Research Article

Emotional Labour of Caring for Hematopoietic Stem Cell Transplantation Patients: Iranian Nurses' Experiences

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Summary

Purpose: The purpose of this study was to describe the emotional labour experienced by nurses who care for hematopoietic stem cell transplantation (HSCT) patients in Iran.

Methods: Eighteen nurses participated in semi-structured interviews. The interviews were analyzed using qualitative content analysis methods.

Results: Three main categories described the emotional labour involved, namely, emotional intimacy, feeling overwhelmed with the sadness and suffering, and changing self. Nurses had compassion for their patients, contributing to a close nurse-patient relationship. The nurses' emotional labour resulted in their feeling overwhelmed with sadness and suffering. Five subcategories described this emotional toll: (a) witnessing suffering, (b) struggling mentally, (c) hurting emotionally, (d) feeling drained of energy, and (e) escaping grief. Dealing with death and dying on an ongoing basis promoted the nurses' changing self.

Conclusion: Iranian nurses who care for HSCT patients experience a range of positive and negative emotions. Establishing appropriate support systems for nurses might help mediate the negative aspects of emotional labour, thereby improving nursing work life and ultimately the quality of patient care.

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Introduction

The term emotional labour was first used to describe how individuals suppress or subordinate their feelings in order to create an atmosphere in which others feel they are safe and cared for (Hochschild, 1983; Smith, 1992). Emotional labour is a vital, essential and inseparable part of the culture of caring (Gray, 2009) and has become important in nursing discourse (James, 1992; McClure & Murphy, 2007). Research has explored the concept of emotional labour (Huynh, Alderson, & Thompson, 2008) and how it is utilized in nursing practice (Aldridge, 1994; Gray, 2009; Henderson, 2001) and education (Smith & Gray, 2001). Emotional labour is commonly used by nurses caring for vulnerable patients, including those with cancer (Hunter & Smith, 2007; Turner et al., 2007). The emotional work involved in the care of cancer patients is considered stressful and challenging (Turner et al.), yet integral to the quality of care for these patients (Kendall, 2006, 2007; Mohan, Wilkes, Ogunsiji, & Walker, 2005). Nursing those who are close to death and dying can also be emotionally challenging and a source of distress (Runne, Sullivan, & Kernohan, 2005; Georges, Gruppong, & De Casterle, 2002; James, 1992; Palsson, Issoaara, & Norberg, 1995; Rietjens, Hauser, van der Heide, & Emanuel, 2007).

Although emotional labour is common in nursing, the nature of this work varies considerably depending on the setting and patient group (Gray & Smith, 2009; Hunter & Smith, 2007). Gray and Smith noted that nurses working in primary care settings, mental health wards, and pediatric oncology wards reported different experiences and specific types of emotional labour.

Hematopoietic stem cell transplantation (HSCT) is the last treatment option for a variety of life threatening diseases, including certain hematologic malignancies, solid tumors, nonmalignant diseases like aplastic anemia, autoimmune disorders, and congenital immunodeficiency syndromes, and metabolic disorders (Cant, Galloway, & Jackson, 2007; Ezzone, 2009). HSCT is not always successful, can be associated with numerous complications and has a high mortality rate (Mercês & Erdmann, 2010). Kächele and
Gruulke (2006) estimated that as many as 40% of patients who undergo HSCT have a fatal clinical outcome. However, the total number of HSCT is increasing (Buchsel, 2009) such that approximately 50,000 patients receive HSCT annually worldwide (de la Morena & Gatt, 2010).

The incidence of transplantable diseases is also high in Iran, reaching 1,500 cases per year (Ghavamzadeh et al., 2010). Since the establishment of the transplantation centers in Iran, a total of 3,170 HSCT have been carried out, with rates increasing yearly (Ghavamzadeh et al., 2010; Ramzi, 2009). In 2007, 74.9% of HSCT patients survived 1–168 months after transplantation (Ghavamzadeh et al., 2009). Ramzi et al. (2010) found 8-year survival rates for 8-thalassemia major, acute myelogenous leukemia, acute lymphoblastic leukemia and chronic myelogenous leukemia to be 72%, 67%, 60% and 62% respectively in an Iranian HSCT center. Similarly, 4-year survival for acute promyelocytic leukemia transplanted patients is approximately 65% in Iran (Alimoghaddam et al., 2011).

The care nurses provide to HSCT patients plays an important role in the success of therapy (Holmes, 1990; Kelly, Ross, Gray, & Smith, 2000). Through her experience as a supervisor in an Iranian research hospital, one of the researchers witnessed the prolonged contact nurses and patients had, often starting before the transplant and continuing for years following the transplant. Patients continue to consult nurses by telephone to cope with their ongoing health issues long after being discharged from hospital. Also, patients are often rehospitalized for a variety of reasons. Approximately 25% die in the hospital in the primary stages of their disease or during readmissions (Ghavamzadeh et al., 2009).

The emotional nature of caring for HSCT patients has been well documented in informal caregivers (Cooke, Gemmill, Kravits, & Grant, 2009; Cooke, Grant, Eldredge, Maziarz, & Nail, 2011) and nurses (Cooke et al., 2009; Kelly et al., 2000; Kiss, 1994). Researchers have investigated burnout in nurses who care for these patients (Akkus¸, Karacan, Goker, & Aksu, 2010; Gallagher & Gormley, 2009; Yilmaz et al., 2009), but there is still no clear understanding of the emotional labour involved. As such, emphasis has been placed on the need for defining the nature of the emotional labour used in different settings (Gray, 2009; Gray & Smith, 2009; McClure & Murphy, 2007; Smith & Gray, 2001). Considering that emotional labour is related to cultural context (Huynh et al., 2008) and that no research has examined the emotional labour involved in caring for HSCT patients in Iran, qualitative research is appropriate. Hence, the current qualitative study aimed to describe the emotional labour experienced by nurses who care for HSCT patients in an Iranian cultural context.

This research is essential for fully understanding how emotional labour shapes the profession of nursing as well as the consequences this work has on individual nurses. This knowledge can be used to develop programs that support nurses, inspire change in nursing practice, and inform nursing policy. Understanding emotional labour may help nurses develop strategies to interact with and care for HSCT patients that attend to patient needs but also help nurses cope with the emotional pressures of caring for these patients (Gray & Smith, 2009). Considering that nurses are an integral member of the HSCT team (Holmes, 1990), reducing nurses’ emotional strain is critical, as it is enabling them to provide therapeutic interpersonal emotional support for patients (Gray, 2009).

**Methods**

**Study design**

A qualitative content analysis was performed to develop an in-depth understanding of Iranian nurses’ perspectives and experiences of emotional labour. At the outset of this research, emotional labour was defined as “the induction or suppression of feeling in order to sustain an outward appearance that produces in others a sense of being cared for in a convivial, safe place” (Hochschild, 1983, p.7).

Qualitative content analysis is a method for analyzing oral, visual, and written data (Elo & Kyngäs, 2008) for the purpose of providing knowledge and an understanding of phenomena (Downe-Wamboldt, 1992). In this study, conventional qualitative content analysis was employed wherein coding categories were derived directly or inductively from the interview data (Hsieh & Shannon, 2005).

**Setting and sample**

The present study was conducted in a university hospital, which is also the main HSCT center in Iran. This center is internationally recognized and is one of the largest in the Middle East. The center has 3 HSCT wards with 25 beds for adults and one pediatric ward with 9 beds. There are also two hematology-oncology wards, each consisting of 12 beds. The most common transplanted disorders in this setting are acute myelogenous leukemia, thalassemia major and acute lymphoblastic leukemia, with the median age of patients being 23 years (4 months to 71 years with Ghavamzadeh et al., 2010). Before HSCT, patients are hospitalized in the hematology-oncology wards where they undergo diagnostic procedures, receive chemotherapy and begin HSCT. Following HSCT, patients who develop complications are often readmitted to these wards.

There are a total of 67 graduate (Bachelor of Science) clinical nurses who work in these wards; 30 nurses in the adult HSCT wards, 15 in the pediatric HSCT ward and 22 in the hematology-oncology wards. All of these nurses work full time (minimum of 35 hours per week) and are directly responsible for HSCT patient care. Participants in this study included 18 nurses. Sampling was purposive and for this reason, nurses selected were those who had at least 1 year of work experience with these patients, worked full time and were able to provide detailed information on the subject. Participants were from the different hospital wards; 10 from the adult HSCT wards, 2 from the pediatrics HSCT ward and 6 from the hematology-oncology wards.

The mean age of the participants was 37.4 years (range: 25–53 years). The nurses had between 1 and 21 years of work experience in HSCT patient care with a mean of 9.3 years. No male nurses participated in this research because there were none who worked in HSCT patient care. Further participant characteristics are presented in Table 1.

**Ethical consideration**

This research was approved by the Institutional Review Board of the Tabriz University of Medical Sciences and Hematology-Oncology and Stem Cell Transplantation Research Center affiliated with the Tehran University of Medical Sciences. Participation in the study was entirely voluntary and all the participants provided informed consent.

**Data collection**

This study was conducted between December 2011 and May 2012. The participants were informed of the aim of the study by the researcher. Following the nurses’ preliminary agreement to participate in the study, the place, date and time of the interview was determined. Each interview lasted for 30–90 minutes and was conducted in Persian and in the hospital.

The data was collected via semi-structured interviews with the main focus of the questions on nurses’ experiences and feelings toward caring for HSCT patients. Examples of the main interview questions are presented in Table 2.
Table 1 Participant Characteristics (N = 18)

<table>
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<tr>
<th>Participant Number</th>
<th>Age (yr)</th>
<th>Years of HSCT nursing experience</th>
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Note. HSCT – hematopoietic stem cell transplantation.

Based on the initial interviews and preliminary data analysis, additional questions were asked of subsequent participants. A second interview with 6 participants was conducted to verify and clarify initial interpretations of the data and emerging research findings. Data collection ended when no new information was collected and the data became repetitive.

Data analysis

All interviews were tape-recorded and transcribed verbatim. Data analysis was conducted in Persian and was performed concurrent with data collection, beginning just after the first interview. All interview transcripts were read more than once and coded line-by-line to reach a comprehensive description of emotional labour. The key concepts in sentences and paragraphs were identified and assigned a code. The codes were then compared based on their similarities and differences; those with similar meanings were placed in the same category. Second interviews were then conducted to enable participants to elaborate on their original descriptions, to verify, and clarify interpretations of the participants’ experiences, as well as to further develop the emerging categories (Kvale, 1996). For example, it was noted during coding that a couple of participants mentioned experiencing “a sense of peace”, but this was not elaborated on in the initial interview. These participants were then asked to provide details of this experience in the second interview, which helped to develop one of the main categories. Each category was assigned a label, resulting in three main categories. The results were then translated into English for this manuscript.

To ensure rigor, the researchers discussed and debated the findings as a group until consensus was reached. The primary analysis and results were also presented to the participants to verify their accuracy and validate the congruity of the codes with their experiences. The credibility of the findings was assured through the above-mentioned procedure along with the ongoing presence of the researcher (LS) in the setting during data collection (Streubert & Carpenter, 2011). The participants varied in age, nursing experience, and the HSCT hospital wards they worked in, which made transferability of the findings possible. To increase the dependability of the study, one of the researchers collected and analyzed the data and the other researchers checked and verified the finding.

Results

Three main categories described the emotional labour involved in providing care to HSCT patients in Iran: emotional intimacy, feeling overwhelmed with sadness and suffering, and changing self.

Emotional intimacy

The nurses described emotional labour as integral to their work and of equal importance to the physical care they provided to HSCT patients. A consequence of this emotional labour was a high degree of emotional intimacy between the nurses and their patients. This emotional intimacy consisted of two subcategories: compassion and a close relationship.

Compassion

The nurses described HSCT as the last thread of hope that patients cling to. The nurse’s understanding of the gravity of their patient’s situation led to great feelings of empathy and compassion. One of the nurses stated the following:

These patients, I have compassion for them. As an end-stage patient, they do not have the chances that other patients have. They have nowhere to turn to. Transplant is their last hope. (Participant 2).

The nurse’s compassion led to empathetic behaviors, which each nurse expressed differently. This often involved nurses going to extraordinary lengths and making significant sacrifices to provide support that was usually given by family members. For example, one nurse had given all her savings to a patient: “We had a case of Fanconi anemia. The patient’s family was really under financial pressure. One of the nurses gave them all her savings so they could rent a house.” (Participant 7).

Another nurse remained at the hospital after her shift was over to stay with her patient who did not have any family members or friends attending him: “Sometimes, when I worked day-shifts, I just punched my card at the end of my shift and came back to stay with the patient.” (Participant 5).

Other nurses prepared food at home and brought it to the hospital for their patients: “Sometimes we cook food at home, using the ingredients the patient can eat, and bring it to the hospital.” (Participant 11).

Close relationship

The nurse’s prolonged contact with these patients resulted in a close relationship. A nurse who was working in two hospitals with two different groups of patients explained that: “Unlike other wards, we are really close to patients here. The patients are not just hospitalized for a day or two; sometimes you see them for 3 years or more.” (Participant 9).

The nurse-patient relationship was so close that nurses gave more, emotionally, than typically expected, overstepping their

Table 2 Example Interview Questions

| What is it like for you to care for HSCT patients? |
| Describe an experience or situation that represents the thoughts and emotions that you experience while working with HSCT patients. |
| Describe a situation of how you managed or coped when patients were experiencing emotional difficulties. |
| How has caring for HSCT patients affected you emotionally? |

Note. HSCT – hematopoietic stem cell transplantation.
professional boundaries. The nurses often knew not only about their patient’s health issues but also family and personal problems:

The nursing staff have telephone contact with some patients. Some patients have the cell phone number and even the home number of the nurses and they know all about the patients’ problems, their sorrows. (Participant 3).

Some patients maintained their friendships with the nurses years after successful HSCT and discharge from hospital:

There is a patient whose birthday is on the 21st of March, I think. She brings cake every year. We threw her a birthday party once or twice here at the hospital. We became like buddies after a while. (Participant 2).

The same nurse described the high level of reciprocal attachment that came to characterize these nurse-patient relationships in the long-term: “The most important thing here is the close and friendly relationship that is developed between us and the patients; they bond with us and we bond with them.” (Participant 2).

Feeling overwhelmed with the sadness and suffering

The nurse’s emotional labour resulted in their feeling overwhelmed with the sadness and suffering they witnessed. Five subcategories describe the emotional toll this took on the nurses: (a) witnessing suffering, (b) struggling mentally, (c) hurting emotionally, (d) feeling drained of energy, and (e) escaping grief.

Witnessing suffering

The participants described in great detail the constant and tremendous suffering their patients endured following medical procedures, chemotherapy, and complications. The following quote offered by one nurse was typical of descriptions provided by the other study participants:

They have fevers, bleed, they get mouth ulcers, lose their hair, vomit and have nausea. They even get vaginal ulcers, GVHD [graft versus host disease]... they are all upset, hopeless, they weep, they have thousands of problems. You see all that, you see how much they suffer. (Participant 10).

Struggling mentally

The nurses struggled mentally as a result of witnessing the hardships their patients experienced. The nurses described how they became like the Sange Sabure, which roughly translates to “agony aunt”. In Iranian culture, this refers to someone who listens and bears the sufferings of another. One of the participants who had many years experience in the care of HSCT patients stated:

I, personally become mentally involved because we are like their Sange Sabure. They talk to us and the more they vent their feelings, the more we feel filled up. Sometimes my mind gets so busy with their problems that I dream about them while I’m sleeping. It is like you are living with them. (Participant 5).

Some of the nurses encouraged the patients who felt isolated to talk to them about their challenges and how they were coping, despite the emotional toll this took on the nurse. Many years later the nurses still remembered these patients and carried the sadness with them:

I even tried to talk to those who were feeling isolated and convince them to talk to me, so it would change their mood. But when you listen to their problems, you get really sad. I felt overwhelmed. I still remember some of them. (Participant 12).

Feeling drained of energy

The nurses also relayed the emotional hurt and pain they experienced while caring for HSCT patients. One nurse with 3 years experience began to cry during the interview when she described one of her patients. She explained: “I have lost my emotional balance since I started working here.” (Participant 10).

The patient’s death, either in the hospital or after discharge often lead to depression among the nurses, as described by one of the more experienced nurses: “There were many times we were all depressed over a patient’s death. There were many times that we cried after a patient died, even for those who died after they were discharged.” (Participant 1).

Escaping grief

The nurses in this study were under tremendous emotional pressure and they used different strategies to escape their grief and suffering. Some tried to ignore the deep depression they witnessed among their patients, as evident in one nurse’s quote:

I was really energetic when I started my job here. When I had a patient, I gave them hope, told them that their transplantation would be successful and they would get better. Now after these years, I am not like that anymore. I still remember my eagerness and my high spirit to follow up my patients. I used to visit them, I used to call them and give them support. I cannot do any of those things now. I do not have the energy—I would really like to leave this ward. (Participant 17).

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I try not to get close to the patients. I do whatever I can in my power for the patients as long as they are on the ward, but it is finished for me when they are discharged. I used to follow them up and ask about their health from their doctors. I do not do that anymore. I tell others not to do that as well. I tell them that the presence of these patients in the ward is a kind of pressure and when they are not here and die, it is another kind. I like to think that when the patient leaves the ward, they are better and they carry on with their life. (Participant 12).

A novice nurse with 1 year of experience caring for HSCT patients said the following:

There is a 15-year-old boy in the emergency ward now that has been transplanted twice. Doctors have told his family that there is no hope. I do not want to know anything about him. I do not go to see him. (Participant 6).

Changing self

Despite the emotional toll caring for HSCT took on the nurses, they also described how, over time, they had become more capable of enduring these emotional challenges. This was, in part, because the patients were role models for the nurses, enabling a sort of changing self. Their life expectations had changed and they gained a different perspective on the world:

I learn about humanity from them because those who reach this stage are transformed, they change. I used to be very bad-tempered; I was not patient at all. My insight into the world has changed since I've been caring for these patients. I expect less now and I am more patient. (Participant 5).

Confronted with the suffering and death of their patients, the nurses became more humble and less egotistical, which in turn provided them with a sense of peace: “I think I am more at peace now because I think we all go down the same common path. You lose part of your vanity and pride.” (Participant 8).

Another nurse reflected that her values and character had changed as a result of the interactions she had with these patients: “I used to be a lot more materialistic. I have totally changed, I am exible now.” (Participant 12).

Understanding the reality of death and believing in the afterlife motivated some to go beyond their nursing responsibilities:

I think that if I am giving service to these patients, it is like accumulating meritorious acts for my afterlife... This is based on my religious beliefs, and believing in God and Resurrection. Helping patients makes God feel proud of us. We help the patients that need us. (Participant 2).

Discussion

The nurses in this study developed considerable empathy and compassion for their patients, as has been reported in research with cancer (Kendall, 2007) and vulnerable patients (Clarke, 2007). These nurses conveyed empathy and compassion with little expectation that this would increase their patients’ well-being. Yet, this compassion resulted in a wide range of empathetic interactions and a close nurse-patient relationship, as reported elsewhere (Williams, 2001). Kiss (1994) also described a close nurse-patient relationship in the context of patients undergoing bone marrow transplant. Similarly, in the present study the nurses also experienced a very intimate emotional bond with their patients. The nurses in this study cared for patients when patients were facing the possibility of death and struggling with their own mortality. The experiences shared by patients and nurses created a sense of codependence. Despite reference to a common nurse-patient relationship, there were barriers such as heavy nursing workload, hard nursing tasks, and lack of welfare facilities for nurses to establishing such a relationship in Iran (Anoosheh, Zarkhah, Faghfizadeh, & Vaismoradi, 2009). However, the nurses in this study still managed to show compassion and establish a close relationship. Sabo (2011) described compassionate presence, which included empathy and connection, as an important aspect of HSCT nursing.

All the participants in this study were women. Some have argued that women become more emotionally involved in their relationships and, thus, experience more emotional labour (Bozionelos & Kiamou, 2008; Wharton, 2009). It is highly likely that the work that women nurses perform in Iran is a reflection of the gendered roles and identities preferred in this cultural context (Nasrabadi, Lipson, & Emami, 2004; Nasrabadi, Emami, & Yekta, 2003).

The participants described different ways of feeling overwhelmed with sadness and suffering. Sumner (2008) argued that the emotional involvement nurses have with their patients can lead to personal emotional pain. This is often cited as one of the negative consequences of emotional labour (Huynh et al., 2008). This was evident in the present study wherein the nurses developed emotional problems and eventual burnout as a result of their intense emotional labour. Similar challenges have been documented among nurses caring for cancer patients (Mohan et al., 2005; Palsson et al., 1995; Watts, Botti, & Hunter, 2010), palliative patients (Dunne et al., 2005; Morita, Miyashita, Kimura, Adachi, & Shima, 2004), and bone marrow transplantation patients (Kelly et al., 2000; Sabo, 2011).

The nature of HSCT requires nurses to care for patients over the course of months and even years. Chou, Hecker, and Martin (2012) reported that a nurse’s frequency of interactions with gravely ill patients was positively related to emotionally exhausted and emotional labour. Considering this in addition to the high mortality rate of HSCT (Ghavamzadeh et al., 2009), it is not surprising that the nurses in this study also reported feeling emotional labour.

The nurses described how the patients who were seriously ill, had complex medical problems, were ill for a long time and remained alone in an isolated room would often confide in them. In response, the nurses in this study concealed their own emotions and suffered in silence. They attempted to ignore their emotional pain and distract themselves by staying occupied with other unrelated thoughts. This supports the interrelation of thoughts and emotions in Eastern cultures (Mesquita & Albert, 2007), and the centrality of altruism in caring, which has been also reported by other Iranian studies (Nasrabadi et al., 2003; Yekta & Nasrabadi, 2005).

Changing self was also evident in the nurses’ experiences. They came to consider death as the inevitable destiny of all humans, which led to changes in their perspectives on life and resulted in peace of mind and enhanced spirituality. Another Iranian study suggested that believing in the afterlife helped provide nurses with peace of mind (Zargham, Mohammadi, & Oskuei, 2007). The nurses were also motivated to care for these patients because of their belief in God, feeling that they received God’s approval for their work and were accumulating meritorious acts for their afterlife. Our findings confirmed the results of other Iranian studies wherein nursing is considered a holy and honorable profession (Nasrabadi & Emami, 2006). Spiritual and religious aspects of caring have positive effects for both nurses and their patients (Mazaheri, Falahi Khoshknab, Sadat Madah, & Rahgozar, 2009; Nasrabadi, Yekta, & Emami, 2004; Yekta & Nasrabadi, 2005).

Researchers have previously reported both negative and positive outcomes of emotional labour (Huynh et al., 2008), considering it a double-edged sword (Ashforth & Humphrey, 1993). Other
positive outcomes of emotional labour among nurses include personal satisfaction (Mann, 2005; McQueen, 2004) and a sense of accomplishment (Broderick & Grandey, 2002; Gallagher & Gormley, 2009; Zapf & Holz, 2006). In summary, the results emphasized how emotional labour was an integral and inevitable part of caring for HSCT patients. Emotional labour is an important concept to understand because it can affect the quality of care and provision of emotional support. Further research is needed to determine the role of other clinical staff and the effects of emotional labour on the quality of care provided by nurses and others. Finally, the experience of Iranian nurses can help national and international policy makers and managers to devise plans for improving the quality of care for patients with HSCT and decreasing the negative effects of emotional labour on nurses.

**Limitations**

This study was limited to descriptions and experiences provided by female nurses. Male nurses might identify different perceptions or experiences of emotional labour in the care of HSCT patients.

**Conclusion**

The results suggest that emotional labour is a characteristic of caring for HSCT patients. The nurses experience emotional labour with a range of positive and negative consequences. Altruism, cultural contexts, and spiritual and religious beliefs shaped the nature of this emotional labour. The establishment of support systems or counseling services in these hospital wards might enable nurses to cope with their difficult emotions more effectively. Moreover, educating nurses about emotional labour could possibly familiarize and help prepare nursing students with the emotional challenges involved in the care of HSCT patients.

**Conflict of interest**

The authors declare no conflict of interest.

**Acknowledgments**

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