, 2015, p. 1198). Following perceived or actual tissue damage, it is proposed that an individual's experience of their pain, through their thoughts, feelings and bodily sensations, is influenced by their personal history and biology (intrapersonal factors), and their social and physical context (interpersonal factors). The individual may then express their pain verbally and/or non-verbally, and how they do so will be influenced again by their personal history and biology, and the social and physical context. The assessment of an individual's pain by a caregiver is then informed by their own sensitivity, biases and knowledge (intrapersonal factors) and their relationship and perceived duty to the individual in pain (interpersonal factors). How the caregiver goes on to manage the pain will be influenced by their own judgement, professional training and capabilities (intrapersonal factors), and the setting they are currently in (interpersonal factors). These factors are not independent, but rather feed into and influence one another (Craig, 2009).

A diagram of this process can be seen in Figure 1 and each area will be further explored below.

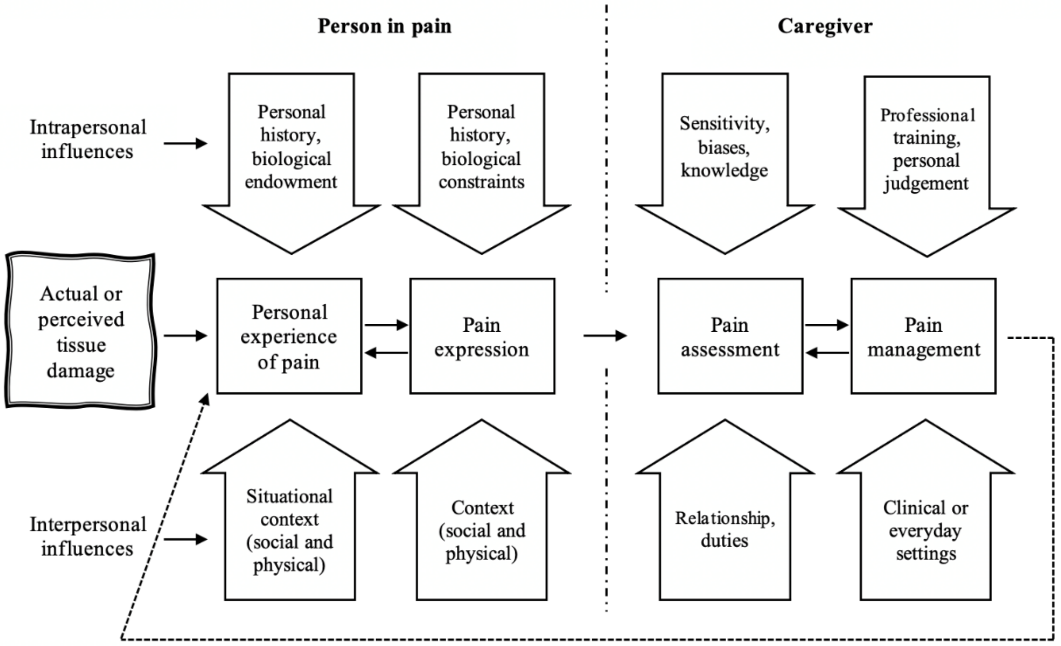

Figure 1. Craig's (2009) Social Communication Model of Pain.

Experience of pain

As outlined in the previous section, an individual's experience of pain can be influenced by a range of intrapersonal factors. Although it is challenging to measure the experience of pain without relying on observable expressions or self-report, there is research that suggests an effect of interpersonal factors (Craig, 2009). A systematic review by Krahé et al. (2013) showed that the behaviours and intentions of social partners, the nature of the prior relationship between a social partner and individual in pain, and individual differences in coping styles can influence the modulation of pain. However, it should be noted that many of the studies included relied on self-report or the observation of pain behaviours, which may therefore represent an impact on the expression, rather than internal experience, of pain. Nonetheless, some physiological differences can be seen; for example, participants who were observed during a cold pressor task, versus those that were alone, showed a significant increase in their systolic blood pressure, suggesting increased arousal (McClelland & McCubbin, 2008).

Krahé et al. (2013) posit that interpersonal factors provide information about the potential threat that pain may be communicating in a given context, and that this may be further influenced by existing individual relational patterns and beliefs. Functional magnetic resonance imaging (fMRI) has shown that holding the hand of another person, during a task when electric shocks are given, appears to downregulate neural responses related to emotional and behavioural threat responses. The influence of this has been shown to be greater when holding the hand of a spouse, particularly when it is reported to be a high-quality relationship (Coan et al., 2006; Redden et al., 2020). There is also an apparent increase in pain tolerance when individuals are simply observed, especially in men when they are observed by male peers (Edwards et al., 2017). However, this may relate to stereotypical beliefs about men appearing stoic and avoiding vulnerability, particularly in front of fellow men, which may therefore be suggestive of suppressed expression rather than reduced experience of pain.

Expression of pain

Examples of pain behaviours include facial grimacing, moaning, sighing, limping and self-report (Craig, 2009). These can function as a way of protecting an individual from further injury and promoting healing or communicating to others the need for care and the presence of a potential threat (Williams & Craig, 2006). Unlike other behaviours associated with pain, research has shown a set of facial behaviours specific to pain expression (Craig et al., 1992), with strong consistency across the lifespan (Craig, 1980) and type of pain stimuli in experimental conditions (Prkchin, 1992), but limited research into the role of culture (Williams, 2002).

The expression of pain has been shown to be modulated by both voluntary and involuntary processes (Craig, 2009). For example, the quick retraction of a limb when it touches something hot is a largely involuntary process, whilst the exaggeration of physical pain behaviours to obtain opioids may be seen as voluntary. However, seemingly involuntary or automatic processes can be overridden or suppressed, such as in cases of deliberate self-harm (Finlay, 2019). How pain is expressed is also dependent on the behaviours available to an individual. For example, whilst some people may be able to express how they feel through verbal language, this may not be possible for young children (Stanford et al., 2005) and individuals with complex physical and/or learning needs (Temple et al., 2012). Beliefs about the expression of pain, influenced by cultural expectations, can affect how and to what extent pain is expressed. For example, research in the British Armed Forces demonstrated that beliefs around ‘no pain, no gain’ and a ‘roughietoughie’ image appeared to influence behaviours; for example, with no verbal expressions of pain heard but pain behaviours, such as facial grimacing and limping, observed (Harper, 2006).

Expressing pain can result in the receipt of care, but also signals vulnerability. The context is therefore important when considering how and when pain is expressed. For example, research has shown that a mother’s self-reported dismissive relationship tendencies are negatively related to her baby’s pain reactivity. This suggests that babies with mothers who may be more dismissive of their needs may express less pain, as their expressions are unlikely to get their needs met (Riddell et al., 2007). Research by Vlaeyen et al. (2009) showed that in a threatening experimental context, the presence of an observer inhibited pain expression. However, it is hypothesised that this could be due to suppression of pain expression to avoid showing vulnerability or the presence of an observer signalling safety and thereby reducing the perceived threat of the pain and therefore the individual’s experience of pain. Conversely, research by Hurter et al. (2014) showed that more pain was reported by individuals who perceived high empathy from their partner, perhaps due to an assurance that expressions of pain will be met with warmth. A significant interaction with attachment style was also found suggesting multiple possible interacting influences, which may not be taken into account in all studies.

Perception of others’ pain

Pain can be salient both to the individual experiencing it and to observers. The areas of the brain activated when observing another person in pain overlap with those activated during the direct experience of pain (Lamm et al., 2011) and for some this extends to vicarious painful sensations (Giummarra et al., 2016). Research suggests that the mirror neuron system allows people to empathise with others in pain (Cheng et al., 2008). From an evolutionary perspective, it is helpful to notice if another person is in pain as it could signal the presence of a nearby threat. It also allows care to be offered which may later be reciprocated (Craig, 1978).

Research has shown that intrapersonal factors, such as individual stress levels, can impact on how pain is perceived. Buruck et al. (2014) demonstrated that stressed observers rated pain intensity in others lower than controls did, and this effect was modulated by the ability to tolerate negative emotions. This suggests that emotion regulation skills may be important in the ability to empathise with another's pain.

An individual's biases and beliefs influence their perception and understanding of another's pain. For example, research has shown that observers rate another's pain as greater when it is believed to be caused by another person, rather than accidentally self-inflicted (Lyu et al., 2014). It is posited that this may relate to research showing that when experiencing pain directly, self-inflicted pain is reported to be less painful than that caused by another (Wang et al., 2011). Other examples include the incorrect beliefs that Black people feel less pain (Trawalter & Hoffman, 2015) and that neonates feel no pain (Krishnan, 2013), leading to biased pain perception.

How pain is expressed can also influence how it is perceived by the observer, with responses that are believed to be involuntary, such as flinching, seen as more reliable than those that are believed to be voluntary, such as self-report (Craig et al., 2010). Whilst a 'better safe than sorry' approach to giving care when witnessing another in pain would be advantageous to the receiver, it leaves the caregiver open to exploitation. It therefore follows that being primed to expect cheating has been shown to reduce observers' estimations of another's pain (Kappesser et al., 2006).

Responses to others' pain

How somebody responds to another person in pain is influenced by their perception of that person's pain, the skillset and resources available to them, the expectations of others, the organisation and culture, and the perceived cost (Craig, 2009). For example: whilst a doctor can provide analgesics, a parent is best placed to offer a hug; the perception that Black people feel less pain, alongside other racial biases, can lead to its undertreatment (Hoffman et al., 2016); and the bystander effect, where the presence of other people reduces the likelihood of an individual offering help, is well documented (Fischer et al., 2011) but also critiqued (Philpot et al., 2020).

Prosocial responses such as empathising and providing help and care may be the more expected or socially acceptable responses to another in pain but are not necessarily a given. Pain can also be denied, ignored and punished by others (Williams & Craig, 2006). Whilst this may sometimes be with malicious intent or due to discriminatory biases, there may also be examples of this happening through necessity, such as a parent taking their child to school with a stomach-ache as they cannot afford to miss a day of work. Witnessing a person in pain can also signal the presence of a threat, which may encourage an individual to keep their distance to avoid suffering the same fate (Craig et al., 2010).

As well as encouraging behaviours that aim to alleviate the suffering of another, empathising with another's experience can be experienced as aversive. In an attempt to protect oneself from personal distress, avoidance and withdrawal behaviours may therefore be used (Bernhardt & Singer, 2012). Following the research by Buruck et al. (2014), it could also be hypothesised that this response may be more likely in individuals who have difficulty regulating and managing negative emotions.

Pain in healthcare

Pain is often what brings people to seek healthcare, yet pain is often poorly managed in healthcare settings (Carvalho et al., 2018). Cassel (1998) wrote “it is not possible to treat sickness as something that happens solely to the body without thereby risking damage to the person” (p. 132). He argued that the focus of medicine on healing the body may mean that the suffering a person can experience, both due to the disease and its treatment, can be overlooked. This highlights that whilst healthcare professionals may often provide relief from suffering, they can sometimes be the cause.

The patient’s experience of reporting pain

Particularly in the case of patient difficulties that doctors are not able to observe or easily diagnose, such as pain and medically unexplained symptoms, patients can sometimes find themselves having to “work … to be believed, understood, and taken seriously” (Werner & Malterud, 2003, p. 1409). Sophisticated social skills may therefore be needed by patients to present as ‘just the right level’ of sick and vulnerable.

However, patient characteristics that are marginalised and to a greater or lesser extent unable to be hidden by patients, such as being female, Black, working class, identifying as LGBTQ+ and experiencing mental health difficulties, can also influence how a patient's pain is responded to in healthcare settings (Craig et al., 2020). Stereotypes and biases about these marginalised groups being more likely to exaggerate pain, be opioid dependent and try to 'cheat the system', for example, can lead to discriminatory healthcare practices (FitzGerald & Hurst, 2017).

The clinician's experience of witnessing, treating and causing pain

Clinicians often face the challenge of making numerous, relatively high-stakes, quick decisions in high pressure environments. Pain management is not as simple as generously providing analgesics as multiple factors need to be taken into account, such as contraindications, the risk or presence of opioid addiction, accessibility and organisational pressures (Todd, 2017). These factors and their prevalence can impact how clinicians respond to pain. For example, research has shown that Accident and Emergency (A&E) staff are more sceptical of pain than their oncology colleagues. This can be understood in the context of the increased likelihood of encountering patients who may be faking or exaggerating pain in A&E compared to oncology (Kappesser et al., 2006), for example when individuals who are dependent on opioids visit A&E to obtain them.

In addition to these factors, clinicians' frequent exposure to people in pain may affect their sensitivity to pain. Research has shown that, in experimental conditions, increased exposure to facial expressions indicative of strong pain led to reduced sensitivity to pain expressions. It is posited that if exposed to high levels of expression of strong pain, the reference point for other pain may be raised (Prkachin et al., 2004). A downregulation of pain responses in physicians has also been shown, with early inhibition of the bottom-up processing involved in perceiving others' pain (Decety et al., 2010). Whilst it can be argued that this may reduce cognitive and emotional strain on clinicians, which may be beneficial to providing effective treatment, it may also result in barriers to empathic pain management.

Additionally, it could be hypothesised that this downregulation is helpful for clinicians when they are required to cause patients pain in the course of treatment. Whilst there is some research into clinicians' experiences of inflicting pain, it is relatively sparse given the frequency of the task. Themes such as 'when caring and torture are the same thing' and 'why are we doing this!' were identified in qualitative research with neonatal nurses, demonstrating some of the difficulties faced (Green et al., 2016). Fagerhaugh and Straus (1977) described an implicit contract created between patient and clinician, whereby the patient complies with painful procedures and limits their expression of pain to what is acceptable to the clinician. They commented that the main priority for staff appeared to be getting the task done, regardless of the pain caused, and that their management of pain focused on ensuring that pain expression did not interfere with treatment. It is suggested that the inability of young children, for example, to enter into this 'implicit contract' could be what makes this a reportedly more distressing client group to administer painful procedures to. Whilst the clinician may have a clear rationale for causing pain, a young child is unlikely to understand or confirm this through their behaviour (Madjar, 1991).

Clinicians are faced with a dilemma: they must provide effective treatment, which may be defined differently by the multiple parties involved; they must make complex decisions about the management of pain, which may be influenced by biases (personal, organisational and societal); they must sometimes be the cause of pain in the course of treatment; and all whilst balancing being empathic enough to be sensitive and responsive to patients' pain without becoming overwhelmed.

The Culture of Nursing

Nursing will be spoken about here from a broadly Westernised view and at times, more specifically, from the perspective of being a nurse in acute physical health hospital settings, in the National Health Service (NHS), in England. However, nursing is, of course, not exclusive to Western cultures nor the NHS. For example, some of the earliest mention of nurses or 'doctors assistants' are in ancient Indian texts (Holden & Littlewood, 2015).

The nurse's place in the NHS

The NHS was set up in the UK in 1948 as a universal healthcare system that would provide care to everyone (Britnell, 2015). Although efforts are increasingly being made to reduce the hierarchies in the NHS, in an attempt to foster an open and supportive environment that benefits staff and patients, structures of power nonetheless continue to exist (Brennan & Davidson, 2019). Practices such as calling doctors by their title and surname, rather than by first names like other staff, and referring to staff by their pay banding, may serve to maintain these hierarchical structures (Hinton & Signy, 2021). The Agenda for Change is a standardised system of pay for all NHS employees, apart from doctors, dentists and very senior managers. Where professionals sit in this pay structure is dependent on their profession and level of experience, with nurses qualifying at Band 5 (Buchan & Evans, 2008). The exemption of doctors from this pay scale could be seen as symbolic of their perceived different status in the system. When considered in the systems that they operate in, nurses can be seen as low in social status and financial remuneration. Whilst nurses undoubtedly have the ability to contribute to and make important decisions about patients' care, it is argued that the systems that nurses work in, such as the NHS, may limit their development and practice (Nelson & Gordon, 2004).

Perceptions of nursing

Florence Nightingale is seen by many as the originator and face of modern nursing (Cohen, 1984). However, other important figures, such as Mary Seacole who also nursed soldiers in the Crimean war, should not be forgotten (Mercer, 2005). These early figures in nursing, and the practices they inspired, still influence the nursing profession as we know it today.

What is expected of nurses?

Healthcare professionals can be expected to be "selfless and put others' needs first; to work long hours and do whatever it takes to help a client or patient or student; to go the extra mile and to give one's all" (Maslach & Goldberg, 1998, p. 63). Beyond this, there is an expectation that the relationship between nurse and patient is emotionally intimate, with nurses taking the time to care for and listen to the patient. The image of the 'good nurse' is often described as one who can hide their own emotions and remain relatively detached from the patient, to keep up appearances (Williams, 2001).

Emotional labour involves managing one's own emotions so that others feel safe and comforted (Hochschild, 2012). This suppression and projection of emotions can lead to compassion fatigue and burnout, due to the excessive pressure to present as the aforementioned 'good nurse' (Gillman et al., 2015). Historically, emotional labour has been viewed as 'women's work' and has consequently been undervalued in a patriarchal society (Gray, 2009). This arguably has contributed to the low status and pay of nurses, given that nursing is traditionally seen as a female profession and emotional labour as a core component of the work (Elliott, 2017).

In attempts to gain recognition for the work that they do, it is argued that nurses may emphasise the physical and task-focused parts of the role, rather than the emotional. However, it is hypothesised that as heavy industrial work declined and men moved into roles involving aspects of emotional labour, the value of the emotional aspects of work increased (Elliott, 2017). Although the emotional parts of nursing work have gained value, it may be that these skills are less quantifiable than technical aspects of the work and therefore more challenging to both measure and acknowledge. Research has shown that an increase in work-related targets is related to an increase in nurse burnout, possibly due to increased emotional labour coinciding with a decrease in support and recognition (Gillman et al., 2015).

There have been calls for all medical professionals to value and do emotional labour, with the suggestion that embracing the vulnerability of becoming emotionally involved with patients could benefit both patient and clinician (Ellis & Bochner, 1999). However, it may be that the expectation of nurses to form emotionally intimate relationships with patients simply does not fit with the reality of the nursing role and the emotional toll this may take on the nurse (May, 1991). Menzies' (1960) seminal paper argued that many nursing practices and procedures may exist to try and manage the nurse's anxiety; for example, by focusing on patients as tasks to be completed rather than people to be cared for.

What do nurses actually do?

A nurse's rationale for joining the profession and the reality of their day-to-day work may often be in conflict. Allen (2004) aimed to move away from the potentially idealised image of nursing, to describe the reality of the contemporary role. She argued that the nurse's role is primarily as a healthcare mediator. The mediator role is described as involving manging multiple demands, patient throughput, the needs of the patient with regard to the needs of the hospital, interprofessional relationships and the work of others, continuity of care by mediating occupational boundaries, communication of information, record keeping, and the prioritisation of patient needs and resources. Nurses are positioned as bringing together the different parts of healthcare and creating order in what can otherwise be a chaotic environment. It is posited that rather than focusing on an emotionally intimate relationship between patient and nurse, there may be more value in concentrating on the nurse's contribution to healthcare systems. However, if this is not the expectation of the system or nurses themselves, dissatisfaction is likely to occur.

Nurses and COVID-19

COVID-19 was declared a global pandemic by the World Health Organisation in March 2020 (Cucinotta & Vanelli, 2020). The events that followed arguably highlighted many of the nuances, complexities and challenges of the nursing role.

During the first Covid lockdown, nurses were hailed as heroes. Many of the public stood on their doorsteps at eight o'clock in the evening to 'clap for carers' and businesses showed their support with adverts and gifts to healthcare workers (Maben & Bridges, 2020). Although all NHS workers were celebrated, nurses appeared to be seen as the true frontline workers, bearing the brunt of the illness and loss caused by

Covid. Beliefs about nurses being ‘selfless’ and ‘going the extra mile’ (Maslach & Goldberg, 1998) seemed to be affirmed and applauded.

However, arguments soon followed that nurses had not signed up to be ‘heroes’ by putting their lives at risk (McKenna, 2020). The initial lack of personal protective equipment (PPE) meant that nurses were required to not only nurse very unwell patients, but to manage their own anxiety and fear whilst doing so (Daly et al., 2020). Boundaries between nurse and patient may have been challenged as nurses lost colleagues and had to consider the risks they may be taking, exposing themselves and potentially also their loved ones at home to Covid (Jackson et al., 2020). The absence of visitors in hospital may also have amplified the perceived need for the nurse to ‘be there’ for the patient, as a calming presence during frightening times (Maben & Bridges, 2020). Nurses from other specialties were redeployed to Intensive Care Units (ICU) and tasked with nursing several patients, who would ordinarily be nursed one-to-one as they were so unwell (Jackson et al., 2020). The potential for moral injury was high as nurses, along with their colleagues, were often unable to care in the way that they had been trained to do so (Maben & Bridges, 2020). This increase in emotional labour was recognised by increasing staff wellbeing support services, but it has been acknowledged that, as with many traumatic experiences, the true impact on nurses may not be known until after the event (McNally et al., 2003).

As the months passed, the responses and perceptions of some of the general public began to change. Nurses that were once applauded had to face crowds of anti-mask protesters outside the hospital after their shift; the gifts stopped and attention was turned elsewhere (Lee et al., 2020). What was once seen as exceptional work was now seen as ‘just part of the job’, although for the nurses they arguably were facing the same, if not more distressing, experiences as before. The government also faced backlash for undervaluing the role of healthcare workers during the pandemic, in particular after their announcement of a one percent pay rise (Pym, 2021). It could be argued that this is demonstrative of how nurses are perceived: as heroes who are expected to go above and beyond, regardless of applause, appreciation or pay.

Empathy

What is empathy?

There are many definitions and theories of empathy in the literature, with little consensus. There is not space in this paper to fully discuss and evaluate these, therefore only brief mention will be made.

Batson (2009) suggests that the concept of empathy is attempting to answer two questions: “How can one know what another person is thinking and feeling? And what leads one person to respond with sensitivity and care to the suffering of another?” (p. 3). He also proposes that the term empathy has been used to refer to eight different concepts: knowing another’s internal state; adopting the posture or mimicking the neural response of another; feeling what somebody else feels; projecting yourself into somebody else’s situation; imagining what another is thinking and feeling; imagining how one would think and feel if they were in the place of another; feeling distressed by another’s suffering; and feeling for another who is suffering. Empathy therefore requires skills in sharing another’s feelings, understanding cognitively what another may be feeling and having the intention and ability to respond compassionately to perceived distress (Decety & Jackson, 2004).

A ‘Russian doll’ model of the evolution of empathy has been proposed by de Waal and Preston (2017). This is based on evolutionary theory which suggests that complex faculties develop incrementally, in layers that build upon one another and are functionally integrated. At the centre is the perception-action mechanism, which involves perception of another's emotion leading to emotional contagion and motor mimicry. The following layer is empathic concern and consolation, and the outermost layer is perspective taking and targeted helping. These two layers require distinction between the self and other, and additional cognitive and emotional regulation capabilities.

Eisenberg et al. (1991) posited that when one's experience of empathy is high enough it is followed by sympathy and/or personal distress. The definition of sympathy is as debated as that of empathy, and they are often used interchangeably. However, one definition of sympathy is of an emotional response to another's perceived situation that can lead to prosocial behaviour (Eisenberg & Fabes, 1990). In contrast, personal distress is a self-focused, aversive affective reaction in response to the perception of how somebody else is feeling. This can lead to prioritising attempts to relieve one's own distress, rather than the other's (Eisenberg & Eggum, 2009); for example, by leaving or ignoring an individual to alleviate the personal distress being experienced in response to their distress. Eisenberg et al. (1996) suggested that this difference in response to empathic feelings can be accounted for by an individual's ability to regulate their emotions. Poor regulation of emotional responses may lead to overarousal and therefore personal distress, and consequently efforts may become focused on relieving one's own aversive personal distress rather than prosocial behaviour (Decety & Jackson, 2004).

This theory has been supported by research by Lockwood et al. (2014) who showed that expressive suppression was negatively associated with prosocial behaviour and that cognitive reappraisal moderated the relationship between affective empathy and prosocial behaviour. Furthermore, they demonstrated that the degree of emotion regulation interacted with the degree of empathy to predict prosocial behaviour. Additionally, individual differences in emotion regulation (specifically cognitive reappraisal and suppression) appear to moderate the association between empathy and personal distress (Powell, 2018). Perhaps surprisingly, the aforementioned research by Lockwood et al. (2014) found that high levels of cognitive reappraisal were linked to lower levels of prosocial behaviour. However, this study did not assess whether participants viewed prosocial behaviour as helpful in the given situations, which may have affected their reporting given that prosocial behaviour is not always beneficial (Oakley, 2013).

The socio-cognitive abilities required to understand how best to help others, based on their needs, are associated with brain areas also activated during mentalising (Bzdok et al., 2012), and there is overlap between brain areas associated with the motivation for prosocial behaviour and empathy (Fan et al., 2011). Whilst this is suggestive of a link between empathy and prosocial behaviour, these studies have investigated single prosocial behaviours with rather small sample sizes, which could limit their generalisability. However, a recent meta-analysis by Bellucci et al. (2020) of 600 neuroimaging studies showed partial overlap between brain areas involved in prosocial behaviour and those associated with mentalising and empathy. They identified that the dorsolateral and ventromedial prefrontal cortices were additionally activated in relation to prosocial behaviour and posit that these are related to the evaluation and planning processes also required. For example, the pattern of activation seen in the dorsolateral prefrontal cortex and associated areas has been linked to skills in adapting behavioural interactions with others, based on evaluations of the character of the other person (Mende-Siedlecki et al., 2013). This highlights that whilst empathy has been shown to be one important prerequisite for prosocial behaviour, there are also likely to be other processes and factors involved.

Empathy in healthcare

Whilst empathy is seen by many as a central tenet of healthcare professions, the sharing of another's emotions is at odds with medicalised cultural beliefs about remaining detached and objective when caring for patients. Halpern (2003) proposed that the meaning of empathy within medicine has been changed to a more intellectual act, to allow for this contradiction. Attitudes and beliefs about the perils of becoming overinvolved with patients persist, despite both healthcare professionals and patients reporting a desire for empathy (Bertakis et al., 1991).

Research has shown that medical students' empathy significantly reduces during their training (Newton et al., 2008). This 'hardening of the heart' is equated with skill and professionalism, as emotions are seen as a threat to objectivity (Halpern, 2003). Further research has shown that whilst there is an overall reduction in empathy across training, there is an increase in cognitive empathy (Smith et al., 2017). This may reflect the form of empathy deemed acceptable in medicine, as proposed by Halpern (2003). This reduction in empathy is not just seen in doctors, as research has shown a significant decline in empathy scores across healthcare professions, including nursing (Nunes et al., 2011).

Despite this proposed reduction in empathy across healthcare professionals through training, evidence suggests that healthcare professionals' empathy towards patients can have benefits for both clinicians and the patient (Weilenmann et al., 2018). Clinicians with high levels of empathy have better clinical outcomes (Del Canale et al., 2012), better patient satisfaction and enablement (Derksen et al., 2013), and improved patient pain (Howick et al., 2018). Duarte and Pinto-Gouveia (2017) reported that more empathic oncology nurses appeared to have improved professional quality of life. Further to this, research by Delgado et al. (2021) demonstrated that healthcare professionals with higher levels of empathic concern and perspective taking experienced greater personal accomplishment when inferring patient mental states, when investigating the link between empathy and burnout.

However, without a good capacity for self-regulation, clinicians are vulnerable to becoming distressed themselves, which is likely to mitigate the proposed positive influences of empathy for both patient and clinician.

Emotion Regulation

What is emotion regulation?

There are many definitions of emotion regulation in the literature, which encompass several factors. Gross (1998) defined it as "the processes by which individuals influence which emotions they have, when they have them, and how they experience and express these emotions" (p. 275). Further to this, emotion regulation is posited as involving both the up- and down-regulation of emotions and can be effortful or automatic, and intrinsic (regulating one's own emotions) or extrinsic (regulating somebody else's emotions) in nature (Sloan & Kring, 2007).

Emotion regulation is often used as an attempt to modify the length and intensity of an emotion (Thompson, 1994). Just as there are differing definitions of emotion regulation, there are different definitions of emotion. One description of emotion is as a subset of affect, alongside other valenced states. In comparison to mood, which is generally thought to be slower moving and less tied to specific elicitors, emotions are defined as relatively brief and linked to internal and external events. It is suggested that emotions are a response to salient events and therefore act as signals of importance and trigger a response, which has likely been shaped by evolutionary processes to promote survival (Rottenberg & Gross, 2007). However, emotions are experienced differently by each individual, even in identical situations, and differing regulation of emotion is one factor in this.

Due to the vast number of potential strategies used by people to regulate their emotions, establishing an underlying order has proven scientifically challenging (Koole, 2009). Whilst attempts have been made at categorisation using exploratory factor analysis (e.g. Thayer et al., 1994) and rational sorting (e.g. Parkinson & Totterdell, 1999), these approaches have limitations in regards to their comprehensiveness and replicability (Skinner et al., 2003). Koole (2009) posits that the most rigorous approach to categorisation would be to combine bottom-up and top-down approaches, by first defining higher-order categories of emotion regulation and then using empirical approaches to see how well specific emotion regulation strategies fit, but this does not yet appear to have been achieved.

Proposed models of emotion regulation will follow the conceptualisation of emotions and their regulation that underlies them. Three broad perspectives have been proposed: neurobiological, whereby emotions are a result of a specific brain circuits and regulated by autonomic and neuro-endocrine responses; socio-constructivist, which suggests that emotions are socially structured and how they are expressed and managed is influenced by the social environment; and cognitive, which posits that emotions are a response to appraisal of salient events (Prosen & Smrtnik Vitulić, 2014). Most models draw upon multiple perspectives. One influential model is the Process Model of Emotion Regulation proposed by Gross (1998), which draws upon mostly cognitive and neurobiological perspectives.

Gross's model of emotion regulation

One established model of emotion regulation is the Process Model of Emotion Regulation by Gross (1998). It is based on the modal model of emotion which posits that emotions are initiated by an internal or external event that is attended to due to its perceived significance and then appraised. The emotion generated is dependent on these appraisals and leads to experiential, behavioural, and neurobiological responses. In turn, these responses can result in changes to the initial triggering event (Gross, 2015). The model suggests that emotion can be regulated at five points in this emotion generative process through situation selection, situation modification, attentional deployment, cognitive change and response modulation (Gross, 1998; Figure 2).

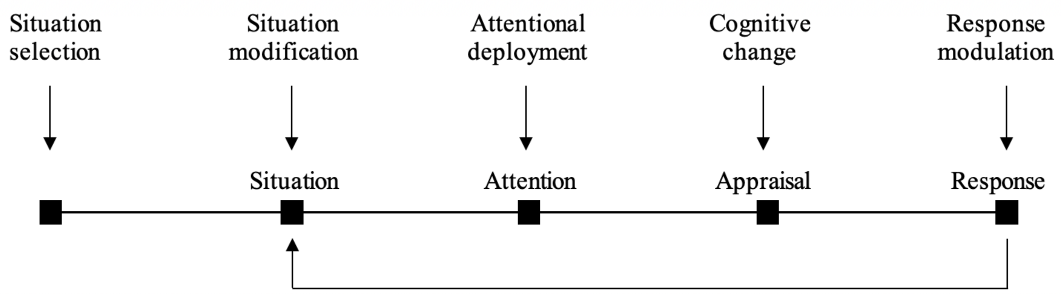

Figure 2. The Process Model of Emotion Regulation (Gross, 2013).

Situation selection

By anticipating which situations may result in what emotions, situations that are believed to result in unwanted emotions can be avoided (or those that lead to desired emotions can be approached) as a way of regulating emotions. Examples could include not volunteering for a presentation at work to avoid the anticipated resulting anxiety or arranging to see a friend in the hopes of feeling happy to see them.

Situation modification

Modifying external events (rather than internal events, as is captured by other strategies) can change the emotional impact of a situation. For example, only giving a very brief presentation at work or asking for help may reduce the duration and/or intensity of the anxiety experienced and organising a fun activity to do with a friend may make it more likely the experience is enjoyable.

Attentional deployment

Choosing (consciously or unconsciously) where to direct attention during a given situation can influence the emotions that are experienced. A common method of doing this is by using distraction, so that attention is not given to an event that is perceived as causing unwanted emotions. For example, in the lead up to an anxiety provoking presentation, scrolling through social media could be used to distract attention from the upcoming event. Conversely, events resulting in desired emotions may lead to intense focus, where distractions are avoided, such as when engrossed in a favourite television show or riveting conversation.

Cognitive change

By modifying how an internal or external event is appraised, the resulting emotion can also be changed. These cognitive changes can be in relation to how the event itself is appraised or about one's own perceived capacity to cope with the event. For example, an anxiety-provoking work presentation could be reframed as an opportunity for career growth and the individual could remind themselves that they have successfully managed their anxiety whilst presenting before. Cognitive changes can also work to amplify positive experiences of emotions; for example, by praising oneself for finding the fun activity that you and a friend enjoyed together.

Response modulation

All of the previous emotion regulation strategies are antecedent-focused, occurring earlier during the emotion-generative process. Response modulation occurs after the experiential, behavioural or physiological emotional response has been initiated, by influencing these responses. Examples include smoking or using drugs, to try and reduce anxiety, and suppressing emotional responses by holding back tears or sitting on your hands to stop them shaking. Response modulation may also be used to increase the experience of an emotion, for example by using illicit drugs resulting in a high which increases positive emotions or becoming more active and shouting to maintain feelings of anger before a fight.

The extended process model

The Process Model of Emotion Regulation has been extended by recognising three stages of the emotion regulation cycle: initial identification, when it is decided whether to regulate an emotion; selection of the strategy used to regulate the emotion; and implementation of the chosen strategy (Gross, 2015). For example, an individual’s ability to recognise their emotions and beliefs about emotions, the type and intensity of an emotion, and the perception of available social and psychological resources are all possible influencing factors (Sheppes, 2013). Central to this are valuation systems, which “interface with the world (W) by perceiving some aspects of it (P), evaluating these aspects in relation to valued goals (V) and initiating actions (A) to bring the world closer to those goals” (Yih et al., 2019, p. 43). This applies to emotion generation and regulation as an iterative, interrelated process, which can be seen in Figure 3. As the emotion is generated, this can become part of the ‘world’ being perceived, evaluated and responded to. As such, emotions can be generated in response to emotions, for example feeling guilty for feeling angry. Similarly, emotion regulation strategies can also influence the ‘world’ being perceived as an emotional experience is changed through regulation.

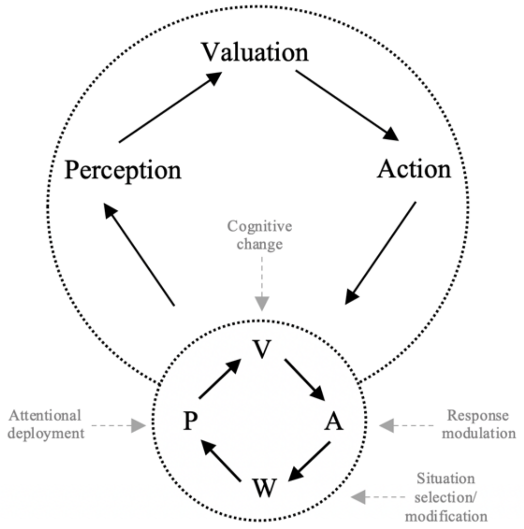

Figure 3. WPVA loops for emotion generation and regulation (Yih et al., 2019).

Limitations of Gross’s model of emotion regulation

The process of emotion regulation involves change that is likely to be “dynamic and dependent on complex processes” (Goldsmith & Davidson, 2004, p. 361). The relatively simple Process Model of Emotion Regulation is therefore likely to be a simplification of the processes occurring in real life. The process model assumes that responses to emotions occur in a fixed cycle; however, research has shown that the order can be variable, for example with bodily behaviours activating emotions (Niedenthal, et al., 2005).

The Process Model of Emotion Regulation has been critiqued due to its intrapersonal focus and apparent lack of consideration of relational, social and cultural factors (Burkitt, 2018). Given that 98% of emotion regulation is reported as occurring in social settings (Gross et al., 2006), these interpersonal aspects of emotion regulation are arguably significant. Relational perspectives on emotion regulation highlight the importance of the purpose of regulation, and posit that individuals often have instrumental, as well as hedonic, motivations (Campos et al., 2011). Emotions play a key role in relationships and their regulation is therefore often socially motivated. Emotion regulation can have affiliative goals and may reflect both the needs of the individual and of the people around them (English & Growney, 2021). Cultural factors also play a role as they define the expectations and norms for 'self-presentation' and relationships, and influence the individual's social and physical environments (Mesquita et al., 2013).

Nonetheless, the simplicity of the Process Model of Emotion Regulation means that it is a clear and accessible way of conceptualising emotion regulation processes. Although its cognitive and neurobiological perspective omits social and cultural factors, there is room in the model for these to be considered if deemed appropriate, particularly in the extended process model. The process model is also well established in scientific literature meaning that there is an existing evidence base regarding the use and effectiveness of defined strategies (e.g. Webb, et al., 2012).

Emotion regulation in healthcare

There is relatively sparse literature applying the theory of emotion regulation to healthcare professionals. However, emotion regulation may be reported indirectly, for example when doctors are described as having ‘hardened hearts’ (Newton, 2013) and clinicians are reported to ‘distance’ themselves from (Pyszczynski et al., 1995; Michaelsen, 2012) or dehumanise (Diniz et al., 2019) patients. These phenomena may be describing outcomes of attempts at emotion regulation. Similarly, research has explored the relationship between forms of emotion regulation, such as reappraisal and suppression, and clinician burnout and stress (Fasbinder et al., 2020), again focusing on outcomes rather than the emotion regulation process. Whilst these examples provide limited evidence for the mechanisms of emotion regulation in healthcare, they demonstrate that emotion regulation does not necessarily lead to empathy or better outcomes.

Research by Hayward and Tuckey (2011) applied the Process Model of Emotion Regulation to nurses. This qualitative study of 12 Australian nurses, working across a range of specialities, reported examples of nurses using all five emotion regulation strategies (situation selection, situation modification, attentional deployment, cognitive change and response modulation) and suggested an additional way of understanding emotion management, through the manipulation of emotional boundaries. They propose that emotional boundaries bring together multiple emotion regulation strategies in the form of a nurse’s professional persona. This persona is used to regulate anticipated or felt emotion by distancing and connecting with patients as needed. It is argued that this explanation better acknowledges the utility of emotions and how they can be managed reactively and proactively.

Whilst this research demonstrates the potential usefulness and applicability of Gross’s (1998) process model in understanding how nurses regulate their emotions at work, it provides only a relatively general description of the strategies used by nurses. Emphasis is placed upon the manipulation of ‘emotional boundaries’, which appears to be based on nurses' use of the emotion regulation strategies described in the process model. Therefore, whilst the emotion regulation strategies used are clearly identified, specific details about how nurses deploy these skills in their work are omitted. Furthermore, as Hayward and Tuckey's research aimed to consider the use of emotion regulation in the workplace broadly, and used nurses simply as an example of a highly emotive profession, it lacks discussion of the potentially unique aspects of emotion regulation in nursing and relevant contextual factors.

Given the expectations on nurses to engage in emotional labour to provide empathic care, and the central role of emotion regulation in this process, the use of emotion regulation in healthcare warrants further exploration.

Summary and Aims of the Thesis

Summary

Nurses are required to manage multiple, often conflicting, demands. Whilst their task may broadly be considered as being 'to care', the definition of what this means is influenced by societal and organisational expectations. Societal perceptions may mean that the emotional labour of nursing is undervalued, and focus is preferentially given to the physical tasks involved (Elliott, 2017). There also appears to be an expectation of nurses to put the patient first and remain professional, which is often equated with being emotionally detached (Williams, 2001).

There is no 'one size fits all' when caring for patients in pain as the experience and expression of pain by the patient, and the perception and management of pain by the nurse, are individual experiences influenced by a multitude of factors (Craig, 2009). However, it is known that witnessing others in pain activates largely the same areas of the brain as the direct experience of pain

(Lamm et al., 2011), which is an aversive experience (Porreca & Navratilova, 2017); but also that greater clinician empathy leads to better outcomes for both patient and clinician (Weilenmann et al., 2018). Here, therefore, lies a balancing act for nurses whilst causing pain: of feeling enough to care, but not so much that they are overwhelmed by their own distress.

It is proposed that for empathy to lead to empathic nursing care, rather than personal distress, nurses need to be able to effectively regulate their emotions (Eisenberg et al., 1996). Although emotion regulation appears to play an important role in facilitating prosocial behaviour, there is also evidence to suggest that other factors, such as the perceived helpfulness of acting pro-socially, are also involved (Bellucci et al., 2020). Emotions can be regulated in many different ways and the effectiveness of an emotion regulation strategy does not necessarily equate to helpfulness in the nurse-patient relationship. One way of categorising emotion regulation strategies is the Process Model of Emotion Regulation (Gross, 1998). This model takes a cognitive and neurobiological perspective of emotion regulation, and whilst it has strengths in its simplicity and being well established in the research literature, it also has limitations due to its lack of explicit consideration of relational, social and cultural factors (Burkitt, 2018).

Despite the apparent importance of emotion regulation as one key factor influencing empathic care, which has important implications for both patient and nurse, there is limited research, grounded in theory, exploring this aspect of the role.

Aims of the thesis

This thesis aims to explore how nurses regulate their own emotions, specifically whilst causing patients' pain during burns dressing changes. It will use a qualitative approach, using semi-structured interviews, to explore the ways that burns nurses experience and manage their emotions whilst completing dressing changes. It will aim to go beyond simple narratives of the burns dressing change by facilitating an in-depth exploration of the processes underlying nurses’ management of their emotions. By advancing understanding of the emotion regulation strategies available to and used by nurses, it is hoped that their role in the effectiveness of pain management, patient experience and staff wellbeing can be further considered and explored in future research.

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Part 2: Empirical Paper

Exploring how nurses regulate their emotions whilst causing patients' pain during burns dressing changes

Abstract

Aims: Previous research has shown that burns pain is often poorly managed and that the personal coping strategies used by nurses when inflicting pain can be a barrier to effective pain management. There is limited existing research into burns nurses' coping strategies when inflicting pain. The present study therefore aims to explore how nurses regulate their emotions whilst causing pain during burns dressing changes.

Method: Eight adult burns nurses were recruited and completed semi-structured interviews and an empathy questionnaire, the Interpersonal Reactivity Index (Davis, 1980). The qualitative data was analysed using thematic analysis (Braun & Clarke, 2006).

Results: The analysis yielded 14 subthemes, organised into five themes: Emotions get in the way of being a good nurse; Pain's an inevitable and justifiable part of treatment and healing; If I'm not made aware of the pain, maybe there is no pain; The pain's due to other factors, not my actions; and Sometimes it's too much. Due to the small sample size and consistency in qualitative reports, it remains unclear if there is a role of trait empathy, length of nursing experience or the nurse's appraisal of the needs of the patient.

Conclusion: Burns nurses' attempts at regulating their emotions are influenced by their beliefs regarding what makes a 'good' nurse. The findings provide an in-depth understanding of the strategies used by nurses to regulate their emotions. Further research is needed to investigate the helpfulness of the identified emotion regulation strategies for nurses and patients.

Introduction

Burns are an injury caused by heat, radiation, electricity and corrosive substances that typically affect the skin, but can also damage airways, muscles, bones and internal organs (Stylianou et al., 2015). It is estimated that 250,000 people sustain a burn injury each year, 175,000 of these people attend Accident and Emergency (A&E), and 16,000 people are consequently admitted for specialist burns care in the United Kingdom (UK). Children under five and the elderly are most at risk of sustaining a burn injury (NICE, 2020). The most common cause of burn injuries are scalds, followed by flame and contact burns. Injuries can be intentional or non-intentional, and self-inflicted or inflicted by others. Research has shown that intentional burns are likely to be larger and have higher rates of mortality and psychological distress (Kaufman et al., 2007). Moreover, there has been shown to be a high prevalence of depression, anxiety and post-traumatic stress disorder (PTSD) in all burns patients and scarring can lead to concerns regarding pain, itching, mobility and appearance (Shepherd & Beveridge, in press).

The severity of a burn is assessed according to its location, size, extent and depth. The depth of a burn is classified according to the layers of skin affected and the appearance of the skin. A full thickness burn, which extends through all the layers of the skin, may be painless due to severe nerve damage. However, most burns are a mixture of different depths and pain is typically reported for all other depths of burn (Culleiton et al., 2013). There are reports of the pain experienced following a burn injury being severe and excruciating (Perry & Heidrich, 1982), but a number of factors influence the experience of pain beyond the nature of the injury.

Pain is defined by the International Association for the Study of Pain as "an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage" (Raja et al., 2020, p. 1976). It is "a complex, biopsychosocial phenomenon", which is a product of many interacting systems and processes (Garland, 2012). The experience of pain is therefore highly individualised. The Social Communication Model of Pain proposed by Craig (2009) describes the interrelationship of the intra- and inter-personal aspects influencing the experience, expression, perception and response to pain, by both the person in pain and the caregiver. Richardson and Mustard (2009) have written specifically about the experience of pain in burns. They suggest that each person will have a unique pain experience, even if they have an identical burn injury, and that the pain experienced by an individual evolves over time. They posit that pre-disposition, context, nature of the burn, cognition, mood and drug factors influence an individual's experience of burn pain and that the factors sensitive to external influence should be targets for pain management. A range of pharmacological treatments, including analgesia, as well as non-pharmacological interventions, such as relaxation and distraction (e.g., Ang et al., 2021), are used to manage burn pain to varying degrees of success.

Pain is not just experienced when the burn injury occurs. In fact, it is reported that burn procedural pain can be worse than the pain experienced at the time of the injury (Choinière et al., 1989). Following initial assessment and treatment, patients are often required to have frequent dressing changes, which are usually completed by nurses. If surgery and grafting has been required, dressings can cover both the initial burn injury site(s) and skin graft site(s). A change of dressing involves removal of the previous dressing, assessment of the burn wound, any required treatment (e.g., debridement, removal of staples, cleaning, taking swabs), and re-dressing. Prevention of infection is a key priority in relation to healing, as a shallow wound that becomes infected can convert to a deeper wound that requires more intensive treatment (Judkins & Clark, 2010).

Research has shown links between poor burns pain management and negative outcomes for patients (Richardson & Mustard, 2009). Greater burn procedural pain during hospitalisation (averaged over a five-day period) was found to be associated with poorer psychological adjustment up to one-year post-injury, independent of pre-morbid mental health. It was also shown that pain during hospitalisation was a stronger predictor of adjustment than the size of the burn or length of hospitalisation (Patterson et al., 2006). More specifically, greater pain severity at discharge has been shown to predict increased risk of suicidal ideation up to one-year post-discharge (Edwards et al., 2007) and higher pain scores have been associated with higher levels of post-traumatic stress (Taal & Faber, 1997).

Despite the acknowledged importance of effective pain management, burn pain continues to be reported to be inadequately managed (Carrougher et al., 2006). Beyond practical medical constraints, such as the risks of using high doses of opioids during fluid resuscitation, which is common in burns (Sullivan et al., 2004), the personal coping strategies used by nurses when inflicting pain during the procedures described above have been identified as a barrier to effective pain management (Nagy, 1999).

It has been reported that burns nurses can feel that they do not have time to deal with their emotions whilst at work (Cronin, 2001). This does not mean that burns nurses do not experience emotions, in fact burns nursing has been reported to be emotionally exhausting due to the suffering witnessed (Bayuo, 2018). Nagy (1999) proposed four categories of self-protective strategies used by burns nurses to manage their emotions whilst causing patients' pain: distancing from the patient's pain, engaging with the patient’s pain, seeking social support and reconstructing the nurse’s core role. A further study exploring ‘resilience’ in burns nurses identified six ways that burns nurses coped with the role: toughening up (becoming desensitised), natural selection (only the nurses who could cope, stayed), emotional toughness (being tough with patients), coping with the challenges, regrouping and recharging, and emotional detachment (Kornhaber & Wilson, 2011a). Similarly, Bayuo and Agbenorku (2018) described three coping strategies used by burns intensive care nurses: seeking and obtaining support, distancing, and recreation. However, all of these studies described the strategies identified broadly, with little reference to underlying theory or mechanisms.

Outside burns nursing, research suggests that somewhat overlapping brain processes are activated both during the first-hand experience of pain and the observation of others in pain (Cheng, et al., 2008). However, research by Decety et al. (2010) demonstrated a down-regulation of this pain response in physicians who were presented with visual stimuli of painful situations, when compared to matched controls. They suggested that emotion regulation inhibits the bottom-up processing of the perception of pain in others. The mechanism of emotion regulation was not explored, but its function in allowing physicians to tolerate patient distress, possibly to the detriment of patient wellbeing, was acknowledged.

Experiencing empathy for another involves identifying what somebody else might be feeling and having one’s own experience of this feeling (Batson, 2009). It is proposed that when one feels high empathy for another it can result in sympathy, leading to prosocial behaviour, and/or personal distress (Eisenberg et al., 1991). Efforts to relieve one’s personal distress can be to the detriment to the person who is being empathised with, for example if the observer ignores the individual to alleviate their own distress (Eisenberg & Eggum, 2009). It is therefore suggested that for empathy to lead to prosocial behaviour, effective emotional regulation strategies are needed to prevent overarousal (Decety & Jackson, 2004).

An established model of emotion regulation is Gross's (1998) Process Model of Emotion Regulation. This suggests that emotions may be regulated at five points in the emotion generative process: situation selection, situation modification, attentional deployment, cognitive change and response modulation. Briefly, this suggests that individuals can regulate their emotions by influencing which situations they are exposed to, changing aspects of the situation, influencing which parts of the situation they attend to, altering their cognitive representation of the situation, and directly modifying emotion-related actions. Gross (2015) extended this model by distinguishing three stages of an emotion regulation cycle: initial identification, where it is decided whether to regulate an emotion; selection of the strategy used to regulate the emotion; and implementation of the chosen strategy. As emotions play a key role in relationships, each of these stages is likely to be influenced both by the needs of the individual and the people around them (English & Growney, 2021), and cultural expectations (Mesquita et al., 2013).

Summary

The management of burns pain continues to be a challenge for patients and nurses. How burns nurses manage their own emotions whilst causing and witnessing patients' pain during dressing changes may impact how well the patient's pain can be managed. Current theory suggests that effective emotion regulation is important in preventing overarousal that can lead to a focus on relieving personal distress, rather than prosocial behaviour. However, existing research into burns nurses' coping strategies whilst completing dressing changes makes modest reference to underlying theory or mechanisms, limiting understanding of the role of nurses' emotion regulation in patient pain management.

Present study

The present study therefore aims to complete an in-depth exploration of the processes underlying nurses' management of their emotions whilst carrying out painful burns dressing changes, informed by the existing literature on emotion regulation. Semi-structured interviews will be used to explore nurses' experiences in an open-ended way, and information regarding nurse characteristics such as trait empathy and length of experience will be collected to support discussion of possible variation in emotion regulation. Whilst the interview protocol will be informed by emotion regulation theory, the analysis will aim to be inductive by staying close to the participants' responses to allow for complexity and inconsistency.

Research questions

The following research questions will be explored:

1. What emotion regulation strategies are used by nurses when causing pain during burns dressing changes?
2. Do the emotion regulation strategies used by nurses during burns dressing changes vary with nurse characteristics such as length of experience or trait empathy?
3. Do the emotion regulation strategies used by nurses during burns dressing changes vary with the nurse's appraisal of the needs of the patient or the quality of the relationship with the patient?

Method

Ethics

The study was sponsored by the University College London Hospital/ University College London joint research office (IRAS ID: 276942) and received ethical approval from the Health Research Authority Research Ethics Committee (REC reference: 20/HRA/4072; Appendix A). Confirmation of capacity and capability was also received from the host NHS trust.

Recruitment

Participants were recruited from an adult burns unit. The unit offers inpatient, outpatient and outreach assessment and treatment, by a multidisciplinary team of doctors, nurses, occupational therapists, physiotherapists, clinical psychologists and social workers. Referrals typically come from the patient's General Practitioner (GP) or local Accident and Emergency (A&E) department. The unit can support patients who require an intensive care, high dependency or ward bed, as well as those who do not require an inpatient stay. Nurses typically work as either an inpatient, outpatient or outreach burns nurse. However, there may be times when nurses are required to work in a different area due to staff shortages, therefore it is common that they have experience across inpatient and outpatient settings. In addition to routine nursing duties, burns nurses are required to complete regular dressing changes, which include the removal of previous dressings, wound assessment, cleaning and debridement, and re-dressing.

The inclusion and exclusion criteria for participants were as follows:

Inclusion criteria: Qualified nurses who worked on the specified adult burns unit between 2019-2020 and routinely completed painful procedures, including burns dressing changes.

Exclusion criteria: None identified.

The study aimed to recruit 15-20 participants and purposive and snowball sampling strategies were used for recruitment. All qualified nurses employed on the ward were contacted via email (Appendix B) by the ward psychologist on behalf of the researcher and information about the research was displayed via poster (Appendix C) in the staff room on the unit. As not all nurses regularly accessed their emails, they were also approached by members of the psychology team and senior nursing team to inform them of the study. These members of staff also identified and contacted nurses who had recently left their role on the unit. Interested nurses were asked to contact the researcher via email for further information. Upon completion of the interview, participants were encouraged to inform other nurses of the study.

Stakeholder involvement

During the initial design of the study, the researcher visited the burns unit to complete observations of dressing changes and have informal conversations with five nurses working on the unit regarding their experiences of completing dressing changes. These discussions were kept general but used to confirm that the proposed research questions were likely to be useful and relevant to the burns unit staff. The lead psychologist and senior sister on the burns unit were consulted regarding the design and methodology, including the interview schedule. Following their suggestions, it was decided to ask participants for their consent to share that they had participated in the research with other participants and the senior sister was nominated as a key person that participants could contact if they were distressed by their experience of the interview.

Potential participants were also asked to indicate their preferred interview location via a short online survey and following this it was decided that UCL and the clinic room on the burns unit would be offered as interview locations. However, following this, COVID-19 restrictions meant that face-to-face interviews were no longer possible, and phone or video calls were offered instead.

Procedure

Nurses who expressed interest in participating were sent an information sheet (Appendix D) about the study and asked to complete an online consent form (Appendix E). A research appointment was then arranged to complete the interview by video or phone call, dependent on participant preference.

At the beginning of the call, it was confirmed that participants had read the information sheet and they were given the opportunity to ask questions. Participants were interviewed for around one hour, outside of their working hours. The interview was guided by the interview schedule (Appendix F) and audio recorded. After the semi-structured qualitative interview, the participants were asked to report their age in years, the number of months/years they had been qualified as a nurse, the number of months/years they had worked on any burns unit and whether they were still working on the unit. Whilst on the call, participants were emailed a link to complete the Interpersonal Reactivity Index (IRI) and were asked to do so immediately after the call.

The IRI (Davis, 1980; Appendix G) is a widely used multidimensional measure of dispositional empathy, which is freely available. It consists of four, seven item subscales: perspective taking, empathic concern, personal distress and fantasy. The measure reports to capture both affective and cognitive empathy. Each of the 28 items are answered on a five-point Likert scale, ranging from ‘does not describe me well’ to ‘describes me very well’. Higher scores indicate greater self-reported empathy. The IRI demonstrates reasonable reliability and validity. Internal consistency (Baldner & McGinley, 2014) and test-retest (Davis, 1980) reliability is good, but there is mixed evidence for construct validity (Davis, 1980). For example, research comparing the IRI to other psychometrics has shown that three factors may better represent the empathy construct: an empathy factor (combining empathic concern and perspective taking), a fantasy factor and a personal distress factor (Alterman et al., 2003). However, research has shown that IRI scores significantly correlate with scores on the Jefferson Scale of Physician Empathy, which is a specifically designed measure of empathy in healthcare professionals (Hojat et al., 2005).

Following completion of the interview and IRI, participants were asked not to discuss the content of the study with their colleagues whilst the research was ongoing. However, they were asked for consent to share that they had completed the interview with future participants and were given the names of their colleagues who had already completed the interview (and consented to their names being shared). This list of names was given to participants regardless of whether they consented for their own name to be shared. They were advised that they were able to discuss the interviews with these identified people if they wished. Participants were also informed that they could contact the burns senior sister or psychology team if they wished to discuss any issues raised during the interviews.

Participants

Eight participants were included in the study. Due to the second wave of COVID-19 and consequent re-deployment of nurses, recruitment was stopped early, and fewer nurses were therefore recruited than originally proposed. Two of the participants were male and six were female. Their ages ranged from mid-twenties to late-fifties. Participants had been qualified as nurses from between two years to over 30 years and working in burns from a few months to over 15 years. Participants 1, 2, and 9 had been working in burns for over five years and the remaining participants had been working in burns for less than five years. Two of the participants no longer had a permanent contract working on the burns unit. More detailed information on individual participants' characteristics is not provided in order to maintain confidentiality.

All participants completed the IRI and their scores can be seen in Table 1. The maximum score for each scale is 28 and each item is scored between zero and four. Higher scores indicate greater self-reported empathy. Due to the small sample size, no formal analysis was completed. Variability can be seen across scales and participants, although all of the scores on the empathic concern scale were relatively high and scores appear to vary less across the perspective taking scale. The personal distress scale showed the largest range in scores. As the fantasy scale is least relevant to medical settings (Konrath, 2013) it was not considered. Participant six had the lowest scores overall.

Review of the participant scores suggest that they are in line with the scores of medical students (which were shown not to significantly differ from normative data) reported by Coman et al. (1988) and comparable with the mean scores of midwives (unpublished data provided by author: Perspective taking: 19.4, Fantasy: 14.3, Empathic concern: 20.7, Personal distress: 9.44; Williams et al., 2013).

Table 1

Participant IRI scores

Participant ID	Perspective-taking Scale Score (mean)	Fantasy Scale Score (mean)	Empathic Concern Scale Score (mean)	Personal Distress Scale Score (mean)
1	20 (2.86)	7 (1.00)	26 (3.71)	13 (1.86)
2	21 (3.00)	4 (0.57)	28 (4.00)	10 (1.43)
3	26 (3.71)	19 (2.71)	28 (4.00)	9 (1.29)
4	16 (2.29)	17 (2.43)	18 (2.57)	11 (1.57)
5	21 (3.00)	24 (3.43)	21 (3.00)	21 (3.00)
6	11 (1.57)	5 (0.71)	19 (2.71)	4 (0.57)
7	13 (1.86)	19 (2.71)	21 (3.00)	12 (1.71)
8	16 (2.29)	22 (3.14)	23 (3.29)	24 (3.43)
Total mean	18 (2.57)	14.63 (2.09)	23 (3.29)	13 (1.86)

Data analysis

Interview data was transcribed by the researcher and analysed using thematic analysis, which is “a method for identifying, analysing and reporting patterns (themes) within data” (Braun & Clarke, 2007, p. 79). This method was deemed most appropriate as it has relative flexibility in regard to the philosophical frameworks underpinning the analysis (Clarke & Braun, 2018) and does not make theoretical assumptions about what might be learnt from the data (Willig, 2001). It also allows for generation of unanticipated insights, which is useful in exploratory research (King, 2004).The researcher took a critical realist approach (Willig, 2012), which suggests that there is a real social world that can be attempted to be understood, but how close this understanding is to reality will vary. It posits that experiences can be measured and explained but that what is communicated and observed will always be filtered through "human experience and interpretation" (Fletcher, 2017, p. 183).

The thematic analysis was used to develop themes that captured the emotion regulation strategies participants reported they used during burns dressing changes. Although existing emotion regulation theory was used in the development of the interview protocol, the analysis aimed to be inductive: staying close to the data when developing themes, rather than using a particular theoretical framework (which might have suggested the choice of framework analysis). The use of theoretical, rather than inductive, thematic analysis was considered, given the use of existing emotion regulation theory in the development of the interview protocol. However, as the evidence base for applying Gross's (1998) model of emotion regulation in the given context was relatively sparse, it seemed a risky way of analysing the data.

Interpretative phenomenological analysis (IPA) and grounded theory were also considered as alternative methods for analysing the qualitative data. IPA focuses on how participants make sense of their experiences (Smith et al., 2009). Whilst this approach would have provided more detail regarding individual accounts, which can be lost in thematic analysis, the focus of the present study was not to understand how individual nurses made sense of their experiences of emotion regulation and IPA lacks the theoretical flexibility seen in thematic analysis (Braun & Clarke, 2013). Grounded theory aims to build theory from data (Charmaz, 2006), which was also not the aim of the present study. Whilst the current evidence base regarding the use of Gross's (1998) model of emotion regulation was not deemed sufficient to be used to inform the analysis, it nonetheless provided a broadly useful way of interpreting data.

The six phases proposed by Braun and Clarke's (2007) were used to complete the thematic analysis:

1. **Familiarisation with the data:** The interview data was transcribed by the researcher and checked for accuracy. The transcripts were then read, and initial ideas noted (see Appendix H).
2. **Generating initial codes:** Interview transcripts were coded in NVivo 2020 for Mac (QSR International Pty Ltd., 2020) by the researcher. The content of the entire data set was coded with equal attention, as it was assumed that participants might share pertinent information even when not directly talking about their experiences of regulating their emotions. An example of initial coding can be seen in Appendix I.
3. **Searching for themes:** Codes were collated and sorted into initial relevant themes, which can be seen in Appendix J.
4. **Reviewing themes:** Themes were then revised and refined to create a coherent narrative (Appendix K). Coded extracts of each proposed theme and the accuracy of the themes as a whole were reviewed to ensure that the proposed thematic map reflected the data set.
5. **Defining and naming themes:** Each theme and subtheme was defined and how each fit into the wider narrative was considered (see Appendix L). Comments and reflections from peer reviewers were integrated at this point.
6. **Producing the report:** Extracts that demonstrated the identified themes were identified and the analysis was written up for this thesis.

Formal statistical analysis was not used to analysis the IRI scoring. This data was used to contextualise and enrich the qualitative data, rather than formally test hypotheses.

Credibility checks

Following good practice guidelines for qualitative research, a number of credibility checks were completed (Barker & Pistrang, 2005). Discussions about the analysis were ongoing between the researcher and internal supervisor throughout the process. A peer reviewer was provided with Appendix L, which defined the themes and subthemes, and coded two transcripts to check for data not captured by the themes. Any differences in coding or identified ambiguities were discussed and resolved. A thematic map (Appendix K) and description of the themes and subthemes (Appendix L) were shared with the burns lead psychologist and senior sister to check for coherence and understandability and seek their reflections.

A summary of themes (Appendix M) was shared with participants via email. They were asked to provide feedback via an anonymous online form, if they wished to comment. Three questions were used to guide feedback:

1. Do you have any reflections, thoughts or comments on the initial analysis shared with you?
2. Do you have any reflections on the process of taking part in the interview? (How did you find talking about this topic? Did you have any further thoughts after the interview?)

3. Having taken part in the interviews and now seen the initial analysis, do you have any thoughts about any further conversations, support or actions that could be helpful?

Reflexive statement

Prior to conducting the qualitative interviews, I completed a bracketing interview to examine my own assumptions, biases and beliefs in relation to the research topic. I also kept a reflective research diary throughout the research process, to assist with engaging in an ongoing process of reflection. These processes did not aim to completely avoid bias but rather intended to ensure that, where possible, biases were brought into awareness so that they could be acknowledged and reflected upon (Barker & Pistrang, 2005).

I am a White British, female trainee clinical psychologist at University College London. Prior to doctoral training, I worked as an assistant psychologist on the burns unit where the research was conducted. The idea for the research was borne from my own observations about my apparent desensitisation to hearing patients in pain, whilst working on the ward. This led me to wonder how the nurses managed being the ones to cause this pain, but also meant that I likely held beliefs about desensitisation playing a role in this. Whilst working on the burns unit, I had not experienced the nurses talking about their feelings around completing dressing changes and causing pain, and therefore had some assumptions that this may be something they would find difficult or be unwilling to speak about. I aimed to be mindful of this during the interviews, for example by noticing when I was more hesitant to ask about the emotional aspects of experiences.

Due to some of my own experiences of managing my emotions in the workplace, I was aware that I came into this research holding beliefs about avoiding emotions as a clinician being unhelpful. This belief may also have been strengthened by my clinical training and work, which often involved encouraging connection with one's emotional experiences. It was helpful to remain aware of the impact of this and that the aim of research was to explore how nurses regulated their emotions, rather than the helpfulness of regulation strategies.

Results

Five themes were identified during the thematic analysis of the interview data: Emotions get in the way of being a good nurse; Pain's an inevitable and justifiable part of treatment and healing; If I'm not made aware of the pain, maybe there is no pain; The pain's due to other factors, not my actions; and Sometimes it's too much. These themes comprised of 14 subthemes, as can be seen in Table 2. The relationships between the themes and subthemes can be seen in Figure 1.

Table 2

Summary of themes

Themes	Subthemes
1. Emotions get in the way of being a good nurse	1.1 Expectations of patients, colleagues and myself 1.2 Don't show or process how I feel until later 1.3 Try not to acknowledge I cause pain or the impact on me
2. Pain's an inevitable and justifiable part of treatment and healing	2.1 Heal to justify the pain 2.2 The importance of doing a good job 2.3 Focus on the task
3. If I'm not made aware of the pain, maybe there is no pain	3.1 Keep the patient comfortable and compliant 3.2 Don't ask
4. The pain's due to other factors, not my actions	4.1 Sometimes the pain doesn't match the burn 4.2 Burns patients are special 4.3 Sharing the responsibility
5. Sometimes it's too much	5.1 Getting away from the pain 5.2 Coping and processing after it's done 5.3 Feeling frustrated and guilty for feeling

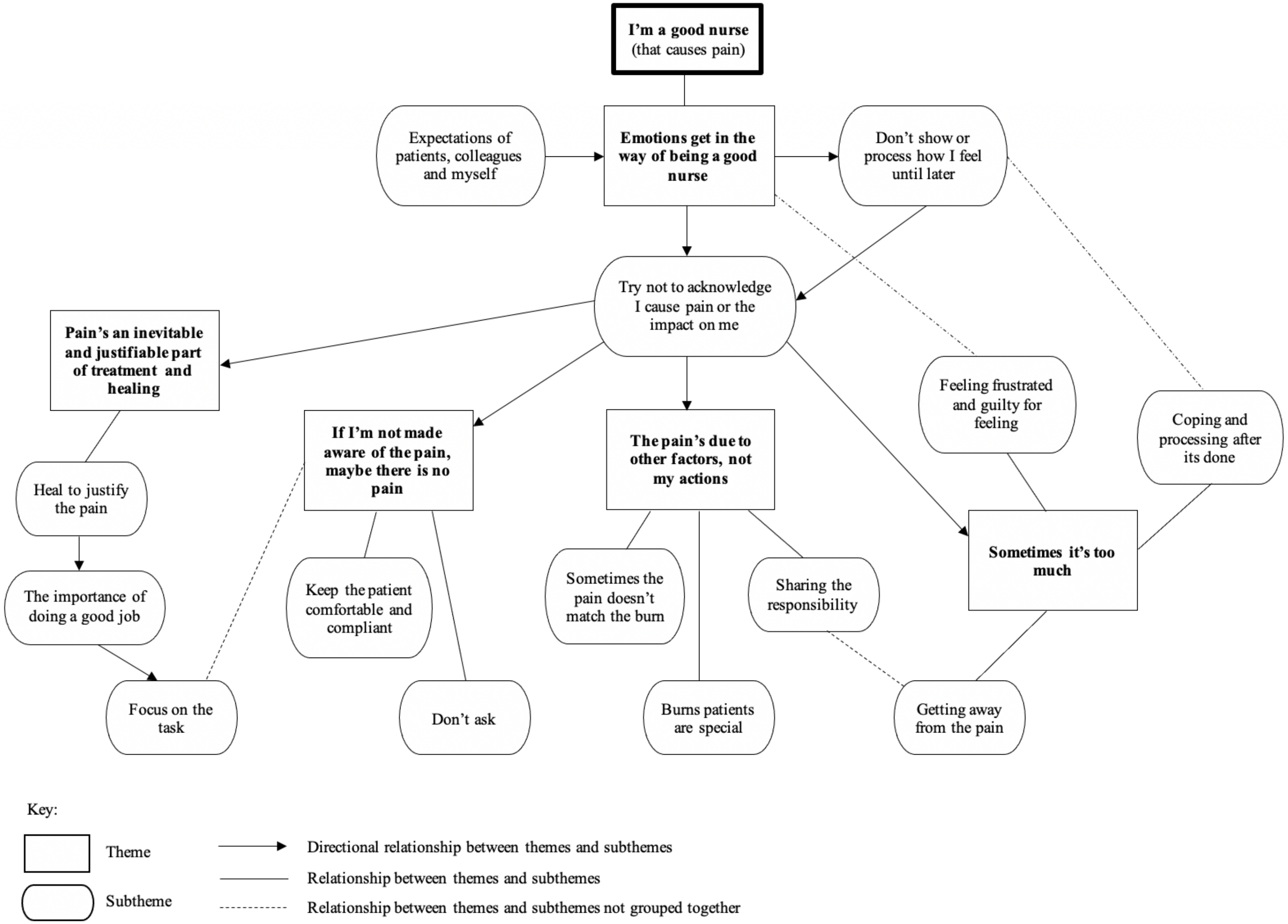

Figure 1. Relationships between themes and subthemes.

Theme 1, ‘Emotions get in the way of being a good nurse’, sets the scene for the consequent other four themes. All of the participants appeared keen to communicate that they are a ‘good’ nurse, which they said involved not showing their emotions (particularly in front of patients), appearing competent and confident, being technically skilled, and putting the patient first and making them better. Much of what the participants spoke about was therefore shared through this lens and at times it seemed that there were things participants felt unable to say or censored. Many of the strategies for managing their emotions, which have been captured by the other themes, were also spoken about as part of being a good nurse, rather than explicitly as ways of regulating their emotions.

Participants were unanimous in their reports of the importance of not showing or being distracted by their emotions during dressing changes. It therefore follows that they reported strategies for regulating their emotions at these times. Theme 2, ‘Pain’s an inevitable and justifiable part of treatment and healing’, captures the importance of healing for nurses to feel that the pain they are causing is justified. As healing is so important for this justification to feel valid, participants also spoke about making sure that they do a practically (rather than emotionally) proficient dressing change, and that they will often focus on the task to achieve this. Whilst focusing on the tasks of a dressing change may promote healing, it may also allow nurses to ignore the pain they are causing, as participants spoke about “zoning out”.

Theme 3, ‘If I’m not made aware of the pain, maybe there is no pain’, refers to nurses’ attempts to keep the patient comfortable and compliant. Whilst this was communicated as part of the role of a ‘good’ nurse who cares for patients, participants also spoke about it making the dressing change easier for them too. In addition, they shared that sometimes they prefer ‘not to ask’, so that they are not made aware of pain or distress that they may feel unable to soothe.

Theme 4, ‘The pain’s due to other factors, not my actions’, describes the ways that participants spoke about explaining away the patient’s pain by trying to understand it, and the importance of building relationships with patients to be able to do this. This appeared to release them from some of the responsibility of causing pain and this responsibility seemed to be further shared amongst colleagues and with the patient.

Finally, theme 5, ‘Sometimes it’s too much’, explores the times when nurses were less able to effectively downregulate their emotions. Participants shared feeling guilty for feeling during the dressing change and sometimes having to manage this by leaving the situation. However, participants primarily spoke about the ways that they managed their “emotional fallout” after the dressing change.

Credibility checks

The initial analysis was shared with a peer reviewer who was largely in agreement with the analysis but did highlight some areas where perhaps more emphasis was needed. These included the importance and role of shared responsibility and building a relationship with the patient.

Following peer review, the analysis was shared with the burns ward psychologist and senior sister who provided feedback and clarification regarding the presentation of the themes. As non-participants, but members of the burns team, they shared that they felt the themes fit with their experiences and observations.

Four participants responded to the request for feedback on the themes and interview process. All of the participants who responded reported that they felt the analysis captured their experiences and that they appreciated the opportunity to reflect on their emotional experiences.

Theme 1: Emotions get in the way of being a good nurse.

This theme describes nurses' views about their own emotions and how they should be managed. Participants spoke throughout the interviews about what being a 'good' nurse means and appeared keen to communicate that they themselves are good nurses. It seemed that in order to be a good nurse, participants felt they could not show or process how they felt until they were away from the patient – emotions were seen as getting in the way.

1.1 Expectations of patients, colleagues and myself. Almost all of the participants spoke about the importance of appearing confident and competent. Most often, this was in the context of ensuring patients thought that they were competent and therefore felt they could trust them as nurses.

P2: *I want to come across as like strong and I know what I'm doing and that like it's ok, I'm going to take the lead and focus on it and umm (pause) and yeah, I suppose me being, me like displaying a sense of that you're in safe hands I suppose. That like I'm going to do the best I can for you so just relax…*

P8: *I think having knowledge and I think that helps patients as well because if you're dithering around and sort of humming and hawing and look like you don't really know what you're doing then that's not going to give patients any confidence.*

Participants also expressed that they felt not appearing confident and competent might cause their patients anxiety or frustration and that they would be to blame for this.

P5: I mean for example I think sometimes anxiety also can be like transferred ... [patients] will be worried like 'oh why is this, what's happening, they cannot answer my questions'.

P2: I always tell [patients] sometimes longer than it is because at least then that anticipation because if you don't deliver something, they'll think you're useless, they'll think that you don't know what you're doing and like it's your fault, even though it's like the domino effect. It's just like you're the first person in the firing line…

One participant commented that they wanted colleagues, as well as patients, to perceive them as confident and competent. They spoke about working with "world class colleagues" and being aware of how they are seen by the team.

P6: I always want to hold myself and show myself in a way which would gain their respect and that they'd know that they would be able to rely on my actions at work ... because it's such a specialist acute area with such a small team that you work in, you want to portray yourself in the best way possible.

There was a strong sense amongst most participants that their job was to make patients feel better and that they experienced discomfort when they were not able to do so.

P1: We just want the patient to be happy. When the patient is not happy it is harder. Obviously.

P4: That's what's really hard because I think we're all as healthcare professionals wanting to fix something. We want to say here's the problem, here's how you fix it.

Due to this emphasis on the expectation that nurses will help patients feel better, some spoke about focusing on the things that they could help with, e.g., dressing the burn, rather than those they cannot fix, e.g., emotional difficulties.

P7: So, when we get sucked into much more complex emotional or social issues we're certainly as a practitioner kind of stuck and obviously there isn't for many of them a fix, but I think in burns we like to fix things. So yeah, I think it kind of runs counter to the culture of the, the process which is see people and in that very lovely way make them feel better and send them away.

As part of their efforts to ensure patients are left feeling better, participants reported putting the patient's needs before their own. Some noted that they do not tend to think about themselves when with patients, as their attention is focused on their care.

P2: I don't think about me at the time, I just think about maybe the task and (pause) yeah, I suppose maybe getting the job done I suppose.

P3: *I think I'm sort of like ok I'm here for this person right now, in this moment in time I'm here for this person.*

1.2 Don't show or process how I feel until later. As part of appearing confident and competent, and ensuring that the patient's needs are put first, participants reported feeling like they should or could not show their emotions or process their feelings about the dressing change until they were away from the patient.

P1: *I just try to cover them and try make sure that emotion doesn't interfere with the patients.*

P7: *I think nurses often override their own feelings or fears or worries or anxieties and get the work done. And like I said there's often the expectation that that will always be the case and it should be the case and that nurses are kind of worker bees or drones and they'll continue to do this sort of stuff. So, I mean, I think most nurses would probably appreciate that as part of their practice, is that actually they don't often engage with their own emotions or feelings about umm the nature of the work or the injuries…*

Participants explained that showing their emotions felt like it would be unhelpful. Some gave a sense that they viewed emotions as if they were transmissible and that it was therefore important for them to conceal more difficult or uncomfortable emotions.

P2: *I suppose it’s like if you’re stressed it’s like, as like a captain of a ship, if you’re stressed everyone else will be. But if you’re like you know level-headed like ‘it’s ok, it’s happened’, how like we’ll just like deal with it. But inside I might be like ‘oh my god, we’ve got to like do this and this’ and be like ‘it’s ok if we just get, get stuck in like then it’ll all be ok’.*

P8: *Umm, well I think if I was sort of showed that I was anxious or worried then you know that's just going to make them more anxious and worried. And you know something, there’s no point both of us worrying (laugh).*

One participant shared that they thought they should not express their emotions as it would not help the patient and would get in the way of completing the dressing change, and that they therefore would deal with their own emotions later.

P4: *Yeah, it’s not going to help you know if you’re getting upset or angry with them whilst you’re doing a dressing ... it’s them that’s having the injury, it’s them that’s going through the trauma of whatever they’ve gone through so yeah, you need to put your own emotions aside for it. You can certainly go and have a cry later if it’s something really harrowing and awful. But it’s not going to help them in that situation ... I think if you are letting your emotions get involved too much during the dressing it’s probably just going to slow it down ... that would annoy me more in the long run or be more frustrating in the long run. So, it’s good to just try and get the dressing done, get the patient sorted and then deal with any fall out later on.*

Another participant emphasised that they did not just hide their emotions for the benefit of patients, but also for their colleagues. Whilst they started by commenting that this was to maintain "team morale", they also shared that showing their emotions may be perceived as weakness and a sign of incompetence.

P6: *I would hide it from my colleagues as well to a reasonable extent, and that's why that persona would be there because you'd want to seem jovial, you wouldn't want to bring down the team morale in that sense. And also you wouldn't, well this sounds slightly silly, but you wouldn't want to seem like you umm, not weak in that sense, but under performing and not able to perform your role. Because it is a very specific role, we are there to do not the nicest of dressings and things like that and if you are unable to do it then (pause), did you, yeah maybe that's why I wouldn't have ever mentioned it to someone.*

Participants described a number of ways of hiding their emotions, often in general terms. Half of the participants spoke about putting on a "persona", "mask" or "armour" when they came into work, which allowed them to cope with the tasks expected of them.

P2: *I think when you like step onto any ward and you put your uniform on it's like you've putting on a piece of armour I suppose, you go, not like you're going to war but as in like you're hiding behind something, you've, not hiding behind something but as in like you umm (pause) I'm a nurse that day, oh I'm a nurse every day, but as in like I have, I dunno like a professional duty or*

I've got umm I've got like expectations I need to fulfil umm and I, people always say to me like you're completely different outside of work than you are in work.

P6: *I almost like put up a different persona I suppose when I'm working. I don't really feel like myself when I'm working almost. Sometimes I feel like I'm acting, like umm I'm playing that role where my job is I get paid to do the job and I'll do it and I'll kind of isolate myself away from that.*

One participant commented that hiding their emotions in this way could be emotionally exhausting in itself and another said that, although effective at preventing frustration in particular being expressed, it may not be a good tactic.

P1: *The fact that sometimes we need to wear the mask or the cape, it's a reason itself for making us feel exhausted at the end of a shift.*

P6: *Yeah even if the persona was just to slightly isolate yourself from people, to be slightly more icy, maybe that would, if you were like that but you knew you weren't going to be then, be snappy or lose your rag because of something else which is happening then I think that's probably beneficial, in a way. Probably not the best tactic (laugh).*

A few participants spoke about having developed a "thick skin" or gotten used to the things that they see and do in their role. Whilst one of them thought that this was appropriate, as they needed a way of coping with aspects of their role, another appeared embarrassed or ashamed to say that this was the case.

P3: *I definitely learnt that I have a thick skin when people are like 'ah how was your day' and then I'll be telling them about my day and they're like 'oh my god, are you ok' and I was like 'yeah, fine' and then you're like 'ok I've got a bit thicker skin than I thought I would' and you know and I think that's fine because I think you, I think I mean you need something to cope with it.*

P4: *I think umm it's one of those things you get used to it (laugh), it's horrible to say that you do.*

1.3 Try not to acknowledge I cause pain or the impact on me. All of the participants appeared keen to communicate that they were a good nurse. Most expressed that not thinking about their role in causing pain or their emotional response to the work was part of being a good nurse, as they were focusing on the patient. However, some did acknowledge that this may also be an act of self-preservation as facing up to the realities of the work or being perceived as not 'good' may be unbearable.

P7: *You do get nurses who are very personable and are very emotive with patients, but they're often not regarded as nurses who are the most efficient. And actually, I think nurses really pride efficiency and getting the work done because this might be a particularly sad and gruelling case but actually there's another one sat in the waiting room as well, so how thin can you spread yourself? So, I think part of it is self-preservation that we you know keeping our emotional energy and reserves to ourselves and for our colleagues because, you know, there's enough hard luck stories amongst nurses but yeah certainly it's, you kind of feel if you did let your guard down* *where would it end. You'd get washed away by the sea of sorrow, certainly in burns.*

Many of the participants reported trying not to think about the difficult aspects of burns nursing as this may cause anxiety or impact on their enjoyment of the role.

P6: I try not to dwell on it too much because it can, it can be reasonably anxiety provoking when you get home, you don't really want to be thinking too much about umm especially how you're portrayed in work I think because you know that you are going back to it. So, I try not to think about stuff like that too much because I think it could probably umm, it could probably grind you down a little bit too much and you wouldn't be able to either enjoy your time off or umm to be able to, to give your best while you're at work I suppose.

P8: I'd say I love the job so I don't, you know, I don't sort of think, I don't dwell on the fact that I'm causing people pain (laugh). Maybe I should, maybe I should be kinder.

Participants' attempts not to acknowledge their emotional experience or that they cause pain was also noted in the process of the interview. All of the participants required support to identify and explore their emotional experiences, with some explicitly commenting that they do not know how they feel and appearing uncomfortable speaking about the topic.

P4: *Oh god I don't know. Do not ask me how I feel umm (laugh). (pause) I think if I'm umm stressed, if I know, if I know there's a lot going on the ward then that will certainly reflect in umm I'll feel rushed and I sometimes worry that I'm rushing it too much umm and not doing the best job.*

The question of how participants felt whilst completing dressing changes often had to be returned to as participants spoke exclusively about the positive or practical aspects of the task.

P2: *Umm. (pause) How do I feel? I like doing you know, it's enjoyable like doing like a day in clinic, because you see like so many people coming in and you see people that have been on the ward umm for like say I don't know a month, or a couple of months, they've had like a really, a really, they've sustained a large burn…*

P3: *Umm I think, I struggle more with the bigger dressings because we're normally in the bigger gowns, they take longer, you get hot and it is very, you're doing lots of limbs and stuff but you normally have two people there.*

P8: *Umm, well I mean I feel fine. I love my job, absolutely love it. So you know every dressing change is a joy really (laugh).*

However, a few participants were more able to readily identify and speak about their emotional experience and they tended to speak about feeling anxious or stressed.

P1: *I can feel a bit stressed sometimes. If the patient is very anxious. Automatically it just, I'm not comfortable anymore, because if the patient is extremely anxious it means that it is going to be hard for the patient and for us, obviously.*

P5: *Hmm sometimes to be honest sometimes I feel like anxious. You know when I see like umm especially for example like if it's a big dressing.*

Theme 2: Pain's an inevitable and justifiable part of treatment and healing.

This theme describes the ways that nurses justified causing patients' pain during dressing changes and the importance of doing a 'good job' and healing for these justifications to feel valid. As part of ensuring that they did a good job, participants spoke about focusing on the task to make sure that the dressing change was completed well. However, this also meant that they sometimes ignored the patient's pain.

2.1 Heal to justify the pain. Most of the participants spoke about seeing patients heal being one of the most rewarding parts of their job. Several participants compared burns with other specialties and commented that what made it different and more enjoyable for them was being able to see most patients get better.

P2: *It's nice seeing them when they're healed and they're back at work and back into like normal life.*

P3: *This is why I think I like burns, is because you know they're getting better and then I send them off. And then it's really nice to see them either when they come back or if they come and visit and I'm like 'oh my god you look amazing'.*

P4: *You get people that come in with an injury and you heal them and they leave. That doesn't happen in many places.*

A few participants explicitly named seeing patients heal as a rationale or justification for causing them pain during the dressing change.

P4: *At the end of the day this kind of needs to happen. I try and kind of balance it as much as I can, so we've tried to give as much analgesia as possible but it will still hurt but just reassuring them that it's going to be for their benefit and hopefully it will heal. And there's one good thing about working in burns is that you, more often than not, you get them coming in in a state with a horrible wound, horrible injury, and they end up walking out healed. And it's lovely.*

P8: *I suppose because you know that you're doing something, you know for, that you're going to get them healed eventually. You know you're doing something good. Umm and you, so, and I think people, I think most patients realise that you know, you can't have a, they are incredibly painful burns and umm so it's understandable that they're in pain. But equally it's very, very rewarding because they do, you know a superficial burn which looks absolutely horrendous and is incredibly painful, could well be healed within 10 days.*

There was a sense from some participants that healing is the priority and that if the dressing change is in the interest of effective healing, it just "has to be done".

P5: *I'm well aware of [the pain], you know like every time I do the dressing, you know we need to clean it, it will cause pain for the patient. Even though I don't want to, I don't want to cause any more pain for them, but it's for them. We need to do the dressing, we need to clean the wound.*

P6: *You'll be watching for signs, for little things, winces, stuff like that. But whether that would still change the, the dressing that I was planning to do? Probably not. Because you are applying the dressing that you think is going to have the most benefit so even if you were reassessing it probably wouldn't change the outcome too much … I think probably we would carry on (laugh), which might seem umm, which seems quite harsh almost when you're umm, when you're saying it out loud doesn't it? That regardless of doing an ongoing assessment your outcome wouldn't change. But I think that's pretty fair to say because we have done some pretty large dressings and people have been in excruciating pain and we have still continued and completed the dressing, because at the end of the day you've still got to get it done.*

All of the participants spoke about explaining to the patient what they were doing and why, during a dressing a change, and many agreed that they were justifying their actions to both themselves and the patient at these times.

P1: *I say, 'I'm not doing anything that you don't want me to do, I'm here just to help, you need to have your change of dressing done, it's important, we need to cover it as soon as possible because it's exposed, it's a source of infection being exposed to the air'.*

P2: *[I say,] 'I'm going to do the best I can for you so just relax, this isn't going to last forever ... it's not going to get better unless we do this'.*

P3: *I'll say, 'I don't want to cause you harm, you know if you need more painkillers we can start with that and, but this does need to be done' and it's sort of reiterating the benefits of this.*

One participant shared that they are further reassured by the patient, as their responses suggest they understand the justification for the pain that the nurses cause.

P4: *But you do cause a fair amount of pain going through that but I think most of them tend to understand why you've had to do it and they don't, I've never have known anyone to sort of like hate you for it anyway or to, you'd think they would you know when you come in and say dressing time, you'd think they'd run away but they, they know it needs to be done as, I think as well.*

Some participants reported liking it when there are immediate benefits to the patients, that they can feel or see, and seemed to experience this as further reassurance that there is a justification for the pain they are causing.

P7: *In terms of patients that you're causing lots of pain to, obviously it's not, it's not pleasant but you're often doing it in a way that you see a very obvious, visible response. You're not just like cleaning a wound to get, for no purpose and afterwards they're in a lot of pain and discomfort but, and there's no noticeable difference, you're often able to scrub a wound clean and be able to show them that actually you've just removed a wedge of gooey bacteria* *and grossness and actually things look better now. So, I think that kind of umm is a nice antidote to the, you know, the fact that you are causing harm.*

P4: Because I think a lot of us, well I certainly am, bit of a perfectionist with my dressings and I want them to be perfect, I want them to be nice. I think that's my way of justifying it again. If the dressing at the end is lovely, the patient's often more comfortable ... you always feel like you've done a good job when you leave them like that.

Many of the participants spoke about causing pain or distress being part of the job and that they felt there was only so much they could do to manage this.

P1: In the end, it's just my job and I just try and do my best and umm what can I do more? If the patient is happy, brilliant. If they're not, I feel like I've done my bit and I've done my best and that's it.

P4: I mean there's times when you can do a whole like, I did a four-hour dressing once with somebody and then another two-hour dressing with somebody else and the whole time all I did was feel like I was causing them agony. And there's just only so much you can do and only so much [analgesia] you can give, and you (pause) just have to keep going and just remind them it's for their benefit but it… that was quite tough I think, I remember that day (laugh).

Participants spoke about the limits of what they were able to do to support patients during dressing changes. In part, this referred back to the ideas of self-preservation, but participants also spoke about the constraints on access to analgesia and time.

P5: *With the ward attenders you only have like one hour to finish them. So, you're thinking how can I wrap it up fast or finish it within an hour because there's also something that I need to do after this or maybe the next patient is coming and I'm also assigned with that patient.*

P4: *I think it's more access to analgesia really ... you need it to be prescribed, you've got to go find the doctor, get it prescribed and all of this. And you don't always know who's going to need it, so you can try and plan it, that you book them in for that, but they might not need it and then you've got the ones in clinic that end up needing it and you didn't think they would and you don't, you just have to say to them sorry I don't have anything stronger to give you and you end up, you're just doing it and they're in pain.*

P7: *As we all know paracetamol and ibuprofen's not going to cut it if you've got a serious injury and I think people expect that this is a hospital why can't you give me some pain relief and then we have to go into a whole legal spiel about how we're nurses not doctors and we don't have patient directive and it'll take an hour to dish out any meds etc etc. So it's, it, pain is often an inconvenient thing for us to have to deal with initially.*

Two of the participants spoke about pain being a good thing in burns, as it is suggestive of a less severe burn, and that this provides reassurance to both the nurse and the patient about the presence of pain.

P4: *In the initial stages the pain we tell is a good thing (laugh) because it means that it's not that deep and it's the only way we can kind of justify it to them, so if it hurts try to remember that's because it's not deep. It's superficial and that means it'll heal. So, you can try and kind of flip the negative of it. And yeah I suppose that's the way I have to sort of say it to myself.*

2.2 The importance of doing a good job. Participants spoke about how important it was to them to do a technically good job so that their patients' wounds heal well. It appeared that this was particularly crucial for upholding their justifications for causing pain.

P4: *So, you certainly always be wanting to do a really good job with the dressings. I think when things do get frustrating or difficult in the dressing change it usually reflects on that you can't do the dressing as you would like it to be done. Knowing it's done the right way it's going to be in the benefit of the patient and their wound and their healing.*

P6: *Being able to take your time in doing it made it a lot easier to be able to complete the dressing, so it was nicely done and then you're going to reduce the incidence of having to do it again, which is not something that I ever really wanted to do, I wanted to do the dressing once, make sure it's a really good job and hopefully keep that in situ for as long as possible. Because that was better for us, for our workload and it's better for patients as well because you don't really want to, to umm receive multiple dressings.*

Half of the participants spoke about burns being a specialist area of nursing and alluded to holding specialist knowledge that allows them to effectively treat patients.

P6: *From the way it's managed through to the nurses on the ward and the ability of the unit too be reasonably isolated within itself but have such incredible results is umm, yeah it's, it's hard not to want to work there I think ... you feel like you're delivering a world class service ... that gold standard of care which was given and the amount of funding which we had to give that and the amount of resource that we had, from psychology through to specialist OTs and specialist nursing, specialist consultants.*

P7: *It's a very specialist, niche area and you become quite expert in quite a short amount of time.*

Most of the participants commented on how important they thought it was to have the right skills and knowledge to ensure that they are doing the dressing change well. Many of these participants commented that they considered this the most important aspect of the dressing change for them to focus on.

P2: *I suppose the most important thing for me is like you're properly assessing that wound and you're, and in your assessment, being able to have like the right knowledge and on how like the burn's progressing ... because I've got like that underpinning knowledge, I can be like this treatment would really be good for them and I've got some insight into that.*

P4: *The most important thing when I'm doing a dressing is that I'm choosing the right dressing for the wound, umm that it's been reviewed by a doctor if it needed to do and that I'm doing the right thing with it.*

2.3 Focus on the task. As part of ensuring that participants were able to complete an efficient and successful dressing change, almost all of them spoke about focusing solely on the practical tasks involved. One participant acknowledged that a downside to this is that it can make it difficult to notice if the patient is not tolerating the procedure, suggesting the pain is being ignored in the process of focusing on the task.

P4: *I sort of, just maybe zone into the dressing a little bit.*

P5: *I try to focus on like on the work like so I will need to do this.*

P3: *I can sort of put that out of my mind and then you do become a bit more task orientated. And then you're like 'right ok just crack on, let's just do this quickly'. But I have, but I do think that that can be good and that can, you know that can be not very good as well because if they get to their limit and then I'll be sort of zoned out, that's why it's good to have another person there as well.*

One participant spoke about feeling that they have to focus on the task, as completing the dressing change is what is expected of them in their role.

P7: *And although as a nurse you are supposed to be a holistic practitioner at all times umm nurses are often very task focused and we're always expected to* *get the [dressing change] done, kind of regardless of what's umm of what's in front of us.*

Half of the participants shared that they like to plan their dressing changes so that they can focus on the task without interruptions or difficulties, and control for the aspects of the dressing change that they can.

P3: I like to go in and get things ready so then you know my partner who I'll have, we'll sort of come in and we'll do it together. I mean sometimes you can't help it, it just takes a long time, but at least have it prepared so it won't take as long as it would've needed to if you don't get everything ready.

P6: Yep and keeping it very task orientated as well. Being able to, because we were talking earlier weren't we about planning everything out and planning that, the specific sections of what you wanted to do within, within the job of changing a dressing. So being able to stick very strictly to that definitely helps, it helps the process I think, and it helps being able to manage the situation from the patient point of view because they know exactly what you're going for, exactly what you're aiming for.

All of the participants said that there are times when they just have to keep going during a dressing change and many commented that when this happens, they will try to focus on the task and get it over and done with as quickly as possible.

P2: Sometimes it can be really difficult say if the patient isn't able to communicate with you umm that can be more, that can be difficult because *there's nothing, I feel there's sometimes nothing you can do apart from just conduct the dressing change as quickly as possible so they're in like less distress.*

P3: *Sometimes it's difficult because (sigh), I've had someone like screaming and you know you can hear them from the other doors and stuff, so I've definitely learnt how to, not zone out but (pause) umm just sort of carry on, if that makes sense because I was like this is their coping mechanism and that's fine … I've given them everything that I can so then I just sort of 'ok, zone out, quick we'll do it' and then carry on, which definitely helps.*

P5: *Sometimes I have to explain to the patient that umm that we just need, that, we just need to finish this one, it will be fast so just hang on in there.*

Theme 3: If I'm not made aware of the pain, maybe there is no pain.

This theme describes the way that nurses may try to forget about the patients' pain. Participants spoke about simply not asking patients about their pain or trying to keep the patient as comfortable and compliant as possible, so as to mitigate the pain or not be reminded of the pain being caused. It also includes examples of when nurses are made aware of the pain (e.g., if patients scream or flinch) and how difficult they find this.

3.1 Keep the patient comfortable and compliant. All of the participants commented that a more compliant patient makes completing the dressing change easier.

P5: *I think what makes it like easier is if the patient is like cooperative, is less anxious … for example, like they're helping you like, they just let you do the* *dressing, something like that. Some of the patients will be like 'oh please stop, it's painful' even though you're just taking down the dressing. So, it's also, well the minute that you come up to them they will start to cry, they will wiggle.*

P8: *A compliant patient [makes it easier]. A patient who's umm who you know, I think probably the hardest patients are the ones who maybe can't deal with pain as well as others may be able to, so yes people who are leaping around on the bed and you know sort of just pulling away from you all the time.*

A few participants gave the extreme example of when patients are sedated in the Intensive Care Unit (ICU) and that this means that they do not have to think about the pain at all and can focus on the dressing change.

P3: *If it's an ICU it tends to be easier because your patient's asleep so that definitely does help and you have the ICU team monitoring them.*

Participants spoke about patients' compliance often being related to their levels of pain and anxiety, and that when patients found the dressing change difficult it often meant the nurses did too.

P4: *There are times when you could be doing the bigger dressings quite a lot and if the patient, if the patients really do struggle with it, it's very frustrating, very time consuming. Umm for both parties, I think.*

P6: *It would make it easier in the fact that I feel like the patient would be able to be more receptive to be able to receive the dressing change. If they were in* *complete agony then it is really, really hard to persuade someone to be able to sometimes take off quite large areas of dressings.*

P7: I guess the patient's demeanour and their mood plays a large part of what makes it easy. Yeah if, obviously if they're friendly, they're engaged, if they are umm accepting of their burn injury, if it's something that they're quite used to and that obviously plays a part in how we interact with them and deal with the burn. If they, if it's something that they are frightened of, if they don't want to engage with it, if it's an injury they don't want to look at for example, then obviously that makes things a bit more difficult.

Participants reported a number of ways that they support patients with their pain, including distracting and reassuring them and trying to make jokes. It seemed that whilst these were reported as attempts to make the dressing change more comfortable for the patient, it also often made it more comfortable for the nurse too.

P3: I always like to see if the patient wants the radio on, just because I like the radio on (laugh) but if they don't then it's fine, but like some people like the TV on because then it's a distraction and I quite like it because I think that's a distraction for me.

P4: I think it's just distraction techniques are probably the best thing you can do because we can't take the pain away completely … sometimes there's two of you which is quite good because you can have one person if they're really struggling just holding their hand, just talking to them, asking about their day, where they've come from, what do they do for work umm or coronavirus *(laugh), whatever's the latest topic of conversation and yeah just something. And I usually try to make them laugh in some way.*

A few participants shared how difficult it could be when participants expressed their pain, for example by screaming, and that they wished they would stop as it made it harder for them to carry on with the dressing change.

P2: The first 20 minutes of that dressing change was like horrendous and they were like screaming and you're like 'ok' and you want to be like 'please stop screaming because I don't like, there's nothing else I can do', but you have to be like that's their way of like dealing with it and be like 'ok just like breathe' and umm but yeah sometimes that can be hard because especially if you're say working with somebody with who's quite junior and never really experienced it before and they're like 'oh my god' or a student and to be like, 'it looks like torture but it's, it's not', it doesn't happen all the time…

P4: I ended up getting a colleague, my senior colleague in to do it with me and she just went you just need to rip it off and I was like 'oooh my god' and we just sort of did it for the patient and obviously they understood as well, but god they screamed and it was horrible.

3.2 Don't ask. Half of the participants said that they sometimes would not ask the patients about their pain, injury or general wellbeing. They spoke about this as a way of protecting both themselves and the patient from the answer, as if by not bringing the distress into awareness, it meant it was not there.

P4: *There are times like I've, you know they want to ask you, when they're still a bit confused or when they're not sure and you're like 'oh god do I tell them that this has happened, do I tell them?' You know, you don't want to be that first person to broach it about what's happened.*

P6: *I'd want them to know that I was, if I wasn't directly asking them about how they were feeling, how the dressing change was affecting them, umm then I was almost quite overtly assessing them, I wouldn't be directly asking them, I didn't want to be intrusive in that way but you'll be watching for, for signs, for little things, winces, stuff like that.*

P7: *Yeah, out of sight, out of mind. Don't ask the question because then you might get an answer that you don't necessarily like. I have a pretty good understanding of how lots of people live and it's often not very pretty umm so I choose to steer clear often … for lots of the issues there isn't an easy answer or any answer, so I kind of feel rather than put myself in a position of offering vain hope or opening up a whole can of worms that I'm going to be somewhat responsible for fixing, I kind of choose to not ask.*

One participant shared that they prefer to be led by the patient, rather than proactively asking, as they worry about saying the wrong thing and/or causing further distress.

P2: *My advice is just to like be led by the patients really because, yeah [asking a patient if they were okay and them responding "well no like I've, I've burnt my face and hands like it's not, like it's not okay"] was just such an eye opener for me and it was completely right. Umm and I felt terrible after it* *because I was like, 'oh god like have I said the wrong thing' and umm and I've apologised but it was just one of those things you've said isn't it.*

Theme 4: The pain's due to other factors, not my actions.

This theme describes the ways that nurses try to understand and explain patients' pain, releasing themselves from the responsibility of causing the pain. It includes ideas from participants about the pain associated with a burn and the other factors that can influence patients' pain experience. Participants spoke in detail about the support of the wider burns team and feeling that they are not making decisions or acting alone, and that they also ask patients to take a role in managing their pain. The responsibility of causing pain may therefore be shared.

4.1 Sometimes the pain doesn't match the burn. Many of the participants spoke about patients appearing to overact to the pain of a dressing change or having experiences of pain which were more than the nurse would expect, given the presentation of the wound and/or the patient.

P1: *Sometimes it's hard (pause) sometimes we think that the patient is overreacting about the pain. But then I try to think maybe it's just the way the patient reacts to any pain is just, it's strange, people are so different.*

P8: *Quite often people will say, oh you know you say, 'well what's the worst pain you know, 10 being the worst pain ever, where's your, where's the pain of this?' and there'll be sort of sitting there and they'll go 'nine', but you're sitting chatting to them and you're thinking no that's not somebody who's, who's in you know excruciating pain. But obviously they, to them it's, they* *feel that it's a 9 but I don't think it's umm, I think you know you can see that it's not (laugh).*

One participant shared that they have been encouraged by more experienced colleagues to try and judge if a patient is “really in pain” before deciding whether to pause the dressing change.

P5: I will just sometimes go out of the room and ask someone else, but they will say like ‘are they really in pain, if not just continue, finish it’, then I’ll take a few deep breaths myself and go back and explain to the patient that umm that ‘we just need to finish this one, it will be fast so just hang on in there’.

Some participants identified differences in how people appeared to respond to pain based on personal characteristics, such as age and gender.

P1: It’s very interesting that very similar people act completely different depending on their age ... So, it’s just for example so many young people they come through this door and they are already, they’re not even in the room and they’re already asking for pain killers. And their pain is 10 out of 10 already and I haven’t even touched them. When they were talking on the phone outside and laughing and acting normally. If your pain is 10 out of 10, then it’s strange. That upsets us a little bit, do you know what 10 out of 10 pain is?

P3: I do find, you know this is very stereotypical, but umm younger women tend to be umm sort of more hysterical in their pain. Umm and I find your middle-

aged men, some of them you know this is very, very stereotypical, I mean lumping them all together, but some can be very you know 'I need to be tough, I need to be tough'. And you're like 'no you need to tell me if this painful because I can get you more painkillers' and things like that. Umm and then, yeah. I just, so that makes me more aware of thinking, yeah I think younger women I'm thinking ok well they'll probably need a lot more reassurance and a lot more umm sort of onboard before we even start, in regards to painkillers.

Many of the participants were thoughtful about the different factors that could be influencing the patient's experience of pain, when they felt that the high level of pain they were expressing did not match the nature of the injury. All of the participants spoke about the impact of psychological difficulties on patients' ability to cope with the dressing change and burn injury.

P2: I think the more complex the patient umm so maybe, they may have like anxiety or they might have a mental health background or some like psychological aspect that you know that is going to like negatively impact on what you need to do. So they may have like had, I don't know a bad pain experience or they're just really nervous or umm quite young.

P4: It's difficult because people's tolerances are different so it's understanding who's actually really in pain and who it's just their tolerance for it and it's an awful thing to say because you're like you, the way you word it is like 'oh the, the pain is umm doesn't match the wound' or something like that so then you sort of go ok there's something else happening here for this patient. They *might be, it's the anticipation for that pain, or the, something else, or making it seem a lot worse than it is. So again I think that when you sort of recognising that but it's not the wound, the wound shouldn't be hurting them this much and then that's when you're trying to think of the other things that might be going on to try and make that dressing change better ... Usually if those patients have had really tricky times with the dressings it's because of either what happened with the burn or their previous mental health history or previous issues that they might have like anxiety or something like that and then we can team up with the guys in psychology.*

Half of the participants shared that at times they will try to "put themselves into their patients' shoes" to try and understand why they are experiencing and expressing their pain and distress in the way that they are. Some commented that they particularly found themselves doing this when they shared characteristics with the patient.

P1: And sometimes what I do is try to put myself in the patient's situation. Which is hard because I'm not feeling it. But as much as I can I try to imagine being the patient, so that I can understand the situation a bit better. And I think 'what would I like to hear if I was the patient at this point?' or 'what would I like to be done?' or 'what would help?', and then I just try my best.

P4: I always wonder if something like this happened to me how would I behave and I'm definitely on the other end. I'd be the one still in the bed, not moving (laugh). So, I kind of, I sometimes say that to the patients as well like 'I don't think I could tolerate this or cope with this', like 'it's incredible', whatever, *it's that continued bigging them up and reassuring them and just trying to encourage them. I think that in itself can sometimes be very draining when it's not getting you anywhere with the patient and they're just not responding to it.*

All of the participants commented on the importance of getting to know the patient and it seemed that this helped them to understand the patient and their pain, as well as assisting them with providing effective treatment.

P3: I think that's why I like the getting to know them so much and also you think 'oh ok so that's why (pause) I don't know, they're', (laugh) one of my patients they only drink Coke and I'm like 'well no wonder you have so many headaches because you only used to drink Coke and now you have this and stuff' and I probably wouldn't have known that if I didn't really get to know them so, yeah.

4.2 Burns patients are special. Some of the participants spoke about the types of people that they felt typically presented for burns care. They described them as "special" and that they are often people who have already experienced or are experiencing multiple challenges in life and explained that this can lead to difficulties during treatment.

P1: There are quite weird situations sometimes. So, we used to say that the burns patients can be quite difficult, because the burn can affect the quality of life *for the rest of the patient's life and yeah, it's quite, they're very special patients.*

P7: I think the nature of the patient population in burns, that they are more likely to be homeless, have mental health issues, substance misuse issues umm have you know neurological conditions or sensory loss, all of this sort of stuff means that you are dealing with umm I guess people with you know umm, bad luck cases I guess is the impolite colloquial way of describing it. And the term 'the mad, the bad and the sad' is used a lot in nursing actually, regardless of where you go. But yeah, there's certainly a lot of that in burns

However, two participants commented that despite these challenges causing some difficulties, they enjoyed working with this client group.

P1: There is like kind of a joke, that in the end is quite true, that a burns patient is always bad, mad or sad (laugh). They all are one of these. It's like a very old thing that I was told by the old staff members, because sometimes it's really difficult ... Unfortunately, lots of the patients that sustain burns have mental health issues. So the work is a bit of psychiatry as well (laugh) which is very challenging but also I always liked psychiatry ... I like my job and one of the reasons is because we have interesting patients and they are quite particular.

P8: I mean it's probably not so much the dressing change [I enjoy]. It's the patients. I mean burns patients are so quirky anyway, I mean a lot of them are very, you know, unique (laugh). You don't find many of them.

4.3 Sharing the responsibility. All of the participants talked positively about the support of their nursing colleagues and the wider burns team. Whilst some of this was pastoral, there was a sense that participants felt they had the backing of the team when completing the tasks involved in a dressing change.

P3: *You're never really doing it on your own which is good like 'I might need to get a doctor to come and see this' or 'let me just go get my senior nurse to come and have a look' and stuff ... sometimes you do need that and with the difficult situations and stuff and you think 'ooh ok, I haven't dealt with this, I don't really know' or someone telling you something you like 'ooh ok that doesn't really add up, I think I need somebody else to hear this' and stuff. So that also does help, I think knowing that you have a really good team that will support you, I think is really good and important.*

P4: *There's always been a good level of senior support in that you wouldn't, you, you're not expected to do it on your own either or know what to do, so I think the structure in the unit's quite good like that.*

P6: *The team definitely helped in supporting you to feel like you could [do the dressing change] and it's good because you always really worked in pairs while you were nursing on the ward. So that, that gave you that extra bit of confidence as well that you were working alongside someone else who would either agree with you or, or not.*

It seemed that the team approach to burns care helped participants to feel that the responsibility for patients' care, and the dressing changes as part of this, was shared.

P6: *It takes that responsibility away from you, you can almost put the onus on someone else … I think it just almost puts your mind at ease a little bit. It makes you think that there's been multiple people involved in this, multiple safeguards of people that this idea is ran through and this is the outcome that we've come to and it's been a real multidisciplinary approach towards the care. And I think that almost reduces the amount of responsibility which you felt for making and implementing that care plan. Our role was for the implementation and that's what we are responsible for, but the actual planning of it someone else was directly responsible and accountable to that. It was, we were accountable to complete it but we're not accountable for the plan itself, which is quite nice reassurance to have. And then you know you have the backing from your colleagues as well because it was discussed as a team to start with so, so that was something always that we, well I definitely appreciated that's for sure.*

Participants also spoke about sharing the responsibility for the pain involved in a dressing change with the patient, for example by asking the patient to tell them if the pain became too much.

P1: *If I feel like I'm going to cause more pain that specific moment, I tell them in advance and I ask them to prepare by taking a deep breath and telling me to stop if they need to.*

P3: *Especially like if I'm doing a dressing and I'm looking down and I'm not looking at their face I'm like 'so I'm going to be cleaning' and I was like 'you* *need to tell me if this is too painful and you need me to stop because I'm not looking at you'. So, then I can just sort of, now that I've sort of said that in a way, I'll keep checking on them but in a way that sort of you know they need to sort of, put that responsibility a little bit back on them so then I can sort of carry on with the task, if that makes sense.*

P5: *I explain to them if there's like, at any point you can't handle the pain anymore just tell me to stop.*

Some participants gave examples of times when they were aware that the patient was in pain, but the patient told them to keep going nonetheless.

P3: *You know sometimes I'll need to spend more time and sometimes, especially taking out staples. So, I've had you know that's a long, painful process because it just takes time. Some people are like 'yeah, nope, go, go for it, I won't look, I won't look', and I just can do them really quickly. Whereas others you know you're like 'ok how was that', you know 'ok, alright, I'll have the couple more tokes of Entonox and then we'll do 10 more' and then you know, then they can count them in their head if they want to. Others don't want to count, so (laugh), they'll tell you as well, which is nice. And you're like 'oh ok, probably 10 more' and they're like 'just don't tell me, it's fine'. So it is, it is the communication as well I think, definitely.*

Theme 5: Sometimes it's too much.

This theme describes the times when nurses found that they were no longer able to put their own emotions aside during the dressing change, perhaps due to difficulties avoiding or justifying the pain they were causing, and how they managed this.

5.1 Getting away from the pain. Some participants spoke about moments when inflicting pain became too much and they therefore stopped the dressing change, although this usually appeared to be led by the patients saying they could no longer tolerate it, rather than the nurse.

P1: *I always make sure the patient can tell me to stop straight away if the pain is too much and I will stop straight away. If it's too much, even if the patient doesn't tell me to stop, I can realise when it is too much and I stop and I just take the patient to the ward.*

P7: *If they are in a lot of pain, obviously you'll know about it quite quickly, they won't really umm consent to a lot of what you're doing, they'll remove their hand or their limb from, from the situation. They will cry, they'll get distressed, they'll shout and at certain point you'll have to say we can't continue with this today, they'll have to, we'll have to rebook them to come back onto the ward where they can get Entonox or gas and air or some other stronger pain relief that we're not able to give in the outpatient clinic.*

Many of the participants said that there are times when they have to hand over a dressing change to one of their colleagues. Sometimes this was because the dressing change was started in clinic and they needed to be admitted to the ward for analgesia, but other times it was due to an acknowledgment that there was only so much distress the nurse could tolerate.

P1: We just have to move and do it and if we can’t then unfortunately, I’ll have to hand it over to my colleagues.

P2: You know we’ve had like cases where the, anything that we’ve done and everything we’ve tried, the one particular patient and it was, I think everyone was, the whole ward was just like psychologically like, we just never won with the dressing changes … And umm you’d have to like anticipate well if you’ve done it last time it’s somebody else’s turn to do it and it was just awful.

P4: If they’re not dealing with it very well you might have to get somebody else in to take over, because I think it’s definitely got a very personal touch to it and the patient might suddenly be like really having a horrible time, screaming and all sorts, get somebody else in and they can do nothing differently it’s just that new face and they might just de-escalate the situation, calm them down a little bit and then they’ll let them do the dressing.

A few of the participants shared that there are times when they appreciate having the opportunity to leave the room where they are doing the dressing change, to take some time away to manage their emotions.

P3: Umm I mean we have had some sort of domestic violence cases and things like that which are hard to deal with and you know sometimes I have had to be like ‘ok I’m just going to go get this person’ and then it’s that sort of time is like a nice like ‘oof, oh god, ok’ (laugh) and then you have a breather and then you can go back in.

P4: That was, that one was when I was reasonably new I think and I felt awful like and I can remember like just coming out and needing just a break from it.

5.2 Coping and processing after it's done. Many of the participants shared there were moments when they found parts of their role and the dressing change difficult.

P1: It's hard sometimes, it's difficult. It's difficult … I've thought many times, why do I like this job so much if it's so hard?

P4: It was just draining so, so much and we made a point that everyone would not be there for more than a day in a row and if you were, God it was hard.

P6: Especially when it comes to like the self-harm side of burns, to suicide side of burns and having to support people through their aftercare physically but also knowing that they had these (pause) intentions to end their own life in, to do it in such a horrific way is umm it's just very saddening, I think. Very saddening.

Participants spoke about managing these difficulties after the dressing change, away from the patient, in a number of ways. Half of the participants said that they sometimes "take it home" with them and that it can feel easier to process the emotions of the day at home, rather than at work.

P1: I don't take this kind of situation… I do take it, actually, home sometimes. It upsets me a little bit, but after an hour or so I'm just fine again. Following day's a new day and I don't carry it for a long time.

P3: *I think it depends on the situation because I think, you do a little bit of dealing with these situations at work but you sort of can fully emotionally sort of deal with it at home if that makes sense. Like you said, once your shift's finished. And you can be like 'ah ok that was a crap day' or you know like 'that I really struggled with' and stuff. So then you can sort of, and then you sort of put it to bed and that's it.*

P6: *I felt like it probably catches me up and those feelings of maybe guilt, maybe anxiousness, umm would catch up on me. Usually when I was at home.*

Some of the participants explained that they found that their commute was an important and helpful opportunity to process the day.

P2: *I suppose like when I'm, like on my commute home I find like I process the day a bit better. Like when I lived really, I used to live really near to work and it was just, I felt like I never left work because sometimes you weren't able to, I don't know, yeah process your day and be like 'ah this went well or this went terrible'.*

P6: *Especially on the worst days I'd definitely walk back. No buses, that was the rule. Even if it is raining, I'd stroll home and that would usually help after a bad shift I suppose.*

All of the participants said that they found talking to somebody about their experiences helpful. Almost all participants said that they would talk to their nursing colleagues and that it was helpful that they had an implicit understanding of the nature and challenges of a dressing change and the burns nursing role.

P1: *It is just good to talk to them. Especially to people who have been through the same situation before. That's quite a relief sometimes talking to them.*

P3: *I'm friends with a lot of people umm that I work with so that's really helpful. Especially because like you can meet some of them outside of work as well and you can sort of, 'oh yeah I remember that one, you know that wasn't very nice' or you can, someone that was actually in the thick of it with you.*

However, some participants said that sometimes speaking to somebody who is impartial can also be helpful to process the things that they have seen, heard and done.

P4: *I, usually if it's been a particularly harrowing day and you know we've had a horrible burn in or something like that or it's, it's often the story that goes along with the burn. I think when it's the attacks or the deliberate harms or the domestic violence. Things like that, they're the ones that sort of get you. I'm just like oh God that's, you don't know how to process it sometimes. I definitely need to talk about it, so I'll sort of talk about it to my friends who have nothing to do with nursing, so they're quite good because they're quite impartial. They don't want the details of how it looked but they certainly will listen.*

Many participants shared that it was helpful to be able to debrief immediately after they have left the patient, to allow them to process what has just happened before moving on to the next patient.

P3: *It's nice to sort of have that person to talk to about it after and then you just sort of comfort them in that moment in time because you're not really (pause) you're just sort of like well I'll just you know hold my emotions in because you can't, it's not professional to you know start crying (laugh) in front of [the patient] but it is nice for them to see that you're concerned, that you're 'oh you know that is really horrible, I'm sorry that happened to you' and stuff and then, then you think '(sigh) wow that was really horrible' after and then you, you can sort of go to those emotions already and then you know sort of right after you've seen them, which is nice because you will have a couple of minutes before you're 'ok now I need to go do this next thing', which is helpful.*

However, as much as participants' colleagues were spoken about as a source of support, a few participants also shared that they could bear the brunt of the emotions that they did not feel able to express to patients.

P1: *But sometimes even in our relationship with our other colleagues, we cannot give our bad energy to the patients so sometimes we give it to our colleagues and we shouldn't. And that obviously is like a snowball. It gets even worse if I'm stroppy with a colleague because I'm having a horrible day, for example.*

P6: *It does put that strain on working relationships so it's usually going to go one of two ways. If the strain's either going to make the relationship a lot better and mean that you're able to work together a lot better because you know that you've been able to go through something like that, but then on the* *flipside it may do the, may do the opposite as well I suppose. But I think that's like any job isn't it. The more you work with someone, especially if it's six o'clock in the night shift, I was always a right grouch around that time so that was always my time to fall out with people (laugh).*

5.3 Feeling frustrated and guilty for feeling. For many participants, the emotion they reported experiencing the most, and also being most concerned about concealing from patients, was frustration.

P3: *You know there's been many occasions where I've nearly wanted to snap at a patient and probably have done before or been a bit short with them and you think 'oh my God that was probably a bit short with them, I shouldn't have done it like that' but you can get yourself into a sort of frustration.*

P7: *One of my patients said to me 'oh you guys don't get paid much but you must have wonderful job satisfaction', and all I could think was like you've obviously never met a nurse - nurses are angry and frustrated.*

It often seemed that this frustration was related to not being able to complete the technical tasks of the dressing change as efficiently and effectively as they would like.

P4: *Think more, my emotion that's most likely to come out if I'm doing a dressing would be more frustration I think and then with the dressing not going right because I want it to go a different way and I'm getting annoyed or frustration* *if the patient's just being slightly more (pause) troublesome (laugh) and I need to move it along because I'm running out of time.*

A few participants shared that they could feel guilty for feeling frustrated at patients as they think they should not be feeling this way as a nurse.

P1: Sometimes we feel mean. Why am I feeling so frustrated the patient was in pain? I shouldn't. So yeah, frustration is the one of the feelings that we have a lot. But also the guilt of feeling frustrated.

More generally, a few participants shared a sense of guilt, embarrassment or shame at having emotions and showing them to others. They spoke about their emotional experiences feeling like a "guilty secret", as being emotional was not seen as being a 'professional' nurse.

P1: It's interesting because talking with other nurses about the same experiences it makes me feel like I can relieve a bit of the tension. But at the same time, I feel guilty that I really shouldn't be showing my emotions like this ... Because if you're professional you shouldn't be feeling certain kind of feelings? Oh I don't know, it's hard. Maybe, maybe everyone experiences the feelings, but they don't ever talk about them?

P7: I think it is great there's this belated recognition that we need as much support as every other healthcare worker does. Yeah and hopefully we'll move away from this idea that we should be breeding resilience in nurses and actually recognise that rather the situations we do get put into are you know

> *physically and emotionally and mentally very unhealthy and very unsustainable in the long term. So yeah I think, I'm sure lots of these behaviours that I've internalised in terms of not asking difficult questions because I don't think I can face not having any answers for my patients or because I have this very outdated mode of professionalism which is really just a cover for my own personal anxieties, I'm sure hopefully at one point those will be umm bred out of future nurses.*

Discussion

The current study aimed to explore the emotion regulation strategies used by nurses whilst causing patients' pain during dressing changes, with consideration of the influence of nurse characteristics, such as length of experience and trait empathy, and nurses' appraisal of patient needs.

The results demonstrated that the nurses' desire to present as 'good' nurses was central to understanding how and why they regulated their emotions in the ways that they communicated. They described their beliefs that they are there to help the patient, that it is not about them and that they should not feel or show how they feel so that they can appear confident and competent to their patients and colleagues. Participants appeared to think that being a 'good' nurse and also a nurse that caused pain and experienced emotions were in conflict with one another (Theme 1). They consequently spoke about the ways that they managed both patients' pain and their own emotions, which made them a good nurse. The findings showed that participants justified and ignored the pain by focusing on the practical tasks (Theme 2), tried to forget about and mitigate the pain by keeping patients comfortable and compliant (Theme 3), and explained away the pain by understanding the patient and sharing the responsibility (Theme 4). All of these strategies were framed as ways of helping the patient but can also be seen as serving a dual purpose of helping the nurses manage their own emotions. This is in line with Menzies' (1960) proposition that many nursing practices and procedures develop to help nurses manage their anxiety. Nevertheless, participants shared moments when the dressing change became 'too much' and, consistent with findings by Cronin (2001), reported 'taking their emotions home', as it felt easier to process them away from the patient and the hospital (Theme 5).

The participants were mostly consistent in their reports and represented a range of length of burns nursing experience. However, it is possible that nurses who did not opt to participate may have shared a different perspective. All of the nurses who were interviewed reported enjoying their work, and those who had left the role said that it was for personal reasons unrelated to burns nursing. The sample studied may therefore have captured the experience of nurses who have developed relatively effective methods of managing their emotions and may have missed the experience of those who struggle more with this. The wider context, of personal and professional pressures related to COVID-19, might have prevented some nurses from taking part. Again, it could be hypothesised that these might be nurses who have more difficulty regulating their emotions or perhaps are more reluctant to explore their emotional experiences. Those who did take part shared that, whilst some of them felt nervous before participating, they had appreciated and enjoyed the experience. The findings therefore potentially represent just one version of how nurses manage their emotions during burns dressing changes.

Nursing has often been referred to as a 'calling' or 'vocation' (Begley, 2010) and the stereotypical image of a nurse is often of somebody who is caring, helps others and puts the patient's needs before their own (Maslach & Goldberg, 1998). It could be hypothesised that the nurses in this study felt the need to emphasise that they were 'good' nurses because a core part of their work as burns nurses, completing dressing changes that often cause pain, is in conflict with many of these characteristics. Although not focused on burns nurses, research by Green et al. (2016) reported that neonatal nurses' experience of inflicting pain was "agony for us as well" (p. 182) and could leave them questioning their role as a nurse. Given that nurses are often viewed as the alleviators of suffering, it may feel contradictory to be the cause of pain and therefore inevitable that this will be defended against.

By justifying the pain that they are causing during burns dressing changes, nurses are modifying their appraisal of the situation through what Gross (1998) would define as 'cognitive change'. This reappraisal of causing pain resulting in harm, to resulting in healing, is likely to help downregulate the nurses' own potential feelings of distress. Causing pain in the interest of healing is also much more in keeping with the ideals associated with a 'good' nurse (Maslach & Goldberg, 1998) and may therefore mitigate the conflict implicit in being a good nurse who causes pain and/or suffering. Similarly, nurses' attempts to explain the patients' pain, often in ways that relieve them of the responsibility of causing the pain, may represent a cognitive reappraisal of the situation that helps to regulate the nurses' emotions, whilst also demonstrating that they are thoughtful. In order to be able to explain the patients' pain, it seemed important for the nurses to build a relationship with patients so that they understood and were aware of the other factors present. Forming relationships with patients appeared, again, to serve a dual purpose of fitting with cultural expectations of a 'good' nurse that shares a level of emotional intimacy with patients (Williams, 2001) and gets to know each patient to provide individualised care, whilst also allowing them to explain the patient's pain in a way that minimises their role in causing it.

The emphasis on healing, and thoughts regarding this being the priority, may allow nurses to feel justified in focusing on the practical, rather than emotional, tasks of the dressing change. The Process Model of Emotion Regulation (Gross, 1998) would understand this as 'attentional deployment', whereby the nurses downregulate their distress by directing their attention to the wound they are healing, and the technical aspects of this task, rather than to the person whom they are causing pain. Given participants' reports that they liked to be able to fix things, it may be that focusing on the practical tasks also provides them with a greater sense of competency and control, whereas the emotional tasks may lead to feelings of helplessness. This hypothesis is supported by research by Kornhaber and Wilson (2011b), who described burns nurses' feelings of powerlessness and inadequacy in relation to their patients' experiences of high pain and emotion.

Whilst nurses' attempts to mitigate the patient's pain can be understood as part of 'good' nursing, by providing care and relieving suffering, it could also serve as emotion regulation through 'situation modification' (Gross, 1998). By keeping the patient 'comfortable and compliant', the dressing change is likely to be a less aversive experience for both the patient and nurse. Attempts to complete the dressing change as quickly as possible, by working with others and ensuring it is planned and organised, may also serve to minimise distress for both parties.

Nurses' attempts at suppressing their expression of emotions such as anxiety, sadness and frustration until they are away from the patient, and sometimes also the hospital, could be an example of regulating emotions through 'response modulation' (Gross, 1998). This 'response modulation' is also known as emotional labour

(Hochschild, 2012), which is considered a core aspect of the nursing role but is also reported to lead to compassion fatigue and burnout (Gillman et al., 2015).

As outlined in the extended process model of emotion regulation (Gross, 2015), the (conscious or unconscious) decisions about how and when to regulate emotions may be influenced by a range of factors, including beliefs about emotions. It therefore follows that the ward culture and expectations in relation to nurses' experience and expression of emotion is likely to have had an impact on how nurses regulated their emotions. Further to this, the research findings showed the importance of the support of colleagues to the burns nurses feeling able to complete their work. Without the perceived support and backing of colleagues, reinforcing the nurses' justifications for the pain being caused, the nurses could be at increased risk of moral injury. This is defined as "profound psychological distress which results from actions, or the lack of them, which violate one's moral or ethical code" (p. 317) and includes experiences of betrayal by leaders, as well as acts of perpetration and omission (Williamson et al., 2020). This apparent importance of culture and organisational and societal expectations also highlights some of the limitations of Gross's process model which, although it has space for considering relational, social and cultural factors, does not explicitly include such factors in the model (Burkitt, 2018).

Furthermore, it appeared that the presence of an integrated burns psychology team supported nurses in taking a thoughtful, holistic view of patients' presentations and needs, which, in turn, allowed them to understand the patients' experience of pain as not solely a result of their actions. The British Burn Association (2018) national standards recommend that all patients admitted to a burns unit for over 24 hours receive a psychosocial screen. Research by Shepherd and Beveridge (in press) showed that 95% of patients admitted to the burns unit studied (a different unit to the present study) received input from the psychology team, including contribution to multidisciplinary discussion. This high level of input may support nursing staff in thinking psychologically about patients and also with reassurance that they can refer patients for psychological support, beyond what they feel able offer, if needed.

Trait empathy did not appear to be linked to participants’ reports of their attempts at managing their emotions during burns dressing changes in any obvious way. Given that, despite some variability in the IRI scores, there was not significant variability in participant self-reports during interviews, it could be hypothesised that the presence or absence of empathic behaviour by nurses may be more a product of contextual factors rather than of differences in trait empathy. The strong beliefs conveyed by nurses that they are expected to put their own emotions aside to be able to care for the patient suggest an impact of wider cultural expectations but are also consistent with the proposition that for empathy to lead to prosocial behaviour, emotions must be regulated (Decety & Jackson, 2004). It can also be hypothesised that the beliefs and strategies described by participants are not due to atypical trait empathy profiles, as their IRI scores were in line with scores reported for medical students (Coman et al.,1988) and midwives (Williams et al., 2013), and with normative data (Coman et al.,1988).

Similarly, the sample size was too small, and participant reports too similar, to comment on the potential impact of length of experience on the emotion regulation strategies used by nurses. However, there were some reports that nurses felt they had learnt how to regulate their emotions through experience, and that they might have developed a ‘thicker skin’ over time. This is congruent with previous research showing that increased exposure to facial expressions indicative of strong pain leads to reduced sensitivity to pain expressions (Prkachin et al., 2004).

Themes indicative of the impact of the nurse's appraisal of the needs of the patient or the quality of the relationship with the patient on the emotion regulation strategies used by nurses are notably missing from the findings. Given that participants often did not explicitly report the emotion regulation strategies they used, instead communicating them through discussion of the behaviours they felt were expected of them, it may be that they were unable to identify explicit differences in their approach, even when asked. It could be suggested that acknowledging the need for different emotion regulation strategies dependent on patient characteristics would be experienced as in conflict with their ‘duty of care’ to patients, to provide treatment regardless of individual characteristics, and therefore difficult to express. Brief comment was made by some nurses about additional challenges of treating patients whose accounts have personal resonance and that these may be the times they are more likely to speak to colleagues or friends. Ideas regarding transference and countertransference in the nurse-patient relationship have been explored in psychodynamic literature, which has proposed that these concepts can provide insight into the unconscious responses of nurses to patients and the resulting impact on the care provided (O’Kelly, 1998).

Limitations

The sample for this study was recruited from one burns unit. Whilst many of the tasks and demands of burns nursing are likely to be consistent across different units, there appeared to be a considerable influence of the ward culture on how nurses regulated their emotions. It is therefore possible that the themes described may be somewhat unique to the burns unit studied. There were also limits to how much information could be provided about the nurses recruited, to situate the sample, due to the limited pool of participants. If more detailed information had been provided about participant characteristics it is likely that the nurses who opted to participate would be identifiable. Whilst situating the sample is important in allowing readers to consider the relevance of findings, it is a priority to respect the confidentiality of participants, where this has been agreed (Elliott et al., 1999).

Due to the small sample size and high consistency in qualitative reports, it was not possible to fully consider the role of length of experience or trait empathy scores from the IRI on the emotion regulation strategies described by participants. A sufficiently powered quantitative or mixed methods study would likely be best placed to explore this, allowing for statistical analysis of the relationship between IRI scores, length of experience and emotion regulation strategies. However, this would require an established system for categorising nurses' reported emotion regulation strategies. The present research provides some evidence that Gross's (1998) process model may be a useful resource.

Similarly, the research question regarding the impact of the nurse's appraisal of the needs of the patient or the quality of the relationship with the patient on the emotion regulation strategies used by nurses was not answered, as this did not appear in the themes. This limits the conclusions that can be drawn regarding factors influencing nurses' regulation of their emotions. As previously hypothesised, acknowledging the need for different emotion regulation strategies dependent on patient characteristics might be experienced by nurses as in conflict with their 'duty of care' to patients. The absence of themes indicative of the impact of the nurse's appraisal of the needs of the patient or the quality of the relationship with the patient on the emotion regulation strategies used by nurses is unlikely to represent an absence of these processes occurring. It seems more likely that this may be representative of the limitations of the present study and highlight an area for further research.

The current study relied on participant self-report regarding their emotion regulation strategies. Most participants reported being unfamiliar with considering how they manage their own emotions during their clinical work, which may have meant they had difficulty accessing and articulating their experiences. Furthermore, participants were aware that the researcher is a trainee clinical psychologist who has previously worked in the psychology team on the burns unit. This may have influenced how participants spoke about their experiences, perhaps making them more likely to have considered and shared the psychological aspects of their work.

Research and clinical implications

The study results demonstrate that there are a number of ways that nurses regulate their emotions whilst causing patients' pain during dressing changes. The strategies used and communicated by nurses were influenced by perceived expectations in relation to being a 'good' nurse. This highlights the importance of taking wider contextual factors into account, when investigating what is occurring at both the individual and collective level.

Burns nurses spoke about the significance of a supportive team in allowing them to manage their role. In particular, they said that they felt the responsibility for the pain they were causing was somewhat shared as they knew they had the team's backing for their clinical decisions, and that they could turn to colleagues for support. This may have implications when considering how to create 'healthy' workplace environments and highlights the need to focus on organisation cultures, as well as individual resilience. A recent review by Cooper et al. (2021) reported that workplace factors that affect nurse resilience are under-researched, which limits the development of interventions to support resilience.

Many of the participants commented that they had enjoyed the interview process, despite some saying that they initially felt nervous about participating, and that they had not had similar conversations before but would appreciate more discussion regarding their experiences of their work. The researcher was not aware of any distress experienced during or after the interviews, when the nurses' emotional experiences were discussed. This suggests that nurses may value space to speak about and reflect upon their emotional experiences. It may be that this space is particularly appreciated early in nurses' burns nursing careers, before they have developed a 'thicker skin' and other ways of coping through experience. Without the same provision for regular supervision as other healthcare professionals, such as psychologists, it may be most feasible for this to occur during joint working and informal conversations with colleagues. Given that the present research highlighted the importance of the local and wider culture and perceived availability of support from colleagues, clinical psychologists may have an important role in facilitating helpful cultural shifts. This could occur by emphasising the importance of valuing and accepting the emotional experiences of nurses, by modelling and facilitating this on wards and providing input to education and policy. Direct psychological interventions for staff have been shown to have low uptake in physical health settings with a preference for peer support (Billings et al., 2020). There could, however, be a role for clinical psychologists to provide consultation and supervision to more senior members of nursing staff, whom junior nurses may be more likely to approach for support and guidance.

Lewis et al., (2013) suggest that the generalisability of research can be split into three domains: representational, inferential and theoretical. Based on the outcome of credibility checks, it appears that the current research is representative and therefore should be generalisable to the unit where the research was carried out. It is less clear if it can be generalised to other burns settings, due to the potential impact of local contextual factors, and specialities other than burns, due to the unique qualities of burns dressing changes. However, some of the theoretical principles have potential for being generalised to other settings. This research found Gross's (1998) process model of emotion regulation to be a helpful framework for understanding the study's findings. It is acknowledged that the model was used to inform the design of the interview schedule and is a relatively broad model, therefore it may have been unlikely that the identified themes would not have been able to be explained by it. Nonetheless, it provided a link to theory that has been missing in previous research exploring nurses' experiences. It may be that the process model is a helpful way of understanding similar phenomena in different medical specialties. Linking the findings to established theory also provides opportunities for further thought regarding the usefulness of different emotion regulation strategies. For example, research has shown that reappraisal (i.e., 'cognitive change') is more effective at downregulating emotions than suppression (i.e., 'response modulation'; Kalokerinos et al., 2015). However, the limitations of Gross's model should also be held in mind, in particular the absence of clear incorporation of social and cultural factors in emotion regulation. This is particularly important given the apparent substantial importance of culture in nurses' reports of their emotion regulation. It could be suggested that Gross's model provides a useful framework for understanding how nurses regulate their emotions but falls short of explaining why.

The aim of this research was to explore how nurses regulate their emotions whilst causing patients' pain during burns dressing changes. It will therefore be important for future research to consider the impact of the emotion regulation strategies used on both nurses and their patients. It cannot be assumed that what is helpful for the nurse will necessarily be helpful for the patient, and nurse and patient emotion regulation processes are likely to interact. For example, whilst there is evidence suggesting that cognitive reappraisal is an effective emotion regulation strategy (Kalokerinos et al., 2015), this could lead to patients feeling invalidated if the reappraisal minimises or dismisses their reported symptoms. Invalidation of patient symptoms has been linked to a range of negative outcomes, including delays in seeking care and poor mental health (Bontempo, 2021). Whilst there is existing research showing that the strategies used by nurses to regulate patients' emotions can also affect the nurses' emotional experiences (Martinez-Íñigo & Totterdell, 2018), further research is warranted to fully explore the relationship between nurses' and patients' emotions and their regulation. One potential way of investigating this could be to video nurse-patient interactions during dressing changes to analyse the interplay between nurse and patient verbal and non-verbal behaviour. Alternatively, qualitative interviews or a questionnaire could be completed with both nurses and patients following a dressing change to explore and compare their individual experiences of the same interaction.

As this research was not able to fully explore or answer the research questions pertaining to the role of nurse characteristics, such as trait empathy and length of experience, and the nurses' appraisal of patient characteristics on the emotion regulation strategies they used, these areas will require further research. A larger scale quantitative study or mixed methods design, and perhaps direct observation of nurses' behaviour during burns dressings, may be better suited to their elaboration, particularly when considering the potential relationship between nurse characteristics and the emotion regulation strategies used. The results of this study suggest that participants are keen to present as a 'good nurse' and it has been hypothesised that this could limit how able they feel to share differences in their treatment of patients. When exploring this in future research, it will be important for this to be taken into account and to consider how best to encourage open and honest reporting; one potential adaptation could be the use of an anonymous survey to collect participant data.

Conclusion

In conclusion, how nurses regulate their emotions whilst causing patients' pain during burns dressing changes was influenced by their beliefs regarding what makes a 'good' nurse. There were a number of strategies used by nurses during the dressing change which they thought made them a good nurse, but also appeared to help them manage their emotions. Nurses reported focusing on the practical tasks of a dressing change to ensure that they healed the wound, which helped to justify the pain that they were causing and sometimes ignoring. They also aimed to keep the patient comfortable and compliant and reported to not always ask about pain or distress, to keep the pain they were causing out of awareness. Additionally, nurses thought about patients' pain holistically, taking into account the numerous factors that could explain their pain expressions, which allowed them to feel that the pain may be due to factors other than their actions. They also felt that they had the support of their team, which further helped to justify their actions and share the responsibility of any pain caused. Finally, there were times that causing the patients' pain could become "too much" and at these times nurses took the opportunity to get away from the pain or suppressed their own emotions until they were away from the patient. However, nurses could feel guilty for feeling, especially if they expressed their emotions in front of patients.

These findings provide an in-depth understanding of the strategies used by nurses to regulate their emotions. They have implications for senior burns staff and future researchers. The research has highlighted the importance of a supportive burns team and that nurses valued the opportunity to explore their own emotional experiences. Future research should investigate the effectiveness of the identified emotion regulation strategies for nurses and patients.

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Part 3: Critical Appraisal

Introduction

This critical appraisal will reflect on the process of designing, executing and writing up this research, with a particular focus on how my own views, beliefs and assumptions about the subject matter changed over time. Whilst my views were influenced by the process of completing the research itself, there was also an undeniable impact of the wider context, including my own training and personal experiences, and the COVID-19 pandemic.

It is acknowledged that any researcher will bring their own personal experiences, knowledge and assumptions to qualitative research and that these factors will influence how research data is collected, analysed and presented (Fischer, 2009). Engaging with the influence of these beliefs and assumptions on the research process is known as reflexivity. Although reflexivity aims to somewhat mitigate the impact of the researcher’s views by bringing them into awareness, it also includes an acceptance that the researcher is not an impartial observer, but rather plays an important part in the research process and therefore the conclusions drawn (Willig, 2013).

Further to this, given that this research has focused on nurses’ emotional experience of their work, it feels pertinent that, as the researcher, I reflect on the same.

The initial idea

Prior to starting my doctorate in clinical psychology, I worked as an assistant psychologist on the burns unit that eventually hosted my research, and a considerable amount of time before this I had considered a career in medicine. I therefore approached this role with an interest and appreciation for both the psychological and the medical and had likely had more exposure to the medical world and culture than other junior psychologists. This might be why I do not recall being shocked by what I initially saw and heard on the burns unit, or at least did not express any shock to my colleagues. I think I felt that this would be perceived as me not being ‘cut out’ for working on the ward and that witnessing pain and distress was just part of the role.

However, I distinctly remember a moment when I was working on my computer in the office based on the ward and could hear a patient screaming during their dressing change, a short distance from me. I was struck that this patient had been screaming for several minutes and I had been carrying on with my work, barely acknowledging the distress that was being experienced so close by. Although I could begin to understand my response as a functional avoidance of distress that I perhaps felt powerless to help, I became intrigued by how the nurses who were inflicting this pain coped with this.

I only worked on the burns unit for a relatively brief period of time, but in this time I do not recall hearing the nurses talk about their experiences of causing pain. This does not, of course, mean that these conversations did not occur, and in fact the interview data provides evidence to the contrary. However, it did lead me to believe that this was a part of the burns nursing role that was seen as ‘routine’ or ‘normal’ and largely not questioned or reflected upon. I could certainly notice how I became desensitised to the injuries I saw and traumatic stories I heard, and my own casualness about my work compared to how people outside the burns team viewed the role.

I therefore left the burns unit feeling that I had been a part of the culture on the ward, which in my experience was of being ‘okay’ with what had to be seen, done and heard; but with a lingering feeling that much of this was not ‘normal’ or ‘day-to-day’ and that as human beings working on the ward, we must have developed ways of coping with this.

Beyond the burns unit

The culture of my first placement, following my time on the burns unit, was a very different one. The theoretical stance of the service was largely relational and therefore the emotional experience of the clinician and the patient was often at the forefront of discussions. I was encouraged to consider my emotional reactions to the work I was undertaking and the processes that both my patients and I were using to manage these emotions. I personally found this type of reflection helpful, although at times somewhat confronting, in managing the interpersonal and more challenging aspects of the role.

Through my clinical work and training, I was learning about how people naturally and understandably develop ways of coping with the difficulties and distress in their lives. I was also starting to appreciate that these ways of coping or managing could be effective, without necessarily being helpful, and that they often developed out of necessity.

Implications for the development of the study

When developing my idea for this study, I started with an assumption that clinicians are just human beings and that the psychological theories I was learning about and applying to my clinical work must therefore apply to them too: I assumed that nurses must have developed ways of managing their emotional reactions to causing patients’ pain.

My own experiences were of seemingly becoming desensitised to the distress on the ward and perhaps avoiding it, and also of having valued subsequent spaces to reflect on my own emotional experiences of my work. Hence, my motivation for conducting this research may have been to give nurses an opportunity to explore their experiences in a way that I had not witnessed whilst working on the ward.

The ethics process

As the research was initially designed to take place on hospital premises, I was required to complete an NHS ethics application. This detailed process meant that great thought was given to the potential impact of the interviews on the nurses who would take part.

Given my own beliefs about the helpfulness of a space to reflect on one's emotional experience of one's work, I was not concerned about conducting interviews exploring this with the nurses. My experience of the burns nurses was also as resilient and assertive professionals, and I therefore did not anticipate them being unable to manage discussions relating to their emotions.

However, I gained a different perspective from senior members of the burns team as part of the ethics process. They shared their concerns about asking nurses about their emotional experiences and were keen to ensure that appropriate support was in place. Whilst an important consideration, I also felt this may be an interesting reflection on the ward culture and how the sharing of nurses' emotions relating to their work may be viewed. Although not explicitly said, my sense was of a fear that speaking about their emotional experience may cause nurses distress and perhaps even difficulties coping with these parts of their role.

Nurses as participants during COVID-19

During the design and setting up stage of the study, the first wave of COVID-19 hit, and the research came to a standstill. For a short period of time, applications for NHS ethics were limited to research pertaining to Covid and the potential role of the burns nurses in providing care to Covid patients was unknown. In the first few months, I assumed that the research would not be able to go ahead, as all time, energy and attention was given to Covid. I was undoubtedly influenced by the images I was seeing in the news and media of exhausted nurses and overstretched hospitals, but also by my own experiences of close family and friends being redeployed to Covid wards and ICUs. I recall being hesitant to even email the burns staff as I did not wish to add to their workload.

However, once I did contact the senior burns team, they reported that they were keen to go ahead with the study. At this point, I noticed a shift in roles and/or perspectives between the senior burns staff and myself. During the ethics stage, the senior burns staff had presented as more protective of the nurses and as perceiving them as more 'fragile', whereas I had perceived the nurses as resilient and capable of withstanding discussions regarding their emotions. These roles felt reversed with the advent of Covid. I felt notably more protective of the nurses and cautious about introducing additional demands and opening up discussions regarding their emotional experiences, whereas the burns senior staff assured me that it was appropriate to go ahead with the research.

Implications for recruitment

On a practical level, by the time that I had received NHS ethics approval and set up the study at the host hospital site, the second wave of Covid was on the horizon. There was therefore a time pressure to recruit participants before demands on the hospital and staff inevitably increased. Initial uptake for participation in the study was good, but quickly plateaued. I wondered if those who did not sign up were too busy and overwhelmed, or perhaps felt that exploring their emotional experience would not be helpful at present. I therefore did not send multiple prompting emails as I otherwise might have, as I wanted to respect the decision of those who had chosen not to reply to the initial invite. There are, of course, a multitude of reasons that nurses may not have replied, beyond those related to Covid, but my perception of nurses and the role they were taking during Covid certainly influenced my approach to recruitment.

Furthermore, the second wave of Covid and third national lockdown coincided with when I might have put out a second call for participants. Given this timing, it felt inappropriate to continue recruiting as once again attention and effort was directed at managing the response to Covid. Upon reflection, although there is little doubt that this was not the time to be placing extra demands on nurses, it is interesting how my relationship to the nurses shifted with the wider societal narratives to a much more protective role. Viewing this from my initial perspective of nurses as resilient and assertive, I might have approached this differently, as I would have considered the nurses capable of making their own decisions about whether it was an appropriate time for them to be taking part in the research.

Implications for data collection

The nurses who opted to participate in the study engaged with the interviews openly and enthusiastically. Despite my previous reflections about feeling protective towards the nurses, I did not notice these feelings during the interviews. All of the participants presented as relatively calm, and they made very few references to Covid. It seemed that directly speaking with the nurses re-confirmed my perception of them as resilient. I do wonder how much this was reassuring for me, knowing that the nurses working on ‘the frontline’ were robust, but also an expectation that the nurses felt they had to fulfil: to present as stoic and unaffected.

Over time, I noticed subtle shifts in the public perceptions of nurses as the response to Covid continued. There have been justified criticisms of the framing of nurses as ‘heroes’ (McKenna, 2020) but it has also seemed that, for some, as frustration with Covid restrictions has increased, sympathy for the frontline staff has decreased. It seems inevitable that these wider public perceptions will have influenced the way that nurses feel they must present themselves, and that this will have likely influenced how they portrayed themselves in the research interviews.

Silver linings

Alongside the many challenges brought by Covid, there may also have been some ‘silver linings’ or benefits. It was always planned that interviews would have to take place outside of the nurses’ usual working hours. However, due to Covid-related restrictions, the interviews were changed from face-to-face to video or telephone calls. Whilst some nurses still completed the interview from work, after their shift, most completed it in their own homes on their day off. Given the often long and unpredictable shift patterns that nurses work, this may have made the research more accessible to some of the nurses. I also wonder if it may have felt easier for the nurses to explore their emotional experiences in their own homes, rather than the hospital, given their reports that they often ‘take their emotions home’.

Covid has also brought a greater recognition of the challenging work that is expected of nurses and the support that they may therefore require. Messages such as ‘it’s ok not to be ok’ and staff-specific support services have become particularly prevalent during Covid. This may reflect a slight cultural shift towards an acknowledgment that nurses have their own emotional experiences of their work and some acceptance that they may also have their own struggles at times. I wonder if this may have led to the discussions in the interview feeling more familiar and/or the nurses feeling more able to express how they feel.

Focusing on the ‘how’ and the ‘why’

The focus of this research from the outset was to explore *how* nurses regulate their emotions whilst causing patients pain during burns dressing changes. What I found was that the nurses also went to great efforts to communicate *why* they regulate their emotions, speaking in detail about being a ‘good’ nurse. These two elements felt intrinsically linked and an understanding of the *why*, helped with an understanding of the *how*.

What was not explored in this research was how effective the emotion regulation strategies used by the nurses were, either for themselves or for their patients. I found that I had to remind myself of this throughout the research, as I would often realise I was making assumptions about the usefulness of different strategies or approaches. When presenting the initial analysis to the senior burns staff, they also began to question if they should be doing things differently and particularly expressed concerns about nurses ‘taking it home’.

With the aforementioned increased focus on staff wellbeing during Covid, in some ways it felt indulgent to be conducting research that was solely focused on an in-depth exploration of the underpinnings of nurses' emotion regulation, with no comment on its helpfulness. As somebody who has chosen to work in a 'helping profession' and at times during Covid certainly felt helpless, I am not surprised that I was pulled towards wanting to be able to comment on what could support nurses and patients. I also wonder if this somewhat mirrored some of the processes that the nurses described of wanting to 'fix' and focusing on the 'doing', rather than the 'feeling'. However, I found it helpful to return to the purpose of the study and also to what I had learnt through my clinical work: that a solid formulation or understanding of a phenomenon is essential to beginning to work out how to help.

The role of psychology in physical health teams

The process of conducting this research led me to have some broader reflections about the role and positioning of psychology within physical health teams and services. My impression was that psychology was highly regarded and valued on the burns unit where the research was based. I also felt that this came through in the interviews; although it is important to acknowledge that the participants knew I had previously worked as part of the psychology team and may therefore have been unlikely to express negative views of psychology.

I also felt that the interviews demonstrated that the nurses were able to think compassionately and holistically about the ways that their patients presented. Some of them explicitly spoke about how the ward psychologists had helped them with this thinking. From my relatively brief experience working on the ward, many of these conversations happened informally, in corridors or the staff room, but it seems that they may have had an important impact.

This has led me to wonder if this more informal influence of psychology could also apply to supporting nurses with exploring and acknowledging their emotional experiences at work. As has been demonstrated by the low uptake of formal psychological support by frontline workers during Covid and reported preference for peer support (Billings et al., 2020), traditional, formal interventions by psychology may not be the most helpful. Rather, psychology may have a role in facilitating a cultural shift, whereby the emotional experience of nurses is valued and accepted and can therefore be more readily and openly discussed amongst all staff.

Conclusion

My experience of conducting research with nurses during COVID-19, whilst challenging at times, led to some interesting and important reflections about how wider narratives influenced my perception of the nursing role and consequently the way that I approached the research. Particularly as Covid continues to be a part of our lives, it may be important to consider if, as researchers, we also regulate our emotions by avoiding the more difficult topics and shying away from emotions, and what this means for the research we conduct.

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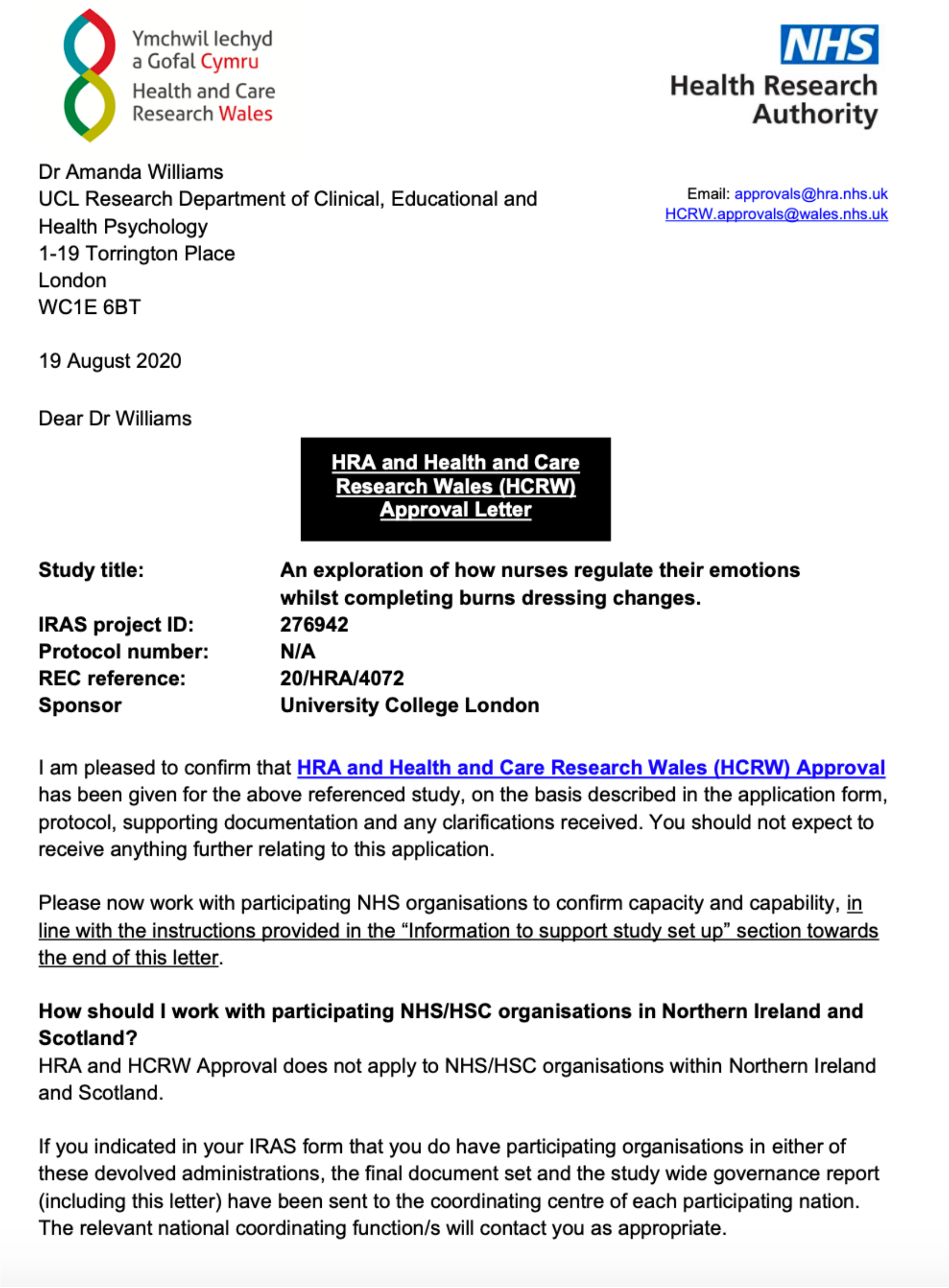
Appendices

Appendix A. Ethical approval documents.



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19 August 2020

Dear Dr Williams

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title: **An exploration of how nurses regulate their emotions whilst completing burns dressing changes.**
IRAS project ID: **276942**
Protocol number: **N/A**
REC reference: **20/HRA/4072**
Sponsor **University College London**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The *"After HRA Approval – guidance for sponsors and investigators"* document on the HRA website gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **276942**. Please quote this on all correspondence.

Yours sincerely,
Barbara Cuddon

Approvals Specialist

Email: **INSERT for nation of sender** approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

Copy to: *Suzanne Emerton*

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Copies of advertisement materials for research participants [Recruitment Poster]	1.1	14 August 2020
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Evidence of Sponsor Insurance]	1.1	28 July 2020
Interview schedules or topic guides for participants [Interview Schedule]	1	29 May 2020
IRAS Application Form [IRAS_Form_04082020]		04 August 2020
Letter from funder [Funding Declaration Letter]	1	12 February 2020
Letter from sponsor [Confirmation of UCL Sponsorship]	1	07 July 2020
Letters of invitation to participant [Email invitation template]	1	29 May 2020
Organisation Information Document [Organisation Information Document]	1	02 July 2020
Other [Local Collaborator Confirmation re COVID-19]	1	26 May 2020
Participant consent form [Consent form]	1.1	14 August 2020
Participant information sheet (PIS) [Participant Information Sheet]	1.2	14 August 2020
Referee's report or other scientific critique report [Peer Review]	1	21 February 2020
Research protocol or project proposal [Protocol]	1	29 May 2020
Research protocol or project proposal [Protocol]	1.1	14 August 2020
Schedule of Events or SoECAT [HRA Assessed Version]	1.0	10 August 2020
Summary CV for Chief Investigator (CI) [Chief Investigator CV]	1	10 January 2020
Summary CV for student [Student CV]	1	10 July 2020
Summary CV for supervisor (student research) [Supervisor CV]	1	10 January 2020
Summary CV for supervisor (student research) [External Supervisor CV]	1	21 November 2019
Validated questionnaire [Interpersonal Reactivity Index]		

Appendix B. Participant recruitment email.

Dear nurses,

I am interested in hearing about your experiences of completing dressing changes on the burns unit. I am hoping to recruit 20 nurses to take part in a confidential interview about their experiences and to complete a short questionnaire. It's hoped that this research will help to design further studies to improve both staff and patient wellbeing during burns dressing changes.

The interview and questionnaire should take no longer than 1 hour and 15 minutes to complete, and you will be offered a £10 voucher or donation to Dan's Fund for Burns for taking part. We would meet outside of your usual working hours, either in the psychology room on the burns unit, at UCL or via phone/video call, depending on your preference. The options available to you may vary depending on the current guidance from the NHS regarding face-to-face contact in the context of COVID-19.

If you are interested, please read the information sheet attached for more information or feel free to contact me on the email below if you have any questions. If you do decide to take part, please let me or [ward psychologist] know so that I can get in touch to arrange a convenient time to meet.

Thank you and best wishes,

Lucy

Lucy Rudkin
Trainee Clinical Psychologist

Email : [REDACTED]

Appendix C. Participant recruitment poster.

UCL Research Department of Clinical, Educational & Health Psychology
1-19 Torrington Place
University College London
London
WC1E 7HB

ARE YOU A QUALIFIED NURSE WHO WORKED ON THE BURNS UNIT BETWEEN 2019-2020?

We are interested in hearing about your experiences of doing burns dressing changes

What

A confidential interview and short questionnaire lasting no longer than 1 hour 15 minutes. You will get a £10 voucher or donation to Dan's Fund for Burns for taking part. We hope to interview 20 nurses from the ward.

Where

Either the psychology room on the burns unit, at UCL or via phone/video call, dependent on your preference.

When

Outside of your usual working hours, but otherwise at a time to suit you.

Why

It's hoped that this research will help to design further studies to improve both staff and patient wellbeing during burns dressing changes.

How

If you are interested, please contact Lucy Rudkin ([redacted]) or speak to [redacted] (Burns Psychology) to find out more.

Nurses' emotional experience when completing dressing changes.
Recruitment Poster, v1.1, 14/08/20, IRAS 276942, Page 1 of 1

Appendix D. Participant information sheet.

UCL Research Department of Clinical, Educational & Health Psychology
1-19 Torrington Place
University College London
London
WC1E 7HB

Information Sheet (Version 1.2)

14/08/2020

Nurses' emotional experience when completing dressing changes

We are inviting you to take part in a research project, but before you decide whether to take part it is important that you understand why the research is being done and what this study will involve. Please take time to read the following information carefully and discuss it with others if you wish. If anything is not clear or you would like more information please just ask the researcher.

What is the purpose of this study?

This study aims to explore nurses' emotional experiences when completing burns dressing changes. We hope to understand how nurses manage their feelings during these procedures. There is no right way to manage feelings; we are interested in *your* personal experiences. This study is being carried out by Lucy Rudkin, a Trainee Clinical Psychologist undertaking the Doctorate in Clinical Psychology at University College London (UCL). The study will form part of an academic qualification and be supervised by Dr Amanda Williams (Reader in Clinical Health Psychology, UCL).

Why have I been invited?

You have been invited to participate in this study as you are a qualified nurse who worked on the burns unit at XXX Hospital between 2019-2020, who completes dressing changes. You can therefore provide valuable insights into your personal experience whilst administering these procedures. We will be asking all qualified nurses that work on the burns unit to take part.

Do I have to take part?

No. You are under no obligation to take part in this study. If you do decide to take part you will be given this information sheet to keep and asked to sign a consent form. If you decide to take part you are still free to withdraw at any point by telling the researcher. You are not required to give a reason and any data collected will be destroyed. This study is completely independent of your employment contract and a decision not to take part or to withdraw at any point will not affect your employment.

What will I be asked to do?

By taking part in this study you will complete a one-to-one interview and a short questionnaire with the researcher (Lucy Rudkin, Trainee Clinical

Psychologist). This will take place either in the psychology room on the burns unit, at UCL or via phone/video call, according to your preference. Video calls will be completed using Microsoft Teams. However, in circumstances where this is not available an alternative video platform with end-to-end encryption will be offered. The options available to you may vary depending on the current guidance from the NHS regarding face-to-face contact in the context of COVID-19. You will need to participate in the study outside of your usual working hours.

The interview will focus on your experience of completing burns dressing changes. Completing the study will take up to 75 minutes – up to 15 minutes will be spent ensuring you understand the study and what it involves, the interview will then take around 45 minutes, followed by up to 15 minutes completing a short questionnaire. Following analysis of the data you will be given the opportunity to give feedback on the themes identified via email (you are not required to give feedback for inclusion in the study).

What are the benefits of participating in this study?

Participating in this study will give you the opportunity to discuss and reflect on your experiences of completing dressing changes on the burns unit. We hope the results from this study will help to design further studies to hopefully improve both staff and patient wellbeing during burns dressing changes. You will be offered either a £10 voucher or donation to Dan's Fund for Burns to thank you for your participation.

What are the risks or downsides of participating in this study?

You will need to dedicate up to 75 minutes of your own time to take part in the study. Discussing your experience of administering painful procedures may be distressing (see below).

Who can I speak to about my participation in the study?

If you feel upset by or would like to discuss your experience of the study you will able to speak to XXX (Burns Senior Sister) or XXX and XXX from the burns psychology team. We ask that you do *not* speak to your colleagues about the interview whilst the study is ongoing, as we want to hear about people's personal experiences without influence from others. However, you will be provided with the names of other participants who have already completed the interviews, and consented to their names being shared, and will be able to speak to them about your experience if you wish. You will also be asked for your consent to share your name with other participants. This is completely optional and not required for participation in the study or receipt of the list of names of other participants.

Who will have access to my information and how will my information be kept confidential?

All data will be handled according to the Data Protection Act 1998 and will be kept strictly confidential. Your paper consent forms and contact details will be kept securely and separately from all your other information.

Interviews will be audio-recorded and transcribed by Lucy Rudkin (Student Researcher). Only Lucy Rudkin and Dr Amanda Williams (Chief Investigator) will have access to the recordings. No member of the burns ward staff will have access to any of the interview recordings. The audio-recorded data from interviews and completed questionnaires will be anonymised (meaning all identifiable information will be removed) and stored securely on the UCL secure server. Any results reported or published will be anonymised so that participants cannot be identified. The information collected will only be used for research purposes as part of this study. The study data will be archived and destroyed after 20 years.

Further information is available at:
www.ucl.ac.uk/legal-services/privacy
www.ucl.ac.uk/legal-services/privacy/ucl-general-privacy-notice-participants-and-researchers-health-and-care-research-studies

Who is the Sponsor for this Study?
University College London (UCL) is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and UCL will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. UCL will keep anonymised information from the study for 20 years after the study has finished. This is stored in a safe and secure off site location and access is strictly controlled.

What will happen with the results of this study?
Once the study has been completed the results will be published as a thesis as part of the academic requirements for the Doctorate in Clinical Psychology at University College London (UCL). We also hope the results will be submitted to peer review journals. Following completion of the study and write up you will be sent a short summary of the findings. Confidentiality and anonymity will be maintained, and it will not be possible to identify you from any publications.

What if I no longer want to take part in this study?
If you no longer want to take part in this study, please let the researcher know. Your participation in the study is entirely voluntary. Any data collected will be removed from the study. You do not need to give a reason for withdrawing and not taking part will in no way affect your legal rights or employment. Following circulation of the initial analysis of the data you will no longer be able to withdraw your data from the study.

Who has reviewed the study?
The study has been peer-reviewed by Dr Vaughan Bell, an Associate Professor within UCL’s Research Department of Clinical, Educational and Health Psychology.

Who is organising and funding the research?
This study is being organised and funded by University College London.

What if there is a problem?

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated by members of staff you may have experienced due to your participation in the research, the UCL complaints mechanism is available to you. Please contact the Chief Investigator, Dr Amanda Williams: [REDACTED].

In the unlikely event that you are harmed by taking part in this study, compensation may be available. If you suspect that the harm is the result of the University College London or the hospital's negligence then you may be able to claim compensation. After discussing with your research doctor, please make the claim in writing to Dr Amanda Williams who is the Chief Investigator for the research and is based at UCL (please see above). The Chief Investigator will then pass the claim to the Sponsor’s Insurers, via the Sponsor’s office. You may have to bear the costs of the legal action initially, and you should consult a lawyer about this.

You are encouraged to ask any questions about the study. Please let the researcher know if anything is not clear or if you would like any further information.

Thank you for your interest in this project. This information sheet is for you to keep.

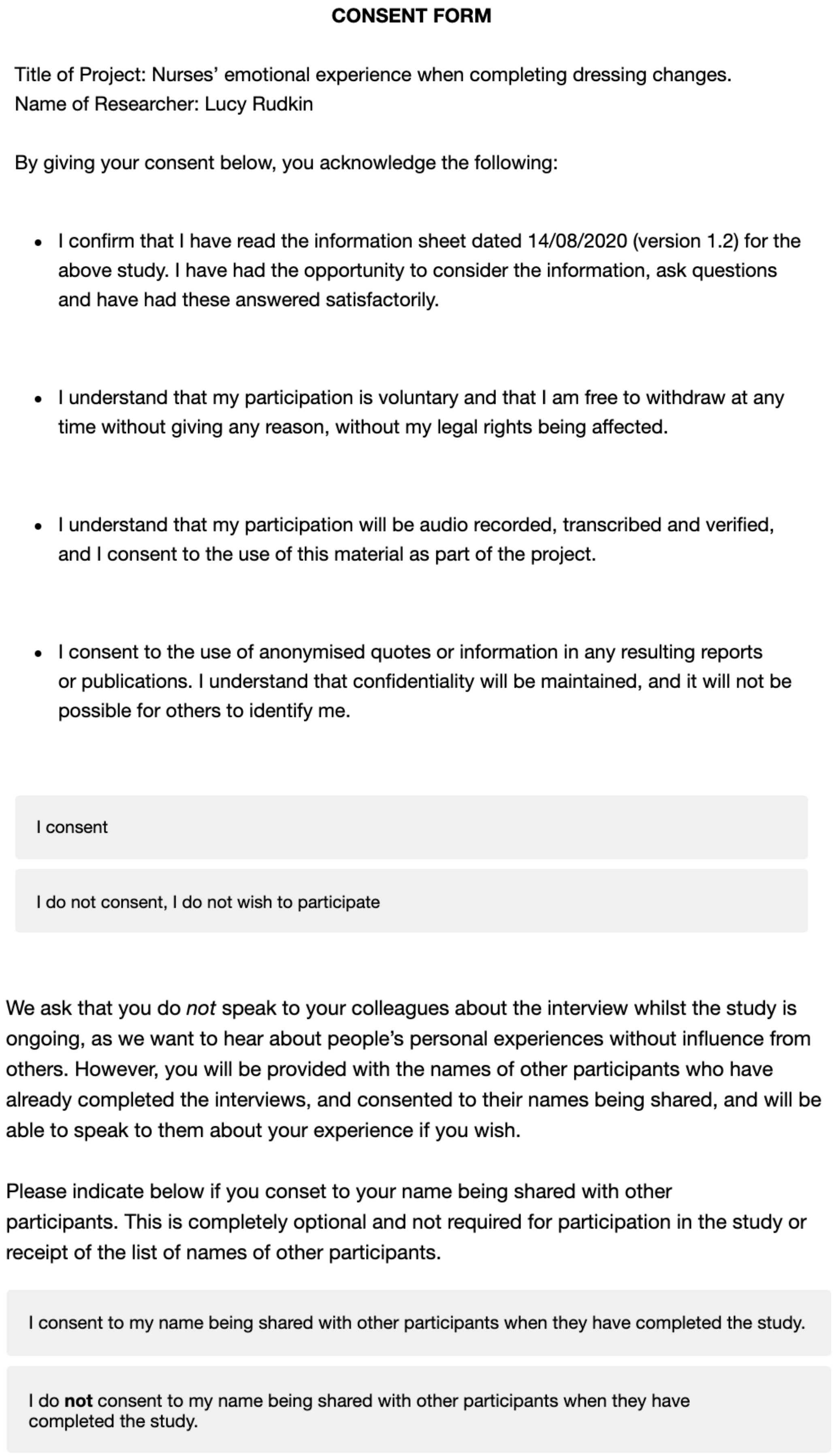
The Research Team

If you have any questions about this study please contact:

Lucy Rudkin
Student Researcher
UCL Research Department of
Clinical, Educational & Health
Psychology
1-19 Torrington Place
University College London
London WC1E 7HB
Email: [REDACTED]
Tel: [REDACTED]

Dr Amanda Williams
Chief Investigator
UCL Research Department of
Clinical, Educational & Health
Psychology
1-19 Torrington Place
University College London
London WC1E 7HB
Email: [REDACTED]
Tel: [REDACTED]

Appendix E. Online consent form.



CONSENT FORM

Title of Project: Nurses’ emotional experience when completing dressing changes.
Name of Researcher: Lucy Rudkin

By giving your consent below, you acknowledge the following:

- I confirm that I have read the information sheet dated 14/08/2020 (version 1.2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

- I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected.

- I understand that my participation will be audio recorded, transcribed and verified, and I consent to the use of this material as part of the project.

- I consent to the use of anonymised quotes or information in any resulting reports or publications. I understand that confidentiality will be maintained, and it will not be possible for others to identify me.

I consent

I do not consent, I do not wish to participate

We ask that you do *not* speak to your colleagues about the interview whilst the study is ongoing, as we want to hear about people’s personal experiences without influence from others. However, you will be provided with the names of other participants who have already completed the interviews, and consented to their names being shared, and will be able to speak to them about your experience if you wish.

Please indicate below if you conset to your name being shared with other participants. This is completely optional and not required for participation in the study or receipt of the list of names of other participants.

I consent to my name being shared with other participants when they have completed the study.

I do **not** consent to my name being shared with other participants when they have completed the study.

Appendix F. Interview schedule.

Interview Schedule

Nurses' emotional experience when completing dressing changes.

Introduction

Thank you for meeting with me today and taking part in this study.

As you may know, I used to work in the psychology team on the burns unit and therefore have some awareness of what burns dressing changes involve for both patients and nurses. I'm really interested to hear about your experience of completing dressing changes and will be asking you some questions about this during the interview. Some of the things I ask about you may not have thought or spoken about before, so feel free to take your time to think about and answer the questions. There are no right or wrong answers, I really am just interested to hear about your experience. If there is anything I don't ask, that you feel you would like to share, please do let me know. Also, just to remind you, that everything we talk about will only be shared in completely anonymised form – the only people with access to the raw data from these interviews will be me and my supervisor at UCL, Dr Amanda Williams. Nobody from the burns service will have access to the raw data, including [ward psychologist] who is my clinical supervisor.

Do you have any questions before we start?

Setting the scene

1. What makes a dressing change easier for you to do?

2. What makes a dressing change more difficult for you to do?

3. How aware are you of patients' pain during dressing changes?
   - *Do you think dressing changes are painful for patients?*
   - *How aware are you that you are causing pain by doing the dressing change?*
   - *Are there things that you look for that tell you the patient is in pain (and not saying so)?*
   - *Are there any factors that make you more aware/conscious of causing the patient pain?*

4. What do you think is most important for you to focus on during dressing changes?
   - *The technical aspects? The patient's pain? The patient's emotions/worries? Your emotions?*
   - *Where did this idea come from?*

Emotional experience

5. How do you feel when doing dressing changes?

- *How aware are you of your feelings? / Do you pay much attention to your emotions during dressing changes?*
- *What goes through your mind?*
- *What affects how you feel about doing a dressing change?*
- *Have your feelings about doing dressing changes changed over time?*
- *(If interviewee focuses on patient or technical aspects) I notice you're focusing on the patient/technical aspects rather than your feelings, is this what happens during dressing changes?*

6. Do your feelings vary with different patients?
   - *What about patients means that you feel differently?*
   - *Which patients do you find most difficult emotionally? Why?*

Emotion regulation

7. Can you describe how you manage your emotions whilst doing dressing changes?
   - *(If needed bring focus to strategies used during dressing changes, rather than after)*
   - *Are you aware of using particular strategies to manage your emotions?*
   - *Do you ever try to suppress your emotional response when doing dressing changes?*
   - *Is there a certain way that you do dressing changes that helps you to manage your emotions?*
   - *Do you think about the impact of doing dressing changes on you or the patient?*
   - *How do you explain to yourself the need to do dressing changes and the pain this may cause?*
   - *What makes it easier to use these strategies of managing your emotions?*
   - *What makes it more difficult to use these strategies of managing your emotions?*
   - *What impact does this way of managing your emotions have on you?*
   - *Do these strategies work well for you? For the patient?*

8. Do you manage your emotions differently with different patients?
   - *What about patients affects how you manage your emotions?*
   - *Is this a conscious decision?*
   - *When is it most difficult to manage your emotions?*
   - *What impact do you think the way you manage your emotions has on the patient's experience?*

9. How did you learn to manage your emotions in this way?
   - *Were you taught?*
   - *Have you always managed your emotions in the same way?*
   - *What advice would you give to a nurse just starting on the ward, doing dressing changes?*

Reflections/closing

10. Have you spoken about how you feel about this part of your job before?

- *(If no) Have you thought about these things before?*
- *How was it speaking about this with me today?*
- *Would you like to speak about this more?*
- *Do/would you speak to any colleagues about this?*

<u>Additional questions</u>

11. What's your age?

12. How many months/years have you been qualified as a nurse?

13. How many months/years have you worked on any burns unit?

That's the end of the interview. I really appreciate you sharing your experiences with me. Thank you very much for agreeing to take part. Any questions before we finish the interview?

Complete Interpersonal Reactivity Index.

Remind of support available as described on information sheet.

Appendix G. Interpersonal Reactivity Index (Davis, 1980).

INTERPERSONAL REACTIVITY INDEX

The following statements inquire about your thoughts and feelings in a variety of situations. For each item, indicate how well it describes you by choosing the appropriate letter on the scale at the top of the page: A, B, C, D, or E. When you have decided on your answer, fill in the letter on the answer sheet next to the item number. READ EACH ITEM CAREFULLY BEFORE RESPONDING. Answer as honestly as you can. Thank you.

<u>ANSWER SCALE</u>:

A	B	C	D	E
DOES NOT DESCRIBE ME WELL				DESCRIBES ME VERY WELL

1. I daydream and fantasize, with some regularity, about things that might happen to me. (FS)

2. I often have tender, concerned feelings for people less fortunate than me. (EC)

3. I sometimes find it difficult to see things from the "other guy's" point of view. (PT) (-)

4. Sometimes I don't feel very sorry for other people when they are having problems. (EC) (-)

5. I really get involved with the feelings of the characters in a novel. (FS)

6. In emergency situations, I feel apprehensive and ill-at-ease. (PD)

7. I am usually objective when I watch a movie or play, and I don't often get completely caught up in it. (FS) (-)

8. I try to look at everybody's side of a disagreement before I make a decision. (PT)

9. When I see someone being taken advantage of, I feel kind of protective towards them. (EC)

10. I sometimes feel helpless when I am in the middle of a very emotional situation. (PD)

11. I sometimes try to understand my friends better by imagining how things look from their perspective. (PT)

12. Becoming extremely involved in a good book or movie is somewhat rare for me. (FS) (-)

13. When I see someone get hurt, I tend to remain calm. (PD) (-)

14. Other people's misfortunes do not usually disturb me a great deal. (EC) (-)

15. If I'm sure I'm right about something, I don't waste much time listening to other people's arguments. (PT) (-)

16. After seeing a play or movie, I have felt as though I were one of the characters. (FS)

17. Being in a tense emotional situation scares me. (PD)

18. When I see someone being treated unfairly, I sometimes don't feel very much pity for them. (EC) (-)

19. I am usually pretty effective in dealing with emergencies. (PD) (-)

20. I am often quite touched by things that I see happen. (EC)

21. I believe that there are two sides to every question and try to look at them both. (PT)

22. I would describe myself as a pretty soft-hearted person. (EC)

23. When I watch a good movie, I can very easily put myself in the place of a leading character. (FS)

24. I tend to lose control during emergencies. (PD)

25. When I'm upset at someone, I usually try to "put myself in his shoes" for a while. (PT)

26. When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me. (FS)

27. When I see someone who badly needs help in an emergency, I go

to pieces. (PD)

28. Before criticizing somebody, I try to imagine how I would feel if I were in their place. (PT)

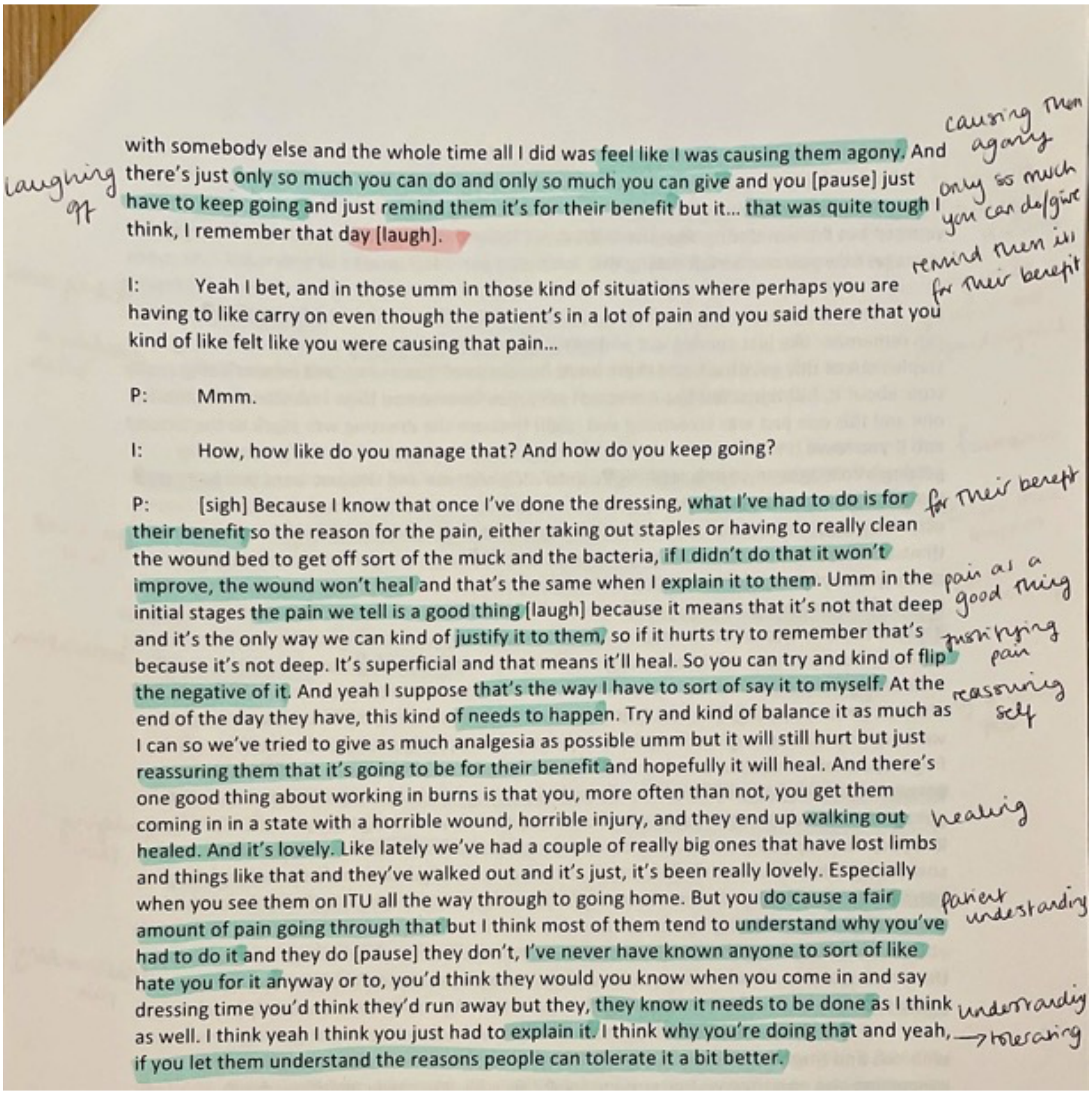
NOTE: (-) denotes item to be scored in reverse fashion
PT = perspective-taking scale
FS = fantasy scale
EC = empathic concern scale
PD = personal distress scale

A = 0
B = 1
C = 2
D = 3
E = 4

Except for reversed-scored items, which are scored:

A = 4
B = 3
C = 2
D = 1
E = 0

Appendix H. Transcript excerpt showing familiarisation with the data.



laughing off

with somebody else and the whole time all I did was feel like I was causing them agony. And there's just only so much you can do and only so much you can give and you [pause] just have to keep going and just remind them it's for their benefit but it... that was quite tough I think, I remember that day [laugh].

causing them agony

only so much you can do/give

remind them it's for their benefit

I: Yeah I bet, and in those umm in those kind of situations where perhaps you are having to like carry on even though the patient's in a lot of pain and you said there that you kind of like felt like you were causing that pain...

P: Mmm.

I: How, how like do you manage that? And how do you keep going?

P: [sigh] Because I know that once I've done the dressing, what I've had to do is for their benefit so the reason for the pain, either taking out staples or having to really clean the wound bed to get off sort of the muck and the bacteria, if I didn't do that it won't improve, the wound won't heal and that's the same when I explain it to them. Umm in the initial stages the pain we tell is a good thing [laugh] because it means that it's not that deep and it's the only way we can kind of justify it to them, so if it hurts try to remember that's because it's not deep. It's superficial and that means it'll heal. So you can try and kind of flip the negative of it. And yeah I suppose that's the way I have to sort of say it to myself. At the end of the day they have, this kind of needs to happen. Try and kind of balance it as much as I can so we've tried to give as much analgesia as possible umm but it will still hurt but just reassuring them that it's going to be for their benefit and hopefully it will heal. And there's one good thing about working in burns is that you, more often than not, you get them coming in in a state with a horrible wound, horrible injury, and they end up walking out healed. And it's lovely. Like lately we've had a couple of really big ones that have lost limbs and things like that and they've walked out and it's just, it's been really lovely. Especially when you see them on ITU all the way through to going home. But you do cause a fair amount of pain going through that but I think most of them tend to understand why you've had to do it and they do [pause] they don't, I've never have known anyone to sort of like hate you for it anyway or to, you'd think they would you know when you come in and say dressing time you'd think they'd run away but they, they know it needs to be done as I think as well. I think yeah I think you just had to explain it. I think why you're doing that and yeah, if you let them understand the reasons people can tolerate it a bit better.

for their benefit

pain as a good thing

justifying pain

reasoning self

healing

patient understanding

understanding → tolerating

Appendix I. Transcript excerpt showing generation of initial codes.

I = Interviewer P = Participant

Text	Initial codes
I: Yeah. And you mentioned umm when I asked about what makes dressing changes easier to do, you mentioned that if the patient's in a lot of pain that's something that can make it more difficult?	
P: Yeah. I mean there have been like situations where, I mean it's not always a smooth ride. Umm and because their, say for example, in pain because they've come in and maybe they haven't required an analgesia the previous time but they have this time and [pause] that can be difficult because you're having to be like ok I don't have them admitted, I don't have any analgesia prescribed, I need to umm be quick now in trying to keep them as calm as possible and like relaxed but also knowing that like 10 seconds to them is also… 10 seconds to me is like 10 minutes to them, because obviously they're in pain, it's getting worse, people just want things quick. Umm. But sometimes I suppose, but you can utilise distraction techniques and like just covering the wound and just stop what you're doing umm and just I suppose talking to them, sometimes, again it's helpful, when you were saying what makes it easier, it's like if you're doing the dressing with somebody else because you can be like ok you stay with the patient, I'll go and do this, and you more or less know what you can, what you can give quite quickly. Umm. And it, but it just happens that you know, it's like if your doctor's busy and those things happen but I suppose when that happens, it's just, I find it useful just like saying to the patient this is going to take like I dunno 20 minutes, I mean it, and I always tell them sometimes longer than it is because at least then that anticipation because if you're, if you don't deliver something, they'll think you're useless, they'll think that you don't know what you're doing and like it's your fault, even though it's like the domino effect. It's just like you're the first person like in the firing line I suppose, sometimes.	Not tolerating pain well Access to analgesia Distracting the patient Talking with the patient Working in a team Wanting the patient to be happy Want to look confident and competent
I: Mmm. And what's it like for you during those more difficult dressing changes?	
P: Stressful because like I'm like the one in charge so I need to be able to like, ok this is what we need to do, umm, and just delegate so give other	Feeling stressed

people, like just like give jobs so you can achieve so many things at the same amount of time, rather than doing one thing and having to do the next thing. So just teamwork I suppose.	Handing over to colleagues Working in a team
I: Mmm. And the… Sorry what was that?	
P: And just like supporting your colleagues.	
I: Mmm. Yeah, you've mentioned colleagues quite a few times. Umm. And is there any other things that come to mind that can make a dressing change feel more difficult for you?	
P: Umm. [pause] Umm. Probably workload. If you've got like a lot of dressings to do. Particularly inpatients, because sometimes there's an expectation that you know you've got to get all of your dressings down for your doctors to see because if you don't then they're going to be off in theatre and have other clinical umm like duties to do. And then it just means that if you don't do your dressings in the morning, then you have your outpatients coming and then you're having to squeeze is in between like physio or whatever that patient may have in that time. So sometimes it's like multiple dressing changes and then you don't feel that you can give like, you can't take your time with it because you are rushed. Umm. Not that you're doing a bad job, but it's just sometimes that when you like take your time doing a dressing, not because, most of the time, not because you should take time, but as in like you could do a dressing quite efficiently and do it right, but sometimes you can do it slower because you're talking to the patient. Some people like that interaction. Umm. But other people, other patients, just like they just like want to get it over and done with because they don't enjoy it and they want to go back to their breakfast or have a cup of tea. You know whatever may be. Whereas some people's like perception might be well like if you take a good hour and half at it, it means it's a good job even though it's a small burn and you could do it in 10, 20 minutes. And I just find that when you're, when you've got a lot of dressings to do umm that's something that really can just add an additional burden on you, on your mind, I suppose.	Meeting expectations Time pressures Rushing Getting it over and done with Doing it right or well (a good job)

Appendix J. Preliminary organisation of codes.

Themes	Subthemes	Codes
Nurse experience	Hard for nurses too	Difficult for us; Don’t have it under control; Patient reacting unexpectedly; Feeling frustrated; Feeling stressed; Feeling anxious; Causing pain; Not tolerating pain well (hard for the nurses); Physically hard work; It makes me upset as well; Exhausted at the end of the day; This is too much; Nature of the burn; Feeling scared of patients; Story that goes with the burn is the hardest; Pain’s a big issues; Previous bad dressing experiences for the patient; Feeling uncomfortable
	Multiple demands	Time pressures; Rushing; Other demands (being pulled everywhere); Have to just assume everyone’s alright
	Burns are special	Special burns patients; Burns is a specialist area; ‘Mad, bad or sad’ (patients); Nurse willingness to deal with difficult things; Psychological concerns (about patients); Never get bored; Enjoy work; Adrenaline
Expectations	Here to help	Want to make patients happy/better; Makes us feel powerless (not being able to help); Offering practical help; Not here to judge

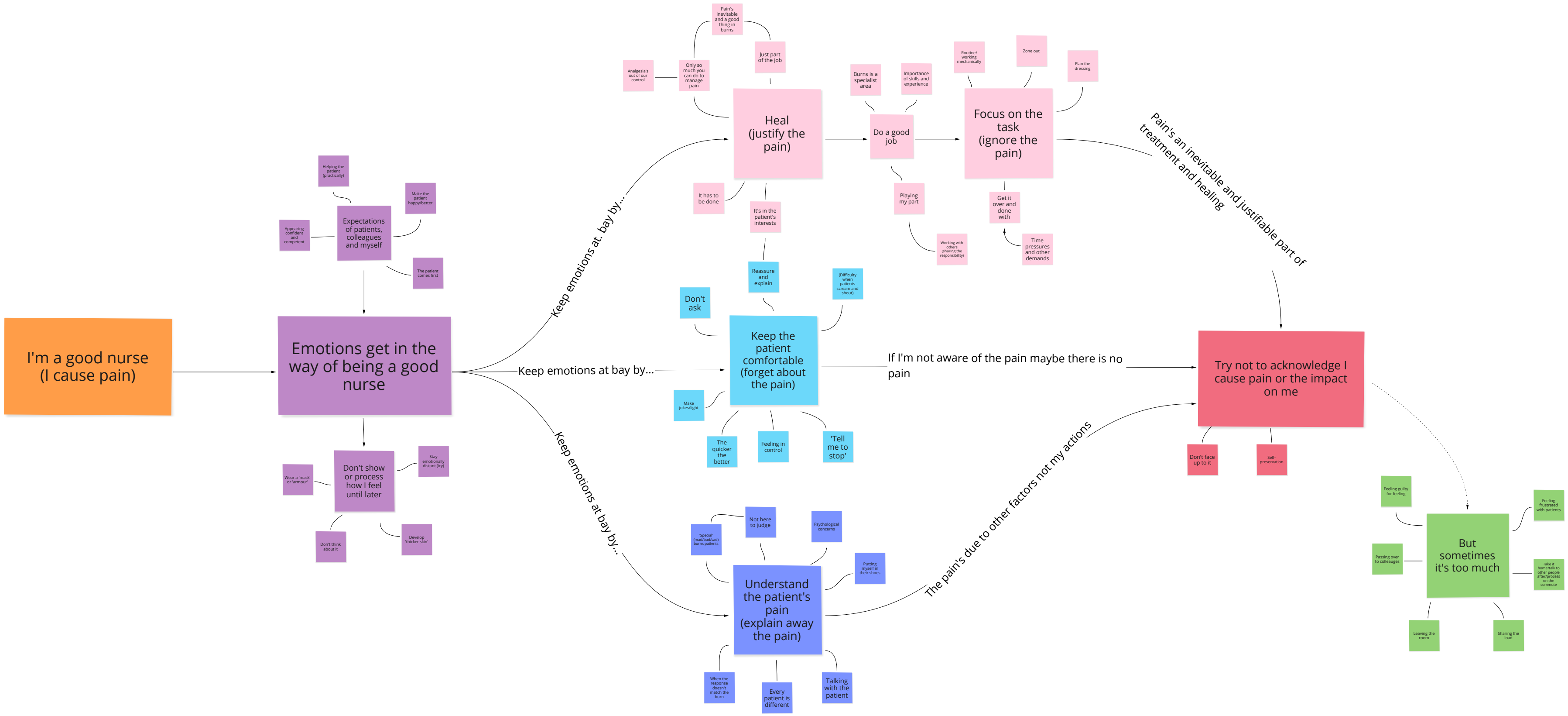
A confident and competent nurse	In good/safe hands; Importance of skills and experience; Look confident/competent; Appearing reliable; Pride in efficiency; Having the right knowledge; Being kind and caring; Learning with experience; Feeling incapable/incompetent
Shouldn’t feel how I feel	Get used to it/thicker skin; Don’t let things bother me; I don’t carry it; Is it just me?; Feeling guilty (for feeling); So finding it hard is normal; Working with junior staff (reminds you); Finding the balance (check yourself); Finding things hard makes you human
Shouldn’t show how I feel	Try my best not to show it; Professionals shouldn’t feel/show certain feelings; Shouldn’t be showing my emotions like this; Try to be cheerful; Meeting expectations; Patient expectations
It’s not about me	Don’t think about me; Here for the patient; Prioritising the work
Emotions get in the way so put them aside	Your feelings aren’t’ going to help them; Managing your emotions to manage the patient’s; Emotions get in the way; Putting emotions aside; Overriding feelings; Talk about it, then get on with it
Dealing with emotions away from the patient	Taking it home; Talking to someone who

		understands; Takin git out on colleagues; Feelings catching up with me; Talking to someone impartial; Processing on the commute
Understanding the patient and their pain	Connecting with the patient	Talking with the patient; Forming bonds with the patient; Getting to know each other; Good opportunity for patients to open up; Trust; Noticing pain expressions; Every patient is different; Getting involved in patients' lives
	Empathising with the patient	In the patient's shoes; Pain can change the patient; The patient is a person; Not feeling what they're feeling; Just have to be understanding; Don't take it personally
Justifying the pain	Got to make it worth it	Doing a good job; Just try my best; Doing my best; I hope it works
	Doing it for a reason	Seeing patients heal; Reassuring yourself; Explaining to the patient; Doing it for a reason; Patient appreciation; It has to be done; Talk to the patient and myself; Just here to help; Just my job
	Sharing the responsibility	Shared responsibility; Talking to colleagues; Never on your own; Supportive team; Working in a team; Feeling supported; Asking for help; Tell me to stop

	Reframing	Thinking about it differently; Pain’s a good thing in burns; Patient’s overreacting to pain; The burn’s not that bad; Only so much we can do; Nothing else I can do; Don’t panic
Distancing/avoiding	A comfortable patient makes it easier for both of us	Cooperative (good) patient; Access to analgesia; Easier for both of us; Distracting the patient; Pain’s an inconvenience; Reassuring the patient; Please stop screaming/shouting; Techniques to manage pain; Patient collaboration; Persuading/negotiating with the patient; Comfortable patient; Encouraging the patient; Harder for both of us
	Getting away from the pain (through action)	Handing over to other colleagues; Leaving the room; Stopping if the pain is too much
	Get it over and done with	Get it over and done with; Just keep going
	Don’t think about it	Don’t ask; Don’t think about it; Don’t face up to realities; Things you don’t want to face up to; Easier if I don’t have to think about pain
	Keep your (emotional) distance	Keeping distance; Wearing a ‘mask’/’armour’; Making jokes; ‘Guess the burn’; Being an abrupt/icy nurse

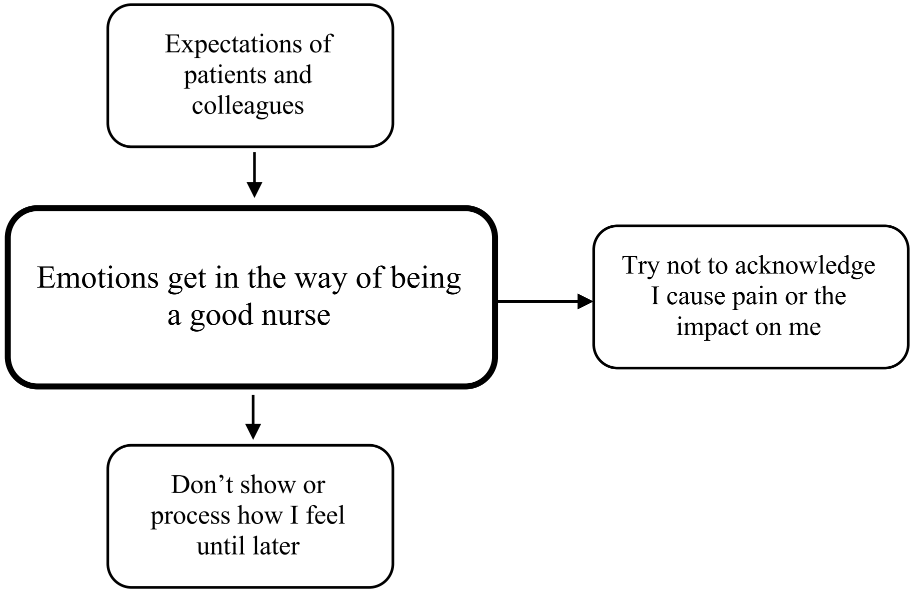
	Task focused	Focusing on the task; Zoning out; Working mechanically; Leaving the outside world; Using your hands
Taking control of what you can		Planning the dressing change; Routine and predictability; Keep saying the same thing; One step at a time; Labelling patients
Process observations		Avoiding talking about feelings; Censoring language; Denying pain; Remembering patients; Seeming too hard to say

Appendix K. Preliminary thematic map (before reviewer comments).


I'm a good nurse (I cause pain)
Emotions get in the way of being a good nurse
Expectations of patients, colleagues and myself
Helping the patient (practically)
Make the patient happy/better
Appearing confident and competent
The patient comes first
Don't show or process how I feel until later
Wear a 'mask' or 'armour'
Stay emotionally distant (icy)
Don't think about it
Develop 'thicker skin'
Keep emotions at. bay by...
Keep emotions at bay by...
Keep emotions at bay by...
Heal (justify the pain)
Pain's inevitable and a good thing in burns
Analgesia's out of our control
Only so much you can do to manage pain
Just part of the job
It has to be done
It's in the patient's interests
Do a good job
Burns is a specialist area
Importance of skills and experience
Playing my part
Working with others (sharing the responsibility)
Focus on the task (ignore the pain)
Routine/ working mechanically
Zone out
Plan the dressing
Get it over and done with
Time pressures and other demands
Keep the patient comfortable (forget about the pain)
Reassure and explain
(Difficulty when patients scream and shout)
Don't ask
Make jokes/light
The quicker the better
Feeling in control
'Tell me to stop'
Understand the patient's pain (explain away the pain)
Not here to judge
'Special' (mad/bad/sad) burns patients
Psychological concerns
Putting myself in their shoes
When the response doesn't match the burn
Every patient is different
Talking with the patient
Pain's an inevitable and justifiable part of treatment and healing
If I'm not aware of the pain maybe there is no pain
The pain's due to other factors not my actions
Try not to acknowledge I cause pain or the impact on me
Don't face up to it
Self-preservation
But sometimes it's too much
Feeling guilty for feeling
Feeling frustrated with patients
Passing over to colleauges
Take it home/talk to other people after/process on the commute
Leaving the room
Sharing the load

Appendix L. Theme definitions and structure.

THEME 1: Emotions get in the way of being a good nurse	
This theme describes nurses' views about their own emotions and how they should be managed.	
Expectations of patients, colleagues and myself	*This theme describes the nurses' thoughts about what makes a 'good nurse' and the expectations that come with this, in particular putting the patient first and appearing confident and competent.*
Don't show or process how I feel until later	*This theme speaks specifically about how nurses feel they should manage their emotions, by keeping their distance so that emotions are dealt with later.* *Key: This describes the ways that nurses manage their emotions generally, in vague terms (e.g. keeping emotional distance, wearing a mask and not thinking about it) with little detail about how this is done.*
Try not to acknowledge I cause pain or the impact on me	*The theme covers nurses' reports of trying not to think about what they do, including causing pain, and their emotions as an act of self-preservation.*



<table>
<tr><th colspan="2">THEME 2: Pain's an inevitable and justifiable part of treatment and healing</th></tr>
<tr><td colspan="2"><i>This theme describes the ways that nurses justify causing patients pain during dressing changes and the importance of doing a ‘good job’ and healing for these justifications to feel valid.</i></td></tr>
<tr><td>Heal to justify the pain</td><td><i>This theme speaks to the nurses’ beliefs about the importance of healing and that completing the dressing change is in the patient’s best interests. It also covers the inevitability of pain during treatment and healing and nurses’ perceived lack of agency regarding pain control.</i></td></tr>
<tr><td>The importance of doing a good job</td><td><i>This theme includes nurses’ beliefs about what makes a good job and their beliefs regarding the importance of this.</i></td></tr>
<tr><td>Focus on the task</td><td><i>The theme describes the ways that nurses focus on the practical tasks involved in a dressing change, including zoning out and taking control by planning the dressing.</i></td></tr>
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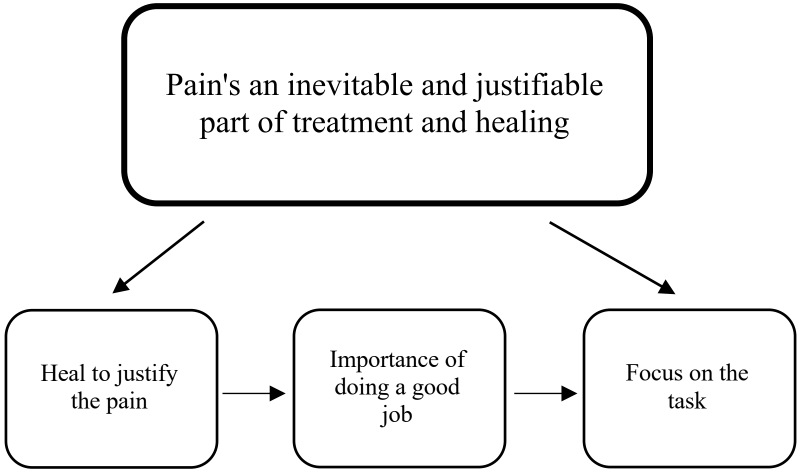
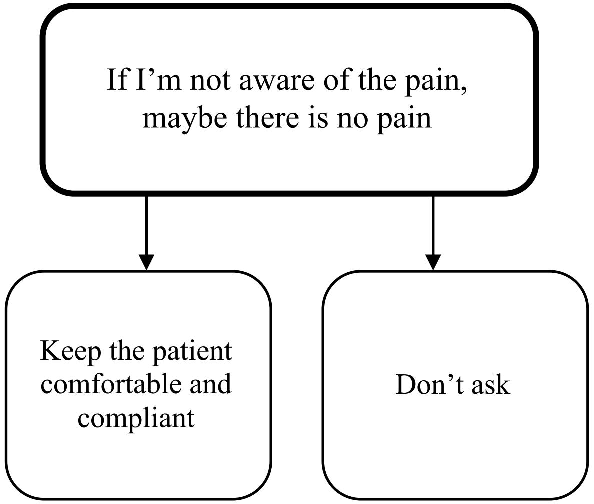
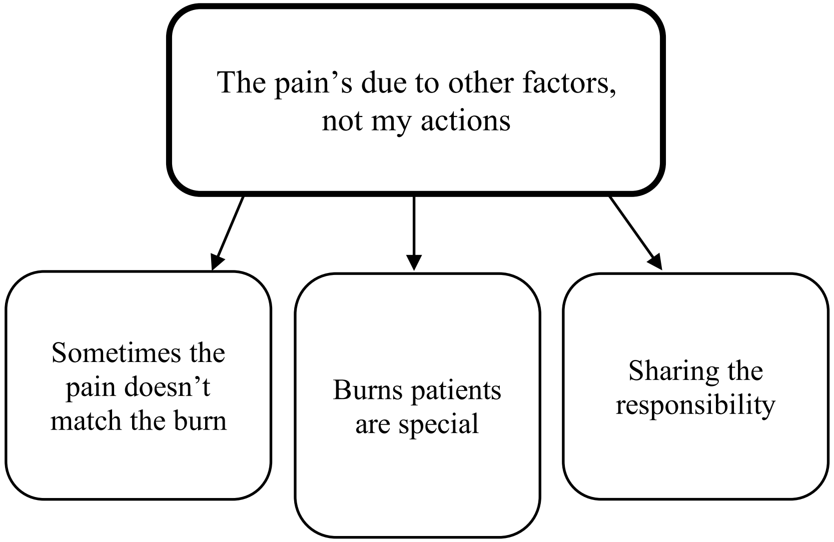


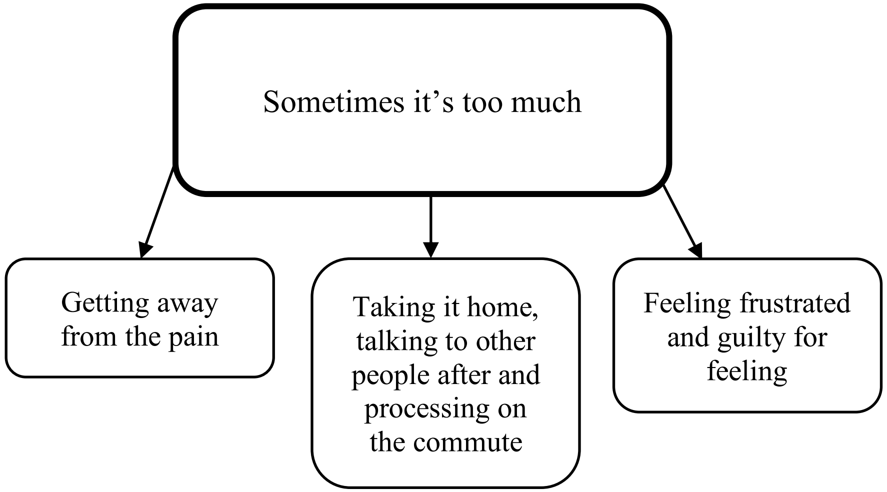
THEME 3: If I'm not made aware of the pain, maybe there is no pain	
This theme describes the way that nurses may try to forget about the pain by either pretending it's not there or mitigating it. It also includes examples of when nurses are made aware of the pain (i.e. if patients scream or flinch) and how difficult they find this.	
Keep the patient comfortable and compliant	*This theme describes the ways that the nurses try to keep the patient comfortable and compliant (and therefore reduce expressions/reminders of pain) by reassuring them, explaining what's happening and creating a light-hearted atmosphere by making jokes.*
Don't ask	*This theme describes the ways that the nurses avoid being aware of the patient's pain by not asking them about it or giving the patient the responsibility; for example, by telling the patient to tell them when to stop.*



THEME 4: The pain’s due to other factors, not my actions	
This theme describes the ways that nurses try to understand and explain patient’s pain, releasing themselves from the responsibility of causing pain.	
Sometimes the pain doesn’t match the burn	*This theme describes the ideas that nurses have about pain in burns, in particular their perceived knowledge about how much pain a dressing change causes. It also covers the nurses’ perceptions of the importance of getting to know patients and empathising with their experience and expression of pain.*
Burns patients are special	*This theme describes nurses’ descriptions of the uniqueness and ‘special’ nature of burns patients and the prevalence of psychological difficulties, which they believe contributes to the experience of pain.*
Sharing the responsibility	*This theme covers nurses’ reports about the supportiveness of the burns team and how the team’s backing means that they feel the responsibility for their actions is shared. It also includes the ways that nurses share the responsibility for pain with the patient, e.g., by asking the patient to tell them when to stop.*



THEME 5: Sometimes it’s too much	
This theme describes the times when nurses no longer feel able to avoid or justify the pain they are causing and/or how emotions that have been avoided in the moment are managed after the dressing change.	
Getting away from the pain	*This theme describes the ways that nurses may escape from the pain, perhaps when the coping strategies above haven’t worked, through practical steps such as leaving the room or passing over to colleagues. It also includes nurses’ thoughts about the importance of working in a team and being able to rely on colleagues to hand over to and share responsibility.*
Coping and processing after it’s done	*This theme describes the ways that nurses cope with their thoughts and feelings about a dressing change after it has happened by taking it home, talking to other people after and processing on the commute.*
Feeling frustrated and guilty for feeling	*This theme describes the frustration that nurses can feel when patients aren’t compliant or the dressing doesn’t go to plan, but also the guilt that nurses can experience when they have these (and other) feelings.*



Appendix M. Theme summary shared with participants for feedback.

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AN EXPLORATION OF HOW NURSES REGULATE THEIR EMOTIONS WHILST COMPLETING BURNS DRESSING CHANGES

Thank you for taking part in this research. The aim of the study is to explore how burns nurses manage their own emotions during dressing changes; it is not judging the effectiveness or helpfulness of these strategies. Rather, it is assumed that a burns dressing change is a challenging task and that nurses will therefore have developed strategies to manage this.

This document is a short summary of the initial analysis of the interviews. I used thematic analysis, which identifies patterns (themes) within the data (interviews). The themes identified were:

THEME 1: Emotions get in the way of being a 'good' nurse
What it means to be a 'good' nurse came up in many of the interviews, and it appeared important for participants to communicate that they themselves are a 'good' nurse. It was harder to talk about causing patients' pain, and some spoke about not facing up to this part of the role as an act of self-preservation. This led me to believe that being a nurse who causes pain is seen as in conflict with being a 'good' nurse.

Participants talked about how patients, colleagues and they themselves expect nurses to put the patient first, make the patient better and/or happy, help the patient, and appear confident and competent. In order to do these things, participants felt they could not show or process how they felt until they were away from the patient – emotions were seen as getting in the way. Staying emotionally distant, wearing a 'mask' or 'armour', developing a 'thick skin', and not thinking about things, were all spoken about as ways of not showing or experiencing emotions.

THEME 2: Pain is an inevitable and justifiable part of treatment and healing
The inevitability of pain was spoken about by some participants. Nurses could feel that they had limited options for pain relief, particularly when not on the ward. Emphasis was placed on pain being a justifiable part of treatment if the outcome is healing; so healing was seen as an integral, but also rewarding, part of the job. Participants consequently spoke about the importance of doing a 'good' job, which was often equated with having skills and experience leading to a technically well executed dressing change and promoting healing. To achieve this, participants shared that they focus on the practical tasks in a dressing change, ensuring it is planned and zoning out when needed. Focusing on the practical tasks not only made sure that nurses were helping patients to heal (and therefore justified the pain they were causing), but also distanced them from the emotional side of a dressing change.

In addition to the justification of healing, participants also spoke about sharing responsibility between nurses and the MDT. Participants knew they had the support and backing of the wider burns team for their actions, as part of the treatment plan, and that the responsibility of any pain or distress caused was therefore shared.

THEME 3: If I'm not made aware of the pain, maybe there is no pain

This theme describes the ways that the participants were able, to some extent, to forget about the pain they were causing. Participants talked about finding patients challenging when they expressed pain, for example those who screamed or flinched. Expressions of pain reminded nurses of the pain they were causing, and they spoke about how 'horrible' this could be. Participants shared that they try to ensure that patients are comfortable, by reassuring them or making jokes. They spoke about how a comfortable patient is usually more compliant, which makes it easier for them to do a technically good dressing change. Keeping the patient comfortable also reduced the reminders of the pain being caused and participants talked about not always asking patients about their pain. By requesting that patients let them know if the pain is too much or they want the nurse to stop, the nurses were able to further distance themselves from the pain they were causing, as the responsibility was on the patient to manage this.

THEME 4: The pain's due to other factors, not my actions

Participants spoke thoughtfully about all the different factors contributing to a patient's pain. By trying to understand and explain the patient's pain, nurses may release themselves from the responsibility of causing the pain. There was a sense from participants of knowing how much pain a dressing change causes and that sometimes the pain expressed by patients 'does not match the burn'. Importance was placed on getting to know patients to help with understanding and empathising with their experience and expression of pain. Participants also spoke about burns patients as a group often being 'special', given their often complex circumstances and presentations. Almost all participants recalled memories of particularly difficult dressing changes, where patients had found it difficult to comply or expressed high levels of pain, and participants appeared to focus on empathically understanding this experience rather than their role in causing the pain.

THEME 5: Sometimes it's too much

Although many participants spoke about how much they enjoy burns nursing, they also shared that there are difficult times. Leaving the room, 'getting it over and done with', or passing the dressing change over to other nurses were mentioned as ways of escaping from the patient's pain, perhaps when avoiding it or justifying it was no longer possible. Participants talked about how much they valued having colleagues that they felt able to hand over to and that understood if they needed to take a moment away from the patient. Similarly, participants appeared to value having colleagues that they could talk to after a dressing change, to offload and seek support. However, participants also spoke about taking their feelings home with them and processing them on the commute or once they arrived home, by talking to friends and family or having a glass of wine. When participants described the times they did experience emotions whilst completing dressing changes, they also expressed guilt for having these feelings. The emotion mentioned most was frustration as a result of the patient not complying or the dressing change not going as planned. In these moments it may be much harder for a nurse to feel like a 'good' nurse and to therefore avoid and/or justify the pain they are causing.