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Communication Experiences of Nursing students with Children and Their Families: A Qualitative Study

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Abstract

Background: The clinical setting is often a stressful and anxiety-provoking environment. In particular, caring for pediatric patients causes students to experience anxiety in the clinic. It is extremely important to learn how to communicate effectively with the child's parents and family members in overcoming this difficulty and providing effective care.

Aim: The aim of this study is to determine the communication experiences of students with children and their parents during the clinical education of pediatric nursing course.

Methods: The phenomenological approach, which is a qualitative research method, was used in the study. The population of the study comprised fourth-year students from the Faculty of Nursing, who accomplished the pediatric nursing course. The study was conducted with 15 students, who agreed to participate voluntarily, via in-depth interviews.

Results: The themes emerging as a result of the interviews conducted with the students were "difficulties and facilitators," "family-centered care experiences," and "acquisitions." In the study, most of the student nurses stated that they felt fear, restlessness, and anxiety when they first came to the service, and they had difficulty in communicating with the hospitalized child and the family. The students stated that they had difficulties in communication especially due to the age and diagnosis of the children.

Conclusion: The study revealed that it is necessary to develop students' skills of communication with children and their families. Accordingly, it is necessary to increase the communication skills of student nurses by organizing trainings. It is recommended to create interactive environments where student nurses can express their difficulties.

Keywords: Children, pediatric nursing, communication, clinical experience, student

Introduction

Clinical practice areas are an integral part of nursing education. Clinical practice areas are settings that enable the development of basic nursing skills.[1] In these settings, critical thinking, problem-solving, and communication skills are developed by using real-life experiences to put knowledge into practice. Creating appropriate settings in clinical practice is essential for a good learning experience.[2]

The clinical setting is often a stressful and anxiety-provoking environment. In particular, caring for pediatric patients causes students to experience anxiety in the clinic.[3] Liang et al (2019) have pointed out in their study at nursing schools that the clinical practice of pediatric healthcare and diseases during the nursing course for student nurses is the one in which the most feared, difficult, and stressful situations are encountered. It has been determined that the 2 basic skills that cause the most anxiety are psychomotor and psychosocial skills.[4] Oermann and Lukomski (2001)[13] have pointed out in their study that the psychomotor skill that causes the most anxiety in students is the administration of drugs to children. Other sources of psychomotor concern are administering treatments, performing procedures, and performing a pediatric evaluation. The sources of concern regarding psychosocial skills are how to communicate with patients, how to work with sick children and their families, and how to support them.[3] In addition, one of the difficulties faced by students in the clinical practice of the nursing course pediatric healthcare and diseases is to provide developmental care to the child together with his/her family. Learning how to communicate effectively with the child's parents and family members and learning how to communicate with the child in accordance with his age

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are extremely important in overcoming this difficulty and in providing effective care.[5] In addition, family members have high anxiety about the child's condition and prognosis and are in need of information. Therefore, communication with families is important.

Appropriate clinical and educational settings are needed to develop the students' self-confidence and competencies in clinical practice. It is emphasized that student nurses need support in these settings and that educators play an important role in providing this support.[6] The goal of clinical education should be to maintain a moderate environment for learning by being aware of students' stress and facilitating them to cope with stressful situations, helping them become more competent in their practice, and providing constructive feedback and formal assessments to enable better learning.

The communication skills of nursing students in clinical settings, their individual perceptions, and the conflicts between the roles taught at university and the actual roles cause student nurses to have difficulties in their duties as a pediatric nurse. Positive experiences during pediatric clinical practice can improve nursing care in clinical settings. For this reason, it is very important for a nursing student to have positive experiences in order to ensure professional socialization through experiences in clinical settings.[7]

If students experience too much stress in a clinical setting and cannot cope with clinical situations that cause anxiety, their learning processes and clinical performance are adversely affected.[8,9] Environments where a lot of anxiety is present cause negative perceptions and a further decrease in the quality of care. Reducing perceived anxiety levels with regard to psychomotor skills, psychosocial support, and harming the child will support the roles of pediatric nurse students. For this reason, it is extremely important to define students' communication experiences with children and their families during clinical practice.[10] The aim of this study is to determine nursing students' communication experiences with children and their parents during their clinical training. An in-depth determination of students' experiences will enable the development of learning experiences and education concerning children and their parents.

The study focused on the following research questions:

1. What are the nursing student's communication experiences with children?
2. What are the nursing student's communication experiences with the child's family?

Materials and Methods

Purpose and Type of Study

This research was carried out using the phenomenological approach, which is a qualitative research method, in order to determine the communication experiences of a nursing student with children and their parents during their pediatric clinical practice.

Population and Sample

The study population consisted of fourth-year students at the Faculty of Nursing who successfully completed the pediatric healthcare and diseases nursing course. A total of 15 students were included in the research with the purposeful sampling method. The announcement regarding the study was posted on the student notice board of the school. Fourth-year nursing students were invited to participate in the research in the second week of the fall semester between February 2019 and June 2019. The contact numbers of the students who wanted to participate in the study were taken and interviews were planned outside class hours at a time that was most convenient for them. The sample size was determined by the repetition of the data (reaching the saturation point) and a total of 15 interviews were conducted.[10]

The pediatric healthcare and diseases nursing course is a 15-week course consisting of 5 hours of theory and 16 hours of clinical practice.

Criteria for inclusion in the study:

- Having communicated with a sick child and the child's family during clinical practice
- Being a fourth-year student
- Successfully having completed the pediatric healthcare and diseases nursing course
- Volunteering to participate in the study

Criteria for exclusion from the study:

- Declaring not wanting to participate in the study

Data Collection Tools

The research data were collected with a semi-structured interview form. This form consisted of questions prepared by the researchers to determine the experiences of nursing students with regard to communicating with children and their families in clinical practice. The questions in the interview form were as follows:

1. Could you tell us a little about yourself?
2. Could you tell us about your experiences in the process of caring for children during the clinical practice of the pediatric healthcare and diseases nursing course?
3. Could you tell us about your experiences in communicating with children during the clinical practice of the pediatric healthcare and diseases nursing course?
4. Could you tell us about your experiences in communicating with parents during the clinical practice of the pediatric healthcare and diseases nursing course?

Implementation of the Research and Data Collection

Data were collected through semi-structured in-depth individual interviews. Individual interviews were conducted with students who agreed to participate in the study in the meeting room of the Faculty of Nursing, where the interview would not be interrupted, at mutually agreed times. Interviews were conducted by two researchers. Written consent was obtained from the students who volunteered to participate in the study and permission was obtained to make use of audio recordings during the interview. Each interview lasted approximately 30-45 minutes.

Data Analysis

Descriptive statistics (numbers, percentages, and mean) and the thematic content analysis method (semi-structured interview data) were used in the analysis of the data. The process of content analysis brings together similar data within the framework of certain themes and concepts and interprets them in a way the reader can understand.[10] This research consists of the stages of creating codes,

categories, and themes. In the first stage of the data analysis, the audio recordings obtained from the qualitative interviews were transcribed by the researcher during the interview stage right after each interview ended, whereby each interview was transferred to a separate word file, resulting in a data set of 33 pages. Each audio recording was listened to twice after being transcribed. The data were read repeatedly and evaluated by 2 researchers. The results obtained from the research data were analyzed by 2 people at different times. After consensus was reached and taking into account the titles of the semi-structured interview questions and knowledge of the literature, the framework of the three categories was formed. Within the scope of this main framework, the records were read many times and the similarities in the expressions were compared and conceptualized. This way, the themes and sub-themes that would fall under the categories began to be determined. It was attempted to observe the saturation point of the data in this manner. During the analysis, attention was paid to ensure that the sub-themes and themes formed a meaningful unit, both within themselves and among each other, in a way as to reflect the whole concept map. Transcripts were analyzed and transcribed by the researchers through the exchange of ideas and joint discussion, after which three themes and nine sub-themes were developed. The process of data analysis is given in Figure 1.

Validity and Reliability of the Study

The Creswell and Miller criteria were taken into account for the validity and reliability of the study.[11] The concepts of internal validity, persuasiveness, and external validity were used. The concepts of internal reliability, consistency, external reliability, and verifiability were used. In order to ensure the credibility of the research, the interviews were recorded with a voice recorder. Concurrently, the researcher kept observational notes. Transferability means that research results cannot be generalized, but results can be adapted to such environments. The qualitative findings of the research are provided in detail in a way that comparisons can be made with similar research findings. Consistency is about accepting the variability of the events and reflecting this variability in the study in a consistent manner.[10,11] The researchers asked questions to each individual with a similar approach and recorded them during their semi-structured interviews. The qualitative data of the research were presented by directly quoting the participants. Verifiability can be expressed as the ability of the researcher to constantly verify the results obtained with the data collected and to offer a logical explanation to the reader.[10,11] For the verifiability of this study, the results obtained by the researchers were conveyed to the reader in a clear and understandable manner. The qualitative results of the research were compared with similar research findings, supported by the literature and explained in the discussion paragraph.

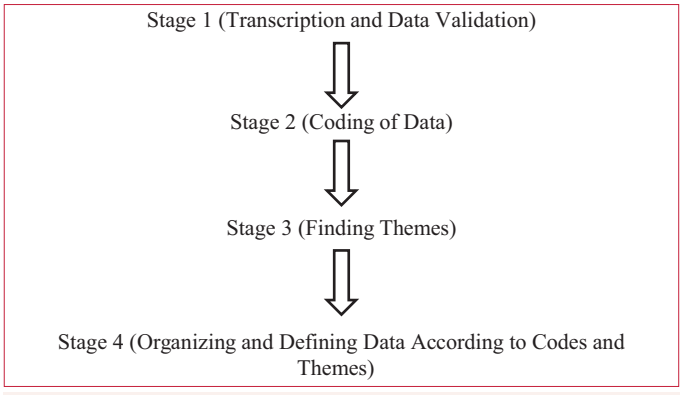

Figure 1. Data analysis process.

Results

Descriptive Findings Concerning Students

The mean age of the students was 22.46 ± 0.74 (min: 22 max: 24), and 73.3% of them were female (Table 1).

Three themes were determined as a result of the findings obtained from the interviews with the participants (Figure 2). These were "difficulties and facilitators," "family-centered care experiences" and "learning outcomes." In the quotes directly derived from the statements of the students, the names of the students were anonymized according to the order of the interview and abbreviated to S1, S2, etc.

Theme 1. Difficulties and Facilitators

During the interviews, the difficulties and facilitators experienced by student nurses participating in the study at the time of their pediatric healthcare and diseases nursing course clinical practice were revealed. These difficulties and facilitators were as follows:

Sub-theme 1.1. Difficulties with Empathizing

Students experience excitement and fear in the early stages of the pediatric nursing course clinical practice and during their time at the clinic. Some of the students who participated in the interviews stated that they were worn out due to the emotional burden of the pediatric nursing course clinical practice and felt sadness and helplessness about the situation of the children and their families, but also experienced situations where empathy was replaced by sympathy. The students expressed their difficulties in empathizing with the following statements:

> *S4. Seeing many children, whom we always regard as innocent, being sick was more difficult than other internships. It is normal for adults to be sick, but we always want children to be well. That's why I felt more upset from a psychological point of view. It was an internship during which I had difficulties with the care.*

> *S7. Working with children is very nice, but the intensive care unit was a disaster for me. I was very depressed from a psychological point of view. It was very sad to see them like that. İt was not*

Table 1. Descriptive Characteristics of Students (n=15)

Descriptive Characteristics	n	%
Age		
22	10	66.7
23	3	20.0
24	2	13.3
Gender		
Female	11	73.3
Male	4	26.7

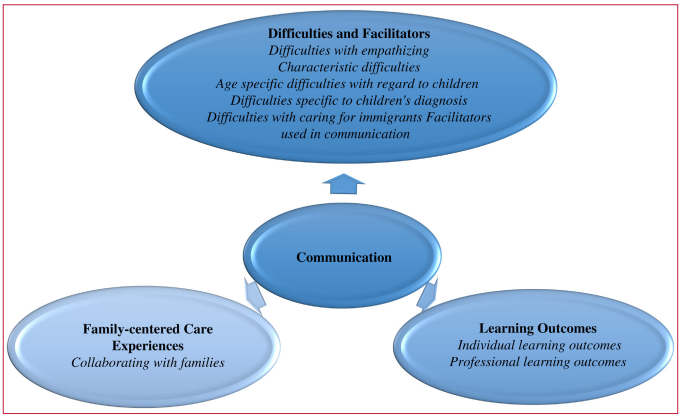

Figure 2. Classification of themes and sub-themes.

empathy but something more special than empathy... A procedure is carried out. It felt like I was suffering in their place. I was absent from my intensive care internship because I was so worn out. I did go in the beginning of the care and was trying to do something, but my head was spinning. I was going through so much pain myself that I left halfway through the care. I also noticed this. After I became an aunt myself, it felt as if a part of me died because I put everyone in the place of my niece.

Some students are afraid to make mistakes or to hurt the child.

S5. I would not like to work with children in the future. The reason for this is that they seem very delicate to me. It is easy to communicate with children. I can also communicate with the children around me but caring for them when they are sick makes me sad. That's why I don't plan to work in a children's hospital in the future. I treated the children full of fear that I would harm them. While I was not afraid of anything during my previous clinical internship, I was scared during the smallest procedures, even injections, with children. Recently, I was able to treat them as if they were normal patients, as if they were adults rather than children, without empathizing, but this was a difficult process for me.

Sub-theme 1.2. Characteristic Difficulties

Students stated that character traits affected their communication with children. Students with a stern character stated that they especially experienced difficulties in communicating with children.

S10. The pediatric internship was the internship I had the most difficulty with because I'm not one to get along with children. I couldn't get along with the children at the clinic either. Frankly, I had a hard time communicating. I didn't have a problem with families and nurses, but I had a hard time even taking the blood pressure of children. The children were afraid of the cuff and cried and I was not able to calm them down. However, I did not experience any negative situations with families and nurses. On the contrary, families have been the most helpful to me.

S11. The hardest internship for me was the pediatric internship, since I couldn't get along with small children. I couldn't communicate. In general, my friends call me stern. I guess that's why the kids were scared of me. This has been a disadvantage for me. Actually, I am a person who keeps the communication going on very well after the first contact. However, children were afraid of me probably because I appear to be stern. I was unable to initiate contact.

Sub-theme 1.3. Age-Specific Difficulties with Regard to Children

Students experienced difficulties specific to children's ages during their pediatric clinical practice. Students stated that they experienced difficulties in communicating with babies and adolescents.

S8. I had difficulty communicating with babies in the 0-1 age group, because mothers tend to be more anxious. The baby can't talk or explain his problem. In primary care, I had a child who had difficulty swallowing. He was 2 months old. I was only communicating with his mother. I could not communicate with the child at all. I have one more memory. I had an 8-year-old patient. He was very attached to me. His mother said that he was waiting for me from when the internship ended on Wednesday until Monday. She told me he was trying to do the homework I gave him. I read a book to the child and told him to read the rest. I told him to do the exercises at the end of the book and that I would come and evaluate it later. He did it very eagerly. His mother told me that he told everyone about me, that he told his sisters about me too. That made me very happy.

S9. I had an adolescent patient who was first diagnosed at the age of 15. There was no trust relationship with the doctor, because his doctor said at first that he could recover. Afterwards, he informed me that he might become disabled. He thought he couldn't walk and go to school anymore. We didn't know what to do, because no one could calm him down and he wanted to be discharged. He also refused treatment. That day was difficult for me. I really didn't know what to do. I did not communicate with that boy.

S13. I think that I communicate well with children at the age of 1-3 and 3-6. I also am an aunt myself. One of my nephews is 2 years old and the other is 1 year old. That probably has some influence also. I think I get along very well with children who are at a school age, because I can talk to them like adults. At this age, we can play writing and memory games. However, some of the adolescents could be introverted due to their illnesses. Then I would experience difficulties. The group I had the most trouble with was adolescents.

S14. Naturally I had difficulties with understanding very young children. I could only feel their discomfort at that moment when I saw their facial expressions or heard them cry. Since we are dressed in white, children would not let us approach them, because they were very afraid. The children had a fear of white coats.

Sub-theme 1.4. Difficulties Specific to Children's Diagnosis

Students stated that they experienced difficulties specific to their patients' diagnoses during clinical practice.

S6. I could not communicate with patients whose condition was very severe and patients who were on mechanical ventilation. However, this was because of the child. It wasn't due to me. In fact, there were many children with whom we formed playgroups in the clinic or who wanted to come and sing with us or communicate with us while we were sitting. This was due to our clinical setting. We approached them sincerely. They also loved us. I only experienced communicational issues because of their illness.

S9. I worked in the adolescent clinic. One of my patients left a real mark on me. He had just been diagnosed. He had a lesion on his brain. We couldn't communicate. He was very uncommunicative. His mother was constantly crying. He was arguing with his mother. I didn't know what to do at that time. It could also be due to the fact that I couldn't improve my communication skills but he definitely needed some contact. Even the doctor could not help our patient. Clowns would come to the clinic, but they could not communicate with the child. We need to improve ourselves, especially when it comes to communication.

S12. I had difficulty communicating with children diagnosed with Down syndrome and respiratory distress. I mostly tried to communicate by playing with children's toys. We drew pictures with deaf children. I found it difficult to communicate just by doing and showing things.

S10. The children with whom I had difficulty communicating were children with cleft palates. I had a hard time communicating with the children because the cleft prevented them from speaking.

Sub-theme 1.5. Difficulties with Caring for Immigrants

Students stated that they specifically had difficulty communicating with families and caregivers with an immigrant background.

S1. Cultural characteristics of families could differ in terms of communication. Some of the families did not understand Turkish. Even if they understood Turkish and no medical terminology was used, the families did not want to comprehend the child's situation. Since families were usually extremely anxious, they would perceive a raised eyebrow of the child very differently and ask many questions. It was a little difficult to explain in these situations.

S10. I had no difficulty in communicating with families. There is one exception though. We had a Syrian patient. He couldn't communicate very well. We were talking to him through a translator. I haven't experienced any problems, except with this family. On the contrary, the parents were much better to me. I was able to communicate better with adults than with children. That's why families have been a facilitating factor for me.

Sub-theme 1.6. Facilitators Used in Communication

Students stated that they used games to establish a good relationship with children and their families, to understand the feelings of children, to listen to their demands, to respond to their needs, and to support them. Students generally stated that they played games, drew pictures, and used clowns in their communication with children.

S1. I communicated with the developmental period characteristics of the child in mind. It was also very easy when I had a conversation about the things that children liked. Speaking in the second person instead of the first person is the wrong perspective in communication. When you tell them that you also have a nephew their age and mention his toys, the child may respond as follows. Your nephew is elsewhere, but I am here. That's why we need to talk about the child himself, about how great his toys are.

S2. The child was crying because we wanted to draw some blood. Since the person coming out of the blood collection room was crying, the children would enter the room crying and would be very nervous. There was a cartoon in the room. We would talk about it. We would try to divert their attention. This way, we had positive contact with the children.

S3. I did an internship at the oncology department. While I was taking the child's blood pressure, I told him that we would take his blood pressure. I showed him how to attach the cuff to his arm and tried to explain that it wouldn't hurt. Also I told him that if he wanted, he could first measure my blood pressure and that we would measure his afterwards. By including him in the process, the treatment progressed more reciprocally. This put the boy a little more at ease. That's how he allowed us to treat him. I suggested drawing to another child as well. I told him to first do his treatment and then draw a picture together. He had brought pencils with him. We drew pictures together. I tried to understand what he drew for me. In general, I tried to react positively.

S10. When we first entered the room with white aprons, especially the little children started to cry upon seeing us. They thought we were going to hurt them when they saw our white coats. There were clowns at the hospital. I mostly went into the room with them and tried to communicate afterwards. I tried to get down to their eye level, to be a little like them. Also, I tried to approach children with games and the toys they played with.

Students stated that they first established a good relationship with the children and families in order to gain the children's trust and understand their concerns, after which they treated them.

S2. I firstly introduced myself. I made contact with the mother first and did not directly communicate with the child. I tried to gain their trust. After the child would realize that I was not a stranger, he would start talking to me. We also improved our communication by playing games.

S6. The child in my first internship was 10 years old. My patient was very depressed because there were so many trainee student groups. He would react by telling me that I would come and get information, fill in some documents and leave without doing anything. Since he came from a distant city, the child was staying alone at the hospital. I would go to him to chat, rather than to gather information. Afterwards I would go completely for the purpose of communication. First I attended his care routine and then I observed what they did during the routine. I saw him playing a game on the phone, which he loved very much. At first, I talked about the game summary. Later I found out that he liked puzzles. I brought him puzzles. This way our communication progressed. The next week, when I started asking for information about his care, there were no problems.

Theme 2. Family-Centered Care Experiences

In the interviews, the students who participated in the study talked about their experiences in family-centered care practices in the clinic.

Sub-theme 2.1. Collaborating With Families

Participants cooperated with families while communicating with children. They tried to establish relationships with families in order to understand the concerns of children and to communicate better. The students stated that families experienced less stress and were satisfied with the care this way.

S1. Some parents thought that the child was very bored in the clinic and, quite frankly, that the child was confined there. When you would do something to distract the children and the parents, the parents were really pleased. They told that we really met their expectations as a nurse. This is due to the fact that some parents were aware that care is not just about giving medication, injections and dressing wounds. You feel like you're doing something right when you support this.

S5. Actually, maybe the ones we ignore are the parents. Often it were the parents who bore the burden. A mother was not willing to communicate with me. I had a very difficult time filling out the form at first. I thought about what was important to her in life. For her, the most important thing in life was her child. I had taken her child to the playroom. The mother started talking to me more openly when she realized that I really cared about her child in the playroom. She even started to cry when I went to her while her child was sleeping and asked her how she was doing and feeling. Her spouse was in another city. She was alone. I saw that she was a mother in need of support. She expressed her concerns about what would happen to her child when she talked to me. She was concerned that she wouldn't be able to get better before her child got better and that something would happen to her before her child got better.

The students stated that children may experience difficulties when families talk about their illness in the presence of their children,

S4. I paid more attention to listening to the children. I tried to look at the communication with his family. I tried talking to families about their child's illness. I got some feedback. For example, I realized that children of crying families had the need to talk about their illness. Families needed support in this regard. I tried to communicate with other disciplines. For example, there was a pediatrician in the playroom. That was a very big disappointment. I think pediatrics should be approached in a more interdisciplinary manner. Child development workers were not effective in communicating with families and children and nurses were focused on medication. I tried to take the children and families to the playroom so they could interact with each other and saw that it had a positive effect on families. Families had a chance to chat there. I noticed that families, especially mothers, took care of their children very devotedly. However, there was a painful aspect that negatively affected the psychology of the children. For example, when you would tell them not to talk about something in the presence of the child, this would be disregarded. When talking to us about the disease in the presence of their children, they were not aware of the fact that it could hurt them and that some things they would hear could make them sad. The child would realize the sadness of the family in that moment, would feel guilty, and feel that he was a burden to the family.

Theme 3. Learning Outcomes

During the interviews, the students expressed the positive effects of their clinical experience as "a personal achievement." The learning outcomes of the students in their clinical experiences are discussed in 2 sub-paragraphs.

Sub-theme 3.1. Individual Learning Outcomes

Students stated that the positive effects of clinical practice were being content with helping and learning to communicate with children. Students were of the opinion that they had gained self-confidence and learned to be strong in clinical practice.

S15. My first communication with children was in the oncology clinic. I didn't consider working with children. I thought it would be challenging for me. Instead of communicating with children, I communicated directly with their families. I regarded them as being unimportant. One of our patients received intrathecal administration. His name was X. He was 8 years old. When I went to take his blood pressure, he didn't want to. He was rude and asked why we wanted something again. The next day I asked him how he was doing and if he was feeling well. I told him that he got some medication the previous day and that he wasn't himself and reminded him of what he had said. He was surprised and told me he was very sorry. He was very embarrassed, but it was not my intention to embarrass him. Every time I went to visit him, he approached me with interest and love. He made me a rose out of paper. I thought that I could work with children there and give good care. The moment I started communicating, I saw that they would respond and would do everything without expecting something in return. I realized that if I would communicate patiently, I would always get very good feedback. That's why I gained so much from the pediatric internship.

S13. My pediatric internship was the best internship in my entire life. That is because I love children and I worked in hematology. There were mostly cancer patients. The parents there needed support. The children's cheeks were swollen from the steroids. Because of this, the children's body image was distorted. I focused on the good features of children, had a smile on my face and started communication by playing with toys. The clinic I went to had a visitor restriction. Therefore, parents also needed more support. I got a lot of satisfaction from the parents and children during my internship.

Sub-theme 3.2. Professional Learning Outcomes

The students stated that they approached children from an emotional point of view with the purpose of giving them attention before but did not know how to approach children in a special situation and that their perspectives towards children changed after they took the pediatric nursing course and gained experience with children in the clinic.

S2. I had a bad perception of oncology. I cannot empathize with children. This was very frustrating for me. I was afraid. I had this thought that the child's health would deteriorate, that he would not be able to speak at all and would be sick all the time. But later on in the clinic, when I provided care, I saw that they were not very different from other patients. The children were not aware of their disease and wanted to play. Having an oncological patient did not prevent them from playing games. That's how I learned to communicate with children by playing games.

Discussion

The opinions of 15 nursing students who completed the clinical practice of the pediatric healthcare and diseases nursing course with regard to their communication experiences with children and their families during their first time in a pediatric clinical setting were examined.

During the interviews, it was determined that the student nurses participating in the study encountered difficulties during their experiences in the pediatric clinical environment. Difficulties experienced by students are observed in expressions of fear, stress, and anxiety at the beginning of their pediatric clinical practice. Blomberg et al[9] (2014) reported that nearly half of student nurses experienced stress during their clinical experience. Student nurses were particularly afraid of making mistakes and a lack of self-confidence when caring for patients. In 1 study, student nurses reported that they did not feel confident in administering treatments to children, explaining to children about medication or treatments or managing the process.[12] Oermann and Lukomski[13] (2001) reported that the most difficult aspects of the clinical experience of students in the pediatric clinic were the psychosocial approach, learning to care for sick children and developmental problems. In the study of Bayar et al[14] (2009), students stated that they were the most afraid of having a negative experience as a result of a wrong application in clinical practice. In another study, student nurses stated that they did not feel secure in administering treatment to children, managing the process, and explaining to children about medication or treatments.[15] Our research findings are similar to the studies conducted. Due to the negative emotions they experience, student nurses may stay distant from patient interventions, have difficulty in communicating with children and their families, and experience difficulties in their role as a pediatric nurse. In our study, nursing students reported that they had difficulties in communicating with children and families. The students stated that they had more difficulty in communicating and giving care to children than adult patients. In 1 study, 44% of nursing students reported that it was more difficult to care for children and communicate with them, compared to adult patients.[13] Students stated that they had difficulties communicating with immigrant families and caregivers. Nurses may encounter various problems during the care for these individuals, especially language barriers.[16,17] In the study of Savcı et al[16] (2019), it was determined that nurses and midwives mostly experienced "language barriers in the communication with patients" (81.7%), "language barriers with patient relatives" (73.3%), and "language barriers with caregivers" and that they faced the problems of "lack of knowledge about their medical background" (74.2%) and "intercultural differences" (57.1%) when caring for immigrant/asylum seeker/refugee patients. Therefore, it is necessary to include transcultural nursing practices in our trainings and to include cultural care models in patient care.

Students stated that they experienced difficulties specific to patients' diagnoses during clinical practice. It has been determined that students had communication difficulties, especially when working with intensive care and oncology patients. In studies conducted, it has been determined that students had more difficult experiences in these clinics compared to other clinics.[13,18] In the study conducted by Kürtüncü et al[18] (2017) which was carried out with the purpose of determining the experiences of student nurses in the pediatric oncology clinic, most of the students stated they felt anxious, nervous, and fearful before coming to the clinic for the first time, felt that their knowledge about approaching a child with cancer and their parents was insufficient, found it difficult to use the words "leukemia" and "cancer" and were highly affected by the reactions of patients and parents during invasive procedures. It is recommended that competencies are increased through trainings that include approaching children with cancer and their parents, knowledge, and skills in the field of oncology but also that interactive group meetings be held where students can express the difficulties they encounter.

In our study, nursing students reported that games facilitated communication with children. Student nurses realized that play can improve communication and good relations with pediatric patients, thus reducing children's fear and anxiety. Studies which have been carried out, support this finding.[19,20] Less evident in the literature, however, is the difficulty of creating effective games as pediatric patients' cognitive development differs.

During the interviews, student nurses stated that hospital clowns were effective in communicating with children. Pediatric nurses reported that hospital clowns used in a therapeutic setting were effective in coping with the stress experienced by children due to hospitalization.[21]

Establishing a trusting and collaborative therapeutic relationship with both children and their families is a fundamental principle of family-centered child nursing care.[22,23] Strong communication in nursing care helps to build trust, avoid conflicts, and establish good relationships.[24] Cultural competence and interpersonal skills training is an integral part of nursing education. Although cultural knowledge and sensitivity cannot be acquired within a short time, cultural sensitivity training programs can help ensure competent care among a variety of pediatric patients.[25] Researchers also recommend that prior to invasive treatment educators meet to discuss and create an environment that reflects the culture and preferences of the patient and family. Recognizing specific learning needs and the best strategies in this regard will result in the most successful skill development for student nurses.[4,26,27]

Among the student nurse-family communication experiences, the participants emphasized clearly answering the questions of the families. In particular, nurses should provide concrete answers to family members or direct their questions to the appropriate healthcare workers. It is especially important to provide information based on a comprehensive assessment when family members are burdened with stress and other concerns.[4] Nurses should avoid sensitive topics and explain the patient's condition when providing information to family members, while also taking into account the patient's willingness to listen to such details and the family's emotional competence. Also appropriate language should be used and jokes about patients or engaging in provocative conversations with family members should be avoided.[28,29] Students also stated that it is very important to listen to patients' families during the communication process. Active listening is a key skill in developing supportive relationships.[26]

In the study, student nurses stated not only the difficulties but also the positive experiences they had during clinical practice. Student nurses stated that clinical practices had individual benefits and made positive changes in their professional perspectives as well. In our study, the majority of the students stated that the positive effects of pediatric clinical practice were the happiness of helping, gaining knowledge, and learning to communicate with the child and his family. In the study conducted by Voght et al[30] (2011), student nurses were of the opinion that they learned critical thinking, flexibility, and communication skills while giving care to pediatric patients. In another study conducted, it was determined that student nurses who took the pediatric healthcare and diseases nursing course developed skills with regard to the procedures and diagnoses specific to pediatric

patients during their clinical practice.[13] These results are similar to our research.

Emotions play a crucial role in student nurse-family communication and compassion and emotional intelligence largely determine the effectiveness of this type of communication. While developing their communication skills with families, nursing and medical students need to learn how to deal with emotional reactions.[31] On the one hand, nursing students have to soften a family's emotional and spiritual pain; on the other hand, they need to be able to manage their own emotions in providing healthcare. While previous studies focused on the patient's and family's anxiety in the therapeutic process,[28,29] participants in this study expressed more about their own feelings of happiness, anger, and sadness. Due to the lack of clinical experience and knowledge, nursing students were also worried when communicating with patients' families or performing care in the presence of family members. Therefore, in addition to teaching professional skills in the nursing curriculum, nurse educators should also be aware of the emotional aspects of students' communication with patients and family members. Student nurses should have more opportunities to gain practical experience and an intensive training workshop including role-play concerning communication with families should be provided. More importantly, opportunities to reflect on one's own strengths, values, and limitations of communication skills should be encouraged.

Limitations

Single in-depth interviews with student nurses are unlikely to reveal all aspects of student nurse–child–family communication. Therefore, there are some limitations to this study and the following three recommendations are suggested.

First, as student nurses gain experience in communicating with pediatric patients and their families during their clinical practice, a longitudinal follow-up study is recommended to research the changes in participants' views when they become nurses in the future. Second, a comparative study should be conducted on the similarities and differences between nursing students and nurses in the communication with children and their parents so that the nursing curriculum can be designed to respond to the needs, expectations, and clinical practice of each group. Finally, to further improve patient recovery and the quality of nursing care, it is recommended that more research be conducted on the perspectives and changes in students' experiences in clinical settings from university education to post-graduation.

Conclusion

With this study, a perspective was provided to understand the experiences of student nurses in pediatric clinical practice. With this study, it was determined that student nurses (1) have difficulties in communicating with children and their parents, (2) converted family-centered care experiences, and (3) the positive experiences they had during their clinical experience into learning outcomes. In addition, students realized that family-centered care is important in pediatrics. The student nurse-family communication is important in building relationships, promoting mutual understanding, inviting families to participate in care plans, and preventing medical errors that result from miscommunication. The findings may also provide knowledge for the development of the curriculum of nurse educators in pediatric clinical practice and creative teaching approaches. These may include simulations, reflection on clinical practice, scenario-based learning, problem-solving, or the associated use of both problem and case-based studies.

Ethics Committee Approval: Ethics committee approval was received for this study from the Non-Interventional Clinical Trials Ethic Committee of Hacettepe University (date and number: 2018-16969557/2221).

Informed Consent: Written informed consent was obtained from the participants who participated in this study.

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