

Lived Experiences and Insight on Development of Emotional Intelligence in Professional

Nursing Practice

A Dissertation submitted

By

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to

College of Saint Mary

in partial fulfillment of the requirement

for the degree of

DOCTOR OF EDUCATION

with an emphasis on

Health Professions Education

This Dissertation has been accepted for the faculty of

College of Saint Mary by:

May 21, 2017

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## DEDICATION

This dissertation is dedicated to the health care professionals who have mentored me and countless others to becoming the nursing professionals we are today. Without their emphasis on caring, compassion, empathy, and grit many would have unnecessarily struggled to practice in a way that embodies the holistic nature of this profession. Those who practice with emotional intelligence reap many benefits, but those who *teach* emotional intelligence pass those benefits on to others. It is my sincere hope that the work of this research will honor those who have positively influenced the care of others.

I would also like to dedicate this work to my children. May the values of empathy, compassion, and determination always remain a part of your lives, both personally and professionally.

## ACKNOWLEDGEMENTS

This dissertation was only made possible with the consistent support and prodding of many accomplished people in my life. Without their belief in my abilities I would not have persisted in this endeavor. I would like to especially thank Dr. MJ Petersen not only for serving in the arduous task of being my dissertation chair, but believing that I would be worthy of teaching and starting me on this path long ago. Many thanks to Dr. Patricia Morin and Dr. Joy Martin for their extensive support which went beyond the expectations of serving on my committee. Dr. Lois Linden also has my sincere gratitude for her help in guiding me to this finished project. My research subject, Kay, has my appreciation for agreeing to let me into her home and sharing all the details of her nursing history. I am forever grateful for your generosity.

I would also like to thank my parents and siblings for their unwavering support during the years in completing my graduate education. The many days and nights helping watch my two young children so that I could research and write were invaluable to reaching graduation. My mother especially deserves my gratitude, as she has never once doubted what I was capable of accomplishing. Thank you, Mom, for always thinking my work was perfect (when I assure you it wasn't).

Lastly, thank you to Jake and Max. You have only known your mother as a student and I am sorry for all the babysitters when I had class, the nights spent eating reheated food, and the days your mother lost patience when she should have had more. Thank you for never once complaining about the time you spent at the library. Thank you for tolerating the conference calls and group study dates. Thank you for always being proud of me; I would not be here if it were not for you.

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### Abstract

The purpose of this qualitative, experiential narrative study was to examine how emotional intelligence is applied in clinical nursing practice and how a nurse develops those skills in professional practice using a qualitative, experiential narrative design. The selected research participant was asked to verify her emotional quotient (EQ) score with the MSCEIT emotional intelligence test and participate in repeated interviews detailing the major events, patients, coworkers, mentors, and support systems in her life from her first experiences in healthcare to the present. Evidence of emotional intelligence (EI) was identified in her stories and applied to the Salovey and Mayer model of EI (Salovey & Mayer, 1990). NVivo 11 was selected for concept analysis and several themes emerged including Dignity and Respect, Formal Teaching, Experience, Mentorship, and Reflection. The interviews were then analyzed for structure using the Labov and Waletzky's model (Labov & Waletzky, 1997). The structural analysis found large segments of complicating action and reflection, which coincides with the concept analysis. Further research could include research on reflective practice and formal teaching experiences of emotional intelligence in nursing school and when changing nursing positions. Development of simulation activities, clinical measures of compassion and empathy are areas of focus for the development of emotional intelligence in nursing practice. Creating a learning environment according to the Jessen Model for Environments that Facilitate EI Development may be applied to clinical and classroom settings. Additional research into the role clinical empathy plays in the development of emotional intelligence is suggested for future studies.

## CHAPTER I: INTRODUCTION

Professional nursing care is described as both an art and a science (American Association of Colleges of Nursing, 2016; Nightingale, 1969). To provide effective patient care nurses need a solid understanding of complex physical processes and treatment options; but in addition to this theoretical knowledge, nurses need to be skilled in therapeutic relationships and effective communicators. High performing nurses understand that the science of nursing must coexist with the art of nursing, and without equal attention to both, nurses will be unprepared to effectively treat the complexities that exist within healthcare today (American Association of Colleges of Nursing, 2016; Nightingale, 1869). Therefore, the education of today's nurses should focus on this amalgamation of skills. While a large amount of nursing focuses on the cognitive knowledge needed to become an effective nurse, what attention is being given to the affective knowledge required of professional nursing practice?

These affective skills would most appropriately fall into the category of emotional intelligence (EI). EI has been defined as an ability to recognize emotion in one's self and others and to use emotional knowledge to reason and guide critical thought (Mayer, Caruso, & Salovey, 2000). EI is a concept popularized in the last decade by the business world as a method of improving leadership and employee performance (Goleman, 1995; Sadri, 2012; Trehan & Shrivastav, 2012). Proponents of EI argue that it may be more effective in predicting professional success than traditional intelligence tests (IQ) (Goleman, 1995; Sparkman, Maulding, & Roberts, 2012). In previous studies, researchers found that the largest contributions to life-related success were abilities that included things such as controlling emotions, handling frustration, and getting along with other people (Goleman, 1995; Sparkman et al., 2012). According to these studies, professional and life-success seem more influenced by EI than IQ.

Therefore, in pursuit of balance between critical knowledge and empathetic reasoning, the concept of emotional intelligence presents itself as a necessary skill for the professional nurse.

### **Background**

Nursing work itself is a career that demands a large amount of emotional labor to effectively communicate and provide care (Karimi, Leggat, Donohue, Farrell, & Couper, 2014; Por, Barriball, Fitzpatrick, & Roberts, 2011). The physical work is demanding, but often times the emotional strain of dealing with vulnerable patients, navigating ethical decisions, and delivering compassionate care is apparent (Karimi et al., 2014; Sharif, Rezaie, Keshavarzi, Mansoori, & Ghadakpoor, 2013). The demanding level of psychological and physical care leaves nurses vulnerable to stress, and consequently, burnout (Collins, 2013; Dusseldorp, Meijel, & Derksen, 2009; Por et al., 2011; Sharif, et al., 2013). Clinical nurses are expected to be managers, leaders within the clinical team, and work closely with caregivers of all types (Saghafi, Hardy, & Hillege, 2012).

As our healthcare landscape is changing, there are even more pressures on nurses to perform to high standards (Adamy, 2012; Geiger, 2012). Nurses are being judged as customer service representatives and hospital reimbursement is dependent on patient satisfaction levels (Adamy, 2012; Geiger, 2012). These nurses deal with increasing acuity loads and shorter hospital stays, which in turn, lead to increasing problems with nurse turnover, nurse burnout, and nurses leaving healthcare altogether (Dusseldorp et al., 2009).

Nursing literature indicates that there is a large amount of job turnover within the first year of graduation (Delaney, 2003). New nurse graduates remark on feeling unprepared, unable to manage emotional needs of patients, struggling with communication, and sometimes victims of lateral violence or incivility amongst seasoned nurses (Delaney, 2003; Hickey, 2009; Pfaff,



Baxter, Jack, & Ploeg, 2014; Saghafi et al., 2012; Thomka, 2001). Attending to and educating on emotional intelligence offers a possible solution to mitigate these factors.

Emotional intelligence literature suggests that nurses and students with higher levels of EI are more likely to successfully deal with the stressors that a demanding career or curriculum might entail (Claros & Sharma, 2012; Collins, 2013; Karimi et al., 2014; Por et al., 2011; Sharif, et al., 2013). In a study by Claros and Sharma (2012), EI was correlated with less engagement in risky behaviors such as alcohol and substance abuse and higher amounts of self-control and coping with stressors. The positive effects of EI have been linked to improved mental and general health, increased resiliency against depression, increased independence, greater anger management skills, stronger work performance, and overall a better optimism towards life (Por et al., 2011; Sharif, et al., 2013). Students with high levels of EI showed increased feelings of control, which helped them to adopt an active and effective coping strategy when dealing with stress. These student nurses were able to use their ability to control their emotions and regulate their moods to decrease anxiety (Por et al., 2011). This ability to manage stress, cope with emotional demands, and possess a positive outlook on life certainly has applicability to student retention and better matriculation through a nursing program (Collins, 2013). Additionally, this greater capacity to handle stressful situations could potentially lead to increased job satisfaction and less job turnover in demanding patient care settings (Karimi et al., 2014).

### **Statement of the Problem**

Emotional intelligence is a term where lack of consensus makes the concept difficult to quantify (Mayer et al., 2000; Mayer, Salovey, & Caruso, 2004; Mayer, Salovey, & Caruso, 2008). While researchers continue to define and provide research attesting to validity, studies are being conducted to correlate nurse EI with quality improvement measures in clinical practice

(Codier, Kamikawa, Kooker, & Shoultz, 2009; Holbery, 2014; James, Andershed, Gustavasson, & Ternestedt, 2010). Nursing research has linked EI to improved nurse retention, increased sensitivity and compassion, increased nurse performance, and greater levels of wellbeing for those who scored highly on the EI scale (Codier, et al., 2009; Holbery, 2014; James, Andershed, Gustavasson, & Ternestedt, 2010).

However, little to no research has been done on the lived experiences of emotionally intelligent nurses and how they gained these emotionally relevant skills. Insight into what contributes to EI behavior, both positive and negative, has been hypothesized and studied quantitatively, but little descriptive qualitative data exists. Therefore, it remains unclear how a professional nurse learns to be emotionally intelligent.

### **Purpose of the Study**

The purpose of this study was to examine how emotional intelligence is applied in clinical nursing practice and how a nurse develops those skills in clinical practice. There are clear implications for EI in both the academic setting and bedside care settings, but without insight into how or when emotional intelligence is developed, adequate educational techniques cannot be developed (Holbery, 2014; James et al., 2010; McQueen, 2004; Unal, 2012). For the purposes of this study, one nurse was extensively interviewed regarding her personal lived experiences developing and applying emotional intelligence skills in this descriptive, narrative, qualitative study.

Creswell stresses that the rationale for qualitative research should include a phenomenon to be explored in great detail in its natural setting (Creswell, 2013). By conducting a qualitative narrative approach investigating emotional intelligence, the unique viewpoint and insight into the nurse's own emotional understanding and her personal growth can be studied with great detail

(Andrews, Squire, & Tamboukou, 2008; Creswell, 2013; Elliott, 2005; Riessman, 2008). The meanings of her experiences can be used to identify important patterns and themes as they relate to the development and growth from a novice nurse to a high performing, emotionally intelligent nurse in a direct care setting.

### **Significance of the Study**

This study provided insight into how emotional intelligence is built during one's career in nursing. Real life examples and personal reflection demonstrated how emotional knowledge affects the development of a quality clinical practice in the acute care setting. Insight into the personal knowledge and growth of one woman's emotional ability have provided invaluable data to nursing education and future research. Future research into emotional intelligence as it pertains to the field of nursing can be focused to provide meaningful insight into effective teaching methods, resulting in positive outcomes for the patient, the organization, and the nurse.

### **Research Questions**

To adequately investigate the contributing factors affecting the development and use of emotional intelligence, this study investigated the following questions:

1. How has emotional intelligence contributed to the daily practice of a professional acute care nurse in a Midwestern hospital setting?
2. What factors, positive or negative, have influenced how the professional nurse becomes emotionally intelligent based on the lived experiences of one emotionally intelligent acute care nurse in a Midwestern hospital setting?

The research questions explored the affective nature of nursing through the personal experiences of an emotionally intelligent nurse in order to provide insight into its development and application in a Midwestern acute care setting.

### Definition of Terms

The following operational terms are defined for measurement within this research study:

**Acute care nurse.** A nurse who primarily works at the bedside performing direct patient care. Acute settings treat patients with a goal of stabilizing and discharging the patient within a short amount of time (American Association of Colleges of Nursing, 2016).

**Emotional intelligence.** An ability that includes the recognition of emotion in one's self and others, and to use emotional knowledge to reason and guide critical thought as measured by the Mayer Salovey Caruso Emotional Intelligence Test (MSCEIT) (Mayer et al., 2000; Salovey & Mayer, 1990).

**Professional Nurse.** A nurse who practices based on scientific theoretical knowledge and specialized skills guided by standards and ethics set by a professional organization and has made nursing practice their primary career (American Association of Colleges of Nursing, 2016).

The following additional terms are defined for use during the course of this research:

**Clinical practice.** The nurse practice setting where patient care occurs (American Association of Colleges of Nursing, 2016).

**Emotions.** Short, internal events that are frequently the result of changing events or relationships (Mayer et al., 2000).

**Emotional labor.** The work related to managing interpersonal communication, expression of personal feelings, and carrying out the treatment of patients and families while dealing with high levels of emotional stress (Dusseldorp et al., 2009).

**Nurse burnout.** The behavior used to describe a nurse when the emotional labor of nursing work results in a decrease in the quality of their relationships with patients or coworkers (Dusseldorp et al., 2009).

**Nurse graduate.** A nurse who has successfully completed their education and licensure examination and is within their first year of practice (American Association of Colleges of Nursing, 2016).

**Well-being.** A subjective feeling of contentment with one's health, happiness, relationships, and/or finances (Bar-On, 2010).

### **Assumptions**

In this study it was assumed that the interviewed nurse would provide in-depth and detailed answers to the interview questions. It was also assumed that she would have a variety of situations and examples using emotional intelligence within her nursing practice. The study also assumed that how she came to develop emotional intelligence is known to her in a way that can be articulated to the researcher.

### **Limitations**

Due to the selected qualitative design, this study is limited in its generalizability to a greater population. While narrative research is considered appropriate for research that desires a holistic viewpoint and rich, detailed data, one person's experiences may limit the representation of multiple viewpoints (Flyvbjerg, 2006). The importance of large population sampling and the idea of single case generalizability has been debated by researchers in the field (Flyvbjerg, 2006). Based on the historical works of Galileo, Newton, Einstein, Freud, among others, Flyvbjerg (2006) makes an argument that because of the attention to detail and lack of strict singular focus, all sciences, both human and natural, can benefit from the knowledge gained in a single descriptive case study. Flyvbjerg (2006) believed that case-study research had its own rigor with its main advantage being able to explore how the phenomenon under study unfolds in

real-life situations. This argument reveals that narrative research models may allow for a larger view point and the inclusion of multiple theories rather than a limitation on generalizability.

### **Delimitations**

This research study selected the Salovey and Mayer theoretical framework for its definition of emotional intelligence. This definition has shown to provide the highest amount of validity and reliability in current research (Mayer et al., 2000), and it omits several debatable facets of emotional intelligence, such as personality, that are often times included in other research studies (Mayer et al., 2000). This specific framework, and consequently, measurement of testing was selected for the sake of measuring an ability model of emotional intelligence alone. Further discussion of framework will be presented in Chapter II.

The selection of the participant was chosen to represent nurses who work in acute care settings. The populations seen by this type of nurse presents a high volume of opportunities to use emotional intelligence skills in daily practice. The field of acute care nursing where the nurse-patient relationship can be complicated by the inclusion of technology and other barriers to communication presents unique challenges for nurses (O'Connell, 2008). Application of EI skills may encourage nurses to meet the mutual needs of the nurse, patient, and their families (O'Connell, 2008). This study will attempt to view EI principles through the lens of an acute care nurse in attempt to learn how EI skills are applied to this population.

The participant chosen was known to the researcher which could potentially reflect a personal bias in the research. However, the known qualities of the studied nurse also provided insight into her professional practice. The nurse's use of emotional intelligence skills has been verified over the course of the relationship and her professional skills have been witnessed over many years personally by the researcher. In addition, the participant's calculated emotional

intelligence score was collected. The EI score was then used to validate her experiences with EI scores proven to be representative of someone with a high level of emotional intelligence.

### **Summary**

Quality clinical nurses have many highly developed skills. Preparation to work in the clinical environment includes a focus on cognitive knowledge of disease processes, physical assessment skills, and prioritization abilities (American Association of Colleges of Nursing, 2016; Nightingale, 1969). Along with those abilities, nurses are additionally valued for their compassion and empathy. Nurses are encouraged to develop bedside manner and recognize changes in what the patient or family understands. Communication abilities, both with the interdisciplinary team and the patients, are a highly developed skill in nurses who are exemplary in their practice.

Developing emotional intelligence skills for the professional nurse may be one way to enhance the performance, promote wellbeing, and reduce turnover in the field of nursing (Akerjordet & Severinsson, 2007; Bailey, Murphy, & Porock, 2011; Claros & Sharma, 2012; Collins, 2013; Karimi et al., 2014; Landa & Lopez-Zafra, 2010, Por et al., 2011; Sharif, et al., 2013). Learning more about practicing nursing with emotional intelligence and what directly contributes to the development of emotional intelligence within the professional nurse is essential to educate nursing students, new nurse graduates, and practicing nurses who would benefit from these skills.

The goal of this study was to investigate the lived experiences of one emotionally intelligent nurse in order to understand the phenomenon from a very detailed and personal point of view. The participant's experiences in acute care detail her perception of EI development and application in this population of patients. By examining her reflections, finding insight in her

experiences, and understanding the significance of those transformative events as they relate to the Salovey and Mayer (1990) theoretical framework of emotional intelligence, the greater community of nurses can expand their viewpoint on what it means to practice compassionately, empathetically, and effectively with those entrusted to their care.



## **CHAPTER II: LITERATURE REVIEW**

Emotional Intelligence (EI) is a concept that while having been studied extensively since the 1990s, lacks a great deal of consensus among disciplines and EI theorists (Freshwater & Stickley, 2004; Lyon, Trotter, Hold, Powell, & Roe, 2013; Montes-Berges & Augusto-Landa, 2014; Seema, 2012). The purpose of this Chapter is to review the research in the field of emotional intelligence, define the operational models, and discuss relevant measurement regarding their theoretical constructs. The Salovey and Mayer (1990) four branch model of EI will be discussed in terms of its applicability to themes in the literature concerning professional nursing behaviors. Instructional techniques concerning EI will be examined and discussed as they appear, sometimes sparingly, in the literature.

### **Theoretical Framework**

The term “emotional intelligence” arose from the works of such theorists as Jung, Gardner, and Thorndike who proposed that intelligence was made up of much broader abilities than just cognitive abilities (Mishra, & Mohapatra, 2009; Seema, 2012). Its history has early beginnings. Carl Jung’s work in the 1920s was one of the first to suggest that feelings and perception were important to human functioning in society (Hollis, 2013). Building from his work, modern psychologists attempted to understand the role emotions play in personal abilities (Hollis, 2013).

The psychologist Edward Thorndike concentrated his career on the study of animal and human intelligence, applying his findings to the human educational experience (Plucker, 2013). In the 1930’s his research findings indicated that standard intelligence tests were too narrow, and discussed the importance of developing additional measures to quantify other types intellect, such as social intelligence (Plucker, 2013).

In 1983, Dr. Howard Gardner proposed the theory of multiple intelligences. Echoing the sentiments of Thorndike, Gardner also believed standard intelligence testing to be too narrow a measurement for human potential (Armstrong, n.d.; Gardner, 1993; Plucker, 2013). Gardner proposed eight different types of intelligence, including interpersonal and intrapersonal intelligences, which are the building blocks of the theory of emotional intelligence (Armstrong, n.d.; Gardner, 1993).

From the work of these theorists and others, the term ‘emotional intelligence’ has since been assigned to describe the recognition of emotions in oneself and others and the ability to use that knowledge to facilitate critical thought and action (Seema, 2012). From that concept definition, several models have been proposed.

### **Models of Emotional Intelligence**

EI has been defined and revised a number of times since its original conception, but today two main models of EI exist: ability and mixed model of EI (Mishra, & Mohapatra, 2009). The ability model operationalized EI as an ability or set of skills and distinguishes itself from preferences or matters of personality (Mishra, & Mohapatra, 2009; Salovey & Mayer, 1990). The mixed model of EI combined a mixture of abilities and inherent personality traits (Bar-On, 2010; Goleman, 1995; Mishra, & Mohapatra, 2009). While these models contain some overlap, they operate very differently on how they are defined and a variety of results can be expected based on the framework selected (Mishra, & Mohapatra, 2009). The different models and their corresponding frameworks are described below.

#### **Ability Model of Emotional Intelligence**

The theorists that first published and defined the term EI for use were psychologists Peter Salovey and John Mayer (1990). Salovey and Mayer recognized that people range in their

abilities to understand and utilize emotions. While this information was not new to clinicians, these authors sought to define this ability as a type of intelligence (Mayer et al., 2000, Salovey & Mayer, 1990). Salovey and Mayer believed that their theory differed from other models of intelligence, such as social intelligence, which encompassed both the management of relationships and aspects of personality (Mayer et al., 2000; Salovey & Mayer, 1990). Salovey and Mayer proposed that EI was a subset of social intelligence that focused purely on the ability to recognize and manage emotional expression (Salovey & Mayer, 1990). Using their definition, EI is used to refer to a person's ability to stay calm while they are feeling anxious rather than a person's level of self-confidence (Mayer et al., 2000; Mayer et al., 2008). Salovey and Mayer concluded that emotional intelligence is the ability to perceive emotions, understand their meanings, and apply that knowledge to critical thought (Mayer et al., 2000; Mayer et al., 2008; Mayer et al., 2004; Salovey & Mayer, 1990). Their model for EI consisted of four main branches: Perceiving emotions, Using emotions, Understanding emotions, and Managing emotions (Grewal, Brackett, & Salovey, 2006; Mayer et al., 2000; Mayer et al., 2004; Mayer et al., 2008; Salovey & Mayer, 1990).

### **Mixed Model of Emotional Intelligence**

Based upon the work of Salovey and Mayer (1990), EI theorist Daniel Goleman popularized the term "emotional intelligence" and applied the theory to the business world in 1995. His best-selling book *Emotional intelligence: Why it can matter more than IQ* proposed that EI was comprised of the same basic principles Salovey and Mayer (1990) introduced (the ability to recognize and manage emotion in self and others), but that it also contained personality traits such as persistence, motivation, and optimism (Mayer et al., 2008; Seema, 2012;). Goleman (1995) defined EI in terms of interpersonal and intrapersonal skills. Interpersonal skills

refer to the ability to manage relationships and cooperate with other people. People with interpersonal skills are able to negotiate social settings and empathize with others (McQueen, 2004). Intrapersonal skills are described as a person's ability to recognize their own feelings and use that knowledge to modify their behavior (McQueen, 2004). People with intrapersonal skills have self-awareness of their own emotional responses, can manage those responses, and have motivation for self-improvement (Seema, 2012).

Goleman (1995) wrote that EI may matter more than IQ for the reason that IQ stays relatively static throughout one's lifetime, EI has the ability to grow and improve with age and experience. In Goleman's work, top performers in companies could point to their level of EI as justification for success (Goleman, 1995). These sensational claims propelled EI into the public eye, and consequently, the Goleman construct of EI is heavily researched in business and leadership within major corporations throughout the world (Mayer et al., 2008).

Based on the works of both Salovey and Mayer (1990) and Goleman (1995), Bar-On (2010) provided another mixed-model definition of emotional intelligence. His definition stated that EI is an array of non-cognitive abilities that combines both emotional and social competencies to impact human behavior (Bar-On, 2010). Bar-on distinguished himself by the large inclusion of personality characteristics. The Bar-On model is comprised of five meta-components of emotional intelligence which are identified as intrapersonal skills, interpersonal skills, stress management, adaptability, and general mood. Within these five components, 15 subscales exist. Intrapersonal skills are described in terms of self-regard, emotional self-awareness, assertiveness, independence, and self-actualization. Interpersonal skills are defined as empathy, social responsibility, and interpersonal relationships. Stress management can be measured in terms of stress tolerance and impulse control. Adaptability includes reality-testing,

flexibility, and problem solving. General mood is comprised of optimism and happiness (Bar-On, 2010).

For Bar-On, EI has a significant impact on positive psychology and significantly impacts a person's ability to perform at work, their health and well-being, and their level of happiness and satisfaction in life. Bar-On noted that his construct of EI was based on a "Darwinian" way of approaching survival and the ability to thrive and adapt in life (Bar-On, 2010).

### **Measurement of EI**

With two uniquely different constructs of the same concept, the measurement of EI has warranted several issues (Brackett & Geher, 2006; Mayer et al., 2004). For those attempting to measure an ability construct, performance measures became uniquely relevant. Testing that included emotion identification that allowed for scoring indicated a higher ability or knowledge of emotions (Brackett & Geher, 2006). For those using a mixed model, a self-report scale along with ability measures was necessary to include the measurement of personality traits (Brackett & Geher, 2006).

### **Performance Measures**

According to Brackett and Geher (2006), two of the most widely used performance measures of EI include the Emotional Accuracy Research Scale (EARS) and the Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT) (Mayer, 2004; Mayer & Geher, 1996). In these exams, participants were asked to demonstrate emotional knowledge by answering questions identifying emotions in pictures of faces expressing certain emotions or making judgments based on information provided in emotionally charged vignettes (Brackett & Geher, 2006; Mayer et al., 2000). This type of test was considered a "performance" test because there are answers that are considered more correct than others. EI scores are determined either by consensus or expert

scoring. With expert scoring, psychologists, philosophers, mental health professionals, or other experts were asked to identify emotions displayed in the vignettes or photos (Brackett & Geher, 2006; Mayer et al., 2000; Mayer et al., 2004). Consensus scoring was determined by answers that match those collected from a representative sample of the general public (Brackett & Geher, 2006; Mayer et al., 2004).

The EARS test was one of first exams to measure EI based on performance (Brackett & Geher, 2006). However, poor internal reliability caused concern (Brackett & Geher, 2006). The MSCEIT has shown to be both valid and reliable, including at each of the branches tested and at the full score level ( $r = .91-.93$ ) (Brackett & Geher, 2006; Mayer et al., 2000, Mayer et al., 2004). Appropriate discriminant validity was shown from measures related to cognitive intelligence and those scales that use self-report measures or that measure personality (Brackett & Geher, 2006; Grewal et al., 2006; Mayer et al., 2000, Mayer et al., 2004). The MSCEIT has shown to be significantly related to measures similar to those found in the Big Five Personality scales, but independent of them (Brackett & Geher, 2006; Grewal et al., 2006; International Personality Item Pool, n.d.; Lopes et al., 2004; Mayer et al., 2000, Mayer et al., 2004). Mayer, Salovey, and Causo (2008) identified the significance of this correlation with personality scales when they stated, “Whether or not people are sociable or emotional, they can be smart about emotions” (p. 508). While validity points to the MSCEIT measuring what it set out to measure, and reliability showing the same scores repeated on multiple administrations of the exam, it remained a lengthy and costly measure of EI that is also reliant on trained professionals to administer (Lyon et al., 2013).

**Self-Report Measures.** Self-report scales of EI asked participants to rate their abilities or describe themselves using a Likert-type system of measurement. Those individuals who have

a higher level of self-understanding will therefore be more precise than those whose self-concept is less accurate (Brackett & Geher, 2006; Codier, Muneno, Franey, & Matsuura, 2010). Existing literature suggested that people are commonly poor judges of their own intellectual capacity (Ehrlinger, Johnson, Banner, Dunner, & Kruger, 2008).

To add validity to this system of measurement, a format has been developed that not only includes self-report measures, but also reports of observers. These observers may be co-workers, peers, managers, or anyone very familiar with the participant. However, these type of reports tended to measure a person's character or their reputation rather than their actual ability. Three of the most widely known self-report EI exams are the Schutte Self-Report Inventory (SSRI), the Emotional Quotient Inventory (EQ-i), and the Emotional Competency Inventory (ECI).

The SSRI self-report exam is a single-factor, 33 item scale (Schutte et al, 1998) that was free to use (Lyon et al., 2013). While brief, this scale had a high internal and test-retest reliabilities (Brackett & Geher, 2006; Lyon et al., 2013). There is criticism related to the validity of the SSRI when held against the theoretical framework of Mayer and Salovey (Brackett & Geher, 2006). Experts purported that when held against the four-branch model, the SSRI does not equally or adequately measure all four branches of emotional identification and regulation (Brackett & Geher, 2006).

The EQ-i is a self-report model of EI testing based on the conceptualization of Reuven Bar-On (2004). It is one of the most widely used and frequently studied measures of EI (Brackett & Geher, 2006; Codier et al., 2010). Frequently seen in the community health arena, the EQ-i measures many personality factors within its 133 item exam. Research indicated strong internal reliability ( $r = .69-.86$ ), but validity is debated (Brackett & Geher, 2006; Codier et al., 2010; Dawda & Hart, 2000; De Weerdts & Rossi, 2012). Traits measured within the EQ-i have

correlated with those personality measures that exist on the Big Five Personality test (International Personality Item Pool, n.d.). This correlation may indicate that the overlap between the two translates to the two tests measuring the same phenomenon (Brackett & Geher, 2006; Codier et al., 2010; Dawda & Hart, 2000; De Weerdts & Rossi, 2012; Mayer et al., 2004).

The Emotional Competency Inventory (ECI) stemmed from the work of Daniel Goleman (1995). While this exam is self-report in nature, it attempted to give a larger view of the participant's ability by including observer reports as well (Brackett & Geher, 2006; Codier et al., 2010; Wolff, 2005). This test grew from the desire to predict business related results and EI capability in the work context (Brackett & Geher, 2006; Codier et al., 2010). Consisting of 72 items, this exam measures emotional and social sub scales. Test items can directly relate to leadership and teamwork abilities within the context of the business world. Again, internal consistency is somewhat reliable ( $r = .63$ ) (Wolff, 2005), but the validity related to measurement of emotional ability as defined by the theoretical framework was questionable (Brackett & Geher, 2006). Evidence is mixed related to overlap within the Big Five Personality test (Brackett & Geher, 2006; Codier et al., 2010). Within the business world, predictive ability appears to be strong. Work performance outcomes correlated with high EI scores on the ECI (Brackett & Geher, 2006). However, this has not translated to predictive ability within the academic world (Brackett & Geher, 2006). Similar to the MSCEIT, the ECI is an exam that is lengthy, requires training, and can be extremely costly (Brackett & Geher, 2006).

### **General Discussion of EI Measurement**

Due to the lack of consensus related to the definition of EI, it is no surprise that existing measurements of EI did not correlate highly with each other (Brackett & Geher, 2006; Lyon et al., 2013). This discrepancy has led to many criticisms related to EI and its value as a construct.



Self-report measures have a higher instance correlation, but between ability and self-report measures, there was disagreement. Self-report measures ask participants to rate themselves and make predications on their own behaviors, but social desirability and self-deception could highly influence these ratings. Ability measures ask the participant to demonstrate emotional knowledge which leads to a possibility of using EI scores to predict future behavioral responses. However, assessing such choices outside of the emotionally charged situations these dilemmas present does not adequately measure the participants' actual behavior, but their desired behavior (Grewal et al., 2006; Mayer et al., 2000; Mayer et al., 2004). Measurement outside of direct observation does not reflect this variable. With these criticisms in mind, research thus far has favored ability measurement approaches to EI (Akerjordet & Severinsson, 2007; Brackett & Geher, 2006; Mayer et al., 2008).

#### **Four Branches of EI**

The reliability and validity of the performance measures, along with the narrowed focus of the ability model, makes the Salovey and Mayer (1990) conceptual framework appealing as a theoretical framework for healthcare research and implementation. Because EI is viewed as a skill, and one that can be developed, its applicability within the nursing field can be demonstrated. While many of the EI models differ slightly in their global focus, most agree that EI at its minimum can be described as the identification of emotions in one's self and other, the ability to understand those emotions, and the ability to manage and apply those emotions to action. This will be discussed in terms of the Salovey and Mayer four-branch model of EI, and how these abilities affect the professional nurse.

### **Perceiving Emotions**

The first branch of the Salovey and Mayer model of EI is arguably the most basic to the concept of emotional intelligence. As stated by Freshwater and Stickly (2004), “It is generally accepted that very little of our lives is governed by logic alone. It is rather our emotional world that motivates our decisions and actions” (p. 91). Identifying emotions accurately included speech, non-verbal expressions, and using cues such as intonation and behavior to decipher emotional meaning. Perceiving these emotions in others was important, but also perceiving emotions responsibly in oneself was an ability reflective of an emotional intelligent individual (Akerjordet & Severinsson, 2007). Mayer, Salovey, and Caruso (2004) described emotions as “signals for changes in a relationship, real or imagined” (p. 250).

**Patient safety.** Correct identification of emotions, the first branch in the Salovey and Mayer framework, is the direct role of the professional nurse (Montes-Berges & Augusto-Landa, 2014). Emotions run high within the field of nursing and are included in all of the day-to-day interactions with patients, families, and colleagues. Whether nurses are dealing with death and dying, a difficult diagnosis, poor clinical outcomes, a lengthy hospital stay, or just daily interaction, patients and family members interact with their nurses emotionally. The constant interaction required nurses to properly identify emotions to promote patient safety (Freshwater & Stickley, 2004).

As the direct care provider, nurses are in charge of identifying emotional changes. Identifying fear rather than frustration or even shame is important for the nurse to decide if his or her next course of action is therapeutic or potentially harmful (Akerjordet & Severinsson, 2007; Cadman & Brewer, 2001). Similarly, correctly discriminating between honest and false emotional expressions is a developed skill of a nurse who needs to correctly interpret the

meaning behind the patient's needs or desire (Akerjordet & Severinsson, 2007; Brackett, Rivers, & Salovey, 2011). This emotional awareness allows the nurse to connect these emotions to a therapeutic course of action as the need presents itself. In fields that require high levels of emotional perception, such as the emergency department, behavioral health, or hospice specialties, the ability to correctly recognize emotions is a prerequisite for competent care (Codier, Freitas, & Muneno, 2013; Dusseldorp et al., 2009). Correct emotional recognition then becomes important for all nursing areas as a means of increasing workplace performance (Beauvais, Brady, O'Shea, & Quinn Griffen, 2011; Brackett et al., 2011; Codier et al., 2013; Codier, Kooker, & Shoultz, 2008; Kooker, Shoultz, & Codier, 2007; Rankin, 2013).

### **Using Emotions**

Salovey and Mayer's framework of emotional intelligence gave importance to the skill of correctly identifying emotions, but once that skill is established, the emotionally intelligent practitioner then used those emotions according to context. Using emotions to facilitate thinking refers to actively reasoning about emotions using information found in the environment or from general knowledge about the person. Using emotions demonstrated an ability to actively reason, problem solve, and engage in interpersonal communication (Brackett et al., 2011; Holbery, 2014; Rivers & Brackett, 2011).

**Interpersonal communication.** One such use of emotional reasoning was the ability to communicate effectively both socially and professionally (Beauvais, et al., 2011; Codier, 2008; Mayer et al., 2008; Rivers & Brackett, 2011). Socially competent individuals have been found to have better quality interpersonal relationships (Mayer et al., 2008). Effective nurses were those who built empathetic interpersonal relationships with their patients and their families and did so with highly developed communication skills (Holbery, 2014; Shanta & Gargiulo, 2014).

Communication skills were a means of extracting important assessment data, but also were used as a method of establishing trust and collaboration with patients.

Low EI levels were predictive of interpersonal conflict (Mayer et al., 2008). In areas of nursing with high amounts of conflict and intense emotional situations, coping strategies became important for successful nursing practice (Dusseldorp et al., 2009). As a nurse, a certain level of assertiveness is required to be able to efficiently and competently manage relationships with colleagues and patients, especially in emotional charged situations (Dusseldorp et al., 2009; Unal, 2012). High levels of self-awareness and self-esteem, properties correlated to high levels of EI, facilitated assertiveness and development of communication skills that allowed nurses to use their professional knowledge and skills more effectively (Dusseldorp et al., 2009; Sharif et al., 2013; Unal, 2012).

**Teamwork.** Other skills associated with emotionally intelligent individuals included being able to listen attentively while deciphering meaning and feelings, an understanding of how one is perceived by others, and the desire to understand others (Benson, Martin, Ploeg, & Wessel, 2012). Considering that a majority of adults spend large amounts of their time at the workplace, skillful attention to relationships and high levels of emotional understanding are desirable of a coworker (Mayer et al., 2008; Mishra, & Mohapatra, 2009). Many researchers drew attention to correlations between teamwork and team effectiveness, improved communication, collaboration and high emotional intelligence scores (Codier, et al., 2008). Positive conflict styles and leadership capabilities were frequently cited to those with high emotional intelligence scores, and actively developed as a means of creating a healthier work environment (Codier, 2008; Hutchison & Hurley, 2013).

### **Understanding Emotions**

Recognizing and using emotions to facilitate thought made clear appearances in professional nursing practice literature. Understanding emotions, especially when related to a nurse's ability to empathize and act compassionately, correlated with the construct of EI as well. Understanding emotions with a high level of EI was demonstrated when individuals were able to recognize how a specific emotional response affected the consequences of events (Mayer et al., 2008). Emotions were not only perceived and labeled, but the similarities and differences between these complex emotions were explored (Brackett et al., 2011). For some, this meant higher attention and accuracy with detecting emotion-related physiological responses (Mayer et al., 2008).

Commonly, this empathic ability is linked to understanding the grief process (Bailey et al., 2011; Codier, 2012; Dusseldorp et al., 2009). Being able to understand the different stages of the very complex grief process may have changed the nurse's perception regarding emotional displays or actions by the patient or their family members and led them to provide a better level of care (Codier, 2012). The ability of a nurse to identify these processes with her patient and show compassionate care was a reflection of this branch of EI.

**Empathy and compassion.** Empathy was a construct commonly linked to EI abilities. Salovey and Mayer (1990) described empathy as "the ability to comprehend another's feeling and to re-experience them in oneself" (p. 194). They described empathy as a central ability to EI behavior and reflected that empathy is only achievable once a person has ascertained the feelings of oneself and those of another (Salovey & Mayer, 1990). Empathy could arguably present itself under the recognizing emotions branch, but empathy not only involves the identification of

emotions, but a more sophisticated understanding of the connections and transitions between emotional states (Brackett et al., 2011).

Empathy and compassion, or the expression of empathetic care, are at the core of nursing practice (Freshwater & Stickley, 2004). While practical knowledge and psychomotor skill acquisition was important to nursing education, the argument existed that affective skills and holistic approaches to nursing have been neglected (Freshwater & Stickley, 2004; Karimi, et al., 2014). The significance of human relationships and their ability to impact health and wellness was demonstrated numerous times within the research (Bailey et al., 2011; Freshwater & Stickley, 2004). In an article by Holbery (2014), she reflected on the lack of EI care during her experience having a loved one involved in a trauma. Holbery described the care as “mechanic” and “protocol driven” and the need that she desired to have filled was the consideration of her and her family for their humanistic needs (Holbery, 2014). The holistic care that came with compassion, a caring attitude, and a desire to understand the significance of the problems facing patients are relevant to the emotionally intelligent nurse (Holbery, 2014; Shanta & Gargiulo, 2014). Empathetic and compassionate nursing care is often dependent on complex relationships with patients and their families, which was stated as skills developed using EI principles (Bailey et al., 2011; Codier et al., 2010; Holbery, 2014).

### **Managing Emotions**

The last branch of Salovey and Mayer’s EI framework was that of managing or regulating emotions. An emotionally intelligent individual using skills in this area would use decision making factors to decide the usefulness or appropriateness of an emotion depending on the situation or response desired (Salovey, 2001). This included allowing oneself to feel emotions in a range of pleasantness and choosing to engage or detach from them (Brackett et al.,

2011; Salovey, 2001). Continual reflection on one's personal feelings was essential to skillful use of this branch of EI (Brackett et al., 2011).

There was also evidence to suggest that higher levels of EI lead to better clinical decision making, planning and evaluation, knowledge utilization, and relationship management (Beauvais et al., 2011; Codier et al., 2010; Collins, 2013). Problem-solving skills and critical thinking were essential for clinical practice, both of which were shown to be present in individuals with higher EI scores (Collins, 2013). The ability to manage emotional concerns manifested itself in several ways, including the ability to handle stress and retention within an organization or the field of nursing itself (Collins, 2013).

**Stress management and burnout prevention.** One way that nurses were able to use the fourth branch of Salovey and Mayer framework of EI was by mitigating the stressful responses related to nursing work (Codier et al., 2008). Nursing work itself is a career that demands a large amount of emotional labor to effectively provide holistic care (Karimi et al., 2014; Por et al., 2011). The physical work is demanding, but often times the emotional strain of managing vulnerable patients, navigating ethical decisions, and delivering compassionate care is overwhelming (Karimi et al., 2014; Sharif et al., 2013). The exhausting level of psychological and physical care left nurses vulnerable to stress, and consequently, burnout (Collins, 2013; Landa & Lopez, 2010; Por et al., 2011; Salovey, 2001; Sharif, et al., 2013).

EI literature suggested that nurses with higher levels of EI were more likely to successfully deal with the stressors that a demanding career entailed on a daily basis (Akerjordet & Severinsson, 2007; Bailey et al., 2011; Claros & Sharma, 2012; Collins, 2013; Karimi et al., 2014; Landa & Lopez, 2010, Por et al., 2011; Sharif, et al., 2013). In a study by Claros and Sharma (2012), EI was correlated with less engagement in risky behaviors such as alcohol and

substance abuse and higher amounts of self-control and coping with stressors. The positive effects of EQ have been linked to improved mental and general health, increased resiliency against depression, increased independence, greater anger management skills, stronger work performance, and overall a better optimism towards life (Por et al., 2011; Salovey, 2001; Sharif, et al., 2013).

**Retention and organizational commitment.** Often times, EI was examined for its potential related to increasing workplace satisfaction and organizational commitment (Hutchison & Hurley, 2013). For nursing students, this was commonly discussed in terms of student retention and matriculation through a nursing program (Collins, 2013). Large amounts of EI research pertaining to nursing students aimed to link high levels of EI to academic performance including grade point average (GPA) and retention (Codier et al., 2009; Collins, 2013; Fernandez, Salamonson, & Griffiths, 2012; Por et al., 2011; Rankin, 2013; Sparkman et al., 2012).

The results of the studies relating to the link between EI and academic performance have been met with mixed results. Several studies determined there was no link to academic performance as measured by GPA and emotional intelligence (Fernandez et al., 2012). This may be indicative of the fact that cognitive intelligence is separate from emotional intelligence (Mayer et al., 2000), but this lack of correlation is not found in all studies (Collins, 2013; Fernandez et al., 2012; Rankin, 2013; Sparkman et al., 2012). Research by Fernandez et al. (2012) found that EI was significantly and positively correlated with peer learning, help seeking, and critical thinking. Likewise, in other studies EI was a moderate predictor of academic success and a strong predictor of retention (Codier et al., 2009; Fernandez et al., 2012; Rankin, 2013).



Sparkman et al. (2012) found several EI attributes (social responsibility, impulse control, and empathy) that strongly predicted graduation.

Within the organization context of the professional nurse, desired traits such as accountability, autonomy, and self-control were demonstrated competencies of EI (Codier et al., 2008; Kooker et al., 2007). These desires were also relevant when considering practices that lead to increased nurse retention and greater work-life balance in the organizational setting (Codier et al., 2009, Codier et al., 2011, Kooker et al., 2007). EI research pointed to nurses with higher levels of EI engaging in happier and healthier relationships within their personal and professional lives (Akerjordet & Severinsson, 2007; Codier, 2008; Kooker et al., 2007; Gorgen-Ekermans & Brand, 2012). High levels of EI were shown to combat workplace violence, reduce workplace stress, and stimulate the search for a deeper understanding of what it means to be a professional nurse (Akerjordet & Severinsson, 2007; Littlejohn, 2012). In a study examining the relationship between perceived levels of EI and life satisfaction by Montes-Berges and Augusto-Landa (2014), nurses who tried to maintain emotional clarity and repair negative emotions reported the highest amount of life satisfaction. As a business initiative, research points to EI as a construct valuable for retaining high performing nursing professionals.

### **Factors Influencing Emotional Intelligence Development**

Research has shown that competence in EI has applicability in health care professions, and has value to both the individual and the organization; and although EI competency has been demonstrated to be influential on nursing practice, it is less clear how EI skills are developed within the practicing or novice nurse (Shanta & Gargiulo, 2014). Researchers continue to look for factors that determine differences in composite EI scores. Factors such as age, experience, gender, and instruction have all been discussed as possible determinants.

**Gender**

Several studies have attempted to examine the relationship between gender and EI score (Shanta & Gargiulo, 2014; Jorfi, Yacco, & Shah, 2012; Brackett, Mayer, & Warner, 2004).

Within nursing research, gender differences have been largely ignored due to the fact that nursing tends to be a female-dominated field (Shanta & Gargiulo, 2014). Traditionally, females have scored higher on EI scales (Brackett et al., 2004). The literature suggests that the areas of the brain that deal with emotional processing are more highly developed in female brains than male brains. These dissimilarities may account for the observed differences when it comes to male and female EI scores. Furthermore, males with lower EI scores engaged in riskier social behaviors such as using illegal drugs or drinking alcohol excessively (Brackett et al., 2004; Claros & Sharma, 2012). With more males entering the field of nursing, gender differences will become increasingly important to EI research as it applies to the healthcare professions (Shanta & Gargiulo, 2014).

**Age and Experience**

Age also presents itself as a pertinent factor concerning development of EI (Beauvais et al., 2011; Codier et al., 2009; Codier et al., 2010; Claros & Sharma, 2012; Dusseldorp et al., 2009; Fernandez et al., 2012; Rankin, 2013; Sparkman et al., 2012). EI is known to increase with age and EI focused education (Benson, Ploeg, & Brown, 2010; Fernandez et al., 2012; Rankin, 2013; Salovey & Mayer, 1990; Sparkman et al., 2012). In a study by Rankin (2013), EI along with age was a powerful predictor of clinical practice performance. Multiple studies have linked academic and clinical performance, retention, and age (Beauvais et al., 2011; Fernandez et al., 2012; Rankin, 2013). However, these students of a more mature age seeking additional degrees might be more representative of intrinsic motivation and the value of lifelong learning.

These attributes relating to motivation and lifelong learning are commonly displayed in those with higher levels of EI (Beauvais et al., 2011; Fernandez et al., 2012). Additionally, students with more exposure to clinical practice may be better judges of their clinical performance and have more opportunities to practice skills needed for higher levels of EI (Benson et al., 2010; Benson et al., 2012). In a cross-sectional study of BSN nursing students, EI scores increased with each successive year in the program (Benson et al., 2010). This jump could be attributed to the additional clinical experiences, but it could also be affected by increased age, personal life experiences, or some other unknown factor that has yet to be explained (Beauvais, et al., 2011; Benson et al., 2010; Benson et al., 2012). Future studies would benefit from a homogenous sample of students with similar levels of clinical exposure and age to determine the relevance of EI to clinical practice (Bailey et al., 2011; Beauvais et al., 2011; Benson et al., 2012; Rankin, 2013).

### **Instruction**

With the recognition of EI as both a form of intelligence and an ability that can be modified and improved upon, purposeful instruction of EI competencies then become a means of influencing EI scores. For some, this can simply be identifying EI qualities and skills to those who already possess adequate levels of EI (Clarke, 2006; Swanson, 2012). Formal and informal educational programs exist as a way of raising the EI capabilities of those who participate (Bar-On, 2010; Goleman, 1995; Salovey & Mayer, 1990; Shanta & Gargiulo, 2014; Swanson, 2012). EI instruction is often complex and recognizes the relationship that exists between other methods of intelligence and oneself (Freshwater & Stickley, 2004). Nursing curriculum and organizational cultures that embraced a holistic or patient-centered philosophy often made use of reflective practices, self-awareness, and mentoring which are frequently used tools to also teach

EI principles (Freshwater & Stickley, 2004; Karimi et al., 2014; Shanta & Gargiulo, 2014; Unal, 2012).

Nursing curriculum is frequently cited in the literature as having multiple opportunities to teach EI (Beauvais, et al., 2011; Benson et al., 2012; Karimi et al., 2014; Shanta & Gargiulo, 2014; Unal, 2012). Benson et al. (2012) found that during a four-year undergraduate nursing program, there was little change in EI levels. This could be reflective of nursing professions attracting those who already have EI levels (Benson et al., 2010). In a study by Benson et al. (2010), changes in EI scores related to caring occurred immediately following the introduction of clinical experiences. Leadership courses, psychiatric and mental health courses, and communication courses have been suggested as appropriate areas that EI principles can be introduced to the nursing student (Bailey et al., 2011; Benson et al., 2010; Benson et al., 2012; Freshwater & Stickley, 2004). Investment into teaching emotional identification, empathetic practice, and compassionate care may be seen as a departure from the technical knowledge that is primarily given focus, but research supports the inclusion of EI into nursing curriculum (Cadman & Brewer, 2001; Hefferman, Quinn Griffen, McNulty, & Fitzpatrick, 2010; Karimi et al., 2014; Shanta & Gargiulo, 2014; Unal, 2012). Of the instructional techniques highlighted by the research, three models for teaching EI stand out as recurring themes.

**Role play and simulation.** Teaching practices that allow the student of EI to practice identifying and managing emotions may be beneficial in teaching emotional intelligence skills (Shanta & Gargiulo, 2014). Simulation in nursing is commonly used for practice of technical or practical skills, but may also serve as a means to teach EI competencies (Holbery, 2014; Lyon et al., 2013). Faulk, Parker, and Morris (2010) stated that changes in professional growth and development can happen when students are given practice experiences in which they may test

their abilities and challenge previously held assumptions. Being given a simulated experience provided a new frame of reference and an opportunity for transformative learning (Faulk et al., 2010). Some researchers described role play as a method that may be utilized to practice EI competencies, but cautioned that anxiety associated with role play may be a limitation (Lyon et al., 2013). Other researchers argued that role play allows for a safe environment to experience potential emotional situations while delivering or receiving feedback in a positive manner (Unal, 2012).

**Reflective practices.** Multiple models for reflection exist, but center around the task of allowing students to explore their personal experiences with depth and breadth. By doing so, reflection was able to stimulate the development of necessary nursing clinical skills, such as empathy (Johns, 2012). Johns (2012) described the process of reflection as a way to develop mindfulness and foresight. By teaching students to self-reflect, especially in the moment, students may develop intuition and self-assess (Johns, 2012).

Reflection, and the dialogue that emerges from reflective practices, played a significant part in analyzing emotional components of professional practice (Clarke, 2006; Nelms, Jones, & Grey, 1993; Swanson, 2012). Reflection was also found in the research to be significant in developing a professional identity while enhancing self-awareness (Clarke, 2006; Holbery, 2014). Faulk et al. (2010) discussed the importance of finding hidden assumptions that a student might possess, and using reflection as a tool to challenge previously held beliefs. By uncovering these attitudes, meaningful change could take place and influence professional behaviors (Faulk et al., 2010).

In an article by Hannigan (2001), the complex nature of nursing education was explored. Hannigan (2001) acknowledged that nursing practice is commonly filled with overlapping

physiological, psychological, and social issues (Hannigan, 2001). These issues may not have one clear solution for each person and can best be discussed using reflective decision making techniques (Hannigan, 2001). The reflection and dialogue that occur in the moment could help students to make meaningful connections and guide professional practice by sorting through a multitude of variables that occur with holistic nursing practice (Hannigan, 2001).

The use of storytelling as a type of reflective practice can be helpful in analyzing nursing interventions by providing insight and closure to emotional situations that need attention (Clarke, 2006; Kooker et al., 2007; Swanson, 2012). Nurses who shared stories or narratives of patient experiences allowed the emotional points of the reflection to become the focal point of the discussion (Clarke, 2006; Kooker et al., 2007). Cangelosi and Whitt (2006) examined their experiences with storytelling as a teaching strategy with online students. They acknowledged the potential storytelling had for not just students, but also the instructor's ability to reflect on challenges, successes, and the development of a sense of community amongst the group (Cangelosi & Whitt, 2006).

**Role modeling and mentorship.** Role modeling professional nursing behaviors was largely utilized in nursing education and clinical practice (Freshwater & Stickley, 2004; Nelms et al., 1993). The use of role modeling with EI competent nurses provided the opportunity to impart these skills to those entering practice (Swanson, 2012). Role modeling EI behaviors not only had the potential to bring about a more skilled clinician and improve the life satisfaction of the nurse, but also improved clinical outcomes and the working relationships of the nurses and other members of the healthcare team (Montes-Berges & Augusto-Landa, 2014).

In an Iranian study of nursing students, a role modeling teaching style was used to develop professional attitudes while practicing in the clinical environment (Nouri, Ebahi, Alhani,

Rejeh, & Ahmadizadeh, 2013). This study revealed competence and confidence influenced by a good role model ultimately increased the self-confidence of the students (Nouri et al., 2013). Students reported higher levels of self-motivation and self-discovery which led to competent care in the clinical environment students (Nouri et al., 2013).

Role modeling professionalism and caring has shown to be important in the literature, but an inclusion of mentorship by positive nursing influences may also affect the emotional intelligence development of novice nurses (Ness, Duffy, McCallum, & Price, 2010).

Mentorship, which can include questioning student decision making, thinking aloud, guided reflection, action planning, and debriefing can influence the emotional and professional development of nurses (Nelms et al., 1993; Ness et al., 2010). Mentors and role models in clinical practice have the ability to direct and facilitate the aforementioned techniques of role play, simulation, reflection, and role modeling which can promote the transfer of professional nursing skills nurses (Nelms et al., 1993; Ness et al., 2010). Success of the role modeling and mentorship teaching methods were described as heavily dependent on the student, the mentor, and the opportunities or experiences they were provided (Ness et al., 2010).

### **Summary**

Confusion regarding the very definition of EI has led to a broad range of applicability of the term, and in some cases, this lack of consensus has led to its dismissal as a usable construct (Mayer et al., 2000; Mayer et al., 2004; Mayer et al., 2008; Lopes et al., 2004; Lyon et al., 2013). Discussion of the theoretical models, leading theorists, and their models of measurement has been discussed and applied to professional nursing practice. The ability model proposed by Salovey and Mayer most appropriately applies to healthcare professions. Factors affecting the

development and instruction of EI have been proposed, but not widely studied. A need for clarity regarding the process in which EI skills presents itself as a gap in the literature.



### **CHAPTER III: METHODOLOGY**

The aforementioned problem statement and comprehensive review of the literature led to the development of the following procedures used in this study. In this Chapter methods of research, study participants, sampling procedures, and the data collection setting are described. In addition, the data collection methods, tools, and analysis procedures are discussed in relation to the methodology.

#### **Research Design**

Due to the lack of research investigating ways in which emotional intelligence skills are learned within nursing practice, and the affective nature of the concept under study, narrative research emerges as an opportune method to deeply explore an individual's experiences that exemplify this process. Narrative research is a qualitative approach that focuses on a single person and the role that certain life experiences have made on their practice (Sandelowski, 1991). These significant episodes, or stories, are gathered by means of interview using written or spoken words. This research method is appropriate for research regarding how a professional nurse might become emotionally intelligent because the narrative researcher is able to draw conclusions on the meaning of these events as told by the individuals who experienced them (Andrews et al., 2008; Elliott; 2005; Riessman, 2008; Sandelowski, 1991). Emphasis is placed on the significance given to the lived experiences as told by the research subject (Creswell, 2013; Elliott; 2005). Both what the subject chooses to share and how they choose to share these stories allow for a better understanding of how emotional intelligence skills are gained in the professional nurse (Andrews et al., 2008; Elliott; 2005; Riessman, 2008).

For the purposes of this study, an experience-centered narrative research is used to collect data on the individual's lived experiences. Narrative inquiry focuses on personal experiences as important sources of knowledge and transformation that can be conveyed through the selection

of spoken words, written text, observed emotional responses during interviews, and through chronologically sequencing events (Andrews et al., 2008; Creswell, 2013; Elliott; 2005).

According to Andrews et al. (2008), narratives that describe experience share four characteristics in common: a) they rely on the sequencing of events meaningful to the phenomenon under study, b) there exists a search for meaning with examination in the experiences, c) they will reconstruct events to represent the experience from the perspective of the individual, and d) the experience is transformative in their life. Studying the experiences that led to the research subject becoming an emotional intelligent professional nurse greatly benefited the understanding of how the participant obtained EI skills in her nursing practice. By examining these critical components as they related to learning EI skills, the method of transformation from novice to expert has the potential to be revealed for deeper study.

### **Study Participant**

The study involved an acute care nurse with strong emotional intelligence skills, both observed and measured, from a direct care setting in a Midwest hospital. This participant was known to the researcher as a former colleague and was selected for her consistent emotionally intelligent interactions with patients, family members, and coworkers. While Creswell (2013) cautions that convenience samples may sacrifice information and credibility, the participant and researcher no longer shared full-time employment at the same institution or agency. Creswell (2013) also states that narrative samples should be chosen to best represent the theory under study. Therefore, the risk of compromised data on the basis of shared interests is not valid. Intimate knowledge of the participant's work environment, organizational culture, and comfort with the prior established relationship yielded a richer more in-depth gathering of data.

### **Sampling Procedure and Size**

As previously stated, the participant for this study was known to the researcher and was purposely selected for her consistent display of emotional intelligence skills. The participant was briefed on what constitutes an emotionally intelligent nurse and self-identified as performing to those standards. This type of sampling is consistent with narrative research under the definition of “capturing the detailed stories or life experiences of a single life” (Creswell, 2013, p. 55). The participant’s emotional intelligence skills were also validated by her emotional intelligence score (EQ) as determined by the MSCEIT.

Selection of a participant known to the researcher could interject a risk of bias, but alternatively, with a known interviewer the participant may be more inclined to be forthright, honest, and open during the interview process. Creswell (2013) stated that having rapport with the participant may lead them to disclose a more detailed account of the phenomenon under study. With this in mind, the goal of this study was to select a participant who embodied the principles of an emotionally intelligent nurse and was able to convey her lived experiences through storytelling and in-depth interviews.

### **Setting for Data Collection**

The research setting used to facilitate interviews with the participant was set up in a location suitable for in-depth interviewing over extended periods of time. Narrative interviews typically appear as informal conversations with the interviewer allowing the participant’s perspective to lead the direction of the study (Riessman, 2008). This was best accomplished in a setting in which the participant felt comfortable, relaxed, and free to express her experiences in acute care nursing. A location which was quiet and free from distractions was essential. Therefore, the researcher scheduled data collection sessions at the residence of the research

participant with her permission. Interviews were conducted at the participant's kitchen table with only the participant and the researcher present.

### **Ethical Considerations**

The research study proposed made every reasonable effort to ensure the ethical collection of research. The following paragraphs highlight steps that were taken to ensure the participant and the data collected were protected in regards to confidentiality and without coercion. Institutional Review Board (IRB) approval, informed consent, data storage, and analysis procedures are described.

#### **IRB Approval**

In an effort to ensure that all ethical aspects related to human subjects were met, the College of Saint Mary IRB was asked to review the research proposal for professional use of the research design. This research included an emotional intelligence score where the participant's identity is known to the researcher. Due to the sensitive and personal nature of the data, a full-panel review by the IRB board was conducted.

#### **Informed Consent**

After IRB approval was gained, the research participant of interest was approached via social media to initiate a meeting in a neutral location and convenient time for the participant. At this meeting, the research participant was informed of the design of the study, the methods of data collection, and the topic under study. The concept of emotional intelligence was described according to Mayer and Salovey's theoretical framework as identified in Chapter II (Salovey & Mayer, 1990). Examples of emotionally intelligent interactions, emotional intelligence skills, and applications within nursing were described to the participant. The participant then self-identified as an emotionally intelligent nurse and as having multiple emotionally intelligent

experiences to share. The researcher then formally invited the participant to participate in the study.

The participant was given *The Rights of Research Participants* form (Appendix C) and asked to review the details of the study. The research participant was made aware that multiple interviews would be collected over what was anticipated to be many hours over several weeks, and that the opportunity to review the transcripts would be provided prior to completion of the study. The participant was informed of her ability to leave the study at any point without fear of any negative consequences. The participant reiterated that she was willing to participate in the study and informed consent was obtained (Appendix D).

### **Confidentiality Procedures**

The participant in this research study was known to the researcher, but to ensure anonymity, all data collected was kept confidential. Any statements related to that participant's identity, or that would make the participant identifiable, were removed from the data. A pseudonym of the participant's choice was used in place of identifying statements. Furthermore, all data collected were kept at a location separate from place of employment chosen by the researcher.

Data collected both via interview recordings and from handwritten notes were properly labeled with date and time for cataloging. Data collected were not be shared with any other individual other than the researcher, the participant, and the research committee. All data collected were converted to electronic form and stored on the researcher's personal computer with printed materials being destroyed. Data stored on the researcher's personal computer were password protected and only available to the researcher. A backup copy of data was transferred to an external drive and kept in a locked drawer during the research process. The external drive was

kept in a locked drawer only accessible to the researcher. After the research study's completion, these data will be kept for a period of three years, after which, all data will be destroyed.

### **Data Collection Procedures**

The method of data collection for the research study is discussed in this section. Semi-structured interviews, and the participant's EQ score as determined by the MSCEIT was utilized to answer the aforementioned research questions. The following section also reviews the procedures used for recruitment and the instrumentation used to collect the data.

### **Participant Recruitment**

Following IRB approval from College of Saint Mary, the intended participant was contacted via social media with an invitation to participate in a study involving EI in nursing practice (Appendix E). The participant indicated an interest to learn more and a face-to-face meeting lasting approximately 30 minutes was set up according to the participant's availability. At this face-to-face meeting the content and design of the study was addressed. The participant was asked if they felt they satisfactorily understood the concept being studied, and if they would categorize themselves as emotionally intelligent.

The participant self-identified herself as emotionally intelligent which is detailed in Chapter four. She was informed that she would first need to complete an online emotional intelligence test. This test indicated that the participant was considered emotionally intelligent according to the Mayer & Salovey framework of emotional intelligence, and the study proceeded. The desire for multiple interviews discussing the participant's personal journey through her nursing career was made exceedingly clear. The opportunity for the participant to complete journal entries detailing specific instances where EI skills were used or learned was communicated as well. However, the participant declined to journal any such experiences. The

participant was well informed that she was entitled to complete anonymity, the ability to review all documents related to the study prior to publishing, and freedom to leave the study at any point.

At this stage, the *Rights of Research Participants* form (Appendix C) and the informed consent document (Appendix D) were provided for the participant to sign. Any questions the participant had regarding the study were addressed. Should the participant desire time to reflect on participation in the research study, a date of follow-up communication was set at a mutually convenient time for both the participant and the researcher. Any questions regarding the data collection procedures could be discussed via phone call, email, or in a face-to-face meeting.

### **Data Collection Instruments**

In addition to the *Rights and Responsibilities of Research Participants* (Appendix C) documents and the informed consent (Appendix D), the researcher collected more information using specific data gathering tools intended to thoroughly answer the research questions.

**MSCEIT.** Upon consenting to participate in the research study, the researcher first attempted to verify the emotional intelligence of the participant by completing the Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT) (Mayer, 2004). Based upon the Salovey and Mayer (1990) theoretical framework of emotional intelligence, the MSCEIT is an ability-based scale that measures a person's success at solving emotionally based problems (Mayer et al., 2008). The participant completed this 144 item exam online. Results for the MSCEIT included a Personal Summary Report which yielded an overall EI score along with a breakdown of sub scores in the four branch model (Mayer et al., 2008).

**Interviews.** Narrative research typically dictates that interviews will take place during the collection of data (Andrews et al., 2008; Creswell, 2013, Elliott; 2005; Riessman, 2008).

However, separate from traditional semi-structured interviewing, narrative research focuses on generating details surrounding the experience rather than general statements to describe the event (Reissman, 2008). While describing the process of narrative interviewing, Reissman (2008) states, "If we want to learn about an experience in all of its complexity, details count," (p. 24). This attention to detail, context, and meaning can mean that narrative interviews resemble a different exchange of information than the traditional open-ended or close-ended questioning style. In this type of interviewing, the interviewer and the participant often resemble a more collaborative exchange in where the two work together to construct the narrative (Elliott; 2005; Reissman, 2008). A method of questioning that produces "recollection of details, turning points, and shifts in cognition, emotion, and action" (p. 25) may necessitate a technique in which investigators give up control of the interview and follow participants "down *their* trails," (Reissman, 2008, p.24). This process typically will extend over multiple interview sessions (Elliott; 2005; Reissman, 2008).

***Phase one interviewing.*** In the first meeting with the participant, the investigator attempted to learn most of the demographic and background data essential to the study. This initial "getting-to-know you" interview served as a way to slowly introduce the process and deflate anxieties surrounding the process. Information regarding the participant's background, family, support systems, schooling, employment, and the timeframe in which these events took place allowed the investigator and participant to become accustomed to their surroundings, the process, and allowed for the investigator to prepare a "life history grid" that was completed in subsequent interviews with the participant (Reissman, 2008, p. 25).

In addition to collecting demographic information, time was dedicated to an explanation of the Salovey and Mayer (1990) definition of emotional intelligence. Specific examples of



emotionally intelligent behaviors in nursing, as identified by this particular framework, were discussed. The article *Emotional intelligence: Why walking the talk transforms nursing care* by Codier (2012) was provided for the participant to review (Appendix A). This interview was the shortest of all subsequent interviews.

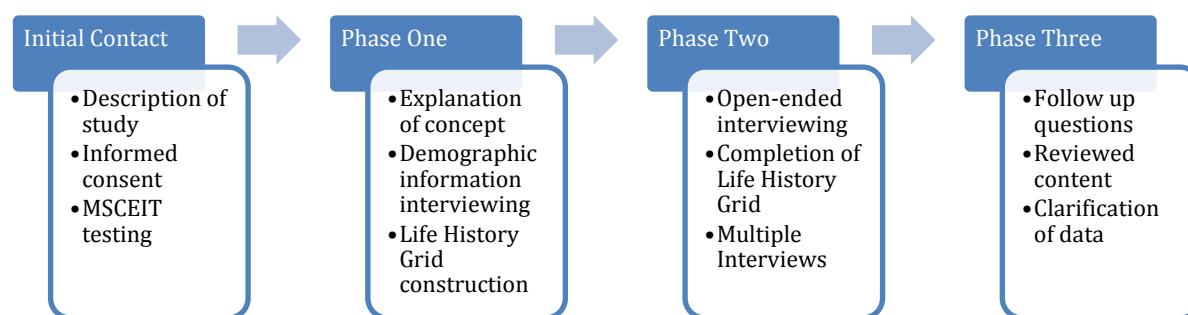
***Phase two interviewing.*** Following the construction of the life history grid, the participant and interviewer met to generate conversation regarding experiences involving EI and how EI was learned by the participant. Andrews et al. (2008) suggests asking participants to begin with stories related to real events and encouraging expansion when the topics are not spontaneously covered. The construction of the life history grid proved useful to encourage dialogue and connected meaning to certain life events. The process of relinquishing control of the interview is discussed by Reissman (2008) and encouraging participants to “speak in their own way,” (p. 24). The investigator conducted the interview in a way that asks questions that open up topics, but still allowed the participant to respond in a way that she found meaningful. Follow-up questions that probed into the significance of the event were utilized. Observations regarding the participant’s non-verbal behavior, hesitations, or affect were recorded on field notes and video recordings of the interviews. These interviews were limited to one-hour intervals, continuing until the entire life history grid was completed and there was saturation of data. A total of four, approximately one-hour interviews were conducted during Phase Two to achieve the desired level of detail and data saturation.

***Phase three interviewing.*** After the completion of the life history grid, the researcher reviewed the collection of interviews for any inconsistencies or gaps in data. One final interview was conducted to follow up with chronological questions, clarifying information, and exploration of subject interpretation. Andrews et al. (2008), sees these post-interview interactions as a way

for the participant to have power over the materials produced and provide more information as they review the content. This triangulation of data is further discussed during data analysis.

**Journals.** In addition to interviews, the participant was invited to journal her thoughts and any potential stories that relate to EI between interviews. This was an effort to provide the participant a means to organize relevant content that is significant for the next interview. It attempted to provide the participant a way to reflect on her thoughts on what was discussed during interviews. The participant chose not to journal.

Figure 1 provides a visual representation of the data collection procedures conducted during this study.



*Figure 1.* Data Collection Procedures

### Data Analysis Plan

When data collection was completed, the researcher completed the transcription process using a professional transcription service. Verbatim transcripts of the audio and video taped interviews were collected at the completion of each interview. The participant reviewed these transcripts for accuracy and veracity prior to data analysis. In attempt to triangulate data, both thematic and structural analysis of data were conducted on the research interviews.

### **Thematic Analysis**

In narrative research, the content of the story is the central focus, but also the chronological order, or the sequence of the events, is preserved (Reissman, 2008). Rather than break a long narrative story into subsequent themes and discuss implications based on the overall appearance in the discussion, the story is kept intact, valuing the order in which significant events take place and categorizing these accounts into what is being told (Reissman, 2008).

Thematic analysis involves the process of “restorying” or reorganizing personal accounts of events into a logical order for interpretation (Creswell, 2013; Reissman, 2008). Key elements are identified and often times include when the story took place, where, and what conflicts might be involved (Creswell, 2013). Details and similarities among stories based on the details of time, place, interaction, and situation are compared to provide discussion and analysis of meaning in the story (Creswell, 2013).

In this thematic analysis process, little attention was given to the interviewer and the interviewer’s role in uncovering the stories. The active role of the investigator was removed from the writing and the reader is left with the text of the participant. Emphasis was placed on the context of the speech and what is being “told,” (Reissman, 2008). The language used to express these themes is viewed more as a tool rather than a subject under study (Reissman, 2008). The investigator’s role was to analyze these themes for meaning, keeping in mind the experiences of the individual are not isolated from their environment, but those contained within the culture of an acute care nurse.

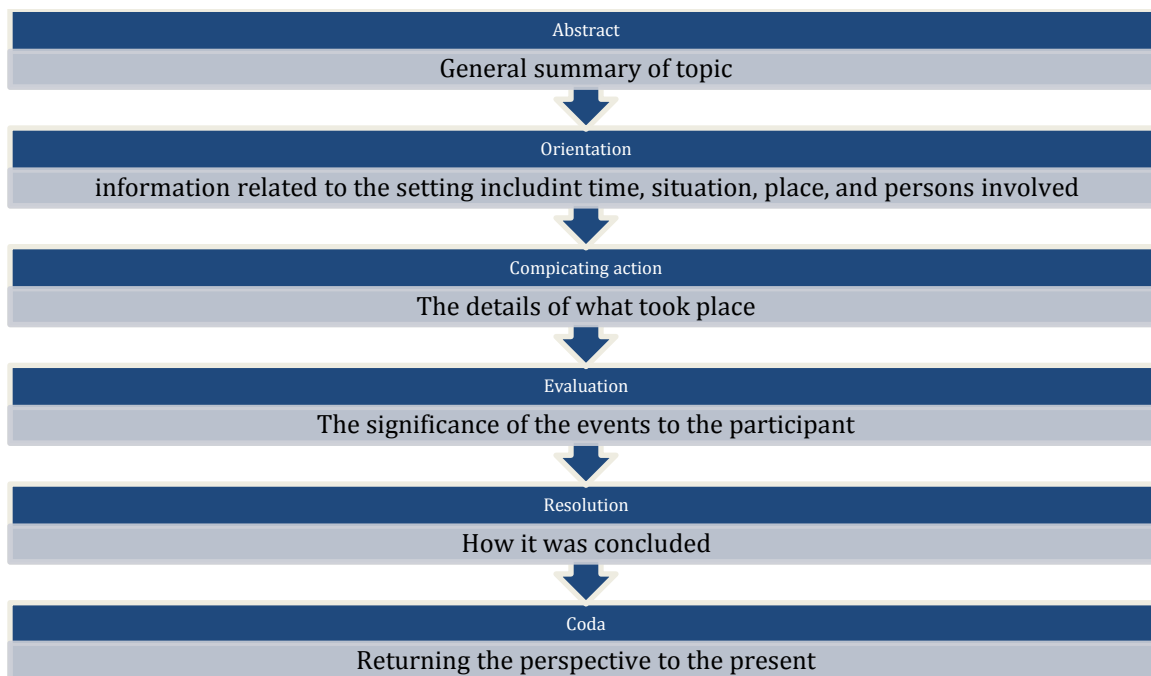
Thematic analysis began with general reading and notation of the participant transcripts to develop a sense of the data and form initial codes. Important stories and transformative events were located within the text (Creswell, 2013). To further assist in investigator coding, transcripts

were organized by the researcher using NVivo 11 software (QSR International, n.d.). The data were reviewed using this software multiple times and coded for themes and subthemes. At this stage, the dissertation chair was invited to review the identified themes and subthemes to establish validity. In one final interview, the participant was provided with the thematic analysis and her thoughts related to the themes extracted from the data were transcribed, compiled, and added to the study data.

### **Structural Analysis**

When engaging in structural analysis of a narrative interview, the language chosen and the sequence of its appearance is analyzed for meaning. Many narrative scholars apply the work of William Labov and Joshua Waletzky (1967) who developed a method of structural analysis. The Labovian method of structural analysis entails dissecting the narrative transcripts into segments. Each of these segments is given an identifier related to the function of the clause (Andrews et al., 2008; Reissman, 2008). Structural analysis then allows researcher to examine if particular sequences of action are repeated across varying types of narratives.

During structural analysis, the content of the narrative is largely ignored. Rather, stories within the narrative are identified and described as having six separate elements: abstract, orientation, complicating action, evaluation, resolution, and coda (Elliott, 2005). Figure 2 describes Labov and Waletzky's structural model as it relates to these elements (Elliott, 2005).



*Figure 2.* Structural Analysis Elements (Elliott, 2005).

By examining the transcripts for these specific elements, especially those found within the evaluation portion, the significance of the narrative to the participant becomes evident. This systematic form of structural analysis can then be compared against the thematic analysis to search for relationships, meaning, and knowledge that could or could not exist describing emotional intelligence within the context of acute care nursing.

### **Data Quality Assurance**

To ensure that every effort was made to validate the accuracy of the research findings and confirm consistency with other forms of research, certain quality measures were instituted (Creswell, 2014). Validations of the researcher's findings occurred at many stages of the research, including certifying that all transcripts were accurate, the use of detailed information in describing the setting, and the procedures discussed below. In addition, an audit trail was performed by the doctoral committee chair of the author's dissertation committee (Appendix G).

**EI Validation**

The process of requiring the participant to complete the MSCEIT emotional intelligence scale validated that the participant is qualified to remark on learned EI behaviors and skills. Having the participant self-identify before conducting the research further validated that the participant had experiences that she was able to describe for research purposes.

**Investigator Bias**

Qualitative researchers can bring a number of personal biases to the study (Creswell, 2014). Prior to engaging in interviews with the participant, the researcher engaged in reflective journaling to examine any preconceptions about the concept and what might emerge from the data. Certain assumptions and preconceived notions were brought to light, examined, and set aside. The data was able to be interpreted openly and without bias. This process was then continued throughout the research study so as to minimize any investigator bias affecting the research study results.

**Triangulation**

Triangulation of data includes referencing several sources of data to justify the analysis of themes found in the data (Creswell, 2014). When combining structural and thematic analysis, triangulation of data can be achieved (Reissman, 2008). Structural themes that are found to be recurrent were examined next to the prevalent themes found within the narrative for similarities or differences. These results are detailed in Chapter IV.

**Member Checking**

Member checking is a verification process of the participant to review the data produced during the research process (Creswell, 2014). In effort to preserve the participant's perspective and narrative accuracy, the participant was provided copies of the transcripts from each interview

and edits were completed as necessary. The participant was invited to review the thematic analysis for accuracy related to interpretation of the narrative (Creswell, 2014). Her review of these data is reflected in the final interview and her further clarification and insight is represented in Chapter V.

### **Summary**

Chapter III discussed the research design selected for the problem under study. A narrative research design provides rich and descriptive data with a focus on transformation over time, and the participant's understanding of the meaning of these events (Andrews et al., 2008; Elliott; 2005; Riessman, 2008). Sampling for this research design is purposive, focusing on a singular research participant. Methodology for inviting this research participant was described, with ethical considerations discussed. Data collection methods, data analysis, and data quality measures were outlined to ensure that the data collection process was an efficacious means of research.

## CHAPTER IV: RESULTS

### Introduction

The purpose of this qualitative, experiential narrative study was to examine how emotional intelligence is applied in clinical nursing practice and how a nurse develops those skills in professional practice. Specifically, the study aimed to answer the following two questions:

1. How has emotional intelligence contributed to the daily practice of a professional acute care nurse in a Midwestern hospital setting?
2. What factors, positive or negative, have influenced how the professional nurse becomes emotionally intelligent based on the lived experiences of one emotionally intelligent acute care nurse in a Midwestern hospital setting?

This chapter will discuss analytical methods used to evaluate the data, results of the analyses, and the significant findings as they relate to the research questions. The first section of this chapter will address the participant, major life events, an examination of her education, details of her time in nursing, and her EQ score. The second section will discuss evidence of emotional intelligence found within the narrative interviews as a means of answering research question one. Subsequent sections will answer research questions two. The third section of this chapter will present the results of thematic analysis while the fourth section will review the structural analysis. The final section of chapter four will address the intersection of the two major types of analysis and the findings generated from comparing these separate types of evaluation.

### Research Participant

The participant under investigation for this research study has chosen the pseudonym, “Kay,” to protect her anonymity. Kay is a Caucasian female in her 50’s from a small



Midwestern town. Kay's family growing up consisted of her mother and father and brothers and sisters. Her first experiences in health professions began when she was 16 years old as an aide at a local nursing home. She continued to work there part time after she entered college during her summer breaks.

Choosing a bachelor of science in nursing (BSN) program for her education was a decision that stemmed from her exposure to nurses at her job as a nurse's aide.

"I thought, 'I could be a nurse.' I guess because at the nursing home, those nurses pass out meds and sit all day. They would sit all day. They wouldn't interact with the patients at all. I thought, 'I don't know. I bet I could be a better nurse than those girls.'"

Kay did not identify a specific desire to care for or nurture individuals. Her choice was first to attend the University, then deciding on nursing for her major. She describes the decision as "dumb luck."

"I didn't think about it. I just remember thinking, "It can't be that hard." That's a dumb story, because it was the best decision I ever made professionally, without knowing it."

Kay entered the BSN program in the Fall of 1981 which she attended for four years. Her traditional nursing program was characteristic of traditional BSN programs with long-term care within the first two years; psychiatric nursing, obstetrics, pediatrics, and community health in the second and third years; and medical-surgical and critical care nursing at the end of the program. Patient exposure and clinical experiences increased in acuity and length as she progressed to graduation.

Three months after her graduation Kay was wed to her husband of over 30 years. The couple have three sons over twenty years old. Kay's husband does not work in healthcare, but has become an Emergency Medical Technician (EMT) in the last 10 years.

**General Disposition**

Kay is a petite woman with short hair and glasses. She is a consummate host and has a welcoming presence. Describing Kay's disposition would include her very metered responses and lack of impulsiveness. She spoke often with a contemplative attitude, and often from the point of view of her patients. She would paraphrase their words and articulate their responses by mimicking the facial expressions and mannerisms she remembered from their exchanges. Kay is difficult to overwhelm and approached our meetings with patience and a casual attitude. At one point, she was brought to tears by retelling the story of a patient who she felt she had provided poor care, but she recovered quickly as the topic progressed. When speaking with Kay you get the sense that she is critically analyzing the questions asked of her, and that she wants to preserve the integrity of the story by interjecting dialogue. She uses dry humor delivered with a dead pan expression and sarcastic tone, and peppers her stories with many examples. She is quick to use humorous, self-deprecating comments regarding her knowledge and skills, but still conveys an awareness and confidence of her nursing abilities. Kay was calm, pleasant, and entertaining as she delivered her stories. If she displayed frustration, it was only when she couldn't articulate her answer or find an answer she felt was suitable.

**Nursing Experiences**

After graduating in the mid-Eighties, and completing her nursing licensure examination in June of the same year, Kay was presented with two job offers at local hospitals. While trying to decide which path to take, she considered that one of the hospitals was offering her an internship position with an assigned mentor for six months.

“They were going to teach me as we went, so I knew that I had a gap of lack of information, of tasks and skills, but I had an idea of what I was going to need to be doing.

I knew that that gap needed to be bridged and they were offering that. I'll go for that, because I just got out of school, so it's not like it's going to be that hard to keep learning.”

This is what ultimately led Kay to take the position at the hospital where she still works. She has been employed at this hospital from 1985 to present time, in a variety of positions.

Kay's first position as a registered nurse was in the Post Intensive Nursing Service (PINS). For the first year and a half Kay worked alternating weeks of day and night shifts, but ultimately settling into the evening shift for another five and half years. After seven years as a PINS nurse, Kay decided to move to the float pool for lifestyle purposes. At this stage in her life their family was growing and she desired more flexibility. While in the float pool Kay would alternate between PINS, the Intensive Care Unit (ICU), the Medical-Surgical Unit (med-surg), and occasionally, the Behavioral Health Unit. The majority of her time was spent with the Medical-Surgical patients, which Kay preferred.

“I think I liked the med-surg better because the patients were a little bit healthier. They were able to talk to you. There was more social interaction back and forth with the patients. When they're so sick in ICU it's basically, it's just tasks basically, not a lot of relationship work with your patients.”

In 2000 Kay made the decision to move to the Post Anesthesia Care Unit (PACU) where she is currently employed. In this position, Kay works a variety of day shifts, occasionally being called in during the night to recover patients on an emergency basis. She was cross-trained to the Perioperative Care Unit and continues to alternate between these roles.

In 2005 Kay was trained as the nursing team lead to provide coverage for her manager in the event the manager would be gone. She defines her role this way:

“If there was a patient that was angry, or family angry, it was my role to go and visit with them. Following up with the families in the waiting room, so kind of the liaison between the family room staff and the nurses...”

Kay is able to step into the leadership role on an as-needed basis and continues to do so with a frequency of approximately two times a week. Other leadership roles include serving on the Board of Nebraska Nurses Association when she was first out of college in 1986 for approximately two years. Kay has been an active member of the Nebraska Association of Perianesthesia Nurses (NAPAN) since approximately 2006. She maintains her involvement with the group and has served as the Vice President, President, Past-President, and the organization’s newsletter. Kay has also been involved in her hospital as an organization, frequently mentoring nursing students or new graduates during their preceptorships. She has served on committees, attended conferences with the senior leadership team, and has been certified as a Perianesthesia Nurse since 2004 (Figure 3). She credits this certification for continued development of her nursing abilities.

“That was really a good thing. I remember thinking, "I am learning so much about my career and I've been working at it like for five years and I didn't know, like a third of the stuff that I was learning. ... you should be required to get it.”

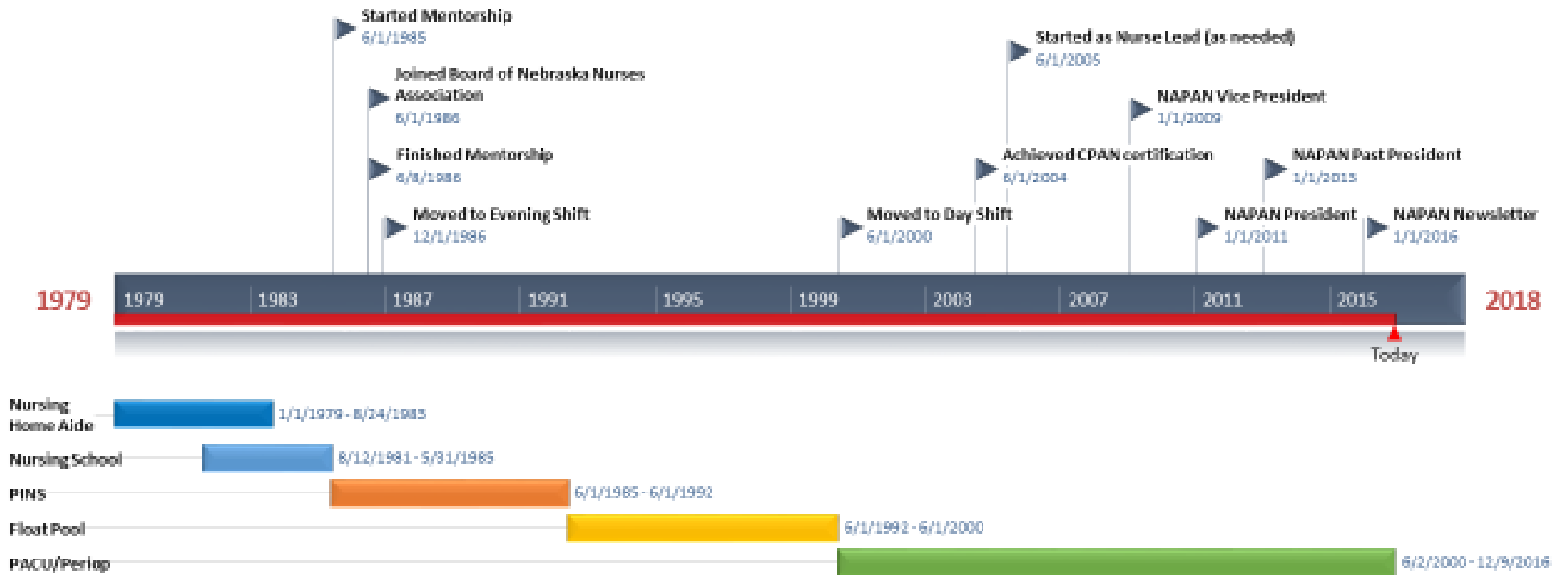


Figure 3. Timeline of Nursing Experiences in Relation to Interviews

**Support Systems.** It is worth mentioning that Kay identifies certain groups as her major support systems during her schooling and career as a nurse. While discussing her experiences in nursing school, her Bible study group served as an outlet from the demanding program in which she was enrolled.

“I just remember thinking, "I'm tired of these people that I'm with all the time." You get the people that are hypersensitive and you get the people that all they want to do is study. They cry if they get an A minus. I'm like, "Are you kidding me?" I think this group of people was a wonderful escape for me. I was able to manage my studying and still do some fun stuff.”

She goes on to state this group was very helpful in managing her stress and helping her through the program. Her nursing peers, especially her roommate, also had significance on her nursing success. While she may have found this group to be stifling at times, she also relied on them to help her manage her time.

“She stressed a lot more than I did. She was very organized. I would say, "Do we have clinical tomorrow?" She'd say, "Yeah, we do. You got to be ready by 5:30 in the morning." I was like, "Okay. Thanks." I relied on that which was manipulative on my part too.”

Kay also mentions coworkers in several of her healthcare jobs serving as mentors, teachers, and as teammates that either made her job more or less enjoyable. These relationships were sometimes expressed positively:

“You really have to be very, very intuitive with each patient and how you're going to care for them. Then find the people in the group that you're going to be able to go to for

advice, or assistance. You also have to use some intuition, too, to find that person, to find that leader in the group.”

And sometimes negatively as a means of support:

“When you're in the float pool, you don't always trust your co-workers because you don't even always know them very well.”

### **Beliefs Regarding EI**

When defining EI for the purposes of the study, Kay was confident in her definition and her own abilities as an emotionally intelligent nurse. She characterizes the term this way:

“I would say that it is the ability to recognize emotions, and be able to put a name to them, in yourself and in others. Being able to work with emotions, and maybe even be able to manipulate things a little bit. [...]In a good way, or in a bad way. Sometimes, there's people who are pretty evil who are very good at emotional manipulation. They can read people, and they know what their weak spots are, and they can capitalize on those. That's what I would tell people.”

Kay is quick to list EI skills amongst the qualities that designate one as “a good nurse.”

“That's my opinion because I think a wonderful nurse has to have a good mixture of all of it. I think they need to be skilled and they need to be able to make quick decisions, recognize problems, be empathetic and yet have boundaries.”

Often, she would state the importance of treating patients with compassion and empathy as not only a strategy for healing and good care, but also as a means of retention and customer service.

“I think that you can have a healthy outcome with both kind of nurses but I think that emotional aspect of the outcome ... I think that you're more likely to get people that say,

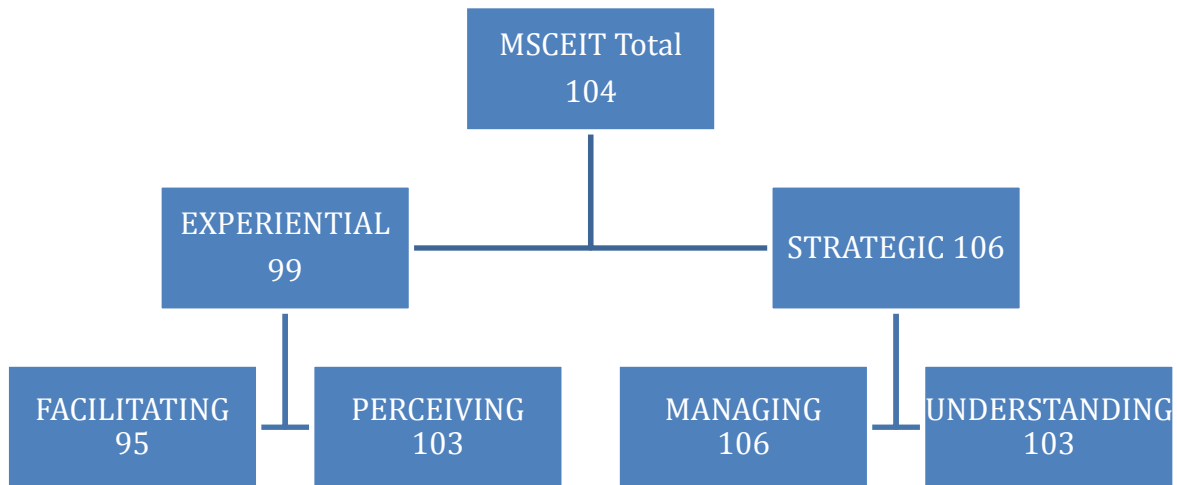
"Yeah. I'm going back there because I was treated so well. I was treated like a sister or a ... I don't know. Relative. Someone that you like."

### **MSCEIT Testing Results**

Kay's emotional intelligence abilities were confirmed prior to conducting the narrative interviews with the Mayer Salovey Caruso Emotional Intelligence Test (Mayer et al., 2008). The MSCEIT is a performance test of emotional intelligence which requires the participant to solve problems related to emotions and the ability to use emotions to solve problems (Mayer et al., 2008). The scores are reported similar to traditional intelligence tests, but scored against the normative sample and not the general population. The MSCEIT provides a total EI score as well as two area scores and four branch scores (Mayer et al., 2008).

Kay's total EQ level was reported as 104 out of a possible 150, which the MSCEIT reports as competent in EI (Mayer et al., 2008). Her area scores, Experiential and Strategic, were 99 and 106 respectively. The branch scores reported were Perceiving Emotion (103), Facilitating Thought (95), Understanding Emotion (106), and Managing Emotions (103) (Figure





4).

*Figure 4.* Research Participant's MSECEIT Scores.

#### **Data Analysis**

While analyzing data collected from the narrative interviews, focus was placed in two areas: evidence of emotional intelligence in nursing practice, and evidence of gaining emotional intelligence skills. Six interviews were conducted with the research participant. The first interview focused on gathering relevant demographic data and constructing a timeline of her life events. The following interviews, two through five, move through the participant's life and experiences. Interview two starts with her experiences as a nurse's aide and entering nursing school. Interview five details many of her leadership roles and current position. The sixth interview is a discussion of the results.

The following sections will discuss the interview results as they relate to the research questions. Evidence of EI in Kay's experiences will be discussed in terms of frequency, distribution, and EI branches. Concept analysis results will focus on the central themes as they

related to how EI skills are learned. Structural analysis results will identify similarities and differences in story structure that may or may not validate the finding of the concept analysis. A discussion of these findings will conclude data analysis.

### **Evidence of EI**

General statements were extracted from the narrative interviews showing evidence of EI skills in Kay's description of her nursing care. From the first five interviews, 65 references to EI skills were highlighted. Of these interviews, references to EI skills were made in all five interviews. Interviews two and five had the highest numbers of references, 18 and 16 respectively. While interviews three and four had lower numbers of EI evidence (15 and 13 references), the distribution of EI evidence is fairly even (Table 1).

Table 1

#### *Distribution of EI References*

Interview Number and Subject	Number of References
1: Timeline Construction	3
2: Nurse's aide- first half of nursing school	18
3: Second half of nursing school	15
4: PINS and Float Pool	13
5: PACU and Leadership Roles	16

The sections below discuss each of the branches of EI and where evidence of these skills were found in the narrative.

**Perceiving emotions.** The perceiving branch of the Mayer and Salovey EI definition could be considered the most basic of EI skills (Mayer, Caruso, & Salovey, 2000). This branch

includes identifying emotions accurately included speech, non-verbal expressions, and using cues such as intonation and behavior to decipher emotional meaning in oneself and others (Akerjordet & Severinsson, 2007). Common references included naming the emotion that the participant identified, often comparing it to another emotional response. Kay's responses focused often on looking at body language or non-verbal responses.

“I really, really rely on facial expressions, and their body language, the tenseness, if their fingers are clenched.”

Kay would not only observe these emotional reactions, but she would seek them out, often trying to name the phenomenon.

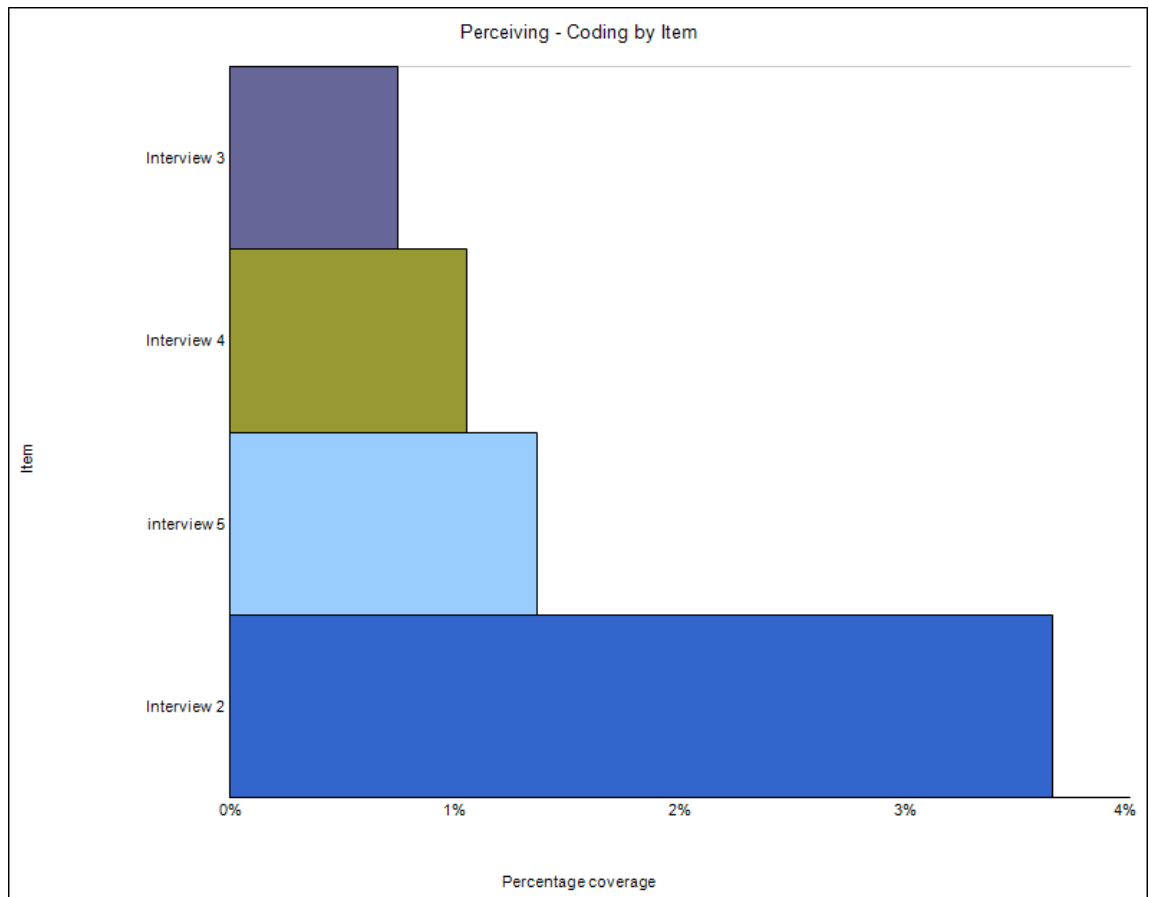
“That's what it was. I could tell by the way he was acting, he was terrified. It was just like a terror that you just, you could smell it on him. It was a horrifying, terrible face that he was making. Then it was just like, it wasn't pain and it wasn't sadness, or anguish, it was just ... I remember thinking, "What would cause that?" You're just thinking all these things, "What would cause terror?" That's what it was.”

Kay was cognizant of her desire to know the emotional states of her patients.

“I think I often will search for something in their eyes to see if there's anything going on or if there is any emotion or any thought process. You just don't know how much is going on in there. I seek for that. I want to see something in their eyes. I remember seeing in his eyes and I remember thinking, there's just despair.”

Perceiving emotions was referenced 16 times, with similar frequency to managing and understanding emotions, the third and fourth branches, respectively of the MSCEIT. Statements that indicated the participant was perceiving emotions most frequently occurred in interview two (3.7% coverage) or earlier in Kay's health professions career. While perceiving was identified in

interviews three through five, it occurred much less frequently, with less than 2% coverage (Figure 5).



*Figure 5.* Percentage Coverage of Perceiving Emotions Branch in Narrative Interviews.

**Using emotions.** Using emotions to facilitate thinking refers to actively reasoning about emotions (Brackett et al., 2011; Holbery, 2014; Rivers & Brackett, 2011). Statements involving using emotions frequently centered on directing conversations, organizing cares based on emotional information, or interpersonal communications. This is evidenced in statements such as

“Have her in there with her husband because I just think that, that improves their care, if they have what's comforting to them around them.”

Other statements related to communication with patients and how to extract the desired outcome.

“I think sometimes just in your conversation with them, you could tell, this one isn't going to do as well with direct confrontations. Sometimes you're going to need to go around them a little bit and make deals.”

Using emotions was not limited to patients, but also extended to communication with the healthcare team.

“I remember taking that nurse into a private area, because I thought, "If this was me, I would want to be talked to in a private area.”

Using emotions occurred with the largest frequency of any EI skill (22 references). Using emotions appeared in all of the interviews gaining frequency as time progressed. Interview two had the lowest coverage (1.7%), but by interview five, using emotions had occurred with the most coverage (4.7%) (Figure 6).

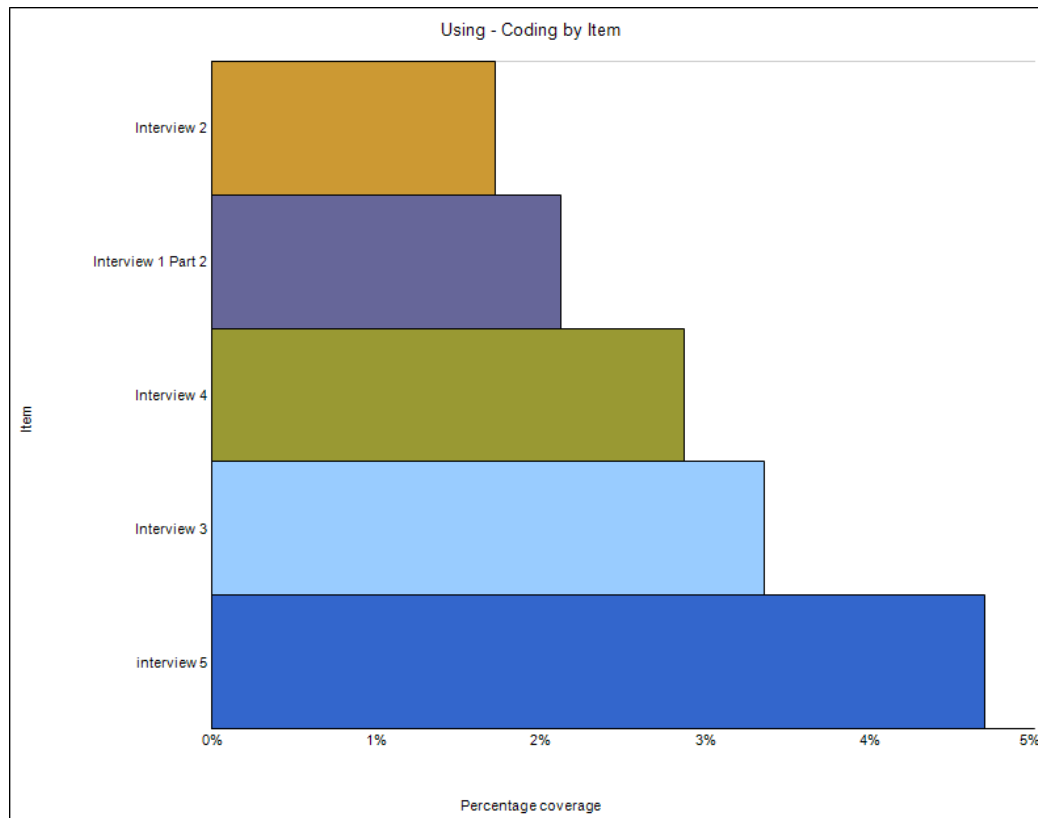


Figure 6. Percentage Coverage of Using Emotions Branch in Narrative Interviews.

**Understanding emotions.** Understanding emotions, the third branch of the MSCEIT, refers to individuals who are able to recognize how a specific emotional response affected the consequences of events (Mayer et al., 2008). Consistent with the literature, evidence of Kay's experiences with understanding emotions frequently manifested as statements relating to compassion and empathy (Brackett et al., 2011; Mayer et al., 2008). In a conversation discussing patients suffering from mental health issues, Kay tries to understand and rationalize the reactions of patients and their families.

“I think it's just people's fear. I think that we're just afraid of it. I don't know if we're afraid it's going to happen to us or afraid that somebody that we love or know is going to experience it. I don't know.”

She demonstrates a grasp of the difference between correctly identifying emotions and using them in practice and empathizing with those reactions.

“You're not very effective if you don't really understand what's behind behavior or attitude.”

These empathic statements occurred with lower frequency in the interviews (14 references) and most commonly occurred in the earlier interviews. These statements can be found in all interviews, but were most likely to occur early on during the participant's years as an aide or in nursing school (2.3%-3.0% coverage) (Figure 7).

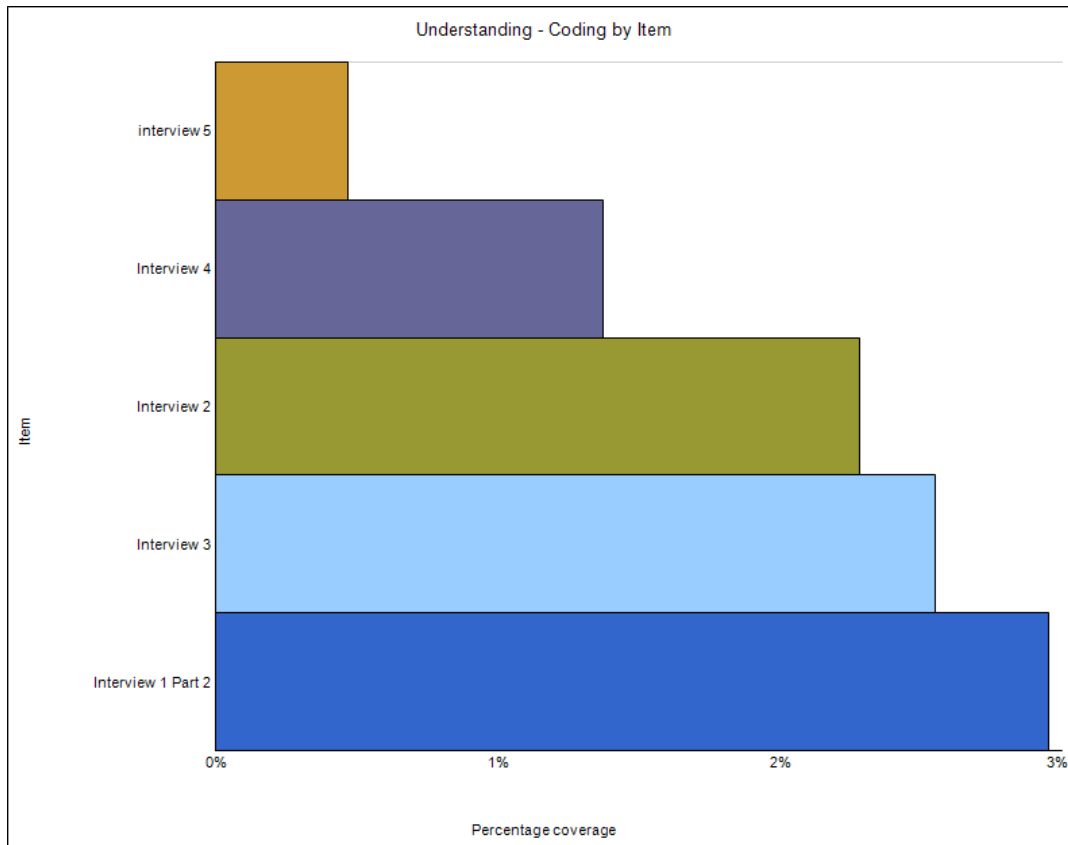


Figure 7. Percentage Coverage of Understanding Emotions Branch in Narrative Interviews.

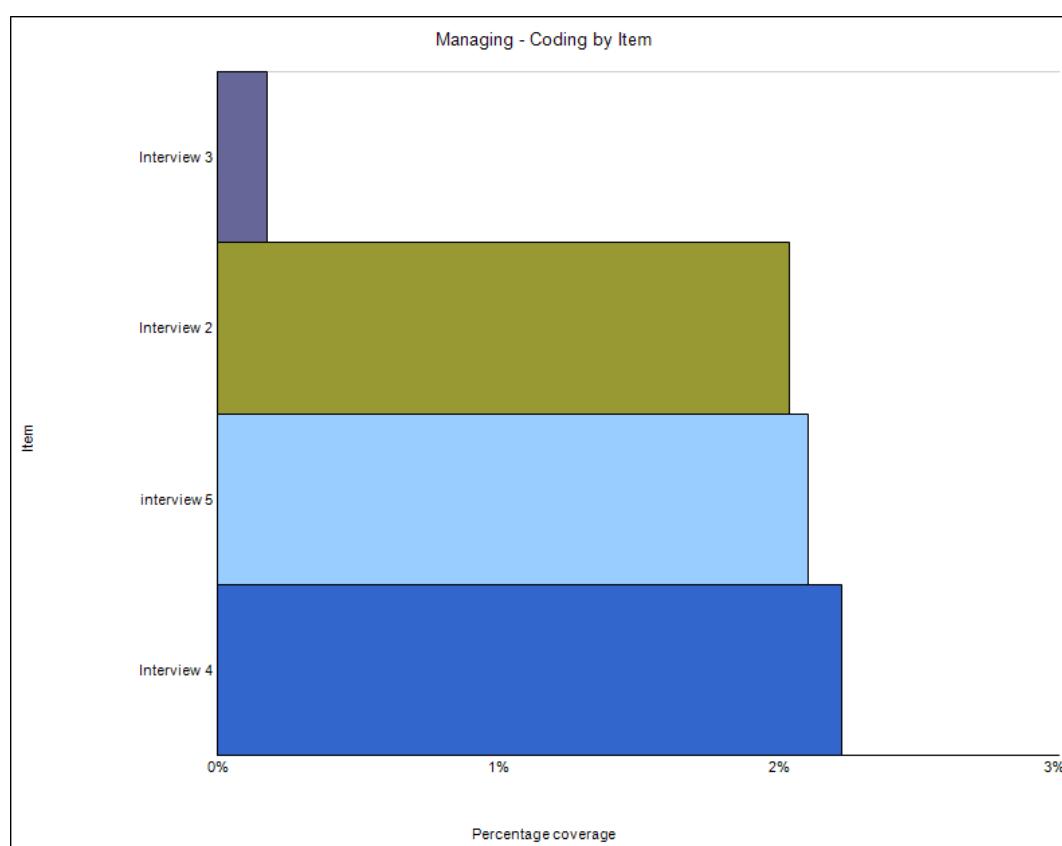
**Managing emotions.** The last branch of the EI model deals with regulating or managing emotions. An emotionally intelligent individual decides the usefulness or appropriateness of an emotion and can self-regulate their responses; choosing to engage or detach from them (Brackett et al., 2011; Salovey, 2001). These statements most often appeared in the interviews when the participant was discussing her own emotional reactions dealing with conflict related stress. She states:

“I learned to not get shook up by extreme reactions. It doesn't have anything to do with me and that it is a normal reaction for that person in their crisis and that everybody reacts their way in a crisis and it doesn't make it wrong or you don't judge.”

The “crisis” she described was not limited to the patients she served, but also the coworkers she worked with or observed. Kay would go on to say:

“I think you have to censor yourself emotionally. You can't get yourself caught up in their drama, or their crisis because that's what really drains you and I think that it's difficult...”

Managing emotions occurred the least frequently in the narrative interviews (18 references). Of these references, managing emotions appeared with similar frequency in interview two, four, and five or in the first half of nursing school and during her professional nursing career (coverage 2.0%-2.2%) (Figure 8).



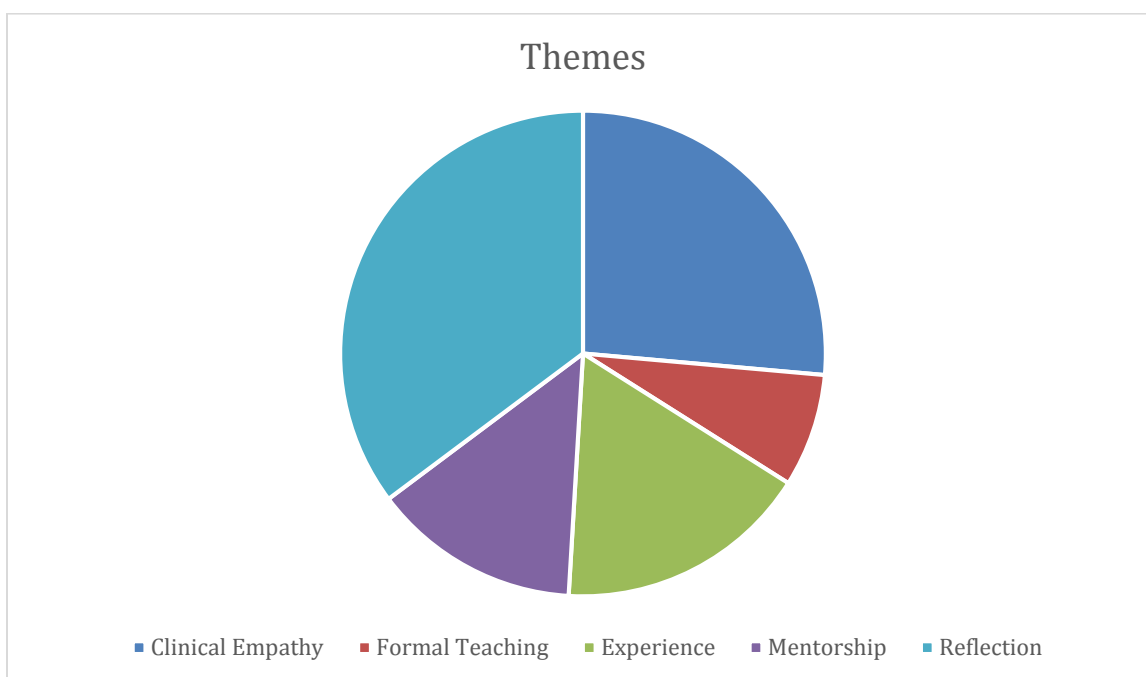
*Figure 8.* Percentage Coverage of Managing Emotions Branch in Narrative Interviews.

### Concept Analysis Results

Careful analysis of the interviews revealed a number of themes that can be discussed as they relate to how emotional intelligence is developed in a nursing professional. From the five interviews conducted with the participant, six main concepts emerged: Clinical Empathy, Formal



Teaching, Experience, Mentorship, and Reflection. As Figure 9 depicts, the greatest number of references were in relation to the concept of Reflection (56 references). Clinical Empathy made up the second largest number of references (42), with the remaining concepts (Formal Teaching, Experience, Mentorship) making up the last third of the concepts (12, 27, 22). Each of these concepts will be discussed in terms of typical statements made and the timeframe of when these references were experienced (Figure 9).



*Figure 9.* Frequency of Themes found Within the Narrative Interviews.

**Formal teaching.** Throughout the narrative references were made to when Kay's nursing program or other instructional classes directly influenced her development of EI skills. These references largely centered on her instructors' desires for her to practice "holistic care" and empathize for her patients. Kay states:

"I was watching this. It was as a group. We were just like, "Ah." An instructor at the time said ... She goes, "I want you to know how horrible this feels, so that when you're

putting this in your patient you have some empathy for that patient. I think we had some excellent instructors. Well it was all about holistic healthcare.”

Kay specifically remembered a book that was used in class to discuss communication styles and appropriate responses by the nurse. She referenced this book several times during our interviews.

“Our first year of nursing school, back in the theory class, we had a book that talked about correct responses and incorrect responses. It talked about how a nurse would come in to the room and say, "It's time for our bath today." I remember thinking, "I'm never doing that. I'm never going to say, 'How are we today?'"

Formal teaching, while largely discussed during her years in nursing school, was also mentioned during the latter part of her career. Kay recalled training she had received as a Perioperative nurse:

“We had some training just as a group that we should do the scripting, and you might try this and then that. It resonated with me right away.”

While Formal Teaching is referenced in all five interviews, its largest presence is in interview two, which detailed her time in nursing school. The smallest amount of references (one) came from interview five, which related to the training program mentioned above.

**Mentorship.** While an argument could be made that Mentorship is another form of Formal Teaching, the interviews revealed that Kay discussed Mentorship differently than when she discussed her clinical instructors or her class work. Mentorship was a sought after experience by Kay, as mentioned in her choice to select a position that included a six month mentorship program. Kay not only discusses this time in her life as influential, but also

dedicated time to describing the nurses she worked with as a nurse's aide and other peers as she moved positions in her nursing career.

“It was always a lot of working together. I took direction fairly well because I knew that they knew what we were doing and I would watch them. I watched how they would deal with the patients.”

In all of these references, Mentorship largely took the form of task organization and prioritization of cares. Many of her statements related to prioritization of cares or organization of care.

“She was trying to show us that the real world nursing is different from book nursing, or TV nursing. You do the urgent.”

Kay found this experience to be helpful and useful when caring for her patients.

“It was very helpful. I found that it helped me set priorities, like if they're nauseated, it's okay, we'll just make sure that they get this pill. Just to kind of prioritize which of the meds are the most important to this patient for what they have going on [...]”

Within the 22 references related to Mentorship and developing a professional nursing practice, only seven references specifically related to witnessing emotional intelligence skills. When affective skills are mentioned, Kay made a clear association to emotional intelligence.

“She wanted us to connect with the patient, look at them, talk to him and touch him. That was an interesting step to take, to start touching my patients.”

Not all of the direction was direct. Kay was able to witness EI skills practiced by her mentors as well.

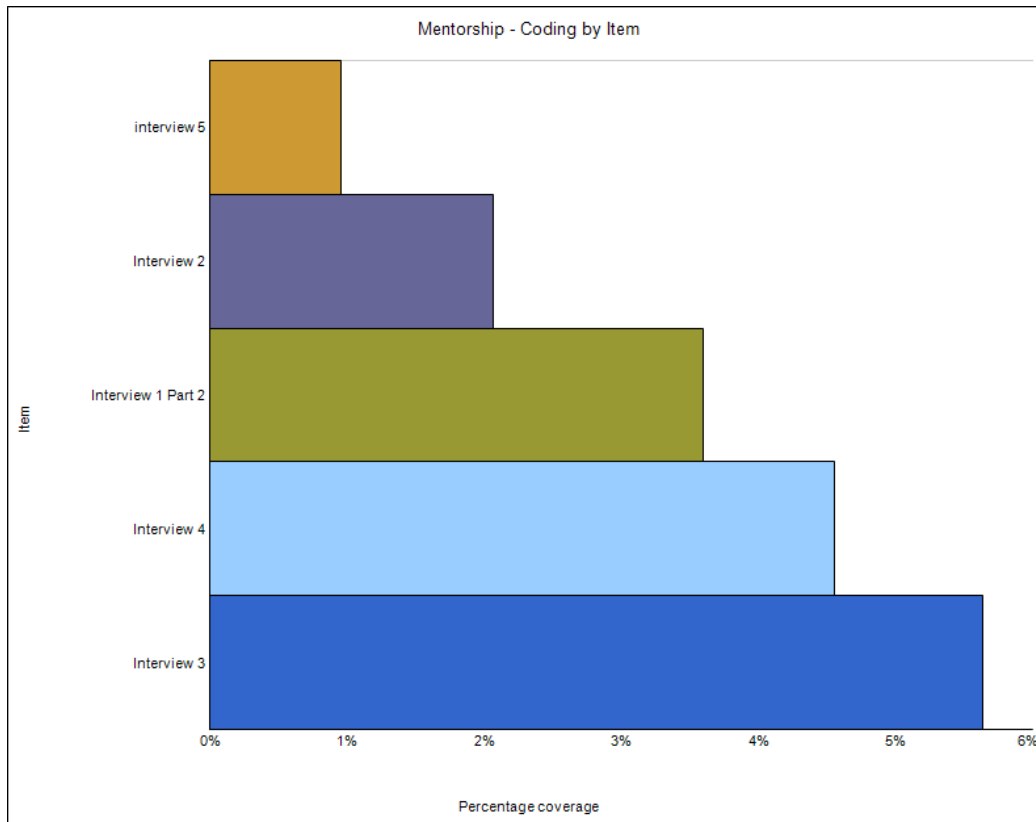
“I do remember watching and seeing if the things that I feel like doing, or interacting with a patient, and I would watch and see if that was how she was interacting and dealing

with the patient. I felt validated if I saw that that is how she reacted, or treated her patients.”

Of those references, one of the experiences was negative, yet still influenced her emotional intelligence development. This unhappiness Kay experiences with her mentors was identified in a statement related to lack of direction she received while working as a new nurse:

“They discourage you. They would say things like [...] “You need to figure out how to get your work done and it's not all about books." It's like, "Well but don't you want me to know why we want to do a cardio output maybe and to understand what it is?"

Mentorship was referenced with a similar frequency to Experiences, but more commonly than Formal Teaching (22 references). The largest share of references clustered around interviews three and four, which would coincide with the latest part of Kay's nursing education and her first years as a new nurse. While Kay mentions Mentorship in all five of the interviews, the fifth interview included only one reference; made regarding a coworker that mentored her after she had taken a new position as a perioperative nurse (Figure 10).



*Figure 10.* Percentage of Mentorship References Found in Interviews.

**Experience.** Experience is a concept that is identified in the literature as being influential on EI development. Kay’s experiences leading to increased EI skills often took the form of the participant “watching” and working through situations with trial and error.

“I think it's just observing things all through my life, seeing things and thinking, "Oh, that's kind of sad. Well why are they acting like that?"

Kay frequently describes this method as “experimenting” with multiple approaches to care.

“I think it was more of an experiment, too, just to see, think, "I think I'm going to try this and see if that ... " I don't even think it's as much thinking that you're going to do it, you just do this and if that doesn't work, then you do this.”

Sometimes these were positive examples that she was able to work with patients to achieve the best outcome, but she does describe difficult situations in her younger years where she misread a situation and did not receive the desired action.

“There were times when people I, maybe, misread a little bit and I thought something was funny and it wasn't. They were embarrassed or whatever. That was, I think, being a kid and you just start learning what might be humorous to me and something to kid about is definitely not to them.”

The importance on Experience as a learning environment was apparent to Kay as well. At times she found it difficult to explain her methods or how she learned them. She would state that she had learned what she did by trying out different methods.

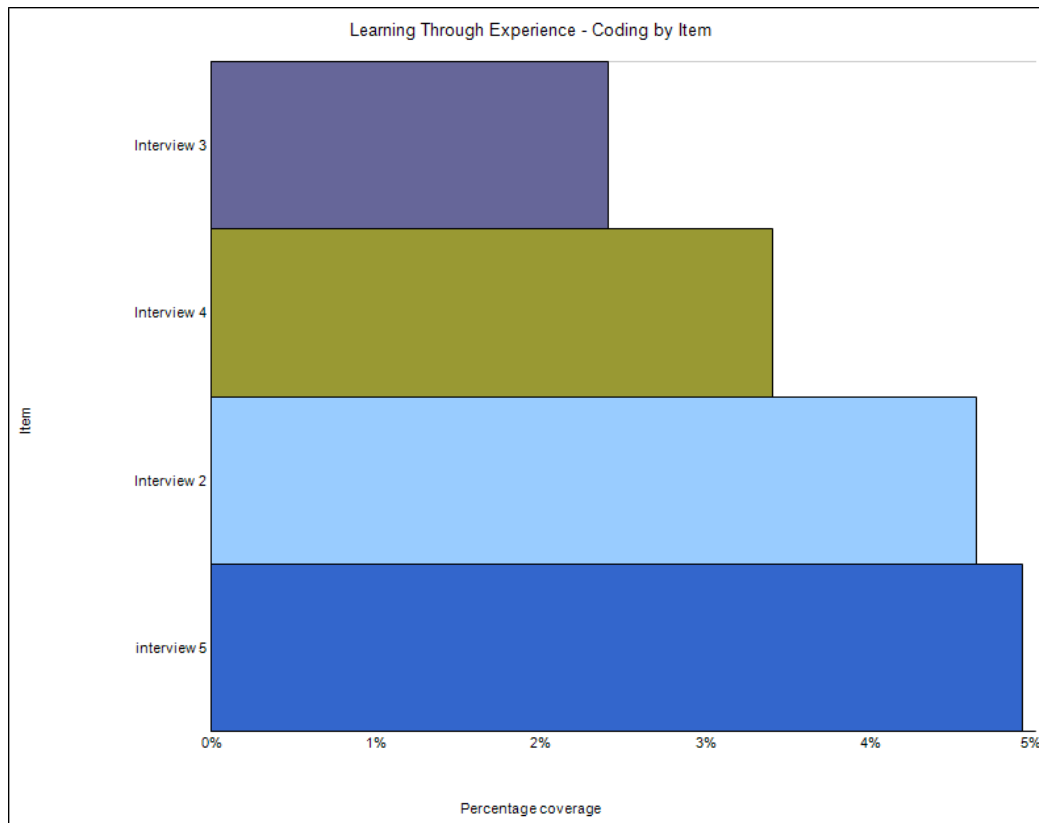
“I don't even know. I think it was just more or one of those things where you have to just experience it. I think I was supposed to talk to her about goals and taking her medication and that kind of thing. Really, it was just more looking at her in her environment.”

Kay does not believe that these are intentional decisions to grow her EI abilities, or that she is hoping to learn something specific, but that she is making attempts to do what is right for her patients.

“Right, it's not conscious decision, it's just more, you come at it from an oblique. If that didn't work, then I'm going to come around and go from another oblique and then I'm going to go straight on and then I'm going to come around from behind and see if I can get what I believe to be the right thing done.”

Experience references made up approximately 17% of the total amount of references. It appeared in the narrative with a similar frequency to Mentorship (27 references). Experience

references were found in interviews two through five without much variance. References appeared fairly evenly throughout the narrative interviews (Figure 11).



*Figure 11.* Percentage of Experience References Found in Interviews.

**Clinical Empathy.** One phenomenon that appeared within the narrative interviews focused on respect for the dignity of each person. The participant commonly used the term “respect” or the phrase “don’t dehumanize” while she was discussing the rationale for her behaviors. This concept was difficult to quantify, so the researcher consulted an academic doctor of philosophy at a private Midwestern University for help in categorizing the term. The researcher was then pointed to research in the medical field that discusses “clinical empathy” as cognitive attribute separate from personality (Boodman, 2015). Empathy is described by Mercer and Reynolds (2002), as a “complex, multi-dimensional concept that has moral, cognitive, emotive and behavioural components,” (p. 9). This would satisfy all of the statements by Kay in

her narrative interview. After reviewing the interviews, clinical empathy was decided on as the best descriptor for the experiences described by the research participant.

According to this research, empathy in a clinical setting would encompass the cognitive aspects that Kay describes with her patients (Boodman, 2015). Statements such as “It was more trying to give him some dignity,” or “It goes back to treating people with respect, I think and recognizing that there's a reason for every behavior,” depict a viewpoint that is rooted in morality consistent with empathy as defined by Boodman, 2015. Kay’s frequent answer to questions regarding the rationale for her emotionally intelligent behavior is uncertain with her citing “it’s just the right thing to do.” Often, Kay will use the term “humanize” in her descriptions.

“It was a task-oriented environment. I think that if that's what you’re always thinking about is the task, then you dehumanize their patients.”

“She talked about troubleshooting but I think it went back to just the dehumanization of the wires, the tubes and the ventilators.”

Kay’s focus is often on the value of the person, which drives her behavior and choices.

“I saw people that I admired how they were doing. I remember thinking, "That's what I'm going to do too," because I saw the value in the way people were being treated.”

Instead of attending to her patients based on the fastest way to care for them or most successful method of treatment, she would place herself in the position of the patient. Her choices were driven by the values she believed they were assigned.

“I think it was probably instinct for me to just be that way or I was like a magnet. That kind of behavior drew me. I was like that's exactly what I want to do. That's how I want to relate to my patients or my families.”



***Innate ability.*** A subtheme of Clinical Empathy could be the frequency at which Kay stated, “I don’t know.” Kay was frequently asked throughout her interviews how, when, or where she thought her emotional abilities were learned. Kay responds with some frequency that she is unaware of why she learned that treating patients in this manner was important to her practice.

“I don't think I knew that. I don't think anybody ever told me that.”

She at times will answer that the choice to treat a patient with Clinical Empathy was never directly taught, but came from herself. These statements appear in three out of five sources and represent five of the 42 references on Clinical Empathy.

Clinical Empathy made up 26% of the references to the study’s themes. These statements were most frequently made in her developing years as a nursing assistant and first years in nursing practice, but then saw an increase again toward the current part of her nursing career. Clinical Empathy statements were found in all five of the narrative interviews (42 references) (Figure 12).

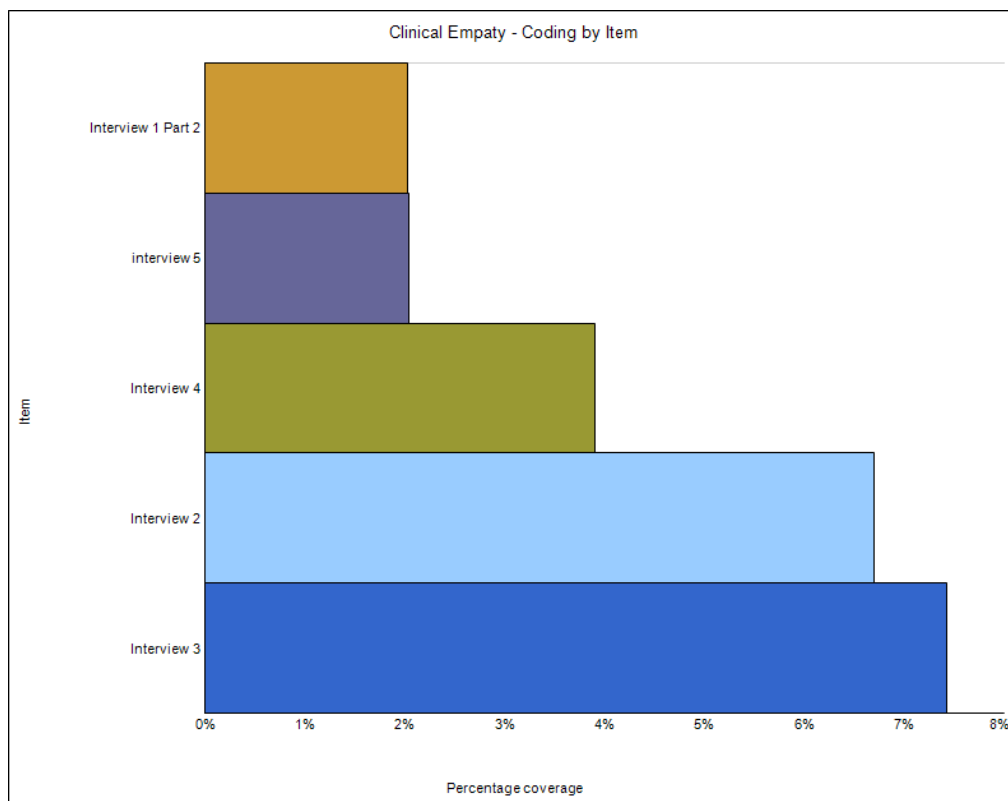


Figure 12. Percentage of Clinical Empathy References Found in Interviews.

**Reflection.** Reflection practices appeared in the narrative interviews with the highest frequency of all concepts. In fact, evidence of Reflection that influenced EI appeared in all interviews and often followed the other concepts. For instance, if Kay had made statements about gaining EI skills after Experience, she would then make statements about how she reflected on the event.

“You go through all that, you think, "Here's what I could have done differently, or here's where I needed to have told that doctor no, I'm not doing that right now.”

If Kay made statements discussing how she learned EI skills from her nursing mentors, she would follow with how she reflected on that experience and gained knowledge from the event.

“I saw people that I admired how they were doing. I remember thinking, "That's what I'm going to do too," because I saw the value in the way people were being treated.”

Reflection was used as a means to study the interaction and make value statements or judgements based on the EI skill being witnessed.

“I would hear her say, "You just seem a little crabby right now, but it's important that we get this taken care of and here's why." I remember thinking, "She's verifying and validating that their feelings, and she's not saying that they shouldn't feel like that, but she's also saying that 'even though you feel like that, you still have to do this.'" I think that that was helpful to treat.”

Reflection was found after all other concepts identified in the study. The only time that Reflection was not expressly discussed was when Kay made statements regarding her innate abilities with EI skills. When Kay couldn't name how she had learned an emotionally intelligence skill there was an absence of reflective statements.

Reflection was also used in all branches of the EI framework including perceiving,

“I remember thinking, that gives her so much pleasure and yet, I don't think she knows her name,”

to using,

“I remember thinking, "What am I doing?" I remember thinking, "I wish that I had known that he was Jewish." I would have been respectful of that. Because I was disrespectful to him,”

to understanding,

“I think I'd place my dad in his position often in my mind thinking, "How could you do that? How could you take care of your parents in your home like that?"

and managing,

“I wondered if I was spending too much time with each patient or I just wasn't efficient and tired.”

*Self-talk.* Reflection was especially apparent when the managing branch of the EI framework was used. Kay would frequently use “self-talk” to regulate her own emotions and her response to them.

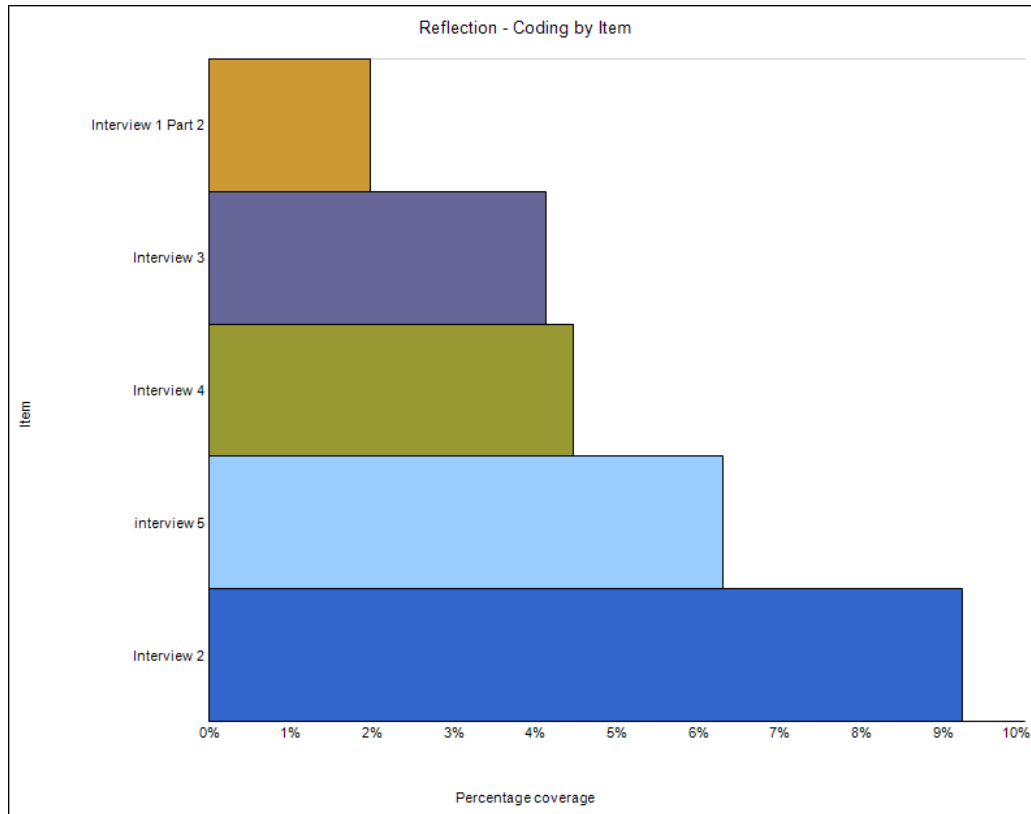
“You just leave thinking you didn't satisfy everybody, and yet reality is, you can't satisfy everybody 100% of the time. I think having a grasp on reality certainly helps, to say, "Realistically, what could I have done differently?" Just talking myself through that driving home.”

She would specifically identify self-talk as a means of mitigating her stress and anxiety.

“I would just say, "Okay, that problem is not my problem. It's a problem that I have to work with while I'm here and I can think about it a little bit, maybe when I'm sleeping. If I don't know I'm thinking about it, but I need to not think about it now because I need to enjoy my time off," because otherwise, your cup is always empty.”

Self-talk specifically appeared in interviews three, four, and five during the latter parts of her schooling and throughout her career.

Reflection and self-talk appeared in the narrative with the most frequency. Thirty five percent of the references made relating to the themes can be attributed to some form of Reflection. Frequently, these statements would follow references made regarding Experiences, Formal Teaching, and Mentoring. Reflection statements were found in all five interviews (56 references). Together, Reflection and Clinical Empathy make up 61% of the themes found in the narrative interviews (Figure 13).



*Figure 13.* Percentage of Reflection References found in Interviews.

The thematic analysis has reviewed the content of the narrative interviews under study. The major themes have been discussed in terms of frequency of occurrence, their temporal relationship to the research questions, and their relationship to each other. Thematic analysis is one way to interpret data collected with narrative inquiry, as it focuses on events and experiences and the chronological order of which they occur (Elliot, 2005). Structural analysis, or a focus on the form or of the stories recounted by the research participant, focuses mainly on the way in which the story was recounted and how their data are conveyed (Elliot, 2005). The next sections discuss this form of data analysis and how the results compare to the thematic analysis.

### **Structural Analysis Results**

Structural analysis for this study was completed using Labov and Waletzky's (1967) structural model of narrative (Andrews et al., 2008; Elliot, 2005; Riessman, 2004). Rather than

search for meaning in the words and phrases used during the interviews, this model looks at structure and form of the stories included in the narrative (Andrews et al., 2008; Elliot, 2005; Riessman, 2004). Once the data are broken down into stanzas, each line is assigned an element of either abstract, orientation, complicating action, evaluation, resolution, or coda (Labov & Waletzky, 1967). A fictional example is provided in Table 2.

Table 2

*Fictional Example of Structural Coding for Narrative Analysis*

Narrative Elements	Definition	Fictional Example
Abstract (AB)	General summary of topic	“There were funny times at work.”
Orientation (OR)	Information related to the setting including time, situation, place, and persons involved	“I remember I was a new nurse.” “I must have been 22 years old.”
Complicating Action (CA)	The details of what took place	“I was supposed to keep track of my equipment.” “I was always leaving my stethoscope around the unit.”
Evaluation (E)	The significance of the events to the participant	“I think my coworkers really wanted to teach me a lesson.”
Resolution (R)	How it was concluded	“They hid my stethoscope, keys, pens, and scissors for an entire week.”
Coda (C)	Returning the perspective to the present	“That week was really the beginning of my manic organization phase.”

*Note.* Adapted from “Structural Analysis” by C.K. Riessman, 2008. *Narrative Methods for the Human Sciences*, p. 92. Copyright 2008 by SAGE Publications.

While not all stories contain all elements, they similarly follow a typical pattern with abstract and orientation segments preceding complicating action. Resolution typically ends the story, with evaluation to follow. Each segment may have a coda, or brings the action back to the present (Andrews et al., 2008; Elliot, 2005; Labov & Waletzky, 1967; Riessman, 2008).

This narrative study found 42 specific instances of unique stories relating to Kay's nursing history for structural analysis. The large majority of these stories were found within the third interview. The first interview (largely demographic information) included one story (2%). Interview two included 11 stories (26%); interview three included 14 stories (33%); interview four included nine stories (21%); and interview five included seven stories (17%) (Figure 14).

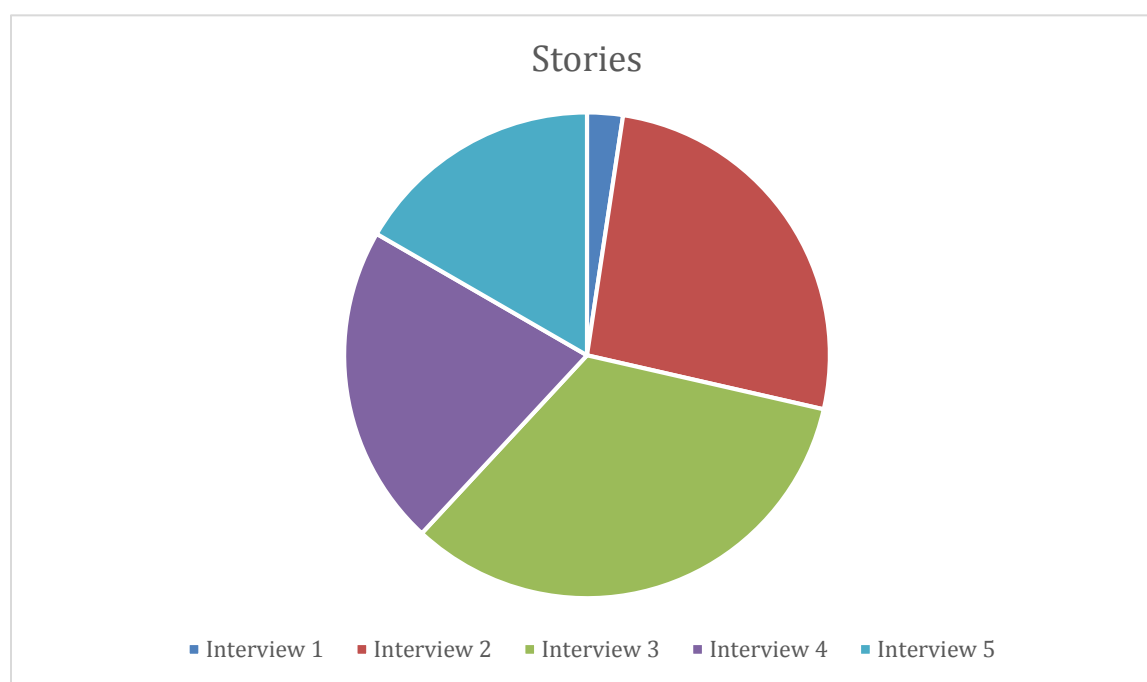
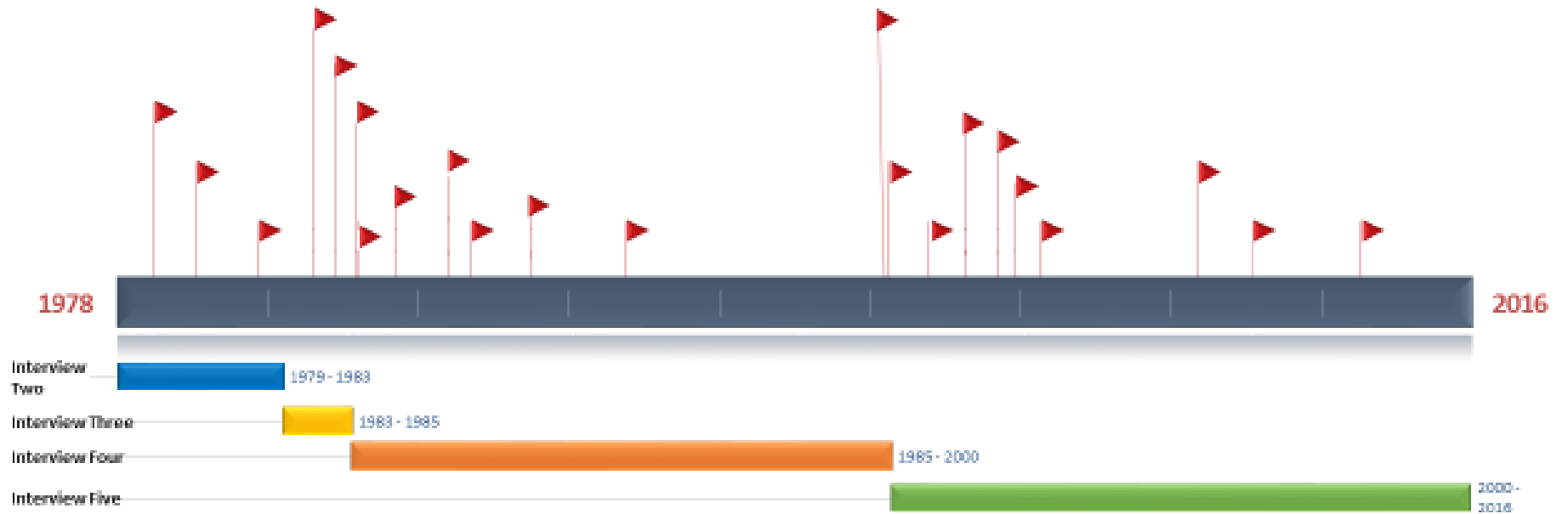


Figure 14. Identified Stories for Structural Analysis.

Nursing stories occurred throughout the interviews, but fall largely during the early or middle of Kay's career. An example of this is represented with a timeline that identifies the Using emotions branch as they appeared in Kay's narrative interviews over time (Figure 15).



## USING EMOTIONS

Figure 15. Nursing Stories where Using Emotions Appeared.



**Major themes.** The structure of Kay's narratives were unique to her in that she would often start with an orienting statement, but very quickly skip to complication action (Figure 16).

Refer to Table B for code identification.

I remember one time	A
talking to a young couple	OR
and I had to talk to them	CA
about when they could resume sexual intercourse.	CA
I could tell by them looking at each other	E
that they were amused by my discomfort	E
which made me more uncomfortable.	R

*Figure 16.* Typical Structural Analysis Example.

The majority of the coded stories in Kay's interviews focused on complicating action (a descriptor of the circumstances) and evaluation (commenting on the meaning or emotions of the story). Some of the stories that Kay describes would reach resolution quite quickly, and the majority of her stories would contain evaluation (Figure 17).

I don't know about manipulated	A
as much as maybe misunderstood.	A
There were times when you couldn't ...	CA
I would with the 3-11 shift	CA
and I couldn't get everything done in that evening	CA
and so, I would say,	CA
"If you guys could get that tonight	CA
because I just was not able to get to that,"	CA
and I ... This gal, she met me	CA
when she came out of report	CA
and she said, "You think that this is...	CA
we have our own stuff,	CA
or that we don't have anything to do on nights?"	CA
well I had been working nights.	OR
I was now on evenings	CA
after a couple of years.	OR
She didn't know either what my evening had been like,	E
that I hadn't been able to do 1 thing there with ...	E
Anyway, to pass it on to the next shift	R
to do because it's a shift operation,	R
well she resented that.	R
I still remember that	E

because I remember thinking,	E
"I don't think I do slop my work off on the other shift,"	E
but she felt that I did	E
and that surprised me.	E
It really did.	E
That took me back	E
because I remember thinking,	E
"I don't think I do that."	E
Then like I said,	E
I'm usually quick to think,	E
"Well maybe I'm wrong,	E
maybe I do."	E
I kind of watched myself after that pretty carefully	R
and I don't think I did.	E
I think it was just her night to be cranky.	E

Figure 17. Structural Analysis with Primarily Complicating Action and Evaluation.

Three of the 42 stories ended without any evaluation at all. Four times a story was resolved, evaluated, and then went back to complicating action. These stories were the exception as 29 stories were completed with long amounts of complicating action followed by long passages of evaluation.

**Comparison of analysis types.** From the evaluation of two separate types of data analysis, comparisons can be made. The large segments of evaluation stand out as the most compelling argument for data validity. The concept analysis found that reflection followed circumstances where EI was learned, developed, or practiced. The structural analysis supports

this theory by showing large segments of evaluation that include reflective statements. The participant structured her stories in such a way that each time she retold her story she identified her thinking and her feelings at the time. While one might make the argument that the nature of narrative inquiry requires such participants to reflect on their experiences, this was not true of all of Kay's stories. There were several instances (three stories) where no evaluation took place and the story abruptly ended (Figure 18).

Some people didn't have families	A
that were anywhere near,	A
and so they wouldn't come and visit.	A
If they had dementia so badly,	CA
they'd come	CA
but they didn't know [the patient].	CA
Not that they could really communicate with them.	E
Margaret, she had her puppy	CA
and she would go, "Puppy, puppy."	CA
She'd cry	CA
and laugh	CA
at the same time.	CA
I always make sure	R
that she had her puppy	R
and she would just hold that puppy.	R

Figure 18. Structural Analysis with Abrupt Ending.

Kay chooses to use expressions such as “I remember thinking” or “I remember feeling” without prompt from the researcher. These passages tend to have lengthy reflection pieces as a result (Figure 19).

I remember thinking,	E
"What am I doing?"	E
I remember thinking,	E
"I wish that I had known	E
that he was Jewish."	E
I would have been respectful of that.	E
Because I was disrespectful to him.	E
I didn't know.	E
I learned to go deeper.	E
Someone is just refusing something.	E
You need to find out why.	E
Go deeper,	E
don't argue with him,	E
don't try to force them,	E
dig a little deeper	E
and find out	E
why are they refusing.	E
There was always a reason.	E
Maybe, they're razor pulls.	E
Maybe, it pulls their whiskers.	E

This guy was Jewish.	E
It was the Sabbath.	E
You don't shave on the Sabbath	E
and I knew that.	E
I knew that about Jewish people.	E
I didn't know he was Jewish.	E
I couldn't understand it.	E

Figure 19. Structural Analysis with Lengthy Evaluation.

### Summary

In summary, the research participant, Kay, was discussed in detail depicting her health professions experiences over time. Her EQ scores as tabulated by the MSCEIT (Mayer, 2004) showed competency in emotional intelligence and the researcher's personal experiences observing her behaviors with patients and coworkers coincides with her score. Kay herself self-identifies as emotionally intelligent according to the Mayer and Salovey (1990) model of emotional intelligence.

Several methods of data analysis were completed in order to answer the research questions. The data were examined for instances of emotionally intelligent behavior which was then assigned to one of the four branches of the Mayer and Salovey (1990) emotional intelligence model. Multiple references were made to emotionally intelligent behavior or thinking in all five of the interviews, which were fairly evenly spread throughout the narrative interviews (Table 1). The research participant showed strength in the Using Emotions branch, correlated with a total of 22 references. Her lowest score was in facilitating thought (95) while her highest score was in understanding emotion (106).

The concept analysis was able to answer question two, which addressed instances where the research participant identified how she had learned an EI skill or behavior. Major concepts included Formal Teaching, Mentoring, Experiences, Clinical Empathy, and Reflection. The highest number of references were of Reflection, which seemed to follow other concepts such as Formal Teaching, Mentoring, and Experiences. Clinical Empathy was the second most common reference.

Structural analysis was completed as another means of data analysis attempting to bring validity to the concept analysis findings (Figures 17-19). The structural analysis found large segments of complicating action and evaluation, which coincides with the concept analysis. Further discussion of these findings and their implications are explored in Chapter V.

## CHAPTER V: IMPLICATIONS

### Discussion and Summary

The purpose of this qualitative, experiential narrative study was to examine how emotional intelligence is applied in clinical nursing practice and how a nurse develops those skills in professional practice. The study design was intended to elicit a detailed and personal point of view on the practice of emotional intelligence in acute care nursing. The selected research participant was asked to verify her EQ score with the MSCEIT emotional intelligence test (Mayer, 2004) and participate in repeated interviews detailing the major events, patients, coworkers, mentors, and support systems in her life from her first experiences in healthcare to the present. These interviews were subsequently transcribed and analyzed. Evidence of EI was identified in her stories and applied to the Salovey and Mayer model of EI (Salovey & Mayer, 1990). NVivo 11 (QRS International, n.d.) was selected and used for concept analysis. Several themes emerged including Dignity and Respect, Formal Teaching, Experience, Mentorship, and Reflection. The interviews were then analyzed for structure using the Labov and Waletzky's model for structural analysis (Labov & Waletzky, 1967). The structural analysis found large segments of complicating action and evaluation, which coincides with the concept analysis.

In this Chapter, the results of this study are discussed as they related to the research questions and the existing body of literature on emotional intelligence in nursing. Limitations of the study are examined. Conclusions that can be ascertained from this study identify areas for future research in this field and recommendations for current nursing educational practices.



**Research Question #1: How has emotional intelligence contributed to the daily practice of a professional acute care nurse in a Midwestern hospital setting?**

Throughout the interviews, there were a variety of stories that involved the use of emotional intelligence skills. All interviews included either perceiving, managing, using or understanding skills, but interviews two and five had the highest amount of references. This could be attributed to several factors. Interview five covers the longest period of time in the research participant's life, approximately 16 years, so it is very appropriate to have a large portion of stories from this amount of time. Also, this is the nursing position that she currently holds. Her most recent memories could be more vivid and applicable from this period of time.

Interview two holds a great deal of information from the participant's years as a nurse's aide and her first years in nursing school. The participant at this time is spending a considerable amount of time with direct patient care while newly starting her formal education years. It is possible that the process of learning nursing techniques within that area led her to reflect on those skills and created more memorable instances of using emotional intelligence skills. Interviews three and four include these opportunities to reflect as well, and they are only slightly less referenced in the narrative.

Of the emotional intelligence skills perceiving, understanding, and managing emotions happened with a similar frequency. Perceiving often occurred early in the participant's career (Figure 20). This may be attributed to the perceiving emotions branch being defined as a basic function of correctly identifying emotions in one's self and others. The participant describes instances of this in nursing homes because she may have been experiencing them for the first time. Kay expressed that as a young student the emotions of the infirmed and elderly, especially for someone who is now serving in a caregiver role, made a lasting impression. Kay's use of the

understanding branch follows a similar pattern (Figure 21). Her understanding skills are best represented with feelings of compassion and empathy. These statements still occur throughout the narrative, but for a young student, this may have been a period where Kay was incorporating new learning into her tasks and schooling.



Figure 20. Nursing Stories where Perceiving Emotions Appeared



### UNDERSTANDING EMOTIONS

Figure 21. Nursing Stories where Understanding Emotions Appeared

Managing emotions occurred the least frequently in the narrative. When referenced, Kay used statements related to managing emotions to describe how she personally dealt with stressful situations and her ability to do her job effectively. This level of emotional intelligence builds on the other branches, especially identifying emotions in oneself. This higher level of emotional intelligence would not occur as frequently, and therefore, it follows that the frequency that it appears in the narrative would not be as common. Its appearance more frequently in the later years of Kay's career may be attributed to the fact that she is more frequently in a leadership role where she has the opportunity to use the managing branch with more regularity (Figure 22).



Figure 22. Nursing Stories where Managing Emotions Appeared.

Using emotions made the largest appearance in the interviews. Frequent mentions of the using branch included Kay's conversations with patients, organizing her care of others, and communicating with the healthcare team. This large frequency of using emotions validates the amount of communication accomplished by nurses in a clinical day. Planning, organizing, and teaching are bedrocks of the nursing process (American Association of Colleges of Nursing, 2016; Nightingale, 1969). It follows that using emotions would be largely represented in the narrative stories (Figure 15).

The nursing process not only revealed itself when identifying the branches of the emotional intelligence model, but in the structural analysis as well. The nursing process commonly lists background knowledge and assessment information before formulating a diagnosis. Kay's frequent pattern of listing pertinent nursing data first before moving on to reflection and analysis resembles the process in which nurses are taught to communicate their thoughts in the medical record and with the health care team (American Association of Colleges of Nursing, 2016).

**Research Question #2: What factors, positive or negative, have influenced how the professional nurse becomes emotionally intelligent based on the lived experiences of one emotionally intelligent acute care nurse in a Midwestern hospital setting?**

The research study found six concepts that were important to the development of emotional intelligence. Many of these correlated with available literature on EI, but several manifested in unexpected ways for the research participant, Kay.

Life experience is important for developing an emotional vocabulary needed for the perceiving branch of EI (Fernandez et al, 2012). Without witnessing or experiencing complex emotions it would be difficult for one to readily decipher between similar emotional responses

(Fernandez et. al, 2012). Within nursing, it follows suit that experiencing a variety of emotional responses to the care provided would help the novice nurse develop an emotional vocabulary and practice using emotional skills. In the literature, experiences gained are said to lead to higher levels of emotional intelligence, and therefore, the nurses who have had the opportunity to participate clinically leave more skilled (Fernandez et. al, 2012).

When looking at the stories presented, Kay's experiences with emotional intelligence were largely described early in her nursing school career, while she was working as a nurse's aide, when she started in the PINS unit, and again when she moved to the PACU (Figures 15, 20-22). Early learning of emotional intelligence in these areas contradicts that emotional intelligence would be experienced and practiced more towards the later years in a clinical area after the novice nurse was able to do more hands-on learning. Kay's experience depicts EI being more prominent during areas of recent transition to different areas of nursing practice.

Kay's ability to learn through Experience did not always manifest itself with trial and error attempts. Kay identified her ability to visibly watch coworkers or mentors handle difficult situations was just as important as her experiencing the situations herself.

“Visually watching I would say. That’s just because I don’t really like making mistakes so I have always believed that if you watch other people make their mistakes, and then you learn from that, and then you just avoid that mistake.”

Kay goes on to describe the process further.

“Because I don’t just look. I watch and I listen and I look at their faces and think, he’s not buying what she’s selling right now and I wonder what I would do differently. I really do, I learn a lot from watching even some of the staff interacting together.”



Visually watching for Kay was just as powerful as actively participating in patient care, but she does name an especially important experience for her developing empathy and understanding for her patients. In nursing school, her instructors simulated an event that put students in crisis. She is quick to state that the experience was uncomfortable and controversial, but reiterates it was an extremely worthwhile learning opportunity that not only allowed her to experience crisis, but observe others go through it as well.

“They said this is a psych class, but this is something that is going to serve you all through your lives. I would say that that is really true. That has perhaps probably been the most powerful instruction I had on a response to crisis and how I am going to handle it as a nurse and how I am going to recognize it.”

While importance may be placed on giving students, and novice nurses, hands-on opportunities for learning how to handle difficult emotional scenarios, these results speak to the value of observation and discussion which can serve as similarly valuable learning experiences.

Mentorship and Formal Teaching are also discussed as concepts for development emotional intelligence skills. Available research places emphasis on the guidance a good nursing mentor can provide a novice nurse or student (Hickey, 2009; Nelms et al., 1993; Saghafi et al., 2012; Thomka, 2001). Formal Teaching of emotional intelligence is not typically a stand-alone concept of nursing programs, but large emphasis is placed on communication skills throughout the curriculum (Cadman & Brewer, 2001; Clarke, 2006; Freshwater & Stickley, 2004; Shanta & Gargiulo, 2014). Prior to completing the research study, the researcher completed reflective journaling to reduce study bias. This journaling revealed that Mentorship was the expected area where EI skills would be developed. Within this research study Mentorship does appear as a

desired and important concept, but Formal Teaching practices were more frequently cited in the interviews as being important to development of EI.

Kay discusses two major mentors in her career: when she first started on the PINS unit and again when she started on the PACU unit. Nurses who mentored her in the nursing home are also discussed as both positive and negative influences. These formative nurses, while important, were not discussed with the same frequency that Kay's clinical instructors and theory instructors were discussed.

Kay's experience in nursing school regarding EI development was very positive. She could articulate a communication textbook that she utilized for developing her EI skills. She describes mentally referencing this text in her current nursing practice. Her instructors would lead pre-clinical meetings to discuss patient and family concerns, facilitate discussion on EI skills immediately following patient interactions, and also prior to entering patient rooms. Kay's instructors deliberated appropriate emotional responses to patients with difficult diagnosis or prognosis and simulated these events when appropriate. Clinical instructors, while perhaps not consciously completing emotional intelligence development, appeared to be largely influential on the development of Kay's EI abilities.

Clinical instructors may have been making use of another concept discussed in the narrative: Reflection. Reflection was very prevalent in the narrative interviews (Figure 9). While some of the noted Reflection can be attributed to the fact that narrative inquiry is in fact asking the research participants to reflect back on experiences that are meaningful, Kay's Reflection was extensive and methodic. It was the estimate of the researcher that Reflection would follow major emotional events as a way for EI to be developed, but it was found that Reflection also preceded development of EI as well. In many of the stories, Reflection was

initiated by the research participant, and her questioning led to her ability to then engage the patients or try to rationalize her responses. From that inquiry, she was able to better manage her own responses or react to the responses of others. Much of this Kay attributes to her innate personality, but does agree that it was encouraged by her nurse mentors and nursing program. With this in mind, Reflection and Self-Talk appear to not only be a precursor to development of emotional intelligence, but a strategy to develop it as well.

One concept that was continually discussed by the research participant was Clinical Empathy. Kay describes it as “value of the human” and “the dignity of human life.” While she stated that Clinical Empathy was essential for development of empathy, compassion, and professional nursing, it was not a requirement for emotional intelligence. Empathy for suffering, anxiety, and frustration often triggered Kay to reflect on the situation and further her EI development. Kay is also one that will admit that nurses who do not share her viewpoint that each person has value are still able to respond with emotional intelligence.

“There’s some people that can really read people. They’re good at it and they can con you. They don’t care what happens to you.”

Emotional intelligence, while influenced by Clinical Empathy, does not necessarily depend on the concept. For practicing nurses where empathy, dignity, compassion, and respect for human life are integral to the profession, this concept is a necessary factor in developing EI skills for professional nursing practice.

### **Correlation to Literature**

The initial aim of the study was to verify that emotional intelligence skills are evident in the practice of the professional nurse. Throughout the study, clinical descriptions reinforce emotional intelligence literature that nursing practice has a prominent position in daily functions

of a nurse. The four branches of the Mayer and Salovey model of emotional intelligence are well represented throughout Kay's nursing career.

Perceiving emotions, or identifying emotions accurately in speech and behavior, was evident in many of Kay's descriptions of her care. Freshwater and Stickly (2004) strongly contend that this understanding and attention to verbal and non-verbal emotional details is a prerequisite skill for any healthcare practitioner. Kay's descriptions detail her search for signals and cues in the body language of patients or understanding of processes. She describes periods where she is at risk for physical assault and making decisions related to giving medications. The repercussions for patient and nurse safety is evident and directly correlates with Akerjordet and Severinsson's (2007) statement that "a nurse's EI is an essential ability in all decision-making and creative processes based on feelings and intuition, as it consciously captures and interprets the immediate context," (p. 1410). Quickly ascertaining a patient's emotional state was evident in Kay's practice as an aide, as a student, and as a practicing nurse throughout her career.

Teamwork and interpersonal communication are skills commonly associated with the using emotions branch of the EI model. Kay's experiences and descriptions correlate with the literature as well (Holbery, 2014; Shanta & Gargiulo, 2014). Her stories detail communication with physicians as a novice nurse and as a nurse leader. She discusses her abilities to "manipulate" these discussions to provoke certain emotions and facilitate better care for her patients. Descriptions of delivering feedback to her colleagues or working within a team environment show her ability to adjust her communication style to what the situation dictates. Use of humor to diffuse a tense situation or connect with her patients was evident in a large amount of the narrative. Alternatively, boundary setting with patients, their families, and coworkers made a strong appearance as well. Methods for establishing effective communication

are vital to the nurse-patient relationship. The ability to use knowledge about emotions and how emotions affect communication not only allows the nurse to negotiate complex problems, but facilitates cohesion within the healthcare team (Shanta & Gargiulo, 2014).

One of the more common phenomenon of the study was the discussion related to empathy and compassion in nursing practice. Kay's descriptions validate existing literature that therapeutic relationships are enhanced for both the patient and the nurse when compassion and empathy are part of the nurse's professional practice (Freshwater & Stickely, 2004; O'Connell, 2008). The understanding branch of the EI model allows for the nurse to use emotional knowledge to facilitate thought and guide practice. Kay wrestles with her experiences very early in her career comparing the prognosis and care of her patients to the care of her family members. Her empathetic and compassionate care is evident when she discusses caring for a gentleman whom she struggled to understand. Her reaction was one of being brought to tears as she recounted the story for the researcher. These experiences carried over throughout her career, especially as she describes her patients who are at varying stages of the surgical process. Her description of the patients being "in crisis" shows an understanding of how complex emotions surrounding medical procedures may affect patient outcomes (Holbery, 2014). This sensitivity to emotional responses not only allows her to empathize with her patient's experiences, but also plan effective and compassionate care (Holbery, 2014).

Probably the strongest correlation to literature was Kay's descriptions of managing her emotions in nursing practice. The managing branch of the EI model suggests that those with high levels of EI are able to engage in emotions or detach from them as necessary (Salovey, 2001). The usefulness of this has been explored in nursing literature as it relates to nursing burnout (Akerjordet & Severinsson, 2007; Bailey et al., 2011; Claros & Sharma, 2012; Collins,

2013; Karimi et al., 2014; Landa & Lopez, 2010, Por et al., 2011; Sharif, et al., 2013). Kay's experiences with managing emotions was prevalent in mitigating criticism or dealing with difficult coworkers. She is concrete in her belief that selectively detaching from her emotions was critical to her success as a healthcare practitioner.

“I don't know why they feel like it's a selfish thing to take time away, or to not think about the problem at work, but to me, you have to be selfish in your emotions otherwise you just can't survive.”

The secondary aim of the study was to investigate how EI is developed throughout the course of one nurse's professional nursing career. The findings of this study exposed several concepts that have reinforced similar findings in existing literature, while emphasizing certain areas that would be beneficial for future study. The first concept was the theory that experience can further the development of EI. In a 2009 study by Dusseldorp et al., age, work experience, and EQ score was studied to determine if a positive, significant correlation could be found. The results found no support for this hypothesis (Dusseldorp et al., 2009). In other studies where EQ was studied in students with more exposure to clinical practice, finding suggested that students had more opportunities for EI growth (Benson et al., 2010; Benson et al., 2012). Clearly the literature is not in agreement with the significance that experience holds for EI development.

In Kay's stories, experience was key for development of increased EI, but she is explicit that for her, experiences did not have to be firsthand. Kay's belief was that her ability to observe her mentors, other students, and her instructors was equally beneficial in her development of EI abilities. Albert Bandura, as part of the social learning perspective, would agree (Bandura, 1969). In 1969 Bandura stated that role-modeling was a fundamental means by which new

behaviors are acquired. Imitation or observational learning was a way of integrating behavior patterns based on the social cues around them (Bandura, 1969).

Kay's ability to observe positive and negative communication interactions led to her either adopt or omit similar behaviors in her own nursing practice. Furthermore, her most influential firsthand experience was not necessarily one with a patient, although those did exist in the narratives as well. Her most influential lesson on patients in crisis came from a simulated experience in nursing school. For this reason, the strong emphasis on experiences validates that EI is influenced by clinical experience (Nelms et al., 1993).

Existing EI literature also highlights formal and informal educational programs as a means of increasing EI skills (Bar-On, 2010; Goleman, 1995; Salovey & Mayer, 1990; Shanta & Gargiulo, 2014; Swanson, 2012). There is a dearth of formal EI instruction in nursing curriculum amongst the vast evidence that nursing care positively benefits from incorporation of EI skills (Freshwater & Stickley, 2004; Holberry, 2014). Freshwater and Stickley (2004) state that "when teachers' pay little or no attention to emotional development, they fail to communicate with students the significance of human relationships," (p. 93). Existing literature focuses on the influence of nurse mentorship once nurses reach practice (Hickey, 2009; Thomka, 2001), but Kay's experiences highlighted the vast influence of her nursing theory and clinical instructors in imparting EI skills.

Kay does highlight the direct influence her mentors and role-modeling had on her cognitive, psychomotor, and affective skills, but the numerous examples of formal education influencing her practice were evident. This manifested itself as coaching from her clinical instructors who were with her at the bedside, simulation exercises at her school of nursing, and

even lessons on communication techniques and empathy. This period of time appeared to be very formative for developing her EI skills.

Much of the literature in nursing education pointed to the influence that mentorship could possibly have on the development of EI skills (Ness et al., 2010; Nouri et al., 2013) especially with mentors facilitating techniques such as simulation, reflection, and role-play. With Kay, this was less true of nurses in practice, but more representative of the experiences she had in nursing school with formal teaching. Her experiences with mentorship once she reached practice were identified as helpful, but more related to understanding skills and inspiring an attitude of caring. This experience may be that of only this individual as they relate to these particular mentors, or this could be experienced more broadly by other novice nurses.

Original assumptions stemming from the literature would be that Kay would have developed her EI skills later in her education once her clinical skills were solidified. Kay herself addressed the need for first focusing on basic clinical priorities before continuing to develop further EI skills.

“I think that I talked to my patients more in each area that I worked the longer I was there. As I gained confidence, I was more into my element. I was able to do things a little bit more freestyle.”

Kay's comfort and confidence in her ability to perform her job enhanced the formal and informal education she received. After mastering basic job functions, she was able to place more emphasis on her relationships. In the data, this presents as an increase in EI development following each of her job transitions and again when she assumes a leadership role.

Reflection in nursing practice was a key concept in this research study. Threaded throughout the narrative, this study found that reflection was integral in the development of EI



abilities. In the literature, reflection is addressed in broad terms. Many authors discuss the value of reflective practice (Clarke, 2006; Nelms et al., 1993; Swanson, 2012), but reflection is not uniformly mentioned as a strategy for development of EI skills. Kay's experience with reflection was consistent and vast. Each story retold was presented in a manner that examined her own thinking quite literally. The words 'think, thinking, thinks' appeared in the narrative interviews 487 times. Kay repeated the phrase "I remember thinking" when she went on to describe her experiences and how she made meaning of them. Narrative research itself is a process of reflection, but Kay did more than recall previous stories. Independently she sought meaning from the events and reflected on the purpose they held in her professional nursing practice. The process of reflection preceding EI development is absent from the literature and was a significant finding of this research study.

The theme that was absent from the reviewed literature was Clinical Empathy. Previously reviewed literature on the topic of EI in nursing practice discusses the need for caring, compassion, and empathy in professional practice (Baily et al., 2011; Freshwater & Stickley, 2004; Heffernan et al., 2010; Holbery, 2014; McQueen, 2004; Rankin, 2013), the skill of empathetic behavior, either positive or negative, is not discussed as a means of increasing the emotional intelligence in practicing nurses. For Kay, this was a central means of gaining insight into her patients and developing relationships. She relied on empathy to help her make decisions regarding their care and respond to conflict. Empathy was evident in her managerial style and her behavior towards her coworkers. When Kay would discuss her empathetic behavior she was repeatedly asked "How did you know to respond that way?" Often, she would state "It was the right thing to do. It was the right way to be, I think. I don't know. It was probably just instinct," or respond with regard to the belief that each human deserves equal and compassionate care.

“We work and care for everybody, no matter what kind of, whether they’re a jerk or not. Some people, it’s a little bit more of a struggle to care for than it is others.”

This is a human being. This is a human being. They are depraved, but they’re a human being and it’s my job to care for them like I would care for my grandma.”

“My place is to care for and treat and I’m not the judge.”

Clinical empathy is a skill that can be improved if it is embedded in the experience of the nurse or student (Mercer & Reynolds, 2002). It also has the potential to greatly improve the care provided to patients and the personal experience of the nurse (Mercer & Reynolds, 2002).

### **Recommendations**

The importance of the previously discussed concepts for development of emotional intelligence skills in nursing practice has led to several recommendations for practice. Based on the research participant’s lived experiences in the nursing profession, increasing student experiences with patients and the healthcare team (by way of clinical experiences or simulation) should be a priority for nursing curriculum. Many of the foundational and significant events for this research participant stemmed from her exposure to patients as a nurse’s aide. The direct patient care that she provided gave her insight on the emotional needs of a population of aging patients with significant health concerns. Kay was able to use her existing knowledge on communication techniques and apply them in a clinical setting with the help of formative mentors at this early stage of her nursing development.

Perhaps nursing curriculum should require experience working as an unlicensed nursing technician or exposure to patients in the healthcare environment as a prerequisite for entering a caring profession. Having previous experiences with patients and healthcare providers would allow clinical instructors to work with students who already have a familiarity with patient care.

Once this comfort with the clinical environment is established, improved student confidence will allow more time for the development emotional intelligence skills.

Nursing instructors may also want to explore explicit integration of nursing instruction on the concept of emotional intelligence. Current practice gives much attention to the safe completion of tasks and skills, but holistic nursing care is more than the amalgamation of a series of psychomotor tasks (Freshwater & Stickley, 2004). The clinical setting is an ideal place for this type of evaluation to occur, but attention to including emotional intelligence, and at the very least, naming the concept in theory discussions may be appropriate. While instruction on communication skills is a worthwhile concept to impart, it does not go far enough to address the complex ability to navigate emotional skills (Freshwater & Stickley, 2004; Holberry, 2014). Freshwater and Stickely (2004) state, “Where communication skills training is separated from the emotional content of human interaction the art of nursing is reduced to the science of the technician,” (p. 94). Advances in nursing simulation present a unique opportunity to give students firsthand opportunities to experience a range of emotions or practice recognizing them in others (Jumah & Ruland, 2015; Kelly, Berragan, Eikeland, & Orr, 2016; Tilton, Tiffany, & Hoglund, 2015). Additionally, opportunities for observation have been shown in this study to present similar if not equally meaningful opportunities for students to gain experience and formal instruction in EI.

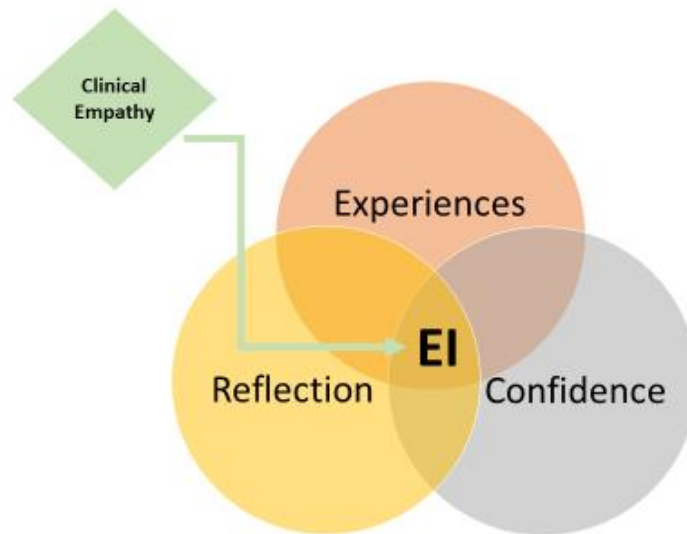
This study also confirmed the necessity of teaching reflection that is both critical and transformative (Akerjordet & Severinsson, 2007). Mezirow’s transformative learning theory is an adult learning theory that involves the metacognitive process of reason assessment involving the reformulation or validation of ones’ assumptions or beliefs (Mezirow, 2009). Mezirow’s theory has relevance in the process of advancing a nurse’s EI ability through the practice of

critical reflection. The process of critical self-analysis and discourse can challenge previously held judgments and allow students to make meaning in the events that they experience. Simple reflection is not enough to achieve transformative learning, therefore, would be best facilitated by an instructor or competent mentor (Mezirow, 2009). Critical junctures for this reflection was identified in this study as prior to patient engagement and immediately following engagement.

Based on the discussion surrounding the importance of Clinical Empathy, nursing education should reexamine how compassion and empathy are imparted to students during the length of their education. The current climate in nursing education is one that embraces the evidence-based nature of practice and adhering to national practice standards (Freshwater & Stickley, 2004). Finding a place for emotional development in students and an emphasis on empathic care could not only improve patient outcomes, but also bring a higher satisfaction within their nursing career (Akerjordet & Severinsson, 2007; Dusseldorp et al., 2009; Freshwater & Stickley, 2004; Holbery, 2014, Shanta & Gargiulo, 2014). Placing emphasis on compassionate care, and evaluating for it in a clinical setting, communicates an understanding that professional nursing care embodies holistic care of the patient.

A model of nursing education that teaches emotional intelligence skills would include the fundamental concepts discussed in this study. The resulting opinion of this study is that experiences (formally and informally taught), confidence in abilities once mastery of basic tasks is achieved, and critical reflection pre and post experiences are necessary in the development of emotional intelligence (Figure 23). Furthermore, a concerted effort to teaching Clinical Empathy for patients, families, and members of the healthcare team positively affect the ability of the nurse to practice as an effective, professional nurse. Facilitating an environment where these

concepts are foundational to nursing instruction encourages the development of emotionally intelligent professional nurses.



*Figure 23.* Jessen Model for Environments that Facilitate EI Development

The Jessen Model for Environments that Facilitate EI Development (Figure 23) is one that combines these findings in a way that increases the likelihood of advancing EI of nursing students. The first principle, Confidence, relates to a sense of familiarity with a student's surroundings. Mastery of the discipline is not necessary, but a lack of anxiety and trepidation regarding what the student is capable of accomplishing is necessary for additional learning. In relation to a clinical rotation, emotional intelligence skills might not ideally be the focus of the first or second week of instruction, but introduced towards the second half or the end of the clinical rotation. The student will have built up some clinical knowledge, familiarity with the personnel and facility, and confidence regarding patient care.

Experiences and interactions are required to practice and develop EI skills. The experiences provided do not necessarily need to be first-hand involvement with patients, but may

be anecdotal in nature. Student observation experiences can elicit the same information in a variety of settings without any risk to patients or undo burden on instructors or mentors. These experiences are not limited to patients, but interactions between team members (patient hand-offs, nurse to physician communication, care-rounding) could serve as experiences where students would witness emotional intelligence skills at work.

Reflection is the third component of the model. As Mezirow (1990) defines reflection, it is the action of making meaning of an experience (Mezirow, 1990). This research study found that when the results of reflection are used to guide decision making, emotional intelligence has the ability to be developed. This type of critical reflection can help students critique, correct, and revise their personal beliefs. Critical reflection may be used to influence behaviors and allow the nurse to improve her emotional intelligence skills. This type of deep reflection may necessitate the guidance of a mentor or instructor to achieve the level of reflection and focus necessary to make meaning from these experiences (Mezirow, 1990).

The overlapping of these three components; confidence, experiences, and reflection; provides the necessary environment for the development of emotional intelligence. From this research study, it was also found that Clinical Empathy, when present in the nurse or student could influence the development of emotional intelligence in these individuals. The research participant states herself that Clinical Empathy is not necessary to be emotionally intelligent, but found it important and meaningful in developing her professional practice. More research is needed in the role of Clinical Empathy in development of EI, but the limited research available and the findings of this study identify it as an asset in providing compassionate care to patients and assisting the nurse in emotional regulation.

### **Limitations**

Due to the selected qualitative design, this study is limited in its generalizability to a greater population. The research study was able to extract rich, detailed data regarding the experiences of one professional nurse, however her experiences may not represent the experiences of all nurses. While narrative research is considered appropriate for research that desires a holistic viewpoint, the study may lack the insight that would come from multiple interviews with varying professionals (Flyvbjerg, 2006).

### **Delimitations**

This research study selected the Salovey and Mayer theoretical framework for its definition of emotional intelligence. This definition has shown to provide the highest amount of validity and reliability in current research (Mayer, Caruso, & Salovey, 2000), and it omits several debatable facets of emotional intelligence, such as personality, that are often times included in other research studies (Mayer, Caruso, & Salovey, 2000). Results of this study made mention that inherent personality traits, such as a tendency to engage patients in conversation without prompt, may have held some significance in the development of EI. Since the framework chosen ignores these traits and measures on ability alone, another facet of EI development may have been overlooked.

The selection of the participant was limited to an acute care professional nurse. Much EI research has also examined nurses in areas with high amounts of emotional load such as trauma and mental health (Dusseldorp et.al, 2009; Holbery, 2014). While this study was able to view EI principles through the lens of an acute care nurse, future work into the development of EI skills may need to be researched in order to learn how EI skills are applied and developed in multiple nursing populations or if they are developed in a similar manner.

The participant chosen was known to the researcher which was fundamental in facilitating an open and detailed discourse over the length of the study. While known participants could potentially reflect a personal bias in the research, it also allowed for validation of emotional intelligence skills.

The narrative design of the study, which has been discussed as a limitation, may also be interpreted as a delimitation. By selecting this type of qualitative design, the research was able to examine how and when EI skills were applied and developed over the course of 37 years. Interviews involving a larger sample of nurses would provide for a larger representative sample, but would not be able to provide the same level of personal detail especially in regards to when traits were developed and how they changed over the course of time. It was therefore beneficial to begin investigative research with one participant with exceptionally high levels of detail so that future research may build on the findings from this experiential design.

### **Future Research**

The results of this study have pinpointed several areas for future research in the development of emotional intelligence in nursing. This study could be repeated as a phenomenological qualitative study where a sample of nurses discuss their experiences learning how to practice with emotional intelligence while in nursing school or when moving to different positions in nursing. Focus on formal teaching experiences or clinical practice would be beneficial not only to expand the understanding of how nurses learn EI skills, but to validate the findings of this study.

Reflective practices and their ability to influence the development of emotional intelligence should also be explored in nursing education. Investigative studies that particularly look at the ability to critically analyze and reflect deeply could be explored as a means to



improve EQ scores. Both qualitative and quantitative information would provide insight on development of EI skills.

Development of simulation exercises intended to increase compassion and empathy would be beneficial for future research. Simulation exercises where students are both participants and observers would further identify if students can gain experience developing EI outside of the clinical setting. Development of a clinical measure of compassion and empathy would allow for greater research to be completed. Clinical Empathy, its definition in nursing and its role in emotional intelligence, would benefit from further research and inclusion in EI literature.

### **Summary**

In this Chapter, focus on the interpretation of findings as they related to the research questions and their correlation to literature has been presented. Implications and recommendations for practice have been offered as well as suggestions for future research. Limitations and delimitations that may detract from the research findings have been addressed. Based on the experiential narrative approach, practical concepts, individual perspective, and resulting understanding has been offered to further the study of how emotional intelligence is learned over the course of time.

The theoretical framework for the purposes of this study has been thoroughly described according to the Salovey and Mayer model of EI. Salovey and Mayer (1990) concluded that emotional intelligence is the ability to perceive emotions, understand their meanings, and apply that knowledge to critical thought (Mayer et al., 2000; Mayer et al., 2008; Mayer, Salovey, & Caruso, 2004; Salovey & Mayer, 1990). This framework was chosen for its reliability and validity with performance measurement and narrow focus that excludes factors such as

personality. Viewing EI as a skill, one that can be developed and applied within the nursing field, is attractive for healthcare research and education. The findings of this research suggest that perhaps the narrow focus of this model ignores a facet of emotional intelligence, namely personality, which may not be able to be separated from the construct. It could also be that another phenomenon, Clinical Empathy, stands alone outside of emotional intelligence as a contributing factor to the wellbeing, health, and success of nursing professionals. How emotional intelligence is defined is central to how it is taught and measured, and any outside factors should be examined in future research.

The Jessen Model for Environments that Facilitate EI Development (Figure 23) views emotional intelligence education with these outside factors in mind. Creating an environment where nursing students are exposed to different clinical experiences, have completed basic nursing skills with confidence, and have the opportunity to deeply reflect on their actions will allow for the practice and development of emotional intelligence skills. Adding Clinical Empathy, while not essential to EI development, may also positively affect EI development.

There is still much to be explored in this very important aspect of holistic patient care. Strategies that enhance empathy, compassion, teamwork, safety, and overall satisfaction in nursing should be pursued not only to increase patient satisfaction and outcomes, but to support the health and well-being of the nurses who have made it their career to care for others. Providing education that stimulates a desire to increase emotional competence is at the heart of learning to care, both for oneself and for others.

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**Appendix A: Institutional Review Board Approval**

May 8, 2016

Dear Jennifer,

Congratulations! The Institutional Review Board at College of Saint Mary has granted approval of your study titled *Lived Experiences and Insight on Development of Emotional Intelligence in Professional Nursing Practice*.

Your CSM research approval number is **CSM 1605**. It is important that you include this research number on all correspondence regarding your study. Approval for your study is effective through June 1, 2017. If your research extends beyond that date, please submit a "Change of Protocol/Extension" form which can be found in Appendix B at the end of the College of Saint Mary Application Guidelines posted on the IRB Community site.

Please submit a closing the study form (Appendix C of the IRB Guidebook) when you have completed your study.

Good luck with your research! If you have any questions or I can assist in any way, please feel free to contact me.

Sincerely,

*Vicky Morgan*

Dr. Vicky Morgan  
Director of Teaching and Learning Center  
Chair, Institutional Review Board \* [irb@csm.edu](mailto:irb@csm.edu)

## Appendix B: Emotional Intelligence in Nursing Article

# Emotional intelligence: Why walking the talk transforms nursing care

Publication Date: **April 2012 Vol. 7 No. 4**

Author: [Estelle Codier, PhD, RN](#)

Since the first emotional intelligence (EI) research in the late 1990s, EI has rocked the business world and challenged leaders and employees from dozens of professions to work differently. After hundreds of research studies, several dozen of them in nursing, some findings are clear. The highest performers, both in leadership and clinical practice roles, also have the highest measured EI scores. Emotional intelligence has been correlated with improved retention, less burnout, and both physical and emotional wellness in nurses. Patients' perception of nurse caring has been correlated with measured nurse EI, and there is evidence that EI skills correlate with professionalism and expert practice.

## What is emotional intelligence?

Several models of EI are in use. Much of the existing nursing EI research is based on the Ability Model, which defines EI as a set of abilities that can be learned, improved, and taught to others. According to John Mayer and Peter Salovey, psychologists who coined the term "Emotional Intelligence," EI is made up of four basic abilities:

## Correctly identifying emotions in self and others

This ability sounds easy...but it isn't. Imagine a patient who confronts you angrily. He appears angry, he acts angry, and he sounds angry. But when you talk with him, you realize that what looked like anger at first was really something else. Perhaps he was really very frightened, frustrated, or even ashamed. If emotions are not identified correctly, a particular nursing intervention may be not only inappropriate, but even harmful.

My patient was a young man admitted to the ICU for a self-inflicted gunshot wound to the head. He had attempted suicide after coming out of the closet as a gay man. His mother, a



stern and stoic woman, visited him every day. At each visit, she had angry exchanges with the nursing staff. She continually criticized his care, even blaming nurses for changes in his condition. Her angry behavior alienated the staff and isolated the family. One day, in the face of yet another tirade, a nurse quietly said to her, “Do you know this isn’t your fault?” The mother, caught completely off guard, immediately burst into tears and sobbed inconsolably in the nurse’s arms. This emotionally intelligent nurse had correctly identified that what appeared on the surface to be anger was in fact deep guilt. Only when she looked past the angry behavior and spoke to the guilt was she able to reach this woman who in reality was in terrible pain.

Identifying emotions correctly is also important for collegial and team relationships. I recently observed a hostile interaction between a nurse and a physician. Both parties were competing for “who was right” about a patient-care issue. Leaving the interaction, the nurse made several negative comments blaming the physician for the interaction. Later, I found the nurse in tears. She said, “I’m never good enough; he always makes me feel stupid.” As we talked about her relationship with the physician, she came to realize that feelings of inferiority drove her into repeated conflict with him. She tried to prove her worth by challenging his care decisions. Once she correctly identified her emotions, she was able to make better choices in this problem-prone relationship. As she did this, her relationship with the physician improved dramatically.

## Using emotions to reason

In complex situations, people with good EI skills use emotions to reason more effectively. When nurses do this, feelings inform their reasoning. At the same time, reasoning also informs their feelings. I call this the ability to “think/feel.” It may be, as some nursing research suggests, that what nurses often call “intuition” or “trusting your gut” is really this ability to “think/feel”! CS: I changed singular nurse above to plural to match plurals used elsewhere in paragraph.

In the ICU one day, I had a series of interactions with my patient’s family that left me feeling angry. Other nurses usually describe me as kind and unusually compassionate with families. But for no apparent reason, every interaction with my patient’s son left me feeling increasingly angry. There came a point when I decided to accept my anger as data, some

kind of important information about the situation. In EI terms, I used my emotions to inform my reasoning. Only then did I realize that the son had behaviors that were very manipulative. I was responding with anger to his continuous subtle manipulation. When I used my emotions in the reasoning process, I was able to identify the family member's behavior and problem solve the situation more effectively.

I realized that the son's manipulative behavior was the result of the family's lack of trust in the nursing staff. A short family meeting with the staff addressed and quickly resolved the trust issues. The manipulative behavior stopped, my anger never returned, and the patient's care improved. I also came away from this situation having learned something about myself. For me, anger may be an early indicator that I am in a situation in which I am being manipulated.

## Understanding emotions

The third ability that makes up EI is the ability to understand emotions. This involves knowing about emotions themselves, the way they evolve, change, and blend with each other. A good example of this is the grieving process. Nurses are well versed in the phases of grief—shock, anger, denial, and acceptance. Part of understanding these phases is the knowledge that they are not linear, but rather may cycle back and forth. A newly diagnosed cancer patient may have gone through initial shock and denial and finally have begun to show signs of acceptance, only to cycle back to anger or denial. An understanding of grieving in all its dimensions is crucial for effectively working with grieving patients or family members.

An emotionally intelligent hospice nurse I worked with shared an example of this with me. A deeply caring nurse who typically had close emotional relationships with her patients, this nurse was having difficulty getting through to one of her patients who was close to death. She could not connect with him, nor get close enough to identify what his feelings and concerns were. In the end, her understanding of the final stage of grieving, withdrawal, changed her perspective on the situation. She remembered that as grief is resolved, dying people often begin to withdraw from others. This introversion isn't a rejection of other people, but rather a continued positive movement into the experience of death. Her understanding helped her to respect her patient's emotional boundaries and also helped his

family understand what felt to them like rejection. As the nurse understood her patient's emotions, she was able to care for him more effectively.

Understanding emotions is also an important skill for stress management and burnout prevention. A close coworker was one of the most emotionally intelligent nurses I knew. She was particularly good with dying patients and their families, and regularly took on the most challenging assignments. At one point in her career, over a period of months, she began to complain that she was feeling more and more detached. She regularly bitterly joked, "They don't pay me to care." She chose to do a school assignment on burnout and to her alarm found that the detachment, withdrawal, and cynicism she was experiencing were classic signs of professional burnout. Equipped with this understanding, she decided to intervene in her own burnout process. She diagnosed the cause of her burnout—in her case, "high-tech death" that violated the honorable dying process she believed in. She took a leave of absence to work in a hospice for 6 months, where her faith in the integrity of the dying process was restored. Later she was able to return to the ICU ready again to do the work she loved. This illustrates research findings in both nursing and other professions. Measured EI has been demonstrated to correlate with improved stress response, improved retention, and decreased burnout.

## Managing emotions

Managing emotions in one's self and in emotional situations is the last of the four EI abilities identified by Mayer and Salovey. Managing emotions is proactive and problem-focused. It is not the same as denying emotions, repressing them, or pretending they are not there. As the proverb goes, "If you don't manage your emotions, they manage you." A common example of this is nurse anger. Nurses often experience anger at patients, their families, and at other nurses and multidisciplinary team members. Anger that arises in these relationships is common and understandable, but typically not well managed. CS: I changed "comes up" to "arises" to avoid the more colloquial "comes up"

Nurses are taught to care, and often fundamentally see themselves as altruistic, supportive individuals. Even accepting that they are angry with a patient may be difficult. If nurses do not use EI skills—if anger is not identified, reasoned with, understood, and managed—the consequences for patient care are serious. Unidentified, unmanaged anger with patients

easily results in less frequent nursing rounds, late medications, and even less-than-gentle physical and emotional care. In these cases, patient safety is compromised as soon as a nurse is not able to identify and manage anger. When anger between colleagues or multidisciplinary members is not identified and managed, teamwork suffers.

Managing emotions often involves expanding our “menu” for managing an emotion. One particularly volatile nurse came to me for help with her temper. She could identify only two things to do when she was angry—yell and cry. I asked her if she had ever considered walking away from situations when she was angry so she could think them through and decide how to act. The nurse looked at me dumbstruck. She had never considered it. She walked out of my office shaking her head and mumbling in disbelief, “I could just walk away!” One very small addition to her menu changed everything.

## **Transform challenges with EI skills**

The four abilities of EI offer simple ways to transform challenges in patient care, teamwork, and self-care. Next time you are stumped, think of putting one of these abilities to work and see what EI can do for you.

**Estelle Codier is assistant professor at the University of Hawaii at Manoa in Honolulu.**

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**Appendix C: Rights of Research Participants****THE RIGHTS OF RESEARCH PARTICIPANTS\*****AS A RESEARCH PARTICIPANT AT COLLEGE OF SAINT MARY  
YOU HAVE THE RIGHT:**

1. TO BE TOLD EVERYTHING YOU NEED TO KNOW ABOUT THE RESEARCH BEFORE YOU ARE ASKED TO DECIDE WHETHER OR NOT TO TAKE PART IN THE RESEARCH STUDY. The research will be explained to you in a way that assures you understand enough to decide whether or not to take part.
2. TO FREELY DECIDE WHETHER OR NOT TO TAKE PART IN THE RESEARCH.
3. TO DECIDE NOT TO BE IN THE RESEARCH, OR TO STOP PARTICIPATING IN THE RESEARCH AT ANY TIME. This will not affect your relationship with the investigator or College of Saint Mary.
4. TO ASK QUESTIONS ABOUT THE RESEARCH AT ANY TIME. The investigator will answer your questions honestly and completely.
5. TO KNOW THAT YOUR SAFETY AND WELFARE WILL ALWAYS COME FIRST. The investigator will display the highest possible degree of skill and care throughout this research. Any risks or discomforts will be minimized as much as possible.
6. TO PRIVACY AND CONFIDENTIALITY. The investigator will treat information about you carefully and will respect your privacy.
7. TO KEEP ALL THE LEGAL RIGHTS THAT YOU HAVE NOW. You are not giving up any of your legal rights by taking part in this research study.
8. TO BE TREATED WITH DIGNITY AND RESPECT AT ALL TIMES.

**THE INSTITUTIONAL REVIEW BOARD IS RESPONSIBLE FOR ASSURING THAT YOUR RIGHTS AND WELFARE ARE PROTECTED. IF YOU HAVE ANY QUESTIONS ABOUT YOUR RIGHTS, CONTACT THE INSTITUTIONAL REVIEW BOARD CHAIR AT (402) 399-2400. \*ADAPTED FROM THE UNIVERSITY OF NEBRASKA MEDICAL CENTER, IRB WITH PERMISSION.**

### Appendix D: Informed Consent



**Title of this Research Study: LIVED EXPERIENCES AND INSIGHT ON DEVELOPMENT OF EMOTIONAL INTELLIGENCE IN PROFESSIONAL NURSING PRACTICE**

You are invited to take part in this research study. The information in this form is meant to help you decide whether or not to take part. If you have any questions, please ask.

**Why are you being asked to be in this research study?** You are being asked to be in this study because you display traits of an emotionally intelligent nurse who has works in an acute care setting at a Midwest hospital.

**What is the reason for doing this research study?** Emotional intelligence has shown to be an important concept for nursing practice however, little to no research has been done on the lived experiences of emotionally intelligent nurses and how they gained these emotionally relevant skills. The purpose of this study is to deeply examine how emotional intelligence is applied in clinical nursing practice and how a nurse develops those skills in clinical practice by asking (1) What factors, positive or negative, have influenced how the professional nurse becomes emotionally intelligent based on the lived experiences of one emotionally intelligent acute care nurse in a Midwestern hospital setting, and (2) How has emotional intelligence contributed to the daily practice of a professional acute care nurse in a Midwestern hospital setting?

**What will be done during this research study?** The interviewer will collect informed consent and deliver *The Rights of Research Participants* to you. After addressing any concerns and collecting appropriate signatures, the following will occur:

- The interviewer will send you a web address to complete the MSCEIT emotional intelligence exam. Results will be reviewed with you, the interviewer, and a certified instructor. *Estimated time: 45 minutes for the exam, 30 minutes to review*
- *Phase One Interviewing:* The interviewer will conduct an interview asking about simple demographic information, experiences in nursing school, support systems, etc. You and the interviewer will construct a “life experiences grid” to organize future interviews. *Estimated time: 1-3 hours*
- *Phase Two Interviewing:* The interviewer will return to continue interviewing you regarding emotional intelligence skills, experiences in nursing, and completion of the “life experiences grid.” You will be encouraged to journal your thoughts between interviews. *Estimated time: multiple interviews 2 hours in length, estimation of 4-6 interviews total*
- *Phase Three Interviewing:* The researcher will review the collection of interviews for any inconsistencies or gaps in data. A final interview will be scheduled to follow up with chronological questions, clarifying information, or exploration of subject interpretation. *Estimated time: 2-4 hours*

You will be provided with written transcripts of her interview and themes identified from her responses. You will then have the opportunity to confirm these findings or refute the conclusions. *Expected completion date: August 1<sup>st</sup>, 2016*

**Participant Initials** \_\_\_\_\_

**ADULT Consent Form - PAGE TWO**

**What are the possible risks of being in this research study?** There are no known risks to you from being in this research study.

**What are the possible benefits to you?** You are not expected to get any direct benefit from being in this research study.

**What are the possible benefits to other people?** Possible benefits exist to current and future nurses and nursing students who are learning emotional intelligence skills. Information provided in this study may influence best practices in nursing programs.

**What are the alternatives to being in this research study?** Instead of being in this research study you can choose not to participate.

**What will being in this research study cost you?** There is no cost to you to be in this research study.

**Will you be paid for being in this research study?** You will not be paid or compensated for being in this research study.

**What should you do if you have a concern during this research study?** Your well-being is the major focus of every member of the research team. If you have a concern as a direct result of being in this study, you should immediately contact one of the people listed at the end of this consent form.

**How will information about you be protected?** Reasonable steps will be taken to protect your privacy and the confidentiality of your study data. Audio recordings will be collected and subsequently destroyed by the interviewing researcher after transcription. Written transcriptions will be identified only by pseudonym and destroyed after 3 years. The only persons who will have access to your research records are the primary investigator and any other person or agency required by law. Your identity will be kept strictly confidential with any presentation of data.

**What are your rights as a research participant?** You have rights as a research participant. These rights have been explained in this consent form and in *The Rights of Research Participants* that you have been given. If you have any questions concerning your rights, talk to the investigator or call the Institutional Review Board (IRB), telephone (402) 399-2400.

**What will happen if you decide not to be in this research study or decide to stop participating once you start?** You can decide not to be in this research study, or you can stop being in this research study ("withdraw") at any time before, during, or after the research begins. Deciding not to be in this research study or deciding to withdraw will not affect your relationship with the investigator, or with the College of Saint Mary. If the research team gets any new information during this research study that may affect whether you would want to continue being in the study, you will be informed promptly.

**Participant Initials** \_\_\_\_\_



**ADULT Consent Form - PAGE THREE**

**Documentation of informed consent.** You are freely making a decision whether to be in this research study. Signing this form means that (1) you have read and understood this consent form, (2) you have had the consent form explained to you, (3) you have had your questions answered and (4) you have decided to be in the research study.

If you have any questions during the study, you should talk to one of the investigators listed below. You will be given a copy of this consent form to keep.

If you are 19 years of age or older and agree with the above, please sign below.

Signature of Participant:

Date:

Time:

My signature certifies that all the elements of informed consent described on this consent form have been explained fully to the participant. In my judgment, the participant possesses the legal capacity to give informed consent to participate in this research and is voluntarily and knowingly giving informed consent to participate.

Signature of Investigator: \_\_\_\_\_ Date:

Time:

**Authorized Study Personnel.**

Principal Investigator: Jennifer Jessen` Phone: (402) 658-4401

Research Advisor: MJ Petersen Phone: (402) 399-2651

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**Appendix E: Recruitment Email**

(To be sent via social media connection)

Hello (Participant name),

You may or may not remember that I am a doctoral student at the College of Saint Mary pursuing my Ed.D degree with an emphasis on Healthcare Professions Education. As a part of fulfilling the requirements of my degree, I am writing a dissertation thesis that studies how Emotional Intelligence is developed by professional nurses. My dissertation is unique in that I am intensely studying one individual's journey through this process; it is called narrative qualitative design.

I would love for you to be the participant I interview for this study. I have known you for multiple years, in many different roles, and I certainly believe that you would be an excellent fit. If you'd like to discuss the requirements, procedures, and time commitment required of participating, I'd be happy to meet with you to provide all of the information and answer any questions you might have.

Thank you and I hope to hear from you soon,

Jennifer Jessen Ed.D(c), RN

**Appendix F: Life Grid Protocol & Journal Instructions**

Completion of the Life Experiences Grid will be outlines and developed with the participation of the research participant. Follow up and clarifying questions will be included as necessary.

TIMELINE	Age/location/ significant life changes (such as marriage or divorce)	Support systems & Important influences	Type of learning utilized	Research Question 1 & 2  <i>General Impressions</i>	Research Question 3 & 4  <i>Understanding Emotions</i>	Research Question 5  <i>Identifying Emotions</i>	Research Question 6 & 7  <i>Using Emotions</i>	Research Question 8 & 9  <i>Managing Emotions</i>	Research Question 10  <i>Learning EI</i>
Early life healthcare experiences  Years:									
Nursing School									
Pre-clinical Experiences  Years:									
Clinical Experiences  Years:									
Novice Nurse									
Orientation  Years:									
Nursing Positions									



**Interview Questions based on the Four Branch Model of Emotional Intelligence:**

General Impressions:

1. What experiences have most influenced how you practiced as a nurse?
2. What has had the most influence on how you progressed as a professional nurse?

Branch One: Understanding Emotions

3. What have you learned about emotions that helps you predict patient responses or guide your clinical judgment?
4. Can you describe an experience when you felt overwhelmed or discouraged as a nurse? How did you react?

Branch Two: Perceiving Emotions Accurately in Self and Others

5. Can you describe a time when you were surprised by the reaction of a patient, family member, or colleague?

Branch Three: Using Emotions for Critical Thought

6. What experiences have you had where intuition or a 'gut feeling' helped guide your decisions?
7. Can you describe an experience where you felt manipulated by a patient or colleague?

Branch Four: Managing Emotions to Attain Specific Goals

8. Can you describe a time in your career when you had to manage a difficult patient, family member, or colleague?
9. How would you compare your ability to manage your feelings at this time compared to earlier in your career?

Learning EI:

10. (In response to each answer given for questions 3-9) How did you learn that this was the correct or incorrect way to respond?

**Personal Journal Instructions:**

Throughout the course of interviewing you may have additional comments or recollection of events related to topics we have discussed in our interviews. If this happens, please keep a written record of your thoughts in a Word document saved to the provided flash drive. This can be as simple as jotting down a few words to spark your memory next time we meet, or it could be an in depth record of an event that you would like to include. This is not a required part of the research process, but another way for you to feel that you have completely communicated or clarified your thoughts and feelings. Please let me know if you have any questions via email or phone, as I would be happy to answer them.

Jenny Jessen  
402-658-4401  
jjessen@csm.edu

**Appendix G: Audit Trail Letter**

February 23, 2017

Jenny Jessen requested an Audit Trail be conducted for her qualitative dissertation, “Lived Experiences and Insight on Development of Emotional Intelligence in Professional Nursing Practice”. The Audit Trail was conducted on February 22, 2017.

In my opinion, the study followed the established processes for qualitative studies, remaining consistent with the intended purpose statement, research questions and planned procedures approved by the Institutional Review Board. NVivo 11 and manual coding were used to assist in organization of themes that emerged from the qualitative data analysis. The themes identified flowed directly from the documents that were in interview format. The procedures utilized were clear, transparent, and well documented.

In summary, I attest that the criteria for trustworthiness, credibility, and dependability of the findings met the standards for data quality management. I served as auditor as part of my role as Doctoral Committee Chair.  
Sincerely,

*MJ Petersen*

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