2018

Emotional Self-Management Experiences of Practical Nursing Students

Cindy Ko
Walden University

Walden University

College of Health Sciences

This is to certify that the doctoral dissertation by

Cindy Ko

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Kimberly Dixon-Lawson, Committee Chairperson, Health Services Faculty
Dr. Jacqueline Fraser, Committee Member, Health Services Faculty
Dr. Nazarene Tubman, University Reviewer, Health Services Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2018

Abstract

Emotional Self-Management Experiences of Practical Nursing Students

by

Cindy Ko

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Services

Walden University

August 2018

Abstract

In Ontario, Canada, practical nurses (PN) are educated through a 2-year diploma program. A review of PN program curricula in Ontario suggested that emotional intelligence (EI) and the core concept of emotional self-management are not specified in curriculum outcomes or courses. The study explored PN students' lived experiences with emotional self-management in the clinical settings where they are exposed to stress related situations using van Manen's orientation to hermeneutic phenomenology. The original four-branch ability model of EI by Mayer and Salovey was used as the theoretical framework to guide the explorative and interpretative processes of the study. Face-to-face interviews were conducted with a purposive convenience sample of 10 PN students at a southern Ontario community college in Canada. Van Manen's selective reading thematic analysis approach was used to analyze the data. Findings of this study suggested that the participants perceived themselves to have basic EI knowledge and are usually aware of their own and others' emotions, and indicated the notion of professionalism, ability to reflect, and empathy were meaningful in relation to EI. Participants expressed that their first knowing of EI provided them with more confidence and awareness and they would like to learn more about EI. An increased understanding of emotional self-management could enhance teaching and learning approaches, particularly with PN students who are exposed to high-stress clinical environments, thereby contributing to positive social change.

Emotional Self-Management Experiences of Practical Nursing Students

by

Cindy Ko

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Services

Walden University

August 2018

Dedication

I dedicate this achievement to my late maternal grandparents (Mr. and Mrs. K.Y. Fan) who were scholars in their own rights, and re-built their lives in British Hong Kong despite escaping from WWII and then the Chinese communists' government. Your hard work and determination taught me the significance of resilience, excellence, and legacy. To my parents, I am forever indebted to you for your sacrifice and love. To Pastor Wing and Alice Mak, Gord and Emma Mak, Pastor Paul and Vera Follett, Dr. Joyce Engel and Mr. Stan, Uncle Alex and Aunt Medeline, Uncle Flip and Auntie Margriet, Geraldine Parrera (my Jenny), Lily Yip, Heather King, and Angela Butt, without whom, there would be no Dr. Cindy Ko. To my dearly beloved husband, John Robert Rikkerink, you are my best friend and I am grateful for your sacrifice, love, and commitment to us. Grow old along with me, the best is yet to be, John Bear! Finally, I dedicate this dissertation to God, who was, is, and will always be there every second, and every step of my entire journey.

Acknowledgments

This dissertation has been a labor of thoughtfulness, efforts, evolution, and growth. Through discussions with my chair and committee member, I have learned infinitely more than the texts on these pages. This dissertation is not exclusively mine; rather, it belongs to a group of people to whom I am forever indebted:

My committee chairperson, Dr. Kimberly Dixon-Lawson, and committee member, Dr. Jacquie Fraser: Thank you both, for your expert counsel and guidance. I am eternally grateful. I shall never forget our serendipitous encounter during my first residency that brought us together, rather, led me to you ladies! XOXO

Dr. Nazarene Tubman: the University Research Reviewer; your feedback was instrumental for making the product of this dissertation a quality one.

Dr. Joyce Engel: my mentor and friend, you are my inspiration in phenomenology among many other things. Words cannot express my gratitude for your love, kindness, and support.

Dr. John D. Mayer: Thank you for graciously endorsing my reimagined figure of your four-branch emotional intelligence model and Penrose-Escher staircase representation, and even posting it on your website. Your support and Sunday email chats motivated me immensely.

Heather King: Thank you for your love, understanding, food, wine, executive assistant's editorial expertise, and friendship.

Dr. Carole Lynn Stewart: Thank you for your wordsmithing support at various stages of this study. God bless you for your patience!

Dr. Tim O'Connell: Thank you for your cheers and support through the years. Our numerous conversations motivated me immensely. Your book on reflective journaling was a lifesaver during the interpretation stage of my study.

My boss, Dean Ms. Carolyn Triemstra: Thank you for your tireless and ongoing support both professionally and academically.

My other boss-friend Mrs. Angela Butt: Thank you for always helping me to appreciate and consider different perspectives in humorous ways. I am so grateful for you in my life.

In addition, I am thankful to all my family, true friends, and professional colleagues. The list is endless! You know who you all are! I love you!

Table of Contents

List of Tables vii

List of Figures viii

Chapter 1: Introduction to the Study 1

Introduction 1

Background 2

Problem Statement 4

Purpose of the Study 6

Research Questions 6

Theoretical Framework – The Four-Branch Ability Model of EI 7

Nature of the Study 8

Operational Definitions of Terms 10

Assumptions, Limitations, and Delimitations 12

Assumptions 12

Limitations 12

Delimitations 13

Significance of the Study 14

Summary 16

Chapter 2: Literature Review 18

Introduction 18

Historical Perspectives on EI 20

The Four-Branch Ability Model as Theoretical Framework 22

Perception, Appraisal, and Expression of Emotion 24
Emotional Facilitation of Thinking 25
Understanding and Analyzing Emotions; Employing Emotional Knowledge 25
Reflective Regulation of Emotions to Promote Emotional and Intellectual Growth 26
Definition of EI 26
Penrose-Escher Staircase Representation of the Four-Branch Ability Model 29
Principles of the Four-Branch Ability Model 30
The Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT)–a Brief Explanation 31
EI and Students in the Healthcare Field 32
EI and Nursing Education 40
General Development of EI in Nursing Students 41
EI and Student Nurses' Academic and Clinical Performance 45
EI and Coping and Stress of Nursing Students 49
EI and Leadership Development in Nursing Students 60
Emotional Labor in Nursing Students 63
Implications for Research and Practice 67
Conclusion 70
Chapter 3: Research Method 72
Study Purpose 72

Research Questions 72
Research Methodology 73
Historical Overview& Rationale 73
My Role as the Researcher and Reflexivity 82
Recruitment of PN Participants 84
Ethical Considerations 85
Preliminary Pilot Study of the Interview Questions 86
Data Collection and Management 87
Data Analysis and Synthesis 88
Issues with Trustworthiness 94
Summary 96
Chapter 4: Results 98
Introduction 98
Pilot Study 99
Interviews 100
Setting Demographics 100
Participants' Profiles 101
Data Collection 102
Bracketing/Epoché and Reflexivity 104
Bracketing Epoché 104
Reflexivity 106
Data Analysis 107

Description of Specific Prominent Meaning Units and Themes 109
Evidence of Trustworthiness.....111
Credibility 111
Transferability..... 112
Dependability..... 113
Confirmability..... 113
Study Results 114
Themes..... 115
Lifeworld Existentials..... 126
Summarized Answers to the Research Questions.....134
Summary.....139
Chapter 5: Discussion, Conclusions, and Recommendations.....141
Introduction.....141
Key Findings.....143
Interpretation of Findings 144
Knowledge of EI and Personal Awareness of Emotions 145
The Perception of EI/Emotions in Self and Others..... 148
Personal Meanings of EI..... 152
The How Experience of Emotional Management in the Clinical Settings 154
The First Knowing and Perception of Self as a Nursing Student 155
Integration of Theoretical Framework.....158
Branch 1: Perception, Appraisal, and Expression of Emotion..... 159

Branch 2: Emotional Facilitation of Thinking 160
Branch 3: Understanding and Analyzing Emotions; Employing Emotional Knowledge 161
Branch 4: Reflective Regulation of Emotions to Promote Emotional and Intellectual Growth 161
Penrose-Escher Staircase Representation of the Four-Branch Ability Model 162
Limitations of the Study 165
Recommendations 166
Implications for Social Change 169
Organizational Level 169
Conclusion 171
References 173
Appendix A: Interview Protocol 199
Introduction 199
Audio Recorder Instructions 199
Procedure 199
Exit Procedure 200
Appendix B: Interview Questions 201
Appendix C: Recruitment Poster 203
Appendix D: Permission to Reprint the Four-Branch Ability Model 205
Appendix E: Excerpts of Journal and Bracketing Notes 207
Appendix F: Meanings and Themes Developing 210

Appendix G: Participants Lived Experiences 222

List of Tables

Table 1. Participants' Profile 102

Table 2. Themes and Meaning Units 110

List of Figures

Figure 1. The Four-Branch Ability Model.....23

Figure 2. Adaptation of the Four-Branch Model…….....24

Figure 3. The Four-Branch Model of emotional intelligence, with added areas of reasoning.....28

Figure 4. Penrose-Escher Staircase Representation of the Four-Branch Ability Model...29

Figure 5. Kaleidoscope representation of synthesized themes and lifeworld existentials 139

Chapter 1: Introduction to the Study

Introduction

In Ontario, Canada, practical nurses (PN) are educated through a 2-year diploma program (Ontario College, 2018). Self-management of emotions is a component of emotional intelligence (EI) and is recognized as the ability to elicit emotions to propel personal growth (Goleman, Boyatzis, & McKee, 2015; Mayer & Salovey, 1997; Mayer, Caruso, & Salovey, 2016). Researchers support that the ability to self-manage emotions is a key factor in students' coping effectiveness in stressful situations and overall emotional management (Conley, Durlak, & Kirsch, 2015; Görgens-Ekermans, Delport, & Du Preez, 2015; Ivcevic & Brackett, 2014; Stelnicki, Nordstokke, & Saklofske, 2015). This phenomenological study explored PN students' lived experiences with emotional self-management in the clinical settings where they are exposed to stress-related situations.

There is no existing literature found that specifically addresses EI and PN students in Ontario, Canada or in equivalent diploma nursing programs in Canada. Various international researchers suggested that nursing students at the university level are presented with implicit fragments of EI concepts in classrooms where leadership development or patient-centered care are discussed as they relate to interprofessional collaborations, healthcare outcomes, and patient satisfaction (Benson, Martin, Ploeg, & Wessel, 2012; Carragher & Gormley, 2017; Rankin, 2013; Shanta & Gargiulo, 2014). As a result, nursing students may learn about the definitions of emotional self-management as a theoretical EI concept; however, there is not a good understanding regarding their

ability to position or apply it as a powerful professional tool (Fitzpatrick, 2016; Ranjbar, 2015; Shanta & Gargiulo, 2014).

PN students are learning requisite skills to take care of others in the communities. EI is a vital self-care tool that they should also acquire in order to stay in control of their emotions, interact and empathize with others, cope with stress, and prevent burnout in the workplace (Aradilla-Herrero Tomás-Sábado & Gómez-Benito, 2014a; Aradilla-Herrero Tomás-Sábado, & Gómez-Benito, 2014b; Chan, Sit, Lau, 2014; Shanta & Gargiulo, 2014). Being able to self-manage emotions involves students understanding their own emotions in furtherance of sound decision making, professional behaviors, and has bearing on students' health, well-being, academic success, and ongoing life and professional journey (Faguy, 2012; Fitzpatrick, 2016). The implications to include EI with an emphasis on self-management of emotions in PN departments' curricula were examined.

Background

The nursing field lacks literature that specifically discusses emotional self-management as an exclusive concept. Researchers mainly measured EI as a whole with the recognition of emotional self-management as a vital subsumed element (Ball, 2013; Cheshire, Strickland, & Carter, 2015; Foster, McCloughen, Delgado, Kefalas, & Harkness, 2015). The exploration of available studies suggested that EI has been primarily linked to academic success for students in various health care disciplines and management of mental health concerns, such as burnout and stress (Grant, Kinman, &

Alexander, 2014; Uchino, 2015). Therefore, the existing gap of exploring emotional self-management as a standalone construct in the nursing field may warrant some attention.

In Ontario, Canada, there is a lack of studies that exclusively explore EI in the PN level, more specifically, the emotional self-management of PN students. I was only able to obtain two Canadian studies about EI and nursing students with respect to leadership and reducing bullying in the workplace (see Bennett & Sawatzky, 2013; Benson et al., 2012). Thus, the exploration of PN students' lived experience with emotional self-management has not occurred.

Codier and Odell (2014) discussed the issues of mental health, stress, and coping skills of nursing students as they impact their quantitative academic achievement. The authors recognized EI training as a valuable intervention strategy to alleviate anxiety and stress for students (Codier & Odell, 2014). Although Codier and Odell did not explicitly mention emotional management in their article, there was a strong implication of it in terms of how students coped or managed with stress. Similarly, Aradilla-Herrero et al. (2014a; 2014b), Aradilla-Herrero, Sábado, and Gómez-Benito (2013), and Rankin (2013) offered an overall insight into nursing students' perceived EI as a whole, their coping skills, suicide risks, attitude toward caring for patients, and their notion of death. Likewise, Benson et al. (2012) measured EI and nursing students' leadership and caring abilities, and Chan et al. (2014) examined EI and conflict management style of nursing students. These authors did not discuss emotional self-management independently, but implicitly embedded it into their studies, and explored how EI may influence coping skills relating to various aspects of nursing work.

Beauvais, Stewart, DeNisco, and Beauvais (2014), Cheshire et al. (2015), Fernandez, Salamonson, and Griffiths (2012), and Jones-Schenk and Harper (2014) considered EI as a whole and its impact on nursing students' academic success in terms of grade point average (GPA). Correspondingly, Rice (2015) quantitatively used EI to predict nursing students' success in clinical performance. Chun and Park (2016), Jack and Wibberley (2014), Msiska, Smith, and Fawcett (2014), and Oner-Altiok and Ustun (2013) are the only authors I found who qualitatively reviewed nursing students' emotional experience in the clinical settings. Msiska et al. made a token use of the term emotional management, but did not specially link it to EI. A more detailed discussion of the research literature that supports these findings and identifies the gap and the need for my study is presented in Chapter 2.

Problem Statement

I did an online review of PN program curricula in Ontario, Canada, and spoke to associate deans from two of the largest PN programs in Ontario. Dr. De Luca is one of the board of directors and the Ontario representative for the Canadian Association of Schools of Nursing (CASN). She is also the associate dean of the School of Nursing at Fanshawe College, Ontario, which is affiliated with the Arthur Labatt Family School of Nursing, University of Western Ontario, Canada. These sources confirmed that EI and the core concept of emotional self-management are not specified in curriculum outcomes or courses (A. Butt, personal communication, November 11, 2016; S. De Luca, personal communication, June 6, 2017). This further indicates that neither EI as a whole, nor emotional self-management as a particular concept in EI, are explicitly taught in any PN

programs in Ontario. This is a problem because most PN students in Ontario, Canada are placed in the clinical environments after approximately four months in the classroom. The students are assigned to preceptors; however, most colleges are experiencing a shortage of preceptors. From my personal communication with the associate deans, I learned that on average, there are 10 students to one preceptor and students find it stressful with such sparse support. This is especially a concern when students are dispatched to different units and the preceptor has to travel to various areas within a large hospital during a shift in order to provide clinical guidance (A. Butt, personal communication, November 11, 2016; S. De Luca, personal communication, June 6, 2017).

There is a direct relationship between EI and clinical performance in terms of coping with stressful situations such as handling challenging clinical cases and conflict resolutions (Aradilla-Herrero et al., 2013, 2014a, 2014b; Chan et al., 2014; Rice, 2015). However, it is currently not understood how PN students make sense of emotional self-management in the clinical settings. In this study, I explored whether PN students' lived experiences with emotional self-management may make a difference in their performance in the clinical settings. The review of the literature presented in Chapter 2 served to demonstrate that, despite research about what comprises EI and researchers' advocacy to include it in curricula, it is not yet understood how students position and make sense of it in their clinical learning environments. In addition, the lack of research explicitly addressing emotional self-management may warrant examining it as a separate construct, especially when emotional self-management is recognized as the precursor EI component

that produces the other elements, such as the ability to perceive emotions, the facilitation of thinking, and understanding emotions (Goleman et al., 2015; Mayer & Salovey, 1997; Mayer et al., 2016).

Purpose of the Study

The purpose of this study was to explore PN students' lived experiences with emotional self-management in the clinical settings where they are exposed to stress related situations. The ability to self-manage emotions may serve as a major psychological asset in the students' repertoire for sustainable academic, professional and personal achievements, and mental well-being (Benson et al., 2012; Faguy, 2012; Fitzpatrick, 2016; Ranjbar, 2015; Rankin, 2013; Shanta & Gargiulo, 2014). There appears to be a gap with respect to understanding PN students' positioning and embracing of emotional self-management. In order to address the gap of gaining understanding on PN students' self-management of emotions, I conducted an interpretive qualitative study; the specific approach was phenomenology. In-depth, face-to-face interviews with PN students were used. The following research questions were formulated to achieve the goals of this study.

Research Questions

1. What are PN students' experiences of emotional management in the clinical settings?
2. How do PN students in the clinical settings experience the management of their emotions?

3. How does emotional self-management affect PN students' learning experience in the clinical settings?

The data gathered from the interview questions was analyzed from which themes emerged. These themes described the essence of participants' experiences. Data analysis is further described in Chapter 3.

Theoretical Framework – The Four-Branch Ability Model of EI

The original four-branch ability model of emotional intelligence by Mayer and Salovey (1997) was used as the theoretical framework for this study. The authors, with colleague Caruso, updated the model in 2016 to add areas of reasoning (Mayer et al., 2016). The authors stipulated that the ability to perceive emotions, integrate emotion to facilitate thinking, understand, and manage emotions to promote personal growth are paramount to professional achievements and mental health and well-being (Mayer et al., 2016). In addition, the appropriate use of emotions is vital and enables people to decipher and navigate their social environments (Mayer et al., 2016).

The four-branches of EI ability are (a) perception, appraisal, and expression of emotion, (b) emotional facilitation of thinking, (c) understanding and analyzing emotions, employing emotional knowledge, and (d) reflective regulation of emotions to promote emotional and intellectual growth (Mayer & Salovey, 1997). The ability to perceive emotions is being able to identify emotions in oneself and others. The ability to facilitate thinking is the ability to prioritize and direct emotions to judge feelings in varying situations. The ability to understand emotions is being able to interpret the meanings of

emotions in the self and others. Management of emotions is the ability to regulate emotions reflectively (Mayer et al., 2016).

The four-branch ability model of EI encompasses emotional self-management as a central component (Mayer & Salovey, 1997); therefore, it provided a background for me to define emotional self-management in the study. The constructs in the model helped me design some of the interview questions for the participants. Furthermore, the four-branch ability model provided a source by which I could interpret the findings without dictating the interpretations. In Chapter 2, I further explained the four-branch ability model and its relevance to my study.

Nature of the Study

Phenomenology was used as the research method for this study. The entire premise of phenomenology is that reality consists of entities and events (phenomena) as they are perceived, experienced, and understood in the human consciousness (Heidegger, 1927/2010; Husserl, 1913/1983; van Manen, 1997, 2014). Traditional and contemporary phenomenologists have integrated the old and the new in the phenomenological pool to understand the lived human experience and seek to understand the "what does it mean to be", or what is it like to be experience (van Manen, 1997, p.42). In this study, I used a combination of descriptive (Husserl) and interpretive (Heidegger and van Manen) phenomenology in order to capture the essence of the lived experience of the PN students' emotional self-management. Moreover, hermeneutics was an integral part of the phenomenological process because it focuses on texts and meanings; hence, it allowed me to explore the students' lived experience by their telling, told, and re-telling

(van Manen, 1997, 2014). Chapter 3 provides a more detailed account of the integration of EI and the use of a phenomenological approach in this study.

Van Manen's (1990) selective reading thematic analysis approach was used to interpret and analyze the data in my study. Phenomenology requires the researcher to attempt to understand the meanings of the participants' experiences (van Manen, 1997). Thematic analysis entails the researcher organizing the themes to glean meanings because the themes are the "structure of the lived meaning" and the participants' "structures of experience" (van Manen, 1997, p. 79). In this study, I did not use software NVivo Pro 11 for coding. A detailed explanation of this is in the methodology section in Chapter 3. I used NVivo Pro 11 to assist in the development and organization of the themes from the transcripts of the participants' interviews to gain understanding of their lived experience of emotional self-management.

Van Manen's (1997) lifeworld existentials were utilized. Van Manen described the everyday human experiences and relational situations as the "human lifeworld" (p. 101). Recognizing that there are distinctive human existences and experiences, van Manen asserted four fundamental existential themes that permeate the lifeworlds of all human beings, and emphasized them to guide the phenomenological research process. They are "lived space (spatiality), lived body (corporeality), lived time (temporality), and lived human relation (relationality or communality)" (van Manen, 1997, p. 101). These existentials were relevant to my analysis because I was collecting data to gain understanding of the participants' lived experience with emotional self-management in their clinical settings (lived space) as they physically experienced it whether

unconsciously or intentionally (lived body). In addition, the subjective lived time during the students' clinical practice and their interactions with patients, colleagues and other healthcare professionals (relationality or communality) were considered. Therefore, to understand the PN students' lived experience with emotional self-management was to explore into their lived world. In Chapter 3, I provide a detailed explanation of how I applied van Manen's (1997) data analysis approach for my study.

Operational Definitions of Terms

The following is a list of study terms along with their definitions:

Befindlichkeit (attunement): The way one finds oneself in the world (Heidegger, 1927/2010; van Manen, 2014). Heidegger (1927/2010) defined it as people's understanding are always attuned to the affective states.

Being: The "whatness" of the existing subjective and objective reality, or presence (Heidegger, 1927/2010). Human beings' quest to seek for the meanings of being or existence (Heidegger, 1927/2010).

Bracketing: The act of suspending one's judgements, experiences, or realities in order to understand others' experiences or realities (van Manen, 1997; 2014).

Dasein: Being present or aware (Heidegger, 1927/2010).

Epochè: The suspending of the moment(s) or experience(s) that people lived in order to reflect on them (van Manen, 2014).

Hot intelligence: The ability to decipher information that is significance to the self (Mayer et al., 2016). For example, hot intelligence allows individuals to feel proud when sensing that they are being socially accepted.

Intentionality: The fundamental framework of an experience as people's intention directs the experience toward something by virtue of its meaning (Husserl, 1931/2012). To identify intentionality is to describe how people perceive and imagine experiences, the relationship between perceptions, judgements, and evaluation of the experience, as well as the intention to act and the intended goal (Husserl, 1931/2012). The content of the experience is directed by the intentionality (Husserl, 1931/2012).

Interpretation: From the hermeneutic phenomenological perspective, to interpret does not mean the researchers will hear the participants' words and then make their own interpretations (van Manen, 1997). Rather, it is a possibility for understanding; that is, "to interpret a text is to come to understand the possibilities of being revealed by the text... to look for the metaphor that may be seen to govern the text" (van Manen, 1997, p.180).

Intersubjectivity: The shared objectivity that each individual experience is available to others (Heidegger, 1927/2010). All human beings need others' perspectives to validate their own (van Manen, 1997).

Noema: The whatness of being, or the object of the experience (Heidegger, 1927/2010; van Manen, 1997).

Noesis: The interpretive act of human beings attunement of the way they find themselves (Heidegger, 1927/2010; van Manen, 1997).

Patho: To evoke something in people. The something that is being drawn out by whatever it is people are experiencing (van Manen, 2014).

Pathtic understanding: The way that reflective practice generates insights that are situated, relational, embodied, and enactive to the human experiences (van Manen, 2014).

Sinn des seins: The sense of being, being with regard to, to illustrate when an experience becomes intelligible (Heidegger, 1927/2010).

Assumptions, Limitations, and Delimitations

Assumptions

Phenomenology emphasizes a focus on individuals' lived or subjective experiences and interpretations of the world (van Manen, 1997, 2014). I sought to understand how the concepts of EI appeared to the PN students and to understand their lived experiences. This led to the following assumptions for the current research project:

- The participants have little to no knowledge of EI;
- The participants would recognize the term EI, but would not fully understand its meanings or application;
- The participants would answer the interview questions honestly.

Limitations

There was a possibility that the interview questions were answered based on what the participants felt was the best answer and not necessarily an honest answer or one that was representative of their true experiences. Participants needed to be interested in EI concepts and articulate, which might have been a problem if they had difficulties expressing themselves due to various reasons, such as age, comfort level with interviewer, and command in English.

In addition, this was a qualitative study using phenomenology; there are many phenomenological traditions and they are continuously evolving (van Manen, 1997, 2014). The original Husserlian/Heideggerian texts were written in German and certain meanings of words may have been lost in translations. Some researchers also argued that the subjectivity of the data in phenomenology leads to difficulties in establishing reliability and validity of the research findings (Creswell, 2013, Denzin, & Lincoln, 2005, Hycner, 1985, Moustakas, 1994). Furthermore, it might be difficult to prevent researcher-induced bias using phenomenology as a research method, which might have led to a skewed objectivity in the interpretation of the data. Moreover, the sample size was small; thus, it might be difficult to conclude that the experiences were typical. Chapter 3 offers a more detailed discussion on quality checks, limitations, and addressing bias.

Delimitations

The inclusion criteria were PN students from a community college in southern Ontario, Canada. Students who I teach and will teach were excluded. In addition, students who have not been exposed to the clinical setting were excluded. I selected hermeneutic phenomenology as my method because I wanted to limit my study to finding out the lived experiences of the participants. To the best of my knowledge, there was no existing phenomenological study concerning EI and nursing students. I decided against using grounded theory or case study as my method because I was not interested in generating a theory or hypothesis to understand the processes in which the PN students experience emotional management in the clinical settings. Rather, I wanted to explore

how the PN students make meanings from their emotional management experiences. Therefore, phenomenology was appropriate because it is purely explorative in areas where there is little knowledge of individuals' subjective experience.

I only used interviews or research conversations for data collection (see van Manen, 1997). Other researchers suggested the use of participants' journaling, and alternative expressions, such as drawings, music, or poetry (Edward & Welch, 2011). I believed interview was the most appropriate because I was able to limit the duration of the conversation, as well as redirect the discussion had it gone off track. In addition, any of the alternative expressions would have created bias for interpretation that was beyond the parameter of the definition of data interpretation in phenomenological research.

Significance of the Study

My study was significant because I focused specifically on how PN students gained meanings from their emotional self-management. I explored the significance of students' emotional self-management ability from a lived perspective and its impact in the stressful clinical settings. Self-awareness in emotional self-management is the most important element of EI because without it, the development of the other components may not follow as readily (Goleman et al., 2015). I collected data that may provide insights to address a gap about what emotional management is as an integral component of EI, and how students make sense of it when they acquire lived meanings to the concept. My study was unique because I aimed to illuminate an under researched area of higher education that does not focus on academic scores. I presented the original contribution of the noncognitive or lived experience of an essential component of EI (van

Manen, 1997, 2014). The findings of my study have the potential to support how PN students call emotional management "into being" (van Manen, 2014, p. 51) from abstract (cognitive understanding) to concrete noncognitive meanings that could provide a personal knowing for them and propel their professional growth. If the findings of my study support that understanding the lived experiences of emotional self-management could positively impact PN students' clinical performance, this gap in the curriculum is significant and has implications for the education of practical nurses.

The purpose of positive social change is to improve human and social conditions (Walden University, n.d.). The findings of my study might increase understanding of emotional self-management and could be used to enhance teaching and learning approaches, particularly with PN students who are exposed to high stress clinical environments. In addition, the inherently demanding and stressful environment in the healthcare workplace can result in conflict and negative patient outcomes (Nowrouzi et al., 2015; Thistlethwaite & Jackson, 2016). Therefore, the findings of my study might serve to bring into light PN students' perceptions and lived experiences of emotional self-management with respect to functioning in stressful environments. If educators and researchers were able to understand how PN students position and make sense of emotional self-management, it might be possible to increase the positive outcomes of their EI in general, enhance their overall learning experience, and improve their preparation into the workforce.

Summary

In Ontario, Canada, PN are educated through a 2 year diploma programs. In this phenomenological study, I explored PN students' lived experiences with emotional self-management in the clinical settings where they were exposed to stress-related situations. There is a lack of literature that specifically addresses EI and nursing students. Globally, numerous researchers indicated that nursing students at the university level are presented with inherent fragments of EI concepts (Balls, 2013; Cheshire et al. 2015; Foster, 2015). Consequently, nursing students may learn about the definitions of emotional self-management as a theoretical EI concept; however, it is not fully understood whether they learn how to position or apply it as a powerful professional tool (Fitzpatrick, 2016; Ranjbar, 2015; Shanta & Gargiulo, 2014). Being able to self-manage emotions necessitates students understanding their own emotions in order to make essential practice decisions, exhibit professional behaviors, and has significant impact on students' well-being, academic success, and ongoing life and professional endeavor (Faguy, 2012; Fitzpatrick, 2016). Hence, it is important to know how PN students situate themselves in their experience with EI.

This chapter offered a brief overview of the background and need for this study by presenting key points on the topic. The study problem and purpose, research questions, theoretical framework, nature of the study with its scope and limitations, and the significance of this study were provided. Chapter 2 offers historical and current literature on the subject along with a detailed description of the theoretical framework. Chapter 3 defines the methodology and data collection, and explains the data analysis.

Chapter 4 describes the study results, and Chapter 5 summarizes the interpretation and application of the findings, the implications for social change, recommendations on the utilization of the findings, and implications for future research.

Chapter 2: Literature Review

Introduction

There was a lack of literature in the nursing field that specifically discussed emotional self-management as an exclusive concept. Researchers in the selected studies evaluated EI as an eclectic whole with the concession of emotional self-management as a fundamental amalgamated component. The exploration of available studies suggested that EI had been primarily linked to academic success for students in various health care disciplines and the management of mental health concerns such as burnout and stress. There was an absence of research in which the singular concept of emotional self-management among nursing students at the university or the college level was explored.

In this review, I included literature from peer-reviewed journals and books on the importance of EI. Authors who addressed the various definitions and interpretations of EI, the application of EI at the postsecondary education level, the overall significance of incorporating EI in personal and work life, the relevance of EI in the healthcare workplace with respect to interprofessional practice, and EI pertaining to nursing students were reviewed. Seminal works by researchers who offered historical perspectives were also included to support the literature review.

An electronic search of Walden University Library, The University Toronto Alumni Library, The Brock University Library, and Google Scholar provided published literature germane to the subject matter of EI. These systems granted access to the following electronic search engines: The Cumulative Index to Nursing and Allied Health Literature (CINAHL), Cochrane Database, Journal of the American Medical Association

(JAMA), MEDLINE, Nursing & Allied Health, Ovid Nursing Journals, ProQuest, PsycINFO, and PubMed. Each search used the key words *emotional intelli*gence combined with one of the following terms: *postsecondary education, postsecondary/university/college students, nursing students, practical nursing students, practical license nursing students, licensed vocational nurse, diploma nursing program, healthcare, health care workplace, emotional regulation, emotional management, emotional skills, emotional competency, lived experiences, phenomenological research/studies,* and *qualitative research*.

The inclusion criteria for the searches were English, peer-reviewed, scholarly journals with publication dates between 2012 and 2016. The inclusion of seminal work prior to 2012 provided exemplars of EI concepts to corroborate the literature review. The key words used were not limited to authors, abstracts, or citations; therefore, articles in which the key words were present within the manuscript were included. The initial literature search resulted in 356 research articles that met the search criteria. From this preliminary list, I excluded articles that did not consider EI in the healthcare or nursing field. However, I reviewed articles that addressed EI in the postsecondary education system in general to gain insights, and their references led to other articles with a nursing education focus. In addition, I reviewed the reference lists of all the eligible articles and obtained more articles that were relevant. I repeated this process of reviewing the reference lists until I reached saturation. As a result, I included 36 nursing articles in this review, two of which were published in January 2017. None of the 36 articles discussed emotional self-management as a stand-alone construct.

I commenced this review with a brief discussion of the historical perspectives on EI followed with a discussion of the Mayer and Salovey (1997) and Mayer et al. (2016) four-branch ability model as the theoretical framework. Because of a lack of articles in the healthcare field that address emotional self-management as a stand-alone construct, I began by discussing studies in the healthcare field that linked EI with academic success, the compassionate elements, and emotional self-management indirectly. Then I presented nursing studies that explored the broad influence of EI in nursing students' academic performance, clinical success, and other caring factors, such as coping skills, stress management, and interprofessional relationships. I concluded this review with implications for research and practice.

Historical Perspectives on EI

Thorndike (1920) inaugurated the publications of EI in the 20th century, described, defined, and assessed social intelligence and socially competent behaviors. Since the time of Thorndike, various scholars contemplated different approaches to understanding emotional and social intelligence. It is generally accepted in the field of psychology that Beldoch (1964) first wrote about EI with respect to emotional meanings in communication. Subsequently, EI emerged considerably in the arena of psychology approximately three decades ago and continues to gain recognition in the social sciences and academic communities (Salovey & Mayer, 1990, Mayer & Salovey, 1997, Goleman, 1995, 1998).

Seminal theoretical work by Salovey and Mayer (1990) and Mayer and Salovey (1997) formally defined EI, and prominent books by Goleman (1995, 1998) led to the

voluminous studies that elucidated the function of EI. These experts designated EI as the ability to recognize emotions in oneself and others, understand how emotions emanate, mature, evolve, and employ EI to improve thinking and behaviors (Goleman, 1995, 1998; Mayer & Salovey, 1997; Salovey & Mayer, 1990). EI researchers investigated whether an established assemblage of abilities regarding emotions and emotional data would assist in enhancing the understanding of the outcomes of human behaviors and performance, such as job performance, academic achievement, and leadership effectiveness (Mayer & Salovey, 1997; Mayer, Salovey, & Caruso, 2004; Salovey & Mayer, 1990). The researchers concluded that there is a positive relationship between EI and academic achievement, leadership skills, social outcomes, psychological and physical well-being, and performances (Mayer & Salovey, 1997; Mayer et al., 2004; Mayer, Roberts, & Barsade, 2008).

Traditionally, there are four models of EI. The first is the original ability model that focuses on the ability to process emotional information and use it to navigate the social environment (Mayer & Salovey, 1997; Salovey & Mayer, 1990). The second is the trait model, which measures an individual's behavioral traits and self-perceived abilities (Petrides, 2001). The trait model focuses on individuals' personality or behavioral dispositions and their emotional self-efficacy; thus, it leans toward suggesting that EI is a personality trait (Petrides, 2001). The third is the Bar-On Model (2003), which emphasizes on the personal and social expression of emotions, the outcomes of behaviors that result from the emotions, and the effective adaptation of EI behaviors. According to Bar-On, emotionally and socially intelligent people are able to manage,

adapt, and change in order to solve personal and interpersonal problems; therefore, these individuals are able to understand and express themselves, get along well with others, and cope with daily demands and stresses. The fourth is a mixed model of both the ability and trait EI models, which emphasizes the influences of self-awareness, self-regulation, and empathy in people's cognitive abilities in workplace effectiveness, leadership development, overall physical and mental health, and relationships (Goleman, 2015). The authors of all four models agreed that EI addresses the emotional, personal, and social dimensions of intelligence, which are arguably more important for every day functioning than the traditional standard pre-eminence of cognitive intelligence.

The Four-Branch Ability Model as Theoretical Framework

As Figure 1 shows, arranging on a vertical continuum from basic (bottom row) to complex (top row), the four branches of the ability model are (a) perception, appraisal, and expression of emotion, (b) emotional facilitation of thinking, (c) understanding and analyzing emotions; employing emotional knowledge, and (d) reflective regulation of emotions to promote emotional and intellectual growth (Mayer & Salovey, 1997). Each rung is a branch, the bottom rung is Branch 1. At each branch, there is a horizontal continuum from left to right where an individual may progress across prior to moving up onto the next branch. At the far left of Branch 1 is the most basic EI ability to identify emotions, feelings, and thoughts in the self, but not in others. At the far right of Branch 1 is the ability to identify emotions in others before proceeding up to Branch 2 and so on (Mayer & Salovey, 1997).

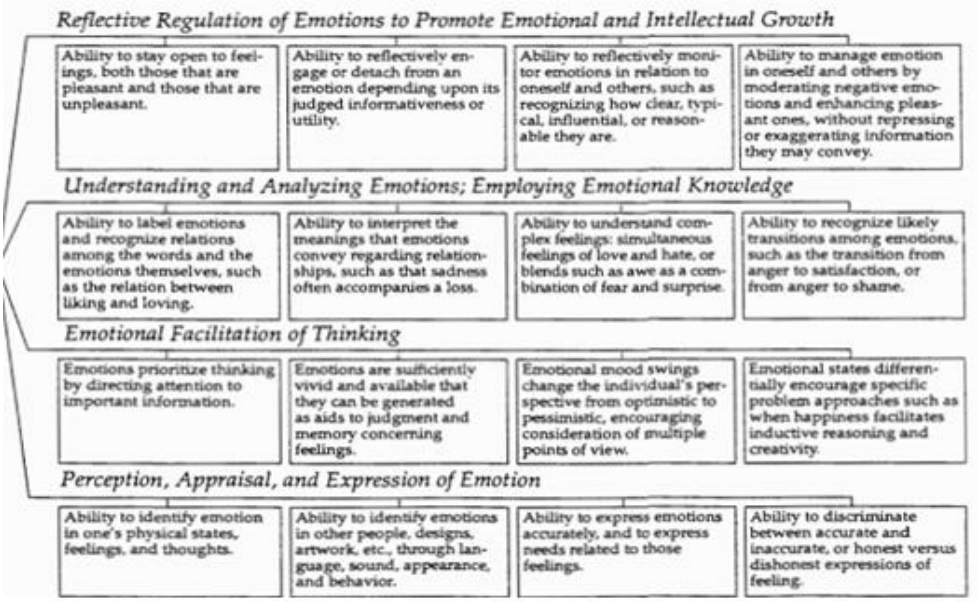


Figure 1. The Four-Branch Ability Model. Reprinted from What Is Emotional Intelligence? (p.11), by J. D. Mayer & P. Salovey, 1997, New York, NY: Harper Collins. Copyright 1997 by Harper Collins. Reprinted with permission.

Figure 2 is an adapted or reimagined representation of the four-branch ability model that displays the flow from one step to the next with no change to the textual information of the original Mayer et al. (1997) model. The arrows illustrate where one may begin and proceed from start to finish. Theoretically, it is a linear progression of EI growth and development one step and one branch at a time. This adapted representation is endorsed by Mayer (2017) and posted on his website (personal communication, October 19, 2017).

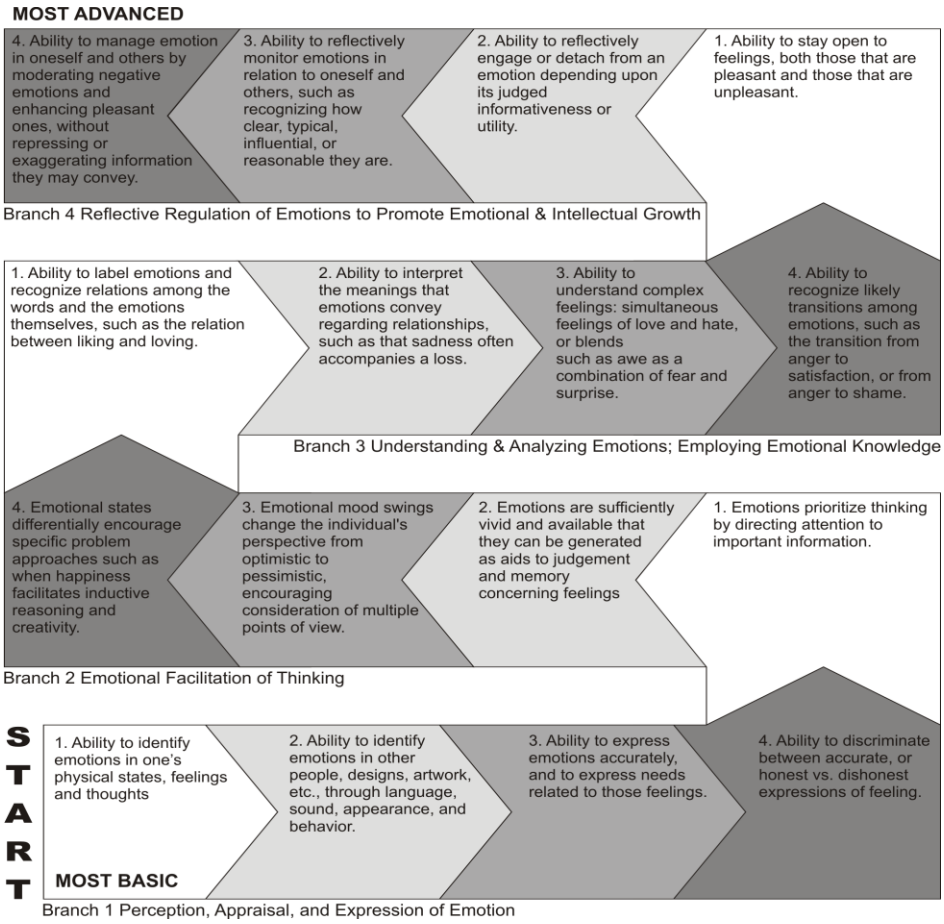


Figure 2. Adaptation of the four-branch ability model, by Cindy Ko.

Perception, Appraisal, and Expression of Emotion

The ability to perceive emotions is being able to identify and appraise emotions in oneself and others (Mayer & Salovey, 1997). It includes the ability to articulate emotions appropriately, honestly, and accurately in order to convey emotional needs. At the lowest level, first branch, individuals may be able to perceive their own emotions, but are unable to identify emotions in others, or express their emotions accurately. As one's EI develops, the ability to perceive, assess, and express emotions in oneself and others would become more precise. In addition, one is able to perceive emotions that are

contextual to the environment and culture (Mayer & Salovey, 1997). Thus, to perceive emotions requires the ability to appraise and express emotions appropriately.

Emotional Facilitation of Thinking

The facilitation of thoughts requires one to prioritize and direct emotions to judge feelings in varying situations (Mayer & Salovey, 1997). This includes the self-awareness of one's moods and understanding that frame of mind may influence thinking and perspectives. A person with more developed EI at this second branch is able to use emotions to facilitate problem solving, generate creativity with more ease, and demonstrate empathy (Mayer & Salovey, 1997). Therefore, emotional facilitation of thinking requires a certain level of self-awareness in order to gauge one's own feelings and direct subsequent actions.

Understanding and Analyzing Emotions; Employing Emotional Knowledge

The ability to interpret the meanings of emotions in the self and others is key to the third branch (Mayer & Salovey, 1997). The sophistication at this level is the capacity to analyze emotions and employ the knowledge to understand complex emotions that are often simultaneous, mixed, or transitional, such as love and frustration, sadness and relief, and anger and shame. At this branch, an individual also understands the difference between moods and emotions and is able to forecast future emotions in different circumstances and evaluate situations that plausibly educe emotions. Additionally, the advanced ability to understand emotions permits an individual to detect cultural differences in the assessment of emotions. Therefore, this branch is essential in

relationship building and emotional self-growth because it requires one to use emotional knowledge to understand and analyze emotions (Mayer & Salovey, 1997).

Reflective Regulation of Emotions to Promote Emotional and Intellectual Growth

This is the fourth and highest branch; an individual at this level possesses the ability of all four branches. At this stage, one is open-minded to emotions and is able to regulate emotions reflectively in the self by engaging or detaching from any emotion after judging a situation (Mayer & Salovey,1997). In addition, one is able to monitor emotions and recognize how emotions influence the self and others. Ultimately, one is able to manage emotions in oneself and others by assuaging antagonistic emotions and amplifying cordial ones diplomatically without inhibiting or overstating the message the emotions attempt to communicate (Mayer & Salovey,1997).

Definition of EI

The momentum that propels the popularity of EI spurred various researchers to offer different definitions, conceptualizations, and operationalizations that derived from the influential works of Goleman (1995, 1998, 2015), Mayer and Salovey (1997), and Mayer et al. (2016). For the purpose of clarity, I used the original definition and the four-branch ability model of EI by Mayer and Salovey:

> Emotional intelligence involves the ability to perceive accurately, appraise, and express emotion; the ability to access and/or generate feelings when they facilitate thoughts; the ability to understand emotion and emotional knowledge; and the ability to regulate emotions to promote emotional and intellectual growth. (p. 10)

The original definition and the four-branch ability model of EI by Mayer and Salovey provided guidance for me to analyze and interpret my findings.

Mayer and Salovey (1997) with colleague Caruso, updated the original the four-branch ability model in 2016 to add areas of reasoning (Mayer et al., 2016). In the updated model (Figure 3), Mayer et al. emphasized the importance of people's mental ability to reason about emotions. An individual may exhibit high intelligence in aptitude and domain specific knowledge such as quantum physics, but intelligent analytical skills do not automatically coincide with intelligent behaviors (Mayer et al., 2016). Mayer et al. stand by the original 1997 definition of EI and offered a succinct description of the long form definition as "the ability to reason validly with emotions and with emotion-related information, and to use emotions to enhance thought" (p. 296). In essence, Mayer et al. suggested that it is important to cultivate EI because EI will inevitably enhance other areas of learning and intellectual growth.

The Four Branches	Types of Reasoning
4. Managing emotions	• Effectively manage others' emotions to achieve a desired outcome[b] • Effectively manage one's own emotions to achieve a desired outcome[b] • Evaluate strategies to maintain, reduce, or intensify an emotional response[b] • Monitor emotional reactions to determine their reasonableness • Engage with emotions if they are helpful; disengage if not • Stay open to pleasant and unpleasant feelings, as needed, and to the information they convey
3. Understanding emotions	• Recognize cultural differences in the evaluation of emotions[c] • Understand how a person might feel in the future or under certain conditions (affective forecasting)[c] • Recognize likely transitions among emotions such as from anger to satisfaction • Understand complex and mixed emotions • Differentiate between moods and emotions[c] • Appraise the situations that are likely to elicit emotions[c] • Determine the antecedents, meanings, and consequences of emotions • Label emotions and recognize relations among them
2. Facilitating thought using emotion[d]	• Select problems based on how one's ongoing emotional state might facilitate cognition • Leverage mood swings to generate different cognitive perspectives • Prioritize thinking by directing attention according to present feeling • Generate emotions as a means to relate to experiences of another person[c] • Generate emotions as an aid to judgment and memory
1. Perceiving emotion	• Identify deceptive or dishonest emotional expressions[b] • Discriminate accurate vs. inaccurate emotional expressions[b] • Understand how emotions are displayed depending on context and culture[c] • Express emotions accurately when desired • Perceive emotional content in the environment, visual arts, and music[b] • Perceive emotions in other people through their vocal cues, facial expression, language, and behavior[b] • Identify emotions in one's own physical states, feelings, and thoughts

Note. [a]The bullet-points are based on Mayer and Salovey (1997) except as indicated in superscripts b and c. Within a row, the bulleted items are ordered approximately from simplest to most complex, bottom to top. The four-branch model depicts the problem-solving areas of emotional intelligence and is not intended to correspond to the factor structure of the area.
[b]An ability from the original model was divided into two or more separate abilities.
[c]A new ability was added.
[d]Note that the Branch 2 abilities can be further divided into the areas of *generating emotions to facilitate thought* (the bottom two bulleted items) and *tailoring thinking to emotion* (the top three bulleted items).

Figure 3. The four-branch model of emotional intelligence, with added areas of reasoning. Reprinted from "The ability model of emotional intelligence: Principles and updates" by J. D. Mayer, D. R. Caruso, and P. Salovey, 2016, *Emotion Review*, *8*(4), p. 295. Copyright 2016 by Emotional Review.

The four-branch ability model is relevant and widely used today. The premise of the model is that emotions can impel people to think more intelligently and understand more astutely about emotions. It concisely links intelligence with emotions and indicates that the ability to perceive, access, generate, understand, and manage emotions can assist in cultivating emotional and cognitive development (Mayer & Salovey, 1997; Mayer et al., 2016). The purpose of emotional reasoning is to attain optimal frame of mind in

oneself and others by using cognitive processing that activates emotions and information (Mayer et al., 2016).

Penrose-Escher Staircase Representation of the Four-Branch Ability Model

It is noteworthy to highlight that the management of emotions is the most advanced level of EI and it begins with the management of emotions in the self (Mayer et al., 2016). Emotional self-management is the antecedent to the other EI components. Self-awareness is the first step in order to achieve the optimum level of emotional management. The ultimate goal would be to stay as close to the top branch for as much time as possible. However, the development of EI is not linear, nor is it exactly circular because varying factors and life events may influence people's EI daily, or even from moment to moment resulting in a fluctuation of their EI abilities. Therefore, I believe that my adapted design of the Penrose-Escher Staircase (Figure 4), endorsed by Dr. Mayer represents the four-branch ability model in a more realistic or practical manner (personal communication, March, 6, 2017). The Penrose Staircase (1958) illustrated by Escher (1960) is a never-ending continuous staircase, which is metaphorical of the fact that the development of EI is a lifelong journey that will have its ups and downs.

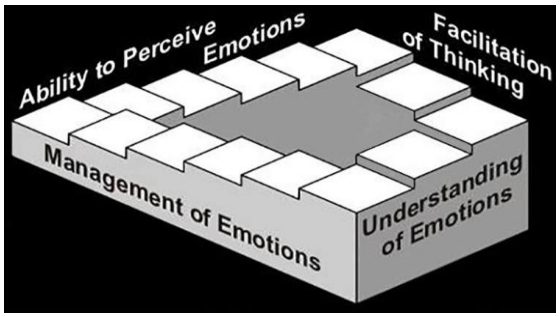


Figure 4. Penrose-Escher Staircase representation of the four-branch ability model.

Principles of the Four-Branch Ability Model

Embedded in the four-branch ability model, Mayer et al. (2016) provided a set of principles to direct the theorizing of EI. These principles include the belief that EI is a mental ability that is measurable. Valid tests comprised of precise questions can explicate pertinent mental abilities. Furthermore, Mayer et al. believe that there is a significant bifurcation between intelligence and behavior. That is, a person who possesses high intelligent quotient (IQ) may not deploy behaviors that are emotionally intelligent, and someone with low to average IQ may behave in a highly emotionally intelligent manner. Therefore, depending on social, cultural, and personality context, people's demonstration of behaviors would vary and are independent of their IQ (Mayer et al., 2016).

Moreover, EI is a "broad" intelligence that focuses on "hot" intelligences (Mayer et al., 2016, p.3). Broad intelligence refers to the multidimensional aspects of intelligence and recognizes the unique human cognitive and mental abilities from general to abstract in the way people process, understand, store, and retrieve information. While cool intelligences are those that contend with comparatively objective learning, such as mathematic skills and vocabularies, EI makes conspicuous the hot intelligences of reasoning with knowledge that is personal and evokes feelings (Mayer et al., 2016).

The four-branch ability model served as the theoretical framework for my study as the authors specified that the ability to perceive emotions, coalesce emotion to facilitate thinking, understand, and manage emotions were vital to personal growth, professional achievements, mental health and well-being, as well as enabled people to

decipher and navigate their social environments (Mayer et al., 2016). The four-branch ability model interposes emotional management as a fundamental element; thus, it provided a background for me to define emotional self-management in my study. The definitions in the model helped me set up some of the interview questions for the participants. Furthermore, the model provided a source by which I could interpret the findings without dictating the interpretations.

The Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT)–a Brief Explanation

A number of the researchers of the articles referenced in this literature review utilized or modified the Mayer-Salovey-Caruso EI Test (MSCEIT) that is universally used and adapted for testing participants' overall or a particular component of EI in relation to attributes such as coping skills or academic achievements (Mayer, Salovey, & Caruso, 2000, 2002). Although I did not administer the MSCEIT, this brief explanation offers context later on in this chapter when I discuss and compare the various relevant studies. The MSCEIT is an ability-based test consisting of 141 items designed to assess total EI along with the four branches of EI described. Mayer et al. (2002) indicated that the MSCEIT has face validity in its tasks to evaluate EI. The detailed explanations of the four branches demonstrate its content validity because the MSCEIT represents all facets of the constructs in the four-branches (Mayer et al. 2002, 2016). Brackett and Mayer (2003) verified the convergent, discriminant, and incremental validity of the MSCEIT. In addition, the split-half reliability coefficients for the complete test is almost perfectly positive at $r = 0.91$, and the four branches range from $r = 0.8$ to 0.91 (Mayer et al., 2000).

EI and Students in the Healthcare Field

Researchers believe that EI is essential to everyday life, social functioning, and overall mental health and well-being (Faguy, 2012; Hildebrand, Volberding, & Carr, 2012; Mayer et al., 2016; Ruiz-Aranda, Extremera, & Pineda-Galán, 2014). There are strong implications with respect to EI and personal, social, academic, and workplace achievement. Researchers continue to correlate EI and individuals' intra and interpersonally functioning in the academic settings. In healthcare, researchers advocate that EI is instrumental in the enhancement of interdisciplinary partnerships (Faguy, 2012; Hildebrand et al., 2012; Ruiz-Aranda et al., 2014; Pop-Jordanova & Demerdzieva, 2015). The authors of the following articles discussed EI as a multifarious whole; the literature search did not result in any article by researchers who addressed emotional self-management as a stand-alone construct. However, all authors acknowledged that the management of emotions, which hails from self-control and self-awareness, is a precursor to the successful development of EI.

There is a consensus that EI is an essential skill for healthcare practitioners (Faguy, 2012; Hildebrand et al., 2012; Ruiz-Aranda et al., 2014; Pop-Jordanova & Demerdzieva, 2015). Academic brilliance does not automatically equate to successful careers, social competence, life happiness, or salubrious interpersonal relationships (Faguy, 2012; Hildebrand et al., 2012; Ruiz Aranda, et al., 2014). It is important for healthcare professionals to possess the necessary cognitive intelligence to perform their clinical tasks, such as patient assessment and execute patient care plans; however, intellect alone is inadequate (Pop-Jordanova & Demerdzieva, 2015). Researchers

advocate that EI is a requisite for clinical practice because it can positively affect patient care and satisfaction, reduce healthcare providers' stress, and enhance job fulfilment (Msiska et al., 2014; Rice, 2015). There is a strong recommendation to incorporate EI into the healthcare educational curricula (Faguy, 2012; Hildebrand et al., 2012; Pop-Jordanova & Demerdzieva, 2015).

Myriads of researchers focus on linking EI to academic achievement in the healthcare field. Notwithstanding, Faguy (2012) and Pop-Jordanova and Demerdzieva (2015) described the general qualities of EI and their positive influences on students. Faguy (2012) in her discussion paper offered definitions of EI, compared briefly the various models, and discussed the importance of teaching EI to healthcare students and professionals. Pop-Jordanova and Demerdzieva used selected EI tests to compare the EI scores of a heterogeneous group of 169 first year healthcare students to those of 90 healthcare practitioners. Their results supported Faguy's claim that EI is learned and can positively influence the complexities of the healthcare workplace by reducing stress level and improving communication to decrease conflicts.

In addition, Grant, Kinman, and Alexander (2014), in their cross-sectional study, and Stanley and Bhuvaneswari (2016), in a mixed methods study, discussed social work students' reflective ability and empathy as they related to their EI. The researchers in both studies reported that students' level of understanding in empathy and reflective ability are not adequate, and students are emotionally unprepared for the workplace. Social work students are exposed to laborious emotional work and EI can help them to manage their emotional reactions more effectively (Grant et al., 2014; Stanley &

Bhuvaneswari, 2016). Unfortunately, Grant et al. did not offer further understanding of how students may change or progress over time. Also, the sample size of 73 female students from a private university in India was small and homogeneous. The pre and post intervention mixed method study of Stanley and Bhuvaneswari had an even smaller sample size of 17 students from a university in the United Kingdom (UK) completing the study. However, the researchers were able to confirm the students' level of improvement pertaining to overall EI literacy and application to practice. The students reportedly experienced an increase in their reflective and empathy abilities, as well as feeling better able to manage psychological distress (Stanley & Bhuvaneswari, 2016). The authors in both studies agreed that it is important to include EI in social work education.

Hall, Hanna, Hanna, and McDevitt (2015) are also UK researchers who utilized an online questionnaire to measure empathy in 318 undergraduate pharmacy students. Their results indicated that there was a significant variation in scores over the four levels of students ranging from the lowest score in first year to highest in fourth year. Hall et al. did not specifically state empathy as an element of EI; rather, they recognized empathy as an essential quality for pharmacy students. Although Hall et al. did not measure empathy in the same way as Grant et al. (2014) and Stanley and Bhuvaneswari (2016), it is noteworthy to recognize that they concurred regarding the importance of empathy and that it is a learned, not an innate attribute. Hall et al. also recommended that pharmacy programs in the UK must consider more strategies to enhance students' empathetic ability. The inclusion of EI in the curriculum may be one such strategy.

Concurrently in the United States, Nelson, Fierke, Sucher, and Janke (2015) wrote a statement article proposing that EI should be included in pharmacy curricula to help students achieve better Center for the Advancement of Pharmacy Education (CAPE) Outcomes. CAPE is an initiative of the American Association of Colleges of Pharmacy (AACP) led by an advisory experts' panel, which aimed to review pharmacy curricula and recommend improvement opportunities. The most recent CAPE outcomes in 2013 supported universities and colleges of pharmacy to build affective and EI categories into the curricula with best practices guidelines and recommendations. The AACP strongly believe that EI is paramount in the cultivation of leadership skills, collaboration in teamwork, self-awareness, professionalism, and stress response (Nelson et al., 2015).

Nelson et al. (2015) are the only authors in this literature review who offered a cursory discussion on self-management of emotions as a single construct and highlighted on its relevance in relation to the other EI components. Nelson et al. underscored the value for students to develop in self-awareness so that they can strengthen their ability to manage their emotions. Nelson et al. asserted that the evolution of the healthcare workplace continues to move toward interprofessional collaboration. Therefore, EI is a foundational component to help students develop affective skills.

Volberding, Baghurst, and Brown (2015) echoed the findings by Nelson et al. (2015) in their emphasis of self-management of emotions as a foundational EI component. However, Volberding et al. did not elaborate on self-management of emotions after their introduction, and discussed EI in general terms. Volberding et al. conducted a cross-sectional study using an Internet-based survey of the four-branch

ability model and a convenience sample of 130 undergraduate students in the kinesiology program from a university in the United States. The results indicated that students lacked EI skills. Volberding et al. noted that low EI levels in healthcare professionals such as inadequate communication, social, and critical thinking skills, combined with a lack of empathy are potential contributing factors that result in the inability to understand emotions and collaborate within the interdisciplinary team environment.

As was the case with the aforementioned studies of Grant et al. (2014), Stanley and Bhuvaneswari (2016), the results of the Volberding et al. (2015) study are similar with respect to their report finding healthcare students to be lacking in EI. Furthermore, Volberding et al. subscribed to the same emphasis in their promotion of EI in the healthcare workplace and expatiated on the relevance of EI toward improving overall success in job performance and satisfaction, interpersonal relationships, coping and mental well-being, and prevention of burnout. The recommendations of Volberding et al. resonate with the others that the designing of curricula should include enhancing students' EI throughout their academic preparation.

In the dental and medical fields, researchers internationally reported on the relationships between EI and students' clinical performance and academic achievement (Cherry, Fletcher, O'Sullivan, & Shaw, 2012; Cherry, Fletcher, O'Sullivan, & Dornan, 2014; Chew, Zain, & Hassan, 2013; Chun & Park, 2016; Hojat et al., 2015; Johnson, 2015; Kumar, Puranik, & Sowmya, 2016; Ravichandra et al., 2015; Shetty et al., 2013; Uchino et al., 2015; Victoroff & Boyatzis, 2013). Victoroff and Boyatzis used a 72-item Emotional Competence Inventory-University (ECI-U) tool and multiple linear regression

analysis to explore the association between EI and 100 American dental students' clinical performance. The students' GPAs were included in the analysis and the results supported that there is a positive relationship between cognitive ability and high GPA. In addition, the results provided positive empirical support between EI and clinical performance. Therefore, there is a direct association between cognitive ability, EI, and academic and clinical success (Victoroff & Boyatzis, 2013). Nevertheless, high GPA, cognitive ability, and knowledge do not automatically translate into empathetic care, professional communication, and coping skills in the clinical settings; therefore, EI is vital for clinical and work performance (Victoroff & Boyatzis, 2013).

Kumar et al. (2016) and Ravichandra et al. (2015) reinforced the findings of Victoroff and Boyatzis (2013) by conducting cross-sectional surveys using the same 30-item Sterrett EI Self-Assessment Checklist to measure EI and academic performance of 386 dental students from various universities in India. The researchers in both studies reported that there is a positive association between EI and academic scores. However, most students lacked self-awareness, self-control, and empathy; hence, there is an urgent need to support the improvement of students' EI in order for them to cope with the emotional demands in the clinical settings (Kumar et al., 2016; Ravichandra et al., 2015). Kumar et al. and Ravichandra et al. acknowledged that cultural variance exists in comparison to American students and those in other countries. Nonetheless, these researchers recommended that EI should be a part of the dental education curricula (Kumar et al., 2016; Ravichandra et al., 2015; Victoroff & Boyatzis, 2013).

Likewise in medical schools, researchers are urging medical programs to include EI in medical training (Cherry et al., 2012; Cherry et al., 2014; Chew et al., 2013; Hojat et al., 2015; Shetty et al., 2013; Uchino et al., 2015). Chew et al., Hojat et al., and Shetty et al. endorsed that EI positively links with academic performance in medical students. Although using different tools, both Chew et al. and Hojat et al. conducted cross-sectional studies to measure students' academic accomplishment. Shetty et al. utilized the same 30-item Sterrett EI Self-Assessment Checklist as Kumar et al. (2016) and Ravichandra et al. (2015) with 150 first year medical students. These researchers reported comparable results and indicated that students who have higher EI in the first year continued to perform successfully in their final examination in the final year. Students who were more emotionally intelligent experienced less burnout, were more empathetic, and more optimistic. The authors assented with the others that EI ought to be a part of medical curriculum and recognized EI as an important contributing factor in students' academic achievement and coping skills (Chew et al., 2013; Hojat et al., 2015; Shetty et al., 2013).

Cherry et al. (2012) reviewed 14 studies between the years 1991 and 2009 conducted by researchers in the United States, Europe, and Asia who measured medical students' EI with emphasis on empathy and communication skills before and after structured workshops with varying durations. The findings suggested that structured educational sessions significantly improved medical students' EI and equipped them to interact with patients more effectively. Cherry et al. (2014) subsequently conducted a critical review of EI in medical education to support clinical educators who advocated for

increasing the focus on EI in the medical curriculum in the UK. This review was timely in the UK because a national report by the Royal College of Physicians in 2013 indicated that patients were suffering from a lack of effective communication and compassionate care by doctors. The international implication emphasized by Cherry et al. is that doctors in all developed nations must hold themselves accountable by demonstrating compassionate care in the way they communicate.

Cherry et al. (2012) and Cherry et al. (2014) advised that less concerns should be placed on the cognitive intelligence of physicians because admission is highly competitive and students are selected for admission on cognitive ability (GPA and other empirical standardized academic scores). Rather, there is a need to focus on improving the students' emotional training so that they can be sensitive in providing empathetic care. Similarly, Uchino et al. (2015) conducted a literature review and concurred with Cherry et al. (2012) and Cherry et al. (2014) that EI can assist in the training of physicians to improve overall patient outcomes, decrease burnout, and enhance physician-patient relationships. There needs to be increased efforts to advocate for raising the awareness of EI and its benefits in medical education globally (Uchino et al., 2015).

The researchers in this section agreed that EI is essential in the healthcare workplace to procure satisfactory patient and employee experience. Presumably, students have the cognitive capacity to gain the requisite knowledge by virtue of their admission into healthcare programs. Nonetheless, cognitive intelligence, academic achievements, and clinical expertise alone are not sufficient to execute comprehensive patient care in

complex healthcare systems. EI is an indispensable tool to understand and ameliorate behaviors that influence patient care. Healthcare education programs need to incorporate EI into their curricula to ensure that students are emotionally well prepared beyond their academic requirements (Rosenstein & Stark, 2015). Johnson (2015) recommended workshops or seminars are not ideal forums for students to develop EI skills. Students need to perceive EI as an integral standard part of their learning and not something separate or extra to their already saturated curriculum. EI training should be multidisciplinary and methodical with practical opportunities to apply it.

EI and Nursing Education

I obtained a total of 36 nursing articles for this review; 34 were published between 2012 and 2016, and 2 were published in January, 2017. All of the articles were studies conducted in university settings, and researchers did not discuss emotional self-management as an independent construct in any of them. To the best of my knowledge, no article was available with respect to EI and practical nursing students in Ontario, Canada, or from any equivalent nursing education level in the United States, UK, and countries where English is one of the official languages. In all except three of the studies, the authors agreed that EI should be an essential skill for nursing students and urged nursing programs to include EI in their curricula. The majority of the researchers identified their study as quantitative or mixed-methods, and some were discussion papers. There were four qualitative studies. I organized the articles under the following themes, (a) general development of EI in nursing students, (b) EI and student nurses' academic and clinical performance, (c) EI and coping and stress of nursing students, (d) EI and

nursing students' death attitudes, (e) EI and bullying and conflict management of nursing students, (f) EI and leadership development in nursing students, and (g) Emotional labor in nursing students.

General Development of EI in Nursing Students

In the majority of research on nursing education discussed in this section, self-reported questionnaires and surveys to present the association between EI and student characteristics, such as academic success, stress, coping, and leadership, were used. Yet, there was a lack of evidence to identify how to help nursing students to pursue and elevate their EI skills (Shanta & Gargiulo, 2014). Perhaps before deciding on how to facilitate the development and improvement of students' EI, there is a need to understand how they experience EI first. There was insufficient qualitative research on nursing students' emotional experiences, their emotional labor, and their perspectives. Between the search inclusion criterion of 2012-2016, only four qualitative articles exist (Chun & Park, 2016; Jack & Wibberley, 2014; Msiska, Smith, & Fawcett, 2014; Oner-Altiok & Ustun, 2013).

Foster et al. (2015) conducted an integrative literature review of 17 articles from 1992-2014 published in the UK, the United States, and New Zealand. The authors proposed that these 17 articles specifically represented the types of existing theoretical EI constructs in nursing education, the most important EI components that nursing curricula should include, and reasonable strategies to incorporate EI in nursing curricula. A possible explanation for the lack of inclusion of EI in nursing curricula may be due to the absence of consensus in EI definitions of constructs, framework, and an empirical

measurement of students' EI (Foster et al., 2015). The authors strongly recommended the Mayer and Salovey (1997) ability model as a sound framework because it includes personal and interpersonal emotional management components that students can use to organize, develop understanding, and practice EI (Foster et al., 2015).

Similarly, Whitley-Hunter (2014) conducted a literature review of 19 articles from 2001-2013 and agreed with Foster et al. (2015) by expressing that the apparent gap is in the nursing curricula. Whitley-Hunter indicated that the quality of nursing care is directly dependent upon the effectiveness of communication with patients. Nursing curricula may consider combining EI and transactional analysis (TA) as a framework because TA is a method for understanding the process of communication and interactions between people (Whitley-Hunter, 2014). Foster et al. agreed and highlighted communication and interpersonal skills as essential EI elements that nursing curricula should include. In order to communicate effectively with patients, student nurses must acquire EI skills while in training so that they can continue to advance empathy and communication skills (Foster et al., 2015; Whitley-Hunter, 2014).

In an analogous manner, Shanta and Connolly (2013) and Pryce-Miller and Emanuel (2014) in their discussion papers concurred that successful communication is fundamental to compassionate care; therefore, students nurses need to develop their EI skills as early as possible. Although Pryce-Miller and Emanuel (2014) did not recommend any particular EI framework, they mentioned all the EI components within the four-branch ability model (Mayer et al., 2016) that are necessary for nursing students to improve communication skills and empathy. Shanta and Connolly on the other hand

linked the four-branch ability model with nursing theorist King's interacting systems theory to emphasize the significance of effective emotional interactions between nurses and patients. King's theory demonstrates the reciprocal relations of individuals (patients and nurses, nurses and nurses, et cetera) in interaction, perception, communication, transaction, and considers each individual's perceptions of self, role, levels of growth and development, and the perceptions of others (Shanta & Cononlly, 2013). King's theory mirrors the four-branch ability model almost flawlessly. Shanta and Connolly suggested that the four-branch ability model and King's theory are complementary frameworks that can improve nurses' provision of holistic care for patients, colleagues, and themselves.

Shanta and Gargiulo (2014) noted that the difficulties in incorporating EI in nursing curricula are related to the lack of consistent EI models in nursing research. Foster et al. (2015) discussed the same concern two years later. Ball (2013), Shanta and Gargiulo, Vishavdeep et al. (2016), and Kaya et al. (2017) affirmed the position of Foster et al. (2015) in terms of lack of frameworks. Shanta and Connolly (2013), Pryce-Miller and Emanuel (2014), and Whitley-Hunter (2014) indicated in their findings that teaching EI to nursing students has positive effects in improving the quality of patient care, students' critical thinking skills, and overall coping and sense of self.

Shanta and Gargiulo (2014) conducted a quasi-longitudinal study and Kaya et al. (2017), in a longitudinal study, explored whether there is a link between teaching EI concepts and the development of EI in nursing students. Their results differed from one another in which Shanta and Gargiulo indicated no significant differences in EI development in the students over two semesters, and Kaya et al. revealed a positive

correlation of EI growth over one academic year . Nonetheless, the authors concurred that a longer timeframe is required to measure more accurately the implications of EI in nursing education. Despite the contrasting results, the authors asserted support to implement EI into nursing curricula and believe EI is vital for nursing students to evoke empathy and enhance therapeutic relationships with patients (Kaya et al., 2017; Shanta & Gargiulo, 2014).

The pre-experimental study by Vishavdeep et al. (2016) confirmed the aforementioned researchers' claims that EI training has positive effects for nursing students. Vishavdeep et al. conducted seven EI training sessions with 224 nursing students from a university in India based on Goleman's (1998) mixed EI model. Vishavdeep et al. did not specify the components evaluated; however, the participants' one-month post test EI scores indicated a significant improvement in their overall EI. In addition, Vishavdeep et al. included eight of the same articles I considered in this review and succinctly provided a synopsis of the importance of EI in nursing education.

As evidenced by the findings of the above mentioned researchers, there is a valid call for the incorporation of EI into healthcare education curricula. Research in nursing is not exempt from this growing trend. Numerous authors wrote about the concepts of EI and its implications in nursing practice; however, few reported frameworks that explicitly address the inclusion of EI into nursing curricula (Foster et al., 2015). Overall, researchers acknowledged the importance of EI in nursing education, attempted to justify and substantiate its place in nursing curricula, and explained its usefulness (Ball, 2013; Kaya, Şenyuva, & Bodur, 2017; Pryce-Miller & Emanuel, 2014; Şenyuva, Kaya, Işik, &

Bodur, 2014; Shanta & Connolly, 2013; Shanta & Gargiulo, 2014; Vishavdeep et al., 2016; Whitley-Hunter, 2014).

EI and Student Nurses' Academic and Clinical Performance

The traditional nursing curriculum is essentialist education that is conservative in nature. That is, nursing instructors pass on academic and clinical knowledge to students and aim to ensure a common culture that is task oriented and simultaneously necessitates holistic patient-centered care (Armstrong, 2012; Kessler, Heron, & Dopson, 2015; Odland, Sneltvedt, & Sörlie, 2014; Whitley-Hunter, 2014). Therefore, it is not surprising that many nursing researchers examined the relationship between EI, academic, and clinical performance as the practice of nursing continues to evolve and juxtaposes between tasks expertise and emotional engagement (Beauvais, Stewart, DeNisco, & Beauvais, 2014; Cheshire, Strickland, & Carter, 2015; Codier & Odell, 2014; Collins, 2013; Fernandez, Salamonson, & Griffiths, 2012; Rankin, 2013; Rice, 2015).

Beauvais et al. (2014), Cheshire et al. (2015), Codier and Odell (2014), and Collins (2013) all utilized the four-branch ability model as their framework and the MSCEIT in their studies. Both Beauvais et al. and Cheshire et al. were descriptive studies in which participants completed the MSCEIT online. Beauvais et al. had 124 participants consisting of 73 undergraduate and 51 graduate nursing students from a Catholic university in the United States. The participants in the study by Cheshire et al. were 82 undergraduate nursing students from a university in the southwestern United States who responded to their online test. The researchers of both studies concluded that academic success as measured by GPA does not correlate with EI as measured by the

MSCEIT. There were students in both studies who achieved high GPA, but scored low in their EI and vice versa. Those students who achieved high GPA and scored high in their EI were assessed to be better able to concentrate on their studies; however, the authors did not elaborate or explain how these students did so (Beauvais et al., 2014; Cheshire et al., 2015).

The findings of the studies by Codier and Odell (2014) and Collins (2013) are similar to Beauvais et al. (2014) and Cheshire et al. (2015). Collins used the MSCEIT to test 219 graduate students registered in nurse anesthetist programs from four universities in the southeastern United States. All students needed to have a high GPA as an admission criteria. Collins conducted a cross-sectional quantitative correlational study at 3 points – the beginning, in the middle (1 year), and in the final semester. Collins' findings indicated that, despite the students' high GPA at admission and throughout the program, students were able to recognize emotions, but unable to manage their own and others' emotions. There was a significant positive linear association between semesters in the program and higher EI skills. Codier and Odell conducted an exploratory, descriptive, quantitative study with 72 first year undergraduate nursing students from a university located in the south-central region of the United States. Congruent with the results of Collins, the students' admission GPA indicated the students had adequate cognitive abilities; however, all of these students scored low in their overall EI skills. Both Codier and Odell, and Collins in effect corroborated that regardless of the semester or year in the nursing program and cognitive abilities, students could benefit from additional EI skill training.

The authors of the above studies concurred that high GPA alone does not guarantee nursing students' ongoing employment success in the high stress and emotionally demanding clinical work environment. EI has an important role in nursing education because it offers non-cognitive psychosocial factors to enhance academic and clinical performance, provides students a practical tool to cope with stress associated with academic pressure, and improve success in the workplace post graduation (Beauvais et al., 2014; Cheshire et al., 2015; Codier & Odell, 2014; Collins, 2013). Therefore, designers of nursing curricula need to consider appending EI as part of the education to ensure post graduation success and prevent burnout (Beauvais et al., 2014; Cheshire et al., 2015; Codier & Odell, 2014; Collins, 2013).

Conversely, Fernandez et al. (2012), Rankin (2013), and Rice (2105) supported that EI is a positive predictor to students' clinical practice success and academic performance. Fernandez et al. employed a prospective survey design and an adapted version of a 144-item Trait EI Questionnaire to examine the impact of EI on the academic performance of 81 first year nursing students in an Australian university six weeks following commencement. The results from a stepwise multiple regression analysis that included the students' GPA at six months follow-up, indicated the statistical relationship between EI and GPA to have $\beta = 0.25$, and $p = 0.023$ (Fernandez et al., 2012). Statistically, any β value less than 1 indicates that the data have little volatility, and any p value less than 0.05 means the null hypothesis can be rejected (Frankfort-Nachmias, & Nachmias, 2008). Therefore, Fernandez et al. demonstrated a positive association between EI and GPA, and EI is a significant predictor of academic achievement. In addition, the highest

possible GPA is 7.0 and the mean score was 4.9 with a standard deviation of 1.2, which means that each student on average is 1.2 points from the mean; thus implies little volatility.

Tantamount to the findings of Fernandez et al. (2012), Rankin (2013) conducted a one year longitudinal survey study of 178 first year nursing students in a UK university. The researcher used the Assessing Emotions Scale (AES) consisting of a 5-point Likert scale with 33 items to predict the relationship between EI, clinical performance, academic performance, and progression in the education program. The AES is essentially a short form of the MSCEIT as it comprises items from the four-branch ability model (Rankin, 2013). Rankin used mean assignment scores instead of GPA as an indicator for academic performance. The results indicated that students who received high grades in their assignments reported higher EI abilities. Students who were successful clinically reported higher in their EI functioning and received a grade of pass for their clinical practice (Rankin, 2013). The results revealed that there is a strong relationship between EI, clinical practice success, and academic performance. The logical prediction is that successful first year students will progress onto the next year of studies, continue to develop their EI, and thrive academically and clinically (Rankin, 2013).

Comparatively, Rice (2015) conducted a descriptive correlational survey study using the MSCEIT to explore students' self-efficacy and EI as indicators for successful clinical performance. There were 56 nursing students from five accredited associate degree programs in the northern United States who participated in Rice's study. The findings strongly supported that students with higher EI scores have greater self-efficacy,

which directly resulted in their successful clinical performance (Rice, 2015). Fernandez et al. (2012), Rankin (2013), and Rice purported that EI would be a very valuable tool in the education of future nurses to enhance the quality of their clinical practice. It is noteworthy to mention that these researchers' findings conflicted with those of Beauvais et al. (2014), Cheshire et al. (2015), Codier and Odell (2014), and Collins (2013). The discrepancy may be due to differences in methodology, sample sizes, participants' heterogeneity, and varying interpretations of the potential usefulness of EI.

EI and Coping and Stress of Nursing Students

Internationally, nursing is one of the most stressful professions (Boamah & Laschinger, 2016; Gorgens-Ekermans & Brand, 2012; Kalyoncu et al., 2012; Littlejohn, 2012). Sources of nurses' stress, such as nursing shortages compounded by heavy workload, insufficient time to respond to patients' needs, exposure to death and human suffering, complicated ethical decision making, fear of committing medical errors or negligence, power disparity and bullying, lack of peer and organizational support, and workplace conflicts, contribute to high attrition rate, burnout, and job dissatisfaction (Gorgens-Ekermans & Brand, 2012; Kalyoncu et al., 2012; Littlejohn, 2012). These stressors can elicit detrimental emotional responses that can result in compromising nurses' physical and mental health, as well as quality nursing care. EI is one of the stress and coping management strategies that can assist nurses to manage their emotions, promote mental well-being, and maintain the quality of their performance. Nursing curricula need to consider EI developmental interventions to prepare nursing students to

manage the stressors in the nursing program and afterwards in the workplace (Gorgens-Ekermans & Brand, 2012; Kalyoncu et al., 2012; Littlejohn, 2012).

Orak et al. (2016) investigated the effect of EI in nursing education with stress management in mind. Orak et al. are proponents of EI training in nursing education and insisted that it is increasingly more important because many students enter into a four-year nursing degree program straight from high school. These students are young with little life experience; thus, they are unprepared for the stress they are about to face. Orak et al. conducted a four-month quasi-experimental study of 66 first year nursing students from a university in Iran using the four-branch ability model and a modified MSCEIT. The researchers divided the students into an experimental and a control group; the students in the experimental group attended eight 2 hour EI sessions for eight consecutive weeks. To mitigate ethical concerns, the students in the control group received EI training after the study. Using the Chi-square and Mann-Whitney U analyses to calculate the pre and post tests scores, the results surprisingly indicated only a slight increase in EI scores from Time 1 to Time 2 for the experimental group; otherwise, the overall results were statistically insignificant. The results contradicted the hypothesis that EI education has positive effects on EI scores.

Orak et al. (2016) attributed their contradictory findings and failed intervention to the small sample size of novice nursing students with no, or minimal clinical experience; therefore, they were unable to appreciate the importance of learning EI skills. In addition, the students received a large amount of EI information in eight weeks, but had limited opportunity to apply their knowledge (Orak et al., 2016). Notwithstanding, Orak

et al. echoed Foster et al. (2015) and Shanta and Gargiulo (2014) in their support of the need to include EI in nursing curricula. The questions remain with respect to agreeing on the content focus and design of EI, the stage in the curricula when EI training begins, and the structure, length, frequency, and methods to teach EI (Foster et al., 2015; Shanta & Gargiulo, 2014; Orak et al., 2016).

Contrarily, Chen and Hung (2014) and Chun and Park (2016) explored third year nursing students' perceptions of stress and coping strategies. The study by Chen and Hung was a descriptive study conducted in Taiwan and used a cross-sectional design, questionnaires, and multiple regression analysis to confirm whether perceived stress, gender, and personality were predictors to nursing students' physio-psycho-social responses. There were 101 (85 females, 16 males) third year students who participated in this study and the results indicated that there is a positive relationship between perceived stress and physio-psycho-social responses. The researchers used a translated Chinese instrument that consisted of EI related items such as social adaptiveness and emotional stability. The researchers found that those students who reported as extroverted, emotionally stable, and socially adapted, perceived less stress and were able to use problem-solving skills to mitigate stressful situations (Chen & Hung, 2014). These items are parallel to the EI components of self-awareness, emotional management, and emulated the EI definition of "the ability to reason validly with emotions and with emotion-related information, and to use emotions to enhance thought" (Mayer et al., 2016, p. 296).

Chun and Park (2016) did not identify a theoretical framework or model, but cited a Mayer and Salovey (2005) discussion paper and briefly mentioned the components of EI. Chun and Park used Q methodology to conduct an exploratory study in Korea. Q methodology is controversial as a qualitative method because it is usually a brief single case study of the participants' subjective experience, not in their own words, but by their ranking of prescribed statements (van Exel & De Graaf, 2005). There were 15 third year nursing students who participated in the Chun and Park study and offered their subjective ranking of the researchers' prepared statements on EI. Chun and Park stated that the participants engaged in in-depth interviews and completed a 40-statement questionnaire, but neither parts of the interviews nor the 40 statements were published with the study.

Chun and Park (2016) presented their results by organizing the students' ranking of the prepared statements into three types of characteristics: sensitivity-control (consider others' emotions, but control their own), sympathy-motivation (value the sharing of emotions and do not avoid challenges), and concern-sympathy (enjoy sharing of emotions and able to read others' emotions). Chun and Park claimed that all three types of characteristics are important in the human services and concluded that curricula need to include EI as a vital tool for students to cope with stress when caring for others. It is difficult to know the accuracy of Chun and Park's study since the researchers did not explain whether the participants offered more narratives during their interviews on their subjective views beyond the ranking of the prepared statements. However, it is notable that in their explanation of the three types of characteristics, the authors provided

reasonable parallels to the Mayer and Salovey (2005) definitions of EI, and the four-branch ability model of Mayer et al. (2016).

EI and students' death attitudes and risk of depression and suicide. Nurses face human suffering and death in their work; it is an unavoidable occupational stress. Espinoza and Sanhueza (2012) used an adapted Spanish version of the Mayer and Salovey EI trait model, questionnaire, and descriptive analysis to conduct a descriptive cross-sectional study of 188 university nursing students in Chile (3^{rd}, 4^{th}, and 5^{th} levels described as latter years of study) to understand the relationship between their fear of death and EI. It is interesting to note that the authors emphasized the unique Chilean culture and their open expression of emotions. From a Chilean context, since most nurses are female, and Chilean women have unique patterns of emotional expression, it is natural that they take on the traditional "emotional work" that is nursing (Espinoza & Sanhueza, 2012, p. 611). Notwithstanding, Espinoza and Sanhueza found that both female and male students who possessed higher EI were more in control of their emotions and experienced less fear of death. The ability to control emotions adequately implied positive psychological adjustment, which results in a lesser fear of death thus ensuring the quality of therapeutic interaction with dying patients and their families (Espinoza & Sanhueza, 2012).

Similarly, Aradilla-Herrero et al. (2013) conducted a cross-sectional-correlational study of 243 (214 females, and 29 males) nursing students in Spain (110 year one, 66 year two, and 67 year three) to explore their EI and death attitudes using a voluntary questionnaire and multiple linear regression analysis. Consecutively, the authors

conducted a cross-sectional and observational study of 1,208 Spanish nursing students and 209 hospital nurses to determine the relationship between perceived EI, self-esteem, alexithymia, and death anxiety using questionnaire and confirmatory factor analysis (Aradilla-Herrero et al., 2014a). Concurrently, they published another descriptive cross-sectional study of 82 first year Spanish nursing students to review the associations between EI, depression and suicide risk in nursing students using self-reported questionnaire and multiple linear regression analysis (Aradilla-Herrero et al., 2014b). The researchers used the EI Trait model and scale in all three studies; however, they credited Mayer and Salovey (1997) for their preliminary model, which other models are based on.

Aradilla-Herrero et al. (2013) found that students who presented a better understanding and management of their emotions reported healthier death attitudes, such as less stress toward the dying process. Consequently, these students were able to manage the effect of contact with death, dying, and cope with loss. In addition, the researchers discussed emotional clarity and its positive association with psychological adjustment; that is, when student nurses are clear about how they feel, they can regulate their attitudes to carry out their clinical practice (Aradilla-Herrero et al., 2013). The researchers found that nursing students, who reported higher perceived EI, reported higher self-esteem and less alexithymia and death anxiety (Aradilla-Herrero et al., 2014a). Whereas the researchers concentrated on the students' attitudes toward the concepts of death and dying with respect to the understanding of their emotions in the first study (Aradilla-Herrero et al., 2013), their perceived EI and its impact on self-esteem

and ultimate influence on death anxiety were the focus of the subsequent study (Aradilla-Herrero et al., 2014a). The findings distilled from both studies confirmed that EI contributes to healthy self-esteem and can act as a defence against anxiety. Moreover, the findings are concomitant with those of Espinoza and Sanhueza (2012) in terms of EI being a vital constituent in helping nursing students to deal with death and suffering.

Furthermore, Aradilla-Herrero et al. (2014b) found that nursing students, who were more emotionally intelligent and with higher self-esteem, were at less risk of depression and suicide because EI cushioned them with better clarity and coping skills. Nursing students experience high levels of anxiety in their clinical placements mainly owing to inexperience and lack of confidence. This can lead to low self-esteem, depression, and suicide ideation. Without coping strategies such as EI training, these negative emotions can perpetuate into their work life after graduation. Although the specific reasons for the elevated risk of suicide and depression in health-related professionals are unknown, contributing factors such as stressful work environments, shortages, burnout, anxiety, and low-esteem are likely suspects (Aradilla-Herrero et al., 2014b).

Aradilla-Herrero et al. (2013, 2014a, 2014b), Chen and Hung (2014), Chun and Park (2016), Espinoza and Sanhueza (2012), and Orak et al. (2016) conducted studies pertaining to the relationship between EI, stress and coping of Asian and Spanish university nursing students. The inclusion criteria for this literature searches were English, peer-reviewed, scholarly journals with publication dates between 2012 and 2016. To the best of my knowledge, no researchers from the United States or other

official English speaking nations have explored the relationships between EI and death anxiety in nursing students between 2012-2016. Many of the researchers in this literature review examined stress, anxiety, and depression in nursing students; however, none linked these variables with EI. The above researchers reinforced the global emphasis on including EI in nursing curricula and provided a cultural snapshot of EI. The education systems and the cultural expressions of emotions in Asia and Spanish speaking nations differed fundamentally from that of any western nation. The researchers listed the differences as limitations; perhaps these differences are in fact strengths. The nursing workforce in developed nations such as Canada, the United States, and the UK are becoming more diverse owing to immigration and globalization (Alexander, 2016). Nursing programs in these countries may incorporate the findings of Aradilla-Herrero et al. (2013, 2014a, 2014b), Chen and Hung (2014), Chun and Park (2016), Espinoza and Sanhueza (2012), and Orak et al. (2016) to ensure that they consider the cultural differences of their increasingly diverse student body when considering the inclusion of EI in their curricula.

EI and bullying in nursing students. The common expression "nurses eat their young" is based on the historical fact that nurses bully each other (Gillespie et al., 2017). For years, nurse researchers contemplated issues of bullying in nursing and advised different strategies to resolve this international phenomenon (Echevarria, 2013; Gillespie et al., 2017; Mitchell, Ahmed, & Szabo, 2014). Bullying is complicated. Generally, it includes aggressive behaviors such as verbal abuse, verbal and/or physical threats, and intimidation; and passive-aggressive behaviors such as exclusion, micro body language

(e.g. eye rolling), and sarcasm (Echevarria, 2013; Gillespie et al., 2017; Littlejohn, 2012; Mitchell et al., 2014).

Iorga, Ciuhodaru, and Soponaru (2016) conducted a correlational study using an adapted version of the Bar-On and Goleman's mixed model EI test to identify the types of hostility among 89 first year nursing students and their EI in a Romanian university. Their results indicated that there was a negative correlation between higher EI and resentment, hostility, suspicion of others, irritability, and negativity. Therefore, those students who scored higher in their EI test had a better understanding of their own and others' emotions and were able to use emotions appropriately (Iorga et al., 2016). How nursing students behave and socialize while they are in school can have a ripple effect on how they will continue to treat their colleagues and patients. The development and demonstration of EI is fluid; thus, it may be nurtured (Iorga et al., 2016). It is unclear why bullying persists in nursing programs and in the profession. Many authors believe that it is stress and anxiety related because nursing programs are compact and competitive (Echevarria, 2013; Gillespie et al., 2017; Iorga et al., 2016; Mitchell et al., 2014). The experience of stress and anxiety produces negative emotional responses such as destructive behaviors. Hence, the positive effect of high EI is an upward spiral of better self-awareness, improved emotional well-being, and cordiality. Some researchers believe that EI is the missing link to reduce workplace stress and violence (Bennett & Sawatzky, 2013; Iorga et al., 2016; Littlejohn, 2012).

Iorga et al. (2016), and Chan et al. (2014), in an earlier cross-sectional quantitative survey study, agreed that, theoretically, students with healthier EI would

effectively manage conflict. Bullying and incivility can lead to conflict and unresolved conflict will fuel bullying behaviors (Chan et al., 2014). Chan et al. used the Rahim Organizational Conflict Inventory-II (1983) and Schulte EI Scale (1998) to survey 568 (138 males, 414 females, and 16 unreported) 2nd, 3rd, and 4th year nursing students from a Hong Kong university. Correlational and linear regression analyses of the students' responses revealed that EI is a remarkable predictor for Rahim's (1983) five conflict management style of integrating, obliging, dominating, avoiding, and compromising. The higher the students' EI, the more they utilized the integrating style, which is the most collaborative, respectful, and solution focused style (Chan et al., 2014). In addition, students often followed their professors' example; thus, it is imperative that faculty model behaviors that exhibit EI. Conflict is inevitable; therefore, the key is management that would lessen stress, eradicate bullying and other disruptive behaviors, and promote workplace civility. It is crucial that EI is included in nursing curricula so that students may develop their emotional skills prior to entering the workforce (Chan et al., 2014; Iorga et al., 2016).

Bennett and Sawatzky (2013) and Littlejohn (2012) emphasized that bullying and incivility in nursing results in increased stress, decreased job satisfaction, ineffective patient outcomes, and atrocious work conditions. From an organizational perspective, bullying leads to increased attrition rate, overall costs, and legal expenditures caused by avoidable medical errors. The ultimate price of workplace hostility is the increased threat to patient safety. In the United States, the National Academy of Medicine (NAM, 2016) attributed thousands of avoidable medical errors annually to human factors such as stress,

fatigue, and burnout. Therefore, the stress caused by bullying has immediate effects on productivity and quality of care. There needs to be a realistic strategy to shift the paradigm at the education level in order to propel sustainable changes for the next generation of nurses to eliminate bullying in the workplace (Bennett & Sawatzky, 2013; Coffey et al., 2017; Littlejohn, 2012). Coffey et al. suggested that in order to address the overwhelming stress such as bullying faced by healthcare professionals, the approach ought to begin systemically within the education curricula and then proceed beyond to the workplace.

EI is a pragmatic strategy to eliminate bullying and reduce stress (Bennett & Sawatzky, 2013; Littlejohn, 2012). One of the reasons for the pervasiveness of bullying in nursing is because traditional training taught nurses to accept bullying as a rite of passage; thus, nurses refute that their behaviors are inappropriate and condone it as part of the job (Bennett & Sawatzky, 2013; Littlejohn, 2012). In addition, nursing is a predominantly female profession; women are an oppressed group, and oppression causes people to behave aggressively or in passive aggressive manners. Many nursing researchers believe that bullying in nursing perpetuates because nurses justify bullying as a coping strategy to deal with stress caused by interpersonal conflict and heavy workload (Bennett & Sawatzky, 2013; Littlejohn, 2012). This mentality needs to stop (Bennett & Sawatzky, 2013; Littlejohn, 2012). The development of EI is on a continuum as people acquire life and professional experiences. Regardless of framework, nursing curricula need to incorporate EI so that students can gain exposure to its concepts and embrace EI as a valuable tool to manage stress caused by conflict (Bennett & Sawatzky, 2013;

Littlejohn, 2012). Furthermore, when nurses are aware of and can regulate their emotions, they are better able to manage their external environment and attain a sense of control in the workplace (Bennett & Sawatzky, 2013; Littlejohn, 2012).

EI and Leadership Development in Nursing Students

The ongoing nursing shortage results in inexperienced nurses filling in leadership positions before they acquire management skills to be effective leaders (Bennett & Sawatzky, 2013). Leadership is a component in the university nursing curricula; researchers believe that the integration of EI into leadership courses is a logical option to develop students' EI. In fact, researchers support that EI and leadership skills are interdependent and the inclusion of EI should exist throughout the nursing education program at all levels (Anderson, 2016; Benson, Martin, Ploeg, & Wessel, 2012; Carragher & Gormley, 2017; Renaud, Rutledge, Shepherd, 2012; Szeles, 2015).

Anderson (2016), Carragher and Gormley (2017), and Renaud et al. (2012) recognized the Mayer et al. (2016) four-branch ability model as the most comprehensive EI model in academia because abilities are measurable. These researchers in their discussion papers validated that the recommendation to teach EI concurrently in leadership development courses is cogent because most of the popular leadership models contain elements of EI. Anderson posited that it was Florence Nightingale who coined the terms servant leadership and emotional intelligent. In fact, Nightingale (1914) discussed nursing as a godly service and implied the concepts of servant leadership and EI when she wrote, "the very first element for having control over others, is of-course, to have control over oneself. ... A person in charge must have a quieter and more impartial

mind than those under her" (p. 12-13). Notwithstanding, servant leadership is relational, focuses on the needs of others, and the ability to inspire followers by serving their needs so that the team can achieve their collective goals (Anderson, 2016). Linking the four-branch ability model and servant leadership in nursing is brilliant because EI emphasizes the fact that people can only control their own behaviors toward others; thus, EI can influence nursing students' desire to serve and lead when they know how to control their emotions. To be effective, nursing leaders must have a sound understanding of how their emotions and actions affect the people around them. When leaders are better able to relate to and collaborate with others, the more successful they will be (Anderson, 2016; Carragher & Gormley, 2017; Renaud et al., 2012).

By contrast, Carragher and Gormley (2017) did not specifically include servant leadership in their article. However, in their summary of traditional and emerging leadership theories, they identified transactional, congruent, and authentic leadership as relational leadership theories. These theories required leaders to demonstrate their true persona and incorporate personal values and beliefs as they lead in order to reap mutual benefits. Servant leadership as described by Anderson (2016) also included the importance of authenticity; the servant leader is sincerely empathetic, and leads by encouragement and facilitation, not power. Students have fewer formal opportunities once they graduate to intentionally apply what they learned about leadership theories in the classroom and associate them to EI by virtue of the workload and demands in the workplace (Carragher & Gormley, 2017; Renaud et al., 2012). Leadership theorists discuss the importance of leadership behaviors, and EI experts teach the appropriate

expression of behaviors. Therefore, it may be pertinent to link leadership theories and development with EI learning in nursing students. It is reasonable to expect effective nursing leaders to demonstrate higher EI; the conundrum remains in where to include EI into nursing curricula in order to foster EI development (Anderson, 2016; Carragher & Gormley, 2017; Renaud et al., 2012).

Consistent with Carragher and Gormley (2017) and Anderson (2016), Benson et al. (2012) and Szeles (2015) considered EI as a vital element of effective nursing leadership. Benson et al. conducted a longitudinal study using a correlational and repeated measures design to describe the development of EI and leadership in 52 (5 male and 47 female) undergraduate nursing students in a Canadian university. Students completed the same questionnaires that used Bar-On EI Quotient Inventory and the Smola (1988) Self-Assessment Leadership Instrument (SALI) at the entry of the program (T1), after their second year and first clinical experience with patients (T2), and at the end of their fourth year before gradation (T3). Benson et al. found that while the mean score of the students' EI did not change over time, their EI scores improved between T2 and T3. There is a positive statistical significance of the correlations between changes of EI and leadership skills development.

Szeles (2015) conducted a mixed-methods exploratory study to measure the effect of a peer coaching intervention on the EI of student nurses. Peer coaching is recognized as an effective process that fosters leadership development (Szeles, 2015). Thirteen students attended a seminar (unspecified length) on EI, participated in a pre intervention EI test using the MSCEIT, engaged in a weekly peer coaching meeting for 15 weeks, and

9 students completed the post intervention EI test. Although Szeles provided a brief explanation of peer coaching and its influence on leadership development, she did not explain the exercises involved in this study. Based on the Szeles's description of peer coaching, the assumption is that the participants used their knowledge of EI from the seminar to critique and empower each other as they applied it. Szeles used descriptive analysis and inferential statistics to analyze their data. Szeles reported that the students' total EI scores improved post intervention, and all the students identified peer coaching as a valuable leadership skill in helping to improve their EI ability.

Both Benson et al. (2012) and Szeles (2015) stated that their major limitation was the small sample size. Nonetheless, the researchers believed that nursing curricula should include EI with respect to leadership development. The components of EI encapsulate the attributes of effective leadership such as communication, collaboration, and optimism. Thus, effective and emotionally intelligent nurse leaders will support and empower other nurses thereby contributing to stress prevention, improving job satisfaction, impeding bullying, and acting as role models (Benson et al., 2012; Szeles, 2015).

Emotional Labor in Nursing Students

There were three phenomenological studies that resulted from the literature search for this literature review (Jack & Wibberley, 2014; Msiska, Smith, & Fawcett, 2014; Oner-Altiok & Ustun, 2013). None of the researchers in these three studies used the term EI; however, they identified the stress that the nursing students experienced during clinical and classroom training as emotionally laborious. It is relevant to include these

three studies because in an earlier section of this chapter, various researchers identified the association between EI and coping and stress management in nursing students (Chen & Hung, 2014; Chun & Park 2016; Gorgens-Ekermans & Brand, 2012; Kalyoncu et al., 2012; Littlejohn, 2012; Orak et la., 2016). In addition, others discussed EI and students' ability to manage the stress caused by the notion of death and dying patients (Espinoza & Sanhueza, 2012; Aradilla-Herrero et al., 2013; Aradilla-Herrero et al., 2014a, 2014b). Furthermore, the healthcare workplace is emotionally charged and requires the use of emotional labor (Psilopanagioti, Anagnostopoulos, Mourtou, & Niakas, 2012). Emotional labor is the effort that employees in the service industry use during interpersonal transactions to exhibit appropriate emotions to demonstrate understanding and sympathy with other people (Psilopanagioti et al., 2012). According to Psilopanagioti et al., it is also effortful to restrain negative emotions, such as anger, fear, annoyance, or displeasure, to demanding patients, or patients with complicated medical conditions. Hence, EI is an important factor in the execution of emotional labor because components of EI, such as the ability to perceive and manage emotions may enhance the effort in emotional labor and thereby reduce stress level (Psilopanagioti et al., 2012).

Jack and Wibberley (2014) explored the meaning of emotional work to the nursing students in a UK university. Msiska et al. (2014) reviewed the perception of nursing students' emotional experience from a university in East Africa. Students from both studies reported difficulty in expressing their emotions for fear of discipline or the perception of unprofessionalism. In addition, students from both studies reported feeling uncomfortable when dealing with the emotions of the patients, yet too intimidated by

their instructors to express their feelings of uncertainty and insecurity. The students' report confirmed the explanation of emotional labor provided by Psilopanagioti et al. (2012). The researchers from both studies indicated that there is a need for nursing students to attain emotional balance in order to carry out the emotional work required to practice in clinical settings.

Moreover, students identified that nursing curricula do not explicitly teach coping strategies, and there is a lack of effective role models whom they may emulate (Jack & Wibberley, 2014; Msiska et al., 2014). The students' reports of insufficient role models confirms the previous researchers' claim that there is a need to include EI in leadership development courses within the curricula (Anderson, 2016; Benson et al., 2012; Carragher & Gormley, 2017; Renaud et al., 2012; Szeles, 2015). One can extrapolate that when students have constructive role models or mentors, they will no longer feel intimidated and insecure, but inspired and empowered to ask questions or express their emotions professionally. Consequently, they will attain emotional balance more easily.

Similarly, Oner-Altiok and Ustun (2013) did not specify EI in their phenomenological study. They considered the different sources of stressful feelings experienced by second year Turkish nursing students. Their findings aligned with those of Jack and Wibberley (2014) and Msiska et al. (2014) with respect to the following feelings from students: a general fear of their clinical instructors; a sense of intimidation and bullying by nursing and other professional staff; a lack of self-confidence and self-efficacy; and a lack of control over their emotions. Jack and Wibberley, Msiska et al., and Oner-Altiok and Ustun did not recommend that nursing curricula should include EI.

However, the authors agreed that the lack of coping skills and effective mentors are contributing factors to students' anxiety and emotional burden during their training. Theses researchers supported that nursing is the work of caring for other human beings; therefore, students need to understand human emotions. It is necessary to explore more ways that are creative and positive to support the emotional needs of nursing students, and EI may be such a method.

Self-Compassion and Self-Awareness in Emotional Labor

Nursing is emotional labor (Jack & Wibberley, 2014; Msiska et al., 2014). Thus, it is imperative that nursing students are self-aware of their emotions in order to effectuate their emotionally laborious work. Many authors discussed self-compassion and self-awareness of nursing students from the lens of self-care and mindfulness (Bazarko, Cate, Azocar, & Kreitzer, 2013; Hofmeyer et al., 2016; Orellana-Rios et al., 2017). Şenyuva, Kaya, Işik, and Bodur (2014) are the only researchers published between 2012-2017 who discussed self-compassion and EI in nursing students in a descriptive correlational study of 471 nursing students in various years from a Turkish university. Participants completed a questionnaire that measured their sense of self-compassion and EI. Şenyuva et al. asserted that essentially self-compassion is self-awareness because one needs to be self-aware in order to be self-compassionate. The researchers proposed that it is crucial to be compassionate to oneself first prior to the ability to exert compassion for patients and their loved ones, and self-compassion will drive the development of self-awareness. The researchers used a Turkish self-compassion scale to measure students' self-kindness, self-judgment, common humanity,

alienation/isolation, and self awareness, and an adapted EI assessment scale to measure self-awareness, self-management, self-motivation, empathy, and relationship control/social awareness. Their results indicated that there is a positive correlation between self-compassion and EI. Şenyuva et al. argued that it is through the process of self-compassion that student nurses can become more self-aware of their own and others' emotions.

Mayer et al. (2016) in their explanation of the four-branch ability model suggested that it requires conscious efforts for individuals to progress across and up each branch. Therefore, it is reasonable to infer that self-awareness is the key factor that generates the development of emotional self-management to propel the growth of the other essential EI components. When nursing students are aware of their own emotions, they can begin to understand and navigate beyond themselves to manage others' emotions and cope with stressful emotional work (Ball, 2013; Şenyuva et al., 2014).

Implications for Research and Practice

To date, Carragher and Gormley (2017) and Gillespie et al. (2017) indicated that they are not aware of EI being a specific topic in any nursing curricula in developed nations. As evidenced by study results already discussed, students can improve their EI with education, and EI is positively associated with academic achievement, clinical performance, coping, stress management, leadership, and prevention of bullying. The lingering question is how to situate a rightful place for EI in the curricula (Fitzpatrick, 2016).

It may be fair to say from the published evidence in this literature review that there is sufficient observed proof that EI has a direct positive influence on nursing students' learning development. Therefore, researchers may begin to focus on two areas. The first is to understand qualitatively how nursing students position EI and gain personal meanings. That is, what does it mean to nursing students to be emotionally intelligent? There is a scarcity of qualitative research concerning EI in nursing students. I was only able to obtain four publications between 2012 and 2016 (Chun & Park, 2016; Jack & Wibberley, 2014; Msiska et al., 2014; Oner-Altiok & Ustun, 2013). As mentioned previously, Jack & Wibberley, Msiska et al., and Oner-Altiok & Ustun in fact did not use the term EI; rather, a tacit presentation of the EI components was between the lines. In order for nursing students to embrace EI as a significant component in their repertoire of skills, they need to comprehend the concepts beyond the academic definitions.

The second area is to determine a framework that would best fit the nursing curricula. The majority of the researchers in this literature review gravitated toward the four-branch ability model (Mayer et al., 2016). These researchers regarded EI as a measurable ability; hence, it may make sense to use the four-branch ability model to train nursing students to improve upon their EI competency. In addition, Fitzpatrick (2016) recommended the 2016 Emotional Competence Framework offered by the Consortium for Research on Emotional Intelligence in Organizations as a resource for educators. This framework included the four-branch ability model as key EI components; thus, it may offer curricula designers innovative ideas to weave the two into a practical blueprint for nursing education.

Furthermore, the articles I reviewed presented a wide international interest with respect to EI and its potential impact in nursing students. Some of the researchers translated and/or adapted the four-branch ability model and others to meet their specific cultural differences. Developed countries such as Canada, the United States, Singapore, and the UK are multicultural nations where there are diverse nursing students (Alexander, 2016; Goh & Lopez, 2016). Thus, EI frameworks in the curricula must ensure cultural appropriateness and inclusivity and cross-cultural comparisons are required to understand how social determinants such as culture, geography, and gender, influence EI growth and development in nursing students.

Moreover, as mentioned in the historical perspective section earlier, Thorndike (1920) was the first to begin the study of socially competent behaviors, and then Beldoch (1964) first wrote about EI with respect to emotional meanings in communication. Subsequently, Salovey and Mayer (1990), and Goleman (1995) wrote extensively about EI and its importance and various benefits. Although there is still much to discover in terms of exactly how EI evolves within individuals or how much of it is abilities and personalities, it is not an emerging concept and the research community and scholars should stop referring to it as such (Carragher & Gormley, 2017; Gillespie et al., 2017). EI advocators in nursing are suggesting that EI should be at the core of nursing curricula, and the priority for nursing educators and is the teaching of EI (Benson et al. 2012; Carragher & Gormley, 2017; Gillespie et al., 2017).

Conclusion

The majority of the researchers in this literature review carried out their studies linking EI and students at the university level. Overall, these researchers regarded EI and its concepts in their entirety. Researchers from the general healthcare fields recognized that EI is as important as cognitive intelligence for practitioners to ensure patient safety and satisfaction, job fulfilment, and the prevention of burnout. Some researchers associated EI with empathy and communication. Others correlated EI with clinical performance and academic achievements. Nelson (2015) and Volberding et al. (2015) were the only researchers who made a token mention of the term emotional management. However, they did not elaborate on the term emotional management, but attributed it as the building block of the other EI components.

I organized the nursing articles in respective themes. The majority of the researchers self identified their studies as quantitative or mixed methods. There were researchers who discussed the general development of EI in nursing. Various researchers explored EI and nursing students' academic and clinical performance. Numerous researchers reviewed EI and coping and stress in nursing students, stress related to death attitudes, and bullying and conflict management. Several researchers discussed EI and leadership development in nursing students. There were three phenomenological studies conducted by researchers who explored the meaning of emotional labor in nursing students.

None of the nursing researchers discussed emotional self-management as an individual construct. Notwithstanding, all the researchers discussed the importance of

nursing students' ability to manage emotions. There is an absence of research that examines emotional self-management as a distinct construct in nursing students. Studies that exclusively explore EI in the Practical Nursing level, more specifically, the emotional self-management of PN students have not been conducted in Ontario, Canada. I was only able to obtain 2 Canadian studies on EI and nursing students between the search criterion of 2012-2016 (Bennett & Sawatzky, 2013; Benson et al., 2012).

Chapter 3: Research Method

Study Purpose

The purpose of this study was to explore PN students' lived experiences with emotional self-management in the clinical settings where they are exposed to stress related situations. In order to address the gap regarding an understanding of PN students' self-management of emotions, I conducted an interpretive qualitative study; the specific approach was a hermeneutic phenomenological design. In-depth, face-to-face interviews with PN students were conducted. The goal was not to authenticate my findings as fact, rather to explore the experience with its intersubjective characteristics.

Research Questions

The locus of van Manen's (1997, 2014) hermeneutic phenomenology and the study of lived experiences were used to guide the research process. Van Manen (1997) emphasized the importance of excavating into the core of the "what it is like" or "what does it mean to be" question (p.42). The main research question leading this study was *What are PN students' experiences of emotional management in the clinical settings?* The hermeneutic interview/conversational approach required the interview questions to be open and oriented to the substance of the experiences in question (van Manen, 1997). In addition, van Manen's hermeneutic phenomenology is relational; that is, as the participants shared their lived experience with me, I would meet them in the interpersonal space I share with them. This was important because, as the researcher, I was immersed in the phenomenological process. I suspended my own judgment and experience. The subquestions supporting the primary question include:

1. How do PN students in the clinical settings experience the management of their emotions?
2. How does emotional self-management affect PN students' learning experience in the clinical settings?

The interchanges between the researcher and the participants are phenomenologically collaborative (van Manen, 1997). These open conversations may occasionally drift off to other tangents; therefore, the interview questions served as the cornerstone to the phenomenological dialogues so that I could direct the discussion back on track should it wander off.

This chapter includes a detailed review of the methodology and research method that I used in this inquiry and the rationale for the selected approach. I explain my role as the researcher and provide a description of the participants and the recruitment strategy. I explain the research design, which includes data collection methods and management, data analysis and synthesis. Finally, I discuss the ethical considerations, validity, reliability, and trustworthiness of the study findings.

Research Methodology

Historical Overview& Rationale

I used phenomenology as the research method for my study. The entire premise of phenomenology is that reality consists of entities and events (phenomena) as they are perceived, experienced, and understood in the human consciousness (Heidegger, 1927/2010; Husserl, 1931/2012; van Manen, 1997, 2014). Traditional and contemporary phenomenologists have integrated the old and the new in the phenomenological traditions

to understand the lived human experience and seek to understand the what is it like to be experience (van Manen, 1997, 2014). In this study, I used hermeneutic phenomenology, which is a combination of descriptive (Husserl) and interpretive (Heidegger and van Manen) phenomenology, in order to capture the essence of the PN students' lived experiences with emotional self-management (Heidegger, 1927/2010; Husserl, 1931/2012; van Manen, 1997, 2014). The rationale for using hermeneutic phenomenology is in the traditions section.

Traditions. There are many phenomenological traditions, and the debates of the definitions of phenomenology continue today. Husserl and Heidegger are the two philosophers in the early 20th century who imparted seminal influence in the phenomenological movement (Gibson, 1928, as cited in Spiegelberg, 1971). Phenomenology is the study of the systematic human consciousness as experienced from the first-person perspective (Husserl, 1931/2012). Phenomenology is also the study of phenomena as they emerge in the conscious experience, in how people experience them, and followed by their ascribing subjective meanings to the experience (Heidegger, 1927/2010; van Manen, 1997, 2014).

Phenomenology as a methodology is controversial (van Manen, 1997). There are ongoing debates with respect to phenomenological variations and how best to conduct phenomenological research in practice (Finlay, 2009; van Manen, 1997). Notwithstanding, phenomenology offers researchers a unique way to achieve a deeper understanding of a particular phenomenon (van Manen, 1997). Phenomenology is metamorphosing and provocative in its distinctive manner in approaching meanings,

understanding, and knowledge of an experience. Husserl's (1931/2012) classical descriptive phenomenology seeks to discover the essences of experience and focus on how things appear. The focus of Heidegger's (1927/2010) traditional interpretive approach is on the search behind the appearance into the art of interpreting the hermeneutics. By contrast, contemporary phenomenologists such as van Manen (1997, 2014) have a less conformist approach and believe that phenomenology and phenomenological research are a type of scholarly knowledge that "animate inventiveness and stimulate insight" into illuminating meanings to the experience (van Manen, 1997, p. 30).

Regardless of the ongoing debates with respect to the purview of phenomenology, it is the researcher's position within the specification of a conceptualization of an experience that permits the interpretation and knowing of a phenomenon (McConnell-Henry, Chapman, & Francis, 2009). Van Manen (2014) explained that the goal of phenomenology is to find meanings and agreed with Heidegger's interpretive position of attunement of and seeking for the meaning of being. Being is a vital component of becoming; when human beings are able to understand their being, they become what they can be (Heidegger, 1927/2010). Experiences put people in touch with their being; thus, being is a consequence of experiences, and there has to be a wilful interest to seek it (McGrath, 2008; van Manen, 2014).

Husserl (1931/2012) presented intentionality as the fundamental framework of an experience because people's intention directs the experience toward something by virtue of its meaning. To identify intentionality is to describe how people perceive and imagine

their experience, the relationship between perceptions, judgements, and evaluation of the experience, as well as the individual's intention to act and the intended goal. The content of people's experience is directed by their intentionality (Husserl, 1931/2012). For example, when Jane intended an apple to be red and round, that is to say that she directed her mind toward the apple by perceiving it as red, round, and describing it as such. Intentionality is important in phenomenology because to be intentional is being mindfully aware and conscious of perceptions and experiences (McIntyre & Smith, 1989).

Heidegger (1927/2010) did not use the term intentionality; however, he addressed the meaning of being, and stated that being is both at once universal and obscure because being is the whatness of people's existing subjective and objective reality, or presence. Heidegger also discussed the idea of attunement (befindlichkeit) and suggested that people's understanding is always attuned to their affective states. Thus, to understand the meanings of a particular experience, people need to be deliberately aware of their attuned being (Heidegger, 1927/2010; McIntyre & Smith, 1989). In addition, Heidegger used the terms dasein, which is German for being present, and sinn des seins, the sense of being, or being with regard to, to illustrate when an experience becomes intelligible. In essence, an experience is purposive in so far as the awareness of experience embodies intentional behaviors, which are established through practical engagement with the environment (Heidegger, 1927/2010; Husserl, 1931/2012). Heidegger emphasized the importance of discourse in order to summon people's experiences. Hence, hermeneutics is essential in the existential and thematic analytic to clarify, express, and interpret people's experiences (Heidegger, 1927/2010).

Hermeneutic phenomenology was appropriate for my study because I explored the PN students' lived experiences with EI in the clinical settings. That is, I described how the students perceived and imagined their experiences, the relationship between perceptions, judgements, and evaluation of their experiences, as well as the students' intention to act and their intended goal (Husserl, 1931/2012; McIntyre & Smith, 1989). Furthermore, hermeneutic phenomenology was apposite because in the process of my interviews with the participants, I engaged into a discourse with them that would summon their experiences into being. I was then able to clarify, express, and interpret their experiences (Heidegger, 1927/2010). To interpret does not mean that I made my own interpretations of what the participants said; rather, it was to unspool, or unscramble what they said to distil the essence of their experiences (van Manen, 1997, 2014).

For the purpose of clarity, I used van Manen's (1997) orientation of hermeneutic phenomenology to signify the amalgamation of descriptive and interpretive phenomenology. Hermeneutic phenomenology is considerate to both the descriptive and interpretive methods because it allows experiences to appear as they are and let them speak for themselves (descriptive), while at the same time claims that it is impossible to have uninterpreted phenomena (van Manen, 1997). This tacit antithesis is rectifiable when researchers accept the phenomenological fact that lived experiences are always meaningful and made tangible by language; thus, it is certainly an interpretive process (van Manen, 1997). Hermeneutics were an integral part of the phenomenological process of my study because it focuses on texts and meanings; hence, it allowed me to explore the students' lived experience by their telling, told, and re-telling (Heidegger, 1927/2010; van

Manen, 1997, 2014). The symbiotic integration of descriptive and interpretive phenomenology in my study aligned with hermeneutic phenomenology as defined by van Manen. This was possible because phenomenology is inherently flexible as long as the variations are consenting to phenomenological principles (Finlay, 2009; Giorgi, 2008).

Moreover, phenomenology is reflexive. In reflection, phenomenology provides an intricate description of awareness (van Manen, 1997). Temporal awareness is people's present conscious awareness of time, change, and may consist of past or future oriented emotions that can generate strong influences in the present states of consciousness (Heidegger, 1927/2010). Spatial awareness is the awareness of being in the world and the perceptions of being in place and space (Heidegger, 1927/2010). Self-awareness is the consciousness of how the self thinks, behaves, moves, communicates, and understands meanings (Heidegger, 1927/2010). Awareness of the others involves empathy (Heidegger) and intersubjectivity (Husserl), which are part of the shared objectivity that people's individual experience is available to others (Heidegger, 1927/2010; Husserl, 1931/2012; Luft & Schlimme, 2013). Therefore, the reflexive intentionality of phenomenology offers the possibility of the layering of the participants' experiences into subjective, practical, and social contexts to provide meanings.

Phenomenology does not reject rationalism or empiricism; it is expansive, does not presume orthodoxy, and consists of various philosophical roots (Giorgi, 2008; van Manen, 1997, 2014). My position was in accordance with the understanding that phenomenology is the rich description of the lived experience (Heidegger, 1927/2010; van Manen, 1997), where I, the researcher suspended or bracketed (epoché) my own

knowledge and prejudice of the phenomenon while maintaining an open phenomenological attitude (Giorgi, 2008; Husserl, 1931/2012). This process allowed me to identify and halt any preconceived notions that I may have had about the phenomenon I was researching. In so doing, part of my bracketing was phenomenological eidetic reduction, which is to bracket all tangential meanings in order to unpack the experience to reach its essence (Giorgi, 2008; Husserl, 1931/2012). It is important to note that eidetic reduction is not a simplification or contraction of an experience; rather, it is the attempt to offer a hint of how a piece of text may bring an experience into being or view (Heidegger, 1927/2010; van Manen, 1997, 2014).

In addition, my position of the PN students' lived experiences was interpretative and required the use of hermeneutics to unpack and make the experience known so that it could show itself (Heidegger, 1927/2010; van Manen, 1997). There are researchers who do not agree that the researcher can simultaneously bracket while using hermeneutics (Finlay, 2009). Husserl (1931/2012) discussed a pure form of bracketing that suggests the researcher is able to disconnect or detach. However, to bracket, Husserl (1931/2012) meant to draw upon his mathematician roots to illustrate the action of putting aside; that is, to bracket any judgement. Husserl (1931/2012) also described the use of imaginative variation while bracketing to indicate that any perspective of the lived experience is a possibility because there has to be considerations for the differences in the frames of reference in approaching the phenomenon and how it is lived in each individual's consciousness.

Heidegger (1927/2010) in agreement wrote extensively about the possibility of being and underscored that the essence of people's experiences is the possibilities of what they can be as they penetrate into all the dimensions of their understanding. In order to interpret and understand the meanings and essences of experiences, researchers must be open to explore the possibilities in multiple ways (van Manen, 1997). The essence is entrenched in "the ti estin question" or the "whatness" of the phenomenon (van Manen, 1997, p. 33). It is fair to say that there is no one universal truth to a lived experience; rather, the multitudinous possibilities of what it could be. Therefore, to facilitate the uncovering or discovering of meanings of the lived experiences of the PN students' with EI, I used hermeneutics to elucidate the essence of their experiences (van Manen, 1997, 2014).

Furthermore, Husserl's (1931/2012) descriptive phenomenology is rooted in the subjectivity of the lived experience (Moustakas, 1994). The subjectivity comes from reflections of the lived experience. It is through reflection that people discover the essence (van Manen, 1997, p.77). Husserl (1931/2012) described people's conscious experience of a phenomenon as tri-sphere: the existence of the world as they accept it, the psychological, and the consciousness. It is in the sphere of the consciousness where experiences and intuition can intertwine to create meanings. Husserl used the example of the man in the street to describe the fact that people will accept his physical existence, they psychologically know that he is there, and when he is gone, they can still visualize him there, albeit he may be different in their imaginations (Husserl, 1931/2012). Thus, to understand the essence of a lived experience is to set aside real existence (scientific

reality), and focus on describing the subjective perception (abstract), as it is perceived in the immediate present, or the "hic et nunc*"* (here and now) (Husserl, 1931/2012, p.129). People's understanding of any given experience is not only in perception, but also consciously in the memories and imaginations. The essence of an experience derives from the meanings people assign to it from the real, the possible, and the imagined along with past experiences (Husserl, 1931/2012, p.66).

I believed that hermeneutic phenomenology, which consists of both the interpretive and descriptive could coexist in my study. In both methods, the researcher pays attention to the participants' descriptions of the lived experiences (van Manen, 1997, 2014). In the process of unspooling the participants' descriptions, I used the original definition and the four-branch ability model of EI by Mayer and Salovey (1997) to distil and reveal the unknown meanings of the described phenomenon. As a result, it may offer the shared relationships between the knowledge, meanings, and contexts of the phenomenon. The descriptive method does not ask the researcher to make interpretation, but to peruse the participants' descriptions of their lived experiences. I used the statements expressed by the participants to present their described perspectives.

Van Manen (1997) also proposed that the phenomenological researcher must first have experience of a phenomenon because the meanings of the experience are related to the descriptions by the person who perceives it reflexively. Husserl (1931/2012) conveyed that experiences are perceived and then described as a knowledge in the consciousness; whereas Heidegger (1927/2010) and van Manen asserted that what people encountered "shows itself" in contextual relevance, which requires interpretation. Hence,

hermeneutic phenomenology helped me understand the students' experience "from the inside" (van Manen, 1997, p.8).

My Role as the Researcher and Reflexivity

I was the researcher carrying out each of the face-to-face interviews and all data collection. I was responsible for all information acquired throughout the interviews and ensured secure storage and format of the data. I analyzed and verified the data prior to writing the dissertation.

Van Manen (1997) discussed the beginning of the phenomenological process as the researcher's "personal experience" (p. 54). I needed to be "reflectively aware" of the structure of my own lived experience with EI so that I could orient myself throughout the process (van Manen, 1997, p. 57). The phenomenology researcher acknowledges that any phenomenon is a possible human experience; thus, my reflexivity involved my empathy of the others (the participants), and my understanding of the intersubjectivity that my experience was also possible to others (Heidegger, 1927/2010, Husserl 1931/2012, van Manen, 1997). That is, however I experience and make meanings of EI may be similar to how my participants do as well. Therefore, my goal was not to offer an absolutist exposition of the participants' experiences. I recognized the interview itself as a context of interactive meaning-making.

Reflexivity is the process of examining both myself as researcher and the research relationship. I bracketed my personal experiences of EI in so far as to set them aside in order to suspend my judgement. It is impossible for the researcher to stand in a space of absolute objectivity because phenomenology inherently includes the researcher's

presence (van Manen, 1997). Husserl (1931/2012) discussed the "empirical consciousness" where the consciousness experiences "the same" object, albeit different people may use different words to describe the object, thereby constituting different ways of experiencing it (p. 281). I was an interpretive and reflective being as the researcher; therefore, by bracketing my own narrative, I primarily sought to understand the participants' lived meanings with EI. Bracketing my judgement and preunderstanding my own experiences allowed the participants to show the essence of their lived experience (van Manen, 1997). I acknowledged my experience as an inquisitor within the sphere of the phenomenon (van Manen, 1997). For this reason, I conducted this study using the first-person to illustrate the intersubjectivity I shared with the participants (Heidegger, 1927/2010; Husserl, 1931/2012; van Manen, 1997). I did not assume that their meanings were absolute or objective; rather, they were the result of their socially and culturally constructed realities that were shaped within particular contexts (Heidegger, 1927/2010; van Manen, 1997).

Reflexivity is a self-given awareness, which is the ability to be introspective toward myself as an inquirer and reflective toward the external factors that can shape my research (van Manen, 1997). Therefore, my reflexivity involved being aware of the fact that I was responsible in the meaning production. Moreover, to be reflexive required me to be aware of how I situated myself within the phenomenon. I needed to deliberately "make explicit my understandings, beliefs, biases, assumptions, presuppositions, and theories" (van Manen, 1997, p. 47) about EI. This is not to say that I abandoned the preunderstandings of what I came into the study of the phenomenon with, but it was so

that I could explicate them in a way that would guide me back to the essence of the "what is it like" question, and to keep open the possibilities the question I find myself so deeply interested (van Manen, 1997, p.43). I utilized journaling for the sole purpose of acknowledging and connecting to my presuppositions, assumptions, and insights on how they influenced my inquiry as I progressed through the phases of the study (Hycner, 1985; O'Connell & Dyment, 2013; van Manen, 1997). This reflexive journal served as my active bracketing to keep my own experiences in check, while staying focused on the participants' descriptions of their experiences (van Manen, 1997).

Recruitment of PN Participants

The inclusion criteria are PN students who are at least 18 years old from a community college in southern Ontario, Canada. Students needed to have been involved in one clinical setting for at least one semester. There may have been a possible threat that those students who had been enrolled for longer may have had more insight into EI; however, this was part of the exploration into their lived experience. Students who I was teaching and would teach were excluded. A purposive convenience sample of participants was recruited via posters (Appendix C) and word of mouth. When the study was approved by the Research Ethics Board of this college, they provided a letter of cooperation for me to recruit my participants. Once the potential participants contacted me, I confirmed that they meet the inclusion criteria, that they understood that this was a research study, the time commitments, and answered any questions that they may have had, as well as set up a time and place for the interviews. The interview protocol is in Appendix A.

There are no rules for sample size in qualitative inquiry (Creswell, 2009, 2013; Denzin & Lincoln, 2005; Patton, 2002; Rudestam & Newton, 2015). The goal of phenomenological studies is to generate data that are rich and in depth. Creswell, Denzin and Lincoln, Patton, and Rudestam and Newton did not provide an explicit rationale for the recommendation of sample size. However, the reason can be inferred from their agreement that a small sample size is sufficient because phenomenological research requires fine-grained analyses that are rich in depth and ideographic (Creswell, 2009, 2013; Denzin & Lincoln, 2005; Patton, 2002; Rudestam & Newton, 2015). Therefore, I recruited 10 participants for my study. I considered that data collection was complete when no evidence of new ideas in the interviews emerged; otherwise, the research conversations continued until it became repetitive (Moustakas, 1994; van Manen, 1997).

Ethical Considerations

This qualitative hermeneutic phenomenological study required PN students to share personal experiences regarding emotional self-management in the clinical settings. The study did not commence until I received approval from the Institutional Review Board (IRB) at Walden University (approval number 12-15-17-0369832) and the Research Ethics Board (REB) at Niagara College (approval number CEC-NC-2017-14). There was minimal risk to the participants. The interviews could have caused stress or anxiety for the PN students to reflect on certain clinical situations that have arisen in the past to describe how their EI was applied. However, the safety measures were that participation was voluntary and the participants did not have to answer when they did not feel comfortable. Participants were free to speak as they wished about their lived

experiences in a secure and private office space. Participants were aware of the study's purpose, and were reassured of their privacy and confidentiality. The participants signed an informed consent to ensure they understood that their participation was voluntary and they were free to withdraw at any time. At the signing of the informed consent, participants were provided with information regarding data collection and storage, and my contact information should they need further information pertaining to the study or their involvement.

Preliminary Pilot Study of the Interview Questions

I piloted the interview questions with three nursing colleagues and two fourth year nursing students from another university where I taught part-time. I used the same interview questions (Appendix B). The purpose of the preliminary pilot was to establish the clarity of the interview questions as well as their effectiveness in answering the research questions, and to provide an approximation of the duration of each interview (Gill et al., 2008; Jacob & Furgerson, 2012). The duration of each pilot was between 20 to 30 minutes. The participants offered their insights as to the clarity of each interview question and attempted to answer the questions.

The consensus was that the questions were clear with a few minor adjustments to the phrasing of two questions. In addition, I was able to trial van Manen's (2014) recommendation to be patient and use silence to wait for the participants to speak before prompting them by reasking or rephrasing a question if a participant did not understand. I used probes such as "Uhha" and "go on", as well as requesting examples to assist them to stay close to the experience and the purpose of the study. These strategies helped to

flesh out description and experience and avoided the danger of having too many set questions that took over the interview from the participant (van Manen, 2014).

Once the Walden University IRB approved this proposal, I formally piloted the same interview questions with two students who replied to the recruitment call. The interview protocol (Appendix A) was explained to these two students, and they were asked to sign the informed consent. The pilot interviews took place in a private and confidential office space where there would not be any distraction. The pilot interviews were audio recorded. The purpose of the pilot interviews in qualitative studies is to help further refine the interview questions and procedure (Creswell, 2013; Jansick 2011). These two students from the pilot were invited to suggest additional questions that might be relevant to include in the interview. Any changes and improvement to the interview questions or process as a result of the pilot have been reported.

Data Collection and Management

Prior to the commencement of data collection, the Walden University Institutional Review Board granted approval of this study. Once I had approval, face-to-face interviews with the participants commenced until data reached a point where they were repetitive. The duration of each interview depended on the individual participant. However, generally, healthcare interviews approximately 20-60 minutes (Gill, Stewart, Treasure, & Chadwick, 2008). The preliminary pilot of the interview questions suggested that each interview would fall within the 20-60 minute timeframe.

I transcribed each interview myself. I used NVivo Pro 11 computer software by QSR International to assist in the organizing, sorting, and saving of the verbatim

transcription after each interview. NVivo Pro 11 was not used for coding in this study; a detailed explanation for the specification of the term coding is in the forthcoming section. To ensure the security of the collected data, the interview transcripts and my reflexive journal were stored in my home that has a security alarm system. In addition, the electronic files of all the participants' data and interview transcripts were saved in a secure, password-protected server with firewalls that would restrict any unauthorized access. I was the only person who had access to the electronic files. To protect the confidentiality of the PN students, the interview transcripts and observational notes were identified by participant codes, and an alias was assigned to each participant.

Data Analysis and Synthesis

Van Manen's (1997) selective reading thematic analysis approach and lifeworld existentials was used to analyze the data in the study. Phenomenology requires the researcher to attempt to understand the meanings of the participants' experiences (van Manen, 1997). Thematic analysis entails the researcher to organize the themes to glean meanings because the themes are the "structure of the lived meaning" and the participants' "structures of experience" (van Manen, 1997, p. 77).

Van Manen's (1997) lifeworld existentials allowed me to explore into the lived world of the PN students' lived experiences with emotional self-management. Van Manen (1997) emphasized four lifeworld existentials to guide the phenomenological research process. They are "lived space (spatiality), lived body (corporeality), lived time (temporality), and lived human relation (relationality or communality)" (van Manen, 1997, p. 101). These existentials were relevant to my analysis because I collected data to

gain understanding of the participants' lived experiences with emotional self-management in their clinical settings (lived space) as they physically experience it whether unconsciously or intentionally (lived body). In addition, the subjective lived time during the students' clinical practice, and their interactions with patients, colleagues and other healthcare professionals (lived human relation) were considered.

In order to come to the four lifeworld existentials, I followed van Manen's (1997) selective reading approach of analysis. It is important to note that van Manen's (1997) approach to phenomenological description and interpretation is not restricted to systematic rules; rather, it is a process of "insightful invention, discovery or disclosure to formulate a thematic understanding" (p. 79). The selective reading approach requires the researcher to read the interview transcripts as many times as necessary to highlight, circle, or underscore participants' statements that capture the essence of their experiences. Subsequently, the researcher can utilize these statements to write the phenomenological interpretation (van Manen, 2014).

From Transcripts to Results

In my study, NVivo Pro 11 was not used for coding, but to help in the organization and storage of initial phrases and sentences that stood out in the transcripts as relevant to answering the research questions. This organization enabled me to see how often similar phrases and sentences appeared as well as to begin to see patterns in the data. These were the meaning clusters that I linked and organized into themes of experiences. NVivo Pro 11 helped to develop trees that showed how I got from data to findings. In general, I have identified experiences that most or all of the participants had

in common. As much as possible, I identified phrases and words in the transcripts that were particularly evocative of the experience and used these to identify themes and to support my results. The lifeworld existentials were guides that aided in enriching and deepening the understanding of the lived experiences. This process enabled me to illuminate and work out the possibilities to project understanding by identifying and clustering themes as exhaustively as possible from the participants' experiences through their thorough, repeated, and rich narratives (Heidegger, 1927/2010).

As mentioned in the section where I specified my role as the researcher, I was reflectively aware to bracket my presuppositions throughout the research process. Hermeneutic phenomenology is at once descriptive and interpretative (van Manen, 1997, 2014). Established phenomenologists discussed the interpretation of people's lived experiences through phenomenological texts and conversations (Giorgi , 2008; Husserl, 1931/2012; Moustakas, 1994, van Manen, 1997, 2014). As a novice researcher, I did not interpret my participants' statements; rather, I aimed to understand their experiences through the language from the themes I attained (Heidegger, 1927/2010).

Furthermore, the term focusing phenomenological meanings was used instead of coding in this study. Coding is not consistent with pure phenomenology language (van Manen, 2014). Surprisingly, neither van Manen nor leading proponents of phenomenological traditions definitively offer another term in place of coding. Moustakas (1994) used listing and grouping themes into a "gestalt of interconnected meanings" (p.11). Hycner (1985) used delineating, isolating, and explicitation of meanings. Van Manen (2014) used annotating, handling, arranging, and focusing

phenomenological meanings. Van Manen (2014) strongly discouraged the mixing of other qualitative research terminologies. For example, to code or codify is fitting for grounded theory and its effort to develop a theory; whereas phenomenology is not concerned with generating theories (van Manen, 2014). Coding and data saturation of data in research methods such as grounded theory suggest finality to the data, and assume that understanding is complete (Creswell, 2009, 2013). Phenomenology assumes that understanding will continue to come (van Manen, 2014). Therefore, to say that the themes/data reached a point where they are repetitive would be more in line with the phenomenological notion that there could potentially be more meanings in the future (van Manen (2014). Van Manen's (1997, 2014) approach to theme analysis is a process of recovering structures of meanings that are embodied in the lived experiences that are represented in texts. Metaphorically, phenomenological themes or structure of experiences are like the many colorful reflections of looking into a kaleidoscope; each reflection is a lived experience reflected upon each other to create meaningful wholes.

The resistance of phenomenological researchers such as van Manen, Hycner, and Moustakas using prescribed techniques is to preserve the integrity of the phenomenon; notwithstanding some guidelines are necessary. For the purpose of clarity in my study, I summarized van Manen's selective reading approach and lifeworld existentials into the following steps:

1. Read the entire transcript of each participant as many times as necessary.
2. Select statements or phrases that contain direct significance to the lived experiences under investigation. Focusing phenomenological meanings will

begin at this step by using NVivo Pro 11 to organize the data to develop themes from the participants' words, phrases, and sentences. Focusing phenomenological meanings will continue as the analysis unfolds with new meanings until the data becomes repetitive.

3. After the acquisition of an inventory of significant statements, I will group the statements into more prominent meaning units to formulate themes. For example, if participant 1 states: "I believe I might have applied EI in the clinical setting", participant 2 states: "I think I may know how to apply EI during clinical", and participants 3 states: "I am not sure if I always apply EI in the clinical setting". The main theme from these three statements is that students are unsure if they in fact know how to apply EI in the clinical setting. Table 2 was used to illustrate the progression of theme development, interpretations, and outcomes of interpretation.
4. Each significant statement will be examined to explore how each of the lifeworld existentials may guide the understanding of the participants' lived experiences as the lifeworld existentials relate to their realities. Please see Appendix H for the organization of this section.
5. Invite participants to read the transcript and offer interpretive insight. Van Manen (2014) promotes this step; however, he does not use and disagrees with the term member checking.

Thus, van Manen's approach requires the researcher to read the entire text or transcript several times and then select the statements that would reveal the essence of the

lived experience being studied. These statements will formulate into meanings and themes. As themes began to emerge, it was possible to observe recurring themes as commonality or possible commonalities; they assisted in capturing the main tenor of the themes in my study (van Manen, 1997, 2014). Van Manen (1997, 2014) also emphasized the importance of keeping the hermeneutic interview or conversation open so that the meanings of the lived experiences would become free to be seen. To that end, participants were invited back to reflect on their transcripts and possibly the draft description of the phenomenological themes to offer their interpretive insights.

Van Manen's (1997, 2014) hermeneutic phenomenological approach to understanding lived experiences is less procedural than other prominent phenomenologists such as Colaizzi (1978) whose data analysis process is more concrete in terms of categories and structure, which is at odds with interpretive work. Van Manen's lifeworld existentials and selective reading approach helped me arrive at discovering and explicating the participants' lived meanings more intersubjectively. The more formulaic data analysis processes such as Colaizzi's may offer seemingly more tangible steps for analysis; however, I felt that van Manen's less rule-bound method allowed me to enter into the lifeworld of the participants. Van Manen's approach also permitted me to assume a position that was close to the data (the participants) and at the same time constantly able to bracket, step back, and maintain a phenomenological orientation of reflectivity. The results were a comprehensive description of the lived experiences, validated by the participants. Moreover, van Manen's (1997) lifeworld existentials helped me evoke the participants' lived experience and achieve the

"phenomenological nod"(p.27); that is, the participants' lived experiences were something that may potentially be experienced by others.

Issues with Trustworthiness

Credibility. Validity is the accuracy or correctness of the research findings (Creswell, 2009). In qualitative research, credibility, or internal validity is the believability or truthfulness of the research findings, which is indicated by the depth and richness of the data (Creswell, 2009; Patton, 2002; Shenton, 2004). Van Manen (2014) in defence of pure phenomenology insisted that measures from other qualitative methodologies such as content validity, or criterion-related validity are not compatible with the phenomenological research traditions. Van Manen (2014) maintained that "no procedure such as members' check or triangulation of multiple methods can fulfil such demand for validating a phenomenological study" (p. 348). The validity of a phenomenological study is whether the study provides insights and accuracy in the interpretation of the participants' lived experiences. Although van Manen (2014) resisted using the term member check, he agreed that it is possible to confirm with the participants whether the descriptions of their anecdotes resonates with their original experience. To that end, step 5 of the data processing described above where the participants were invited to read the transcript and offer interpretive insight served to validate the credibility of the findings. In addition, phenomenologists claim that there is no one universal absolute truth in lived experience; hence, the essence of the PN students' lived experience from the abstracted themes would provide meanings (van

Manen, 2014). Therefore, from a phenomenological perspective, each of the participant's experience was credible (van Manen, 2014).

Transferability. Transferability is the external validity in qualitative research and refers to the applicability of the research findings to other contexts with similar situations and populations to allow comparisons (Patton, 2002; Shenton, 2004). It was difficult to predict whether the findings of my study would be transferable because it was nearly impossible to imagine transferring any human experience to different contexts (Patton, 2002). However, Patton suggested a middle ground might be to consider the "fittingness" of context (p. 584). It is possible that my findings would be fitting for others to consider when researching EI and postsecondary students. In addition, I could not guarantee that my research findings would be fully transferable, but I would be able to provide the data that would make transferability judgments possible for other researchers (Creswell, 2009, 2013).

Dependability. Dependability is the qualitative counterpart to reliability and is the extent that other researchers could repeat the study and that the findings would be consistent (Creswell, 2013; Patton, 2002; Shenton, 2004). Reliability in qualitative research is also not locked into the quantitative-positivist notions of replication, but in the richness of its information (Patton, 2002). The findings of my study contain rich in-depth information of the participants' lived experiences; thus might contribute to reliability. In addition, Giorgi (1988) recommended that to establish reliability in phenomenological research, the researcher needs to choose a method that is committed to the phenomenological philosophy and attitude. I believed that my explanation and

commitment to van Manen's (1997, 2014) orientation of hermeneutic phenomenology was sound and might provide reliability to my study. Furthermore, my commitment to the phenomenological practice of bracketing my presuppositions and experience aided in achieving and contributing to the truthfulness of the study (Hycner, 1985; van Manen, 2014). Moreover, the in-depth methodological description of my study, the use of van Manen's (2014) lifeworld existentials and selective reading approach of data analysis offered dependability in terms of the steps to repeat the study. Nonetheless, there was no way to completely guarantee the consistency of the findings because another population of participants might have an entirely different essence of their lived experience than mine.

Confirmability. Confirmability is the qualitative counterpart to objectivity, or the degree of neutrality in the findings of the research study; that is, findings are exclusively based on participants' statements (Patton, 2002; Shenton, 2004). To establish confirmability, I used direct quotes from the participants in the results. In addition, I used bracketing as aforementioned, and declared my beliefs and assumptions about my own lived experience with EI in the clinical settings.

Summary

This chapter was comprised of a detailed review of the methodology and research method that were used for my proposed study with rationale to support the chosen research approach. In addition, my role as the researcher, a description of the participants and selection process were presented. The research design, including data collection methods and management, data analysis, and data synthesis were provided. Ethical

considerations and an explanation of addressing validity, reliability, and trustworthiness of the study findings concluded this chapter.

Chapter 4: Results

Introduction

The purpose of this interpretive qualitative study was to use a hermeneutic phenomenological design to explore PN students' lived experiences with emotional self-management in the clinical settings where they often experience stress-related situations. In order to address the gap regarding an understanding of PN students' self-management of emotions, I conducted in-depth, face-to-face interviews with PN students. The goal was to explore the students' experiences with its intersubjective attributes, and not to asseverate my findings as fact.

The following research questions were used to direct my investigation:

1. What are PN students' experiences of emotional management in the clinical settings?
2. How do PN students in the clinical settings experience the management of their emotions?
3. How does emotional self-management affect PN students' learning experience in the clinical settings?

This chapter will begin with a report of the pilot study and the impact it had on the main study. The next section describes the procedures I took to suspend my own judgment and experience from the experiences of the participants in order to meet them in the interpersonal space I shared with them (see van Manen, 1997, 2014). A detailed account of the data collection process will follow. In the data analysis section, I reported

the process of using van Manen's (1997) selective reading thematic analysis approach and lifeworld existentials to isolate the participants' phrases and sentences to focus phenomenological meanings, their relationships to the lifeworld existentials, and addressed the research questions.

Pilot Study

In an effort to determine the feasibility and appropriateness of the interview questions, I conducted a pilot study with two participants individually in the privacy of my office. These participants were subjected to the exact measures of the interview protocol and signed the informed consent. I reviewed the interview protocol with both participants and informed them that they could stop the interview at any time without reason or any reprimand. They received a $10 gift card of their choice at the end of their interview.

Both participants of the pilot confirmed that the interview timeframe of 20 to 60 minutes was appropriate and, in fact, fit in comfortably with their timetables without any unnecessary inconvenience. The feedback the participants provided was that the interview questions were clear and they believed the usability of the questions would result in meaningful information for the study. There were no changes made to the interview questions other than the order in which I asked them. Consequently, there was no change made to the research questions.

Interviews

Setting Demographics

Seven participants responded to the call to participate via the electronic poster posted in the Blackboard homeroom where all students could see communications and upcoming events within the nursing department. Three responded via word of mouth. All the participants initiated their interest to participate via email and then came to the interview on a mutually agreed upon date and time. All the interviews took place in the privacy of my office at a college in southern Ontario, Canada. I arrived for each interview approximately 15 minutes early to ensure that my office was comfortable, my recorder was in working order, and I was calm and ready to begin. Prior to the beginning of each interview, I reviewed the purpose of the study, the interview protocol, data collection and storage, potential ethical concerns, and addressed terms of confidentiality with the participants. I explained the format and confirmed the approximate length of the interview. I also informed the participants regarding how the data would be used and the disposal of it 5 years after the termination of the study. The participants were given the assurance that if they felt uncomfortable or experienced any stress, they could choose to stop the interview at any time without consequences. The participants were asked if they had any questions, then signed the consent form before the interview began.

I started each interview with a casual conversation asking how they were doing or the weather in order to put the participants at ease. I asked the interview questions in sequence as they appeared in Appendix B. Occasionally, the participants requested me to repeat a question or further clarify it during the interview. I waited for the participants to

reply to each question, and I asked one question at a time using minimal probes such as "can you expand on that?" or "can you tell me more?". I encouraged responses with occasional nods of the head or "uh huh". I refrained from exhibiting any facial expressions in case they might influence the participants' answers. I also monitored for nonverbal expressions to cue me to either retreat or redirect the question more appropriately.

At the end of each interview, each participant was given a $10 gift card and I reminded them of how to get in touch with me should they have further questions. I informed the participants that I would contact them via e-mail to verify the transcripts. I made voice files for each recorded interview, labelled each with the assigned pseudonym, and stored them in password protected NVivo Pro 11 and a USB memory stick. I transcribed each of the interviews into a Microsoft Word document and stored them in NVivo Pro 11. The digital recorder, the USB stick, NVivo Pro 11 in my laptop, and the printed transcripts were stored in a locked cabinet in my home with a security alarm system. I sent each participant an email to offer them an opportunity to review their transcript. Seven participants declined, three responded and came to my office to review the printed transcripts, and none provided further information or comment.

Participants' Profiles

All the participants were practical nursing students who were either in their final semester of the program or in the final clinical practicum before graduation; thus, they were homogenous with insignificant different characteristics that did not impact my study. Table 1 provides a summary of the participants' profile. I was not teaching any of

these students this semester nor would I be in the future. Each participant was preassigned a pseudonym. I used the participants' pseudonyms in the results section to ensure confidentiality as well as to acknowledge the intersubjectivity I shared with them as a fellow human being, which is in accordance with the phenomenological traditions.

Table 1

Participants' Profiles

Pseudonyms	**Gender**	**Age Range**	**Previous Postsecondary Education Experience**
Audrey	F	20-30	
Cece	F	20-30	✓
Dee	F	30-40	✓
Devin	M	30-40	
Dora	F	40-45	✓
Jasmine	F	20-30	✓
Julie	F	20-30	✓
Liz	F	30-40	
Richard	M	20-30	✓
Sass	F	30-40	✓

Data Collection

The data collection period for this study was during January to February, 2018. Ten participants participated in my study. Each interview took place in the privacy of my office and the duration of each interview was between 20 to 45 minutes. Each interview went smoothly with no interruptions. Each interview was audio recorded using a digital recorder. Handwritten notes were made during the interview on the paper in which the interview questions were printed and identified by the participants' pseudonyms.

After I transcribed the interviews, I followed van Manen's (1997) selective reading approach of thematic analysis by reading the transcripts numerous times to glean understanding of my participants' lived experiences and to familiarize myself with the

data. Van Manen referred to this approach as unrestricted to systematic edict, and a process of "insightful invention, discovery or disclosure to formulate a thematic understanding" (p. 79). Subsequently, I used NVivo Pro 11 to organize the transcripts and arranged the data using the participants' words, phrases, and sentences into different meaning units and themes. As explained in Chapter 3, I did not use NVivo Pro 11 for coding, but to aid in the organization and storage of phrases and sentences that stood out in the transcripts as relevant to answering the research questions. NVivo Pro 11 enabled me to see how frequently similar phrases and sentences emerged as well as to establish patterns in the data. I also linked and organized the meaning clusters into themes and identified the lifeworld existentials. NVivo Pro 11 helped me develop trees that demonstrated how I got from data to findings. In general, I identified experiences that most or all of the participants had in common using NVivo Pro 11. As much as possible, I identified phrases and words in the transcripts that were notably indicative of the experience and used them to identify themes and support my results. NVivo Pro 11 enabled me to illuminate and consider the possibilities to frame understanding by identifying and clustering themes as exhaustively as possible from the participants' narrated experiences. Van Manen's selective reading approach of thematic analysis and the use of NVivo Pro 11 as an organization process assisted me in focusing phenomenological meanings, as well as exploring their relationships to the lifeworld existentials, and addressing the research questions.

In addition, van Manen's (1997) selective reading approach of thematic analysis demands the researcher to organize the themes to glean "structure of the lived meaning",

and the participants' "structures of experience" (p. 77). I attempted to exercise phenomenological purity in the phenomenological research process tradition by physically submerging into my participants' subjective realities while bracketing. I did this by printing the transcripts, cutting them into smaller pieces, taping them to the wall in my home office, hand managing, and arranging some of the themes, as well as placing the handwritten notes from the interviews next to the themes. I then sat back to read the wall slowly from one cutting to the next and back and forth repeatedly in an attempt to put myself into the participants' shoes. It is impossible to completely enter into the lived experience of the other; however, the tactile process was a kind of simulation of the submersion and attempt to imagine the participants' subjective experience. The physical process of selective reading approach of reading the interview transcripts repeatedly, to highlight, circle, and underscore participants' statements helped me captured the essence of the participants experiences and focused phenomenological meaning-making (van Manen, 1997, 2014). As mentioned in Chapter 3, to interpret does not mean that I imposed my own interpretations on the participants' statements; rather, interpretation was the unspooling, or unscrambling of what the participants said and distilling the essence of their experiences (van Manen, 1997, 2014).

Bracketing/Epoché and Reflexivity

Bracketing Epoché

Before the interviews, I practiced epoché, or bracketed my judgement and preunderstanding of my own experiences with emotional management by journaling. I used my journal for the exclusive purpose of acknowledgments and connections to my

presuppositions, assumptions, and insights on the way they influenced my inquiry as I progressed through the phases of my research (Hycner, 1985; O'Connell & Dyment, 2013; van Manen, 1997). This reflexive journal served as my active bracketing. Excerpts from my journal are in Appendix E.

During the interview and data analysis process of each participant, I continued to practice epoché to suspend my own judgments, experiences, or realities regarding emotional management in the clinical settings in order to understand my participants' experience while, at the same time, I practiced dasein, or being present and aware (see Heidegger, 1927/2010; van Manen, 1997, 2014). I did this by consciously reminding myself during the interviews and had the word epoché posted on the wall behind where the participants sat. During the repetitive reading and analysis of the data, I clicked out of NVivo Pro 11 and wrote in my journal to bracket.

Van Manen (1997, 2014) discussed the fact that the phenomenological process is a personal experience for the researcher. By consciously bracketing my own narratives, I was able to understand the participants' lived meanings with emotional management in the clinical settings. Van Manen (1997, 2014) recognized that it is unachievable to suspend in unmitigated objectivity because the researcher is always intrinsically present in phenomenological research. My effort in bracketing my judgement and preunderstanding permitted the participants to illustrate the essence of their lived experiences.

Reflexivity

Reflexivity is a self-given awareness (van Manen, 1997, 2014). Van Manen (1997) advised, "to be aware of the structure of one's own experience of a phenomenon may provide the researcher with clues for orienting oneself to the phenomenon and thus to all the other stages of phenomenological research" (p. 57). I was an interpretive and reflective being as the researcher; hence, it was important that I was reflectively aware of the structure of my own lived experience with emotional management to orient myself throughout the data collection and analysis process. My reflexivity involved my empathy toward the participants as the others who may share the same or similar intersubjective lived experiences and my appreciation of the intersubjectivity that my experience was also possible to them. I acknowledged the fact that the interviews themselves were a context of interactive focus for phenomenological meaning-making.

Moreover, my reflexivity demanded my being aware of my responsibility in the production of meaning; therefore, my reflexivity allowed me to be cognizant of how I situated myself within the research process. Posting the word epoché on the wall behind the participants and writing in my journal were my deliberate actions to "make explicit my understandings, beliefs, biases, assumptions, presuppositions, and theories" about emotional management (van Manen, 1997, p. 47). Practicing reflexivity does not mean that I deserted the preunderstandings of what I knew prior to and entering into the study, but it was for the purpose of illuminating them so that I could keep open the possibilities of the "what is it like question" I found myself so intensely riveted on (van Manen, p. 43).

Furthermore, van Manen (1997, 2014) discussed phenomenologists' general objection to the term data because it implies something quantifiable, and lived experiences are not quantitative. However, the word data, derived from datum in Latin, means something given or granted; thus, when the participants shared their lived experiences with me, they gave or granted their experiences (van Manen, 1997, 2014). Hence, data pertaining to phenomenological inquiry is "when someone has related a valuable experience to me then I have indeed gained something, even though the "thing" gained is not a quantifiable entity" (van Manen, 1997, p. 53). These gains are the findings from my study. Therefore, my reflexivity permitted me to clear the research passageway to arrive at the sinn des seins of my participants from their orientations; that is, to expose their experiences when they become intelligible (Heidegger, 1927/2010).

Data Analysis

I organized and focused phenomenological meanings of my study using van Manen's (1997) selective reading approach and lifeworld existentials. First, I read the entire transcript of each participant as many times as necessary. I then selected statements or phrases that contained direct significance to the lived experiences under investigation. Focusing phenomenological meanings began at this step by using NVivo Pro 11 to organize the data to develop themes from the participants' words, phrases, and sentences. Focusing phenomenological meanings continued as the analysis unfolded with new meanings until the data became repetitive. After the acquisition of an inventory of significant statements, I grouped the statements into more prominent meaning units to formulate themes. Table 2 provides a list of meaning units to illustrate the progression of

themes development. Please see Appendix F for a more information. Next, I examined each significant statement to explore how each of the lifeworld existentials guided the understanding of the participants' lived experiences as the lifeworld existentials related to their realities. Appendix G provides a list of sample statements to demonstrate the organization of this section. Finally, I invited participants to read the transcripts to verify their interviews.

The interview questions served to direct the intentionality and draw out the patho of the participants' lived experiences with emotional management in their clinical settings. Consequently, the interviews and data analysis process generated pathic understanding for me as the researcher because the participants' significant statements, words, and phrases offered insights that were situated, relational, embodied, and enactive to their lived experiences (van Manen, 1997, 2014). The interview questions also helped to organize my thoughts as I classified the emerging themes. All the themes and the significant statements led me to identify and examine them in relation to the four lifeworld existentials.

The premise of phenomenology is to seek meanings, and all the textual statements of the participants in descriptive and hermeneutic phenomenology are letting something show or naming something (van Manen, 1997, 2014). The abstraction of phenomenological themes or structure of experiences is like an archaeological excavation where each piece of artifact is a composite of lived experience building upon each other to construct meaningful wholes. Hence, instead of deriving sub-themes, I grouped the prominent meaning units to abstract the main themes. This was more in keeping with van

Manen's notion of keeping the themes open because no thematic procedure can unseal entirely the complete deep meanings of the structure of lived experiences, and there could possibly be more meanings to come.

Furthermore, phenomenological interpretation was not my imputed interpretations of the participants' statements; rather, it was the distillation of the essence of their experiences (van Manen, 1997, 2014). Therefore, although a detailed interpretation of my research findings is in Chapter 5, the results in this chapter present a certain level of phenomenological meaning-making as I unpacked the interwoven layers of the participants' statements to deduce the themes. It is nearly impossible to refrain from phenomenological interpretation when analysing meaningful texts because hermeneutic understanding is inherently interpretive (van Manen, 1997, 2014). Hence, it was imperative that I bracketed and practiced reflexivity to the best of my ability since it would have been easy to dance between "distanciation and participation" because hermeneutic phenomenology is at once descriptive and interpretive (van Manen, 1997, p. 180).

Description of Specific Prominent Meaning Units and Themes

After thorough reading and rereading of the transcripts, I procured prominent meaning units and abstracted themes from them. Since meaning production in phenomenology is continuous, I signified the repetitive reading, arranging, and organizing of the focusing phenomenological themes development using multiple double arrows above Table 2.

These prominent meaning units came from similar chunks of text that represented the participant's comparable perspectives. Please see Appendix G for a more detailed list of the participants' significant statements.

Table 2

Themes and Meaning Units

Themes	**Meaning Units**
1. Knowledge of EI and personal awareness of emotions	- know how to control emotions. - know how to identify emotions - know you are feeling the emotions - not overreacting - managing certain situations - understand feelings and emotions - relate to others' emotions with empathy, sympathy, and compassion - an emotional being - showing emotions on faces - aware of own triggers - stop and think - being in control
2. Perception of EI/emotions in self & others	-perceive through body language, tone of voice, and facial expressions - perceive through observations - perceive through interactions - perceive through awareness
3. Personal meanings of EI	- to be reflective - to learn more about it - being professional - positive relationships - personal growth - learning experience - providing better care to patients - more professional - better able to accept constructive feedback
4. The *how* experience of EI or emotional experience	- to be aware of people and situations - physical responses - observations of self and others - to relate and connect with others

5. The *first knowing* of emotional management and perception of self as a nursing student	- more aware of it now - more confident - more assertive - more mindful - more flexible - strengthened relationships

Discrepant cases

I did not have any discrepant cases in my study because none of the participants stated anything that was divergent from the themes I abstracted. I used van Manen's (1997, 2014) orientation of hermeneutic phenomenology, which acknowledges the many possibilities in a lived experience. Thus, the themes are the core ideas that may have multiple other phenomenological interpretations. The various possible interpretations of a lived experience suggest that the realms of their relevance are fluid, and do not make them inconsistent (Husserl, 1931/2012; van Manen).

Evidence of Trustworthiness

Credibility

Credibility is the confidence in the authenticity of the research findings in qualitative research, which is supported by the depth and richness of the data (Creswell, 2009; Patton, 2002; Shenton, 2004). Van Manen (2014) resisted the measures from other qualitative methodologies that are not compatible with the phenomenological research tradition and insisted that "no procedure such as members' check or triangulation of multiple methods can fulfil such demand for validating a phenomenological study" (p. 348). Rather, van Manen discussed whether a phenomenological study offers understanding and illuminations in the interpretation of the participants' lived

experiences. Nevertheless, van Manen consented to the possibility of authenticating with the participants whether the descriptions of their narratives express their original experience. Therefore, in step 5 of the data processing, I invited the participants to read their transcript to verify the accuracy of the information conveyed during the interviews. Asking the participants to do more than reading and verifying their transcripts would have been incongruent with the phenomenological traditions (Bradbury-Jones, Irvine, & Sambrook, 2010; McConnell-Henry, Chapman, & Francis, 2011; van Manen, 2014). From the lens of phenomenology, each of my participants' experiences was credible since there was no single ubiquitous truth in lived experiences because truth is multiple, context-specific, and the meanings may evolve each time an experience is remembered (van Manen, 2014).

Transferability

Transferability in qualitative research is the external validity, or the applicability of the research findings to other contexts (Patton, 2002; Shenton, 2004). It was difficult to vaticinate whether the findings of my study are transferable because human experiences are unique and contextual (Patton, 2002). Nonetheless, there might be fittingness for others to consider when researching emotional self-management and postsecondary students. Thus, while I cannot guarantee the transferability of my research findings, I should be able to share the data that allowed possibilities for others to judge transferability in their research (Creswell, 2009, 2013). In addition, transferability is whether a study has real-world implications for practice (Kuper, Lingard, & Levinson,

2008). I believe the findings of my study may have implications for practice at the postsecondary education level. I will discuss these implications in Chapter 5.

Dependability

Dependability is the qualitative equivalent to reliability and is the extent to which other researchers could repeat the study to achieve consistent findings (Creswell, 2013; Patton, 2002; Shenton, 2004). Dependability is not affixed to the quantitative-positivist definitions of replication; rather, it is in the richness of the data (Patton, 2002). The findings of my study were comprised of the copious descriptions of the participants' lived experiences; thus, they may contribute to dependability. In addition, Giorgi (1988) suggested that researchers establish reliability when they choose a method that demonstrates commitment to the phenomenological philosophy and attitude. I believe I demonstrated a sound commitment to van Manen's (1997, 2014) orientation of hermeneutic phenomenology. Furthermore, my commitment to the phenomenological practice of bracketing assisted in attaining the truthfulness of the study (Hycner, 1985; van Manen, 2014). Moreover, the use of van Manen's selective reading approach of data analysis and lifeworld existentials contributed to dependability in terms of the process to repeat the study. Nevertheless, another group of participants may have completely different lived experiences than those in this study; therefore, it is impossible to guarantee the consistency of the findings in phenomenological research.

Confirmability

Confirmability is objectivity in qualitative research, or the degree of neutrality in the findings (Patton, 2002; Shenton, 2004). The findings of my study were entirely

based on the participants' statements and I used direct quotes to establish confirmability. In addition, as aforementioned, I used bracketing to suspend my beliefs and assumptions about my own lived experiences with emotional management in the clinical settings; therefore, my constant reflexivity during the data collection and analysis contributed to the objectivity of my study.

Study Results

Through the study, I gained an understanding of the PN students' lived experiences with emotional self-management from the participants' account of their experiences in clinical placements. Specifically, the themes that emerged answered all three research questions. In essence, the *what* is getting at the participants' total experiences of emotional self-management and their, as objectively as possible, lived experiences about their observations of how others managed or expressed their emotions. The *how* is strictly focused on the participants' own subjective lived experience of emotional self-management.

I focused the phenomenological meanings by examining the significant statements that would answer the research questions. The synthesis of the prominent meaning units and themes described the noema or the whatness of being, or the object of the experience; in this case, the participants' lived experiences with emotional self-management in the clinical settings (Heidegger, 1927/2010; van Manen, 1997). My phenomenological meaning-making of the participants' descriptions is the noesis, or the how of their lived experiences. Noesis is the interpretive act of the participants' attunement of the way they find themselves in the clinical settings (befindlichkeit), which

includes any patho such as perceptions, feelings, thoughts, memories, or judgments that are concealed from their consciousness. I attempted to make these patho sinn des seins (intelligible) (Heidegger; van Manen, 2014).

Each participant's lived experiences were individually distinctive; however, the resulting five themes captured the essence of their experience. This section introduces each of the themes that were abstracted when at least three participants expressed the corresponding perspectives. I used exact participants' statements to support the themes and used ellipses to signify participants' hesitations, or moments of silence when they were thinking. Nuances such as um, like, so yeah, were included because they are phenomenologically meaningful to bring a lived experience into being or view (Heidegger, 1927/2010; van Manen, 1997, 2014). Specific quotations and phrases from the participants exemplified in each theme are in Appendix F.

The five resulting themes are:

1. Knowledge of EI and personal awareness of emotions
2. The perception of EI/emotions in self and others
3. Personal meanings of EI
4. The how experience of emotional management in the clinical settings
5. The first knowing and perception of self as a nursing student

Themes

Theme one: Knowledge of EI and personal awareness of emotions. All the participants admitted that they knew very little about EI and should learn more about it. Notwithstanding, the participants verbalized that they knew EI was "basically" the ability

to know their own emotions and feelings. All the participants articulated that they ought to know their emotions. For example, Audrey stated, "Um, so, like, really like in kind of making sure that you know how to control your emotions in certain situations and when it's right to, you know, kind of hold back I guess sometimes and when you need to overcome certain emotions and, uh, continue on that way". Correspondingly, Jasmine said, "[EI is] within your control, um, and it's not IQ. You're not born with it, um, and it's about your emotions". Cece said she believes EI is "knowing your own emotions and how to identify them", and Dee's response was similar and described her understanding of EI as "understanding what you're feeling, um, how you're expressing your feelings at the time that you're feeling them. What other people are feeling, I'm just trying to understand what they're feeling". Likewise, Julie indicated EI is the "ability to understand my own feelings and emotions and I think it's also, um, being able to understand other people's emotions".

The participants indicated that they are usually aware of their own emotions in one way or another. Dora, while sharing about her growing up experience in a strict household, articulated that her basic knowledge of EI helped recognized how she was feeling by stating, "I felt stifled... I'm not happy... and I don't need to hold on to this and I can actually express myself". Devin described his personal awareness candidly, "I know that I'm a very emotional person and I go from extreme to extreme. So, I always have to be aware of it and, uh, I think I do generally a good job, but there's always room for improvement... it's definitely something I need to learn more about and constantly work at". Jasmine provided an example of when she felt frustrated waiting in line at the

grocery store, but asked herself, “Why am I frustrated? I’m just going to take a minute... I feel like I am controlling my emotions”. Dee quantified her personal awareness and stated, “I’d say 75% of the time I am... But, there are times when I’m not aware”. On the other hand, Sass identified the awareness of her emotions was usually a physical one:

> Um, when I’m feeling low, or stressed, or depressed, or anxious, usually I can tell. There are sometimes physiological symptoms, um, that I can feel if I’m anxious there are palpitations and get very anxious, um, shakes a little bit. Um, or if I’m feeling low, I can tell when I’m feeling low, like I can feel just the weight in my body, um, if I’m feeling depressed or whatever.

Julie also described similar physical responses to her own emotions:

> Um, sometimes you get like tense, like you feel kinda tense, like if something, if you hear something or if you feel like you’re going to be upset about something. Somebody maybe says the wrong thing to you and it just kind of bugs you. I start to feel kind of tense. Sometimes I get butterflies in my stomach, red in the face.

These quotations demonstrated that the participants had the basic knowledge of EI and were generally aware of their emotions. However, while what they said about EI was correct in terms of knowing their emotions basically, none of them attempted to articulate a more elaborate explanation or definition of what they think EI is. There were many hesitations; in fact, some stated they were not sure if they answered the questions correctly. On the other hand, the participants were more comfortable and less hesitant to share that they were usually aware of their own emotions. Devin’s confidence in professing that he was very emotional, and Dee’s honest quantification of 75% of the

time she was aware, confirmed their basic knowledge of EI, which begins with self-awareness (Mayer et al., 2016).

Theme two: Perception of EI/emotions in self and others. All the participants indicated that they perceived themselves to have some EI, and their basic understanding of EI allowed them to perceive emotions in others occasionally. For example, Audrey described that she perceives her EI ability as being able to stay balanced. She said, "I try to stay pretty even and I do my best to stay even keeled". Audrey used an example from a clinical situation to demonstrate that she perceived she had effectively used EI. She noted that when she was upset with her preceptor she managed to stay even keeled. She said, "I honestly wanted to like start bawling in the hallway, but I didn't. So, that was, uh, you know, trying to be emotionally intelligent". Julie described a similar perception of her EI ability as Audrey in terms of her attempt to hide her true feelings. Julie said:

> Sometimes I have like a 'fake it 'til I make it' kind of attitude... if things aren't going as planned and maybe I am upset about something or taken off guard... you wouldn't even be able to notice this because I put on like a smile and a brave face and kinda deal with it.

It seemed an easier task for all the participants to acknowledge that they were able to perceive EI/emotions or lack thereof in others. All of them indicated that they could usually perceive others' emotions through body language, tone of voice, facial expressions, and general observation of others. Audrey stated, "I think a lot of it is, like visual, but, um, also the tone of voice people are using or, like different, um, tics that they seem to have or if they're asking a lot of questions or if they're like holding back". Liz

summed it up rather pointedly: “For the most part, I think people generally have their emotions under control... it’s easily identified when they don’t through interactions with them”. Liz continued with an example of witnessing nurses who allowed their emotions to negatively impact quality patient care: “I was very upset at the time... frustrated with these people, [they] should know better”. Similarly, Dee described a situation in a clinical setting when a nurse was behaving inappropriately in front of the patient over a defective blood pressure machine. Dee stated, “...it was very hard ‘cause I don’t think it’s acceptable when there’s patients sitting there and you could tell it was making more than just me uncomfortable”.

This theme overlapped with the first theme of personal awareness of emotions. The philosophical difference between perception and awareness rests in the appearance (van Manen, 2014). For example, if I see a twig but misunderstood it to be a caterpillar, that is my perception; awareness is realizing it is, in fact, a twig. Therefore, awareness is dependent on perception and vice versa, assuming that I knew what a caterpillar and twig look like because I have seen them before. Hence, the participants’ basic knowledge and awareness of their own emotions allowed them to perceive their own and others’ emotions because they had seen it before.

Theme three: Personal meanings of EI. Being reflective and professional are the main premises of the participants’ descriptions of what it meant to be emotionally intelligent. This was likely owing to the fact that reflective practice and professionalism are two of the specific nursing professional practice standards and learning requirements (College of Nurses of Ontario [CNO], 2015). For example, Cece stated, “Um, I just think

to me personally, it means to self-reflect and to identify how I'm feeling, um, in the clinical setting when I have patient encounters that may evoke an emotional response within myself or something new that I have seen". Devin said, "It's a difference between being professional and not... I do a lot of self-reflection... pretty much every day on my way home I kinda think, okay, what happened, what could I do differently, why is this happening... what could I do differently".

In addition, participants emphasized the ability to control their emotions was meaningful to them in the clinical settings because it was the professional thing to do. For example, Julie stated, "I guess I feel that it's important to be aware of your own feelings and your own emotions. I just feel like it's important to be in control of your own emotions and when it's important to share them and how you want to share them with other people". Richard shared a similar sentiment when he said: "Stay level headed and, uh, think rationally... while emotions can be running rampant". In agreement, Jasmine stated, "Because it lets you, like, control. You know that you're controlling your emotions and that you're staying professional".

Furthermore, the participants remarked that the abilities to empathize and sympathize with colleagues and patients were meaningful to them for relational reasons. A few participants used the words empathy, sympathy, empathize, and sympathize, while others indicated being able to understand how others are feeling. For instance, Sass asserted: "Being able to, um, understand people and what they're feeling and what they're thinking and being able to relate to them through their emotions, empathizing if they are struggling". Liz stated, "[It means] to be able to identify and control their own

emotions and how, um, it relates to an inter-disciplinary team and relationships, both personal and colleagues".

This theme of personal meanings overlapped with the theme of personal awareness because the participants repeated the importance of being aware of their emotions so that they could control them to be professional. Notwithstanding, it is worth noting the distinction between the notion of awareness and the cultivation of personal meanings of EI, albeit the themes may appear similar or repetitive. The rationale is that awareness may not automatically translate into meaningful personal knowledge; many people stay at the most basic level of minimal awareness without moving forward toward growth and reflective regulation of emotions (Mayer et al., 2016).

It may be accurate to suggest that the notions of professionalism, reflection, and empathy emblematize the essences of what it means to be emotionally intelligent for the participants at this stage in their clinical learning. In sharing their examples in the clinical settings, these meanings are also closely linked to nursing and becoming nurses. For example, Richard described empathy in nursing as: "I mean making someone happy isn't necessarily the goal of nursing, but making someone comfortable, and making someone's feelings heard, making someone, uh, and just being with them, with what they're going through, is a big part of nursing". Sass reflected on why EI was meaningful as a student nurse:

> learning that [EI] as a student is something you will carry with you for the rest of your career... Right now it might be a little, it might not be enhanced right now, but it's something that's going to come more with experience I find. So it's

important to learn it now, as a student, and carry that with you through the rest of your career.

Theme four: The how experience of emotional management in clinical settings. The how experience of anything is completely subjective (Heidegger, 1927/2010; Husserl, 1913/1983; van Manen, 1997, 2014). All the participants including those in the pilot study initially found it difficult to describe how they experienced emotional management in the clinical settings. I used the analogy of going to a rock concert to clarify how I experienced the music perhaps by sitting back to listen might be completely different than how others experienced it by dancing and singing along with the band. This analogy served to palliate the abstractness of the how experience for the participants.

All participants expressed being observant as a way to experience emotional management in the clinical settings. This observation included being aware of their own emotions while being open minded about others, and the awareness of their physical environment. Thus, how the participants experienced emotional management also overlapped with theme one: knowledge of EI and personal awareness of emotions. Audrey acknowledged that there are various ways to experience emotional management in the clinical settings; however, it is important to be aware of one's surroundings: "Um, I think you have to be aware of, um, what's happening around you generally. Um, so, depending on what's happening, in your like area I guess, um, there's different ways you can experience it". Cece was more introspective in her response and noted the relevance in being able to separate herself: "I think it's important for someone to realize, um, their

own feelings and the feelings of their patients and just have that, clear divide, um, between the two because it's about your patient in the clinical setting. So you can't let your own affect that". Devin's perspective was also to acknowledge that everyone's experience is unique depending on their role, he stated: "Everybody is there for a different purpose... everybody has different feelings about being there. For the patient, it's probably the worst day of their life and I'm a guy there just having fun, trying to learn as much as I can".

In addition, the participants discussed their physical responses or the observation of their own body language, facial expressions, and tone of voice in how they experienced emotional management in the clinical setting. Julie discussed consciously putting on "a smile and a brave face", while Sass talked about physically experiencing "palpitation", "shake", and the "burden of weight". Audrey believed that she could sense a change in her own voice, and metaphorically described being physically aware because she wears her emotions on her sleeve. Cece shared about knowing the "triggers" and stated, "There's a physical response that happens for me... that happens within me and I'm able to identify that response". Cece went on to describe her eye rolling that triggers other physical responses:

> Uh, I think for me, like my facial expressions are pretty big. Even though I can't see them, but, like I can tell, um. So. For me, I have a big thing with eye rolling, but like, it's to the point where I don't even feel when I'm doing it, so like, people are saying 'stop rolling your eyes' and I don't know I'm doing it. I'm so sorry. Um, soo I know I do that. So, that's something I have to be aware of. Um, but I

> guess for me, like if I'm in a sticky situation or like a really, um, I don't know, intense situation where I don't know what I'm doing, I can feel my face get hot instantly. So, I get I have a physical reaction to what's happening. Um, yeah, I guess physical and I'm probably really awkward if, uh, if something weird is happening. But, I try not to be. So, I try to be aware of what is happening.

Furthermore, the notion of professionalism is a central factor in how the participants experienced emotional self-management. Dora and Jasmine both stated the importance of "listening and communicating" with others professionally regardless of how they may be feeling. Jasmine offered a personal example of the numerous times when patients or family members questioned her wearing a hijab and despite feeling offended or targeted, she would use professional communications to calmly explain and educate the cultural reasons of the hijab: "Um, at first, I was kind of offended, but, then I was, like, thinking and then I thought, like, instead of being upset...I just tried to remember stay professional, stay professional". The act of professionalism as a contributing factor that influenced how the participants' experienced emotional self-management was in line with the previous theme when they emphasized being professional is personally meaningful. The notion of professionalism is important to note as meaningful because it is a concept and practice that is constantly reinforced in nursing education and by the governing body (CNO, 2014). It is not surprising that the participants have all used the term professional to either describe or express their lived experiences during the interviews.

Theme five: First knowing and perception of self as a nursing student. The participants openly shared some of their examples of when they might have effectively used emotional management in the clinical settings given their limited knowledge. EI and the core concept of emotional self-management are not specified in any nursing curriculum as confirmed by my personal communications with Dr. De Luca and Butts in Chapter 1, as well as findings from literature reviews in Chapter 2. The participants' basic knowledge of EI was a result of secondary classroom discussions pertaining to topics such as conflict resolutions in the workplace and therapeutic communication. The participants' introductory learning of EI began with an incidental definition in the classroom and then they were entirely left to their own initiative to research and learn more about it. Therefore, this theme of the first knowing presented a glimpse into the 'a-ha' moments when the participants utilized emotional management effectively, and the insights of those moments consequently equipped them with more self-confidence and their ability to link the importance of EI in the clinical settings.

This theme specifically answered the third research question of how emotional self-management affected the PN students' learning experiences in the clinical settings. All participants indicated that the first knowing of EI and emotional management had made them more self-aware and they felt more confident as student nurses. Cece felt she already possessed EI; however, she did not know its official name until one of the lectures. Cece indicated that the official first knowing propelled her to "become more mindful... You know what to look for..., are able to identify them, pinpoint them, and work on them in a clinical setting. From that point knowing has become better". Audrey

concurred with Cece by stating, “I feel like, um, it’s just very, once you know about it, it’s very easy to place it in the clinical setting and um, to be more aware of different things... I’m aware of it now, whereas before, I probably wasn’t”. Dee echoed this sentiment: “when I’m out in placement, I am more aware of what’s going on around me”. Devin stated similarly, “now that I’m aware of it, I am able to use that to my advantage, it makes me more professional. I feel good about myself knowing”.

This theme directs all the themes full circle and illustrates their overlap. The first knowing of EI required the participants to first be self-aware and have some basic knowledge of what it is. Thus, the first knowing provided the ability for the participants to perceive EI in themselves and others, as well as offered some context to ascribe personal meanings and ways to experience it. Since EI is not an explicit learning topic in any PN curricula in Ontario, the participants only managed to acquire a limited knowledge of its concepts. Nonetheless, the basic understanding gave the participants a certain level of confidence in their clinical settings, and they were beginning to recognize its usefulness.

Lifeworld Existentials

Further to the five abstracted themes that described the essence of the structure of the participants’ lived experiences with emotional self-management in the clinical settings, I applied van Manen’s (1997, 2014) lifeworld existentials to explore the structure of the participants’ lived world with emotional self-management. Please see Appendix G for the organization of this section.

There are various existentials, such as language, a sense of longing, or death and dying; however, van Manen's four lifeworld existentials are the fundamental universal permeable aspects of every human being regardless of individual, cultural, social, or historical context. These lifeworld existentials are "lived space (spatiality), lived body (corporeality), lived time (temporality), and lived human relation (relationality or communality)" (van Manen, 1997, p. 101). Lived space is a physical felt space and a space in the thought or memory because lived spatiality is not restricted to physicality. Any given physical space where a lived experience is possible is instantly a space in the memory because now is always too late; thus, a felt space in the here and now is at once a space in the thought where it is processed, authenticated, and remembered (Heidegger, 1927/2010, Husserl, 1913/1983, van Manen, 1997, 2014). Lived body is a person's physical presence while experiencing something, whether intentionally or not. Lived time is one's subjective temporal way of orientation in the world in the past, present, or toward the future. Arguably, there is no real present because it is always a split second too late (Heidegger, 1927/2010, Husserl, 1913/1983, van Manen, 1997, 2014). Lived human relation is the interpersonal space we maintain as we live relationally (van Manen, 1997, 2014). The four lifeworld existentials are interrelated; thus cannot be separated. However, I provisionally extricated the four existentials for the purpose of my study while discerning that one existential inevitably brings forth the others.

The clinical settings were the lived space in which the participants' experienced emotional self-management, and whether they physically, subconsciously, or intentionally experienced it is the lived body. The lived time was the participants'

subjective time spent in clinical settings, and the participants' interactions with patients, colleagues, and other healthcare professionals was the lived human relation. The following participants' significant statements offered a representation of the structure of their lived world with emotional self-management in the clinical settings.

Audrey's lived space and lived body existentials in the clinical setting were captured when she stated:

> You have to be aware of what's happening around you generally (lived space). I feel like once you know about it [EI], it's very easy to place it in the clinical setting (lived space) and to be more aware of different things, because then you're kind of watching yourself (lived body), especially as a nursing student, you're kind of under like the microscope and so you're aware that you're under the microscope (lived body or a figurative lived space).

Compared to Audrey, Devin's expression was rather transcendental and portrayed being in clinical as "always strange... everybody has different feelings about being there". Devin's use of the word 'strange' was powerful because it embodied his subjective lived time as a kind of strangeness while in clinical, as well as his lived body and space when he described the strange feelings about the clinical setting. Devin went on to say, "A big part of our job is to help our patients emotionally and that's probably one of the best things I can do at my stage right now for my patients is to be there for them". This statement demonstrated Devin's lived human relation, and the metaphorical lived space and subjective lived time of "to be there" In addition, Devin expressed the importance of "setting up those boundaries in a calm, collected, and respectful manner" in the clinical

settings, which illustrated his figurative lived space and lived human relation. Dora also mentioned boundaries as a necessary lived space: “it’s ok to set up those boundaries”. As though summing up what Audrey, Dora, and Devin said, Jasmine described her lived time and space in clinical in one short sentence: “... it just makes your day (lived time) at clinical better (lived space) when you use it [emotional management]”.

In addition, the act to reflect exemplified the subjective lived time (van Manen, 1997, 2014). By virtue of participating in the interview for this study, all the participants engaged in a kind of reflection or a recalling of their experiences. Some of the participants mentioned the ability to reflect as an important tool they use in the clinical settings. When the participants reflect, they are recollecting a temporal dimension that is in the past and a landscape they use to influence the future. For example, Cece knew that she preferred happier patients and described the decision for her future job resulted from reflection:

> I just kind of did what I needed to in the situation to be there for my patient, but then I reflected on it afterwards and really, you know, talked with myself and saw, okay, this is what you like, this is what you don’t like and these are the types of patients you do or don’t want to deal with. I think reflection is the most important piece [in emotional management] because then you really decide, okay, this is what we did, this is good.

In Richard’s case, reflecting can positively influence performance in future clinical settings when receiving constructive feedback from clinical instructors:

> reflecting is a good thing to help practice [in the clinical settings]... to really think about how things make you feel and how things might affect your perspective... reflect that maybe there is something I can improve on in the situation rather than you know, reacting, maybe getting snippy or getting angry.

Julie reflected on her experience with her first knowing as feeling "like a wake up call (lived time)... Um, yeah, I think. I mean I still don't know what I want to do, but I'm getting there. I'm learning. I'm growing". When describing a stressful situation, Julie also stated, "I'm probably going to experience that several times, or several times a day, in my career. So, um, just learning to control it at the time (lived time) and then go through the proper channels to have it dealt with later". It is significant to note that Cece, Julie, and Richard's statements illustrated the elusiveness of the lived time existential. The here and now are always too late because the present of now is never possible (van Manen, 2014). Therefore, lived times are always the snapshots of the subjective time in the past and prediction or hope of the future. Thus, the participants were only able to describe their subjective lived time by the act of reflecting on their experiences and projection toward the future.

Furthermore, all the participants described negative interactions (lived human relations) with their patients, colleagues, or preceptors in the lived time and body existentials in their descriptions of taking a few deep breaths, stepping back (lived body), and taking time to cool off or to reflect (lived time). For example, Julie stated, "you need to kind of be able to deal with your own emotions for five minutes, ten minutes, however long it is". Dee explained the juxtaposing of being able to "control how long I'm going

to be feeling that way (lived time and body), as opposed to I can't really stop myself completely from feeling something, ... I try to step back and see" (lived body). In agreement with Julie and Dee, Devin, Dora, and Richard indicated the importance in the clinical setting to take the extra time to think, step back to regroup, and not react in a negative way; this also illustrated their lived time and body existentials.

Lived human relation is the existential that received the most nods by the participants, albeit its intricateness with the other existentials. All the participants acknowledged the importance of developing therapeutic relationship or rapport with their patients and colleagues and recognized that they have to deal with different personalities professionally in the workplace. For instance, Cece indicated that the way she builds rapport with her patients is to "pay attention to what they're saying, their cues and body language, their tone of voice and overall interactions". Cece gave an example of a patient who received some bad news and she had to stay strong: "I need to be there for them emotionally and I need to do this for them even though I wanted to cry myself because the situation was very sad". Cece continued to declare the importance of "having good connections and good relationships with people and being able to recognize that someone's not feeling okay, that someone has a worried look on their face or isn't themselves". Dee's lived human relation with her patients and colleagues is to be "a good listener and try to understand what people are feeling on top of what I'm feeling". Devin shared the way he maintains professional relationships with colleagues was by emphasizing the importance of being understanding and to "reflect on my own actions and consider other people's actions cause I know that they might also be reacting the

same as me, and might not mean what they say. There are breakdowns every day, and you have to be there and support each other emotionally". Concurring with Devin's attitude of being understanding, Julie said, "It's important for me to have an influence on other people and realize that everybody's different, everybody has different preferences and to be a little bit more open minded".

Moreover, within the context of the lived human relation existential, the participants identified the relational factors of being professional and building positive working relationships in the clinical settings. Julie described a disempowering experience of being bullied by another nurse but maintained her composure:

> It made me feel pretty terrible actually. Heh, heh. Just, um, because there are a lot of nurses that understand that you're a student and everything, um, but, yeah it was my first taste of like, you know, um, like the older nurses eating the baby nurses... Um, yeah, so it was just like, I don't know, this is what it's going to be like.

Devin described a disagreement with colleagues and felt that he was able to manage his emotions and maintain a positive working relationship by being professional: "A difference between being professional and not... I think it [emotional management] makes me more professional". Devin continued to indicate that the ability to stay "cool and calm" can elicit a sense of power and control, he stated:

> You feel like you have the power, like I controlled that situation. And, when someone else, when you are able to de-escalate the situation, it really puts you in control. And not saying that I always want to be in control. I definitely like other

> people to take the lead, but when it comes time to shut things down, you need to just be calm and be cool and calm.

Jasmine recalled taking care of a patient with heart failure and that being professional helped her to contain herself somewhat: “the situation is really sad and you’re trying all you can do, but they’re upset and then you get upset. You start crying, but you’re supposed to calm them down... I just tried to. I really couldn’t, but. To, to control it, um. I just tried to stay professional”. Richard shared a time when he made an honest mistake in the clinical setting. He didn’t think his preceptor was being fair and wanted to defend himself but didn’t. Richard stated feeling “really frustrated and I had to keep my emotions in check because being a nurse is about being professional... and accepting feedback and being able to improve”. Sass described an emotional experience of taking care of a palliative patient who eventually died and her professional interactions with the family members:

> The family was there throughout the whole day... I had to try very hard not to have tears and cry in front of them... I had to put on that professional appearance... empathize with them, but still keep check on my own emotions... I think that they go hand in hand, like being aware of other people’s emotions, what they’re thinking and feeling, but being professional at the same time. They have to be equal.

The lifeworld existentials are the universal phenomenological themes of life as they occur continually in the reality of all human beings (van Manen, 2014). The participants’ lived experiences with emotional self-management in the clinical settings

are complex. The lifeworld existentials guided the understanding and exploration of the participants' lived experiences and meaning structures as the lifeworld existentials relate to their subjective realities in the clinical settings. The lived space of the clinical settings facilitated the participants' experienced emotional self-management physically, subconsciously, and intentionally in their bodies. The participants' subjective time spent in the clinical settings is their lived time and accounts for their lived human relations that pertains to emotional management during interactions with patients, patients' family members, and colleagues. The participants' significant statements as they relate to the themes and lifeworld existentials represented the essence in the structure of their lived experiences and answered the research questions.

Summarized Answers to the Research Questions

The research questions are:

1. What are PN students' experiences with emotional management in the clinical settings?
2. How do PN students in the clinical settings experience the management of their emotions?
3. How does emotional self-management affect PN students' learning experience in the clinical settings?

Each theme overarchingly answered all three research questions and it is unrealistic to separate the research questions to answer each individually. Van Manen (1997) discussed that clear research question(s) are required for sound human science research; however, it is nearly impossible in phenomenological research to systematically

explore singularity in any lived experience. Van Manen advised the importance of achieving a "phenomenological nod"; that is, a good phenomenological study is "an adequate elucidation of some aspect of the lifeworld that resonates with our sense of the lived life" (p. 27). Van Manen went on to caution researchers to not fall into the trap of simply ordering or arranging the text to fit them into "some sense of forced quality" (p.168). Rather, we should “search for a sense of organizational form and organic wholeness of the text consistent with the methodical emphasis of the research approach" (p. 168).

The essence deduced from theme one: knowledge of EI and personal awareness of emotions and two: the perception of EI or emotions in themselves and others demonstrated the participants’ basic knowledge of EI. The themes suggest that the students do not yet have a well developed cognition of what emotional management means, so they cannot necessarily assert components of EI, and had a difficult time articulating it. The seemingly incessant usage of nuances, such as like, so like, and um, confirms their struggle in the articulation. Notwithstanding, the participants have a foundational awareness (dasein) of their own emotions and how these are expressed, or what others might see when they are expressed illustrated the whatness of their experiences.

Themes one and two addressed the first and second research questions with respect to what the participants’ experiences are with emotional management, and how they experience the management of their emotions in the clinical settings. The participants’ acknowledgment of having limited understanding of EI influenced the

intentionality of their total experience in what and how they experienced emotional self-management, as well as how emotional self-management affect their learning experience in the clinical settings. Consequently, the limitation of their knowledge in EI signified that the participants might not know what to look for; that is, the noema of their experience with emotional self-management. However, the participants' responses of usually being aware of their own emotions implied that their awareness provided an elementary level toward the possible ongoing and more advanced level understanding of EI. Therefore, the participants' basic EI knowledge allowed them to identify some of their own feelings and observed, or recognized when others are not behaving appropriately. The participants' examples of staying calm or not showing their negative emotions suggested that they experience emotions in the self and others in the clinical settings via observation.

Furthermore, the participants identified the concepts of self-reflection, professionalism, empathy, and sympathy as meaningful. This identification suggested that the whatness and intentionality of their total experience with emotional management in the clinical settings at this stage were centered in their ability to self-reflect, conduct themselves professionally, and appreciate others' feelings, especially those of the patients. The participants continued to state that they try to stay personally aware of their own and observe others' emotions, and are concerned with directing attention to focus on the importance of being professional. In addition, the vividness of some of the participants' physical responses in how they experienced emotional management

suggested that they are learning or attempting to judge their emotions in the clinical settings.

Theme three: personal meanings of EI, and four: the how experience of emotional management in the clinical settings answered the third research question in terms of how emotional self-management affect the participants' learning experience in the clinical settings. These two themes illustrated that the participants are starting to reflect on how their emotions might influence others' behaviors in the clinical settings (intersubjectivity), albeit at this stage, this intersubjectivity appears egocentric and limited primarily to their own emotions and centricity, which is fitting for novices. Nevertheless, the participants definitely have the awareness and acknowledgement of emotional management as it relates to professional being. Thus, the invariant essence is that they are thinking EIat this point; however, it is not second nature.

Theme five: the first knowing and perception of self as a nursing student answered aspects all three research questions. All the participants indicated that the first knowing of EI and emotional management had made them more self-aware and they feel more confident as student nurses. For example, Cece indicated that the official first knowing propelled her to "become more mindful" because she knew "what to look for". Audrey concurred with Cece and stated, "once you know about it, it's very easy to place it in the clinical setting… I'm aware of it now, whereas before, I probably wasn't". Devin stated similarly, "now that I'm aware of it, I am able to use that to my advantage, it makes me more professional. I feel good about myself knowing". Hence, although the participants are exhibiting the basic level of understanding regarding emotional

management, they feel that they would have a more positive learning experience in the clinical settings because they are more aware of it since they began to learn about EI.

Overall, the synthesis of the themes and the lifeworld existentials answered the research questions because the amalgamation described the noema of the participants' object of emotional self-management experience; that is, the whatness of the lived experiences (Heidegger, 1927/2010; van Manen, 1997, p.33). The participants' descriptions is the noesis, or the how and the interpretive act of the participants' befindlichkeit of how they attune themselves with experiencing emotional self-management in the clinical settings and my attempt to make their patho sinn des seins (intelligible) (Heidegger; van Manen, 2014).

Notwithstanding, it is impracticable to separate so distinctively the research questions of what and how in the case of my participants. This is because what needs to come before how, and self before others. The participants need to understand themselves before they can become fully aware of others' emotions and the interactions of these with their own. Moreover, awareness precedes action or how. Thus, at this point, the how is limited to the participants consideration of how to behave professionally in relation to emotions, and their contemplation about how to control their own emotions rather than definitive actions. To that end, I visualize the resulting themes and lifeworld existentials as a tubular kaleidoscope where one or more parts would reflect upon one another indefinitely. Figure 5 is a representation of this visualization. The ideal goal for the participants would be to not spin around forever in the same spot; rather, to grow and develop continuously.

Figure 5. Kaleidoscope representation of synthesized themes and lifeworld existentials

Summary

The purpose of this interpretive qualitative study was to use van Manen's (1997) hermeneutic phenomenological design to explore PN students' lived experiences with emotional self-management in the clinical settings where they often experience stress related situations. The participants' descriptions of their experiences addressed the research questions.

I began this chapter with a report of the pilot study and the impact it had on the main study. I described the procedures I undertook to suspend my own judgment and experiences from the experiences of participants in order to meet them in our shared interpersonal space. I used NVivo 11 Pro to assist me in the organization of the meaning units and themes. I provided a specific account of the data collection process. In the data

analysis section, I reported the process of using van Manen's (1997) selective reading thematic analysis approach and lifeworld existentials to isolate the participants' phrases and sentences to abstract themes and focus phenomenological meanings, their relationships to the lifeworld existentials, and presented the compendious essence of the participants' lived experiences. The 5 themes that emerged from the analysis are:

1. Knowledge of EI and personal awareness of emotions
2. The perception of EI/emotions in self and others
3. Personal meanings of EI
4. The how experience of emotional management in the clinical setting
5. The first knowing and perception of self as a nursing student.

In addition, I addressed the evidence of trustworthiness as stated in Chapter 3. Finally, I summarized the answers to the research questions.

In Chapter 5, I reviewed the purpose and nature of this study. I compared my phenomenological interpretation of meanings and findings to the peer-reviewed literature as summarized in Chapter 2. Furthermore, I discussed my study's limitations with respect to trustworthiness, implications for social change, theoretical implications, practice recommendations, and recommendations for future research. The summary and conclusion of this study complete Chapter 5.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this interpretive qualitative study was to explore PN students' lived experiences with emotional self-management in the clinical settings where they experience stress-associated situations. I used a hermeneutic phenomenological design. The goal was to explore the students' experiences with the intersubjectivity of emotional management and not to assert my findings as fact. The premise of phenomenology is that subjective reality is as it is perceived, experienced, and understood in the human consciousness (Heidegger, 1927/2010; Husserl, 1913/1983; van Manen, 1997, 2014). Classical and current phenomenologists have amalgamated the venerable and the contemporary traditions in the phenomenological exegesis to seek to understand the what is it like to be lived human experience (van Manen, 1997, 2014). I used a combination of descriptive (Husserl) and interpretive (Heidegger and van Manen) phenomenology to capture the essence of the lived experiences of the PN students' emotional self-management (Heidegger, 1927/2010; Husserl, 1913/1983; van Manen, 1997, 2014). Hermeneutics was a constitutive part of the phenomenological process in my study because the focus is on texts and meanings; thus, it allowed me to explore the students' lived experiences by narrated accounts (van Manen, 1997, 2014).

Various international researchers discussed the fact that nursing students at the university level are introduced with tacit snippets of EI concepts in classrooms as they relate to interprofessional collaborations, healthcare outcomes, and patient satisfaction topics (Benson et al., 2012; Carragher & Gormley, 2017; Rankin, 2013; Shanta &

Gargiulo, 2014). Consequently, nursing students may sporadically learn oblique definitions of emotional self-management. Therefore, there is not a good understanding with respect to students' capability to position or employ EI as an effective professional skill (Benson et al., 2012; Carragher & Gormley, 2017; Fitzpatrick, 2016; Ranjbar, 2015; Rankin, 2013; Shanta & Gargiulo, 2014).

In order to address the gap regarding an understanding of PN students' self-management of emotions, I conducted face-to-face interviews with a purposive convenience sample of 10 PN students at a Southern Ontario community college in Canada who were recruited via electronic posters and word of mouth. Each participant was interviewed using an 11-question low structured interview format (Appendix B). The process was guided by van Manen's (1997) selective reading approach of thematic analysis and lifeworld existentials as presented in Chapter 3.

The research questions that oriented my study are:

1. What are PN students' experiences of emotional management in the clinical settings?
2. How do PN students in the clinical settings experience the management of their emotions?
3. How does emotional self-management affect PN students' learning experience in the clinical settings?

These questions directed the research process to pierce into the core of the what it is like or what does it mean to be questions (van Manen, 1997, 2014). In this chapter, I further elaborate on the themes and findings presented in Chapter 4 by comparing them

with what has been found in the peer-reviewed literature in Chapter 2. This chapter includes the interpretation of the findings, limitations of the study, recommendations, implications for social change, and concluding thoughts resulting from the experiences of the study.

Key Findings

One of the key findings of this study was that all the participants shared they are usually aware of their own emotions but knew little about EI and would like to learn more about it. This finding of the participants' minimal knowledge of EI and general awareness of their emotions was substantiated because none of them endeavored to articulate a more sophisticated explanation or definition of what they think EI is. All the participants expressed they perceived themselves to have some EI and their rudimentary understanding permitted them to occasionally perceive emotions in others. This finding overlaps with personal awareness of emotion because the theoretical distinction between perception and awareness is in the previous appearance since awareness is dependent on perception (van Manen, 2014). The participants have seen emotions before because their basic knowledge and awareness of their own emotions allow them to perceive their own and sometimes others' emotions.

Another key finding was that the notions of professionalism, reflection, and empathy encapsulated the essence of what it means to be emotionally intelligent for the participants at this juncture in their clinical education. The participants identified that being professional is the ability to control their emotions and to empathize with patients and colleagues in the clinical settings. A further finding that overlaps with

professionalism is in how the participants experienced emotional self-management; that is, by demonstrating professionalism in their conduct. All the participants indicated that being observant was a means to experience emotional management professionally in the clinical settings. This included being observant of their own emotions while being open-minded about others, as well as being aware of their physical responses or the observation of their own body language, facial expressions, and tone of voice.

Moreover, a particularly noteworthy key finding is the first knowing of EI. Although EI is not an explicit learning topic in any PN curricula in Ontario, the participants obtained enough of a limited knowledge of the subject to have a general understanding and awareness. This first knowing provided the participants with some basic EI understanding, context, personal meanings, a sense of confidence, and the beginning ability to recognize its value in the clinical settings.

Interpretation of Findings

The findings and interpretations presented in this section have been generated inductively from the experiences shared by the participants and comparative review of understanding discussed in the body of literature presented in Chapter 2. The themes that emerged answered all three research questions. The what is to understand to the greatest extent the participants' complete experiences of emotional self-management and as objectively as possible, their lived experiences about their observations of how others managed or expressed their emotions. The how is intently focused on the participants' own subjective lived experiences of emotional self-management. In addition, the synthesis of the themes and lifeworld existentials illustrated the noema*;* that is, the

participants' lived experiences with emotional self-management in the clinical settings (Heidegger, 1927/2010; van Manen, 1997). The noesis, or the how of the participants' lived experiences was described from my phenomenological meaning-making of the participants' descriptions, or the interpretive act of their attunement (befindlichkeit) of the way they find themselves in the clinical settings (van Manen,1997, p.183). This befindlichkeit includes any patho such as perceptions, feelings, thoughts, memories, or judgments that were obscured from the participants' consciousness, and my endeavour to make them sinn des seins (intelligible) (Heidegger; van Manen, 2014).

Knowledge of EI and Personal Awareness of Emotions

The key findings of my study indicated that the participants have minimal knowledge of EI, albeit their basic understanding allows them to be aware of their emotions at a primal level. This finding was confirmed by researchers in the healthcare field, as well as nursing researchers, presented in Chapter 2 who agreed that students are lacking in EI abilities, and strongly recommended that EI be incorporated into the healthcare education curricula (Chan et al., 2014; Chun & Park, 2016; Codier & Odell, 2014; Faguy, 2012; Hildebrand et al., 2012; Pop-Jordanova & Demerdzieva, 2015; Rice, 2015). EI is a learned skill, not an innate attribute, and may be cultivated continuously (Grant et al, 2014; Hall et al, 2015; Nelson et al., 2015; Stanley & Bhuvaneswari, 2016). All the participants in my study confirmed that they have not formally heard of EI prior to entering the PN program. One participant (Cece) indicated that she believed she has EI, but did not know its name. The participants believed that EI is learned and they

indicated their desire to learn more about it. Some (Devin, Dora, and Liz) expressed that it should be part of the curriculum.

In corroboration with my study, Stanley and Bhuvaneswari (2016) substantiated in their pre and postintervention mixed methods study that healthcare students are lacking in EI and reported an improved overall level of EI literacy and application to practice in social work students. In addition, Stanley and Bhuvaneswari reported students indicated enhanced abilities to reflect and empathize better equipped them to handle psychological distress postintervention. Stanley and Bhuvaneswari's preintervention claim of students' lack of EI abilities is confirmatory to my findings because the participants in my study shared their basic knowledge of EI afforded them tangential capacity to reflect, empathize, and manage certain stressful situations. The most cogent evidence of my participants' minimal knowledge with EI is in their struggle to articulate its descriptions because they only heard or learned bricolages of EI from miscellaneous lectures. The participants' inability to expound what EI is renders it questionable whether they fully understand the other notions they mentioned such as sympathize, empathize, and reflection. They might have merely learned the superficial meanings and regurgitated professional buzz terms because the CNO practice standards emphasize those concepts. If so, it is imperative that nursing educators incorporate EI into the curricula in order to prepare students emotionally in the workplace because students need to consider EI as an integral part of their learning and not as something extra (Cherry et al., 2012, Cherry et al., 2014, Johnson, 2015; Rosenstein & Stark, 2015; Uchino et al, 2015).

Furthermore, many authors agreed that there is a direct positive association between cognitive ability, EI, and academic and clinical success (Beauvais et al. 2014; Cherry et al., 2012; Cherry et al., 2014; Cheshire et al., 205; Chew et al., 2013; Chun & Park, 2016; Codier & Odell, 2014; Collins, 2013; Fernandez et al., 2012; Hojat et al., 2015; Johnson, 2015; Kumar et al., 2016; Rankin, 2013; Ravichandra et al., 2015; Rice, 2015; Shetty et al., 2013; Uchino et al., 2015; Victoroff & Boyatzis, 2013). However, these authors also concurred that students who possess the cognitive ability to achieve high GPA do not automatically know how to apply their knowledge into empathic care, effective communication, and coping strategies in the clinical settings. I did not ask my participants about their GPA; nonetheless, all the participants are at the near graduation phase in their studies, so it may be reasonable to assume that their GPA is at least satisfactory. Thus, EI is the sine qua non factor that could link students' academic achievements toward the improvement of success in job performance and satisfaction, interpersonal relationships, and coping and mental well-being; this, thereby could result in the pathic understanding (van Manen, 2014) and attunement (Heidegger, 1927/2010; van Manen, 2014) in the way they find themselves in the clinical settings.

Moreover, Nelson et al. (2015) and Volberding et al. (2015) were the only authors who offered a cursory discussion of self-management of emotions as a single construct and emphasized its relevance as a foundational constituent in relation to the other EI components. Emotional self-management is the antecedent element to the other EI components (Goleman et al., 2015; Nelson et al., 2015; Mayer et al., 2016; Volberding et al., 2015). My study may extend the knowledge and emphasis regarding the importance

of self-management of emotions as a stand-alone construct that would propel the learning and development of other EI elements. My findings supported the idea that self-management of emotions warrants an independent construct to be examined because hitherto the participants did not have a trained comprehension of what emotional management means, and labored to state the components of EI. The participants have a foundational awareness (dasein) of their own emotions and how they are expressed; thus, they have embarked on the beginning stages of developing EI since the ability to manage emotions requires emotional awareness (Goleman, 2015; Mayer et al., 2016).

The Perception of EI/Emotions in Self and Others

I reviewed 36 nursing articles in Chapter 2. Aradilla-Herrero et al. (2013) were the only authors who explicitly used the term perception to discuss nurses' perception of EI in relation to death anxiety, and concluded that students who presented a better understanding and management of their emotions were found to cope more effectively with the dying process. The other authors stated EI components such as effective communication, interpersonal skills, emotional labor, conflict management, and compassion that would require the ability to perceive emotions (Ball 2013; Chen & Hung, 2014; Chun & Park, 2016; Jack & Wibberley, 2014; Foster et al., 2015; Kaya et al., 2017; Msiska et al., 2014; Oner-Altiok & Ustun, 2013; Pryce-Miller & Emanuel, 2014; Shanta & Connolly, 2013; Shanta & Gargiulo, 2014; Vishavdeep et al., 2016; Whitley-Hunter, 2014). For example, Chun and Park (2016) discussed sensitivity-control in terms of students' considerations of others' emotions while being able to control their own. Whitley-Hunter (2014) illustrated the importance of effective communication and

its direct link to quality nursing care. Similarly, Pryce-Miller and Emanuel (2014) and Shanta and Connolly (2013) emphasized the inherent relationship between effective communication and compassionate care. Kaya et al. (2017) and Shanta and Gargiulo (2014) underscored empathy and therapeutic relationships with patients. These authors agreed that nursing students who have more self-awareness of their own emotions seemed to cope and manage better with clinical related stress.

Furthermore, the authors described in Chapter 2 who discussed coping and stress, death attitudes and risk of depression and suicide, bullying, leadership development, self-compassion, and emotional labor concurred that EI is the missing link in the nursing curricula (Anderson, 2016; Aradilla-Herrero et al., 2013; Aradilla-Herrero et al., 2014a, 2014b; Bennett & Sawatzky, 2013; Benson et al., 2012; Carragher & Gormley, 2017; Chen & Hung, 2014; Chun and Park, 2016; Espinoza & Sanhueza, 2012; Gorgens-Ekermans & Brand, 2012; Iorga et al., 2016; Jack & Wibberley, 2014; Kalyonu et al., 2012; Littlejohn, 2012; Msiska et al., 2014; Oner-Altiok & Ustun, 2013; Orak et al., 2016; Renaud et al., 2012; Şenyuva et al., 2014; Szeles, 2015). Gorgens-Ekermans and Brand (2012), Kalyonu et al. (2012), Littlejoin (2012), and Orak et al. (2013) discussed EI as an effective stress and coping strategy. Chen and Hung (2014) reported a positive relationship between perceived stress and physio-psycho-social responses to mitigate stressful situations. Aradilla-Herrero et al. (2013) and Espinoza and Sanhueza (2012) indicated that EI could assist nursing students to be more in control of their emotions, experience less fear of death, and lower the risk of depression and suicide. Bennett and Sawatzky (2013), Iorga et al. (2013), and Littlejohn (2012) concluded that EI could help

students better handle bullying issues emotionally. Anderson et al. (2016) and Renaud et al. (2012) advocated that EI will support the relational and collaborative aspects in leadership development. Jack and Wibberley (2014), Msiska et al. (2014), and Oner-Altiok and Ustun (2013) promoted EI as an invaluable skill for nurses to manage the emotional labor related to their work, as well as to recognize self-compassion as acceptable. The common unspoken stipulations shared by the aforementioned authors are that there must first exist an elementary awareness or perception of emotions before the teaching and understanding of EI could follow, and EI may be the tool that could bridge the gap between nursing students' overall emotional well-being and successful learning in the clinical settings.

All the participants in my study indicated that they perceived themselves to have some EI, and their basic understanding allows them to occasionally perceive emotions in others. The participants agreed that the ability to perceive emotions in themselves and others helps them to empathize and behave professionally. Nevertheless, the hesitations in the participants' responses suggested that they are not yet proficient in the way they perceive emotions in themselves and others. The participants do not yet have a developed cognition of what emotional management means, so they cannot necessarily claim and name the components of EI; however, they have a beginning awareness of their own emotions and how to express them, or what others might see when they express them.

In addition, the participants shared examples of observing others who behaved unprofessionally with fewer hesitations. Presumably, it is easier for the participants to

describe or notice EI or lack thereof by another person. Furthermore, they are beginning to consider how their emotions might impact the behaviors of others in clinical settings, although their awareness still seems very egocentric and confined mainly to their own emotions and centricity. Awareness precedes action; the participants need to see themselves before they can become fully aware of others' emotions and the interactions with their own. At this point, their knowledge or lived experiences with EI seem limited to how to behave professionally in relation to emotions, which is more about contemplation with respect to how to control their own emotions rather than definitive actions. Therefore, my findings and interpretation regarding EI as an effective tool to cultivate nursing students' capability to perceive emotions in the self and others are consistent with the authors presented in Chapter 2 who indicated that EI is paramount to nursing practice.

In order to use EI as a coping strategy to manage stress caused by issues such as death anxiety, bullying, and the emotional labor of nursing, or to avow self-compassion and develop leadership skills, it is necessary to be able to perceive and articulate the emotions involved. Returning to phenomenology, humans seek for meanings of being, and people's understandings are always attuned (befindlichkeit) to the affective states (Heidegger, 1927/2010). Hence, my participants' emotional dasein (awareness) is in the intentionality and intersubjectivity of their pathic understanding of perceiving and understanding emotions in themselves and others (Heidegger, 1927/2010; Husserl, 1931/2012; van Manen, 1997, 2014). The ongoing development of EI will help the

participants to attain the noema and noesis in the acquisition of EI as it becomes sinn des seins (Heidegger, 1927/2010).

Moreover, the authors in my literature review agreed that nursing students should acquire EI skills while in training (Foster et al., 2015; Kaya et al., 2017; Pryce-Miller and Emanuel, 2014; Vishavdeep et al., 2016). The participants of my study expressed their aspiration of honing their EI skills while in the PN program. Thus, students yearn to attain EI ability and they are curious as to its absence in the curriculum. Many authors indicated a lack of evidence to identify how to facilitate EI development owing to an absence of consensus in EI framework and definitions in the nursing curricula (Ball 2013; Foster et al., 2015; Kaya et al., 2017; Orek et al., 2016; Shanta & Gargiulo, 2014; Vishavdeep et al., 2016; Whitley-Hunter, 2014). Hence, educators need to come to an agreement with an appropriate and effective framework to bridge the teaching and learning gap in nursing students' EI development.

Personal Meanings of EI

None of the authors specifically discussed a personal meaning of EI. However, the authors who conducted the three qualitative studies I found within the search criteria of 2012 to 2016 alluded to it (Jack & Wibberley, 2014; Msiska et al., 2014; Oner-Altiok & Ustun, 2013). The authors who discussed self-compassion as a form of self-care and mindfulness for the nursing students also implied it (Bazarko et al., 2013; Hofmeyer et al., 2016, Orellana-Rios et al., 2017; Şenyuva et al., 2014). Jack and Wibberley (2014) explored the meaning of emotional work to the nursing student, and Msiska et al. (2014) reviewed the cognizance of nursing students' emotional experience in the clinical

settings. Oner-Altiok and Ustun (2013) considered the various sources of stressful feelings experienced by nursing students. These authors reported students' sense of trepidation, discomfort, uncertainty, insecurity, lack of self-confidence and self-efficacy, a lack of control over emotions with their instructors and patients, and fear of discipline and being seen as unprofessional. Bazarko et al., (2013) Hofmeyer et al. (2016), Orellana-Rios et al. (2017), and Şenyuva et al. (2014) emphasized the significance of self-compassion in order to effectuate the emotionally laborious work nurses do. These authors discussed the importance for nursing students to attain emotional balance to facilitate emotional empowerment. Thus, I could safely infer the authors implied that it would be meaningful for nursing students if they could procure emotional balance, because the opposite of feeling fearful, insecure, and uncertain would mean a certain level of emotional stability.

In a sinuous sense, my findings are aligned with the above authors' with respect to the participants' personal meaning of EI. The participants shared that it is meaningful to them when their limited knowledge of EI succeeded in helping them feel less anxious, more confident, and professional. My interpretation is that the participants at this stage of their understanding associate professional conduct or the ability to maintain professionalism as meaningful pertaining to their emotional management experience. EI is an abstract concept with multiple and continuous growth levels; therefore, once nursing students learned it, they could begin to explore ways to find personal meanings, and position those meanings in such a way that would support their emotionally laborious work.

The How Experience of Emotional Management in the Clinical Settings

The interpretation of how my participants experience emotional management in the clinical settings is an extension to the interpretation of personal meanings. The participants indicated that the way in which they experience EI is through reflection, and the observation of their own and others' body language, tone of voice, as well as their own physical responses in some cases. In addition, when they knew that they had conducted themselves professionally, the sense of professionalism is tangible for them. The findings indicated that my participants put a great deal of emphasis on professional behaviours; thus, it is a corporeally meaningful way for them to experience emotional management via their professional conducts. As previously mentioned, although the participants have a beginning-egocentric awareness, they do not yet have a developed knowing of what emotional management means, and could not automatically claim and identify components of EI, or explain precisely how they experience it. At this stage, the participants are limited to understanding how to behave professionally in relation to emotions. Lazzeretti (2017) and Lee (2017) referred to Carl G. Jung's notions of individuation, self, and the realization of self to explore to development of self and emphasize the process of recognizing the self first before others. Guskey (2014) used the analogy of knowing what the destination of a trip is before planning how to get there; thus, what needs to come before how because the what will provide the purpose and contribute to the determination of how to attain the what. My findings and interpretation are congruent with the ideas of Lazzeretti, Lee, and Guskey in terms of the participants' onset of self awareness of EI, exiguous understanding of what EI is, and struggle in

expressing how they experience EI. The participants did not fully know what EI was at this stage; hence, they were unable to describe how they experienced it.

None of the authors in my literature review suggested concrete ways for healthcare or nursing students to experience EI, albeit they advocated the need to include it in the education curricula. Coming back to phenomenology, noema comes before noesis, and sinn des seins will follow (Heidegger, 1927/2010). It may be logical to interpret that when students understand what EI is, they will know how to experience it more accurately, and then it will become more intelligible and meaningful. My study confirmed the idea, noted by other researchers, that there is insufficient support to apprehend how EI is learned and experienced because it is not explicitly indicated in the nursing curricula (Carragher & Gormley, 2017; Fitzpatrick, 2016; Gillespie et al., 2017. Hence, there appears to be an enigmatic vortex in the discussions of teaching, learning, and experiencing of EI as researchers continue to advocate its importance, yet its absence is maintained in the curricula. The discussion of the first knowing of EI in the next section will serve to further interpret how the learning and experiencing of EI is intertwined.

The First Knowing and Perception of Self as a Nursing Student

My participants reported feeling more confident and professional with their first knowing of EI. This finding is an extension to the personal meanings and the how experience of emotional management for my participants. As with the above two sections, none of the authors in my literature review discussed students' first knowing of EI; rather they discussed how little students understand EI and emphasized the

importance of knowing it. Fernandaz et al. (2012), Rankin (2013), and Rice (2015) reported that students who have higher EI consistently have higher GPAs and were successful clinically. These authors believed there is a strong relationship between EI, clinical practice success, and academic performance; however, they did not explain how these students acquire their EI. Thus, the inference is that the successful students would logically thrive better and possess a positive sense of self as nursing students.

The findings of my study suggested that my participants' first knowing of EI was an a-ha moment. For example, Audrey stated, "...once you know about it, it's very easy to place it". Cece described her a-ha moment of EI when she learned the name. In addition, the findings of my study confirmed that it is challenging for students to articulate how they experience EI and ascribe personal meanings because they have limited knowledge of precisely what it is. Therefore, by comparing my findings to the authors' in Chapter 2, it may be tenable to suggest that an area to extend knowledge in the existing literature is in the teaching of EI that would also include an emphasis on its practical applications so that students may experience it more tangibly.

In researching and interpreting the notion of first knowing, I discovered Boudreau and Fuks (2015) and Ortony and Rumelhart (2017) who discussed ways of knowing, doing, being, and the representation of knowledge in memory. Boudreau and Fuks explored the notion of connecting professional identity and activity for medical students that would continue to nurture the development of personhood in character and virtues. Ortony and Rumelhart described knowledge as part of memories and noted that there has to be a first memory of something in order to gain true knowledge of it. As an example,

my knowledge of the ocean may not be true if I have never been to an ocean, and have no first memory of it. If someone tries to describe the ocean to me, or shows me pictures or videos of it, I would only gain the objectivised subjective meanings of the ocean by the person who described it to me. It is arguable whether I have knowledge of the ocean because I have not yet obtained a real first memory. Therefore, it is reasonable to infer that there needs to be a first memory of EI in order to begin its knowing

The authors presented in Chapter 2 did not explain how students would acquire the first knowing of EI beyond introducing academic definitions to them. The findings of my study along with Boudreau and Fuks (2015) and Ortony and Rumelhart (2017) prompted me to consider the nursing scholar Carper's (1978) seminal work of fundamental ways of knowing to bridge this gap. Carper proposed four fundamental ways of knowing: empirical, personal, ethical, and aesthetic. Empirical knowledge is factual knowledge from science, or other external sources that are empirically verifiable. Carper called this the science of nursing. Personal knowledge is knowledge and attitudes originated from personal self-understanding and empathy. Ethical knowledge is knowledge and values developed from ethical frameworks and moral codes. Aesthetic knowledge is an awareness of the immediate here and now, and actions. Carper described aesthetic knowing as the art of nursing that brings the other knowing full circle because it is an individual "process of discovery in the empirical pattern of knowing" (p. 16). Thus, Carper's ways of knowing, especially personal and aesthetic knowing, may provide a framework to help interpret students' experience of learning EI and how they come to their first knowing. Furthermore, there was an over-emphasis of the empirical

knowledge of EI and its impact on students' GPA by the authors in my literature review. Carper's way of knowing may offer the understanding of how students attain EI knowledge from a more personal and intuitive lens.

Integration of Theoretical Framework

I used Mayer and Salovey's (1997) four-branch ability EI model as the theoretical framework to support my findings. The original definition and the four-branch ability model of EI by Mayer and Salovey is:

> Emotional intelligence involves the ability to perceive accurately, appraise, and express emotion; the ability to access and/or generate feelings when they facilitate thoughts; the ability to understand emotion and emotional knowledge; and the ability to regulate emotions to promote emotional and intellectual growth (p. 10).

EI abilities are arranged on a vertical continuum from basic (bottom row) to complex (top row) in the model. The four-branches of the ability model are: a. perception, appraisal, and expression of emotion, b. emotional facilitation of thinking, c. understanding and analyzing emotions; employing emotional knowledge, and d. reflective regulation of emotions to promote emotional and intellectual growth (Mayer & Salovey, 1997). The bottom row is Branch 1. At each branch, there is a horizontal continuum from left to right before an individual may move up onto the next branch. At the far left of Branch 1 is the most basic EI ability of an individual to identify emotions, feelings, and thoughts in the self, but not in others. At the far right of Branch 1 is a person's ability to identify emotions in others before proceeding up to Branch 2 and so on.

In 2016, Mayer and Salovey with colleague Dr. David Caruso updated the original four-branch ability model and added areas of reasoning (Figure 3). Mayer et al. (2016) emphasized the importance of cognitive ability to reason about emotions. Mayer et al. upheld the original 1997 definition of EI and offered a compendious description of the first definition as "the ability to reason validly with emotions and with emotion-related information, and to use emotions to enhance thought" (p. 296).

Branch 1: Perception, Appraisal, and Expression of Emotion

Mayer and Salovey (1997) and Mayer et al. (2016) noted that individuals at the far left of Branch 1 may be able to perceive their own emotions but be unable to identify emotions in others, or express their emotions accurately. As a person's EI develops, the ability to perceive, appraise, and express emotions in the self and others would become more precise, and contextual to the surroundings and culture. The findings in my study indicated that the participants are in the middle of Branch 1 moving toward the right and ready to step up to Branch 2. All the participants stated that they are able to perceive their own emotions and know when they are feeling sad or upset, and always attempt to express their feelings professionally. Notwithstanding, it would be fair to assert that the participants may not always comprehend what they are feeling, albeit they recognize the particular emotions. The participants are likely not proficient to articulate emotions accurately in order to convey emotional needs. All the participants shared examples of when they were upset during clinical assignments and reflected upon the situations. However, besides citing their desire to maintain professionalism, none of them indicated

when they might have communicated their emotional needs to their classmates or instructors.

Branch 2: Emotional Facilitation of Thinking

Branch 2 of the ability model describes a self-aware individual who is able to facilitate thoughts in order to prioritize and direct emotions to judge feelings in varying situations and understand that state of mind may influence thinking and perspectives (Mayer & Salovey, 1997, Mayer et al., 2016). The findings of my study suggested that the participants are beginning to conduct emotional facilitation of their thinking. For example, Devin described he felt harassed when nurses spanked him in jest, but made a conscious decision to maintain professionalism rather than launch any formal complaint. At that point, Devin thought it was more important to ensure civility because he was there to learn. Jasmine struggled with much disfluency to describe her experiences when patients asked about her hijab, yet she was able to facilitate her anger to remind herself to "stay professional". In addition, Jasmine was able to empathize and considered the possibility that the patients' question was genuine in nature. All the participants shared that they tried their best to empathize with patients. In Branch 2, a person's ability to use emotions to demonstrate empathy is emphasized (Mayer et al.). The participants expressed their understanding of empathy when they described patient experiences. For example, Cece acknowledged her emotion of sadness when she realized that a patient was dying and stated, "Medically, there is nothing really that I can do to help this person any longer, so I need to be there for them emotionally and I need to do this for them". Dee indicated her frustration when she witnessed colleagues who labelled patients as

"difficult". Dee stated the importance of meeting patients' needs by listening, "I always try to understand where the patient's coming from, what they're actually really asking". The findings indicated that all participants are most likely at the beginning of Branch 2.

Branch 3: Understanding and Analyzing Emotions; Employing Emotional Knowledge

The focus of the third branch is on an individual's sophisticated capacity to analyze and understand complex emotions that are often concomitant, coalesced, and evolving such as love and disappointment, sadness and anger, and rage and embarrassment (Mayer & Salovey, 1997; Mayer et al. 2016). At this branch, an individual is able to anticipate future emotions in varying circumstances and evaluate potential emotions in different situations, as well as to consider cultural differences in emotions (Mayer et al.). The findings of my study revealed that the participants were demonstrating incipient indications of analytical emotional ability. For example, Richard described his disappointment when he felt his instructor's feedback was unfair, but he was able to reflect and used the experience to remind himself not to repeat the same mistake in the future. Notwithstanding, none of the participants elaborated on any experience that demonstrated the ability to analyze emotions beyond their recognition of the feelings they experienced from the emotions.

Branch 4: Reflective Regulation of Emotions to Promote Emotional and Intellectual Growth

The fourth and highest branch is where an individual possesses the ability of all four branches to be open-minded to emotions, monitor and reflectively regulate emotions

by engaging or detaching from any emotion after assessment. Thereafter, an individual at the end of Branch 4 is able to manage emotions in the self and others by pacifying hostile emotions and strengthening affable ones tactfully without restraining or exaggerating the meaning(s) the emotions aim to convey (Mayer et al., 1997; Mayer et al., 2016). The findings of my study suggested that none of the participants is at Branch 4. It is fair to state that at a superficial level, the participants are aware, reflective, and even able to regulate their emotions; however, they are merely checking themselves from potentially behaving unprofessionally, not because they truly understand the utilization and significance of EI at Branch 4. Therefore, the participants' understanding and awareness were not analytical; rather it was the professed recognition of emotions. The proof of this is in each of the participant's description of an emotionally challenging situation in which they used their understanding and demonstration of professionalism to explain their reactions and actions.

Penrose-Escher Staircase Representation of the Four-Branch Ability Model

Emotional self-management is the antecedent to the other EI components. The management of emotions is the most advanced level of EI at Branch 4 and begins at Branch 1 with self-awareness (Mayer et al., 2016). The ultimate goal would be to remain at Branch 4 for as much as possible. Nevertheless, different daily factors and life situations may affect people's EI abilities, rendering the development of EI as non-linear. Hence, I believe my adapted design of the Penrose-Escher Staircase (Figure 3), endorsed by Dr. Mayer illustrates the four-branch ability model in a more practical manner (personal communication, March 6, 2017). The continuous Penrose Staircase by Escher

(1960) is metaphorical of the ups and downs in the lifelong developmental journey of EI. The findings of my study confirmed that the participants are on the EI Penrose-Escher Staircase as they continue to navigate and learn to manage their emotions in the clinical settings. For example, Richard recalled that the day he felt frustrated with his instructor's feedback was a day he was feeling extremely tired and admitted that he might have managed his feelings better otherwise. Audrey stated, "I'd say in certain situations I'm aware". Devin when describing that he is an extremely emotional person said, "I always have to be aware of it and, uh, I think I do generally a good job, but there's always room for improvement". Liz shared that she is "usually cool-headed... and I am mostly in control". These statements confirmed that the Penrose-Escher staircase is applicable to the participants' EI journey.

Mayer et al. (2016) asserted that there is a considerable division between intelligence and behavior. That is, a person who has a high IQ may not deploy emotionally intelligent behaviors and vice versa. Thus, social, cultural, and personality context are contributing factors in the way people demonstrate EI behaviourally, and it would be independent of their IQ (Mayer et al., 2016). The findings in my study confirmed that the participants' different social, educational, past experiences, and individuality are contextual to the way they perceived themselves emotionally and has little to do with their IQ. For example, both Sass and Devin are aware that they are very emotional people. Cece described herself as "private" and her awareness "comes from having to struggle". Jasmine's hesitation may be cultural. The fact that Dora is slightly

older and had a previous career as a real-estate agent may have influenced how she demonstrated her professional behaviors.

The four-branch ability model served as the theoretical framework for my study as the authors emphasized that the ability to perceive emotions, utilize emotions to facilitate thinking, understand, and manage emotions are fundamental to personal growth, professional achievements, mental health and well-being, and equip people to interpret and maneuver their social environments (Mayer & Salovey, 1997; Mayer et al., 2016). The definitions in the four-branch ability model helped me set up some of the interview questions for the participants. The model afforded me a background to define emotional self-management in my study, and provided a source by which I interpreted the findings without dictating the interpretations.

Furthermore, of all the different models available and described in Chapter 2, the four-branch ability EI model is the most widely used and adapted internationally owing to its easy to follow and logical explanations (Mayer & Salovey, 1997; Mayer et al., 2016). The model was appropriate as a theoretical framework for my study. The goal of using a theoretical framework in a research study is not to make the findings and interpretations fit into the framework; rather, it is to use the framework to guide the interpretations to seek potential new understanding (Creswell, 2009, 2013; Denzin & Lincoln, 2005; Frankfort-Nachmias & Nachmias, 2008). Foucault (2010/1972) discussed the limitation of language and emphasized that certain aspects of human experiences are impossible to express because of the structure and restraints of languages. Therefore, a well-designed and theoretically informed framework such as the four-branch ability

model assisted in the unfolding of the linguistic structure of my interpretation of the participants' responses, and offered an adequate process for me to attempt to understand how the participants experienced EI. Moreover, phenomenology as a research method faces continuous criticism (van Manen, 1997, 2014); thus, the sound theoretical framework of the four-branch ability model provided me with a more solid footing to support my research findings. Finally, Dr. Mayer's support in endorsing my reimagined adaptation of the model as well as the Penrose-Escher staircase illustration was tremendous in the analysis and interpretation of my data.

Limitations of the Study

Several limitations of this study have been identified. The definition of EI and its components are new and abstract to the participants at this stage in their clinical learning experience. The participants' knowledge of EI is also implicitly learned and limited. There is a possibility that the participants answered the interview questions based on what they felt was the best answer and not necessarily the true representations of their experiences. All the participants were interested in the concept of EI, but they were not as articulate as they would have liked because they had difficulties expressing themselves owing to their limited knowledge of EI.

In addition, there are many phenomenological traditions and they are continuously evolving (van Manen, 1997, 2014). Some researchers argued that the subjectivity of the data in phenomenology contributes to complications in establishing reliability and validity of the research findings (Creswell, 2013; Denzin, & Lincoln, 2005; Hycner, 1985; Moustakas, 1994). Furthermore, some of the original Husserlian

and Heideggerian phenomenological texts in German may have been lost in translations. Many German words cannot be translated with an English compound word (Elliott, Frank, Sima'an, & Specia, 2016). Consequently, researchers who use phenomenology often end up writing long and awkward English sentences that may influence the interpretation of their findings (Elliott et al., 2016). An example in my study is the German word Befindlichkeit (attunement), which is the way one finds oneself in the world, and Heidegger defined it as people's understanding that are always attuned to the affective states (Heidegger, 1927/2010; van Manen, 2014). Given the controversy regarding phenomenology as a research method, I hope I was accurate in describing the attunement of the participants where they found themselves in the clinical settings. Moreover, I may have been biased unconsciously, which may lead to a skewed objectivity in the interpretation of the data, albeit I practiced epoché. Finally, the sample size was small; hence, I cannot definitively conclude that the participants' experiences were typical.

Recommendations

Based on the strengths and limitations of the current study as well as the literature reviewed in Chapter 2, there are three recommendations for further research. First, more research is required regarding EI and diploma nursing students. The researchers presented in Chapter 2 investigated the EI abilities of healthcare and nursing students at the university level. There is no existing literature that specifically addresses EI and nursing students in diploma or equivalent programs. Coffey et al. (2015) discussed for various reasons, many people are choosing to become registered nurses by first becoming

diploma practical nurses, and the diploma programs are as vigorous as the university degree programs. Vila, Zhuang, Tan, and Thorne (2018) acknowledged the internationalization development of nursing education, and advocated for increasing focus on the pervasive elements of the profession that would cater to the ongoing evolution of the discipline. EI is one such universal element (Vila et al., 2018). Thus, there is a need to expand knowledge on the EI abilities of the nursing students in the college level programs in Canada and abroad.

Secondly, there is a lack of qualitative studies that explored EI, and particularly emotional management as an independent construct. I reviewed 36 nursing articles in Chapter 2; only four of the thirty-six articles were qualitative studies. Nurse researchers in the selected studies explored EI as an encyclopedic ensemble with the recognition of emotional self-management as an amalgamated component. The discipline of nursing lacks research literature in which emotional self-management as an exclusive concept. All the authors presented in Chapter 2 discussed EI as a multifarious whole; the literature search did not result in any articles by researchers who addressed emotional self-management as an individual construct. Thus, the singular concept of emotional self-management among nursing students at the university or the college level may need more exploration qualitatively.

In addition, various international researchers suggested that nursing students at the university level are provided with pieces of EI concepts in the classrooms (Benson et al., 2012; Carragher & Gormley, 2017; Faguy, 2012; Fitzpatrick, 2016; Ranjbar, 2015; Rankin, 2013; Shanta & Gargiulo, 2014). Consequently, nursing students may learn

about the definitions of EI as abstract theoretical concepts. Therefore, more qualitative studies may provide insights in understanding how nursing students self-manage and understand their own emotions in pursuance of other attributes such as comprehending others' emotions, professional behaviors, empathy, as well as the influence on their well-being, and academic success. Qualitative studies may help researchers to bridge the gap in understanding nursing students' ability to position and apply EI.

Thirdly, on a wider scale, phenomenology seeks to integrate acts of consciousness, which include thoughts, feelings, language, social interactions, and the noema and noesis to which people's consciousness is befindlichkeit. However, phenomenology is an under-utilized research method due to the contentious ongoing debates among researchers and scholars regarding its purview (Fendt, Wilson, Jenkins, Dimmock, & Weeks,2014; van Manen, 1997, 2014). I believe I evoked the pathos in the participants' experiences into dasein and being, identified the structure and intentionality of the participants' experiences that illustrated their intersubjectivity, and generated pathic understanding in bringing their experiences to sinn des seins (Heidegger, 1927/2010; Husserl, 1913/1983; van Manen, 1997, 2014). In essence, I believe the use of phenomenology for this study was successful in calling and clarifying EI into being and gave meanings for the participants (Heidegger, 1927/2010; Husserl, 1913/1983; van Manen, 1997, 2014). Therefore, I hope this study might invite researchers who are opponents of using phenomenology as a research method to reconsider its appropriateness in exploring, and giving voice and sinn de sein to lived experiences.

Implications for Social Change

The findings of this phenomenological qualitative study support the broad generalizations regarding the effectiveness of using EI in the clinical settings for PN students. EI is recognized globally as an essential tool for personal and professional growth and success (Goleman et al., 2015; Mayer & Salovey, 1997; Mayer et al., 2016). The findings of my study may contribute to positive social change at the postsecondary education level.

Organizational Level

Upon near completion of this dissertation, I read a recent mixed methods study by Sharon and Grinberg (2018) who reported that they are not aware of any nursing program that includes teaching EI as part of the core curriculum. Sharon and Grinberg's study highlighted a positive correlation between the level of EI and the degree of students' success in becoming well-adjusted nurses. Sharon and Grinberg advocated that EI should be included in the curriculum, as well as using EI testing in the admissions process. I believe my study offers similar advisability as Sharon and Grinberg to urge leaders in nursing education to consider the inclusion of EI in the curricula. I could begin to advocate the same at the college where I teach.

In addition, I was able to obtain the abstract of a July 2018 publication by Foster et al. who concurred with the authors' findings in Chapter 2 and reinforced EI as an effective strategy for healthcare students to manage stress, and emphasized that EI can be improved through educational interventions. Foster et al. also advocated the need to include EI in healthcare curricula. Coincidentally, the CNO hosted a 2018-2019 PN

Program Approval Curriculum mapping workshop for the Ontario colleges in June, 2018. The purpose of the workshop was to recommend "a systematic approach for schools to document their curriculum against each entry to practice competency for their PN program", as well as to offer "an opportunity for schools to assess their curriculum and provide evidence of the teaching and learning experiences required to prepare graduates to be competent and safe practicing nurses" (CNO, 2018, slide 5). Although the CNO (2018) did not explicitly indicate EI as an entry to practice competency requirement, it was implied that many aspects such as sound decision making, reflective practice, and professional responsibility and accountability require EI abilities. Therefore, my study could lend support to champion for the explicit inclusion of EI in the nursing curricula starting at the college where I teach.

Furthermore, I will be asked to provide a brief presentation of my dissertation at the college where I teach once I graduate; I hope my study will generate a soft ripple effect and contribute to the reinforcement of EI development in nursing students as they prepare to take on the emotional laborious work that is nursing. Self-management of emotions is an essential component of EI and is regarded as the ability to elicit emotions to propel personal growth (Goleman et al., 2015; Mayer et al., 2016). Researchers support that EI is a key factor in students' coping effectiveness in stressful situations and overall emotional management (Conley et al., 2015; Görgens-Ekermans et al., 2015; Ivcevic & Brackett, 2014; Stelnicki et al., 2015). I hope this study will contribute to nursing students' aspiration and intention to learn and cultivate EI for their own sake as well as to reinforce their identity as future nurses. The learning of EI at the intellectual

level is not enough (Mayer et al., 2016). I hope nursing students will learn EI not as another theory they have to know, but to embrace it as a practical personal skill.

Conclusion

In this interpretive qualitative study, I used a hermeneutic phenomenological design to explore PN students' lived experiences with emotional self-management in the clinical settings where they are frequently exposed to stress associated situations. International researchers mainly discussed nursing students at the university level and EI from the perspective of academic success, interprofessional concerns, and healthcare outcomes. Therefore, there is not a sound understanding with respect to nursing students', specifically PN students' ability to position or utilize EI as an effective professional tool.

Face-to-face interviews were conducted with a purposive convenience sample of ten PN students at a Southern Ontario community college in Canada who were recruited via electronic posters and word of mouth. The research process was guided by van Manen's (1997) selective reading approach of thematic analysis and lifeworld existentials. I used Mayer and Salovey's (1997) four-branch EI ability model as the theoretical framework to guide the explorative and interpretative processes of the study.

Findings of this study suggested that the participants perceived themselves to have basic EI knowledge. The participants believed they are usually aware of their own and others' emotions, and indicated the notion of professionalism, ability to reflect, and empathy as meaningful in relation to EI. In addition, the participants expressed that their

first knowing of EI, albeit limited, provided them with more confidence and awareness and they would like to learn more about EI.

This study has demonstrated that EI is an important skill that nursing students should acquire during their training. Carper (1978) described nursing as an art as well as a science in her work on ways of knowing. It is essential that future nurses be trained to know the science and technologies pertaining to their work, but also in the art, which includes the cultivation of EI. EI is the essential soft skill that experts argue as more important than IQ because it helps individuals to know beyond the scientific or trade skills to connect with themselves and others in appropriate and empathetic manners (Goleman et al., 2015; Mayer et al., 2016; Wheeler, 2016). It is recommended that more qualitative research should be conducted to understand how nursing students employ EI and position themselves with their EI knowledge, specifically emotional self-management. It is hoped that the findings of this study will stimulate the leaders in nursing education to continue their momentum to urge the inclusion of EI in the curricula in all levels and programs.

References

Alexander, G. R. (2016). Multicultural education in nursing. In D.M. Billings & J.A. Halstead (Eds.), *Teaching in nursing: a guide for faculty* (pp. 263-281). St. Louis, MO: Elsevier

Anderson, D. (2016). Servant Leadership, Emotional Intelligence: Essential for Baccalaureate Nursing Students. *Creative Nursing, 22*(3), 176-180. http://dx.doi.org/10.1891/1078-4535.22.3.176

Aradilla-Herrero, A., Tomás-Sábado, J., & Gómez-Benito, J. (2013). Death attitudes and emotional intelligence in nursing students. OMEGA-*Journal of Death and Dying, 66*(1), 39-55. http://dx.doi.org/10.2190/OM.66.1.c

Aradilla-Herrero, A., Tomás-Sábado, J., & Gómez-Benito, J. (2014). Associations between emotional intelligence, depression and suicide risk in nursing students. *Nurse Education Today, 34*(4), 520-525. http://dx.doi.org/10.1016/j.nedt.2013.07.001

Aradilla-Herrero, A., Tomás-Sábado, J., & Gomez-Benito, J. (2014b). Perceived emotional intelligence in nursing: Psychometric properties of the trait metamood scale. *Journal of Clinical Nursing, 23*(7-8), 955-966. https://doi.org/10.1111/jocn.12259

Armstrong, J. S. (2012). Natural learning in higher education. In M.N. Seel (Ed.), *Encyclopedia of the Sciences of Learning* (p. 2426-2433). Heidelberg, Germany: Springer. Retrieved from http://repository.upenn.edu/marketing_papers/140

Ball, L. S. (2013). Accelerated baccalaureate nursing students use of emotional intelligence in nursing as 'caring for a human being': A mixed methods grounded theory study. *International Journal of Nursing Education Scholarship, 10*(1), 293-300. https://doi.org/10.1515/ijnes-2013-0015

Bar-On, R. (2003). How important is it to educate people to be emotionally and socially intelligent, and can it be done? *Perspectives in Education, 21*(4), 3-15. http://hdl.handle.net/10520/EJC87229

Bazarko, D., Cate, R. A., Azocar, F., & Kreitzer, M. J. (2013). The impact of an innovative mindfulness-based stress reduction program on the health and well-being of nurses employed in a corporate setting. *Journal of Workplace Behavioral Health, 28*(2), 107-133. http://dx.doi.org/10.1080/15555240.2013.779518

Beauvais, A. M., Stewart, J. G., DeNisco, S., & Beauvais, J. E. (2014). Factors related to academic success among nursing students: a descriptive correlational research study. *Nurse Education Today, 34*(6), 918-923. http://dx.doi.org/10.1016/j.nedt.2013.12.005

Beldoch, M. (1964). Sensitivity to expression of emotional meaning in three modes of communication. In J.R. Davis (Ed.), *The Communication of Emotional Meaning* (pp. 31–42). New York, NY: McGraw-Hill Book Company

Bennett, K., & Sawatzky, J. A. V. (2013). Building emotional intelligence: a strategy for emerging nurse leaders to reduce workplace bullying. *Nursing Administration Quarterly, 37*(2), 144-151. https://doi.org/10.1097/naq.0b013e318286de5f

Benson, G., Martin, L., Ploeg, J., & Wessel, J. (2012). Longitudinal study of emotional intelligence, leadership, and caring in undergraduate nursing students. *Journal of Nursing Education, 51*(2), 95-101. https://doi.org/10.3928/01484834-20120113-01

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking A tool to enhance trustworthiness or merely a nod to validation?. *Qualitative Health Research, 26*(13), 1802-1811. https://doi.org/10.1177/1049732316654870

Boamah, S. A., & Laschinger, H. (2016). The influence of areas of worklife fit and work life interference on burnout and turnover intentions among new graduate nurses. *Journal of Nursing Management, 24*(2), 164-174. https://doi.org/10.1111/jonm.12318

Boudreau, J. D., & Fuks, A. (2015). The humanities in medical education: ways of knowing, doing and being. *Journal of Medical Humanities, 36*(4), 321-336. https://doi.org/10.1007/s10912-014-9285-5

Brackett, M. A., & Mayer, J. D. (2003). Convergent, discriminant, and incremental validity of competing measures of emotional intelligence. *Personality and Social Psychology Bulletin, 29*(9), 1147-1158. https://doi.org/10.1177/0146167203254596

Bradbury-Jones, C., Irvine, F., & Sambrook, S. (2010). Phenomenology and participant feedback: Convention or contention? *Nurse Researcher (through 2013), 17*(2), 25-33. Retrieved from https://www.researchgate.net/profile/Sally_Sambrook/publication/41908630_Phe

nomenology_and_participant_feedback_convention_or_contention/links/0fcfd5123afc44d30f000000/Phenomenology-and-participant-feedback-convention-or-contention.pdf

Carper, B. A. (1978). Fundamental patterns of knowing in nursing. *Advances in Nursing Science*, *1*(1), 13–24. https://doi.org/10.1097/00012272-197810000-00004

Carragher, J., & Gormley, K. (2017). Leadership and emotional intelligence in nursing and midwifery education and practice: a discussion paper. *Journal of Advanced Nursing*, *73*(1), 85-96. https://doi.org/10.1111/jan.13141

Chan, J. C., Sit, E. N., & Lau, W. M. (2014). Conflict management styles, emotional intelligence and implicit theories of personality of nursing students: A cross-sectional study. *Nurse Education Today*, *34*(6), 934-939. https://doi.org/10.1016/j.nedt.2013.10.012

Chen, Y. W., & Hung, C. H. (2014). Predictors of Taiwanese baccalaureate nursing students' physio–psycho-social responses during clinical practicum. *Nurse Education Today, 34*(1), 73-77. http://dx.doi.org/10.1016/j.nedt.2013.02.021

Cherry, M. G., Fletcher, I., O'Sullivan, H., & Shaw, N. (2012). What impact do structured educational sessions to increase emotional intelligence have on medical students? BEME Guide No. 17. *Medical Teacher, 34*(1), 11-19. https://doi.org/10.3109/0142159x.2011.614293

Cherry, M. G., Fletcher, I., O'Sullivan, H., & Dornan, T. (2014). Emotional intelligence in medical education: A critical review. *Medical Education, 48*(5), 468-478. https://doi.org/10.1111/medu.12406

Cheshire, M. H., Strickland, H. P., & Carter, M. R. (2015). Comparing traditional measures of academic success with emotional intelligence scores in nursing students. *Asia-Pacific Journal of Oncology Nursing, 2*(2), 99-106. https://doi.org/10.4103/2347-5625.154090

Chew, B. H., Zain, A. M., & Hassan, F. (2013). Emotional intelligence and academic performance in first and final year medical students: A cross-sectional study. *BMC Medical Education, 13*(1), 44. https://doi.org/10.1186/1472-6920-13-44

Chun, K. H., & Park, E. (2016). Diversity of emotional intelligence among nursing and medical students. *Osong Public Health and Research Perspectives, 7*(4), 261-265. http://dx.doi.org/10.1016/j.phrp.2016.06.002

Codier, E., & Odell, E. (2014). Measured emotional intelligence ability and grade point average in nursing students. *Nurse Education Today, 34*(4), 608-612. http://dx.doi.org/10.1016/j.nedt.2013.06.007

Coffey, S., Lindsay, G. M., Cochrane, M., Cummings, K., Macdonald, K., Mairs, S., ... & Bell, R. (2015). Making the grade through the front door: evaluation and innovation in a registered practical nurse to bachelor of science in nursing program. *Journal of Education and Training Studies*, *4*(1), 32-38. https://doi.org/10.11114/jets.v4i1.1012

Coffey, D. S., P. Cuff, K. Eliot, E. Goldblatt, C. Grus, S. Kishore, M. Mancini, R. Valachovic, P. H. Walker (2017). A multifaceted systems approach to addressing stress within health professions education and beyond. National Academy of Medicine, Washington, DC. https://doi.org/10.31478/201701e

Colaizzi, P. (1978). Psychological research as the phenomenologist's view it. In R. Vale & M. King (Eds.), *Existential–Phenomenological Alternatives for Psychology* (pp. 48–71). New York, NY: Oxford University Press.

College of Nurse of Ontario. (2015). Practice reflection: Learning from practice. Retrieved from http://www.cno.org/globalassets/4-learnaboutstandardsandguidelines/prac/learn/teleconferences/practice-reflection--learning-from-practice.pdf

College of Nurse of Ontario. (2014). Teaching and learning professionalism in nursing. Retrieved from http://www.cno.org/globalassets/4-learnaboutstandardsandguidelines/prac/learn/teleconferences/teleconference--teaching-and-learning-professionalism-in-nursing.pdf

College of Nurses of Ontario (2018). *PN program approval: Curriculum mapping workshop: June 2018.* [PowerPoint slides]. Retrieved from www.cno.org

Collins, S. (2013). Emotional intelligence as a noncognitive factor in student registered nurse anesthetists. *American Association of Nurse Anesthetists Journal*, *81*(6), 465-472. Retrieved from https://www.researchgate.net/profile/Shawn_Collins3/publication/260560765_Emotional_intelligence_as_a_noncognitive_factor_in_student_registered_nurse_anesthetists/links/542d43320cf27e39fa9422ce.pdf

Conley, C. S., Durlak, J. A., & Kirsch, A. C. (2015). A meta-analysis of universal mental health prevention programs for higher education students. *Prevention Science, 16*(4), 487-507. https://doi.org/10.1007/s11121-015-0543-1

Creswell, J. W. & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory into Practice, 39*(3), 124-131. Retrieved from https://people.ucsc.edu/~ktellez/Creswell_validity2000.pdf

Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (Laureate Education, Inc., customed.). Thousand Oaks, CA: Sage Publications, Inc.

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

Dahlberg, K. (2006). The essence of essences—the search for meaning structures in phenomenological analysis of lifeworld phenomenon. *International Journal of Qualitative Studies on Health and Well-being, 1*(1), 11-19. https://doi.org/10.1080/17482620500478405

DeRosset, L. (2013). Grounding explanations. Philosopher's Imprint, 13(7), 1-26. doi: http://hdl.handle.net/2027/spo.3521354.0013.007. Retrieved from http://quod.lib.umich.edu/cgi/p/pod/dod-idx/grounding-explanations.pdf?c=phimp;idno=3521354.0013.007

Denzin, N. K., & Lincoln, Y.S. (Eds.). (2005). *The sage handbook of qualitative research* (3rd ed.). Thousand Oaks, CA: Sage Publications, Inc.

Echevarria, I. M. (2013). Change your appetite: Stop “eating the young” and start mentoring. *Nursing Critical Care, 8*(3), 20-24. http: //dx.doi.org/10.1097/01.CCN.0000429384.33344.2a

Elliott, D., Frank, S., Sima'an, K., & Specia, L. (2016). Multi30k: Multilingual english-german image descriptions. *arXiv preprint arXiv:1605.00459*. Retrieved from https://arxiv.org/pdf/1605.00459.pdf.

Emanuel, E. J., Abdoler, E., & Stunkel, L. (2014). Research ethics: how to treat people who participate in research. *Clinical Center Department of Bioethics, National Institutes of Health*. Retrieved from https://bioethics.nih.gov/education/FNIH_BioethicsBrochure_WEB.PDF

Escher, M.C. (1953). M.C. Escher – Life and Work. The Collection, National Gallery of Art. National Gallery of Art, Washington. Retrieved from http://www.nga.gov/content/ngaweb/features/slideshows/mc-escher-life-and-work.html#slide_23

Espinoza, V. M., & Sanhueza, A. O. (2012). Fear of death and its relationship with emotional intelligence of nursing students in Concepción. *Acta Paulista De Enfermagem, 25*(4), 607-613. http://dx.doi.org/10.1590/S0103-21002012000400020

Faguy, K. (2012). Emotional intelligence in health care. *Radiologic Technology, 83*(3), 237-253. Retrieved from https://www.researchgate.net/profile/Nina_Kowalczyk/publication/221768715_Perceptions_of_the_use_of_critical_thinking_teaching_methods/links/54199b5c0cf2

03f155ae0831/Perceptions-of-the-use-of-critical-thinking-teaching-methods.pdf#page=27

Fendt, L. S., Wilson, E., Jenkins, J., Dimmock, K., & Weeks, P. (2014). Presenting phenomenology: Faithfully recreating the lived experiences of Surfer Girls. *Annals of Leisure Research, 17*(4), 398-416. https://doi.org/10.1080/11745398.2014.938668

Fernandez, R., Salamonson, Y., & Griffiths, R. (2012). Emotional intelligence as a predictor of academic performance in first year accelerated graduate entry nursing students. *Journal of Clinical Nursing, 21*(23-24), 3485-3492. https://doi.org/10.1111/j.1365-2702.2012.04199.x

Finlay, L. (2009). Debating phenomenological methods. *Phenomenology and Practice, 3*(1), 6-25. Retrieved from https://journals.library.ualberta.ca/pandpr/index.php/pandpr/article/view/19818/15336

Fitzpatrick, J. J. (2016). Helping nursing students develop and expand their emotional intelligence. *Nursing Education Perspectives, 37*(3), 124. https://doi.org/10.1097/01.nep.0000000000000020

Foster, K., McCloughen, A., Delgado, C., Kefalas, C., & Harkness, E. (2015). Emotional intelligence education in pre-registration nursing programmes: An integrative review. *Nurse Education Today, 35*(3), 510-517. https://doi.org/10.1016/j.nedt.2014.11.009

Foster, K., Fethney, J., Kozlowski, D., Fois, R., Reza, F., & McCloughen, A. (2018). Emotional intelligence and perceived stress of Australian pre-registration healthcare students: A multi-disciplinary cross-sectional study. *Nurse Education Today, 66*, 51-56. https://doi.org/10.1016/j.nedt.2018.04.001

Frankfort-Nachmias, C., & Nachmias, D. (2008). *Research methods in the social sciences* (7th ed.). New York, NY: Worth Publishers.

Future Hospital Commission. (2013). Future hospital: caring for medical patients. A report from the Future Hospital Commission to the Royal College of Physicians. London: Royal College of Physicians, 2013. Retrieved from https://www.rcplondon.ac.uk/file/382/download?token=rsdOb_j6

Gill, P., Stewart, K., Treasure, E., & Chadwick, B. (2008). Methods of data collection in qualitative research: interviews and focus groups. *British Dental Journal*, *204*(6), 291-295. https://doi.org/10.1038/bdj.2008.192

Girogi, A. (1970). Toward phenomenologically based research in psychology. *Journal of Phenomenological Psychology, 1*(1), 75-98. https://doi.org/10.1163/156916270x00076

Giorgi, A. (1988). Validity and reliability from a phenomenological perspective. In *Recent Trends in Theoretical Psychology* (pp. 167-176). Springer, New York, NY.

Giorgi, A. (2008). Difficulties encountered in the application of the phenomenological method in the social sciences. *Indo-Pacific Journal of Phenomenology, 8*(1), 1-9. http://dx.doi.org/10.1080/20797222.2008.11433956

Gharetepeh A, Safari Y, Pashaei T, Razaei M, Bagher Kajbaf M. (2015). Emotional intelligence as a predictor of self-efficacy among students with different levels of academic achievement at Kermanshah University of Medical Sciences. *Journal of Advances in Medical Education and Professionalism,3*(2), 50-55. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4403564/

Gillespie, G. L., Grubb, P. L., Brown, K., Boesch, M. C., & Ulrich, D. L. (2017). "Nurses eat their young": A novel bullying educational program for student nurses. *Journal of Nursing Education and Practice, 7*(7), 11-21. https://doi.org/10.5430/jnep.v7n7P11

Goh, Y. S., & Lopez, V. (2016). Acculturation, quality of life and work environment of international nurses in a multi-cultural society: A cross-sectional, correlational study. *Applied Nursing Research, 30*, 111-118. https://doi.org/10.1016/j.apnr.2015.08.004

Goleman D. (1995). *Emotional intelligence*. New York, NY: Bantam

Goleman D. (1998). *Working with emotional intelligence*. New York, NY: Bantam

Goleman, D., Boyatzis, R., & McKee, A. (2015). *Mindful leadership: Emotional intelligence collection* (4 Books). Harvard Business Review Press.

Görgens-Ekermans, G., Delport, M., & Du Preez, R. (2015). Developing emotional intelligence as a key psychological resource reservoir for sustained student success. *South Africa Journal of Industrial Psychology, 41*(1), 1. http://dx.doi.org/10.4102/sajip.v41i1.1251

Government of Canada, Post Secondary Education (2017). Retrieved from https://www.canada.ca/en/immigration-refugees-citizenship/services/new-immigrants/new-life-canada/enrol-school/post-secondary.html

Grant, L., Kinman, G., & Alexander, K. (2014). What's all this talk about emotion? Developing emotional intelligence in social work students. *Social Work Education, 33*(7), 874-889. https://doi.org/10.1080/02615479.2014.891012

Guskey, T. R. (2014). Planning professional learning. *Educational Leadership, 71*(8), 10-16. Retrieved from https://uknowledge.uky.edu/edp_facpub/15

Hall, M., Hanna, L. A., Hanna, A., & McDevitt, C. (2015). Empathy in UK pharmacy students: assessing differences by gender, level in the degree programme, part-time employment and medical status. *Pharmacy Education, 15* (1), 241 – 247. Retrieved from http://pharmacyeducation.fip.org/pharmacyeducation/article/view/393/342

Heidegger, M. (2010). *Being and time,* (J. Stambaugh,Trans.). Albany, NY: State University of New York Press. (Original work published 1927).

Hildebrand, R., Volberding, J., & Carr, W. D. (2012). Examining emotional intelligence differences in athletic training undergraduates students and first-year graduate assistants. *Journal of the Oklahoma Association for Health, Physical Education, Recreation, and Dance, 49*(1), 47-56. Retrieved from http://ojs.library.okstate.edu/osu/index.php/OAHPERD/article/view/673

Hofmeyer, A., Toffoli, L., Vernon, R., Taylor, R., Fontaine, D., Klopper, H. C., & Coetzee, S. K. (2016). Teaching The Practice Of Compassion To Nursing

Students Within An Online Learning Environment: A Qualitative Study Protocol. *Contemporary Issues in Education Research (Online), 9*(4), 201. Retrieved from http://files.eric.ed.gov/fulltext/EJ1116433.pdf

Hojat, M., Vergare, M., Isenberg, G., Cohen, M., & Spandorfer, J. (2015). Underlying construct of empathy, optimism, and burnout in medical students. *International Journal of Medical Education, 6*, 12 -16. https://doi.org/10.5116/ijme.54c3.60cd

Husserl, E. (2012). *Ideas: General introduction to pure phenomenology*. (W. R. Boyce Gibson, Trans.). New York, NY: Routledge. (Original work published 1931).

Hycner, R. H. (1985). Some guidelines for the phenomenological analysis of interview data. *Human studies, 8*(3), 279-303. https://doi.org/10.1007/bf00142995

Iorga, M., Ciuhodaru T., & Soponaru, C.(2016). Emotional intelligence and types of hostility among nurse students. *International Journal of Medical Dentistry, 6*(2), 104-110. Retrieved from http://www.ijmd.ro/articole/480_06%20Magdalena%20IORGA.pdf

Ivcevic, Z., & Brackett, M. (2014). Predicting school success: Comparing conscientiousness, grit, and emotion regulation ability. *Journal of Research in Personality, 52*, 29-36. http://dx.doi.org/10.1016/j.jrp.2014.06.005

Jack, K., & Wibberley, C. (2014). The meaning of emotion work to student nurses: A Heideggerian analysis. *International Journal of Nursing Studies, 51*(6), 900-907. http://dx.doi.org/10.1016/j.ijnurstu.2013.10.009

Jacob, S. A., & Furgerson, S. P. (2012). Writing interview protocols and conducting interviews: Tips for students new to the field of qualitative research. *The*

Qualitative Report, 17(42), 1-10. Retrieved from http://nsuworks.nova.edu/tqr/vol17/iss42/3

Janesick, V. J. (2011). *Stretching exercises for qualitative researchers* (3rd ed.). Thousand Oaks, CA: Sage Publications, Inc

Johnson, D. R. (2015). Emotional intelligence as a crucial component to medical education. *International Journal of Medical Education, 6*, 179 - 183 https://doi.org/10.5116/ijme.5654.3044

Jones-Schenk, J., & Harper, M. G. (2014). Emotional intelligence: An admission criterion alternative to cumulative grade point averages for prelicensure students. *Nurse Education Today, 34*(3), 413-420. http://dx.doi.org/10.1016/j.nedt.2013.03.018

Kaya, H., Şenyuva, E., & Bodur, G. (2017). Developing critical thinking disposition and emotional intelligence of nursing students: a longitudinal research. *Nurse Education Today, 48*,72-77. https://doi.org/10.1016/j.nedt.2016.09.011

Kumar, A., Puranik, M. P., & Sowmya, K. R. (2016). Association between dental students' emotional intelligence and academic performance: A study at six dental colleges in India. *Journal of Dental Education, 80*(5), 526-532. Retrieved from https://www.researchgate.net/profile/Sowmya_K_R2/publication/301835160_Association_Between_Dental_Students'_Emotional_Intelligence_and_Academic_Performance_A_Study_at_Six_Dental_Colleges_in_India/links/572b17b208ae057b0a0924ed.pdf

Kuper, A., Lingard, L., & Levinson, W. (2008). Critically appraising qualitative research. *British Medical Journal*, *337*(aug07_3), 687-392. https://doi.org/10.1136/bmj.a1035

Lazzeretti, L. (2017). An essay on transformative learning in relation to Jungian synchronicity and individuation. *Journal of Transformative Learning*, *4*(1), 68-77. Retrieved from https://jotl.uco.edu/index.php/jotl/article/viewFile/190/125

Lee, I. (2017). The Role of the Ego in Jungian Individuation and Yogacara Buddhism's Enlightenment. *Pastoral Psychology*, *66*(2), 281-293. https://doi.org/10.1007/s11089-016-0743-z

Littlejohn, P. (2012). The missing link: Using emotional intelligence to reduce workplace stress and workplace violence in our nursing and other health care professions. *Journal of Professional Nursing*, *28*(6), 360-368. https://doi.org/10.1016/j.profnurs.2012.04.006

Luft, S., & Schlimme, J. E. (2013). The phenomenology of intersubjectivity in Jaspers and Husserl: on the capacities and limits of empathy and communication in psychiatric praxis. *Psychopathology*, *46*(5), 345-354. https://doi.org/10.1159/000353272

Mayer, J. D., & Salovey, P. (1997). What is emotional intelligence? In P. Salovey & D. J. Sluyter (Eds.), *Emotional development and emotional intelligence: Implications for educators* (p. 3–34). New York, NY: Harper Collins.

Mayer, J.D., Salovey, P., Caruso, D. (2000). Models of emotional intelligence. In R. J. Sternberg, (Ed.), *The handbook of intelligence* (p396-422). New York: Cambridge University Press.

Mayer, J. D., Salovey, P., & Caruso, D. R. (2002). Mayer–Salovey–Caruso. Emotional Intelligence Test (MSCEIT) users manual. Toronto, Canada: Multi-Health Systems.

Mayer, J.D., Salovey, P., & Caruso, D. R. (2004). Emotional intelligence: Theory, findings and implications. *Psychological Inquiry, 15*(3), 197-215. https://doi.org/10.1207/s15327965pli1503_02

Mayer, J. D., Roberts, R. D., & Barsade, S. G. (2008). Human abilities: Emotional intelligence. The *Annual Review of Psychology, 59*, 507-536. https://doi.org/10.1146/annurev.psych.59.103006.093646

Mayer, J. D., Caruso, D. R., & Salovey, P. (2016). The ability model of emotional intelligence: Principles and updates. *Emotion Review, 8*(4), 290-300. https://doi.org/10.1177/1754073916639667

McConnell-Henry, T., Chapman, Y., & Francis, K. (2009). Husserl and Heidegger: Exploring the disparity. *International Journal of Nursing Practice, 15*, 7-15. https://doi.org/10.1111/j.1440-172x.2008.01724.x

McConnell-Henry, T., Chapman, Y., & Francis, K. (2011). Member checking and heideggerian phenomenology: A redundant component. *Nurse Researcher (through 2013), 18*(2), 28-37. https://doi.org/10.7748/nr2011.01.18.2.28.c8282

McIntyre, R. & Smith, D. W. (1989). Theory of intentionality. In J. N. Mohanty & W. R. McKenna (Eds.), *Husserl's phenomenology: A textbook* (p.147-179). Washington, D. C.: Center for Advanced Research in Phenomenology and University Press of America. Retrieved from http://www.csun.edu/~vcoao087/pubs/intent.pdf

Miles, M. B., Huberman, A. M. & Saldana, J. (2014). *Qualitative data analysis: A methods sourcebook* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Mitchell, A., Ahmed, A., & Szabo, C. (2014). Workplace violence among nurses, why are we still discussing this? Literature review. *Journal of Nursing Education and Practice, 4*(4), 147. https://doi.org/10.5430/jnep.v4n4p147

Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage Publications

Msiska, G., Smith, P., & Fawcett, T. (2014). Exposing emotional labour experienced by nursing students during their clinical learning experience: A Malawian perspective. *International Journal of Africa Nursing Sciences, 1,* 43-50. http://dx.doi.org/10.1016/j.ijans.2014.07.001

Morrow, R., Rodriguez, A. and King, N. (2015). Colaizzi's descriptive phenomenological method. *The Psychologist, 28*(8), 643-644. ISSN 09528229. Retrieved from http://eprints.hud.ac.uk/id/eprint/26984/1/Morrow_et_al.pdf

National Academy of Medicine (NAM) (2016). Accessed on Feb 27, 2017. https://nam.edu/national-academy-of-medicine-launches-action-collaborative-to-

promote-clinician-well-being-and-combat-burnout-depression-and-suicide-among-health-care-workers/

Neuman, W. L. (2014). *Social research methods: Qualitative and quantitative approaches* (7th ed.). Boston, MA: Pearson Education.

Nightingale, F. (1914). *Florence Nightingale to her nurses: A selection from Miss Nightingale's addresses to probationers and nurses of the nightingale school at St. Thomas's hospital*. R. Nash (Ed.). London, UK: Macmillan and Co., limited. Retrieved from https://ia802606.us.archive.org/21/items/florencenighting00nighiala/florencenighting00nighiala.pdf

Nelson, M. H., Fierke, K. K., Sucher, B. J., & Janke, K. K. (2015). Including emotional intelligence in pharmacy curricula to help achieve CAPE Outcomes. *American Journal of Pharmaceutical Education, 79*(4), 48. https://doi.org/10.5688/ajpe79448

Norlyk, A., & Harder, I. (2010). What makes a phenomenological study phenomenological? An analysis of peer-reviewed empirical nursing studies. *Qualitative Health Research, 20*(3), 420-431. https://doi.org/10.1177/1049732309357435

Nowrouzi, B., Lightfoot, N., Carter, L., Larivière, M., Rukholm, E., Schinke, R., & Belanger-Gardner, D. (2015). Work ability and work-related stress: A cross-sectional study of obstetrical nurses in urban northeastern Ontario. *Work, 52*(1), 115-122. https://doi.org/10.3233/wor-141976

O'Connell, T.S. & Dyment, J.E. (2013). *Theory into practice: Unlocking the power and the potential of reflective journals.* Charlotte, NC: Information Age Publishing Inc.

Odland, L. H., Sneltvedt, T., & Sörlie, V. (2014). Responsible but unprepared: Experiences of newly educated nurses in hospital care. *Nurse Education in Practice, 14*(5), 538-543. http://dx.doi.org/10.1016/j.nepr.2014.05.005

Oner Altiok, H., & Ustun, B. (2013). The stress sources of nursing students. *Educational Sciences: Theory and Practice, 13*(2), 760-766. Retrieved from http://files.eric.ed.gov/fulltext/EJ1017246.pdf

Ontario Colleges (2018). https://www.ontariocolleges.ca/en/programs/health-food-and-medical/nursing

Orak, R. J., Farahani, M. A., Kelishami, F. G., Seyedfatemi, N., Banihashemi, S., & Havaei, F. (2016). Investigating the effect of emotional intelligence education on baccalaureate nursing students' emotional intelligence scores. *Nurse Education in Practice, 20,* 64-69. https://doi.org/10.1016/j.nepr.2016.05.007

Orellana-Rios, C. L., Radbruch, L., Kern, M., Regel, Y. U., Anton, A., Sinclair, S., & Schmidt, S. (2017). Mindfulness and compassion-oriented practices at work reduce distress and enhance self-care of palliative care teams: a mixed-method evaluation of an "on the job "program. *Bio Med Central Palliative Care, 17*(1), 3. https://doi.org/10.1186/s12904-017-0219-7

Ortony, A., & Rumelhart, D. E. (2017). The Representation of Knowledge in Memory 1. In R. C. Anderson, R. J. Spiro, & W.E. Montague (Eds.). *Schooling and the acquisition of knowledge* (pp. 99-135). London, England: Routledge.

Patton, M.Q. (2002). *Qualitative research and evaluation methods*(3rd ed.).Thousand Oaks, CA: Sage Publications Inc.

Penner, J. L., & McClement, S. E. (2008). Using phenomenology to examine the experiences of family caregivers of patients with advanced head and neck cancer: Reflections of a novice researcher. *International Journal of Qualitative Methods, 7*(2), 92-101. Retrieved from http://journals.sagepub.com/doi/full/10.1177/160940690800700206

Penrose, L.S., Penrose, R. (1958). Impossible objects: A special type of visual illusion. *British Journal of Psychology*, *49* (1), 31–33. https://doi.org/10.1111/j.2044-8295.1958.tb00634.x

Petrides, K. V. (2001). A psychometric investigation into the construct of emotional intelligence. Doctoral dissertation. University College London. Retrieved from http://www.psychometriclab.com/adminsdata/files/Thesis%20abstract.pdf

Pop-Jordanova, N., & Demerdzieva, A. (2015). Is the level of emotional intelligence in students and health workers satisfactory? *International Journal of Innovation and Research in Educational Sciences, 2*(4), 2349–5219. Retrieved from https://www.researchgate.net/profile/Aneta_Demerdzieva/publication/282294385_Is_the_Level_of_Emotional_Intelligence_in_Students_and_Health_Workers_Satisfactory/links/560af99908ae4d86bb14ac2b.pdf

Psilopanagioti, A., Anagnostopoulos, F., Mourtou, E., & Niakas, D. (2012). Emotional intelligence, emotional labor, and job satisfaction among physicians in Greece. *BMC Health Services Research, 12*(1), 463. https://doi.org/10.1186/1472-6963-12-463

Pryce-Miller, M., & Emanuel, V. (2014). Developing compassion in pre-registration education. *Nursing Times, 110*(37), 17-19. Retrieved from https://www.nursingtimes.net/roles/nurse-educators/developing-compassion-in-pre-registration-education/5074552.article

Ranjbar, H. (2015). Emotional intelligence training: A necessity for nursing education curriculum. *Nurse Education Today, 35*(11), 1053. http://dx.doi.org/10.1016/j.nedt.2015.08.028

Rankin, B. (2013). Emotional intelligence: Enhancing values based practice and compassionate care in nursing. *Journal of Advanced Nursing, 69*(12), 2717-2725. https://doi.org/10.1111/jan.12161

Ravichandra KS, Ravi GR, Kandregula CR, Vundavalli S, Srikanth K, Lakhotia D.(2015). Emotional intelligence among dental undergraduate students: An indispensable and ignored aspect in dentistry. *Journal of International Oral Health, 7*(4), 69-72. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4409800/

Renaud, M.T., Rutledge, C., Shepherd, L. (2012). Preparing emotionally intelligent doctor of nursing practice leaders. *Journal of Nursing Education, 51*(8), 454-460. https://doi.org/10.3928/01484834-20120523-03

Rice, E. (2015). Predictors of successful clinical performance in associate degree nursing students. *Nurse Educator, 40*(4), 207-211. https://doi.org/10.1097/nne.0000000000000136

Rieck, T., & Callahan, J. L. (2013). Emotional intelligence and psychotherapy outcomes in the training clinic. *Training and Education in Professional Psychology, 7*(1), 42-52 https://doi.org/10.1037/a0031659

Rosenstein, A., & Stark, D. (2015). Emotional intelligence: A critical tool to understand and improve behaviors that impact patient care. *Journal of Psychology and Clinical Psychiatry, 2*(1), 1-4. https://doi.org/10.15406/jpcpy.2015.02.00066

Ruiz Aranda, D., Extremera, N., & Pineda Galán, C. (2014). Emotional intelligence, life satisfaction and subjective happiness in female student health professionals: the mediating effect of perceived stress. *Journal of Psychiatric and Mental Health Nursing, 21*(2), 106-113. https://doi.org/10.1111/jpm.12052

Saklofske, D. H., Austin, E. J., Mastoras, S. M., Beaton, L., & Osborne, S. E. (2012). Relationships of personality, affect, emotional intelligence and coping with student stress and academic success: Different patterns of association for stress and success. *Learning and Individual Differences, 22*(2), 251-257. https://doi.org/10.1016/j.lindif.2011.02.010

Salovey, P., & Mayer, J. D. (1990). Emotional intelligence. *Imagination, ognition and Personality, 9*(3), 185-211. https://doi.org/10.2190/dugg-p24e-52wk-6cdg

Şenyuva, E., Kaya, H., Işik, B., & Bodur, G. (2014). Relationship between self-compassion and emotional intelligence in nursing students. *International Journal of Nursing Practice, 20*(6), 588-596. https://doi.org/10.1111/ijn.12204

Shanta, L. L., & Connolly, M. (2013). Using King's interacting systems theory to link emotional intelligence and nursing practice. *Journal of Professional Nursing, 29*(3), 174-180. http://dx.doi.org/10.1016/j.profnurs.2012.04.023

Shanta, L., & Gargiulo, L. (2014). A study of the influence of nursing education on development of emotional intelligence. *Journal of Professional Nursing, 30*(6), 511-520. http://dx.doi.org/10.1016/j.profnurs.2014.06.005

Sharon, D., & Grinberg, K. (2018). Does the level of emotional intelligence affect the degree of success in nursing studies? *Nurse Education Today, 64*, 21-26. https://doi.org/10.1016/j.nedt.2018.01.030

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for information, 22(*2), 63-75. https://doi.org/10.3233/efi-2004-22201

Shetty, S., Venkatappa, K. G., Parakandy, S. G., Sparshadeep, E. M., & Das, S. K. (2013). Assessment of emotional intelligence in first year medical students: A questionnaire based study. *IOSR Journal of Dental and Medical Sciences, 3*(4), 23-6. https://doi.org/10.9790/0853-0342326

Shosha, G. A. (2012). Employment of Colaizzi's strategy in descriptive phenomenology: A reflection of a researcher. *European Scientific Journal, ESJ, 8*(27). ISSN: 1857-7431. Retrieved from https://eujournal.org/index.php/esj/article/viewFile/588/657

Spiegelberg, H. (1971). From Husserl to Heidegger: Excerpts from a 1928 Freiburg diary by WR Boyce Gibson edited by Herbert Spiegelberg. *Journal of the British Society for Phenomenology, 2*(1), 58-83. http://dx.doi.org/10.1080/00071773.1971.11006166

Stanley, S., & Bhuvaneswari, G. M. (2016). Reflective ability, empathy, and emotional intelligence in undergraduate social work students: a cross-sectional study from India. *Social Work Education, 35*(5), 560-575. https://doi.org/10.1080/02615479.2016.1172563

Stelnicki, A. M., Nordstokke, D. W., & Saklofske, D. H. (2015). Who is the successful university student? An analysis of personal resources. *The Canadian Journal of Higher Education, 45*(2), 214 – 228. Retrieved from https://files.eric.ed.gov/fulltext/EJ1073616.pdf

Szeles, H. M. (2015). Developing emotional intelligence in student nurse leaders: a mixed methodology study. *Asia-Pacific Journal of Oncology Nursing, 2*(2), 89. https://doi.org/10.4103/2347-5625.157575

Thistlethwaite, J. E., & Jackson, A. (2016). Conflict in practice-based settings: Nature, resolution and education. *International Journal of Practice-based Learning in Health and Social Care, 2*(2), 2-13. https://doi.org/10.11120/pblh.2014.00036

Uchino, R., Yanagawa, F., Weigand, B., Orlando, J. P., Tachovsky, T. J., Dave, K. A., & Stawicki, S. P. (2015). Focus on emotional intelligence in medical education: From problem awareness to system-based solutions. *International Journal of Academic Medicine, 1*(1), 9-20. https://doi.org/10.4103/2455-5568.172703

Van Exel, J. & De Graff, G. (2005). Q methodology: A sneak preview. Retrieved from https://www.researchgate.net/profile/Gjalt_Graaf/publication/228574836_Q_Methodology_A_Sneak_Preview/links/02bfe50f946fc9978b000000.pdf

van Manen, M. (1997). *Researching lived experience: Human science for an action sensitive pedagogy* (2nd ed.). New York, NY: Routledge

van Manen, M. (2014). *Phenomenology of practice: Meaning-giving methods in phenomenological research and writing*. Walnut Creek, CA: Left Coast Press.

Victoroff, K. Z., & Boyatzis, R. E. (2013). What is the relationship between emotional intelligence and dental student clinical performance?. *Journal of Dental Education, 77*(4), 416-426. Retrieved from http://www.jdentaled.org/content/jde/77/4/416.full.pdf

Vila, V., Zhuang, J., Tan, E., & Thorne, S. (2018). Reflections on Nursing Educational Advancement Within Diverse and Evolving National Cultural Contexts. *International Journal of Nursing Education Scholarship, 15*(1). https://doi.org/10.1515/ijnes-2018-0017

Vishavdeep, S., S., Das, K., PrahbhjotMalhi, & Ghai, S. (2016). A pre experimental study to assess the effect of emotional intelligence skill training on emotional intelligence of undergraduate nursing students. International *Journal of Nursing Education, 8*(2), 203-208. https://doi.org/10.5958/0974-9357.2016.00076.3

Volberding, J. L., Baghurst, T., & Brown, T. C. (2015). Emotional intelligence levels of undergraduate kinesiology students: Brief report. *North American Journal of Psychology, 17*(1), 37-44. Retrieved from

https://www.researchgate.net/profile/Timothy_Baghurst/publication/271517531_Emotional_Intelligence_in_Undergraduate_Kinesiology_Students_Brief_Report/links/54f484fc0cf2eed5d734c45e.pdf

Walden University (n.d.) Social Change. Retrieved from https://www.waldenu.edu/about/social-change

Whitley-Hunter, B. L. (2014). Validity of transactional analysis and emotional intelligence in training nursing students. *Journal of Advances in Medical Education & Professionalism, 2*(4), 138-145. Retrieved from, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4235560

Wheeler, R. E. (2016). Soft skills: The importance of cultivating emotional intelligence. *American Association of Law Libraries Spectrum*. Retrieved from http://www.bu.edu/law/faculty-scholarship/working-paper-series/

Appendix A: Interview Protocol

Introduction

Hello, my name is Cindy Ko. Thank you for coming today. The purpose of this interview is to get your perceptions of your experiences with emotional intelligence in the clinical settings. Please feel free to express your honest thoughts and feelings because there are no correct or incorrect answers. The task is not diagnostic; this interview is not devised to evaluate individual abilities. Your responses will be kept confidential during all phases of this study. You will be assigned a pseudonym. The transcripts and all the documentations pertaining to this study will be kept in a security-patrolled office in a locked cabinet.

Audio Recorder Instructions

I will be recording our conversation so that I can obtain details while I focus on a meaningful conversation with you. Our discussion is confidential. I will compile a report that contains all students' statements without any reference to individuals.

Consent Form

Do you have any questions? If not, please take a few minutes to read and sign this consent form before we begin.

Procedure

An in-person, in-depth, low-structured interview will be conducted with each participant by Cindy Ko. Each interview will be conducted in a private office for approximately 20-60 minutes. Each interview will be audio taped and transcribed verbatim.

The purpose of the study and the participants' rights will be explained prior to the beginning of each interview. Signed informed consents will be obtained from all the participants.

A few minutes at the beginning of each interview will be allocated to build trust and rapport. Participants will be asked open-ended questions regarding their experience with EI in the clinical settings.

Exit Procedure

At the end of the interview, the participant will be reminded that the conversation is private and confidential. They are free to contact the researcher if they have questions or concerns. The participants will be reminded that they will be asked to verify their statements and a summary of the description of their statements in a few weeks time. In addition, each participant will be compensated with a $10 (Cdn.) gift card of their choice to Starbucks, Tim Hortons, or Chapters/Indigo Bookstore.

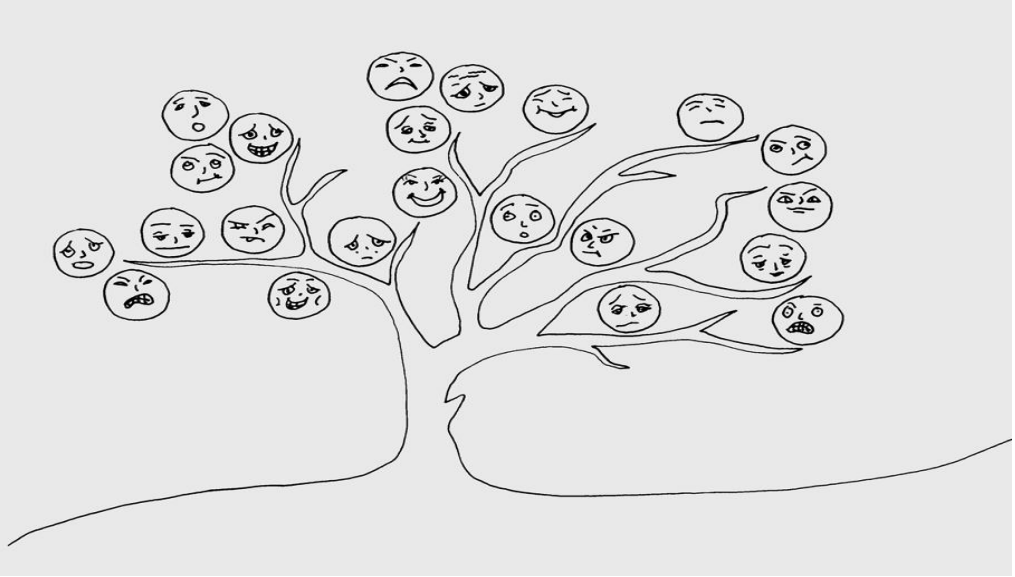
Appendix B: Interview Questions

1. What do you know about emotional intelligence?
2. What are the meanings of emotional intelligence to you?
3. Are you usually aware of your own emotions? Can you provide examples to help me understand how you do so?
4. Was there a time when you had to control your own emotions in a clinical setting? Please describe.
5. Was there a time in the clinical setting where you had to de-escalate someone's emotions, or acknowledge someone's emotions? Tell me more about it...
6. How do you experience EI in the clinical settings?
7. How do you perceive emotions in yourself and in others?
8. Can you recall any meaningful experience when you managed (or could have managed) your emotions in a clinical setting?
9. How did you know when you had utilized EI effectively/ineffectively in the clinical settings? And how did that make you feel?
10. What has your clinical experience been like since your first "knowing" or utilization of EI?
11. Has the recognition of using EI changed the perception of yourself as a student nurse? If so, how?
12. What did we not discuss that you wish to share?

These questions will enable the participants to express their personal and subjective experience unreservedly in their own words as much as possible. When necessary, additional questions for clarification and elaboration will be asked. Furthermore, silence will be used to prompt participants' recollections of their experience. More general questions will be used to prompt the participants to expand their experience or to redirect the discourse should it become too general; these may include:

1. Tell me more about what you mean when you said....?
2. How did you feel when...?

Appendix C: Recruitment Poster



Calling Term 4 NURSING Students!!

Do you know what emotional intelligence is? Or think you know what emotional intelligence is?

A researcher is interested to hear how you apply it in your clinical settings.

Requirement:

You must be a Term 4 Nursing Student or in Consolidation.

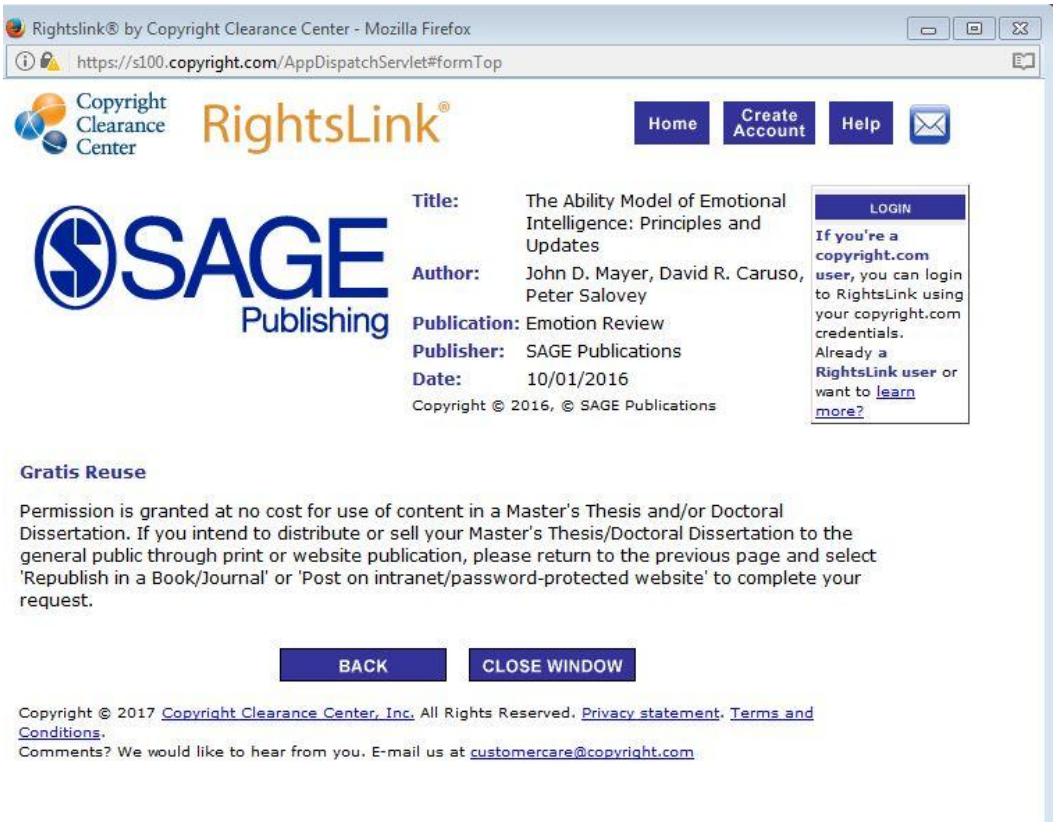
- You must be at least 18 years old
- Approximately 20 - 60 minutes of your time for a **confidential one-on-one interview**
- You'll receive a choice of $10 Chapters/Indigo, Starbucks, or Tim Horton's gift card
- Please contact Cindy Ko for more information

Niagara College Research Ethics Board approval # CEC-NC-2017-14

Institutional Review Board for Ethical Standards in Research approval #12-15-17-0369832

Appendix D: Permission to Reprint the Four-Branch Ability Model

The email thread below indicates permission provided by Dr. John Mayer to use his tables from 1997 and 2016. Emotional Review indicated that permission is not required to use any item from their journal. Please see screen shot:



Harper Collins representative indicated over telephone that Haper Collins has sold the College text department to Pearson Education. An email request was sent to Pearson and currently waiting for a reply.

On 4 September 2017 at 21:40, Mayer, John < > wrote:

Hi Cindy,

Yes, you have my permission, but I would guess Harper Collins owns the copyright. You also could consider our newer table (Table 1) in *Emotion Review*.

Best,

Jack

From: Cindy Ko [mailto:]

Sent: Saturday, September 2, 2017 2:10 PM

To: Mayer, John < >

Subject: Copy right question & permission

Hello Dr. Jack,

I hope this email finds you and yours well and not impacted by Harvey.

Dr. Jack, I am using your Four Branch Ability Diagram from: (please also see attached)

Mayer, J. D., & Salovey, P. (1997). What is emotional intelligence? In P. Salovey & D. J. Sluyter (Eds.), Emotional development and emotional intelligence: Implications for educators (p. 3–34). New York, NY: Harper Collins.

Does Harper Collins own the copyright, or do you?? I am assuming it is you. If so, may I have your permission to reprint it in my dissertation, please?

Thank you!

Cindy

Appendix E: Excerpts of Journal and Bracketing Notes

Bracketing note: Audrey

- Oh my gosh, focus, I am judging Audrey, spit it out, why can't she spit it out, stop saying like already. Was I like that at her age? It's not kinda anything!
- I don't think you know what it is at all
- Ok, ok, you are getting somewhere
- Yes, I wear a lot of my face too
- I hope I am not showing anything on my face right now
- I can identify with this example, I felt the same way. Stop, stop, just listen. Focus on the Epoché behind you.

Bracketing note: Devin

- No, what does it mean to you! Not how much it means to you. Ahhh.... silent scream, sorry.
- What? Someone spanked you? Did you report it? My EI would have kicked into high alert.
- Look at the Epoché sign, listen to this man, not what you would have done. Listen!

Bracketing note: Jasmine

- I am glad you know that EI is not IQ. I don't think I knew that when I was a student. Ok, stop, it's not about me
- I can't stop thinking about the racists who asked about this poor girl's hijab! I am so angry. I can't help her though here. It's about the interview. Let her speak.

Journal entry: Overall Epoché

I feel that from all the research I have done students know very little about emotional intelligence, let alone how to apply it in their clinical settings. I try to think back to when I was a nursing student and how little I knew about anything, but thought I knew everything. There was not so much emphasis on professionalism when I was in school, so these guys are doing well in comparison. But they are so immature, so that's not helping. Now that I have to think about my own experience with EI and I feel that I can't separate myself in terms of how I got to this point of knowing. I remember my first knowing was such an explosive moment when Dr. Wynn told us in one of her lectures and then I have been obsessed with it since. I judge myself harshly when I am not conducting myself in an emotionally intelligent way, so I need to not judge my students because they are just babies. Did anyone give me the same benefit? Perhaps not.

Journal entry: Audrey

Audrey said she's a body language person. Yes, me too. I need to listen and read her transcript and stop thinking about myself. Body language is one small component of EI, but Audrey doesn't know that. To her, it's huge. Set that aside, focus on her transcript. How would I use my EI to deal with the nurse who was mean to Audrey? Ok, stop again. Poor Audrey, I wish I was there to smack the nurse for her. Ok, stop. My EI is not her EI.

Journal entry: Devin

Yes, you mentioned control a lot. I try to control myself too. There's a different between in control and controlling, which am I? Ok, stop, focus on what Devin meant by control, oh ok he actually said it, the difference, good for him.

Why didn't you report the nurses who spanked you? Do you secretly enjoy it? OK, I am judging. Is it a confidence thing? I need to stop thinking about how I would have handled the situation with my own EI knowledge.

Journal entry: Jasmine

There is not much meat here Jasmine. Ok, think pure phenomenology. I am not fitting the transcripts into my study! I am getting frustrated. Need to take a break, going for a walk with Tofu (my dog).

Appendix F: Meanings and Themes Developing

Sample statements/words from participants	Prominent Meaning Units	Focused Phenomenological Themes
Audrey: Um, so, like, really like in kind of making sure that you know how to control your emotions in certain situations and when it's right to, you know, kind of hold back I guess sometimes and when you need to overcome certain emotions and, uh, continue on that way. I'm the type of person that shows a lot on my face - I'd say in certain situations I'm aware - I tend to wear my emotions on my sleeve - I'm very aware of my, unless it's on my face, I can try to harness that but it doesn't always work all the time **Cece:** knowing your own emotions and how to identify them. - It's something that you learn over time, over your lifetime, and I think it comes from having struggles, uh, and a really being in dark place where you kind of have to pry yourself open and figure what you're feeling and why your feeling it. Um, so unfortunately it comes as a result of something negative, but, I don't know, you just have to learn it, I guess, within yourself - knowing those things and knowing your own triggers, um, is important **Dee:** understanding what you're feeling, how you're expressing your feelings at the time that you're feeling them. - controlling your emotions. Well you can't really control them, but you can. - not overreacting. like when I am in clinical placement, I	- know how to control emotions. - know how to identify emotions - know you are feeling the emotions - not overreacting -managing certain situations - understand feelings and emotions - relate to others' emotions with empathy, sympathy & compassion - an emotional being - showing emotions on faces - aware of own triggers - stop and think - being in control	Knowledge about EI & personal awareness of emotions

know that there's a lot of different personalities that I've come in contact with and learn to refrain from saying something just to a person because I don't like the way that they're acting or I don't like something that they're doing. I'm not really in a position right now as a student to maybe speak up and tell them how I'm feeling as much as I'd like to - when I'm in the clinical setting, that I have to stop and really think about what I'm going to say and if it's going to make a difference and how it's going to come across **Devin:** basically is just despite what your emotions are to a question or situation you just need that moment, taking that moment to think before you react. It's just not over reacting. - yeah I am and I do my best to keep them under control because I know that I'm a very emotional person and I go from extreme to extreme. So, I always have to be aware of it and, uh, I think I do generally a good job, but there's always room for improvement. **Jasmine:** it's within your control, um, and it's not IQ. You're not born with it, um, and it's about your emotions. How you can manage them, um, and you use it to control certain situations. **Julie:** ability to understand own feelings and emotions and I think it's also, um, being able to understand other people's emotions. - I feel like I am usually pretty aware of my emotions. Um, I can tell when I feel a little bit off or annoyed about something and if I am coming off like I am annoyed about a specific person or patient, I try to almost hide it. Um, I talk a lot with my hands and my face so I try to, um, like if I'm upset or mad that I guess I try to hide it.		

Liz: for oneself to be able to identify and control their own emotions and how, um, it relates to an inter-disciplinary team and relationships, both personal and colleagues. -Um, yeah. Mostly, I'm in control. **Richard:** kind of the way that you interact with people, um, and the way that you handle situations and your, and deals with your, um, ability to emotionally, uh, connect with people and emotionally deal with stressors that you may encounter. **Sass:** being able to relate to people's emotions and how they're feeling with empathy and sympathy and compassion and understanding. - I'm a pretty emotional person. So, yes, I'm very aware of how I feel.. when I'm feeling low, or stressed, or depressed, or anxious, usually I can tell. There are sometimes physiological symptoms, um, that I can feel if I'm anxious there are palpitations and get very anxious, um, shakes a little bit. Um, or if I'm feeling low, I can tell when I'm feeling low, like I can feel just the weight in my body		
Audrey: **When describing perception of EI in herself:** I guess I'm a body language person... my voice kind of tends to change, I try to stay pretty even and I do my best to stay even, even keeled I guess, but, um, in certain situations, I can, I can change I guess. **When describing perception of EI in the others:** I think a lot of it is, like visual, but, um, also the tone of voice people are using, tics that they seem to have or if they're asking a lot of questions or if they're like holding back. **Cece:** **When describing perception of EI in herself:** like my facial expressions are	-perceive through body language, tone of voice, and facial expressions - perceive through observations - perceive through interactions - perceive through awareness	Perception of EI/emotions in **self & others.**

pretty big. Even though I can't see them, but, like I can tell, um. So. For me, I have a big thing with eye rolling... I know I do that. So, that's something I have to be aware of. Um, but I guess for me, like if I'm in a sticky situation or like a really, um, I don't know, intense situation where I don't know what I'm doing, I can feel my face get hot instantly. So, I get I have a physical reaction to what's happening. Um, yeah, I guess physical and I'm probably really awkward if, uh, if something weird is happening. But, I try not to be. So, I try to be aware of what is happening and then, um. I guess I'm a pretty private person and I'm not going to like start crying in front of anybody or anything like that. I keep to myself, my emotions unless they're happy. **When describing perception of EI in the others:** I pay attention to what they're saying, um, mainly. Um, also, um, cues and body language, um, I pay attention to that. Um, tone of voice is also a good one that I really pay attention to, um, and just overall interactions. So, how they're interacting with other members of their health care team or their family members or whoever is present in the room, I will pay attention to that. **Dee:** **When describing perception of EI in the others:** I will watch **Devin:** **When describing perception of EI in himself:** I'm a very emotional person....I perceive them, my emotions, as a good thing. I think they are going to make me a caring nurse... I think I experience things probably a little more extreme than most people, which really helps me empathize with my patients and it might		

not help my personal life a lot, but my professional life, I think it will definitely help and that's probably what led me to be here, because I probably wouldn't be a nurse if I didn't have these super feelings. **When describing perception of EI in the others:** I really wish other people would let theirs show, but, that's just how they are. **Dora:** **When describing perception of EI in herself:** that component that I have to say 'hey, you know what, that's in this box' and I put that there and move forward **When describing perception of EI in the others:** I can see them in like their, their attributes and what they, what their strengths are and when I see someone that's kind of struggling or maybe having a bad day. **Jasmine:** **When describing perception of EI in the others:** their non-verbal, I would say non-verbal─frowning, happy, from their gestures, closed/open posture. With non-verbal mostly I would say I see emotions. **Julie:** **When describing perception of EI in** herself: I'm very like conservative in the way I act I find. Um, sometimes I have like a 'fake it 'til I make it' kind of attitude about me. So, sometimes if things aren't going as planned and maybe I am upset about something or taken off guard or something like that, sometimes you wouldn't even be able to notice this because I put on like a smile and a brave face and kinda deal with it. **When describing perception of EI in the others:** Body language I think is very important. I think sometimes people don't communicate verbally, um,		

so body language, facial expressions, um, is very important. **Liz:** **When describing perception of EI in herself:** usually cool headed, in control. Um, it takes a lot to get me to blow up or, um, react in a way that I would be disappointed in myself later. Um, yeah. Mostly, I'm in control**When describing perception of EI in the others:** For the most part, I think people generally have their, um, their emotions under control. Um, it's easily identified when they don't, um, through like interactions with them. **Richard:** **When describing perception of EI in himself: '**you definitely feel it, if you see something upsetting that you may feel upset yourself physically, um, you have to be able to recognize how you're, that that you are feeling those things **When describing perception of EI in the others:** perceive it from facial, uh, facial expressions, from the way that things they say and, uh, yeah, just from interacting, uh, with people both verbally and with body language **Sass:** **When describing perception of EI in herself:** I'm a very emotional person, you feel all kinds of different things. Some days, I'm anxious and I can feel the physiological response and I always try to do something to kind of draw myself away from that, whether it's meditation or listening to relaxing music. **When describing perception of EI in the others:** basically non-verbal. Just being able to understand body language and posture... Um, so just being able to know that there are so many emotions that people can feel and feeling them myself because I'm an emotional person.		

Just understanding that there is a wide range and being able to distinguish the different emotions that someone can feel.		
Audrey: I felt like a personal growth there...part of that like moving on was, you know, um, being the bigger person...it felt like a growing up kind of moment I guess... Just like a learning experience. **Cece:** it means to self-reflect and to identify how I'm feeling, um, in the clinical setting when I have patient encounters that may evoke an emotional response within myself or something new that I have seen. Um, so just being able to recognize those feelings and know what to do with them **Devin:** I need to learn more about and constantly work at it cause, you know, it really is everything... to me it means, like I said, it's a difference between being professional and not. - I want to protect my career and not explode in the clinical setting. I think, uh, you really have to be aware of, especially in a clinical setting, how you react. I know there are going to be times when I feel crappy and people put me down, and people yell at me, and, uh, in a meaningful way I have to react while protecting myself because you don't want to let one, one incident, jeopardize everything. To be able to manage a situation just by being calm, because even when you want to yell and scream. Rarely does that make anything better, rarely. **Dora:** it means is being able to step outside of that and to actually, like, grow, and boundaries... it's okay to set up those boundaries and it's okay to voice your opinion that things aren't always rosy, but to do it in a calm, collected and respectful manner	- to be reflective - to learn more about it - being professional - positive relationships - personal growth - learning experience - providing better care to patients - more professional - better able to accept constructive feedback	Personal Meanings of EI

Jasmine: You know that you're controlling your emotions and that you're staying professional. **Liz:** positive relationship or a working relationship **Richard:** reflecting is a good thing to help practise with that, um, to, to really think about how things make you feel and how things might affect your perspective. Um, so I think having good emotional intelligence ties in with reflecting and, so for me, that's, yeah, that's where it's at - um, so to, to be able to kinda take a step back and not maybe react in a negative way and accept the criticism and, perhaps, reflect that maybe there is something I can improve on in the situation rather than, um, rather than, you know, reacting, maybe getting snippy or getting angry. **Sass:** I had to put on that professional, um, appearance that I could control my emotions and empathize with them, but still keep check on my own emotions.... I felt it was important to be able to keep my emotions in check...And then after that, I was just like okay that happened, let's move on to the next thing.		
Audrey: I think you have to be aware of, um, what's happening around you generally... depending on what's happening, in your like there's different ways you can experience it. It's a lot of like speaking up and not just kind of standing back and watching things. You have to get in there. **Cece:** just knowing yourself, knowing how you feel and what your triggers... guess if I'm presented with a situation...there's like a very strong feeling within myself... there's a physical response that happens for me to know like 'Okay, you're feeling like	- to be aware of people and situations - physical responses - observations of self and others - to relate and connect with others	The *how* experience of EI or emotional management experience

this...there's like a physical response that happens within me and I'm able to identify that response and I don't know if it's just through, uh, experience or whatever, but that's how I sense that something is happening within me, uh, that may involve my emotional intelligence. **Jesmine:** when I'm trying calm myself down. **Richard:** to observe things that you might not like and, or you experience conflict with colleagues that is not positive and keep that level headed... **Sass:** being able to relate to people and what they're feeling, especially with patients... it's understanding and feeling that you've made a connection with them.		
Audrey: I think I've been striving to be more emotionally intelligent, for sure. I'm aware of it now, whereas before, I probably wasn't. I'm trying to constantly to be better. So, I've definitely changed with using emotional intelligence, I think. ...it helps when dealing with different people in the clinical setting because you have to know that. - I feel like, um, once you know about it, it's very easy to place it in the clinical setting and um, to be more aware of different things, as well, because then you're kind of watching yourself - I started becoming more mindful. I started looking into that and just being more self-aware of myself... You are able to pick up more cues on their end and realize how you're feeling on your own end. - I think you just become more aware. So me, having a very good Emotional Intelligence, that's very important to me, um, because I feel like that's what makes	- more aware of it now - more confident - more assertive - more mindful - more flexible - strengthened relationships	The *first knowing* of emotional management and perception of self as a nursing student

you a better person. So, being able to identify them and being able to pinpoint them and work on them and, um, identify them in a clinical setting, like, from that point of 'knowing' has become better. **Cece:** I think it's very good that I know about it and I feel that it makes me a better nursing student because I'm more aware. I'm more intuitive. I'm more aware of my patients and what they're feeling. It's not just about tasks and providing care and whatever. It's so much more. **Dee:** I think I feel more confident and more, ...stronger as a person **Devin:** I can see how having emotional intelligence and not having it could be the difference between someone being successful or not...I am able to use that to my advantage and not just fly by the seat of my pants. Anything else I could look up in a book if I need it, but emotional intelligence you need it when you need it. I don't have time to research that. I have to use it on the spot. I think it makes me more professional. It's a good feeling to know that no matter what you're going to be the, you know, the standard. So, it works well. I feel good about myself knowing that whatever situation arises, I could handle it, emotionally at least, maybe not whatever physically needs to be done but emotionally I'll be the guy that says 'it's okay, settle down, we're going to be okay' **Dora:** feeling more confident, stronger, assertive... more confident... more sure of myself... and it's also strengthened relationships with others around me, whereas, I was that shaking leaf. **Jasmine:** better for sure. It makes you more aware of your own emotions, so it makes you feel like you have more		

control. I think of myself as more professional in a way... it definitely helps me in my practice. It's like an added skill... I think it just makes your day at clinical better when you use it. **Julie:** I'm able to be a little bit more adaptable and work with different people, different personalities. Um, I'm able to provide better care to patients... and I feel like it's definitely something that I'm still growing, cause I'm still new at this, so it's something that I'm going to constantly be changing and altering and getting better at. - I think I feel more confident in myself as a nursing student. ... it's definitely made me feel more confident in myself when approaching, um, a situation that I'm not really sure what to do about. Confidence is probably the biggest thing. **Richard:** ultimately, I think that what it's done is enhanced my ability to care and I think that that is a really important part of nursing. it's given me confidence...It makes me feel good, Uh, it also makes me confident in my ability to, um maybe have empathy, So, uh, it makes me recognize that I may have come a long way even with something that, uh, to be honest with you, I used to think that was a little more innate than practised, but I have come. I got into nursing, one of the reasons I got into nursing is because I'm logical and I like science. Um, and I think that the art form of nursing, which I think has a little more to do with the emotional intelligence, um, definitely **Sass:** It's made me more aware of, ...the wide range of emotions that I can feel and whatever I could be feeling at any given time, how that could not deliberately be projected onto somebody else. Just being aware of it and just		

knowing how important it is to see it in yourself and how it can relate to other people. But, it is very important to understand it within yourself, what you are thinking and what you're feeling and not projecting it negatively onto somebody else. As a student, right now it might be a little, it might not be enhanced right now, but it's something that's going to come more with experience I find. So it's important to learn it now, as a student, and carry that with you through the rest of your career		

Appendix G: Participants Lived Experiences

Participants' lived experience with Emotional Management and Lifeworld Existentials

Sample Significant Statements	Lifeworld Existentials
Audrey: to be aware of what's happening around you generally - you're kind of watching yourself, especially as a nursing student, you're kind of under like the microscope and so you're aware that you're under the microscope. [also lived body] **Cece:** I kind of pay attention to everything that's happening around **Devin:** probably one of the best things I can do at my stage right now for my patients is to be there for them. - it's okay to set up those boundaries - In clinical situations, everything's always strange. I mean everybody is there for a different purpose. Everybody is there for a different reason. Everybody has different feelings about being there. For the patient, it's probably the worse day of their life and I'm a guy there just having fun, trying to learn as much as I can. So, even just providing care, their experience of it is much different than me, than mine **Dora:** it's okay to set up those boundaries	Lived Space
Audrey: see lived space **Cece:** I guess if I'm presented with a situation. Uh, there's, there's like a very strong feeling within myself and I don't know if it's like a pain in my heart or something, but there's a physical response that happens for me to know like 'Okay, you're feeling like this. You're on the verge of tears.' or 'You're feeling like this. You may be crying, um, or may be happy or whatever it is.' but, there's like a physical response that happens within me and I'm able to identify that response and I don't know if it's just through, uh,	Corporeality - Lived body

experience or whatever, but that's how I sense that something is happening within me - Um, but I guess for me, like if I'm in a sticky situation or like a really, um, I don't know, intense situation where I don't know what I'm doing, I can feel my face get hot instantly. So, I get I have a physical reaction to what's happening. Um, yeah, I guess physical and I'm probably really awkward if, uh, if something weird is happening. - I started becoming more mindful. **Dee:** see lived time **Dora:** see lived time **Sass:** it is hard because you have to keep it all internal, um, and you have to be careful about how you articulate your emotions through your body language. So, I think being able to acknowledge what you're feeling, but still being able to put on that professional appearance is very important	
Audrey: felt like a wake up call... Um, yeah, I think. I mean I still don't know what I want to do, but I'm getting there. I'm learning. I'm growing **Cece:** I think it (when successfully management your emotions) just prepares you better for your next experience. - Um, I think it comes. It's something that you learn over time, over your lifetime, and I think it comes from having struggles, uh, and a really being in dark place where you kind of have to pry yourself open and figure what you're feeling and why your feeling it. **Dee:** If I'm feeling something, I can control how long I'm going to be feeling that way, where as opposed to I can't really stop myself completely from feeling something [also lived body] - I try to step back and see **Devin:** I try to take that extra time to think - the best things I can do at my stage right	Temporality - Lived Time

now for my patients is to just be there for them [also lived space] **Dora:** you gotta take a step back [live body] and re-group and, you know, think 'well okay, this has nothing to do with where I'm going now' and it's, it stays at the door [figurative lived space] basically **Jasmine:** I think it just makes your day at clinical better when you use it. **Julie:** you need to kind of be able to deal with your own emotions for five minutes, ten minutes, how ever long it is, deal with it - I'm probably going to experience that several times, or several times a day, in my career. So, um, just learning to control it at the time and then go through the proper channels to have it dealt with later **Richard:** to be able to kinda take a step back and not, not maybe react in a negative way and accept the criticism and, perhaps, reflect that maybe there is something I can improve on in the situation rather than, um, rather than, you know, reacting, maybe getting snippy or getting angry.	
Audrey: Um, well it made me feel pretty terrible actually. Heh, heh. Just, um, because there are a lot of nurses that understand that you're a student and everything, um, but, yeah it was my first taste of like, you know, um, like the older nurses eating the baby nurses I guess, Um, yeah, so it was just like, I don't know, this is what it's going to be like. - I feel like it [EI] helps when dealing with different people in the clinical setting because you have to know that. I mean, everyone's different **Cece:** if I see that somebody's feeling, you know, a little bit uncomfortable with their family around, I might ask them to leave, you know, whatever, so I can communicate with the patient and see what their needs are because they are my main priority. So, I kind of pay attention to everything that's	Relationality - Lived Human Relation

happening around and see how they're interacting with certain people, um, and also other nurses specifically, um, because there are some patients who just don't get along with some nurse and they get along great with others, so I pay attention to that and see what the ones they do not get along with are doing so then I don't do the same thing and I re-approach it and get them to open up. - I need to be there for them [patients] emotionally and I need to do this for them and, even though, I wanted to cry myself because the situation was very sad. Um, I know I couldn't do that because then that would just make the patient cry even more - So, I think having good connections and good relationships with people and being able to recognize that someone's not feeling okay, that someone has a worried look on their face or isn't themselves, which comes with, you know, experience, I guess, and being able to identify that and ask the person 'Are you okay? Is there anything I can do to help you?' That's really important, um, just for your team member and the nursing team. - it means that like when I am in clinical placement, I know that there's a lot of different personalities that I've come in contact with and learn to refrain from saying something just to a person because I don't like the way that they're acting or I don't like something that they're doing. **Devin:** big part of our job is to just, you know, help our patients emotionally and that's probably one of the best things I can do at my stage right now for my patients is to just be there for them - There are breakdowns every day. Definitely, almost daily, you have to be there and support each other - emotionally when you use it [EI] well, you feel like you have the power, like I	

controlled that situation. And, when someone else, when you are able to de-escalate the situation, it really puts you in control. And not saying that I always want to be in control... but when it comes time to shut things down, you need to just be calm and be cool and calm **Julie:** I feel like it's very important to be professional and I don't want to cause conflict - I get angry very easily, so I kind of had to take a second and be like okay, like don't blow up, ha ha, and be calm and just deal with it professionally - it's important for me to have an influence on other people and realize that everybody's different, everybody has different preferences and to be a little bit more open minded **Liz:** I try to actively participate, um, by developing therapeutic relationships with my patients and colleagues and, um, leaders, mentors **Richard:** kind of the way that you interact with people, um, and the way that you handle situations and your, and deals with your, um, ability to emotionally, uh, connect with people and emotionally deal with stressors that you may encounter **Sass:** being able to relate to people and what they're feeling, especially with patients it's understanding and feeling that you've made a connection with them - So, I feel like it's more than just talking to someone, trying to understand. You also have to be able to read their body language, as well - Being empathetic and compassionate and even if they're a hostile patient, there's a reason they're hostile. - I think that they go hand in hand, like being aware of other people's emotions, what they're thinking and feeling, but being professional at the same time.	