Understanding and Use of Emotional Intelligence among Clinical Nursing Instructors

by

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Abstract

The purpose of this qualitative study was to explore clinical nursing instructors understanding and use of emotional intelligence (EI). Emotional intelligence can be defined as “the ability to monitor one’s own and other’s feelings and emotions, to discriminate among them and to use this information to guide one’s thinking and actions” (Salovey & Mayer, 1990, p.189). Mayer and Salovey’s Four-Branch Model of Emotional Intelligence was used as a conceptual framework to examine nine clinical nursing instructors’ experiences of how they perceive and use EI in their clinical practice. Data was collected over a 3-month period using semi-structured interviews and analyzed using open coding to categorize and develop themes. Two major themes and several subthemes emerged from the data to describe clinical nursing instructors’ understanding and use of EI. The two themes identified were Emotional Awareness and Managing Emotions. This study demonstrated that clinical nursing instructors have the ability to perceive and use emotions in themselves and others. This is an important finding, as advancing nursing education with emotionally intelligent educators will assist in meeting the demands of evolving health care needs. Although there are nursing studies that explore emotional intelligence in nursing and nursing students, there has only been one study examining emotional intelligence and clinical nursing instructors. This exploratory, qualitative study adds to the knowledge of EI and clinical nursing instructors, contributing to a better understanding of clinical nursing instructors’ perceptions and use of EI.

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Dedication

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Chapter 1- Introduction

Background

Healthcare today consists of rapidly changing, complex environments. In addition to nursing shortages due to retirements; there are also diversity, economic and consumer demand challenges (Shaffer, Davis, Dutka & Richardson, 2014).There are changing demographics of the clients for whom nurses care. Individuals are living longer, with more chronic and complex health conditions (Grady & Gough, 2015). There are multi-cultural diversity needs with new immigrants arriving with potential global health issues. Canada's impoverished populations, including many Indigenous and Northern communities, continue to face health inequities and challenges (Marchildon, Katapally, Beck, Abonyi, Episkenew, Pahwa, & Dosman, 2015). In addition, there is consumer demand for improved health services, including more family and caregiver collaboration with health care workers. Technologic advances pose challenges to health care workers striving to keep up with continuous developments. In addition, economic trials are present, including productivity numbers that need to be met, and constant health care policy reforms including provincial health care cutbacks (CBC News Online, nd; Grady & Gough, 2015). All of these challenges impact nurses who will be working in the health care environment. Nurses who will be working in this environment will be expected to possess advanced skills, leadership, and the ability to critically think to meet these demands. Entry level nurses will need good teachers, and willing mentors who love the profession (Meinecke, 2012), and who can instill confidence and excellence in to the next generation of nurses to help meet these challenges

One concept that is positively associated with nurses' ability to meet the demands of health care today is emotional intelligence (EI). Emotional intelligence is defined as "the ability to monitor one's own and other's feelings and emotions, to discriminate among them and to use this information to guide one's thinking and actions" (Salovey & Mayer, 1990, p. 189). Individuals who work in healthcare who display high levels of EI are able to deal with work stressors better, have less burnout, greater job satisfaction, and display improved quality patient care (Spano-Szekely & Quinn Griffith, 2016). Nursing is a stressful profession. Some challenges include having to critically think in life and death situations on a daily basis, deal with emotionally charged patients and families, and do so in a calm and professional manner. Individuals who display EI have been shown to have less stress and are able to moderate their stress better (Spano-Szekely & Quinn Griffin, 2016). Additionally, those with high levels of EI are able to effectively use emotional information to make sense of their reactions to stressors, and to guide adaptive reactions (Ju, Lan, Li, Feng & You, 2015). Cherry, Fletcher, O'Sullivan and Dornan (2014) agree that EI has an impact on people's ability to manage stress. In their review, the authors found that EI positively influences the ability to identify others' emotional expressions, and also makes people more satisfied with relationships, better able to manage moods, and more adaptable to handle stress.

It is important to point out that individuals will never be stress-free. Stress is a part of life and is certainly a part of the nursing profession (Grady & Gough, 2015). Nonetheless, the effects of prolonged and unmanaged stress can negatively impact individuals, particularly in their work life. Nurses' stress has been linked to burnout (Shafer et al., 2014), which in turn may lead nurses to leave the nursing profession. In

Canada, the Canadian Nurses Association (CNA) predicts a shortage of 60,000 registered nurses by the year 2022 (CNA, 2009). However, emotionally competent nurses who are self-aware could actively work to reduce their stress levels, which in turn would lead to less burnout (Allen, Ploeg & Kaasalainen, 2012), and fewer nurses leaving the profession.

Nurses with understanding of EI have less job burnout (Spano-Szekely & Quinn Griffin, 2016). Allen and colleagues (2012) postulate that EI is a significant predictor between emotional exhaustion and burnout. The more aware individuals are of their emotions, the quicker they can identify when they are experiencing uncomfortable issues in the workplace, and find solutions to those matters. Dealing with emotional issues quickly and not letting them continue for an extended period of time would help mitigate emotional exhaustion. In their study with middle school teachers, Ju et al. (2015) found EI and social support were protective factors for teacher burnout. The fact that both professions (education and nursing) have similarities suggests that the results are useful for nurses as well. Finally, individuals who have EI are able to effectively use emotional information to make sense of their reactions to stressors, and find solutions (Ju et al., 2015). This ability to reduce stress and manage solutions in the workplace also helps mitigate burnout.

Additionally, EI has been linked to greater job satisfaction and success, particularly in business and organizational leadership roles (Allen et al., 2012). High levels of EI are linked to a person’s emotional and social function, capacity to self-actualize, and success (Allen et al., 2012). In their study of EI and middle school teachers, Yu et al. (2015) agree that teachers with high levels of EI were able to form

supportive interpersonal relationships with others, which led to an increase in job satisfaction. Therefore, having the ability to manage emotions, and deal with relationships with colleagues in a professional and effective manner leads to greater job satisfaction. People enjoy their jobs more when they “get along” with their colleagues.

Another common measure of intelligence is Intelligence Quotient (IQ), which can be defined as a score used to determine the relative intelligence of a person based on a standardized test (Webster’s dictionary, n.d.). In their study, Allen et al. (2012) suggest that although IQ is important, EI is instrumental in career success and the ability to form successful relationships in the workplace. Cherry et al. (2014) argue that EI actually matters more than IQ for professionals who work every day with emotionally charged workplaces, such as in healthcare. Therefore, while nursing is a profession where a high degree of critical thinking and intelligence is required to be successful, the combination of relative intelligence and emotional intelligence is essential. An example is a nurse manager who possesses high IQ, but lacks the ability to manage his/her emotions and displays unprofessional behavior. Cherry et al. (2014) argue that the job satisfaction of their staff is less than a care area with a nurse manager who has the ability to manage their emotions when interacting with staff.

Nurses who possess high levels of EI have longer careers and greater job satisfaction (Spano-Szekely & Quinn Griffin, 2016). Most of the research to date focuses on EI and nursing leadership. There is a significant amount of research supporting the importance of EI in nursing leadership (Feather, 2009). Nurse leaders with EI have the ability to understand emotions of staff and colleagues, and more effectively manage by providing support, feedback, and guidance in their respective

positions (Spano-Szekely & Quinn Griffin, 2016). Furthermore, creating a work atmosphere where staff feels understood, respected, and listened to in turn create increased job satisfaction.

Nurses who have high levels of EI not only have increased job satisfaction, they also provide care that generates an increase in patient satisfaction (Shanta & Gargiulo, 2014). Shanta and Gargiulo (2014) maintain that nurses' EI scores were significant predictors of quality patient care outcomes. One way nurses contribute to an increase in patient satisfaction is by having good communication skills. Nurses who have EI are able to establish ways to communicate by using their awareness of their own emotional responses and the emotional responses of others (Shanta & Gargiulo, 2014).

Research has also identified positive influences in other professions such as business, education and medicine (Corcoran & Tormey, 2013). One review examined the relationship between EI, patient satisfaction, and medical education. In their review, the authors claim there is evidence that doctors' EI influences their ability to deliver safe and compassionate health care (Cherry et al., 2014). Therefore, physicians who deliver safe, competent care while maintaining compassion and being aware of emotions increases patients' satisfaction levels.

Disciplines such as medicine and education have seen the importance of EI and have adopted EI education in to their curriculum (Cherry, Fletcher, O'Sullivan, & Dornan, 2014; Lefkios, 2013). Medicine has seen the value of EI in their programs, with EI being linked to the contribution of professionalism and enhanced communication skills in medical students (Cherry et al., 2014). Educational disciplines also recognize

the value of developing EI in their students. For example, Allen et al. (2012) discuss the need for blending emotional and social skills into curriculum to enhance the development of future leaders in education fields.

Nursing must evolve to meet the demands of a dynamic health care system, and nurses need to lead and partner in the transformation of healthcare (Handwerker, 2012; Spano-Szekely & Quinn Griffin, 2016). Advancing nursing education will support the transformation of the nursing profession. Benner and colleagues (2009) called for radical transformation in nursing education. As demonstrated in medicine and education fields, one way nursing education can be transformed is to develop faculty and students' understanding of EI. Nursing education needs to model these other disciplines and include EI based curricula in their programs to assist nurses in meeting the evolving demands of current health care issues.

The development of competencies necessary for nursing begins in entry-level education programs (Shanta & Gargiulo, 2014). The way in which students are educated helps to develop compassionate, skilled, and competent nurses. In nursing education, the importance of emotions related to students' clinical performance has been demonstrated (Allen et al., 2012). Students need to learn to control their emotions in the clinical setting and in their professional activities to enhance clinical practice. In recent studies, nursing students who had better control of their emotions and manifested an increase in EI showed an increase in professional competence (Allen et al., 2012; Ranjbar, 2015). EI is an important aspect of nursing education and may facilitate the development of future leaders. Therefore, EI should be an important part of nursing curriculum. However, although authors agree that EI is important for nurses to

possess, it is less obvious how nursing education might influence the development of EI (Shanta & Gargiulo, 2014).

Although the positive impact emotionally intelligent nurses have on their profession is demonstrated (Feather, 2009), there are gaps in current research regarding how to develop EI in nursing students. Shanta and Gargiulo (2014) claim that there is a gap between competencies needed for contemporary nursing and current education. Additionally, Benner (2009) called for radical transformation in educating nurses to meet increasing demands of health care. To decrease education to practice gaps in nursing, and help transform nursing education, nurse educators need to be part of the solution. A part of the transformation of nursing education depends on faculty to continue to create, and actively respond to health care environment changes (Benner, 2009). Yet Shanta and Gargiulo ascertain that a gap continues in how nursing students are educated (2014). One way that may help to address this education to practice gap is to develop clinical nursing instructors' emotional intelligence.

Pedagogically, to help develop a particular skill in nursing students, nurse educators need to understand and model that particular skill (Allen et al., 2012). For example, to teach a nursing student how to establish an intravenous, the nursing instructor requires the necessary skills and knowledge to demonstrate the skill. The same could be said for EI. In order for nursing students to learn about the significance of EI on their practice and how to develop EI, in clinical skills, the students need to see their instructors model EI. It is suggested that faculty must play a role in the development of EI competencies in students (Allen et al., 2012). Therefore, to develop EI in students, faculty should possess well-developed EI competencies themselves.

However, based on a review of the literature by the author, only one study was found that examined EI and clinical instructors (Allen et al., 2012), and this leads to a gap in the understanding and use of EI among clinical nursing instructors.

Purpose of the Study

The purpose of this study was to understand clinical nursing instructors' perception of emotional intelligence, and how they use emotional intelligence in their clinical settings. A qualitative approach was used, incorporating Salovey and Mayer's Four-Branch Model of Emotional Intelligence (Salovey & Mayer, 1990). There has been one research study found examining emotional intelligence and clinical nursing instructors (Allen, Ploeg & Kaasalainen, 2012); however, there is a need for further research exploring this area. Allen and colleagues stress that to develop EI, clinical instructors need to possess EI themselves, but "little research has been done in this area" (2012, p. 233), thus the purpose of their study on EI and clinical instructors. There is a demand for nurses who can function in roles that require advanced skills in communication, leadership, and self-awareness. The need for emotionally intelligent leadership in health professions is acknowledged in the literature (Carragher & Gormley, 2016). In their study, Carragher and Gormley (2016) demonstrate the important link between leadership and emotional intelligence, and recommend that an emphasis be placed on developing EI in undergraduate nursing curricula. Therefore, it can be argued to foster leadership and EI in nursing education, educators, including clinical nursing instructors would need to understand and model EI competencies.

Research Questions

The research questions that guided this overall qualitative study included:

1) What are clinical nursing instructors' perceptions of emotional intelligence?
2) How do clinical nursing instructors use emotional intelligence?

Terms and Operational Definitions

Emotional intelligence. The "ability to monitor one's own and other's feelings and emotions, to discriminate among them and to use this information to guide one's thinking and actions" (Salovey & Mayer, 1990, p.189).

Clinical nursing instructor. The "teaching staff and members of the administrative staff having academic rank in a nursing school" (Reference MD, ND). For the purpose of this study, clinical nursing instructors can be further defined as members of the academic staff in a bachelor-nursing program in a post-secondary educational institution, who are responsible for overseeing students on clinical placement experiences.

Conceptual Framework

The term emotional intelligence was first introduced in the scientific literature in 1990 by social psychologists Peter Salovey and John Mayer (Salovey & Mayer, 1990), and made popular outside of academia in the business world by Daniel Goleman (1995). With the rising popularity emotional intelligence has gained over more than 20 years, many theories have been proposed regarding this topic. However, there are three theories that can be consistently described in academic literature (Bulmer Smith, Profetto-McGrath, & Cummings, 2009). These three theories include the ability model

by Salovey and Mayer (1990); Bar-On's Emotional-Social Intelligence (ESI) model (Bar-On, 2005); and the emotional competencies workplace model by Goleman (1995).

Salovey and Mayer (1997) characterize emotional intelligence as a set of four related abilities; perceiving, using, understanding, and managing emotions. These researchers believe that the key to having emotional intelligence lies in one's ability to be able to process emotional information. Emotional intelligence, like academic intelligence, can be learned, increases with age, and is associated with life success (Salovey & Mayer, 1997). Salovey and Mayer (1997) developed a four-branch model of emotional intelligence. The model is comprised of four abilities; perception, assimilation, understanding and regulation of emotions.

Bar-On (2005) concurs with Salovey and Mayer that emotions are a predictor of life success, and that emotional intelligence can be taught. However, Bar-On's theoretical approach to EI is broader, as it includes an environmental and social aspect to EI. Bar-On conceptualizes that emotional intelligence is "a set of personality traits and abilities that predict emotional and social adaptation within environments" (Bulmer Smith et al., 2009, p. 1626). Bar-On's ESI conceptual model consists of five key competencies; interpersonal skills, intrapersonal skills, adaptability, stress management, and general mood (2005). Based on the abilities associated with these five key competencies, Bar-On developed the Emotional Quotient Inventory (EQ-*I)* tool to measure emotional intelligence.

Goleman (1995) made emotional intelligence popular with his book, suggesting that emotional intelligence has an influence on many areas of our lives, including work life. Goleman suggests that emotional intelligence is a set of learned skills and

competencies and with his colleagues has developed leadership models based on this perspective (Bulmer Smith et al., 2009). Goleman posits that EI is comprised of five essential elements; knowing one's emotions, managing emotions, motivating oneself, recognizing emotions in others, and handling relationships (Goleman, 1995). Goleman's EI models are the most widely known outside of the academic world.

While all three models of emotional intelligence can be used to further an understanding of the perception and use of EI among nursing faculty, the Mayer and Salovey (1997) model is the most appropriate for the proposed study. All three models are reflective of self-awareness, self-management, and social-relationship attributes (Codier, Mumeno, Franey & Matsuura, 2010). The models differ in the disciplines from which they emerged, their measurement tools, and the definition of emotional intelligence. However, the validity of Salovey and Mayer's ability model that is seen in the literature specific to nursing (Bulmer Smith et al., 2009) asserts this model is suitable for studying emotional intelligence and nursing faculty. Codier et al. (2010) agree that the Ability Model has been used most frequently in nursing, and can capture elements of emotional labor intrinsic to nursing.

Four Branch Model of Emotional Intelligence

Branch One- Perceiving Emotions

The bottom branch of the Four Branch Model of Emotional Intelligence consists of *perceiving emotions*, which is considered the most basic aspect of EI (Salovey & Grewal, 2005). Included in this branch is the ability to recognize emotions shown on people's faces and in their voices. Additionally, we not only perceive emotions in

people, we can decipher emotions expressed in artifacts; such as pieces of artwork, in literature, and songs. Perceiving emotions also includes the ability to recognize ones' own emotions (Salovey & Mayer, 1997). This is considered as the most basic step to emotional intelligence, as one has to be able to perceive emotions before one is able to manage them. Being open and receptive to non-verbal body language, including facial expressions enables one to accurately perceive the emotion being expressed. Nurse educators with advanced leadership skills including EI competencies would facilitate safe learning environments for students (Allen et al., 2012).

Branch Two- Using Emotions

The second branch of the Four Branch Model of Emotional Intelligence is *using emotions* (Salovey & Mayer, 1997). This branch of using emotions helps individuals think through situations or use emotions to promote thinking and problem solving (Salovey & Grewal, 2005). The authors pose a hypothetical situation in which an individual is required to complete a difficult assignment. The importance and impact of a mood can greatly affect how individuals tackle a difficult assignment. A good mood can stimulate not only our motivation to complete the assignment, but also stimulate creative thinking. Conversely, a bad, sad mood may decrease ones' creative side, but perhaps ones 'ability to be methodical and careful would be enhanced (Salovey & Grewal, 2005). Therefore, the emotionally intelligent individual can use their changing emotions to best meet the task at hand.

Branch Three- Understanding Emotions

The third branch of the Four Branch Model of EI is *understanding emotions* (Salovey & Mayer, 1997). This branch addresses the ability to comprehend and

interpret the cause of emotions, including the sometimes complicated relationships between emotions. The degree of understanding emotions comprises the ability to perceive emotions, including the knowledge that emotions can change over time. This consists of being sensitive and aware of slight changes in emotions, such as being aware of the difference between shock and grief (Salovey & Grewal, 2005). The ability to understand emotions is vital in nursing. As nurses provide care for their clients, in sometimes stressful, sensitive and emotionally charged situations, the ability to understand the emotions expressed enhances the overall care provided to the client. For example, when performing an initial dressing change on a mastectomy patient, a nurse who possesses emotional intelligence and understanding of emotions may be aware that the patient may be experiencing a variety of emotions, including shock, loss and fear. The nurse who is aware of these emotions can therefore acknowledge to the patient how difficult that initial dressing change may be, and offer support as needed.

Branch Four- Managing Emotions

The final branch of the Four Branch Model of EI, which is located at the top of the model, is *managing emotions* (Salovey & Mayer, 1997). Considered the most integral part of being emotionally intelligent, managing emotions consists of the ability to regulate not only our emotions, but also respond appropriately to the emotions of others (Salovey & Grewal, 2005). The individual with high emotional intelligence can harness both positive and negative emotions, and manage them to complete whatever goals or tasks may be required (Salovey & Grewal, 2005). A nursing instructor who possesses high emotional intelligence not only possesses the skills to be aware of his/her students' emotions, but has the ability to manage those emotions as well. For example, students

may be unhappy with their exam results, and the nursing instructor is planning on conducting an exam review in class. The instructor demonstrates awareness that the students are upset, and plans to acknowledge the unhappy emotions surrounding the exam results, yet has the ability to keep the review professional and in control.

Significance of the Problem

The message in the literature concerning the future of nursing is consistent; the health care environment is becoming increasingly complex and stressful for health care workers (Allen et al., 2012; Grady & Gouph, 2015; Shafer et al., 2014). Nurses are faced with nursing shortages, as well as challenges in diversity, economics and consumer demands (Codier, Freitas, & Muneno, 2013). It is argued that the foundation for development of all skills and competencies essential for nursing practice, including EI competencies, begins with nursing education (Shanta & Gargiulo, 2014). Therefore, EI should be an integral part of nursing education, with nurse educators who have high levels of EI. However, although there is significant research demonstrating the importance of EI in nursing leadership, very little research has looked at EI and clinical nursing instructors.

It is important to acknowledge that the researcher held certain assumptions regarding EI and clinical nursing instructors. As an experienced clinical nursing instructor, the researcher recognizes that there are some pre-conceived ideas or thoughts regarding how clinical instructors should handle emotions. Some clinical instructors with more years of experience may have more EI than instructors with less experience. The idea of EI may be unknown to some clinical nursing instructors, as it is a newer concept in nursing education. Finally, clinical instructors may handle emotions

very well, yet be unaware that this is EI. Please see Appendix A for researcher assumptions.

Chapter Summary

This chapter presented the nature of the problem and described the purpose of the study. The assumptions underlining the study were outlined, and key terms relevant to this study were defined. Additionally, the conceptual framework that guided the study was explained, as well as the significance of the framework to nursing education. The following chapter will provide a review of the empirical literature relevant to the topic of the study.

Chapter 2 – Review of the Literature

The purpose of this chapter is to present the background and conceptual content based on the current state of research and literature as it applies to emotional intelligence and nurse educators. The chapter is divided into six sections. The first section identifies the search strategy used for this literature review, and outlines the current literature on emotional intelligence, including the evolution and background of the concept. This section also examines EI in relation to the disciplines of medicine and education. The second section compares different theoretical constructs and instruments used in EI by Goleman (1995), Bar-On (1997), and Salovey and Mayer (1990). The third section examines EI in the context of nursing, including nursing leadership. The fourth section examines EI as it pertains to nursing education, including clinical teaching. The fifth section outlines the search strategy used to review the literature on EI and nursing education specifically. Tables and a figure are provided to summarize relevant theoretical and empirical research articles about EI and nursing education. The last section of this chapter will summarize gaps found in the literature regarding EI and nursing education, as well as the need for further research that investigates the relationship between EI and nurse educators.

Search Strategy

The purpose of the literature review was to establish what is currently known on the theoretical and empirical basis of EI in relation to clinical nurse educators. The review was guided by the following questions:

1. What is the state of the knowledge development of EI in relation to nursing education, specifically clinical instructors?
2. What are clinical nursing instructors understanding of EI?
3. How is EI currently used among clinical nursing instructors?

Methods

A systematic approach to searching and reviewing the state of science within the discipline of nursing involved the use of primary sources found in peer reviewed nursing and associated disciplines journals. Then, secondary sources, including a number of systematic reviews were utilized to illustrate different ways of looking at EI within nursing and nursing education (Polit & Beck, 2012).

Search History

The literature was searched using CINAHL, Medline, PubMed, Scopus, ERIC and PsycINFO. The integrative review included all articles from January 2007 to March 2017 to illustrate the most current knowledge on EI and nurse educators, as well as historical literature on the development of EI. In addition to articles retrieved from the databases, other sources were acquired by follow up references listed in the papers reviewed (Polit & Beck, 2012). This review focused on both theoretical and research based published papers. The search key words used were: EI, EI and nursing, EI and nursing education, EI and education, EI and nurse educators, EI and teach*, EI and theories.

Emotional Intelligence

When examining the origins of EI, some literature suggested that roots of EI are founded in the concept of social intelligence. Social intelligence was first identified in

1920 by Thorndike, an American psychologist, and defined as “the ability to understand and manage relations between men and women, girls and boys” (Law, Wong, & Song, 2004, p. 484). In 1985, a doctoral student, Wayne Payne introduced the term emotional intelligence in his dissertation on the study of emotion. However, it was not until 1990 when two American university professors, John Salovey and Peter Mayer, brought the concept to the academic world (Salovey & Mayer, 1990).

While painting a house and discussing their research on cognition and emotion, Salovey and Mayer first came up with the idea that emotions play a part on an individual’s intelligence, believing that smart decision making requires more than just intellect (Goleman, 1995). It was around that time that Goleman, a science reporter for *The New York Times*, read the seminal article in an obscure journal, and was intrigued by the notion of EI. Later, Goleman published his bestseller, *Emotional Intelligence: Why it can matter more than IQ* (1995), thereby introducing the concept to everyday people and the business world. EI has been one of the most influential ideas in the business world, spawning a plethora of websites and conferences, teaching and leading people to identify the importance emotions play in their lives. In the academic world, a growing number of empirical and theoretical articles continue to be published annually in a number of disciplines, including medicine, education and more recently, nursing.

Emotional Intelligence and Medicine

The importance of EI in medical education and practice is evident in current literature. Numerous reviews looking at the relationship between EI and physicians were located, as well as a number of research articles and editorials (Arora et al., 2010; Cherry et al., 2013; Cherry et al., 2014; Mintz & Stoller, 2014). Literature indicates EI is

linked with improved patient satisfaction (Hammerly, Harmon & Schwaitzberg, 2014), improved communication skills of physicians (Cherry, Fletcher, & O'Sullivan, 2013), and enhanced professional collaboration and leadership skills (Mintz & Stoller, 2014). Arora et al. (2010) in their review of 16 articles examining EI and physicians identified themes of teamwork, stress, leadership, patient trust, and patient satisfaction as all being correlated to physicians' level of EI. Furthermore, there is research evidence that physicians with EI have improved ability to deliver safe, compassionate health care (Cherry, Fletcher, O'Sullivan & Dornan, 2014).

Literature suggests that physicians with EI are better able to deal with emotionally charged situations, have improved leadership skills, and are better equipped to meet the competences required of the medical profession (Arora et al. 2010). Hammerly et al. (2014) state that to be a successful physician in today's rapidly changing healthcare environment, both cognitive and emotional intelligence is required, and EI is essential for physicians to extend past their technical and cognitive skills to meet patient needs. Hammerly et al. (2014), discuss numerous improved health outcomes related to physicians with strong emotional awareness. These positive health outcomes include increased patient satisfaction, improved treatment regimens, improved clinical outcomes, decreased physician burnout and turnover, decreased medical errors, and essentially a decrease in overall health costs (Hammerly et al., 2014). Cherry, Fletcher, and O'Sullivan (2013) agree that effective patient-provider communication between physicians and their patients, including the ability to identify patient's emotional distress, is important for patients' health and well-being, as well as the delivery of high quality medical care.

Physicians work in highly emotionally charged environments, and must be able to interpret and respond to quickly changing emotions of their patients. Medicine is an emotionally demanding practice, and having a good awareness of emotions enhances one's ability to manage these demands. Cherry et al. (2014) found that doctors with EI are better able to meet these demands. Chun and Park (2016) conducted an exploratory study using Q methodology examining EI among nursing and medical students. In their study, Chun and Park (2016) agree that both nursing and medicine are professions with high social demands and stress, and the ability to notice and control emotions helps build effective coping mechanisms which leads to increased problem solving skills.

Finally, another theme that emerged from literature regarding EI and medicine is that EI assists physicians to meet the competencies of their profession (Hammerly et al., 2014). Six competencies were identified by the American Board of Medical Specialties (ABMS) (1999), which are to be assessed, documented, and incorporated into practice. These six competencies include medical knowledge, patient care, practice-based learning, professionalism, and interpersonal/communication skills (Hammerly et al., 2014). Hammerly et al. (2014) argued that two of the six core competencies; professionalism and collaboration/communication skills, require physicians to succeed in measures associated with EI. Mintz and Stoller (2014) agree that EI is a key competency, not only in these two areas, but threaded throughout all clinical settings.

Emotional Intelligence and Education

Emotional intelligence is also linked to positive outcomes in the teaching profession, including educational performance (Rahmat, Ghalavandi, & Jesarati, 2014), teacher satisfaction (Yin, Lee, Zhang, & Jin, 2013), and a decrease in teacher burnout (Corcoran & Tormey, 2013). A descriptive correlational study of 450 faculty members at an Iranian university investigated the relationship between faculty members' EI and educational performance (Rahmat et al., 2014). A significant relationship was found between the faculty members' components of EI that was studied and their educational performance. The components of EI in this study based on Bar-On's model include: intra-personal skills, interpersonal skills, problem solving, stress management, and general mood (Rahmat et al., 2014).

When exploring EI and education, there has been some research done exploring the relationship between teachers' EI and emotional labor (EL) strategies (Yin et al., 2013). EL was first identified in 1983 by Archie Hochschild, and described as the management of feeling to create a publicly observable facial and body display (Yin et al., 2013). Initially introduced to service sector workers such as bill collectors, clerical workers, and flight attendants, EL has since been applied to other professions including doctors, lawyers, and now educators. Specific to education, face-to-face contact between teachers and students, the need to express emotion (excitement, joy, etc.), and adhering to cultural sensitivities requires EL. As previously identified, EI is the ability to perceive, understand and regulate emotions. Therefore, the association between EI and EL should be extremely close; however, the relationship between teachers' EI and EL has been underexplored (Yin et al., 2013).

Yin et al. (2013) explored teachers' EI, emotional labor (EL) strategies, and their influence on teachers' sense of job satisfaction in China, and found that there was a significant and positive influence of teachers' EI on teachers' satisfaction. In their study of 1281 Chinese schoolteachers, the authors discussed EI as the teachers' ability to accurately perceive and positively regulate emotions, and EL as the teachers' perceived need to make efforts to suppress or manage their emotions and feelings in their jobs (Yin et al., 2013). This perceived need to manage feelings to create a publicly observable facial and body display known as EL may lead to increased job stress. Therefore, the finding that teachers' EI has a positive influence of their EL leads to an increase in job satisfaction, which provides some empirical evidence concerning the role of EI and EL in teachers' work.

Two studies found higher EI to be associated with a decrease in teacher burnout. A descriptive, correlational study investigated the role of workplace social support on the relationship between EI and teacher burnout on 307 middle-school teachers in China (Ju, Lan, Li, Feng, & You, 2015). These authors argued that there is a growing body of evidence associating EI with teacher burnout, and EI could render teachers' less vulnerable to burnout when they able to make sense of their reactions to stressors. The findings are similar to those found by Corcoran and Tormey (2013), who state that teachers with increased test scores on EI measurement tests report less burnout and an increase in job satisfaction. These authors argue that there are good theoretical grounds seeing EI as important in the teachers skill set, yet there was a lack of data on student teachers levels of EI. Therefore, they conducted a quantitative study of 352 student teachers at a university in Ireland. Although research suggests growing

evidence that emotions play an important part of a teacher's skill set, their study revealed no evidence of a relationship between student teachers' levels of EI and performance as teachers in schools (Corcoran & Tormey, 2013). One possible answer was that the school system within which the students worked tended not to assign priority to social or emotional learning. Regardless, the authors suggested that the lack of association does not mean emotions are not important to teacher performance, and further research is indicated (Corcoran & Tormey, 2013)

Contrary to these findings, two reviews on EI and education offer criticism to and limitations of the implementation of EI, suggesting that further research is needed. Humphrey, Curran, Morris, Farrell and Woods (2007) found unclear definitions of what EI is, and inconsistent research linking EI with student's academic success. The authors argue that few longitudinal studies evaluating the long-term impact of student learning and EI in schools have been done, with the focus of previous studies being primary school students (Humphrey et al., 2007). Lefkios (2013) agrees that emotional intelligent has vague definitions and weak scientific support and argues that caution needs to be considered before using EI in education. This author also noted, however, that real people and organizations have seen the introduction of EI into workplaces that did actually work. Therefore, EI can be used as a tool to help meet standards and maximize performance. Nonetheless, it is important to be aware of implications EI has on teachers, including sacrifices it demands on their personhood (Lefkios, 2013), which in turn can affect EL as well.

Emotional Intelligence Models

There are three main conceptualizations of EI that influences scholarship, each one of them significantly contributing to EI knowledge and research: Reuven Bar On, Daniel Goleman, and the team of John Mayer and Peter Salovey (Smith, Profetto-McGrath, & Cummings, 2008). Each of these leading theorists conceptualized EI in a slightly different way to help guide their research. Mayer and Salovey (1997) defined EI as an ability, Bar On (2005) defined EI as a set of traits and abilities, and Goleman (1995) viewed EI as a combination of skills and abilities.

Bar On's emotional-social conceptualization of EI is founded in community health, and poses that EI is a set of personality traits and abilities that help predict social and emotional adaptation to the environment (Smith et al., 2008). Essentially, EI is a function of personality. Bar On (1997) measured social-emotional intelligence using the Emotional Quotient Inventory (EQ-i), based on five behavioral abilities of interpersonal skills, intrapersonal skills, adaptability, stress management and general mood. Bar On acknowledges that his conceptual model of EI is influenced by other environmental adaptation theories. Bar-On's trait EI model has been adopted by many scholars, with proponents of this approach asking people to judge, and report how good they are at perceiving others' emotions (Brackett, Rivers, & Salovey, 2011).

Goleman's theory of EI, the most widely known outside of academia, was popularized after the release of his best-selling book *Emotional Intelligence: Why it can matter more than IQ* (1995). Goleman views EI as a set of learned skills and competencies that are separate from cognitive intelligence, and complimentary to academic performance (Smith et al., 2008). Goleman's mixed-model posits that EI is

both an ability and a function of personality (Codier, Freitas & Muneno, 2013). Goleman's mixed-model theory is composed of five parts: self-awareness, self-regulation, motivation, empathy, and social skills. The Emotional Competence Inventory developed by Goleman and his colleagues used to measure emotional competency in the workplace has been criticized for face and discriminate validity issues related to an overlap with personality tests (Codier et al., 2013).

Finally, Salovey and Mayer's Ability Model (1997) of EI has its origin in cognitive psychology. These researchers assert that the brain has a separate processing system for dealing with emotional information, and like academic intelligence, EI can be learned, and increases with age (Smith et al., 2008). Mayer and Salovey (1990) define EI as the ability to accurately perceive, appraise, regulate, and express emotions. EI depends on the ability to process and regulate emotional information. The authors built a four-branch model of EI, and corresponding tools to accurately measure the construct. The four branches of the model include the ability to perceive emotions, use emotions to facilitate thought, understand emotions, and manage emotions (Mayer & Salovey, 1997). The instrument used to assess levels of EI using this model that has undergone rigorous face and validity testing is the Mayer-Salovey-Caruso EI Test (MSCEIT) (Codier et al., 2013).

For the purpose of this study, the ability model of EI will be used due to its documented validity that has been demonstrated across a wide range of disciplines, including nursing. There has been debate about the ideal method to measure EI, with some scholars arguing that self-report is more desirable (Brackett et al., 2011). Self-report scales are less costly, easier to administer, and take less time than performance

tests. However, self-reports are also problematic, because participants can “fake” their responses, with more socially desirable answers (Brackett et al., 2011). Therefore, the ability-based model by Mayer and Salovey (1997) is preferred for this study.

Emotional Intelligence in Nursing

Nursing is an emotional profession, and nurses’ EI is correlated with enhanced leadership skills (Heckeman et al., 2015), reduced burnout, job retention and quality patient care (Codier, Muneno, Franey, & Matsura, 2010). There are a number of published literature reviews related to EI and nursing (Akerjordet & Severinsson, 2007; Akerjordet & Severinsson, 2008; Akerjordet & Severinsson, 2010; Foster, McCloughen, Delgado, Kefalas, & Harkness, 2015; Smith, Profetto-McGrath, & Cummings, 2008). Akerjordet and Severinsson (2007) analyze and discuss the epistemological and empirical perspectives of EI and relate their conceptualization to nursing. These authors conducted two other literature reviews on EI and nursing leadership to contribute to the growing body of knowledge surrounding EI and nursing (Akerjordet & Severinsson, 2008; Akerjordet & Severinsson, 2010). Smith et al. (2008), presented findings of an integrative literature review specific to EI and nursing, concluding that the literature reveals widespread support of EI concepts in nursing. More recently, Foster et al. (2015) conducted a literature review specific to EI education in pre-registration nursing programs. These authors found that a wide variety of EI constructs were used in nursing education, leading to strategies to enhance students’ EI skills. However, there are limited curricula components and frameworks reported in the literature, and ability-based teaching approaches are recommended (Foster et al., 2016). Finally, although nursing may have been slower than other disciplines to develop EI theory (Smith et al.,

2008), taking the time to understand and consider published criticisms might have its advantages in furthering EI theory related to nursing.

Several studies published associate EI with enhanced leadership skills in nursing and job performance (Foltin & Keller, 2012; Heckemann, Schols & Halfens, 2015; Spano-Szekely & Quinn Griffin, 2016). In their qualitative, descriptive content analysis, Heckemann et al. (2015) explore the meaning of EI in nursing leadership, and propose a reflective framework as a practical application to foster EI in nurse leaders. These authors pose that there is a ripple effect from nursing leaders with enhanced EI; these EI leaders create a healthy and supportive work environment for their staff, which in turn, fosters staff to perform their best, and cope with stressful working conditions better. One strategy proposed to foster emotionally competent leaders is reflection (Heckemann et al., 2015; Horton-Deutsch & Sherwood, 2008; Taylor, Roberts, Smyth, & Tulloch, 2015). Horton-Deutsch and Sherwood (2008) identify reflection as a key strategy to prepare transformational nurse leaders to help meet the fast-paced clinical world of increasing patient complexity. Heckemann et al. (2015) also propose a reflective framework based on the perspective of EI to foster emotionally intelligent nurse leaders. Taylor et al. (2015) reported similar findings in their study which aimed to raise nurse managers' critical awareness of practical problems and uncover practical constraints to improve work effectiveness. However, these authors argue that strategies adopted for feeling less drained by their work cannot guarantee success every time without EI, as EI is integral to nurse management. Furthermore, EI results in nurse managers who demonstrate poise and composure under pressure, which in turn, helps nurse managers feel less exhausted by their work (Taylor et al., 2015). Feather (2009)

also identifies the importance for leaders to have the ability to recognize emotions within oneself and others and express those feelings to enable leaders to use positive emotions to influence others and facilitate the vision of organizations.

A second theme associated with enhanced EI and nursing is reduced burnout (Basogul & Ozgur, 2016; Codier et al., 2013; Codier, Muneno, Franey, & Matsuura, 2010; Hong & lee, 2016; Kaur, Sambasivan, & Kumar, 2013). Basogul and Ozgur (2016) analyzed the association between EI levels and conflict management strategies of nurses in their cross-sectional descriptive study of 277 nurses in Turkey. These authors determined that nurses' EI affects choice of conflict management strategies in a positive way, which leads to less emotional demands in the workplace and less burnout. The correlation between EI, burnout and patient care is also evident in literature. Kaur et al. (2013), who investigated the effect of spiritual intelligence, EI, psychological ownership, and burnout on the caring behavior of 550 nurses in Malaysia, found that identifying factors that affect caring behaviors of nurses is critical to improving the quality of patient care, and one of these factors is EI. The authors claim that nurses who recognize their own and patients' emotions are more likely to manage emotions and effectively care for patients. Heydari, Kareshki and Armat (2016) also found a significant relationship between EI personality scores and nurses' competence, which is crucial for influencing the health status of patients.

Codier et al. (2010) conducted a mixed -method exploratory study describing EI attributes of professionalism, performance, and nursing intuition that are important in nursing. Subsequently, Codier et al. (2013) explored the impact of an EI ability developmental program on staff and patient care in an oncology unit. The authors pose

that research indicates that EI demonstrated outcomes leads to decreased burnout and improved staff retention. Surprisingly, in their study, the ability to identify emotions was demonstrated less frequently (Codier et al., 2013). The nurses' ability to identify emotions in self and others were limited qualitatively, but the MSCEIT scores revealed that nurses scored in the positive emotional self-management scores (Codier et al., 2013). The authors attributed this anomaly between qualitative and quantitative data to the possibility that the nurses working on the oncology unit developed coping strategies to deal with emotional stress on the unit by avoiding the identification of emotions, despite having the ability to do so.

Codier et al. (2010) were the first authors to identify a correlation between EI and job retention in nursing. The authors discuss the emotional labor intrinsic to nursing, and recommend further research into the EI ability model and its conceptual application to nursing to help mitigate stress, burnout, and retention issues. Consistent with Codier et al.'s. findings, Hong and Lee (2016) showed that enhanced EI might critically decrease nurses' turnover intention by decreasing the effect of emotional labor and burnout. The authors argue that emotional labor, job stress and burnout increased the turnover intention of nurses in their study of 211 Korean nurses.

Nurse turnover is a global phenomenon leading to a shortage of nurses (Hong & Lee, 2016). Therefore, although nursing may have been slower to research the significance of EI than other disciplines, in the past 10 years a substantial body of literature has been devoted to establishing whether measures of EI act as predictors of nurses' success.

Literature Review on Emotional Intelligence in Nursing Education

Inclusion and Exclusion Criteria and Analytical Framework

Although emotional intelligence as seen in the literature has been addressed in the broader sense in the preceding sections, it is important to examine EI's relevance specifically to nursing education. Therefore, a more targeted literature review was conducted and presented here. A broad scope of the literature using the electronic databases previously mentioned was conducted, with the following criteria: 1) articles in English; 2) articles and abstracts published in the last 10 years (2007-2017), with one exception of foundational research (2003); 3) focus on theoretical and/or empirical perspectives; 4) a focus on EI and nursing education. Articles were screened with a goal of finding the most current knowledge on EI and nursing education. Both theoretical and empirical studies were included.

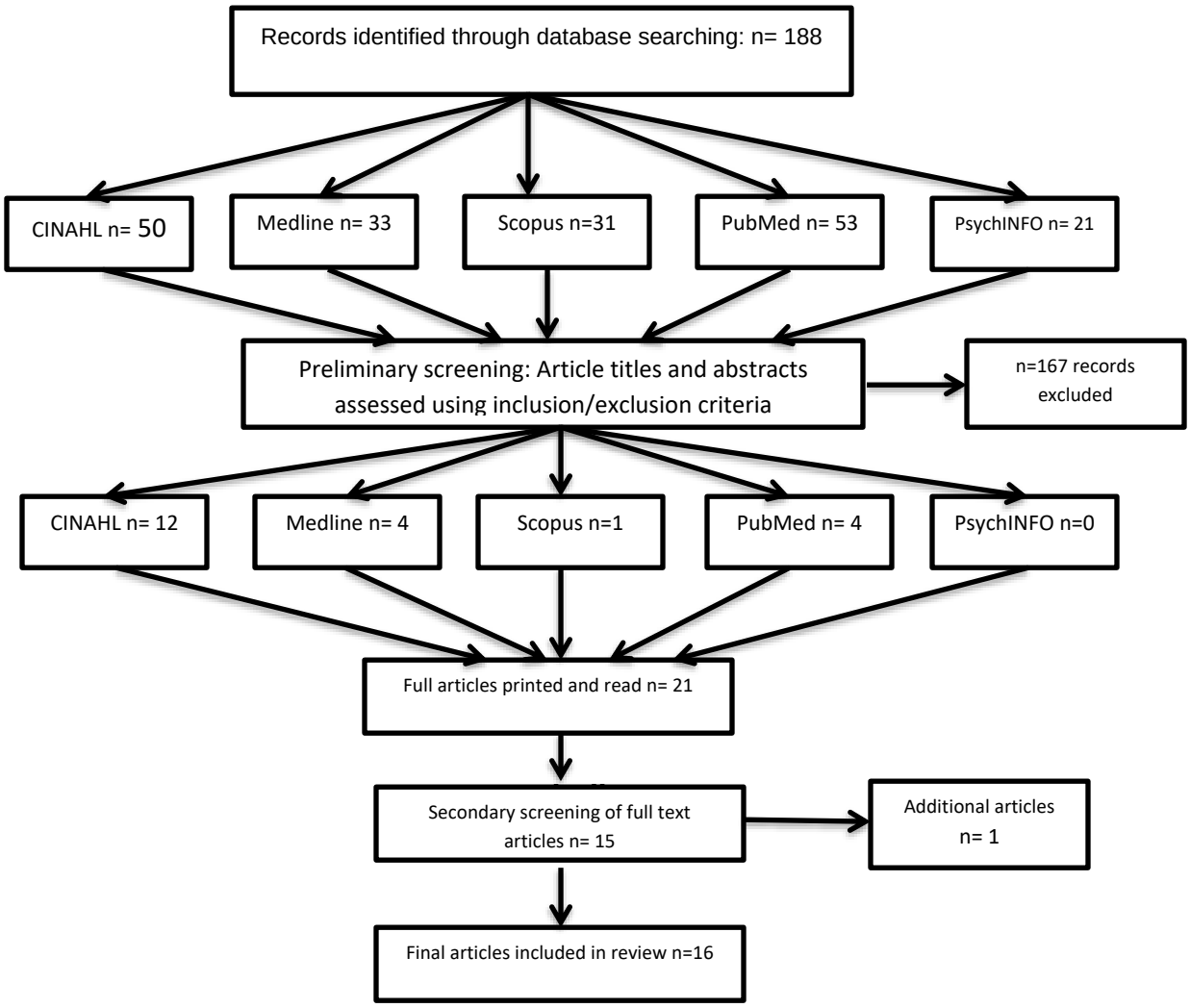
The methodology used in this literature review was inspired by Whittemore and Knafl (2005), and the study by Foster et al. (2015). Polit and Beck's (2012) strategies for finding and critiquing literature were also incorporated into this review, using a matrix and table to show an overview of articles chosen (see Table 2.1). Peer-reviewed research or discussion papers focusing on EI and nursing education from 2007 to 2017 was included. Literature reviews were included for the overall picture they provide on the topic, but grey literature was not scoped due to the lack of relevancy.

Screening Process

A three-step screening process was used to obtain the final sample of articles. Step one was a broad search of the literature to identify abstracts that meet the inclusion criteria. The search outcome revealed 188 articles, including dissertations,

anecdotal reports, editorials, as well as theoretical and empirical research articles. In total, 51 titles and abstracts were printed, duplicates were eliminated and the remaining abstracts were screened using the inclusion/exclusion criteria. Full articles from the retained abstracts were then printed and carefully read to further establish if they were appropriate to use for this review. The final sample included 16 articles (See Table 2.1). The goal of this review was to determine the state of knowledge related to EI and nursing education. To accomplish this, patterns, themes, similarities and differences were determined. Retained articles were read three times to determine the quality of the writing, and to analyze and synthesize themes that emerged from the sample (Polit & Beck, 2012).

Figure 2. Search Strategy



The review included 16 published articles from 2003-2017 (Table 2.1). These were mainly primary research studies (14/16), with two discussion /opinion papers. The authors were from United Kingdom (UK), United States of America (USA), Canada, Australia, Turkey, and Asia. Two authors had written more than one article on the EI concept. A majority of the articles addressed EI in the context of nursing education from a student perspective, with only two focusing on EI and nursing faculty. Findings are categorized according to themes that emerged throughout the review. A range of constructs and definitions were referred to, such as EI (Kaya, Senyuva, & Bodur, 2017) and emotional competence (Rice, 2015). The primary theorists were Salovey and Mayer (6/16), Goleman (3/16) and Bar-On (2/16); with the remaining (5/16) using other theories such as Q-Methodology and the Schutte EI Scale (SEIS).

Table 2.1
Research Articles on Emotional Intelligence and Nursing Education

Authors(s)/ Year	Purpose	Theoretical Framework/Research Design	Findings
Kaya, Senyuva & Bodur (2017)	Determine nursing students' critical thinking disposition and EI in an academic year	Goleman (1998)	Nursing students have a low level of critical thinking and intermediate level of EI both in the beginning and end of the academic year, and a positive correlation at a medium level between nursing students' critical thinking and EI
Branscum, Brown & Sharma (2016)	Examine the role of EI and social support on the performance of health educators	Goleman's personality Model of EI (states most frequently used)	EI constructs are important in the career success of health educators and must be nurtured. Mood management was a significant predictor, and

			indicated increased EI scores are related to ability to manage emotions and react appropriately
Chun & Park (2016)	Identify types of perception of EI among nursing and medical students	Q methodology	The ability to notice and control their emotions is helpful in building effective coping mechanisms to problem solve with nursing and medical students
Orak, Farahani, Kelishami, Seyedfatemi, Benihashemi & Havaei (2016)	Investigate the effect of EI education on baccalaureate nursing students EI scores	Four Branch Mental Ability (Salovey and Mayer)	The study groups did not differ significantly in terms of EI scores before and after the education program. This finding contraindicates earlier studies. Two possible explanations are that the study was done on first year students, who may not yet see the importance of EI, and time available to practice EI was insufficient
Li, Cao, Cao & Liu (2015)	Investigate the relationship among post-traumatic growth (PTG), EI and psychological resilience in nursing students who experienced childhood adversities	Emotional intelligent Scale (EIS) Chinese version by Schutte (1998)	There was a curvilinear relationship between EI, PTG and psychological resilience, implying that resilience and EI can help nursing students cope with adversity in future clinical work
Rice (2015)	Explore self-efficacy and EI as predictors for successful clinical performance in nursing students	Mayer, Salovey and Caruso EI Test (MSCEIT)	Demonstrates significant relationships among EI, self-efficacy and student rated clinical competence, which support the importance of fostering clinical self-efficacy and building EI abilities in students

Beauvais, Stewart, DeNisco & Beauvais (2014)	Describe the relationship between EI, psychological empowerment, resilience, spiritual well-being and academic success in undergraduate and graduate nursing students	Mayer, Salovey & Caruso Four Branch Model of EI , and the MSCEIT	EI was not correlated with academic success in undergraduates; however in graduate students, EI was moderately correlated with academic success
Codier & Odell (2014)	Exploratory, descriptive, quantitative study that explored the relationship between measured EI ability and grade point average of first year nursing students	Mayer-Salovey-Caruso EI Test (MSCEIT)	There was some relationship between GPA and EI, but lower than average range scores in some areas; suggests that further research is warranted between academic success and EI correlation
Shanta & Gargiulo (2014)	Quasi-experimental study investigated if baccalaureate-level nursing education increased the level of EI	Mayer & Salovey's (2004) Four Branch Ability Model of EI	Failed to reveal significant results in the differences between senior nursing students and any level of education, thus did not provide evidence that nursing education increased EI over level of other undergraduate education
Allen, Ploeg & Kaasalainen (2012)	Explore the relationship between EI and clinical teaching effectiveness in nursing faculty	Self-report Bar-On Model using the EQ-i:S instrument	There was a significant relationship between EI and clinical teaching effectiveness. Faculty exhibit effective overall EI functioning with room for improvement, and faculty members are effective in their clinical teaching
	Examine the association	Goleman's Trait EI Model (1986)	This study revealed a statistically significant

Fernandez, Salamonson & Griffith (2012)	between trait EI and learning strategies and their influence on academic performance among first-year accelerated nursing students		correlation between EI scores and critical thinking, help seeking and peer learning; EI emerged as a significant predictor of academic achievement.
Beauvais, Brady, O'Shea & Quinn Griffin (2011)	Examine the relationship between EI and nursing performance in nursing students	Mayer, Salovey, Caruso Emotional Intelligence Test (MSCEIT)	EI was related to nursing performance; four out of six nursing performance subscale scores (teaching/collaboration, planning/evaluation, interpersonal relations/communication & professional development) were significantly correlated with the total EI scores.
Por, Barriball, Fitzpatrick & Roberts (2011)	Explore the EI of nursing students and its relationship to perceived stress, coping strategies, subjective well-being, perceived nursing competency and academic performance	Schutte EI Scale (SEIS) (1998)	EI was positively related to well-being, problem-focused coping and perceived nursing competencies and negatively related to perceived stress, suggesting that increased feelings of control and emotional competency assist nursing students to adopt active and effective coping strategies when dealing with stress
Benson, Ploeg & Brown (2010)	Describe the EI scores of baccalaureate nursing students and determine if there was a difference among the students across the four years of the program	BarOn Emotional Quotient Inventory Short (EQ-i:S)	Undergraduate nursing students in each of the four years of the program had EI scores within the emotionally and socially effective functioning capacity, identifying them as being able to establish satisfactory interpersonal relationships and work well under pressure

Wilson & Carryer (2008)	Explore the views of nurse educators about the challenges they encounter when seeking to assess a students' development of emotional competence during the three year bachelor of nursing degree	Qualitative exploratory study	Emotional competence, like EI, is important to nursing. Both practicing nurses and nurse educators should be able to role model emotionally competent communication.
Feshwater & Stickley (2003)	Discuss the manner in which EI can be more realistically and appropriately integrated into the profession of nursing		EI needs to be firmly at the core of nurse education; when emotional development is neglected, students are denied the opportunity to fully develop intellectually. For this to occur, teachers need to be aware of their own emotions

A majority of the articles (12/16) addressed the effects of EI on student performance, including academic performance, critical thinking/ clinical performance, and stress/coping. The remainder addressed EI and clinical educators. The following discusses the themes that were identified in the review.

Two studies focused their research on EI and academic performance among nursing students. Fernandez, Salamonson, and Griffith (2012) conducted a prospective survey design with 81 first year nursing students in an accelerated nursing program in Australia, examining the association between trait EI and learning strategies, and their influence on academic performance. The authors found a statistically significant correlation between EI scores and critical thinking, help seeking, and peer learning,

indicating that students' EI was found to be a predictor of academic success (Fernandez et al., 2012). However, this is in contrast to findings from Beauvais, Stewart, De Nisco and Beauvais's (2014) study which examined the relationship between EI and academic success in 124 undergraduate and graduate nursing students in the USA, where academic success was not correlated with EI in the undergraduate participants. However, in the same study, EI was moderately correlated with academic success in graduate nursing students. One explanation offered regarding the positive correlation between EI and academic success in the first year accelerated students and the graduate student participants, is the goal orientation of the students. Both graduate students, and students enrolled in an accelerated program are believed to possess high personal goals to improve themselves, which could in turn lead to academic success (Beauvais et al., 2014; Fernandez et al., 2012). Furthermore, researchers agree that historically, nursing education has focused solely on grade point average (GPA) or IQ when evaluating academic success, and there is a need to look further with other factors that lead to academic success, such as EI.

In another study, Codier and O'Dell (2014) explored the relationship between measured EI ability and GPA's of 72 first year nursing students in the USA. The authors found some relationship between the GPA and measured EI ability, but lower than average range scores in several EI scoring sections. These authors argue that the below average EI scores in this study indicate that first year nursing students are not performing well clinically, as perceiving emotions is an essential skill for dealing with patients and families (Codier & O'Dell, 2014). Codier and O'Dell (2014) indicate that these findings are interesting, as scholastic GPA has not consistently been shown to

correlate with postgraduate clinical performance, whereas EI scores have. Students who have advanced GPA's in school have not necessarily performed well clinically after graduation, while students with higher EI scores have more advanced clinical skills post-graduation. Therefore, it is recommended to examine students EI skills in the clinical environment.

In addition to academic success, EI has been linked to positive outcomes in student clinical nursing performance, including critical thinking skills (Beauvais, Brady, O'Shea & Quinn Griffin, 2011; Kaya et al., 2017; Rice, 2015). A descriptive correlational design was conducted with 56 Associate Degree in Nursing (AND) students in two Northeastern states to investigate the relationship between self-efficacy and EI as predictors for successful clinical performance in nursing students (Rice, 2015). This study used the Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT). A significant correlation among EI, self-efficacy, and student rated clinical competence was demonstrated. Hence, it was recommended that nursing programs give students the opportunity to receive instruction in courses that increase EI (Rice, 2015). Consistent with Rice's findings, Beauvais et al. (2011) demonstrated that among their sample of 87 undergraduate and graduate nursing students there was a significant relationship between EI and nursing performance, indicating that EI education should be considered for inclusion in the undergraduate and graduate nursing curriculum. Furthermore, the authors argued that EI education is feasible and inexpensive, and nursing students' clinical performance can be improved by preparing students to not only critically think, but also integrate EI into clinical practice (Beauvais et al., 2011).

Contrary to these findings, Kaya et al. (2017), using a longitudinal quantitative design with 197 first year nursing students in Turkey, found that nursing students have a low level of critical thinking and intermediate level of EI both in the beginning and at the end of the academic year. This study aimed to determine nursing students' critical thinking disposition and EI over an academic year. Although the authors attributed this finding to the fact that the study was limited to freshman students, the fact that development of both critical thinking and EI requires a long time could have also been a factor (Kaya et al., 2017).

When examining nursing students and stress or coping skills, findings are similar. Three studies found a relationship between EI and positive outcomes regarding stress and coping strategies among nursing students (Chun & Park, 2016; Li, Cao, Cao, & Liu, 2015; Por, Barriball, Fitzpatrick, & Roberts, 2011). A prospective correlational survey investigated the EI of nursing students and its relationship to perceived stress, coping strategies, subjective well-being, perceived competency, and academic success of 130 third year diploma, third year degree, and second year accelerated nursing students in the UK (Por et al., 2011). This study found that EI was positively related to well-being, problem-focused coping, and perceived nursing competency, and negatively related to perceived stress. The authors suggest that increased feelings of control and emotional competence assists nursing students to adopt active and effective coping strategies when dealing with stress, and nursing students must be ensured that their feelings are not dismissed and suppressed, but acknowledged by nursing instructors(Por et al., 2011).

Consistent with Por and colleagues (2011) findings, Chun and Park (2016) in a study of 35 nursing and medical students demonstrated students with high EI had decreased levels of stress, high adaptability to their environment, and made correct professional decisions. The results indicated that perceptions of EI by nursing and medical students can represent an effective coping strategy in a situation where emotion is involved (Chun & Park, 2016). Hence, the ability to notice and control their emotions is helpful in areas of human services including medicine and nursing, because it helps build effective coping mechanisms to problem solve (Chun & Park, 2016).

Although EI was found to be a significant predictor related to stress and coping in nursing students in the previous two studies described above, the optimal level of EI was not reported. However, in Li et al's. (2015) study investigating the relationships among post-trauma growth, EI and psychological resilience in 216 nursing students in China, the optimal level of EI was indicated. These authors asserted that moderate levels of resilience and EI can help nursing students cope with adversity in clinical work. Furthermore, low-level EI may be insufficient to stimulate growth because those individuals are less able to respond to feelings, self-regulate, or have coping skills (Li et al., 2015). Alternately, nursing students with high levels of EI can cope with greater adversity and stress less when confronting crisis, therefore may not have the same resilience skills as individuals with moderate EI (Li et al., 2015). Students with moderate EI had to develop ways to cope with stress and crisis, and therefore have built up more resilience than students who already had the coping skills to deal with stress and crisis. However, the generalizability of this study is limited due to the sample of young and highly educated individuals.

Contrary to Chun and Park's (2016) findings, Orak, Farahani, Kelishami, Seyedfatemi, Banihashemi and Havaei (2016) using a quasi-experimental study of 69 first year nursing students in a Tehran University found no significant difference in terms of EI scores before and after an EI educational program. The study intervention included 2-hour sessions teaching EI skills over 8 weeks. The study groups did not differ significantly in terms of EI scores before or after the educational program (Orak et al., 2016). The authors attributed this finding to the fact that only first year nursing students were in the sample, and the lack of clinical experience may have led to the lack of perceived need to learn EI skills.

This finding is inconsistent with Benson, Ploeg and Brown's (2010) study involving 100 Canadian nursing students that described the EI scores of baccalaureate nursing students to determine if there was a difference among the students across the 4 years of the program. The authors found that the difference in EI scores between year one and four was statistically significant, where students in the upper years of the program, were more likely to have enhanced EI skills (Benson et al., 2010). These findings suggest that EI develops over time. However, it is unclear if EI is related to developmental growth, clinical experience or other life experiences, and warrants further research.

The concept of EI in nursing education, specifically investigating clinical teaching effectiveness among nursing faculty, is at the beginning stages of research. Freshwater and Stickley (2003) discussed the manner in which EI can be more realistically and appropriately integrated into the nursing profession, and concluded by suggesting a model of transformatory learning for nursing education. These authors argued that

training versus educating nurses is not enough, and every nursing intervention is affected by EI, that is, it is not enough to attend to practical procedures without considering the human recipient. When teachers pay little or no attention to emotional development, they fail to communicate the significance of human relationships (Freshwater & Stickley, 2003). These authors further identified that nursing education needs to examine the role of EI in curriculum, which requires teachers to be aware of their own emotions to facilitate learning. Teachers need to be in intimate contact with their own emotions, to be able to facilitate learning in others from a position of self-knowledge. However, some authors argue that teachers have low levels of EI, and rather than adding EI to its curricula, EI needs to be firmly placed at the core (Freshwater & Stickley, 2003). Furthermore, Branscum, Brown and Sharma (2016) examined the role of EI and social support on the performance of health educators in their study of 151 masters' prepared health educators who worked in a college or university. These authors identified that EI constructs are important in the career success of health educators and must be nurtured, and individuals with increased levels of EI are able to cope with emotional stress and pressure of their work better (Branscum et al., 2016).

It is argued that there is a demand for nurses who can function in roles that require advanced skills in communication, leadership and self-awareness, and EI is an important aspect of nursing education that may help to develop such leaders (Allen, Ploeg, & Kaasalainen, 2012; Wilson & Carryer, 2008). According to Allen et al. (2012), there is a significant relationship between EI and clinical teaching effectiveness. Nursing faculty plays an important role in student learning, and EI in clinical nursing faculty may

help develop teaching effectiveness. However, while the overall level of EI for the majority of nursing faculty was in the effective category in their cross-sectional correlational study of 47 clinical teachers, only 25% scored in the “enhanced functioning” category (Allen et al., 2012). However, while faculty with increased EI demonstrates more effective clinical teaching, little is known about faculties EI, and these authors argue that further research is warranted. Wilson and Carryer (2008) agree that educators and practicing nurses must uphold the expectation that emotional competence, which is similar to EI, is a requisite ability, and should themselves be able to role model emotionally competent communication. However, how educators and nurses within classrooms and clinical settings effectively help students to develop emotional competence, or EI, is not evident within nursing literature (Wilson & Carryer, 2008). The authors suggest a need for educators and students to have a clearer understanding of what emotional competence in nursing is, and how this knowledge can be realistically incorporated into nursing curriculum.

Shanta and Gargiulo (2014) collected data from 251 participants to investigate if baccalaureate-level nursing education increased the level of EI using Mayer and Salovey’s (2004) four-branch ability model. The authors argued that nursing requires cognitive ability to manage highly charged and emotional work, and there is emerging evidence associating nurses’ EI and quality patient care. Furthermore, the foundation for the development of competencies essential to nursing practice begins with nursing education; therefore, it is important to explore how nurses gain EI. However, the authors found no significant differences between senior nursing students compared to three control groups; thus this study did not provide evidence that nursing education

increases EI over the level of other undergraduate education (Shanta & Gargiulo, 2014). The importance of this study reveals that although there is insufficient research on ways to improve EI in students, nursing education must continue to find effective ways to improve the emotional competence in nursing students to contribute to quality health care, and perhaps the answer is the EI of the educators themselves.

Integrating EI into curriculum with emotionally intelligent nursing educators will provide future nurses with a greater opportunity to understand themselves and others, and the way to build positive relationships and communicate. The subsequent impact on therapeutic relationships and patients' illness and care is indisputable.

Despite promising research findings as presented in this chapter, criticism remains surrounding EI. Primarily is the confusion surrounding consistent definitions of EI. Problems remain in terms of unresolved definitions, and the multiple ways that EI is defined, which can make it difficult to synthesize results. Also, EI has been criticized for measurement issues. A number of problems have been reported in literature related to internal consistently reliability of the Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT) (Akerjordet & Severinsson, 2010). The MSCEIT is the most widely used measurement tool for EI. Additionally, there are documented differences in the way men and women experience EI, so it recommended that further studies are done to explore this phenomenon (Powell, Mabry, & Mixer, 2015).

Finally, the impact of cultural differences surrounding EI has to be addressed. According to research, emotions can be both universal and culturally specific (Shao, Doucet, & Caruso, 2015). In their study, Shao et al. (2015) found that perceiving emotions was universal across cultures compared to other emotional domains such as

understanding and using emotions, which was culture-specific. For example, emotional perception of facial expressions is understood across different cultures, whereas understanding emotions may be more culturally specific due to differences in cultures (Shao et al., 2015). Although scholars are starting to explore the importance of emotions and culture, research is limited. Therefore, although the role of EI in nursing has been well documented, these inconsistencies may make it difficult to synthesize results and translate in to current nursing practice.

Chapter Summary

In the general workforce, EI scores have been positively correlated with workplace outcomes such as improved communication, enhanced team performance, decreased burnout and an increase in staff retention (Brackett et al., 2011; Salovey & Grewal, 2005). In the past 20 years, nursing research has grown to include nursing studies on EI and leadership (Carragher & Gormley, 2016), clinical practice (Foster et al., 2016), nursing education (Freshwater & Stickley, 2003), patient outcomes, stress, burnout and job retention (Codier et al., 2010). In the preceding sections of this literature review, an examination of the conceptions of EI, and descriptions of the scope of current research in the field was outlined. The nursing profession is constantly evolving, and nurse educators play an important role in delivering current, best practices, which arguably includes EI. The nurse educator's role as an emotionally intelligent leader is crucial for the success of students to meet today's complicated health care needs. As described in this chapter, the effects of EI on student performance, including academic performance, critical thinking/ clinical performance, and stress/coping is evident in the literature. Also apparent is the importance of nursing

faculty to possess and model EI to their students. However, there were no research studies that examine clinical nursing faculty's understanding and use of EI. The main research approaches examining EI and nurse educators have been grounded in quantitative statistical facts. By exploring clinical nurse faculty's understanding and use of EI, a foundation can be built that can guide further research. As demonstrated in the preceding chapter, literature is contradictory when examining EI and nursing education with the different models used, different research methods used, and the focus has been on EI and students. Furthermore, different terminology has been used such as EI, EL, and emotional competence. Therefore, this study aims to contribute to the knowledge of the understanding and use of EI among clinical nursing faculty, to promote EI in nursing education, nursing students, and future nursing practice.

Chapter 3- Methodology

In this chapter, the methodology and research design of this study will be discussed. The research design, proposed methods for data collection and analysis, setting of the research study, sample criteria, participants and potential ethical implications will be outlined.

Qualitative research can help researchers access the experiences of research participants, leading to the development and understanding of the meaning of the research topic. Sutton and Austin (2015) suggest that qualitative research is used to gain insight in to people's thoughts and feelings. Qualitative research consists of the collection of data, in this case a semi-structured interview, the analysis of data through the development of coding, categories, and themes, and the dissemination of the research findings. There is limited research about emotional intelligence (EI) and nursing instructors, and there is only one quantitative study that examines EI and clinical nursing instructors (Allen, Ploeg, & Kaasalainen, 2012). The purpose of this study was to explore the understanding and use of emotional intelligence (EI) among clinical nursing instructors. This study explored the understanding and use of EI among clinical nursing instructors in a post-secondary educational institution in western Canada. The methodology used in this study was Qualitative Description (QD) (Kim, Sefcik, & Bradway, 2017). Qualitative description is used in studies that are descriptive in nature, and has been used to describe health care and nursing related phenomenological studies (Kim et al., 2017; Polit & Beck, 2012). QD is appropriate for research questions focusing on experiences, or when a straight description of a phenomenon is desired (Kim et al., 2017).

The purpose of this study was to explore clinical nursing instructors' subjective perceptions and use of EI in their work. Studies that use QD strive to produce a straightforward description, and comprehensive summary of the phenomenon of interest. In this study, the researcher explored the understanding and use of EI among clinical nursing instructors, using participants' language and staying close to the data (Kim et al., 2017). Choosing the research method that is best suited to the line of inquiry is vital to obtaining the desired results of studies. Qualitative research methods enable health sciences researchers to delve into questions of meaning and social processes (Starks & Trinidad, 2007), such as the understanding and use of EI among nurse faculty members. The goal was for the participants to describe their experiences of EI, while probing for details and gaining clarity into the research question. Therefore, QD is a suitable method for investigation of this phenomenon important to nursing instructors. Mayer and Salovey's (1997) Four-Branch Model of Emotional Intelligence was selected as the framework guiding this study.

Sample

Unlike quantitative research, which is concerned with generalizing study results to the population, the aim of qualitative research is to discover the meaning of a phenomenon, not to generalize to a target population (Polit & Beck, 2012). In qualitative research, participants are not selected randomly, as the goal is selecting people who are knowledgeable regarding the chosen topic of interest, and who have experienced the phenomenon. Starks and Trinidad (2007) suggest that sampling depends on five things; scope of the study, nature of topic, quality of data, study design, and use of shadowed data (when participants speak of others' experiences as well as their own).

While there are no fixed rules for sample size, qualitative research is concerned with exploring in depth the richness of interpretations, and small sample sizes are commonly used, typically 10 or fewer participants (Polit & Beck, 2012).

To find participants who have experienced the phenomenon, and be able to articulate what it is like, purposive sampling is used in QD (Kim et al., 2016; Polit & Beck, 2012). Purposive sampling occurs when the researcher recruits participants who have lived the experience, and who will most benefit the study. Participants recruited should be able to provide rich descriptions of the data to reach data saturation, which is defined as sampling to the point that no new information is obtained (Polit & Beck, 2012). Sample sizes are deliberately kept small in qualitative research to allow the researcher to conduct in-depth examinations and analysis about the topic of inquiry (Streubert & Carpenter, 2011).

Recruitment Process

After appropriate approval from the University of Manitoba Education and Nursing Research Ethics Board (ENREB) was obtained (see Appendix B), access to the chosen post-secondary education institution was gained. A letter describing the study was sent to the Dean of Nursing (see Appendix C). Permission was requested to attend the fall clinical nursing instructors' orientation/start-up meeting in August to present information about the study and invite nursing instructors to voluntarily participate in this study. Potential participants who expressed an interest in participating in the study were contacted by the principal investigator via email, and individual meetings at a mutually convenient time and place were made.

Data Collection

The primary source of data collection in qualitative research is interviewing study participants. However, due to the nature of data potentially evolving over the course of the study, the qualitative researcher needs to demonstrate flexibility when conducting data collection (Polit & Beck, 2012). The use of more than one data collection strategy is called triangulation, which ensures completeness of findings and assists in the confirmation of the findings (Streubert & Carpenter, 2011). Using triangulation helps to ensure depth to studies, which then enables the researcher to give a more accurate picture of the phenomenon. To ensure triangulation in this study, in addition to the interviews, field notes were made during the interview process and kept in a journal.

The data collection methods used for this Qualitative Descriptive study included semi-structured individual interviews, field notes reflecting the researchers' thoughts and reflections, and digital recordings. Semi-structured interviews involve a few pre-determined questions, with possible prompts to help deepen and guide the conversation (Petty, Thomson, & Stew, 2012). Semi-structured interviews encourage participants to talk openly and freely about the topic of interest, and tell their stories in their own words. The interviews for this study were conducted face-to-face, lasting approximately 60 minutes, and were digitally recorded for later transcription. (Please see Appendix D for the Interview Guide). The interview questions were developed by the author and based on Salovey and Mayer's Four Branch Model of Emotional Intelligence (1997). These four branches include perceiving emotions, using emotions to facilitate thought, understanding emotions, and managing emotions (Salovey & Mayer, 1997).

One salient field issue in QD is the delicate balance between gaining the trust of the participant, yet keeping a certain objective distance (Polit & Beck, 2012). Although it is impossible to rid one's self of what we know and think; researchers must be aware of pre-existing biases, must recognize what has influenced our pre-suppositions on the topic, and try to suspend and set aside these issues as much as possible. This is identified as "bracketing" one's views, where the researcher builds rapport, encourages candor, listens while preparing what to ask next, and does so handling their own emotions (Polit & Beck, 2012). One way to facilitate bracketing is for the researcher to write assumptions prior to the onset of the study. (See Appendix A)

Field notes were also used during the data collection of this study. This included taking detailed notes during and after the interview; including personal insights, details of the environment and surroundings during the interview, and physical mannerisms of the participants (Polit & Beck, 2012). These field notes helped to capture any elements that may have been impacted on the data collection process while still fresh and clear in the researcher's mind.

Data Analysis

In qualitative research, data collection and data analysis often occur simultaneously (Petty et al., 2012; Polit & Beck, 2012). Typically, the researcher moves back and forth between data collection and data analysis. There are no rules in analyzing data in qualitative research, and Petty et al. (2012) argue that there are a variety of ways to conduct this time consuming and arduous task. Methods of analysis include thematic analysis, content analysis, constant comparison, discourse analysis, conversation analysis, and analysis of narratives (Petty et al., 2012). Regardless of the

method chosen, the purpose of data analysis in qualitative research is to organize, provide structure and elicit meaning from the collected data. Two commonly used approaches to qualitative data analysis are content analysis and thematic analysis. Historically, boundaries between the two approaches have not been clearly specified, and confusion and overlapping has occurred (Vaismoradi, Turunen, & Bondas, 2013). Despite many similarities, the main difference is the possibility of quantification of the data in content analysis based on the frequency of findings, whereas thematic analysis involves the search for identification of common threads of data that extends across an interview or set of interviews (Vaismoradi et al., 2013).

The method of data analysis that was used for this study was qualitative thematic analysis. In qualitative thematic data analysis, participants' experiences are described in a straightforward, focused, and detailed way that allows for study results in a rich, straight description of experiences. (Kim et al., 2016). The outcome of qualitative thematic data analysis is a straight description, with no mandate to re-present the data in any other terms (Sandelowski, 2000). Thematic analysis involves analyzing narrative material, including description and interpretation of the data to generate common themes.

Description of the Coding Process

Coding is the process of identifying topics, issues, similarities or differences that are revealed through participants' narratives and interpreted by the researcher (Sutton & Austin, 2015). As a novice researcher, it is suggested the researcher code anything and everything (Saldana, 2009). It is important to incorporate a large margin on the right hand side of the transcript when typing up interview data to allow for the coding

process. Although there are computer programs available to assist with qualitative coding, it is recommended that beginner researchers code their own data independently. A hard copy of the transcript is printed, and the researcher sits with highlighters and a pen to start the process.

Some authors suggest a process called “pre-coding”, where the researcher circles, highlights or underlines anything in the participant’s narratives that would be considered significant when initially reading the transcript (Saldana, 2009). The literature similarly describes “initial coding”, where the researcher develops words or phrases as a first impression (Sutton & Austin, 2015). Creswell (2013) suggests that to start the initial stage of data analysis, the researcher reads the interview transcript and performs a general review, jotting down words or short phrases that reflects the data. Regardless of how the process of coding is depicted in the literature, the idea is to read, and re-read the participant’s narrative (constant comparative analysis) to become intimately familiar with the data, keeping the goal of the study in mind. In this study, the researcher started by reading the transcripts through, highlighting words or phrases that reflected the data, which was followed by more in-depth reading of the transcripts to expand on the initial review.

Creswell (2013) recommends a short list of five or six tentative codes to begin the process, expanding as needed and ending with five or six major themes. Munhall (2012) suggests aiming for five to seven central concepts or themes, while Wolcott (1994) argues that three of anything major is an adequate number for reporting qualitative research.

Coding is not merely labeling, rather it is the beginning process of data analysis. Coding is rarely done correctly the first time. Coding is a cyclical process, where the researcher continues to read and become increasingly more familiar and immersed in the data. This process of recoding allows the researcher to refine and further manage the essence of the data. Saldana (2009) coins this as “essence capturing”.

To conclude, as a novice qualitative researcher, it was imperative to remember that coding is not an exact science, rather it is predominantly an interpretive act (Polit & Beck, 2012). Using thematic analysis in this QD study gave the researcher a method for identifying, analyzing, and generating themes from the data, thus assisting in the interpretation of the data. Vaismoradi et al. (2013) argue that thematic analysis provides core skills for novice researchers conducting QD studies. Furthermore, to increase the credibility of the coding, the research chair independently coded one transcript, and then discussed the similarities and differences. Furthermore, the researcher asked two participants to review the emerging themes; also known as member checking (Sutton & Austin, 2015). Member checking can help clarify and confirm the research findings.

Once the arduous task of applying codes to the data was completed, the next step was to aggregate and cluster codes. Saldana (2009) describes six patterns to look for in coding at this stage of data analysis. The first and most obvious was to look for similarities or things that happen the same way or in a comparable way. Conversely, the next pattern was to look for differences in the data. In this case when looking for inconsistencies, it was important to note that idiosyncrasy is a pattern. The next pattern used in coding was the frequency in which certain pieces of the data occurred. Whether codes occur frequently or seldom, both aspects were considered a pattern. The order in

which the codes occurred or the sequence was also important to note. Next, the researcher looked at any data that seemed to relate with other pieces of the data; did any events happen in relation to certain activities or events. Lastly, the researcher looked at causation, which examined whether any of the data appeared to lead or influence other pieces of data (Saldana, 2009).

The next step in qualitative data analysis was finding themes that emerged from the data. Essentially, themes were an outcome of coding. As Saldana (2009) suggests, as the data were carefully read and reviewed, an emerging theme or two were determined. Therefore, following coding the data, categorizing and analytic reflection was performed, and themes were identified. A theme is defined as “a phrase or sentence that identifies what a unit of data is about and/or what it means” (Saldana, 2009, p. 139).

Craver (2014) offers a term for finding themes in qualitative research called ‘thematic analysis’. Thematic analysis is described as a method for identifying themes or patterns in qualitative data in relation to a specific research question. There are seven stages in thematic analysis as presented by Craver; transcription, reading and familiarization, coding (selective and complete), searching for themes, reviewing themes, defining and naming themes and writing a report (2014). In this study, the researcher completed all seven stages of thematic analysis, from transcription to writing a report as presented in this thesis.

Trustworthiness of the Findings

Although qualitative researchers agree on the importance of conducting good research, how qualitative research is evaluated is a contentious issue (Polit & Beck,

2012). Some authors argue for the same criteria used in quantitative research, while other authors argue that qualitative research requires different criteria due to different epistemological assumptions (Petty et al., 2012). Regardless, there is agreement on some different approaches that can be used to generate confidence or trust that one can have of a study and its research findings, known as trustworthiness (Petty et al., 2012; Polit & Beck, 2012). These approaches used in qualitative research are confirmability, dependability, credibility, and transferability.

Confirmability is the extent to which the findings from the research can be attributed to the study, and not from researcher bias (Petty et al., 2012). According to Polit and Beck (2012), confirmability is concerned with establishing that the data represents the information from the participants, and not just invented based on interpretation of the data by the researcher. One way to help establish confirmability in qualitative research is to create audit trails. Audit trails are a documented recording of activities over the time of the study that can be easily followed, and help to illustrate the evidence being as transparent as possible (Streubert & Carpenter, 2011). A detailed audit trail was established at the beginning of this thesis, and continued throughout the study.

It is argued that in qualitative research, due to variations between people and contexts, the passage of time, and the dynamic process of data analysis by the researcher, no study can be replicated exactly (Petty et al., 2012). Dependability refers to the extent to which a study could be repeated, and variations understood (Polit & beck, 2012). In other words, dependability refers to the consistency of the study findings. One way to demonstrate dependability is to document the data collection

process throughout the study, including all methodological and analytical decisions. Another method that helps to contribute to the dependability of study findings is triangulation, which refers to the use of more than one type of data collection to provide a deeper understanding, or completeness of the study (Streubert & Carpenter, 2011). In this study, the researcher used in-depth interviews, and field notes to ensure appropriate triangulation, which contributed to the dependability of the study findings.

Credibility is identified as the degree to which the findings of the study can be trusted or believed (Petty et al., 2012), or the confidence in the content and interpretation of the data (Polit & Beck, 2012). There are a number of ways to help establish credibility. Prolonged engagement, or a substantial involvement through the interviews with the participants of the study, persistent observation of the researcher to gain a deeper understanding of the phenomenon, peer debriefing, and performing member checks contribute to credibility (Petty et al., 2012). Member checking is verifying participants' data to the research questions. One way this can be done is by providing feedback to the participants about emerging interpretations, and assessing their reactions to these (Polit & Beck, 2012). Member checking was used throughout this study during the semi-structured interviews to allow the researcher to reflect and evaluate the effectiveness of the research questions, and identify any outstanding features of the participants' responses that need further clarification. Furthermore, two participants were sent emerging themes as the study progressed for feedback to help credibility. The two participants confirmed that the themes were reflective of their answers from the interviews.

The final method to help establish the trustworthiness of this study used in qualitative research is transferability. Transferability is identified as the extent to which the study findings can be applied to other contexts, or with other participants (Petty et al., 2012). Unlike quantitative research, in qualitative research, the findings are not intended to be generalized to large populations. The goal of most qualitative research is to provide a deep understanding of human experience related to a phenomenon of interest, and to enable others to determine the degree to which the findings may be applied to others in similar situations (Polit & Beck, 2012). Therefore, the intent of this study was to understand perceptions and use of EI among clinical nursing instructors for use by other academics in similar programs and settings.

Ethical Considerations

Strategies to adhere to ethical considerations when conducting research include promoting privacy and confidentiality, minimizing risks, ensuring voluntariness and guaranteeing researcher qualifications (Meert et al., 2008). Prior to conducting this study, ethical approval was obtained from the University of Manitoba Education and Nursing Research Ethics Board (ENREB). Written consent was obtained prior to the start of data collection, including information on the voluntary nature of the participation (see Appendix G). Participation was voluntary and participants were able to withdraw from the study at any time. Participants were given the opportunity to receive a copy of the study results after completion of the research project by mail if requested.

The ethical duty of confidentiality refers to the obligation of the researcher to safeguard entrusted information, and includes obligations to protect participant information from unauthorized access, use, disclosure, modification, loss or theft

(Canadian Institute of Health Research [CIHR], 2010). Polit and Beck (2012) identify confidentiality as a pledge that any and all information participants provide will not be publicly reported in a way that identifies them, and data will not be accessed by others not involved in the study. Fulfilling the ethical duty of confidentiality is essential to the trust relationship between the researcher and participant, and to the integrity of the research study. Additionally, an important aspect of privacy is the right to control personal information about oneself.

For the purpose of this study, a digital recording device was used during the interview process, with the recording being identified by only a code number and the date of the interview. Anonymity in qualitative research is especially important due to the small sample size. Only the researcher knew the names of the participants. The advisor analyzed one anonymous transcript. The data will be stored for 7 years, and then destroyed as per ethical considerations (CIHR, 2010). Transcribed interviews were stored on a password protected computer hard drive. Field notes and demographic information were stored on the computer hard drive. Access to computer files were password protected and data were encrypted with access limited to the researcher.

Researchers have a responsibility to avoid, prevent, or minimize harm and risk (Polit & Beck, 2012). Risk in research can be defined as the probability and degree of possible harm inflicted by participating in the research study (CIHR, 2010). All research involves some risk, but risk should be kept as minimal as possible. Additionally, nursing research has the ethical responsibility to design and conduct research that upholds sound ethical principles and protects human rights (CNA, 2008). This study involved minimal risk to the study participants.

Limitations

This study was limited to the small, purposive sample of clinical nursing instructors in one post-secondary education degree-nursing program. Furthermore, because of the small sample size and recruitment method, individuals who choose to participate in this study may not reflect all clinical nursing instructors in other jurisdictions.

Chapter Summary

This chapter described the methods and procedures that were used to conduct this qualitative descriptive research study on the understanding and use of EI among clinical nursing instructors. A description of the proposed methodology, sampling approach, and recruitment procedures were presented. Additionally, the methods for data collection and data analysis were offered. Lastly, strategies to establish the trustworthiness of the findings, and ethical considerations were also presented.

Chapter 4- Findings

The purpose of this study was to explore clinical nursing instructors' perceptions of emotional intelligence, and how they use emotional intelligence in their clinical settings. To explore clinical nursing instructors' understanding and use of EI, one-on-one interviews were conducted with nine clinical nursing instructors employed in a post-secondary educational institution. As the research study progressed, it became increasingly evident throughout the interviews that the participants were eager to share their experiences regarding emotions in the clinical setting. This chapter describes the findings of the study, characteristics of the sample, participants' understanding of EI, and how the participants use emotional intelligence in their varied clinical practice which included acute care, long-term care, and simulation lab.

Characteristics of the Sample

Following ethical and access approval, participants were recruited at the orientation meetings for clinical nursing instructors, at which time the study was described, and participants were invited to participate (see Appendix E). Interviews were conducted between September 15 and November 6, 2018. The final sample consisted of nine participants who were employed in a degree-nursing program at a post-secondary educational institution in western Canada. Qualitative content analysis was used to analyze the data. Data that emerged from the interview process were subjected to content analysis, and themes that evolved were identified. Themes that became apparent were gained from reflection of the participants' views and insights about emotional intelligence. Two themes were identified from the data: i) emotional

awareness, and ii) managing emotions. The uncovering of these two themes assisted the researcher to answer the research questions of the study, which were:

1. What are clinical nursing instructor's perceptions of emotional intelligence?
2. How do clinical nursing instructors use emotional intelligence?

The nine participants who were recruited and participated in this study had an average age of 40.5 years; with ages that ranged from 25-59. Participants worked in a variety of clinical settings (see Table 4.1). All nine participants were female, and registered nurses. The average number of years of nursing experience was 17.5 with a range from 5-38 years. The average number of years that the participants held roles as a clinical nursing instructor was 3.94 years. Participants' education ranged and included being diploma educated, having a Bachelor of Nursing degree or graduate degree, and currently completing a Master of Nursing. All participants were clinical nursing instructors in either acute, long-term care (LTC) or in the simulation lab.

Table 4.1

Demographic Summary of Participants

Participants	Gender	Mean age (years)	Mean years of nursing experience	Mean years clinical experience	Clinical Area
9	9 female	40.5 Sx= 12.36	17.5 Sx= 14.65	3.94 Sx=3.59	Acute, LTC, simulation lab

Characteristics of the Interview and Transcripts

Each of the nine participants was interviewed once, in a mutually agreed location. The interviews ranged from 39 to 70 minutes, with an average interview length

of 49 minutes. The interviews were numbered 1-9 to assist with documenting each participant's responses for the purpose of this thesis. The level of discussion, and responses to the questions asked during the interviews were varied. Mature clinical instructors with more than 15 years of nursing experience shared more in-depth and comprehensive responses to the questions asked. Data saturation was evident after eight interviews, and one final interview was conducted to ensure no new emergent themes developed. The generic label used throughout this thesis and study, clinical nursing instructor, will be used in place of other terms used by the participants in the findings to ensure anonymity and confidentiality.

Introduction of the Themes

The semi-structured interview guide (see Appendix D) had 12 key questions aimed to capture participants' understanding and use of emotional intelligence. Findings from the interviews were analyzed and revealed two main themes, i) emotional awareness, and ii) managing emotions. Each of these two themes were further broken down into categories and sub-categories as seen below in Table 3.1.

Table 3.1

Theme 1- Emotional awareness	**Theme 2- Managing emotions**
Category 1. Self-awareness a) Emotional maturity b) Checking-in	Category 1. Managing emotions in themselves a) Taking a moment b) Venting to someone safe c) Enhancing self-care
Category 2. Emotional awareness in others a) Observing b) Knowing students c) Be “in-tune” to emotions	Category 2. Managing emotions in others a) Role-modelling b) Responding to emotions of others

Emotional awareness had two categories: self-awareness and emotional awareness in others. Self-awareness had sub-categories: emotional maturity, and the ability to “*check-in*” with oneself. Emotional awareness in others had three sub-categories: observing (both verbal and non-verbal cues), knowing the students, and being “*in-tune*”. Two categories emerged from the second theme: managing emotions in self, and managing emotions in others. The category of managing emotions in self was further divided into three sub-categories: taking a moment, venting to someone safe and enhancing self-care. The second category of managing emotions in others had the sub-categories: role-modeling, and responding to emotions of others. The themes, categories, and sub-categories emerged through in-depth data analysis. The following is a presentation of the themes.

Theme 1- Emotional Awareness

Emotional awareness was identified by all the participants. Although described differently, the ability to be aware of emotions in themselves and others, including nursing students, and staff on the units, was evident. As the participants elaborated on how emotions were involved in their role as clinical instructors, two categories emerged: self-awareness, and emotional awareness in others, or as one participant described it, *"the gift of insight" (participant #2)*. Participants' abilities to be aware of emotions in themselves was related to age, time in nursing, and time as a clinical nursing instructor (emotional maturity), and their ability to "*check-in*" with themselves. Participant's ability to be aware of emotions in others, including nursing students and unit staff, was related to their ability to observe (both verbal and non-verbal cues), knowing the students, and being "*in-tune*" to others' emotions. Each participant had unique ways of describing emotional awareness in themselves and others. The ability to be aware of emotions, as described by the participants, was instrumental to being able to meet the demands of the role as clinical nursing instructor.

Self-awareness

Participants' ability to be aware of emotions in themselves was described in different ways. Participants' self-awareness of emotions was divided into two sub-categories: their emotional maturity levels, and their ability to check-in with themselves and how they were feeling. The sub-categories helped to describe how aware the participants were of their emotions.

Emotional Maturity. Emotional maturity was related to age, number of years in nursing, and number of years as a clinical nursing instructor. Some participants described their ability to be aware of their emotions as increasing with age. Age and number of years of nursing experience seemed to have a direct impact on some participants' sense of their emotional self-awareness. One participant, who had 38 years of nursing experience, acknowledged that being older gave her the ability to be better aware of her emotions. She described a number of times throughout the interview that she was an "*old lady*" now, or an "*old nurse*", and how that helped her develop skills to deal with emotions as a clinical nursing instructor.

> *Well I'm an old woman now, an old nurse, so my emotions are very well checked…I come from the glass bottle IVs and the counting the drops and the doing the health care aide stuff, and I have watched over the years, I have seen a lot. Because I think as typical young nurses we want to be everything to everybody, right? And then families, and then going to the point you are sucked, and your emotional tank is done, and I actually do not let it get that far anymore. (Participant 1)*

Another participant with more than 27 years of nursing experience described similar thoughts on age and the ability to be aware of her emotions. She described how being older helped her be aware of her emotions.

> *…I think with life experience, and age, and other things, you learn to let things slide. You know? You don't get as upset about things as you might have gotten upset about 30 years ago. (Participant 7)*

However, it was interesting that the younger participants (less than 10 years nursing experience and/or less than 5 years as a clinical nursing instructor) did not talk about their age, number of years nursing, or number of years as a clinical nursing instructor as contributing to their emotional maturity.

Checking-in. The second sub-category was the ability to check-in with themselves. Participants offered various ways they checked-in with their emotions, and what they were feeling, and how this aided them meeting the demands of their role as a clinical instructor. One participant described starting her clinical day by checking-in with herself and how she was feeling that day.

> *I always want to center myself, and how I am feeling that day, right! Because some days you get out of bed and you're good, and other days you're not so great, so I always try to sit and focus on what my goal is today, and my goal is always to assist in the learning and supporting students. (Participant 2)*

This idea of checking-in was echoed by another participant when asked how she identified emotions in herself.

> *I know this sounds silly, but I ask myself often "how am I feeling and why am I feeling this way"? I try and stay very neutral and try not to let my emotions get into play. Especially with students, I try to be very neutral. So, to recognize it in myself I think is just check-in with myself regularly. (Participant 4)*

Another participant described being in-tune to herself, and using emotional awareness when she realized it was time to switch positions in her job.

> *I remember when I was getting burned-out in the ER, just before I went on maternity leave. I realized that I was turning in to the kind of nurse that I really don't like, and that's when I had to take a break from doing that, so I did a project. I think that also requires some awareness. (Participant 7)*

She described the importance of being aware of her emotions on an on-going basis to meet the demands of her current role as a clinical nursing instructor.

> *I'm always conscious… that if I'm getting a little more irritable or anything, I have to be careful not to take it out on the patients or students. (Participant 7)*

This participant further described how she was aware how she was feeling physically and the potential impact on her emotions.

> *I'm always thinking about emotions, and also, if I'm feeling really tired, or PMS, or vulnerable, not sleeping well, I know that it's going to be harder for me… (Participant 7)*

Another participant shared this regarding emotions.

> *So I wonder, do people that sort of need to be maybe more emotionally intelligent, where they need to look at themselves, are they going to care about something like this because they don't have the insight to say "Hey"! Like, I wonder, you know, the [clinical nursing instructors] that were*

> *mean, that ridiculed you, that, you know, didn't provide a safe learning environment, do they know they were doing that, you know? Do nurse bullies know that they're bullies? (Participant 6)*

This quote suggests that people who are not aware of their emotions, including clinical instructors, are probably also not aware that they lacked emotional intelligence.

Emotional Awareness in Others

The ability to be aware of emotions in themselves (self-awareness) was instrumental for participants to be aware of emotions in others. The ability to demonstrate awareness in perceiving and understanding emotions in others was instrumental to being successful in their role as clinical nursing instructors. This awareness of others' emotion, including both nursing students and staff on the units on which the clinical instructors were working, was identified in three interrelated sub-categories: being able to observe, getting to know the students, and being in-tune to others emotions.

Being able to observe. Participants frequently used the word "*observe",* and the ability to observe emotions in others was instrumental to being able to observe emotions in others. Being able to observe emotions included observing both students and staff on the units to which they were assigned. In this example, the participant used cues to observe her students' emotions and how their day was going. She was instructing in a simulation lab where groups of students rotate through different stations to gain clinical experience in different scenarios. As one group rotated through, she noticed through non-verbal observations that one student was upset. She took the

opportunity to address what she observed a distressed student in need of some support.

> *I could tell by this girl, her coloring. She is pretty fair-skinned, and I could tell she was upset about something. And so I said, "How did the last thing [simulation] go guys?", and they went "Oh, well okay". And no one would really tell me how it went. The [one girl] started crying because of something that happened, and I said "Let's talk about it". So I took seven minutes of our precious sim [simulation] time to defuse and kind of debrief that situation, and I said, "You're not going to be active, you're going to be an observer, but I'm gonna give you a specific role. This is what I want you to do" and I gave her specific things to observe for and then we just moved on and went and did our simulation and she was fine. (Participant 2)*

There were numerous times throughout the interview with this particular participant identified making observations in relation to emotions in others. She stressed the importance of observing non-verbal cues.

> *I watch people because I learned a lot over my career that the non-verbal is where you get your cues…her face was blotchy you know because she'd been emotional and probably, you know, blushed and cried. She was blotchy which most of us are when we are emotional, and so I really pay attention to body language, and that's what I'm going to do, and always that checkpoint. (Participant 2)*

Another participant expressed similar skills in making observations. This participant described paying particular attention to students prior to performing skills to cue in to any potential issues.

> *Before they are doing skills and stuff, I try to see it [anxiety, stress or nervousness] in their eyes, and the little hand shakes. (Participant 5)*

Another participant described how she perceives emotions in her students.

> *…mostly body language, how they interact…I can identify them whether they are sullen, whether they are miserable, whether they are teary, whether they are vibrating… (Participant 1)*

This participant described being able to perceive emotions in her students throughout the clinical day.

Knowing the students. Another sub-category of emotional awareness of others was knowing the students. Participants described how managing emotions in their role as a clinical nursing instructor was related to how well they have to know their students. One participant described how being able to deal with emotions in her students was predicated on how well she has to know students at the beginning of the clinical rotation.

> *I want to do best when I know my students a little bit, so I get a handle on how they are, and the university actually realizes that because they give us a cheat sheet. It says "all about me", and it has about six questions on it and so I gave it to my students already, and I asked them to hand it back*

> *to me before we start, and we only start clinical practice next week, but I've gotten two back already, and I read them on the weekend, and it was really, it was good because it just helps me know a little bit more. (Participant 2)*

Another participant described how she used observation and her experience as a clinical nursing instructor to get a "read" on her students to help in her role.

> *I sit back, I can sit back and I can truly tell you. I sit back and watch, I figure you out, you can tell me anything under the sun that you want, but I can figure you out in about three interactions. That's what I get to carry on now, that's one of the best skills I have, like I can start IVs and all that stuff, but I am more aware of situations, so within about three clinical days, I can tell you if I am going to have a hard time with you, what your issues might be, whether you are going to sneak around on me. (Participant 1)*

This participant described that sitting back and observing her students gave her some insight in to her students, therefore getting to know them a bit as the relationship grew.

Being in-tune. The final sub-category based on emotional awareness of others was being in-tune. Participants described their ability to be aware of emotions in others was based on being "in-tune", using "intuition", or as one participant stated, having a "*spidey-sense*" (Participant #1). One participant described having intuition in a broad sense.

> *I think I'm pretty good and pretty in-tune with [students' emotions]. Yes, with students, with my co-workers, with everything in general. I feel like I pick up on it. I am the kind of person that will approach somebody and say,"Hey, you seem a little off today". Or, "Is there something wrong? Can we talk about this"? And if they say "No", I leave it. (Participant 4)*

Another participant described how she used her intuition and interactions with students in the lab setting.

> *I do sometime see students that look very, very stressed out in the skills lab. Just looking at them today, they had two major exams on Monday, and they were just almost like, you know, out of it. I could sense that. I went around to some of them, I said "Oh you're such a nice class", and I gave them little hugs, when it's appropriate. I know that some people don't like to be touched and all that, but I'm quite huggy. And they giggled, and I tried, I'm very aware it [exams} has been hard on them. (Participant 7)*

Finally, one participant described this regarding intuition.

> *We work well with our co-workers and are better with patients because we're more attuned to people, yeah…there was this nurse, she's useless, I wouldn't even ask her for help because she's useless…this woman was clueless, like honestly, she was there for herself to take care of her patients, and that was it, and she did a mediocre job of that. But did she ever look around? Raise her head and look around her and see her*

colleagues in trouble and go offer help? No, now we know where she is on the emotional intelligence scale. (Participant 2)

This quote demonstrates how intuition assisted her in working well with her co-workers. In this, she also shared a frustrating experience with a co-worker whom she felt lacked intuition altogether.

Summary- Theme 1

The ability to identify emotions was described by participants as their ability to identify emotions within themselves, and an ability to identify emotions in others. Participant's ability to identify emotions in oneself was related to participant's emotional maturity level, and their ability to "*check-in*" with themselves. The ability to identify emotions in others was associated with participant's ability to observe, both verbal and non-verbal cues in others, knowing the students, and be "*in-tune*" to emotions. The ability of participants to identify emotions in themselves and others, including both unit staff and students, provided the clinical nursing instructors with vital information to facilitate clinical work with students.

Theme 2- Managing Emotions

The second theme that emerged from the data analysis was managing emotions. Two categories emerged in participants' abilities to manage emotions: the ability to manage emotions in self, and the ability to manage emotions in others. In each category there were sub-categories. The ability to manage emotions in one's self had three sub-categories: taking a moment, venting to someone safe, and self-care strategies. The ability to respond to the emotions in others was related to the sub-

categories of role-modeling and responding to emotions of others. The following discusses participants' descriptions of managing emotions associated with working as a clinical nursing instructor.

Managing Emotions in Self

The ability to manage emotions associated with being a clinical nursing instructor was vital for participants to perform their jobs. Participants described a variety of ways they managed their emotions: i) taking a moment, ii) venting with someone safe, and iii) doing activities that enhance self-care. One of the biggest challenges described by participants was the need to care for themselves when they were feeling "caught in the middle" from the demands of the job. A number of participants identified this challenge.

> *It's hard…not just managing the students, but managing the staff, the unit, you know, finding the balance in between. (Participant #7)*

This was shared by another participant.

> *Sometimes as an instructor, I feel a bit alone. I feel like I'm getting opinions from both sides, or three sides. From the students, from the university, and from the staff. So, sometimes I feel like I'm caught in the middle. (Participant #8)*

Another participant shared this challenge, and even described this as contributing to the high turnover of clinical nursing instructors.

> *From what I can see, I don't think it's a surprise that clinical nursing instructors don't really last in the role…because you're not just managing*

> *the students. But you're managing the staff, right? Like, you're that go between and I think that can be difficult at times. (Participant #6)*

Managing emotions is instrumental as a clinical nursing instructor. The following sub-categories describe how the participants found ways to manage their emotions.

Taking a moment. All participants interviewed described a variety of scenarios in which they managed their emotions by taking a moment, or taking a "*deep breath*". One participant described how she managed her emotions by "*taking a moment"* when a patient a student was assigned to reminded her of her mother who died recently.

> *I would control that [the fact that this patient reminded me of my mother who had recently died]. So I would have to say all the time, this isn't about me; this is about the patient, or the student, their experience with the patient. And so, you have to, I mean, sometimes I have to go into the medication room, take a few deep breaths… (Participant #7)*

Another participant shared this strategy for dealing with emotions when she was feeling angry, upset, or stressed while on the unit with students. She recognized that these personal emotions could impact her interactions with students, patients, and families, so took a moment to control her emotions.

> *Well sometimes I have to take a deep breath, and I don't have time to go for a long time and then come back and face that [situation with the student that was upsetting]…I usually try to distance myself a bit and then go take a break. I try not to vent to the staff about students, although*

sometimes I do, because that just leads to more gossip and negativity. (Participant # 8)

In addition to describing the importance of taking a moment, or a deep breath, this participant shared that the more you use this approach to manage emotions, the more routine it becomes for you.

I check myself, like deep breaths, mindfulness for myself. Sometimes that means keeping your composure while you're talking to the students, and then going down the hall, let a breath out, or journal or mindfulness. It's hard, I think it's hard to describe when you're practiced at just dealing with them [emotion]. Because it's like riding a bike. It becomes a routine for you. (Participant #9)

This participant also shared that in addition to taking a moment to control her emotions when she is feeling upset, she also used a technique she learned in a mindfulness class to deal with difficult situations.

I guess one of my other techniques is to know that that's their emotion, it's not mine. I don't need to absorb it. I don't need to. I can feel it, but I don't need to make it mine or absorb it. This is my bubble, that's their bubble. It was a really good technique. They said just even pushing your button and you're employing your bubble now. It's not to say that you're in that bubble all the time, but okay, this is your emotion, your issue. (Participant #9)

The tools learned in the mindfulness class assisted this participant in managing her emotions.

Venting with someone safe. The second sub-category described by the participants was finding someone safe with whom to vent. Venting when faced with difficult situations assisted the participants in managing their emotions, whether this was their spouse or co-workers.

> *One way [to manage difficult emotions] would be to decompress with a fellow [clinical nursing instructor], a counterpart, on most part, I'm friends with, and so we can just, "Okay, how are you doing? How's your day going? I need some Starbuck's, I'm out of here", whatever. So that is helpful, and she works on the unit, so she knows things a little better so I can be like, "This happened, is that normal here, or am I crazy?" Like" "What's going on?" (Participant #5)*

This strategy was shared by another participant when asked how she manages her emotions when feeling upset with the students.

> *I come home and sometimes I'm grouchy at home. Yes, I do vent to my husband and other nursing friends. (Participant #8)*

However, there was one participant who did not share this description of using co-workers to vent to for support in managing her emotions, as she felt a lack of rapport with her co-workers, and strived to maintain a distance at work.

> *It's a very superficial relationship. I've tried. I had, in fact over the years I try to stay away from co-workers. I do not want to know their intimate parts of their life, and I've found that over the years things you have said come back to bite you. So, I don't say much anymore. (Participant #1)*

This purposeful distance from coworkers worked for this particular participant in managing emotions.

Enhancing self-care. The final sub-category that participants used to manage emotions was taking part in activities that enhanced self-care. Some of these activities included exercising, going to the gym, journaling, keeping a healthy separation and walking family pets. One participant shared this.

> *Well I'm an old woman now (laughing), an old nurse, so my own emotions are very well checked. I do personal stuff for myself, time out, and that doesn't mean going to your room (laughs). I mean, my two dogs, going for a walk, going to the gym, and going to church. Rest is incredibly important. If I'm in good shape, then I can handle the students. I'm very aware. (Participant #1)*

Another participant also shared the importance of self-care measures in managing her role as a clinical nursing instructor.

> *I don't want to sound, like, cold, it's not that…it's, it's not cold, and it's probably a very healthy separation. It's not, like, I never get affected by my work, but it doesn't help to carry it home and be upset, or…yes, you know what I found that not that it happens every time, but when I started nursing, I would come home, like, very tired and stressed and just, like, maybe edgy. And I found that going to the gym between work and home helped…being active helps (Participant #5)*

One participant shared the importance of engaging in self-care activities such as walking the dog and going to the gym.

> *I walk the dog. Walking is good for me. I'm more like a thinker and walker, so it's good, yoga, the gym, just the regular self-care measures. (Participant #9)*

This participant elaborated further that all the journaling that she did as a nursing student is something she found extremely valuable, as she continues to practice it today in managing her emotions.

> *I'm naturally very analytical, so I analyze all my behaviors and my thoughts. That's just who I am as a person. And so, identifying emotions in myself, sometimes it's through journal reflection. (Participant #9)*

Another participant shared this strategy of journaling.

> *So for me, I kind of push through it, but I definitely am the kind of person that will come home and reflect on it, for sure. Either I'll, you know, in a very generic sort of way talk to my husband or rant about it at the dinner table, or say," You know, people are so mean", you know. I might get a little worked up, or I'm like…I'm a bit of a journaler thanks to nursing school. So, I will like only like…usually when I'm mad. Like honestly the most when I do, like I don't…I have a problem being sad and feeling you know, I need to get this out. Like I just need to get this out. And sometimes it helps you come up with strategies like what am I going to do going*

> *forward and sometimes it's just like get it out. It's just release it, let it go. (Participant #6)*

In addition to other strategies, journaling assisted this participant to manage her emotions in potentially upsetting situations.

Managing emotions

The ability to manage one's emotions as a clinical nursing instructor was described by the participants in a variety of ways. Being able to manage one's emotions, whether it was with their nursing students, or staff on the units they were assigned to, was instrumental. Participants stressed that by managing their emotions, they were better able to deal with potentially difficult situations. There were two sub-categories that emerged: role modeling and responding to emotions in others.

Role modeling. Participants described the importance of role modeling appropriate emotional responses, especially with the nursing students. Participants shared a number of instances when they demonstrated to students that showing emotions was a healthy approach in front of patients and families, as long as you keep those emotions in control. One participant shared with her students, and let them know she has cried with patients before.

> *But I said, and it's okay for you to do the same. I said "What's not okay, for us to do as health care professionals, is to make it [the situation] about us. If we're in a room with a patient and the patient is dying, and you're crying with the family because you have compassion for them, that's okay. But, they shouldn't be giving you the Kleenex."…I think it's important to teach*

> *students that having some emotion is perfectly all right, as long as they're able to do their job and manage it. (Participant #7)*

Another participant had similar thoughts that showing their emotions was acceptable as a nurse and enhanced the nurse-client relationship.

> *I want to say I think it's important that we show our emotion, that we not be stoic for lack of a better word…I think it's important, if you're talking about a palliative patient's last few days or something a family does or whatever. You know there's nothing wrong with showing your emotions. You shouldn't be sobbing as much as the family, but there's nothing wrong with showing it, I think it actually helps families, and I've had families tell me that "I see our loss affected you a great deal". I would say "Of course, how could it not? I'm human". You know, but just showing emotions is okay because you're gonna be a better nurse and you're gonna have a better rapport with your patients and families if you show a little bit of emotion for what they're going through, and I think that is a part of our emotional intelligence. (Participant #2)*

Another participant described this regarding role-modeling.

> *I'm not afraid to cry, you know. I've had students cry because they felt sad and like it's totally okay. You know, we can cry together. I've cried with clients, you know, and I think that's okay, but I think, I don't ever want to be angry or get upset, or raise my voice, or look like I'm not in control, because I think we need to be at least in control of our emotions. I have to*

> *regulate my emotions to role model them. I felt the same way with the students…there were so many times where I could have just lost it and just burst in to tears, or run away but I'm also a role model. Even though I'm a teacher I need to make sure I'm behaving appropriately. (Participant #6).*

Therefore, this participant described comparable thoughts regarding role modeling and the benefit of showing emotions, but controlling them at the same time.

Responding to emotions in others. The ability to respond to difficult emotions expressed by others was something the participants believed was vital in their role as a clinical nursing instructor. A number of participants described responding to emotions with unit staff when they displayed unprofessionalism towards them or their students. The comfort and ability to address emotions was related to the degree of experience as a clinical instructor. Although clinical instructors with fewer years of experience still demonstrated the ability to address emotions, while participants with more experience were more descriptive. One participant described how her experience assisted her in responding to a difficult staff member on the clinical unit. She described how at times the behavior of the staff member was so negative with students that she felt she had no recourse but to go to the unit manager. She tried to address the concern with the staff member initially but went to the unit manager when there was no change in the staff members behavior.

> *But I think with age I'm getting better at that. So now I'm thinking, you know what, I'm 50 years old. I'm really going to let this person make me wet my pants? I would meet with the manager and say... I didn't always want to go directly to that health care aide. I might go to that health care aide and say "You know, the students are just learning, and you know, they've had that [situation] before, they know that", I would always try again to do it nicely. (Participant #7)*

Another participant shared a similar experience where she responded to emotions of others by trying to go the staff member first. She described tension and feeling unwelcome, when her clinical group needed to meet as a group, or even find somewhere to put their jackets and lunches. When going to the staff member first did not resolve the issue, she went to the unit manager when the clinical group felt they were unwelcome.

> *I would say "You know, I know we are a big group, is there somewhere else you could suggest that we might be able to go instead"? And I actually did talk to the unit manager and said "You know, are we doing something that's wrong? Because we, I feel like we're getting a lot of push back." [asking for a place to meet]. Respectfully, but I did have to address a couple of items. (Participant #6)*

Another participant described being more comfortable because of her experience in addressing issues with either the staff member themselves, or the unit manager.

> *The last couple of years at [name of hospital], I confronted the nurses. I got more of a voice and I actually spoke to the nurses. I actually went to the manager and said "This is what's happening, it's not appropriate". [Nurse] is being mean to my students. (Participant #8)*

A different participant described how she responded to the emotions of a problematic staff member by addressing the behavior in a conversation. In this situation, the staff member's unprofessional behavior and attitude was contributing to a negative "*vibe*" on the unit.

> *One example is that there's a nurse I think that we have on the ward that is very good at her job but she lets her emotions get the best of her 99% of the time. I often pull her aside and go "hey, do you realize that this is how you're coming off?" Or, "You know, what's going on? Can I help you in your day to settle this a little bit because your attitude and emotions are actually contributing to the whole vibe of the unit and all the other workers"? (Participant #4)*

Recognizing and addressing emotions were not only described when dealing with staff members on the units, but with student emotions as well. One participant shared how she responded to the emotions of a student who was upset with her evaluation by acknowledging the emotions but being clear with expectations.

> *You support them differently based on who they are. In the end, I said to her "okay I know this is upsetting to you, but we need you to know this because here are the objectives that you need to meet before this [clinical*

> *rotation] is done and you're not changing clinical groups. This is where you are at". (Participant #2)*

Another participant described responding to a student's emotions by being aware of where she communicated with the student, so she did not contribute to the student's anxiety.

> *I tried to change my approach to her as well. Everything to try to decrease her anxiety, right? Like being cognizant of where I'm talking to her when I am asking her questions so she doesn't feel on the spot. (Participant #9)*

This participant also described how she addresses unprofessional behavior in her students.

> *I offer them the opportunity to explain themselves, or when the situation where the student is very angry, to reflect back. Why are we in this situation? To sort of help deepen their understanding of A, why it's happening, but also their emotions associated with it, right? (Participant #9)*

Finally, one participant summed up how she responds to emotions in students with this.

> *Yes, student emotions…I think just calming them down. They're just, they're always very anxious and nervous, and I understand that, and I try to remember just being so scared of everything as a student…it hasn't been a confrontation, just more of a conversation". (Participant #5)*

This participant illustrates how keeping calm assists her in managing her student's emotions.

Summary- Theme 2

Participants' abilities to manage emotions involved two categories: managing emotions in one's self, and responding appropriately to the emotions in others. The ability to manage emotions in one's self included taking a moment when needed, venting to someone safe, and doing activities that enhanced self-care. Participants described responding to emotions in others by role modeling, and dealt with the emotions of both unit staff members and students. The ability to manage emotions was something that increased with the number of years and experience as a clinical instructor. As instructors' comfort level grew in managing their own emotions, so did their comfort level grow in addressing emotions in others.

Summary of Findings

In summary, the findings from the data analysis, which occurred over a 3-month period are presented in this chapter. The qualitative data analyzed from all the participants generated two themes that emerged from the analysis: 1) emotional awareness (including self-awareness, and emotional awareness in others), and 2) managing emotions (both in themselves and in the ways they respond to others, including unit staff and students). The interviews provided data that were rich, with a full description of the themes identified. The participants had the ability to be aware of emotions, and manage emotions in their practice as a clinical nursing instructor.

Chapter Five will discuss this particular research in relation to Mayer and Salovey's Emotional Intelligence Model (1997). The limitations of the study will be discussed, as well as recommendations for further areas of research and study. Implications for clinical nursing instructors will also be discussed.

Chapter 5- Discussion, Recommendations and Conclusion

The purpose of this qualitative study was to describe clinical nursing instructors' understanding and use of emotional intelligence. Government mandates to cut health care costs, nursing shortages, increasing demands on nurses due to chronic, complex health conditions, and advancing technology all contribute to the challenges nurses face today (CBC News Online, nd.; Shaffer et al., 2014). Nurses are expected to possess advanced skills, leadership, communication and the ability to critically think to meet these demands of current health care. One concept that is positively associated with nurses' ability to meet these demands is emotional intelligence. (Grady & Gouph, 2015)

Individuals who work in health care who display high levels of EI are able to deal with work stressors better, have less burnout, greater job satisfaction, and display improved quality patient care (Spano-Szekely, & Quinn Griffith, 2016). Researchers agree on the value of EI across a number of disciplines, including health care. A number of studies have explored EI and nursing, including the positive impact EI has on nurses and nursing students' performance. However, based on a review of the literature by the author there has only been one known study published that examined EI and clinical nursing instructors (Allen et al., 2012). By gaining an understanding of clinical nursing instructors' understanding and use of EI, a foundation can be built for enhancing EI as an ability instrumental to future nurses' practice. This research adds to the previous literature in the area of EI and clinical nursing instructors.

Qualitative research, which included in-depth, one-on-one semi-structured interviews, assisted the researcher to develop an understanding of the experiences and

perceptions of EI among clinical nursing instructors. Through the semi-structured interviews, analysis of the data was developed through coding, categories, and ultimately identification of themes of the study. Qualitative Description (QD) was the methodology used in this study providing the means to develop a description of the clinical instructors understanding and use of EI. Following ethical approval from ENREB, access was gained to clinical nursing instructors through orientation meetings, and email communication. Interviews with nine participants provided the researcher with a rich description of clinical nursing instructors understanding and use of EI in their work.

Mayer and Salovey's (1997) Four Branch Model of Emotional Intelligence represents the ability to perceive, use, understand, and manage emotions in oneself and others. EI refers to the ability to process emotions expertly, and to use this information to help guide certain cognitive abilities such as problem solving and critical thinking. The concept of EI suggests an alternative to demonstrating intelligence other than the standard IQ test, and that these abilities may be developed, and have a positive impact on the workplace, including health care. Although there are studies that demonstrate how emotional intelligence contributes to nursing, there is only one known study done exploring EI and clinical nursing instructors (Allen et al., 2012). Therefore, this qualitative study aimed to explore and described the understanding and use of EI of nine clinical nursing instructors in a post-secondary nursing program in western Canada. As discussed in Chapter Four, two themes emerged from the data: i) perceiving emotions in themselves and others, and ii) managing emotions in themselves and others. The following is a discussion of the results of the study, including a

discussion of the interpretation of the findings using Mayer and Salovey's (1997) Four Branch Model of Emotional Intelligence, implications for nursing education, limitations, and suggestions for future research.

Perceiving Emotions

The findings of this study revealed the understanding and use of how clinical nursing instructors are aware of their emotions in themselves and others, and how they manage emotions in themselves and others. The first branch of EI begins with the ability to perceive emotions in oneself and others; being able to recognize emotions shown on faces, to decipher those emotions, including recognizing one's own emotions (Mayer, Roberts, & Barsade, 2008). Being able to perceive emotions is the first step in having the ability to manage emotions. Although each participant had a different way of describing their awareness of emotions, some similarities emerged which became sub-categories under emotional awareness.

The first research question was clinical nursing instructors' perceptions of EI. The first theme that emerged from the data related to clinical nursing instructors' perceptions of EI was "emotional awareness". Findings revealed that being aware of emotions fell into two categories: self-awareness and emotional awareness in others. The ability to be self-aware of one's emotions as they are occurring was described by a number of participants. According to Salovey and Grewal (2005), perceiving emotions and being self-aware of one's emotions represent the initial step, or most basic aspect of EI. Participants' number of years of nursing and clinical experience, and the ability to

"*check-in*" with themselves were two sub-categories associated with participants being self-aware of their emotions.

Self-awareness was described by the participants as being aware of what they were feeling in specific situations. Participants described being aware of their emotions when faced with a variety of clinical situations, such as difficult interactions with students or unit staff members or simply dealing with student issues. This ability of being aware of their emotions was described by all participants to some extent. However, participants with more than 10 years of nursing experience, and/or with more than 5 years of experience as clinical instructors discussed the ability to be aware of their emotions in more depth throughout the interviews. There were multiple instances where the more mature participants cited their age and experience as contributing to their ability to be aware of what they were feeling and why. Participants found that their greater number of years of nursing and clinical experience were a precursor to emotional perception of oneself.

The findings from this study are supported by Mayer and Salovey (1997), and Sternberg and Hedlund (2002), in their argument that emotional intelligence increases with age. Although the average age of the participants was 40.5 years, three participants had more than 25 years of nursing experience, and were over 50 years old. It was these three participants who provided the richest descriptions and data regarding being aware of their emotions. Therefore, this aligns with Mayer, Salovey, and Caruso (2004), who found age-related differences in their ability to perceive emotions as people get older; especially within the age cluster of 50 years and above. Mayer et al. (2004) argued that people's EI increased with age. In a more recent study examining age and

gender related differences and EI in adults, EI varied with age according to an inverted-U curve (Cabello, Sorrel, Fernandez-Pinto & Fernandez-Berrocaal, 2016). Cabello et al. (2016) conducted a study of 12 198 adults between the ages of 17-76, and found that cognitive ability and life experience facilitates EI in the first half of adult life, peaking in middle-adulthood, then decreasing as people reach older adulthood. These findings align with the results of this study, where the middle-aged clinical instructors provided richer descriptions of EI than the clinical instructors that were in the young adulthood age group. The significance that age has on an individual's EI, in this case clinical nursing instructors, is important for institutions to recognize and develop. Educational institutions that employ younger clinical nursing instructors (who would be considered to potentially have lower levels of EI than middle-aged clinical nursing instructors), would benefit from providing EI training. This EI training can be in the form of workshops or presentations during regular term instructor meetings. Furthermore, more mature clinical nursing instructors can be buddied with younger clinical nursing instructors to share and model how they manage emotions in their roles. As reflected in this study, there are numerous positive effects that clinical nursing instructors with enhanced EI have in their relationships with unit staff and students.

The second category that emerged under the self-awareness of emotions was having the ability to "*check-in*". Participants shared a variety examples where they stopped, took a moment, and checked-in with how they were feeling. Some participants started their day by doing this check-in; some used this strategy as needed throughout the day. This deciphering of emotions and having the ability to recognize emotions is included in Mayer and Salovey's (1997) first branch of EI, perceiving emotions. The

clinical nursing instructors interviewed who used this strategy to take a moment and decipher what emotions they were feeling throughout their clinical day, found this strategy a useful tool in managing their emotions.

Emotional awareness in others was determined by participants' abilities to observe (both verbal and non-verbal cues), know their students, and be "*in-tune"*. Having the ability to observe the responses by others, including both verbal and non-verbal cues, enabled the participants to analyze and understand others' emotions. Listening to what others were saying included being aware of the tone and word choice used. In addition to being aware of what was said, participants also determined non-verbal cues in others by being aware of facial expressions, changes in skin coloring (flushed), and body language. One participant shared a situation where she "*felt*" things were not going well in a simulation lab setting by being observant of the verbal and non-verbal cues of students in a group, and stopped what she was doing to address the students' emotions. In this study, there were multiple instances where clinical instructors were aware and perceived emotions in their surrounding environments. Mayer (2004) stated that a person's perceptions of their surrounding environments focused on external, observable, and discreet aspects of their surroundings, which is part of perceiving emotions in EI.

It is important to note that this study consisted on only female participants. In a study by Brackett, Rivers, Shiffman, Lerner and Salovey (2006) females had higher emotional intelligence scores than males, and were able to read non-verbal cues including facial expressions better than their male counter-parts. Therefore, a question

for future research might be to consider the types of strategies that male clinical nursing instructor's use regarding emotional awareness.

The instructors also described the importance of taking the time to know their students and the ways in which this contributed to the ability to be aware of emotions of their students. Participants described that the better they knew their students, the easier it was to identify emotions expressed by their students. Some participants made an effort to get to know their students prior to the start of the clinical rotation by having the students complete a questionnaire that asked specific questions about the student as a person. Alternatively, other participants got to know their students through a series of interactions. Regardless of how the instructors approached this, knowing the students assisted the clinical nursing instructors in being able to be more aware of their students' emotions. The importance of the student-teacher relationship in clinical components of nursing programs is supported by Collier (2017), who found that developing interpersonal relationships is considered the most valued skill for the effectiveness of clinical nursing instructors. Other attributes of this vital student-teacher connection included spending time getting to know the students, providing opportunities for the student to talk, and being emotionally available (Collier, 2017). Therefore, the importance of developing student-teacher relations as seen in the literature supports the view of participants in this study who described the importance of getting to know their students in being able to perceive emotions.

The last strategy explored that clinical nursing instructors used to be aware of emotions in others was having the ability to be "*in-tune*". Participants frequently spoke of being 'in-tune", using their intuition, or as one participant described it, have a "*spidey-*

sense". This idea is supported by Caruso and Salovey (2003), who state that experienced leaders make more insightful observations about others, and often know how others are feeling.

Using Emotional Intelligence

The second branch of Mayer and Salovey's (1997) Four Branch Model of Emotional Intelligence is using emotions. This branch of using emotions helps individuals think through situations, or use emotions to promote thinking and problem solving (Salovey & Grewal, 2005). EI can help individuals meet tasks by using their emotions. In this branch the importance and impact of mood is highlighted. Although this branch was not as evident in the data obtained in this study to generate a theme, there was some discussion by participants where they managed their moods to assist in their role as a clinical nursing instructor. For example, one participant recognized a students' reaction to an evaluation, in which the student was not happy. The participant recognized this unhappiness and was able to have a conversation with the student to explain how the objectives for the clinical rotation were not being met. This aligns with Caruso, Mayer, and Salovey (2002), where the ability to use emotions includes the ability to redirect attention to important issues or events.

Additionally, the second branch provides efficiency in the ability to process information (Caruso et al., 2002). Emotions assisted the participants in considering the diverse perspectives of others. For example, one participant described how she tried to reflect and understand a unit staff member's actions and behaviour that she was demonstrating, that to the instructor, seemed unprofessional. This participant was able

to acknowledge the unit staff member's concerns, and used this information as a foundation to address the issue. In the second branch, Caruso et al. (2002) state that emotions should be generated, felt, manipulated, and examined in order to problem solve. This particular participant used her understanding of others' differing emotions to aid in the resolution of this problem.

Understanding Emotions

The third branch of Mayer and Salovey's (1997) model includes the ability to comprehend and interpret emotions, and to be sensitive and aware of emotions. Although the data did not generate a theme specific to this branch, participants were able to provide examples about emotional understanding. One participant described how her mother's recent death affected her emotions while in her role as a clinical nursing instructor. She felt sad when one of her students had a patient that reminded her of her deceased mother and linked the sadness to her recent loss. The instructor was able to share her emotions with her students, and helped them recognize that it was okay to show their emotions, and understand that there is the potential that they will face similar situations as nurses. The participant also recognized that if her loss was not managed well, over time her feelings of grief could have potentially affected her role as clinical nursing instructor. Understanding her emotions allowed the participant to anticipate her feelings and helped inform her when it was time to take some time off to deal with her grief. According to Salovey et al. (2002), one of the most fundamental competencies in the third branch concerns the ability to label emotions and recognize the relationships among them.

Managing Emotions

The fourth branch of Mayer and Salovey's (1997) model is arguably the most complex, yet integral part of EI. In this branch, individuals regulate their emotions and respond to the emotions of others. Salovey and Grewal (2005) state that emotionally intelligent persons can harness emotions, even negative ones, and manage them to achieve intended goals. Managing emotions is one of the more complex branches, because emotional management depends on the ability to first perceive and then understand emotions. However, Mayer, Caruso, and Salovey (1997) caution that there is a misconception about management of emotions being confused with controlling or restraining emotions. The opposite is true. The skill in managing emotions and knowing when and how to use them to assist in decision-making and intellectual growth is vital to clinical nursing instructors. From the results of this study, the second theme that emerged was managing emotions, both in themselves, and in responding to emotions of others.

Participants described that an important aspect of managing emotions in themselves involved "*taking a moment*". When faced with challenging situations as a clinical nursing instructor, a common strategy in managing one's emotions was to step away from the situation for a brief moment to collect one's thoughts. In some cases, this meant reflecting on what the instructor was feeling, and what she might do next. Mayer and Salovey (1997) discuss the importance of reflection in the emotional management of oneself. Participants acknowledged that in order to respond to the emotions of others, they must first step back from particular situations and reflect on what they were feeling.

This management of their own emotions through "*taking a moment*" was an important component of emotional management of themselves.

Another strategy participants discussed in the management of their emotions was finding someone safe with whom to vent, whether that person was a co-worker or family member. When referring to venting, the participants discussed sharing upsetting situations or concerns in a confidential manner, respecting the privacy of the people involved by omitting all names or any descriptors that could possibly be used to identify the people involved. The basis for finding someone safe with whom to vent was having trust in that person for keeping his or her confidence in what was shared. Prati, Douglas, Ferris, Anmeter, and Buckley (2003) state that enhanced EI results in higher levels of trust with individuals who demonstrate emotional intelligence and awareness. Participants described the importance of having someone safe with whom to vent when needed, either in their work environment or in their personal lives. Venting was as instrumental in aiding them in the management of their emotions. For example, one participant shared that she managed difficult emotions by decompressing with a fellow clinical nursing instructor by going for coffee and venting how her day was going. She found this sharing helpful in managing her emotions that otherwise could have negatively affected her day.

The third impactful strategy that participants described in the management of their emotions was enhancing self-care. Participants shared various self-care strategies such as walking family pets, going to the gym, getting enough sleep and journaling at the end of the day. The benefits of adequate rest and exercise are well documented (Crane & Ward, 2016). Exercise increases positive endorphin levels, which in turn

reduces stress and overall physical and mental fitness. Reflective journaling is describing, analyzing, and synthesizing the events of the day, including the emotions and feelings associated with it (Horton-Deutsch & Sherwood, 2008). In nursing, reflective journaling is associated with increased self-awareness, and developing self-awareness is central to nurses' abilities to integrate feelings with knowledge and experience, which in turn assists in managing their emotions (Taylor et al., 2015). Taking inventory of emotions and journaling can provide nurses with a perspective on their current responses to stressful situations and whether these responses are helpful or need to change.

Another self-care strategy identified was the ability to maintain a *"healthy separation";* nurses are notorious for self-neglect. For example, individuals who enter the nursing profession dedicate themselves to helping others, and so do not always attend to their own emotional needs (Gracia-Gracia & Olivan-Blazquez, 2017). Unfortunately, this dedication to meeting patient and organizational needs may lead to nurses not caring for themselves. A number of participants described ways in which they managed their work stress. One of these was having the ability to maintain a healthy separation from individuals or situations that are causing stress or other uncomfortable emotions. This awareness of what emotions are being felt could be considered a form of mindfulness.

Mindfulness is a theoretical construct that comes from Oriental traditions (Theravada Buddhism) that is increasing in popularity in Western culture (Crane & Ward, 2016). Mindful practice among nurses has been associated with many benefits, including improved coping, increased relaxation, overall satisfaction, increased self-

control and decreased emotional exhaustion (Gracia-Gracia & Olivan-Blazquez, 2017). Mindfulness is considered an integral component of self-care. Mindfulness can be described as developing intentional awareness that is open and accepting, and allowing oneself to respond rather than react to situations (Halm, 2017). Therefore, having the ability to acknowledge feelings, such as when an individual feels the need to keep a healthy separation from others, would be considered beneficial rather than harmful. Furthermore, there is scientific evidence that self-compassion, which includes mindfulness, is associated with emotional intelligence (Gracia-Gracia & Olivan-Blazquez, 2017).

Therefore, since self-care strategies such as mindfulness can be beneficial to nurses and clinical nursing instructors, how can practice environments promote self-care? First, organizations need to see the value in educating nurses, in this case clinical nursing instructors, about self-care (Crane & Ward, 2016). Encouraging self-care leads to more balanced, healthy individuals. Practicing mindfulness can be learned in a relatively short period, therefore offering clinical nursing instructors a significant self-care tools at relatively little to no cost. Offering educational sessions during routine clinical meetings that teach the importance of self-care may be another option to assist in the promotion of self-care and emotional intelligence of clinical nursing instructors. This concept is supported by Halm (2017), who suggests that finding ways to integrate mindfulness into workplaces, even in brief segments, warrants further research and exploration.

As earlier identified, the fourth branch of EI also includes responding to the emotions in others. In this study, participants responded to emotions in others by role

modeling and navigating the emotions of others. Participants discussed how they manage them appropriately while interacting with patients and families One participant described how she shared with her students where she cried with a family whom loved one had just died. She felt it was important to model for her students that feeling emotional is human, and as nurses we can share our emotions with patients and families. However, the participants cautioned that these emotions should have limits, ensuring that the focus remains on the family and their emotional needs, not the nurses' emotions. In their study, Baldwin, Mills, Birks, and Budden (2017) examined the importance of role modeling by experienced nursing instructors as being a key factor in undergraduate nursing education.

Mayer and Salovey (1997) discussed the regulation of emotions in promoting intellectual and emotional growth. Participants reflected throughout the interviews that responding to the emotions of others was an important factor in managing emotions. Participants shared experiences responding to the emotions of students and unit staff members when needed by facing the person and having a conversation about the concern. Not being afraid to face those difficult conversations was common among the clinical nursing instructors. In other words, responding to emotions meant addressing unprofessional or inappropriate behavior of others. In doing this, participants felt they dealt with the emotions, which in turn assisted in managing those emotions in those difficult circumstances. Basogul and Ozgur (2016) assert that individuals who have high levels of emotional intelligence can help mitigate conflict in their work environments. The participants who discussed responding to conflict that raised difficult emotions believed that addressing those emotions helped "*clear the air"* and mitigate conflict.

Furthermore, creating an environment of open communication without reacting to anger is consistent with emotionally intelligent nurse leaders (Heckeman et al., 2015). As Mayer and Salovey (1997) argue, when individuals are faced with disharmonious situations, having emotional self-awareness and self-regulation helps them to manage their own feelings of frustration and attempt to respond in a positive manner (Foltin & Keller, 2012).

Limitations

The following limitations of this study must be acknowledged: i) sample size, ii) gender bias, iii) generalization to other nursing programs, iv) model branch exploration, and v) culture. Although data saturation was obtained with nine participants, the relatively small sample size may not provide a comprehensive in-depth understanding on the topic of emotional intelligence and clinical nursing instructors as a larger sample may have. The sample consisted of all female respondents even though the study was presented to both female and male nursing clinical instructors. Although Grewal and Salovey (1997) state that gender differences may be small and only affect certain parts of the EI model, Brackett et al., (2003) identified in their study that females had higher emotional intelligence scores than males. Powell et al. (2015) also agree that EI is experienced and understood differently between women and men, and future studies are needed to explore gender differences. Therefore, the fact that this sample comprised exclusively female participants means gender differences could not be explored.

Furthermore, because the study was drawn from only one post-secondary baccalaureate-nursing program, transferability to nursing instructors of other nursing programs may be limited. The findings of this study generated themes that applied mainly to the first and fourth branches of Mayer and Salovey's (1997) Four Branch Model of EI. There were limited responses to fully address the remaining two branches in this study. An explanation may be the way interview questions were structured, or the way in which the questions were asked. Finally, the culture of participants in this study was limited to multi-generational white Canadian women, therefore exploring specific cultural and racial differences related to EI and culture was not addressed.

Implications

The study results indicate a number of implications for emotional intelligence and clinical nursing instructors. Research on EI and nursing continues to emerge as a growing field; however, little is known about EI and clinical nursing instructors. This is only the second research study examining EI and clinical nursing instructors. In the clinical setting, clinical nursing instructors' role as an emotionally intelligent mentor is important for the success of nursing students.

Facilitating EI in undergraduate nursing students has numerous positive outcomes on nursing students' performance. EI assists nursing students and nurses to better understand themselves, deal with the demands of their profession, and may lead to more effective relationship building with patients and families. Clinical nursing instructors who possess, and model EI are instrumental to developing EI in their students, revealing benefits and positive outcomes.

Recommendations

This research addressed a gap in current literature that examines EI and clinical nursing instructors. The goal was to expand on current knowledge. While the findings of this study regarding clinical nursing instructors understanding and use of EI were insightful, more research needs to be done. This study used qualitative description (QD), including the use of semi-structured interviews to help deepen and guide the conversation. In QD, there is a delicate balance between gaining the trust of the participant and keeping a certain objective balance. Although bracketing was used to mitigate researcher bias, it is impossible to eliminate oneself from what one knows and thinks. Therefore, building on these results with future qualitative or quantitative research could add to this emerging knowledge base. In addition, research is needed to explore gender-based experiences in the understanding and use of EI among clinical nursing instructors, as this study comprised solely of female participants. Additionally, since research identifies emotions that are both universal and culture specific, it is recommended that further research be done surrounding EI, and nursing instructors of different races, culture and ethnicities.

This research contributed to the literature regarding EI and clinical nursing instructors, and the positive impact EI has on their surroundings, including unit staff and students. This is a topic that needs further research. As programs and curricula evolve to meet the demands of health care today, facilitators of post-secondary nursing programs need to understand the importance of emotionally intelligent instructors, and learn strategies to enhance EI among their educators.

This study revealed the understanding and use of emotional intelligence of nine clinical nursing instructors. Through in-depth interviews, insights were gained on how these clinical nursing instructors experienced EI. From these insights, the following recommendations are proposed. First, as supported by the literature, EI contributes to the success of nurses, in this case clinical nursing instructors. Educational institutions that find ways to enhance clinical nursing instructors' understanding and use of EI would see many benefits. Clinical nursing instructors who have an increased ability to perceive and respond to emotions, including their own, unit staff and students, would be better equipped to deal with challenges faced on clinical assignments.

Enhancing EI can be done through educational strategies that include having clinical nursing instructors complete a Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT). The MSCEIT is a self-report measure that could be completed by clinical nursing instructors to assess a baseline level of EI and identify development opportunities. Following the completion of the test, there are many recommendations associated with these measurement tools that teach ways to enhance EI and improve participants' identified EI weaknesses. In addition to self-report measures, a number of leadership studies looking at developing EI have shown that there is value in incorporating interpersonal and group activities where participants can practice EI in different scenarios (Golnaz, 2012). Therefore, offering opportunities for clinical nursing instructors to get together and work through a variety of challenging clinical situations focused on incorporating EI would be beneficial to developing their EI skills.

Secondly, this study reveals the importance of self-care for clinical nursing instructors. The benefits of self-care, including incorporating mindfulness into nurse

instructors' daily practice is well supported by literature. Educational institutions can take the opportunity to teach mindfulness techniques in routine clinical instructor meetings. These short teaching sessions by a mindfulness coach would be considered low cost, relatively quick to do, and with many potential benefits.

Conclusion

This chapter discussed how the findings of this study contributed to previous research to strengthen the understanding and use of EI among clinical nursing instructors. Findings were interpreted by using Mayer and Salovey's (1997) Four Branch Model of Emotional Intelligence. These findings were then compared to the limited literature that exists examining EI and clinical nursing instructors. Following a discussion of the findings, the implications of this study to potential future clinical nursing instructors was discussed. Finally, recommendations for further research were addressed.

The purpose of this study was to examine the understanding and use of emotional intelligence among clinical nursing instructors. Two themes identified from the data analysis of this study included i) emotional awareness of themselves, and others, and ii) managing emotions of themselves and others. Although the body of literature examining emotional intelligence and nursing is growing, research investigating emotional intelligence and clinical nursing instructors is just beginning. Current understandings of emotional intelligence and clinical nursing instructors will benefit from further inquiry and research that asks salient questions to promote depth of understanding of this phenomenon. This study demonstrates the importance EI has for

perceiving and managing emotions in clinical nursing instructors, aiming to further knowledge in this area.

This study demonstrated that participants had emotional awareness, and the ability to manage emotions in their role as a clinical nursing instructor as described by branch one and four of Mayer and Salovey's (1997) model. Further research could add to this knowledge by conducting additional qualitative studies that more specifically examine the second and third branch of emotions and clinical nursing instructors.

The importance of emotional intelligence and clinical nursing instructors will continue to increase as the demands of health care also rise and become more complex. Clinical nursing instructors who are aware of emotions, both their own and of others around them, and who can manage those emotions will facilitate them in their role. Although the benefits of high emotional intelligence are demonstrated, in the nursing profession, there has only been one study exploring EI and clinical nursing instructors. The findings of this exploratory, qualitative study contribute to a better perception of clinical nursing instructors understanding and use of EI.

References

Akerjordet, K., & Severinsson, E. (2007). Emotional intelligence: A review of the literature with specific focus on empirical and epistemological perspectives. *Journal of Clinical Nursing, 16*(8), 1405-1416.

Akerjordet, K., & Severinsson, E. (2008). Emotionally intelligent nurse leadership: A literature review study. *Journal of Nursing Management, 16*(5), 565-577.

Akerjordet, K., & Severinsson, E. (2010). The state of the science of emotional intelligence related to nursing leadership: An integrative review. *Journal of Nursing Management, 18,* 363-382.

Allen, D., Ploeg, J., & Kaasalainen, S. (2012). The relationship between emotional intelligence and clinical teaching effectiveness in nursing faculty. *Journal of Professional Nursing, 28*(4), 231-240.

Arora, S., Ashrafian, H., Davis, R., Athanasiou, T., Darzi, A., & Sevdalis, N. (2010). Emotional intelligence in medicine: A systematic review through the context of the ACGME competencies. *Medical Education, 44,* 749-764.

Baldwin, A., Mills, J., Birks, M., & Budden. L. (2017). Reconciling professional identity: A grounded theory of nurse academics' role modelling for undergraduate students. *Nurse Education Today, 59,* 1-5.

Bar-On, R. (2005). The Bar-On model of emotional-social intelligence (ESI). *Psicothema Special Issue on Emotional Intelligence, 17,* 1-28.

Basogul, C., & Ozgur, G. (2016). Role of emotional intelligence in conflict management strategies of Nurses. *Asian Nursing Research, 10,* 228-233.

Beauvais, A.M., Brady, N., O'Shea, E., & Quinn Griffin, M. T. (2011). Emotional intelligence and nursing performance among nursing students. *Nurse Education Today, 31,* 396-401.

Beauvais, A. M., Stewart, J.G., DeNisco, S., & Beauvais, J.E. (2014). Factors related academic success among nursing students: A descriptive correlational research study. *Nurse Education Today, 34,* 918-923.

Benner, P. (2009). Educating nurses: A call for radical transformation – How far have we come? *Journal of Nursing Education, 51*(4), 183-184.

Benson, G., Ploeg, J., & Brown, B. (2010). A cross-sectional study of emotional intelligence in baccalaureate nursing students. *Nurse Education Today, 30,* 49-53.

Brackett, M.A., Rivers, S.A., & Salovey, P. (2011). Emotional intelligence: Implications for personal, social, academic, and workplace success. *Social and Personality Psychology Compass, 5*(1), 88-103.

Brackett, M.A., Rivers, S.A., Shiffman, S., Lerner, N., & Salovey, P. (2006). Relating emotional abilities to social functioning: A comparison of self-report and performance measures of emotional intelligence. *Journal of Personality and Social Psychology, 91*(4), 780-795.

Branscum, P., Brown, D., & Sharma, M. (2016). Using emotional intelligence and social support to predict job performance of health educators. *American Journal of Health Education, 47*(5), 309-314.

Bulmer Smith, K., Profetto-McGrath, J., & Cummings, G.C. (2009). Emotional intelligence and nursing: An integrative review. *International Journal of Nursing Studies, 46,* 1624-1636.

Cabello, R., Sorrel, M.A., Fernandez-Pinto, I., & Fernandez-Barracal, P. (2016). Age and gender differences in ability emotional intelligence in adults: A cross-sectional study. *Developmental Psychology, 52*(9), 1486-1492.

CBC News Online. (n.d.) 2017 Manitoba health care cuts and changes. Retrieved from http://www.cbc.ca/news/canada/manitoba/topic/Tag/2017%20Manitoba%20healt

Canadian Institute of Health Research Natural Sciences and Engineering Research Council of Canada Social Sciences and Humanities Research Council of Canada (Ed.). (2010). *Tri-council policy statement: Ethical conduct for research involving humans* (2nd ed.). Ottawa, ON: Interagency Advisory Panel and Secretariat on Research Ethics.

Canadian Nurses Association (2008). *Code of ethics for registered nurses.* Ottawa, ON: author.

Canadian Nurses Association. (2009). Testing solutions for eliminating Canada's nursing shortage. *Canadian Nurses Association.* Retrieved from https://www.cna-aiic.ca/en/news-room/news-releases/2009/eliminating-canadas-rn-shortage

Caruso, D.R., Mayer, J.D., & Salovey, P. (2002). Emotional intelligence and emotional Leadership. In R.E. Riggio, S.E. Murphy, & F.J. Pirozzolo (Eds.) *Kravis-de roulette leadership conference* (pp.55-74). Mahwah, NJ: Lawrence Erlbaum Associates Publisher.

Cherry, M.G., Fletcher, I., & O'Sullivan, H. (2013). The influence of medical students' and doctors' attachment style and emotional intelligence on their patient-provider communication. *Patient Education and Counseling, 93,*177-187.

Cherry, M.G., Fletcher, I., O'Sullivan, H., & Dornan, T. (2014). Emotional intelligence in medical education: A critical review. *Medical Education, 48,* 468-478.

Chun, K. H., & Park, E. (2016). Diversity of emotional intelligence among nursing and medical students. *Osong Public Health Res Perspect, 7*(4), 261-265.

Codier, E., Freitas, B., & Muneno, L. (2013). Developing emotional intelligence in oncology nurses: A clinical rounds approach. *Oncology Nursing Society, 40*(1), 22-29.

Codier, E., Muneno, L., Franey, K., & Mutsuura, F. (2010). Is emotional intelligence an important concept for nursing practice? *Journal of Psychiatric and Mental Health Nursing, 17,* 940-948.

Codier, E., & O'Dell, E. (2014). Measured emotional intelligence ability and grade point average in nursing students. *Nursing Education Today, 34,* 608-612.

Collier, A.D. (2017). Characteristics of an effective nursing clinical instructor: The state Of the science. *Journal of Clinical Nursing, 27*(1-2), 363-374.

Corcoran, R.P., & Tormey, R. (2013). Does emotional intelligence predict student teachers' performance? *Teaching and Teacher Education, 35,* 34-42.

Crane, P.J., & Ward, S.F. (2016). Self-healing and self-care for nurses. *AORN Journal, 104*(5), 386-396.

Craver, G. A. (2014). Not just for beginners- A review of successful qualitative research: A practical guide for beginners. *The Qualitative Report, 19*(48), 1-4.

Creswell, J. (2013). *Qualitative inquiry and research design: Choosing among five approaches. (3rd ed.).* Thousand Oaks: Sage.

Feather, R. (2009). Emotional Intelligence in relation to nursing leadership: Does it matter? *Journal of Nursing Management, 17,* 376-382.

Fernandez, R., Salamonsson, Y., & Griffith, R. (2012). Emotional intelligence as a predictor of academic performance in first-year accelerated graduate entry nursing students. *Journal of Clinical Nursing, 21,* 3485-3492.

Foltin, M., & Keller, R. (2012). Leading change with emotional intelligence. *Nursing Management, 11,* 20-25

Four Branch Model of Emotional Intelligence (ND). Retrieved from https://ntinm4.wikispaces.com/Emotional+Intelligence

Foster, K., McCloughen, A., Delgado, C., Kefalas, C., & Harkness, E. (2015). Emotional intelligence education in pre-registration nursing programs: An integrative review. *Nurse Education Today, 35,* 510-517.

Freshwater, D., & Stickley, T. (2003). The heart of the art: Emotional intelligence in nurse education. *Nursing Inquiry, 11*(3), 91-98.

Fujino, Y., Tanako, M., Yonemitsu, Y., & Kawamoto, R. (2014). The relationship between characteristics of nursing performance and years of experience in nurses with high emotional intelligence. *International Journal of Nursing Practice, 21,* 876-881.

Goleman, D. (1995). *Emotional Intelligence.* New York, NY: Bantam Books, Inc.

Golnaz, S. (2012). Emotional intelligence and leadership development. *Public Personal Management, 41*(3), 535-548.

Gracia-Gracia, P., & Olivan-Blazuez, B. (2017). Burnout and mindfulness self-Compassion in nurses of intensive care units. *Holistic Nursing Practice, 7,*225-233.

Grady, P., & Gough, L. (2015). Nursing science: Claiming the future. *Journal of Nursing Scholarship, 47*(6), 512-521.

Halm, M. (2017). The role of mindfulness in enhancing self-care for nurses. *American Journal of Critical Care, 26*(4), 344-348.

Hammerly, M.E., Harmon, L., & Schwaitzberg, S.D. (2014). Good to great: Using 360-degree feedback to improve physician emotional intelligence. *Journal of Healthcare Management, 59*(5), 354-365.

Handwerker, S. (2012). Transforming Nursing Education: A review of current curricular practices in relation to Benner's latest work. *International Journal of Nursing Education Scholarship, 9*(1), 1-15.

Heckemann, B., Schols, J., & Halfens, R. (2015). A reflective framework to foster emotionally intelligent leadership. *Journal of Nursing Management, 23,* 744-753.

Heydari, A., Kareshki, H., & Armat, M.R. (2016). Is nurses' professional competence related to their personality and emotional intelligence? A cross-sectional study. *Journal of Caring Sciences, 5*(2), 121-132.

Hong, E., & Lee, Y.S. (2016). The mediating effect of emotional intelligence between emotional labor, job stress, burnout and nurses' turnover intention. *International Journal of Nursing Practice, 22,* 625-632.

Horton-Deutsch, S., & Sherwood, G. (2008). Reflection: An educational strategy to develop emotionally competent nurse leaders. *Journal of Nursing management, 16,* 946-954.

Humphrey, N., Curran, A., Morris, E., Farrell, P., & Woods, K. (2007). Emotional intelligence and education: A critical review. *Education Psychology, 27*(2), 235-254.

Ju, C., Lan, J., Li, Y., Feng, W., & You, X. (2015). The mediating role of workplace social support on the relationship between trait emotional intelligence and teacher burnout. *Teaching and Teacher Education, 51,* 58-67.

Kaur, D., Sambasivan, M., & Kumar, N. (2013). Effect of spiritual intelligence, emotional intelligence, psychological ownership and burnout on caring behaviour of nurses: A cross-sectional study. *Journal of Clinical Nursing, 22,* 3192-3202.

Kaya, H., Senyuva, E., & Bodur, G. (2017). Developing critical thinking disposition and emotional intelligence of nursing students: A longitudinal research. *Nurse Education Today, 48,* 72-77.

Kim, H., Sefcik, J.S., & Bradway, C. (2017). Characteristics of qualitative descriptive studies: A systematic review. *Research in Nursing and Health, 40,* 23-42.

Law, K.S., Wong, C., & Song, L.J. (2004). The construct and criterion validity of emotional intelligence and its potential utility for management studies. *Journal of Applied Psychology, 89*(3), 483-496.

Lefkies, N. (2013). Emotional intelligence and educational reform. *Education Review, 65*(2), 140-154.

Li, Y., Cao, F., Cao, D., & Liu, J. (2015). Nursing students' post-traumatic growth, emotional intelligence and psychological resilience. *Journal of Psychiatric and Mental Health Nursing, 22,* 326-332.

Marchildon, P., Katapally, T., Beck, C., Abonyi, S., Episkenew J., Pahwa, P., & Dosman, P. (2015). Exploring policy driven systemic inequities leading to Differential access to care among Indigenous populations with obstructive Sleep apnea in Canada. *International Journal for Equity in Health, 14*(148), 2-9.

Mayer, J.D. (2004). A classification system for the data of personality and adjoining Fields. *Review of General Psychology, 8*(3), 208-219.

Mayer, J.D., Caruso, D.R., & Salovey, P. (2000). Emotional intelligence meets traditional standards for an intelligence. *Intelligence, 27*(4), 267-298.

Mayer, J.D., Roberts, R.D., & Barsade, S.G. (2008). Human abilities: Emotional Intelligence. *Annual Review of Psychology, 59,* 507-536.

Mayer, J.D., & Salovey, P. (1990). Emotional Intelligence. *Imagination, cognition and Personality, 9*(3), 185-211.

Mayer, J.D., & Salovey, P. (1997). *What is emotional intelligence? In: Salovey, P., Slutyer, D.J. (Eds), What is emotional intelligence*? Basic Books, New York, NY.

Mayer, J.D., Salovey, P., & Caruso, D.R. (2004). A further consideration of the issues of Emotional intelligence. *Psychology Inquiry, 15*(3), 249-255.

Meert, K.L.,…Nicholson, C. (2008). Ethical and Logistical Considerations of Multicenter Parental Bereavement Research. *Journal of Palliative Medicine, 11*(3), 444-450.

Meinecke, J. (2012). To a new generation of nurses. *Nursing2012,* 27.

Mintz, L.J., & Stoller, J.K. (2014). A systematic review of physician leadership and emotional intelligence. *Journal of Graduate Medical Education, 3,* 21-31.

Munhall, P. (2012). *Nursing research: A qualitative perspective (5th ed.).*Mississauga: Jones & Bartlett.

Nursing faculty. (n.d.) Reference MD. Retrieved from http://www.reference.md/files/D005/mD005181.html

Orak, R.J., Farahani, M.A., Kelishami, F.G., Seyedfatemi, N., Banihashemi, S., & Havaei, F. (2016). Investigating the effect of emotional intelligence education on baccalaureate nursing students' emotional scores. *Nurse Education in Practice, 20,* 64-69.

Petty, N.J., Thomson, O.P., & Stew, G. (2012). Ready for a paradigm shift? Part 2: Introducing qualitative research methodologies and methods. *Manual Therapy, 17,*378-384.

Polit, D.F., & Beck, C.T. (2012). *Nursing Research: Generating and assessing evidence for nursing practice* (9th ed.). New York: Lippincott Williams & Wilkings.

Por, J., Barriball, L., Fitzpatrick, J., & Roberts, J. (2011). Emotional Intelligence: Its relationship to stress, coping, well-being and professional performance in nursing students. *Nurse Education Today, 31,* 855-860.

Powell, K.R., Mabry, J.L., & Mixer, S.J. (2015). Emotional intelligence: A critical Evaluation of the literature with implications for mental health nursing Leadership. *Issues in Mental Health Nursing, 36,* 346-356.

Prati, M., Douglas, C., Ferris, G., Anmeter, A., & Buckley, R. (2003). The effect of Positive feelings on risk taking: When the chips lie. *The International Journal of Organizational Analysis, 11*(1), 21-40.

Rahmat, N., Ghalavandi, H., & Jesarati, A. (2014). Relationship between the faculty members' emotional intelligence and educational performance at Urmia University. *European Journal of Experimental Biology, 4*(1), 95-103.

Ranjbar, H. (2015). Emotional intelligence training: A necessity for nursing education curriculum. *Nurse Education Today, 35,* 1053.

Rice, E. (2015). Predictors of successful clinical performance in associate degree nursing students. *Nurse Educator, 40*(4), 207-211.

Rimando, M., Brace, A. M., Namageyo-Funa, A., Parr, T. L., & Sealy, D. (2015). Data collection challenges and recommendations for early career researchers. *The Qualitative Report, 20*(12), 2025-2036.

Saldana, J. (2009). *The coding manual for qualitative researchers.* Thousand Oaks, CA: Sage publications Inc.

Salovey, P., & Grewal, D. (2005). The science of emotional intelligence. *Current Directions in Psychological Science, 14*(6), 281-285.

Salovey, P., & Mayer, J. D. (1990). Emotional Intelligence. *Imagination, cognition and Personality, 9*(3), 185-211.

Sandelowski, M. (2000). Whatever happened to qualitative descriptive? *Research in Nursing and Health, 23,* 334-340.

Shafer, F.A., Davis, C.R., Dutka, J.T., & Richardson, D.R. (2014). The future of nursing: Domestic agenda, global implications. *Journal of Transcultural Nursing, 25*(4), 388-394.

Shao, B., Doucet, L., & Caruso, D.R. (2015). Universality versus cultural specificity of Three emotion domains: Some evidence based on the cascading model of Emotional intelligence. *Journal of Cross-Cultural Psychology, 46*(2), 229-251.

Shanta, L., & Gargiulo, L. (2014). A study of the influence of nursing education on development of emotional intelligence. *Journal of professional Nursing, 30*(6), 511-520.

Smith, K., Profetto-McGrath, J., & Cummings, G.C. (2009). Emotional intelligence and nursing: An integrative review. *International Journal of Nursing Studies, 46,* 1624-1636.

Spano-Szekely, L., & Quinn Griffin, M.T. (2016). Emotional intelligence and transformational leadership in nurse managers. *The Journal of Nursing Administration, 46*(2), 101-108.

Starks, H., & Trinidad, S.B. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research, 17*(10), 1372-1380.

Sternberg, R., & Hedlund, J. (2002). Practical intelligence and work psychology. *Human Performance, 15*(12), 143-160.

Streubert, H.J., & Carpenter, D.R. (2011). *Qualitative research in nursing: Advancing the humanistic imperative* (5th ed.). New York, NY: Lippincott Williams & Wilkings.

Sutton, J., & Austin, Z. (2015). Qualitative research: Data collection, analysis and management. *The Canadian Journal of Hospital Pharmacy, 68*(3), 226-231.

Taylor, B., Roberts, S., Smyth, T., & Tulloch, M. (2015). Nurse manager's strategies for feeling less drained by their work: An action research and reflection project for developing emotional intelligence. *Journal of Nursing Management, 23,* 879-887.

Trust. (n.d.). Dictionary.com. Retrieved from http://www.dictionary.com/browse/trust

Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic Analysis: Implications for conducting a qualitative descriptive study. *Nursing and Health Science, 15,* 398-405.

Whittemore, R., & Knafl, K. (2005). The integrative review: Updated methodology. *Methodological Issues in Nursing Research, 52*(5), 546-553.

Wilson, S.C., & Carryer, J. (2008). Emotional competence and nursing education: A Zealand study. *Nursing Praxis in New Zealand, 24*(1), 36-47.

Wolcott, H. F. (1994). *Transforming qualitative data: Description, analysis and interpretation.* Thousand Oaks, CA: Sage publications Inc.

Yin, H., Lee, J., Zhang, Z., & Jin, Y. (2013). Exploring the relationship among teachers' emotional intelligence, emotional labor strategies and teaching satisfaction. *Teaching and Teacher Education, 35,* 137-145.

Appendix A

Additional Assumptions:

1. The writer acknowledges that as an experienced clinical instructor, she has some pre-conceived ideas/thoughts regarding how emotionally intelligent clinical instructors “should be”.
2. Some clinical instructors will have more EI than others, perhaps based on years of experience.
3. The idea of EI may be unknown to some clinical instructors as this concept is fairly new (within the last 20 years) to post-secondary education, and even newer to nursing education.
4. Clinical instructors may handle emotions well yet be unaware that this is EI.
5. Clinical instructors deal with emotions every day in their work.

Appendix B

UNIVERSITY OF MANITOBA Research Ethics and Compliance

Human Ethics
208-194 Dafoe Road
Winnipeg, MB
Canada R3T 2N2
Phone +204-474-7122
Email: humanethics@umanitoba.ca

PROTOCOL APPROVAL

TO: **Tara Roberts** **(Advisor: Judith Scanlan)**
Principal Investigator

FROM: **Zana Lutfiyya, Chair**
Education/Nursing Research Ethics Board (ENREB)

Re: **Protocol #E2017:080 (HS21056)**
"Emotional Intelligence of Clinical Nursing Instructors"

Effective: September 7, 2017 **Expiry:** September 7, 2018

Education/Nursing Research Ethics Board (ENREB) has reviewed and approved the above research. ENREB is constituted and operates in accordance with the current *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans.*

This approval is subject to the following conditions:

1. Approval is granted only for the research and purposes described in the application.
2. Any modification to the research must be submitted to ENREB for approval before implementation.
3. Any deviations to the research or adverse events must be submitted to ENREB as soon as possible.
4. This approval is valid for one year only and a Renewal Request must be submitted and approved by the above expiry date.
5. A Study Closure form must be submitted to ENREB when the research is complete or terminated.
6. The University of Manitoba may request to review research documentation from this project to demonstrate compliance with this approved protocol and the University of Manitoba *Ethics of Research Involving Humans*.

Funded Protocols:
- **Please mail/e-mail a copy of this Approval, identifying the related UM Project Number, to the Research Grants Officer in ORS.**

Appendix C

Dr. Beverley O'Connell
Dean

Tara Roberts
[redacted]

Dear Dr.O'Connell,

My name is Tara Roberts. I am a graduate nursing student here at the University of Manitoba, College of Nursing. As part of my Master's program, I will be conducting a research study entitled "Emotional intelligence of clinical nursing instructors". The overall questions guiding this study are "What are clinical nursing instructor's perceptions of EI, and how do clinical nursing instructors use EI"?

Emotional intelligence can be defined as "the ability to monitor one's own and other's feelings and emotions, to discriminate among them and to use this information to guide one's thinking and actions" (Salovey & Mayer, 1990. p. 189). Individuals who work in health care who possess EI are able to deal with work stressors better, have less burnout, greater job satisfaction, and display improved quality patient care (Spano-Szekely & Quinn Griffith, 2016). Nursing must evolve to meet the demands of health care today, and nurses need to lead and partner in the transformation of healthcare. Advancing nursing education will support in the transformation of the nursing profession, and one way nursing education can do this is to develop faculty and students' EI skills. However, nursing research studies examining nursing faculty and EI at a clinical level are rare. By exploring clinical nursing instructor's understanding and use of EI, a foundation can be developed to guide further research.

Participants will be asked to participate in a one-on-one digitally-recorded interview that should take about 60 minutes to complete. Also, after the data are collected and analyzed, participants may be asked to review emergent themes via email, to ensure the data are representative of their perspectives. The information collected during the interview will be used only for the purposes of research at the University of Manitoba, College of Nursing. All information collected in this study will be kept confidential and anonymous. Only the researcher will know particpants identity. The thesis chair, Dr. Judith Scanlan, will have access to the study data only after all identifying data are removed. This study poses minimal risk to the participants, and participation is completely voluntary.

The final results of the study will be disseminated through presentations, peer reviewed journal articles, and conferences.

If you have any questions, please contact myself, Tara Roberts RN BN, at [redacted] or by email at Umrob269@myumanitoba.ca. The faculty advisor for this research study is Dr. Judith Scanlan, RN, PhD, and she can be reached at [redacted] or by email at Judith.scanlan@umanitoba.ca

Thank you,

Tara Roberts, RN BN

Appendix D

Interview Guide

1. Can you share with me how emotions play a part of your daily work as a clinical instructor? *For example, can you share a time that you had to identify emotions in yourself or others?*

2. Can you describe how you identify emotions in yourself and others? *How do you differentiate between different emotions?*

3. Can you share with me how you use emotions as a clinical nursing instructor? *For example, how does using emotions affect your thinking/prioritizing in your clinical practice?*

4. Can you tell me about a time you used emotions to assist in your role as clinical nursing instructor? *How did that make you feel?*

5. Can you describe how you identify with different emotions? *(For example, putting your feelings in to words, knowing what external events affect your moods, knowing what is upsetting you)*

6. How would you say you describe your feelings?

7. Can you describe how you manage emotions (both positive and negative) in your role as a clinical nursing instructor? *Can you give any specific examples in which you had to control your emotions when you felt angry/upset/stressed?*

8. Can you tell me about a time when you maintained your composure during a stressful situation or interaction with a student*? How did you feel about that?*

9. Can you tell me about a time when you felt challenged by the demands of your job as a clinical nursing instructor? *How did you feel?*

10. How do you feel the changes in our Manitoba Health care system have affected your role as a clinical nursing instructor? How do you feel about these changes?

11. Have you had to do things differently because of these changes? How did it affect the students/staff on the unit?

12. Can you share with me any situations where you had to manage the emotions of others (either students or unit staff) regarding the changes to our health care system? How did you do that?

Is there anything else you would like to share regarding the use of emotions and your role as a clinical nursing instructor that I have not asked?

Appendix E

College of Nursing
Helen Glass Centre for Nursing
Winnipeg, Manitoba
Canada R3T 2N2
Telephone 204-474-7452
Fax 204-474-7682

UNIVERSITY OF MANITOBA

Rady Faculty of Health Sciences

Dear Potential Participants,

My name is Tara Roberts. I am a graduate nursing student at the University of Manitoba, College of Nursing. As part of my Master's program, I will be conducting a research study entitled "Emotional intelligence (EI) of clinical nursing instructors". The overall questions guiding this study are "What are clinical nursing instructor's perceptions of EI, and how do clinical nursing instructor's use EI"?

Emotional intelligence can be defined as "the ability to monitor one's own and other's feelings and emotions, to discriminate among them and to use this information to guide one's thinking and actions" (Salovey & Mayer, 1990. p. 189). Individuals who work in health care who possess EI are able to deal with work stressors better, have less burnout, greater job satisfaction, and display improved quality patient care (Spano-Szekely & Quinn Griffith, 2016). Nursing must continue to evolve to meet the demands of health care today, and nurses need to lead and partner in the transformation of healthcare. Advancing nursing education will support in the transformation of the nursing profession, and one way nursing education can do this is to develop faculty and students' EI skills. However, nursing research studies examining nursing faculty and EI at a clinical level are rare. By exploring clinical nursing instructor's understanding and use of EI, a foundation can be developed to guide further research.

You are being asked as a clinical nursing instructor to participate in a one-on-one digitally-recorded interview that should take about 60 minutes to complete. Also, after the data are collected and analyzed, you may be asked to review emergent themes via email, to ensure the data are representative of your perspectives. Reviewing of this data should take approximately 30 minutes at the most. The information collected during the interview will be used only for the purposes of research at the University of Manitoba, College of Nursing. All information collected in this study will be kept confidential and anonymous. Only the researcher will know your identity. The thesis chair, Dr. Judith Scanlan, will have access to the study data only after all identifying data are removed. Additionally, Dr. Scanlan, who is the advisor overseeing this study, will independently review at least one transcript for emerging themes. This study poses minimal risk to you and participation is completely voluntary. If you decide not to participate, your decision will not be disclosed to others.

The final results of the study will be disseminated through presentations, peer reviewed journal articles, and conferences.

If you have any questions, you can contact the primary investigator, Tara Roberts RN BN, who is available to answer any questions you may have and can be reached at [redacted] or by email at

Umrob269@myumanitoba.ca. The faculty advisor for this research study is Dr. Judith Scanlan, RN, PhD, and she can be reached at [redacted] or by email at Judith.scanlan@umanitoba.ca

If you choose to participate, please contact the researcher by email (Umrob269@myumanitoba.ca) or telephone ([redacted]) and we will set a mutually convenient time and place for the interview. At that time, you will be asked to sign a Consent Form and receive a copy for your future reference. This proposal has been approved by the University of Manitoba Ethical Education/ Nursing Research Ethics Board (ENREB). The Human Ethics Coordinator's email address and phone number is humanethics@umanitoba.ca and [redacted].

Thank you for considering this request; I look forward to meeting and talking with you.

Yours truly,

Tara Roberts, RN BN

Appendix F

College of Nursing
Helen Glass Centre for Nursing
Winnipeg, Manitoba
Canada R3T 2N2
Telephone 204-474-7452
Fax 204-474-7682

UNIVERSITY OF MANITOBA

Rady Faculty of Health Sciences

Directions: Please read each of the following 9 items. Complete each item by filling in the line or checking the right answer. All answers will be kept confidential. Results will be reported in aggregate form, making identification of respondents highly unlikely.

1. Gender: _____

2. Current age : __ 20-29
   __ 30-39
   __ 40-49
   __ 50-59
   __ 60-69

3. How many years have you been a nurse? _____

4. Of those years that you have been a nurse, how many have been as a clinical nursing instructor? _____

5. How long have you been in your current position/job title? _____

6. Please check the type of nursing education that you have? ___ Diploma
   ___ Bachelor
   ___ Masters
   ___ Doctorate

7. Please explain any additional education you have obtained?

   _____

8. What type of clinical experiences do you teach?

   _____

9. Please indicate the number of students you typically oversee in a clinical rotation? _____

Appendix G

University of Manitoba | Rady Faculty of Health Sciences

College of Nursing
Helen Glass Centre for Nursing
Winnipeg, Manitoba
Canada R3T 2N2
Telephone 204-474-7452
Fax 204-474-7682

Research study title: Emotional intelligence among clinical nursing instructors.

Principle Investigator: Tara Roberts, RN, BN, Graduate Nursing Student, University of Manitoba
Umrob269@myumanitoba.ca

Research Supervisor: Dr. Judith Scanlan, RN, PhD, Associate Professor, College of Nursing
[redacted]

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about, and what your participation will involve. If you would like more detail about anything mentioned here, or additional information not included here, you should feel free to ask at any time. Please take the time to read this carefully and to understand any accompanying information.

This certifies that I, _____ having met the conditions for this study, agree to participate in the study entitled "Understanding and use of emotional intelligence among nurse educators". The proposal has been approved by the University of Manitoba Ethical Education/Nursing Research Ethics Board (ENREB) and access approval has approved from appropriate educational institution.

Specifically, I understand and agree to the following:

1. The purpose of this study is to explore and describe the experiences related to emotional intelligence of clinical nurse educators working in a degree nursing program in a post-secondary educational institution, and understand the clinical nurse instructor's use of emotional intelligence in their work.

2. The study is being conducted by Tara Roberts as part of the requirements of her Masters of Nursing program. The members of the thesis committee include: Dr. Judith Scanlan (Thesis advisor); Dr. Diana McMillan (Internal Member); Dr. Melanie Janzen (External Member).

3. I have been provided with an explanation of the study.

4. I understand that my participation in the study involves one interview, and perhaps a follow up email from the principal investigator. Interviews will be held at time and place mutually convenient to me and the principal investigator, will be digitally-recorded, and last approximately 60 minutes.

5. I understand that I may withdraw from the study at any time without penalty to myself. I may decline to answer specific questions in the demographic questionnaire or during the interview if I so wish.

6. I understand that any information which I provide during the course of the study will be kept confidential at all times. Only the principal investigator, advisor, and a transcriptionist will have access to the digital recording and transcripts of the interview in which I participate. The digital recording and transcripts will be identified by a code number only. My name will not appear on any digital recording or transcript. Only the principal investigator will know the names of those who participate in the study, and this list will be kept separate from the list of the code numbers. Both lists will be kept in a secured and locked filing cabinet in the researcher's office. Further, I understand that I will not be identified in any way in the report of the study.

7. I understand that this study poses minimal risk to the participant, that is, your involvement in this study will provide risks that are no greater than those encountered by you in those aspects of your everyday life.

8. I understand that the results of this study may be published and that anonymity and confidentiality will be maintained if the results of the study are published.

9. I understand that I may contact Tara Roberts, Principal Investigator, at any time if I have further questions about my participation in this study. Her telephone number is [redacted] or by emailing Umrob269@myumanitoba.ca.

10. I understand that if I wish to receive results of the study, I can indicate my desire by signing and giving my address at the end of this consent.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate. In no way does this waive your legal rights nor release the researcher from her legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering and question(s) you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.

This research has been approved by the University of Manitoba Ethical Education/ Nursing Research Ethics Board (ENREB). If you have any concerns or complaints about this project, you may contact any of the above named persons, or the Human Ethics Secretariet at [redacted] or email Margaret_bowman@umanitoba.ca. A copy of this consent form has been given ot you to keep safe for your records and reference.

I have read or had read to me the details of this consent form.

My signature below indicates my willingness to participate in this study.

Participant Signature Date

Researcher and/or Delegate's Signature Date

_____ YES, I would like to receive a summary of the research results

_____ NO, I would not like to receive a summary of the research results

If YES, please indicate your preferred method:

_____ posted mail

_____ Email

Name _____

Address _____

_____

_____

Email _____

If you have chosen to receive a summary, one will be provided to you approximately March 2018