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A qualitative exploration of emotional competence and its relevance to nursing relationships

**A thesis presented in partial fulfilment of the
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Abstract

This qualitative research project explored the experiences of nurse educators who sought to assess aspects, which could be related to facilitation of emotional competence, in nursing students. Focus groups were conducted in three different educational institutions, offering a Bachelor of nursing degree. Each of the participants had a teaching and assessment role within the school of nursing. The contributions of the nurse educators and their interactions were audio taped, transcribed and then later, analysed using thematic and focus group analysis practices.

From the analysis of the experiences of the nurse educators, four predominant themes arose which capture the areas of importance to the participants. Student nurses can develop emotional competence by critically reflecting during classroom and clinical experiences. Continuous consideration must be made within each practicing area of nursing, of the environmental and relational challenges which inhibit or facilitate nurse's ability to practice with emotional competence. Educators and practicing nurses, who work alongside students, must uphold the expectation that emotional competence is a requisite ability and provide opportunities to foster emotional growth and skills to resolve conflict within the culture of nursing.

A common view shared by the educators was that the profession of nursing needs to have a clear understanding of what constitutes emotional competence. Strategies to realistically incorporate emotional competence into the educational curriculum and competency based assessment opportunities within nursing education are required.

Suggestions are presented from which undergraduate nursing education can facilitate development of emotional competence with those students working toward becoming a registered nurse. Emotional competence is suggested as an essential learning outcome in the movement toward transformative nursing education and a collaborative nursing profession.

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Chapter one: Introduction

"The greatest of faults is to be conscious of none"

Thomas Carlyle

1.0 Background to the study

My interest in exploring the understanding and use of emotion in nursing began with some of the first experiences I had as a nurse. Grappling with the framework of a therapeutic relationship and what roles I would have within that, motivated me to think further about the impact of positive and negative emotions experienced in interactions. This involved not only communication with patients and families, but also with colleagues and peers. Processing our own emotions makes working with others' emotions possible. Horsfall and Stuhlmiller (2000), suggest there is a connection between our ability to accept another person's emotional distress and our capacity to accept ourselves and our own distress.

My educational background as a comprehensive nurse has enabled me to undertake nursing roles in various institutional and community settings. The focus of my own practise has been predominantly mental health nursing. Over the last few years, my role has been within nursing education. I facilitate a variety of learning opportunities within an undergraduate nursing degree programme. Over time, I have developed a heightened awareness of how emotions are experienced, explained and used – effectively or not, through personal reflection and various clinical supervisory relationships. It has been a particular focus when undergoing specific education in relation to psychotherapy principles,

with the obligation to reflect on my own life experiences in order to prepare myself to work with people experiencing mental distress. At times there has been a need to juggle emotional closeness and distance in the therapeutic relationship, to manage my own and the patient's dependency. Self acceptance and managing ones' own ego are necessary processes. This means facilitating communication which involves minimal advice, even when it is being asked for.

When I first began facilitating learning in the classroom and clinical practice venues, within the undergraduate programme, I was overwhelmed by the expectation students held, of educators being such experts in their field. My perception led me to believe the students were waiting to be told what to do and how to do it. This was a distressing time for me, particularly since I didn't have all the answers, nor did I think this way of interacting would be helpful for the students. I believe nursing more than any other profession increases our exposure to the emotions of others. Accepting such emotions and validating this experience is essential when establishing a relationship. However, managing our own emotions and working with the emotions of others is not an entirely teachable skill.

'Caring neutrality' is a phrase coined by Peplau, (1988). She suggests that the nurse is required to develop a level of congruence between what they say and how they act towards the person with whom they work. Nursing by its nature should symbolise healthy communication and personal competence. It is useful for nurses to recognise and be careful about how we express our views, our language, our own behaviour and expression of feelings. Being authentic, realistic and hopeful are key

ingredients for outcomes of the relationships, in which we participate as nurses (Horsfall, 1997). Reflection on our own unique capabilities and limitations can assist us to recognise this in others. This includes being able to recognise and deal with conflict with others and within ourselves.

As nurses we are required to question our responses within ourselves and regulate how we react and interact with others in situations of stress or conflict. Freshwater (2000) suggests the emergence of horizontal violence within nursing is a result of unexpressed conflict within an oppressed group. A cultural narrative of nursing is to be subordinate and various authors who describe nursing as an oppressed group argue that nurses lack self esteem, autonomy, accountability and power (Skillings, 1992; Street, 1992). Educators and nurses when engaging with students, appear at times to have selective memory about their own experiences as learners. I can recall myself and have been told numerous stories from students, educators and nurses about the sometimes uncaring nature of nursing. The story-tellers almost always recount where emotion and conflict were not dealt with in a constructive manner and remain unresolved.

Those individuals who choose to undertake education to become a registered nurse are a group of people with wide and varied experiences and capabilities. In order for students to gain confidence, effective communication skills, and the ability to convey hope and regard for others within their relationships, they must recognise and understand emotions. By developing the skills of recognising and understanding emotion, students can use this awareness to manage their own responses and relationships with others. There is a great deal of

discussion among educators which takes place when a student is unable to relate to others in this emotionally competent way. However, how emotional competence is integrated with other forms of assessment to provide feedback to students about their strengths and weaknesses is not so apparent.

In various roles throughout my time working as a clinical nurse, nurse leader and educator, I have been in the position of deliberating on other people's competence. This has been made fraught at times because of the subjective nature of assessments available to determine and provide feedback as to how an individual has met, or not met certain competencies, in order to pass a prescribed standard. As required by the Nursing Council of New Zealand (NCNZ), the focus of these standards is the practical competence of the nurse. Such an approach suggests a certain level of knowledge and skill required within a particular scope of nursing practice. It is not clear which indicators or competencies address the issue of emotional competence. Yet not adequately addressing this vital dimension of personal and professional functioning, means that relationships with patients, their families, nursing colleagues and other people who make up the community that cares for the patient, may be jeopardised (MacCulloch, 1998).

Having begun with preliminary thoughts, I began to reflect on how we as nurses examine our own emotional competence and how is it played out in our relationships? Is it a vital prerequisite for healthy, emotionally competent nursing practice? The nurse educator, working for a recognised institution, is entrusted by the Nursing Council of New Zealand to assess the capabilities and competence of students in

application to the professional nursing register. The way in which nurse educators interpret the competency framework (NCNZ, 2004), in relation to emotional competence has not been a feature of the nursing literature. Nor has a collective description of emotional competence been established in nursing education or practice. This raises the question of what relevance emotional competence, as a concept, holds for nursing?

1.1 Research question and aims

The overall research question is: What challenges are encountered by nurse educators who seek to assess aspects which could be related to emotional competence in nursing students? This question was broken down to three research aims:

1. To determine how a group of nurse educators recognise and describe what emotional competence is.
2. To discuss environmental and relational complexities which affect student learning and assessment of emotional competence.
3. To examine the current competency assessment framework (NCNZ, 2004) and consider its usefulness to recognise and provide feedback to students in relation to their emotional competence.

1.2 A reference to terminology

Within the educational and nursing based literature explored during this research, a number of terms are used to identify what I refer to in this study as 'emotional competence'. My reason for choosing this term emotional competence, rather than similar ones (emotional intelligence,

emotional literacy), is in keeping with the overall intended description of how educators describe ability and progression of student learning within the degree framework (NCNZ, 2004). The term emotional competence was suggested by me when the summary of literature [appendix I] was posted out to potential participants and again at the commencement of each focus group. The summary of literature includes a number of working definitions which summarises an individuals' ability to recognise and understand emotion, and the skills required to use this awareness to manage self and relationships with others. The utility of the term emotional competence was endorsed during the analysis phase.

1.3 Organisation of the thesis

In chapter one, I have begun with an explanation of why and how I became interested in what relevance emotional competence might have in nursing. The overall research question and three aims have been outlined.

Chapter two explores the literature around the concept of emotional competence. The concept of emotional competence from a historical perspective is discussed. Alongside this, contemporary research is reviewed. The nursing literature in relation to emotional competence follows. Whilst most of the literature written with consideration to emotional competence remains in the disciplines of psychology, business and education, there is an emerging reference to studies within professional nursing literature. The majority of literature is American or from the United Kingdom with a small amount also reviewed from New Zealand publications. The literature reviewed suggests there is a basis

for understanding emotional competence within nursing education. However, it also suggests that concepts such as emotional intelligence have been blindly accepted as useful within professional practice. Therefore there is a need to critically examine the usefulness of emotional competence and what unique skills are involved in understanding emotions, how you manage your behaviour and how you manage relationships.

Chapter three outlines the qualitative research design and my rationale for employing this approach to the study. The method of focus groups and the utilisation of thematic and focus group analysis employed during this study are then explained, along with the ethical considerations and soundness of the research.

Chapter four provides an overview of the analysis and addresses the first aim of the research project; to determine how a group of nurse educators recognise and describe what emotional competence is. Discussion focuses around a working definition based on the first theme: ***determining emotional competence***. The definitions of personal and social competence, along with the skills involved, resulted from the ways in which nurse educators describe and recognise this competence in nursing students. Also within this chapter, I attend to the first part of the third aim of this project; examination of the current competency assessment framework (NCNZ, 2004).

Chapters five and six address aim two of the research project. The discussion outlines the environmental and relational complexities which might affect learning and assessment of emotional competence. Chapter

five is in relation to the second theme: *fitness to practice, through personal competence*. Chapter six relates to the third theme: *caring in nursing through social competence*. These chapters outline the challenges that the participants encounter in their relationships with students and colleagues. How these complexities might affect teaching and assessment of emotional competence in nursing students is critically argued with support from literature.

Chapter seven presents discussion of the study and critiques some of the tensions experienced during the research project. This includes addressing the second part to the third and final aim of the project; to consider the usefulness of the current competency assessment framework (NCNZ, 2004), to recognise development of emotional competence within nursing students. Competency based assessment is discussed in relation to the research findings alongside how the competencies can be used to assist with recognition and feedback to students. Chapter seven concludes with the implications of the research for nursing education and practice. Emotional competence within a context of education and practice are discussed including reflection on the research and recommendations for future study.

1.4 Summary

This chapter presented the introduction and background of this research project. The overall research question and aims were outlined followed by a plan of the chapters which follow. The next chapter will provide a literature review of relevant research. The focus of the review includes research that relates to the ways in which people understand and

manage their own emotion and that of others. An extension of this includes current research generated within nursing literature on emotional competence.

Chapter two: Literature review

2.0 Introduction

This chapter reviews the literature on emotional competence as a theoretical concept. A search of nursing databases including CINAHL, Medline and EBSCO Host was employed to explore writing on the concept of emotional competence in the nursing literature. Key words used for the search were 'emotions', 'competence', 'intelligence', 'emotional competence', 'emotional intelligence' and 'emotions and nursing'. In addition to the articles retrieved from the databases, other sources were gained by hand searching current nursing journals and reviewing literature suggested in the references listed in the papers reviewed. The articles reviewed were evaluated to provide a theoretical perspective relating to emotional competence and its application to nursing, in particular nursing education.

There is debate in the literature about what emotional competence is and what link it has to personal satisfaction, professional ability and indeed how it came to be defined. The concept of emotional competence is a psychological one. From a historical perspective, psychology traditionally focused on intellectual competence in relation to outcomes, individual performance and productivity. An overview of the historical literature on competence and intelligence is discussed. The emergence of emotional competence in popular psychology and organisational literature is apparent from the 1990s. The notion of emotional intelligence (EI) – the ability to perceive, understand and manage emotions' gained popularity generating various books, TV talk shows and

websites. EI, along with other similarly defined concepts, is reviewed and summarised from the educational and psychology literature. Finally the review shows the emergence of emotional competence within the nursing literature and suggests the importance of understanding and incorporating this concept into nursing education and practice.

2.1 Historical overview

Original writing and thinking about intelligence focused on cognitive aspects such as problem solving and memory. Some researchers also recognised that there were non-cognitive aspects to intelligence. Thorndike (1920) first proposed that social intelligence was of value in human interactions and relationships and discretely different from academic ability. In the early 1940s, researcher David Wechsler defined intelligence as: "The aggregate or global capacity of the individual and to deal effectively with his environment" (Wechsler, 1940, p. 444). He later referred to non-intellective elements, by which he meant affective, personal and social factors. When considering measurement and appraisal of adult intelligence, he suggested: "The question is whether non-intellective, that is affective and cognitive abilities, are admissible as factors of general intelligence" (Wechsler, 1958, p. 103). Wechsler contended that these factors were not only admissible but also necessary and that testing of intelligence had to include measures of non-intellective factors in order to be a valid appraisal.

More specifically, in an assessment centre based in Ohio in America, the consideration of emotional competence was being studied as an important aspect of leadership. Murray (1938) suggested that leaders

who are able to establish mutual trust, respect, and a certain warmth and rapport with members of their group, will be more effective. Studies comparing the concept of competence rather than intelligence were undertaken by a psychologist, McClelland (1973) based on earlier work by the same author and colleagues of the research on talent in society (McClelland, Baldwin, Bronfenbrenner & Stodbeck, 1958). The focus of the research was to highlight that IQ is not necessarily a predictor of success.

According to Hochschild (1983) who introduced a concept called 'emotional labour', individuals require the ability to regulate their emotional reactions in relationships with others. She suggested that the ability to care for others might at times, require the induction or suppression of feeling in order to sustain an outer appearance so that the person being cared for feels safe and worthy. Hochschild stated: "emotional labour is the kind of labour that calls for co-ordination of mind and feeling, and sometimes draws on a source of self that we honour as deep and integral to our individuality" (p.7). Furthermore, Hochschild (1983) argues emotional labour is guided by 'feeling rules' and suggests that emotional life is socially controlled. The rules are derived from social conventions, the reactions from others or from within the individual. The purpose of emotional labour is to promote in others a feeling of being cared for.

In 1983 researcher Howard Gardner began to write about multiple intelligence. He proposed that 'intrapersonal' and 'interpersonal' intelligences are as important as the type of intelligence that was being traditionally measured by IQ testing and related methods (Gardner,

1983). The concept of non-cognitive intelligence was also being researched in relation to leadership. By the 1990s there was a body of research on the role of non-cognitive factors helping individuals to achieve, both in their personal lives and their places of work. This earlier work on the concept of emotional competence is still reflected in the current literature.

2.2 Current literature on the topic of emotional competence

Emotional intelligence or emotional competence, are interchangeable terms. Just exactly what they are is open to interpretation. It has been suggested that emotional intelligence is a sort of conceptual inkblot, an unstructured notion that is open to a number of interpretations (Caruso, 2004).

In 1990 two psychologists, Peter Salovey and John Mayer, first coined the terms emotional intelligence (EI). They refer to EI as the ability to recognise the meaning of emotions and their relationships, and to reason and solve problems on that basis (Salovey & Mayer, 1990). Originally, these researchers concluded that EI consisted of three mental processes. They were appraising and expressing emotion in the self and others, regulating emotion in self and others, and using emotion in adaptive ways. In 1997, they further refined EI into four mental abilities: perceiving/identifying emotions, integrating emotions into thought processes, understanding emotions, and managing emotions (Mayer & Salovey, 1997). Furthermore, Salovey and Mayer described emotional intelligence as: "A form of social intelligence that involves the ability to

monitor one's own and others feelings and emotions, to discriminate among them, and to use this information to guide one's thinking and action" (1990, p. 186). The research programme that they led developed a measure of emotional intelligence to explore its significance.

Various models of emotional competence have been discussed and ways in which the criteria can be measured have been developed. Mayer and Salovey (1997) concluded that emotional intelligence is actual intelligence and as such can be measured through an ability test. The MSCEIT (Mayer Salovey Caruso Emotional intelligence Test) was based on their definition and the measurement of EI continues to be of interest psychology and its related fields (Bar-On & Parker, 2000; Freshwater & Robertson, 2002). These authors suggest that emotional competence is a core ability related to an individuals' capacity to reason with their emotions, in particular how they are affected in relationships and interaction.

Daniel Goleman undertook research in the early 1990s, (based on Salovey & Mayer's work) which lead to his book 'Emotional Intelligence' (1995). Goleman was a psychologist and a journalist for the New York Times, who wrote about the brain and behaviour from a scientific point of view. The most recent findings of further research following the second book 'Working with emotional intelligence' in 1998, can be found in writings published through the Consortium for Research on Emotional Intelligence in Organisations (www.eiconsortium.org).

According to Goleman (1998), emotional intelligence is defined as: "The capacity for recognising our own feelings and those of others, for

motivating ourselves, and for managing emotions well in ourselves and our relationships" (p.317). The theory of emotional intelligence includes several features such as character, personality, soft skills and competence. Maturity is also seen as a factor in the development of emotional intelligence (Goleman, 1998). His book is divided into five parts; beyond expertise, self mastery, people skills, a new model of learning and the emotionally intelligent organisation. Although Goleman discusses IQ, leadership and job performance, for the purpose of this literature review the focus will remain on the interpersonal and social aspects of the EI theory.

Goleman suggests several components of personal competences. This includes theorising that they are not meant to stand alone, but together each is important for learning. The five emotional intelligence areas are self awareness, self regulation, motivation, empathy and social skills (Goleman, 1998). Self awareness as a foundation includes emotional self awareness, accurate self assessment and self confidence. Self awareness is also a key factor in empathy. According to Goleman, empathy "represents the foundations skill for all the social competencies important for work" (1998, p.137). Political awareness, understanding and developing others and service orientation make up the social competencies.

Goleman (1998) also discusses social skills. In order to relate to each other and work with other people's emotions we need social skills. These social skills include communication, influence, leadership, conflict management and being the catalyst for change. The EI guidelines in relation to social skills include: self control, trustworthiness,

conscientiousness, adaptability and innovation. According to Goleman it is important to have self regulation of these emotional competencies so an individual can handle impulses and distressing feelings. Alongside the personal and social competencies sit motivational aspects identified as drive, commitment and optimism (Goleman, 1998).

Another social researcher writing more recently on the theory of EI describes emotional competence but defined it as: "Emotional literacy, the ability to recognise, understand, handle and appropriately express emotion" (Sharp, 2001, p.1). Sharp's likens his concept of emotional literacy to emotional intelligence, a term found abundantly in the literature. He suggests literacy is a more appropriate term due to the term intelligence having accrued a pejorative connotation.

The aims of emotional literacy, according to Sharp, are to: "build self-esteem in individuals who then promote group literacy, leading to a robust and emotionally literate society" (Sharp, 2001, p.3). Emotional literacy involves: recognising our emotions in order to label or define them; understanding our emotions in order to be effective learners; handling (managing) our emotions in order to develop positive relationships; expressing emotions so we can help ourselves and become emotionally healthy – being then, in a position to help others.

In support of this term, emotional literacy, Park (1999) expands by suggesting it is also important because positive emotion influences concentration, memory, problem solving and learning skills – the traditional aspects of intelligence. Furthermore by enhancing these abilities, the individual is better equipped to build positive relationships

and the capacity to break out of dysfunctional relationships. Park also suggests that emotional literacy builds creativity, innovation and leadership aspects of an individual's capability that leads to a measurable impact on personal and organisational performance. Theories of emotion attempt to explain the relationship between subjective emotional experiences and an event. However, the same event may result in very different emotional experiences in each individual. An understanding of emotional literacy in nursing education may assist educators to reflect on the individual experiences students have within their learning. Emotional literacy acknowledges the importance of subjective emotional experience and its use in enhancing relational ability essential in nursing.

The importance of education, personal growth, awareness and self-analysis is advocated by Heron (1990). Heron describes emotional competence as a required state that helping professionals must be in, in order to interact with clients. This is so the individual is in a position to facilitate personal understanding and growth within the client. He uses a concept called 'unresolved personal distress' to describe the source of negative responses that helping professionals can take with them to helping relationships.

A theme throughout Heron's writing suggests that many, if not all of us, experience situational or enduring trauma or difficulties that remain unresolved, and that there is a universal phenomenon in society which indicates the need for education in emotional competence for children and adults (Heron, 1992).

2.3 Historical summary

Emotional competence has its foundation in the social intelligences first propositioned by Thorndyke (1920). Traditional views of intelligence had been linked with performance in IQ tests however over recent decades authors such as Hochschild (1983) and Gardner (1983) distinguished between two types of intelligence: interpersonal and intrapersonal. Their theories suggest a link to capability and success with development and use of multiple intelligence and labour within the caring professions. Salovey and Mayer (1990) and Goleman (1998) took these ideas and extended the view that people who possess the skills of these social intelligences can form connecting relationships with others easily, read other people's feelings and responses accurately, lead and organise other people and handle disputes successfully. The skills of emotional competence and the way in which they can be developed and nurtured has been explored by various authors, of note, Heron, 1990; Salovey and Mayer, 1990; Goleman, 1998; and Sharp, 2001.

2.4 Emotional competence and the nursing literature

Having established that there is a lengthy history of concepts likened to emotional competence in the psychology and education literature, I broaden the literature review to explore nursing research related to the concept.

2.41 Emotions in nursing

Emotional competence as a concept has an established history in the psychology and social science literature and is becoming an emerging feature in the nursing literature (Evans & Allen, 2002; Freshman & Rabino, 2002; Vitello-Ciccui, 2002; McQueen, 2004). Many nursing theories emphasise that nurses should be able to develop relationships which include empathy in order to undertake the role of professional caring (Ramsden, 1990; Peplau, 1992; Newman, 1994; Barker, 1999). Cadman and Brewer (2002) suggest, as do various other authors (Freshwater, 2004; McQueen, 2004) that the ability to manage our emotional life, while interpreting the emotional life of other people, is a prerequisite skill for any caring profession. Despite this there is only an emerging reference with the nursing literature as to how gaining this skill is facilitated or nurtured in nursing education.

2.42 Emotional competence and nursing leadership

The majority of research in relation to emotional competence in nursing relates to developing leadership skills in nursing. Bellack et al. (2001) suggest there is increasing need for effective leadership in nursing. They argue that Goleman's (1998) framework of emotional intelligence provides a structure which can operationalise teaching leadership competencies within nursing education. Snow (2001) contends that effective leadership in nursing is one of the most elusive keys to organisational success, yet it is the key ingredient to making any organisation work. Snow undertook a five year study exploring what separates superior leaders from average leaders and concluded that

emotional intelligence is linked to better performance and leadership qualities in nurses.

The most widely recognised author on emotional competence and nursing leadership is Vitello-Ciccui (2002). This author suggests that emotional intelligence is being touted within popular literature as an important characteristic for successful managers and leaders. However, he cautions that clarification is required in linking emotional intelligence to workplace success. Molter (2001) posits that to be successful, transformational leaders of nursing need to lead with their heart and to identify and manage the emotional aspects of work-related issues. Both authors recommend research is still required as to how emotional competence is developed and utilised in nursing.

2.43 Emotional competence and dealing with conflict

Jordon and Troth (2002) explored the utility of emotional competence in predicting an individual's preferred style of conflict resolution. The outcome of this empirical study suggested that individuals with high emotional intelligence prefer to seek collaborative solutions when confronted with conflict. In an Australian study with mental health nurses, Humpel and Caputi (2001) explored the relationship between work stress and emotional competence. They reported that a significant relationship was found between emotional competency and years of experience and that the relationship was stronger for female as opposed to male nurses. Furthermore they found that personal self doubt was significantly more apparent in nurses with less than two years experience (Humpel & Caputi, 2001). The relationship of emotional

competence to an ability to cope with conflict and stress in nursing was also explored by Tjion (2000). In a quantitative study, the author reports that there is a significant relationship between emotional intelligence and hardiness and coping with job stress in nursing.

2.44 Emotional competence and nursing education

Dos Santos, de Almeida and Lemos (1999) in a descriptive exploratory study, concluded that the majority of nursing students have basic characteristics of emotional intelligence. The development of this ability allows the student to be in tune with their clients, understand them and also make themselves understood. Estima and Silva (2000) argue emotional competence is required to establish a caring relationship in nursing practice. Cadman and Brewer (2001) suggest a selection process is required in the recruitment of undergraduate nursing students to determine levels of emotional competence prior to starting the course. They argue that certain levels of emotional competence in students may be a predictor to success in both clinical and academic aspects of study. They note however, that emotional competence cannot be developed quickly through interpersonal skills training, and that assessment strategies need to be developed within nursing education to identify the progress of students.

Procter and Welbourn (2002) outline how the teaching of therapeutic communication through an experiential approach offers the potential for student's self awareness and reflective skills. They argue understanding the role of emotional labour and emotional intelligence in nursing can promote therapeutic and communication skills. Freshwater and Stickleby

(2004) have contributed significant research and discussion on the developmental relationship of emotional competence and competent nursing practice. They argue that much of what is described within the curriculum documentation is little more than rhetoric and that some educators and practitioners have embraced the concept of emotional competence uncritically without a full understanding of its meaning and relevance. They suggest a transformatory model of learning for nursing education, which requires reflection in action.

2.5 Summary

Emotional competence has been linked to strengthening leadership ability and relational skills within nursing. It has been established that the ability to recognise and handle emotional reactions at a personal level supports the capability to undertake and manage emotional aspects of work-related issues. Those individuals who develop emotional competence are more likely to manage conflict and seek collaborative solutions within relationships. It is likely that students at the beginning of a nursing degree have some established skills related to emotional competence. Nurturing of these skills requires assessment strategies within nursing education to identify the strengthening and progress of these.

Various other authors also argue for emotional competence to be included in the screening of undergraduate students (MacCulloch, 1998; Strickland, 2000; Evans & Allen, 2002; Freshman & Rabino, 2002; Freshwater, 2004; McQueen, 2004). Alongside this is the need for

clarification of the key characteristics of emotional competence, both in relation to teaching and assessment of the concept within nursing education. Furthermore the authors suggest the necessity for student nurses to develop emotional competence and to realistically incorporate teaching and assessment of the concept within nursing education. However, how educators within a New Zealand context, describe and explore with students and each other, what is emotional competence is unclear. With the exception of MacCulloch (1998), so too is research as to how the current competency framework (NCNZ, 2004) relates to assessment of emotional competence in nursing education and practice. Furthermore, the challenges nurse educators might encounter, when they seek to assess aspects which could be related to emotional competence in nursing students, has yet to be explored.

Chapter three: research design and method

“Meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things they encounter”

Michael Crotty

3.0 Introduction

The purpose of conducting this qualitative study was to explore what challenges nurse educators encounter within their assessment role and to describe their experiences when seeking to assess aspects which could be related to the development of emotional competence in nursing students. In this chapter, the qualitative methodology selected is outlined, along with the justification for the method chosen. I discuss the process of participant selection, ethical considerations, and provide an overview of focus groups and their use in data collection for this study. The principles and processes of focus group and thematic analysis as they were employed during this project are outlined.

3.1 Qualitative methodology

The methodology within any research process should be congruent with other fundamentals of the research design such as epistemology, theoretical perspective and method (Crotty, 1998). I have chosen to take an interpretive approach to knowledge and the research process within this project. They have shaped the way I understand what emotional competence to be in nursing. I hold the view that reality is inseparable from the mental categories people use to understand their world and believe that theory cannot be separated from observation nor

facts from values. This ontological position means the methods I have chosen have constructed the data. The data represents relationships, which I have encountered alongside the participants' experience. The theory of knowledge is embedded in an interpretive paradigm. This approach to epistemology attempts to explain how it is that we know what we know. The interpretive paradigm theorises through analysis of socially meaningful action. This is through direct relationships with others in their own setting, to arrive at an understanding and of how people create and maintain their own social world (Davidson & Tolich, 2003). Therefore, I have chosen qualitative methodology to best explore how emotional competence may be understood with the groups of nurse educators in this study.

There are assumptions held within a qualitative interpretive approach. These include that the reason for the research is to understand and describe meaningful social action by and for the group participating. It is also assumed that the nature of their social reality or situation is created by the participants themselves and participants are understood as social beings who create meaning and sense of their situation (Heron, 2004). It is assumed also that common sense is an everyday tool used by everyday people and those tools are like a description of how that group make sense of its use, generates new understanding or sustains the status quo. A qualitative inquiry acknowledges the evidence embedded in the context of social relationships present (Habermas, 1972). Those who are part of the research project decide what is right and true for them and that there is no 'one truth' that exists. No one group's values are right or wrong, only different – they are an integral part of social life (Crotty, 1998).

The task of interpretation within this project is not for the purpose of criticising or dismantling the unjust or undemocratic practices or intentions of nurse educators, nor for transforming them (Howe, 1998). The task has an underlying philosophical assumption that self transformation results in an interpretational interchange. Having a belief in the power of critical reflection is to open up new ways of viewing the situation and our role within. Critical reflection is characterised by autonomy and authority. The understanding that results from interpretation then becomes new choices that can be made; the freeing from hegemonic or authoritarian structures becomes a possibility with new knowledge. Gallagher (1992) suggests knowledge is: "An ongoing process within educational experience, rather than the end result of critical reflection" (p. 272). An interpretive inquiry is a practice which involves people in context, not simply a way of knowing. A moral-political commitment is required to understand what others are doing or saying in the research context in order to transform that knowing into interpretive research (Denzin, 1997).

3.2 My leaning toward a critical lens

Critical researchers propose that knowledge should not be generated for its own sake, but also for the sake of cultural or social criticism. Lather (1991) and Kincheloe and McLaren (2000) suggest that action, or the potential for action, at a socio-political level is the intended outcome of critical research. This type of inquiry suggests exposing hidden power imbalances by assisting individuals, groups or communities to take action themselves. Critical inquiry keeps the spotlight on power

relationships within society so as to expose the forces of hegemony and injustice. With every action taken, the context changes and critique of our assumptions must occur again. It is a cyclical process of reflection and action (Crotty, 1998).

The combination of research in action, or praxis, is embraced by critical researchers and the agenda is to produce change through personal, group empowerment, or alterations in systems. The possibility of developing critical consciousness is dependant on the participants' intention to understand the values, norms and social knowledge that they have come to accept as part of their social lives. Critical consciousness, as Freire discusses, allows people: "...to develop their power to perceive critically the way they exist in the world within which they find themselves; they come to see the world not as a static reality but as a reality in process, in transformation" (1972, p. 70). Fundamental to this is valuing people as experts in their own lives and situations. There is no agenda to control or predict, to understand or describe. The goals are for change; therefore the challenge to knowledge must be up to task (Ford-Gilboe, Campbell & Berman, 1995).

3.3 Methodological assumptions

According to Harding (1987) and more recently by King (1994), the distinction between method and methodology has been misunderstood. Methodology refers to a set of principles which guide the research and decision making in a number of areas. These areas include the relationship between researcher and participant, and the ways in which subjective meanings are values and incorporated into the research. This

also includes how, through the process of interpretation, the participants are incorporated, or not, in the analysis and dissemination of the findings.

This study is praxis orientated and emancipatory in intent. Lather (1991) suggests emancipatory knowledge increases awareness of the contradictions hidden or distorted in everyday understandings. In doing so, it directs attention to the possibilities for social transformation inherent in the present configuration of social processes. The aspects of description and explanation hold relevance in qualitative inquiry. There is no intention in this study to suggest the interpretation or findings can be generalised or be predictive in nature. The findings are situated with a particular group of people at a given time.

During this research process I aimed to reflect the opinions of the nurse educators who participated in this research. I also sought to offer interpretations of these opinions whilst recognising my own positionality. Qualitative research relies on inductive reasoning to interpret and structure the meanings that can be derived from the data. The participants' explanations should be contextualised and not removed from the situation in which they occur. However, there is a need to not just tell stories about what was discussed during the research process. I have a responsibility to contextualise the research: "To acknowledge the layers of past experiences, both personal and professional, which clearly affect the way researcher's, hear and interpret what respondents say" (Wilson, 1997, p. 212). Qualitative researchers study meaning (Sandelowski, 1993). The process of quality research into meaning and interpretation is not assured by simply following a procedure;

interpretations and meanings are situated. In order to demonstrate trustworthiness and rigor there is a requirement that the analysis follows a well thought out procedure and an understanding that this procedure reveals the structures of understanding of the participants.

3.4 Ethical issues

The research project received ethical approval from the Massey University Human Ethics Committee. In addition, approval to invite nurse educators to participate in the study was obtained from the Dean of the Faculty of each institution from which the participants were recruited. The Massey University *Code of ethical conduct for research and teaching involving human subjects* (Massey University, n.d.) guided the research process. The four principles set out in the code are discussed below. Research ethics as outlined by Denzin and Lincoln (2003) and Davidson and Tolich (2003) have informed the interpretation throughout the process.

First, do no harm. Snook (2003) rightly proposes that the point of research is to improve the situation of human beings. Both means and ends must be subjected to ethical appraisal and researchers are obliged to deal with their participants and their research community in an honest and truthful way. All participants were nurse educators with whom I had no current professional relationship, in terms of teaching or academic commitment. All were recruited from outside the institution in which I work.

All participants will be voluntary. A letter requesting permission to recruit nurse educators within various schools of nursing was sent to the Dean of the faculties [appendix I]. An invitation to participate, along with an information sheet [appendix II] outlining the intention of the research, was disseminated by the Dean of the educational institution after they agreed to recruit participants within their particular school of nursing. The inclusion of educators to participate in the study was that they were currently undertaking a teaching and assessment role within the undergraduate nursing degree. The information sheet outlined the research question and the intention of focus groups as an opportunity to explore the question. The participants then contacted me directly to state their interest. On stating their interest in being a participant in the project, they were posted or emailed another copy of the information sheet and a summary of literature [appendix III] on emotional competence to read. Following that I asked that they reflect on the information and then indicate their interest in being involved in a focus group. After agreeing to participate in the study, each group decided on the time and location of the focus group in negotiation with me. At the beginning of the focus group a discussion about informed consent was held and written consent was obtained.

Minimising of harm. Although it was not anticipated that this research project would cause harm to any of the participants, I was mindful to minimise any inconvenience in terms of the location and timeframes being acceptable to them. I was also aware to maintain privacy and confidentiality both in the description of the focus groups and the content of the discussions. I negotiated with the participants at the

completion of as what best suited them in relation to keeping their experiences anonymous throughout the research process.

Truthfulness. A truthful account of the research aims and motivation for undertaking the project was given to each of the participants at the information sharing stage or prior to the commencement of the focus groups. Discussion and negotiation took place as to what feedback process best suited the participants with an open offer to renegotiate this at any point.

3.5 Focus group method

The term method refers to the way in which data are collected. The methods chosen must be consistent with the methodological assumptions and give consideration as to what choices are most able to contribute to bringing about change.

3.51 Focus Groups – the literature

I chose the method of focus groups for this research. Davidson and Tolich posit that: “The nature of focus group research is usually non-quantitative and provide a powerful means for gaining an insight into the opinions, beliefs and values of a particular segment of the population” (2003, p. 251). Focus group research uses group discussion to identify and explore the thoughts and perceptions about a specific area of interest.

Basch (1987) suggests that focus groups have much potential use in health research. They have been used widely in a variety of nursing

research studies. According to Krueger focus groups are described as: "A carefully planned discussion designed to obtain perceptions on a defined area of interest, in a permissive non-threatening environment (2000b, p. 18)". The facilitator of the group has the responsibility for creating a non-threatening environment that encourages sharing of opinions and experiences by the participants (Basch, 1987; Kitzinger, 1994b). Consistent with these authors, Basch outlines that the focus group interview: "Is a qualitative research technique used to obtain data about feelings and opinions of small groups of participants about a given problem, experience, service or other phenomenon" (1987, p. 414). Morgan (1996a) suggests that focus groups are less efficient than individual interviews at generating responses from the participants, however they facilitate greater insight into the sources of behaviour and motivation of those involved. Therefore, focus group method supports the aims of this research study.

3.52 The use of focus group method

The focused discussions that took place with groups of nurse educators, teaching at three different educational institutes in New Zealand, provided the primary data for this study. Primarily, I chose focus groups because they sit well within the nature of qualitative inquiry in generating opinions and feelings, but also because of their potential to provide an opportunity to communicate those opinions and feelings with others, at a relational level. As Kitzinger (1994a) suggests, integral to this method is the use of group dynamics, or synergy, to produce data and insights that would be less accessible without the interaction found in the group. The notion of emotional competence suggests that as

humans, we are not isolated. I would suggest that as nurses, we are without purpose if no relationship exists. My inquiry centred on the types of personal and social competence that requires individuals to become self aware and use that self awareness. Furthermore, it centred on competence that enables individuals to understand how others operate and how to effectively manage those interactions, through effective communication. Therefore, focus groups had the potential to help the participants and I jointly explore and clarify our views, in ways that would be less accessible in a one to one interview.

My decision to use a focus group approach was also because they were reported in the literature to be flexible in the way they could be conducted. Morgan and Spanish suggest there is “nothing sacred” about how they are conducted and that the dynamic of the focus group approach is not static (1994, p. 225). This is supported by Krueger, who argues that: “The approach and methodology are constantly changing” (2000b, p. 9). This sat well in terms of my critical stance that no one truth or way of doing things exists. Moreover, knowledge and the process of understanding should be purposeful for those involved, within the context of their ability to participate.

There are characteristics that make focus groups an ideal method for data collection for this study. Focus groups offer the opportunity to explore what relevance emotional competence might have in nursing education. Without predetermining what those perceptions might be, the group has the potential to generate current and new understandings by discussion and clarification of the emerging points of view. When followed through to the process of analysis, a commitment to that

interaction allows themes and the realities of the educators relationships with each other and their students to emerge. The process of interaction provides opportunity for multiple perspectives to be represented, reflected on and understood (Kevern & Webb, 2001). Therefore focus groups are a useful means of collecting qualitative research data and facilitating an ongoing dialogue during the analysis of themes.

3.6 Sampling

Participants were identified by purposive sampling (Kruger, 2000b). According to Miles and Huberman (1994) the aim of purposive sampling is to identify the perceptions of a specific group of people about a specific topic. Roberts (1997) shares this view. He describes the sampling frame as aiming to: "Ascertain theoretical insights from articulate representatives of the cultural variables of the population" (1997, p. 80). This type of sampling was also consistent with the aims of the research whereby familiarity (Torn & McNichol, 1998), has the potential to create homogeneity (Krueger, 2000b). There is debate in the focus group literature as to the familiarity of the participants (Morgan, 1996b). The goal was to learn about a range of perceptions concerning a specific concept within nursing. Therefore the participants needed to have familiarity of the language, terminology, institutional practices and regulations involved in nursing education (*see table one for the characteristics of the participants for this study*).

The sampling process was designed to recruit a sample that showed variation of perceptions of individual educators and homogeneity within

the groups with education being the focus. As Firestone (1993) suggests, the aim was to achieve authentic views, rather than sample to population generalisation. All volunteers met the criteria for inclusion in the study and no further sampling was required once the initial samples had been recruited from the various institutions. I made no attempt to recruit participants who held a particular view of emotional competence (Kruger, 2000b). Nevertheless, self identification of participants may have contributed a bias. This bias may be in favour of the participants indicating the concept of emotional competence being relevant in nursing.

Characteristics of the participants (Table one)

<p><i>Age range:</i> between 33 and 66 years old. Average age: 50</p>	<p><i>Highest academic qualifications included:</i> M.Midwifery (2); P.G.Dip (3); M.Phil (2); M.Ed (2); M.HSc; M.N (2); M.A; Ph.D; B.A (Hon).</p>
<p><i>Key areas of teaching included:</i> family health; ethics; cultural safety; praxis; pathophysiology; fundamentals of nursing practice; anatomy and physiology; nursing management; research; health promotion; Maori health; child health; sociology; maternal health; medical and surgical nursing; mental health; philosophy.</p>	<p><i>Length of time as a registered nurse:</i> between 12 and 47 years (average time frame= 25.5 years)</p> <p><i>Length of time as a nurse educator:</i> between 4 months and 35 years (average time frame= 16.8 years)</p>

3.7 Data collection

A list of potential questions [Appendix IV] was developed prior to the first focus group to facilitate exploration of perceptions around the research aims. The questions attempted to strike a balance between generating discussion and the need to limit data collection according to the purpose of the research. The aim was to facilitate and focus discussion rather than control it.

There were fifteen individual participants who took part in three separate focus groups at three different venues. My decision on how many groups should take place was based on the guidelines provided by Morgan, 1996a; Kitzinger, 1994a; and Greenbaum, 1998. These authors consistently suggest that data collection should continue until sufficient data is collected to answer the research questions. There were no problems encountered during the focus groups. As facilitator of the group I attempted to encourage discussion through the use of probes and clarifying questions. During discussion I reflected on examples from the literature on emotional competence to highlight points under discussion.

Each of the focus group discussions was audio taped by me on the day the interviews were conducted. I also recorded my thoughts and questions in a journal on completion of the group. Each of the focus groups took place at the participants' place of work. The audio tapes from each of the groups were transcribed by me within a week of the group (Kruger, 2000a). This assisted with the ongoing analysis and reflection of the question structure and relevance for the next group. The

aim of the timeframe was to avoid, as much as possible, loss of recall and accuracy of the observations made during the group. By transcribing the tapes myself I was able to listen and hear 'differently' the content, tone and interaction that occurred within the group.

There are multiple dimensions to consider in the analysis of focus group interviews (Krueger, 2000a). The transcription process allowed me to think about the comparison of words (e.g. when a question was asked, two people answered using different words, yet had the same meaning); comparison of meaning (when the group members were having a conversation they were not always talking about the same thing); along with the intensity or the group members responses; and the consistency in the position they took on an issue. I found myself hearing more detail out of the role of facilitator. I was more able to 'listen' for meaning, both in what was said and not said during the group interaction. Within two days of the transcribing I listened again to the tapes and re-read the transcripts to complete the summary which was sent back to each of the participants.

At the completion of the group I negotiated what type of feedback and consultation about the transcripts and emerging ideas best suited the participants. They were offered the choice of an individual copy of the typed transcripts, a summary of the transcripts, or something of their suggestion. Each of the groups suggested due to time and availability that they would prefer a four to five page summary of the transcripts to be posted to them individually so that they could read and comment and return their views to me. A summary of each group was sent to the participants involved; they either individually or collectively as a group

sent back their comments to me as the researcher. No inter-group comparisons were made during the data collection or during analysis. The participants were invited to reflect on and contribute to the process of analysis by offering their opinions on the emerging themes in the summary of the transcripts. After the thematic analysis took place further comment was sought from the participants. The process of data collection and analysis were continuous rather than separate processes (Krueger, 2000a). The comments of the group members helped to shape the construction of the perceptions along with the interaction within the group. The issue of interaction within the group was addressed within my journal of field notes and are included as further data for analysis.

3.8 Data Analysis

This section describes the process of analysis used within this research project. Various sources of literature were used to inform the process and they are included throughout the discussion. The theoretical issues which arose in the analytic process of this research are considered along with the steps used in the analytic process of this study.

3.81 Understanding

Qualitative inquiries which sit within an interpretive paradigm share a commitment that there is a need to approach the data analysis with caution and an awareness that the word 'analysis' itself, is grounded in positivist assumption that certainty exists (Denzin & Lincoln, 2003). As Wolcott (2001) indicates, meanings derived from the process of qualitative research are not fixed or final but rather created during the

research process, based on understanding of the individuals present in the given context. According to Shusterman, all varieties of interpretive research: "insist on rejecting the very idea of any foundational, mind-independent, or permanently fixed reality that could be grasped or even sensibly thought of without the mediation of human structuring" (1991, p. 103). Understanding and interpretation of what others are doing or saying requires acknowledgement of the context or background of the meanings, values, and beliefs systems in which they have been formed (Denzin & Lincoln, 2003).

An interpretive stance during the research process can inform the researcher undertaking the data analysis in a different ways. Firstly, the data can be made sense of through the assumption that we always see (make sense of) everything through interpretation, concluding that, everything is in fact constituted by interpretation (Denzin & Lincoln, 2003). No one conclusion or interpretation is more correct, better or worse, than another. Justification or clarification of meaning is a non-issue; rather the data is textualised within personal or political subjectivity (Richardson, 1997). This way of viewing knowledge within an interpretive paradigm can also be termed strong holism (Denzin & Lincoln, 2003). Strong holists may conclude that there are multiple realities. This then leads to many equally acceptable interpretations. In summary, strong holists judge which interpretation is proper, based on whether or not the information invites, persuades, compels, entertains, evokes or delights (Bernstein, 1986).

Non-sceptical or weak holism is an alternative way of viewing knowledge within an interpretive paradigm. This perspective concludes that

knowledge of others is always dependant on a background of understanding and argues there is no need or desire to be suspicious of this. The need to limit or fix meaning is impossible because all such evaluation of data will always be comparative and revisable. A better interpretation is possible, which encompass the strengths or weakness of a previous interpretation, (Denzin & Lincon, 2003). Weak holism denies the need for a final, definitive or complete interpretation. In summary, interpretation is better understood when justification from one interpretation to another occurs (Taylor, 1995). Therefore, although the term analysis is used to describe this part of the research process (that is the steps used to reduce, organise and interpret the data), understanding and meaning of the information is constructed on a reflexive account of the process. It is this reflexive account which underpins interpretation for this study.

3.82 A systematic process

According to Kruger (2000a) there are critical ingredients of qualitative focus group analysis. The systematic protocol for focus group analysis aims to provide results that are as authentic as possible. The first step in the analytic process is identifying key questions which relate to the research aims and exploration of the topic followed by capturing the data. The second step in the process is summarising the key ideas of the data. On completion of the transcribing I summarised the key points according to the research question framework. Answers throughout the group process were assigned to a question. The third step involves verification from the participants. I sent a copy of the summary to each of the group participants and invited their comment. They returned e-

mail, written and verbal feedback which was included in the data for analysis. The fourth step, according to Krueger (2000a), involves debriefing between moderators. I independently facilitated and transcribed the groups so did not have an organised relationship to do this part of the systematic process. However, mindful of being open to multiple views I listened to my field notes dictated on the day of the group, discussed verbally how the group had gone with my supervisor and then debated the summaries with her at a later date. I utilised the principles and process of thematic analysis (Boyatzis, 1998) to code and interpret the data. The steps within that process are outlined in the next segment. Following thematic analysis, I returned the themes to the groups and discussed the findings with the participants.

A systematic process assisted in viewing the analysis in manageable chunks, it also challenged my assumptions about the research process and the understanding I held on emotional competence in nursing relationships. Furthermore, the systematic process allows the reader of the study to see how the researcher has attempted to be thorough and how another researcher could arrive at a similar conclusion using the available data – the analysis must be verifiable (Krueger, 2000a). Focus group literature suggests there is a continuum of interpretation in the research method (Basch, 1987; Kitzinger, 1994b; Morgan, 1996b; Greenbaum, 1998; Krueger, 2000b).

3.83 Thematic analysis

Coding in thematic analysis is the process of identifying themes or concepts that are in the data. The researcher attempts to systematically

build an account of what has been observed and recorded. Themes emerge through this coding process. Coding links the data to an emerging theory (Boyatzis, 1998). The initial identification of topics, referred to as sensing themes, is exploratory, looking in the data for codes. As the coding format becomes more developed new themes emerge and are able to be used to enable the development of an argument around which the research report is organised (Green, 1998).

The aim of thematic analysis is to identify themes within the data. It uses an inductive process to turn categories into themes. These categories are 'induced' from the data. General issues are identified during the process of planning and data collection and determined prior to the analysis. The specific nature of the categories and themes that emerge are not predetermined and potential issues are not yet anticipated (Boyatzis, 1998).

The data was examined to elicit the factors that underlie challenges nurse educators face when seeking to assess aspects which could be related to emotional competence in nursing students. The interactions which took place, strategies and tactics that were adopted by the educators and consequences were identified. The transcripts were examined for commonly used terms and ideas used by the educators, I made notes in the margin and compared similarities and differences between events and examples.

The first stage of coding during thematic analysis is described as recognising the codable moment or sensing themes (Boyatzis, 1998). One example of sensing a theme was the theme of 'getting personal'.

This theme emerged as I read through the data for the first time, making notes in the margin. The notes in the margins of the transcripts highlighted the experiences of the educators when challenges arose when working with nursing students. As I read through the marginal notes I noticed a theme about how the ability to understand oneself is vital to relationship building and communication. I wrote in my journal that 'personal understanding' could be broken down to self exploration and self awareness. I named the theme 'getting personal'. This took a considerable amount of experimentation with the three focus groups transcripts. I experimented with a variety of categories, labels and codes until I found one that seemed to best fit the data.

The next step in thematic analysis is recognising the codable moment and encoding it consistently (Boyatzis, 1998). Miles and Huberman (1994) caution the researcher within the process of recognising codes and encoding consistently, not to focus on their interests rather than the issues and concerns of the participants. Thus thematic analysis suggests a particular way of constructing data analysis that focuses on the coding process and on the relationship of codes to the whole process (Miles & Huberman, 1994). This part of the process helped me to explore the codes, examine the relationship between codes and begin comparing the codes with the pre-existing theory on emotional competence.

An example of this process is how the theme of personal competence was broken down to self awareness and self management. The data suggested that there was a complexity with nursing students when they begin (and throughout) the degree, having diverse capabilities. In order

for students to develop in a professional sense, they require a type of maturity in nursing, by exploring what their capabilities are. The educators needed the ability to 'tune into' the students' level of maturity in order to assess their professional development. Self awareness is a key feature within the literature on emotional competence, being aware of your own capability and examining the way you think, feel and behave facilitates new understandings in how you learn about yourself and your capabilities (Goleman, 1998; Heron, 1990; Salovey & Mayer, 1990).

The next stage of coding involves the identification of the core categories around which the analysis focuses (Boyatzis, 1998). Developing codes occurs later in the process when major themes have emerged and core categories are repeatedly verified or revised after re-checking the transcripts. The development of a code within thematic analysis requires five key elements. The code must have a label which names it. A definition of what the characteristics of the code are or the issues that constitute the code must be made clear. How the theme is 'flagged' or a description of how to know when the theme occurs is the next element. A description then follows, of any qualifying or exclusion criteria to the identification of the theme. Lastly, to eliminate possible confusion when looking for a theme, "positive and negative examples must be identified" (Boyatzis, 1998, p. 13).

Checking with the participants whether they accept the account of themselves in the interpretation is an ongoing process. Morrow and Smith suggest: "Codes and categories are sorted, compared and contrasted until saturated – that is, until analysis produces no new codes or categories" (1995, p. 26). It is noted that it will always be possible to

discover new information in the data (Denzin & Lincoln, 2003), but saturation is achieved when the coding that has already been completed adequately supports and extends the emerging themes (Miles & Huberman, 1994). The aim is to avoid the knowledge of existing theory's forcing the analysis of the data into these pre-existing categories. Emerging codes may be named to be consistent with pre-existing theory however, modification and building an emerging theory that fits both with the current research data and existing theory is the goal.

3.9 Soundness of the research - what I mean by critical research

My intention when commencing this research project was to undertake a project where I would find new meaning or greater understanding for my role as a nurse and educator. I had done some reading, thinking and discussion about critical inquiry and I subscribed to the position that the concepts and people involved in nursing and education were not able to be viewed as 'objective'. Phenomena, as Cheek (1996) suggests, do not stand alone but are implicated, embedded and located in wider contexts that are not entirely innocent. Furthermore, such structures are maintained through the exercise of political and economic power which is legitimated through ideology. I also subscribed to the notion that there is a need to stand apart from the situation and ask how that came about and that right from the beginning of the project, be up-front about doing so.

The idea of deconstructing and then reconstructing appealed to my own way of learning, but I was also mindful that I would be exposing anyone I worked with during the project to that interrogation and potential new synthesis. I was also clear that my mission was not to find fault in participants or the groups in which they belonged. My view, about theory and creating theory through research, is to open up the possibility of choosing a different valid perspective, where the problematic becomes an opportunity to create a different world. Denzin and Lincoln state:

Critical researchers respect their participation in the production of their craft as they collect and document their experiences; at the same time, however, they argue that a significant aspect of the critical research process involves challenging the ideological assumptions that inform the interpretation of their experience (2003, p. 282).

This approach to developing critical theory can lead toward the construction of a larger picture of the whole. Therefore, viewing interpretation through a critical lens enables insight to the often messy web of power relations going on, without losing touch of the everyday emotions being experienced.

I have a belief that whatever people do, they do because of their capability at the time. This includes not only whether they use their personal knowledge and experiences usefully or not, but also the circumstances in which they find themselves knowingly or not. When I chose the group of people I wanted to work with in exploring my research question and aims I was conscious of the issue of reflexivity within the research process. Shacklock and Smyth suggest:

Reflexivity is an attempt to identify, do something about, and acknowledge the limitations of the research: its location, its subjects, its process, its theoretical context, its data, its analysis and how accounts recognise that the construction of knowledge takes place in the world and not apart from it (1998, p. 7).

The potential for greater understanding of myself and the opportunity to work with colleagues to discuss the notions of personal and social competence in nursing, was important to me, and I believe valued to the profession of nursing. Critical research also provides the opportunity for insight, through reflection on how I am to deal with the power and subjectivity within my role as a researcher and the producer of the research findings.

3.10 Summary

This chapter has outlined a qualitative methodology. The use of this methodology and supporting method, have been justified. The characteristics of the participants, ethical considerations and data collection processes have been discussed. The ontological positioning of this project within an interpretive paradigm has shaped the ongoing process of data analysis. Furthermore, the movement toward critical inquiry as the project developed has been justified.

The following chapter will begin the presentation of the findings and provide discussion concerning the first theme; **determining emotional competence**, which resulted from the data analysis. The process of analysis throughout the next and two following chapters is outlined according to the research question and the aims. A working definition

of emotional competence, informed by the participants within the focus groups, is proposed. The ways in which the participants recognised development of emotional competence through their relationship with nursing students, is critically discussed.

Chapter four: determining emotional competence

"What lies behind and before us are tiny matters compared to what lies within"

Oliver Wendell Holmes

4.0 Introduction

This chapter introduces the concept of emotional competence from the perspective of the participants and addresses the first aim of this research project. I will outline the participants' collective description of the personal and social capabilities, and the way in which emotional competence can be recognised by both educator and student. The way in which the participants articulate emotional competence will be discussed in relation to previous research outlined in the literature review. Following the working definition of emotional competence for nursing education, I will discuss the current competency assessment framework (NCNZ, 2004) and address the first part of the third aim of this research project. Discussion which completes the second part to the third aim takes place in chapter seven.

4.1 Emotional competence within a nursing context

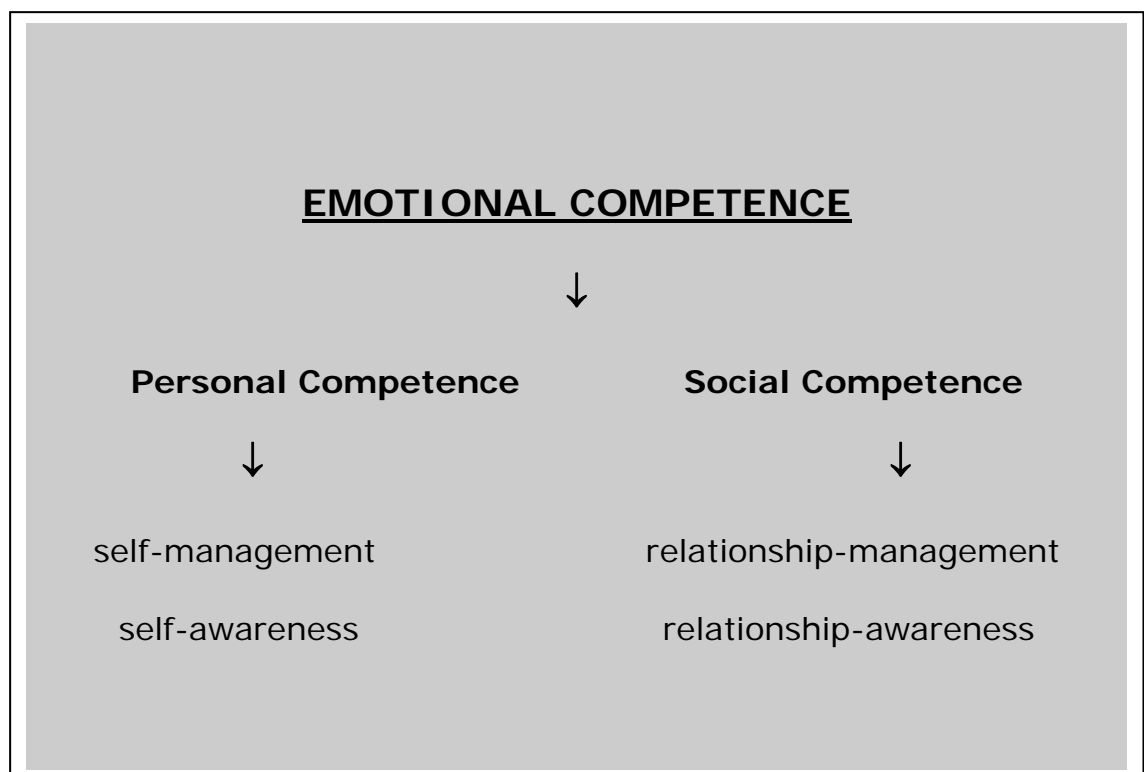
The first aim of this research project was to determine how a group of nurse educators recognise and describe what emotional competence is in nursing. It became apparent early into each of the focus groups that the educators had similar ideas as to what constituted emotional competence to them personally, and professionally how they sought to recognise a type of emotional competence in nursing students when working with them. The following is an informative and practical

definition of emotional competence developed from the focus group data and analysis (see diagram A). The definition is twofold; personal and social competence, collectively termed emotional competence:

Personal competence is being able to become self aware and having regard for yourself (self-awareness). Being personally competent means you continuously work on aspects of your personal coping and emotional reactions, so that you are more aware of how you operate with others (self-management).

Social competence is using your self-awareness, managing it and moving beyond it (relationship-awareness). This social ability enables us to become able to work with another person's issues and needs, including effective management of conflict in relationships (relationship-management).

Diagram A



The educators also argued that there are few defining criteria that separate the personal from the professional in relation to emotional competence, but that the key aspects develop over time within relational experiences. This connection of a developing professional within the individual was captured by an educator during the first focus group:

...somebody who is making sense at a personal level about who they are, can then develop into a professional person and can then undertake whatever relationships occur as a nurse (Group 3, p.3)

The terminology used within the literature on emotional competence seemed mostly unfamiliar to the educators who took part in the focus groups.

Although a summary of literature on emotional competence was sent to each of the participants prior to the focus group, only some of the educators had read this. Several of the participants had heard of concepts such as emotional intelligence or emotional competence. However, it seemed they had little collective recognition of what defined the concepts or what criteria could be used within their teaching and assessment practice, as educators. The definition of personal and social competence developed from this research project, used in the following chapters, was developed from the various descriptions and understanding offered by the educators during the focus group. Their terms and discussion have been summarised by me as the researcher, based on interpretive qualitative methodology. Summaries of interpretation have been returned to the participants and their validation and feedback is included within the following data chapters.

The educators who participated in the focus groups discussed the complex challenges they encounter when working with students. Those challenges which related to the emotional well being and relational ability of students were highlighted by the educators as key factors which determine whether or not a student is assessed as being fit to practice at the completion of the degree. This discussion takes place in detail during chapter five. There was much debate within each of the focus groups about the competency assessment criteria, and in identifying which ones related to emotional or relational capability. The competencies (NCNZ, 2004) and how emotional competence relates to this assessment framework is discussed within chapter seven.

4.2 Personal competence

The personal competencies of self-awareness and self-management (Goleman, 1998; Salovey & Mayer, 1990) support the need for nursing students to gain a level of nursing maturity through self-regulation. Personal competence includes key characteristics of becoming self-aware and having regard for yourself. This means students require opportunities and support to work on their personal coping so they become more aware of how they operate with others. Maturity and personal competence according to the group:

...comes with age and experience...that age is not necessarily meaning chronological number of years but rather length of time in nursing (Group 1, p.4)

The following comments indicate how maturity develops over time and involves experiences within nursing situations to progress. Nursing

maturity grows as the student becomes more able to regulate their emotions:

...it's learning how to deal with feeling (Group 3, p.4)

...it's changeable in different situations (Group 1, p.6)

...it involves the individual's feelings and them considering their reactions within their individual cultural norm (Group 2, p.4)

Maturity of personal competence indicates the student is developing the ability to understand their own belief and value systems. Heron (1990) argues that in order for helping professionals to connect at an emotional level with a person, they must begin to recognise and then process what their own needs and potentials are.

The individual nature of gaining emotional competence, increasing consciousness and understanding how emotions inform and affect behaviour, was also suggested by the educators:

...it's an individual experience so it can't be taught, but it can be developed (Group 2, p.5)

...it's a conscious state of being, to be able to stand back and consider what drives what you know and how you behave (Group 3, p.5)

In so doing, the student develops an ability to 'tune in' to the needs of the community with whom they are learning and working:

...it's what drives their [the student] reactions to others, how they focus on the other, by not letting their preference or need override what they are there for when nursing (Group 2, p.5)

...it's being committed to genuinely becoming aware that others don't necessarily share your perspective (Group 1, p.7)

...the ability to keep the personal emotional reactions separate, whilst trying to make sense of the patient's needs and abilities (Group 3, p.9)

This 'tuning in' is supported by Hochschild's (1983) suggestion that nurses engage in emotional labour. This labour is guided by social conventions as students relate with others. The social rules or expectations of how others display emotion assist students to recognise and regulate their own emotional reactions. Hochschild argues that when individuals can use their awareness of emotion, they can promote a feeling of being cared about in others.

Student nurses need to gain self-awareness and self-management skills. These skills enable individuals to become flexible and take risks to achieve reciprocity in communication (Goleman, 1998). The educators also supported the need for students to strengthen personal competence, as they begin to position themselves to communicate professionally with others:

...it's using self knowledge in a purposeful way (Group 3, p.8)

...it's about learning your own self capabilities and looking after yourself and being open to doing things, informed by your emotion (Group 3, p.8)

...it requires relationships to grow and those relationships are changeable and so is the student; it's about standing back and considering your behaviour and achieving communication that the

patient requires, as well as doing what is within your own capability
(Group 2, p.7)

Adapting and modifying one's communication style, particularly in times of conflict, enables negotiation to occur within relationships. Recognising emotional cues as they are being experienced enables students to take risks and try something different in their approach. Taking risks to negotiate a win-win outcome in conflict, leads to reciprocity in relationships (Goleman, 1998).

4.3 Social competence

As students develop skills in personal competence, they are more able to demonstrate social competence. The characteristics of social competence include using self-awareness, managing it and moving beyond it to become able to work with another person's issues or needs. Social competence includes recognising and managing conflict effectively.

The first aspect of social competence determined by the educators is relationship- awareness. Relationship-awareness is the student's ability to pick up on emotions in other people, according to the educators:

...it's using your personal awareness and emotional awareness and tuning in to others and not taking things personally, in situations of conflict (Group 3, p.8)

...by taking into account the situations others might be in, before judging their behaviour (Group 1, p.8)

Picking up on other people's emotions, promotes the ability to recognise what they might be feeling (Salovey & Mayer, 1990). This includes the clients, families, peers and others with whom they are learning and working alongside:

...it's about being aware of your own inadequacies and abilities and becoming attuned to those in others (Group 2, p.6)

...the student then develops the ability to understand what is really going on, through accurately picking up on emotional cues (Group 3, p.9)

Sharp (2001) argues that this social awareness can have a flow on effect for society. He suggests the development of social awareness facilitates groups to recognise the needs of others, fosters tolerance and acceptance within communities. At the core of his argument is the idea that individuals have a human need to care for others, and be cared about within relationships. Sharp suggests this fosters competence within society (Sharp, 2001).

The second aspect of social competence described by the educators is relationship-management. Relationship-management according to the educators:

...it's about taking into account the situations others might be in before judging their behaviour, noticing those cues people give out and thinking about how to not react in a negative way to their feelings (Group 3, p.25)

...by allowing yourself to become close to others, being genuine in your response to them and being aware that others don't necessarily share your perspective (Group 2, p.8)

...it means they[the student] are able to think about their own personal reactions, acknowledge those feelings they are experiencing and challenge themselves to behave in a way that is going to be helpful to the person they are talking to or working with (Group 1, p.10)

According to the educators they recognise and can describe this competence in relationship-management, when students show ability to use awareness of their emotions and the emotions of others:

...it's being able to adapt to another persons situation (Group 1, p.11)

...it's about examining how you reacted to another person who you perceive is being unhelpful and trying a new approach to the next situation (Group 2, p.8)

...by consciously framing your view of the situation in a positive way and being open to the possibility that a different outcome is possible, when you try looking at it from a different angle; by taking risks even when trust has been broken and not taking things personally, when in situations of conflict (Group 3, p.23)

This use of personal and social competence then results in managing interpersonal situations successfully. This includes caring communication and effective handling of conflict (Salovey & Mayer, 1990; Goleman, 1998; Heron, 2004).

The key aspects of relationship-awareness highlight the need for students to authentically communicate and move beyond their own difficulties (Heron, 1990), through self-awareness and self-management. In order for students to demonstrate compassion and empathy within their nursing practice, they must position themselves in a non-judgemental way:

...it's about valuing emotion, not always getting your own way and validating for others that their experience is real (Group 3, p.21)

Non-judgemental positioning, along with becoming accountable to the nursing profession, the public, each other and the clients with whom they work, is developed through various learning opportunities. Learning opportunities occur as students develop relationships with the educators.

As students gain nursing experiences there are opportunities for them to utilise their awareness of emotion. By using this awareness the student's are then able to consider the emotional needs of others. One of the educators highlighted this emotional awareness when considering the ongoing realities and limits of their facilitation role:

...awareness, I would suggest in life, its trial and error and in nursing I'd argue there is still an element of that around. Even with the best will in the world we [educators] might steer them [students] in certain directions, they really don't understand what you are talking about until they are in situ [working with clients and others]; and situations that are occurring when people say to them

*you don't seem to be paying attention, you are not with me today,
or and so on (Group 3, p.2)*

Critical feedback is suggested by the educator group as an essential process in facilitating learning with students. This feedback provides opportunities for educators to communicate their assessment and recognition of the students developing emotional competence:

...Initially we [educators] need to initiate situations for students to consider how they cope with others vulnerabilities (Group 1, p.13)

...sometimes modelling reflection and critical thinking, say talking about a situation when I [educator] had difficulty and learnt about how I reacted and maybe what I could have done differently...you know using the 'me' as an example, its important they [students] know we are constantly developing our own emotional competence (Group 2, p.10)

...it's about modelling honest communication and giving the student honest feedback about how they are managing situations of conflict or when they seem to be behaving in a way that isn't considering the needs of others. You know, when they seem to be caught up or distracted or something, it's letting them know that focus is required, but acknowledging that something real is going on with them and validating that as real, not dismissing it (Group 3, p.4)

Furthermore, when students strengthen their emotional competence, they can become more able to make informed decisions and facilitate health education in partnership, with clients and families with whom they work.

The learning of emotional competence and practice with others is suggested by the educators, to be developed over time:

*...it's a developmental thing aye, hugely; it's something that grows
(Group 3, p.2)*

*...it's developing the ability to know what is appropriate and what
the consequences might be, that takes time and practice (Group 2,
p.11)*

The ability to manage our emotional life, whilst working alongside and interpreting others, is a prerequisite ability for any caring profession (Cadman & Brewer, 2002). It is argued by various authors that the core of nursing is the patient centred relationship. The nurse ought to be able to develop an empathic relationship, in order to undertake that role (Peplau, 1992; Newman, 1994; Freshwater, 2002). Emotional competence is being able to become self aware and having regard for yourself. Being emotionally competent means you continuously work on aspects of your personal coping and emotional reactions, so that you are more aware of how you operate with others. Emotional competence is recognised when the individual uses that self-awareness, manages it and moves beyond it. This social ability positions individuals to become able to work with another person's issues and needs. This includes effectively managing conflict in relationships. The emotionally competent nurse is aware of their own emotional needs, whilst maintaining professional communication and boundaries required for a caring relationship. Recognising the demonstration of emotional competence by educators and students, through competency based assessment, is discussed in the next part of this chapter.

4.4 Being objective in a subjective way

Examination of the competency assessment framework (NCNZ, 2004) is the first part, of the third aim, of this study. Competency based assessment provides an opportunity for educators to recognise and feedback to students, their ongoing demonstration of emotional competence. I took along with me copies of the nursing competencies (NCNZ, 2004) to each of the focus groups. Each participant was asked to consider the usefulness of the competency framework and describe which of the eleven competencies could be used to provide feedback to the student in regard to their demonstration of emotional competence in clinical practice.

An underlying tension within the relationship between educator and student is a statutory requirement that learning must be measured and documented, in accordance with the NCNZ (2004) eleven competencies. This challenges educators to articulate subjective experiences and understanding of students' learning into objective language or outcomes. The educators argued against the requirement of objective checklists, within an assessment process. They suggest this requirement, at times, undermines the learning aims and relational experiences of students. Furthermore, this way of assessment limits their role as facilitators of nursing education.

As students progress through the degree, they practice new relational skills. Assessment opportunities in nursing education include written, oral and practical experiences in which the student can demonstrate knowledge and skill, in relational ability. Within the assessment

relationship with students, the educators use objective criteria as well as their sometimes intuitive knowledge to facilitate awareness of those relational capabilities. The following comment suggests the use of intuition some educators utilise when working with students:

...and sometimes there is that gut feeling when you are working with someone [a student], you can't always describe it but you know there is something there and you think, you know, you've got it (Group 1, p.19)

Facilitation of learning, from an educator's perspective, requires being flexible and adaptive to the various learning styles and capabilities of the students (Heron, 2004). The issue of having to write reports on students in the form of summative assessments and match their ability next to a criteria means that educators are forced to objectively put to the student what is essentially, a subjective appraisal of learning taking place. This is in direct opposition to the educator's proposal, of valuing emotion within the teaching relationship, and promoting assessment as an ongoing opportunity to appraise the student's ability. In this current paradigm of scientific and outcome based ideology in nursing (Watson, 2005), the use of subjective knowledge and understanding, which is informed partially by emotions experienced within relationships, has been discouraged. However, as these educators suggest a rational or detached view is not necessarily logical:

...what logic is that...making a subjective judgment but having to present it in an objective way (Group 3, p.66)

...we are very conscious of making subjective judgements, who are you to say my bloody feelings are real or not? (Group 1, p.35)

The essence of this frustration expressed by the educators suggests a collaborative approach is desired.

This desire for collaboration in relationships is emphasized by Jordon and Troth (2002). They posit that those individuals who possess self-awareness and self-management prefer to seek collaborative solutions. Facilitating feedback with the students is an important skill required of educators to encourage learning and motivation. The following statement from an educator in the third focus group, sums up the frustration of not including subjective knowledge within the assessment relationship:

...making things in the world which are hugely inter-subjective, objective, is a real problem and we've tried to do it in nursing education for many years now, and to be honest, it's a farce really (Group 3, p.54)

Nursing is a social practice. de Carvalho (2004) argues teaching and assessing the practice of care pragmatics, whether in or outside of a hospital setting is complex. The educator's comment below sums up just how complex the relationship might be:

...in many people that ability, [emotional competence] I suspect mechanism, of how it comes about, are manyfold and can be worked on formally and informally. That's a catch you see with teaching it of course, because we like to be formal and formalise things when we teach, but we are talking about an informal ability and at times that is not easily taught (Group 3, p.18)

A clear understanding and disclosure of the teaching activities among the educator group enables transparency. For the students, transparency permits processes to be clear and a common

understanding of expectations (Bayliss-Webber, 2002). This encourages students to become self-directed; goals orientated and take control of their learning outcomes. Transparency of the teaching activities, and a consistent approach to assessment, can contribute positively to the students' overall development of personal and social competence. Having a shared understanding of how the competencies (NCNZ, 2004) can be used to recognise and feedback to students their development of emotional competence is vital.

Nursing education has the role of preparing competent nurses to meet the current and future healthcare needs of the communities in which they work. Vernon (2000) suggests nursing education needs to review outcomes of traditional teaching strategies and seek to explore alternatives which enable a satisfactory teaching and learning environment, for educators and students alike. There was agreement within the educator groups that consistency in process of assessment and learning outcomes are required. However, the tick box system and criteria's to score meant having to state to those students who did not fit the box, that they had failed. Failure, at the expense of identifying with the student where their current ability is and where learning may need to take place, as this educator points out:

...see you can't tell people how they [the student] should feel or don't feel. They will develop their own patterns in the therapeutic sense...there is no one emotionally competent rule or level...all that objective ticking off should be almost finished I think; I am fed up with ticking off because its nonsense (Group 3, p.51)

Many of the competencies (NCNZ, 2004) relate to learning and progress of an individual's knowledge and skill development; rather than tasks and described actions.

Diekelmann and McGregor (2003) argue that nurse educators sometimes see students who fail as challenges to their academic, moral and ethical requisite to maintain high professional standards of practice. They suggest the dominant discourse in nursing is that educators recognise incompetent nursing care and issue failure grades when warranted. However, there is little research or clarity within the faculty to guide clinical educators in complex situations where students are failing or do fail; highlighted in this educators comment below:

...you end up having to say that you [the student] were unsafe by deliberately breeching or going against requirements, its very subjective and I can either like or dislike you and it has to cloud the assessment (Group 1, p.35)

This is an important aspect to consider in terms of subjective knowing within the student-educator relationship. Given the fact that the educators group could all be argued as mature, it is important to note that the focus group discussion was not suggesting that the students become emotionally competent in comparison to how the educators saw their own capability. The educators were not suggesting that emotional competence was assessed by default. That is, they were seen as competent until they objectively didn't 'do' something in an emotionally competent way. Rather, the educators consistently suggested that personal and social competency to manage emotion and enhance relational ability, is required within nursing practice. The educators are

advocating the value of emotion. Moreover, that the nature of emotion and the sometimes subjective context in which emotion is experienced, should be acknowledged and valued within the process of teaching and assessment.

4.5 Summary

This chapter has discussed the way in which personal and social capability within emotional competence, is recognised and described by a group of nurse educators. Emotional competence is recognised by the educators as the student's ability to become self-aware, have regard for themselves and work on aspects of their personal coping and emotional reactions so that they are more aware of how they operate with others. Emotional competence is also recognised by the educators when students use their self-awareness, manage it and move beyond it. In so doing, the student can begin to work with another person's issues and needs. This includes managing conflict within relationships. The description of emotional competence articulated by the educators and the way in which objective and subjective knowledge can be used within competency based assessment has been debated.

In the next chapter I critically discuss the second theme: **becoming fit to practice, through personal competence**. Chapter five results from the second theme in the data and describes the environmental and relational complexities which might affect learning and assessment of personal competence in nursing students. The complexities call attention to surfacing environmental and relational aspects of nursing education,

so that development of the personal competencies of emotional competence, within nursing students can be nurtured.

Chapter five: fitness to practice, through personal competence

“Don't bother to be better than your contemporaries or predecessors.

Try to be better than yourself”

William Faulkner

5.0 Introduction

This chapter addresses the second aim of the research project. Using the second aim as a framework, I explored the environmental and relational complexities of nursing education, encountered by the educators. In particular, those challenges which affect learning and assessment of personal and social competence. The previous discussion within the last chapter demonstrated how the educators describe and recognise personal and social competence. Collectively, these dimensions of personal and social competence are termed emotional competence. The educators recognise characteristics of emotional competence and describe them as the ways students relate and begin to professionally care. The **personal competencies** recognised and described by the educators alongside the literature on emotional competence are the focus of this chapter, (Goleman, 1998; Salovey & Mayer, 1990; Heron, 1990). These ideas are critically discussed according to the educator's view of challenges within environmental and relational aspects of teaching and learning.

The emphasis for nursing education is on producing an individual who is fit for practice. The prerequisite for nursing registration in New Zealand is a bachelor of nursing degree and a pass in the final examination

overseen by the Nursing Council of New Zealand, the statutory body for nurses. Each educational facility or nursing school must state that the student is eligible to sit the state examination by providing an endorsement to the NCNZ that the student is a fit person to practice nursing without compromise to public safety (NCNZ, 2002). The school of nursing and its educators must comply with the Health Practitioners Competency Assurance Act, (2003) and the Education Act, (1987). When the school of nursing endorses a student as fit to practice they are suggesting the student has demonstrated ability in relation to the competencies of nursing practice (NCNZ, 2004), and educational learning outcomes. However, as Drake and Stokes (2004) point out, there is a lack of clarity about how the council standards and learning outcomes are utilised to assess students. Alongside this, there are challenges within various schools of nursing about which criteria are used to deem a student fit for practice.

Freshwater and Stickley suggest nurse education has been viewed as an essentialist education and: "by its very nature moulds the student" (2004, p. 92). The types of learning opportunities for students undertaking a degree in nursing are underpinned by a body of knowledge and technical skills of application. The goal of education is to teach specific skills and knowledge, so that students can demonstrate a certain standard of behaviour, attitude and skill in accordance with the NCNZ and the educational facility in which they are enrolled.

The educators who participated in the focus groups discussed complex challenges they encounter when working with students. Those challenges which relate to the emotional well being and relational ability

of students were highlighted as key factors which determine whether or not a student is seen to be fit to practice at the completion of the degree. The terminology used in the literature to describe personal competence, was not familiar, for most of the participants. However, the educators agreed that facilitating learning of self-awareness and self-management were essential components of their teaching and relationships with students. The following discussion is broken down into the sub-themes of the second theme; fitness to practice, through personal competence.

5.1 Differing capabilities amongst the group of students

The first aspect of personal competence, described by the educators is self awareness. The educators depict self awareness as the student's growing ability to accurately perceive their own emotions and stay aware of them as they are happening. This includes the way, in which students grasp how they tend to respond to familiar and new, situations and people.

When students arrive at the beginning of their degree journey the educators described the complexity of *differing capabilities in the individuals who make up the new group starting*. This challenge, of differing capabilities, fell into two main aspects. Firstly, students have a wide and varied age and developmental range:

...I think that a youngster who hasn't got a lot of life experience, who has in fact got a naivety about them, they don't always internalise or see things, as perhaps somebody who has life experience would see it (Group 1, p.13)

...I don't think it's about age necessarily, some of those mature students may well have lived a lot of life, but aren't particularly mature in the way they behave or cope with learning (Group 3, p.13)

The chronological age within the student group ranged from eighteen year old school leavers, through to young adults and mature students, who entered tertiary education later in life.

Those individuals, who returned to formal education as mature students, make up a large proportion of nursing students. It has been suggested that mature students may be a more motivated group, but face unique challenges within tertiary study (Lechte, 2003). These unique challenges, involving some mature student's, were a common feature in discussion:

...and the second chance learners [mature students] of course, because of the very nature of second chance learning, they want to make a go of it, they want to achieve and they really do put their everything on hold (Group 1, p.13)

...we have a large group of mature students, you know, women mostly, who come with a career change in mind, or might even be studying for the first time since school twenty years ago. They are here looking for a solid chance to reset their life pathway, they are a very different group of people to the school leavers, who are maybe still sorting out what they want to do in life (Group 1, p.14)

Developmental aspects of students can be described as internal or external in nature and may inhibit learning. Adult learners differ widely in their personal characteristics. Individual differences encompass characteristics such as age, gender, and emotional characteristics such

as self awareness, confidence, motivation and personality. These characteristics may expose the individuals to barriers in development of personal competence. Common barriers to learning identified by Reece and Walker (2000) and Quin (2000) include lack of support from family, underachievement at school with fear of further learning, social and family commitments, culture and age.

Secondly, maturity is described by the educators in terms of learning ability, and growth in self-direction. Self-awareness is more likely to be developed, in the educator's view, when students became familiar with their own learning style:

...I think they [students] have to be very strong individuals. They might be emotionally mature but I think they also have to be strong in the clinical environment and be responsible for doing something with the responsibility to learn and be informed (Group 2, p.6)

Furthermore, setting expectations to develop independence in learning was a recognised need, in order to develop self-awareness:

...some students come with no experiences of academic or tertiary study, it's a huge learning curve for them to put together an essay, or get their heads around the whole study expectations, some of them have never even used a computer, before let alone done a literature search (Group 2, p.8)

Many students' prior experiences of education have accustomed them to passive pedagogical approaches to learning (Knowles, 1990). Students do not always find it easy to adapt to a learning situation in which they

are required to take responsibility for what happens. The adaptation to self-direction, from an educator's perspective, is described below:

...when I ask them [student] why they have chosen nursing, I find that those who answer at a very surface level, tend to be those who are sort of thinking about whether nursing will fit them or quite what, but those who are more reflective and have obviously processed some of that stuff [reasons for choosing nursing], prior to actually being in class, are more prepared to engage in their learning because they really want to be there, this is going to be their life commitment and they take every opportunity to get what they can out of class (Group 1, p.20)

In the situation of nursing education, when the students are asked to contribute to what happens during the time spent with educators, they experience being unsure and inhibited in self-direction (Quin, 2000).

Setting an expectation, at the beginning of the students learning that self-awareness is of value, sets a foundation for personal competence being nurtured within the students' development. As this educator points out:

...they [the student] need to get their heads around learning about themselves right from the beginning...we [educators] talk about this all the time, you can regurgitate anything out of a book or you can rote learn anything but this self awareness stuff I believe needs to be taught right from the beginning (Group 3, p.4)

The diversity of self-awareness in students, was often put forward by the educators who participated within the focus groups. These examples summarise their collective understanding:

...in a group [of students], you may have people with similar age ranges, who have done a lot of things that are clinically focused, rather than academically focused and there is a huge amount of life skills and knowledge (Group 2, p.9)

...it's a mixed bag...some young people seem very mature for their age and some older people seems rather immature at times, there is no formula, its simply a question of number of years lived, life experiences and the way they have coped (Group 3, p.12)

A continual challenge to nurse educators is to assess what students already know. Diekelmann, Swenson and Sims (2003) suggest teaching what students already know leads to boredom for educators and students. It wastes valuable class time and increases frustration for all involved. They argue the need to avoid the 'middle of the road' approach, which may miss both the students with little knowledge and those with a lot. Positive regard for the student is required, alongside this understanding. This regard can enable educators to recognise and work individually with student's differing capabilities. The student and educator can then plan learning around a collection of realities and potentials, according to need.

5.2 The multiple life roles of student nurses

The second complexity, also in relation to self-awareness, is that *nursing students have multiple roles in life that may impact negatively on their learning*. Whilst the student is developing ability to accurately perceive their own emotions and stay aware of them as they are happening, they

also need to keep on top of how they tend to respond to familiar and new, situations and people.

The following statements emphasise the educators assessment of the need for students to understand how their own emotional problems can lead to unhelpful communication, within their interaction with others:

...some of the most difficult people [students] that I have dealt with clinically [when supervising a student in clinical practice] have been older students who have been incredibly damaged in their life experiences (Group 3, p.12)

...students come from different backgrounds and are at different levels and do, or not do life well. They come into nursing with a need to engage with patients or staff and it's almost as though they can't put aside their own stuff [emotional problems] in order to work with the need (Group 2, p.9)

In recognition of this challenge, mindful regard was expressed by the educators, of the reality that many students face in life whilst engaging in tertiary study:

...a major contributor to responding to new things is not having too many other worries to weigh you down. Look at the issues of student loans, childcare, fitting employment around class and clinical experience, they're running two lives some of them (Group 1, p.11)

Recognising students are individuals who have other commitments outside of their academic life is essential. Quin (2000) confirms that some students may lack confidence in their academic ability. The success of individualised learning often depends on the student being an

active rather than passive participant. Motivation to learn can be impaired by social circumstances within the students' life. If the circumstances prevent the students developing personal competence a referral to, or suggestion of personal counselling, may benefit and enable the student to focus on learning. Regular praise, providing encouragement and positive reinforcement can help increase self-motivation in students. Motivation however, depends as much on the attitude of the educators as on those of the students (Rodgers, 1998). Encouragement is required for students who are learning to cope with and overcome a multiple of life roles, whilst they are developing self-awareness.

The educators frequently expressed that considering the students as individuals and acknowledging external demands outside of academic life was a commitment. This was in recognition that the majority of students make the most of their learning:

...they [the students] know when they finish here that they are going to do their jobs that they need to complete then they've got to go and look after their kids with this growing awareness of time lacking and they don't always have a lot of tolerance for what they perceive might be a waste of time (Group 1, p.7)

Empathic communication from the educator is required to approach and understand the students' situation. Working in partnership with the student to develop strategies in problem solving and the use of probing can help students clarify and focus on issues of concern. This then enables students to improve time management, develop appropriate study skills and assume responsibility for their own learning (Ashcroft & Foreman-Peck, 1994).

Student's life roles may also affect their ability to understand and focus on the client's story gained through assessment. With growing maturity and self-exploration of their reactions to emotional cues, students then need to 'tune out' of their own difficulties and 'tune into' the client's needs. This tuning into the clients needs means engaging clients at a personal level. This engagement is a satisfying and rewarding experience for the student (McQueen, 1997). Yet, balance is required. The student aims to provide intimate attention to the client whilst learning to recognise their personal limitations. This balance is something many students come to understand as they develop personal competence as indicated in the following educators comment:

...one of the problems we have with students in maternal health is their extreme over-identification with the situation and their responses...for instance, their inability to recognise there are barriers in what to reveal to clients; and to not treat people like they are your kids or family, and I think it tends to be the older student that is at risk of that (Group 2, p.8)

Learning which takes place in relation to self-awareness may also promote the development of professional boundaries, essential within nursing relationships. Self-awareness was described by the educators as a pre-requisite to the students' ability to set boundaries within professional relationships:

...they [the student] need to be able to step out of their role as mother, partner, friend, and develop responses in a nursing role (Group 1, p.8)

In doing so nursing students are then able to regulate their own emotional reactions internally and behave towards clients and peers in a purposeful manner. This internal regulation and understanding emotional reactions can enable the student to manage emotions when interacting with others, as these educators point out:

...to work out how they [the student] are going to relate to the patient there just seems to be this thing about how you can put aside where you are and what you are and what's going on in your own immediate sort of history, to actually get on with the nursing stuff [role] (Group 3, p.14)

...I think it is a central part of nursing that we [all nurses] are able to separate out our own problems because it is not good for the patients to pour our own issues, or whatever, on top of them (Group 2, p.9)

Bolton (2001) argues that nursing has long been distinguished as an occupation requiring extensive amounts of emotional work. This highlights the importance of a student's ability to manage emotion and present the desired demeanour in a number of clinical and relational settings throughout their learning. Whilst juggling the emotional demands of everyday life, students are required to present an acceptable nursing face. This was summed up by an educator in the third focus group:

...in nursing you are in a situation where you are looked on as a professional and therefore your behaviour has to reflect that no matter what or how you feel (Group 3, p.15)

Emotional reactions to current, perceived or pending workload may leave the student feeling exhausted or under pressure (Yong, 1996). Gaining awareness about personal coping mechanisms and developing new strategies that enable the student to tune into the other when interacting is essential to the student's overall capacity to professionally care. Each of the focus group discussions highlighted that there is little separation of the personal and professional coping skills in relation to managing self-awareness, this is summarised in the following comment from an educator in the third group:

...the private and professional thing is interesting because in my opinion there aren't huge differences between the two; it's not as if a nurse goes to work and puts on a cloak – a nursing cloak, and that becomes the nurse. And when she takes the cloak off at the end of the day she becomes the private person again; we are both simultaneously private and public persons (Group 3, p.15)

However, it is doubtful that education programmes prepare students adequately to be self-aware and provide psychological support to the clients with whom they work. The literature suggests that student's are given little preparation for providing psychosocial support in nursing education (Evans & Allen, 2002). Although, it was clear from the educators that their understanding of the public perception of a nurse means:

...making yourself available and relating to the patient is expected in nursing its expected by the clients I think because that is the one thing they imagine should be there is that the nurse will actually care about them, not for them but about them (Group 3, p.60)

There is acknowledgment that nurses require the ability to manage their own emotional needs in order to understand the clients. However,

where and how this learning takes place within nursing curricula is unclear (MacCulloch, 1998; Henderson, 2001).

5.3 A fragmented curriculum

The second part to personal competence described by the educators is self-management. This is the student's ability to use their awareness of emotions to stay flexible and positively direct their behaviour, when caring for clients and working with peers. Self-management is recognised by the educators as students' develop the ability to manage emotional reactions to familiar and new, situations and people.

Students, during undergraduate education and through-out their role as a registered nurse, are required to develop an understanding of how their own beliefs and values develop into a philosophical stance, enabling moral practice (Woods, 2005). The first complexity in relation to self-management is the challenge of working within a school of nursing which has a fragmented curriculum and lack of shared philosophy, this was the case for all three of the institutions.

Fragmentation within the curriculum may impair the student's ability to develop self-management and overall development of a foundational nursing philosophy. By not having a clear philosophical underpinning in the curriculum, the delivery of teaching may become fragmented. Alongside this, the educators described a compartmentalised approach to learning outcomes. Furthermore, there is a lack of clarity for the educators as to how teaching and assessment of personal competence is linked to and valued within the students developing nursing practice.

Therefore, both educator and student experience a lack of consistency in the approach to learning outcomes, highlighted in these educator's comments:

...many students face compartmentalised learning (Group 1, p.40)

...there is very much segregation between the years and I think that as a new lecturer coming in, I have no idea of what they are taught (Group 2, p.39)

In the following statement, an educator rationalises that there is an assumption that a philosophical stance underpins the curriculum and that a philosophy of nursing is communicated throughout the three years of the degree by the educators. However, how that is communicated and understood is not necessarily clear to all:

...I would have expected year one [educator's teaching first year papers] would look at developing philosophy, but who knows, they should be (Group 2, p.40)

The importance of emotion, for moral perception and moral agency, has been explored by Scott (2000). She suggests an essential aspect of being a good nurse is having emotional sensitivity to other human beings. This emotional sensitivity permits students' to perceive more accurately the context and perspective of the person for whom they are caring. She argues that promotion of a nursing philosophy during foundational educational years assists with the development of morally sensitive clinical practice (Scott, 2000).

Beside the need for students to develop moral practice, if beliefs, values and ethical development were not an ongoing process that was communicated across the three years, then the educators suggested

other potential issues arose for the learners and them. Whilst students are learning the competency of self-awareness they also develop beliefs and values which represent the core of nursing and education within the school (Bickley, 2000).

Perhaps then, what students may learn through the experience of participating at the school of nursing is a type of hidden curriculum. An example of how this hidden curriculum may be contributed to by the educators is highlighted in the following comments:

...we talk about students in the staffroom sometimes, that they scraped through or shouldn't have got through or why didn't someone do something about them (Group 2, p.38)

...the other students notice when issues aren't dealt with and it affects their motivation, why should they try and do their best if other students don't behave in a way that nursing values, why should they (Group 1, p.44)

These comments may also support the perpetuation of perceived powerlessness, which I discuss in relation to the development of social competence in chapter six. The issue, which is apparent here, is that students learn to react to the educators, rather than develop independence and self-direction.

According to Haralambos (2000), this type of learning is gained through experience of the relationships with the educators and institution rather than learning what is stated within learning objectives. The student learns ideas that are not actually taught in a formal way, or stated in the curriculum. These ideas result in an understanding of informal rules, values and attitudes. Some students may learn values that may be

unrecognised and unintended by those educators who formulate them. These informal values experienced by students within their relationships with educators, supports the notion of institutional challenges within the school as suggested by Drake and Stokes (2004). These informal values may result in the educators questioning the validity of some student's 'fitness to practice'.

During the focus groups the commitment to provide education which is innovative was clearly communicated by the educators however, the constraints sometimes lead to uncertainty in a collective approach to curriculum delivery:

...maybe its just workload, we [educators] are just so busy trying to get our own stuff [teaching responsibilities] done and sometimes, I say oh well, I presume you have done this in year one, say some real developmental stuff, I'm never actually sure they have (Group 2, p.39)

Nurse educators operate as individuals within teams. Educators have a triad of role expectations unique to the various schools nursing. These role expectations include teaching, service and research. Combining academic expectations within the clinical environments or orientation of the educator is not necessarily a compatible match (Pappas, 1988).

The degree of role conflict present and the coping strategies used by educators to manage or resolve conflict, are critical elements which affect the educator's ability to function effectively. This means that some educators may not be in agreement that certain students meet the requirements of fitness to practice. This may lead to educators

distancing themselves from relationships within the school as indicated in the following comment from an educator:

...our processes [educational practice guidelines] seem to be so thin that students slip through without the right challenging sometimes, they well may have graduated from here, but we wouldn't be shouting out loud about it (Group 3, p.39)

Furthermore, those coping strategies have a direct impact on relationships with students and the students overall ability to develop personal competence.

Failure to resolve or decrease conflict may threaten educators self-esteem, success and satisfaction of their role. It may also lead to complacency or lack of accountability for the individuals and a type of group apathy, or powerlessness. Concern about the lack of caring and support on the part of nursing faculty members for each other as well as for students, is an issue that must be addressed to enable an environment which values and models caring.

5.4 Valuing student nurses in the clinical environment

When learning takes place in relation to self-awareness and self-management, maturity and confidence can grow within the student. This maturity enables development of purposeful nursing action in practical experiences. According to the educators, the type of facilitation and engagement in learning relationships within clinical practice can be problematic. Sometimes, *student nurses are not always communicated with in a respectful way or valued in clinical environments*. This can

affect the students' potential growth of personal competence, in particular their developing skills of self-management.

Debate among the educators about clinical environments led to them reflecting on their own experiences of how helpful nurses are to each other and how learning is not necessarily nurtured within the profession:

...for a caring profession you know, when I reflect back, we haven't been good at looking after each other. I don't know whether it's a women's thing or what, but certainly in my background you were expected to cope and if you didn't, well, the door was there (Group 2, p.18)

...I think nurses and midwives have definitely been left to sink or swim emotionally on their own and through some enormous emotional events in many ways (Group 2, p.17)

In the planning of clinical practice, educators worry about finding clinical settings which are high quality caring environments. Despite the preparation on the part of students and educators for clinical practice, students frequently report situations in which they experience varied levels of quality nursing care being provided. Additionally, students need to reflect on their attempts to try to counteract care they deemed less than adequate which they experienced within learning environments (Ironsides, Diekelmann & Hirschman, 2005).

Reflection and a commitment to consolidate theory and practice within a clinical setting, from the educator's point of view, is an ongoing challenge:

...preceptors [RN supervising the student in practice] have such an important opportunity to role model positive communication to the students but they don't always act professionally in front of them and we spend much of our time talking about what behaviour was seen in the nurse that the student will try never to repeat in their own practice (Group 2, p.31).

...I think there's big crushing machines out there, once they get into the system [health care agencies] they have no chance to be individuals, well very little chance and they just got to get on with it and if they don't like it they leave (Group 1, p.44)

The educators also identified that students often seek out moments to make sense of their emotional reactions to unhelpful behaviour from nurses, within the clinical setting:

...they come to me often in the dem [clinical skills demonstration] room, a bunch on a bed, and away they go and I'll say this or that but it can be one or two people or groups in the dem room where they will grab you and want to talk through situations and how they felt. I will generally keep out of it and say as peers you need to sort this out and these are strategies you could try (Group 1, p.17)

However, this reflection initiated by the student needs careful facilitation by the educator (Brackenreg, 2004). It is a teachable moment, one in which the student can critically develop greater awareness of their own capability through recognition and validation from the educator.

Many of the educators commented that nurses within the clinical environments are helpful teaches and mentors to students. However, when negative experiences occurred for students, the educators

suggested it influenced how clinical learning was perceived in the future. The following comments, suggest how development of self-management can be influenced by learning relationships:

...a lot of nurses at the hospital are good to their patients but not so good to our student (Group 1, p.49)

...it is a problem when they have had a lousy time; it knocks their confidence in that placement and screws up their perception about working as a nurse (Group 2, p.21)

This may lay a foundation in nursing where personal competence is not promoted and where ongoing lack of personal competence perpetuates within the wider nursing professional group.

5.5 Summary

This chapter has discussed several environmental and relational complexities nurse educators recognise, when seeking to teach and assess personal capability, within the students developing emotional competence. The competencies of self-awareness and self-management have been described within the relational and environmental challenges of nursing education. To become fit to practice, the student is required to examine his or her own interpersonal capabilities and develop self-regard. In doing so, they can gain maturity in both emotional awareness and learning style. Recognising learning barriers and defining purpose within a nursing role may develop within the student and educator, further ability to explore their emotional reactions, tune into the needs of others and manage effective nursing care. A consistent approach to teaching, from educators and preceptors, can assist students to recognise and strengthen their self-awareness and self-management.

The environment, in which learning takes place and the relationships within, have a key role in facilitating a sense of value and personal competence within the student.

Social competence is the second component of emotional competence. Whilst students are gaining fitness to practice, they are developing and practising skills in relationship-awareness and relationship-management. The educators recognise these characteristics of emotional competence and describe them, in the ways students begin to professionally care. I will provide further critical discussion of the environmental and relational complexities, which affect learning and assessment of relationship-awareness and relationship-management, in the next chapter.

Chapter six: caring in nursing, through social competence

"The noblest question in the world is what good may I do in it?"

Benjamin Franklin

6.0 Introduction

This chapter presents a critical discussion of the environmental and relational aspects of nursing education. The discussion centres around the third theme generated within analysis: **caring in nursing, through social competence**. This theme surfaces further challenges which occur for educators, as they seek teaching and assessment of the social competencies within emotional competence. Social competence and the skills involved can be recognised and described by educators within various teaching and learning opportunities. As determined by educators, the learning environments in which students participate are complex and do not always support growth of emotional competence within them.

The skills of personal competence, the first part of emotional competence includes the student becoming self-aware. This means, as the student begins to recognise their personal strengths and limitations, they start to work on developing regard for themselves and managing their own emotional reactions. Social competence is using that self-management and moving beyond it so you can begin to work with another person's needs or issues. This includes recognising and managing conflict within relationships. The following discussion outlines the environmental and relational factors which affect the social capability

of students, along with how these factors impact on their ability to develop caring relational competence.

The first aspect of social competency determined by the educators is relationship-awareness. Relationship-awareness is the student's ability to pick up on emotions in other people. This includes the clients and families they work with, along with their peers and others involved in their learning experiences. The student then develops the ability to understand what is really going on, through accurately picking up on emotional cues. This requires understanding what other people might be feeling, even if the student doesn't feel the same way. The second aspect of social competence, described by the educators is relationship-management. According to the educators, students demonstrate competence in relationship-management when showing ability to use awareness of their emotions and the emotions of others, resulting in managing interpersonal situations successfully. This includes caring communication and effective handling of conflict. The following discussion is broken down into the sub-themes of the third theme; caring in nursing, through social competence.

6.1 Emotional 'baggage'

Relationship-awareness is the first aspect of social competence required for caring practice. This is the student's growing ability to accurately pick up on emotions in other people and understand what is really going on. This includes the student understanding what others might be feeling, even when they don't think and feel the same way. The educators suggested that this may become problematic for those

students who have unresolved issues (emotional baggage). Emotional baggage includes transferring old hurt-laden agendas into current situations; it is recognised by others when the individual displaces repressed emotional distress, including fear and anger (Postle, 1991; Heron, 1992).

At times, as outlined in the following comment from an educator in the third focus group, emotional baggage may prevent the students' ability to relate effectively to clients, peers and others:

...students have life events or divorce or stuff like that and they can't say oh well sorry I'm not going to think about the fact that my partner has just left me (Group 3, p.17)

Emotional baggage may hinder development of relationship-awareness or inhibit any learning and practicing of this competence at all.

The level of stress experienced by nursing students remains a feature in the literature. However, exploring what students use as coping mechanisms in response to stress is not apparent. The situations students experience as they gain self awareness and self-management may be chaotic. Students are likely to encounter a changing self, loss of previous defences and regain management of self and new coping strategies, as they progress through learning (Shipton, 2002).

The impact of a student's prior life experience and the way in which they have learned to cope, may influence their development of social competence. This next extract highlights the developmental context of learning relationship awareness. The educator acknowledges the need

to consider the developmental nature of emotional competence when undertaking assessment with students:

...this stuff [learning coping strategies] starts from when you are a child, it starts from what your parents teach you and what your school teacher and peers teach you, it's not suddenly something that happens when you start nursing (Group, 1, p.39)

As nursing students begin to understand the role of emotional labour within their developing practice, they can begin to tune out of their own issues, tune into the clients needs and utilise therapeutic communication skills (Freshwater & Stickley, 2004). According to Ryan, Carryer and Patterson (2003, p. 53): "The core business of nursing which sets it apart from all other professions is that nurses work to integrate or encompass the lived body as they care for the corporeal body". This means that nursing student's require skills to attend to the physical issues experienced by their clients whilst understanding and incorporating care which encompasses the psychosocial, cultural and political context of the client. As this educator's comment below highlights, nursing students require relationship-awareness in order to gain skills to professionally care for others:

...some students are so caught up in their personal difficulties that they totally miss the cues of each other in class or behave in a way towards us that you end up thinking hell, what planet are you on, how are you going to be able to focus on the patient in pain, you are not even looking after yourself (Group 2, p.6)

Heron (1990) outlines the need to manage emotions in everyday life, heal emotional distress and develop competence in professional application of emotional competence. There is a need for those working

in caring professions to work toward addressing unresolved distress, so the people in the position of requiring care are not jeopardised (MacCulloch, 1998). The educators suggested that those students who are experiencing unresolved distress, or those who might have ongoing difficulties coping with emotional issues, pose problems for the clients for whom they are required to care:

...it can be a matter of time; it's almost like a fuse. They [the student] can manage it for a period, then it comes out in terms of relationships with other staff or shown in the way they lack care for the patient. It comes to a point where they don't cope any longer because they put it aside without dealing with it (Group 3, p.16)

...they [student's] need to develop the ability to know that there are issues [in how they personally cope], to put it aside at work, while they are at work, but they are continuously working on it to manage it or solve it so they don't burn out (Group 2, p.6)

The previous and following comments represent the collective group understanding. What is being emphasised is the ongoing need for critical feedback within the assessment relationship. This is so students can begin to address unresolved emotional issues that may impact on their relationships with clients:

...they've got lots of life skills and a number of those are poor life experiences and negative attributes and some of their coping skills are not positive ones, or helpful to others in the therapeutic sense (Group 3, p.8)

Identifying that there are multiple aspects to interpersonal communication is key to learning personal and social competence. In

doing so, educators can foster relationship-awareness in students, as they learn the values and expectations of a nursing culture.

6.2 Perceived powerlessness in a hierarchical context

The complex culture of nursing involves ongoing environmental and relational challenges as students work to develop competency in relationship-awareness. Within nursing education, there are teaching and learning environments that do not always support awareness and growth of emotional competence. The historical context of hierarchical relationships and learned powerlessness can inhibit the student valuing their contribution to nursing and negatively affect their self-regard and personal competence. Nurses, and nursing as a profession, have been historically shaped and positioned in a particular way (Papps, 2001). There is a historical context of powerlessness and hierarchy in nursing (Davey, 2002; Jackson, 2004; O'Malley, 2004; Borbasi & Jackson, 2005; Leiper, 2005), which I argue, is not constructive to the students developing ability to practice nursing, in a caring way.

An educator with many years of clinical and leadership roles within nursing, who recently began teaching in an undergraduate programme, pondered the ways in which students learn about power and control within the clinical learning environment:

...when I came here from the clinical field and then went out with students in practice, within a few months of me starting, I began to hear nurses, say - in the unit, talk about clients in a very derogatory manner. I would think to myself, this is my colleague

and this poor student is listening to this, how am I going to defend it. But I quickly realised, I don't need to defend them, or make excuses, I just need to use it as a learning example (Group 2, p.16)

The environments in which clinical practice takes place were suggested by the educators to be an exciting and emotionally charged learning milieu. The following comment from an educator in the second focus group is acknowledging the anticipation students convey as they prepare for practice venues:

...the students talk about the action being in clinical and that's where they are most likely to have their spirits knocked by some of the ways that nurses behave (group 3, p.15)

However, as the educator points out, despite the positive anticipation felt by students and educators of the opportunity to work alongside clients and health professionals, the reality of their experience does not necessarily reflect the intended learning expectations. Comments such as these from educators, question the way in which the powerful learning environment of clinical practice facilitates a sense of powerlessness and lack of self-regard within the student.

Working with student nurses is enjoyable for many staff nurses in practice. This is shown in the way they welcome and orientate students, engage them in learning opportunities and include their opinions as valuable within their own practice and in relation to outcomes of client care. However, as Birx (2002) contends, some are cold toward nursing students and irritated by the additional demand of helping to educate nurses of the future. A nursing culture which fosters support, mentoring and valuing is expected by students.

The skills of relationship-awareness, which would arguably promote the students emotional sensitivity toward others and foster culturally safe practice in the student, are however, not necessarily conveyed by some nurses working within the clinical practice venues. As this educator points out, if students do not receive positive affirmation for their presence and contribution during practice, they can learn to expect less than adequate emotional competence from their teachers and role-models:

...I can think of countless times when students have been new on a placement and been totally ignored by a group of nurses at the beginning of the shift...some of them are so disappointed at being left without support or being included, they are so keen to be involved and sometimes I can't believe that the RN's have forgotten what it is like to be new and learning (Group 2, p.13)

Some nurses do not see working with students as part of their job description or their professional responsibility. Their lack of accountability to provide education and support student learning, outlined in the previous comment, illustrates how the students can learn to accept a lack of caring. When the student does not experience caring and feels unvalued, there is potential for them to displace this emotional experience into the next clinical practice environment. The student also has the potential to learn how to respond to others in a similar way, such as showing a lack of value towards others, within their relationships with clients and each other.

A preferred clinical learning environment for a nursing student is one that fosters caring relationships. Caring relationships among nursing

students, nurse educators and clinical nurses, can enhance student learning in the clinical setting (Birx, 2002). A positive role model, demonstrating the competence of relationship-awareness, needs to be visible and available to the students in their learning experiences. Yet, some clinical learning environments lack positive role models, as indicated here:

...we [educators] challenge them [students] to be respectful and somehow they go out to clinical and they are not getting the same respect for their own [registered nurses working in clinical practice, in particular new graduate registered nurses] (Group 1, p.46)

Student nurses are looking for supportive environments and seeking high quality interpersonal relationships in which to learn caring nursing practice. However, some nursing cultures may facilitate in the student, perceived powerlessness rather than positive, powerful learning. It seems this is a longstanding challenge within the culture of nursing, as this educator points out:

...we know from a historical perspective that sometimes certain registered nurses are not perhaps that helpful and show judgemental behaviour and label the patients or their families (Group 3, p.15)

McAlister rightly suggests student nurses require skills to: “persuasively challenge authority and to resist practices that ought not to be supported” (2005b, p. 14). Therefore, overcoming problems associated with hierarchical education and clinical environments is essential if students are to be prepared for registration and retained within the nursing profession (Holland, 2002).

Hidden values and practices perhaps likened to covert learning in the educational facilities and the hidden curriculum, may lead to informal rules and a type of perceived powerlessness amongst students. This perception of powerlessness is learned by students in their relationships with others:

...I remember students saying a couple of years ago, when you go onto this particular ward, you play this game and you'll be fine there... you will survive the placement otherwise they will chew you up and spit you out; and they use the words like, they are all bitches up there [certain hospital settings] (Group 1, p.46)

Furthermore, if the nursing workforce is unable to develop social competence and challenge this perceived powerlessness, the continued perpetuation of a hierarchical nursing context is likely to continue.

The following comment summarises the cyclical nature of learning as it affects development of relationship-awareness:

...it affects them as new grads too, they end up fitting in with the hierarchy and then they become the preceptors dealing to students in a way they were unhappy about being treated themselves (Group 2, p.30)

Hierarchy is displayed to students in various unhelpful ways. The students are not always included in learning experiences and shown regard by the nurses and health care team. The students experience that in order to fit in their growing ability to work effectively with the client's emotions is compromised. This is learned in their experience of judgemental language and lack of compassion shown to them and the clients alike. An educator from the first focus group summed up this:

...they [the student] are straight out learning to survive (Group 1, p.44)

Freshwater argues the emergence of this type of behaviour which she states is a type of horizontal violence within nursing "is a result of unexpressed conflict within an oppressed group" (2000, p. 481). Nurses adopt the adaptive strategies of oppressed group behaviour. They do so by directing their unhappy experiences and dissatisfaction inwardly toward each other, toward themselves and eventually toward those less powerful than them, e.g. students and sometimes clients.

Farrell (1997) contends that nurses are dominated and oppressed by a patriarchal system lead by doctors, administrators and nurse managers. This leads to a type of oppressed group behaviour by nurses lower down the power structure, where they resort to aggression amongst themselves. Research about nurse-on-nurse aggression, indicates that the hostile undercurrents and non-physical attacks between nurses, are a type of "professional terrorism" (Farrell, 1997, p. 504). Behaviours such as sabotage, back-stabbing, negative criticism and scape-goating may be displayed within nursing relationships. Students may experience a lack of privacy or openness, non-verbal innuendo, undermining, an unwillingness to be helped out or a lack of availability to be supported in their learning.

The historical context of hierarchy within nursing continues to perpetuate a sense of perceived powerlessness within the overall nursing profession. This powerlessness permeates throughout the educational and clinical workforce of nursing. This complexity not only affects the students

perception of their worth but also has an impact their confidence and ability to practice in a socially competent way. A perception of powerlessness can prevent the students practicing the skills of recognising and managing conflict; if the student feels powerless to have an opinion they are unlikely to critically reflect and plan to work in a different way (Ironsides, et al., 2005). One of the key aspects of gaining personal competence discussed in the previous chapter highlighted the need for students to work on their own emotional reactions. I would suggest nurses learning and working in any nursing arena need to recognise this ongoing work which is required to overcome perceived powerlessness within the profession. Alongside their development of skills in self-regard and recognising the needs of others, students require opportunities to experience caring relational skills from the educators and nurses with whom they work. However, the educational environments in which students learn do not necessarily role-model competent relational ability.

6.3 An emphasis on technology over relational ability

This complexity of nursing education relates to the way in which the general public, alongside the emphasis of technology-driven health care industry, perceives nursing. Relationship-awareness and relationship-management are recognised by educators, when students begin to demonstrate empathic communication and a holistic approach to care. Understanding and interpretation are key aspects to empathy (Watson, 1990). The educators suggested the emphasis of technical ability over relational ability in the curriculum, is an issue which, prevents opportunities for students to demonstrate the type of care that the

public expects from them. This lack of care and emphasis on technology is possibly mirrored in the health care industry. The emphasis of technological competence over relational skills may undermine the students' opportunities to learn and have recognised, maturing social competence. This indicates the need to consider the ways in which skills of empathy, decision making, and relational ability are taught and assessed with students.

According to the educators, an expectation and an assumption made by the public is that nurses will be emotionally competent. Yet there is very little clarity as to how the competence is fostered in nursing education:

...there is an assumption that if you are a nurse you are emotionally competent, because you must be, because you are dealing with human beings: its communication and professionalism and you don't need to kind of do too much, that things will just occur (Group 3, p.45)

The institution of nursing education emphasises the importance of practicing from a theoretical or scientific foundation. This theoretical basis for interpersonal nursing was initially borrowed from the social sciences (Arnold & Bloggs, 1995), but has been worked on considerably since. As a result, many of the dominant understandings of interpersonal ability have emphasised the behavioural performance of nurses. This teaching of a behavioural approach, which provides prescribed methods and behaviours of interpersonal communication and relational skills, is perhaps appealing to some educators, as it provides concrete actions students can perform.

Nonetheless, there are a number of constraints to this approach. An educator indicates in the following comment, the caution required when facilitating reflective dialogue with students during their learning:

...one of the main questions I ask students when they tell me about their clinical skills list is how do you know you did the best thing for the patient? They can tell me all the components of the task, but what actually stood out for them and the patient is the action they took to relate to the patient's need. It takes a while for them to get this, because they focus so much on performing something on somebody (Group 1, p.48)

Students experience much uncertainty during their classroom and clinical learning experiences (Evans & Kelly, 2004). According to Saltzberg (2002) uncertainty is inherent in nursing, and the ability to recognise and manage uncertainty is essential for developing nursing practice. However, uncertainty is not adequately addressed in nursing education. Discussion within the focus group on developing the student's ability to accurately pick up on the emotions of others, led to an educator's account of uncertainty, in a student's practice:

...I am thinking about the various times when I have said to students how do you know what is needed for the patient? They [the student] march up with the medication to calm the patient down, but they're clearly unsure about why they are giving it, let alone what difference it is intended to make (Group 2, p.32)

Saltzberg undertook a qualitative research study, exploring and describing the epistemological perspectives of nursing student's ability to organise and make sense of their uncertainty experiences. She found that unless students integrate cognitive (intellectual) and affective

(emotion based) perspectives to nursing problems, then professional judgement and decision making remains uncertain (Saltzberg, 2002).

Feelings of uncertainty, which accompany decision making, require reflection between the educator and student. In order to accurately pick up on the emotions of others and really understand what is going on, the student needs to integrate the technical knowing with the emotions experienced by the client and themselves, to make informed decisions. Teacher directed learning or a behavioural approach, may not foster the type of learning that incorporates feeling, in decision making (Pardue, Tagliareni, Valiga, Davidson-Price & Ordhowsky, 2005).

Doane (2002) suggests that prescribed methods of teaching interpersonal skills may also inhibit spontaneity and development of authentic communication by nursing students. This was also suggested by the educator participants:

...the patient doesn't remember the aseptic technique but they do remember that the nurse introduced themselves, and that they knew when the nurse was coming to spend time, and when she was coming to do the aseptic technique (Group 3, p.62)

Behaviourally focused teaching methods may also hinder emotions of human interaction and relational nursing practice. Doane invites educators to move beyond a behaviourist approach and to consider using pedagogy of interpretive inquiry. She asserts this change in approach can: "create opportunities for nursing students to learn and experience the transformative power of relationships, gain confidence in their capacity for relational being and a sense of trust in their ability to be with people, in ways that are authentic and meaningful" (2002, p.

400). Furthermore, a change in teaching approach provides an opportunity for students to develop a humanistic relational ability, within their nursing practice. Perhaps captured in the following statement from one of the educators, about a longstanding debate and conflict of nursing ideology:

...it's the arts or the art of nursing we are talking about (Group 2, p.34)

Emotions are intricately involved in the meaningful and significant realities of human life and nursing. Psychologically, emotions have been linked to instincts and in regard to relationships they help create a deeper meaning. Wright (2004) argues that the very essence of nursing has been diminished; the intimate and compassionate caring for others has seemingly become of less value to nurses. Instead, nursing is pursuing the use of technology and delegating the relational engagement of the client's issues to others; or alternatively not including it with any regard in their so-called care. This argument was apparent in the educators' discussion around the ways students are informed of the need to become socially competent within their nursing practice. The educators consistently confirmed the value of relationship-awareness and relationship-management within the student's ability, as suggested by this educator:

...if the student is not developing relational skills then they are performing nursing only at a certain level, therapeutic care is required in a complex package of knowledge and ability to use that knowledge in a caring way (Group 3, p.65)

However, the reality of an emphasis of technology over relational ability, both within the educational curriculum and the health care industry,

means the educators must politically argue why recognition of emotional competence is required in nursing:

...we [nurses] have to take ownership of the profession, all this crap about what the students need to know...it's not just education becoming technological, it's around nursing and the role becoming more and more task orientated and less person centred (Group 3, p.64)

The developing ability of social competence, within the student, enables the client to experience the technical skills of the nurse, in a caring manner. This care represents to the client that the nurse cares about them and their situation, as well as having an ability to interpret what is required to address the need.

Diekelmann and Smyth (2004) suggest the need to move toward student centred learning in nursing education, in order to facilitate this relational competence in nursing students. They argue that educators need to shift the attention away from the technical content and link the content to practice, by exploring the experiences and use of emotion within the relational context of the student's learning. This sentiment was also conveyed by the educator group:

...we can't be responsible for, but we can talk to the students about how they feel about what is happening in practice. To ask, do they agree with it [inadequate uncaring practice] or do they perpetuate it? And to try to instil a sense of value, or morality, or what ever it is that makes a nurse a nurse. Not just the skill level. A student can perform a b or c and have a knowledge base, but be as therapeutically devoid as possible, that's not going to be a nurse, that's a technician (Group 3, p.66)

Ray (1994), in a phenomenological study, established how nurses intertwine their moral and ethical principles and emotional competence, with their technological competence. Much debate has taken place since then including the concept of 'Robonurse' suggested by Locsin (2001). Locsin inferred nursing had surrendered to the models of business and medicine to work in ways which lacked relational ability and caring presence with clients. As a result nursing practice was seen as robotic and focused on doing tasks and following procedures, at the expense of morally sensitive, client centred care (Locsin, 2001). More recently, authors such as Freshwater (2004) and McQueen (2004) have attempted to reunite the apparent polarised emphasis on technology as opposed to humanistic relational caring. They suggest there is a need for nurse educators to value both technical and relational ability with even-handedness; this includes taking a stance of valuing emotion within nursing and fostering an attitude which pays attention to the needs of self and others.

6.4 Summary

This completes exploration of the environmental and relational complexities nurse educator's face, when seeking to teach and assess the social capabilities of emotional competence. Learning and assessment of the relationship-awareness and relationship-management skills have been described within the relational and environmental challenges of nursing education.

Developing the ability to demonstrate caring in nursing requires students' to recognise, interpret and work alongside the emotions of others. To do so, they must develop the ability to understand what is really going on within their relationships and the environments in which those relationships occur. In order for students to develop social competence, they are required to work on and resolve their prior emotional distress. As learning progresses, students gain maturity in relationship awareness required for resilience with a historical hierarchal culture in nursing. The environments in which learning takes place and the relationships within have a key role in facilitating a sense of value and social competence within the student.

In the next chapter, discussion of emotional competence in the context of holistic nursing practice and competency based assessment takes place. I will provide some critique of the tensions I experienced during the research project and argue that there is space for change in the way in which nurses can utilise emotional competence and approach conflict differently. Subsequently, I address the second part of the third aim of this project; and consider the usefulness of the competency framework (NCNZ, 2004) for educators and nurses working alongside nursing students. Implications for nursing education and practice, together with conclusion of the project, will take place in chapter seven.

Chapter seven: Discussion and implications for nursing education and practice

7.0 Introduction

Chapter seven of this thesis constitutes a discussion of the findings. This chapter discusses emotional competence in the context of holistic nursing practice and competency based assessment. At this point I provide some critique of the tensions I have experienced in the production of this thesis and indicate that there is space for change in the way nursing approaches conflict. Following this, I address the second part of the third aim of this project; to consider the usefulness of the competency assessment framework to recognise and provide feedback to students in relation to their development of emotional competence. Finally, I will present the implications for nursing education and practice which have been raised by this work.

7.1 Space for change

As the student's manage their emotions and tune into the needs of others, they become more able to recognise the client's emotional needs, this enables students to engage clients in effective communication. Caring communication and effective handling of conflict are key outcomes of emotionally competent nursing practice. As the students begin to recognise the needs of others they can encounter conflict which needs to be addressed. Conflict and resolving differences was a challenging complexity described by the educators.

Dissatisfaction voiced by the educators was particularly directed toward acute hospital care facilities, in which the majority of graduating students begin their professional nursing career. This led the educators to consider some of the critical factors which influence learning in students and the potential outcomes for those nurses, who want to practice with emotional competence. This included the mode of reactive practice (getting through the shift with a check list of tasks to manage) rather than a 'whole person' (Barker, 2003) approach to nursing care.

Conflict in nursing is clearly apparent, both in terms of how care is delivered, alongside the continued silencing of a nursing voice within the health care industry. For educators, this generates a number of questions to critically consider when facilitating the learning of communication and dealing with conflict within student learning. The way in which students see conflict resolution role-modelled and learn to address their own strengths and limitations requires a new approach. Critical thinking skills and relationships in which to practice this ability, are key to the student leaning and developing skills within emotional competence.

Bell, Heye, Campion, Hendricks, Owens and Schoonover, (2002) suggest whilst much nursing research has focused on the measurement of critical thinking as an outcome, there has been little investigation as to the promotion of critical thinking skills for undergraduate nursing students. To prepare for interpersonal engagement, with a variety of individuals and groups during their learning, nursing students must develop the ability to communicate clearly and learn how to effectively handle conflict. However, as McSherry and Marland (2002) point out, some

students discontinue their undergraduate education citing various reasons of resourcing, lack of availability of educators and support within their learning. They propose nurse educators, whilst espousing holism and evidence based practice, consider to what extent they may be neglecting to support the most distressed and vulnerable in our care – nursing students.

It seems that nurse educators are very aware of the potential and actual conflict experienced by undergraduate or newly graduated nurses. However, there appears to be an assumption made by nurses and educators that students can somehow resolve this conflict if they were to recognise the presence of it and learnt how to effectively manage it. The previous data chapters have outlined some of the complexities which affect the ability for students to learn and have recognised their emotional competence. Given the factors which may inhibit this learning and recognition, their assumption is not actually reasonable. This sentiment from an educator represented the feeling and emotional awareness which underpins their understanding:

...the students are expected to be our storm troopers in the system but in actual fact they do get battered hard by the system, so out of every ten that are in the group, only one will survive [practice nursing in a caring way] a year or two. The others will fall into line, or go under (Group 3, p.79)

This educator is saying, that although students might be prepared during their undergraduate education to be capable of caring nursing practice, their inability to practice that within the current reality of some nursing environments, disables their capability. The student may have the knowledge, skill and desire to care, but they do not necessarily have the

confidence or retain the confidence, to act on these abilities if the group in which they belong does not support them.

Each individual nurse, educator and student is accountable to the nursing profession and the general public, to critically address conflict. This means we are collectively responsible for recognising and considering the pros and cons of environmental and relational factors which affect nursing practice. What society rightly expects of nurses is that they can effectively work together and monitor their own and each others competence. Students can learn emotional competence by reflecting on experiences in practice and can assess their ability with the educators during practice and in retrospect (Price, 2005). However the skills of self-monitoring, self-assessment and self-direction are something the student must acquire during undergraduate education (Heron, 2004). If the students do not participate in learning environments which foster critical thinking, experiential learning and participation in assessment, they are unlikely to be prepared professional nurses within the current health care industry. Critical consideration of the complex environment in which nursing leads care, requires a holistic approach. Therefore, continuous consideration must be made within each practicing area of nursing, not just in education, to work on environmental and relational factors which inhibit the ability to practice with emotional competence.

The inclusion of emotional competence within the curriculum and learning relationships needs to be considered within the context of a community. It is a community in which students, educators and clients belong. Nursing students need to develop skills of critical reflection

within their practice. Adequate preparation and meaningful reflection within interpersonal situations are vital to this process (Smith & Johnstone, 2002). When students are taught that emotional competence is a required competence within professional nursing practice, the nursing professionals that students work alongside, must uphold this expectation and provide opportunities to foster emotional growth in the students and support their learning and practice of the competence.

The Nursing Council of New Zealand requires that all registered nurses provide evidence of their competence to practice. The competency framework (NCNZ, 2004) is the assessment framework utilised by nurse educators to determine the developing competence of nursing students. The competency framework (NCNZ, 2004) is intended to provide guidance to educators and students as to what knowledge, skill and attitudes are developing within the students' learning. However, it is not proposed to prescribe particular outcomes nor is it quantifiable in terms of measurability. The competencies are not an assessment tool to determine failure. The council competencies provide a framework in which students and educators in partnership can begin to recognise skill and knowledge development.

The following discussion summarises the usefulness of the competency assessment framework (NCNZ, 2004). The eleven competencies are in no particular order, but are linked to the themes generated within the research process; taken into account is the developmental nature of emotional competence. The following discussion addresses part two of

the third aim of this study; the usefulness of the competency assessment framework (NCNZ, 2004) to provide feedback to students in relation to their development of emotional competence.

7.2 Recognising learning in relation to emotional competence

Management of the environment

The opportunity for the student to identify their learning needs in relation to personal competence is sometimes lost in the process of the educator having to articulate failure in an objective way. Becoming flexible and positively directing behaviour in relation to self-management can be assessed in an objective and subjective manner, within the competency *Management of the environment*. The council defines this competency as the student's ability to promote an environment that maximises client safety, independence, quality of life and health (NCNZ, 2004). Within this competency, the student can demonstrate the types of processes and frameworks they use to engage the client and work in a safe manner. Utilising frameworks in practice enables the student to reflect on what processes they are using to assess and make decisions (how they are managing the awareness and experiences within the context). This competency also provides an opportunity for educator and student to recognise developing self-awareness and where learning might need to take place.

The focus of the management of the environment competency is to mobilise capability according to potentials and use of nursing knowledge. Here, educators can feedback to the student recognition of self-

management being demonstrated. Nursing action can become more purposeful and confidence can increase within the student as they recognise their ability to positively direct their behaviour, and own their professional development.

Professional development

The challenge of differing capabilities within the student group surfaced the variety of ages, learning styles and expectations students arrive with at the beginning of the programme. There is increasing emphasis within the nursing literature of the need to undertake learning and advance professional qualifications however, there is little to describe the principles and skills required in adult learning (Freer, 2002). Expectations of both the learner and educator need to be made clear from the beginning. The ability of the student to reflect upon their self-awareness and set goals toward maturity is essential. Neary (2000) cautions us as educators however, that students will require help and guidance to reflect on their abilities and experiences. Learning is a process and can be described as a journey. Establishing a partnership, with the student working towards autonomy, acknowledges this journey in learning. This can help an individual recognise, that what you don't yet know about yourself, can be discovered in reflecting on the past and present. There is emerging reference within nursing literature to working in partnership (Heinrich et al., 2005).

It is widely argued that student nurses need to learn to become reflective practitioners and that self-assessment plays an important part in this (Ekebergh, Lepp, & Dahlberg, 2004; Thorpe, 2004). Learning goals need to be planned, based on the student's self-assessment and in

partnership with the educator. Maturity in learning can be achieved through self awareness and reflective self-assessment. An opportunity for ongoing assessment could be facilitated through the competency of *professional development*. The professional development competency, describes the student taking responsibility for their own development and contribution to the development and recognition of professional nursing practice (NCNZ, 2004). Whilst the student is being responsible for their own ongoing self exploration, nursing maturity can be assessed by both them and the educators by reflecting upon interpersonal situations. By linking the development of self awareness to the professional development competency, the student may be more able to learn more about their capabilities and areas for development. It is these capabilities which enable the student to manage nursing care.

Management of nursing care

Nursing students often have multiple life roles which impact on their ability to develop emotionally competent nursing practice. The opportunity for ongoing assessment of the ability to 'tune in' to own and others emotions, is apparent in the way students begin to manage nursing care. The competency, *management of nursing care*, is developed so that the student manages nursing care that is responsive to the client's need (NCNZ, 2004). The nursing care undertaken by students must be supported by nursing knowledge. Through ongoing self-reflection, they can develop a manner in which they are open to the client's needs and begin to utilise nursing knowledge, to understand and address the issues within the client's story. Nursing practice which is underpinned by caring encompasses empathy for and connection with people. Teaching and role modelling caring is a challenge to the nurse

educators who facilitate learning within educational environments (Fahrenwald et al., 2005).

A holistic approach to differing capabilities and acknowledgement of the individual students' valuable contribution in nursing needs to be fostered, to facilitate personal competence. A student, who is able to recognise and manage their own strengths and limitations, is then able to provide care which fosters emotional competence in clients. If students are to practice nursing in a holistic way then they must first understand humanistic theory, which underpins this type of care.

Patterson and Zderald describe humanistic nursing as: "An experience lived between human beings" (1976, p.7). Suggesting to those nurses learning or working in education or practice that there is a need to move beyond the technical 'doing' of nursing, to become able to experience the feeling and 'being' of nursing. This humanistic approach to nursing supports the ability to move beyond the well-being of clients, to the potential capabilities and 'more being' of clients and individuals (Doane, 2002). A humanistic approach can foster reciprocity within nursing relationships and enhance the experience for learner and teacher. Valuing relationships and supporting each other can create opportunities for both students and educators, to gain confidence in their relational being and a sense of trust in their ability to be with people, in ways that are meaningful and authentic. Feeling valued and supporting others extends in nursing to clients, peers and colleagues from various other disciplines.

Interprofessional healthcare

There is an opportunity to facilitate feedback to the student in relation to demonstration of self-management, within the *competency of inter-professional healthcare*. The inter-professional health care competence outlines the student's requirement to promote a nursing perspective, within the inter-professional activities of the team (NCNZ, 2004). Through self-awareness and self-management, the students can understand their personal capabilities and begin to transform those capabilities, into a professional nursing perspective. When educators work in an honest way, are flexible and adaptive to the student's individual needs, the students are enabled to take risks and be honest about their ability. This flexibility creates for the student, an opportunity to recognise learning, rather than trying to avoid failure. A careful and prepared approach to taking risks can enable students to challenge a seemingly unsupportive environment, within nursing. Honest, positive communication with peers and being open to recognising the perspective of another, can lead to establishing reciprocal and respectful interdisciplinary relationships. A clinical practice environment is required in which learning and the role of students is valued. When this is so, students can progress their skills of self-management, within personal competence.

Ethical accountability

As students begin developing self-awareness and move toward self-management, they can gain greater understanding of their own value and belief systems. It is these beliefs and values which will inform their philosophical stance and moral practice. Students require a sound understanding and a consistent approach to nursing values from the

educators group (Leininger & Watson, 1990). In a phenomenological study by Fahrenwald et al., (2005), carefully integrated values with the curriculum ensure that the legacy of caring behaviour embodied by nurses is strengthened for the students. This careful integration contributes to recruitment and retention within the educational and clinical workforce. Values of human dignity, integrity, autonomy, altruism and social justice are also core nursing values, essential to baccalaureate education (Fahrenwald et al., 2005). Collaboration within the educators group, about what core values underpin learning and caring in the curriculum is essential.

Nursing students require opportunities to understand their own value and belief systems, in order to manage them. The learning of emotional competence is also required to manage emotional reactions in nursing situations. With development of moral and ethical practice in mind, the student and educator have an opportunity to assess and develop personal competence, through the competency of *ethical accountability*. Ethical accountability requires the student to practice in accordance with ethical and moral principles. Ethical accountability promotes the clients interest. The student's practice is required to acknowledge the client's individuality, abilities, culture and choice (NCNZ, 2004). Consistency in the curriculum about the requirement of self management, role-models to and supports the student in their development of a nursing ethic and ethical accountability within nursing. The need for ethical reflection and development is well documented in the nursing literature (Owen-Mills, 1995; Woods, 2002; O'Conner, 2003; Watson, 2005).

Ethical action is demonstrated by nurses in behaviour that is underpinned by moral reasoning and the skills of relationship-awareness. This ethical action is recognised by educators when students undertake emotional labour within their relationships. The concept of emotional labour, suggested by Hochschild (1983), indicates the need for students to learn how to regulate their emotional reactions within relationships with others. The student must learn how to care for others, even though they may be experiencing emotional difficulties at a personal level. Therefore their emotions may, at times, require the induction or suppression of feelings in order to sustain an outer appearance, so that the person being cared for feels safe and worthy. The purpose of emotional labour, as the students develop relationship-awareness, is to promote in others a feeling of being cared for, through authentic communication (Hochschild, 1983).

Communication

Learning and assessment needs to take place in regard to emotional competence, if the student is to achieve authenticity in their communication with others. An opportunity for the assessment of this ability, relates well to the *communication competency*. This competency requires students to demonstrate the ability to relate in a professional manner. This includes communicating effectively, to support the client through the health care experience (NCNZ, 2004). An acronym FIDeLity coined by Fink (2003) suggests a 'best practice' method for developing understanding of learning through consistent feedback. FIDeLity represents: F for frequent, I for immediate, D for discriminating, distinguishing features of good and poor performance in ways that are clear to the student. The L stands for lovingly delivered,

with empathy and personal understanding. Encouragement to identify emotional issues that might distract the student, from caring for the client, requires a direct but caring approach. Tanner advocates with caution in mind, that: “when the bar is set high, students will not do well initially and need encouragement” (Tanner, 2005, p. 152). Positive communication, critical feedback and creating a learning environment that captures student participation, can contribute to the student’s evolving social competence and caring practice.

Caring is a challenging entity to explain or define. Many authors suggest that caring is the central and unifying domain of nursing. It is important that nursing students understand and experience caring, in order to be clear about what good nursing care is. Moreover, creating a teaching and learning environment that validates the requirement of students to learn this, whilst being cared about by others, is critical to the development of social competence within the individual student, and the future of nursing as a professional group. A caring relationship between educator and student can assist in development of social competence and promote in those students who have unresolved emotional issues, the need to address this in order to be able to care within a nursing role.

In order to overcome a historical context of oppressed group behaviour, the student’s perceived powerlessness requires challenging in context. Students require opportunities to continually reflect on their experience and plan how those experiences might be transformed into practice. Individuals within nursing who are able to critically reflect and work with each other enables the environment and culture of nursing to transform (McAlister, 2005b). When educators facilitate critical reflection, students

experience enhanced self-direction and mutual respect between each other (Goldenberg, Andrusyszyn & Iwasiw, 2004). This reflective practice may initially surface tension and conflict, but also provides an opportunity to consider the status quo of relationships that may inhibit the student working toward accountability.

Legal responsibility

Accountability belongs to each individual nurse to act in a personally and socially competent way. Students require opportunities to gain skills in awareness of potential conflict in order to critically problem solve and become accountable to their desire to behave in a caring way. An opportunity for ongoing assessment of social competence can be viewed through the *Legal Responsibility competency* within the Nursing Council competencies. Here the student is learning to practice in accordance with relevant legislation. With accountability having been made explicit through the Health Practitioners Competency Assurance Act (2003), there is an ongoing requirement for all nurses to continually demonstrate fitness to practice, through personal competence. Alongside this legal accountability, is a mandate to uphold client's rights which also derive from that legislation (NCNZ, 2004). Promoting learning and practice of relationship-awareness and relationship-management, enables students to maintain personal competence and those obligations of nursing practice sanctioned in law. Whilst their skills in critical reflection are developing, the student can develop accountability, through political awareness and an attitude that upholds professional standards and expectations.

With recent changes to competency assessment in relation to cultural safety (NCNZ, 2005), educators are required to facilitate learning with students which enables them to explore issues of power. Richardson and Carryer propose that: “students require a critical understanding of the socio-political forces shaping the delivery of nursing and health care and the nursing patient relationship” (2005, p.208). The facilitation of cultural safety indicated in nursing education, is a necessary learning requirement. This supports the need to promote relationship-awareness within the students learning. The necessity of caring and relational ability is well documented in the nursing literature, as is the need for advancement in technology and scientifically sound, evidence based practice. Caring with emotional competence is not necessarily in direct opposition to the current environment of nursing practice in which students learn, however, it is not so easily recognised or discussed.

Cultural safety

Being compassionate and non-judgemental in nursing facilitates a caring approach (Watson, 1985) and cultural safety in practice (Ramsden, 1990). Compassion is recognised by educators when students accurately pick up on the emotions of other people and understand what is going on. Having the skills of relationship-awareness equips the student to recognise the client’s needs, even if they are not being told it directly. The student is required to show regard for others, position themselves to work with the client’s preferences and values and treat all people with respect, within the *cultural safety competency*. The student is obligated to practice nursing in a manner that the client determines, as being culturally safe (NCNZ, 2004). When educators link relationship-awareness within the competency of cultural safety,

recognition of the student's ongoing growth of personal competence and practical ability of social competence can be discussed with them. The assessment of cultural safety is an opportunity to understand how the student is relating in a caring manner toward clients and peers and provides an opening for feedback to them of their ability to demonstrate emotional competence. As the student begins to demonstrate culturally safe nursing practice, the clients experience care in which their emotion is being valued and acknowledged as they interact with the student. Caring communication skills can then be used by students as they begin to teach clients new ways of managing their own needs and issues.

Health education

Choices of learning experiences provided by educators, facilitates within the student, various ways of knowing how to work with the variety of interpersonal situations within nursing. An opportunity to assess this relational ability and the skills of understanding and interpretation is within the *Health education competency*. This competency requires student's to develop an ability to assist clients and groups, to achieve satisfying and productive patterns of living, through health education (NCNZ, 2004). Here the student can use various ways of knowing to establish choices, teach the client and evaluate that their communication is effective.

Giving and receiving critical feedback in relation to interpersonal skill demonstrated, enables the student to develop relationship-awareness within the teaching and learning relationship, it is a two-way process between student and educator. Health education is a two way process, between nurse and client. This process is mirrored in the educator-

student relationship and can be fostered within the wider student group. Learning to give and receive feedback for themselves and their clients is a skill for students to learn. Abraham (2004) argues that emotional honesty, self-confidence and emotional resilience can promote superior performance; if positive feedback is delivered in an emotionally honest manner, it promotes critical awareness of learning needs. It is essential then that structures are put in place to establish relationships, so that the student can gain critical feedback. This feedback is required, so the student can work toward independent critical thinking skills to assist in managing their relationships and communication within.

Quality management

Practicing in a socially competent way and being open to finding solutions to address conflict, is a collective accountability in nursing. Students require opportunities to gain awareness of potential conflict, in order to reflect and practice critical thinking skills to support their desire to behave in a caring way. An opportunity for ongoing assessment of this ability to critically reflect can be viewed through the *competency of quality management*. This competency requires that students contribute to ongoing quality improvement in nursing practice and service delivery (NCNZ, 2004). When students begin to develop social competence, they are able to effectively manage conflict and address quality issues, within their practice. The student can develop negotiation skills to address change and implement best practice within clinical environments through maintaining an attitude that upholds professional standards and expectations (Clark-Callister, Matsumura, Lookinland, Mangum & Loucks, 2005).

A learning environment which values emotion and trust within relationships is essential for the development of emotional competence in nursing students. Emotional honesty was also highlighted consistently within the focus groups, as a foundation required for the educators to facilitate teaching and assessment of emotional competence. Personal and social competence in nursing is not developed in individual isolation. Within all aspects of nursing education, situations involve overt content (aims and learning outcomes of the curriculum documents) and covert (the hidden curriculum) content. Historically, the message has been sent to nursing students not to get emotionally involved with their clients. I would suggest this message is also apparent for educators within nursing educational facilities. Students and educators unmistakably work with human emotion, whether this is disappointment, sadness, discomfort, joy, relief or hope. Therefore, by facilitating feedback to the student in regard to their demonstration of emotional competence, the student is more likely to begin to make clinical judgements and decisions which are supported by critical thinking.

A consistent relationship, which is reliable and trustworthy, facilitates confidence in students and capability to recognise their current skills and learning needs. However, nurse educators need to engage in education which validates emotional competence as a required competence; this will be the upshot of addressing such conflict. Nurse educators are positioned to develop purposeful nursing practice which is underpinned by emotional competence, in partnership with nurse learners and future practitioners.

Professional judgement

In order for the student to become purposeful, they need to develop an understanding of their abilities and learning needs, through critical feedback. Despite the complexities of an inconsistent approach to the curriculum and the apparently lack of opportunity to critical reflect within clinical settings, students aspire to develop fitness to practice in a caring manner, as they work towards entry to the professional nursing register. An opportunity to facilitate assessment of this ability is within *the Professional Judgement* competency. This competency requires students to develop sound judgements that will enhance their nursing practice (NCNZ, 2004). Developing the ability to make professional judgements to act on, which are informed by personal and social competence, rather than reactive practice, needs to be a focus within the assessment relationship (Diekelmann, 2003). This then establishes a stable platform for students to develop a nurse-client relationship, based on care. Moreover, it lays a foundation for nursing practice to be co-operative with and accountable to the community as a whole.

7.3 Summary of discussion

This component of the final chapter has provided a critical discussion, of the necessity for educators and nurses in clinical practice, to reflect on their own unique capabilities and limitations. Accordingly, this can assist us to recognise opportunities for understanding and change, including the ability to recognise and deal with conflict with others and within ourselves. Furthermore, this chapter has addressed the second part of the third aim of this research project; to consider the competency assessment framework (NCNZ, 2004) and its usefulness to recognise

and provide feedback to students in relation to their demonstration of emotional competence.

Knowledge, skill and attitudes in nursing are developed within a teaching and learning relational context. Emotional competence within a context of nursing education and practice are discussed in the final section of this chapter. Reflections on the research and implications for nursing education and further study will be addressed.

7.4 Implications for nursing education and clinical practice

The complexities highlighted in the previous chapters challenge nurse educators to critically view environmental and relational factors that impact on the teaching and assessment of emotional competence. In doing so, educators are able to describe the ways in which emotional competence can be developed. In this concluding section, I will discuss the critical features of emotional competence within the context of nursing education and practice. My argument includes the need for educators and clinicians to think critically about their capacity to provide emotionally competent nursing education and how to nurture this competence in the students with whom they work. In conclusion, my presentation of the implications for nursing education will be outlined with rationale.

7.5 Summary of findings

Education is a challenging and complex domain for the discipline of nursing. Those individuals who choose to undertake education to become a registered nurse are required to develop effective

interpersonal skills which include the ability to convey hope, understanding and regard for others within relationships. Emotional competence is a type of personal and relational ability that enables an individual to recognise the meaning of their emotions and their relationship to reason and problem solving. This competence is a vital dimension of personal and professional functioning because as nurses, we are required to develop skills of recognising and demonstrating an awareness of our own emotions and the emotions of those with whom we work. The first aim of this study was to determine how a group of nurse educators recognise and describe what emotional competence is in nursing. The educators define the concept of emotional competence as developing the ability to:

Become self aware (*self-awareness*), develop regard for yourself and work on ways to manage your emotional reactions (*self-management*). Emotional competence includes using that self-management, moving beyond your own needs (*relationship-awareness*) and working with another person's issues or need, including recognising and managing conflict (*relationship-management*).

The developmental nature of emotional competence, and the way in which educators recognise learning of this ability in relation to competency based assessment, was presented in chapter four. By utilising various ways of knowing, including subjective and objective understanding, nurse educators can facilitate with students, freedom in expression of their ideas and emotional connection to their learning.

The second aim of this study was to explore with the educators the environmental and relational complexities which affect student learning and assessment of emotional competence. This discussion takes place in chapters five and six. Along their journey to gain fitness-to-practice in nursing, it is vital that students examine their individual interpersonal capabilities and develop regard for themselves. Consequently, they can gain maturity in their emotional capability, strengthen their skills of personal competence and begin to define purpose within a nursing role. Furthermore, developing the ability to demonstrate caring in nursing requires students to recognise, interpret and work alongside the emotions of others. The educational environments and relationships within, in which learning takes place, have a key role in facilitating a sense of value and social competence within the student.

The third aim of the study was two-fold. The first part of this aim, examination of the competency assessment framework (2004) with the educators, is critically discussed following the working definition of emotional competence in chapter four. Student nurses require opportunities to learn what emotional competence as a concept is. The definition of the concept must be realistic and able to be incorporated into learning outcomes. The competencies (NCNZ, 2004) are currently available to assist students and educators to recognise where their skills of emotional competence are being used effectively within nursing relationships. The second part to the third aim is addressed in the discussion chapter. By utilising subjective and objective assessment, educators can draw on the competency based assessment framework to

recognise and provide feedback to students in regard to their development and demonstration of emotional competence.

7.6 Valuing emotionally competent nursing practice

There is a nursing shortage in New Zealand and throughout the world (Thies & Ayers, 2004). The challenge of recruiting and retaining innovative educators and nurses to facilitate teaching and learning, in a dynamic curriculum, is at risk. Thies and Ayers (2004) suggest nursing faculty shortages demand innovation from nurse educators and nursing leaders, to prepare nursing students for the environment in which they will work. Clinical agencies and sites in which students undertake clinical practicum are limited, making the conventional model of practice education complex to sustain (Kelley, 2002). Nevertheless, the classroom environment and indeed, any situation where relational skills are used, is a learning environment within nursing education.

It is clear that educators and clinical nurses influence the values of nursing within students, both in classroom and clinical teaching. The evaluation of students is important not only for the student's growth and development, but has a direct impact on the current and future of clients within the health system. Diekelmann (2002) suggests critical feedback within the educator group is useful for raising consciousness of values and leads to a greater understanding of practices that the group undertakes. Communication, which is honest and addresses the strengths and limitations of individuals and groups within nursing, necessitates progress beyond the historical and current oppressed group

behaviour evident within the nursing profession. Emotionally competent dialogue among nurses working in educational and clinical settings can facilitate critical reflection and competent nursing practice with nursing students. As individuals and groups of nurses take up this challenge of practicing with emotional competence, they model to and nurture the competence within student learning.

Being authentic, realistic and hopeful are key elements for outcomes in the relationships we participate in with others (Horsfall, 1997). These critical factors facilitate communication and trust between the educator and student. This trusting relationship takes time and effort to establish with the educator taking a leading role initially to facilitate the students growing awareness of their capabilities as they work toward independence in their nursing relationships. In order for students to work in a purposeful caring way with clients, the educators are required to facilitate purposeful feedback, to enable the student to understand what their professional judgement is; and how they have come to view situations and use problem solving skills within their learning.

Emotional competence, which is closely aligned with emotional intelligence and emotional literacy in the literature, suggests the ongoing need for feedback to develop awareness and management of this ability. Orbach's (1999) suggestion of emotional literacy implies that nurses develop caring responses to situations they encounter; acknowledging those responses personally is required, so that understanding and nursing action is directed in a recognised way. Given that the nature of emotional competence is one that develops with influence of societal, familial and cultural factors (Goleman, 1995; Orbach, 1999), potential

emotional incompetence or emotional immaturity may be a challenge that the student learns about themselves in the feedback process. Therefore, the ongoing development of trust, within familiar and reliable relationships with educators, is more likely to facilitate development of emotional competence within the student.

For the educators, being open to the expectation that they can learn from the students and being active about demonstrating this in their interaction, may assist students to value and promote motivation to discover their own learning needs. Tanner (2005) suggests educators can benefit from trying to learn something new themselves and consider how their learning is influenced positively or not, by other teachers. Little research has been done on the factors of what makes a real difference in student learning (Trifonas, 2003). However, what is clear from the research to date is that the relationship between the student and the educator and the quality of their interaction, is extremely important in the learning outcomes.

The personal competencies of self-awareness and self-management (Goleman, 1998; Salovey & Mayer, 1990) support the need for nursing students to gain a level of nursing maturity through self regulation, understanding of their belief and values systems and 'tuning in' to the needs of the community with whom they are learning and working.

Gaining competence of self-awareness and self-management enables educators and students to become flexible and take risks to achieve reciprocity in communication.

The key aspects of relationship-awareness highlight the need for students to authentically communicate and move beyond their own difficulties (Heron, 1990), through self-regard. In order for students to demonstrate compassion and cultural safety within their nursing practice, they must position themselves in a non-judgemental way. This positioning, along with becoming accountable to the nursing profession, the public, each other and the clients with whom they work alongside, is developed through critical feedback and a trusting relationship with the educator. Furthermore, the development and ability of social competence within the student enables them to make informed choices and facilitate health education with clients and families.

Facilitation of social competence within education creates the potential for students to understand and overcome the historical oppressed group behaviour and perceived powerlessness, in both the education and health care systems. The transformative effect of recognising personal and social competence, within emotional competence, has the potential to change and improve the way in which nurses practice quality care. The practice of quality nursing care fosters credibility for the profession and confidence within the professional nursing voice.

7.7 Transforming nursing education

A challenge to teacher-centred approaches within education is becoming apparent. The behavioural educational model, underpinned by psychology, fostered passive-student, directive-teacher centred learning. This behaviourist focus on the learning process as opposed to the content, was argued to promote independence and a self-directed

approach to learning (Doane, 2002). However, this skills based training approach has been at the expense of fostering emotionally competent relational ability within nursing practice. Progress is now required to move beyond this, to a more humanistic approach. Reece and Walker (2000) suggest that a good teacher develops a feeling for the students' emotional needs, social background and learning development. For educators, this means a genuine interest in the welfare of the student can promote learning. Within nursing education, students come from a variety of backgrounds, cultures and age groups. We as educators must therefore adapt to meet the diverse needs of the students with whom we work.

7.8 Transformative nursing educational practice

Development of emotional competence within nursing education supports a move toward transformative teaching. McAlister suggests: "Transformative teaching is about showing students that knowledge is relevant to practitioners and that critical discussion of practical skills is important" (2005a, p.15). This means, within every day teaching encounters, the interaction should reveal how knowing is linked to action. Our emotions inform or interfere with practice and ought to be surfaced and valued as contributing knowledge to our ability.

For students, becoming personally and socially competent and utilising their developing awareness of how their own emotions, and those of others, can be managed is required. The nursing profession requires 'fit to practice' graduates who are able to interact successfully within a great deal of conflict faced in nursing, at this present time (Cottingham,

2003). Developing an attitude which is open to working with possibilities and a solution focused approach to the environment, may assist the students to critically reflect on the workplace and build up a type of resilience. This resilience may enable the students to cope with the complex relationships and conflict within. Moreover, development of emotional competence within nursing education may foster accountability, within the professional group. Progress toward transformative education is required to address the very real complexities of conflict within the nursing profession.

The emerging reference to transformative educational practice challenges educators to consider how they critically reflect on their own practice and the way in which they contribute to supporting critical inquiry within the school of nursing (Heron & Reason, 2001). A responsibility for educators, within their own schools and at a national level, is to commit to a critical inquiry process which explores each others evaluative practices and sources of influence on those practices (Mahara & Jones, 2005). Furthermore, enabling transparency of evaluative practices within all relationships is necessary to address conflict in the wider health care context.

The differing ways of knowing proposed by Carper, (1978) and more recently Heath (1998), suggest development of interpersonal, evidence based nursing is a challenge within the current health care system, where there is an increasing emphasis on technology, over relational ability. The educators suggest the way in which emotional competence can be developed in students and communicated by them, is through the caring interpersonal relationships they have with each other and the

clients for whom they care. A transformative teaching approach, which includes the value of emotional competence within the curriculum, is suggested as the key to overcoming the emphasis of technical ability over relational ability.

When nursing is taught from a humanistic perspective, both students and educators can learn what values, both personal and professional, underpin their philosophy of caring and ethical practice. Collaboration within inter-professional relationships is enabled by open minded self reflection, critically reflective dialogue and feedback. However, a transformative approach to facilitating learning in nursing requires reflection-in-action. Reflective practice through educator facilitated discussion, peer review or clinical supervision, creates potential space for transformatory learning to take place (Freshwater, 2000). This provides the students and educators with an opportunity to surface conflict and promote awareness of issues such as inequity, powerlessness or oppression that may be taking place within the educational and clinical practice environments.

According to McAlister (2005a), there is a myth that a theory-practice gap exists. She suggests that whilst in theory, the student is practising new knowledge and skills and whilst in practice, knowledge and theory is being generated. The development of collaboration, through nurturing emotional competence and critical reflection within nursing education, has the potential to emancipate students and educators and strengthen the emotional competence and the professional voice of nursing as a whole.

Freshwater and Stickley (2004) suggest the process of self inquiry and reflection within students and educators alike may not always be orderly, or comfortable. In order to move beyond surface understanding students must engage in reflective learning and critical thinking. When nurse educators aim to facilitate critically reflective discussion about relational aspects of nursing and their experiences, it enables students to transform their understanding of the experience. Students and educators can learn to practice differently. Transformatory learning, according to Freshwater: "enables the student to learn, and how to learn, but also facilitates the process of transformation in that learning" (2002, p. 84). Critical reflection between students, educators and within the educators group, challenges all involved to become critical of dominant ways of thinking rather than passively accepting them.

McAlister (2005b) suggests critical consciousness isn't just about believing something or going along with what others say should happen. Rather it is a way of understanding that is demonstrated in authentic, reflective action. For educators, McAlister proposes: "the focus of teaching is to show ways that theoretical issues are lived out in practice; to provide vivid, memorable examples of how understanding, insight and development changes peoples lives" (2005b, p. 11). Therefore, the way in which educators facilitate the learning of technical and relational knowledge in nursing education should be critically considered. Both educators and students should look beneath the surface of their stories, to reveal dominant beliefs and examine the relational dynamics taking place.

When educators pay little attention to the emotional development of students, they fail to communicate the significance of human relationships. Kosowski, Wilson and Grams (2004) undertook a qualitative study which explored the use of caring groups within an undergraduate degree programme. Nurse educators served as facilitators of caring groups with students, to provide opportunities for students to learn and practice the art and science of caring. Findings included the view from educators that their own self-awareness and personal growth increased, alongside the opportunity to re-examine pedagogical practices from an individual and group perspective (Kosowski et al., 2004). It is not sufficient to teach communication skills or techniques, as there is a risk that communication becomes just another nursing skill similar to, for example, dressing a wound or taking a blood pressure. Communication and emotional human interaction, promotes the art of caring within the student and encourages the students feeling of being supported and valued (Freshwater & Stickley, 2004).

A facilitative approach and including students in curriculum development is suggested by Goldenberg et al., (2004). They advocate the use of teaching approaches that include the student group's critique of the course and curriculum. This can result in enhanced self direction, self-esteem and mutual respect among students, educators, as well as authentic curriculum development in a safe, caring and supportive context. Development of emotional competence and a transformative curriculum requires feedback of a reciprocal nature. There is a need to find ways to incorporate teaching and assessment of the ability to use our emotions and the emotions of others, to manage interactions

successfully. Within nursing education, research and practice we should not lose sight of the contribution that caring makes in everyday interactions with clients and families. More importantly, we should not lose sight of the difference it makes in everyday interactions with students and with each other.

7.9 Strengths and limitations of the study

Emotional competence, in the perception of the nurse educator participants, has emerged as a foundational concept for nursing education. The focus of the single concept with the small group of participants, necessarily limits the scope of this research, and the implications of the results. However, the study gains significance from the conceptual and practical relevance. Although emotional competence is not considered to be dependant on theory for its development, its application in practice supports development of a theoretical and practical understanding.

This study focuses on nurse educators' perceptions of emotional competence and how they work with students to develop this competence. Their perceptions of emotional competence, inform their educational practice and relational being, when working with students. The project explored how the participants made sense of relational and environmental challenges, when seeking to develop with nursing students, personal and social competence. Previous authors of research (Cadman & Brewer, 2002; McQueen, 2004) argued the need to clarify how emotional competence is collectively understood and incorporated into nursing education. However, what this collective understanding

might be and how it can realistically be integrated within educational practice and competency based assessment, requires critically embracing the concept in context.

7.10 Recommendations for future research

This study has ascertained the relevance of emotional competence within a context of nursing education and practice. The discussion has raised a variety of environmental and relational dimensions which reveal areas that need to be addressed within the nursing profession. Continuous consideration must be made within each practicing area of nursing, of those challenges which inhibit nurse's ability to practice with emotional competence. Those educators and nurses, who work alongside students, must uphold the expectation that emotional competence is a required ability and facilitate opportunities to foster emotional growth, skills in conflict resolution and caring communication, within the culture of nursing.

Given the limitations of working with a small group of educators within this project, it is appropriate to recommend further nursing research. Further focus groups with educators and nurses working in postgraduate education, in particular those working with new graduate nurses, can further strengthen the practical usefulness of incorporating emotional competence within undergraduate and postgraduate nursing education.

7.11 Conclusion

In the literature review, I discussed the historical and contemporary development of emotional competence as a concept relevant to helping

professionals. More recently nursing as a profession, in particular nurse educators, have embraced the idea that emotional competence is required in order to work effectively alongside others. Moreover, that the emotional labour of nursing requires students to learn about themselves, their emotional capabilities and how to recognise what is required to care for themselves individually and within their peer nursing group. Critical reflection of the historical and current educational environments can assist educators to recognise the strengths and limitations of those factors that contribute to a student developing emotional competence. This critical conscious raising between educators and nurses may contribute to development of emotional competence within the nursing profession as a whole.

There is a need for educators and students alike to have a clearer understanding of what emotional competency is in nursing and how these competencies can be realistically incorporated into the curriculum, learning and assessment opportunities. A model of transformative learning (Randle, 2001; McAlister, 2005a), which includes the development of personal and social competence, is a suggested recommendation arising from this study. Furthermore, clarification of the terminology used to describe emotional competence in nursing is essential. There is a need to link the description and a critical understanding of the relational and environmental complexities which affect the development and recognition of emotional competence, to the professional standards of practice (NCNZ, 2004).

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Appendix

- I** **Permission letter**
- II** **Information sheet**
- III** **Summary of literature**
- IV** **Focus group question framework**
- V** **Consent form**

Appendix I: Permission letter

Dean of Faculty

Date

Dear

My name is Stacey Wilson. I am a Registered Nurse and Lecturer in Nursing at the Universal College of Learning (UCOL) in Palmerston North. I am undertaking a Master of Philosophy in nursing at Massey University and researching the concept of emotional competence with Nurse Educators. The research project is titled: *A qualitative exploration of emotional competence and its relevance to nursing relationships*.

I would like your permission please, to advertise the research study with the undergraduate Nursing Faculty at [*name of institution*], by making available the enclosed advertisement to Nurse Educators who work within your team. I have also enclosed an information sheet, which outlines the intended study, and contact details.

I would appreciate your support to make available this information to colleagues working with nursing students in the undergraduate degree. If you would like to discuss this further or have any questions, please contact me on (06)9527000 (work) or (06)3548009 (home). My Supervisor is Professor Jenny Carryer, at Massey University – her contact phone number is 027- 4491302.

Thank you for your time and support.

Stacey Wilson
96 Florence Avenue
PALMERSTON NORTH

Appendix II: Information sheet

A qualitative exploration of emotional competence and its relevance to nursing relationships

INFORMATION SHEET

My name is Stacey Wilson. I am a current Master of Philosophy student at Massey University. I am employed as a Lecturer in the undergraduate-nursing program at the Universal College of Learning (UCOL) based in Palmerston North. My contact details are (06)9527000 (work) and (06)3548009 (home). My research supervisor is Professor Jenny Carryer; her contact telephone number is 027-4491302.

My research project will involve facilitating discussions with groups of nurse educators in an undergraduate nursing degree program. The focus groups will explore the aims of the project, generating discussion around the phenomena of emotional competence and the ability to assess this with nursing students. An invitation is extended to Nurse Educators working with students undertaking a Bachelor of Nursing degree. There will be no more than ten participants in each group.

When you have indicated your interest in participating in the project (either by phoning me directly or emailing me directly), I will explain further the projects procedure. The focus groups will take place at an agreed venue convenient to your workplace. There will be two focus groups, the first one taking approximately two hours. A further focus group will take place approximately three months later to discuss and feedback the themes generated in the data collection. It is anticipated that your commitment of time will be no longer than four hours including both focus groups.

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- Decline to answer any particular question*
- Withdraw from the study at any stage*
- Ask any questions about the study at any time during participation*
- Provide information on the understanding that your name will not be used at any time*
- Be given access to a summary of the project findings when it is concluded*
- Ask for the audio tape to be turned off at any time during the focus group*

If you are interested in participating in this project or have any questions regarding the information sheet or about the project, please contact me directly (06)3548009, S.Wilson@ucol.ac.nz or my supervisor Professor Jenny Carryer, phone 0274491302, J.B.Carryer@massey.ac.nz . I look forward to speaking with you.

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Application 04/159. If you have any concerns about the conduct of this research, please contact Professor Sylvia V Rumball, Chair, Massey University Campus Human Ethics Committee: Palmerston North, telephone 06 350 5249, email humanethicspni@massey.ac.nz.

Appendix III: Summary of Literature

A summary of literature on the theory of emotional competence.

The original writing and thinking about intelligence focused on an individual's performance in an IQ test. There are several types of intelligence referred to in the literature; abstract intelligence (concerned with verbal and mathematical skills), concrete intelligence (concerned with manipulation of objects) and social intelligence which is concerned with understanding self and others and relating to people (McQueen, 2004). It is this writing in reference to social intelligence that the concept of emotional competence is informed.

Thorndike (1920) first proposed that social intelligence was of value in human interactions and relationships and that it is discretely different from academic ability. In the early 1940's social researcher David Wechsler defined intelligence as "the aggregate or global capacity of the individual to deal effectively with their environment" (1940, p.444). He later referred to non-intellective elements, by which he meant affective, personal and social factors. He argued that testing of intelligence must be inclusive of these non-intellective factors in order to be a valid appraisal.

Howard Gardner (1983) proposed that the theory of 'multiple intelligence' 'intrapersonal' and 'interpersonal' intelligences is as important as the type of intelligence that was being traditionally measured by IQ testing. The concept of non-cognitive factors helping individuals to achieve both in their personal lives and their places of work are most evident within the literature from the 1990's onward. Emotional intelligence or emotional competences are interchangeable in the literature and the current work notes the contribution of this early research.

According to Hocshschild (1983) who introduced a concept called 'emotional labour', individuals require the ability to regulate their emotional reactions in relationships with others. She suggested that the ability to care for others may at times require the induction or suppression of feeling in order to sustain an outer appearance so that the person being cared for feels safe and worthy. She stated "emotional labour is the kind of labour that calls for co-ordination of mind and feeling, and sometimes draws on a source of self that we honor as deep and integral to our individuality" (Hocshschild, 1983, p.7). Furthermore, emotional labour is guided by 'feeling rules' and argues that emotional life is socially controlled. The rules are derived from social conventions, the reactions from others or from within the individual. The purpose of emotional labour is to promote in others a feeling of being cared for (Hocshschild, 1983).

Emotional competence is described by Heron (1990) as a required state that helping professionals must be in, in order to interact with clients so that they are in a position to facilitate personal understanding and growth within the

client. He uses a concept called 'unresolved personal distress' to describe the source of negative responses that helping professionals can take with them to helping relationships. A theme throughout Heron's writing suggests that many, if not all of us, experience situational or enduring trauma or difficulties that remain unresolved and that there is a universal phenomenon in society which indicates the need for education in emotional competence for children and adults (Heron, 1992). Heron developed levels of emotional competence and defined the competence criteria into three categories. These include criteria in everyday living; healing distress emotion and professional applications of emotional competence (Heron, 1990).

In 1990, two psychologists, Peter Salovey and John Mayer, first coined the term emotional intelligence (EI). Referring to EI as ability to recognise the meaning of emotions and their relationships, and to reason and solve problems on the basis of them (Salovey & Mayer, 1990). They concluded that EI consisted of three mental processes: appraising and expressing emotion in the self and others; regulating emotion in self and others; and using emotion in adaptive ways. They redefined these abilities in 1997 to include: perceiving/identifying emotions; integrating emotions into thought processes; understanding emotions; and managing emotions (Mayer & Salovey, 1997). An overall definition concluded that EI is "a form of social intelligence that involves the ability to monitor ones own and others feelings and emotions, to discriminate among them, and to use this information to guide ones thinking and action" (Salovey & Mayer, 1997, P.186).

Based on Salovey and Mayer's earlier work, Daniel Goleman published his first book 'Emotional Intelligence' (1996). According to Goleman, emotional intelligence is defined as "the capacity for recognising our own feelings and those of others, for motivating ourselves, and for managing emotions well in ourselves and our relationships" (1998, p.317). He suggests a person's character, personality and maturity influence their development of emotional intelligence and the potential for it to be developed. Although Goleman discusses IQ, leadership and job performance as themes in his writing for the purpose of this review the focus on his work is limited to the personal and social aspects of the EI theory. The five EI areas of relevance are: self awareness; self regulation; motivation; empathy and social skills (Goleman, 1998). Self awareness as a foundation includes: emotional awareness, accurate self assessment and self confidence. Self awareness is also a key factor in empathy. Goleman argues 'empathy represents the foundational skill for all the social competencies important for work (1998, p.137). Political awareness, understanding and developing others and services orientation make up the social competencies.

Goleman (1998) also suggests that to become or be seen as emotionally intelligent, competence is required in social skills. These social skills include communication; influence; leadership; conflict management; and being the catalyst for change. The EI guidelines in relation to social skills include: self control; trustworthiness; conscientiousness; adaptability and innovation.

According to Goleman it is important to have self regulation of these emotional competencies so an individual can handle impulses and distressing feelings.

Sharp refers to emotional competence but labels it as emotional literacy, “the ability to recognise, understand, handle and appropriately express emotion” (2001, p.1). The aims of emotional literacy according to Sharp are to build self esteem in individuals who then promote group literacy, leading to a robust and emotionally literate society (Sharp, 2001, p.3). Emotional literacy involves: recognising our emotions in order to label or define them; understanding our emotions in order to be effective learners; handling (managing) our emotions in order to develop positive relationships; expressing emotion so we can help ourselves become emotionally healthy – being then in a position to help others.

I have chosen not to include what opinion Nursing might have in the literature about emotional competence in this summary. It is suggested that the concept of emotional competence is a psychological one (Heron, 1990; Salovey & Mayer, 1997, Goleman, 1998). From a historical perspective, psychology traditionally focuses on intellectual competence in relation to outcomes, individual performance and organisational productivity. There is debate in the literature about the various labels used to describe what emotional competence is. I have chosen to refer to the concept as emotional competence in acknowledgement of the language used to describe capability within assessment frameworks, set out by the various educational institutes and that of the Nursing Council of New Zealand.

Appendix IV: Focus group question framework

Focus group questions

Overall question: What challenges are encountered by nurse educators who seek to assess aspects which could be related to emotional competence in nursing students?

1. Based on your understanding of what emotional competence is, what do you think are its key elements?
2. In what ways do you assess your own emotional competence?
3. What ways do you communicate or role model emotional competence personally?
4. What ways do you communicate or role model emotional competence as a nurse educator?
5. How do you currently assess emotional competence in nursing students?
6. In what ways does the competency framework (NCNZ, 2004) and other curriculum guidelines inform and guide you to when assessing emotional competence in nursing students?
7. What challenges, tensions, and difficulties do you encounter in relation to demonstrating, teaching or assessing emotional competence?

Appendix V: Participant consent form

[Print on Massey University departmental letterhead]
[Logo, name and address of Department/School/Institute/Section]

A qualitative exploration of emotional competence and its relevance to nursing relationships

PARTICIPANT CONSENT FORM

This consent form will be held for a period of five (5) years

I have read the Information Sheet and have had the details of the study explained to me.

My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being audio taped.

I agree to not disclose anything discussed in the Focus Group

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: _____ **Date:** _____

Full Name - printed _____

Signature: Stacey Wilson, Researcher	Date:
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