Let’s talk about stress: Community child health nurses experiences of stress in whānau engagements

Anne Hodren

A Thesis Submitted to Auckland University of Technology in Partial Fulfilment of the Requirement for the Degree of Doctor of Health Science (DHSc)

2025

Abstract

Background

While stress is considered a normal part of daily life community child health nurses are often experiencing multiple complex stressors as part of their care of whānau. While community child health nursing is undoubtedly valued and highly skilled work, the very nature of this work inevitably exposes community child health nurses to multiple psychologically demanding challenges and stressors that could significantly impact on the nurse’s wellbeing, and their capacity to engage with, and be attuned to, whānau. While there is some evidence that explores and describes the impact of stress in general and in nursing, little is known about how community child health nurses in Aotearoa New Zealand experience stress when engaging with whānau and how this affects their capacity to be attuned to the whānau they are supporting.

Objective

This study aimed to explore community child health nurses’ experiences of, and perspectives on, self-regulation and attunement in times of stress when working with whānau. Two research questions were posed; firstly, *how do Aotearoa New Zealand Community Child Health nurses describe the relationship between stress and the capacity to self-regulate their stress response when engaging with whānau?* and secondly, *how do Aotearoa New Zealand Community Child Health nurses describe the influence of stress on attunement, the capacity to build trust, and their ability to reflect on whānau relationships?* Using interpretive descriptive methodology, this qualitative study was undertaken in two phases, with phase one being a vignette-based survey with 26 community child health nurse participants, and phase two being a semi-structured interview with 10 community child health nurse participants.

Findings

Unique to this study was the rich description of the experience and impact of stress by Aotearoa New Zealand community child health nurse participants when engaging with whānau; a relatively unexplored area of nursing practice in the literature, especially as the study focused solely on exploring the impact of stress within engagement with whānau and describing what the experience is genuinely like for the nurses. The findings provide a unique picture of the complexity the nurse participants faced in navigating whānau relationships, while simultaneously being in a state of stress, which, at times, made it difficult for the nurses to recognise their own stress, and hindered their capacity to make sound decisions, while also remaining attuned and professional. The findings revealed the individual nurse’s experience of stress to be unique, complex, and unpredictable, and shaped by context, as the nurse participants strived to establish and maintain therapeutic relationships with whānau, while managing their own stress responses. The resulting impact on nurses and whānau relationships requires urgent attention to reduce the negative impact of stress on community child health nurses, and improve knowledge, resourcing, and supports to ensure safe and quality care.

Conclusions

The significance of the study findings lies in the 'laying bare' of the nurse participants' experiences of the pervasive nature of stress, and its profound impact on both the nurses themselves, and their care of whānau. Attention needs to be drawn urgently to the consequences of stress on community child health nurses, so that the quality and continuity of care in community child health nursing is not compromised. The normalisation and acceptance of stress within the nursing profession has served to further entrench stress as an inevitable part of nursing practice, thereby limiting opportunities for personal, professional and systemic change. As a key outcome of the study, a multipronged approach is proposed that buffers and ameliorates the negative impacts of stress, lifting the sole responsibility for managing stress off the shoulders of nurses and redistributing it across employers, government, education, and other institutions within the Aotearoa New Zealand context. When managing stress is everyone's responsibility, there is a greater chance of change.

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor used artificial intelligence tools or generative artificial intelligence tools (unless it is clearly stated, and referenced, along with the purpose of use), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed

02 June 2025

Acknowledgements

I would like to express my gratitude to all the participants of this study for their invaluable contributions, willingness to share their experiences and passion for their roles in supporting whānau in their joys and struggles. Your stories and experiences hold a special place in my heart.

I extend my heartfelt thanks to my wonderful supervisors, Dr. Ellen Nicholson and Dr. Julie Blamires, for your unwavering support and guidance. Your advice, dedication and constant encouragement is truly appreciated. Every step of the way you have been there for me.

I want to thank my amazing colleagues, friends, and whānau, who played such an important role in this journey, I am so grateful for your support. Heartfelt thanks to Whānau Āwhina Plunket for enabling me to undertake this study, especially to the wonderful team I work. Katrina thanks for leading the way to and through Doctoral studies.

I am so grateful to Agnes, Tracy and Julie for taking the time to provide me with valuable feedback on my drafts and encouragement to keep going.

Most importantly, I wish to acknowledge my whānau for their endless love and support. Thank you, John, for your constant encouragement, love, and for all the meals and cups of tea, as well as for your understanding while I dedicated time to my studies. To Nikki, Sanjay, Andy and Laura, your love and belief in me throughout this process has meant the world, as well as your advice and encouragement along the way. Lastly, to my parents, Molly and Duncan, for their love and guidance through life and shaping who I am today.

Table of Contents

Abstract i

Attestation of Authorship iii

Acknowledgements iv

List of Tables ix

List of Figures ix

Chapter One: Introduction 1

- Introducing the Study 1
- Introducing the Participants 3
- The Aotearoa New Zealand Tamariki Health Context 4
- Nursing Stress and the Stress Response 6
- Positionality of the Researcher 8
- Structure of the Thesis 10
- Chapter Summary 11

Chapter Two: Literature Review 12

- Search Strategy 12
  - Database Search 12
- Part One: Health Professionals and Regulation of the Stress Response 14
  - The Impact of Stress on Health Professionals 14
  - The Regulation of Stress 15
  - Individuals’ Unique Attributes Impact on Stress and Regulation 17
  - Stress Regulation Strategies Use by Health Professionals 19
- Part Two: The Impact of Stress on Health Professionals’ Attunement and Relational Care 22
  - Attunement in Health Professional Practice 22
  - The Impact of Stress on Attunement and Relational Care 23
  - Stress Regulation Strategies and Attunement 24
  - Self-Awareness and Attunement 25
  - Nurses Capacity to Mentalise Whānau Mental States 25
  - The Impact of Whānau Stressors and Attachment on Relationships 26
  - The Aotearoa New Zealand Context of Attunement and Relational Practice 27
- Strengths and Gaps in the Literature 28
- Chapter Summary 30

Chapter Three: Methodology 31

- Interpretive Description (ID) 31
- Foundational Underpinnings of Interpretive Description (ID) 32

Interpretive Description and Nursing 34

Acknowledging the Limitations of Interpretive Description 34

Scaffolding the Study 35

Reviewing the Literature 35

Locating the Researcher in the Study 35

Evaluation Criteria 41

Epistemological Integrity 41

Representative Credibility 42

Analytic Logic 42

Interpretive Authority 42

Beyond Evaluation 43

Chapter Summary 44

Chapter Four: Methods Chapter 45

Design of the Study 45

The Study Proposal 45

Development of the Research Questions 46

Data Collection 46

Phase One: Vignettes with Reflective Questions 47

Phase Two: Semi-Structured Interviews 48

Ethics 49

Selection of Data Capture Tool 51

Sampling 51

Inclusion and Exclusion Criteria 52

Sample Size 53

Recruitment 53

Phase One Recruitment (Vignettes) 54

Phase Two Recruitment (Semi-Structured Interviews) 54

The Participants 55

Vignette Participants 55

Semi-Structured Interview Participants 55

Collection of the Data 56

Participation in the Vignette Questionnaire 56

Participation in the Semi-Structured Interviews 56

Storage and Privacy of Data 58

Data Management 58

Transcription 58

Data Analysis 58

Familiarisation with the Data 59

Coding 60

Generation of Tentative Protype Themes 61

Developing and Reviewing Themes 62

Final Themes Defined and Named 62

Report Writing 62

Reflexivity During the Process 63

Chapter Summary 63

Chapter Five: Findings (Identifying Themes and Theme One) 64

The Weaving of the Data Throughout Two Themes 64

Theme One: CCH Nurses' Experience of Stress in Whānau Engagements is Unique, Multifaceted, and Shaped by Context 65

1.1 Who the CCH Nurse is Matters 66

1.2 Stressors are Unique, Varied, and Multifaceted 74

1.3: Stress Does not Happen in Isolation, it is Shaped by Context 78

Chapter Summary 84

Chapter Six: Findings (Theme Two) 86

Theme Two: The Impact of CCH Nurses' Stress on Attunement and Whānau Relationships Requires Attention 87

2.1: Stress has a Negative Impact on CCH Nurses and their Relationships 87

2.2: Navigating stress demands both self-regulation and engagement focused strategies. 93

2.3 Others Play a Critical Role After Whānau Engagement 107

Chapter Summary 109

Chapter Seven: Discussion 111

Summary of Findings 111

Stress is Pervasive and Impacts Heavily on the Nurse 113

Negative Stress Very Likely Impacts on Attunement, Whānau Engagement, and Providing Quality of Care 118

The Problematic Normalisation of Stress in Nursing 121

Recommendations 124

Destigmatise and Shifting the Narrative of Stress 125

Emphasising Wellbeing 125

Improving Communication and Education 127

Being Proactive and Make Resources Available 128

Building Trustworthy Mechanisms 128

Why Action Matters 129

Limitations of the Research 130

- Recommendations for Further Research 130
- Conclusion 131

References 133

Appendices 149

- Appendix A. Vignette Scenario Questionnaire 149
- Appendix B Semi-Structured Interview Questions 151
- Appendix C Ethics Approval Letter 153
- Appendix D Vignette Information Sheet 154
- Appendix E Information Sheet Phase Two 158
- Appendix F Consent Form Semi Structured Interview 162
- Appendix G Networking Diagram. Researchers Relationship with Potential Participants 164
- Appendix H Invitation to Participate in the Study 165
- Appendix I Reflective Journal 166
- Appendix J Photos of Themes development 167

List of Tables

Table 1 - Participant Ethnicity for Vignettes 55
Table 2 - Years of Nursing Service 55
Table 3 - Years in CCH Nursing Practice 55
Table 4 - Interview Participants Years in CCH Practice 56

List of Figures

Figure 1 - Findings Themes and Subthemes (Theme One) 65
Figure 2 - Findings Themes and Subthemes (Theme Two) 86

Chapter One: Introduction

Stress is a recognised part of life, with many daily situations causing some level of stress response (Lazarus & Folkman, 1984). Low levels of stress can usually be regulated quickly but when faced with multiple stressors, such as in nursing, stress can be intense, enduring, and difficult to regulate (Babapour et al., 2022; Glawing et al., 2023; O'Connor, 2019; Rushton & Boston-Leary, 2022). Nurses are frequently managing multiple stressors that are innate when working in human relationships. Experiencing high levels of stress can have negative short and long-term effects on nurses' wellbeing, their professional and personal life, and their relationships (Babapour et al., 2022; Blanco-Donoso et al., 2019; Jackson-Koku & Grime, 2019; Lascelles et al., 2024; Salvarani et al., 2019; Sandstrom et al., 2020; West et al., 2018). It is therefore crucial for nurses, their employers, governing bodies, government, and society to develop clearer understanding of the stressors nurses encounter and how they respond to stress, and to identify effective strategies for nurses and nursing to reduce stressors and manage stress (Babapour et al., 2022; Rushton & Boston-Leary, 2022). Community Child Health (CCH) nurses, in particular, have an important role caring for whānau[1] to meet the health and developmental needs of tamariki[2], so tamariki can grow to their fullest potential (NZNO College of Child and Youth Nurses, 2024). While community nursing can be a satisfying and rewarding area of nursing practice, at times the role is also known to be both challenging and stressful (Sandstrom et al., 2020).

This opening chapter introduces to the thesis, including the aims of the study, the research questions, and the selected methodology. The context of CCH nurses' practice, tamariki health needs and the rationale for the study in the Aotearoa New Zealand context is discussed, followed by a definition of stress and stress responses. My position as the researcher is explored in the context of this study and the chapter concludes with an overview of the structure of the thesis.

Introducing the Study

CCH nurses are in the unique position of being an essential agent to action the Aotearoa New Zealand government's (Minister of Health, 2023) goal to improve health outcomes for tamariki and their whānau (NZNO College of Child and Youth Nurses, 2024). As whānau navigate meeting the health needs of their tamariki, they seek empathy, validation, answers to questions, and support from the healthcare professionals that provide care to them (Hornsey et al., 2024). CCH nurses are part of the healthcare services that provide this care. CCH nurses work in partnership with whānau and tamariki through holistic practice shaped by whānau values, culture, worldview, beliefs and caregiving practices (Doane & Varcoe, 2015; NZNO College of Child and Youth Nurses, 2024). CCH nurses are required to hold multiple considerations in their minds, balancing the holistic needs of tamariki and whānau whilst navigating the sociopolitical influences on whānau health. While the role of CCH nurses to provide care of whānau and tamariki is undoubtedly important and highly skilled work, the very nature of this work also includes nurses inevitably being exposed to multiple psychologically demanding challenges and stressors which evoke positive and negative emotions and positive and negative reactions and significantly impact on the nurse's wellbeing (Doane & Varcoe, 2015; Lee et al., 2021; NZNO College of Child and Youth Nurses, 2024; Sandstrom et al., 2020).

---

[1] Whānau is the te reo Māori word for a family group or extended family

[2] Tamariki is the te reo Māori word for children

Stress in nursing is not a rare or unique issue; it is well documented that stress occurs to varied levels and frequency in nurses' professional and personal day-to-day lives. While the level of stress in the workplace may vary between geographical, cultural, and clinical settings, stress is undoubtedly a global problem among nurses (Glawing et al., 2023). Being exposed to stressors can result in emotions being felt more acutely, with the stress response resulting in adaptive or maladaptive outcomes for nurses and whānau (Lazarus & Folkman, 1984). From a positive aspect, even in challenging stressful situations, building relationships with whānau and tamariki can be empowering and rewarding work, which motivates nurses and can help workplace retention (Duggan et al., 2018; West et al., 2018). However, working in nursing can feel messy and stressful for nurses leading to maladaptive outcomes due to the complex myriad of factors occurring and the broader context in which care is provided (Thorne, 2016). Although it is often accepted that stress will occur in community practice, exposure to stress has been found to deeply affect community health professionals. This places them at risk of becoming exhausted and overwhelmed, often experiencing compassion fatigue, secondary traumatic stress, burnout, and job withdrawal (Doane & Varcoe, 2015; West et al., 2018).

Of concern within the research exploring stress experiences of nurses, is the suggestion that the nurses' capacity for attunement, care, and compassion for whānau can be impacted by their individual physical and emotional responses to personal and workplace stressors (Bernstein, 2019). These experiences of stress and their consequences for nurses are therefore likely to impact the quality of relationships with whānau. Regulation of stress is a crucial aspect of nursing care and therapeutic relationships, so that nursing services can be relationship-focused, strengthening, and engaging in a culturally responsive and attuned way (Frechette & Carnevale, 2020; Munns, 2023). As such, the impact of stress on CCH nurses and their care for whānau needs to be further explored, to gain a deeper understanding of their experiences in order to develop strategies to better manage and reduce the potential short-and-long-term outcomes of work-related stress on nurses (Glawing et al., 2023). However, the current literature on the practitioners' experiences of stress when supporting whānau in community practice is limited (West et al., 2018). With limited existing evidence, this study offered a valuable opportunity to explore this important issue, providing a better understanding of CCH nurses' stress in whānau engagements and to identify strategies to reduce the risk of potential harm to both the nurses and their relationships with whānau.

This thesis presents the findings of an interpretive descriptive study that explored Community Child Health (CCH) nurses' experiences of, and perspectives on, self-regulation and attunement in times of stress when working with whānau. To meet this aim, two questions were posed.

- How do Aotearoa New Zealand Community Child Health nurses describe the relationship between stress and the capacity to self-regulate their stress response when engaging with whānau?
- How do Aotearoa New Zealand Community Child Health nurses describe the influence of stress on attunement, the capacity to build trust, and their ability to reflect on whānau relationships?

Interpretive description (ID) was chosen as the methodology for this study as an inductive analytic approach design that supported deep understanding of the clinical phenomena of interest through an interpretative lens (Thorne et al., 2004). ID provided structure for the study, while also enabling flexibility and a non-prescriptive approach to the design decisions, data collection, and analysis (Thorne, 2016). The flexibility of ID, and the ID framework enabled the selection of an approach that best suited addressing the study aim and questions, while also complementing the complex context and practice of CCH nursing. The overall aim of the study was to produce findings with practice-based implications relevant to navigating, informing, and addressing the social, political, and ideological complexities of nursing, and community child health nursing.

Introducing the Participants

Two groups of Aotearoa New Zealand community child health (CCH) registered nurses, Well Child Tamariki Ora provider nurses and specialised community child health nurses participated in the study. Within the Aotearoa New Zealand practice context, Well Child Tamariki Ora nurses provide well child nursing care, guided by the Well Child Tamariki Ora schedule, to whānau with tamariki under five years old (Ministry of Health, 2015). Specialised community child health nurses (e.g. neonatal and paediatric community nurses) care for whānau with tamariki with a wide range of specialised health needs, including tamariki with a terminal illness (NZNO College of Child and Youth Nurses, 2024).

Despite the differences in areas of practice across the CCH nurses' roles, there are also commonalities which informed the rationale to recruit both groups as study participants. It was anticipated that there would be some shared and similar experiences with regards to stress as both groups of nurses work in the community supporting whānau to maintain and improve tamariki and whānau health and wellbeing, navigate health issues, and reduce the impact of trauma and adversity (Kanda et al., 2023; Ministry of Health, 2015; NZNO College of Child and Youth Nurses, 2024). Another commonality is that CCH nurses mostly engage with whānau as a sole practitioner in the community; only occasionally are they accompanied by a colleague or observer, for example, a student, new staff member, preceptor, or manager. As a result, access to collegial support is usually limited (Munns, 2023). Importantly, CCH nurses work with tamariki and their whānau during a unique and vulnerable developmental stage of life. This is a critical stage for growth, learning, development, and emotional wellbeing, which are the foundations for lifelong health and wellbeing (Moton et al., 2022). During this developmental stage, tamariki are particularly vulnerable due to their rapid growth and development and dependence on adult caregivers to meet their needs. Because of these factors, they have an increased risk of poor short-and-long-term physical, developmental, and emotional health outcomes (Moton et al., 2022; Munns, 2023; NZNO College of Child and Youth Nurses, 2024). Additionally, some health conditions, treatments, and how they are experienced by tamariki differ from how young people and adults experience them, requiring the CCH nurse to hold specialised knowledge and expertise (Munns, 2023; NZNO College of Child and Youth Nurses, 2024). Unique to CCH nurses, is the community environment they work in, providing care to tamariki and their whānau in homes, at community locations, and virtually. There is usually at least the tamariki and one caregiver present, but often other whānau and friends are also present, less commonly there is a caregiver or tamariki on their own (NZNO College of Child and Youth Nurses, 2024).

The Aotearoa New Zealand Tamariki Health Context

CCH nursing requires consideration of the unique developmental stage and health needs of tamariki, while also supporting whānau to reduce the impact of adversity from a holistic socio-economic approach (NZNO College of Child and Youth Nurses, 2024).

In Aotearoa New Zealand, whānau face increasing pressures and challenges which may adversely impact their health and wellbeing. These include the impact of poverty, overcrowding, climate change, societal issues, limited access to services, intergenerational trauma, family violence, and colonisation (Moton et al., 2022). These health factors affect tamariki wellbeing significantly, with Māori tamariki and their whānau disproportionately experiencing health and wellbeing risk factors (Edmonds et al., 2022; New Zealand Government, 2019). Māori tamariki have significantly higher rates of mortality, morbidity, and hospitalisation rates than non-Māori (Paine, 2023). Despite the disparity in health outcomes, Māori tamariki have lower utilisation of health services, with unequal access to health care (Paine, 2023) with higher rates of physical, emotional, and behavioural problems than non-Māori (Edmonds et al., 2022). The impact of unmet needs on Māori whānau and tamariki health is also evident in the high proportion of Māori tamariki in Oranga Tamariki (the New Zealand Ministry for Children) care and the justice system as well as those with long-term mental health issues (Ministry of Health, 2012).

The UN Committee on the Rights of the Child has previously expressed concerns about Aotearoa New Zealand's minimal progress in addressing the experience of disparity, childhood poverty, and vulnerability for Māori tamariki alongside the high prevalence of abuse and neglect among Aotearoa New Zealand's tamariki (Child Matters, 2016; Wynd, 2013). In the absence of buffering secure relationships, tamariki living in a disadvantaged or stressed whānau are more likely to be exposed to adverse experiences (Ministry of Health, 2012; New Zealand Government, 2019; NHS, 2012). Working within communities with whānau requires CCH nurses to take into consideration their role in reducing disparity of health outcomes in their care provision (NZNO College of Child and Youth Nurses, 2024).

The New Zealand Health Strategy (Minister of Health, 2023) sets out the ways that the Government aims to improve the health outcomes of individuals, whānau, and community environments. This was to achieve health equity for diverse communities, including Māori and Pacific people and those with poorer health outcomes. Additionally, the Ministry of Health's (2016) Health Strategy acknowledges that many factors influence a person's ability to live well, stay well, and get well, building on enhancing support and promoting the healthy development of tamariki and whānau and recognising the importance of early care for lifelong outcomes (Ministry of Health, 2012), a goal that "requires investment in prevention and interventions that make the environment in which tamariki grow, learn and play a healthy one" (Ministry of Health, 2016, p. 14).

While holistic care and wraparound support are critical for whānau and tamariki outcomes (Edmonds et al., 2022), the Ministry of Health (2012) has identified significant gaps in health services offered to whānau, more specifically in maternal and tamariki mental health services. At that time the Ministry recommended that service providers strengthen their capacity to cater to gaps in tamariki and whānau health needs (Ministry of Health, 2012). But there is little evidence this ‘call to action’ has resulted in the promised outcome for tamariki and whānau. As recently as 2022, Edmonds et al. (2022) recommended that health practitioners, decision-makers, and researchers should challenge and transform the current systems to improve whānau and tamariki wellbeing and reduce the disparity of health outcomes. CCH nurses are in a crucial position to directly influence changes, reduce the impact of adverse factors and support improved health outcomes for whānau and their tamariki (Ministry of Health, 2016). This includes supporting whānau to increase resilience factors for their tamariki and themselves (NZNO College of Child and Youth Nurses, 2024). However, this is complex and challenging for CCH nurses. The gaps in current systems and the complexity of supporting tamariki and their whānau in the community to improve health and wellbeing outcomes is likely to increase stress on CCH nurses. The exploration of the impact of stress on CCH nurses whānau care is important, considering the significance of CCH nurses’ role of in the community and the exposure to varied levels of operational stressors and the emotional impact of their work.

Nursing Stress and the Stress Response

Critical to undertaking this study was determining a position on the aetiology of stress, to provide a basis for the context of discussing the CCH nurse experiences of stress throughout the study and the thesis. Stress is considered the result of the interplay between the unique characteristics of the person and the nature of the environment that is considered stressful or that exceeds the person’s resources, endangering their wellbeing (Navarro-Prados et al., 2024). Lazarus and Folkman (1984) described two critical aspects of stress that are relevant to how CCH nurses may respond to stressors in whānau engagements. The first aspect is related to the nurse’s cognitive appraisal of the interrelation of themselves and the stressful environment and the second is concerned with the nurse’s coping processes to manage the demands of the situation and the emotions generated.

Stressors may vary significantly, falling within two main types of stressors; physical (for example, an infection) and psychological (for example, anticipating a difficult conversation), stressors. Stress can range from acute stress, repeated acute stress, or prolonged chronic stress (Chu et al, 2024, Godoy, et al, 2018). Stress responses are complex processes where the stressor is detected and interpreted as a real or potential threat, which results in multifaceted, autonomic whole-body response that may or may not be noticed (Chiu et al., 2022; Jackson-Koku & Grime, 2019). There is a common response pattern to stress with an initial shock phase, followed by an alarm reaction, then adaptation to the stressor, and if persistent aversive stimulation overwhelms the ability to resist the stressor, an exhaustion phase (James et al., 2023). When exposed to a stressor individuals' biological, neurological response and emotional arousal will follow this common pattern, but it is of note that each response is unique to the individual and the situation (Rushton et al., 2013). Variations are influenced by genetics, factors unique to the person, prior stress exposure, and the level, timing, and duration of the stressors (Godoy et al., 2018).

Exposure to stressors triggers a coordinated autonomic activated stress system response engaging different overlapping neuronal networks and neuroanatomical responses with a rapid activation of a complex interplay of the nervous, endocrine and immune systems (Chu et al., 2024; Godoy et al., 2018). Stressors cause an activation of the sympathetic-adreno-medullar (SAM) axis, the hypothalamic-pituitary-adrenal (HPA) axis, and the immune system (Chu et al., 2024; Godoy et al., 2018). Hormonal responses activate the amygdala and limit a higher limbic response, enabling a rapid response to perceived or threating situations (Silverman & Hutchison, 2019). The hypothalamus plays a major role in arousal of this autonomic stress response. Corticotrophin Releasing Factor (CRF), a brain neuromodulator, is responsible for coordinating autonomic, behavioural, and cognitive responses to stress (Jackson-Koku & Grime, 2019). In states of high arousal, the coordinated autonomic activated stress system responses cause sympathetic activation which has physical responses, for example, vaso-constriction of blood vessels, increased heart rate, increased respiration, dry mouth, increased muscle tone, and often voice changes, such as high-pitched tone (Kozlowska et al., 2015). These physiological responses alongside, emotional and cognitive consequences help to prepare for internal or external challenges but can also impact on the capacity to respond to stressful situations (such as difficulty regulating emotions, impacts on memory, concentration, and decision-making) (Chu et al., 2024; Lazarus & Folkman, 1984).

In stressful situations, positive and negative responses have been found to occur with relatively high frequency resulting in short-term or long-term consequences (Chu et al., 2024; Godoy et al., 2018). Not all stress is considered detrimental, as some stress can be coped with, considered enjoyable, stimulating, and inspiring. This is where acute episodes of mild-intensity stress enhance cognitive functioning, with increased social and psychological resources leading to an increased focus and performance, counterbalancing distress and resulting in positive outcomes (referred to as eustress)

(Chiu et al., 2022; De Cordova et al., 2024). Conversely, stress can have significant negative short and long-term impacts on individuals and their capacity to respond (Chu et al., 2024; Folkman & Moskowitz, 2004). Distress one of the impacts, refers specifically to negative stress that overwhelms an individual's coping abilities. Distress may have adverse effects on physical and mental wellbeing (Chiu et al., 2022; De Cordova et al., 2024). In respect to cognition, stress can have a varied impact on cognition depending on the unique individual, the intensity, timing, and duration of the stress and it can impact on memory, cognitive processes, and cognitive reasoning (James et al., 2023). Additionally, emotions can be felt acutely in times of stress, with stress causing varied emotions, for example fear, anger, worry, or anxiety (Fasbinder et al., 2020; Grabbe, 2015; Greenberg et al., 2020; Kokkonen et al., 2014)

If the physiological response to stress does not restore a sense of safety or some equilibrium there is a continued reliance on an activated nervous system. As such the person's nervous system will remain activated. This may reduce the person's capacity to regulate their stress response, restricting their ability to provide support and to be attuned to others (Silverman & Hutchison, 2019). For CCH nurses, this means the whole-body responses may not only have conscious and unconscious neurobiological impacts but can also impact how they navigate their stress response and engage with and respond to whānau. For the purposes of this study, I have primarily focused on stress that the participants considered had a negative impact on themselves and their whānau engagement rather than eustress.

Nurses' experiences and views of their physical, emotional, and cognitive responses to stressors and their capacity to provide care to whānau is central to this study. It is of note that nurses may not always be aware of their responses to stressors thus, while at times, they may notice their physical and emotional responses, at other times they may not pay attention to their reactions. This is likely dependent on a range of factors. It is outside the scope of this study to explore neither the level of awareness of their cognitive, emotional and physical responses to stressors nor the accuracy of their accounts. Instead, it relies on self-reported memories of physical, emotional, and cognitive responses and on the nurses' views of the impacts of their responses on whānau engagements.

Positionality of the Researcher

Thorne (2016) highlighted the need for the researcher to be within the discipline being studied while being mindful of the implications of positionality within the study context. The positioning of the researcher within the study context where the setting is already known has advantages and disadvantages (Thorne, 2016). As the researcher, I closely connect with CCH nursing as I have worked in this field for over 30 years. I have held various roles in clinical practice and leadership in CCH nursing. I have experienced stress in my practice and listened to many colleagues’ stories of stress. Listening to colleagues’ personal and professional experiences of stress led me to wonder how they navigated their stress response while being in whānau relationships and how this impacted their capacity to attune to whānau.

Over time, I have learnt about the physical and neurological impacts of stress and the importance of relational engagements for both the whānau and the nurse; this increased my curiosity about the impact of stress on nurses and whānau engagements. I was intrigued that stress was mostly talked about with regard to generic workplace/workload stressors combined, and less about how stress impacted on the nurse in the relational engagement with whānau. This led me to develop this study’s aim to explore CCH nurse's experiences and perspectives on self-regulation and attunement in times of stress when working with whānau. I was aware that the context and external stressors may also impact the experience, but I wanted to focus primarily on CCH nurse's experiences when in professional relationships with whānau.

My connection with CCH nursing practice has influenced my position as a researcher. I consider that my nursing and life experiences, my knowledge in CCH nursing practice, relational practice, tamariki health, and working in diverse communities was advantageous to the study. I balanced what I have experienced and learnt about stress and relationships in my professional and personal life with my role as the researcher. This helped guide my decisions about the study and choice of a methodology, data gathering, analysis, and presentation of the findings. Conversely, I needed to be mindful of the difficulties involved in stepping into the role of researcher while working in CCH nursing, especially with an emotion-provoking topic. This required me to ensure that my personal experiences, values, and beliefs did not significantly impact the study participants or the research process. I needed to acknowledge that my own experiences of navigating stressors personally and professionally, my own self-awareness and views of stress and practice were my unique experiences and may not be like others.

I was conscious this is a potentially emotional topic for the participants and myself. I was aware that they could find sharing their experiences emotionally triggering and I could find it emotionally difficult listening to and reading their responses. To support me during this study, I had two Auckland University of Technology (AUT) supervisors who I met with on a regular basis and also an advisory group, which consisted of a Māori Advisor, Pacific Advisor, and Asian Advisor, who all worked in community child health and provided guidance for the study. Throughout the research process, my passion for

CCH nursing and for the relational experience of CCH nurses and the whānau they support has been central. My hope is that the findings of this study help raise awareness and action change within nursing, management, and policy to reduce the impact of stress on the nurse and whānau relationships.

Structure of the Thesis

The thesis is divided into seven chapters:

- Chapter One provides an overview of the context for this research study, defining the aetiology of stress, the Aotearoa New Zealand context, the background, and rationale for the study. This chapter concludes with the positionality of myself as the researcher and the layout of the thesis.
- Chapter Two presents a literature review that summarises the current body of evidence that has explored health professionals' self-regulation in response to stressors, unique characteristics that influence self-regulation, and the impact of stress on attunement and relationships. The literature review identifies the research gap related to CCH nurses' experiences of stress when engaging with whānau.
- Chapter Three describes the methodological approach used to frame this study, namely interpretive description.
- Chapter Four presents the methods employed during the study and the demographics of the participants.
- Chapter Five presents the first theme of the findings namely that CCH nurses' experience of stress in whānau engagements is unique, multifaceted, and shaped by context. This theme is discussed under three sub themes, providing a synthesis of the CCH experiences of stress while acknowledging the uniqueness of their experiences.
- Chapter Six presents the second findings theme namely that the impact of CCH nurses' stress on attunement and whānau relationships requires attention. This theme has three sub themes with a focus on the impact of stress on the CCH nurse and their relationships with whānau
- Chapter Seven concludes the thesis by integrating the study's findings with a discussion of the outcomes, it makes recommendations for nurses, organisations and policy makers, and the study's strengths and limitations are critiqued. Finally, recommendations for future research are identified.

Chapter Summary

This chapter introduced the aim of this study, which was to provide new insights into CCH nurses’ experiences of stress when in whānau engagements. Moreover, the background of the rationale for undertaking this study and the aetiology of stress were provided. The chapter also introduced the participants of the study, and the positioning of myself as the researcher, and concluded with providing the structure for the thesis.

Chapter Two: Literature Review

Following on from the introduction to the context, methodology, and rationale for the study in Chapter One, this chapter presents a critical review of the existing literature relevant to the exploration of Aotearoa New Zealand CCH nurses’ experiences and perspectives of self-regulation and attunement in times of stress with whānau. A description of the literature review process is provided followed by an analysis of the literature with a specific focus on nursing. This analysis begins with an exploration and analysis of the literature related to self-regulation of stress, followed by an exploration and analysis of literature on attunement in relation to stress. Strengths and gaps in the literature are then discussed before the chapter is closed.

Search Strategy

The purpose of the literature review was to summarise and interpret the knowledge of the topic and establish what needs to be discovered (Theile & Beall, 2024). In undertaking the literature review I first immersed myself in the literature by familiarising myself with the foundational concepts of the topic from nursing and other disciplines and exploring potential topic areas I considered important for the study. Subsequently, search terms were established for the data base searches that were guided by the research questions (Thorne, 2016). Due to the complexity of the topic and diverse range of potential topics I could explore, I recognised that I was not able to include all relevant literature and that a systematic review process was not the best fit for the study (Sukhera, 2022). As such, a narrative review framework was chosen to enable a robust, flexible, practical, and comprehensive appraisal and synthesis of the current literature (Polgar & Thomas, 2013; Sukhera, 2022; Theile & Beall, 2024) without the researcher becoming overwhelmed by the amount of literature available or the expectation of a prescriptive search process. Additionally, narrative reviews have an important place in health professions (Polgar & Thomas, 2013) as they allow the researcher to incorporate their expertise and unique perspective on the research topic within the complex health system (Jacobsen, 2021), important considerations for this study.

Database Search

A literature search of online data bases was undertaken (for example, Scopus, CINAHL, Ebsco, PubMed, Cochrane library) as a literature management strategy. To ensure access to the most current literature, the literature search was limited to full text articles published in English within the last 15 years. In some instances, the literature included in the review is older than 15 years if published by a seminal author or sourced via the reference lists of selected articles.

Deciding on search terms that would comprehensively capture the complexity of the topic presented a challenge, as the practice area of community child health in Aotearoa New Zealand is unique and there are multiple factors that could be of significance to nurses' experience of stress when in relationship with others (for example, personality, self-regulation strategies, and relational skills). As such, I determined that a range of terms would be needed to access literature on community child health nursing, stress, self-regulation, and attunement in relationships without restricting the literature search or becoming inundated by literature that was not relevant to the topics under review.

The key words selected for the literature searches included: New Zealand, child, nurse, community, health professional, stress, emotional regulation, relationship, mentalisation, attunement, attachment, and adverse childhood experiences. I initially searched the terms child, nurse, community, stress and emotional regulation, self-regulation together. However, searching these terms together yielded limited results. As a result, I tried different combinations of two to three terms, which was more successful. The combination of terms primarily searched for were "stress" and "emotional regulation", with other terms swapped in and out. As I progressed with the literature search, I started combining the original search terms with new keywords, namely New Zealand, health professional, mentalisation, attunement, relationships, attachment, and adverse childhood experiences in different combinations with the initial search terms to identify additional literature. The reason for including these additional terms was to provide a broad enough search to include other factors that may impact on stress, self-regulation, and attunement in health professionals' relationships, while being mindful not to be overwhelmed with literature. Additionally, it was important to examine this topic in a New Zealand context. Specific stressors (for example, caring for terminal tamariki, exposure to whānau hostility) and specific regulation strategies (such as breathing, self-talk) were not included in the search criteria due to the wide range of possible search terms. I anticipated that these topics would be adequately captured within the main search terms, thus providing an overview of possible stressors and self-regulation strategies and therefore would not need to be specifically included in the search terms.

In line with Thorne (2016), who considered theoretical literature, research-based literature, practice-based literature and systematic reviews useful in literature reviews to provide diverse sources of information, the literature considered for this review was from full text quantitative, qualitative, mixed method studies, systematic reviews, and theoretical based literature. Inclusion criteria included literature that explored health professionals' experiences of stress from a range of sources and perspectives, such as during general and/or relational practice. This strategy resulted in 110 full text articles that initially met the search criteria. Upon reviewing the titles and abstracts more fully, 61 were excluded due to their focus on psychological therapies, client stress, parenting strategies, and workload stress with no links to relational engagement. This resulted in 49 full text articles being included in the narrative review. Relevant literature consisted mostly of sources from the social sciences, with articles from the fields of nursing, specifically community nursing, or those with a focus on the Aotearoa NZ health context limited. Only three Aotearoa New Zealand based research studies could be found, and no research of health professionals' experiences of stress in the cultural context of Aotearoa New Zealand could be located.

For ease of organisation and analysis, the literature review is divided into two parts, Part One: Health Professionals' and Regulation of the Stress Response and Part Two: The Impact of stress on Health Professional's Attunement and Relational Care. Both parts of the literature review aim to provide a deeper understanding of what is known in these areas to inform the study, and the exploration of CCH nurses experiences and perspectives of self-regulation and attunement in times of stress when working with whānau.

Part One: Health Professionals and Regulation of the Stress Response

Leading on from the introduction to the aetiology of stress and the neurological and biological responses in Chapter One, the review of the literature starts with an analysis of how the neurological and biological responses to stressors are regulated to establish 'what is known' about the impact of stress on health professionals, managing stress responses and the characteristics that can affect the regulation of stress.

The Impact of Stress on Health Professionals

Memory, cognition, and emotional stability are vital for health professionals, such as nurses, to provide care and navigate relationships, but exposure to unregulated, long term, and high intensity stress, has been found to lead to negative impacts on health professionals' memory, cognitive reasoning, and emotional responses, risking the care they provide (James et al., 2023). Likewise, Barattucci et al. (2019) suggested that stress and anxiety levels have negative impacts on health professionals' workplace behaviour, client satisfaction, quality of care, and errors in care provision. It has also been found that if health professionals cannot regulate stress and emotional distress, tension and self-blame can occur (Diefendorff et al., 2011; Jackson-Koku & Grime, 2019; Restubog et al., 2020). Additionally, when feeling unable to disengage from or change a stressful situation, feelings of helplessness, incompetence, being disheartened, and withdrawing can occur (Barr, 2022). In the long run, exposure to stressors can negatively affect nurses' physical wellbeing and their personal and professional relationships, and for some this may result in burn out (Babapour et al., 2022; Blanco-Donoso et al., 2019; Jackson-Koku & Grime, 2019; Lascelles et al., 2024; Salvarani et al., 2019; Sandstrom et al., 2020; West et al., 2018).

The Regulation of Stress

Despite stress being a common occurrence in health professional practice, few studies could be found that described how health professionals, and in particular nurses, used regulation strategies or how effective these strategies were. Most of the research found was undertaken in acute health settings and focused on a specific type of stress. No literature explored the regulation of stress among CCH health nurses in Aotearoa New Zealand.

Fasbinder et al. (2020); Jackson-Koku and Grime (2019), and Restubog et al. (2020) similarly define regulation of stress (self-regulation) as an internal process that manages emotions and responses to stressors. As such, self-regulation enables individuals to take control and modify physical, emotional and psychological stress responses. This control reduces autonomic responses, moving towards greater equilibrium so higher cortical functioning can occur to enable greater cognitive capacity (Fasbinder et al., 2020; Grabbe, 2015; Greenberg et al., 2020; Kokkonen et al., 2014). Self-regulation provides protection from becoming overwhelmed by one's own or other's suffering and reduces the risk of an overt emotional response being triggered (Jackson-Koku & Grime, 2019; Restubog et al., 2020). The term self-regulation is used in this chapter to include the regulation of emotional, psychological, and physical responses to stress.

Research has found health professionals' regulation of stress responses influences how they navigate stress, process information, and make decisions. Consequently this reduces the risk of poor outcomes for them and their care provision (Jackson-Koku & Grime, 2019; Restubog et al., 2020). Jackson-Koku and Grime (2019) described how the capacity to self-modulate biological and neurological multifaceted whole-body responses (e.g. racing heart, increased respiration) and emotions through self-regulation reduces or adapts health professionals' undesirable emotional outcomes. Blanco-Donoso et al. (2019), who researched community nurses' experiences of emotion regulation, found those who could regulate their emotions were more likely to have positive wellbeing outcomes; however, this study did not specify the strategies used. It is acknowledged that, despite the generalised findings that regulation strategies lead to positive psychological outcomes and stress management, these experiences are unique to each individual and as such the outcomes of stress regulation varies (Diefendorff et al., 2011; Jackson-Koku & Grime, 2019; Restubog et al., 2020).

The capacity to cope and regulate stress has been found to be impacted by the intensity of stressors. High-intensity stress has been found to negatively impact on cognitive processes, cognitive reasoning, and emotions (Fasbinder et al., 2020; Grabbe, 2015; Greenberg et al., 2020; Jackson-Koku & Grime, 2019; James et al., 2023; Kokkonen et al., 2014). Studies using functional magnetic resonance imaging (MRI) showed that people experiencing high levels of work-related stress were less able to regulate negative emotions and experienced altered stress-processing limbic networks (Jackson-Koku & Grime, 2019). It has also been found that high intensity stressors have less variability in stress responses, whereas less intense stressors trigger a wider range of stress responses, and even for some no stress response is triggered (Fasbinder et al., 2020; Grabbe, 2015; Greenberg et al., 2020; James et al., 2023; Kokkonen et al., 2014; Lazarus & Folkman, 1984). While high intensity stressors trigger less variability in stress responses than lower intensity stressors, there can be significant variability in stress regulation responses to high intensity stressors (Fasbinder et al., 2020; Grabbe, 2015; Greenberg et al., 2020; James et al., 2023; Kokkonen et al., 2014; Lazarus & Folkman, 1984). Goldblatt et al. (2020) examination of health professionals' responses to violent clients and visitors highlights the variability in self-regulation responses including not being able to regulate their emotions, distancing and disengaging, rationalising, splitting tactics, using organisational resources, and controlling emotions by suppression. Some felt more in control of their emotions and able to meet their role expectations, others experienced disharmony but regulated their stress to meet their role expectations, whereas others experienced intense emotional flooding so were less likely to regulate their emotions and fulfil their role.

The studies cited above did not distinguish how different levels of intensity of stress were defined by the health professionals nor what influenced the variation in responses (i.e. if some high intensity situations were more difficult to regulate stress in than others). Additionally, no literature was found on how intensity of stress impacts on community practitioners. This is of significance as working alone in CCH nursing practice has some different stressors and intensity of stress than working physically close to other health professionals.

Individuals’ Unique Attributes Impact on Stress and Regulation

Alongside the evidence of the impact of intensity of stress on the capacity to self-regulate, there is also a complex link between an individual’s physiological, cognitive, and neurological responses to stressors and self-regulation strategies (Glawing et al., 2023; O’Connor, 2019). Specific factors have been found to play a part in how stressors are responded to including an individual’s unique genetic predisposition, sex, age, history, personality, the sociocultural context, psychological resilience, and coping mechanisms (James et al., 2023). Research by Barattucci et al. (2019) found health professionals’ individual differences, rather than demographic characteristics (e.g., gender, education, etc.), played a crucial role in responses to perceived stress, and regulation of stress. These authors found that temperament, genetics, neurobiology, adult attachment, adverse childhood experiences, social supports, and environmental stress impacted self-regulation and attunement. Fasbinder et al. (2020) also highlighted the links between individuals’ unique characteristics and emotion regulation. The characteristics they identified included “emotional resilience, emotional intelligence, emotional expressivity, and emotional labor” (p. 190). Similarly, Jackson-Koku and Grime (2019) described research findings that suggest low levels of emotional intelligence and self-efficiency are associated with a high level of work stress for nurses. Research also suggests a genetic link for those with a short version of the serotonin transporter gene to a greater risk of poor coping to stressors (Grabbe, 2015).

Additional to the genetic links to stress regulation, cognitive neuroscientists propose that early life experiences affect the development of the neural basis of attunement, mirror neurons, and affective neural resonance systems. These systems are critical to synchronising attunement to others’ emotions, which helps navigate stressful experiences (Epstein & Street, 2011). Early life experiences of stressors and trauma have been found to affect executive functioning and the autonomic nervous system development, which in turn impacts the stress response system (Fasbinder et al., 2020). This neural impact of adverse childhood experiences (ACE’s), results in increased risk of poorer coping in stressful situations (Freeman, 2016; Girouard & Bailey, 2017; Herzog & Schmahl, 2018; Ordway et al., 2014).

In respect to the influence of nurses’ ACEs on their stress responses, research has found nurses with ACEs and trauma histories were less able to regulate their stress response, be present, connected, form trusting therapeutic relationships and provide care (Girouard & Bailey, 2017; Silverman & Hutchison, 2019). Only one study explores the impact of ACEs on CCH nurses. This study undertaken with Australia child and family health (CFH) nurses by Chavasse (2022), found a link between attachment style, ACEs, and relationships with clients. The author found CFH nurses with unresolved childhood trauma tended to be unconsciously motivated to help clients with similar trauma, had a greater risk of burnout, compassion fatigue and re-traumatisation, high-stress levels, and less effective coping strategies. Chavasse (2022) found CFH nurses who have actively worked on overcoming the impact of their childhood trauma, provided valuable relational care with less re-traumatisation, highlighting the impact healing can have. Taking a different perspective, Grabbe (2015); Halama and Pitel (2016) found having positive and loving experiences as a child with minimal trauma history increased the likelihood of nurses developing positive relationships, mental and physical health, and increased capacity to cope, in stressful situations. Researchers caution making assumptions about the impact of health professionals' history of trauma or lack of trauma on their capacity to cope as this is not guaranteed either way (Grabbe, 2015; Halama & Pitel, 2016), demonstrating the uniqueness for each individual and showing the complexity of the experiences of stress.

As well as the varied impact of early life experiences on levels of stress and self-regulation adult attachment styles were also found to affect health professionals' experiences of stress. Those with secure attachment styles have been found to be more likely to seek proximity to others, monitor their internal responses and external events and as such are more likely to maintain a relational approach in stressful situations (Halama & Pitel, 2016; Kokkonen et al., 2014; Shaver & Mikulincer, 2007). Conversely those with insecure attachment have been found to be less resilient in times of stress, be less empathic, more anxious, feel misunderstood, and to have more negative views of others and lower job satisfaction. Those with attachment-related anxiety tended to focus on their own distress, adopting emotion-focused coping strategies. Those with attachment-related avoidant styles were found to cognitively and emotionally distance themselves from distress, devalue the needs of others, and be less concerned with fairness (Chopik, 2014; Kokkonen et al., 2014).

Literature on nurses' adult attachment is limited but does suggest that nurses' adult attachment style might play a key role in stress regulation. Halama and Pitel (2016) found some nurses' insecure attachment styles correlated with workplace issues, including higher levels of anxiety, difficulties with problem solving and decision-making, and being hypervigilant, all of which impact on self-regulation and client relationships. They proposed that the relationship between attachment and decision making may be self-regulation, which is impacted by stress. Chavasse (2022) study of Australian CFH nurses found insecure adult attachment styles were associated with less sensitive and responsive care whereas a secure adult attachment style was associated with more sensitive and responsive care. However, she did not research the impact of the nurses' stress on the relationship alongside their attachment style. The findings discussed in this section further highlight the significance of the uniqueness of individuals and factors that play a part in their navigation of stressful situations.

Another factor that influences the unique experience of and regulation of stress is the individual's awareness of stressors and stress responses. By exploring the connection between self-awareness of stress and self-regulation, valuable insights of managing stress more effectively can be gained. It is acknowledged that individual differences are likely to impact self-awareness of stressors and self-regulation of stress. Research suggests that the capacity to cope with stressors can be impacted by the professional's self-awareness of their own stress, stress responses and the conscious effort to regulate stress through goal directed processes enhancing the process of self-regulation and the capacity to be attuned to clients (Fasbinder et al., 2020; Grabbe, 2015; Greenberg et al., 2020; Gross, 1998; Jackson-Koku & Grime, 2019; Kokkonen et al., 2014). Those who were aware of stressors and wondered how others might perceive them were more able to regulate their stress response and had a greater sense of control (Andela et al., 2014; Fasbinder et al. 2020; Goldblatt et al., 2020). A study by Andela et al. (2014) explored the association between health professionals' public self-consciousness, private self-consciousness (i.e., self-reflectiveness and internal state awareness), and the emotion-regulation strategies of expressive suppression and cognitive reappraisal. Their findings demonstrated the importance of self-consciousness in the emotion-regulation processes, with association between private self-consciousness and the use of emotion-regulation strategies. The literature findings highlighted the positive impact of self-awareness on self-regulation, but the relevance to CCH nursing practice warrants further research.

Stress Regulation Strategies Use by Health Professionals

Leading on from the discussion of the uniqueness of the individual and the impact of the awareness of stressors and self-regulation, the evidence on how stress is regulated is now explored. As noted earlier, due to the extensive types of self-regulation strategies that can be used (such as grounding, breathing strategies, self-talk) these were not included in the search strategies, instead they are collectively included under mindfulness and regulation strategies. Systematic reviews undertaken by Fasbinder et al. (2020), Jackson-Koku and Grime (2019), and Restubog et al. (2020) revealed health professionals had varied positive and negative responses to stressors and used varied regulation strategies that either regulated or increased stress. As such, the regulation of stress is not always the outcome of strategies used. Jackson-Koku and Grime (2019) found those with strong regulation skills tended to use a wider array of strategies to manage their emotions effectively, thereby enhancing wellbeing and performance.

Research on stress-regulation among healthcare professionals has found stress regulation strategies are used before, during, and after stressful events. Prior to an interaction individuals can become stressed by anticipating stressful events will occur. When anticipating stressful events, avoidance, modification of the situation, and deployment of attention were some of the strategies health professionals used to reduce the risk of stressors occurring or reduce their impact (Howlett et al., 2015). During a stressful event, self-awareness of emotions, problem-solving, surface acting, deep acting, suppression, task-oriented coping, and emotion-oriented coping were some of the strategies found in research to be used by health professionals to try to regulate stress responses (Howlett et al., 2015; Jackson-Koku & Grime, 2019; Zammuner et al., 2003). Surface acting (the conscious expression of the required emotions, without an attempt to feel those emotions) and deep acting (modification of feelings through reappraisal or taking the others perspective) were found to influence health professionals capacity to reduce their stress and its impact on clients (Goussinsky & Livne, 2016; Howlett et al., 2015; Jackson-Koku & Grime, 2019). While the strategies used after stressful events were not the primary focus of the study, it is acknowledged that coping after stressful events likely impacts on future experiences and whānau relationships. Research has found that self-care, mindfulness, undertaking enjoyable activities, debriefing, and supervision were considered beneficial to regulating continued stress responses after stressful events (Jackson-Koku & Grime, 2019).

One of the few pieces of literature that focused on nurses' self-regulation was Fasbinder et al. (2020) who found that self-awareness, control, emotional expression, and active thinking were four key attributes that helped nurses manage workplace stressors, with multiple strategies used consciously or unconsciously. Additionally, Goussinsky and Livne (2016) found nurses considered surface acting and deep acting as effective strategies to regulate their emotions when working with aggressive clients. Also, research by Dubert et al. (2016) found mindfulness and reappraisal supported nursing students' emotion regulation. These studies demonstrate the benefits of nurses regulating their stress but highlight the complexity of regulation of stress and the unique multiple strategies used at the time to regulate stress.

Mindfulness strategies were discussed in the literature as increasing self-awareness of stress and supporting regulation of stress responses with mindfulness found to reduce oxytocin levels and strengthen neural pathways. Fostering emotional regulation, self-awareness, emotional acceptance, empathy, compassion, cognitive flexibility, and self-compassion through mindfulness therefore reduced stress and anxiety (Barattucci et al., 2019; Bellosta-Batalla et al., 2020; Grabbe, 2015; Greenberg et al., 2020; Halm, 2017; Jonathan, 2019). It appears there is a two-way link between mindfulness and self-awareness of stress, with mindfulness enhancing self-awareness of stress and self-awareness of stress supporting greater use of mindfulness strategies (Bellosta-Batalla et al., 2020). Bernstein (2019) undertook a literature review on the benefits of mindfulness finding outcomes were varied, with some studies inconclusive due to design, sampling, self-reporting, differing interventions, and lack of long-term follow-up. Despite these variations, overall study findings showed positive relationships between mindfulness strategies, awareness of stress and self-regulation, with positive outcomes for relational approaches (Bellosta-Batalla et al., 2020).

It is acknowledged that responses to stress and regulation of stress may be noticed by whānau, but the views and experiences of whānau were not included in the literature review as the focus of the study was on the perspective of the health professional. A few studies discussed how health professionals tried to control and hide their stress, so it was not noticed by whānau. This was described by some authors as health professionals masking their stress responses so they could meet the professional expectations of others and themselves (Andela et al., 2014; Fasbinder et al., 2020; Goldblatt et al., 2020). This means not only were health professionals trying to regulate their stress response, but they were also trying to hide it from those they were caring for. Masking strategies have been described by health professionals to include setting emotional boundaries, suppressing and taking control of emotions, hiding emotions and expressing positive or neutral emotions (Andela et al., 2014; Fasbinder et al., 2020; Goldblatt et al., 2020). These masking strategies aimed to reduce the impact of the health professionals' stress on clients and to enable investment in the client relationship (Andela et al., 2014; Fasbinder et al., 2020; Goldblatt et al., 2020). In respect to nursing, Fasbinder et al. (2020) described how nurses are expected to mask or control their emotions, and to display positive emotions despite their exposure to stressors from clients, families/whānau, colleagues, and the general health system.

The literature review has so far identified how stress regulation is defined and has discussed the impact of self-awareness and strategies used by health professionals. The literature has found stress regulation, individual's genetics, neurodevelopment, and adult attachment styles impact on the experiences of stress. This knowledge will help inform the study's exploration of CCH nurses' experiences of stress and the influence of each nurse's unique attributes, as well as having identified gaps in the literature. The literature review now moves to focus on what is known about the impact of stress on health professionals' attunement and relational care.

Part Two: The Impact of Stress on Health Professionals' Attunement and Relational Care

The concept of attunement and how stress can impact attunement is now discussed, including the factors that impact on attunement such as empathy, compassion, rapport, moral sensitivity, self-awareness, and mentalisation. This is followed by exploring the impact of whānau stress and their attachment styles on attunement. The literature specific to Aotearoa New Zealand on relational care in community nursing practice is then reviewed. Finally, the section concludes by discussing the importance of knowledge in regulating stress, enhancing attunement, and improving relational care.

Attunement in Health Professional Practice

Attunement is considered the feeling of being in stride or on the same wavelength with another person and is critical to caring for others (Silverman & Hutchison, 2019). In the health sector, attunement is considered a key aspect of showing empathy, connection with clients, trust building, and therapeutic decision making. Research has shown that the more present, attentive, and empathic the care provider is the higher client satisfaction (Silverman & Hutchison, 2019).

Nursing tends to be regarded as an interpersonal career that requires deep emotional-care and emotional synchronicity (Doane & Varcoe, 2015; Tuppal et al., 2019). This includes but is not limited to, nurses' capacity to show empathy, compassion, acceptance, and authenticity (Doane & Varcoe, 2015). This is alongside being aware of the other's cues, actions, and feelings, with a motivation to help others regulate their emotions (Tuppal et al., 2019). The sensitive, genuine, honest, and caring approach of the nurse is considered central to being attuned to clients and focusing on their priorities (Price, 2017; Raingruber, 2009). To achieve this a nurse needs to be present, calm and able to regulate stress responses to past and present experiences (Tuppal et al., 2019). Attunement between nurses and whānau can help both sides to better understand the other (Byrne et al., 2019).

In one of the few Aotearoa New Zealand studies on attunement in community health, Smythe et al. (2014) discussed tact between midwives and women. Despite the difference in professions between nurses and midwives, there are similarities in their community practice as they provide care primarily on their own to women and their whānau in community settings. For these reasons and due to the limited New Zealand research on attunement in community nursing practice Smythe et al's. (2014) research is included in this literature review. Smythe et al. (2014) found tact between midwives and women brought a felt sense of care, increased confidence and self-esteem and enabled open communication. This study found listening, observing, and being attuned built positive engagement. Getting tact wrong was seen to break down the relationship, with rapport only able to be rebuilt if there was trust. Smythe et al. (2014) stated that “attunement is strengthened by a spirit of care, a mood of love, and a commitment to work through the challenges faced by the woman” (p.168).

Without attunement, there is a tendency for nurses to avoid sensitive issues, use silences, withdrawal, or divert conversations to avoid conflict, with a lack of attunement potentially leading to an inability to express feelings, a disconnect between behaviour and feelings, and a sense of being less authentic (Tuppal et al., 2019). Critically, nurses may not regard themselves as naturally being able to establish therapeutic relationships (Doane & Varcoe, 2015) or to regulate their stress, two factors that are vital to attunement and relational engagement with whānau (Tuppal et al., 2019).

The Impact of Stress on Attunement and Relational Care

Health professionals’ responses to stressors (for example, traumatic experiences, perceived threats, or triggered memory) have been found to restrict higher level brain functions, which in turn interferes with factors that are central to attunement, such as the ability to pause, reflect, and be curious about others (Silverman & Hutchison, 2019). If regulation is not achieved, rapport, genuineness, and trust may be affected, making both the client and the nurse more emotionally vulnerable (Price, 2017; Tuppal et al., 2019).

Empathy, compassion, rapport, and moral sensitivity, all key aspects of attunement, have been found to influence or be influenced by stress and the regulation of stress (Ordway et al., 2014; Price, 2017; Rushton et al., 2013). Empathy has been found to enhance the capacity to manage in stressful situations, conversely stress impacts on the capacity to demonstrate empathy (Ordway et al., 2014). Additionally, compassion and a quality of presence and connection are more likely to be expressed by those who can regulate their emotions (Rushton et al., 2013). Research has found rapport to be associated with enabling clients to feel at ease during stressful circumstances, but the capacity of nurses to show rapport has been shown to be impacted by stress (Price, 2017). Alongside the impact of stress on empathy, compassion and rapport, moral sensitivity to ethical issues has been found to impact on health professionals’ capacity to navigate stress, self-regulation, to be attuned to whānau, and their capacity to interpret the situation from others’ perspectives (Rushton et al., 2013).

The findings described above demonstrate a link between stress and attunement as a two-way process, with stress impacting on the capacity to be attuned and factors that influence the capacity to be attuned increasing stress levels. However, the literature was not clear on how this interrelationship occurred, what the major contributing factors are, or whether self-regulation strategies are effective in reducing the level of stress and enhancing attunement.

Stress Regulation Strategies and Attunement

Limited literature was found that explored links between self-regulation strategies and attunement. Among the few studies is Restubog et al. (2020), who identified the benefits of self-regulation of stress as facilitating positive social interactions and relationship quality. Other authors have found that self-regulation cultivated empathy, compassion, and helping behaviours while mitigating psychological distress and supporting recovery from stressful situations, two factors that are important for attunement (Diefendorff et al., 2011; Jackson-Koku & Grime, 2019; Restubog et al., 2020). Some authors highlighted links between mindfulness self-regulation strategies and attunement, with mindfulness-based interventions shown to promote emotional regulation, self-awareness, emotional acceptance, empathy, compassion, cognitive flexibility, and self-compassion, which are all associated with the capacity to be attuned (Barattucci et al., 2019; Bellosta-Batalla et al., 2020; Grabbe, 2015; Greenberg et al., 2020; Halm, 2017; Jonathan, 2019).

A study that demonstrates the impact of emotion regulation on attunement was conducted by Rushton et al. (2013), who found that when health professionals had regulated responses to ethical considerations, emotional and cognitive attunement, including empathetic responses, compassionate action, perspective-taking, integrity, and greater resilience were more likely to occur. If ethical considerations and emotion regulation were not aligned, emotional dysregulation and distress could be displayed as autonomic arousal, anxiety, anger, frustration, agitation, sadness, guilt, self-focused behaviours, acute secondary stress, burnout, or not being able to respond to the client’s needs (Rushton et al., 2013).

How knowledge of stress and self-regulation, may impact on attunement and relational engagement was of interest for this study, as it seems likely that knowledge may influence the capacity to be regulated and thus to be attuned with whānau. Research has shown that through enhanced knowledge nurses were more prepared for the stressors they encountered in their role and as such enhanced their relationships with whānau and attunement (Barattucci et al., 2019; Bellosta-Batalla et al., 2020; Grabbe, 2015; Greenberg et al., 2020; Halm, 2017; Jonathan, 2019). This research found preparation also helped reduce stress, improve self-regulation skills, and lower the risk of mental health issues among health professionals (Barattucci et al., 2019; Bellosta-Batalla et al., 2020; Grabbe, 2015; Greenberg et al., 2020; Halm, 2017; Jonathan, 2019). Furthermore, Tipa et al. (2015) and Simkin-Tran et al. (2020) demonstrated that education focused on relationship-building and attunement can effectively enhance attunement skills; however, the studies did not explore how this is affected by stress in CCH nursing.

Self-Awareness and Attunement

Another factor that the literature review explored was the potential link between awareness of stress and self-regulation and the impact on attunement. This discussion leads on from the discussion in Part One which explored the uniqueness of individuals' self-awareness of stress. Research has found when engaging with whānau self-awareness, which includes the awareness of integrating emotions, thoughts, experiences, relationships, behaviours, wishes, and preferences into care, leads to self-knowing, acceptance of relationships, consciousness of one's truth and blocks to authenticity (Tuppal et al., 2019). Self-awareness brings an increased capacity to use oneself, leading to nurses being better able to regulate their stress and develop or maintain a therapeutic relationship (Smythe et al., 2014). Smythe et al. (2014) noted that "understanding self is a prerequisite to bringing tactful understanding to another.…It is heart work as much as head work" (p. 169).

Research has found that as self-awareness increases, health professionals are less likely to react from a place of judgment, power or implicit bias and are more able to support self-determination of their client, increasing understanding and trust (Epstein & Street, 2011; Silverman & Hutchison, 2019; Tuppal et al., 2019). Silverman and Hutchison (2019) found self-awareness an important aspect of attunement for home visiting nurse/midwives, as it combines knowing themselves with an awareness of their subjective experience and being client need. They considered that unless nurses/midwives can reflect at the time they are with whānau, they are more likely to respond with judgment and unconscious bias, resulting in difficulties in providing empathic and attuned care. Similarly, a study by Epstein and Street (2011) showed self-awareness, mindfulness, and self-monitoring are key in being regulated and attentive to clients' concerns during and between engagements. Silverman and Hutchison (2019) also found self-reflection/awareness between engagements resulted in more effective client care and greater capacity to regulate strong emotions rather than being overwhelmed. From these findings it could be assumed there are complex interrelationships between stress, self-reflection, self-awareness, and attunement but this is not clearly evidenced in the literature.

Nurses Capacity to Mentalise Whānau Mental States

Another area considered worthy to explore is the impact of stress on health professionals mentalising whānau mental states due to the possible link to the capacity to attune to whānau. While links between mentalising the internal mental states of others, attunement, and stress were explored, only limited evidence for an interrelationship could be found. One paper by Bate et al. (2018) described the link between mentalising and attunement, whereby understanding another person's perspective and being curious of their inner world helped health professionals better connect to clients' feelings and their behaviours and generally to be more attuned. Fewell (2013) and Ordway et al. (2014) found that mentalising capabilities enabled health professionals to choose a measured response that considered the mindset of others, rather than overreacting or misinterpreting their behaviour. Expanding on from mentalising the internal states of another, Simkin-Tran et al. (2020) researched maternal child health nurses' mentalisation of parent-infant dyads. They found nurses had opportunities to positively guide relationships between tamariki and their mothers through curiosity and empathy, both of which are factors that have been linked to attunement above. These research findings support a link between mentalising and attunement; however, they do not offer insights into whether stress impacts on the nurse's capacity to mentalise whānau or tamariki whānau relationships.

The Impact of Whānau Stressors and Attachment on Relationships

It was decided to also explore in the literature review potential connections between whānau stress on nurses' stress levels and their capacity to be attuned to whānau, as it was considered relevant to how CCH nurses might navigate stress. The studies presented in this section serve to demonstrate the complexity of attuned relationship and the effect whānau stress can have on attunement, rather than to specifically identify types of stressors that impact on whānau. Silverman and Hutchison (2019) considered that a therapeutic attuned relationship can be overtaken by the myriad of whānau needs, which may feel immediate and insurmountable to nurses. Working with clients who have or are experiencing trauma is considered one aspect of nurse's work that is acknowledged to influence their level of stress (Zerach & Shalev, 2015). Ozuah (2024) found that angry client's impact on nurses, making them more guarded, less friendly, and more cautious, which was considered unhelpful when it comes to forging a strong therapeutic bond. The complexity of whānau issues shared with nurses often elicit strong emotions in the nurse. These emotions require a regulated response, so they do not to interfere with the nurse's relationship with whānau and optimal care. If these responses are not regulated the result may be feeling overwhelmed by the needs of others, leading to self-protection, detachment, and callousness in client care (Silverman & Hutchison, 2019; Tuppal et al., 2019).

Additionally, how whānau perceive themselves and respond to the nurse may impact on their attunement, but it is unknown from the literature how stress may impact on this. Research by Harding et al. (2015) has shown that breast cancer patients' perceptions of nurses are influenced by clients' own models of attachment. Those with more positive models of self, reported receiving more support from nurses. Those with negative attachment models saw themselves as unworthy of support. Similarly, Chavasse (2022) study on Australian CFH nurses, noted a powerful influence of the nurse’s and woman’s attachment and ACEs on their relationship, either enriching or disrupting it.

The Aotearoa New Zealand Context of Attunement and Relational Practice

There is limited research in the Aotearoa New Zealand context on attuned relationships and relational practice and no studies were found that also explore the impact of stress in the Aotearoa New Zealand context. An Aotearoa New Zealand study, undertaken by Crowther and Smythe (2016), revealed the importance of relationships between midwives and women. This was founded on mutual understanding and attunement where the mother can flourish, feel accepted, supported, and safe. They found the critical aspects were open, respectful communication, focusing on what mattered to the mother whilst appreciating and acknowledging professional and personal differences. They found when working primarily alone with an absence of help available, there were feelings of isolation, tension, and vulnerability which caused stress for the midwives. This stress could potentially impact on their attunement and relationships with women, but this was not explored in their study. This study also found that, when managing their stress after these events, some midwives remained ‘alone’ despite others being on hand, while others focused on the team, appreciating other’s support (Crowther & Smythe, 2016). These findings are of interest to this study due to the similarity of CCH nurses and midwives working independently in communities with whānau, but despite this similarity the experience stress and attunement in whānau relationships may differ between CCH nurses and midwives’.

Two of the few Aotearoa New Zealand studies in Well Child nursing practice were undertaken by Tipa et al. (2015) and Tipa (2021). In the first of these studies, Tipa et al. (2015) explored the effectiveness of a relationship model called “Family Partnership” in nursing community practice. The research found nurses were worried they might damage relationships with whānau by offering conflicting advice to the whānau beliefs or being disrespectful. As a result, at times they avoiding discussing cultural issues or parenting practices. Tipa et al. (2015) discussed how cultural responsiveness supports relational practice. They noted that “culturally responsive practice is contingent on nurses developing partnerships with vulnerable families, often from different cultural backgrounds, but to benefit the whānau and work with them to provide infants with the ‘best start’, they need ongoing support, mentorship and/or supervision” (p. 47). In this study, nurses explained what was needed to build a good relationship with a client, which included having respectful relationships, being client led, and having skills critical to relational care. These finding are useful for this study as it is an Aotearoa New Zealand and community child health nursing study; however, it did not explore how stress affected the nurse’s relationship with whānau.

Tipa (2021) has undertaken further research to understand what is important to whānau when engaging with Well Child health services. She found whānau want a service that does not judge them, but rather one that meets them where they are. Tipa (2021) thought by enhancing health professionals’ cultural responsiveness, Māori would be more likely to engage with child health services in meaningful ways and achieve better health outcomes. As a result, Mahi Ngātahi, a cultural responsiveness framework, was developed to provide culturally responsive care. This framework includes three stages; being connected, included, and culturally safe. This research highlights that relationship building is fundamental to services capacity to meet whānau needs. It could be assumed from these findings that by being connected, included and culturally safe that relationships between the nurse and whānau may mean there are lower stress levels than if these were not present, but this is unknown.

These Aotearoa New Zealand studies provide some evidence on relationships between nurses/midwives and whānau within the Aotearoa New Zealand community context but are limited in the number of studies and relevance to CCH nurses’ experiences of stress. Tipa et al. (2015) and Tipa (2021) are the only studies with a focus on culturally responsive care within community child health nurses in Aotearoa New Zealand. This has highlighted a significant gap in the literature of working relationally in community practice with whānau, particularly from a cultural context.

Strengths and Gaps in the Literature

This chapter has outlined the findings from the literature review, which included a combination of theoretical and research articles primarily rooted in psychology. The literature highlighted connections between stressors, self-regulation, and the quality of relationships in health professionals’ practice, revealing unique factors that influence this experience. While conducting the literature review, it became evident that there are gaps in the evidence regarding the impact of stressors on CCH nurses during whānau engagements, particularly within the context of Aotearoa New Zealand.

Research indicates that the unique characteristics of health professionals, along with their self-awareness and the intensity of stressors, affect how they experience and manage stress. The findings indicate that health professionals employ various strategies to regulate their psychological and physiological stress responses, which help them achieve a higher level of cognitive function and return towards a state of equilibrium. However, the literature also points out that stress regulation does not always occur; at times, stress responses can be negative, leading to varied outcomes for both the health professionals and the whānau with whom they are engaging.

The literature review found several factors that influenced health professionals' attunement to whānau, including self-awareness, rapport-building, empathy, compassion, mentalisation, and self-regulation skills. Self-awareness, along with mentalising the whānau experiences, have been recognised as important for fostering attunement within relationships. The literature also emphasises the expectation for health professionals to modulate their emotions for the sake of their clients, with masking stress responses identified as a means for health professionals to maintain professionalism, thereby mitigating the impact of their stress on clients and their attunement.

Through the analysis of the literature, it appeared that although the literature was focused on health practice areas that differed to CCH nursing, some findings could inform CCH nurse practice. However, caution must be taken when making assumptions about usefulness and similarities to CCH nursing practice. Despite some research topics being similar to the experiences of CCH nurses, such as exposure to angry clients, most studies were based in hospital settings and in other countries, which constitute markedly different settings compared to working in isolated sole practice in communities in the Aotearoa New Zealand context. Fasbinder et al. (2020) found in their literature review of self-regulation in nursing that most research was from the psychology field, with only six out of 41 articles related to nursing, which helps demonstrate the limited research in this area of nursing.

Despite nursing being considered a stressful and emotion-provoking profession (Doane & Varcoe, 2015; Fasbinder et al., 2020) when reflecting on the literature review findings there was significant gaps in the literature on how nurses experience stress, their capacity to regulate their stress and the impact on attunement to whānau. Despite unique factors being found to influence the experiences of stress, their influence on self-regulation and the varied experiences of stress intensity was not covered. While the influence of self-awareness of stress and stress responses was identified, this is not understood in the specific area of CCH nursing. Furthermore, there are gaps in the understanding of the long-term impact of exposure to fluctuating levels of stress, the inability to regulate stress, and emotion suppression on nurses. Additional to these research gaps, the impact of stressors and self-regulation on attuned relationships and the capacity to build trust and to reflect on whānau relationships in community practice and in particular CCH nursing practice is unknown. There were also identified gaps in how nurses' internal feelings or external expression of emotions, such as fear, sadness, or frustration at a client’s situation, affected the nurse’s capacity to regulate their stress and engage with whānau. Finally, no study has yet discussed nurses’ perceptions of how whānau they are engaging with might view stressful engagements.

Importantly, there is very limited Aotearoa New Zealand research and even less research directly related to Aotearoa New Zealand CCH nurses' practice, as just two studies could be found that explored the concept of nurse-client partnership. Additionally, Tipa et al. (2015) and Tipa (2021) are the only authors who explored relational engagement from a cultural perspective. Of the literature found, no research explored the impact of stressors and emotional regulation on whānau engagements in the Aotearoa New Zealand context. These gaps are of significance considering the poorer health outcomes for tamariki, in particular Māori tamariki, and the role of CCH nurses in supporting whānau navigate the wellbeing of tamariki.

Chapter Summary

This literature review has identified several factors that influence stress responses, stress regulation, and the ability to be attuned to others. However, there are significant gaps in the nursing literature regarding the effects of stress on nurses and their ability to regulate it effectively, especially in CCH nurses’ practice. Furthermore, a comprehensive understanding of attunement and how stress affects attunement in nursing is lacking. This gap is particularly noticeable in the literature from Aotearoa New Zealand, where only a few relevant articles have been found. The gaps the literature on CCH nurses’ ability to navigate the effects of stress on themselves, and their capacity to be attuned with whānau underscore the rationale for this study.

Chapter Three: Methodology

Chapter Two provided a review of literature on stress regulation, the unique factors that impact on the experience of stress and professional relationships. Chapter Three now discusses the chosen qualitative methodology, interpretive description (ID), including the rationale for its use in this clinically based nursing study as well as a discussion of the limitations of this approach. This is followed by a discussion of how the study is scaffolded including alternative methodologies that were explored and my positionality within the research and evaluation criteria. Chapter Four will describe the specific methods used in the study.

Selecting an appropriate methodology was crucial to achieving the aim of this study to explore Aotearoa New Zealand community child health nurses' experiences and perspectives on self-regulation and attunement in times of stress when with whānau. This study aimed to address key gaps identified in the existing literature, and based on this two research questions were developed:

- How do Aotearoa New Zealand Community Child Health nurses describe the relationship between stress and the capacity to self-regulate their stress response when engaging with whānau? and
- How do Aotearoa New Zealand Community Child Health nurses describe the influence of stress on attunement, the capacity to build trust, and their ability to reflect on whānau relationships?

Interpretive description (ID) was selected as the methodological approach for this study as it is an inductive analytic approach designed for exploring inherently multifaceted and complex phenomena of nursing, in order to generate clinically based practice-related knowledge (Ocean et al., 2022; Thorne, 2016). ID offered structure and flexibility in developing the study, data collection, and analysis, which enabled me to undertake a meaningful study that generated practice-based research findings, highlighting the social, political, and ideological complexities of nursing related to the study topic (Kilgour et al., 2025; Thorne, 2016).

Interpretive Description (ID)

ID has been an established methodology for over 25 years (Ocean et al., 2022; Thorne, 2016). ID, developed by Dr. Sally Thorne and colleagues, emerged from nursing epistemology to meet gaps that the more theoretical social science approaches designed for theorizing did not meet (Teodoro et al., 2018; Thompson Burdine et al., 2021; Thorne, 2016). As such, ID provided an alternative methodological approach to answer research questions requiring inductive analysis and an interpretive lens. As a new approach, ID aimed to advance clinical practice issues, honouring the complexity of the health sciences and need for diverse approaches (Teodoro et al., 2018; Thorne, 2016; Thorne et al., 2004). Since its initial nursing origin, ID has been applied in other health fields, for example, medicine, midwifery, and speech language therapy (Bradshaw et al., 2017; Brewer et al., 2014; Ocean et al., 2022; Teodoro et al., 2018).

Foundational Underpinnings of Interpretive Description (ID)

ID embraces multiple knowledge sources to examine the interplay between objective and subjective perspectives. The objective of ID was to retain the coherence and integrity of a theoretically driven approach for research to develop new knowledge. This was while supporting defensible design variations with regard to context, situation, and intent. In so doing, it emphasises a design logic and organising framework that is consistent with the epistemological integrity of the discipline (Ocean et al., 2022; Thorne, 2016). This enables nursing knowledge development to recognise the complex interactions between psychosocial and biological phenomena (Thorne et al., 1997). In Thorne’s (2016) own words,

> Interpretive description is an approach to knowledge generation that straddles the chasm between objective neutrality and abject theorizing extending a form of understanding that is of partial importance to the applied discipline within the context of their distinctive social mandates. It responds to the imperative for informed action within the admittedly imperfect scientific foundation that is the lot of the human sciences (p.29).

ID in nursing is grounded in a philosophical alignment with interpretive naturalistic orientations, acknowledging the constructed and contextual nature of human experiences, while at the same time also allowing for shared realities (Thorne et al., 1997; Thorne et al., 2004). From an ontological perspective, ID takes a realist perspective. Relativism aligns with a subjective view of reality, meaning that it is characterised by the assumption that multiple realities exist while maintaining that there are consistent patterns or phenomena that can be studied (Thorne, 2016; Thorne et al., 2004). Reality is considered complex, contextual, constructed, and subjective, and as such the ways phenomena are understood and interpreted can vary (Thorne et al., 2004). ID’s realist perspective recognises human experience as socially constructed, acknowledging multiple, sometimes contradictory, realities. This approach values both commonalities and differences (Dolan et al., 2023; Thorne, 2016).

ID is grounded theoretically in practice and practice learning, acknowledging that what is known should be foundational fore-structure to a new enquiry (Thorne et al., 1997). The epistemological stance of ID is aligned with the constructivist/interpretivism paradigm (Teodoro et al., 2018). Interpretive research is often connected to constructivism because of the researcher's role and responsibility in creating meanings attached to what is being studied (St. George, 2014). Additionally, ID research is conducted in a natural context whenever possible, as it values subjective and experiential knowledge. This is alongside acknowledging that the researcher and the participants' influence one another and the meaning, with the interactions between the knower and known being seen as inseparable (Hunt, 2009; Thorne, 2016). As such, the researcher does not stand outside the study; rather, they need sufficient grounding within the field and the study to be able to discern the philosophical underpinnings, problems, boundaries, and what constitutes knowledge (Thorne, 2016). The research process is relational and dynamic with knowledge co-constructed by the participants and researcher (Thorne, 2016). ID supports researchers balancing theory with the messiness of everyday practice, where they have the opportunity to take their research questions past theorising and into practice (Thompson Burdine et al., 2021; Thorne, 2016).

ID methodology provides a credible and transparent approach to identifying themes and patterns across both shared experiences and individual differences, generating new knowledge and deeper insights into the complexity of human experiences (Thompson Burdine et al., 2021; Thorne, 2016). ID borrows the best techniques from social sciences without their theoretical constraints, valuing disciplinary knowledge, allowing for flexibility in the research designs that capture the clinical reality and make meaningful analysis while also ensuring conceptual integrity/soundness (Thompson Burdine et al., 2021; Thorne, 2016). It is noted that researchers who are overly attached to a theoretical perspective run the risk of losing their ontological moorings (Hunt, 2009). As a clinically motivated methodology, ID researchers can remain closely engaged with and provide rich interpretation of the phenomena being studied (Brewer et al., 2014; Dolan et al., 2023; Ocean et al., 2022; Sandelowski, 2000). This close engagement enhances the researcher's ability to develop translational findings that meaningfully reflect the complexity of clinical practice (Brewer et al., 2014; Sandelowski, 2000; Teodoro et al., 2018).

Brewer et al.'s (2014) study with speech language therapists exemplifies the design flexibility ID has to offer. This study brought together Kaupapa Māori Research and ID and highlighted that, despite the methodologies coming from different world views, they could be integrated into a cohesive research approach thanks to the flexibility of ID. They suggested that the combined approach enabled them to conduct the research in a manner that gave voice to the participants so they could generate new knowledge

(Brewer et al., 2014). This demonstrates the flexibility of ID so researchers can find the practice-based research approach that fits their specific research context.

Interpretive Description and Nursing

Nursing is considered a complex and messy discipline, drawing from an array of diverse sources of knowledge to navigate the complexity and uniqueness of individual relationships (Thorne, 2016). Therefore, nursing requires knowledge generation to come from an understanding of the practical importance and imperfect scientific foundation of nursing. ID (like nursing) emphasises the complexity and contextual nature of health and illness experiences, advocating for approaches that prioritise the individuality of clients rather than seeking overly generalised patterns (Thorne, 2016). Thus, ID provides a methodological approach that has its epistemological roots in nursing, allowing researchers to move beyond theory into practice, explore patterns of human experience and behaviour, and uncover meanings and explanations to yield practical implications for nursing (Thompson Burdine et al., 2021).

Acknowledging the Limitations of Interpretive Description

While the advantages of using ID for this study strongly supported its selection, it is acknowledged there are limitations which also needed to be taken into consideration. I needed to be mindful of methodological coherence, sufficient sampling, and the development of a relationship between sampling, data collection, and logical analysis (Thorne, 2016). I reflected on these throughout the study and was guided by Thorne (2016) to mitigate the limitations or to acknowledge them as part of the study. One limitation that needs to be acknowledged arises from my role as the researcher, particularly in deciding which information to include and which ideas to highlight or omit. As Thompson Burdine et al. (2021) emphasised, researchers must remain mindful of how these decisions influence the study's outcomes. Reflexivity was critical throughout the research process to ensure I recognised and addressed the impact of my choices.

ID’s conceptual links to other methodologies supported diverse data collection and analysis approaches (Thorne, 2016). While this versatility allowed for a tailored research design, I remained mindful to uphold ID’s methodological integrity by ensuring decisions aligned with its core principles. Being grounded in the discipline and the impact this can have on the research process may be considered a limitation. To counter this, I needed to consider the limitations of my blind spots, beliefs about nursing, and stress. Additionally, I needed to be aware of the potential influence my conscious and unconscious biases may have on the research processes and presentation of findings. Reflexivity and my positioning are described further in this chapter and in the methods chapter.

Scaffolding the Study

With the decision to utilise the ID methodological approach for this qualitative study, I needed to become familiar with the scaffolding of the study under ID principles. Thorne (2016) discussed the importance of scaffolding a study as a form of laying the groundwork to build the design plan, highlighting that decisions made have impact throughout the study. The scaffolding of a research study involves all those aspects that inform the study design, including the review of literature and what I bring into the study.

Reviewing the Literature

Firstly, the review of the literature in Chapter Two helped to critically discuss the state of current knowledge on the topic of stress and its impact on relational practice to provide an understanding of what is known and unknown. Undertaking a literature review helped confirm my initial hunches and the worthiness of the study alongside insight of past studies, problems experienced, and conclusions (Thorne, 2016). As I have been working in CCH nursing for many years, I have gained knowledge from community and child health literature prior to undertaking the study and needed to be mindful of the impact alongside the benefits this had on the literature review.

Locating the Researcher in the Study

The second aspect of scaffolding relevant to this research is how I located myself as the researcher in the study, knowing who I am, what I represent and what I am trying to accomplish. This included my beliefs, values, and assumptions, as well as reflecting on how I am positioned in the study and within the disciplinary orientation. Additionally, I needed to consider what my position represents in evolving knowledge and the potential audience’s realm when receiving the findings (Thorne, 2016). The aspect of locating myself in the study as part of scaffolding is divided into three areas, namely theoretical allegiances, disciplinary orientation, and my position within the ideas.

Theoretical Allegiances

Coming into this study, I was open to exploring a range of methodologies to find the best fit for the study aims and myself as a researcher. I explored a range of methodologies that would meet the aim of the study to describe Aotearoa New Zealand community child health nurses’ experiences and perspective of self-regulation and attunement in times of stress when with whānau. The options considered included mixed methods and qualitative approaches. The selection process involved the careful assessment of the suitability of each, taking into consideration the topic, my grounding in the discipline, the clinical relevance of the outcomes for the nursing profession (and allied professions), and my knowledge of types of methodologies and beliefs about nursing and research.

A mixed methods approach was initially considered as I had planned to use a questionnaire and semi-structured interviews for data gathering. Mixed methodology offered the richness of quantitative and qualitative data in a single study (Edmonds & Kennedy, 2017; Halcomb, 2019). However, some within the academic community consider it is neither possible or desirable to combine quantitative and qualitative methodologies as they belong to separate and incompatible paradigms, holding different ways of viewing the world (Tariq & Woodman, 2013). The approaches are also reflective of different underlying ontological and epistemological positions (Regnault et al., 2018). Moreover, mixed methodology can pose challenges, requiring training and skill in both methodologies as well as the rigorous management of time and resources (Edmonds & Kennedy, 2017; Tariq & Woodman, 2013). Taking these factors into consideration and in line with my focus on the nurses' stories and experiences, I considered it more appropriate to select a qualitative methodology approach rather than mixed methods.

Taking a qualitative approach was considered the best fit for this study as it enabled exploration and understanding of naturally occurring events in CCH practice. My decision was informed by the need to find a methodology that was designed for small sample sizes and broad research questions focused on phenomena situated in human experience and on bringing the hidden into consciousness (Ayres et al., 2017; Davies & Fisher, 2018; Lewin & Glenton, 2018; Scotland, 2012). Additionally, utilising qualitative research resulted in a better understanding of the social and psychological experiences and allowed for the conceptualisation of the world and human experience (Ayres et al., 2017; Lewin & Glenton, 2018; Scotland, 2012).

The interpretive paradigm of qualitative research acknowledges multiple realities shaped by personal perspectives, context, and meaning. This was key to this study, given the expected variations in experience and reality. Another benefit was the ability of qualitative studies to provide rich description through inductive reasoning to generate new knowledge (Ayres et al., 2017; Scotland, 2012; Tariq & Woodman, 2013). The final aspect that factored into the decision to take the study in a qualitative direction was the increasing use and confidence in the findings of qualitative evidence to inform decisions in health, including in policy and systems (Lewin & Glenton, 2018). I considered this reassuring as the findings of this study are intended to uncover the

CCH nurses' experiences of stress in whānau engagements and inform nurses, health, policy, and systems decisions.

Critics of qualitative methodologies have highlighted its limited transferability and applicability to the general population (Davies & Fisher, 2018). Scotland (2012) emphasised challenges such as establishing legitimacy and trustworthiness, noting that reality is subjective and varies between individuals. Additionally, qualitative research produces highly contextualised data, making interpretations complex and affecting outcomes and generalisability (Scotland, 2012). Despite these limitations, it was determined that a qualitative approach was appropriate for this study.

As qualitative methodologies are guided by the paradigm's philosophical stance but differ in their epistemological bases, data collection, analysis, and in the insights they generate (Ayres et al., 2017; Davies & Fisher, 2018), it was important to select the most appropriate methodology for the study's aim. Ethnography, grounded theory, and phenomenology were three qualitative methodologies that were considered alongside ID, as they provided a rich variation of approaches that offered a diversity in choice (Bradbury-Jones et al., 2017).

Ethnography, the primary method of cultural anthropology, gathers data of a particular group to discover cultural and contextual patterns of entire cultures through immersive fieldwork (Bradbury-Jones et al., 2017; Crawford, 2019). For this study, ethnography was not considered an appropriate methodology as the current research is not concerned with investigating the culture of CCH nurses but with exploring one specific issue CCH nurses face when with whānau. Additionally, to immerse myself into the culture would have an unknown impact and potentially alter the nurses stress experience or aggravate the tension. As a result, ethnography would not provide the insights or interpretation of the nurse's experiences of stress when engaging with whānau the study aimed to provide.

Phenomenology, which was developed for the purpose of studying the lived experience of those affected by a specific phenomenon in response to the needs of psychology (Alba & Beck, 2017; Ayres et al., 2017), also did not seem to be a suitable methodology for the current research study. One of the reasons for not using phenomenology was because it expects the researcher to set aside preconceived ideas and beliefs and to see the world from the participants' point of view (Alba & Beck, 2017). The bracketing required by phenomenology expects adherence to specific techniques to gain an inside view in order to ensure that the researcher is disconnected and refrains from judgement (Alba & Beck, 2017; Ayres et al., 2017). However, disregarding my personal insight into the issue would go against nursing's philosophy of building on the discipline’s knowledge and of identifying human and contextual variation to understand how the discipline thinks about the problem (Thorne, 2016). The use of studies of people’s lived experience for clinical practice is limited if interpretation does not occur which is central to this study (Hunt, 2009; Thorne, 2016). Therefore, being disconnected and not applying my own understanding and beliefs to the interpretation of the data would not have acknowledged or enabled my theoretical allegiances, nor would it have acknowledged how I am located in the discipline and my personal relationship with the ideas in the study (Dolan et al., 2023; Thorne, 2016).

The last qualitative methodology considered for this study was grounded theory. Grounded theory arose from within sociology as a methodology to explore social structure and discover fundamental patterns of social processes to develop an explanatory model and theory generation that makes sense of the aspect of the social world being studied (Ayres et al., 2017; Hutchinson et al., 2017). Grounded theory requires the adherence to a set of rules related to sampling, data saturation, and layers of coding to generate theory from systematic research (Hutchinson et al., 2017). This was not possible with this research topic as saturation was not considered possible. Additionally, like phenomenology, grounded theory also presupposes that the structure and processes can be identified and described independently of the researchers’ understanding (Ayres et al., 2017). This was not possible as my understanding of the study is inherently intertwined with the design of the study and analysis of the data. In short, grounded theory was not considered to be the most appropriate methodology for the study as it did not provide the methodological flexibility required and I did not wish to generate theory.

Social science approaches that are used in an applied science context often expect researchers to follow rigorous methodological procedures which hold certain assumptions about knowledge and its creation and disregard their own knowledge, and refrain from judgement, and structured rules (Ayres et al., 2017; Chiu et al., 2022; Thompson Burdine et al., 2021; Thorne, 2011; Thorne, 2016). Thorne’s assertion that “attempts to adhere rigorously to the tenets of grounded theory, phenomenology and ethnography were creating an increasingly obvious tension associated with the (nursing) discipline’s requirements for useable knowledge” (2014, as cited in 2016, p.13) resonated with the tension I was feeling to select the right methodological approach for the study that would meet my desire to produce credible, meaningful, and relevant findings for nursing while also acknowledging my positioning within the discipline. Finding meaningful and applicable interpretation required me to use various approaches from a theoretical positioning that was not static but instead temporary and situational, meeting the research requirements for socially just practice to enable solutions for change (Ocean et al., 2022; Thorne, 2011).

ID became my preferred methodological approach due to its alignment with interpretive naturalistic orientations, which acknowledges shared realities and the contextual nature of human experience (Hunt, 2009; Thorne, 2016; Thorne et al., 2004). I was drawn to interpretivism's view that reality is subjective and shaped by historical and cultural contexts (Uzun, 2016). ID resonated with me, as it emphasises understanding human behaviour through multiple realities, including feelings, beliefs, and values while acknowledging how the researcher and the study participant interact and can influence each other (Thorne et al., 2004).

During the process of selecting a methodology, I was aware of how my biases and beliefs influenced the process. Reflecting on the strengths and limitations, ID emerged as a logical choice, offering both structure and philosophical grounding without rigid rules or constraints. Its flexibility allows for conceptual linkages to other methodologies, using methodological tools common to them, whilst providing a methodological structure, that is based in nursing reality without adherence to one formal theory (Teodoro et al., 2018; Thorne, 2016; Thorne et al., 2004). I considered that as this study was rooted in nursing reality ID would enable the generation of credible and meaningful knowledge.

Disciplinary Orientation

The disciplinary orientation represents a fundamental component of the theoretical forestructure of ID and is made up of three key aspects (Thorne, 2016). The first was locating my theoretical allegiances as I entered the study, which was helped by being guided to ID by my supervisors and reading Thorne (2016) and other literature. The second aspect involved locating myself within the discipline of CCH nursing and the third required locating my personal relationship to the ideas I held.

Theoretical Allegiances

The interpretative paradigm assumes that qualitative researchers are not impartial or detached from the research process or the participants, that they understand the problem, and that they are entwined in the knowledge being produced while knowing who they are and what they represent (Davies & Fisher, 2018; Thorne, 2016). Thorne (2016) considered that being grounded in the discipline enables the researcher to understand the participants' experiences, to discern the scope and boundaries of the study and to know what constitutes knowledge in the discipline's philosophical underpinnings of practice. Conscious awareness of the disciplinary orientation afforded me the epistemological positioning that shaped what I decided to observe, what was seen in these observations and what sense I was able to make of them, while acknowledging rather than eliminating possible biases (Davies & Fisher, 2018; Thorne, 2016).

ID offered me the ability to bring my whole self to the research, to not exert power or privilege in the research process, but be responsive to the participants, and value my expertise while engaging in deep self-reflection throughout the process (Davies & Fisher, 2018). It was important to consider my positioning within the discipline and this study in terms of my agenda, beliefs, and value system from the beginning, as the way research is conducted is influenced by the researcher’s ideology (Scotland, 2012). I also needed to be able to justify the clinical relevance of the study and the usefulness of the findings alongside the need to pay attention to my own reflexivity in meaning and interpretation (Ayres et al., 2017).

Locating Myself Within the Discipline

The orientation of myself as the researcher in the nursing discipline, and more specifically in Community Child Health nursing, arises from 40 years of experience in paediatric, neonatal, and community child health nursing. The largest percentage of this time has been spent working in community child health, specifically in Well Child Tamariki Ora practice. My career has included working in hospital settings, clinical community practice, tele health, leadership, and education. During my career, I have supported whānau with seriously unwell tamariki in acute care, whānau experiencing a range of complex health and social issues, and whānau who are navigating the strengths and struggles of provide loving and nurturing care to tamariki.

Over my career, through my own experiences and talking to other CCH nurses I have become increasingly interested in how health professionals and whānau relationships are navigated, especially in situations when the nurse is stressed. I was interested in how the intersection between professional and personal life and stressors impacted on the nurse. Colleagues’ stories have highlighted how working with whānau, high workloads, expectations of the discipline, employers, society, and the health system have caused stress that impacts on their practice and their own wellbeing. My positioning has also been informed and influenced by my knowledge gained through academic learning on relational practice and neuroscience. I needed to be mindful of how this knowledge could influence my views as the researcher in this study. I acknowledge that my knowledge, experiences of stress, beliefs, assumptions and hopes for outcomes have influenced the research study design, data gathering process, data analysis and the way the findings are reported. However, I anticipate this has been an advantage to the study by generating findings that are relatable and relevant for nursing practice.

Personal Perspective

The third aspect of theoretical allegiances is the researcher's personal perspective. This aspect acknowledges the impact of the researcher's ideas, theories, perspectives, and personal experiences on the design and implementation of the study (Thorne, 2016). My own awareness and experience of the issue has influenced how I view the problem, shaped my focus, observations, and the sense I was able to make of the data (Thorne, 2016). During the study, I reflected on my motivations and biases so I could minimise the unintended impact by managing and accounting for these. I was also mindful of how my personal perspective, knowledge, beliefs, and values have shaped the study. I reflected throughout the study how my personal perspectives have changed over the research period and the impact this could have had on the study (Sandelowski, 2000).

Additionally, I need to acknowledge the influences my upbringing, European ethnicity, being a woman, nurse, mother, whānau member, and friend have had on my beliefs and values and their relevance for the study topic. Having experienced stress in whānau engagement myself has framed my own construct of this experience. I needed to be mindful of these when I listened to others' experiences of stress. During the process of gathering and analysing the data, it was a privilege and honour to hear the experience of the CCH nurses. I used mindfulness, reflection, and supervision throughout the study to reflect on my personal perspective.

Evaluation Criteria

ID studies aim to provide insights into human experience within a qualitative framework; however, given the variability in approaches and study design, concerns about credibility and quality have emerged (Thorne, 2016). To address this, Thorne (2016) emphasised the need for integrity, credibility, and robustness in an ID study, recommending adherence to four key principles: epistemological integrity, representative credibility, analytic logic and interpretive authority. In the following section, I discuss how I have achieved this.

Epistemological Integrity

In ID research, it is expected that a defensible line of reasoning is maintained throughout the research process to assure the integrity of the process (Thorne, 2016). Epistemological integrity enables the researcher to choose which methods are best suited to answer the research questions (Breau et al., 2023). To increase credibility, I have followed the principles of ID as outlined by Thorne (2016), including ensuring the research questions held consistent epistemological integrity. Following this, ID guided the logical process of selecting the study design and data analysis, all the while reflecting and questioning the influence of my theoretical and personal assumptions. I took on the responsibility of ensuring that the findings were sound within the disciplinary logic and context and that they are enlightening to the audiences, while being mindful that there is always a risk that the audience blindly and uncritically accepts them (Thorne, 2016). Epistemological integrity was guided by methodological processes and guidelines outlined by Thorne (2016) while being supported through reflection, consultation with my supervisors, and advice provided by my advisory team.

Representative Credibility

Leading on from the need for epistemological integrity, Thorne (2016) described the need for confidence in the truth of the findings. To ensure the credibility of my findings, I assessed their coherence, representation of participants, and alignment with the study's integrity (Breau et al., 2023). My grounding in the discipline provided a framework for defining the study’s scope, boundaries, and philosophical underpinnings. Additionally, my background in CCH nursing influenced the study design, data interpretation, and dissemination. I remained mindful of the audience’s capacity to interpret and apply the findings (Thorne, 2016). Credibility was further strengthened through data triangulation, employing both vignettes and semi-structured interviews.

Analytic Logic

Analytic logic and decision-making processes needed to be sufficiently visible throughout the thesis to enable the audience to assess the credibility of the study (Thorne, 2016). Analytic logic was supported in the thesis by verbatim accounts from the data and the use of illustrative data that reveal the context of the study findings. Details of the decision-making processes used to inform the development of the analytical process used in this thesis are provided in the next chapter. I used a reflective journal, wrote memos during the analytical process, used diagrams, as well as large pieces of paper and sticky notes to be able to formulate relationships between themes that informed the interpretation of the data as recommended by Breau et al. (2023).

Interpretive Authority

Thorne (2016) emphasised the need for the researcher to assure their audience that their interpretation of the data is trustworthy, sufficient data information is revealed and the truth about bias and experience are revealed so the findings represent the truth of the research subjects. It is acknowledged that my thoughts, beliefs, and lived experience could have impacted the interpretation of the interviews and vignette responses. I utilised self-reflection through writing, journalling, meeting my advisory group, and monthly supervision meetings with my academic supervisors to reflect on the impact of being a new researcher, being in the CCH discipline, and my knowledge and beliefs about the topic. It was important to reduce the influence my bias, motivation, or interests may have on the findings. The use of two data sources supported the reliability of the findings as similar patterns were found across both data sets. Additionally, I revisited the transcripts several times to review and refine my interpretations, which further increased the trustworthiness of how I interpreted what was revealed in them. I also needed to be mindful of transferability as Thorne (2016) warned that transferability of the research findings to different areas of nursing needed to be done cautiously. CCH nursing is a unique sub-discipline within the nursing profession, so I needed to capture the uniqueness of CCH nurses and the study topic and to avoid overgeneralisation of patterns as this could obscure the individuality of each participant and their collective experiences.

Beyond Evaluation

Thorne (2016) considered that, in addition to the evaluation criteria outlined above, there is a set of more subtle ID research criteria, including moral defensibility, disciplinary relevance, pragmatic obligation, contextual awareness, and probable truth. This section now describes how I addressed each of these criteria. The first criteria, moral defensibility, required me to reduce the risk of harm to the participants and be able to defend the need for the study. I achieved this through providing information sheets, gaining informed consent, and being mindful during the study and when sharing the findings to reduce harm. Protecting participants from harm was particularly relevant for the topic as stress can be a deeply emotional part of practice. The second criteria, disciplinary relevance, required me to explain the relationship between the research and disciplinary knowledge. It is hoped that this new knowledge can be used to support other CCH nurses in their practice. The third criteria, pragmatic obligation, required me to reflect on the need for findings to be useable in applied practice, not be understood as purely theoretical (Thorne, 2016), which has helped frame the findings. The fourth criteria, contextual awareness, refers to me acknowledging the context of what is known and unknown and the influence of other invisible shared assumptions, with findings being a moment in time that may not stand the test of time (Thorne, 2016). The final criterion, probable truth, highlights that it is not possible to guarantee that the findings represent the truth; rather, the findings can be conceived of as probable truths until confronted with compelling evidence or reasons to dismiss them, leaving my findings open for challenge (Thorne, 2016).

Chapter Summary

This chapter has provided an overview of the chosen methodology, Interpretive Description. It has outlined the philosophical, epistemological, and ontological underpinnings of ID and its research practice orientated focus and ability to account for the complexity of the study’s aim. After considering multiple approaches to data collection and analysis to capture experiential knowledge and experiences of participants, ID was considered to be an ideal choice due to its theoretically credible structure, theoretical foundation, and flexible approach, that enables the use of a holistic, relational perspective for the exploration of the complex and sensitive topic (Thompson Burdine et al., 2021; Thorne, 2011; Thorne, 2016). The use of a methodology that holds theoretical forestructure while borrowing from other design techniques offered me the opportunity to move beyond rule structures of social science methodologies while aligning with the epistemological underpinnings of nursing (Hunt, 2009; Thorne, 2016). ID also enabled me to cope with exploring the messiness of community child health practice whilst being from the discipline being studied. These benefits resulted in the generation of new knowledge that honoured the nurses experience and capacity in the complex phenomena of stress when engaging with whānau. Moreover, ID supported my interpretivist constructivist positioning and enabled me to locate myself as the researcher in the study.

Chapter Four: Methods Chapter

In this chapter, the methods used for the research design, process, and analysis are described. The discussion of the study design begins with a description of the processes I used to develop the proposal, research questions, approach ethical considerations, and decide on the data sources. This is followed by an account of how the data was analysed and themes developed, leading to the final thesis chapters that bring together the findings and make recommendations for change. As previously discussed, the study explored CCH nurses' experiences and perspectives of self-regulation and attunement in times of stress when with whānau using Throne's Interpretive Description (ID) methodology. As discussed below, ID's principles guided the development of the research design and methods undertaken.

Design of the Study

ID provided a flexible, non-prescriptive framework for the study design and analysis, guided throughout by its core assumptions and principles (Thorne, 2016; Timmins et al., 2023). The first assumption underlying ID is that the study was undertaken in as naturalistic context as possible, respecting participants' comfort, and ethical rights. The second is that the value of subjective and experiential knowledge was attended to as fundamental to insights of applied practice. The third is that commonalities and individual variance were acknowledged, whilst recognising that human experience involves multiple constructed realities that at times may be contradictory. The fourth is that the study attended carefully to the time and context, so the issues were not bound by these. The fifth assumption underlying ID to be highlighted is that the study acknowledged the socially constructed element of the experiences that could not be separated from its essential nature. Finally, the study recognised the inseparable interaction between the researcher and the researched and influences on the research outcome. (Thorne, 2016). Chapter Four now describes the steps taken in designing the study, supported by the above assumptions.

The Study Proposal

Writing the research proposal helped me name the problem and scaffold the study, allowing me to make a case that what I was doing was worthy of studying and to outline a clear map of how I was going to achieve this. This road map began with naming the research questions, followed by a description of how the two types of data collection and decisions on the participant sample were made.

Development of the Research Questions

Central to ID is the principle that the research questions are clinically relevant and benefit clients or the health system (Thorne, 2016). As such, the questions were designed to address the complexities of a nursing phenomenon and advance clinical practice in CCH nursing (Thompson Burdine et al., 2021; Thorne, 2016). It was important to formulate questions that were suitable for a study of CCH nurses' experiences while also addressing the ID assumptions described above. The questions were iteratively developed and adapted during the early stages of the study, with several further iterations occurring during the writing of the literature review and research proposal. Undertaking the process of developing and redeveloping the questions also helped me gain a deeper understanding of myself as a researcher and clarified what I was wanting to explore through the study.

Following a robust development process, the following research questions were developed:

- How do Aotearoa New Zealand community child health nurses describe the relationship between stress and the capacity to self-regulate their stress response when engaging with whānau? and
- How do Aotearoa New Zealand community child health nurses describe the influence of stress on attunement, the capacity to build trust, and their ability to reflect on whānau relationships?

Data Collection

ID methodology aligns with several different data collection methods. The main criteria for the suitability of a data collection approach within an ID methodology is that it is likely to result in the collection of rich practice-based data, that has the potential to generate new findings with greater confidence (Thorne, 2016). I chose two phases of data collection, Phase One a vignette questionnaire and Phase Two semi-structured interviews to enable a broader reach and range for data collection. Thorne (2016) highlighted that nursing epistemology values multiple knowledge sources, recognising that different data sources provide unique insights. Given that health phenomena have no singular truth, diverse perspectives hold the potential to enhance understanding, influencing the decision of data sourcing (Thorne, 2016). By using two data sources for this study, participants could choose if they wanted to just do an anonymous online questionnaire or to carry on to a semi-structured interview. This enabled a wider reach of participants and options for them to share their experiences. Due to the sensitivity of the topic, it was considered that some participants might not want to share their experiences in an interview but might be willing to respond to an anonymous questionnaire. An additional benefit of having two phases was that participants became familiar with the topic during Phase One before progressing to Phase Two. Some participants stated, they felt more prepared for the interview discussion as they had reflected on the topic during and following completing the vignette questionnaire. It is of interest that less than half of Phase One participants chose to progress to Phase Two, potentially without the option of two phases there may have been less participant contribution. Providing the option of two phases appears to have provided a richer amount of data than only one phase would have.

Phase One: Vignettes with Reflective Questions

The online questionnaire consisted of two hypothetical vignettes scenarios, each followed by reflective questions and free text boxes for reflective written responses (see Appendix A). Vignettes are short, anonymous scenarios that provide a brief but realistic snapshot of practice (Bray et al., 2019; McInroy & Beer, 2022). They are typically used to collect participants' attitudes, perceptions, beliefs, values, and abstract concepts in response to the scenarios described in the vignettes (Bray et al., 2019; Zagoto Agulho et al., 2021). Vignettes that simulate real-life experiences have been found to promote authentic reactions as to how the participant would respond in identical real-world situations (Bray et al., 2019; Zagoto Agulho et al., 2021). Hypothetical but realistic vignettes have been found to promote more transparent and honest responses while allowing participants to distance themselves from an ethically sensitive topic by commenting on a hypothetical story (Mah et al., 2014; Veloski et al., 2005). Vignettes were introduced as early as the 1950s in anthropology and became popular in the 1980s in health research (Bray et al., 2019; Zagoto Agulho et al., 2021). In nursing, vignettes started to be used in the 1990s to gain insights into nurses' attitudes, beliefs, and decision-making processes in clinical situations (Zagoto Agulho et al., 2021).

The use of vignettes fits within an ID approach, as Thorne (2016) believed that the purpose of data was to provide a coherent narrative that applies to the intended audience. Using vignettes that were practice based and asked practice-related questions bridged the interface between ID and the discipline of CCH nursing. Using vignettes provided anonymity and confidentiality for the nurse participants and their employers (Mah et al., 2014). This is relevant to this study as the topic of CCH nurses' experiences of stress when engaging with whānau may be considered a sensitive topic making it difficult for participants to provide honest responses. Additionally, it was imperative that the study was undertaken in a context that was as naturalistic as possible, yet respectful of the participants' comfort and ethical rights (Thorne, 2016), and as such, vignettes were determined to be a good fit.

Development of the Vignettes

The vignettes were written to be generic enough to be relevant to the different community child health nurses' roles involved in this study, such as, community paediatric nurses, community neonatal nurses, and well child/tamariki ora nurses, and also to be non-gender specific for the nurse. The vignette scenarios aimed to be realistic and authentic enough so the participants could imagine the situation or place themselves in the nurse’s position without too much detail that could result in the design constraining the responses (Mah et al., 2014; Veloski et al., 2005). The advisory group was consulted during the development of the vignettes and corresponding questions and provided feedback which was subsequently integrated into the vignettes. The vignettes were then piloted with two community child health nurses and refined based on their verbal and written feedback.

Phase Two: Semi-Structured Interviews

Phase Two involved semi-structured interviews. Interviewing was selected as a method for this study as it is considered a valuable approach in qualitative inquiry and a means to develop and refine new knowledge (Holloway, 2017). Terry and Hayfield (2021) identified that interviews provide rich, detailed, and in-depth data from participants who are embedded in a specific topic, drawing on the expert knowledge of participants. Furthermore, semi-structured interviews are centred on knowledge and beliefs that multiple realities are shaped by personal viewpoints, context, and meaning, and that interviews allow for rich descriptions of these (Tariq & Woodman, 2013). Interviews are commonly used to generate knowledge concerning clinical issues (Jamshed, 2014). Terry and Hayfield (2021) considered in-depth semi-structured interviews as one of the most popular and widely recognised qualitative research methods and as a useful approach for exploring sensitive or personal topics. It is important to acknowledge that interviewing has limitations as events can be recalled differently by different people, and recollections of traumatic events can be constructed into an incontestable truth (Thorne, 2016). This is particularly relevant to this study as community child health nurses will likely differ in how they recollect and interpret stressful situations with whānau assuming that their perception of what happened is the only valid truth.

It was anticipated that the use of interviews would complement the insights gained from the vignettes and enable the nurses to share their deep and rich accounts of and perspectives on, real-life practice. The nature and sensitivity of the topic informed the decision to have the vignettes undertaken before the semi-structured interviews. This decision enabled participants to become familiar with the topic, reflect independently in a non-threatening anonymous way before coming together with the researcher, if they chose to continue to Phase Two. Also, having the option of completing the vignette questionnaire without undertaking the semi-structured interview meant they could express their views confidentially without any engagement with the researcher.

Development of the Semi-Structured Interview Questions

The questions for the semi-structured interviews were developed as open-ended questions starting with broad questions, leading to more specific questions as the interview progressed (Jamshed, 2014). (see Appendix B). The question bank included a range of questions to guide the interview in a relational way rather than being a structured questioning (Holloway, 2017). Terry and Hayfield (2021) recommended beginning with questions that put participants at ease, before moving into more sensitive questions as the interviewees become increasingly comfortable. This is in line with Thorne's (2016) guidelines for ID research data collection as it allows the researcher to keep a balance of what the participant wants to discuss and the active role of the researcher in deciding what questions they, to encourage participants to share their experiences.

All the participant interviews were conducted online to provide consistency in the interview process, to minimise travel costs as the participants were nationwide, allow participants to be in a familiar place, and to mitigate any potential impact of Covid-19 on face-to-face interviews. The interviews were recorded via Microsoft Teams (a Microsoft Corporation product for video conferencing) with a back-up recording made on a dictaphone.

Ethics

Following the research proposal being approved by AUT I sought ethical approval. Participant flyers, information sheets for both phases, consent forms, the vignette scenarios and questions, and the semi structured interview information were provided in the ethics application. Ethics was granted from the AUT Ethics Committee for application 21/445 on the 2nd of June 2022 (see Appendix C).

I was cognisant during the research process of protecting privacy and confidentiality and treating the participants with fairness and respect (Holloway, 2017). To avoid coercion, the recruitment flyer and information sheets informed participants that participation in the study was voluntary, and they could decide to what extent they wanted to be involved in the study, be it fully, partially, or not at all and they could withdraw at any time without consequences.

Consent was gained separately for both phases. For Phase One, participants read the information sheet outlining the research aims, role of the researcher, participants rights, and who to contact if questions arose (see Appendix D). Participants then signed a digital online consent box. Consent for Phase Two involved reading the Phase Two information sheet (see Appendix E) and signing an emailed consent form (see Appendix F). The consent form was returned prior to arranging the one-to one interviews to protect participants' right to undertake the study without any coercion.

Confidentiality was maintained by not linking responses to individuals and putting processes into place, so participants were not identified in this study. Confidentiality was maintained during Phase One by the signed consent form being kept separate from Phase One data. Additionally, during Phase One, there was no contact with the participants and their study data was kept anonymous. In Phase Two confidentiality was maintained by keeping Phase One and Two contact details and data separate, storing names and contact details in a password protected REDCap file (REDCap is described in the next section). During the Phase Two interviews, participants' rights and confidentiality were maintained throughout the interviews by being in private spaces. Additionally, contact details, data, and transcripts were stored in password protected electronic files. Interview videos and recordings were deleted once transcribed, codes and pseudonyms were allocated for transcripts, and identifying data was removed or altered in the transcripts, including the names of people and workplaces.

To support meeting ethical requirements, I established an advisory team from within child health. This group consisted of a Māori nurse, a Pacific nurse, and an Asian Advisor from within child health. The group provided me with cultural guidance, advice, and support so I could reflect on my role and positioning as the researcher and the research processes. I used the Māori ethics framework from the Health Research Council of New Zealand Te Ara Tika (Hudson et al., 2010) which consists of the four tikanga based principles, whakapapa (relationships), tika (research design), manaakitanga (cultural and social responsibility), and mana (justice and equity), to act as guiding principles for the study (Hudson et al., 2010). Working in close cooperation with the Māori cultural advisor supported embedding these principles in the study process.

While conducting a research study on CCH nurses' experiences meant that I understood their context, I was consistently mindful of their vulnerability and the influence that potentially knowing me or of me, alongside the influence of my experiences, knowledge, and beliefs about the topic, could have on the thoughts they were willing to share. I was also mindful that, consciously or unconsciously, participants may modify their answers to please me or for their practice decisions to appear in a positive light (Holloway, 2017). As such, I developed exclusion criteria, discussed with participants their rights when commencing the interviews and let them guide what they were prepared to discuss and not discuss during the interview process. I also used self-reflection during the interviews to remain open and accepting of their experiences and to reduce my own beliefs and biases from impacting on the flow of the interview (Holloway, 2017).

As I have worked in CCH practice for over 30 years, I was mindful that the study participants may know me or know of me. As such, if they had known me through a close working, educator/student or supervision relationship they were excluded from the study. This exclusion criteria were shared in the Phase One and Phase Two information sheets alongside my name as the researcher. This exclusion criteria aimed to reduce the influence I may have had on participants' level of comfort in sharing their experiences and my objectivity. I also did not directly approach or encourage anyone to participate in the study, rather the invitation to participate was shared in newsletters or by intermediaries. Additionally, the data gathered in Phase One was non-identifiable. On receipt of the names of those who expressed an interest in Phase Two, I assessed any relationships against the exclusion criteria and the networking diagram of possible relationships (see Appendix G). In relation to those that I did know, I checked we did not have a close working relationship, that I was their educator or supervisor and that I held no reporting responsibilities with or too them. At the start of the interviews, I discussed with each participant my role, and any relationships we had. I offered them the opportunity to not progress with the interview or to stop it at any stage.

Selection of Data Capture Tool

I selected REDCap (Research Electronic Data Capture) to host the collection of Phase One information, consent, questionnaire, data, and the Phase Two expression of interest form. While several options for hosting online questionnaires were explored, REDCap offered benefits over other tools, including being built for clinical research, capable to host the questionnaire, easy of use by participants and myself, ability to store the questionnaire data, and ability to collect and store sensitive information confidentially (Patridge & Bardyn, 2018). Additionally, REDCap was provided free to AUT students, and its use was managed by a designated AUT REDCap support team. The support team set up the hosting space, provided education materials and advice on how to develop surveys in REDCap, including the consent processes and the link between two survey tools that enabled confidentiality.

Sampling

The principles of purposeful and theoretical sampling were used to recruit CCH nurses to explore their experiences of stress when engaging with whānau. It is acknowledged that a sample being completely representative of CCH nurses is not considered desirable or even possible due to the uniqueness of each CCH nurse and situations they encounter in practice (Teodoro et al., 2018; Thorne, 2016). Employing a purposive sampling method meant that participants could be selected based on the inclusion and exclusion criteria described below to ensure both diversity and comparability across the cohort (Oliver, 2012; Thorne, 2016). I discussed with my supervisors and advisory group the possible influence my knowledge and experience in WCTO nursing may have on sampling.

Inclusion and Exclusion Criteria

Nurses who met the inclusion criteria and wanted to participate in the study were deemed likely to have both knowledge and experience of stress when engaging with whānau and the ensuing issues faced in practice from these experiences. To be included in the study, participants had to be:

- A Registered nurse, so the participant group held the same primary qualification and competency requirements.
- A child health nurse, to limit the nurse’s role to be nurses supporting whānau with tamariki.
- Working in community practice as a community peadiatric nurse, or community neonatal nurse or Well Child Tamariki Ora practice (WCTO nurses), to contain the range of potential community practice areas.
- Providing direct care to tamariki and their whānau, so participants could recount experiences of stress during whānau engagement.

Potential participants were excluded from the study if:

- They were not working in direct whānau and tamariki care, as they may not have regular experiences of whānau engagements.
- They know the researcher through a close working, educator/student or supervision relationship. This group were excluded to reduce the influence of the researcher on participants’ level of comfort in sharing their experiences and the researcher’s objectivity.

Participants were informed of the inclusion criteria through the flyer advertising the study, screening questions in the survey, and the information sheets for Phases One and Phase Two. The decision to recruit participants from a range of CCH nursing roles followed consultation with members of the College of Child Health Nurses as well as my AUT supervisors. As discussed in Chapter One, the goal of the study was to capture the experiences of CCH nurses from a range of experiences while also having similarities in their community child nursing roles. One of the key similarities identified across the sample group was the provision of nursing care to whānau with tamariki in their own homes and community venues rather than in hospitals (NZNO College of Child and Youth Nurses, 2024). Additionally, CCH nurses work primarily as a sole practitioner offering personalised, preventive, and integrated care that requires a unique set of skills and perspectives that consider whānau dynamics, cultural background, and socioeconomic factors. The network diagram of the possible relationships (see Appendix G) was created to inform inclusion and exclusion criteria.

Sample Size

Selecting sample sizes for the study's two phases of data collection (an online questionnaire and semi-structured interviews) needed to be both pragmatic and realistic to ensure manageable sample sizes of participants, while also enabling in-depth data collection from a relatively small participant number (Terry & Hayfield, 2021; Thompson Burdine et al., 2021; Thorne, 2016). This sample also needed to include participants who were knowledgeable or experienced in the topic and able to offer valuable insights, while keeping the process within a specified timeframe and the data volume manageable.

Terry and Hayfield (2021) recommended a sample size of 15 to 30 participants for vignette style questionnaires, and six to 10 participants for interviews as they both tend to generate large volumes of data. While considering sample size recommendations, I remained mindful of Thorne's (2016) caution that specifying a sample size is an artificial construct, as there is always more to explore, and data saturation is unlikely to be achieved. Balancing these recommendations, I started with an initial idea of sample size but with the flexibility to either increase or decrease this size depending on the number of participants I would be able to recruit and the data that was produced.

Based on these considerations, it was decided to aim a sample size of 18-25 participants for Phase One's questionnaire (vignettes) and 8-12 participants for Phase Two's semi-structure one-to-one interviews. A larger sample size for Phase One allowed for nurses to opt out of participating in Phase Two while still retaining sufficient participants for the second phase. In the end, 26 participants took part in the vignette questionnaire with 10 continuing to the one-to-one interviews.

Recruitment

The invitation to participate in the study was distributed to community child health nurses via professional networks, including National Well Child Tamariki Ora (WCTO) nurses' networks, neonatal networks, and paediatric networks. The invitation was also distributed via newsletters or emailed to groups of CCH nurses. The electronic invitation included the aim of the study, the structure, procedures for data collection, inclusion criteria, and a weblink to the online questionnaire (See Appendix H). Additionally, two intermediaries were recruited to email the electronic invitation to separate groups of community child health nurses. The use of intermediaries ensured that nurses, from a wide range of CCH practice areas, received the invitation. The intermediaries' only role in the study was to share the invitation with CCH nurses.

Phase One Recruitment (Vignettes)

Phase One recruitment required participants to click the weblink on the participant invitation, read the welcome and study information page, then Select "Yes" or "No" to consent to the study. Selecting "Yes" led to the electronic consent signature tool, then the vignettes questionnaire. Selecting "No" concluded their engagement, with the option to restart the process if they changed their mind.

Phase Two Recruitment (Semi-Structured Interviews)

Recruitment for the semi-structured one-to-one virtual interviews followed completion of the Phase One questionnaire. Recruitment for Phase Two involved reading a brief explanation of Phase Two at the end of the Phase One questionnaire then clicking "Yes" or "No" to indicate interest in taking part in the interview. Selecting "No" concluded the study. Selecting "Yes", led to a second REDCap survey tool which contained Phase Two's information sheet and asked for participants to share their contact details, type of child health practice, length of child health practice, and ethnicity. Having a separate file kept this data separate so Phase One and Phase Two data was not linked. This data was kept on a password protected REDCap spreadsheet only accessible to the researcher. Ten nurses were emailed a consent form and the Phase Two information sheet (provided for a second time). If they did not return the signed consent form, a follow up phone call was made as some of the emails had ended up in junk mailboxes. After receiving the consent form, they were phoned to give them the opportunity to ask any questions they may have about the study and arrange an interview time if they wished to take part in the study.

Recruitment commenced in August 2022 and continued over the following 4 months. The time frame of recruitment was influenced by the timing professional newsletters, featuring adverts for the study, were released and by intermediaries' opportunity to share the flyer. Phase One data collection was completed in November 2022 and Phase Two in December 2022. I talked with my supervisors about participant numbers when there was a slowing in recruitment responses for both Phase One and Phase Two. It was agreed that 26 CCH nurses completing Phase One and 10 completing Phase Two was an appropriate size to cease collecting data. We discussed how data saturation was not considered possible as the experiences of the CCH nurses can have infinite variations. It was considered I had adequate data that recognised variations in perceptions while gaining an understanding of the perspectives of participants (Burdine et al., 2020).

The Participants

Vignette Participants

Twenty-six CCH nurses participated on Part One (the vignettes). The ethnicity of the participants is shown in Table 1:

Ethnicity	Number of Participants
European	21
Pacific	2
Indian	1
Other	2

Table 1 - Participant Ethnicity for Vignettes

There was a range in how many years the vignette participants had worked in nursing as shown in Table 2:

Years of Nursing Service	Number of Participants
0-2	1
2-5	2
5-10	6
10-20	4
20+	13

Table 2 - Years of Nursing Service

There was a range of how many years the vignette participants had worked in CCH nursing practice as shown in Table 3:

Years in CCH Nursing Practice	Number of Participants
Under 1	2
1-5	3
5-10	8
10-20	7
20+	6

Table 3 - Years in CCH Nursing Practice

Semi-Structured Interview Participants

There were 10 CCH nurses who continued on to undertake the semi-structured interviews. The participants ethnicities for the semi-structured interviews are shown in Table 4.

Ethnicity	Number of Participants
European	9
Other	1

Table 4 - Participant Ethnicity for Semi-structured Interviews

The areas of community practice the participants of the semi-structured interviews worked in are shown in Table 5.

Areas of Community Practice	Number of Participants
Well Child Tamariki Ora practice	9
Speciality Community Practice	1

Table 5 - Areas of Community Practice for Participants of Semi-structured Interviews

There was a spread of years the semi-structured interview participants worked in CCH nursing practice as shown in Table 6:

Years in CCH Nursing Practice	Number of Participants
Under 1	1
1-5	0
5-10	4
10-20	1
20+	4

Table 6 - Interview Participants Years in CCH Practice

Collection of the Data

Participation in the Vignette Questionnaire

The participants who consented to undertake Phase One were asked to read the vignettes and answer the questions that followed. They could comment on one or both vignettes and answer as many of the questions they wished to. On completion of the vignettes, there was a final free text box for additional comments. After completing the questionnaire, demographic information was collected, including ethnicity, area of practice, length of time working as a nurse, and time as a community child health nurse. Length of time in practice was collected as it was hypothesised that there may be a variation of experience of stress depending on the nurse’s experience in nursing and community child health practice. Having a range of length of time in practice may have also provided insight into any differences in the experience of stress for novice to expert nurses. In consultation with my supervisors, it was decided not to collect data on the area of community child health practice participants worked in for Phase One as there was a risk that this may identify individual nurses.

Participation in the Semi-Structured Interviews

Terry and Hayfield (2021) recommended practising prior to commencing the interviews, which I did to identify any difficulty with the interview process or any specific questions. Prior to each interview, time was set aside to prepare by refamiliarising myself with the interview question bank and ensuring the dictaphone was functioning. I also used self-awareness techniques of mindfulness to ensure I was able to be regulated at the interviews (Cuyvers et al., 2022).

At the commencement of each interview the participants were welcomed, informed about the interview process, and that guiding interview questions would be asked, but that the flow of the interview would depend on the discussion and their willingness to share. I rechecked consent to participate and be recorded, outlining the procedures that were in place to protect the confidentiality for participants and clients. Participants were informed they could withdraw at any stage of the interview without prejudice and have their information withdrawn until analysis of the data. The participants were asked how they would like to manage emotionally triggering moments (e.g. to take a break, pause, stop the interview).

The interviews began with getting to know one another and time for any questions. This seemed to help the participants feel more comfortable. I used the question bank and the research questions to help frame the interviews. The interviews appeared to take a natural flow, with participants moving between sharing specific experiences of stressful situations with whānau and offering a more generalised discussion of their experiences. Each interview took approximately one hour, with flexibility to share their experiences in a relaxed and not time pressured way. The length of interview varied as participants shared their experiences and the interviews came to a natural closure. After the first few interviews, I changed some of the questions to be more simply worded to provide more clarity for the interviewee, Terry and Hayfield (2021) predicted some degree of variation was normal and is likely informed by the researcher's experiences from previous interviews.

A key element of the context of interviews is the relational space where the data was gathered (Thorne et al., 2016). Throughout the interviews I was acutely and consistently aware of the intimate nature of the study topic and the potential of triggering an emotional response (Holloway, 2017). As many of the participants' stories were emotional experiences, I was mindful of my role to act in a trusting and caring manner and to provide a safe space and to listen empathetically. I regularly offered the opportunity for participants to pause and used empathic statements if they appeared emotional or spoke in an emotional way. I also asked if they required any support to be provided. I informed participants via the information sheet and during the interviews that they could access support through AUT support services.

After completing the first interview, I met with my supervisors to reflect on the interview in terms of both the content and the process used. Following this meeting I continued with further interviews, being careful to pace the number of interviews undertaken to enable reflection between the interviews so that I was not overwhelmed. I chose to complete no more than two interviews in a week as I was also working full time. The interviews only commenced after an adequate number of participants had completed Phase One as I was mindful that starting too early might have risked participants' responses to Phase One being identified. Once I commenced the interviews, there was a period the two phases occurred concurrently with some participants undertaking the online vignettes as others were participating in the semi-structured interviews.

Storage and Privacy of Data

Consent forms, data, Microsoft Teams recordings, and transcripts were stored on a secure computer system. Access to the files required a password known only by me. The Microsoft Teams recordings and the dictaphone recordings were deleted once the transcript was finalised. Participants were allocated different codes and pseudonyms for Phase One data, video recordings, and transcripts. Any identifying data was removed or altered, including names and workplaces, to protect their privacy.

Data Management

Transcription

Microsoft Teams provided the option of computer-generated voice to word transcript. This computer-generated transcription was used to reduce the transcription workload. Transcripts were checked for accuracy by comparing the transcript with the recording before data analysis began. A benefit of correcting the transcripts myself was the opportunity to be immersed in the data and to listen to the inflections in the participants' voices (Terry & Hayfield, 2021). Anonymity was preserved in the transcripts by using pseudonyms and removing identifiable information, such as the names of workplaces, case discussion, peers, and geographical areas.

Data Analysis

ID analysis requires looking beyond the obvious, deconstructing what is seen, testing hunches, identifying similarities and differences, wondering about how they might fit together, and the potential meaning that leads to the findings (Thorne, 2016). Data analysis followed the principles described by Thorne (2016) and reflexive thematic analysis guided the analysis process (Braun & Clarke, 2022; Terry & Hayfield, 2021). The data analysis explored possible relationships among pieces of data gathered and then considered how these relationships played out (or did not) (Terry & Hayfield, 2021). In keeping with an ID approach, analysis required active solicitation of the data as well as exploration of variations and contrasts noted in the accounts, eventually leading to a description of patterns or themes relevant to the research question

(Thorne, 2016). For both vignette and interview data, Thorne's guiding principles as described earlier in this chapter informed the process of interpretive descriptive analysis (2016). These principles supported formulisation of a robust data analysis process, and the interpretation of the data resulting in the emergence of credible and meaningful findings (Thorne et al., 2004). I chose not to use software tools to help the process of data analysis. This is supported by Thorne, who emphasised software management systems do not lead to inductive analysis (Teodoro et al., 2018; Thorne, 2016).

Terry and Hayfield (2021) highlighted that thematic analysis offers a straightforward and rigorous approach to data analysis that can be used in conjunction with most qualitative theoretical frameworks. Reflexive thematic analysis supported the interpretation of the data through my subjectivity and engagement with the data (Braun & Clarke, 2022; Terry & Hayfield, 2021). Reflexivity involved critical reflection on my role as the primary researcher, my assumptions, expectations, and the research process (Braun & Clarke, 2022). Reflexive thematic analysis enabled the interaction of what I brought to the study and my theoretical orientation, enhancing the analysis process while remaining true and grounded in the data. Furthermore, reflexive thematic analysis supported theoretical flexibility, systematic and rigorous engagement with the data, and reflexive contribution to the multi-faceted, conceptual patterns that framed the themes (Braun & Clarke, 2022; Terry & Hayfield, 2021).

Thematic analysis is not a strict rules-based approach of analysis; instead, it is an engagement with data that has guiding principles through six phases (Terry & Hayfield, 2021): Firstly, familiarisation of the data that is thorough and ongoing occurs. Secondly, an organic coding process that is open ended leads to the third phase generation of tentative prototype themes. During the fourth phase prototype themes are developed, reviewed and tested against the data. In the fifth phase themes are defined and named. The sixth phase is when the process concludes with report writing. It is not intended for these steps occur in a completely linear process; instead, these principles are meant to guide the process with movements between phases, sometimes with backwards steps, and at times with more than one phase occurring at a time (Terry & Hayfield, 2021).

Familiarisation with the Data

As recommended by Terry and Hayfield (2021), data familiarisation was my first engagement with the data from the vignettes and semi structured interviews. However, I needed to be mindful during the familiarisation process not to draw premature conclusions (Teodoro et al., 2018; Thorne et al., 1997). Familiarising myself with the data followed Thorne's (2016) suggestion of gaining an overview of the contextual whole first to avoid the risk of making assumptions or jumping to early conclusions.

To assist with data familiarisation, the data from the vignettes was downloaded from REDCap into a spreadsheet that contained no participant identifiers. The anonymised vignette responses and the transcripts from each of the semi-structured interviews were printed off for ease of analysis. Data familiarisation occurred in two stages: the vignette and semi-structured data familiarisation occurred separately before the data was brought together as a whole set. A similar process was used by Cox et al. (2024) who undertook a vignette and semi-structured study of doctors' diagnostic uncertainty. I decided to undertake familiarisation of the semi-structured interview data first, as I had already begun engaging with the data during the interview process (Terry & Hayfield, 2021; Thompson Burdine et al., 2021). This made it easier to keep Phase One data separate from Phase Two data. Familiarisation of Phase One data occurred at a later stage when most responses were completed.

Becoming familiar with the Phase Two data included listening to the recorded interviews and correcting the transcripts. The transcripts were then read for further familiarisation, with removal of unnecessary content such as the interpersonal conversations that took place at the start. During the familiarisation process, brief notes were made on the hard copies of the transcripts so that initial ideas were recorded for later review as themes started to emerge. A reflective journal was also used to capture reflections throughout the process, with journaling emerging as an important part of the reflective process (Braun & Clarke, 2022). A sample of my reflective journal is included in the Appendix (Appendix I). For Phase One, a similar familiarisation process was undertaken with the printed data.

Coding

The second phase of engagement with the data was an open-ended organic coding process. Open coding was used to examine the data, noting similarities and differences, which allowed thematic patterns and recurring ideas to emerge while preserving the overall context (Thorne, 2016; Thorne et al., 2004). Thorne (2016) discussed how coding as a tool should be used cautiously, to avoid premature or excessive coding, and the need to consistently and critically evaluate the coding during the different stages of analysis. It was during this coding phase that I brought the two data sets together. In the coding phase, the data was analysed systematically, and coding was needed to break the data down into more manageable sizes using an inductive approach where the data drove the codes and themes (Terry & Hayfield, 2021). As I had a large amount of data, the coding process enabled me to interpret and reinterpret the data, add meaning to pieces of text, and reduce the amount of text data without losing context. In this sense, coding captured my analytic take on the data (Braun & Clarke, 2022). Coding in action included highlighted text and notes on the transcripts and on sticky notes (see Appendix J). The sticky notes were sorted into similar topics and then placed on A4 paper with a heading that reflected the grouping. Grouping the data enabled further interrogation of the data as an evolving whole as well as looking at relationships between and within groupings. I was mindful to keep codes general enough to enable a broad view while moving down the analytical path (Thorne, 2016). Codes were given names that succinctly and meaningfully captured something specific about the data (Terry & Hayfield, 2021).

Generation of Tentative Protype Themes

Data analysis occurred as I transformed data into patterns by sorting and organising the codes. I was mindful that in ID it is considered important not to be derailed by excessive precision in early coding and instead to look for thematic patterns and recurring ideas (Thorne, 2016). At this stage, I spent considerable time reflecting, reviewing, and shifting the sticky notes around, trying not to feel overwhelmed by the data while invested in a complex sense making process. During this process, the number of groupings became increasingly smaller and clearer, providing a sense of the tentative prototype themes. During this stage I shifted and regrouped data several times. I reflected on the insights gained from the data and looked at what was expected and unexpected. I looked for relationships, commonalities, and differences as well as findings that made sense of the ideas. This iterative process helped make more sense of the relationships as I began to see patterns and built a more coherent narrative and synthesis of new understandings (Terry & Hayfield, 2021; Thorne, 2016). The research questions also guided the data analysis process.

Thorne (2016) highlighted the benefits of continuing to read the data at varying stages of the analysis process. I found theming was not a linear process but a recursive and iterative process, reassuringly Terry and Hayfield (2021) and Thorne (2016) identified this as expected. Rereading the data and transcripts gave me a deeper understanding of the participants’ experiences, allowed me to reflect on my thinking, and test tentative constructs against the data by taking a refining and expansive view concurrently (Teodoro et al., 2018). This was an opportunity to test the initial themes. Interpretations using inductive reasoning required reflection on what each piece of data was saying and how it fitted together to form meaningful patterns and possibilities (Thorne, 2016).

Developing and Reviewing Themes

Developing and reviewing themes involved checking that themes made sense in the context of the coded extracts and the full dataset. Collectively, the themes highlighted the most important patterns in the dataset related to my research questions (Braun & Clarke, 2022). I found myself reviewing and changing themes, including joining some and splitting others. I was mindful that the developing conceptual framework, as it evolved through the iterative process of data collection and analysis, was informed by current knowledge on the topic held by the participants and myself (Oliver, 2012). As themes started to take shape, I reflected on the disciplinary assumptions as well as my expectations. I was careful not to make assumptions from the data and how my practice experience and knowledge influenced the analysis. I was mindful of the impact my beliefs, knowledge, and experiences had on this process, this meant stepping back to challenge my view of the relationships in the data, the emerging themes and my analysis (Thorne, 2016). I used a reflective journal and regular meetings with my supervisors to support this process.

Final Themes Defined and Named

I fine-tuned my analysis as each theme was demarcated and built around a core concept or essence. I reflected on what story the themes were telling me and how they fitted into my overall story about the data. At this stage I named each theme and wrote a synopsis of each one. I still shifted themes and parts of themes at this stage, at times making significant shifts as I analysed each theme and the overall story (Braun & Clarke, 2022). This felt more iterative than sequential; as I moved through the different analysis stages to reach a coherent conceptual structure that captured the important elements that could be understood and helpful in the practice context (Thorne, 2016). Having the ID guiding principles and regular supervision helped to keep me on course or return on course when I had moved off target.

Report Writing

My writing began early in the process as a central part of the analytic process during familiarisation (Braun & Clarke, 2022). I wove together my analytic narrative and quotes from the participants to tell a coherent and persuasive story about the participants’ data that addressed my research questions (Braun & Clarke, 2022; Thorne, 2016). This process enabled me to present findings that go below the surface, challenging current thinking of the issue in new and intricate ways (Thorne, 2016).

Reflexivity During the Process

Thorne (2016) highlighted the inseparable interaction between the researcher and the researched. This includes their interactions and influences on the research outcome. I tried to keep my passion and energy throughout the process and to remain curious about finding out what is fundamental to the research questions and what is part of another story to enable sense and insights to be made from the data. I challenged myself to look at the data from different perspectives. I cycled between confidence and self-doubt in my journey which Thorne (2016) noted was a normal part of the analysis process. I revisited the transcripts on a regular basis to keep grounded in the data. Revisiting data was important while transferring data into findings, to reflect on its relevance to the data and the findings (Thorne, 2016). I tried to keep an open attitude and regularly engaged in critical reflection on what I know, what I do not know, what I am thinking, and the direction my analysis was taking.

I needed to be mindful that some of the stories shared were very stressful for the participants and how my empathy for their situation might impact both the stories they shared or how they shared them as well as my analysis. I also needed to consider that their recollections of trauma or profound experiences could be recalled or changed into a form of truth that becomes incontestable (Thorne, 2016). I was mindful of the socially constructed view of CCH nursing and my beliefs around the CCH nurse’s role and beliefs and experiences of stress within CCH nurses’ relationships with whānau.

The process of doing this study was stressful at times, so it was important for me to reflect on the impact this might be having on my capacity to critically analyse and take a step back to wonder about the data. When I noticed my experience of the study process and stress appeared to be impacting on my analysis, I made sure I stepped away from the process to take some space to recharge so that I could come back to the process with a renewed capacity to engage. Support from my supervisors, colleagues, whānau, and friends helped me navigate the process and my responses.

Chapter Summary

This chapter has provided a detailed discussion of the methods used in this ID study. This discussion covered the rationale for using vignettes and semi-structured interviews to gather the data, the ethical considerations, recruitment, data gathering, and the process used to analyse the data. In the next two chapters the findings will be presented.

Chapter Five: Findings (Identifying Themes and Theme One)

The findings from the vignettes and semi structured interviews have been woven together and are presented as two primary themes:

1. CCH nurses' experience of stress in whānau engagements is unique, multifaceted, and shaped by context; and
2. The impact of CCH nurses' stress on attunement and whānau relationships requires attention.

Each of the above themes has three sub themes. These themes and subthemes represent the complex and comprehensive findings that emerged from the data, and the study, which explored Community Child Health (CCH) nurses' experiences of, and perspectives on, self-regulation and attunement in times of stress when working with whānau. To assist with the appropriate depth of exploration and explanation of the findings, Theme One is presented in this chapter (Chapter Five) and Theme Two is presented in Chapter Six.

The Weaving of the Data Throughout Two Themes

The nurses' descriptions of their experience of stress and of their capacity to regulate their stress response while in engagement with whānau reflect a wide variety of experience and therefore could not be synthesised into a consistent account. Multiple factors and the complexity of stress while being in relationships was consistently highlighted in the stories shared, with each experience unique and complex. There was no clear distinction that emerged to answer the two research questions; instead, both required a weaving and interrelationship of data from both the vignettes and semi-structured interviews. As a result, rather than presenting the findings for each research question separately, they are discussed together across two chapters.

The overarching concepts of the findings stem from the uniqueness and complexity of experiencing stress and self-regulation while in a relationship with whānau. The decision of how to present the themes has been complicated. During the data analysis, the interweaving of the concepts meant there was no clear delineation. In saying that, it has been essential to present the findings in a way that communicated the conceptual meaning clearly and articulately. This is so I could present valuable findings that are accessible to the applied and practised audience (Thorne, 2016), while honouring the participants' complex experiences of stress. Considering these factors and the thematic analysis process that occurred, a decision was made to present the findings in two themes with three sub-themes, as illustrated in the thematic drawing, Figure 1.

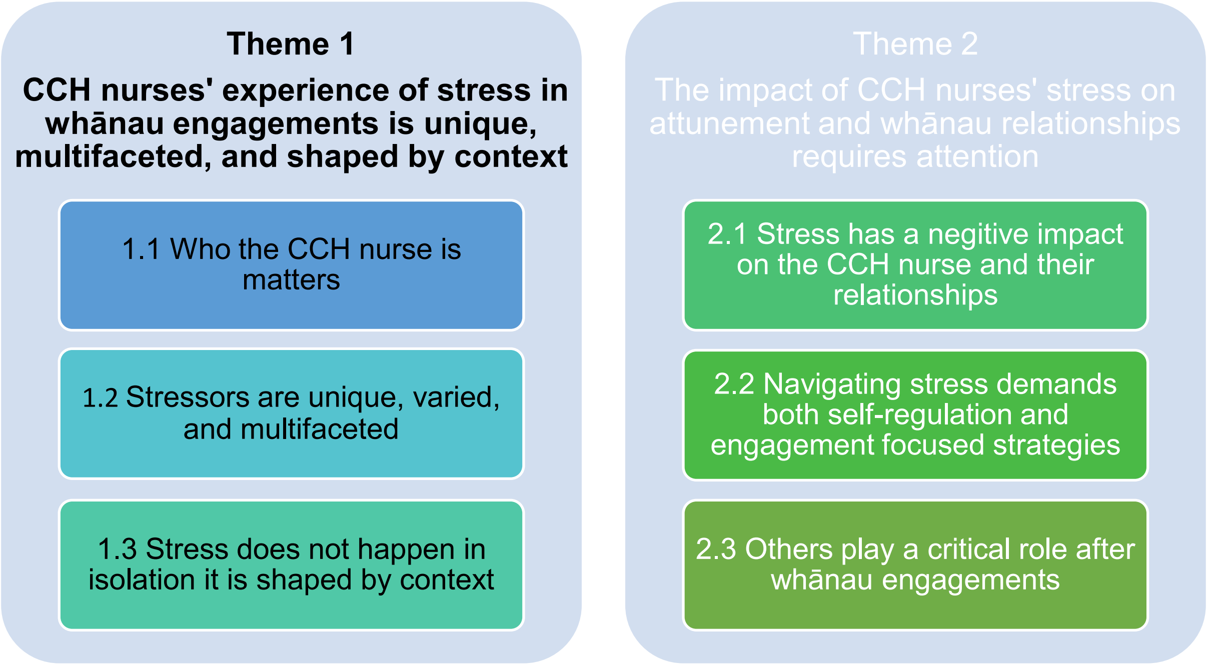

Theme 1
CCH nurses' experience of stress in whānau engagements is unique, multifaceted, and shaped by context
1.1 Who the CCH nurse is matters
1.2 Stressors are unique, varied, and multifaceted
1.3 Stress does not happen in isolation it is shaped by context
Theme 2
The impact of CCH nurses' stress on attunement and whānau relationships requires attention
2.1 Stress has a negitive impact on the CCH nurse and their relationships
2.2 Navigating stress demands both self-regulation and engagement focused strategies
2.3 Others play a critical role after whānau engagements

Figure 1 - Findings Themes and Subthemes (Theme One)

Theme One: CCH Nurses' Experience of Stress in Whānau Engagements is Unique, Multifaceted, and Shaped by Context

Theme One, *CCH nurses' experience of stress in whānau engagements is unique, multifaceted, and shaped by context,* is drawn from the collective stories of the participants as they described the complex factors that influenced their experiences of stress in whānau engagement. This theme is discussed in greater depth through three subthemes as captured in Figure One above; 1.1 *Who the CCH nurse is matters*, 1.2 *Stressors are unique, varied, and multifaceted*, and 1.3 *Stress does not happen in isolation; it is shaped by context*. These three subthemes highlight the individuality of each CCH nurse and how their personal characteristics influence their experiences while also emphasising the unique types and levels of stress they encountered. Furthermore, the themes and subthemes delve into the complexities of the context in which CCH nurses live and work and how these aspects affect their experience of stress when engaging with whānau.

Before sharing the themes of this study, it is useful to provide a collective understanding of how the participants commonly described stressors, stress responses, and self-regulation strategies. The participants described stressors as factors that could potentially trigger an internal stress response. Stress was described by the participants as occurring when a stressor triggered a stress response, which was often described as feeling stressed. Stress responses were described as physiological and cognitive reactions to a stressor, for example a racing heart, becoming internally focused. Self-regulation strategies were described as the strategies the participants implemented, either intentionally or unintentionally, to manage their stress response.

1.1 Who the CCH Nurse is Matters

The first sub-theme, *Who the CCH nurse is matters*, emphasises the uniqueness of the CCH nurse, and how their experience of stressors when engaging with whānau are interpreted and affected by who they are. This includes the impact of personal characteristics and attributes on the participants' experience of stress in whānau relationships. The participants' personalities, beliefs, values, self-awareness, knowledge, experience, and wellbeing played a major role in their stress response. As each participant described different attributes and their impact in unique situations, direct comparisons between individuals could not be made. Instead, these descriptions serve to demonstrate the individual variability of nurses' experiences. During the writing of the thesis, I shifted the sub-theme topics around several times as there were multiple links between them making it complex to have a logical flow. I finally made the decision to start with exploring who the CCH nurse is as I considered the uniqueness of the individual CCH nurse participant as central to how stress was experienced and navigated.

Unique Personal Characteristics

It is of note that there were some similarities in how participants described aspects of their experiences of stress. However, despite these similarities, the more they described their experiences, the more evident it became that these experiences were inextricably linked to and reflective of each participant's individual character and the circumstances surrounding the stress event described. As such, what was considered stressful by one participant may not have had the same stress response or intensity or have been considered stressful at all by others. Notably, this uniqueness of how stress was experienced was observed not only between participants but also in how each participant responded to similar stressors at different times. A participant's stress response in one instance did not predict their response to a similar stressor on another occasion. This variability in people's stress responses was highlighted by Jamie when she stated:

> *Not every response is the exact same for every person. Some people respond to things a lot better than other people. It's just one of those things.* (Jamie)

Individuality can also be seen in how the participants viewed coping in stressful whānau engagements. Some participants thought they generally coped well in stressful situations, whereas others felt they did not. Beth was one of the participants who felt she coped well, stating, “I probably function and do better under stress, which is stupid”. Beth’s view of her capacity to manage stress does not mean she did not experience stress or feel overwhelmed as she described complex, stressful situations during her interview; instead, it suggests she considered stress as something to work through, but that the normalizing of broader beliefs around stress made her see this as “stupid”. The unique and individual experiences of stress is also seen in how Wendy, another participant, describes her capacity to cope in some stressful situations. In the excerpt below, Wendy conveyed the belief that her approach to dealing with stress was different from others:

> *I probably don’t do as well as I could in stressful moments. I’m not the sort of person who takes a breath or break but maybe we just have a little moment where no one talks. I suppose I work differently to others. (Wendy)*

Additional to the uniqueness of the experience of stress and variation in their capacity to cope with stress, participants emphasised that values and beliefs also mattered in their experiences of stress. The importance of values and beliefs was highlighted in descriptions of how attitudes of fairness, justice, and honesty influenced their stress response. For some participants, violation of these precipitated stress during the whānau engagement. Several examples came from concerns about tamariki and whānau wellbeing, whānau being unable to access the support they needed (from the participant or services), or the lack of services. For instance, as presented in the excerpt below, Hana described how fairness was important to her and how this caused her stress when a situation with whānau conflicted with her own belief system. To be able to reduce this stress and support whānau she considered she needed to put these aside:

> *I'm probably quite a stickler for fairness. I try and deal with it, I say to myself in my head, you need to put that aside it doesn't matter. There might be things you don’t agree with or different values, but you have to put that aside. I guess there's scenarios where you would put aside the things that you’re not particularly on board with yourself, like your own values. (Hana)*

Another aspect that became evident in the uniqueness of the CCH nurse and influence over experiences of stress was participants’ views of relationships and how they saw their attributes within this relationship. Thus, Emmy described herself as a people pleaser and shared how she navigates this:

> *I'm somewhat of a people pleaser; I don't like making people angry. I don't deal well with people angry at me. I'll often try and do whatever I can to fix it and*

> *make them like me again. Being a people pleaser, it's nice to go home and not have had anyone be unkind to you in a day. (Emmy)*

Emmy continued this discussion by describing a situation where her multiple attempts to please an angry whānau member were unsuccessful despite trying to find solutions. Her inability to please them caused an emotional response in her.

> *In this situation, I probably became frustrated and angry, from what they were demanding that I couldn’t do. (Emmy)*

Many personal factors, including past experiences of stress and wellbeing, were described by participants as playing a role in shaping their professional persona and impacting how stress in whānau engagement was experienced. Several participants shared how their physical and mental health issues, including depression, anxiety, grief, and trauma history, impacted their capacity to manage stress and be attuned to whānau. These factors formed a framework for how participants experienced and coped with stress. This is illustrated in the following excerpt, where Sara discussed the importance of her wellbeing.

> *My personal life, and my mental health have to be on point and top shape in order to be able to do the job well. (Sara)*

Donna also identified how mental health impacted on the capacity to cope with stress when engaging with whānau. She described her attempts to appear calm and relaxed with whānau to reduce the impact of her stress on the relationship, but there was still an impact on her.

> *There's quite a few of us (CCH nurses) with anxiety and mental health issues. We're all quite open about it (with each other). When with clients I try to be really calm and relaxed. But back at the office, we use each other as sounding boards. (Donna)*

Changes over time were also described by participants to impact on the experience of stress when in whānau engagements. For example, Emmy acknowledged how her responses to stress have changed with time, sharing how stress in engagements felt different once she had their own tamariki:

> *It is much easier to do (protect myself) now that I have 2 girls at home because before I had the girls, I wasn’t so worried, fresh new grad, wanting to change the world. But I am definitely more protective of myself now. (Emmy)*

These examples of the unique experience of stress highlight how the participants' individuality and each unique engagement are complex and how who the CCH nurse is matters in how stress is experienced for each unique whānau engagement.

Self-Awareness of Stress

Participants further noted that being aware of stressors and their own stress responses was another aspect that impacted on how they reacted to stress in whānau engagements. Participants' stories demonstrated how self-awareness of stress was unique to each CCH nurse and the situation. Participants shared how at times they noticed the stressors and their level of stress response, while at other times they were less conscious or intentional. Olivia described the variation in her awareness of stress:

> *Obviously, you need to learn to recognise when you're stressed to be able to regulate, but sometimes you don't recognise when you're stressed. (Olivia)*

Several participants shared how they were not as aware of their stress at the time of the whānau engagement but noticed it afterwards. One of the factors that influenced participants' capacity to be aware of their stress was their focus on the relationship with whānau. For example, Tara illustrated her change in self-awareness in the following excerpt:

> *I didn't have a good feeling at the time. I just tried to focus on teaching factual stuff and bringing my voice down, making a plan and seeing if they could get on board with a plan that worked for them. It really wasn't really till after I left, that I realised just how stressful it had been. I reflected on it later and thought wow, that was actually quite volatile! (Tara)*

Similarly, Olivia described not being as aware of her stress, but how undertaking the vignettes had shifted this for her:

> *I probably don't notice stress much; I just carry on. I don't sit back and think in the moment, I just do.* ……. *I have been making a mental note of all the times I have been flustered and stressed and its actually quite a lot. (Olivia)*

Like Olivia, Tara acknowledged a change in her awareness after undertaking the vignettes for this study. She also noted the benefits of self-awareness and self-regulation in the following statement:

> *When everybody's not regulated [the whānau and myself] the best thing you can do is self-regulate, but I've never thought about it in those terms. It actually helps, checking in am I regulating too….but it didn't occur to me till that moment [undertaking the vignettes] to think about what was going on in my head. I know*

> *that you need to be present, and I was doing that, but it has actually opened me to think about it in a different way. (Tara)*

Furthermore, by actively adopting a more mindful approach and keenly observing shifts in their stress states during these interactions, some participants shared how this could significantly enhance their awareness of stress, playing a crucial role in shaping their overall stress experience. For example, Wendy stated:

> *You have to kind of look at your own stress and not get so stressed about what's happening for them cause you cannot. (Wendy)*

The Influence of Knowledge and Experience

While being exposed to stressors and feeling stressed were considered a reality of practice, (the normalizing of stress is discussed within subtheme 1.3), knowledge and experience appeared to greatly influence how stressors were experienced and managed by the participants. The stories of how participants' knowledge and experience influenced their experiences of stress further highlighted how who the CCH nurse is matters. Although participants' knowledge and experience served as valuable resources during whānau engagements, knowledge and experience could not fully prepare or support the CCH nurse participants due to the unique nature of each situation.

Knowledge and experience were described as helpful in the sense that the occurrence and intensity of stressors could be reduced through learnt self-regulation skills, feeling more familiar, and feeling more confident. Participants described how experience helped them to be faster in making decisions, to "think on their feet", also that their role became like second nature, so they could problem solve more quickly. This meant some felt calmer and able to manage situations that in the past would have been considered stressful. Additionally, they described how knowledge, skills, and experience helped them become less sensitive, more in tune with the situation, and more confident, which put them in a position where they could navigate their stress with more strategies. They felt more aware of which stress management strategies work for them and are effective. In the example below, Tara shared how experience helped her manage unknown situations and develop the capacity to think quickly in the moment:

> *There was no time to do anything else, it may be the training, it may be being caught in situations before. You get better at thinking on your feet and thinking what's going to be really helpful. (Tara)*

Several participants identified that they felt less confident when they were new to CCH nursing practice and faced high stress levels due to a lack of knowledge and skill to manage challenging community nursing situations. For some, this was especially relevant when whānau were experiencing multiple or complex issues. The lack of experience in stressful situations affected how they interpreted the situation and their skills to manage it. Participants shared how they worried about what might or might not happen, feeling they lacked confidence in managing situations that did happen. Some participants discussed how they had high expectations of themselves to cope when they were new to CCH nursing, and that this caused them additional stress. Wendy highlighted how knowledge and experience made a difference to her practice stating:

> *So I was a big rescuer, but this changed as I leant about the community as well as learning about community nursing. (Wendy)*

Some participants described how, over time, the experiences they gained as CCH nurses helped them learn more about relationships with whānau. One of the strategies was to use gentle inquiry and open dialogue to help navigate tricky conversations. This is described by Sara:

> *I guess you don't get experience until you do it, it's got to start somewhere. I think probably if I look back quite a few years I don't think I would have had the same reaction or been able to build that same rapport at that moment (when I was stressed), I was not able to be really transparent. (Sara)*

Knowledge and experience were also found to help develop stronger boundaries. This was noticed by participants especially when they had concerns for whānau experiencing complex issues. For instance, Emmy described how the interrelationship between her personality, knowledge of herself (self-awareness) and experience supported her to put professional boundaries into practice:

> *Because of that people pleasing nature of me, I very quickly had to learn to put boundaries in place. I'm pretty good with those boundaries now. (Emmy)*

Even though all situations were unique, it appears that having knowledge, skills, and experience helped the participants navigate new situations without feeling as overwhelmed as when they first started as CCH nurses. Some participants described being desensitised to stress, compartmentalising it and having an increased acceptance of stress, enabled them to let their feelings go and to not be as affected by stressful situations. Emmy described how she had learnt to desensitise herself and compartmentalise stress despite being a very “empathetic person” as she couldn't “carry the burden of every child she worried about”. Wendy also described the change for her over time:

> *As a new practitioner I felt very overwhelmed when there was a situation I couldn't fix. That is one of the things that I had to learn myself for my own stress. It is good to start off with those professional friend boundaries to try to protect yourself a little bit as well. When you are new to this community role that's a skill you need to learn. (Wendy)*

Additionally, some participants reflected on the impact of their prior nursing experience in becoming desensitised; for example, working in Accident and Emergency departments. These prior high stress roles were considered to have helped cope with stress; however, this did not mean stressful situations did not affect the nurse. Donna, for example, spoke about what she had noticed about nurses from an Accident and Emergency environment:

> *A couple of our team have worked in emergency department, so they're used to stressful work situations. Their anxiety that they feel is more what they share in the office or at home, it's not seen in the visit. (Donna)*

Participants' stories were of multiple situations of significant stress when new to practice and when they faced complex situations, they felt unprepared for. The diverse stories shared by the participants demonstrate significant benefits of how knowledge and experience enhanced participants' capacity to navigate and cope in stressful situations. However, because each whānau engagement is distinct, knowledge and experience could not fully prepare them for every challenge they may face. Additionally, knowledge and experience should not be used as an excuse for exposing CCH nurses to significant and pervasive stress.

Anticipating Stressors

Alongside participants reporting a profound connection between knowledge and experience and coping with stress, they also described how knowledge and experience, or lack of it, also caused them to anticipate stressful challenges. There were multiple unique stories of participants feeling stressed and worried prior to or during whānau engagements from what they knew, had heard or experienced previously or feeling they didn't have the knowledge and experience they needed.

Several participants recounted powerful memories of previous personal or professional challenges that intensified their apprehension. Anticipation of stressors was particularly true when participants recalled stressful events they felt they did not manage well, and they were seeing the whānau again or were in a similar situation with a different whānau. The level of worry from anticipating events appeared unique to each participant as well as to each story of whānau engagement. When these situations arose, participants described feeling anxious, stressed, preoccupied, distracted and not able to be present with the whānau. Some tried to block off the memories and feelings, for other situation the feelings continued as illustrated by Tara’s description of how she anticipated stress throughout the visit which was compounded by her own personal stress:

> *I felt really nervous going in, I felt I was not going to meet her needs making me quite stressed. I was worrying it was going the same way as a previous experience I had with her. I also had lots of stress at home so it piled onto this situation. (Tara)*

In this case, Tara’s worries were unfounded as she found the mother welcoming and the anticipated stress was not realised; a relief for Tara resulting in a reduced stress level.

Similarly, Sara anticipated stressors occurring with a whānau who had multiple complex factors impacting on them. Sara had felt quite stressed revisiting the whānau and during the visit as she could not predict what would happen:

> *I was really nervous going to the visit, but I just about fell off my chair because it could have gone so differently but I think she felt like I had listened to her. Quite a few times in the visit her mood changed which was stressful. I have had some visits with her that haven’t been right and others I have had a really great visit with her. (Sara)*

The subtheme *Who the CCH nurse is matters* has highlighted the uniqueness of each CCH nurse. This section included descriptions of how individual beliefs, values, personality, and wellbeing influenced experiences of stress in whānau engagements. Alongside these factors, participants’ self-awareness, knowledge, and skills were also found to contribute to the nurses’ ability to navigate stressful situations, which highlights the importance of considering who CCH nurses are in coping with stressors. Participants suggested that having experience of stressors in CCH practice, self-regulation skills, or being an experienced practitioner reduced the intensity and occurrence of stress. However, this did not mean participants did not experience stress or felt prepared for potential stressors. Additionally, prior experiences of stress made some participants particularly susceptible as they became stressed anticipating stressors would occur. At times, the participants’ knowledge and experience meant they had strategies available to navigate the situation or the ability to accept the stress; however, a stress response was often still triggered.

1.2 Stressors are Unique, Varied, and Multifaceted

The previous subtheme 1.1 *Who the CCH nurse is matters* identified the uniqueness of each participant and how their uniqueness matters to how they experience stress in whānau engagements, thereby illuminating the unique personal aspects of Theme One, *The CCH nurse participants' experience of stress in whānau engagements is unique, multifaceted, and shaped by context.* Subtheme 1.2 *Stressors are unique, varied and multifaceted*, further illuminates the complexity and uniqueness of the wide variety of stressors experienced by the participants.

While there were some similarities shared in the collective stories, some of which are shared below, the stories are presented here in a way that recognises the uniqueness of each engagement and the varied causes of stress experienced. Firstly, the uniqueness of whānau engagements are described, followed by accounts of the varied intensity of stress. The section finishes with an exploration of the different types of stressors the participants shared. How the stressors were responded to are described in Theme Two, *the impact of CCH nurses' stress on attunement and whānau relationships requires attention.*

The Uniqueness of Stress

Participant stories reflected unique unpredictable stressful situations that were a combination of the participant's individuality, their responses to stressors, the responses of whānau in the situation, and the environment. Participants shared how they expected to encounter stressors but could not precisely predict or anticipate when and how they might occur or their stress response. This was despite their knowledge and experience or how well they knew the whānau and the environment, as no combination of factors was ever the same. In the following exert Cassey described the uniqueness of engagements:

> *Every single situation as a child health nurse is an unusual situation. The dynamics, the way people think, the way people work. All those complexities of human nature make it complicated and at times stressful. (Cassey)*

Similarly, Hana described the unpredictability of being in relationship:

> *I do wonder how they will react because people can react out of character even if it might be someone you know quite well. You don't know whether they will react in a way that you might not expect. (Hana)*

Participants shared their experiences of shifting levels of stress as they navigated varied numbers and intensity of stressors throughout their time with whānau. In some engagements, they experienced low levels of stress or a rise and fall of levels of stress.

Conversely, in others, there was an interplay of a complex mix of stressors that caused continual high intensity of stress throughout the engagement. Donna highlighted the variation for her finding some days were “fine and others not” with varied levels of stress often depended on the complexity of the situation. Donna also reflected on how every person has different triggers resulting in if and how the stressor is experienced. Wendy described the fluctuation of levels of stress during whānau engagement, moving from a stressed state to less stress:

> *The whole focus is maybe on the one thing that's causing the stress, for example a concern about breastfeeding and weight gain. So, in the visit, it's all about that. Then when that stress goes, like if everything's going OK, then you can move on to something else. (Wendy)*

Some stressful situations caught the participants completely by surprise. In the example below, Freya described how she expected a level of stress in a whānau engagement but had not been able to predict the intensity of the stressful situation that occurred:

> *There was a whānau member who was concerned about their tamariki. I know he was worried, but I was not expecting him to get as angry as he did. I was shocked, I was like gosh, what just happened? It was really unpleasant. I felt really bad for the mum. I could support them but not fix it. I didn't see it going that way at all, so out of the blue. At the time, it was way more intense, but I still feel it now. (Freya)*

The Complexity of stress from Internal, Whānau and Relational Factors

The participants discussed how they expected stress to occur within whānau engagements as they were in a professional nursing role. However, they described a wide range of stressors, that were expected and unexpected, often experiencing multiple stressors at one time. The inclusion of the types of stressors experienced is intended to provide context for understanding the unique and complicated experiences of the participants; the intention is not to focus on a particular stress or to categorise the significance of different stressors as there are infinite possibilities of stressors and the stress responses they trigger. The causes of stressors reported by the participants have been grouped into three categories. The aim of categorising stressors was to avoid creating a list of all possible stressors, as that seemed impossible. The use of categories is not meant to minimise the uniqueness of each CCH nurse’s experiences of stressors, the complexity of each stressor, to suggest that only one type of stressor can occur at a time, or to gloss over the fact that multiple stressors can occur at the same time. The three categories are: firstly, stressors from internal factors; secondly, stress from exposure to whānau stress; and thirdly, relational stress between the nurse and the whānau. Stressors within the environment are described separately in the following subtheme.

With regards to exploring and describing stressors stemming from *internal factors*, participants collectively described this stress as internally experienced stress. This category of stress describes the stress experience as unique to, and felt by, the CCH nurse themselves. Participants indicated that they often experienced internally derived stress while engaging with whānau. Some of these internal stressors have already been highlighted in subtheme 1.1, *Who the CCH nurse is matters,* where internal frameworks including beliefs, values, personality and wellbeing, self-awareness, and knowledge were discussed as stressors. Additionally, identified in the prior section was the internal stressors that were bought into the engagement, including anticipating stressors, memories of prior stressors, workplace and personal stress. Many of the participants reported that anticipating stressors prior to or in the engagement contributed to worrying about how the time together would progress, if they could meet the whānau needs, say the right thing, and how whānau would respond to them. They also shared how they worried about missing whānau cues or had missed whānau during engagements, that they felt unable to meet whānau expectations, they couldn’t provide the support whānau needed or that they were not the right CCH nurse to support the whānau. Participants shared stories of becoming stressed when they made the wrong decision, said the wrong thing or were not able to navigate complex situations. Participant also shared stories of internal stress from the environment they were in (this is discussed in more depth in subtheme 1.3).

In addition to the internal factors that led to the nurse participants' stress, they also shared several examples of stressors from issues that were categorised as *exposure to whānau stress*. Many participants described how, at times, they became stressed when whānau shared their worries. There was a wide range of whānau worries that caused the CCH nurse to feel stressed, including physical, emotional, social, and socioeconomic issues for the whānau member or their tamariki. Participants reported that their stress increased if they or other services could not adequately support whānau needs. Participants also described feeling stressed when whānau expressed emotions and appeared to be stressed, struggling, distracted, or overwhelmed. Beth shared her stress response to a mother’s distress:

> *I nearly cried in an appointment the other day because I just felt the mum’s severe frustration and stress as she talked about her complex situation and how it was affecting her. (Beth)*

Participants reported that exposure to whānau stress also included when there were relationship difficulties within the whānau, such as witnessing negative emotions, how whānau spoke to each other, or noticing tension in whānau relationships. Participants also described feeling stressed from noticing tamariki needs not being met. Examples were of whānau missing tamariki cues for attention, displayed anger, intolerance, rejection, or were dismissive towards their tamariki. Additionally, participants described noticing tamariki appearing less responsive than expected, panicked, afraid, or on edge from their caregivers' behaviours. These examples highlight how complex presentations were confronting and stressful, such as when Donna stated:

> *When they don't talk nicely to their children when they are stressed, I find that very difficult. Especially when they are swearing at their child or telling them to be quiet that can be quite stressful. (Donna)*

The third categorisation of stress, *relational stress*, was described as stress between the participant nurse and the whānau. This group of stressors captures participants' descriptions of relational issues or unease between the whānau and nurse, evidenced by, for example, whānau behaviours, specific comments directed towards or about the CCH nurse, or a sense that something was not right in the relationship. To illustrate stress in the relationship, Sara described feeling that something was not right with her relationship with a whānau rather than an apparent rift from something that happened or was said:

> *For me the relationship with the whānau is everything. So, if I feel like there is a tear in the relationship or something is not quite going right, I wear that quite heavily. (Sara)*

Likewise, Dana described noticing how a rift in a relationship affected her

> *It's hard for my own mood not to be affected by a parent's growing tension. You can feel like you are not wanted there or valued. (Dana)*

Wendy also described the complexity of breakdowns in relationships.

> *You're always learning in relationships to look at your own stress and what happens. It takes time to develop relationships and when they breakdown especially when they are new that's kind of very stressful. You take it personally because we are all human. (Wendy)*

Participants provided examples of noticing whānau body language, eye contact, and verbal communication as contributing to a stress response for the participant. They shared examples of whānau being angry, argumentative, disengaged, and not honest with them. Participants reported that, at times, this overt and felt experience of stress in their relationship with whānau made them feel afraid or unwelcome. Tension or ruptures in the relationship appeared to cause high levels of stress for the participants, particularly as they often occurred at the same time as other stressors for example stress from a whānau member angry towards their partner and disengaged with the CCH nurse participant. Olivia shared the complexity of trying to work out the cause of stress and the complexity of trying to navigate the engagement, ultimately the stress impacted on the relationship:

> *I do notice when whānau are stressed that they are probably not as open, you get surface answers, or they might cut you off. Whether that is them stressed or their personality or they are uncomfortable you get to the point where you are feeling its very transactional and its not conversational. I don't particularity like those visits because I don't think either the nurse or the whānau feel open with each other, its stressed and you don't get a real picture because they don't trust you. They don't feel comfortable. We don't want to create more stress. (Olivia)*

Describing the shared experiences of the causes of stress has highlighted how each experience is unique, varied, and multifaceted. There were descriptions of varied causes of stress with often a complex mix of types, intensity, and frequency of stressors experienced. In some situations, the uniqueness of the participant (as described in 1.1), and the personal significance of the stressor (for example moral worries about child protection) tended to trigger a greater stress response, whereas stressors with lower personal relevance tended to trigger less stress. Additional to these causes of stress, the context such as the environment could cause CCH nurses stress, which is described in the next section.

1.3: Stress Does not Happen in Isolation, it is Shaped by Context

This chapter has so far described Theme One, *The CCH nurse participants' experience of stress in whānau engagements is unique, multifaceted, and shaped by context*, under two sub-themes. Subtheme 1.1 illustrated how the individuality of *Who the CCH nurse is matters*, while subtheme 1.2 has described how the causes of stress are *unique, varied, and multifaceted*. This current section discusses the third subtheme, 1.3 *Stress does not happen in isolation, it is shaped by context*. This subtheme describes the participants' shared experiences of the impact of the practice context and external stressors on their experience of stress in whānau engagements. While the study focused on the experience of stress in whānau engagements, the influence of context on the experience of stress in engagement, strongly emerged from the data, interconnected to subtheme 1.2 that described the causes of stress.

The Practice Environment

Participants reflected on the ways that the environment, such as the clinic or whānau home, impacted on their experience of stress. Significantly, participants felt stressed navigating whānau engagements alone with limited immediate collegial support or advice. Wendy shared the difference to working in the hospital setting:

> *As a new person working in the community without the hospital setting that I was used to was stressful. You didn't have those safeguards and boundaries could very easily be overgrown when you should have stopped it before it proceeded. (Wendy)*

Olivia shared a similar experience moving into community practice:

> *It was just kind of being thrown into the deep end and working on it by yourself and not really having a nurse to work alongside you. Obviously, you do have support, but you cannot just turn to someone and ask. So that I think is quite stressful. (Olivia)*

Participants also found where they met (usually a clinic or whānau home) with whānau to be stressful. The participants agreed that, for many whānau, the clinic was considered generally unfamiliar. They shared how some whānau became noticeably stressed, or their tamariki unsettled at the clinic, which caused a stress response in the CCH nurse. Similarly, from the perspective of the participants, home visiting was also often described as stressful due to unknown and uncontrollable factors, such as encountering dogs, or whānau or visitors that were perceived as intimidating or aggressive. Emmy shared how being alone in an unfamiliar environment when working in the community was a stressor for her:

> *When you're in people's homes it's not our safe space. We're in environments that are new to us every time, with massive amounts of variables. (Emmy)*

Conversely, Cassey shared the comfort of being in the whānau home:

> *I'm probably comfortable in their home because it's where the whānau are most comfortable. (Cassey)*

Distraction from Stressors Outside the Engagement.

A common topic discussed by the participants was how their personal lives, workplace, and anticipated stressors impacted on their experiences of stress. Participants described how personal and work stressors have a complex and interwoven relationship as personal stress impacts on workplace stress and vice versa. Personal stressors addressed by participants included mental or physical wellbeing, such as past trauma, personal relationship issues, financial concerns, and navigating demands (especially for those with tamariki). Some of these have been described in subtheme 1.1 *Who the CCH nurse is matters.*

Participants explained that being able to keep personal stressors separate from work was not always possible and dependent on the specific situation. Beth highlighted the variation of her stress and intersection of stressors in personal and professional life stating:

> *My mental headspace at this time of the year is completely exploding with work and personal life. I'm just stressed with everything and everything is stressful right now. (Beth)*

In some instances, participants felt preoccupied and distracted by personal or workplace stressors, which meant they were not fully present during whānau engagements. The impact varied depending on the distractor, the situation, and the participants' capacity to regulate. One participant illustrated this by describing how other distractors caused her to be "more in a feelings state", with less energy and capacity to be calm. Jenny described the complexity as:

> *Holding the prior stress while trying to think and problem-solve with the whānau I was with. (Jenny).*

There were many participant stories of how stress in their personal life impacted on the capacity to be present for whānau. Tara shared how personal stress affected some of her whānau engagement, yet at other times, she felt she was more able to separate her home life, even to the extent she considered work could be an escape from her home stressors. In Tara's interview she did not identify what it was about each engagement that made it different, just that she had noticed it. This highlighted the uniqueness of each situation and the unpredictability that each engagement brings:

> *Sometimes there is so much stress in my own home that it comes to work at other times you can get quite good at separating them (home and work life), with work life the steady ground you can walk on and you don't have to think of all the home stuff. Then you go home and think oh yeah that's right it is still there. It depends on the day at work. (Tara)*

Cassey shared how her team supported each other when someone had personal issues impacting them and their role:

> *We'll absorb it and then it will just flow on. It is just part of being a person in life and everybody goes through personal ups and downs and have no room, no*

> *mental and emotional capacity. If you have got the umbrella you can take the load and hold them until they're ready. (Cassey)*

Participants also described examples of bringing workplace stress into the whānau engagement, causing them to feel stressed. This included examples of the impact of prior stressful whānau engagements, high workload, the complexity of the CCH nurse role, lack of support, working with whānau with other whānau with complex worries, and environmental factors such as traffic. Wendy highlighted the stress CCH nurses feel not just when with whānau, but also between and how this worry not only impacts on herself but for other whānau care:

> *If I am driving around thinking about her and worried, I need to talk to her about something or do something, I need to sort that out so I am free to work with other whānau because otherwise I don't think I am present. (Wendy)*

Several participants shared how these stressors could compound over a day, reducing their capacity to cope with stressors during the day. In the following quote, Sara shared how a stressful day impacted her capacity to be present:

> *When it's feeling like you've got complex visits almost all the time, you start looking at your workday and feeling the anxiety before your workday has even started. If you've emptied your cup with the family before, like a mum's disclosed that she's suicidal and you are intensely listening and being with them at that moment. You look at your watch like 'holy moly, I'm already late'. Then do you really have the same amount of energy that you gave to that whānau? It's impossible to be able to park it. You've given so much so you're on the back foot coming to the next one. You'd have to be superwoman if you were going and giving the exact same amount of care and attention. (Sara)*

Wendy similarly described the compounding impact of stress from whānau engagements along with other stressors on her:

> *At the end of the day you can be so tired and burnt out. I'm not really a crier, but I remember one day just having to go into the little room in the hub and just cry, I was just like, what else is gonna happen to my day that I just couldn't cope with, there was just thing after thing after thing and I was like one more person ring me up and I'm gonna explode. It was everybody, it was all the people's problems of the day that just got too much. (Wendy)*

As illustrated in the quotes presented above, there appeared to be an intersect between personal and work life, but how this stress affected different whānau engagements remained unclear. Additionally, participants not only shared how workplace and personal stress affected them on the day, but they also shared how experience of workplace stress could compound over time, impacting their stress levels and capacity to self-regulate. Freya described the impact of chronic stress and commented on the comparison of the impact with and without chronic stress over time:

> *You go into that feeling state before going into that thinking state. Especially if you have chronic stress, I think you kind of hit that feeling state a bit quicker, there is a cumulative effect. (Freya)*

The Professional Expectations on CCH nurses

Several participants shared how they became stressed from anticipating engagements or being worried about whānau between engagements. Anticipating stressors helped at times to prepare for stressors occurring, but at other times it caused stress, anxiety, worry, and fear prior to and in the engagement. As discussed in subtheme 1.1 *Who the CCH nurse is matters*, the unique personality, knowledge, and experience of participants influenced their level of stress from anticipation and worry about what might happen. Additionally, anticipation and worry were also closely related to the context of the engagement and health and social system resources that reduce or increase stress for the whānau or CCH nurse. This was linked by many of the participants to the expectations of their professional role and expectations on them as CCH nurses. Some examples of these included, having worrying information about whānau they were expected to discuss with them, needing to discuss a confronting topic, feeling unable to meet role expectations and whānau needs, or supporting whānau with multiple social, cultural, and environmental stressors that felt insurmountable. In some situations, due to the complex nature of working in CCH community practice, the participants felt a level of stress if the health and social system were unable to support whānau or them in their role. This was particularly relevant if they felt they were expected to deal with potentially stressful situations and did not have the knowledge or skills expected of them.

Normalising and Accepting Stress

Normalisation and acceptance of stress impacted on the level and frequency of exposure to stressors, including how stress was experienced and managed. Participants described how they were expected to manage stressors in clinical practice and how this was accepted and normalised as part of their CCH nurses' role. This stress came from within themselves, and the real and assumed expectations from their colleagues, organisation, whānau they worked with, and the community. I have used several quotes in this section to bring to light with the voices of the participants the pervasive and hidden aspect of stress in CCH nursing so their experiences of the normalisation and acceptance of stress in the CCH role can be heard.

Participants accepted that stress was a normal part of everyday life and nursing practice. However, they considered regular exposure to stressors and complex stressful events were normalised and accepted in CCH nursing, despite the impact on themselves and whānau care. Acceptance of a high level of stress was highlighted by Harini, who stated that it was "just how it is on the day". Similarly, Beth stated:

> *As child health nurses, we face a lot of stress, probably more than what the average person would recognise. (Beth)*

The far-reaching impact of stress was identified by Olivia who commented that stress was normalised despite the significant impact on whānau, relationships with whānau, and the CCH nurse:

> *I think it is very normalised, particularly being a job mainly women do, that we'll just get on and get over it. I hear some comments, even from men, when I say my job can be stressful. "Your jobs easy, what do you do all day, weigh babies and cuddle them? I have to lift 80 kg's." You're not talking to people about all these heavy complex things. I think it's very normalised stress in the workplace, particularly CCH nursing. It does impact your relationships and your clients and yourself hugely. Then you get all this burnout and turnover. (Olivia)*

Similarly, Bee described how stress is underrated but "has massive impacts on our ability to do our job well". This places the CCH nurse's wellbeing and capacity to provide attuned care to whānau at risk. Annie identified the reality of stress within her role:

> *It's just nursing isn't it? It's always stressful, there is always an element of stress that affects the job. It's unpredictable. Stress impacts our job; it affects how efficient we can be, and it affects the changes we can make. There's never enough I think in place to remove those stresses for staff. (Annie)*

Cassey extended this expectation of stress to community nursing, while also highlighting the need for action:

> *Stress is always going to be there and if you want to be a community nurse you have got to accept that there will be times that there will be stress. I guess this is where you have got to have a toolbox and be able to draw on it. Whether it is education, resources around you, teammates, or supervision. Whatever is in your toolbox gives you resources when you are in the moment with whānau. (Cassey)*

Some participants considered normalising and accepting stress resulted in stress being underrated and hidden. Hidden stress was seen to impact how some participants viewed themselves and believed others viewed them when exposed to stress. Tara viewed the consequences of the hidden aspect as silencing the CCH nurses' voice and noted that "nobody actually asks, how was the nurse?". Similarly, Olivia suggested that the hidden aspects meant that:

> *Nurses probably don't talk about stress as much as they should. (Olivia)*.

Beth reflected on how the personality she tended to present in her professional and personal contexts influenced her capacity to cope in stressful situations and the expectations that had silenced her capacity to share her experiences or worries:

> *I say I'm worried about a client, but I won't ever say I'm worried about myself ever. As humans, quite often we don't really like to voice when things are hard, in my personal life I am pretty much the same. (Beth)*

Beth continued describing how completing the vignette questionnaire helped her notice how much stress she had been experiencing that she had not been aware of herself:

> *I have been making a mental note of all the times I have been flustered and stressed and its actually quite a lot. (Beth)*

Beth's comment highlights how pervasive and hidden stress in CCH practice can be, which relates to the discussion of self-awareness in subtheme 1.1 *Who the CCH nurse is matters*. Beth's self-awareness from reflecting more intently on her stress levels after the vignettes was intriguing and surprising. I had not anticipated that completing the vignettes would have this profound impact on some of the participants.

Accepting and normalising stress as part of the job was a common thread throughout the study; however, this acceptance of stress did not negate its impact on themselves and their relationship with whānau. The undervaluing of the impact of stress on CCH nurses and potentially on the whānau they engage with is a key insight from the study.

Chapter Summary

The discussion of Theme One, *CCH nurse participants' experience of stress in whānau engagements is unique, multifaceted, and shaped by context,* presented in this chapter has highlighted the complexity of the experience of stressors in CCH practice. This has been informed by the participants' stories under the three sub-themes: 1.1 *Who the CCH nurse is matters*, 1.2 *The causes of stress are unique, varied and multifaceted*, and 1.3 *Stress does not happen in isolation, it is shaped by context.*

The intensity, frequency, and length of exposure to stressors alongside the uniqueness and unpredictability of the whānau engagement were found to impact on the experience of stress. Participants shared how they were often continually trying to manage stressors and regulate their stress response when there was a high-intensity and continual level of stress. At other times, their stress was less intense and less complex to navigate. Many participants shared how knowledge, experience, and anticipation of stress either prepared them for situations or increased their stress experience.

Normalisation and acceptance of stress in CCH nurse's practice, the level of exposure to a wide range of stressors, the nurse's belief system, self-awareness, personality, wellbeing, prior experiences, and knowledge are interwoven and interdependent rather than being sole or separate factors. These combined with the context, the uniqueness of the whānau situation and other factors that influenced the experience of stressors in unique moments of time. The complexity and uniqueness of these factors, as well as the uniqueness of the situation of whānau engagement, resulted in varied experiences prior to, during, and following whānau engagement.

Chapter Six: Findings (Theme Two)

The previous chapter explored the first theme drawn from the data, describing the complex ways that *CCH nurses' experiences of stress in whānau engagements are unique, multifaceted, and shaped by context.* The analysis of CCH nurses' stories highlighted how participants' experiences of stress in whānau engagements were affected by the nurses' uniqueness, who the nurses are, the type of stressor they anticipated or encountered, and the nature of the context of the encounter, all of which proved to be unique and complex. Theme Two, *The impact of CCH nurses' stress on attunement and whānau relationships requires attention* builds from Theme One, providing a detailed and rich account of the collective understandings of how the nurse participants', experienced stressors, the impact on their attunement with whānau, and the strategies used to manage (see Figure 2).

This chapter explores Theme Two and the three subthemes in detail, using quotes from the participants to describe and justify the complexity of navigating whānau engagements when stressed. The chapter concludes with a summary of the main findings.

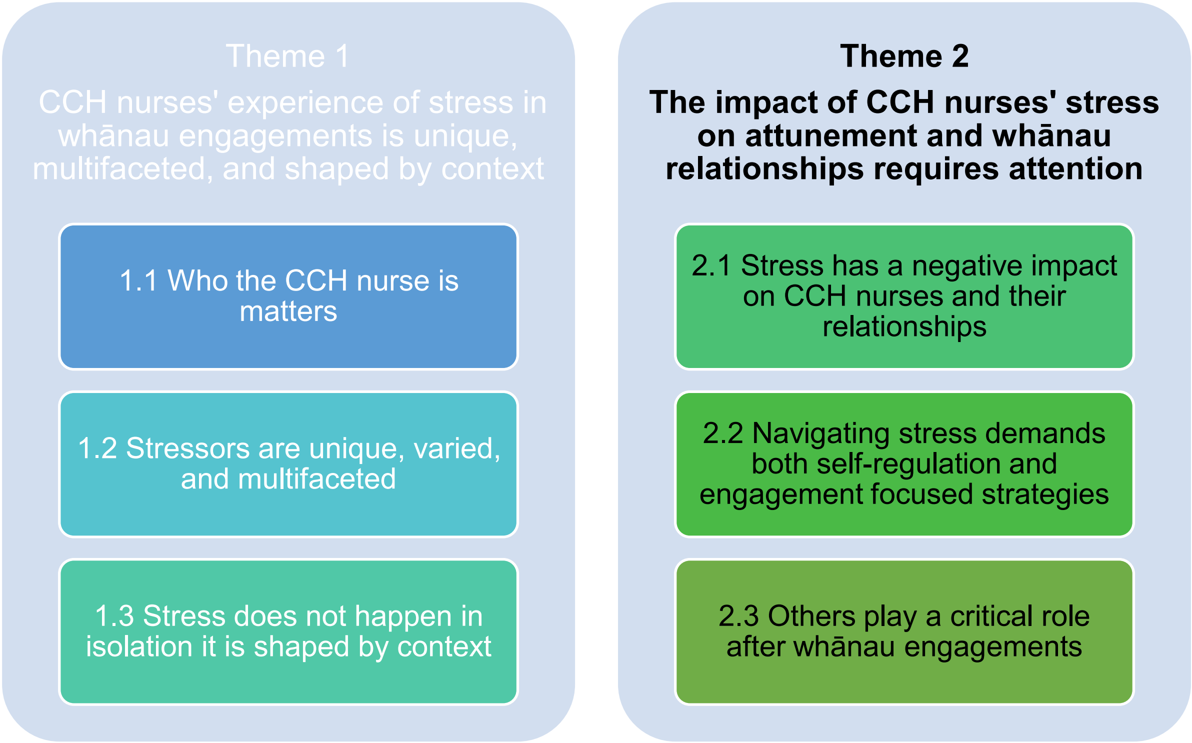

Theme 1
CCH nurses' experience of stress in whānau engagements is unique, multifaceted, and shaped by context
1.1 Who the CCH nurse is matters
1.2 Stressors are unique, varied, and multifaceted
1.3 Stress does not happen in isolation it is shaped by context
Theme 2
The impact of CCH nurses' stress on attunement and whānau relationships requires attention
2.1 Stress has a negative impact on CCH nurses and their relationships
2.2 Navigating stress demands both self-regulation and engagement focused strategies
2.3 Others play a critical role after whānau engagements

Figure 2 - Findings Themes and Subthemes (Theme Two)

Theme Two: The Impact of CCH Nurses' Stress on Attunement and Whānau Relationships Requires Attention

Theme Two, *The impact of CCH nurses' stress on attunement and whānau relationships requires attention* is underpinned by three subthemes that emerged from the data, 2.1 *Stress has a negative impact on CCH nurses and their relationships, 2.2 Navigating stress demands both self-regulation and engagement focused strategies* and 2.3 *Others play a critical role after whānau engagements*.

2.1: Stress has a Negative Impact on CCH Nurses and their Relationships.

Theme Two's first subtheme 2.1 *Stress has a negative impact on CCH nurses and their relationships* identifies the effects of stress on the nurse and their relational engagement with whānau. Participants shared accounts of situations where their physical, cognitive, and emotional stress responses negatively impacted their ability to build relationships, be attuned, and have a relational flow in whānau engagements. Some of the stress responses have been grouped in this chapter for clarity, but it is important to note that in stressful situations, there was a complex mix of physical, emotional, and cognitive responses described that impacted attunement and relationships with whānau, with no clear delineation between them.

Physical, Emotional and Cognitive Stress Responses have Negative Impacts

Participants reported experiencing a diverse array of physical and psychological responses to stress which had a negative impact on themselves, and their attunement and their relationships with whānau. While only some examples are shared to provide a picture of the rich diversity of stress responses experienced by participants, rather than an exhaustive list. These findings are critical for understanding how stress responses affected participants and, ultimately, their capacity to connect meaningfully with whānau. A critical aspect of how stress responses were described was the participants' awareness of their stress and stress responses. Awareness of stress responses varied by participant, situation, and type of response, so there are likely to be many experiences not noticed or shared.

Some similarity in stress responses was identified across the participants, such as a racing heart; however, as the analysis proceeded, it became evident that each situation and response was unique. This was not only from one participant to another but also for the same participant in different situations. The following accounts by Freya and Hana illustrate some of the commonalities and differences in descriptions of stress responses and what they notice.

Freya described noticing a whole-body response when she was in a complex stressful situation as follows:

> *I definitely felt more elevated, just a heightened sense. I guess you have like a fight flight response where you get that adrenaline release, and you can't kind of do anything to stop that when you're stressed. (Freya)*

Hana describes her all-body response differently stating:

> *It is like there is a moment where there is a meeting of stressor and stress response with a sense of flux. (Freya)*

Several participants described some of the *physical stress responses* they noticed when in whānau engagements. These included an increased heart rate, increased or varied respiratory rate, shaking, feeling hot, having a tense body, a tight chest, fidgeting, and having a flipping, churning, or tense stomach. In the following example, Olivia shared some of the specific responses she noticed describing herself as being:

> *A bit more tense, maybe more fidgety. I don't know probably less relaxed and probably not doing very good regular breathing and all that kind of stuff. (Olivia)*

In another example presented below, Sara described physical stress responses to actual and anticipated stressors, which were occurring concurrently as she navigated a complex stressful whānau engagement:

> *My heart was pounding, and I was feeling really stressed from the barking dog running at me as I arrived…. 5 minutes in my heart is still racing, even though I'm trying to calm. And then I realised the dad was there and I had been given a heads up about him, he was not supposed to be there (due to his history of violence). So that was quite a stressful situation, trying to build a rapport when my hearts racing (worried about what might happen) and I'm almost out of breath…. I was shaking absolutely shaking. (Sara)*

Sara's example above illustrates her concern that her physical stress response might impact on her attunement and relationships with the whānau. Like Sara, Beth also described the impact of a physical stress response on her ability to connect with whānau as she stated:

> *When my heart was racing, I was flooded with that nervousness, it was difficult to build a relationship. (Beth)*

In addition to physical stress responses, participants also described *emotional and cognitive responses* to stress in whānau engagement. These responses varied significantly depending on the specific situation and the participant. Some examples of emotional responses to stressors included descriptions of fear, shock, nervousness, frustration, being flustered, not in sync, and overwhelmed. Cognitive impacts of stress included examples of a racing mind, being forgetful, preoccupied, unable to concentrate, and having difficulty focusing. Other descriptions included feeling more disorganised, lacking clarity, making assumptions, or having clouded judgement. Some participants described negative thoughts, self-doubt, inadequacy, and feeling out of their depth and unprepared. Thus, in the following example, Freya describes the impact of stress on her emotionally and cognitively when she held information about a whānau. Freya's mix of emotional and cognitive responses potentially impacted on her attunement and the relationship with whānau:

> *You feel a bit anxious because you have information, and they haven't disclosed it themselves and you are gonna need to ask them about it. It can be a bit consuming in the forefront of your mind. I'm* more elevated, heightened. I go into that feeling state before I go into that thinking state. *(Freya)*

Cassey shared how she worried that the cognitive impacts of stress increased the risk to make mistakes stating:

> *I was triple checking myself and then stressing I still hadn't got it right. You just know you'll make mistakes when you get to a stress point like this. (Cassey)*

Similarly, Emmy described the cognitive impact but for her she described how at times it causes her to be forgetful:

> *I am more likely to forget something in these stressful situations, miss the topic, not be as observant, not looking around as much as I should. (Emmy)*

In the context of naming their emotional and cognitive stress responses, participants noted how stress impacted on their communication, a critical aspect of attunement and relational engagement. Participants described unique experiences depending on the situation, for example not thinking clearly or listening and reflecting as much before speaking, contrary responses of talking less or talking more, talking faster or slower, or having a raised voice pitch. Tara shared the impact of a stressful situation on her communication, saying "I cannot get my words out right." In the following account, Wendy describes the impact of stress on her communication at times talking less and other times she talked more.

> *I probably ended the conversation a bit short I was just in shock I didn't know what to say to the mum. I was lost for words, what can you say?* …. Sometimes *I don't just live in the moment I am somewhere else. I talk a lot but cannot*

> *concentrate on things. If I'm onto something else I'm really thinking about what has just happened. (Wendy)*

Wendy's reflection that as she became distracted and distant and cannot concentrate on what she is doing suggests that in those moments her ability to communicate and connect with whānau was compromised.

Stress Causes Ruptures to the Relationship

Several participants shared how they became more inward-focused when they were stressed and highlighted how this affected their ability to attune to whānau and be available for the relationship. There were descriptions of not feeling present with whānau as the focus shifted from the whānau to themselves. Being introspective and tunnelled meant fewer resources were available for attunement and the whānau relationship. Wendy noticed her internalised response and how she felt disconnected from reality, which she described as "shutting down, not living in the moment, and being somewhere else". As a result, she found it "difficult to concentrate" on the whānau. Another participant, Hana described how she felt "left-of-centre" when she was stressed, suggesting that there was a moment where she noticed her own response and was likely distracted from her whānau engagement. Olivia explicitly addressed how her stress response affected her ability to connect with whānau stating:

> *I find I'm not as present, not holding the space, not focusing my mind on them or what they are saying, not really listening and probably not paying attention to their non-verbal communication. (Olivia)*

Similarly, Tara shared the impact of stress on her capacity to focus and connect with whānau:

> *When I'm stressed, I don't feel on firm ground. I notice I'm not able to think clearly and focus on what I'm supposed to be trying to do, nor listen properly or focus on the client. I feel really left-of-centre on it all….. Sometimes there is so much stress in my own home that it comes to work. I just do my job, but I'm probably not connecting as much, giving as much, hearing as much, or present as much. (Tara)*

There were multiple descriptions of how stress responses negatively impacted behaviour and availability for the relationship. Some participants shared feeling more superficial, methodical, and clinical. There were also descriptions of feeling less empathic, wanting to fix, and quickly find solutions for whānau rather than taking the time to really listen, not exploring issues, or finding solutions together. Hini stated that when she is stressed, she feels she is more likely to "tell whānau what to do." Some participants commented that it affected their ability to communicate ideas and solutions clearly. Others noted that they were slower to respond to questions and avoided making decisions on how to proceed. Yet others described being impulsive or more likely to make mistakes. Some of these experiences are illustrated in Olivia’s example below, including what she considered the whānau perspective might be:

> *When there is stress in the relationship it is very transactional, it’s not conversational. I don’t think the nurse and client feel open with each other. It’s stressful and I don’t think you are getting the real picture as you don’t trust each other. They don’t feel comfortable talking to you and we just want to support whānau we don’t want to create more stress. (Olivia)*

As well as noticing the impact of stress on their availability for the relationship and to be attuned, several participants shared how their capacity to notice relationships within whānau was negatively affected by the participants’ stress. There were stories of noticing the infant and parent relationship less and having less capacity to explore whānau relationships with them. Freya described how she focuses her attention on one person rather than being attuned to all those present:

> *I can't really think of what I notice about the baby (when I’m stressed) because I guess my attentions are more focused on mum. If the mum is looking stressed, then my attention would probably be focused more on the mum and not so much the baby. I guess I am more tunnelled. (Freya)*

Tara described noticing tamariki responses differently during engagements depending on the unique stressful situation, stating that in another situation she noticed the tamariki responses:

> *I was looking at the baby panicking, and I was looking at the parents arguing…... Both of those children looked terrified straight away. I couldn't get that out of my head. But in some of the other (stressful) situations I wouldn't have said that I'd taken a huge notice of the children. (Tara)*

The cause of the stress may be a significant factor in this difference for Tara, but she did not share during her interview, why there was a difference.

Worrying that Whānau Notice the stress

Worrying that whanau noticed stress was also described by participants as having a negative impact on the relationship. Participants raised concerns that whānau noticed their stress, there was a range of opinions of how much whānau might notice they were stressed. Some participants considered at times that whānau did not notice, others hoped they did not notice, whereas others suspected that they probably did. Some participants recounted situations where whānau had possibly picked up on their stress and changed their behaviour as a result. They shared examples of noticing whānau switching off, communicating less, sharing their concerns less, or not being honest with them. They also shared how some whānau seemed frustrated, increasingly angry, standoffish, difficult to engage with, and suspicious of them. It is impossible to tell if the participants' accounts of the clients' behaviour accurately reflect their response to the nurse's stress response or has another cause, as whānau perspectives were not considered in this study. As a result, participants could only make assumptions about what exactly motivated these perceived changes in behaviour; the point is that participants were worried that whānau had changed their attitude and willingness to engage with them and wondered if it was in response to the participant's stress response, often causing further stress for the participant. Olivia described how she thought whānau noticed her stress:

> *I do think they pick up on our stress. It's probably that they may shut down a little bit more or not want to be as open. (Olivia)*

Wendy similarly shared noticing the impact of her stress on whānau:

> *I think they kind of switch off a little too because you're not in the moment so you're kind of just listening. You know yourself if you feel like people aren't listening to you and their distracted by something else. (Wendy)*

Building on the noticed impact of stress on attunement and whānau relationships, participants shared at times feeling an imbalance in power as well as taking things more personally and feeling not wanted. These factors impacted on their capacity to be attuned to the whānau, with some blaming themselves when there was a breakdown in the relationship.

The subtheme 2.1 *Stress has a negative impact on CCH nurses and their relationships* has described some of the physical, emotional, and cognitive stress responses participants noticed about themselves when they were stressed in whānau engagements. The participants' views of how these stress responses impacted on their capacity to be attuned with whānau were described. Participants' descriptions of the impacts of their stress on relationships with whānau were only ever described as negative. It is important to highlight that this study only considers the perspectives of the nurses and therefore does not reflect the whānau experience within the relationship.

2.2: Navigating stress demands both self-regulation and engagement focused strategies.

While subtheme 2.1 explored the participants' physical, emotional, and cognitive responses to stress and how this had negatively affected their capacity to be attuned during whānau engagements. The second subtheme underpinning Theme Two, *The Impact of CCH Nurses' Stress on Attunement and Whānau Relationships Requires Attention* is 2.2 *Navigating stress demands both self-regulation and engagement focused strategies.*

Throughout the data the participants described how, during whānau engagements, there were complex fluctuations of stress, including expected and unexpected decreases and increases in stress levels. Fluctuations occurred in response to participants' feelings, thoughts, decisions, planned or unplanned actions, and in response to whānau actions and behaviours. Sometimes stress was regulated quickly whereas at other times it was enduring throughout the engagement. This reflected the complexity and uniqueness of experiencing stress when in relationships. The strategies participants used to navigate stress while in relationships with whānau were mostly aimed at preventing, avoiding, and reducing stress but at times they increased stress intentionally or unintentionally. This chapter does not attempt to discuss all the possible strategies used rather to provide some examples to demonstrate the complexity for CCH nurses navigating whānau relationships when they are stressed.

Strategies used to navigate stress in whānau engagements are categorised into two interconnected types: a) inwardly focused self-regulation strategies, and b) strategies that have a greater focus on navigating the engagement with whānau while the nurse participant was stressed. It is acknowledged there was a complex interweaving of both these aspects as the participants tried to manage their levels of stress, while attending to the needs of the whānau and the requirements of their CCH nursing role. Trying to navigate the complex interweaving of inwardly focused strategies at the same time as navigating the whānau engagement is described by Sara as:

> *Balancing the internal dialogue (to regulate) while trying to hold another conversation at the same time. (Sara)*

Self-Regulation Strategies

Inwardly focused self-regulation strategies included the strategies participants used to help regulate their autonomic stress response. The participants highlighted how their ability to regulate their stress response varied from situation to situation. Sometimes they were able to regulate quickly, at other times only partly or not until they left the engagement. If self-regulation strategies were successful, participants shared how they were more likely to be calmer and present with whānau. If not, some participants described feeling helpless, overwhelmed, and unable to cope, with many sharing how the memory of stressful situations could continue to trigger a stress response even well after the event. Examples of inwardly focused self-regulation strategies included breathing techniques, pausing to calm, slowing down, speaking more slowly, focusing on listening, talking less, grounding and self-talk. In the following example, Harini described using breathing and pausing to calm herself, stating:

> *I have caught myself taking a deep breath and pausing before speaking. (Harini)*

Similarly, Cassey described the use of breathing, pausing and stepping back as part of a mix of regulation strategies she used when supporting a whānau who were distressed and angry with her:

> *It was just a matter of a few deep breaths and a few steps back, lowering the tone, slowing my voice. Giving them some space. Keeping back, getting the space [to calm]. (Cassey)*

Like Cassey, Tara described how slowing speech helped her regulate:

> *Slowing your voice makes you feel like you can see where you are heading and that you're coming out of mud onto more solid ground. Like you're not going to sink into the water or the mud. (Tara)*

Self-talk, described by Tara as "having a conversation with herself", was a common self-regulation strategy participants described using. Many found that self-talk helped them calm through positive thoughts, focusing on the present, thinking about strengths, and considering the situation from the perspective of the whānau. Some participants described how self-talk helped them think of possible scenarios and be more methodical in their approach rather than reacting quickly. In this sense, self-talk allowed participants to move from a stress response to problem solving. Self-talk was also found to contain emotional responses, reducing the risk of speaking or acting impulsively. Tara shared how self-talked had helped her when she was stressed during an engagement with whānau:

> *I let the thoughts that I was having be a conversation sort of in the back of my mind, having a conversation with myself thinking up things that I might have said that wouldn't have been appropriate, but were just things that were making me feel better in the situation. Helping me try and ground myself. I step back and just listen to what's going on in my head. It helped me as I was trying to ground myself. (Tara)*

Tara also shared an example of how self-talk helped her prepare for an engagement with a whānau with whom she had previously had a stressful engagement. In this case, to calm her anticipated stress, Tara used self-talk, giving herself “a stern talking to”, saying, “come on, you”. Interestingly, when she got to the visit, the mother was welcoming, and the anticipated stress was not realised.

Participants identified the benefit of self-talk as a strategy to notice and acknowledge their stress. This enabled them to accept how they were feeling, resulting in a reduction of their stress response. Freya shared the benefits for her of acknowledging what was happening so she could focus on her professional role:

> *I guess the biggest thing for me is acknowledging the thought, not trying to push feelings aside. You can't. You know how you feel. It’s an acknowledgement and then parking it for a second, thinking about how you're coming across and acting professionally. (Freya)*

However, some participants noted that self-talk had the opposite effect on them in certain situations. In these cases, participants engaged in self-talk to question themselves and their capability in a negative way or analysed the whānau or situation with a biased or preconceived view.

Grounding was another strategy participants found helped them to be available for the relationship. Olivia shared the difference grounding made for her:

> *When I’m feeling more grounded, I have the capacity to listen more and explore more rather than jumping in with a solution that person may actually not be wanting. The conversations with whānau are a lot freer, you can then develop a really lovely rapport. (Olivia)*

Engagement Focused strategies

This section builds on the discussion of the self-regulation strategies participants used to manage their stress, focusing on the challenges of balancing their time with whānau and making decisions under stress. Participants shared various strategies for navigating their relationships with whānau, acknowledging that while some strategies were helpful, others sometimes increased their stress levels. The effectiveness of these strategies depended not only on the participants' actions but also on how whānau responded. Discussed below are the range of ways that participants described navigating stress in the context of preserving whanau engagements including; Being relational and whānau focused; Being empathic and mentalising the whānau experience; Being flexible and whānau led; Balancing relational approaches and authentic human responses with professionalism; Knowing when to be honest; Hiding stress responses; Creating distance from the stressor emotionally and physically; Continuing to try; and Making relational repairs and holding hope.

Being relational and whānau focused was described by participants as engagement focused strategies, but was considered complex as they were also navigating their own stress. Being relational focused was an important part of how the participants intended to practice but also had the additional benefit of easing or reducing the incidence or intensity of stress through a greater understanding of each other. Participants shared some of the relational strategies they used, including listening skills, being friendly, empathetic, kind, compassionate, respectful, inclusive, accepting, and having a softened approach. They felt these supported the establishment and maintenance of a relationship, attunement, and trust, therefore reducing their stress even when there were significant stressors in the engagement. Several participants described the complexity of trying to balance self-regulation and focus on the relationship. At times they were able to balance this and at others the focus was primarily on the whānau relationship rather than themselves. Sara discussed how in a complex and stressful situation she had a greater focus on the whanau than on regulating her stress:

> *I don't think there was any capacity to fill my emotional cup, it was a withhold to meet my needs. It's not about me right now. It was definitely a kind of survival mode. I needed to do what was important for them. (Sara)*

In contrast Donna shared how she focused on being relational and trying to regulate herself:

> *I probably take extra breaths if it is escalated if someone is anxious and the mother is crying. I tend to get into a caring mode and be very calm. (Donna)*

Similarly, Tara described this complex balance:

> *I suppose really quickly I got her trust in me. I talked to mum about positive stuff, about strengths. One of the biggest things I do (when I am stressed) is try and listen more. I slow down my speech. (Tara)*

These quotes demonstrate how CCH nurses often draw on both self-regulation strategies and relational strategies to varied degrees. This combination increased the capacity to be present during the engagement and to tend to the whānau needs, but it is complex. Additionally, Tara's example demonstrated CCH nurses' use of relational strategies that highlighted whānau strengths alongside trying to address their struggles.

Participants identified how learning about each other through whakawhanaungatanga[3] was identified to help establish the relationship and subsequently reduce the incidence of stress for the participants. Participants described the importance of learning about the culture of whānau and were guided by this understanding through engagements. Olivia commented that through getting to know each other, the nurse and whānau could establish a “baseline” for their relationship and that this established trust and promoted honesty, so the visits feel more relaxed with an understanding of each other.

The initial stress of not knowing whānau seemed more intense for some, with interactions feeling transactional. Getting to know whānau often reduced stress as they gained a balance between professionalism and comfort in the relationship. In the following example, Beth explained how knowing each other helped both the nurse and whānau:

> *The more I get to know a whānau the easier and less stressful it is for me I think it is when you initially meet a whānau or when the event happens, I’m quite antsy quite stressed. But then as time goes on and it gets more sorted, I feel a lot calmer, it enables more capacity to manage stress. If they know you, they see you differently you don’t become the service provider you are ‘my nurse’. (Beth)*

Similarly, Emmy talked about the impact building a relationship has for her level of stress:

> *Those tentative ones you probably speak in quite, quite formal, quite professional. I probably even look quite nervous walking in. But once you've got those relationships built, I knock on the door and, mum will, yell out “Yeah, I’m in the lounge” and I'll just, wander on through the house. I'll pet the dog, say hi to the cat, say hi to the older kids. Just kind of plonk myself down on the couch, like, you're an old friend and it's all just comfortable, relaxed. (Emmy)*

Having developed a relationship did not mean participants did not experience stress in whānau engagements, but it appeared to make some stressful situations less intense than they would have been without the relationship. An example of this is when Donna described supporting a mother with very complex health and social issues, and whose behaviour was often unpredictable. Donna experienced fluctuations of attunement while working to maintain a therapeutic relationship. She described how important and rewarding it was to continue to support the mother despite the challenges and stresses:

---

[3] the process of building and maintaining relationships

> *I was really anxious to go and see her. I think because I just keep going back, we have managed to establish a relationship. It was led by her really. But those visits were very stressful because of her mental health and drug use. Often, I would try a very calm approach with her but its very complex and often it was very tense. (Donna)*

Whether using relational strategies for building relationships early in the whānau engagement or throughout an engagement, relational strategies were considered important in practice. This section highlights how relational strategies can decrease both the incidence and level of stress. Despite experiencing stress, the CCH nurse participants were able to navigate whānau relationships by employing relational strategies. Being focused on relational aspects allowed participants to feel more at ease in their interactions with whānau. For some, this understanding reduced their stress or the likelihood of encountering stress. It is surmised that while stressors may still arise, engaging relationally is more likely to facilitate navigating these challenges with less stress stemming from within the relationship.

Participants shared the benefits of *being empathic and mentalising the whānau experience* (imaging/understanding their mental state) as engagement focused strategies. This supported them to consider the situation from the whānau perspective, increased their compassion and understanding and reduced their stress level. However, as described in subtheme 2.1 *Stress has a negative impact on CCH nurses and their relationships* the CCH nurses' stress response at times was to become inwardly focused, which made mentalising the whānau experience difficult at times for some participants. In the following excerpt, Freya described that the benefits of mentalising:

> *I guess it's how you read other people and how you attune to them. Noticing that a person is happy or sad or stressed. Reading between the lines a bit sometimes. Just picking up on their feelings or maybe trying to gauge what they could be thinking. Trying to see it from their perspective and showing compassion for them because who knows what is going on. (Freya)*

Mentalising whānau perspectives at times helped participants to be calmer, manage their stress responses better, and be attuned. Tara shared how viewing the situation and feelings from an angry whānau members' perspective helped her attunement and stress level. Imagining how he was feeling helped her be calmer, thus enabling her to be present despite the stressful situation:

> *He was standing, shouting at me. I think at that point the relationship probably didn't exist. I think he was in such a heightened state. I don't know how he saw*

> *me or what he could see when he was looking at me. I think in the back of my mind I was looking at him, thinking he had obviously been through some terrible stuff. It helped me stand there and feel strong enough to be there. (Tara)*

Imagining the perspective of whānau helped participants be more centred on the whānau and their needs. In some cases, this required them to put some of their values and beliefs aside with the help of mentalising strategies, which allowed them to reduce their stress and focus on the whānau and their needs.

Being flexible and whānau led was also described by participants as a strategy that helped them to navigate engagements despite their stress. Wendy highlighted this discussing the complexity of CCH nurse practice, and the need to be flexible to navigate stressful situations:

> *Sometimes it is just when you are in the moment you sometimes don't know what you're walking into. But in the moment maybe you do the wrong thing, maybe you do the right thing. Sometimes you don't know what it is going to be like. You plan it all out, this is what is going to happen, and then you might have the worst day or the best day. (Wendy)*

Wendy's account of what it can be like when visiting whānau highlights the unpredictability of home visits and the need for nurses to be able to adjust their goals to match the situation they find themselves in. Wendy also highlighted the imperfect side of practice in that nurses sometimes get things wrong or do not know what to do.

Balancing relational approaches and authentic human responses with professionalism were considered important by participants to being engagement focused while also managing stress in whānau engagements. Some participants described how they had human responses to situations where they felt emotional about something they had seen or heard, requiring them to balance professionalism while navigating their emotional response without losing sight of who they are as a person and nurse. For some, this meant taking a moment to respond to their feelings, to regulate these, so they could be available to maintain or reinstate harmony and balance without seeming distant. In the example below, Sara described a moment where she took a step back from the situation, which gave her the opportunity to reflect on what had occurred and offered her the opportunity to wonder about the situation before coming back into the engagement:

> *Initially it's a kind of "Oh, what have I seen, what have I done, how have I presented myself". This is the instant I take a step back. (Sara)*

Being in whānau engagement can lead to situations that trigger strong emotions for CCH nurses. This is shown in the example below, where Beth described how she managed being with the whānau and navigating her emotions after a pēpi[4] she had cared for died:

> *That's the one that hits me the hardest, when you have to really suck it up and you be the strong one which I just feel like you should because you are the professional in this relationship. When stressed its more difficult to hold your composure. They need a sense of someone who can kind of decipher things and help. I don't want to dysregulate my emotions because that's not what it is. But when I cried an empathetic tear, I felt like that was better for our relationship, that she felt understood. (Beth)*

Similarly, Cassey shared the complexity of being relational and professional:

> *You're not there to be the emotional one, you are the one there to see the path, there is something unique about that, the capacity to hold oneself. It's not my place to fall apart, that is not to say you are not sad. The day I stop cry is the day I should stop doing the job, because if you can't feel with the whānau I don't know when you are supposed to. We do shed a few tears together then I step back and they can continue, you know you have to be appropriate and professional. (Cassey)*

Participants also described *the complexity of knowing when to be honest* in whānau engagements, and the influence this had on their level of stress. Participants indicated they found it stressful to navigate the need to raise and be honest about topics that most likely will be met with a negative response from whānau. Being honest and upfront about issues is a key requirement of their role, but raising difficult issues can be hard when feeling stressed and worried about how whānau will respond. Having these conversations were often motivated by their importance to the long-term outcomes for the whānau for example when there were child protection or family violence concerns. Some participants described how honesty at times strengthened their relationship, built trust, and broke down barriers, despite it feeling stressful. However, at other times it had a negative impact on the participants' stress levels and the relationship. Donna shared why being honest is important to her and how her approach was critical:

> *I do try and be as honest and truthful as I can. If I am worried about something, I say I feel really worried about you. I try and bring it back to myself. Rather than sounding judgmental. I would hate a parent to feel judged by me. I think that's*

---

[4] baby

> *probably my biggest fear I guess. We've all experienced stress. I would hate somebody to judge me. (Donna)*

A participant shared an incident when she got what she described as a “prickly response” when raising a difficult topic with a whānau member, which increased her stress further. However, she knew it was an important topic to raise and was willing to take the risk of increasing her stress and affecting the relationship. Another participant shared how she knew that raising a particular topic could impact on or even end the relationship. She decided the topic could not be ignored for the immediate safety of the tamariki and whānau and chose the discussion over the continuation of the relationship and despite the stress.

Knowing the right time to be honest when feeling stressed emerged as a complex issue for participants. They sometimes chose to be honest about stressful topics early in the engagement to reduce their stress from anticipating how to raise the topic and the potential response. At other times, they tentatively approached an issue, waited for whānau to raise it, delayed as long as possible, or chose not to raise it at all. When participants were unsure of whether being honest was the right thing to do, or when they were concerned that their decision may be wrong, it often increased their stress. In the following example, Freya described the stress she experienced from raising an issue, using relational strategies and timing as strategies to manage this. Participants often found that, once they had the conversation that was causing them to feel stressed their stress was reduced as the topic was in the open. Even if there was a negative response, they felt they no longer needed to worry about the potential response, to be pretending, guessing, or making assumptions:

> *You feel a bit anxious because you have information. I guess I feel nervous or anxious bringing it up because I don't wanna rupture that relationship. I guess that's down to the relationship building rapport and whakawhanaungatanga. I put the issue on the back burner and look from the outside in and then try to weave it in somehow. That reduces my anxiety. (Freya)*

Wendy described the more direct approach she uses now:

> *If I had concerning information about a whānau I used to wait for them to tell me and when they didn’t I would have to ask them, but I was stressed all the time waiting for them to bring it up so I probably haven’t listened as well, because I have just been like in my head “tell me, tell me, tell me” and then I will tell you I know. So now I say “I am going to be honest with you….”. It is much better because then it’s over. (Wendy)*

Hiding stress responses was another strategy participants described they used as an engagement focused strategy. In some situations, the participants felt they were unable to regulate their stress response and instead tried to hide or block off their stress response in an attempt for their stress response to not to impact on the whānau or their relationship with them. Hiding stress responses was seen to help keep the focus on the whānau and remain professional, aiming to prevent their stress from becoming a concern for the whānau. Sara described a situation where she tried to hide her stress response to prevent it from affecting her relationship with the mother stating:

> *I was shaking, absolutely shaking. I was trying really hard to not let mum see my hands shake. I was sort of holding them in my lap and like quite firmly. (Sara)*

Like in Sara's description of how she tried to hide that she was stressed so as not to jeopardise the relationship, Freya shared how she tried to hide her responses for the sake of the relationship:

> *If I'm all fidgety and stuff people would pick up on that, if they're noticing I'm anxious that will probably make them anxious as well. I try to recognise it, put it aside and act like I'm not stressed or anxious. You are trying so hard to stay calm through it all. I try to recognise it and not to let it show on my face or in my voice. (Freya)*

But despite these attempts to hide stress from whānau, it was not always possible. Tara shared how a whānau member noticed she was stressed:

> *The mother said, "You weren't yourself at the last visit," which is interesting. I was like I never thought of what they judge of us. Because I had sort of thought that that shouldn't come into a visit with the client. I suppose you're like a duck paddling in the water. You don't think about whether they can see you're stressed or not. (Tara)*

As the study's aim was to explore the impact of stress from the participants' perspective, it is unknown how often the attempts to hide their stress from whānau were, in fact, successful. Despite their efforts to conceal their stress, there is a risk of it affecting the care provided, even when the whānau is unaware of the participants' stress. Participants suggested that self-regulation strategies tended to reduce the level of stress; however, the data collection for this study does not allow conclusions to be drawn on which strategies were most effective for different degrees of stress or on how long the calming effect of the strategies lasted for.

Creating distance from the stressor emotionally or physically was also a way to hide stress and navigate engagements while feeling stressed. When stress levels were high, participants shared how they attempted to reduce their stress and whānau stress by shifting the focus onto something less stressful or stepping back. I will first describe the strategies used to shift the focus then those used to step back.

Strategies participants used to shift the focus included changing the topic, slowing down, exploring familiar activities, and discussing tamariki cares. Tara recounted how in a stressful situation where both parents were present, and the father was very angry with the mother, she tried to change the focus to the baby by discussing dental care to reduce the intensity of the father's emotional response. Tara shared:

> *I was on Autopilot with talking to mum about toothbrushing and looking at the baby panicking (because of the argument). (Tara)*

Tara noted that focusing on a commonly discussed health promotion topic helped her feel calmer so she could manage her thoughts and wonder what to do next as she tried to de-escalate the stressful situation. Similarly, in another situation with an angry parent Tara described biding time by focusing onto the tamariki, as illustrated in the example below:

> *I just tried to focus on, teaching factual stuff and bringing my voice down, making a plan and seeing if they could get on board with a plan that worked for them. I just kind of picked him (the pēpi) up gently, I used this a little bit to calm myself down as well while I was still trying to bide some time to see if there was some way I could sort it out. Normalizing out as much as I could, biding time calming myself as well. (Tara)*

Participants shared times they stepped back and distanced themselves from the whānau to remove themselves from stressors, hoping to reduce their own or whānau stress. There were descriptions of avoiding certain topics, sharing less, speeding up the time together, or having a desire to abandon the interaction. Some participants considered that, despite the potential benefit of reducing stress by avoiding topics or distancing themselves from the relationship, engaging in these strategies was risky as they were unlikely to solve the issue. Participants worried that by stepping back, whānau may get the impression that they are distant, lack in confidence, are uncomfortable, do not wanting to support them, or do not care about the whānau. Wendy described how she has learnt to manage her level of stress when whānau are stressed by being present but not too involved:

> *I always used to worry about them, you get drawn in by their story and feel sorry for them. You have to look at your stress and not get so stressed for them coz you cannot. I had to move away from this otherwise I would probably have left the job. (Wendy)*

Continuing to try to engage with whānau was also described by participants as having a greater focus on the whānau despite feeling stressed. There were several stories shared by participants where they wanted to leave the engagement due to the stress but remained for the sake of the pēpi or another whānau member. In the following example, Tara described how she uses self-talk to make herself stay in situations where her instincts told her to leave:

> *You just think, step back, this can be over as soon as you like, you have some control, some power over it. This will be OK. You can finish this and get out of this, and this will end. It's not gonna be long.... I think the knowledge that we can just leave if we need to for any reason whatsoever makes me feel a little bit stronger. (Tara)*

Tara described an example when a whānau member became angry with her and indicated she needed to leave. At that point she wanted to step away and leave but also to stay for the sake of the mother. As shown in the example below, despite the stress she experienced at the time, Tara again used self-talk to help her regulate, which then allowed her to remain a bit longer to ensure the wellbeing of the mother who she was worried about:

> *That's when I made myself think. Prioritise here. I'm going to have to leave this. What can I do right now that'll make a difference? The words 'now think' went through my head so I didn't stop thinking. Then a teenager comes into the room. He goes: "I've been sent in to ask you to leave". And I was like, OK, that's fine, I'll go. I quickly spoke to the mother a little bit more and then I left. (Tara)*

Tara's example demonstrates the complexity of decision making when with whānau. In this case, Tara decided to increase her own stress for the sake of the mother while determining right time to leave.

Finally, the participants talked about making *relational repairs and holding hope* as engagement focused strategies that had a focus on the whānau and navigating the engagement. Participants commented on the fragility of their relationships with whānau, describing moments of connection but also of distance and even tension. These instances of tension tended to occur in a "rupture-and-repair" sequence that involved the participant doing or saying something that impacts negatively followed by attempts to repair the rupture. When ruptures occurred, participants tried to mend them as they often found these ruptures stressful. Participants shared stories of attempts to repair the relationship to avoid themselves or the whānau becoming distant or withdrawn. Freya described how she kept trying to relate, overcome her bias, and used interpersonal strategies to mend her relationship with the whānau:

> *Then when I saw them again, I was like, “OK you can't let that influence how I'm gonna be”. It was stressful for me because of how our engagement was before and all the things that I've heard. I was conscious I already have brought this bias; I can't let it affect or influence my nursing practice. So, I was trying really hard to be friendly and inclusive using interpersonal skills despite the father being standoffish. (Freya)*

Strategies were used to maintain engagement with the whānau despite having a sense of relational struggles, feeling unwanted, or having risks to their safety. Some participants also described trying to repair relationships by showing they were human and made mistakes too, by being hopeful, validating whānau, softening their approach, and by engaging relationally. Emmy, shared how repairing was important for the relationship stating, “I'll often try and do whatever I can to fix it and help them like me again.” Olivia shared the importance of apologising:

> *Apologising helps them realise I am also human. I had a situation the other day where I said something that upset the mum, so I took a breath and apologised. She thanked me and shared some other stress she had. We talked about that and that made it less stressful. Sometimes your mind can be on something else and you are not listening then when you come back apologising can help repair. (Olivia)*

Participants noted that when a rift was successfully repaired it enabled them to feel closer to the whānau and to navigate the complexity of their relationship together. Participants considered that both sides needed to want to develop or repair a relationship for it to be successful.

Participants shared how being hopeful helped navigate stressors within whānau engagements and provided an opportunity for growth. Participants shared numerous stories of enduring stress where there was often a lower feeling of success as they struggled to try to manage the situation and be attuned. Despite the enduring stress participants shared continuing to keep engaged for the sake of the whānau, in particular for tamariki, because of their professional responsibility and a desire to support them. Freya, for instance, shared the following example of how she kept hopeful that her relational approach would mend the rift in her relationship with a father who respond negatively to her:

> *I tried to include him in the situation and asking questions, he just wouldn't speak to me. He just ignored me or had his back to me. I was just really respectful and trying to be friendly. (Freya)*

Despite stressful situations being difficult to navigate for some participants, there was a sense of satisfaction from doing what they considered the right thing. At other times, by working through the situation with the whānau, they had a closer relationship after navigating through the stressful situations. One nurse spoke about how she felt proud of herself, while another felt privileged that the client had shared the experience with her, including the positive outcome. Donna described how important and rewarding it was to continue to try have an attuned relationship despite how challenging and stressful it was:

> *I was really anxious, but it's actually been a really good learning opportunity. I think because I just keep going back, we have managed to establish a relationship. (Donna)*

In conclusion, the second Theme Two subtheme, *Navigating stress demands both self-regulation and engagement focused strategies* described the strategies participants used to navigate stress while in relationships with whānau. These were mostly aimed at preventing, avoiding, and reducing stress but at times they increased stress intentionally or unintentionally. Participants described their efforts to strike a delicate balance between professionalism and personal connection within whānau engagements. Strategies were categorised into two interconnected types: a) inwardly focused self-regulation strategies, and b) strategies that have a greater focus on navigating the engagement with whānau while the nurse participant was stressed. There was a complex interweaving of both these aspects as the participants tried to manage their levels of stress, while attending to the needs of the whānau and the requirements of their CCH nursing role. Participants shared at times concealing their feelings while actively employing relational and stress-reduction techniques. In some instances, the stress during engagements was overwhelming, making it difficult for the participants to fully regulate or alleviate their stress responses. Even amidst intense stress, many dedicated themselves to prioritizing the needs of the whānau, focusing on maintaining a relational and honest relationship with the whānau. They utilised various strategies, such as viewing situations from the whānau perspective, employing calming techniques, and attempting to mend any relationship ruptures, all while staying attuned to the needs of the relationship. At times, the participants chose to distance themselves or shorten the duration of their interactions to minimise exposure to stressors.

2.3 Others Play a Critical Role After Whānau Engagement

The final Theme Two subtheme, *Others Play a Critical Role After Whānau Engagement* draws from the participants' stories of how they managed enduring stress after the engagement and how others supported them in this. Several participants commented on experiencing an emotional release after the engagement, but this did not always completely alleviate all the stress responses they had.

Memories Remain at Varied Intensity

Participants described varied intensity of their memories of feeling stressed after engaging with whānau ranging from little memory of the stress, lingering memories of the stressful event, still feeling the stress, through to vivid recollections with heightened emotions for a significant period after a stressful event. Participants described ongoing stress responses post-engagement, including feeling shaken, frightened, worried, shocked, panicked, sad, unable to switch off, being distracted, and having trouble sleeping.

Many of the participants shared how they tried to contain their emotional responses in the whānau engagement, but their emotional response continued beyond the engagement bubbling up as an emotional release. Freya shared a situation where she had tried to contain her stress response in the engagement, but once she left, she was able to debrief with her manager and as she was no longer trying to hide her response, her "words were not as calm". Similarly, Tara in her interview vividly recalled how she felt during and after a stressful encounter describing how she had not realised how stressful the engagement had been:

> *It really wasn't till after I left that I realised just how stressful it had been. I reflected on it later and thought, wow, that was actually quite volatile. The major part is to work it through, to work out that I did everything I could have in the situation. I didn't even make it down the road to the turn off before making a phone call to my manager saying "So this has just happened. Oh my God". It's all actually still sitting there, which is interesting… just talking about it with you I can feel the same feelings I felt, none of that's gone. …. I can even remember how I felt driving down the road afterwards. (Tara)*

Freya also noted how her feelings remained after a stressful event but not to the same intensity stating:

> *I still feel it now. At the time it was way more intense. Now I just remember back, and I think it's probably the worst situation I've had. (Freya)*

Others Help Regulate Stress

When debriefing is not possible, there is a good chance nurses take the stress home, which can negatively affect their home lives and wellbeing. Even with debriefing with colleagues several participants shared how they took their stress and worry home with them. In the following example Tara shared how not debriefing had meant she was in a heightened state when she got home, then her memory and stress response were triggered by someone who looked similar to the father who had made her feel stressed:

> *I got home and hadn't debriefed and we had an unexpected visitor and I answered the door and looked at him. I thought, "Holy [expletive], he's [the client who had been angry with her] found me". An instant reaction. I was absolutely shaking and scared and, then I looked and thought there's no way he could know where you live. That's not real. A rational part of me spoke. (Tara)*

Sharing their experiences of stress with others was considered helpful by participants as it provided a sense of reassurance, acknowledgement, and being heard. They described the importance of seeking out others after stressful engagements to work through their stress response. Several participants shared how this need was often met by their colleagues, whānau, or friends. They talked about being there for each other as colleagues, both in terms of being the supporter of others and being supported by others. This helped navigate what had happened and regulate some of the remaining feelings. Knowing each other and having easy access to support were seen to be key factors in enabling debriefing after a stressful event. For some, team support meant not taking stress home as much. In the following example, Donna highlighted the value of others:

> *When I walk away and I'm talking to the staff or coming back to the office, I'm thinking "Oh, yeah, you give yourself some time to reflect on it". We talk about our relationship with clients to be warm and relational, as staff it is the same thing. I think being a team that is honest with each other about stress makes a big difference. We all have got each other's backs … It's a sense of knowing each other and being vulnerable. You can be your best with the whānau, but you know that you can come back to the office and have a good cry. It's just so noisy and they just talk, laughing and crying, whatever they need. It's raucous at times, but it's awesome because you feel supported. Even the ones that experience anxiety and very complex caseloads say they they're not taking it*

> *home because they get support from each other at work after stressful events. (Donna)*

In summary, this final Theme Two subtheme, *Others Play a Critical Role After Whānau Engagement* has described the participants' experiences of how they managed enduring stress after the engagement and how others supported them in this in the context of recognising that *The Impact of CCH Nurses' Stress on Attunement and Whānau Relationships Requires Attention*. This final subtheme reveals the vital role that colleagues and support systems play in helping Child and Community Health (CCH) nurses navigate the enduring stress that often follows these interactions. Many participants recounted emotional releases after stressful events, often realizing only afterward the extent of their stress. They employed various strategies to manage their emotions—ranging from self-regulation techniques to engaging in debriefing sessions with colleagues or seeking support from their own whānau/friends, self-care strategies and journalling. While some found effective ways to mitigate their stress, others reflected on the haunting memories of their experiences, with several expressing that they still felt residual stress during the interviews. This highlights the complex emotional situations CCH nurses navigate and the pressing need for robust support systems to aid them in their work.

Chapter Summary

The findings of this study brought together the shared experiences of a group of CCH nurses which highlighted their individual experiences of stress to be unique, complex, and unpredictable as they strived to establish and maintain therapeutic relationships with whānau while managing their own stress responses. The findings were divided into two themes while acknowledging the interconnection between them.

Theme One, *CCH nurses' experience of stress in whānau engagements is unique, multifaceted, and shaped by context,* revealed a complex mix of diverse interactions with whānau, which involved varying levels of stress in terms of intensity, frequency, and duration. Participants' stories illustrated the interplay between past and present sources of stress from within the participant, from whānau stress, relational stress between the participant and the whānau, and environmental stressors. The participants' unique human qualities, knowledge, coping skills, and the context of their working environment, influenced how they perceived, experienced, reacted to, normalised, and accepted stressful events.

Theme Two, *The impact of CCH nurses' stress on attunement and whānau relationships requires attention*, highlighted how participants' stress responses affected both themselves and their relationship with whānau. The strategies the participants employed in stressful situations, were a mix of inward focused self-regulation strategies and strategies that had a greater focus on navigating the engagement with whānau. These strategies resulted in varied impacts on the participants and their attunement with the whānau at times these were positive and at other times negative. Professional responsibility, attempts to hide their stress from whānau, and a desire to establish and maintain an attuned relationship were commonly described. Collegial support after stressful engagements was highlighted by the participants as being important as it offered an outlet for repressed emotions and to reflect to support the regulation of residing stress.

The findings of this study showed how stressful situations are unique with no prescriptive process or tidy stress regulation strategy to call on in the moment; instead, they are a complex mix of the unique situations, how the situation was experienced by the participant and the unique responses from whānau. These elements significantly influenced how participants perceived and navigated specific situations, which could either reduce or heighten their stress levels based on the context.

Chapter Seven: Discussion

The previous two chapters have described the findings from the study drawn from the participants' experiences of stress, encountered while engaging with whānau and the impacts of their stress on their relationships with whānau. These chapters vividly and comprehensively illustrate the intricate interplay of each participant's unique characteristics, their diverse coping strategies, varying levels of expertise, and the personal and workplace stressors they faced. Furthermore, the findings demonstrate how the broader workforce and the CCH nurse participants' personal contexts profoundly impacted their experiences of stress when in relationships with whānau, shaping their approach to these critical engagements. As a result, stress within CCH nursing is revealed as a significant and complex challenge that warrants immediate attention. By acknowledging and addressing the themes derived from the findings, a more supportive environment can be created that enhances nurse wellbeing while also maintaining and elevating the quality of care provided to whānau.

This discussion chapter serves as the culmination of the thesis, interpreting and articulating the significance of the study's findings in relation to established knowledge, while also illuminating new insights that emerged from the research. The implications of these findings are explored and targeted recommendations for nursing practice, government policy, and future research initiatives are provided, all before drawing the study and thesis to a decisive conclusion.

Summary of Findings

The study's aim was to describe Aotearoa New Zealand community child health nurses' experiences and perspectives of self-regulation and attunement when in relationship with whānau in times of stress. Two research questions were posed; firstly, how do Aotearoa New Zealand community child health nurses describe the relationship between stress and the capacity to self-regulate their stress response when engaging with whānau? and secondly, how do Aotearoa New Zealand community child health nurses describe the influence of stress on attunement, the capacity to build trust, and their ability to reflect on whānau relationships?

Interpretive description (Thorne, 2016) was selected as the methodology informing the study. As described earlier in the thesis, this decision was principally due to the methodology's practice orientated focus and the congruence between the methodology and the complexity of the aim of the study. Interpretive description also provided a flexible and accessible organising logic for the research, which included a holistic, relational perspective and a framework for constructive alignment across the research.

Additionally, the methodology enabled me, as the practitioner-researcher, to bridge the gap between theory and practice while navigating the complexity and sensitivity of the research topic. This approach has enabled the determination of ‘real-world’ practice based findings and recommendations for nursing, organisations and government (Thompson Burdine et al., 2021).

Given the distinct and multifaceted nature of stress arising from individual experiences, the challenge in analysing participants' stories lay in harmonising their narratives while also acknowledging the widespread impact of stress and the varying responses from each individual's perspective. Ultimately, this approach creates a rich and intricate portrait of how stress is navigated both individually and collectively. While it would be unwise to consider ‘community child health nurses’ as a homogenous group, the CCH nurses who participated in the study shared multiple, unique, rich descriptions of their experiences of stress when engaging with whānau. Their stories provided insights into the many ways they navigated, mitigated, minimised, and managed stress in whānau engagements. The nature of stress, the unique participant, and the context of the work environment significantly influenced how stress was viewed in the workplace and experienced in whānau engagement. Significantly, participants overwhelmingly reported negative impacts of stress on both themselves, and their relationships with whānau.

Chapters Five and Six, the findings chapters, explored two compelling themes, drawn from the data. The first theme described the participants’ experiences of *Stress in whānau engagements as unique, multifaceted, and shaped by context*. The complexity of stress in CCH practice was elaborated through three significant sub-themes. First, who the CCH nurse is played a crucial role in shaping their experiences of stress. Second, the origins of stress were unique, varied, and multifaceted, revealing the multiple layers that contributed to the experience. Third, it is essential to recognise that the participants’ stress did not exist in isolation—instead, the environment and context significantly influenced it. The second theme identified that *the impact of CCH nurses’ stress on attunement and whānau relationships requires attention*. Within this theme, three pivotal sub-themes emerged. First, it was evident that the stress the participants endured had a negative effect on their attunement and relationships with whānau. Second, the challenge of navigating stress within these relationships was a complex and multifaceted mix of internal and whānau focused strategies; and third, others played a critical role in helping manage the enduring stress that arose from their engagements with whānau. Of interest is that the influence of stress on the capacity to build trust was included in the second research question, but contrary to expectations, participants seldom referred to trust explicitly, with only two direct incidences across the dataset. This absence itself warrants consideration, as it could suggest that trust may have operated implicitly rather than being overtly discussed. Participants may have regarded trust as assumed and embedded within the themes or that they saw trust occurred from the whānau perspective not their own.

The discussion of the significance of these findings presented here is organised around three central ideas. First, the pervasive nature of stress and its profound impact is explored. Second, attention is drawn to the likely consequences of stress on whānau care and health outcomes, illustrating how stress can compromise the quality and continuity of care. Finally, the discussion addresses the normalisation of stress within the nursing profession, examining how this acceptance serves to entrench stress as an inevitable part of nursing practice, thereby limiting opportunities for systemic change.

Stress is Pervasive and Impacts Heavily on the Nurse

The participants shared stories of navigating unpredictable, multifacted, and varied experiences of stress. These compelling stories illustrated the pervasive nature and profound impacts of stress on them. This is not to imply that the stress participants experienced was at constantly high levels; instead, it fluctuated. The unpredictable fluctuations in stress levels, coupled with exposure to significant stressors, created a challenging landscape for managing stress in and after whānau engagements. This was further complicated by the stress the participants were also experiencing in their personal and professional life and how these stressors impacted on the participants' capacity to cope. The range of physical, emotional, and psychological impacts from stress varied from short term and quickly regulated experiences to feeling completely untenable or longer-term effects. While recognising that some stress is an inherent part of engaging with whānau, many participants described experiences of intense and frequent stress, from multiple stressors, that lingered cognitively, emotionally, and physically. These findings highlight that stress is not just a minor inconvenience; instead, stress is pervasive and impacts heavily on the nurse, at times profoundly affecting their wellbeing and whānau care. As such, it is imperative that the pervasiveness and significant impacts of stress on nurses is acknowledged and addressed to support their wellbeing and the whānau they serve.

These findings are consistent with prior research, which has found varied levels of stress in health professionals' practice, with significant negative impacts on them, both at the time and after the stressful event (Fasbinder et al., 2020; Ireland et al., 2022; Lazarus & Folkman, 1984). Several authors describe how health professionals, through their work in human relationships with others, often experience multiple stressors which can be intense or enduring (Babapour et al., 2022; Glawing et al., 2023; O'Connor, 2019; Rushton & Boston-Leary, 2022). James et al. (2023) highlighted the significant impacts of unregulated, long term and high intensity stress on health professionals' memory, cognitive reasoning, and emotional responses, which poses a risk to the quality of care provided. Similarly, Ireland et al. (2022), when studying exposure to extreme stress events, found it caused "negative affectivity, psychological distress, inter-personal difficulties, unhelpful coping, and negative self-perception" (p. 430). In respect to long-term impacts of stress among health professionals, several studies have found experiencing high levels of stress can have negative long-term effects on health professionals' wellbeing, professional and personal life, relationships, job satisfaction, and for some emotional exhaustion, and burnout (Babapour et al., 2022; Diefendorff et al., 2011; Lascelles et al., 2024; Sandstrom et al., 2020; West et al., 2018).

Participants in this study reported that stress was not only experienced during challenging moments in whānau engagements, but was also intensified by the anticipation of potential difficulties. Given that each whānau engagment is unique and unpredictable, it is not unexpected for individuals to worry about what might happen. However, this study revealed that at times the intensity of anticipatory stress was significant, particularly when participants predicted the situation was going to be highly emotional for the whānau or themselves or they questioned their knowledge and skills to handle the potential situation. Interestingly, despite the stress associated with anticipating an event, the interactions often did not unfold as expected. Even when these situations were indeed stressful as anticipated, many participants felt a sense of relief afterward, as the worry about what might happen had dissipated. Other studies have also found that the anticipation of stressors impacted on health professionals and some similarly described a sense of relief afterwards. Denton et al. (2002) found in a study on home visitors that the home visitors worried about making mistakes, causing them anticipatory stress. Likewise, Du et al. (2024) found anticipation of end-of-life conversations caused their nurse participants to feel stressed. Despite their stress, some participants opted to continue to have the conversations as they were motivated by the perceived benefits to the client, often feeling a sense of relief afterwards. However, participants shared situations where they chose not to pursue certain conversations or actions in attempts to manage anticipated stress and minimise the incidence of difficult emotions (Du et al., 2024). Similarly, in this study, participants described avoiding or delaying certain conversations as an approach to find the right time to raise the topic. At other times the choice to delay was made to mitigate foreseeable conflicts or difficult emotions.

In addition to the effects of anticipating stress and navigating stressful experiences, this study revealed the intricate interplay between the participants' unique characteristics and the stressors they faced. This combination influenced the pervasive nature of stress and its impact on each participants. Moreover, several studies have similarly identified how unique traits shape the experience of stress across various domains. Instead of merely reiterating each other's findings, these studies highlight the diverse aspects of individuality. For instance Folkman and Moskowitz (2004) identified that coping with stress is intricately linked to the individual, alongside the environment and relationships. Barattucci et al. (2019) found that factors such as temperament, genetics, neurobiology, adult attachment, adverse childhood experiences, social supports, and environmental stress played a crucial role in responses to anxiety, perceived stress, and levels of emotional regulation and attunement. Similarily, Gillespie et al. (2024) shared how emergency room nurses had more difficulty remaining emotionally detached and had lingering emotions if they knew their client or their situation was personally familiar. Likewise, Du et al. (2024) found that nurses were more likely to have difficulty emotionally preparing and exhibited strong empathy and negative emotions if they shared similarities with clients. Research has found some home visitors with their own adverse early life experiences find it particularly challenging working with whānau in crisis (Franko, et al, 2019).

This study also echoes findings from previous research that showed that beliefs, resilience and coping were also areas of individuality that impacted on the experiences of stress in health practitioners practice. Doane and Varcoe (2015) describes how different ways of coping with stress can be a way of avoiding emotions or trying not to relate to them rather than letting them be. At times these interpretations of the emotions can create and inner turmoil. Amit-Aharon et al. (2023) considered that an individual's beliefs about stressors and motivation to tackle challenges, along with internal and external coping resources influenced their ability to manage stress effectively. Similarily, Glawing et al. (2023) discovered that vulnerability to stressors and different coping abilities affected how much stress ambulance nurses were able to cope with. James et al. (2023) and Campbell-Sills et al. (2006) noted a complex relationship between stress, resilience, coping and decision making. James et al. (2023) found those with high resilience, belief in their own abilities, and cognitive reserves were more likely to mitigate the cognitive impacts from stress. Furthering this discussion, Campbell-Sills et al. (2006) found there was a continuum of resilience to stress ranging from vulnerability to adaptive outcomes. Additionally, resilience and coping with stress have been found to be influenced by temperament and personality, as well as specific skills (e.g. active problem-solving) (Campbell-Sills et al., 2006; Ogińska-Bulik & Zadworna-Cieślak, 2018).

Alongside the influence of levels and types of stress, and individual characteristics on the experience of stress, the participants in the current study described how varied knowledge and experience in CCH practice played a pivotal part in navigating relationships and managing their experiences of stress. Even though each situation is unique to the individual, there was a collective agreement that prior knowledge, skills and experiences supported participants' capacity to navigate future stressful situations. Likewise, other authors have found knowledge and skills play a part in coping with stress. Ireland et al. (2022) highlighted the greater likelihood of an extreme stress response when a staff member is outside of their knowledge and skills. On the other hand, Du et al. (2024) found knowledge and experience significantly influenced self-regulation strategies. Sarkadi et al. (2015) reported that increased experience related to increased comfort, confidence, and feelings of competence in providing support for nurses. Consequently, Sarkadi et al. (2015) considered the length of time in nursing practice can impact what nurses consider to be stressful, the experience of attunement, and the capacity to reflect on relationships when stressed.

Experiences of stressors and coping skills can have positive outcomes, at times bringing a sense of relief or growth from navigating through a stressful engagement, with growth influenced by personal resources and coping strategies (De Cordova et al., 2024; Ogińska-Bulik & Zadworna-Cieślak, 2018). Prior experiences of stress have been found by Campbell-Sills et al. (2006) to increase resistance to minor stressors. Interestingly, in the current study, prior experience of stress had a two-way impact depending on the situation and individual. At times it increased capacity to cope in stressful situations with whānau, but in other situations it increased stress as memories of prior stressful situations were triggered, heightening anticipatory stress. No other literature was found that discussed the potential of positive or negative impacts of prior knowledge and experience, including what influences this variation. Importantly, knowledge and experience of stress should not be considered the panacea to managing stress in whānau engagements, with the potential of growth from stressful experiences no justification for exposure to pervasive and high levels or continual stress.

Another factor highlighted by the study participants, relating to the prevasiveness and intensity of stress, was their awareness of stress and stress responses. The level of awareness—whether high or low—was critical in their accounts of managing stressful situations while engaging with whānau. Participants shared at times how they recognised both the stressors they faced and their physical, emotional, and psychological reactions to stress, providing them with a greater opportunity to consciously take action to manage their stress and navigate their interactions with whānau. At other times there was less awareness of their level of stress and stress responses during whānau engagement as they were focused on the situation and whānau needs, often becoming more aware of the level of stress they had been experiencing after the engagement. Other authors have also identified how awareness of stressors and stress responses enhance the process of self-regulation and can impact on the capacity to be attuned to clients (Fasbinder et al., 2020; Grabbe, 2015; Greenberg et al., 2020; Kokkonen et al., 2014). Previous studies have found that those who experienced self-awareness of stressors and considered how others might perceive them when stressed were more able to regulate their stress response, had a greater sense of control and had a greater ability to attune to clients (Andela et al., 2014; Fasbinder et al., 2020; Goldblatt et al., 2020; Silverman & Hutchison, 2019). Similarly, Doane and Varcoe (2015) state "consciously noticing the emotions we are experiencing and being as authentic and compassionate with ourselves as we require ourselves to be with others is important" (pg. 112). No literature was found that discussed the impact of limited awareness of stress and stress responses on whānau engagements.

There is a significant gap in existing research regarding the pervasive widespread nature and profound impacts of stress on CCH nurses during whānau engagements. Additionally, no literature was found addressing how individual traits, knowledge, and skills influence CCH nurses' responses to this stress in such engagements. The current study identified that while personal attributes may help mitigate some effects of stress, the fundamental human experience of stress persists. Stressors within the CCH environment invariably triggered stress responses in all participants. However, these responses manifested in unique ways for different participants and even varied for the same participant in different situations.

Lascelles et al. (2024) proposed nurses should not be considered weak or lacking resilience if they are experiencing difficult emotional responses, nor is it acceptable to expose nurses to a high level of stress, regardless of whether they have high levels of resilience or not. Ross et al. (2018) considered it was rare to find studies that show nurses encounter situations that exceed the ability to cope, which makes it complex to bring into the open the levels of stress nurses are coping with if exceeding the ability to cope is not understood. Addressing the various complex factors that impact on nurses is not just beneficial; it is essential for the wellbeing of the nurses, whānau and the communities they serve. While enhancing individual characteristics or implementing strategies to identify factors that amplify or alleviate stress is advantageous, this needs to be done with a holistic approach to help reduce exposure to stressors or enhance nurses' capacity to cope in light of the profound and pervasive consequences of stress on them and the whānau they engage with.

Negative Stress Very Likely Impacts on Attunement, Whānau Engagement, and Providing Quality of Care

Leading on from the discussion of the pervasiveness of stress and how it impacted heavily on the study participants, this section discusses important new practice knowledge, identifying that the participants' stress responses not only impact on themselves, but also at times very likely impact on whānau engagement and potentially compromises their capacity to be attuned and provide quality of care. Much like nurses' experiences of the complex impact of stress on themselves, participants described how their response to stress meant they, at times, were less available for the whānau relationship, less likely to notice whānau cues, less relational, and less attuned to the whānau. Additionally, many of the participants described trying to hide their stress for the sake of the relationship and professional expectations, with attempts to repair ruptures caused by the stress. Their stories were full of examples of how, despite their stress, they caried on trying to meet the needs of the whānau, fulfil the expectations of their roles, and provide care. However, at times their unresolved stress meant their care was more transactional, they explored concerns less, avoided topics, and shortened the time together.

Relational and whānau led practice are considered central to nurses working with whānau to support health outcomes (Doane & Varcoe, 2015). Attunement is considered to have an important role in the capacity to be with others, feel connected, and show compassion and empathy leading to therapeutic decision making (Price, 2017; Raingruber, 1999). Communication that is warm and respectful is considered one of the most fundamental parts of health professionals relationships (Duggan et al., 2018). Additionally, research has shown that the more present, attentive, and empathic the health care provider, the higher the client satisfaction (Silverman & Hutchison, 2019). Within nursing, the sensitive, genuine, honest, and caring approach of the nurse is considered central to being attuned to clients, but it also requires a nurse to be truly present, regulated, and calm, responding with sensitivity and synchrony (Price, 2017; Raingruber, 1999).

Similar to the current research, several studies have identified the impact of stress on the capacity to be attuned to others. Research has found a complex interaction of stress within engagements, the societal and cultural contexts that impact on the whānau, and nurses' capacity to provide care within these contexts (Lascelles et al., 2024; O'Connor, 2019). Vivian et al. (2019) found stress impaired the nurses' ability to experience attuned relationships be able to demonstrate empathy, focused attention, timely responses, and be in the present moment. Likewise, Babapour et al. (2022) and Glawing et al. (2023) found stress can impact on nurses’ level of compassion, ability to empathise with clients, and their quality of care. Similarly, Vahey et al. (2004) found hospital nurses’ workload stress and emotional exhaustion impacted on relational engagement and client satisfaction, while Gillespie et al. (2024) found emergency nurses’ experiences of traumatic stress meant they felt jaded, less compassionate, judgmental, impatient, and had less empathy with whānau. They reported consequences on the nurses’ professional practice and their personal lives. Despite the different nursing roles, all these studies show an impact of stress on health professionals’ care for whānau. Considering the findings of this study alongside the findings of other authors, it is suggested that at times negative stress can significantly impact whānau engagement and compromise nurses' ability to establish attuned relationships and provide quality care. What this study offers is the knowledge of how stress impacted on the CCH nurse participants attunement with whānau.

Leading on from the impacts of stress on participants’ capacity to be attuned to whānau, their stories revealed a strong desire to prioritise the needs of whānau despite experiencing stress. They highlighted the benefits of self-awareness in this process. Participants shared two interconnected types of strategies they noticed using when they were stressed in whānau engagements. Firstly, inwardly focused self-regulation techniques, and secondly those centred on navigating the engagement despite their stress; for instance, focusing on building relationships, being relational, making repairs in relationships, maintaining hope, shifting focus to less stressful topics, and being honest. These strategies are only separated for the benefit of this discussion, it is acknowledged they are strongly interrelated, occurring simultaneously. At times the focus may be inward focused reducing the capacity to focus on navigating the engagement, at other times the focus on the whānau may reduce the capacity of health professionals to notice stress and self-regulate. This section does not attempt to focus in depth on the two types of strategies due to the complex and multiple types, rather it provides a more overarching discussion.

The inwardly focused strategies of self-regulation have been found to facilitate positive social interactions and relationship quality, cultivating empathy, compassion, helping behaviour, mitigating psychological distress, and supporting recovery from stressful situations (Restubog et al., 2020). In respect to strategies focused on navigating the relationship, Kanda et al. (2023), found home visiting nurses adapted their care in response to clients' complex unique needs, so a client-led and joint decision-making approach could occur, but it is unknown how stress impacted on their decision-making process. Whereas Bernstein (2019) and Frechette and Carnevale (2020) found nurses working with whānau and tamariki balanced whānau needs, with role expectations but this meant less opportunity to utilise self-regulation strategies. They considered nurses needed to have the capacity to be emotionally regulated and attuned to whānau to support them in relational and caring ways. Folkman and Moskowitz (2004) described how being inward focused and placing positive meaning to stressful events or reframing them could impact on the experience of stressors. Alongside reframing, coping, another inward focused strategy, has also been highlighted in the literature by Campbell-Sills et al. (2006) who found the use of task-orientated coping, with a focus on problem solving contributed to resilience. Placing positive meaning to stressful events may be helpful but it cannot be used as the only response to stress. Stress may not be mitigated solely by reframing or building self-regulation or coping skills and this mindset may result in the nurse blaming themselves for not having enough resilience or skills to cope with stressors.

The current study highlighted how containment of emotions during engagement was a strategy used to reduce the impact of stress on the whānau relationship and to be able to remain professional. Similarly, Fasbinder et al. (2020) found nurses used strategies such as masking or controlling their emotions, where they display positive emotions despite their exposure to stressors from patients, families, colleagues, and the general health system. Other research has also found that, in stressful situations, setting emotional boundaries, supressing and taking control of their emotions, and expressing positive or neutral emotions instead of showing their stress enabled the nurses to invest in the client relationship (Andela et al., 2014; Fasbinder et al. 2020; Goldblatt et al., 2020).

Several participants shared how after whānau engagements, they had remained stressed with evident feelings of emotions, often feeling they did not need to contain or mask their emotions any longer. For some there was a sense of noticing the level of stress they had experienced more after than the engagement than within the engagement. Colleagues, whānau and friends were found helpful by the participants to support them in managing remaining stress responses after engagements with whānau. Debriefing with colleagues was found to reduce the level of stress participants took home and support they sought from their own whānau. Gillespie et al. (2024) similarly found emergency nurses when providing trauma care, would release emotions after the event; for example, crying was a way they processed residual stress. These nurses found debriefing as soon as possible after stressful events was beneficial to realise they were not alone in what they thought and felt, helped them to accept the outcomes, and reduced second-guessing themselves. Likewise, Du et al. (2024) found their study participants were more likely to seek help from colleagues and other health professionals and less likely to seek support from their own family as they were reluctant to spread negative emotions to them.

The findings of this study demonstrate how negative stress very likely impacts on whānau engagement and potentially compromises the capacity to be attuned and provide quality of care. This study provides a unique perspective of this experience for CCH nurses. The findings provide a picture of the complexity the participants faced in navigating whānau relationships and needs while simultaneously managing their own stress. At times this made it difficult for participants to recognise their stress and stress responses, and to effectively regulate their autonomic physical, emotional, and cognitive biological stress responses. These impacts hindered their cognitive and emotional ability to remain attuned, professional, and make sound decisions.

The Problematic Normalisation of Stress in Nursing

Throughout the analysis of, and reflexivity, on the data and findings from the study, it became increasingly evident that nurses stress in whānau care is often normalised and accepted. Despite the known impact of stress on nurses and their whānau relationships, what emerged from the study as a key finding was a – perhaps unhealthy - acceptance and normalisation of varied intensities of stress by the nurses and the profession, and a silencing of stress as a professional issue. The participants described how they coped despite struggling in stressful situations, with these coping strategies having a positive or negative impact on the participant and relationship.

The unique characteristics of the participants intersected with unique and unpredictable stressful situations, which may mean that the individual's capacity or lack of capacity to manage in stressful whānau engagements may be undermined or misunderstood. As there is no possible benchmark to indicate what types and levels of stress in whānau engagements are manageable or not, for each unique nurse and unique situation, this may play a part in the normalisation and silencing of stress. O'Connor (2019) considered that emotions are filtered through unique personal and professional identities alongside social, cultural and gender-based constructs of emotional skills. Together these likely play a part in the normalisation and acceptance of stress.

The expectation to balance the stress of coping and keeping interactions professional despite high levels of stress was common in participants' stories, with containment of stress linked to professionalism, boundaries, and resilience. O'Connor (2019) considered emotions to be inherent in relational practice, but they are often seen within professions as potentially harmful to the individuals and the relationship and therefore require containment and control. Participants discussed at length how stressors triggered emotional, psychological and physical responses, but there was an internal and professional expectation to supress, hide, or manage stress quickly, regardless of the level of stress or the responses it triggered. This was generally so that whānau engagement was not impacted (or minimally impacted) and the nurse protected the relationship and met the expectations of their role. O'Connor (2019) raised a similar dichotomy for social workers stating that, "emotions are part of professional practice, yet they are not perceived as professional" (p. 654). While O'Connor considered experiences and the use of emotions as linked to the professional role and identity, the place of emotions in the professional practice paradox is problematic, as emotions emerge in relational contexts that are socially constructed, with subjective conscious and unconscious experiences. Gillespie et al. (2024) further discussed the complexity of managing stress in relational practice. The authors highlighted how participants in their study wrestled between empathy, seeing things from the perspective of the client and their whānau, and trying to remain emotionally detached from the situation.

Ross et al. (2018) described the significant risk of the impact of stress being silenced, in that nurses would be unlikely to set boundaries and limits when socialised to the professional norms that dictate silent endurance of work stress. Similarly, health professionals working in trauma often chose not to acknowledge the events as significant, dismissing the negative consequences despite the physiological impacts of stress on the professional and potentially resulting in suboptimal client care (Gillespie et al., 2024). Without the voice to share the largely uncontested and taken-for-granted experiences of stress within their role and their profession, it can therefore be surmised that CCH nurses' experiences of stress in whānau relationships are at risk of remaining invisible and continuing to silently sabotage whanau relationships and outcomes.

The impact of CCH nurses primarily practising alone in homes or clinics undoubtedly contributes to the acceptance, normalising and enduring silence of stress in their practice as they are often struggling alone in highly complex situations. The high complexity was often not understood by those not in CCH nursing, further contributing to the silencing of the stress. Working in sole practice is considered a factor in workplace stress internationally (World Health Organization, 2020). Conversely, Glawing et al. (2023) found that working with a competent colleague reduced stress and prevented the feeling of loneliness. This further highlights the impact of working alone on the CCH nurses' level of stress as they usually do not have readily available colleagues. It was only very occasionally that the participants asked for help, during the whānau engagement by calling a colleague and even then, it was not to come into the stressful situation but rather to ask for advice or to do something for them. Moreover, as the CCH nurse is primarily on their own, their colleagues usually do not witness the situation and therefore are unable to share the emotional load and management of stressors. The lack of sharing in the others' stress because of the privacy of the whānau engagement is not unique to CCH nurses.

Cook (2017) identified the hidden aspect of home visiting in social work and that little is known about how social workers make sense of their experiences of stress in home visiting. Additional to not having colleagues directly available to seek advice and support, Rushton and Boston-Leary (2022) noted there are norms around not asking for help. They considered these norms to have undermined the nurse's awareness, acknowledgement, and willingness to ask for or access help and resources. It is acknowledged that having a colleague continually alongside in CCH nurses' practice is not achievable due to the way CCH practice is currently structured and having others present may have unintended consequences on the whānau relationship; nevertheless, finding ways to mitigate the link between working alone and stress needs to be explored.

Many of the participants of this study grappled with the fear of being considered unable to cope, particularly as a new practitioner, often placing pressure on themselves to manage or hide stress, resulting in them being alone in their struggle. The culture of nursing has a significant role to play in the professional expectations placed on the nurse. Within nursing there is a culture of expecting nurses to manage stressors and to be resilient, implying that if nurses cannot cope they are not robust enough for nursing (Weston & Nordberg, 2022). Nursing has historically created a culture of survival of the fittest and that it is not a good fit for the meek and mild, with the added nursing culture of perfectionism often driven by quality and high standards; which are considered barriers to revealing their human frailty, to make mistakes and not be able to cope with stress (Rushton & Boston-Leary, 2022). Stigma characterised by exclusion, blame, or devaluing is seen in actions, behaviours, and embedded in structures and policies. Feeling alienated and ashamed creates a culture for nurses to suffer in silence (Rushton & Boston-Leary, 2022). There exists tension between how practitioners' emotions are perceived by themselves and how others see them, which reinforces the silencing of the experiences of stress in whānau engagements (O'Connor, 2019). If norms communicate that nurses are not good enough, deficient, or a failure when they struggle in stressful whānau engagements, this can result in denial, shame, guilt, resistance, or feeling judged (Rushton & Boston-Leary, 2022). While being professional is an important aspect of practice, professionalism should not be weaponised to normalise or silence stress. It is therefore timely to highlight the impact of nurses' stress on nurses and whānau relationships as a professional issue, so that nurses can be appropriately supported and whānau receive the best possible care.

Recommendations

Unique to this study was the rich description of the experience and impact of stress by Aotearoa New Zealand CCH nurse participants when engaging with whānau; an unexplored area of nursing practice in the literature. No other study has focused solely on the impact of stress within the engagement with whānau and what the experience is like for the nurses.

It is recommended to take a multipronged approach that buffers and/or ameliorates negative impacts of stress. Such an approach needs to include education, organisational and personal support, resilience, experience and skills, and the capacity to positively re-formulate the event. This lifts the sole responsibility for managing their stress off the nurses' shoulders and redistributes it across a number of actors including organisations, funders education institutions and consumers in the solution (Babapour et al., 2022; Ireland et al., 2022; Lascelles et al., 2024). When it is everyone's responsibility, there is a greater chance of change. A multipronged approach making stress visible and giving nurses the resources they need to mitigate it is necessary. It is not feasible to remove stress in whānau relationships altogether as being in a professional relationship with whānau as they navigate the complexities of life will always bring a level of stress. But it is important to reduce the incidence of stressors and enhance the capacity to cope in stressful situations.

As highlighted by this study, the uniqueness of each CCH nurse matters, so any solutions need to reflect the individuality of the nurse, the unique experience and needs of the individual rather than an approach that provides one solution for all. Any change needs to include acknowledgement of personal humanity, vulnerabilities, and frailties (Rushton & Boston-Leary, 2022). Support needs to be non-stigmatizing, tailored to the health professional, and accessible (Lascelles et al., 2024). Understanding the drivers of stress from the individual's perspective, both personally and professionally, hopefully will support the conception of root-cause solutions (Vivian et al., 2019).

For ease of understanding and readership, I utilised a framework by Rushton and Boston-Leary (2022) to develop the recommendations. This framework offers a comprehensive approach that shifts the focus away from blaming nurses for inadequately coping with stress to recognising various external influences and joint responsibilities. The following themes are outlined to provide a thorough set of recommendations: First, the destigmatising and shifting the narrative of normalisation and acceptance of stress are discussed. Second, the importance of emphasising wellbeing is explored. Third, improving communication and education strategies are highlighted. Fourth, ideas for being proactive and for making resources available are described. Fifth, ideas for building trustworthy mechanisms, aligned with integrity, transparency, humility, and courage are outlined.

Destigmatise and Shifting the Narrative of Stress

The normalisation and acceptance of stress in whānau relationships needs to shift so stress in whānau engagements can be destigmatised and reframed. Bringing the topic into the open will enable approaches to be developed to reduce the incidence and/or the harmful impact of stress on the nurse and the whānau they are working with. This can be achieved by the professionals, service providers, and funders looking within themselves to understand their own bias, values, and expectations of themselves and others, alongside ways to destigmatise the narrative of stress (Rushton & Boston-Leary, 2022). This needs to happen alongside normalised human responses to stress as part of practice which will ideally shift the construct within the profession as well as supporting nurses' self-awareness of stress and their capacity to navigate stress within whānau relationships. Nursing needs to look within to understand how the profession perpetuates the normalisation and acceptance of stress in relationships with whānau. This requires a coherent understanding and message within the nursing profession, so there is a shift from normalisation and acceptance of stress to asking for support and change as acts of integrity and stewardship (Rushton & Boston-Leary, 2022).

Emphasising Wellbeing

Urgent action is needed to enhance wellbeing alongside shifting the narrative of acceptance, normalisation, and silencing of stress by nurses, the nursing profession, organisations, and policy makers. The compounding effects of stress from whānau engagements, anticipation of future stressful whānau engagements, as well as workplace and personal stressors is having a significant long-term impact on nurses (Babapour et al., 2022; Diefendorff et al., 2011; Fasbinder et al., 2020; Ireland et al., 2022; Lascelles et al., 2024; Sandstrom et al., 2020; West et al., 2018). Tackling this issue of nurses' wellbeing requires a multi-pronged approach to reduce stigma and increase understanding and compassion for nurses. There needs to be an increased focus on wellbeing, capacity to cope with stress, and resilience as these have been shown to positively influence outcomes from stress exposure, the capacity to rebound from stress, and the ability to function despite adversity (Campbell-Sills et al., 2006; De Cordova et al., 2024; Ogińska-Bulik & Zadworna-Cieślak, 2018).

Organisations have a responsibility to attend to the wellbeing of their staff to support the delivery of high-quality client-centred care, shifting the norm of acceptance and normalisation (Vivian et al., 2019). Leaders need to understand their own biases and accept nurses as humans who are fallible, and when limits of capacity to cope with stress are met this does not mean resilience is missing (Rushton & Boston-Leary, 2022). Organisations have the capacity to empower their clinicians to speak freely about the stressors they face, but leaders need to be prepared to respond proactively (Dzau et al., 2020). Support and resources from co-workers, supervisors, and organisations have been found to be effective in mitigating the impact of stress and foster wellbeing (Singh et al., 2020), alongside intentional relationally based and timely organisational support (Hazen et al., 2020). In contrast, a lack of managerial support has been found to cause increased stress after a stressful event (Babapour et al., 2022). The development of wellbeing policies is one way to mitigate the link between stress in whānau engagement, emotional impact and poor outcomes, such as burnout and quality of whānau care (Diefendorff et al., 2011).

Increasing nurses' self-awareness of stress and coping skills may go part way towards enhancing wellbeing (Campbell-Sills et al., 2006). Having greater self-awareness, self-compassion, and knowledge of personal and workplace limits will ideally reduce exposure to stressors and enable more effective regulation of stress (Folkman & Moskowitz, 2004; Lascelles et al., 2024). Doane and Varcoe (2015) describe the importance of nurses engaging with their emotional response in a compassionate way, creating a space for openness for emotions and considering these in the light of what is happening, This enables nurses to consciously choose how to respond to themselves and others to promote wellbeing. Developing wellbeing strategies needs to consider the context, the individual, their vulnerability and their types of coping, controllability for themselves and the situation, as well as cultural and spiritual contexts (Folkman & Moskowitz, 2004; Lascelles et al., 2024). Unfortunately, published interventions to reduce psychological distress among nurses in whānau care are scarce (Newman et al., 2023). This is a research area that needs to be addressed.

Growing collegial support, supervision, and reflective practice should support nurses to attend to the emotional impacts of stress and to address ways to better cope in whānau relationships (Hazen et al., 2020; Lascelles et al., 2024). Gilkerson and Imberger (2016) describe the importance of reflection within engagements with whānau and after engagements to enhance attunement. This process enabled health practitioners to be able to look in the mirror and also to have a compassionate way to grow in practice and relational engagement. A literature review by Singh et al. (2020) on compassion fatigue found sharing of experiences from practice with a peer or manager could provide a cathartic outlet, revitalise therapeutic care and reduce depersonalisation. Organisations should prioritise multimodal support for nurses, including post-incident debriefing, formalised peer support, collegial collaboration and team-building initiatives to foster supportive relationships (Glawing et al., 2023; Newman et al., 2023; Singh et al., 2020). Building and formalising peer support would offer nurses a forum to reflect and process their emotional responses to stress, supporting them in coping with the demands of their role and develop strategies for managing stressful situations (O'Connor, 2019).

Improving Communication and Education

If communication and education about stress, and the pervasive impact of stress, were improved this would likely support bringing the impact of stress on health professionals and whānau engagements from silence into the open, shifting constructs, and developing a range of relevant knowledge and skills. Teaching strategies that acknowledge stress and stress responses rather than avoiding or supressing these experiences, is ideal to enhance wellbeing and resilience for future challenges (Rodríguez-Rey et al., 2024) Providing education that raises understanding of the impact of stress on whānau engagement, that increases self-awareness skills, emotion regulation skills, coping strategies, resilience, confidence in accessing support and resources, reappraisal and mentalising the whānau experience, is vital (Folkman & Moskowitz, 2004; Lascelles et al., 2024).

It is also important to build on coping skills that reflect the individual personality of each nurse. Providing a one fits all approach would miss the unique needs of each nurse and undermine their current capabilities to manage in stressful whānau engagements (Folkman & Moskowitz, 2004). Thus, such interventions need to account for the fact that what works well in some situations may not be effective in others, so nurses need to develop flexibility and adaptability in deciding which coping strategy to employ. Additionally, developing nurse confidence and competencies needs to be unique in topics they find stressful and challenging, so they can provide appropriate and timely care to whānau while managing their own stress response (Babapour et al., 2022; Kanda et al., 2022). Providing this education cannot wait until nurses are experiencing stressors in practice, rather it needs to start in undergraduate education, be included in orientation to new roles, and further developed in continuing education programmes (Lascelles et al., 2024; Rushton & Boston-Leary, 2022). As emotion regulation strategies are enhanced through learning this increases the potential to be able to regulate emotional responses to stressors (Fasbinder et al., 2020).

Framing the solution by only increasing communication, offering resources, or through professional development can risk placing responsibility of managing stressors mostly on the individual nurse rather than workplaces, policy makers and government agencies (Ross et al., 2018). Providing nurses with tools and management techniques to help cope with stress should be a responsibility that is shared between the nurse, education system, employer and funders and involve changes to the context of the workplace (Glawing et al., 2023). Alongside education for nurses, there is a need to provide education to supervisors and/or managers to support their role of nurturing colleagues and to address systems that normalise levels of stress in whānau engagements (Singh et al., 2020).

Being Proactive and Make Resources Available

Rather than waiting for problems to occur, there is a need to be proactive, to monitor, and recognise issues early. Creating a culture of openness and support is needed (Rushton & Boston-Leary, 2022). The government needs to take responsibility for moral reasons to support change as the health workforce is an exhaustible resource and already stretched. This not only requires acknowledgement of the issue but also funds for workforce wellbeing and to make resources available. It is important to invest in the workforce to make sustainable structural changes in policies, procedures, resourcing, and priorities that reduce the exposure to high levels of stress within the nursing workforce (Dzau et al., 2020; Rushton & Boston-Leary, 2022).

The Minister of Health (2023) acknowledges that to improve the health of Aotearoa New Zealanders and reduce inequity, there needs to be a shift in the way the health workforce is viewed, towards acknowledging the uniqueness of individual skills, competencies and personal attributes. The Minister of Health's (2023) focus is on the health system being community based, promoting good health, and wellbeing at the earliest opportunity, especially in the early years of life. To achieve this requires investment in the workforce, including reducing the impact of stress on the nurse and their capacity to provide relational whānau care.

Building Trustworthy Mechanisms

The New Zealand Minister of Health (2023) considers it important for the health system to create relationships with education, regulation, and employment settings to ensure safe and effective care, increase flexibility and transparency, with greater accountability for employers to provide safe working environments that focus on workforce wellbeing. Building trustworthy mechanisms aligned with core values of integrity, transparency, humility and courage are recommended (Rushton & Boston-Leary, 2022). Ireland et al. (2022) suggest organisations need to provide nurses with a culture where they feel able to seek support, without fear of blame or judgement, recommending increased support through training, supervision, consultancy and clear policies and procedures to achieve this and as such reduce the impact of stress on the workforce. Moloney et al.'s (2024) Aotearoa New Zealand study explored elements that support community nurses to thrive and found perceived organisational support and empowered leadership had a significant positive effect on vitality, the capacity to thrive at work, and reduced burnout and intention to leave.

Employers and policymakers need to explore the cause of stress, find ways to reduce work stress and help improve working conditions and capacity to cope in stressful situations, rather than primarily focusing on improving coping strategies to decrease the strain and impact from the emotional requirements of the role (Diefendorff et al., 2011; Paterson et al., 2024; Rodríguez-Rey et al., 2024; Singh et al., 2020). This is a priority as the care a health care service provides to whānau is directly proportional to the wellbeing of its staff (Gehrke et al., 2024; Vivian et al., 2019). Advocating for these changes extends beyond the responsibility of nurses, who have spent decades voicing the needs of their profession and whānau. Those in influential positions (i.e. hospital leadership, management and government officials) need to demonstrate the value of nurses' voices, to help shape the perception and value of nurses within society and advocate for change, while including nurses at decision making levels (Diefendorff et al., 2011). These actions would not only benefit nurses and whānau but also organisations seeking to retain nurses, who are costly to train, orientate and replace. Organisations need a culture of safety, wellbeing and acceptance of nurses' uniqueness, strengths and vulnerabilities. Leadership needs to be compassionate and authentic at all levels with realistic expectations (Lascelles et al., 2024). The health care system needs to prioritise stress reduction interventions for the sake of health professionals as well as for the care provided to whānau.

Why Action Matters

It is unlikely that the complex, traumatic, distressing and stressful nature of health care work, that can affect nurses' wellbeing can be completely reduced due to the nature of the nurses roles (Hazen et al., 2020; Ogińska-Bulik & Zadworna-Cieślak, 2018). In saying this it does not mean that stress should be accepted and normalised in practice, rather strategies need to be found at policy and practice levels to reduce the impact of stress and increase the capacity to cope, within the engagement and workplace context on themselves and the whānau they engage with. As there is a deleterious impact from stress in whānau engagements on the physical and psychological wellbeing of nurses and the quality of care, a multipronged approach from nurses, the nursing profession, policy makers, employers and government is necessary to address the link between workplace and levels of stress. Nurses' mental health and wellbeing needs safeguarding. If action is not taken exposure to stressful and challenging clinical settings, trauma and other stressors in whānau engagement are likely to exhaust nurses. This can result in behavioural and emotional responses and cognitive withdrawal from the occupation or compromised empathic resources, leading to distancing from whānau care and poor outcomes for whānau (Singh et al., 2020).

Limitations of the Research

It is acknowledged there are limitations of this study. One limitation was the potentially limited range of practice areas where participants were recruited from. As the vignettes were anonymous and did not ask the participants' area of practice in case of identification, area of practice is unknown for this group. The semi-structured interviews participants were primarily from Well Child Tamariki Ora practice, limiting the representation of a range of practice areas in this group. Another limitation is the limited variation in participant ethnicities. Primarily the participants were non-Māori and non-Pacific, limiting the diversity in cultural views.

Due to the time gap between the stressful events and the data collection, participants' perceptions of the stressors and their responses to stress may have changed. Providing immediate accounts as well as retrospective accounts is likely to yield different insights about stress. Immediate accounts can enhance short-term recall, minimise recall bias, and offer more vivid descriptions of the situation and emotions involved. However, these momentary accounts may overlook the broader conceptualisation and complexity of the experience. On the other hand, retrospective accounts, while likely more subjective and influenced by cognitive responses, can also become distorted and may involve efforts to find meaning (Folkman & Moskowitz, 2004).

Additionally, the participants' shared stories were only their conscious memories of the events, whereas there may be many times they were stressed but unaware or had limited awareness of their stress or response. Additionally, as the data was only gathered from the CCH nurse participants this only provided their context not that of the whānau.

Recommendations for Further Research

Although there are limitations of this study that could have impacted the data collection, analysis and subsequent findings, the conclusions from the findings are in line with the literature on stress and relational engagement, with this qualitative study shedding valuable light on the participants' experiences of stress during whānau engagement. However, to build on these initial findings and cultivate a more comprehensive understanding of the topic, further research is essential.

The following areas are recommended for further exploration: First, that whānau experiences during engagements with CCH nurses are explored to gain insight into their perceptions of stress within the engagement, and their perceptions of the impacts on their wellbeing. Gaining their view is critical for fostering effective engagement strategies. Second, the experiences of stress among CCH nurses is explored through a cultural lens, recognising that cultural factors may significantly affect how stress is experienced and managed. Third, that strategies to reduce stressors and their impact on practitioners and whānau is undertaken with an evaluative process. Assessing the influence of such training on coping mechanisms during stressful engagements can guide professional development initiatives. Fourth, explore how nurses' attachment styles and histories of trauma shape their capacity to cope in stressful whānau engagements. This understanding could lead to tailored support strategies that enhance resilience among practitioners. Fifth, undertake research of nursing and policy leaders in Aotearoa New Zealand to gather their perspectives and uncover innovative approaches in strategy and policy change. Establishing a solid foundation for policy development can significantly improve the wellbeing of both nurses and whānau. By delving into these critical areas, we can significantly enhance the understanding of stress dynamics in nursing, ultimately leading to improved engagement and outcomes for whānau and practitioners alike.

Conclusion

The quality-of-care nurses are able to provide and how whānau feel about their care is impacted by stress, distress, fatigue, and burnout within the workforce (Vivian et al., 2019). The findings of this study have provided new discoveries of the complexity of in how stress impacts on CCH nurses’ and their capacity to provide attuned care to whānau. It has exposed critical gaps in the literature in respect to the experience of stress in whānau engagements. This study has bought together the complex factors that impact on CCH nurses’ capacity to navigate stress in unique whānau engagements, including how their unique attributes, the level of stress, the context and the responses of whānau. Bringing these together has identified the complex factors that impact on CCH capacity to balance inwardly focused self-regulation strategies, and strategies that have a greater focus on navigating the engagement with whānau. There are no similar studies that explored this unique area of Community Child Health or that specifically focused on the experience of stress in whānau engagements.

Stress is a nursing workforce crisis (Larsman et al., 2024). There is an urgent priority for the nursing profession, management and healthcare policymaking to attend to stress. There is an imperative to change the culture for nurses that has created the acceptance, normalisation, and silencing of the experience of stress in whānau relationships. It is necessary to make the impact of nurses’ stress in whānau engagements visible and to develop preventive and restorative approaches and strategies to reduce the impact on nurses and the whānau they are caring for. Change has the potential to redefine the role and demands within the role and enhance organisational strategies and resource development to safeguard the wellbeing of staff and the care provided to whānau. With shared leadership across nurses, organisations, funders and education institutions there is opportunity for change, but awareness, commitment and removing barriers to change are required so innovative change can happen.

References

Alba Barbara, & Beck Cheryl. (2017). *Phenomenology*. Springer Publishing Company.

Andela, M., Auzoult, L., & Truchot, D. (2014). An exploratory study of self-consciousness and emotion-regulation strategies in health care workers. *Psychological Reports*, *115*(1), 106-114. https://doi.org/10.2466/20.16.PR0.115c17z4

Ayres, L., Groves, P,, Mackin, M., & Tripp-Reimer, T. (2017). *Qualitative Research*. Springer Publishing Company.

Babapour, A., Gahassab-Mozaffari, N., & Fathnezhad-Kazemi, A. (2022). Nurses' job stress and its impact on quality of life and caring behaviors: a cross-sectional study. *BMC Nursing*, *21*(1). https://doi.org/10.1186/s12912-022-00852-y

Barattucci, M., Padovan, A. M., Vitale, E., Rapisarda, V., Ramaci, T., & De Giorgio, A. (2019). Mindfulness-based IARA Model ® proves effective to reduce stress and anxiety in health care professionals. A six-month follow-up study. *International Journal of Environmental Research and Public Health*, *16*(22). https://doi.org/10.3390/ijerph16224421

Barr, P. (2022). Dimensions of the burnout measure: Relationships with shame- and guilt-proneness in neonatal intensive care unit nurses. *Australian Critical Care*, *35*(2), 174-180. https://doi.org/10.1016/j.aucc.2021.03.007

Bate, J., Bekar, O., & Blom, I. (2018). A mother, a baby, and two treatment approaches: Discussing a switch case from CBT and mentalization perspectives. *Journal of Infant, Child, and Adolescent Psychotherapy*, *17*(4), 328-345. https://doi.org/10.1080/15289168.2018.1526159

Bellosta-Batalla, M., Blanco-Gandía, M. C., Rodríguez-Arias, M., Cebolla, A., Pérez-Blasco, J., & Moya-Albiol, L. (2020). Increased salivary oxytocin and empathy in students of clinical and health psychology after a mindfulness and compassion-based intervention. *Mindfulness*, *11*(4), 1006-1017. https://doi.org/10.1007/s12671-020-01316-7

Bernstein, S. (2019). Being present: Mindfulness and nursing practice. *Nursing*, *49*(6), 14-17. https://doi.org/10.1097/01.NURSE.0000558105.96903.af

Blanco-Donoso, L. M., Amutio, A., Moreno-Jiménez, B., Del Carmen Yeo-Ayala, M., Hermosilla, D., & Garrosa, E. (2019). Incivility at work, upset at home? Testing the cross-level moderation effect of emotional dysregulation among female nurses from primary health care. *Scandinavian Journal of Psychology*, *60*(3), 267-276. https://doi.org/10.1111/sjop.12535

Bradbury-Jones, C., Breckenridge, J., Clark, M. T., Herber, O. R., Wagstaff, C., & Taylor, J. (2017). The state of qualitative research in health and social science literature: a focused mapping review and synthesis. *International Journal of Social Research Methodology*, *20*(6), 627-645. https://doi.org/10.1080/13645579.2016.1270583

Bradshaw, C., Atkinson, S., & Doody, O. (2017). Employing a qualitative description approach in health care research. *Global Qualitative Nursing Research,* 4. doi:10.1177/2333393617742282

Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide*. SAGE.

Bray, L., Ford, K., Dickinson, A., Water, T., Snodin, J., & Carter, B. (2019). A qualitative study of health professionals' views on the holding of children for clinical procedures: Constructing a balanced approach. *Journal of Child Health Care*, *23*(1), 160-171. https://doi.org/10.1177/1367493518785777

Breau, G., Thorne, S., Baumbusch, J., Hislop, T. G., & Kazanjian, A. (2023). Family physicians' and trainees' experiences regarding cancer screening with patients with intellectual disability: An interpretive description study. *Journal of Intellectual Disabilities,* 27(1), 250-265. https://doi.org/10.1177/17446295211044041

Brewer, K. M., Harwood, M. L. N., McCann, C. M., Crengle, S. M., & Worrall, L. E. (2014). The use of interpretive description within kaupapa Maori research. *Qualitative Health Research, 24*(9):1287-97. https://doi.org/10.1177/1049732314546002

Byrne, G., Sleed, M., Midgley, N., Fearon, P., Mein, C., Bateman, A., & Fonagy, P. (2019). Lighthouse parenting programme: Description and pilot evaluation of mentalization-based treatment to address child maltreatment. *Clinical Child Psychology & Psychiatry*, *24*(4), 680. https://doi.org/10.1177/1359104518807741

Campbell-Sills, L., Cohan, S. L., & Stein, M. B. (2006). Relationship of resilience to personality, coping, and psychiatric symptoms in young adults. *Behaviour Research and Therapy*, *44*(4), 585-599. https://doi.org/10.1016/j.brat.2005.05.001

Chavasse, F. (2022). *How does attachment state of mind affect the nurse-woman caregiving relationship?* [Doctoral thesis, University of Technology Sydney]. OPUS. https://opus.lib.uts.edu.au/handle/10453/164323

Chiu, P., Thorne, S., Schick-Makaroff, K., & Cummings, G. G. (2022). Theory utilization in applied qualitative nursing research. *Journal of Advanced Nursing*, *78*(12), 4034-4041. https://doi.org/10.1111/jan.15456

Chopik, W. J. (2014). Relational attachment and ethical workplace decisions: The mediating role of emotional burnout. *Personality and Individual Differences,* 75, 160-164. Elsevier. https://doi.org/10.1016/j.paid.2014.11.007

Chu, B., Marwaha, K., Sanvictores, T., Awosika, O., & Ayers, D. (2024). Physiology, stress reaction. [Updated 2024 May 7]. *StatPearls [Internet].* https://www.ncbi.nlm.nih.gov/books/NBK541120/

Cook, L. L. (2017). Making sense of the initial home visit: The role of intuition in child and family social workers' assessments of risk. *Journal of Social Work Practice*, *31*(4), 431-444. https://doi.org/10.1080/02650533.2017.1394826

Cox, C., Hatfield, T., & Fritz, Z. (2024). How and why do doctors communicate diagnostic uncertainty: An experimental vignette study. *Health Expectations*, *27*(1), 1-15. https://doi.org/10.1111/hex.13957

Crawford, R. (2019). Using focused ethnography in nursing research. *Kai Tiaki Nursing Research*, *10*(1), 63-67.

Crowther, S., & Smythe, E. (2016). Open, trusting relationships underpin safety in rural maternity a hermeneutic phenomenology study. *BMC Pregnancy Childbirth*, *16*(1), Article 370. https://doi.org/10.1186/s12884-016-1164-9

Cuyvers, K., Van Den Bossche, P., & Donche, V. (2022). Longitudinal case study research to study self-regulation of professional learning: Combining observations and stimulated recall interviews throughout everyday work. In M. Goller, E. Kyndt, S. Paloniemi, & C. Damşa (Eds.), *Methods for researching professional learning and development* (pp. 579-600). Springer International Publishing. https://doi.org/10.1007/978-3-031-08518-5_26

Davies, C., & Fisher, M. (2018). Understanding research paradigms. *Journal of the Australasian Rehabilitation Nurses' Association (JARNA)*, *21*(3), 21-25. https://www.scirp.org/reference/referencespapers?referenceid=3082147

De Cordova, P. B., Reilly, L. L., Pogorzelska-Maziarz, M., Gerolamo, A. M., Grafova, I., Vasquez, A., & Johansen, M. L. (2024). A theoretical framework for acute care nurse stress appraisal: Application of the transactional model of stress and coping. *Journal of Advanced Nursing*, *80*(9), 3835-3845. https://doi.org/10.1111/jan.16061

Denton, M. A., Zeytinoğlu, I. U., & Davies, S. (2002). Working in clients' homes: The impact on the mental health and well-being of visiting home care workers. *Home Health Care Services Quarterly*, *21*(1), 1-27. https://doi.org/10.1300/J027v21n01_01

Diefendorff, J. M., Erickson, R. J., Dahling, J. J., & Grandey, A. A. (2011). Emotional display rules as work unit norms: A multilevel analysis of emotional labor among nurses. *Journal of Occupational Health Psychology, 16*(2), 170–186. https://doi.org/10.1037/a0021725

Doane, G. H., & Varcoe, C. (2015). *How to nurse: Relational inquiry with individuals and families in changing health and health care contexts*. Wolters Kluwer Health/Lippincott Williams & Wilkins.

Dolan, S., Nowell, L., & Moules, N. (2023). Interpretive description in applied mixed methods research: Exploring issues of fit, purpose, process, context, and design. *Nursing Inquiry*, *30*(3), Article e12542. https://doi.org/10.1111/nin.12542

Du, J., An, Z., Wang, C., & Yu, L. (2024). Nurses' self-regulation after engaging in end-of-life conversations with advanced cancer patients: A qualitative study. *BMC Nursing*, *23*(1), 1-11. https://doi.org/10.1186/s12912-024-02016-6

Dubert, C. J., Schumacher, A. M., Locker, L., Gutierrez, A. P., & Barnes, V. A. (2016). Mindfulness and emotion regulation among nursing students: Investigating the mediation effect of working memory capacity. *Mindfulness*, *7*(5), 1061-1070. https://doi.org/10.1007/s12671-016-0544-6

Duggan, A., Portilla, X., Filene, J., Crowne, S., Hill, C., Lee, H., & Knox, V. (2018). *Implementation of evidence-based early childhood home visiting: Results from the mother and infant home visiting program evaluation*. OPRE Report 2018-76A. Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. https://www.acf.hhs.gov/sites/default/files/documents/opre/mihope_implementation_report_2018_10_26_508b.pdf

Dzau, V. J., Kirch, D., & Nasca, T. (2020). Preventing a parallel pandemic - A national strategy to protect clinicians' well-being. *New England Journal of Medicine*, *383*(6), 513-515. https://doi.org/10.1056/nejmp2011027

Edmonds, L. K., Cram, F., Bennett, M., Lambert, C., Adcock, A., Stevenson, K., Geller, S., Macdonald, E. J., Bennett, T., Storey, F., Gibson-Helm, M., Ropitini, S., Taylor, B., Bell, V., Hoskin, C., & Lawton, B. (2022). Hapū ora (pregnancy wellness): Māori research responses from conception, through pregnancy and 'the first 1000 days' – A call to action for us all. *Journal of the Royal Society of New Zealand*, *52*(4), 318-334. https://doi.org/10.1080/03036758.2022.2075401

Edmonds, W., & Kennedy, T. (2017). *An applied guide to research designs: Quantitative, qualitative, and mixed methods* (2nd ed.). SAGE. https://doi.org/10.4135/9781071802779

Epstein, R. M., & Street, R. L., Jr. (2011). Shared mind: Communication, decision making, and autonomy in serious illness. *Annals of Family Medicine*, *9*(5), 454-461. https://doi.org/10.1370/afm.1301

Fasbinder, A., Shidler, K., & Caboral-Stevens, M. (2020). A concept analysis: Emotional regulation of nurses. *Nursing Forum*, *55*(2), 118-127. https://doi.org/10.1111/nuf.12405

Fewell, C. (2013). Mentalization-based treatment: A valuable framework for helping maltreating parents. *Journal of Social Work Practice in the Addictions*, *13*(1), 123-126. https://doi.org/10.1080/1533256X.2012.756786

Folkman, S., & Moskowitz, J. T. (2004). Coping: Pitfalls and promise. *Annual Review of Psychology, 55*, 745-774. https://doi.org/10.1146/annurev.psych.55.090902.141456

Franko, M., Schaack, D., Roberts, A., Molieri, A. Wacker, A., Estrada, M., & Gann, H. (2019). *The region X home visiting workforce study.* Butler Institute for Families, Graduate School of Social Work, University of Denver. https://www.dcyf.wa.gov/sites/default/files/pdf/RegXWorkforceStudy.pdf

Frechette, J., & Carnevale, F. A. (2020). Exploring a hermeneutic perspective of nursing through revisiting nursing health history. *Nursing Philosophy*, *21*(2), Article e12289. https://doi.org/10.1111/nup.12289

Freeman, C. (2016). What is mentalizing? An overview. *British Journal of Psychotherapy*, *32*(2), 189-201. https://doi.org/10.1111/bjp.12220

Gehrke, P., Campbell, K., Tsang, J. L. Y., Hannon, R. A., & Jack, S. M. (2024). Canadian intensive care unit nurses' responses to moral distress during the COVID-19 pandemic, and their recommendations for mitigative interventions. *Journal of Advanced Nursing, 80*(12), 4974-4988. https://doi.org/10.1111/jan.16135

Gillespie, G. L., Meyer, H. A., Daugherty, M., Puthoff, D., Fryman, L. J., & Howard, P. K. (2024). Stress and coping in emergency nurses following trauma patient care: A qualitative grounded theory approach. *Journal of Trauma Nursing*, *31*(3), 136-148. https://doi.org/10.1097/JTN.0000000000000787

Gilkerson, L. & Imberger, J. (2016). Strengthening Reflective Capacity in Skilled Home Visitors. *Zero to Three* *https://eitp.education.illinois.edu/Files/Series/FAN/ZTTarticle1.pdf*

Girouard, S., & Bailey, N. (2017). ACEs implications for nurses, nursing education, and nursing practice. *Academic Pediatrics*, *17*(7S), S16-S17. https://doi.org/10.1016/j.acap.2016.09.008

Glawing, C., Karlsson, I., Kylin, C., & Nilsson, J. (2023). Work-related stress, stress reactions and coping strategies in ambulance nurses: A qualitative interview study. *Journal of Advanced Nursing, 80*(2), 538-549. https://doi.org/10.1111/jan.15819

Godoy, L. D., Rossignoli, M. T., Delfino-Pereira, P., Garcia-Cairasco, N., & De Lima Umeoka, E. H. (2018). A comprehensive overview on stress neurobiology: Basic concepts and clinical implications. *Frontiers in Behavioral Neuroscience*, *12*, 127. https://doi.org/10.3389/fnbeh.2018.00127

Goldblatt, H., Freund, A., Drach-Zahavy, A., Enosh, G., Peterfreund, I., & Edlis, N. (2020). Providing health care in the shadow of violence: Does emotion regulation vary among hospital workers from different professions? *Journal of Interpersonal Violence*, *35*(9-10), 1908-1933. https://doi.org/10.1177/0886260517700620

Goussinsky, R., & Livne, Y. (2016). Coping with interpersonal mistreatment: The role of emotion regulation strategies and supervisor support. *Journal of Nursing Management, 24*(8), 1109-1118. https://doi.org/10.1111/jonm.12415

Grabbe, L. (2015). Attachment-informed care in a primary care setting. *Journal for Nurse Practitioners*, *11*(3), 321-327. https://doi.org/10.1016/j.nurpra.2014.12.014

Greenberg, N., Docherty, M., Gnanapragasam, S., & Wessely, S. (2020). Managing mental health challenges faced by healthcare workers during Covid-19 pandemic. *BMJ*, *368*, Article m1211. https://doi.org/10.1136/bmj.m1211

Gross, J. J. (1998). The emerging field of emotion regulation: An integrative review. *Review of General Psychology, 2*(3), 271-299*.* https://doi.org/10.1037/1089-2680.2.3.271

Halama, P., & Pitel, L. (2016). Relationship between adult attachment and decision making in hospital nurses is mediated by self-regulation ability. *Studia Psychologica*, *58*(2), 122-133. https://doi.org/10.21909/sp.2016.02.711

Halcomb, E. J. (2019). Mixed methods research: The issues beyond combining methods. *Journal of Advanced Nursing*, *75*(3), 499-501. https://doi.org/10.1111/jan.13877

Halm, M. (2017). The role of mindfulness in enhancing self-care for nurses. *American Journal of Critical Care*, *26*(4), 344-348. https://doi.org/10.4037/ajcc2017589

Harding, R., Beesley, H., Holcombe, C., Fisher, J., & Salmon, P. (2015). Are patient-nurse relationships in breast cancer linked to adult attachment style? *Journal of Advanced Nursing*, *71*(10), 2305-2314. https://doi.org/10.1111/jan.12693

Hazen, K. P., Carlson, M. W., Hatton-Bowers, H., Fessinger, M. B., Cole-Mossman, J., Bahm, J., Hauptman, K., Brank, E. M., & Gilkerson, L. (2020). Evaluating the facilitating attuned interactions (FAN) approach: Vicarious trauma, professional burnout, and reflective practice. *Children and Youth Services Review*, *112*, 104925. https://doi.org/10.1016/j.childyouth.2020.104925

Herzog, J. I., & Schmahl, C. (2018). Adverse childhood experiences and the consequences on neurobiological, psychosocial, and somatic conditions across the lifespan. *Frontiers in Psychiatry*, *9*, Aricle 420. https://doi.org/10.3389/fpsyt.2018.00420

Holloway, I., & Galvin, K. (2017). *Qualitative research in nursing and healthcare* (4th ed.). John Wiley & Sons.

Hornsey, S. J., Dobson, A., Ghio, D., Henaghan-Sykes, K., Adams, S., Lovegrove, E., Santer, M., & Muller, I. (2024). Living with unsettled baby behaviours: Qualitative interview study exploring parental perceptions and experiences of help-seeking. *Journal of Advanced Nursing, 80*(10), 4214-4229. https://doi.org/10.1111/jan.16070

Howlett, M., Doody, K., Murray, J., Leblanc-Duchin, D., Fraser, J., & Atkinson, P. (2015). Burnout in emergency department healthcare professionals is associated with coping style: A cross-sectional survey. *Emergency Medicine Journal*, *32*(9), 722-727. https://doi.org/10.1136/emermed-2014-203750

Hudson, M., Milne, M., Reynolds, P., Russell, K., & Smith, B. (2010). *Te Ara Tika. Guidelines for Māori research ethics: A framework for researchers and ethics committee members.* Health Research Council of New Zealand. Retrieved from https://www.hrc.govt.nz/sites/default/files/2019-

06/Resource%20Library%20PDF%20-%20Te%20Ara%20Tika%20Guidelines%20for%20Maori%20Research%20Ethics_0.pdf

Hunt, M. R. (2009). Strengths and challenges in the use of interpretive description: Reflections arising from a study of the moral experience of health professionals in humanitarian work. *Qualitative Health Research*, *19*(9), 1284-1292. https://doi.org/10.1177/1049732309344612

Hutchinson, S., Lindell, D., & Wilson, H. (2017). *Grounded theory*. Springer.

Ireland, C. A., Chu, S., Ireland, J. L., Hartley, V., Ozanne, R., & Lewis, M. (2022). Extreme stress events in a forensic hospital setting: Prevalence, impact, and protective factors in staff. *Issues in Mental Health Nursing*, *43*(5), 418-433. https://doi.org/10.1080/01612840.2021.2003492

Jackson-Koku, G., & Grime, P. (2019). Emotion regulation and burnout in doctors: A systematic review. *Occupational Medicine*, *69*(1), 9-21. https://doi.org/10.1093/occmed/kqz004

Jacobsen, K. H. (2021). *Introduction to health research methods: A practical guide* (3rd ed.). Jones & Bartlett Learning.

James, K. A., Stromin, J. I., Steenkamp, N., & Combrinck, M. I. (2023). Understanding the relationships between physiological and psychosocial stress, cortisol and cognition. *Frontiers in Endocrinology*, *14*, Article 1085950. https://doi.org/10.3389/fendo.2023.1085950

Jamshed, S. (2014). Qualitative research method-interviewing and observation. *Journal of Basic and Clinical Pharmacy*, *5*(4), 87. https://doi.org/10.4103/0976-0105.141942

Jonathan, P. (2019). Mindfulness in organizations (part 1): A critical literature review. *Industrial and Commercial Training*, *51*(2), 104-113. https://doi.org/10.1108/ICT-07-2018-0063

Kanda, K., Blythe, S., Grace, R., Elcombe, E., & Kemp, L. (2022). Variations in sustained home visiting care for mothers and children experiencing adversity. *Public Health Nursing*, *39*(1), 71-81. https://doi.org/10.1111/phn.13014

Kanda, K., Blythe, S., Grace, R., Elcombe, E., Rodgers, K., & Kemp, L. (2023). ‘Everything's adaptable’: A qualitative study of how nurses make decisions in sustained home-visiting care with mothers and children experiencing adversity. *Journal of Advanced Nursing*, *79*(12), 4568-4579. https://doi.org/10.1111/jan.15736

Kilgour, H. M., Lambert, L. K., Howard, A. F., McKenzie, M., & Thorne, S. (2025). Advance care planning in oncology nursing: An interpretive description study. *Journal of Advanced Nursing*. Advanced Online Publication. https://doi.org/10.1111/jan.16879

Kokkonen, T. M., Cheston, R. I., Dallos, R., & Smart, C. A. (2014). Attachment and coping of dementia care staff: The role of staff attachment style, geriatric nursing self-efficacy, and approaches to dementia in burnout. *Dementia*, *13*(4), 544-568. https://doi.org/10.1177/1471301213479469

Kozlowska, K., Walker, P., McLean, L., & Carrive, P. (2015). Fear and the defense cascade. *Harvard Review of Psychiatry*, *23*(4), 263-287. https://doi.org/10.1097/hrp.0000000000000065

Larsman, P., Pousette, A., & Törner, M. (2024). The impact of a climate of perceived organizational support on nurses' well-being and healthcare-unit performance: A longitudinal questionnaire study. *Journal of Advanced Nursing, 80*(12), 4921-4932. https://doi.org/10.1111/jan.16188

Lascelles, K., Groves, S., & Hawton, K. (2024). Suicide among nurses: What can we do to protect our workforce? *Journal of Advanced Nursing*, *80*(5), 1667-1669. https://doi.org/10.1111/jan.15956

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. Springer.

Lee, J., Clarke, S., & Lynn, F. (2021). Understanding the causes of work-related stress among registered nurses working with children at home: An integrative literature review. *Comprehensive Child & Adolescent Nursing*, *44*(2), 90-121. https://doi.org/10.1080/24694193.2020.1745325

Lewin, S., & Glenton, C. (2018). Are we entering a new era for qualitative research? Using qualitative evidence to support guidance and guideline development by the World Health Organization. *International Journal for Equity in Health*, *17*(1), Article 126. https://doi.org/10.1186/s12939-018-0841-x

Mah, C. L., Taylor, E., Hoang, S., & Cook, B. (2014). Using vignettes to tap into moral reasoning in public health policy: Practical advice and design principles from a study on food advertising to children. *American Journal of Public Health*, *104*(10), 1826-1832. https://doi.org/10.2105/ajph.2014.302005

McInroy, L. B., & Beer, O. W. J. (2022). Adapting vignettes for internet-based research: Eliciting realistic responses to the digital milieu. *International Journal of Social Research Methodology*, *25*(3), 335-347. https://doi.org/10.1080/13645579.2021.1901440

Minister of Health. (2023). *New Zealand Health Strategy.* Ministry of Health. https://www.health.govt.nz/system/files/2023-07/new-zealand-health-strategy-oct23.pdf

Ministry of Health. (2012). *Healthy Beginnings: Developing perinatal and infant mental health services in New Zealand.* Ministry of Health. https://www.health.govt.nz/system/files/2012-01/healthy-beginnings-final-jan2012.pdf.pdf

Ministry of Health. (2015). *Well Child / Tamariki Ora Programme Practitioner Handbook: Supporting families and whānau to promote their child's health and development – Revised 2015.* Ministry of Health. https://www.tewhatuora.govt.nz/assets/For-the-health-sector/Specific-life-stage/child-health/Well-Child-Tamariki-Programme-Publications/wcro-practitioner-handbook-october-2015-updates-v2.pdf

Ministry of Health. (2016). *New Zealand Health Strategy: Future direction.* Ministry of Health. https://www.health.govt.nz/publications/new-zealand-health-strategy-2016

Moloney, W., Cheung, G., & Jacobs, S. (2024). Key elements to support primary healthcare nurses to thrive at work: A mixed-methods sequential explanatory study. *Journal of Advanced Nursing, 80*(9), 3812-3824. https://doi.org/10.1111/jan.16058

Moton, T. M., King, P. T., Dalziel, S. R., Merry, S., Robertson, S. P., & Day, A. S. (2022). The current and future state of child health and wellbeing in Aotearoa New Zealand: part 1. *Journal of the Royal Society of New Zealand*, *52*(4), 313-317. https://doi.org/10.1080/03036758.2022.2093434

Munns, A. (2023). Community child health nursing: exploring the way forward. *Australian Journal of Child and Family Health Nursing*, *20*(1), 6-9.

Navarro-Prados, A. B., Rodríguez-Ramírez, Y., Satorres, E., & Meléndez, J. C. (2024). Stress and burnout in nursing home and égida workers during COVID-19. *Journal of Advanced Nursing, 80*(2), 733-744. https://doi.org/10.1111/jan.15849

New Zealand Government. (2019). *Child and youth wellbeing strategy summary document.* New Zealand Government. https://www.msd.govt.nz/documents/about-msd-and-our-work/child-youth-wellbeing/strategy-and-plan/summary-child-youth-wellbeing-2019.pdf

Newman, C., Roche, M., & Elliott, D. (2023). Exposure to patient aggression and health outcomes for forensic mental health nurses: A cross-sectional survey. *Journal of Advanced Nursing, 80*(3), 1201-1211. https://doi.org/10.1111/jan.15885

NHS. (2012). *Social and emotional wellbeing: Early years*. National Institute for Health and Care Excellence. https://www.nice.org.uk/guidance/ph40/resources/social-and-emotional-wellbeing-early-years-pdf-1996351221445

NZNO, 2024. *Child Health Nursing Standards Framework Aotearoa 2024*. NZNO: New Zealand Nurses Organisation. https://coilink.org/20.500.12592/5fclmcs on 23 May 2025

O'Connor, L. (2019). How social workers understand and use their emotions in practice: A thematic synthesis literature review. *Qualitative Social Work*, *19*(4), 645-662. https://doi.org/10.1177/1473325019843991

Ocean, M., Montgomery, R., Jamison, Z., Hicks, K., & Thorne, S. (2022). Exploring the expansive properties of interpretive description: An invitation to anti-oppressive researchers. *International Journal of Qualitative Methods*, *21*. https://doi.org/10.1177/16094069221103665

Ogińska-Bulik, N., & Zadworna-Cieślak, M. (2018). The role of resiliency and coping strategies in occurrence of positive changes in medical rescue workers. *International Emergency Nursing*, *39*, 40-45. https://www.sciencedirect.com/science/article/abs/pii/S1755599X18300181

Oliver, C. (2012). The relationship between symbolic interactionism and interpretive description. *Qualitative Health Researtch*, *22*(3), 409-415. https://doi.org/10.1177/1049732311421177

Ordway, M. R., Sadler, L. S., Dixon, J., & Slade, A. (2014). Parental reflective functioning: analysis and promotion of the concept for paediatric nursing. *Journal of Clinical Nursing*, *23*(23-24), 3490-3500. https://doi.org/10.1111/jocn.12600

Ozuah, P. O. (2024). The scourge of workplace violence. *Pediatrics*, *154*(2), Article e2024066108. https://doi.org/10.1542/peds.2024-066108

Paine, T. H. S.-J. (2023). The economic cost of indigenous child health inequities in Aotearoa New Zealand - an updated analysis for 2003-2014. *The New Zealand Medical Journal, 136*(1568), 23-45. https://doi.org/10.26635/6965.5874

Paterson, C., Davis, D., Roberts, C., Bail, K., Wallis, E., Northam, H. L., Frost, J., Jojo, N., McGrory, C., Dombkins, A., & Kavanagh, P. S. (2024). Sense of coherence moderates job demand-resources and impact on burnout among nurses and midwives in the context of the COVID-19 pandemic: A cross-sectional survey. *Journal of Advanced Nursing, 80*(10), 4113-4125. https://doi.org/10.1111/jan.16125

Patridge, E. F., & Bardyn, T. P. (2018). Research electronic data capture (REDCap). *Journal of the Medical Library Association*, *106*(1). https://doi.org/10.5195/jmla.2018.319

Polgar, S., & Thomas, S. A. (2013). *Introduction to research in the health sciences* (6th ed.). Churchill Livingstone: Elsevier.

Price, B. (2017). Developing patient rapport, trust and therapeutic relationships. *Nursing Standard*, *31*(50), 52–63. https://doi.org/10.7748/ns.2017.e10909

Raingruber, B. J. (2009). Recognizing, understanding, andresponding to familiar responses: The importance of a relationship history fortherapeutic effectiveness. *Perspectives in Psychiatric Care*, *35*(2), 5-18. https://doi.org/10.1111/j.1744-6163.1999.tb00569.x

Regnault, A., Willgoss, T., & Barbic, S. (2018). Towards the use of mixed methods inquiry as best practice in health outcomes research. *Journal of Patient-Reported Outcomes*, *2*(1), Article 19. https://doi.org/10.1186/s41687-018-0043-8

Restubog, S. L. D., Ocampo, A. C. G., & Wang, L. (2020). Taking control amidst the chaos: Emotion regulation during the COVID-19 pandemic. *Journal of Vocational Behavior*, *119*, Article 103440. https://doi.org/10.1016/j.jvb.2020.103440

Rodríguez-Rey, R., Marta, Collazo-Castiñeira, P., Collado, S., Caro-Carretero, R., Cantizano, A., & Garrido-Hernansaiz, H. (2024). Predictors of mental health in healthcare workers during the COVID-19 pandemic: The role of experiential avoidance, emotion regulation and resilience. *Journal of Advanced Nursing, 80*(10), 4089-4102. https://doi.org/10.1111/jan.16122

Ross, C. A., Jakubec, S. L., Berry, N. S., & Smye, V. (2018). “A two glass of wine shift”: Dominant discourses and the social organization of nurses’ substance use. *Global Qualitative Nursing Research*, *5*. https://doi.org/10.1177/2333393618810655

Rushton, C. H., & Boston-Leary, K. (2022). Nurses suffering in silence: Addressing the stigma of mental health in nursing and healthcare. *Nursing Management*, *53*(8), 7-11.

Rushton, C. H., Kaszniak, A. W., & Halifax, J. S. (2013). A framework for understanding moral distress among palliative care clinicians. *Journal of Palliatiove Medicine*, *16*(9), 1074-1079. https://doi.org/10.1089/jpm.2012.0490

Salvarani, V., Rampoldi, G., Ardenghi, S., Bani, M., Blasi, P., Ausili, D., Di Mauro, S., & Strepparava, M. G. (2019). Protecting emergency room nurses from burnout: The role of dispositional mindfulness, emotion regulation and empathy. *Journal of Nursing Management*, *27*(4), 765-774. https://doi.org/10.1111/jonm.12771

Sandelowski, M. (2000). Whatever happened to qualitative description*? Research in Nursing and Health, 23*(4), 334-340. https://doi.org/10.1002/1098-240X(200008)23:4<334::AID-NUR9>3.0.CO;2-G

Sandstrom, H., Willenborg, P., Sparr, M., & Morrison, C. (2020). *Mental health and wellbeing among home visitors: Stressors, supports, and service implications*. National Home Visiting Resource Center Research Snapshot Brief. https://nhvrc.org/wp-content/uploads/NHVRC-Brief-031620-FINAL.pdf

Sarkadi, A., Gulenc, A., & Hiscock, H. (2015). Maternal and child health nurses' self-perceived confidence in dealing with child behaviour problems. *Child Care Health Development, 41*(2), 324-328. https://doi.org/10.1111/cch.12150

Scotland, J. (2012). Exploring the philosophical underpinnings of research: Relating ontology and epistemology to the methodology and methods of the scientific, interpretive, and critical research paradigms. *English Language Teaching*, *5*(9), 9-16. https://doi.org/10.5539/elt.v5n9p9

Shaver, P. R., & Mikulincer, M. (2007). Adult attachment strategies and the regulation of emotion. In J. J. Gross (Ed.), *Handbook of emotion regulation* (pp. 446-465). The Guildford Press.

Silverman, M. E., & Hutchison, M. S. (2019). Reflective capacity: An antidote to structural racismcultivated throughmental health consultation. *Infant Mental Health Journal*, *40*(5), 742-756. https://doi.org/10.1002/imhj.21807

Simkin-Tran, K., Harman, B., & Nicolson, S. (2020). Mentalisation amongst maternal and child health nurses using the newborn behavioural observations with infant-mother dyads: A qualitative study. *Journal of Pediatric Nursing*, *53*, e21-e27. https://doi.org/10.1016/j.pedn.2020.01.018

Singh, J., Karanika-Murray, M., Baguley, T., & Hudson, J. (2020). A systematic review of job demands and resources associated with compassion fatigue in mental health professionals. *International Journal of Environmental Research and Public Health*, *17*(19), Article 6987. https://doi.org/10.3390/ijerph17196987

Smythe, E., Payne, D., Wilson, S., Paddy, A., & Heard, K. (2014). Revealing tact within postnatal care. *Qualitative Health Research*, *24*(2), 163-171. https://doi.org/10.1177/1049732313519704

St. George, S. (2014). Applied interpretation: A review of interpretive description by Sally Thorne. *The Qualitative Report, 15*(6), 1624-1628. https://doi.org/10.46743/2160-3715/2010.1367

Sukhera, J. (2022). Narrative reviews: Flexible, rigorous, and practical. *Journal of Graduate Medical Education*, *14*(4), 414-417. https://doi.org/10.4300/jgme-d-22-00480.1

Tariq, S., & Woodman, J. (2013). Using mixed methods in health research. *JRSM Short Reports*, *4*(6), 204253331347919. https://doi.org/10.1177/2042533313479197

Teodoro., de Cássia Félix Rebouças, V., Thorne, S., de Souza, N., de Brito, L., & Alencar, A. (2018). Interpretive description: A viable methodological approach for nursing research. *Anna Nery School Journal of Nursing / Escola Anna Nery Revista de Enfermagem*, *22*(3), 1-8. https://doi.org/10.1590/2177-9465-EAN-2017-0287

Terry, G., & Hayfield, N. (2021). *Essentials of thematic analysis*. American Psychological Association. https://doi.org/10.1037/0000238-000

Theile, C. M., & Beall, A. L. (2024). Narrative reviews of the literature: An overview. *Journal of Dental Hygiene*, *98*(1), 78-82.

Thompson Burdine, J., Thorne, S., & Sandhu, G. (2021). Interpretive description: A flexible qualitative methodology for medical education research. *Medical Education*, *55*(3), 336-343. https://doi.org/10.1111/medu.14380

Thorne, S. (2011). Toward methodological emancipation in applied health research. *Qualitative Health Research*, *21*(4), 443-453. https://doi.org/10.1177/1049732310392595

Thorne, S. (2016). *Interpretive description: Qualitative research for applied practice* (2nd ed.). Routledge.

Thorne, S., Kirkham, S. R., & Macdonald-Emes, J. (1997). Interpretive description: A noncategorical qualitative alternative for developing nursing knowledge. *Research in Nursing & Health*, *20*(2), 169-177. https://doi.org/10.1002/(SICI)1098-240X(199704)20:2<169::AID-NUR9>3.0.CO;2-I

Thorne, S., Kirkham, S. R., & O'Flynn-Magee, K. (2004). The analytic challenge in interpretive description. *International Journal of Qualitative Methods*, *3*(1), 1-11. https://doi.org/10.1177/160940690400300101

Thorne, S., Stephens, J., & Truant, T. (2016). Building qualitative study design using nursing's disciplinary epistemology. *Journal of Advanced Nursing*, *72*(2), 451-460. https://doi.org/10.1111/jan.12822

Tipa, Z. (2021). *Mahi ngātahi: Culturally responsive ways of working with whānau accessing well child/tamariki ora services* [Doctoral thesis, Auckland University of Technology]. Tuwhera. http://hdl.handle.net/10292/14007

Tipa, Z., Wilson, D., Neville, S., & Adams, J. (2015). Cultural responsiveness and the family partnership model. *Nursing Praxis in New Zealand*, *31*(2), 35-49

Tuppal, C., Reñosa, M., Ninobla, M., Ruiz, M., & Loresco, R. (2019). Amo ergo sum — I love, therefore, I am – Emotional synchrony: A Norris' method of concept clarification. *Nurse Media Journal of Nursing*, *9*(2), 176-196. https://doi.org/10.14710/nmjn.v0i0.23261

Uzun, K. (2016). Critical investigation of a qualitative research article from ontological and epistemological perspectives. *International Journal of Social Sciences and Education Research*, *2*(3), 836-842. https://doi.org/10.24289/ijsser.279027

Vahey, D., Aiken, L., Sloane, D., Clarke, S., & Vargas, D. (2004). Nurse burnout and patient satisfaction. *Medical Care*, *42*(2), II57-1166. https://doi.org/10.1097/01.mlr.0000109126.50398.5a

Veloski, J., Tai, S., Evans, A. S., & Nash, D. B. (2005). Clinical vignette-based surveys: A tool for assessing physician practice variation. *American Journal of Medical Quality, 20*(3), 151-157. https://doi.org/10.1177/10628606052745

Vivian, E., Oduor, H., Arceneaux, S. R., Flores, J. A., Vo, A., & Madson Madden, B. (2019). A cross-aectional atudy of perceived stress, mindfulness, emotional self-regulation, and self-care habits in registered nurses at a tertiary care medical center. *SAGE Open Nursing*, *5*. https://doi.org/10.1177/2377960819827472

Wynd, D. (2013). *Child abuse: What role does poverty play?* Child Povery Action Group. https://www.cpag.org.nz/publications/child-abuse-on-poverty-2013

West, A. L., Berlin, L. J., & Harden, B. J. (2018). Occupational stress and well-being among Early Head Start home visitors: A mixed methods study. *Early*

Childhood Research Quarterly, *44*, 288-303. https://doi.org/10.1016/j.ecresq.2017.11.003

Weston, M. J., & Nordberg, A. (2022). Stigma: A barrier in supporting nurse well-being during the pandemic. *Nurse Leader*, *20*(2), 174-178. https://doi.org/10.1016/j.mnl.2021.10.008

World Health Organization. (2020). *Occupational health: Stress at the workplace*. https://www.who.int/news-room/questions-and-answers/item/ccupational-health-stress-at-the-workplace#:%7E:text=What%20is%20work%2Drelated%20stress,challenge%20their%20ability%20to%20cope

Zagoto Agulho, D. L., Soares Vasques Blaz, B., Darc Chaves Cardoso, J., Delmondes de Oliveira, A., Moreira da Silva, K., & Teixeira Cunha, C. R. (2021). Application of the vignette technique in nursing research with the elderly. *Revista de Pesquisa: Cuidado é Fundamental*, *13*(1), 103-108. https://doi.org/10.9789/2175-5361.rpcfo.v13.7627

Zammuner, V. L., Lotto, L., & Galli, C. (2003). Regulation of emotions in the helping professions: nature, antecedents and consequences. *The Australian e-Journal for the Advancement of Mental Health,* *2*(1), 43-55. https://doi.org/10.5172/JAMH.2.1.43

Zerach, G., & Shalev, T. B. (2015). The relations between violence exposure, posttraumatic stress symptoms, secondary traumatization, vicarious post traumatic growth and illness attribution among psychiatric nurses. *Archives of Psychiatric Nursing*, *29*(3), 135-142. https://doi.org/10.1016/j.apnu.2015.01.002

Appendices

Appendix A. Vignette Scenario Questionnaire

To complete Phase One of this research please read scenarios below and answer the reflective questions in the boxes provided. You are welcome to complete one or both scenarios and answer as many questions as you wish.

Vignette scenario 1:

Kia ora my name is Jamie. I am a community child health nurse and fairly new to the community I am working in. I was home visiting a whānau on a very busy day. Everyone in my team was also busy so I couldn't ask anyone to help. I wanted to not appear rushed as this was the first time I had met the whānau. As I arrived, I thought I heard shouting and someone say "I hate this. I didn't think it would be this bad". I knocked on the door and Dad looked surprised when he opened it but invited me in. I immediately felt there was tension between the mum (Mai), dad (Jake) and grandma (Hana). When Mai started talking, she sounded like she had been crying. I tried to ask how things were going but they seemed so off hand with me and each other that I tried not to ask many questions. Instead, I focused on talking about Sammie and answering their few questions. I seemed to do most of the talking during our time together. At one stage Mai asked Jake to pass her Sammie's cream and he looked really annoyed and walked out of the room slamming the door behind him. After this Mai seemed distracted and did not seem to look at or engage much with Sammie or me. Hana picked up Sammie as he had started to cry and walked around the room with him. When I made suggestions, it didn't seem very clear if they were helpful or not. I have been thinking a lot about this visit, it still makes me feel stressed thinking about our time together.
Reflecting on the vignette scenario • What is your immediate reaction and feelings to reading the scenario? • What do you think influenced your response? • How do you think the stressful situation impacted on Jamie the nurse? • How do you think this stressful situation impacted on Jamie's capacity to build trust and a relationship with the whānau? • Reflecting on this stressful situation what are your thoughts on Jamie's capacity to explore Mai, Jake and Hana's relationships and their relationships with Sammie?

Vignette scenario 2:

Kia ora my name is Alex. I am a community child health nurse with a couple of years' experience. I was visiting a whānau today who are impacted by multiple health and social health issues including a history of inter-partner violence. There are 4 tamariki in the whānau ranging from 2 months to 7 years old. They were all home when I visited as the 7-year-old and 4-year-old were home from school and preschool sick. They have all been unwell for a couple of weeks, and Nina (mum) told me Amaia (the 2 month old) now has a cough and Ari her two-year-old has a wheezy cough. Nina said she knows they need to go to the doctor but she cannot imagine how she is going to get everyone there. She said she is really tired from looking after everyone. During the visit Nina seemed really stressed. The older tamariki were watching TV and Ari was busy trying to find things in my bag. I told Nina I was ok with him doing this, but she seemed to be finding it more and more frustrating and pulled him away a couple of times telling him off. I felt there was growing tension in the air between us. I think she just wanted me to leave and I could feel myself getting more stressed. We agreed she would take the tamariki to the doctor when she could get help to go. She asked if I could make an appointment for her. I'm not sure if she will go.

Reflecting on the vignette scenario

- What are your thoughts about what Alex (the nurse) might be feeling and thinking?
- How do you think this might if at all have impacted on Alex's response to the whānau?
- What are your thoughts about how this stress impacted on Alex's relationship with Nina?
- How might the stress impact on Alex's capacity to explore Nina's relationship with Ari?

Thank you for completing the reflective questions above. Do you have any other comments you would like to make?

Appendix B Semi-Structured Interview Questions

Interview questions

Project title: Self-regulation and attunement in times of stress: A qualitative exploration child health nurses experience and perspective of stress, self-regulation and attunement with whānau.

Intro and Background

Thank you for participating in this interview how would you like to open our time together (Karakia)

Discuss confidentiality for them and also clients

Intro self and for them to talk about themself

Discuss length of interview and capacity to stop and withdraw data.

Introduction

What triggered your interest in this study?

Start in general about stress or a situation if that is more comfortable

Situation

Can you tell me about a time when you felt stressed in a relationship with whānau?

How was this experience for you?

Expand if necessary

- what you felt at the time
- What did you notice in your body, feelings and thoughts?
- what did you do?
- What was your experience afterwards?

Whanau

- What do you think the whānau might have been feeling and thinking?
- What do you think might have influence their response in this situation?

Nurse Whanau relationship

- What do you think was the impact on your relationship with the whānau?
- What did you notice about the tamariki in this situation?

General

- What do you notice about your physically and emotionally responses to stress?
- What do you notice about emotional and cognitive responses when with whānau?
- What do you notice about what you say in stressful situations?
- What do you notice about what you do in these situations?

- What do you notice about your relationships?

Self-regulation

- What do you do to regulate your stress?
- What did you notice about what you did?
- Are there times you feel you cannot regulate your stress response?

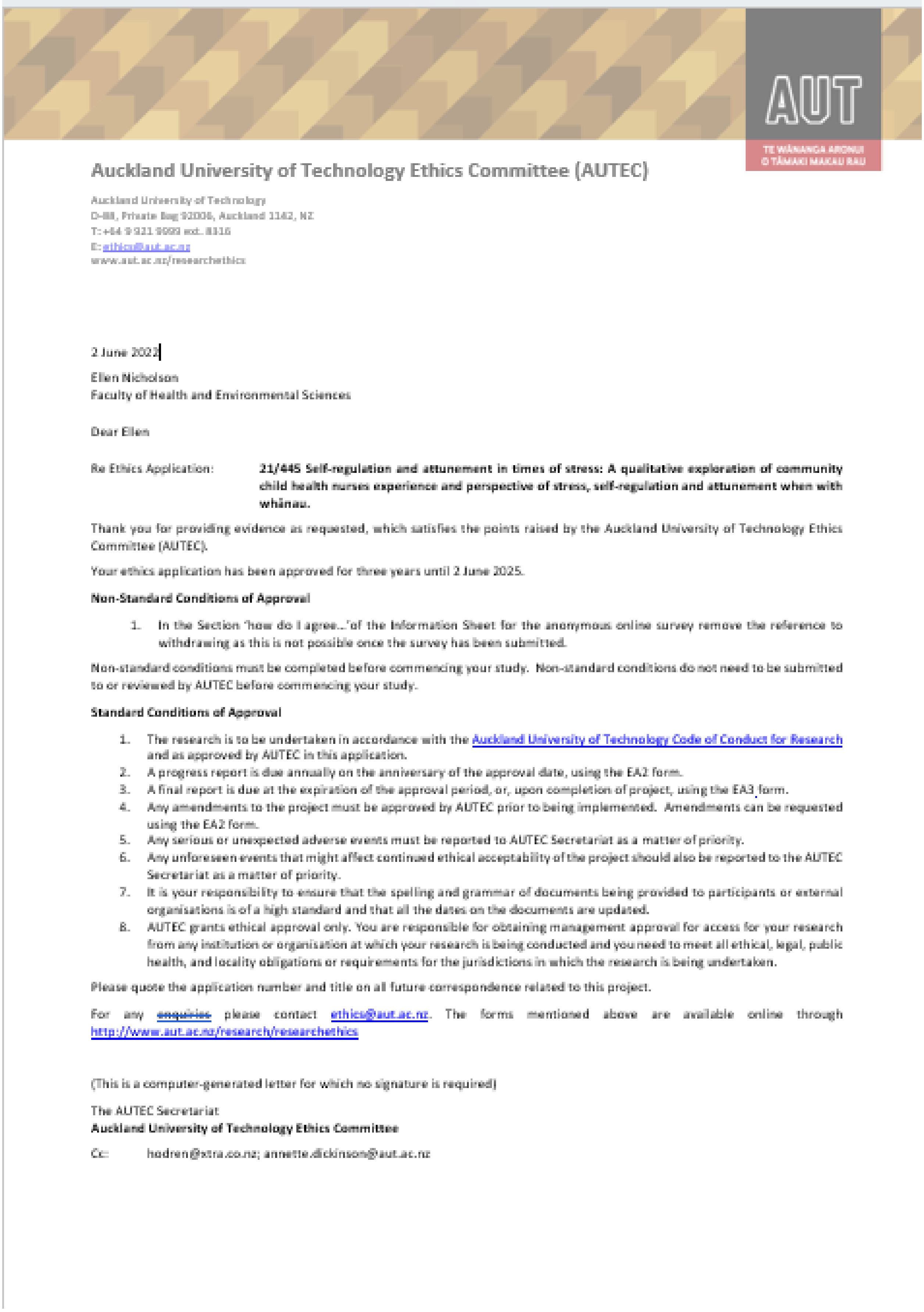
Attunement

- What does attunement mean to you?
- How do you think stressful situations impacts on attunement with whānau?
- What do you notice about your capacity to imagine their experience?
- What do you notice about whānau when you are in a stressed state?
- How does this impact on your noticing the whanau tamariki relationship?

Reflection

- What do you notice about how you feel after the visits?
- What do you think about yourself after these experiences?

Appendix C Ethics Approval Letter



Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

2 June 2022

Ellen Nicholson
Faculty of Health and Environmental Sciences

Dear Ellen

Re Ethics Application: **21/445 Self-regulation and attunement in times of stress: A qualitative exploration of community child health nurses experience and perspective of stress, self-regulation and attunement when with whānau.**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 2 June 2025.

Non-Standard Conditions of Approval

1. In the Section 'how do I agree…'of the Information Sheet for the anonymous online survey remove the reference to withdrawing as this is not possible once the survey has been submitted.

Non-standard conditions must be completed before commencing your study. Non-standard conditions do not need to be submitted to or reviewed by AUTEC before commencing your study.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard and that all the dates on the documents are updated.
8. AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through http://www.aut.ac.nz/research/researchethics

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: hodren@xtra.co.nz; annette.dickinson@aut.ac.nz

Appendix D Vignette Information Sheet

Kia ora

Thank you for your interest in being part in this research.

This qualitative research aims to explore community child health nurses self-regulation and attunement in times of stress when with whānau. Your help with this as a community child health nurse is greatly appreciated.

After reading the information sheet below if you consent to be part of the research you are asked to read two short fictional scenarios of two community child health nurses talking about a stressful situation when they were with whānau. Following reading each scenario you are asked reflective questions related to the scenario.

AUT

TE WĀNANGA ARONUI
O TĀMAKI MAKAU RAU

Participant Information Sheet

Please read the information below about the study. if you consent to be part of the research there is a button at the end that will lead to the research

Date Information Sheet Produced:

dd mmmm yyyy

Project Title

Self-regulation and attunement in times of stress: A qualitative exploration of community child health nurses experience and perspective of stress, self-regulation and attunement when with whānau.

Welcome

Kia ora.

Thank you for considering being part of this research. My name is Anne Hodren an Auckland University of Technology Doctoral student. I am a Registered nurse who has worked in paediatrics, neonatal and well child nursing. I am currently a National Educator for Whānau Awhina Plunket.

What is the purpose of this research?

Community child health nurses experience stressors as they navigate caring for whānau and their tamariki. However, there is limited research on community child health nurses experience of stress and how this impacts on their attunement when with whānau. This research aims to find out about New Zealand community child health nurses' experiences and responses during stressful interactions with tamariki and their whānau.

What is the research?

This research has two phases. Phase One is an online anonymous questionnaire with 2 short fictional scenarios of stressful situations when with whānau. Phase Two is a one-to-one online interview exploring your personal experience of stress during whānau engagement. You are welcome to participate in just Phase One or Phase One and Phase Two.

Why am I being invited to participate in this research?

You have been invited to participate in this research as you are a community child health nurse (Paediatric home visiting nurse, neonatal home visiting nurse or Well Child Tamariki Ora nurse) working directly with tamariki and whānau.

Who is excluded from this research?

If you do not provide direct care to whānau in community child health practice, unfortunately, you are not able to participate in this study. Additionally, if you work closely with, have a student relationship or supervision relationship with the researcher, Anne Hodren, you are also excluded from the study.

If either of these criteria apply to you, please do not proceed with the study.

How do I agree to participate in this research?

If you agree to be part of this research please click on the consent button on this page. Clicking the button indicates that you consent to take part in the research and will take you to the online vignette and questionnaire. If you wish to withdraw just close the browser.

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

Phase One involves an online questionnaire where there are two short vignettes to read. These are hypothetical scenarios of community child health nurses talking about stressful situations when with whānau. Reflective questions are posed after watching each of these scenarios with space to write your response. This phase is anonymous. You are welcome to do both scenarios or just one and answer as many questions as you wish.

At the end of the online questionnaire there will be an invitation to participate in Phase Two. You may choose to stop after Phase One or continue to Phase Two an online interview with the researcher. This interview will explore your personal experience of stress and attunement during whānau engagement. These interviews will be an hour long and will be recorded. The information you share in both phases will be anonymised and only used for the purpose of the research. The researcher is not soliciting information about specific individuals and requests that this information is not disclosed. If this information is disclosed, this data must be deleted.

What are the discomforts and risks?

Reading and reflecting on the scenarios in Phase One and talking about your practice and responses to stress in Phase Two may be an emotional experience for you. You are welcome to stop participating at any time and seek support.

How will these discomforts and risks be alleviated?

If you wish to have additional support after completing either phase. You can access

- EAP through your employer
- AUT Student Counselling and Mental Health support. They offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research and are not for other general counselling needs. To access these services, you will need to:
    - drop into our centre at WB203 City Campus, email counselling@aut.ac.nz or call 921 9998.
    - let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet.

You can find out more information about AUT counsellors and counselling on https://www.aut.ac.nz/student-life/student-support/counselling-and-mental-health

What are the benefits of participating?

Knowledge discovered through nurses' shared experiences may provide insights for you, other nurses, service providers, and child health policymakers to develop new understandings and make meaningful sense of the experience of community child health nurses and their responses during stressful interactions with tamariki and their whānau. This research is towards a Doctor of Health Science where the findings of this research will be presented in a thesis. They may also be used for academic publications and presentations.

How will my privacy be protected?

For Phase One, you will not be asked for any identifying information (e.g. name, address etc). If you consent to Phase Two, your contact details will be collected on a form separate to Phase One questionnaire. For Phase Two any identifying data will be removed and pseudonyms will be used. Please note that even with coding and anonymising data, confidentiality cannot be guaranteed, but this is a very small likelihood.

What will be required of me to participate in this research?

Participating in the research will require some of your time. It is estimated to complete phase One will take approximately 30 minutes. Phase two the online interviews is expected to take an hour. This will be scheduled at a time of your choosing. As some of the conversation may be sensitive you will need a private space. When sharing client stories, it is important to keep this information generic so the client cannot be identified.

What opportunity do I have to consider this invitation?

You will have approximately a month to consider Phase One and between one to two weeks to consider Phase Two.

Will I receive the results of this research?

A one- or two-page summary of the findings will be provided. This will be available by clicking on this url. For those participating in Phase Two they will be offered the opportunity to have these results emailed to them.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Ellen Nicholson email ellen.nicholson@aut.ac.nz Dr Ellen Nicholson

ph 021827419

Any concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, *ethics@aut.ac.nz* , (+649) 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Anne Hodren anne.hodren@gmail.com

Project Supervisor Contact Details:

Project Supervisor, Dr Ellen Nicholson email ellen.nicholson@aut.ac.nz ph 021827419

Approved by the Auckland University of Technology Ethics Committee on *type the date final ethics approval was granted*, AUTEC Reference number *type the reference number*.

I have read the information sheet and consent to be part of this study Click here to continue to next page (Button takes them to page 3)

Appendix E Information Sheet Phase Two

AUT
TE WĀNANGA ARONUI
O TĀMAKI MAKAU RAU

Participant Information Sheet Phase Two

Date Information Sheet Produced:

dd mmmm yyyy

Project Title

Self-regulation and attunement in times of stress: A qualitative exploration of community child health nurses experience and perspective of stress, self-regulation and attunement when with whānau.

Welcome

Kia ora. Thank you for considering being part of Phase Two of my research. My name is Anne Hodren an Auckland University of Technology Doctoral student. I am a Registered nurse who has worked in paediatrics, neonatal and well child nursing. I am currently a National Educator for Whānau Awhina Plunket.

What is the purpose of this research?

Community child health nurses experience stressors as they navigate caring for whānau and their tamariki. However, there is limited research on community child health nurses experience of stress and how this impacts on their attunement when with whānau. This research aims to find out about New Zealand community child health nurses' experiences and responses during stressful interactions with tamariki and their whānau.

What is the research?

Thank you for completing Phase One the online and anonymous questionnaire and considering taking part in Phase Two. Phase Two is a one-to-one online interview exploring your experience of stress during whānau engagement. You are welcome to have just participated in Phase One.

Why am I being invited to participate in this research?

You have been invited to participate in this Phase of the research as you are a community child health nurse (Paediatric home visiting nurse, neonatal home visiting nurse or Well Child Tamariki Ora nurse) working directly with tamariki and whānau and have completed Phase One of the research.

Who is excluded from this research?

If you do not provide direct care to whānau in community child health practice, unfortunately, you are not able to participate in this study. Additionally, if you work closely with, have a student relationship or supervision relationship with the researcher, Anne Hodren, you are also excluded from the study.

If either of these criteria apply to you, please do not proceed with the study.

How do I agree to participate in this research?

If you wish to be part of Phase Two click the link below. This will lead you to a form to complete with your contact details. The researcher will send you an email with the consent form attached. You agree to participate in this research by completing the consent form and returning it to the researcher.

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

Phase Two is an online semi structured interview with the researcher at a mutually agreed time. This interview will explore your experience of stress and attunement during whānau engagement. These interviews will be an hour long and will be recorded. The information you share will be anonymised and only used for the purpose of the research.

What are the discomforts and risks?

Talking about practice and responses to stress may be an emotional experience for you. You are welcome to choose not to answer any questions and continue with the interview of stop participating at any time. research. The researcher is not soliciting information about specific individuals and requests that this information is not disclosed. If this information is disclosed, this data must be deleted. You are welcome to seek support.

How will these discomforts and risks be alleviated?

If you wish to have additional support after completing either phase. You can access

- EAP through your employer
- AUT Student Counselling and Mental Health support. They offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research and are not for other general counselling needs. To access these services, you will need to:
- drop into our centre at WB203 City Campus, email counselling@aut.ac.nz or call 921 9998.
- let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet.

You can find out more information about AUT counsellors and counselling on https://www.aut.ac.nz/student-life/student-support/counselling-and-mental-health

What are the benefits?

Knowledge discovered through nurses' shared experiences may provide insights for you, other nurses, service providers, and child health policymakers to develop new understandings and make meaningful sense of the experience of community child health nurses and their responses during stressful interactions with tamariki and their whānau. This research is towards a Doctor of Health Science where the findings of this research will be presented in a thesis. They may also be used for academic publications and presentations.

How will my privacy be protected?

Your contact details are collected separately to your answers to Phase One to protect your privacy for Phase One answers. For Phase Two confidentiality will be maintained by changing any identifying data and the use of pseudonyms. It is acknowledged that even with coding and anonymising confidentiality cannot be guaranteed, but through these strategies this risk is reduced.

What will be required of me to participate in this research?

The online interviews it is expected to take an hour, at a time of your choosing. As some of the conversation may be sensitive you will need a private space. When sharing client stories, it is important to keep this information generic so the client cannot be identified. For you time you will receive a koha of $30.

What opportunity do I have to consider this invitation?

You will have between one to two weeks to consider Phase Two

Will I receive the results of this research?

A one- or two-page summary of the findings will be available by clicking on this url and you will be offered the opportunity to have these results emailed to you.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Ellen Nicholson email ellen.nicholson@aut.ac.nz 021827419

Any concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, *ethics@aut.ac.nz* , (+649) 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Anne Hodren anne.hodren@gmail.com

Project Supervisor Contact Details:

Project Supervisor, Dr Ellen Nicholson email ellen.nicholson@aut.ac.nz 021827419

Approved by the Auckland University of Technology Ethics Committee on *type the date final ethics approval was granted*, AUTEC Reference number *type the reference number*.

Click here to enter your contact details and the researcher will be in contact with you soon (this leads to a separate data collection site for the contact details)

Appendix F Consent Form Semi Structured Interview

Once contact is made by the researcher the following consent form will be sent to the participant

AUT
TE WĀNANGA ARONUI
O TĀMAKI MAKAU RAU

Consent Form For Interviews

Project title:

Self-regulation and attunement in times of stress: A qualitative exploration child health nurses experience and perspective of stress, self-regulation and attunement with whānau.

Project Supervisor: *Ellen Nicholson*

Researcher: *Anne Hodren*

○ I have read and understood the information provided about this research project in the Information Sheet dated dd mmmm yyyy.

○ I have had an opportunity to ask questions and to have them answered.

○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.

○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.

○ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.

○ I agree to take part in this research.

○ I wish to receive a summary of the research findings (please tick one): Yes○ No○

'By completing this questionnaire you are indicating your consent to participate in this research'.

Participant's signature: ………………………………………………………………………………………………

Participant's name:

....…………………………………………………
……

Participant's Contact Details (if appropriate):

………………………………………………………………………………………..

………………………………………………………………………………………..

………………………………………………………………………………………..

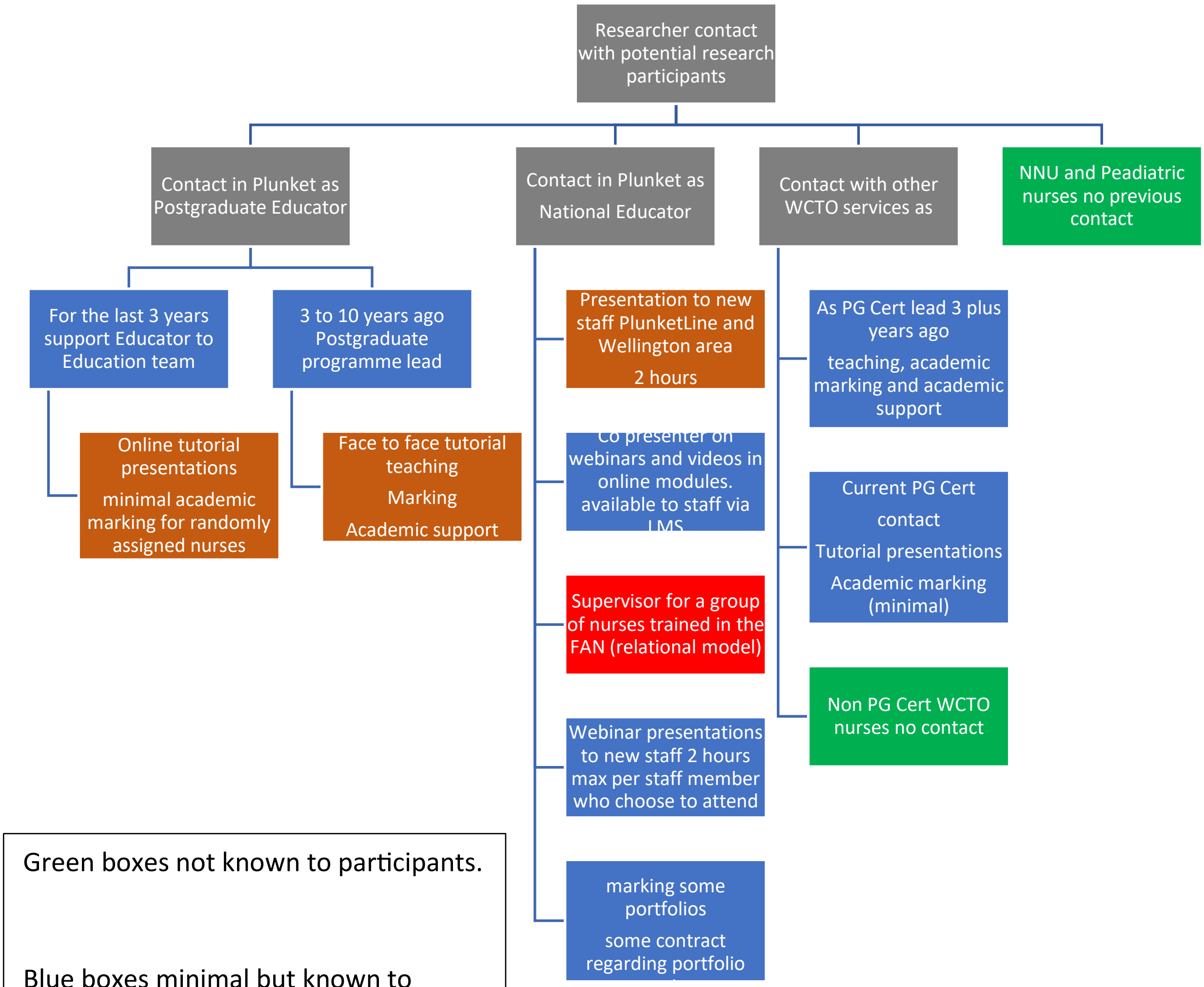
………………………………………………………………………………………..

Date:

Approved by the Auckland University of Technology Ethics Committee on type the date on which the final approval was granted AUTEC Reference number type the AUTEC reference number

Note: The Participant should retain a copy of this form.

Appendix G Networking Diagram. Researchers Relationship with Potential Participants


Researcher contact with potential research participants
Contact in Plunket as Postgraduate Educator
Contact in Plunket as National Educator
Contact with other WCTO services as
NNU and Peadiatric nurses no previous contact
For the last 3 years support Educator to Education team
3 to 10 years ago Postgraduate programme lead
Online tutorial presentations minimal academic marking for randomly assigned nurses
Face to face tutorial teaching Marking Academic support
Presentation to new staff PlunketLine and Wellington area 2 hours
Co presenter on webinars and videos in online modules. available to staff via LMS
Supervisor for a group of nurses trained in the FAN (relational model)
Webinar presentations to new staff 2 hours max per staff member who choose to attend
marking some portfolios some contract regarding portfolio
As PG Cert lead 3 plus years ago teaching, academic marking and academic support
Current PG Cert contact Tutorial presentations Academic marking (minimal)
Non PG Cert WCTO nurses no contact

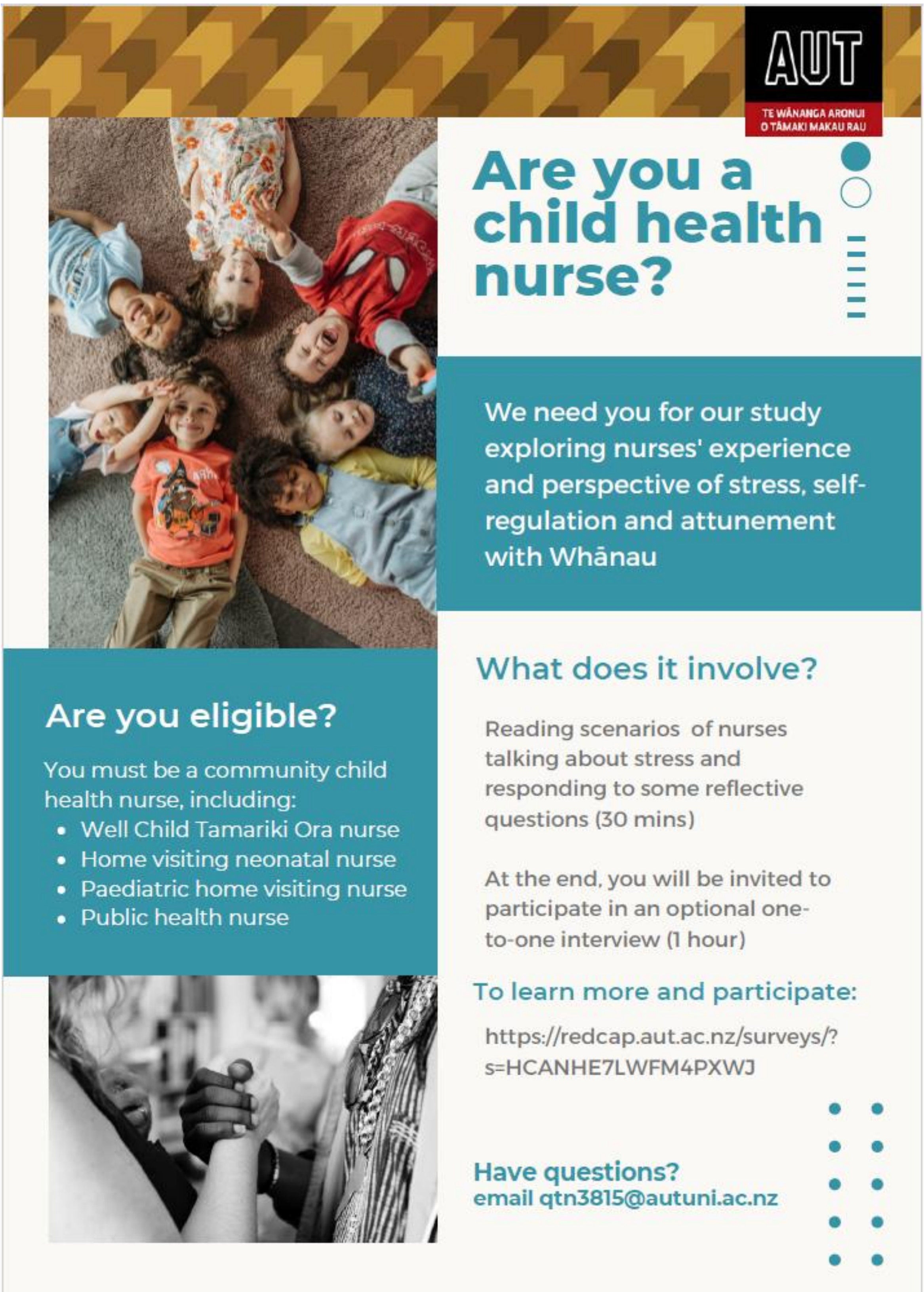
Green boxes not known to participants.

Blue boxes minimal but known to participants or previous historical contact.

Brown boxes some contact but not as direct manager and not on a regular basis, some historical. As Vignettes are anonymous potential impact low. Semi structured interviews nurse may opt on knowing the researcher.

Red box not appropriate to be participants.

Appendix H Invitation to Participate in the Study



AUT
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

Are you a child health nurse?

We need you for our study exploring nurses' experience and perspective of stress, self-regulation and attunement with Whānau

Are you eligible?

You must be a community child health nurse, including:

- Well Child Tamariki Ora nurse
- Home visiting neonatal nurse
- Paediatric home visiting nurse
- Public health nurse

What does it involve?

Reading scenarios of nurses talking about stress and responding to some reflective questions (30 mins)

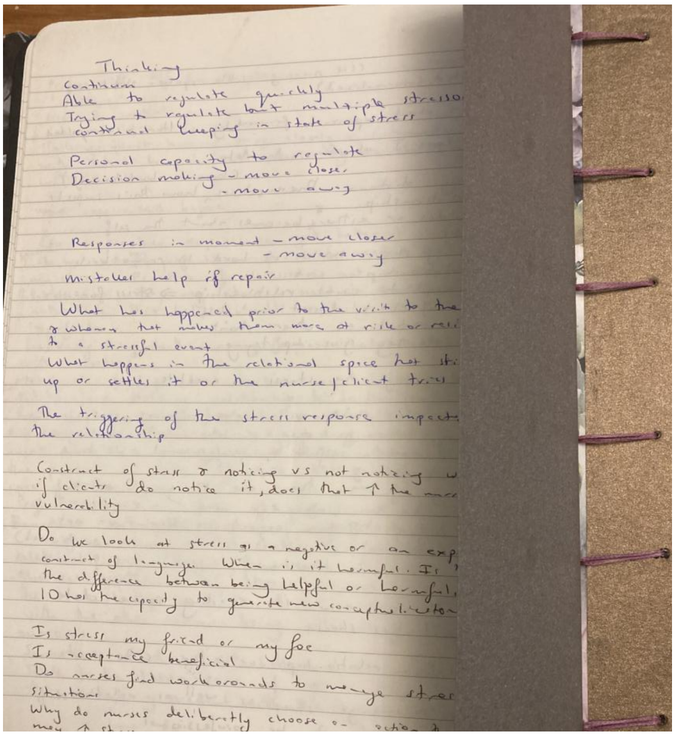
At the end, you will be invited to participate in an optional one-to-one interview (1 hour)

To learn more and participate:

https://redcap.aut.ac.nz/surveys/?s=HCANHE7LWFM4PXWJ

Have questions?
email qtn3815@autuni.ac.nz

Appendix I Reflective Journal



Thinking
Continuum
Able to regulate quickly
Trying to regulate but multiple stresso
continual keeping in state of stress

Personal capacity to regulate
Decision making - move closer
- move away

Responses in moment - move closer
- move away

mistakes help if repair

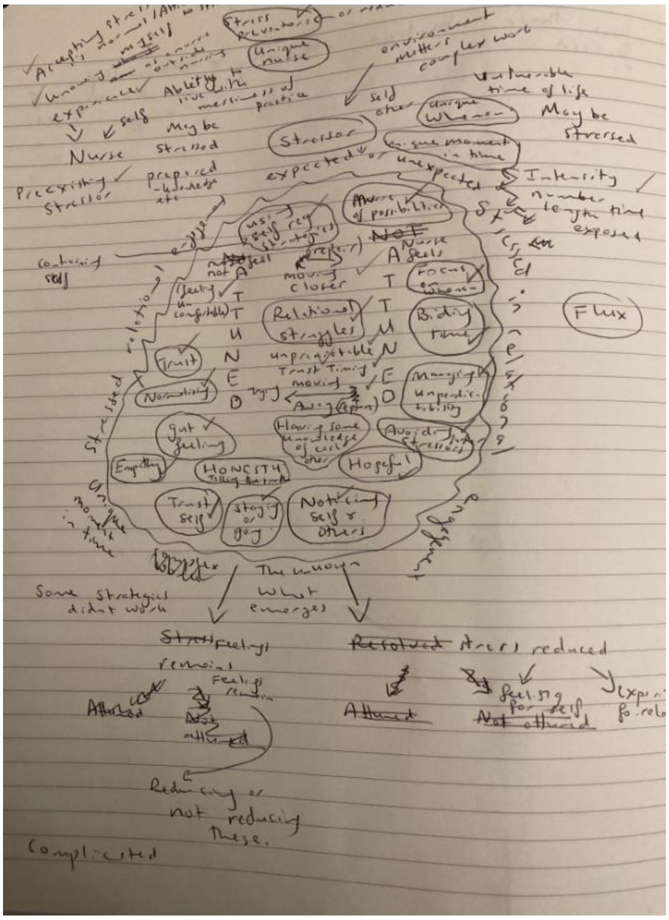
What has happened prior to the visit to the
& woman that makes them more at risk or rel
to a stressful event
What happens in the relational space that sti
up or settles it or the nurse/client tries

The triggering of the stress response impacts
the relationship

Construct of stress & noticing vs not noticing w
if clients do notice it, does that ↑ the nur
vulnerability

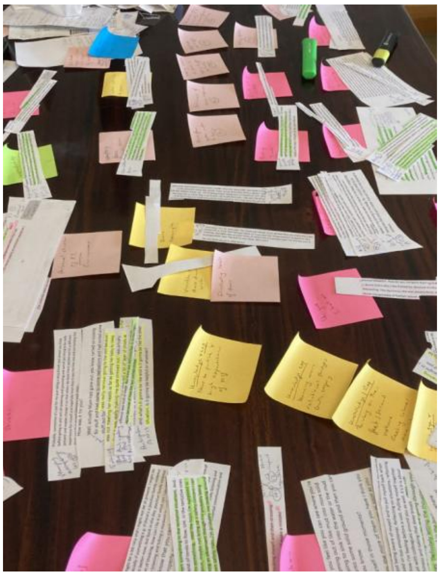
Do we look at stress as a negative or an exp
construct of language. When is it harmful. Is
the difference between being helpful or harmful,
IO has the capacity to generate new conceptualization

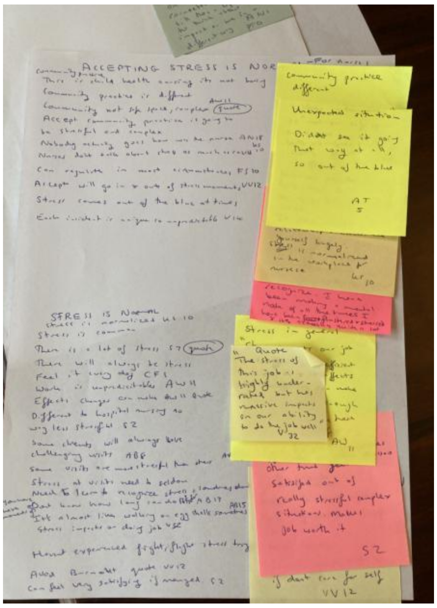
Is stress my friend or my foe
Is acceptance beneficial
Do nurses find workarounds to manage stres
situations
Why do nurses deliberately choose an action t
may ↑ st



Accepting stress / Am
Stress precursors
Unique nurse
environment matters
complex work
Knowing myself
experience
Ability to live with messiness of practice
self
Nurse
May be stressed
Preexisting stressor
prepared - knowledge etc
Stressor
self other
Unique Woman
Unique moment in time
vulnerable time of life
May be stressed
expected or unexpected
Intensity
number
length time exposed
Aware of possibilities
using self reg strategies
reflect
~~NOT~~
Nurse feels
not A
moving closer
A
T
T
U
N
E
D
Focus on Woman
Feeling un-comfortable
T
T
U
N
E
D
Relational struggles
Biding time
Trust
unpredictable
Trust Timing
moving
Away (option)
Managing unpredictability
Normality
gut feeling
Having some knowledge of each other
Avoiding further stressors
Empathy
HONESTY Telling the truth
Hopeful
Trust self
staying or going
Noticing self & others
Flux
containing self
relational
Stressed
Stressed in relationship
Unique moment in time
engagement
Complex Web
The unknown
What emerges
Some strategies didnt work
~~Stress~~ Feelings remain
Feelings remain
Attuned
~~Not attuned~~
Reducing or not reducing these.
~~Resolved~~ stress reduced
~~Attuned~~
feeling for self
~~Not attuned~~
Complicated

Appendix J Photos of Themes development





ACCEPTING STRESS IS NOR

Community practice

This is child health nursing its not busy

Community practice is different

Community not safe space, complex (quote) AW11

Accept community practice is going to be stressful and complex

Nobody actually gets how [illegible] the nurse AN18

Nurses don't talk about stress as much as [illegible] WS 10

Can negotiate in most circumstances, FS10

Accept will go in & out of stress moments, VV12

Stress comes out of the blue at times,

Each incident is unique to unpredictable VV10

STRESS IS NORMAL

Stress is normalised WS 10

Stress is common

There is a lot of stress S7 (quote)

There will always be stress

Feel it every day CF1

Work is unpredictable AW11

Effects changes can make [illegible] Quote

Different to hospital nursing as way less stressful S2

Some clients will always have challenging visits AB6

Some visits are more stressful than others

Stress at visits used to seldom

Need to learn to recognize stress, [illegible]

Don't know how long can do this AB17 AN15

It's almost like walking on egg shells sometimes

Stress impacts on doing job VS2

Haven't experienced fight/flight stress [illegible]

Avoid Burnout quote VV12

Can feel very satisfying if managed S2

Community practice different

Unexpected situation

Didn't see it going that way at all, so out of the blue

AT 5

Nursing largely Stress is normalised in the workplace for nurses

WS 10

Recognize I have been making a mental note of all the times I have been [illegible]

Stress in general

" Quote
The stress of this job is highly underrated but has massive impacts on our ability to do the job well"
VV 12

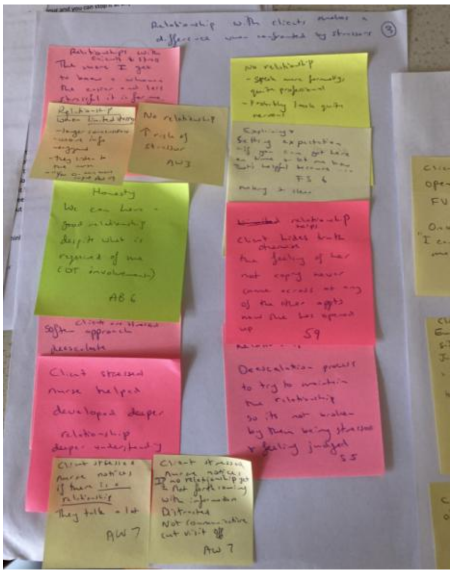
AW 11

other times you get satisfied out of really stressful complex situations. Makes job worth it

S2

if don't care for self

VV 12



Relationship with clients makes a difference when confronted by stressors ③

Relationships with clients & stress
The more I get to know a whanau the easier and less stressful it is for me

Relationship when limited stress
- longer conversations
- more info engaged
- they listen to the nurse

No relationship
↑ risk of stressor
AW3

No relationship
- speak more formally, quite professional
- probably look quite reserved

Explaining & Setting expectation "if you can't get here on time & let me know that's helpful because [illegible]"
FS 6
making it clear

Honesty
We can have a good relationship despite what is required of me (OT involvement)
AB 6

Client not stressed
Softer approach
deescalate

Client stressed
nurse helped
developed deeper relationship
deeper understanding

~~Limited~~ relationship helps
Client hides truth
the feeling of her not coping never came across at any of the other appts now she has opened up
S9

De-escalation process to try to maintain the relationship so its not broken by them being stressed & feeling judged
S5

Client stressed
nurse notices if there is a relationship
They talk a lot
AW 7

Client stressed
nurse notices if no relationship
Not forthcoming with information
Distracted
Not communicative
cut visit short
AW 7