

EMOTIONAL COMPETENCE AND NURSING EDUCATION: A NEW ZEALAND STUDY

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Abstract

Effective nursing practice requires the ability to recognise emotions and handle responses in relationships with clients and their families. This emotional competence includes nurses managing their own emotional life along with the skill to relate effectively to the multiple colleagues and agencies that nurses work alongside. The research was designed to explore the views of nurse educators about the challenges they encounter when seeking to assess a student's development of emotional competence during the three year bachelor of nursing degree. Focus groups were used to obtain from educators evidence of feeling and opinion as to how theory and practice environments influence student nurses' development of emotional competence. The process of thematic analysis was utilised and three key themes arose as areas of importance to the participants. These were personal and social competence collectively comprises emotional competence in nursing; emotional competence is a key component of fitness to practise; and transforming caring into practice. The findings of the study indicate a need for definition of what emotional competence is in nursing. It is argued that educators and practicing nurses, who work alongside students, must uphold the expectation that emotional competence is a requisite ability and should themselves be able to role model emotionally competent communication.

Key Words: Emotional competence, nursing education, emotions, fitness to practise.

Introduction

Collectively those who choose to undertake education to become a Registered Nurse are people with wide and varied experiences and capabilities. In order for nursing students to gain confidence, effective communication skills, and the ability to convey hope and regard for others within their relationships, they must

learn to recognise and understand emotions. Accepting such emotions and validating this experience is essential when establishing a relationship. However, managing emotions and working with the emotions of others is not a readily teachable skill.

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It has been argued that there is a connection between a nurse's ability to accept another person's emotional distress and their capacity to accept themselves and their own distress. Peplau (1988) calls this caring neutrality. She suggests that nurses are required to develop a level of congruence between what they say and how they act toward the persons with whom they work. When nurses learn to process their own emotions, working with another person's emotion is made possible (Horsfall & Stuhlmiller, 2000). Reflection on one's own unique capabilities and limitations can assist individuals to recognise these in others. The nurse educator, working for a recognised institution, is entrusted by the Nursing Council of New Zealand (the Nursing Council) to assess the capabilities and competence of students in application to the professional nursing register, including provision of a statement that the student is fit to practise (Nursing Council of New Zealand (NCNZ), 2002). The way in which educators interpret the competency domains of practice (NCNZ, 2005), as they relate to emotional competence has not been a feature of the nursing literature. Nor has a collective description of emotional competence been established in nursing education or practice.

The primary aim of this study, undertaken as partial requirement for a Master's degree (Wilson, 2006) was to explore the challenges encountered by nurse educators who seek to assess aspects that could be related to emotional competence in nursing students. Exploration of this research

question was broken down to three aims:

1. To determine how a group of nurse educators recognise and describe emotional competence.
2. To facilitate discussion of environmental and relational complexities that affect student learning of emotional competence.
3. To clarify how the competency assessment framework (NCNZ, 2005) can provide a structure for feedback to students about their development of emotional competence.

Literature review

Theories of emotion attempt to explain the relationship between subjective emotional experiences and an event. However, the same event may result in a very different emotional experience within each individual. An understanding of emotional competence within nursing may assist educators and nurses to reflect on the individual experiences students have within their learning. Heron (2004) argues that in order to interact successfully with clients helping professionals must be able to display emotional competence. Within nursing literature the term 'emotional competence' is used interchangeably with related terms such as emotional intelligence (Goleman, 1995; Salovey & Mayer, 1990), emotional labour (Hochschild, 1983) and emotional literacy (Sharp, 2001). Box 1 shows five key characteristics that, collectively, contribute to emotional competence (see Box 1).

Box 1:

Characteristics of emotional competence

Self awareness: knowing your emotions, recognising feelings as they occur and discriminating between them	Mood management: Handling feelings so they are relevant to the current situation and you react appropriately	Self motivation: 'gathering up' your feelings and directing yourself toward a goal, despite self doubt, inertia, and impulsiveness	Empathy: Recognising feelings in others and tuning into their verbal and non verbal cues	Managing relationships: Handling interpersonal interaction, conflict resolution, and negotiations
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By developing the skills needed to recognise and understand emotion, student nurses can learn to manage their own responses and relationships with others. Within the literature on emotional competence there is dispute. Gooch (2006), for instance, refers to the debate about whether the skills of emotional competence are able to be taught. Some argue that emotional competence is the product of life experience as well as professional experience (Goleman, 1995; Reeves, 2005). Others suggest that because emotional competence takes too long to acquire and communication skills training is insufficient within nursing, testing students for emotional competence should occur prior to acceptance into a nursing programme (Cadman & Brewer, 2002; Freshwater, 2004; McQueen, 2004). Findings from this study support the suggestion that emotional competence is the product of life experience alongside development within nursing students' potential practice and beyond.

There is a great deal of discussion within nursing literature about the need for nurses to relate effectively to others (Freshwater & Stickley, 2004;

Lammers & Happell, 2003; MacCulloch, 1998). Nurses and educators readily comment when a student is unable to relate to others in an emotionally competent way (Henderson, Happell & Martin, 2007; Shipton, 2002). However, how educators and nurses within classroom and clinical settings effectively help students to develop emotional competence is not evident within nursing literature.

Method

A qualitative exploratory research method was chosen to investigate factors that affect learning and assessment of emotional competence in student nurses, from a nurse educator's perspective. Focus groups were selected as a means of data collection. Basch (1987, p. 414) outlines the focus group as "a qualitative research technique used to obtain data about the feelings and opinions of small groups of participants about a given problem, experience, service or other phenomenon". Therefore participants in this study needed to have familiarity with the language, terminology, institutional practices and regulations involved in nursing

education. Focus groups enabled interaction among participants and allowed the educators to consider and respond to the views of others (Kevern & Webb, 2001).

The sample criteria were: to be a Registered Nurse employed within a New Zealand polytechnic or university practicing as a nurse educator and actively involved in teaching either classroom or clinical learning experiences for bachelor of nursing students. Permission was sought from the Head of Department at three nursing education schools. A notice was sent by the researcher to each educator working within the schools of nursing requesting expressions of interest with regard to participation in the study. All volunteers met the criteria for inclusion and no further sampling was required once the initial samples had been recruited from the various institutions. The researcher made no attempt to recruit participants who held a particular view of emotional competence, however self

identification of participants may have contributed to a bias. This bias may be in favour of the participants believing the concept of emotional competence to be relevant in nursing.

Fifteen individual participants took part in three separate focus groups at three different venues. A list of potential questions was developed prior to the first focus group to facilitate explorations around the research aim. The questions (see Box 2) attempted to strike a balance between generating discussion and the need to limit data collection according to the purpose of the research. The aim was to facilitate and focus discussion rather than control it.

The study was approved by the Massey University Human Ethics Committee. After the participants responded to the advertisement, they were sent an information sheet, question framework, a brief summary of literature on emotional competence as shown in Box 1, and a consent form

Box 2:

Focus group question framework

1. Based on your understanding of what emotional competence is, what do you think are its key elements?
2. In what ways do you assess your own emotional competence?
3. What ways do you communicate or role model emotional competence personally?
4. What ways do you communicate or role model emotional competence as a nurse educator?
5. How do you currently assess emotional competence in nursing students?
6. In what ways do the competency framework (NCNZ, 2005) and other curriculum guidelines inform and guide you when teaching and assessing emotional competence with nursing students?
7. What challenges, tensions, and difficulties do you encounter in relation to demonstrating, teaching or assessing emotional competence?

to sign. An agreed time and venue was negotiated with the separate groups. At the beginning of each focus group individual written informed consent was gained. Participants were invited to participate in an audio taped focus group interview of approximately two hours in length and conducted in their collective workplace. The researcher had no educational role in any of the institutions involved in this study and full confidentiality was maintained throughout.

After the first focus group took place the audio tapes were transcribed by the researcher within a week as advocated by Krueger (2000). This assisted with the ongoing analysis and reflection on question structure and relevance for the next group. The aim of the timeframe was to avoid, as much as possible, loss of recall and accuracy of the observations made during the group. Transcription by the researcher created the opportunity to 'listen' differently to the content, tone and interaction that occurred during the group – aspects sometimes not apparent while acting as facilitator. At the completion of each group the researcher negotiated the type of feedback and consultation about the transcripts and emerging ideas that best suited the participants. They were offered a choice of an individual copy of the typed transcripts or a summary. Each of the groups requested a four to five page summary of the transcripts to be posted to them individually. This took place and the participants either individually or collectively as a group, contacted the researcher with comments which were then incorporated into the analysis.

There were multiple dimensions to consider in the analysis of the focus group interviews (Kitzinger, 1994; Krueger, 2000; Morgan, 1996). The first steps in the analytic process were identifying key questions that relate to the research aim and exploration of the topic, followed by capturing the data. The next step was to summarise the key ideas in the data. On completion of the transcribing the researcher summarised the key points according to the research question framework. Answers throughout the group process were assigned to a question. Verification from the participants has already been described above. Participants' written and verbal feedback was included in the data analysis. The last step involved debriefing between moderators (Krueger). For this study the principles and process of thematic analysis (Boyatzis, 1998) were utilised to code and interpret the data; following this process the identified themes were discussed with the participants.

Results

The three major themes arising from the thematic analysis of transcripts were that personal and social competence collectively comprise emotional competence in nursing, emotional competence is a key component of fitness to practise, and the transformation of caring into practice.

Personal and social competence collectively comprise emotional competence in nursing

The first aim of this study was to determine how a group of nurse

educators recognise and describe what emotional competence is in nursing. It quickly became apparent during the focus groups that the educators had similar ideas as to what constituted emotional competence to them personally, and professionally how they sought to recognise a type of emotional competence in nursing students when working with them. The definition (see Box 3) was developed from the various descriptions and understandings offered by the educators during the focus group and focus group analysis. It has been summarised by the researcher based on interpretive qualitative methodology. The definition is two-fold showing that personal and social competences collectively are characteristics of emotional competence in nursing. The educators argued that there are few defining criteria to separate the personal from the professional in relation to emotional competence, but that the key characteristics develop over time with relational experiences.

A complex challenge for nurse educators is working with a varied

level of maturity within the student group. Emotional competence if viewed as a developmental or acquired competence, as suggested by Goleman (1995), means that students need opportunities and support in order that they can work on their personal coping and so become more aware of how they operate with others. Maturity of personal competence indicates that the student is developing their own value and belief system (Henderson, et al., 2007). The individual nature of gaining emotional competence, increasing consciousness and understanding how emotions inform and affect behaviour was summed up by an educator in the second focus group:

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

In doing so, students can then develop the ability to 'tune into' the needs of the individuals and communities with whom they are learning and working (McQueen, 2004). The educators argue that this emotional competence is a key component of developing 'fitness to practise' in nursing.

Box 3:

Emotional competence a definition for nursing

(collectively from the educators)

<p>Personal competence: Is being able to become self-aware and having regard for yourself. Being personally competent means you continuously work on aspects of your personal coping and emotional reactions, so that you are more aware of how you operate with others.</p>	<p>Social competence: Is using your self awareness, managing it and moving beyond it. This social ability enables us to become able to work with another person's issues or needs, including effective management of conflict in relationships.</p>
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Emotional competence a key component of fitness to practise

Section 16 of the Health Practitioners Competence Assurance Act (2003) requires students in application to the professional nursing register to demonstrate the ability to communicate effectively. This view of effective communication or 'tuning in' is supported by Hocshschild's (1983) claim that nurses engage in emotional labour. This labour is guided by social conventions as students relate with others. As an educator in the first focus group asserts:

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

The social rules or expectations of how others display emotion, assists students to recognise and regulate their own emotional reactions. Salovey and Mayer (1990) argue that picking up on people's emotions promotes the ability to recognise what others might be feeling. The educators discussed complex challenges encountered when working with students. Those challenges that relate to the emotional wellbeing and relational ability of students were highlighted as key factors determining whether or not a student is seen to be fit to practise at the completion of the degree. Emotional competence as a key component to being fit to practise is the second major theme which resulted from this study.

There was consensus within each of the focus groups that students face

multiple life challenges and as a result struggle to manage their personal competence while learning. As an educator from the second focus group points out, a student's emotional problems can lead to unhelpful communication and impair their development of interpersonal ability:

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

Quinn (2000) confirms that some students may lack confidence in their clinical and academic ability which may lead them to discontinue their undergraduate education. Therefore, given this understanding that students do struggle, there is a requirement that educators and nurses consider to what extent they may be failing to support distressed and vulnerable students in their care.

Transforming caring into practice

The success of individualised learning often depends on the student being an active rather than passive participant. Motivation to learn can be impaired by the student's social circumstances. If the circumstances prevent the student developing personal competence then referral or suggestion of personal counselling may benefit and enable the student to focus on learning. Key authors on emotional competence suggest regular praise, encouragement and positive reinforcement can help students to develop emotional competence

(Freshwater & Stickle, 2004; Humpel & Caputi, 2001; MacCulloch, 1998). However, the attitude of educators toward students with emotional issues affecting their learning is a key factor affecting a student's transformation with respect to caring capability. The transformation of caring into practice is the third theme resulting from this study.

Freshwater and Stickle (2004) suggest nurse education has been viewed as an essentialist education, this type of education has an emphasis on producing individuals who are fit for practice and "by its very nature moulds the student" (p. 92). Empathic communication from the educator is required to understand the students they work alongside. However lack of emotional competence in educators and nurses in practice is an ongoing challenge that students face in their learning. This was summarised by an educator in the third focus group:

there is this assumption that if you are a nurse you are emotionally competent, because you must be if your role is to deal with human beings; its communication and professionalism but unfortunately there is a situation in nursing where we [nurses] do not necessarily role model caring communication to our peers or our young (Gp 3, p. 45).

Working in partnership with the students to develop problem solving skills and the use of probing (Arnold & Boggs, 2007) can help them clarify and focus on their continuum of developing emotional competence. Learning that takes place in relation to personal and social competence can promote the development of

professional boundaries, essential within nursing relationships. One educator summed this point up as follows:

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

The process of educators surfacing issues that affect development of emotional competence in class and in practice enables a transformation of professional caring and communication within the student's developing practice.

Discussion

The emphasis for nursing education is on producing an individual fit for practice. Each facility or nursing school must state that the student is eligible to sit the state examination by providing endorsement to the Nursing Council that the student is a fit person to practise nursing without compromise to public safety (NCNZ, 2002). When the school of nursing endorses a student as fit to practise, they are implying that the student has demonstrated ability in relation to the competency domains of practice (NCNZ, 2005) and educational learning outcomes. However, as Drake and Stokes (2004) point out, there is a lack of clarity about how these competencies and learning outcomes are utilised to assess students. The third aim of this research was to discuss how the Nursing Council competency assessment framework can provide structure for feedback to students about their development of emotional competence. The educators

suggested that emotional competence is a core component of assessing fitness to practise in nursing students, however currently the nominated Nursing Council (2005) competencies to practise do not reflect a requirement of personal and social competence or how it might be assessed.

In preparation for interpersonal engagement, with a variety of individuals and groups during their learning, nursing students must develop the ability to manage their emotions and responses and communicate effectively with others. It seems that while nurse educators are sensitive to the potential and actual challenges experienced by undergraduate students, at the same time there appears to be an unwarranted assumption that students are responsible for, and able to resolve these issues. It is assumed all that is needed is for them to recognise and learn to effectively manage such issues. Yet, given the factors that inhibit development of emotional competence such as a lack of clarity of the concept in nursing, limited understanding of how such competence is linked to learning outcomes in the curriculum, and the presence of multiple life stressors that inhibit learning, along with any emotional problems a student may have, it is not reasonable to expect students to self manage their learning alone. Clearly there is a need to link emotional competence within the current Nursing Council (2005) competency assessment framework.

The competency framework provides a structured series of feedback opportunities to students while they

are in practice and underpins the curriculum and learning outcomes within the bachelor of nursing degree (NCNZ, 2002). The statutory requirement that learning must be measured and documented in accordance with the Nursing Council (2005) competency domains of practice leads to an underlying tension within relationships between educator and student. This challenges educators to articulate subjective experiences and understanding of the students' learning into objective language or outcomes. Educators argue against the requirements of objective checklists within an assessment process. They suggest this requirement, at times, undermines the learning aims and relational experiences of students.

As students progress through the degree, they practise new relational skills. Assessment opportunities in nursing education include written, oral and practical experiences in which the student can demonstrate knowledge and skill in relational ability. Within the assessment relationship with students, the educators use objective criteria as well as their sometimes intuitive knowledge to facilitate awareness of those relational capabilities. Therefore assessment of emotional competence needs to be an indicator within the Nursing Council competency framework.

Facilitation of learning, from an educator's perspective, requires being flexible and adaptive to the various learning styles and capabilities of the students (Heron, 2004). The issue of having to write reports on students in the form of summative assessments and match a student's

ability to a criterion means that educators are forced to put to the student objectively what is essentially, a subjective appraisal of learning. This is in direct opposition to the educator's proposal of valuing emotion within the teaching relationship, and promoting assessment as an ongoing opportunity to appraise the student's ability. In this current paradigm of scientific and outcome based ideology in nursing the use of subjective knowledge and understanding, which is informed partially by emotions experienced within relationships, has been discouraged (Freshwater, 2007; Reeves, 2005; Williams, 2001).

Nursing is a social practice and nurses are part of a community in which they work with individuals, families, and groups in multiple relationships. De Carvalho (2004) argues that teaching and assessing the practice of care pragmatics, whether in or outside of a hospital setting is complex. Clear understanding and disclosure of the teaching activities among the educator group promotes transparency. For the students, transparency permits processes to be clear and generates a common understanding of expectations (Webber, 2002). This encourages students to become self-directed, goal orientated and take control of their learning outcomes. Transparency of the teaching activities, and a consistent approach to assessment, can contribute positively to students' overall development of emotional competence. Having a shared understanding of how the Nursing Council competencies can be used to recognise and provide feedback to students with respect to their

development of emotional competence is vital in this process.

Nursing education has the role of preparing competent nurses to meet the current and future healthcare needs of the communities in which they work. Vernon (2000) suggests nurse educators need to review outcomes of traditional teaching strategies and seek to explore alternatives that promote a satisfactory teaching and learning environment for educators and students alike. There was agreement within the educator groups that consistency in the process of assessment and learning outcomes is required. However, using tick box systems and criteria for scoring results in educators having to state to those students who do not fit the box, that they have failed. There is no opportunity to identify with the student their current ability and where learning may need to take place. Moreover, many of the Nursing Council competencies relate to learning and progress of an individual's knowledge and skill development rather than tasks and described actions.

The above distinction is an important aspect to consider in terms of subjective knowing within the student-educator relationship. The educators who took part in the focus groups were all qualified at post graduate level and had many years of practice and teaching behind them, so all could be argued to be mature nurses. However, it is important to note that the focus group discussion was not implying that students become emotionally competent in comparison to how the educators saw their own capability, or that emotional competence was

assessed by default. Rather than assuming students were competent unless they didn't "do" something in an emotionally competent way, educators consistently suggested that personal and social competency to manage emotion and enhance relational ability is required within maturing nursing practice. The educators are advocating the value of emotion, and moreover that the nature of emotion and the subjective context in which emotion is experienced, should be acknowledged and valued within the process of teaching and assessment.

Conclusion

Emotional competence, in the perception of the nurse educator participants, has emerged as a foundational concept for nursing education. The inclusion of emotional competence within the curriculum and learning relationships needs to

be considered within the context of a community. It is a community in which students, educators and clients belong. Nursing students need to develop skills of critical reflection within their practice. There is a need for educators and students alike to have a clearer understanding of what constitutes emotional competence in nursing and how this knowledge can be realistically incorporated into learning and assessment opportunities. Adequate preparation and meaningful reflection within interpersonal situations are vital to this process. When students are taught that emotional competence is a required competence within professional nursing practice, the nursing professionals they work alongside must uphold this expectation and provide opportunities to foster emotional growth in the students and support their learning and practice of the competence.

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