

Lived Experiences and Insight on Development of Emotional Intelligence in Professional Nursing Practice

Jennifer Jessen, EdD, RN, CNOR, FNAP*

College of Nursing, Creighton University, Omaha, Nebraska, USA.

*Correspondence:

Jennifer Jessen, 700 N 40th St., Omaha, Nebraska, 68131, USA.

Received: 20 Mar 2024; Accepted: 21 Apr 2024; Published: 30 Apr 2024

Citation: Jennifer L Jessen. Lived Experiences and Insight on Development of Emotional Intelligence in Professional Nursing Practice. *Nur Primary Care*. 2023; 8(2): 1-14.

ABSTRACT

The purpose of this qualitative, experiential narrative study was to examine how emotional intelligence (EI) is developed in professional nursing practice. Narrative, qualitative research was conducted with a professional nurse in repeated interviews detailing the major events, patients, coworkers, mentors, and support systems in the research participant's life from their first experiences in healthcare to the present. Evidence of EI was identified in the participant's stories and applied to the Salovey and Mayer model of EI. NVivo 11 was selected for concept analysis and several themes emerged including Dignity and Respect, Formal Teaching, Experience, Mentorship, and Reflection. The interviews were then analyzed for structure using the Labov and Waletzky's model. The structural analysis found large segments of complicating action and reflection, which is congruent with the concept analysis. Development of simulation activities and clinical measures of compassion and empathy are areas of focus for the development of EI in nursing practice. Additional research should be conducted on the role clinical empathy plays in the development of EI. Other areas suggested for future study include how formal teaching experiences of EI impact students in nursing school, and how movement between nursing positions influences emotional intelligence in professional nursing practice.

Highlights

- Emotional intelligence is an important concept for professional nursing practice, but it is unclear on how it is developed
- Qualitative, narrative research study to examine how emotional intelligence skills develop in clinical practice
- Themes emerged related to Dignity and Respect, Formal Teaching, Experience, Mentorship, and Reflection
- Strategies that enhance empathy, compassion, teamwork, safety, and overall satisfaction in nursing should be pursued to support the health and well-being of nurses

Keywords

Emotional intelligence, Professional nursing, Clinical empathy, Nursing education.

Introduction

Professional nursing care is described as both an art and a science [1]. To provide effective patient care nurses, need a solid understanding of complex physical processes and treatment options; but in

addition to this theoretical knowledge, nurses need to be skilled in therapeutic relationships and effective communicators. High-performance nurses understand that the science of nursing must coexist with the art of nursing, and, without equal attention to both, nurses will be unprepared to effectively treat the complexities that exist within healthcare today [2].

Affective skills, such as effective communication, would most appropriately fall into the category of emotional intelligence (EI). EI has been defined as an ability to recognize emotion in one's self and others and to use emotional knowledge to reason and guide critical thought [3]. Proponents of EI argue that it may be more effective in predicting professional success than traditional intelligence tests (IQ) [4-6]. In previous studies, researchers found that the largest contributions to life-related success were abilities that included attributes such as controlling emotions, handling frustration, and getting along with other people [7-9]. Therefore, in pursuit of balance between critical knowledge and empathetic reasoning, the concept of emotional intelligence presents itself as

a necessary skill for the professional nurse.

Nursing work is a career that demands a large amount of emotional labor to effectively communicate and provide care [10-12]. The physical work is demanding, but often times the emotional strain of dealing with vulnerable patients, navigating ethical decisions, and delivering compassionate care is apparent [13-17]. The demanding level of psychological and physical care leaves nurses vulnerable to stress, and, consequently, burnout [18-24]. As our healthcare landscape is changing, there are even more pressures on nurses to perform to high standards [25-27].

Emotional intelligence literature suggests that nurses and students with higher levels of EI are more likely to successfully deal with the stressors that a demanding career or curriculum might entail [28-36]. The positive effects of high EI have been linked to improved mental and general health, increased resiliency against depression, increased independence, greater anger management skills, stronger work performance, and overall a better optimism towards life [37-42]. Students with high levels of EI showed increased feelings of control, which helped them to adopt an active and effective coping strategy when dealing with stress. This ability to manage stress, cope with emotional demands, and possess a positive outlook on life certainly has applicability to student retention and better matriculation through a nursing program [43-45]. Additionally, this greater capacity to handle stressful situations could potentially lead to increased job satisfaction and less job turnover in demanding patient care settings [46-53].

Lack of consensus of the term “emotional intelligence” makes the concept difficult to quantify [54-56]. While researchers continue to define and provide research attesting to validity of the concept, studies are being conducted to correlate nurse EI with quality improvement measures in clinical practice [57-61]. Nursing research has linked EI to improved nurse retention, increased sensitivity and compassion, increased nurse performance, and greater levels of wellbeing for those who scored highly on the EI scale [62-67]. A need for clarity regarding the process in which EI skills are learned presents itself as a gap in the literature.

The purpose of this study was to examine how emotional intelligence skills develop in clinical practice. There are clear implications for the role of EI in both the academic setting and bedside care settings, but without insight into how or when emotional intelligence is developed, adequate educational techniques to increase EI cannot be developed [68-73]. For the purposes of this descriptive, narrative, qualitative study, one nurse was extensively interviewed regarding her personal lived experiences developing and applying emotional intelligence skills. The question under study was as follows:

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

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

Theoretical Framework

Confusion regarding the very definition of EI has led to a broad range of applicability of the term, and in some cases, this lack of consensus has led to its dismissal as a usable construct [74-77]. The reliability and validity of performance measures, along with the narrowed focus of the ability model, makes the Salovey and Mayer [78] conceptual framework appealing as a theoretical framework for healthcare research and implementation. While many of the EI models differ slightly in their global focus, most agree that EI at its minimum can be described as the identification of emotions in one’s self and other, the ability to understand those emotions, and the ability to manage and apply those emotions to action. This is used as an operational definition for this study. Because EI is viewed as a skill, and one that can be developed, its applicability within the nursing field can be demonstrated.

Methods

For the purposes of this study, an experience-centered narrative research is used to collect data on the individual’s lived experiences. Narrative inquiry focuses on personal experiences as important sources of knowledge and transformation that can be conveyed through the selection of spoken words, written text, observed emotional responses during interviews, and through chronologically sequencing events [79-81]. According to Andrews et al. [82], narratives that describe experience share four characteristics in common: a) they rely on the sequencing of events meaningful to the phenomenon under study, b) there exists a search for meaning with examination in the experiences, c) they will reconstruct events to represent the experience from the perspective of the individual, and d) the experience is transformative in their life. Studying the experiences that led to the research subject becoming an emotional intelligent professional nurse had the potential to increase the understanding of how the participant obtained EI skills in her nursing practice. By examining these critical components as they related to learning EI skills, the method of transformation from novice to expert has the potential to be revealed for deeper study.

Study Participant

The participant for this study was known to the researcher and was purposely selected for her consistent display of emotional intelligence skills. This type of sampling is consistent with narrative research under the definition of “capturing the detailed stories or life experiences of a single life [83].” The participant’s emotional intelligence skills were also validated by her emotional intelligence score (EQ) as determined by the MSCEIT. Her total EQ level was reported as 104 out of a possible 150, which the MSCEIT reports as competent in EI [84]. Her area scores, Experiential and Strategic, were 99 and 106 respectively. The branch scores reported were Perceiving Emotion (103), Facilitating Thought (95), Understanding Emotion (106), and Managing Emotions (103) (Figure 1).

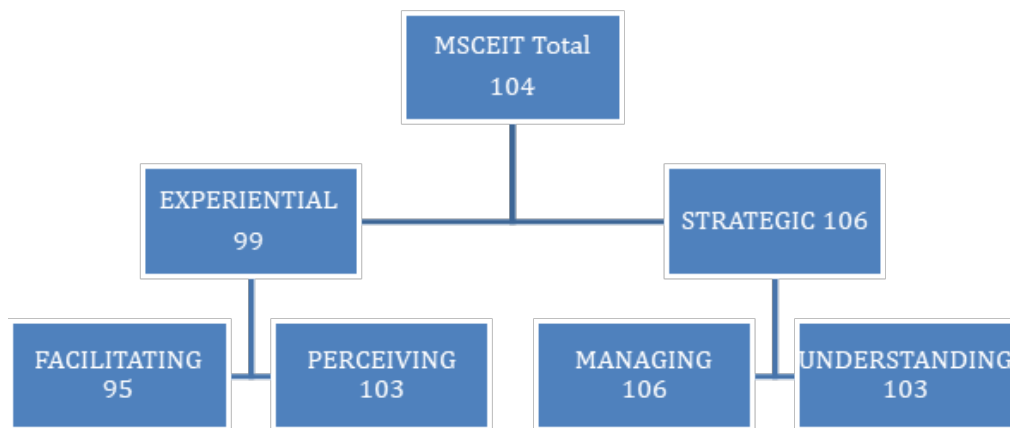


Figure 1: Research Participant’s MSECEIT Scores.

Selection of a participant known to the researcher could interject a risk of bias, but alternatively, with a known interviewer the participant may be more inclined to be forthright, honest, and open during the interview process. Creswell [85] stated that having rapport with the participant may lead them to disclose a more detailed account of the phenomenon under study. With this in mind, the goal of this study was to select a participant who embodied the principles of an emotionally intelligent nurse and was able to convey her lived experiences through storytelling and in-depth interviews.

In an effort to ensure that all ethical aspects related to human subjects were met, the Institutional Review Board (IRB) was asked to review the research proposal for professional use of the research design. This research included an emotional intelligence score where the participant’s identity is known to the researcher. Due to the sensitive and personal nature of the data, a full-panel review by the IRB board was conducted. After IRB approval was gained, an initial meeting was initiated where the participant was informed of their rights, made aware that multiple interviews would be collected over what was anticipated to be many hours over several weeks, and that the opportunity to review the transcripts would be provided prior to completion of the study. The participant was informed of her ability to leave the study at any point without fear of any negative consequences, and informed consent was obtained (Appendix D).

Data Collection

Upon obtaining consent of the participant, the researcher verified the emotional intelligence of the participant by completing the Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT) [86]. Results for the MSCEIT included a Personal Summary Report which yielded an overall EI score along with a breakdown of sub scores in the four-branch model [87].

Narrative Interviewing

Different from traditional semi-structured interviewing, narrative research focuses on generating details surrounding the experience rather than general statements to describe the event [88]. In this type of interviewing, the interviewer and the participant often

resemble a more collaborative exchange in which the two work together to construct the narrative [89,90]. This process typically will extend over multiple interview sessions [91,92]. While analyzing data collected from the narrative interviews, focus was placed in two areas: evidence of emotional intelligence in nursing practice, and evidence of gaining emotional intelligence skills.

Six interviews were conducted with the research participant. Phase one interviewing focused on gathering relevant demographic data and constructing a timeline of life events. Information regarding the participant’s background, family, support systems, schooling, employment, and the timeframe in which these events took place allowed the investigator and participant to become accustomed to their surroundings, the process, and allowed for the investigator to prepare a “life history grid” that was completed in subsequent interviews with the participant [93].

In phase two interviewing following the construction of the life history grid, the participant and interviewer met to generate conversation regarding experiences involving EI and how EI was learned by the participant. These interviews were limited to one-hour intervals, continuing until the entire life history grid was completed and there was saturation of data. A total of four, approximately one-hour interviews were conducted during phase two to achieve the desired level of detail and data saturation. Interview two starts with her experiences as a nurse’s aide and entering nursing school. Interview five details many of her leadership roles and current position.

In phase three interviewing, the researcher reviewed the collection of interviews for any inconsistencies or gaps in data. This final interview was conducted to follow up with chronological questions, clarifying information, and exploration of subject interpretation. Figure 2 provides a visual representation of the data collection procedures conducted during this study.

Data Analysis

When data collection was completed, the researcher completed the transcription process using a professional transcription service. Verbatim transcripts of the audio and video taped interviews were

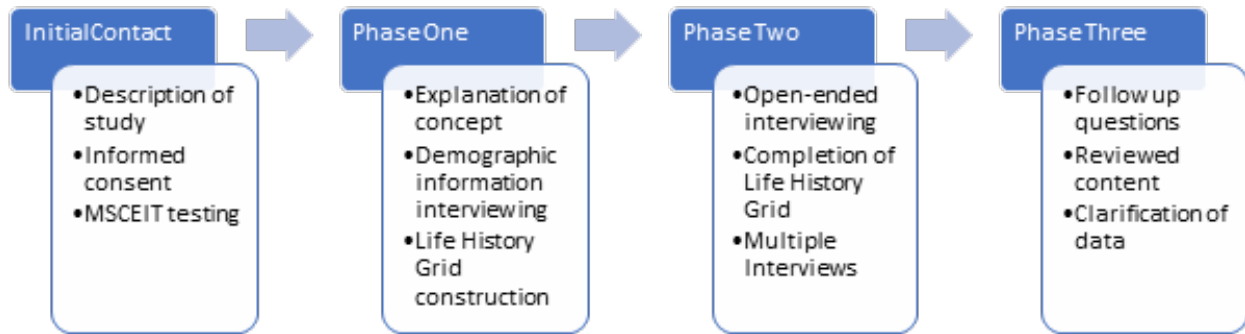


Figure 2: Data Collection Procedures.

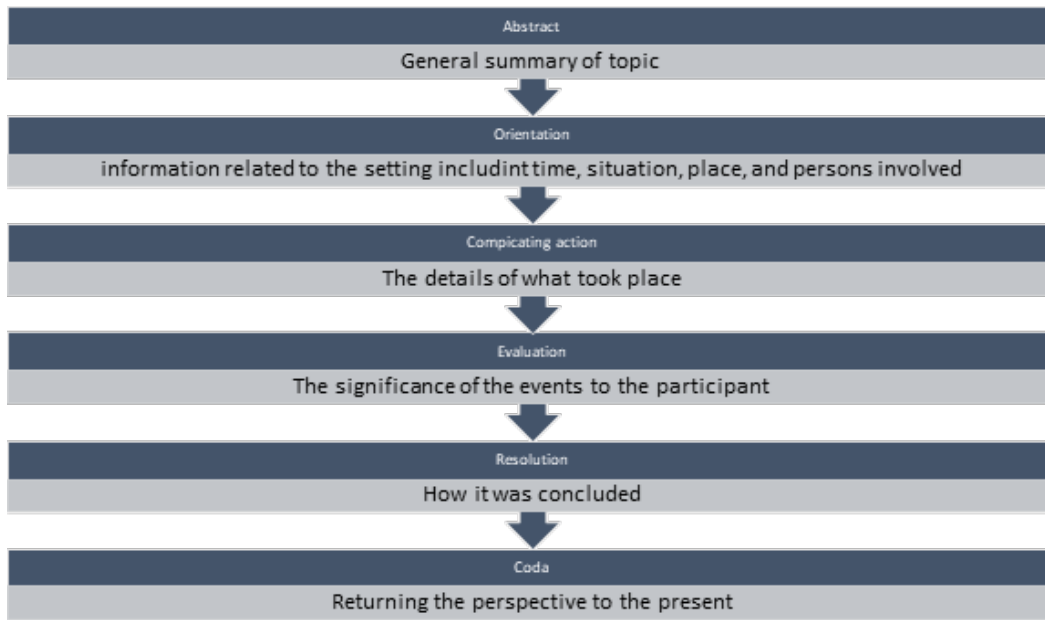


Figure 3: Structural Analysis Elements [99].

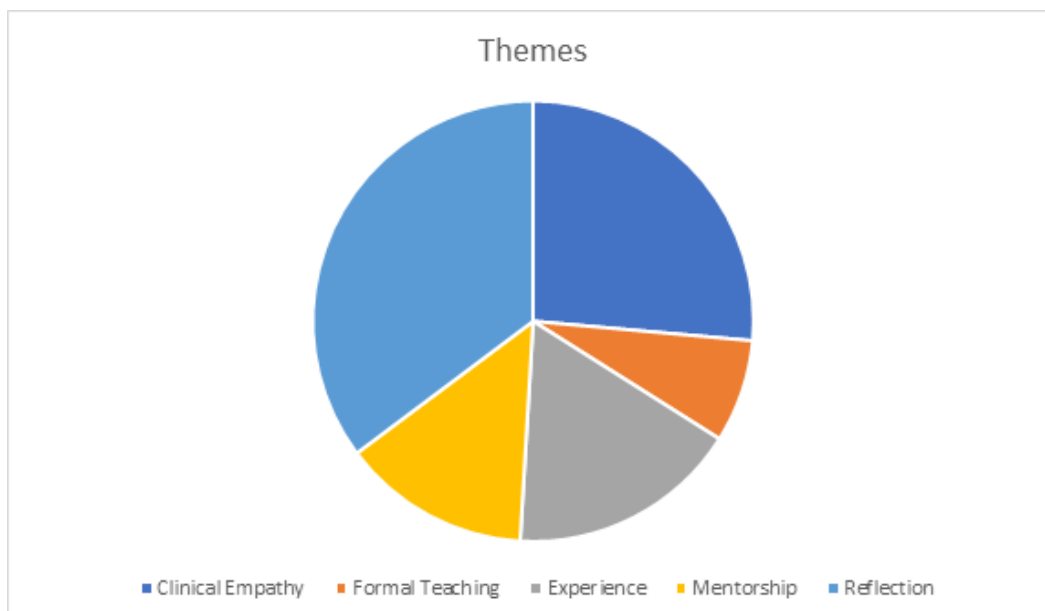


Figure 4: Frequency of Themes Found Within the Narrative Interviews.

collected at the completion of each interview. The participant reviewed these transcripts for accuracy and veracity prior to data analysis. In attempt to triangulate data, both thematic and structural analysis of data were conducted on the research interviews.

Thematic & Structural Analysis

Thematic analysis began with general reading and notation of the participant transcripts to develop a sense of the data and form initial codes [94]. Important stories and transformative events were located within the text. To further assist in investigator coding, transcripts were organized by the researcher using NVivo 11 software [95]. The data were reviewed using this software multiple times and coded for themes and subthemes.

The Lobovian method of structural analysis entails dissecting the narrative transcripts into segments. Each of these segments is given an identifier related to the function of the clause [96,97]. Structural analysis then allows researcher to examine if particular sequences of action are repeated across varying types of narratives. Figure 3 describes Labov and Waletzky's structural model as it relates to these elements [98].

Triangulation of data was completed utilizing structural themes found to be recurrent were examined next to the prevalent themes found within the narrative for similarities or differences. As a method of member checking, the participant was invited to review the thematic analysis for accuracy related to interpretation of the narrative.

Results

The participant chose the pseudonym "Kay" to preserve anonymity in the research study. General statements were extracted from the narrative interviews showing evidence of EI skills in Kay's description of her nursing care. References to EI skills were made in all five interviews, for a total of 65 references. Interviews two and five had the highest numbers of references, 18 and 16 respectively. While interviews three and four had lower numbers of EI evidence (15 and 13 references), the distribution of EI evidence is fairly even (Table 1).

Table 1: Distribution of EI References.

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

Thematic Analysis

Careful analysis of the interviews revealed several themes that can be discussed as they relate to how emotional intelligence is developed in a nursing professional. From the five interviews conducted with the participant, six main concepts emerged: Clinical Empathy, Formal Teaching, Experience, Mentorship, and Reflection. As Figure 3 depicts, the greatest number of references

were in relation to the concept of Reflection (56 references). Clinical Empathy made up the second largest number of references (42), with the remaining concepts (Formal Teaching, Experience, Mentorship) making up the last third of the concepts (12, 27, 22). Each of these concepts will be discussed in terms of typical statements made and the timeframe of when these references were experienced (Figure 4).

Formal Teaching

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

"An instructor at the time said ... She goes, 'I want you to know how horrible this feels, so that when you're putting this in your patient you have some empathy for that patient.' I think we had some excellent instructors. Well it was all about holistic healthcare."

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

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

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

Mentorship

While an argument could be made that Mentorship is another form of Formal Teaching, the interviews revealed that Kay discussed Mentorship differently than when she discussed her clinical instructors or her class work. Mentorship was a sought-after experience by Kay, as mentioned in her choice to select a position that included a six-month mentorship program. Kay not only discusses this time in her life as influential, but also dedicated extensive interview time to describing the nurses she worked with as a nurse's aide. She discussed multiple peers as she moved positions in her nursing career.

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

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

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

“I do remember watching and seeing if the things that I feel like doing, or interacting with a patient, and I would watch and see if that was how she was interacting and dealing with the patient. I felt validated if I saw that that is how she reacted, or treated her patients.”

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

“They discourage you. They would say things like [...] ‘You need to figure out how to get your work done and it’s not all about books.’ It’s like, Well but don’t you want me to know why we want to do a cardio output maybe and to understand what it is?” Mentorship was referenced with a similar frequency to Experiences, but more commonly than Formal Teaching (22 references). The largest share of references clustered around interviews three and four, which would coincide with the latest part of Kay’s nursing education and her first years as a new nurse. While Kay mentions Mentorship in all five of the interviews, the fifth interview included only one reference; made regarding a coworker that mentored her after she had taken a new position as a perioperative nurse.

Experience

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

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

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

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

The importance on Experience as a learning environment was

apparent to Kay as well. At times she found it difficult to explain her methods or how she learned them. She would state that she had learned what she did by trying out different methods.

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

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

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

Experience references made up approximately 17% of the total amount of references. It appeared in the narrative with a similar frequency to Mentorship (27 references). Experience references were found in interviews two through five without much variance. References appeared fairly evenly throughout the narrative interviews.

Clinical Empathy

One phenomenon that appeared within the narrative interviews focused on respect for the dignity of each person. Kay commonly used the term “respect” or the phrase “don’t dehumanize” while she was discussing the rationale for her behaviors. Research in the medical field identifies the phenomenon as “clinical empathy,” a cognitive attribute separate from personality [100]. Empathy is described by Mercer and Reynolds [101], as a “complex, multi-dimensional concept that has moral, cognitive, emotive and behavioral components.”

According to this research, empathy in a clinical setting would encompass the cognitive aspects that Kay describes with her patients [102]. Statements such as “It was more trying to give him some dignity,” or “It goes back to treating people with respect, I think and recognizing that there’s a reason for every behavior,” depict a viewpoint that is rooted in morality consistent with empathy as defined by Boodman [103]. Kay’s frequent answer to questions regarding the rationale for her emotionally intelligent behavior is uncertain with her citing “it’s just the right thing to do.” Often, Kay will use the term “humanize” in her descriptions.

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

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

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

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

Innate Ability

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

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

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

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

Reflection

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

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

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

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

Reflection was used as a means to study the interaction and make value statements or judgements based on the EI skill being witnessed. Reflection was found after all other concepts identified in the study. The only time that Reflection was not expressly discussed was when Kay made statements regarding her innate abilities with EI skills. When Kay couldn’t name how she had learned an emotionally intelligence skill there was an absence of reflective statements.

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

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

to using,

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

to understanding,

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

and managing,

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

Self-talk

Reflection was especially apparent when the managing branch of the EI framework was used. Kay would frequently use “self-talk” to regulate her own emotions and her response to them. She would specifically identify self-talk as a means of mitigating her stress and anxiety.

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

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

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

Structural Analysis

Thematic analysis is one way to interpret data collected with narrative inquiry, as it focuses on events and experiences and the chronological order of which they occur [104]. Structural analysis, or a focus on the form or of the stories recounted by the research participant, focuses mainly on the way in which the story was recounted and how their data are conveyed [105]. From the evaluation of two separate types of data analysis, comparisons can

be made. The large segments of evaluation stand out as the most compelling argument for data validity. The concept analysis found that reflection followed circumstances where EI was learned, developed, or practiced. The structural analysis supports this theory by showing large segments of evaluation that include reflective statements. The participant structured her stories in such a way that each time she retold her story she identified her thinking and her feelings at the time. While one might make the argument that the nature of narrative inquiry requires such participants to reflect on their experiences, this was not true of all of Kay's stories. There were several instances (three stories) where no evaluation took place and the story abruptly ended. Kay chooses to use expressions such as "I remember thinking" or "I remember feeling" without prompt from the researcher. These passages tend to have lengthy reflection pieces as a result. These large segments of complicating action and evaluation coincide with the thematic analysis.

Discussion

The purpose of this qualitative, experiential narrative study was to identify what factors, positive or negative, have influenced how the professional nurse becomes emotionally intelligent. based on the lived experiences of one emotionally intelligent nurse. The study design was intended to elicit a detailed and personal point of view on the practice of emotional intelligence in acute care nursing in a Midwestern hospital setting. The research study found six concepts that were important to the development of emotional intelligence. Many of these correlated with available literature on EI, but several manifested in unexpected ways for the research participant, Kay.

Life experience is important for developing an emotional vocabulary needed for the perceiving branch of EI [106]. Without witnessing or experiencing complex emotions it would be difficult for one to readily decipher between similar emotional responses. Within nursing, it follows suit that experiencing a variety of emotional responses to the care provided would help the novice nurse develop an emotional vocabulary and practice using emotional skills. In the literature, experiences gained are said to lead to higher levels of emotional intelligence, and therefore, the nurses who have had the opportunity to participate clinically leave more skilled [107,108].

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

Kay's ability to learn through Experience did not always manifest itself with trial-and-error attempts. Kay identified her ability to

visibly watch coworkers or mentors handle difficult situations was just as important as her experiencing the situations herself.

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

Kay goes on to describe the process further.

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

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

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

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

Mentorship and Formal Teaching are also discussed as concepts for development emotional intelligence skills. Available research places emphasis on the guidance a good nursing mentor can provide a novice nurse or student [109-113]. Formal Teaching of emotional intelligence is not typically a stand-alone concept of nursing programs, but large emphasis is placed on communication skills throughout the curriculum [114-118]. Prior to completing the research study, the researcher completed reflective journaling to reduce study bias. This journaling revealed that Mentorship was the expected area where EI skills would be developed. Within this research study Mentorship does appear as a desired and important concept, but Formal Teaching practices were more frequently cited in the interviews as being important to development of EI.

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

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

Clinical instructors may have been making use of another concept discussed in the narrative: Reflection. Reflection was very prevalent in the narrative interviews. While some of the noted Reflection can be attributed to the fact that narrative inquiry is in fact asking the research participants to reflect back on experiences that are meaningful, Kay's Reflection was extensive and methodic. It was the estimate of the researcher that Reflection would follow major emotional events as a way for EI to be developed, but it was found that Reflection also preceded development of EI as well. In many of the stories, Reflection was initiated by the research participant, and her questioning led to her ability to then engage the patients or try to rationalize her responses. From that inquiry, she was able to better manage her own responses or react to the responses of others. Much of this Kay attributes to her innate personality, but does agree that it was encouraged by her nurse mentors and nursing program. With this in mind, Reflection and Self-Talk appear to not only be a precursor to development of emotional intelligence, but a strategy to develop it as well.

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

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

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

Implications for Nursing

The importance of the previously discussed concepts for development of emotional intelligence skills in nursing practice

has led to several recommendations for practice. Based on the research participant's lived experiences in the nursing profession, increasing student experiences with patients and the healthcare team (by way of clinical experiences or simulation) should be a priority for nursing curriculum. Many of the foundational and significant events for this research participant stemmed from her exposure to patients as a nurse's aide. The direct patient care the participant provided gave her insight on the emotional needs of a population of aging patients with significant health concerns. Kay was able to use her existing knowledge on communication techniques and apply them in a clinical setting with the help of formative mentors at this early stage of her nursing development. Requiring previous experience with patients and/or the healthcare environment prior to nursing instruction is one strategy toward the advancement of emotional intelligence. By ensuring that comfort with the clinical environment is established, the resulting student confidence will allow more time for the development emotional intelligence skills.

The results of the study also support explicit integration of nursing instruction on the concept of emotional intelligence. Attention to including emotional intelligence in clinical experiences, or at the very least, naming the concept in theory discussions may be appropriate. While instruction on communication skills is a worthwhile concept to impart, it does not go far enough to address the complex ability to navigate emotional skills [119-122]. Advances in nursing simulation present a unique opportunity to give students firsthand opportunities to experience a range of emotions or practice recognizing them in others [123-125]. Additionally, opportunities for observation have been shown in this study to present similar if not equally meaningful opportunities for students to gain experience and formal instruction in EI.

This study also confirmed the necessity of teaching reflection that is both critical and transformative. The process of critical self-analysis and discourse can challenge previously held judgments and allow students to make meaning in the events that they experience. Simple reflection is not enough to achieve transformative learning, therefore, would be best facilitated by an in instructor or competent mentor [126]. Critical junctures for this reflection were identified in this study as prior to patient engagement and immediately following engagement.

Based on the discussion surrounding the importance of Clinical Empathy, nursing education should reexamine how compassion and empathy are imparted to students during the length of their education. Finding a place for emotional development in students and an emphasis on empathic care could not only improve patient outcomes, but also bring a higher satisfaction within their nursing career [127-131]. Placing emphasis on compassionate care, and evaluating for it in a clinical setting, communicates an understanding that professional nursing care embodies holistic care of the patient.

The results of this study have pinpointed several areas for future research in the development of emotional intelligence in nursing.

This study could be repeated as a phenomenological qualitative study where a sample of nurses discuss their experiences learning how to practice with emotional intelligence while in nursing school or when moving to different positions in nursing. Focus on formal teaching experiences or clinical practice would be beneficial not only to expand the understanding of how nurses learn EI skills, but to validate the findings of this study. Reflective practices and their ability to influence the development of emotional intelligence should be further explored in nursing education. Investigative studies that particularly look at the ability to critically analyze and reflect deeply could be explored as a means to improve EQ scores. Both qualitative and quantitative information would provide insight on development of EI skills.

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

Conclusion

The theoretical framework for the purposes of this study has been thoroughly described according to the Salovey and Mayer model of EI. This framework was chosen for its reliability and validity with performance measurement and narrow focus that excludes factors such as personality. Viewing EI as a skill, one that can be developed and applied within the nursing field, is attractive for healthcare research and education. The findings of this research suggest that perhaps the narrow focus of this model ignores a facet of emotional intelligence, namely personality, which may not be able to be separated from the construct. It could also be that another phenomenon, Clinical Empathy, stands alone outside of emotional intelligence as a contributing factor to the wellbeing, health, and success of nursing professionals. How emotional intelligence is defined is central to how it is taught and measured, and any outside factors should be examined in future research.

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

Acknowledgements

The author wishes to thank M.J. Petersen, Ed.D., Patricia Morin, Ph.D., and Joy Martin, Ph.D. for their work in guiding and editing this research study from inception to completion.

References

1. American Association of College of Nursing. Hallmarks of the Professional Nursing Practice Environment. accessed February 22. 2017. <https://www.aacnursing.org/News-Information/Position-Statements-White-Papers/Hallmarks-Practice>
2. American Association of College of Nursing. Hallmarks of the Professional Nursing Practice Environment.
3. John D Mayer, David R Caruso, Peter Salovey. Emotional Intelligence Meets Traditional Standards for an Intelligence. *Intelligence*. 1999; 27: 267-298.
4. Ana Costa, Lusía Faria. The Impact of Emotional Intelligence on Academic Achievement A Longitudinal Study in Portuguese secondary school. *Learning and Individual Differences*. 2015; 37: 38-47.
5. Daniel Goleman. *Emotional intelligence: Why it can matter more than IQ* New York, NY: Bantam. 1995; 9.
6. Larry A. Sparkman, Wanda S. Maulding, Jalynn G. Roberts. Non-Cognitive Predictors of Student Success in College. *College Student Journal*. 2012; 46: 644.
7. Goleman. *Emotional intelligence: Why it can matter more than IQ*. 9.
8. Nicola S. Schutte, Natasha M. Loi. Connections Between Emotional Intelligence and Workplace Flourishing. *Personality and Individual Differences*. 2014; 66: 134-139.
9. Sparkman, Maulding, Roberts. Non-Cognitive Predictors of Student Success in College. 644.
10. Adrian Anzaldúa, Jodi Halpern. Can Clinical Empathy Survive Distress Burnout and Malignant Duty in the Age of Covid-19. *Hastings Cent Rep*. 2021; 51: 22-27.
11. Leila Karimi, Sandra G. Leggat, Lisa Donohue, et al. Emotional Rescue The Role of Emotional Intelligence and Emotional Labour on Well-Being and Job-Stress Among Community Nurses. *J Adv Nurs*. 2014; 70: 176-186.
12. Jitna Por, Louise Barriball, Joanne Fitzpatrick, et al. Emotional Intelligence Its Relationship to Stress, Coping Well-Being and Professional Performance in Nursing Students. *Nurse Educ Today*. 2011; 31: 855-860.
13. Anzaldúa, Halpern. Can Clinical Empathy Survive Distress Burnout and Malignant Duty in the Age of Covid-19. 2021; 51: 22-27.
14. Karimi, Leggat, Donohue, et al. Emotional Rescue The Role of Emotional Intelligence and Emotional Labour on Well-Being and Job-Stress Among Community Nurses. *Journal of Advanced Nursing*. 2014; 70: 176-186.
15. Lian Mao, LingZhi Huang, QiongNi Chen. Promoting Resilience and Lower Stress in Nurses and Improving Inpatient Experience Through Emotional Intelligence Training in China A Randomized Controlled Trial. *Nurse Educ Today*. 2021; 107: 1.
16. Ann M. Mazzella-Ebstein, Kay S. Tan, Katherine S. Panageas, et al. The Emotional Intelligence, Occupational Stress, and Coping Characteristics by Years of Nursing Experiences of

- Newly Hired Oncology Nurses. *Asia Pac J Oncol Nurs*. 2021; 31: 352-359.
17. Sharif F, Rezaie S, Keshavarzi S, et al. Teaching Emotional Intelligence to Intensive Care Unit Nurses and Their General Health A randomized clinical trial. *Int J Occup Environ Med*. 2013; 4: 141-148.
 18. Anzaldua, Halpern. Can Clinical Empathy Survive Distress Burnout and Malignant Duty in the Age of Covid-19. *Hastings Cent Rep*. 2021; 51: 22-27.
 19. Shawn Collins. Emotional Intelligence as a Noncognitive Factor in Student Registered Nurse Anesthetists. *AANA J*. 2013; 81: 465-472.
 20. Loes R L C van Dusseldorp, Berno K G van Meijel, Jan J L Derksen. Emotional Intelligence of Mental Health Nurses. *J Clin Nurs*. 2011; 20: 555-562.
 21. Mazzella-Ebstein, Tan, Panageas, et al. The Emotional Intelligence, Occupational Stress, and Coping Characteristics by Years of Nursing Experiences of Newly Hired Oncology Nurses. *Asia Pac J Oncol Nurs*. 2021; 31: 352-359.
 22. Por, Barriball, Fitzpatrick, et al. Emotional Intelligence Its Relationship to Stress Coping Well-Being and Professional Performance in Nursing Students. *Nurse Educ Today*. 2011; 31: 855-860.
 23. Sharif, Rezaie, Keshavarzi, et al. Teaching Emotional Intelligence to Intensive Care Unit Nurses and Their General Health A randomized clinical trial. *Int J Occup Environ Med*. 2013; 4: 141-148.
 24. Caixia Xie, Xinyu Li, Yanli Zeng, et al. Mindfulness, Emotional Intelligence and Occupational Burnout in Intensive Care Nurses: A Mediating Effect Model. *J Nurs Manag*. 2021; 29: 535-542.
 25. Janet Adams. *The Wall Street Journal*. US Ties Hospital Payments to Making Patients Happy, accessed February 1. 2017.
 26. Anzaldua, Halpern. Can Clinical Empathy Survive Distress Burnout and Malignant Duty in the Age of Covid-19. *Hastings Cent Rep*. 2021; 51: 22-27.
 27. Nina F. Geiger. On Tying Medicare Reimbursement to Patient Satisfaction Surveys. *Am J Nurs*. 2012; 112: 11.
 28. Edith Claros, Manoj Sharma. The Relationship Between Emotional Intelligence and Abuse of Alcohol, Marijuana, and Tobacco among College Students. *Journal of Alcohol and Drug Education*. 2012; 56: 8-37.
 29. Collins. Emotional Intelligence as a Noncognitive Factor in Student Registered Nurse Anesthetists. *AANA J*. 2013; 81: 465-472.
 30. Aganeta Enns, Gloria D Eldridge, Cynthia Montgomery, et al. Perceived Stress Coping Strategies and Emotional Intelligence A Cross-Sectional Study of University Students in Helping Disciplines. *Nurse Educ Today*. 2018; 68: 226-231.
 31. Karimi, Leggat, Donohue, et al. Emotional Rescue: The Role of Emotional Intelligence and Emotional Labour on Well-Being and Job-Stress Among Community Nurses. *J Adv Nurs*. 2014; 70: 176-186.
 32. Stephanie Maillat, Emily Read. Work Environment Characteristics and Emotional Intelligence as Correlates of Nurses' Compassion Satisfaction and Compassion Fatigue: A Cross-Sectional Survey Study. *Nurs Rep*. 2021; 11: 847-858.
 33. Mao, Huang, Chen. Promoting Resilience and Lower Stress in Nurses and Improving Inpatient Experience Through Emotional Intelligence Training in China A Randomized Controlled Trial. *Nurse Educ Today*. 2021.
 34. Mazzella-Ebstein, Tan, Panageas, et al. The Emotional Intelligence Occupational Stress and Coping Characteristics by Years of Nursing Experiences of Newly Hired Oncology Nurses. *Asia Pac J Oncol Nurs*. 2021; 31: 352-359.
 35. Por, Barriball, Fitzpatrick, et al. Emotional Intelligence Its Relationship to Stress Coping Well-Being and Professional Performance in Nursing Students. *Nurse Educ Today*. 2011; 31: 855-860.
 36. Sharif, Rezaie, Keshavarzi, et al. Teaching Emotional Intelligence to Intensive Care Unit Nurses and Their General Health A randomized clinical trial. *Int J Occup Environ Med*. 2013; 4: 141-148.
 37. Andrea C. Bittinger, Karen Dunn, Anne Hranchook, et al. Relationship Between Emotional Intelligence and Occupational Stress Levels Among Certified Registered Nurse Anesthetists. *AANA J*. 2020; 88: 398-404.
 38. Maillat, Read. Work Environment Characteristics and Emotional Intelligence as Correlates of Nurses' Compassion Satisfaction and Compassion Fatigue: A Cross-Sectional Survey Study. *Nurs Rep*. 2021; 11: 847-858.
 39. Mao, Huang, Chen. Promoting Resilience and Lower Stress in Nurses and Improving Inpatient Experience Through Emotional Intelligence Training in China: A Randomized Controlled Trial. *Nurse Educ Today*. 2021.
 40. Por, Barriball, Fitzpatrick, et al. Emotional Intelligence Its Relationship to Stress Coping Well-Being and Professional Performance in Nursing Students. *Nurse Educ Today*. 2011; 31: 855-860.
 41. Schutte, Loi. Connections Between Emotional Intelligence and Workplace Flourishing. *Personality and Individual Differences*. 2014; 66: 134-139.
 42. Sharif, Rezaie, Keshavarzi, et al. Teaching Emotional Intelligence to Intensive Care Unit Nurses and Their General Health A randomized clinical trial. *Int J Occup Environ Med*. 2013; 4: 141-148.
 43. Collins. Emotional Intelligence as a Noncognitive Factor in Student Registered Nurse Anesthetists. *AANA J*. 2013; 81: 465-472.
 44. Mao, Huang, Chen. Promoting Resilience and Lower Stress in Nurses and Improving Inpatient Experience Through Emotional Intelligence Training in China: A Randomized Controlled Trial. *Nurse Educ Today*. 2021.

45. Enns, Eldridge, Montgomery, et al. Perceived Stress, Coping Strategies, and Emotional Intelligence A Cross-Sectional Study of University Students in Helping Disciplines. *Nurse Educ Today*. 2018; 68: 226-231.
46. Anzaldúa, Halpern. Can Clinical Empathy Survive Distress Burnout and Malignant Duty in the Age of Covid-19. *Hastings Cent Rep*. 2021; 51: 22-27.
47. Bittinger, Dunn, Hranchook, et al. Relationship Between Emotional Intelligence and Occupational Stress Levels Among Certified Registered Nurse Anesthetists. *AANA J*. 2020; 88: 398-404.
48. Enns, Eldridge, Montgomery, et al. Perceived Stress Coping Strategies and Emotional Intelligence A Cross-Sectional Study of University Students in Helping Disciplines. *Nurse Educ Today*. 2018; 68: 226-231.
49. Karimi, Leggat, Donohue, et al. Emotional Rescue The Role of Emotional Intelligence and Emotional Labour on Well-Being and Job-Stress Among Community Nurses. *J Adv Nurs*. 2014; 70: 176-186.
50. Maillet, Read. Work Environment Characteristics and Emotional Intelligence as Correlates of Nurses' Compassion Satisfaction and Compassion Fatigue: A Cross-Sectional Survey Study. *Nurs Rep*. 2021; 11: 847-858.
51. Mao, Huang, Chen. Promoting Resilience and Lower Stress in Nurses and Improving Inpatient Experience Through Emotional Intelligence Training in China: A Randomized Controlled Trial. *Nurse Educ Today*. 2021.
52. Daniel Testa, Varunee Faii Sangganjanavanich. Contribution of Mindfulness and Emotional Intelligence to Burnout Among Counseling Interns. *Counselor Education and Supervision*. 2016; 55: 95-108.
53. Xie, Li, Zeng, et al. Mindfulness, Emotional Intelligence and Occupational Burnout in Intensive Care Nurses A Mediating Effect Model. *J Nurs Manag*. 2021; 29: 535-542.
54. John D. Mayer, David R. Caruso, Peter Salovey. Emotional Intelligence Meets Traditional Standards for an Intelligence. 1999; 27: 267-298.
55. John D. Mayer, Peter Salovey, David R. Caruso. A Further Consideration of the Issues of Emotional Intelligence. *Psychological Inquiry*. 2004; 15: 249-255.
56. John D. Mayer, Peter Salovey, David R. Caruso. Emotional Intelligence. New Ability or Eclectic Traits. *Am Psychol*. 2008; 63: 503-517.
57. Estelle Codier, Cindy Kamikawa, Barbara M. Kooker, et al. Emotional Intelligence Performance and Retention in Clinical Staff Nurses. *Nurs Adm Q*. 2009; 33: 310-316.
58. Natalie Holbery. Emotional Intelligence- Essential for Trauma Nursing. *Int Emerg Nurs*. 2015; 23: 13-16.
59. Inger James, Birgitta Andershed, Bernt Gustavasson, et al. Emotional Knowing in Nursing Practice: In the Encounter Between Life and Death. *Int J Qual Stud Health Well-being*. 2010; 5: 13.
60. Maillet, Read. Work Environment Characteristics and Emotional Intelligence as Correlates of Nurses' Compassion Satisfaction and Compassion Fatigue: A Cross-Sectional Survey Study. *Nurs Rep*. 2021; 11: 847-858.
61. Mao, Huang, Chen. Promoting Resilience and Lower Stress in Nurses and Improving Inpatient Experience Through Emotional Intelligence Training in China: A Randomized Controlled Trial. *Nurse Educ Today*. 2021.
62. Bittinger, Dunn, Hranchook, et al. Relationship Between Emotional Intelligence and Occupational Stress Levels Among Certified Registered Nurse Anesthetists. *AANA J*. 2020; 88: 398-404.
63. Codier, Kamikawa, Kooker, et al. Emotional Intelligence, Performance, and Retention in Clinical Staff Nurses. *Nurs Adm Q*. 2009; 33: 310-316.
64. Holbery. Emotional Intelligence- Essential for Trauma Nursing. *Int Emerg Nurs*. 2015; 23: 13-16.
65. James, Andershed, Gustavasson, et al. Emotional Knowing in Nursing Practice In the Encounter Between Life and Death. *Int J Qual Stud Health Well-being*. 2010; 5.
66. Maillet, Read. Work Environment Characteristics and Emotional Intelligence as Correlates of Nurses' Compassion Satisfaction and Compassion Fatigue A Cross-Sectional Survey Study. *Nurs Rep*. 2021; 11: 847-858.
67. Mao, Huang, Chen. Promoting Resilience and Lower Stress in Nurses and Improving Inpatient Experience Through Emotional Intelligence Training in China: A Randomized Controlled Trial. *Nurse Educ Today*. 2021.
68. Holbery. Emotional Intelligence- Essential for Trauma Nursing. *Int Emerg Nurs*. 2015; 23: 13-16.
69. Vickie A. Ireland Emotional Intelligence Competencies in the Undergraduate Nursing Curriculum A Descriptive Qualitative Study. *Nurse Educ Today*. 2022; 1.
70. James, Andershed, Gustavasson, et al. Emotional Knowing in Nursing Practice: In the Encounter Between Life and Death. *Int J Qual Stud Health Well-being*. 2010; 5.
71. Anne CH, McQueen. Emotional Intelligence in Nursing Work. *J Adv Nurs*. 2004; 47: 101-108.
72. Haley P. Strickland, Michelle H, et al. Measured Emotional Intelligence in RN to BSN Education. *Teaching and Learning in Nursing*. 2019; 14: 145-148.
73. Sati Unal. Evaluating the Effect of Self-Awareness and Communication Techniques on Nurses' Assertiveness and Self-Esteem. *Contemp Nurse*. 2012; 43: 90-98.
74. Mayer, Caruso, Salovey. Emotional Intelligence Meets Traditional Standards for an Intelligence. *Intelligence*. 1999; 27: 267-298.
75. Mayer, Salovey, Caruso. A Further Consideration of the Issues of Emotional Intelligence. *Psychological Inquiry*. 2004; 15: 249-255.
76. Mayer, Salovey, Caruso. Emotional Intelligence. New Ability or Eclectic Traits. *Am Psychol*. 2008; 63: 503-517.

-
77. Paulo N. Lopes, Marc A. Brackett, John B. Nezlek, et al. Emotional Intelligence and Social Interaction. *Pers Soc Psychol Bull.* 2004; 30: 1018-1034.
 78. Peter Salovey, John D. Mayer. Emotional Intelligence. *Imagination Cognition and Personality.* 1990; 189.
 79. Molly Andrews, Corrine Squire, Maria Tambokou. *Doing Narrative Research.* Sage Publications. 2008; 2.
 80. John W Creswell. *Qualitative Inquiry and Research Design: Choosing Among Five Traditions.* Sage Publications. 2012; 54.
 81. Jane Elliott. *Using Narrative in Social Research: Qualitative and quantitative approaches.* Sage Publications. 2005; 36.
 82. Andrews, Squire, Tambokou. *Doing Narrative Research.* Sage Publications. 2008; 5-6.
 83. Creswell, Cheryl N. Poth. *Qualitative Inquiry and Research Design: Choosing Among Five Traditions.* Sage Publications. 2012; 55.
 84. Mayer, Salovey, Caruso. Emotional Intelligence: New Ability or Eclectic Traits?. *Am Psychol.* 2008; 63: 503-517.
 85. Creswell, Cheryl N. Poth. *Qualitative Inquiry and Research Design: Choosing Among Five Traditions.* Sage Publications. 2012; 55.
 86. Mayer, Salovey, Caruso. A Further Consideration of the Issues of Emotional Intelligence. *Psychological Inquiry.* 2004; 15: 249-255.
 87. Mayer, Salovey, Caruso. Emotional Intelligence. New Ability or Eclectic Traits. *Am Psychol.* 2008; 63: 503-517.
 88. Catherine K Riessman. *Narrative Methods for the Human Sciences.* Sage Publications. 2008; 1.
 89. Elliott. *Using Narrative in Social Research.* Sage Publications. 2005; 9.
 90. Riessman. *Narrative Methods for the Human Sciences.* Sage Publications. 2008; 4.
 91. Elliott. *Using Narrative in Social Research.* Sage Publications. 2005; 28.
 92. Riessman. *Narrative Methods for the Human Sciences.* Sage Publications. 2008; 2.
 93. Riessman. *Narrative Methods for the Human Sciences.* Sage Publications. 2008; 25.
 94. Creswell. *Qualitative Inquiry and Research Design: Choosing Among Five Traditions.* Sage Publications. 2012; 56.
 95. Lumivero. NVivo: Unlock Insights with Qualitative Data Analysis Software. accessed November 12. 2016. <https://lumivero.com/products/nvivo/>
 96. Andrews, Squire, Tambokou. *Doing Narrative Research.* Sage Publications. 2008; 14.
 97. Riessman. *Narrative Methods for the Human Sciences.* Sage Publications. 2008; 3.
 98. Elliott. *Using Narrative in Social Research.* Sage Publications. 2005; 42.
 99. Elliott. *Using Narrative in Social Research.* Sage Publications. 2005; 42.
 100. Sandra G Boodman. How to Teach Doctors Empathy. *The Atlantic.* 2015. <https://www.theatlantic.com/health/archive/2015/03/how-to-teach-doctors-empathy/387784/>
 101. Stewart W. Mercer, William J. Reynolds. Empathy and Quality of Care. *Br J Gen Pract.* 2002; 52: 9-12.
 102. Boodman. How to Teach Doctors Empathy. *The Atlantic.* 2015.
 103. Boodman. How to Teach Doctors Empathy. *The Atlantic.* 2015.
 104. Elliott. *Using Narrative in Social Research.* Sage Publications. 2005; 39.
 105. Elliott. *Using Narrative in Social Research.* Sage Publications. 2005; 42.
 106. Ritin Fernandez, Yenna Salamonson, Rhonda Griffiths. Emotional Intelligence as a Predictor of Academic Performance in First-Year Accelerated Graduate Entry Nursing Students. *J Clin Nurs.* 2012; 21: 23-24.
 107. Fernandez, Salamonson, Griffiths. Emotional Intelligence as a Predictor of Academic Performance in First-Year Accelerated Graduate Entry Nursing Students. *J Clin Nurs.* 2012; 21: 23-24.
 108. Ireland. Emotional Intelligence Competencies in the Undergraduate Nursing Curriculum: A Descriptive Qualitative Study. *Nurse Educ Today.* 2022. 1.
 109. Mary T. Hickey. Preceptor Perceptions of New Graduate Nurse Readiness for Practice. *J Nurses Staff Dev.* 2009; 25: 35-41.
 110. Ireland. Emotional Intelligence Competencies in the Undergraduate Nursing Curriculum: A Descriptive Qualitative Study. *Nurse Educ Today.* 2022;
 111. Nelms TP, Jones JM, Gray DP. Role Modeling A Method for Teaching Caring in Nursing Education. *J Nurs Educ.* 1993; 32: 18-23.
 112. Farida Saghafi, Jennifer Hardy, Sharon Hillege. New Graduate Nurses' Experiences of Interactions in the Critical Care Unit. *Contemp Nurse.* 2012; 42: 20-27.
 113. Thomka LA. Graduate Nurses' Experiences of Interactions with Professional Nursing Staff During Transition to the Professional Role. *J Contin Educ Nurs.* 2001; 32: 15-19.
 114. Nicholas Clarke. Developing Emotional Intelligence Through Workplace Learning Findings from a Case Study in Healthcare. *Human Resource Development International.* 2006; 9: 447-465.
 115. Dawn Freshwater, Theodore Stickley. The Heart of the Art Emotional Intelligence in Nurse Education. *Nurs Inq.* 2004; 11: 91-98.
 116. Ireland. Emotional Intelligence Competencies in the Undergraduate Nursing Curriculum A Descriptive Qualitative Study. *Nurse Educ Today.* 2022; 1.
 117. Linda Shanta, Leslie Gargiulo. A Study of the Influence of Nursing Education on Development of Emotional Intelligence. *J Prof Nurs.* 2014; 30: 511-520.

-
118. Strickland, Cheshire, Neal. Measured Emotional Intelligence in RN to BSN Education. *Teaching and Learning in Nursing*. 2019; 14: 145-148.
 119. Freshwater, Stickle. The Heart of the Art: Emotional Intelligence in Nurse Education. *Nurs Inq*. 2004; 11: 91-98.
 120. Holbery. Emotional Intelligence- Essential for Trauma Nursing. *Int Emerg Nurs*. 2015; 23: 13-16.
 121. Ireland. Emotional Intelligence Competencies in the Undergraduate Nursing Curriculum: A Descriptive Qualitative Study. *Nurse Educ Today*. 2022; 2.
 122. Strickland, Cheshire, Neal. Measured Emotional Intelligence in RN to BSN Education. *Teaching and Learning in Nursing*. 2019; 14: 145-148.
 123. Jumah JAB, Judith P Ruland. A critical review of simulation-based on nursing education research: 2004-2011. *International Journal of Nursing Education*. 2015; 7: 135.
 124. Michelle A Kelly, Elizabeth Berragan, Sissel E Husebo, et al. Simulation in Nursing Education- International Perspectives and Contemporary Scope of Practice. *J Nurs Scholarsh*. 2016; 48: 312-321.
 125. Kathleen J Tilton, Jone Tiffany, Barbara A Hoglund. Non-Acute-Care Virtual Simulation: Preparing Students to Provide Chronic Illness Care. *Nurs Educ Perspect*. 2015; 36: 394-395.
 126. Mezirow Jack. An Overview on Transformative Learning. *Lifelong Learning: Concepts and Contexts*. 2006; 94-95.
 127. Dusseldorp, Meijel, Derksen. Emotional Intelligence of Mental Health Nurses. *J Clin Nurs*. 2011; 20: 555-562.
 128. Freshwater, Stickle. The Heart of the Art: Emotional Intelligence in Nurse Education. *Nurs Inq*. 2004; 11: 91-98.
 129. Holbery. Emotional Intelligence- Essential for Trauma Nursing. *Int Emerg Nurs*. 2015; 23: 13-16.
 130. Ireland. Emotional Intelligence Competencies in the Undergraduate Nursing Curriculum: A Descriptive Qualitative Study. *Nurse Educ Today*. 2022; 6.
 131. Shanta, Gargiulo. A Study of the Influence of Nursing Education on Development of Emotional Intelligence. *J Prof Nurs*. 2014; 30: 511-520.