

Harnessing Emotion to Inform Clinical Practice

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Declaration

I, John McKinnon confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Abstract

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Background

Clinical judgement is the application of evidence to decision making in a professional healthcare setting. Studies in neuroscience (Immordino -Yang and Damasio, 2007) have shown that effective judgement and decision-making require tempered emotion to provide a guiding 'rudder' revealing knowing to be a feeling state. Emotional labour as a central feature of nursing practice is well documented (Gray, 2009). Theorists have identified emotions as tools for reflection (Bradbury-Jones et al. 2009), but this area of knowledge remains underdeveloped.

Aims

This thesis enquires into the existence of a commonality of emotions in nursing practice with potential as core emotion concepts arising from diverse narratives for use as tools for reflection and professional judgement.

Method

In phase one thirty-three nurses across five specialist areas talked exhaustively about the emotions they experienced while immersed in practice and the causes of these emotions. The data was collected in a London teaching hospital NHS trust and in three community NHS trusts in the East Midlands of England. Following this, in a second phase, six nurses (two supervisors and four supervisees) in a London Teaching Hospital who had not taken part in the first part of the research talked about their experience after two months and four months of using a framework for reflection consisting of seven common core concepts identified in the first research phase. In both phases the interviews were audio-taped, transcribed verbatim and the data analysed using Grounded Theory Method.

Results

The data betrayed professional movement that was characterised by person centred care in the face of complex adversity. Seven core emotional concepts were found to have commonality across practice forming an 'emotion map'. The 'emotion framework' for reflection was shown to increase self awareness, inform and empower practice

Discussion

The design is limited by the singularity of discourse and the sample size. The notion of emotional constituents of a framework for reflection opens up a new frontier in learning in which the details of an experience are the outcome of reflection on emotion rather than the reverse. The framework demonstrated 'organic' properties which permit a harnessing of the sense of salience that is central to human judgement. Increased credence has been given to personal knowledge and intuition.

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Chapter One

The Social Context of Nursing Theory and Practice

Introduction

This chapter sets out the social context within which this doctoral thesis is based. First the origins of the thesis are explained. Afterwards nursing as a community of practice is discussed from historical social and professional perspectives. The notion of clinical judgment is critically considered enroot to the development of a rationale for a new framework to inform practice.

Genesis of Thesis

Some years ago as a nurse specialist in child protection, I became aware of practitioner frustration at the inadequacy of predetermined checklists and vulnerability criteria in representing the focus of concern in practice (Appleton and Cowley, 2004). At the same time I was aware of how often the terms “concern”, “suspicion” or “knowledge” occurred in the supportive practice documentation. I began to wonder why we did not reflect on concepts which relate to our experience rather than experience alone. In the course of my masters degree I became aware of the work of the neuroscientist Antonio Damasio and his colleagues (Damasio, 1999; Immordino-Yang and Damasio, 2007) demonstrating the role of emotions in guiding judgement. I reasoned that emotions could be used as pivotal concepts or triggers. Furthermore it seemed feasible that if a commonality of emotions could be found within a community of practice, those emotions could form a framework to guide practice. This marked the genesis of this thesis.

The Historical Context of Nursing

The writings of Florence Nightingale and the values of altruistic care she espoused have influenced nursing for over 150 years. The extent of Nightingale’s influence means that other salient roots and values which both complement and compete with her ethos risk being lost from public and political view. In fact the origins of modern nursing are as diverse as they are politically controversial.

In the ancient world nurses were as likely to be men as women (Evans, 2004). In ancient India women were forbidden from some areas of nursing (Bett, 1960). The

biblical account at Exodus chapter 2 verse 9 in which Miriam is promised “wages” to nurse the infant Moses lends support to the view that paid caring has always been a respectable and legitimate activity.

The idea that caring is provided by ‘good’ women for little or no payment is a Victorian preoccupation founded chiefly on religious ideals and social policy of past centuries. In Ancient Rome nursing became a vocation for women after Julius Caesar conferred Roman Citizenship on slave girls who assisted physicians (Baly, 1995). Florence Nightingale’s belief that she was preordained by God to become a nurse may relate to the ancient tradition that nursing was a role reserved for the rich and honourable (Ridgely- Seymer, 1954).

By the 4th century C.E. nursing had become a local community service. However with the growth of the Christian Movement nursing became closely associated with holy service. By the 6th century C.E. and throughout the middle ages nursing was the exclusive domain of holy orders tending to the needs of the sick as the inevitable consequence of sin and a sinful world. At this point, nursing in Europe was set apart from any social movement for change within society and isolated from healing informed by science (Baly, 1995).

With the founding of Royal Hospitals in the 16th century local women were employed under the control of a matron to care for the sick abandoned as a consequence of the Poor Laws. From the 18th century nurses were required to live and work within hospital premises for the purpose of giving governors more control over the workforce. This arrangement continued well into the second half of the 20th century (Goward, 1992). This tightly controlled residential system together with the politically disenfranchised status of the women who made up the nursing workforce meant that nursing was prevented from accessing scientific knowledge and skills contemporaneously available to medicine. Consequently nurses were deprived of the social mobility and political power with which medical doctors had been equipped (Davies, 1995).

The Sociology of Caring

The contrasting political and social interests, values and experiences of Nightingale as public health reformer (Monteiro, 1985), Bedford Fenwick as political activist (Baly, 1995), Fry as a campaigner for penal reform (Whitney, 2010) and Seacole as a

protagonist of innovative practice (Ramdin, 2011) foreshadow the tensions and divisive values pervasive in 20th and 21st century nursing.

Nightingale's argument to the effect that prevention is a greater remedy than cure has profound resonance in our time and modern health policy documents have been fashioned to reflect this (McKinnon, 2009). But there are many social and cultural patterns which work to drain nursing of its potential to respond to twenty first century health needs.

Bullying and harassment plagues modern nursing communities (RCN, 2005). Thinly veiled racial discrimination is still common with black nurses waiting several times longer than white nurses for promotion (Giddings, 2005; Bonila-Silva, 2006). There remain many public and political assumptions about nursing misinformed by myth and romantic tradition (RCN, 2014). Society still struggles to view caring as a multi-skilled and intellectually crafted activity additional to any personal qualities a person may possess. The greater the correlation that can be made between a woman's job description and the traditional role of caring, nurturing and subservience the easier it becomes to trivialise expertise as natural behaviour common to women. In this respect Crowe (2000) argues that women in nursing must negotiate issues of recognition not experienced by women in other professions. The persistent view of nursing as women's work also serves to inhibit men in nursing from developing their caring role. There is an inference that a man's chief interest should lean toward acute technical interventions or towards management (Evans, 2004).

The idea of a highly educated and skilled professional working with disadvantaged groups to achieve empowerment, alleviate poverty and promote health through social mobility stands in opposition to the traditional subservience of one who cares purely for the sick as perceived victims of misfortune. This dichotomy is one between a vision of a radical agent for change and a devoted servant of the status quo. A feminist perspective on contemporary nursing sees the potential for social and political displacement within the empowerment of caring as the rationale for strict regimented regulation and control (Davies, 1995). The suppression of women and nursing is reflected in the patriarchal nature of the health service in which nurses are the largest single professional group yet have proportionately a much smaller influence (Wuest, 1994). The lack of women centred approaches such as crèches and flexible working practices in the British National Health Service are in part

responsible for repeated cycles of high natural wastage and consecutive recruitment drives (Davies, 1995).

Florence Nightingale's belief that nursing should be a vocation rather than a profession is not viable in modern times. In our time a scientific evidence base is required to inform the clinical judgement necessary to promote health, sustain recovery or aid a peaceful dignified death. The diverse and rapidly changing demands of health and social care mean that nurses must straddle a larger range of roles than of yore: from social advocate to carer and counsellor and from teacher to medicines manager. It is many years since nursing recruited exclusively from the privileged and the wealthy able to devote their whole lives to service. Moreover this would no longer be desirable. The modern nursing workforce needs to reflect the diversity of its service user base in order to incorporate an understanding of the ontology of health and illness into care planning and profiling. To integrate other life roles within such a professional life role makes for mutual enrichment of both (McKinnon, 2009; 2016).

The Shape of Clinical Judgement in Nursing

For more than a hundred years after nurse 'training' was instituted, emphasis was placed much more on the tasks and skills of caring than on any scientific evidence underpinning those tasks and skills. Throughout the middle of the 20th century attempts to develop a nursing epistemology within an academic framework either followed a biomedical model (Taylor et al. 2005) or were aimed at making nursing knowledge more visible (Marimer-Tomey, 1983; Timmermans and Berg, 2003). Nurse education in higher institutions in Britain did not become the norm until the 1990s with universal bachelor degree status established in 2012. Consequently clinical nursing judgment prior to this era was largely based on a combination of knowledge gained during training and post qualification experience. It is therefore not surprising that much practice was governed by time honoured rituals devoid of an evidence base which supplied more comfort to practitioners than quality to the patient experience (Walsh and Ford, 1989).

The impact of humanistic psychology on nurse education in the latter part of the 20th century caused a shift of emphasis from a paternalistic biomedical model of practice to one centred in the skilled use of self within a therapeutic relationship (McKinnon, 2009; 2011). This has helped to expose 'care' as an over simplistic term for nursing

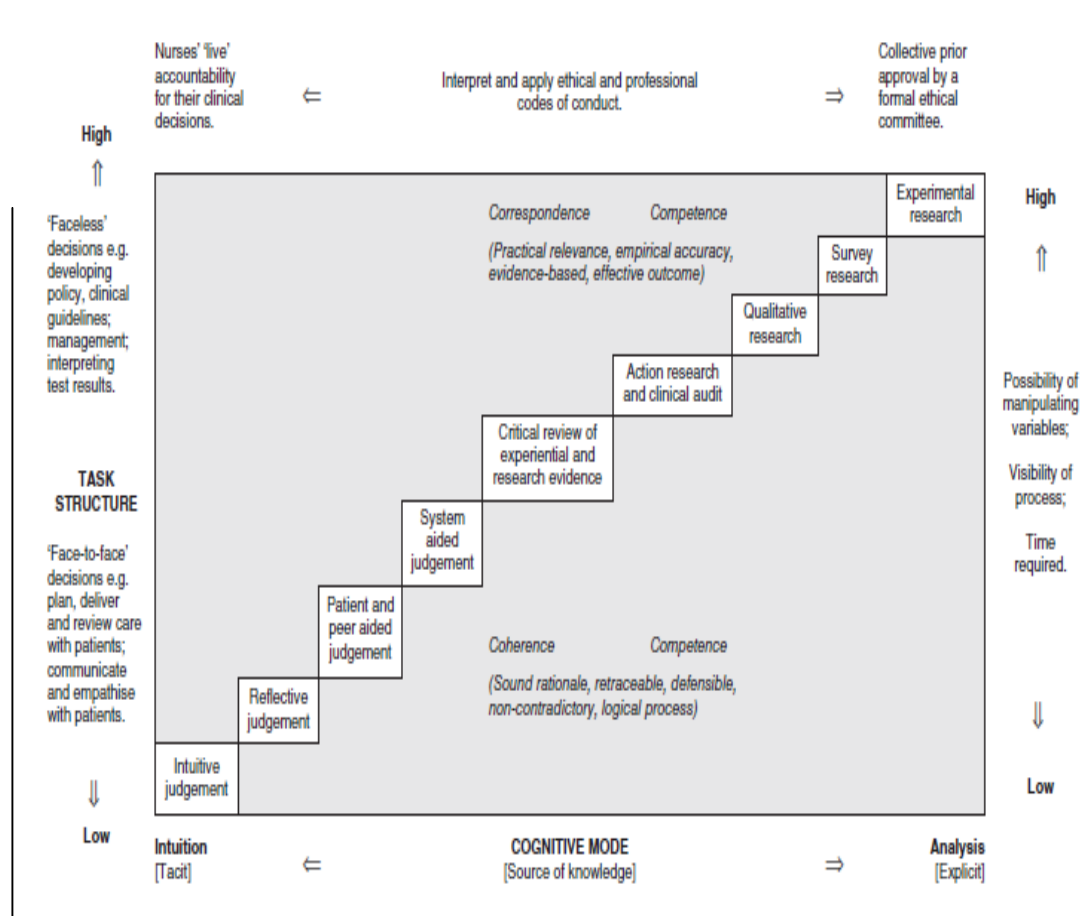
work (McKinnon, 2011). Benner (1984) and Benner and Wrubel (1989) have argued that a preoccupation with the technical knowledge and skills of a nurse devalues the importance of understanding the situation of another in the context of coping in health and illness. Alternatively a person centred approach resting on the use of self prevents the patient being reduced to a set of problems and organic disease states. A person's experience of health and illness together with the questions, opinions, fears, hopes and information they bring to assessment are given central place. Proactive social approaches to disease are not crowded out by reactive pharmacological responses (Freund et al. 2003). The professional carer is not personally distanced from the one being cared for and the fundamental state of humans as social beings is respected. (Malone, 2003) .

The notion of clinical judgment carves a divide between caring as a professional act and caring as an everyday human one. The levels of skill and the complexity of the tasks with which many family and community members care for others cannot be devalued. However this is not professional nursing. Professional nursing is founded in scientifically informed practice governed by principles of assessment, diagnosis, prescription and evaluation within the context of a regulated framework of accountability (RCN, 2014). This perspective underpins the Royal College of Nursing of the United Kingdom's (2014:3) definition of nursing:

the use of clinical judgment in the provision of care to enable people to improve, maintain or recover health, to cope with health problems and to achieve the best possible quality of life whatever their disease or disability until death.

However what constitutes evidence in nursing continues to be the subject of debate. Traynor et al. (2010) describe long term efforts to professionalize nursing by fostering a closer association with scientific evidence. These efforts simultaneously work to distance the concept of judgment and decision making in nursing from notions of personal expertise and intuition that might be associated with unscientific arts of healing.

Table 1.1: Standing's Revised Continuum of Clinical Judgement and Decision Making in Nursing: Nine Modes of Practice (2008)



Professional judgment is a multifaceted exercise. This is implied by Standing (2008:125) who defines judgment as:

the assessment of alternatives regarding possible causes of action and decision making; the management of uncertainty about problems encountered, alternative solutions available and a persons ability to cope.

Standing's continuum of judgement and decision making [see Table 1.1. and Appendix 1] illustrates the range of forms of knowledge which are resourced in nursing judgement and decision making. The continuum while helpful in the demarcation of judgement modes confines mixed methods of thinking to quasi-rationality (pictured in the middle of the chart). In this it does not do justice to the flexibility and complexity of human thought. Talk of "tasks requiring different modes of thinking" (Standing, 2008:127) means that no account is taken of the 'hybrid' styles of

thinking *across* the continuum and this is misleading. Interpretation and reflection have a part to play in any form of knowledge judgement and decision making (Dhami and Thomson, 2012). The reflective practitioner is able to simultaneously use a combination of formal knowledge (research findings, evidence based guidance, professional ethics and values) and informal knowledge (intuitive recognition of patterns and relationships along with common sense understanding borne from experience) to navigate their way with effect in practice (Benner, 1987; Benner et al. 1996; Wilson and Crowe, 2008). Schon (1987) asserted that professional assessment and diagnosis are two separate phases of practice arguing that problems do not present themselves in an organised way but are often hidden in a 'mess' of different forms of information. Diagnosis is the framing or defining of the object of practitioner attention; the end result of assessment which is the structuring and prioritising of events, problems and other characteristics of the practice scene. This uniquely human and extremely flexible approach to the social world means that we are able to act with contingency; 'thinking on our feet' in the face of the irregular and unexpected in the practice landscape. This explains the central place of reflection in clinical nursing judgement: the need to make sense of the ambiguous mess that is the social world in which nurses practice (Schon, 1987; Hannigan, 2001).

Traynor et al. (2010) found two approaches united in nursing praxis by clinical expertise. On the one hand, clinical guidelines professionalized practice, rendering it more visible and protected against litigation by demonstrating accountability. On the other hand, guidelines and protocols had limitations in anomalous practice characterized by indeterminacy and nurses found intuitive approaches useful in such situations. However in Traynor and colleagues' study practitioners avoided the term 'intuition' and the irrational connotations it carried in favour of phrases such as "rapid information processing" arising from clinical expertise (Traynor et al. 2010:1587). Nurses showed themselves able to check intuitive messages for misleading cues and modify or ignore clinical guidelines which proved a 'poor fit' in certain circumstances. Traynor et al. (2010:1588) concluded that "personal agency and experience were emphasized as central in the *modus operandi*" of decision making; "the final arbiter" (p1590) in negotiating intuitive and technical influences on clinical judgment.

These findings explain Dearmun's (1992:28) vision of the archetypical modern nurse which now seems as prophetic as it was appropriate.

The ability to be flexible and adaptable without losing sight of purpose, to be able to work with human individuality rather than against it, is what we are striving to develop in the nurse of 2000 and beyond.

Intuitive thinking continues to make a valuable contribution to nursing judgment and decision-making. However difficulties in articulating such thinking remain. Traynor et al's (2010:1590) identification of experience as the "final arbiter" in judgment aligns with earlier work (Benner, 1984; 1987; Benner, Tanner and Chesla, 1996), suggesting that inexperienced nurses are less astute in arriving at decisions in indeterminate situations. In keeping with this contemporary perspective on nursing judgment, this thesis is concerned with harnessing emotions to inform nursing practice lending shape and validity to the intuitive end of the clinical judgment continuum.

The direction of the thesis is described below.

Chapter two outlines the nature of learning, inclusive of the roles of consciousness, memory, emotion and community. Particular focus will be given to the role of emotion as facilitator of judgment and decision-making leading to the notion of core emotion concepts. The feasibility of core emotion concepts informed by diverse narratives as servants of reflection will be explored.

Chapter three justifies the methodology of the study and will present the epistemology, theoretical perspective, methodology and methods of the research at the centre of the thesis.

Chapter four presents a review of the extant literature as the contemporary evidence base on the seven core emotions and related concepts represented as themes arising from analysis of the data.

Chapter five presents the findings of qualitative analysis of data arising from enquiry into the emotions experienced by nurses in practice and the causes of these emotions. The findings are simultaneously considered against the extant literature.

Chapter six discusses the social and political implications of the messages from the findings presented in chapter five. The chapter will also explore the potential for harnessing emotions commonly experienced across practice within a framework to inform clinical judgment.

Chapter seven presents the findings of an intervention using a framework of emotion concepts for reflection within the context of monthly clinical supervision. Chapter eight will conclude the thesis with an examination of the implications of the pilot study findings. This examination is conducted in the context of the current critique of reflection in professional life. A reflexive self-appraisal is also included.

This opening chapter has set out the historical, sociological and professional context of nursing practice converging on the shape of learning and clinical judgement. The following chapter will explore the nature of learning with particular attention to the inherent role of emotion.

Chapter Two

Towards the Notion of Emotion Concepts as Tools for Reflection

Introduction

Chapter one examined the sociological context of modern nursing together with its historical roots. The discussion culminated in an acknowledgement of the value of intuition to clinical judgement but questions were raised as to how this could be harnessed and validated. In this chapter neural and psychological frameworks are resourced to discuss the centrality of emotion in knowing, learning, judgement and decision making. The implications of this for personal knowledge and communities of professional practice are considered. The notion of emotions as pivotal concepts used as tools for reflection is explored.

Defining Consciousness

Consciousness is a living state of awareness. Awareness of one's existence in the 'here and now' has been termed "core consciousness" (Damassio,1999:16). This consciousness shines no light on the past or the future. A more sophisticated state of awareness termed "extended consciousness" (Damassio, 1999:16) transcends the present by relating with the past and anticipating the future. An integrated appreciation of the self placed on the continuum of time is enabled by accessible memory. Evaluation and future planning would not be possible without consciousness. Extended consciousness is sensitive and creative in that through interaction with the world, the world is changed by the organism and the organism by the world. Stability in the way that the organism moves forward developmentally in time and space is supplied by an awareness of biographical identity (Damassio,1999).

Consciousness in an advanced state is greatly enhanced by language. Speech forms the part of language which characterises the superiority of humans over other life forms. It is a category of language which has multiple classification (Emerson, 1996). An awareness of oneself in time and space is the beginning of learning. Consciousness like the learning it facilitates is experienced in the first person and therefore all experience has personal meaning for the host organism. In addition the

measure of personal meaning attached to information will dictate its value and the extent to which it is used.

Defining Learning

Learning is “any process that in living organisms leads to permanent capacity change and which is not solely due to biological maturation or ageing” (Illeris, 2008:3) (see Table 2.1). The nature of this process transcends intrapersonal, corporal and social domains and is a seamless integral and mutually influential part of human development. Learning is libidinal and closely related to phylogenesis and survival. It may be positive in the way it expands the proficiency of an individual and the contribution they make to society. Learning may also be negative in the shape of the regressive impact that an experience has on a person’s emotional and mental wellbeing. This gives rise to correspondingly negative behaviours which form circular causality in social and societal worlds (Graham and Power, 2004).

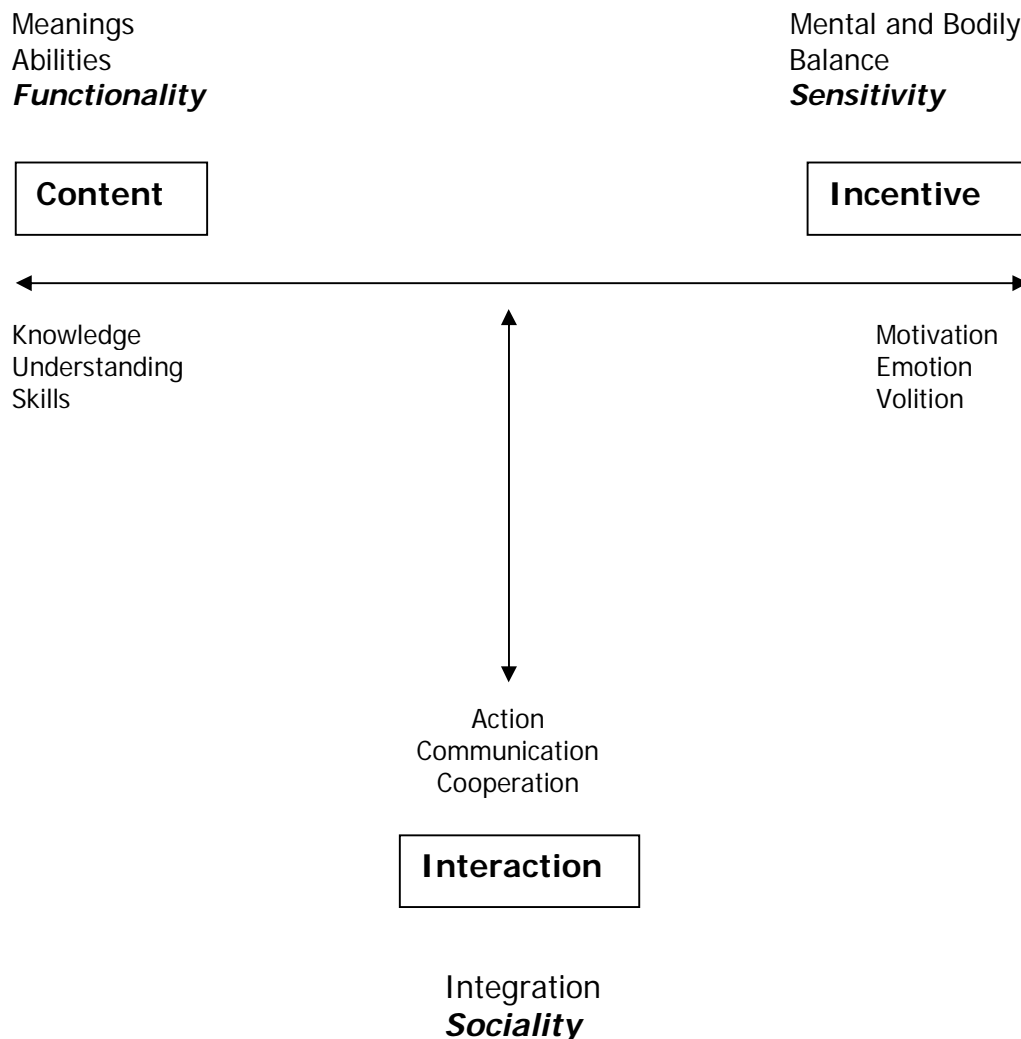


Table 2.1: The Tension Triangle of Learning (Illeris, 2008)

The temporary isolation of any aspect or dimension of learning for the sake of detailed discussion and explanation carries the potential to mislead by implying that such aspects work in isolation. This is not the case. All dimensions and aspects of learning like the structures and influences which power them are parts of a perpetually interactionist and holistic phenomenon. This is demonstrated in Illeris' tension triangle [see Table 2.1].

The acquisition process is the relationship between what is already known and new information. Learning acquisition can be divided into two components; the first of these is the content: the knowledge understanding and skills which can be acquired together with the inherent meanings and concerns as they are perceived by the individual. The ability to work within the content dimension of learning betrays the learner's functionality; the capacity to make flexible use of concepts and translate learning from one context to another. The second component is the incentive. The incentive relates to the sensitivity of the individual; the ability to effectively strive for consistency and equilibrium as they continually attempt to make sense of the changing environment. Motives, values and the emotions associated with the potential to learn all originate within the incentive component. It is the incentive component which lends mobility to learning. The interactive process is the relationship existing within the socio-societal dimension of learning between the communication and collaboration of the learner with their environment. Sociality describes the the ability of the learner to harness and integrate action and communication to engage and interact appropriately across diverse contexts (Illeris, 2008).

While emotion per se may fuel the incentive component of learning, 'emotional intelligence' is not confined to the incentive dimension nor to interactive processes of learning. This is evident from Goleman's definition (1995:19,34,36) :

Competence such as self awareness, self control and empathy and the arts of listening, resolving conflicts and cooperation.... being able to motivate oneself and persist in the face of frustrations; to control impulse and delay gratification; to regulate one's moods and keep distress from swamping the ability; to empathize and to hope... a metability, determining how well we can use whatever other skills we have including raw intellect.

Emotional intelligence is therefore a competence which works across dimensions of learning selecting the appropriate knowledge, understandings and skills within an emotionally regulated embodied performance of interaction with the environment (Goleman, 1995).

Neural Perspectives on Consciousness, Memory and Learning

The 'sense of being' originates in the prefrontal cortex. The left frontal lobe acts as an 'encoder' giving sense to information while the right lobe manages life story themes and places them in context. It is in the prefrontal cortex that working memory is coupled with the decision-making executive (Goldberg, 2001). The ventro medial prefrontal cortex is responsible for translating the meaning of learning for practical living. The prefrontal cortex has links with the parietal and occipital lobes which hold images of events and the posterior temporal lobes which store general scenario schemas (Rose, 2006). The parietal and occipital lobes connect with the special sensory cortices and the amygdala and the hippocampus within the midbrain. The amygdala produces emotions and labels experiential concepts while the hippocampus prioritises memory. Midbrain structures are situated enroute between the frontal lobe and the special sensory cortices and for this reason emotions are experienced in advance of rational thought (Damassio, 1999).

Longterm memory does not exist as a distinct specialised centre but as an associative matrix: a multiple state entity networked across centres by which information is stored through relationship with personal meaning and context. The consolidation of memories which Rose (2006:290) calls "longterm potentiation" takes place when the hippocampus delivers a series of impulses or 'readout' back down the neural networks towards primary sensory regions during sleep and rest. This helps confirm the theory that sleep or temporary retreat from an experience aids learning. The hippocampal 'readout' results in an engram or permanent imprint on neural tissue as the memory is stored. The more defined and integrated a memory the closer it is stored to the special sensory centres.

Neural networks crosslink in terms of their hierarchical and comparative relationships. Networks also have an associative and activational spread which is linked to the sensory mode(s) of the stimuli (visual, tactile olfactory, auditory and gustatory) which trigger retrieval of information (Cohen, 1993). Essentially, the ability

of external cues to retrieve information is dependent not on raw data but on perceived salience and personal meaning (Tulving and Schacter, 1990). This is well illustrated in word association. For example the word 'blind' might be interpreted as the shade cover for a window rather than the description of a person who has no sight. Personal meaning is also evident in a person's ability to recall their situation on 11th September 2001 but inability to recall their situation one week prior to this. The semantic association in the 'stockhold' of memory molds future attention and related behaviours (Humphreys et al. 2003). Cohen (1993:390) calls this the "semantic relatedness effect".

The structure of the neural matrix is what makes possible the specialised storage of knowledge together with the translation and application of knowledge and principles across a variety of areas. For example mathematics can be applied to engineering and pharmacology. Ethics can be applied to law, healthcare and urban development. A sense of salience within an associative network also guides tangential thinking. Sensory experiences will stimulate memories of knowledge associated with the source of the sensory stimulus. For example a particular smell or sound may remind one of an associated event stored in memory banks (Rose, 2006). Tangential thinking is evident in the value of critical incidents; significant events resulting from the perceived meaning they have for their observer (Tripp,1993). This perceived significance relates to conceptual meaning shared between different contexts.

While human neural architecture lends itself well to tangential thinking and accommodative learning it works against the personal transformation of the individual learner. A proclivity for categorisation to aid understanding means that stereotyping, assumption and prejudice are also facilitated. The organisation of memories and new knowledge by the hippocampus is not involuntary. It is intentional. As such it is managed cortically by the attention processes of the individual which in turn are fueled by the emotions, values and motives they harbour (McKinnon, 2014). Critical reflection is therefore necessary to attempt to unravel and identify the role that emotions, values and motives play in warping our perception of experience and meaning making (Mezirow, 2003). More crucially the person must believe that no viable options to change are available. Therefore he changes because he wants to change. This permits the overriding of past prejudices and learned behaviour by higher centres to form new perspectives, intentions and behaviours (Polanyi, 1999).

The multidimensional cerebral neural matrix connects the brain stem with the cortical midbrain. This neural connection between the brain and the rest of the central nervous system means that the body both informs and is informed by thought (Goldberg, 2005). Body learning also takes place in the “physicalisation of learning” (Illeris, 2008:11) when body parts such as fingers are used to count and when tactile sense is used to assess quality and quantity. The body is an expressor of skills and feelings through postures, patterns of movement, gestures and breathing (Polanyi, 1999). Anxiety, humour, pain, relaxed satisfaction and other mental health states are all represented in body posture (Zembylas, 2005).

The semantic nature of stored knowledge means that a person’s state of knowing relates directly to the perceived affective, material and social consequences of experience and decision-making for them. Consequently incentives and inhibitions associated with learning are shaped in accordance with this (Rogers,1994). Our incentive to learn or desist from learning and any related behaviour is the result of the existing associated feelings and memories we experience, the resultant goals we form and the associated outcomes we anticipate (Illeris, 2008).

The roles of consciousness, memory and embodied knowing together define the basis of the acquisition process of learning. The process embraces the learner’s sensitivity to internal and external stimuli including empathy (Kawamichi et al. 2013) and self awareness (Eckroth-Bucher, 2010), flexibility within cognition to transfer concepts from context to context and sociality: the ability to engage skillfully in the environment (Gardner, 1999). Homeostasis is maintained through the individual’s ability to function in a way which is both informed and sensitised by external and internal bodily experience in the past and present (Illeris, 2008).

Personal Ownership of Knowledge

The breach between internalisation through interpretation of material and practice through application is bridged by personal ownership. The ‘knowing in the doing and showing how’ is a different and more sophisticated state of mind than the ‘knowing what’ (Miller, 1990). Once internalised, knowledge does not remain the same. It receives the ‘personal fingerprint’ of its owner in that it is assimilated within their art of application. In the absence of reflective activity, performing an art or a skill; riding a bicycle, playing a musical instrument or engaging a depressed individual in

conversation is a seamless act greater than the sum of its parts and the individual parts go unacknowledged (Schon,1983). The ability to discern patterns, to grasp the detail of a uniquely diverse situation, alternating focus between the parts and the whole, judge similarity between states by degrees, or actively choose salient material from a nebulous picture, are all active products of personal knowledge. These products do not originate with books, although many books may attempt to simulate them through imitation of real life in the use of case scenarios, skill diagrams and tables. An individual declares their own personal knowledge through authorship but even after it is read and memorised by another it is not owned until they have at least demonstrated an intention to utilise it for their own purposes through self articulated description and synthesis (Polanyi,1998). The idea of socially constituted and assimilated knowledge which is personally owned has implications for learning theory and teaching practice.

Personal Knowledge and Approaches to Learning

Any relationship between learning and teaching is often assumed or constructed. The idea of learning represented by a mere transfer of information from the teacher to the learner is an oversimplified misrepresentation of a complex process. Behaviourist approaches are not compatible with notions of individuals applying theory in practice in a way which fits their purpose. It is not that behaviour is not relevant. On the contrary behaviour is a crucial instrument of knowledge acquisition and application through social embedding (Jarvis, 1992). However it is interpretation together with the association of new knowledge with old that is the root of learning (Boud and Walker,1991).

Behaviour demonstrates knowledge but does not necessarily betray the underlying value base or reasoning. Practice serves learning best when it is meaningfully lived or rehearsed as consciously integrated with theory rather than mindlessly repeated as a cluster of tasks. Behaviourally demonstrated knowledge is sustained when facilitated by such practice (Cermak and Craik, 1979). This is borne out by the ability of the learner to relate and integrate theory supporting practical skills previously acquired long after practice is mastered and vice versa. Rogers (2003) calls the former formalised or conscious learning and the latter acquisition or unconscious learning.

As behaviourists are preoccupied by the behavioural responses to environmental stimuli, so cognitivists focus on the role of mental processes such as memory and perception. While Bruner in his earlier work (1977) and Gagné (1985) both gave consideration for the learner as an individual, emphasis was on the quality of instruction. There was little acknowledgement of the learner as a creative participant who moves intentionally. Instead there is a subtle inference that the teacher always knows more than the learner.

Humanist approaches capture the reality of the learner as one who interprets situations as they have meaning for them. The role of affect, positively in the shape of avid purposive interest and enthusiasm, negatively in inhibition of the senses through perceived threat or fear, is seen as central to learning. From this perspective the teacher is a facilitator; an informed companion who is also a learner on an intellectual journey. This is distinguishable from the teacher envisaged as a sage who unilaterally imparts information set apart from the learner who unilaterally receives (Rogers,1994).

The Social Learning Place

If incentives and barriers to learning together with the emotions that relate these to the application of knowledge and understanding are mental and corporal entities, the actual learning is situated in the social world. Consciousness and conscious awareness are derived from interaction in the social world as a 'learning place' (Emerson, 1996).

The social learning place is governed by culture; a socially established way of knowing, understanding, doing, expressing and communicating which identifies one community and era from another. Dialects and dialogue both reflect local and global social and cultural mores of the time period in which they take place. Moreover the most articulate speech is incomplete without complementary semiotics to lend illustration, emphasis, reinforcement, and additional sense to the spoken word. Words are delivered with meaning and in context. A word's meaning remains relatively stable but the sense is subject to change with the context (Emerson, 1996). For this reason a dictionary or thesaurus gives a range of contexts to help the reader to appreciate the range of senses conveyed by a word. This is observable in communication used by deaf people in which the semiotics are exploited to their full

potential. Optimum professional records strive to give a faithful multidimensional testimony rather than a mere lifeless report of what has taken place by recording information which is not just heard or spoken but visual, tactile and olfactory. The role of good qualitative research is to give sociocultural flesh to a verbal skeleton by capturing the sense and context of language. However, a third party may point to gaps or inconsistencies and question the validity of the message contained therein. The limitations of the written page and the challenges and difficulties in mastering the art of good record keeping; of accurately capturing a lived experience in another medium illustrate the external social domain as the natural habitat of knowledge and understanding. Semiotics and semantics cannot take place without a social group. Records carry the potential to misrepresent or failure to acknowledge the context of words and actions. Although groups and communities share values and ideas, meaning is primarily experienced individually before it is shared and therefore language is an act of translation and social negotiation.

Humans are born preprogrammed as prosocial, and their development as sentient, creative and participant beings is reliant on recognition by and interaction with others (Bowlby,1979). Meaning is gradually attributed by a young child to a range of semiotics including mimicry, signs, symbols, vocal, facial and body expression (Minick,1996). The intrigued child is able to tease and test out meaning through participation in social behaviour. In turn social behaviour including speech develops further on the basis of what is gleaned, interpreted and internalised from the social domain. In this way a sense of self and others develops. In addition the child is able to model aspects of themselves through active choosing and appropriation of the behaviour of others (Robbins, 2001).

Culture evolves over time under the influence of its membership, but because of the limited lifespan of birth cohort members, it exerts a far greater influence on them than the other way around. An individual must consciously and actively draw on critical theory to deconstruct cultural concepts, such is the power of culture over his or her perception of the world and actions (Jarvis,1992). A perpendicular and commutative process is set in motion by interaction with the social world. The process is perpendicular in that the individual engages others horizontally in social exchange and vertically between this exchange and his or her mind. This results in mental representation. The process is commutative in that the inner and outer worlds impact on each other. In this way an individual is able to form abstract impressions of the solid world and give shape in the solid world to abstract impressions (Minick, 1996).

The Role of Community

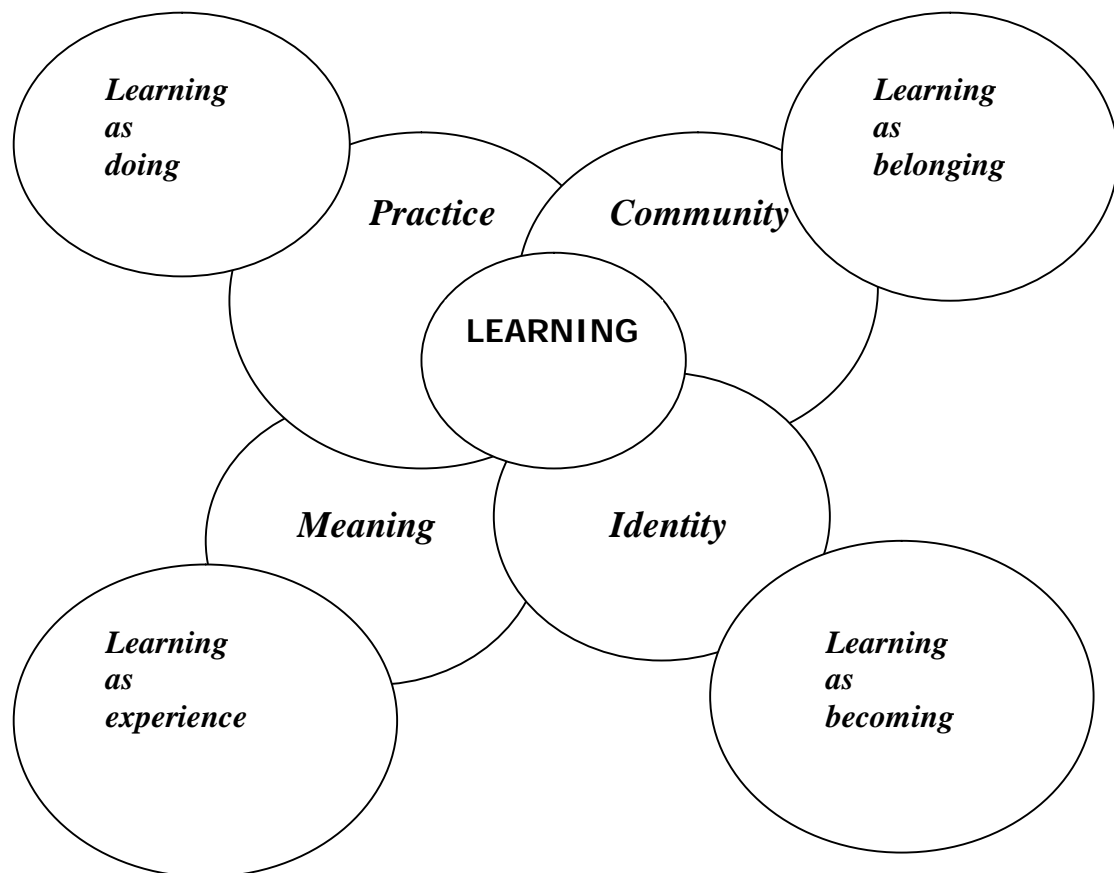


Table 2.2: Community of Practice (Wenger, 1998)

Historically developed sociocultural knowledge, skills and practices are conveyed from one generation to another [see Table 2.2]. This 'social practice' of learning can be misunderstood or not wholly appreciated if viewed cross-sectionally where participants are seen as senior and junior to each other in a fixed frame of reference. A prospective or retrospective view of such roles reveals a community membership of birth cohorts rather than members with fixed levels of experience, each living out a different phase in their biography seeking to meet the needs of their own personal learning trajectory at any given point in time (Polanyi, 1998). In addition varied individual life roles result in co-membership on the part of individuals and in this way communities influence and interact with one another (Lave and Wenger, 1991).

Learning is forged within this socially contextualised participation continuum in time and space. Culture develops to the extent that consciousness is shared and integrated. Cross cultural understanding develops in place of misinterpretation to the

extent that individuals and communities commit to find consensus in ways of knowing and learning (Lave and Wenger, 1991).

Individuals and groups practice social learning when they create meaning through learning as experience; the living interacting and doing in association with identified others within a community of practice (Wenger, 1998). This meaning will have biographical connotations. It is what renders the experience “contextualised” or “socially marked” (Illeris, 2008:129). It informs on societal structures. The doing or practice involves mutual engagement with historically and socially honed knowledge, skills, resources and perspectives. Engagement like this results in competence: the ability of the individual to address unforeseen situations through the combined use of preordered personal qualities and behaviourally demonstrated knowledge. This ‘sharing’ in behaviourally demonstrated knowledge creates a sense of belonging which develops out of a shared sense of loyalty to a common sense of purpose and values embedded in community existence. It is the community that endorses the practices as worthwhile.

When community learning practices take place together there is accelerated learning. Learning from experience through practice as part of a community shapes a sense of one’s identity because our response to developing competence and the evaluation we receive from others is forged within our biography (Wenger, 1998). In this sense Traynor et al (2010:1586) describe professional discourses within communities of practice as “pervasive, available and persuasive”.

Professional judgement rests at the peak of a hierarchical pyramid of knowledge acquisition and management. The lifelong evolution of learning skills spanning the cognitive, affective and psychomotor domains; description to synthesis, awareness to ownership and imitation to creativity form a ‘helix’ of learning trajectories which rest on the nature of human ontogenesis (Anderson et al. 2001). Professional ontology is crafted and honed within an exclusive community of practice.

Within nursing contextual meaning is shaped by the preoccupation with health status of individuals, communities and groups. This forms experiential learning of a nursing culture. Nursing practice is a process driven by a duty to care and the clinical skills and frameworks deemed necessary to execute that care. Competence grows from such practice through skilled clinical performances endorsed by the community. This is learning by doing. The nursing community is a social configuration of the goals and

values by which optimum nursing practice: the learning by doing is measured. Fellowship among those who share these goals and values is learning by belonging. Central to this is the creation of an environment conducive to the effective organisation of care through hierarchies of skill mix teams which reflect clinical need. The impact of 'becoming' a nurse on a person's biography results in the adoption of nursing as a major life role which consequently molds that person's identity. Such an identity is associated with a specialised language set integral to the caring arts and sciences (Taylor et al. 2005).

But how do mental images find meaning among communities and groups? Furthermore how does meaning in the social world translate to mental representation within the individual organism? What is the catalyst?

Emotion, Perception and Learning

The link between reasoned intelligence and social competence is emotion. People with a disabled ventro medial prefrontal cortex although able to grasp logic are prone to irrational decisions. The ability of such individuals to accurately discern learning indicates the independent function of judgement from abstract knowing and the function of the ventro medial prefrontal cortex independent of memory and learning (Modirrousta and Fellows, 2008). Decision-making in the absence of tempered emotion suffers particularly in personal and social matters requiring assessment of risk and conflict. A lack of compassion, guilt, empathy and consideration of the consequences of actions was observable in the behaviour of human subjects who prior to suffering prefrontal lobe trauma had been considerate, courteous and reflective. The inability of these subjects to transfer awareness of skills and knowledge in discussion to the real world of social interaction and decision-making strongly suggests the absence of an "emotional rudder" (Immordino-Yang and Damasio, 2007:6) which guides judgement in everyday life. This guidance is supplied by labelling the particulars of past experienced situations together with the reward and punishment, approval and disapproval they earn. Such 'emotion tagging' by the prefrontal cortex is able to convert information into skill and competence in the social world and intuitive thinking, knowing and doing is able to precede behaviour which is motivated by reason (Traynor et al. 2010). We feel before we think.

Patients with calcified amygdala have been observed to be uninhibited and unaware of danger; completely without experience of fear. Subjects with huge memory and learning defects resulting from damage to the amygdala and hippocampus have been shown to have emotional memory which although unarticulated can be engaged knowingly through action. This was observable in the way they avoided the company or flinched on visual contact with individuals who in a controlled study had previously treated them in a hostile or unhelpful manner (Damasio and Tranel,1993).

Such findings strongly support the notion that an inextricably linked “feeling of knowing” accompanies thought. Emotions, feeling emotions and consciously feeling emotions are three separate ways of being in relation to an experience. Knowing is a state of conscious awareness rather than the sum of information accessible to the senses. It is a feeling state.

Damasio (1999:43) explains:

The fabric of our minds and our behaviour is woven around continuous cycles of emotions followed by feelings that become known and beget new emotions, a running polyphony that underscores and punctuates specific thoughts in our minds and action in our behaviour... emotions are poised at the very threshold between being and knowing and connect with consciousness.

Damasio’s mention of emotions ‘connecting with consciousness’ raise further questions about the role of emotion in the past and its meaning for the future.

The Perennial Symbiotic Nature of Emotion and Cognition

The role of knowing by virtue of feeling emotion rests on the historical place of emotions in human existence. Emotions are a constant in human ecology, life history and development. Diversity in the expression of emotion and universality in emotion have been simultaneously observed across cultural and ethnic boundaries (Lutz and White, 1986). Historical religious and secular records whether chronicling family tragedy, political intrigue, geographical or scientific discovery describe and betray the same emotions of love, hate, ambition and jealousy as those of today (Mackay,2004; Bagnall and Criboire,2006). One example of this is the ancient Egyptian Scroll found

in Alexandria containing a letter of emotional blackmail from a son to his father. The emotional makeup of the deities in mythology created by the ancients are reflections of those peoples as they attributed meaning to their lives. This also evidences the perennial existence of emotion as a driver of thought and reasoning (Maspero, 2004).

Moreover, if emotion and the nature of emotion were not constants in the way described above, stories would not function as agents of values and principles bequeathed to and inherited by successive generations (Bruner, 1999). The novels of Charles Dickens, the plays of William Shakespeare, the tales of the Native North Americans, Cicero's legal tactics, the battle strategies of Julius Caesar and Alexander the Great, the parables of Jesus Christ and the teachings of Mohammed all bear witness to this. All such historical figures continue to inspire modern followers and counterparts. It is true that as centuries pass, interpretations of such stories become more sophisticated and include social critique, but such are at best intellectual appendices in that they do not change the fundamental principles of learning and life guidance. The agent of these values and principles is the story but the learning and knowing catalyst is emotion (Zembylas, 2005).

These arguments should not be read as espousing exclusively either a biological model in which all emotional intelligence is 'hardwired' nor a social model in which emotions are entirely created and shaped by the socio-cultural world. Indeed, that we are born with the neural genetically formed hardware with which to express emotion is clear from a study by Matsumoto and Willingham (2009) in which a comparison between the facial expressions of congenitally blind, noncongenitally blind and sighted individuals across a variety of contexts showed no difference. Our ability to feel and articulate pain in time and space arises from the growth, maturation and myelination of neural networks (Gould and Thomas, 1998). This is evident in the limits to comprehension and articulation of pain in young children which is commensurate with their stage of cognitive development regardless of how intensively they have been socialised (Llewellyn, 1998). Alternatively studies which show huge differences in pain thresholds and the way in which the lived experience of pain is expressed across gender, ethnicity, culture and pattern of life experience (Thomas, 1998; Eccleston, 1998) demonstrate the major impact of the social and cultural world on interpretation and expression. From such evidence it seems that neither polarised position adequately accounts for the origin and nature of emotions and the behaviours they produce.

Instead a third more feasible perspective is one in which cognition and emotion are inseparable as emotional thought in both influencing the way humans move and exist and shape their world, and in the way those same humans are shaped and influenced. Once again this perspective endorses the vision of humans continually interacting with their environment. In the social world emotions are created and nurtured by ritual and major life events such as death and birth together with the practices which manage them. Emotional contagion is experienced at events of national and international significance such as the inauguration of the first black american president or in a declaration of war. In all such events visual imagery, manipulated sound and discursive body movement play a part in shaping and sharing emotions. Furthermore such emotional waveforms are juxtaposed with ways and levels of understanding. At a funeral the view of the deceased in life held by the living can be altered by the shape of the ritual practices played out in a community setting. The management of emotional contagion by a teacher in a structured learning environment will exert a heavy influence on individual and group learning trajectories (Zembylas, 2005).

The symbiotic relationship between emotion and cognition is the product of both preexisting neural tissue and a mercurial social world. Nevertheless as neural tissue can be changed by the impact of the social world and the social world contains predetermined rituals and practices, neither end of the continuum is quite what it seems (Illeris, 2008).

Harnessing Emotion

The importance of exploring emotions attached to an experience has often been identified as a crucial part of reflecting on that experience (McKinnon, 2016). However the ubiquitous function of emotions in the organisation and retrieval of memory, at the seat of judgement and at the threshold of decision-making would suggest that their value in reflection has been underestimated and deserves further attention.

The neural kinetics of memory and attention lend support to the semantic nature of feeling, learning and knowing and explain the mechanism at work in associative and tangential thought (Rose, 2006). Tangential thought, evidenced in the identification of critical incidents (Tripp,1993), is possible because of affective generic particularity:

the cognitive use of a concept shared by two different contexts (Humphreys et al. 2003). This implies that concepts themselves have potency as tools of reflection.

Little work has been done in the area of harnessing emotion for professional practice. Peshkin (1988) argued that examining and declaring one's own subjectivity gave added meaning and rationale to one's activity. Peshkin uncovered in himself 6 subjective 'I's identified arising from the emotions he experienced in the course of his work. He describes how his values, interests and the emotions related to them steered him to linger in enquiry in some areas but not in others. Mazhindu (2003) tabled the idea of reflecting on emotions rather than the outcomes currently beloved of nurse educationalists and argued that learning will not take place without due attention to feeling states.

Peshkin's approach has been adopted in a nursing context by Bradbury-Jones et al. (2009) through application to student nurse journaling. Jack (2012) has also used artwork to help students explore their emotions. All these authors report significant success in raising self-awareness. Nevertheless their arguments, while potent, focus entirely on self-awareness and do not appear to consider that such reflection might be of value to anyone or anything beyond the self. No consideration is given to any commonality of emotions shared between narratives in a community of practice. Neither is there any mention that such commonality could be harnessed to guide judgement. In an eager process of using emotions to disclose the detail of the self, the value of what is provoking such emotions in the social world is overlooked.

The findings of Damasio and his colleagues (1999; 2007) pertaining to the role of emotions in judgement and decision-making suggest that singular emotions can be used as pivotal conceptual points for reflection. Moreover, the theory of a community of practice with shared values also supports the notion of a commonality of emotions experienced within such a community.

The Notion of Pivotal Concepts

Emotions are examples of concepts. Concepts are abstract bodies of summarised ideas with senses and inferences which marshall our thoughts helping us to move virtually in our world. Our world as we perceive it is through "the lenses of our conceptions" (Pratt, 1992:204). We use concepts as tools with which to interpret our surroundings and as such they attach to phenomena. Conceptual theory is derived

from interaction and as life data is analysed, theory is tested through further interaction and higher principles are embedded in the psyche (Daniels,1996; Margolis and Laurence, 2000).

Emotions as pivotal tools for reflection hold the potential for accessing new knowledge in a more comprehensive way than traditional reflection methods which first focus on a particular experience. Emotions such as fear and anxiety have a wide range of inferences and co-references relating to semiotics and semantics unique to individual experience (Margolis and Laurence, 2000). As emotional concepts they exist as remembrancers for wider thought. Tacit knowledge issuing from the perceived significance of situational constituents can be accessed through metacognitive use of a concept which has a broad mode of presentation containing the same constituents as inferences. In short, if emotions guide judgement and decision-making then reflection on specific emotions should reveal the rationale for judgement and decision-making. Used in reflective activity, pivotal concepts which share meaning with a wide range of incidents would engage a much wider 'trawl' of experience than the use of incidents themselves.

The notion of concepts which can be used as pivotal mechanisms for reflection has the advantage of a checklist without the disadvantages. Checklists are summarised main points gleaned from a body of research but disembodied from the real world situation to which they originally applied. They provide associative points to which the owner of experience may attach aspects of that experience. However in these cases the reflective scope is dictated and therefore limited by the detached nature of the predetermined criteria whose origins do not lie with the practitioner or the situation she or he inhabits. Reality begins with particularities, not generalisations. Checklists place logic in reverse in that detached reasoning which can only provide a crude interface with reality takes precedence over skilled judgement. There is an assumption of predictability in their use which ignores the contextual state of all human activity. In their qualitative study of the imposition of child protection checklist criteria as a means of guiding practice, Appleton and Cowley (2004) found that frustration and anxiety punctuated professional movement in the face of failure to determine fittingness of guidelines when they interfaced with practice life. False positives and negatives were common. This lack of 'fit' experienced by individuals working within individual contextual realities guided by probabilistic decontextualised knowledge is unsurprising when the multiple contingencies, conditions and exit points peculiar to a context are considered (Lincoln and Guba, 1979).

A pivotal concept begins with the practitioner. They exist at the seat of enquiry; the means by which people make emotional, factual, ideological, spatial and temporal sense of their world. Knowledge from other contexts is only admitted as relevant when deemed a relevant fit through concept transfer. Because of this the potential for learning is almost limitless. The value to professional practice of concepts as metacognitive tools of perception would appear to warrant further consideration.

The research questions driving this study are:

1. Is there a commonality of emotions shared across the practice community of nursing?
2. Can clinical judgement be informed by the use of shared core emotions informed by diverse narratives as pivotal concepts for reflection?

This chapter has considered the ontology of learning and learning dynamics in the social domain. The symbiotic relationship between emotion and cognition was explored together with the limited exploitation of emotion as a tool for professional judgment. The next chapter will consider the methodological issues and means pertaining to the appraisal of the value and purpose of emotion in nursing practice.

Chapter Three

Methodology

Introduction

Chapter two framed the place of emotion within learning. The chapter concluded with a consideration of the feasibility of emotions as pivotal tools for reflection within a community of practice. This chapter will lay out plans for methodology and method in research enquiring into the ontology of emotion in nursing practice and how it can be harnessed. The theoretical perspective on which this research is based and the underpinning epistemology from which the philosophical stance is derived will be discussed. A compatible methodological approach and the related methods will be critiqued with application to the study, together with an appraisal of the ethical implications.

Methodology describes selected ways of collecting, organising and analysing data. It embodies the theory of decision-making in research (Polit and Tatano Beck, 2013). The methodology in any research is shaped by the seminal research question. The research question is contextualised by a set of assumptions inherent in a particular philosophical paradigm informing and embedded in the methodology (Parahoo, 2014). This theoretical perspective will, in turn, rest on an overarching epistemology or set of understandings as to the nature of knowledge or “what it means to know” (Crotty, 2003:10). This hierarchy provides a framework or scientific ‘scaffolding’ which justifies the research methods.

Epistemology

A philosophical divide exists in the world of scientific enquiry between the natural and the social world. The natural world is to the logical positivist a world of certitude. To the stereotypical natural scientist facts present themselves as they are: as self interpreting objects and entities in forms and patterns which are predictable, comparable and measurable. Facts exist according to certain laws and ‘givens’ and as such they are discovered not interpreted. From this perspective many of the constituents of the social world: the individual and collective values, beliefs, perceptions, feelings and assumptions lack certitude and confirmation through

measurement and testing. As such they are seen as having no value to scientific enquiry (Blaikie, 1993).

The Nature of the Social World

By contrast in the social world scientists strive to ascertain values, beliefs perceptions, feelings and assumptions, both their own and those of others, in order to grasp some glimpse of some event object or topic as a lived experience. This is a world lacking certitude. Certitude proves elusive because of the different possibilities arising from diversity in interpretation. Certitude also proves elusive because of diversity of context and unforeseen circumstances. In this world nothing has meaning until meaning is attributed to it by a conscious being. Material bodies may exist but this is not the same as being interpreted. Objects are what distinguish dreams and fabrications from real life interpretations. The range of interpretation is infinite depending on the interpreter's experience and expertise, ignorance and prejudice, values and culture (Crotty, 2003). No immanent point of view is available and therefore objectivity like certitude is elusive.

The Role of Interpretation

This philosophical divide between natural and social world schools of thought is also an artificial one. Interpretation is central to meaningful existence across all life worlds including the natural scientific one. Klein (2001) supports the notion that any barrier between 'hard' and 'soft' science is a falsely assumed one when he reports that intuitive thinking is behind many of the decisions taken in rigorous controlled laboratory trials. Many of the great fathers of science such as Thomas Edison followed 'hunches' (Carlson and Kaiser, 1999). No 'discovery' is possible without interpretation on the basis of a sifting and assembly of diverse pieces of information at different levels of development. Gaps in a knowledge or evidence jigsaw are filled with guesswork and hypotheses. The interpretative dynamics of 'discovery' reveal this to be the case. No discovery is instantaneous and complete in itself. Rather the range of evidence reveals some aspect of the part or whole which are part of a greater whole (Polanyi, 1998). The discovery is the outcome of a knowledge base born of interpretation clusters evolving and assembled over time. Furthermore, the greater the number of individuals involved in the discovery, the greater the range of meanings and interpretations enhancing the total body of knowledge relating to the

phenomenon in question. This was demonstrated by Penington and Hastie (1986;1988) who explored the behaviour of jurors in court. Jurors were found to compare differing theories and accounts as incomplete narratives choosing the one with the least gaps. Information of different levels and quality ranging from feelings of concern and inconsistent accounts to explicit factual evidence such as bruises or times and dates were sifted and compared, matched and contrasted, in an attempt to find consistency.

From this it can be seen that experience and the object of experience are inseparable as are the interpretation from the experience and the object from the conscious interpretation. This relationship gives meaning to the existence of all the components of our universe. From this perspective, objectivism and subjectivism are polarised oversimplifications of reality. The reality of knowledge and discovery is more precisely reflected in the interaction of object and conscious interpreter (Lotman, 1990).

Human beings are not passive recipients of information who respond to stimuli in predictable ways. Neither are human beings mere carriers or managers and manipulators of information in the way that an electronic system might be defined. They are interpreters and creators. Artificial intelligence units are preprogrammed to react and address certain fixed templates. Beyond this, context has no meaning for such units. The symbols which trigger a response from a computer system have no unified meaning for the computer. Computed actions always follow programming. Robotic pathways carry no evaluative component and have no way of discerning a language system rendered inadequate by an evolving environment.

This is not the human world. Humans exist in a world of situated cognition. Through their interaction with their world humans' thoughts, actions and very being are refined by the world and by their own entrances. Words are given meaning by their context. As Bredo (1999:36) puts it:

a situation in which an expression is used helps disambiguate a situation.

Speakers reflect on their speech and amend it, artists are continually refining their art in progress and writers are molded by their reflections on their written work (Bredo,

1999). This situation of perpetual exchange explains why a person's beliefs and values are not always consistent with their actions.

Constructionism and constructivism have been distinguished one from the other in the following way: constructionism is concerned with the way meaning is generated within a cultural context and seeks to critically unwrap the packaging of culture to reveal phenomena in a fresh light of understanding. Exposing the restrictions placed on a human perspective by history and culture is the goal. Constructivism on the other hand focuses on the meaning of culture and history as it is instrumental in lending justification to the life practices of the individual. As such constructivism rather than seeking to critique culture seeks to preserve it in order to give sense to the actions, language, beliefs and values of another (Crotty, 2003). Metaphorically, a constructivist approach sees our culture in the role of nurse and teacher but a constructionist approach sees culture in the role of jailor (Blaikie, 1993).

Theoretical Perspective

This research is grounded in the 'real world'. It is not merely concerned with posing questions and gaining knowledge as part of some detached forum for discussion. This research is concerned with formulating theory which arises from practice. First the emotions at work in practice are to be described. Second, a conceptual framework arising from this 'emotion map' of a practice community will be formed and piloted in a practical setting. The resulting data will be used to evaluate the framework. The chief thrust of design is practitioner centred. It is a study conducted from the phenomenological perspective.

Even if emotions are studied as neural chemically transmitted mental images, observed in a dramatic performance or narrative, they cannot be understood unless they have been lived and experienced. This is a frame of reference which rests on the vault of experiences, values, emotions and thought processes peculiar to each individual. The value placed on supervision can be assessed. The dynamics and efficacy of each pivotal concept for reflection can be explored. The nature of any relationship between concepts can be described. Variables previously seen and unseen by the researcher are automatically blocked and can be included in the analysis.

The root meaning of 'phenomenology' originates with the Greek Word 'phaenesthai' meaning literally 'to show itself' and the associated German motto 'Zu den Sachen' or 'the things themselves'. This root meaning is coupled with the philosophy of Husserl who valued the suspension or 'bracketing' of the natural attitude in which individuals perceive and interpret objects in a pre-reflective state. Concern over potential misuse of this philosophy has led to extensive criticism of the way in which studies within nursing have labelled the lived experience of a phenomenon as phenomenology (Crotty, 2003).

However this criticism is excessively purist and misguided for two reasons. First Husserlian philosophy can be argued to 'collapse in on itself' in that all understanding is born of interpretation. Bracketing by research participants and the achievement of total objectivity is an unattainable illusion (Lowe and Prowse, 2001). Second the 'new' phenomenology describes the natural evolution of a philosophy. The use of this methodology not only in nursing but in a range of social science forums places emphasis on the living perception of the subject rather than some inanimate object as the phenomenon of interest. It is true that in a direct response to Crotty's criticism, nursing academic McNamara (2005) constructs a methodology which is faithful to the original phenomenological philosophy. However, his study is concerned with the clarification of the role of clinical placement coordinator within Irish nurse education. McNamara's design is desirable here because the phenomenon of interest is a role not a lived condition such as the emotional concepts being studied in this thesis.

The phenomenology envisioned by Husserl in which individuals attempt to disengage from their pre-understandings to reach a state of pure consciousness is not the approach espoused in this thesis. A phenomenological approach is espoused in that the perception of the individual is the phenomenon of interest. However this approach sees personal social and historical meanings as defining an individual. As these meanings are inseparable from that person's being, they shape their perspective. In this the methodology leans toward the hermeneutics of Gadamer (1989) who argued that our understanding is shaped by a fusion of our past and present. As time is perpetually in motion, so the present that was is assimilated within the past and the 'fused horizon' of interpretation is a constant in life. Our individual horizons also fuse with those of others with whom we interact and understandings are shared. Ontology is the evolving product of this continual interaction. Autobiography privatizes history but it is we who belong to history rather than the other way around. An awareness of ourselves as we exist within our culture is always

present before an awareness of ourselves through reflection. This research takes its cue from this perspective.

The interviewees are participants rather than subjects in that they *participate* in the research without charge as part of a partnership of enquiry; voluntarily providing openly declared knowledge of the self. Participants are also partners in that they corroborate or refute the findings of data analysis when they are shared with them. Understanding is not an elitist activity but one common to everyone; a necessary requirement for engagement with everything we do not already know. It is the means by which we relate to others. Stake (2000) has argued that as understanding is based on tacit knowledge it is more closely related to empathy than explaining which is based on propositional knowledge. However when perception and learning are viewed from the phenomenological perspective, understanding and explanation are both empathic ways of being in the world as each requires the knower to grasp what it is like not to know (Bruner, 1999).

Although professional practice is a world of expertise, active perception, understanding and learning remain the same. The strength of such an approach in explaining the behaviour of organisms through exposure to the world as those organisms perceive it to be lends itself particularly well to a study which has judgement and perception at its heart (Dowling, 2007).

Methods

Essentially the research consists of seven steps:

1. A first phase of data collection; individual unstructured interviews were held with a sample of practitioners across four different areas of nursing practice in which participants were invited to speak exhaustively about the emotions which they experienced in practice and the causes of these emotions.
2. The data arising from the interviews was analysed using a grounded theory framework until saturation was reached.
3. Following data collection, relationships between affective concepts arising from data was identified and a framework built around these relationships.
4. Team meetings and opportunistic break times were used to discuss the findings with participants and their managers. There was consensus across speciality boundaries as to the authenticity and clarity of the findings

5. The conceptual framework was delivered as a tool for clinical supervision in a separate small sample of practitioners and their supervisors. The separateness of the second sample membership precluded any foreknowledge of the formation of the framework which could bias the participation experience.
6. A second phase of data collection; individual unstructured interviews were conducted with the practitioners and supervisors making up the intervention sample. Participants were invited to talk exhaustively about their experience of using the framework in practice.
7. The data from the second phase of interviews were analysed using a grounded theory approach, the impact of the framework described and the implications discussed.

Data Collection

In the course of interview, participant talk was recorded on audiotape and afterwards transcribed and subjected to analysis using grounded theory method (Strauss and Corbin, 1999). However the auditory dimension is but one sensory mode among five and one semiotic mode among many. It is by itself insufficient to convey fully the meaning within data yielded at interview. The relationship between primary or closed semiotic models and secondary texts is a complementary one in that while secondary models require closed primary textual models to describe them, secondary textual models give meaning to primary texts through the provision of context appropriate animated facial expression and colour, hand arm and body gestures, vocal tone, modulation and pausing. In the absence of captured secondary texts, meaning can be distorted and misrepresented. In order to preserve a unified message conveyed by an optimum range of modalities, it is necessary to listen to audiotapes following transcription and to document the variance on vocal tone and the pace within the delivery of data at given stages. Further in the course of interview careful observational notes are required of the interviewer to match secondary texts to primary language (Gergen, 1998; Lotman, 2005).

In order to preserve a 'noesis' intact it is necessary to respect the psychology of the disclosure and declaration of the self. Carl Rogers (1994) argued that organismic valuing through unconditional positive regard, empathy and trust sets up a safe and confidentially secure environment in which participants in social exchange feel

predisposed to openness and able to disclose their thought and feelings as they exist as constituents in their lives.

From this it follows that interviews which are used as research tools should seek to simulate natural social interchange. Moreover the scheduled agenda of enquiry, which is faithful to a phenomenological approach, consists of a minimal structure to allow the participant maximum freedom of movement within the agreed area of interest. Priority is given to the participant's sequence and direction of thought and disclosure means that data yielded is not coerced but flows freely at the behest of the subject. Imposed structures in enquiry carry the risk of fragmenting the fragile phenomenological process through disruption, diversion and digression.

Disruption takes place when the train of thought of the participant unanticipated by the interviewer is broken by questions which whether open or closed block the natural flow of data. Whatever the value of any new information gained as a result of this interruption, it is not a natural product of the noesis but a pocket of information retrieved tangentially by the interviewer. The interviewer's interruption issues from *their* agenda not that of the participant and is an inappropriate shift in focus in a study aimed at capturing untainted the perspective of the other.

Disruption and diversion are not the same as techniques used to assist articulation and clarification by the interviewee. The judicious use of an enquiring glance, a period of silence, repeating back to the interviewee what has just been said and open questions to illicit more detail are all examples of subtle probing. These techniques can bring to the surface meaning which would have otherwise remained elusive or ambiguous. They are not preordained but arise spontaneously as a correlative response to the participant.

Giddens (1984) has offered a critique of qualitative data collection based on his theory of the interdependent relationship between social structure and agency. Giddens argues that data collection methods such as interviewing participants is undermined by unintended consequences such as distress, confusion of roles and issues of conduct. According to Giddens, unconscious beliefs or suppressed reasons for participating, tacit knowledge of which the participant may be unaware and cultural influences taint messages from the data.

However, unintended consequences can be managed by obtaining informed consent in advance of participation and having strategies in place to address contingency such as referral routes for counselling (Robson, 1994). Tacit knowledge and suppressed beliefs are more often than not betrayed by qualitative data collection. Hermeneutic approaches hand ownership of issues of which the participant is unaware to the researcher who is able to critically 'read the reader'. This latter point also applies to the unacknowledged impact of culture (Standish et al. 2010). This was apparent when one young nurse spoke apologetically about becoming emotionally attached to patients.

you can't always detach yourself and I think it is important to realize you are only human and you sometimes, especially with long term or chronic patients, you do get attached to them. PIC1 (57-59)

The expression 'only human' would seem to present humanity in nursing practice as a weakness underlining that which is prone to error instead of a strength underpinning care and common sense understanding (Benner and Wrubel, 1989). The evidence for humanity as a strength in practice and the nurse patient relationship as essential to care (Benner and Wrubel, 1989; Theodosius, 2008; McKinnon, 2011) does not appear to occur to the nurse. Thus his narrative unconsciously betrays a powerful cultural influence in his practice: that somehow it is unprofessional to become emotionally attached to patients.

The work of Kohnken et al. (1995) on the validity of statements is also valuable here. Kohnken and colleagues (1995) argued that the statements of those who have experienced events will have certain key characteristics. These would include a logical structure delivered in an unstructured way together with detailed content. Truth tellers also include contextual bedding to their narrative including reproduction of conversation and description of interactions. Honest narrative will also include spontaneous corrections and self-criticism. In view of these considerations, interviews led by a single scheduled question are a robust data collection tool for honest self-disclosure of value based experience.

Analysis and Grounded Theory

Analysis is about making interpretations; the development of concepts through construction. In qualitative research researcher and participant help each other through clarification to discover hidden meaning in a lived experience.

Grounded theory is a useful method in areas where little or nothing is known about a phenomenon. There is a wealth of literature on emotion and the use of emotion in nursing through crafting of the therapeutic self (Malloch, 2000; Scott, 2000; Henderson, 2001; McQueen, 2004; Kirk, 2007; Hunynh et al. 2008; Theodosius, 2008;) together with the threat this poses to practitioner health (Mann and Cowburn, 2005 ;Gray, 2009a;2009b) and the role of emotion as the central focus for reflection (Mazhindu, 2003; Bradbury- Jones et al. 2009 ; Jack, 2012). However this entire body of knowledge is preoccupied with self awareness and the tailoring of the self to fit the practice world. This is despite the fact that Keinemans (2015: 2178) acknowledges that emotions have a “cognitive element” able to hold and evaluate knowledge about an “object external to the person” experiencing the emotion. No evidence exists in nursing practice to test Damassio’s neural theories (1999). Neither is there any evidence base showing how such theories inform nursing practice or shape nursing ontology. Moreover there is a knowledge gap relating any commonality of emotion within nursing and how this might be harnessed. This cognitive potential for emotion to guide professional judgement is a new area of exploration.

Grounded theory is a rigorous and structured way of generating, coding and analysing data arising from qualitative research. Interview conversations transcribed from audiotape are read repeatedly. Afterwards the data is coded. This form of coding differs from other forms of qualitative coding in two ways. First the codes are not predetermined or prescribed. No ‘test’ of theory takes place. The codes arise spontaneously as a creative result of interaction by the researcher with the data. In this way the processes of coding and analysis overlap as the researcher is confronted by further questions about the data which he or she cannot answer. Second, the existence of these questions leads to further enquiry and recoding and in this way a pyramidal generation of theory is grown through the coding process (Strauss and Corbin, 1990).

Memo writing indexed to codes accompany each stage of enquiry, coding and analysis so that contemporaneous discoveries of distinct elements, concepts and themes within rich data are not lost or forgotten. Codes, sampling and memos all supply transparency (Charmaz, 2001).

Grounded theory is a consummate reflective exercise in which evidence from the external world fuels deductive questions and statements which require searching the data for verification. At the same time inductive reasoning occurs when messages within the data raise questions, provide surprising twists in explanation or challenge current understanding. This interplay is simultaneous and continual. The end point of grounded theory analysis is a rich matrix of meaning in which the character of concepts and the nature of relationships between concepts reflects the complexity of human life.

A grounded theory approach works particularly well in partnership with a phenomenological stance because in addition to being a qualitative tool, opportunities are afforded the researcher to explore, mine and evidence the noesis to the point of exhaustion. The use of grounded theory method achieves this in a transparent, structured and disciplined way through layers of staged analysis.

In the past some authors (for example, Baker et al. 1992) have argued that the combined use of phenomenology and grounded theory is unviable because although they are both qualitative approaches focusing on the human experience they are rooted in different intellectual traditions. This is misleading for a number of reasons. First, the authors argue that grounded theory values previous knowledge. They point out that, in contrast, phenomenology requires bracketing; a putting aside of prior knowledge and assumptions about the phenomenon being studied. But bracketing is a prerequisite of descriptive phenomenology not the interpretive form of phenomenology being deployed here (Dowling, 2007). The second philosophical objection is that while phenomenology favours the perception of the individual, grounded theory has its roots in symbolic interactionism; the meanings developed through interaction and experience in the social domain and how they are symbolised. These philosophical assumptions are not in opposition to each other. While the one deals with intrapersonal and the other interpersonal meaning both belong within the interpretivist stable. They are related as are the domains they represent. In addition there is no rigid divide between the intrapersonal and the interpersonal. The lived experience that is the focus of phenomenology is shaped by

social and psychological processes and these processes are shaped by our intentionality (Gadamer, 1989). The interpreter, the interpreted and the process of interpretation are seamless. This relates closely to another objection raised by Baker et al. (1992): the sources of data with which each approach is concerned. Phenomenology favours the perception of the individual as the sole source of data while grounded theory *may* focus on a diverse range of materials. However this is not the case in the study at the centre of this thesis. In this work data arising from phenomenological interviews informs both the lived experience of emotion and social relationships that contribute to and arise from this. While the extant literature on psychological, neurological and nursing sciences is sourced, this serves only to complement and further validate the findings.

Finally Baker et al (1992) point out that validity in phenomenology relies on confirmation by participants as to how accurately findings reflect their lived experience of a phenomenon. Grounded theory requires that findings generate theory which is useful, integrated and comprehensible. But these two perspectives are not irreconcilable. Rather, there is strength in the relationship between their purposes. Grounded theory seeks to discover an area of social knowledge that is unknown. Knowledge of any social situation is incomplete without understanding the lived experience of those inhabiting that situation,

The rationale for combining interpretative phenomenology as a philosophical stance and grounded theory method lies in the nature of emotion as a phenomenon that can be personally or communally owned. In valuing the captured perception and lived experience of the individual, phenomenology has shaped the data collection method in which participants talked exhaustively in response to one question. This method exposes the ontology of emotion. This exposure is important to show the part played by emotion in reasoning and how this extrapolates to the practice world. However this is not the sole aim of this study. A second aim of this study is to explore relationships and processes at work in practice life, which might indicate a commonality between concepts. Any shared commonality points to the meaning that exists *within* a community of practice (referred to in chapter 2) through *shared* perception (Wenger, 1998).

In reference to grounded theory Corben and Strauss (1990) repeatedly refer to their framework as a method, not a philosophy. This aligns with Flood's assertion (2010)

that analytical frameworks are a separate choice from that of a philosophical or theoretical stance although they should be logically related.

In discussing the philosophy underpinning grounded theory Corben and Strauss (1990:8) state:

Formulating theoretical interpretations of data grounded in reality provides a powerful means both for understanding the world “out there” and for developing action strategies that will allow for some measure of control over it

So while a broad phenomenological stance permits isolation of the lived experience, a partnership with grounded theory method links this phenomenon with the social and psychological conditions of the context. Grounded theory method also permits alternating between collection and analysis to develop and consolidate theory. This is particularly important in this study as a derivative framework for reflection is developed. The ability to escalate and develop findings to form frameworks for practice is a requirement of method design. The ‘truth claim’ within the lived experience is the original seed of theory that must then be articulated for useful purpose. By virtue of its power to discern relationships and processes grounded theory method sits well with the second aim of the study in tracing the lived experience of emotion and its part in shaping practice through to the exploration of a framework built on a commonality of emotion. This is evident in the way that purposeful sampling is used in phase one where the lived experience is being sought but theoretical sampling is used in phase two where theory is being developed as to how emotions act as reliable memory triggers (Corben and Strauss, 1992). A consistent commutative relationship is demonstrated between the place of emotions in judgement and the commonality of these emotions in the social domain. Within the ‘family’ of qualitative measures these approaches interlink to produce a more enhanced picture than either one might have produced alone.

According to Strauss and Corbin (1990) the emerging theory must meet four criteria in order to be show grounded character: fit, understanding, generality and control. The theory must ‘fit’ in that meaning making should match the culture of the setting. The theory must permit understanding in that it is comprehensible to those within the setting. The theory permits generality in that while meaning is personal to the participants, the principles relating to the phenomenon are sufficiently generic and

distant to warrant transfer to similar contexts. The theory should provide evidence of control in that findings consistently relate to the phenomenon in a realistic way.

'Fit' is facilitated by a study aimed at generating theory among nurses for use in nursing. The criterion of 'fit' is also met in that meaning is couched in the formal terminology and informal language of nursing. Note the relief expressed by a district nurse as her care planning for a patient with end stage heart failure reaches the terminal period.

I think it's difficult because sometimes it can be almost a relief to admit that we are actually moving into managing some symptoms in the last days of life because it's been a struggle for that patient. And you just feel that they've come to a point where they have had enough. DN3 (166-169)

The expression of relief relates both to emotion as the phenomenon of interest but also to the setting of nursing care 'moving into managing symptoms'. The 'talk' betrays the nursing context of the relief and its character.

In this study the pilot of the framework acts as a test of understanding in that it is the theoretical product of the first phase of data analysis. Understanding is evidenced in the way the participants are able to engage with the framework in a way that is useful to them and their practice. Note the way a nurse endorses the representativeness of the framework.

those are all emotions that you feel at work and you can relate to, you know. P4 (2:106)

The identification of the emotions by the nurse as being relevant to her work and the experience of 'relating to' those emotions show the 'understanding' required by grounded theory: a sense of kinship between community practice members and the meaning of the data which confirms its authentic origins.

The generality of the theory is found in the principles arising from the data that through commonality of meaning find application in other similar nursing settings. In

the following piece of data a staff nurse in an adult surgical ward explains how poor resources frustrate progress in practice.

I think that is a common theme and then you get frustrated because, it is like constant cycle, of every day there is something that shouldn't be happening in your mind, I shouldn't be doing this, this should already have been done for you, the stocks should be there, I shouldn't have to go hunting for things, I shouldn't have to go hunting for drugs I shouldn't have to go running upstairs to find things. And, also, I shouldn't have to be trying to fix this machine, I shouldn't have to be, a lot of things I shouldn't have to do but I am doing them and then you get frustrated based on that. AU3 (240-248)

While the "common theme" identified by the nurse refers to his own practice the problem he describes is also common and applicable to many nursing settings around the world. This is generality. The use of memos enhances the accuracy of translation. Retained memos capture the participant's personality; their tone of voice, their mannerisms and the personal and social context within which their comments were made. Supplying contextual detail strengthens the accuracy of translation which later takes place. A rich portrayal of background meaning enhances application in other settings because findings are 'matched' with greater precision.

Control is evidenced in the way the outcome of analysis and theory generation are related to the phenomenon of interest in this study. Control is about findings which are 'true to life'. The establishment of an 'emotion map' with roots in nursing politics and practice confirm the reliability of the findings.

Grounded theory has a number of phases through which data must be processed to facilitate meaning making. These are theoretical sensitivity, open coding, axial coding, process and theoretical sampling.

Theoretical Sensitivity

Theoretical sensitivity is concerned with being open to what is significant and invites reflection on meaning within the data. Every researcher essentially comes to qualitative analysis with background knowledge of the subject at hand; a student of life as well as of theory. Theoretical sensitivity is attuned by an interface with a

combination of extant literature, personal and professional experience. Life experience and literature inform and equip each other for this process in that while assimilating literature forms part of life experience, life experience supplies an understanding of the literature. A review of the literature as part of a study using grounded theory does not have the role of formulating research questions as is the case in some research designs. In a study using grounded theory a literature review is carried out simultaneously with data collection and analysis with the purpose of providing a relevant technical background to the work. Messages and themes arising from the data can then be compared and contrasted with the extant literature. Questions about the messages from the data will be stimulated and findings validated. The researcher's professional and personal life experience brings added discernment to this process. However it is the declarative knowledge of the participant sample that generates the theory and supplies direction to it. The originality of theory grounded in professional life is evident in the fact that while there are alignments with the literature there will also be variations and new detail described and justified within the findings (Corbin and Strauss, 1990). For example in this research the work of Scott (2000), Kirk (2007) and Kawamichi et al. (2013) provide important evidence of the psychological and neural background to empathy which confirm and are confirmed by the findings. In addition a range of work (Peplau, 1988; Egan, 2002; Stickley and Freshwater, 2006; Berg et al. 2007) is used to supply information on the skills involved in attaining empathy. However theory arising from this study gives new detail on the order of process in empathic practice, the different types of empathy and the relevance of biography, together with the concept's libidinal properties.

Open Coding

At the stage of open coding the data is broken up into parts which can be coded as to their conceptual meaning. Categories are formed out of recognition that pieces of coded data share meaning. Techniques of 'questioning' such as "what is the participant saying here?" and 'comparing' pieces of data which appear to refer to the same aspect of a phenomenon are constants in this process. Open coding also reveals the character and different dimensions of a category. For example in this study anxiety and fear are distinguished respectively as future focused and present focused emotions which produce different behaviours. In spite of this, anxiety shows retrospective properties ("anxiety with hindsight") and concern and panic are situated at different points on a continuum of anxiety.

Caution must be taken in coding practice because the structure of personal narrative varies from one participant to another. The technique of 'line by line coding' recommended by Charmaz (2001) was not found to be practical in this study and some improvisation has proved necessary. The mood of participants in the initial part of the interview was often one of anxiety or exhaustion. This was shaped by a combination of the circumstances they had left behind in practice, extemporaneous thinking and an initial feeling of apprehension at being interviewed. As a consequence of this narratives are often disjointed and convey different meanings when isolated as single lines of transcript separated from context. The following passage of narrative from a paediatric nurse illustrates the point:

...because we've got so many teams involved in those patient's care, its so difficult to get hold of them and when you do have something you really want them to see or to look at, your often chasing around for ages and ages trying to get the right person, to get the right number, "we're not on that number anymore" or "I'll come but I'll come in two hours" and you're thinking, "I want you to come now", so definitely in our surgical end there's a lot of frustration with trying to get doctors to sort of have input because they're in surgery all day. PD7 (7-13)

In line with the character of 'truthful' narrative as described by Kohnken et al. (1995) the nurse includes reproduced segments of conversation, self correction and additional extemporaneous detail to give contextual bedding to her story. She discusses one subject but with a plurality of sub-references. This results in data which is semantically disjointed. Meaning is spread across two or more lines of transcript so isolation of single lines for coding can risk meaning being reduced or distorted. The nurse's description of "often chasing around" in one line is disembodied from the temporal context of "for ages and ages" and from the intentional context of "trying to get the right person" in the following line. In addition, the identity of the subject of reference as a 'doctor' only becomes clear at the end of the passage. Furthermore at some later stage of analysis there is a danger that line meanings will be incorrectly linked, which in reality bear no relationship, because the context is lost. On the other hand the practice of coding by paragraph risks producing a superficial analysis. To offset this, capturing fullness of meaning in transcribed text shares some similarity with active listening and is tailored to the individual talking styles. Paragraphs have been coded as a whole piece of meaning as one would listen to a spoken discourse without interruption or premature assumption. Integrating

messages in memos and listening to vocal tone also help to verify the context. In this way, the coding of 'pieces' or 'chunks' of data with attention to 'micro-meaning' contained within sentences is a serviceable technique.

Axial Coding

Axial coding describes the identification of core categories and their sub categories and relates to description of relationships between the phenomenon's context, cause and effect (Strauss and Corbin, 1990). For example in this study emotional overload was found to be a consequence of prolonged emotional labour and so was identified as a subcategory with emotional labour as its core category. There was a consensus as to the character of frustration but there was a diverse range of causes which formed subcategories. Moreover, frustration was shown to exert a 'vortex effect' on other negative emotion states with negative implications for individual wellbeing increasing with time. These are all relationships and consequences revealed by axial coding. In addition, categories which on initial examination appear similar such as 'relief' (a subcategory of 'emotional impact') and 'recovery' (a subcategory of 'emotional labour') are distinguished one from the other through clarification and comparison of their character profiles.

In the course of data analysis codes do not always present in the hierarchical way described by the authors of grounded theory. Relationships and subcategories are often apprehended by the researcher in advance of axial coding. For example, the following piece of data is strongly suggestive of a relationship between compassion and helplessness.

I still feel that now with one or two patients I have had....just having this sadness and wanting to make it all better for them and just knowing that you can't so there's helplessness I suppose, (469-472) MH2

It is in cases such as this that self discipline on the part of the researcher is required. Suggestions of relationships between concepts and categories early in the analysis process cannot be assumed until verified by evidence elsewhere in the data. It may also find support in the extant literature. In the case of the excerpt above support is found in the narratives of other nurses and also in the literature to the effect that compassion is accompanied by inner pain and sadness (Gilbert and Choden, 2013), and that sadness also enhances one's desire to act fairly toward others (Bower,

2013). Helplessness therefore becomes a subcategory of compassion. This is also part of the axial coding process.

Selective Coding

Selective coding has been described as an integration process built around the identification of a core category which acts as “cement” (Strauss and Corbin, 1990:124) which holds the theory together. Selective coding begins with the establishment of a ‘story line’ along which evidence from the data and aligned descriptive explanatory commentary is laid out in narrative format. Categories and relationships are arranged in an order which best frame and validate the theory. At the point of validation the theory is said to be ‘grounded’. The narrative is ‘wrapped around’ the results of discriminate sampling: the showcasing of data which best illustrates conceptual specificity and density.

The theory arising from this study describes a common set of emotions experienced within the nursing community of practice which can be ‘mapped’ against common experienced source and cause types. The theory also describes the behaviours and skills produced in response to these emotions, emotion cause and source types. This begins in chapter five with the presentation of the data analysis and continues in chapter six with a consideration of the implications and value for practice.

Process

Strauss and Corbin (1990:144) define process in grounded theory as “a way of giving life to data” in a way which shows the dynamics at work within and between categories. Process is essentially the illustrating of change within the data in relation to the phenomenon over time. In order to evidence process it is important to demonstrate through use of data samples how interaction of concepts evolves to produce a defined state of thinking or behaviour. This is demonstrable at microscopic and macroscopic levels. For example at a microscopic level an exploration of the “emotional impact” subcategory named “being on stage” shows how the perspective of anxious parents institutionalised by prolonged vigils beside their hospitalised children interfaces with the lack of confidence inherent in inexperienced qualified nurses. This interaction necessitates a mandatory form of perpetual professional performance without interlude which results in acute emotional stress for nurses. Additional variables within this process are shown to be the size of the nurse’s

workload and the likelihood of respite afforded by a break. In this way the evolving process of “being on stage” is described. Similarly empathy is not only shown to have interacting antecedents but a process emerges as to how the antecedents act as steps to achieving empathy.

At a macroscopic level chapter six shows how the seven core emotions form a comprehensive feeling map representative of all nursing practice. Each of the seven emotions is shown to ‘cover’ an area of practice together with that area’s shape and character. In this way process facilitates the journey of interweaving themes within the narrative to its conclusion. In chapter seven data arising from the framework pilot also confirm the patency of the process by placing it in reverse. Although the data set in chapter seven is generated by a different participant sample, the theory formed is built on that emerging from the data in chapter five. Therefore the oneness of the grounded theory is evident in the internal process and the commutative relationship between emotion map and emotion framework.

Theoretical Sampling

Theoretical sampling takes place across the whole analytical process and involves the presentation of data with the purpose of confirming theory. If selective coding is the cement of theory and process is the order of theory evolution then theoretical sampling provides the evidence or ‘scaffolding’ which must support both. Open sampling is part of open coding and is the inclusion of data samples which show the basic character of categories. In axial coding, relational sampling to demonstrate conceptual relationships and variation sampling to show dimensional properties are utilised. Discriminate sampling is used as part of selective coding to emphasize the ‘story’; giving it cohesive structure and direction by evidencing how one set of relationships relate to another in a meaningful chain of descriptive narrative to coordinate and organise the theory. In each type of sampling the researcher carries the responsibility of making discerning choices in the use of a few data sample segments representative of many which best illustrate the character, dimension, and relationships.

Sampling

Three NHS Trusts (two adult and one mental health) in the east midlands and one hospital foundation NHS Trust in London gave their permission for their nursing staff to be involved in the research. In the first phase of data collection participant information sheets were circulated by a manager in each NHS Trust acting as a research project link between myself as chief investigator and their nursing teams. All registered nurses working within the NHS Trusts involved were free to volunteer their participation. Upon volunteering participants signed a consent form, which they had previously been given the opportunity to read and consider.

This form of sampling is purposive, open and random. Random selection prevents anyone involved in the research process from influencing the selection of participants.

The sample is also purposive in that participants are 'fit for purpose' in that selection takes place within a community of practice with experience of the phenomenon in question. The subject of experienced emotion is deeply embedded in the fabric of their life and work and they manoeuvre comfortably and knowledgeably within it (Parahoo, 2014). Sampling across different landscapes within the same community of practice; for example, in both rural and urban settings of primary and secondary care serves to block variations in the demand for care to which practice must respond. Sampling in a cosmopolitan urban setting also promotes ethnic diversity in research participation.

The sample is open in that no limit is set on the number of participants that can be recruited at the outset. The rationale for this lies in the nature of representativeness. Statistical representation is not what is being sought as it has little meaning here. A community of practice is being represented not by numbers but rather by the values and the resultant attitudes and approaches at work in participants' lives. When analysis of data takes place simultaneously with data collection as afforded by a grounded theory approach, a body of common themes emerge which is representative of the values of the sample. The point at which an increase in the sample membership makes no impact on the emergent themes is the point of saturation when the community of practice is adequately represented in terms of the values at work within it.

The definitive sample for the first phase data collection numbered thirty-three nurses; twenty-eight women and five men. This sample was composed of six district nurses, four health visitors, two school nurses, five nurses from an acute adult surgical unit, three mental health nurses, ten children's nurses and three neonatal intensive care nurses. The ethnicity of the sample was mixed; twenty-six white British, three black African, three African-Caribbean and one Asian. The age grouping of the sample was also mixed; eight nurses aged between 20 to 29 years, nine nurses aged 30 to 39 years, six nurses aged 40 to 49 years and ten nurses aged 50 to 59 years. Years of post registration experience varied; one nurse with less than one year, nine nurses with one to five years, seven nurses with five to ten years, eight nurses with ten to twenty years, five nurses with twenty to thirty years and four nurses with over thirty years practice experience. A gender mix together with diversity of age, experience and ethnicity within the sample was important to capture any variations in the way emotion was experienced and used.

Participants were recruited for the framework pilot (the subject of the second data collection phase) in the same way as participants for the first phase of data collection except that this took place in one NHS Trust. This was a large children's hospital in London. Practitioners from the child branch of nursing form an ideal pilot group for a framework resting on the intuitive end of the cognitive continuum. Children are not linear adults. The perpetual nature of children's physical, emotional and psychological development means that the margin for error in their treatment and care is narrower than in other fields of nursing (Ball et al. 2014). Much of the early research into intuitive thinking in practice took place in paediatric and neonatal settings (Maloni et al.1986; Ball et al. 2014). It follows that the success of a framework for clinical judgement in a child health care setting would signal likelihood of success elsewhere in the nursing community.

In the second phase of data collection the sample was closed and limited to a comparatively small membership. This is sufficient because at this stage the commonality of emotions in the community of practice was established from the first wave of data collection and analysis. The sample for the second wave of enquiry need only be of sufficient size to sustain demonstrable use of the framework arising from the first wave of enquiry (Parahoo, 2014).

Discussion around sample size is closely related to ideas of generalisability and the idea that the larger the sample the weightier the messages from the data and the

greater the capacity for generalisation. Lincoln and Guba (1979:27) define generalisability as:

assertions of enduring value that are context free. Their value lies in their ability to modulate efforts at prediction and control

This is highly questionable. Such generalisations are at best probabilistic. Situations which share similar characteristics nevertheless also have far more distinguishing contextual idiosyncracies which defy generalisation. An individual attempting reconciliation of findings in one setting with another setting which is not dissimilar is obliged to have a working knowledge of both in order to determine degrees of fit. This is not generalisability but transferability (Lincoln and Guba, 1979; Stake, 2000).

Furthermore studies with large samples may not always reserve time for ascertaining other features of representativeness in terms of membership which may influence fittingness. A purposive sample in a qualitative study is therefore most pertinent to transferability. Diversity of culture or specialism within a qualitative sample is more likely to influence fittingness than the size of membership.

Theoretical Saturation

Enquiry ceases when saturation is reached. This is when no new themes continue to emerge, or put simply, when no participant has anything new left to say. This is determined by subjecting the growing script of data to repeated analysis and coding. The end result is a rich multi-layered theory (Robson, 1994).

The concept of saturation deserves some exploration as to its feasibility and its rigour. On initial consideration at least, it seems strange that anyone can say with confidence that the vault of personal experience of a matter is ever exhausted. Although saturation is a well established key component of qualitative methods, until recently there has been a dearth of evidence of saturation in operation and very little practical guidance as to how qualitative saturation can be determined. Moreover no transparent operationalised relationship between saturation and the sample size judged adequate to achieve saturation has been evidenced. Guest et al. (2006) produced a methodology paper arising from their study in which sixty interviews were held with West African Women who discussed and reported on their sexual values

and behaviour. Through use of a code book, theory development and progress toward saturation was traced and mapped against the growth of the participant sample. Out of one hundred and fourteen codes, eighty were identified in the first six interviews and one hundred by the first twelve interviews. A further nine codes were developed between interviews thirteen and thirty and only a further five codes in the course of the last thirty interviews. Of the five final codes developed, four of these were refinements of insights which were already known. Prevalent themes were all established early in the data collection and analysis process. Bowen (2008) concluded that evidence of code and theme development to the point of saturation must be rendered transparent by progressive record keeping. The constant comparative analytical patterns at work in grounded theory mean that the approach is well suited to maintaining such transparency particularly when aided by a qualitative software tool such as NVIVO 8.

Although Guest and his colleagues (2006) cautioned against wide generalisation, their work suggests that in a homogeneous group, responding to a narrow line of enquiry on a defined area of perception and belief, theoretical saturation is achieved much earlier in the data collection than some might imagine. This also reduces the risk of researcher fatigue: a causative factor in premature identification of saturation. However the question remains as to how a steep saturation curve early in the data collection can be explained?

Consensus theory (Romney et al. 1986) maintains that experts who share a common domain of expertise tend to agree with each other. This “cultural competence” (1986:326) is in keeping with the principles of social learning theory where learning is part of belonging and meaning is framed by identity arising from historical and social themes which sustain mutual engagement in action. Cultural competence is exhibited when members of a community of practice share perceptions and beliefs of common experiences which comprise identifiable truths (Wenger, 1998). Validation of this requires that each participant from a community of practice be interviewed separately and privately.

Limitations of Research Design

Qualitative research is designed to take measurements in an uncertain social world in which the level of certainty characterising outcomes is essentially limited. The data

delivers clear messages arising from the ideals of modern nursing and pertaining to seven core emotions. In addition meaning arising from other emotions such as awkwardness and despair were clustered around some of the core themes. Feelings of hate which were not articulated may also have been latent in nurses' expression of anger. There is credibility in how the seven core emotions together related comprehensively to practice. However while consensus theory (Romney et al. 1986) implies integrity in the messages from the data, the power and variance of these messages is limited by the size of the sample. The findings cannot be finite. Furthermore, the very existence of malpractice in nursing points to other less admirable discourses which are not mentioned here. Such silent or less ethical 'voices' are unlikely to respond to the research questions being posed in this work not least because of the professional censure that would ensue. In keeping with the central area of interest, further research might enquire into the values and emotions relating to indifference and malpractice in nursing to create an alternative picture which might complement the one provided here. Limitations of the design of phase two are discussed at the beginning of chapter seven.

Ethical Issues

No research takes place in a morally neutral environment. Like all human practices it is punctuated with decisions which have consequences not just for the researcher but for others who are both involved and uninvolved in the project. Ethical approval of this research was granted by the university ethics committee, the NHS Regional Ethics Committee and the research department of each NHS Trust which participated in the research.

The Value of Ethical Frameworks

The Georgetown Mantra is a theoretical framework of ethical principles which is a most useful evaluative tool for the ethical dimension of research. Zealously pursuing any one member concept alone means that individuals and society suffer as a result of a lack of attention being paid to one of the others. Excessive autonomy means that justice is not always served. Beneficence without due attention to non-maleficence may be fundamentally flawed. Beneficence when possessed of paternalism robs individuals of their autonomy. The model's internal synergy helps maintain a balanced ethical assessment by virtue of the fact that it is greater than the sum of its

parts (Beauchamp and Childress, 2013). Such evaluation is possible because of the relationship which exists between the core principles inherent in the framework and aligned concepts of accountability, consent and negotiation, confidentiality, impartiality and collaboration.

Autonomy

Dworkin (1988:20) defined autonomy as

a second order capacity to reflect critically upon first order preferences, desires and wishes and so forth and the capacity to accept or attempt to change them in the light of higher order preferences and values

Dworkin's definition notwithstanding, it is evident that human beings do not always reflect on their actions and when they do it is not always in a well structured, well reasoned, consistent and honest way (Daly, 1998). The selfless reflective mode described by Dworkin, would seem neither ubiquitous nor constant. On the contrary, the propensity for self justification and self deceiving behaviour is strong (Mezirow, 1981). Any measure of power is therefore only ethically acceptable when it is matched by a corresponding measure of accountability. Accountability is the check on autonomy. In the context of research, accountability is the obligation to render an account or be answerable for the one's conduct in relation to the planning, implementation and publication of research and its impact on others. It is for the researcher to demonstrate awareness of such issues and to evidence relevant procedures which act as safeguards against any abuse of power.

The areas of accountability in this research are:

1. The Participant(s) for their treatment through civil law
2. The Local Research Ethical Committee (s) for compliance with and practice within the conditions under which the research was approved.
3. The Local Caldecott Guardian(s) for compliance with requirements set out by them for research involving interviews with National Health Service (NHS) staff to assure patient safety.
4. The Researchers' professional regulatory body through a ratified code of ethics.
5. The Researcher's Employer through contractual law for adherence to ratified policies and procedures relating to research activity.

6. The Public through criminal law for the consequences any outcome might have for their wellbeing.
7. The Self in terms of sustaining a philosophy of personal integrity

Autonomy, Consent and Research Practice

Consent is the autonomous expression of agreement by an individual to an act or procedure and related directly to the idea that any sentient rational being has the right to self-regulation. It may be given verbally, nonverbally or in writing. Consent may also be implicit (for example when an individual presents themselves to take part in procedure, subject themselves to an examination or treatment) or explicit when the participant responds positively to consent having been sought. Consent can be withdrawn at any time and for this reason in the context of research a participant's signature on an information sheet serves only to show that they have read and understood a summarised rationale and description of the research together with their part in it. Any sense of agreement is for that time only and may be reviewed and reversed by the participant at their leisure. It is a process, not an incident.

Consent can only be valid when it is fully informed. The end stage decision of an informant to take part in a research study must be based on their conscious knowledge of the potential harm and benefits, advantages and disadvantages of sample membership. Consent must also relate through autonomy to negotiation. Negotiation is the level of consultation which recognises the egalitarian partnership which exists between researcher and research participant. Careful explanation and negotiation as to the enquiry structure and process is required which shows due respect to timeliness and to any reservations harboured by participants in relation to time consumption, practical and logistical convenience together with the nature and extent of disclosure expected at interview (Seedhouse, 1998). The nature and content of the interviews should not surprise the participants so that they feel ambushed in an invidious situation through the substitution of consultation for interrogation but the terms of reference, modes of enquiry, analysis and extent of publication should be made known to them in advance.

Principles of autonomy and informed consent have implications for the structure of participation sheets and consent forms. Such forms must address individual issues separately and seek consent for these issues separately. In the second phase of this

research informed consent also required a briefing meeting of the nurses and practice teachers participating in the framework pilot. The 'loop of accountability' is complete when participants help to confirm research findings that are shared with them.

Non-Malificence

Non-Malificence defines the need to ensure that no harm is caused through an intervention which is intended to do good. It takes precedence over beneficence by virtue of its proactive stance. Beneficence or the doing of good is a subjective concept with very little cross-cultural consensus on the actions it constitutes. Beneficence carries potential links with paternalism which seeks to rob an individual or group of their autonomy. Nineteenth century philosopher and economist John Stuart Mill (1859:1:6) expressed the proper relationship between personal autonomy and paternalism in the following way:

The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not sufficient warrant.

Interviews with nursing staff about the emotions encountered in practice are likely to uncover material of a highly sensitive nature which may cause distress to the participants. Ethical committees and research participants therefore require assurance that non-maleficence will be secured in the course of the study through risk management including referral to any professional support deemed necessary.

Rumbold (1999) has argued that where ethical conflict exists, harmful consequences which result from morally good actions are acceptable when their cumulative effect is less than that of the good which results. Furthermore, choice of action is conditional on harm being merely a side effect rather than a descriptor of the action itself.

Rumbold's criteria are met by this research in that the goal of a tool to optimise professional judgement is in the broader public interest and any distress experienced by the sample members is secondary. In addition, if distress is experienced by participants in the course of interview, they have the option to withdraw temporarily or completely from the research process.

Confidentiality

Confidentiality refers to the clear understanding of the boundaries and limits to disclosure of information shared by the participant at interview. It is closely related to ideas of autonomy as an evident demonstration of accountability and to non-maleficence and beneficence through the exercising of sensitivity toward individual personhood. The sample members will understand that material disclosed in the course of data collection would be anonymous. Pseudonyms were used to prevent indirect breaches of privacy. Digital audiotapes were stored in a place secured under lock and key and deleted following the completion of the study (Robson, 1994). Participants were advised in advance of written consent to interview that confidentiality limits exist where information is disclosed which is potentially harmful to the greater public good. This observes the principle of justice (Hendrick, 2000).

Conclusion

This research is a qualitative study enquiring into the potential for harnessing core concepts of emotion informed by diverse narratives to guide nursing practice. First the ontology of emotion in nursing will be explored and the emerging theory used as a basis for a framework for reflection in practice. In a second phase the user experience of the framework is used to inform on its functioning structure and process. Learning outcomes for practitioner and practice are evaluated. The research will be conducted within the theoretical context of interpretive phenomenology resting on a constructionist epistemology. Data arising from individual unstructured interviews in two phases of collection will be analysed using grounded theory method.

The following chapter will consider the extant literature on the active emotions identified within nursing practice in the first phase of the research.

Chapter Four

Literature Review

Introduction

This chapter will critique the extant literature pertaining to the core themes arising from the first phase of data collection and analysis. A literature search was conducted contemporaneously with the data collection and analysis process. For each emotion concept, a combined search was conducted of the CINAHL (Cumulative Index to Nursing and Allied Health Literature), MEDLINE (Medical Literature Online) and 'PsychINFO' databases together with the British and Australian Education Indexes. Each of the emotional terms was used as a key word along with 'nursing' and 'psychology' as accompanying keywords to narrow the search as appropriate to this study's focus. The time frame of the search was adjusted for each search from 2000 to 2014 to 2010 to 2014 depending on the number of papers yielded on the subject of each emotion. A total of eighty-four papers were found. Of these eighty four papers, nineteen were omitted as they did not inform the conceptual structure of emotion or the role of emotion in behaviour. Some seminal works on emotional intelligence and emotional labour predating the year 2000 were also hand searched.

Emotional Intelligence

Emotional intelligence stands separately from abstract intelligence in which a person exhibits mathematical and verbal skills or concrete intelligence in which a person shows skill in the manipulation of objects. Emotional intelligence can be defined as social competence at interpersonal and intrapersonal levels. Emotionally intelligent individuals are the product of a life shaped by positive attachments. The emotionally intelligent person is able to engage with and accurately interpret the emotions of others through an effective demonstration of empathy. They are also able to organise groups. In addition this person is self aware and reflexive; conscious of their own prejudices and values together with their own physical and emotional deportment as they interact with their environment, regulating these as appropriate to the situation (Goleman, 1995). Emotional Intelligence is described by McQueen (2004) as having 5 components:

1. Self-awareness
2. Self-regulation
3. Motivation
4. Empathy
5. Social skill

The shift from paternalism in healthcare towards patient partnership has essentially been accompanied by a parallel shift from emotional detachment to emotional involvement used to inform practice of patient concern (McQueen, 2004). On the continuum of professional judgement emotional intelligence sits with intuition and reflection at the opposite end from research and theory based evidence (Standing, 2008).

Goleman (1995:19:34,36) describes how the emotionally intelligent person could acquire mastery in the field of human understanding and relationships. He has argued that:

Competences such as self awareness, self control and empathy and the arts of listening, resolving conflicts and cooperation.. being able to motivate oneself and persist in the face of frustrations; to control impulse and delay gratification; to regulate one's moods and keep distress from swamping the ability to empathize and to hope... a metability, determining how well we can use whatever other skills we have including raw intellect.

Self-awareness is described by Eckroth-Bucher (2010:300) as conscious knowledge of "inner dialogue" borne of emotions, spontaneous visualisations and other somatic-sensory experience and of how one's representation of these impact on others. Self-awareness of ones own culture, prejudices and value base are important. Such insightful knowledge can act as a check on personal bias contaminating the unconditional positive regard of practice or as a pointer for areas of one's personality which require further work (Eckroth-Bucher, 2010).

The application of emotional intelligence in nursing includes a range of interpersonal skills. Self-awareness is crucial at the opening encounter with another person for the development of trust, compassion and empathy. Knowing and understanding oneself is essential for knowing and understanding others (Eckroth-Bucher, 2010). Stickley

and Freshwater (2006) argue that engagement and listening informed by emotional intelligence are embodied acts which appropriate one's own body language facial expression and vocal tone while simultaneously deciphering that of another. They are prerequisites to compassion and empathy. For this reason Berg et al. (2007) define engagement as evidencing that one wishes to become involved. Shattell et al. (2007) found that community mental health patients sought a stable calming consistent force in their carers. Listening was seen as a skill in its own right, separate from care planning and solution finding. This would appear to be so even in cases of severe psychosis. Chan and Mak (2012) found that listening to and accepting the narrative of a patient suffering from paranoid delusions as '*their truth*' led to a relationship of trust.

The term 'compassion' comes from the latin 'compati' meaning 'to suffer with'. Ballot and Campling (2011) argue that this translated meaning of the original language root is insufficient to convey the intra-relational and inter-relational elements of the quality; the active use of kindness. Compassion moves our focus from one of self-concern to concern for others. It is "sensitivity to pain and suffering in ourselves and others with a deep motivation and commitment towards alleviating and preventing it". Compassion may both instigate a relationship and punctuate the course of that relationship (Gilbert and Choden, 2013:44).

Empathy is the goal of any caring listener. It is the ability to grasp the frame of reference of another. According to Kirk (2007:239) to exercise empathy is

to understand what it is like to be in someone else's position (what it is like to live that person's life) or, perhaps less ambitious, (ii) to understand what it is like to experience phenomena as someone else experiences them.

Kawamichi et al. (2013) distinguish cognitive empathy (the ability to assess the reasons for the emotional state of another and identify with them) from affective empathy (the ability to share the emotional state of another). It seems that humans have an incentive to act with empathy. Kawamichi et al (2013:90) confirmed this "empathic joy hypothesis": the urge to help another through sympathetic concern and compassion stimulated by enhanced sensitivity to vicarious joy and relief. In an experiment functioning magnetic resonance imaging (fMRI) was carried out on 11 romantic couples and 9 male/female pairs while they each played a virtual ball toss

game. The romantic couples played the same game with 2 other virtual players although in an interview afterwards they appeared to believe they were playing with real people. The game was manipulated so that a partner was either permitted or prohibited from tossing the ball to the third party who would always be the same gender as the ball tossing player. At different points a group member would be isolated and unable to play themselves unless the ball was tossed to them. Levels of affection between partners were measured afterwards using a Love/Liking questionnaire.

In both experiments the subjects tossed the ball more often to the isolated player than the non-isolated player regardless of whether the isolated player was a familiar or a stranger indicating sympathetic concern. These results are consistent with the existing body of research which shows that helpful behaviour toward both familiar and non-familiar people promotes empathy (Kawamichi et al. 2013).

Participants reported feeling more positive towards isolated individuals and isolated individuals reported feeling more positive toward other players on receipt of the ball. This behavioural evidence of sympathetic concern was accompanied by activation in the caudate nucleus part of the dorsal striatum.

For the non-isolated player in the 'ball possession' position is a decision crossroads which acts as a cue registered in the dorsal striatum as reward anticipation experienced as positive feeling. fMRI patterns (a first striatum cluster peak) occurred with strangers and paired subjects and correlates with the perspective taking subscale score suggesting cognitive empathy for both familiars and strangers. fMRI patterns (a second striatum cluster peak) showed a correlation with the love subscale score among paired subjects suggesting affective empathy between familiars. Kawamichi and his team (2013) concluded that the intensity of empathy increased with the level of intimacy in a relationship.

Malloch (2000) describes how empathic understanding and compassion are humanising processes translating robotic tasks into personalised unique services. Scott (2000) draws on the notion of educated emotion to highlight the importance of emotion in moral perception. Scott argues that in order to be receptive to a patient's situation we require cognition in the shape of representational thinking or imagination and emotion or the capacity to experience empathy and compassion. Caring practice is not composed of aptitude in beneficent acts alone but is sensitive to situations

which may require those acts. Empathy and compassion are necessary to discern the nature of another's position and also the needs that arise from that situation. Emotional intelligence makes measured use of such processes possible conveying emotional concern as well as physical care to promote wellbeing (McQueen, 2004, Cloutier et al. 2007).

Emotional Labour

Damasio (1999) speaks of a commutative cascade between affect and cognition in which emotions give rise to feelings and feelings give rise to thoughts but in which thoughts also generate feelings and emotions. From this it follows that while a range of influential factors in the external and internal environments can stimulate the affective end of the cascade, higher consciousness may solicit emotions through a range of thoughts and behaviours. Some of these emotions are spontaneous but others are deliberately generated to suit consensual norms in a given situation. Within this contextual framework, acting should not be seen solely as the occupation of individuals who tread the boards of a stage or perform in front of a camera. Acting is a skill employed by everyone throughout life with varying ability and success through the management of emotions for a range of motives. This is emotional labour (EL) and enables practitioners to achieve a desired level of quality of interaction with others. Hochschild (1983) first coined this concept, arguing that individuals regulate inappropriately experienced or expressed emotions which conflict with internalised or professionally imposed standards. Instead those emotions congruent with the tenor of the role are displayed.

Hochschild (1983:246) provided this definition of emotional labour:

the induction and suppression of feelings to sustain an outward appearance that produces in others a sense of being cared for in a convivial safe place.

Hochschild (1983) argued that emotional labour can be exercised in a number of ways.

1. Surface acting in which the focus is on regulation of the emotional expression in the voice or in the face in an exchange with a client. The individual uses body language, gestures, facial expressions and vocal tone

“to portray feelings that they do not really have” (Theodosius, 2008:20). The emotions expressed are those required by the context. The actor knows they are acting but they deceive their audience.

2. Deep acting in which regulation acts not on the emotional expression but on the felt emotions themselves. The ‘actor’ works to produce ‘real emotions’ in the performance. Theodosius (2008) compares this to method acting in which the actor exhorts emotions through the use of imagination aided by conscious emotional memory.
3. The emotions felt are entirely suited to the role and no acting is required although continual monitoring of emotions *is* required.

When discussing ‘deep acting’ Hochschild (1983) argued that in many jobs which entail interaction with the public, the worker’s personality is changed through emotional labour. In this part of her discussion Hochschild had in mind workers such as flight attendants or Disney Land workers who are encouraged to *become* a person with an outgoing positive persona.

All of these modes of emotional labour require a dual task: suppressing a professionally incongruent emotion and expressing a professionally congruent one. Zammuner and Galli (2005) used the term ‘emotional consonance’ to refer to job congruent emotions and ‘emotional dissonance’ to job incongruent emotions. The authors argued that there are a number of variables mediating the degree of effort required to regulate emotions and the psycho-social cost of such regulation. These were:

- The gravity of emotional dissonance or depth of space between the emotions felt and those deemed appropriate.
- The clarity of organisational norms on type and frequency of emotional labour.
- The level of job involvement indicating the intensity of interpersonal work.
- The frequency of contact indicating the rate of need to regulate emotions and the duration indicating the amount of effort needed for regulation.
- Length of time in the job indicating the experience of the worker in regulating emotions

Seven hundred and sixty-nine subjects (men and women) aged 18-65 half of whom had a university degree working across hospitals as care workers and

administrators, a bank, a post office and a shop completed a questionnaire consisting of a combination of scales measuring emotional labour, burnout, affect, and life satisfaction. Contrary to authors' expectations, gender, civil status and training did not make a significant difference between groups as to the dimensions of EL. Job role per se was a poor measurement of emotional labour. Rather the frequency and duration of interactions together with the length of experience as measured by time in the job were telling in terms of EL (Zammuner and Galli, 2005).

The relevance of EL to nursing is explicit in the way nurses are compelled to deal with human suffering on a daily basis. In doing so they are expected to respond with empathic caring rather than a mere task orientated performance (Hunynh et al. 2008). Theodosius (2008) distinguishes between therapeutic, instrumental and collegial emotional labour. Therapeutic emotional labour (TEL) is concerned with building and developing an interpersonal relationship with the patient. TEL places emphasis on the promotion of personhood self-worth and trust. Instrumental emotional labour (IEL) accompanies nursing intervention. IEL serves to relax the patient and create a mind-body state which is receptive to procedures or aspects of care which may prove uncomfortable. Collegial emotional labour (CEL) is the emotional management of relationships with colleagues within the multidisciplinary team. CEL seeks to progress care by negotiating and coordinating communication between colleagues. CEL varies with status and place by finding the shape and tone of communication most appropriate to the level on the hierarchical ladder (e.g.: health care assistant, consultant surgeon, senior nurse) or social context (e.g.: patient, patient's relatives or other staff present). Henderson (2001) found that among 42 nurses from Canada and Britain interviewed individually and in focus groups the emotional engagement detachment continuum was managed differently by each individual nurse. Some nurses viewed EL as a finely tuned practice which they were able to switch on and off. Others in the same sample viewed EL simply as acting.

These aspects of practice are politically invisible because theoretical frameworks of care while providing guidance and values for care planning do not capture the human experience of caring and being cared for. EL is also undervalued. Undervaluation issues from the combined impact of traditional and modern perspectives on nursing. The traditional perspective associates emotional caring with women's work steeped in Victorian Values of maternal duty. The modern perspective has considered emotional caring as inferior to contemporary approaches which have

been underpinned by technical knowledge and sought to shape predictable care pathways and outcomes (Hunynh et al. 2008; Gray, 2009b).

Emotional management cannot be sustained indefinitely. Zammuner and Galli (2005:363) described “virtuous loops” in which tiredness leads to surface acting where deep acting might be ideally required. This leads to a shallow less meaningful relationship with clients, less satisfaction and further exhaustion. The authors concluded that EL rewards investment of emotional effort in a job role with a sense of achievement it also takes its toll if employees are not rested. Niedenthal et al. (2006) showed that perpetual suppressing of emotions can lead to low self-esteem, depressive mood states and poor life satisfaction. Relentless EL also carries a psychosomatic price with an increased incidence of hypertension, coronary heart disease and cancer (Gray, 2009a). Emotional labour can be undermined by a lack of nutrition and hydration as well as rest (Zammuner and Galli, 2005). Night shift has also been shown to impact negatively on mood and performance. A review of six studies (Folkard, 2008) measured the extent of adjustment of night workers through the secretion of melatonin by the mid brain’s pineal gland as an indicator of circadian body clock function. More than 75% of participants showed no satisfactory adjustment. More recently Smith and Eastman, (2012) showed that the body clock of night workers could be reset by the use of simple and inexpensive measures controlling light and dark using outdoor light exposure, sunglasses, sleeping in the dark, and a little bright light during night work. However some of these might prove impractical in nursing.

The costliness of such emotional expenditure was evident in a study by Stayt (2008) into the work of nurses in intensive care units. The significance of death and the way in which sharing the experience of loss with families intensified the nurse patient relationship often resulted in cumulative grief. This outcome arose from the lack of time and opportunity to yield reflective space to loss and led to doubts about competency, loss of identity and low self-esteem.

A pattern of reported stress from EL emerged from a study in mental health nursing by Mann and Cowburn (2005). Thirty-five mental health nurses completed a questionnaire relating to 122 nurse patient interactions. Data was kept specifically relating to the duration and intensity of the interaction, the variety of the emotions expressed, together with the degree of surface and deep acting performed by the nurse. The level of stress the interaction involved as perceived by the practitioner

was also recorded and participants completed daily stress indicator charts. In this way daily stress was distinguished from interaction stress related to EL. There was a positive correlation between emotional labour and both interaction stress and daily stress levels. The deeper the intensity of the interactions and the greater the variety of emotions experienced the more emotional labour was reported. Surface acting was a more important predictor of EL than deep acting. The most important predictors of EL were surface acting, intensity and interaction stress.

The authors conceded that some questions were left unanswered. The high level of stress linked to surface acting may have been related to the impact on EL stress rooted in other activities. They hypothesized that there may be a cyclical relationship in which emotional labour is being used to mask stress and that this is a source of further stress.

While the theory of EL as originally described by Hochschild wins some support from nursing research, it has not escaped critique and there is some variance in the way it is interpreted in the nursing literature. Mazhindu (2003) argues that the traditional concept of EL places emphasis on negative emotions and that this can misrepresent professions such as nursing where practice is seen as bringing its own reward. In Mazhindu's study, 36 nurses were interviewed talking about their practice. Data analysis revealed a strong emotional dimension to decision making. A typology (see Appendix 2) was established based on the extent to which participants managed feelings of conflict, their awareness of levels of emotional control exerted by them and the description of the context in which these activities took place. Six main types (complete engagement, actively monitoring, automatic pilot, going through the emotional aspect, passive spectator and complete removal) indicated nursing management of EL and matched different management approaches to a range of emotions from exhilarating to disturbing. Each type was contingent on four main criteria: direction, intensity, symptoms and impact of feelings. 'Direction' explained the behaviour of the nurse as driven by patient behaviour, inappropriate behaviour of others, her own actions and organisational constraints on actions. 'Intensity' explained the nurse's perception and experience of her own feelings. 'Symptoms' were the effect, mood, somatic responses and actions. 'Impact' was the effect of feelings on participant and her performance.

Mann and Cowburn (2005) propose that surface acting and the consequent detachment from one's own genuine feelings are seen as inauthentic and

incompatible with the beneficence of a caring role. Instead the nurse is seen as labouring to establish a meaningful encounter. The comparison with acting is often rejected in favour of an emotional labour which is seen as an authentic response to embrace, as Hunynh et al. (2008:196) put it: “the holism of the human experience”. De Raeve (2002:470) captures the essence of this position when she distances nursing from any comparison with workers practicing emotional labour in a commercial or consumerist role to emphasize the place of reflexivity and self-awareness. She argues that:

Nurses are not serving customers as flight attendants do, they are responding to the needs of vulnerable, often frightened and suffering people who are partially or totally dependent on their help. These facts combined with the power imbalance between nurses and their patients and the trust that patients generally have in nurses behave nurses to try not to act harshly toward patients but to subject to self reflective enquiry any negative premature judgements that initial emotional reactions may precipitate. In this respect, at least I would want to claim that a nurse’s impetus towards a deepening of his or her understanding and compassion could have nothing to do with acting, whether ‘deep’ or otherwise. The consequences of thinking that it does are utterly counterintuitive.

Thus EL in nursing is seen as the means of achieving an empathic relationship rather than crafting any disingenuous performance. From this perspective nursing practice is more closely aligned with Carl Rogers Person Centred Theory (1986) in which emotional labour provides a tool for ascertaining the internal frame of reference of another person as part of a helping model (Egan, 2002).

Fear and Anxiety

Historically both fear and anxiety are poorly delineated constructs in the literature but recently published authors (Orsini et al. 2011; Sylvers et al. 2011; Sauerhofer et al. 2012) have supplied clarification on the neural and behavioural distinctions between them.

While autonomic arousal occurs during both fear and anxiety states their facilitative pathways are only partly shared. Both emotions can take place with or without awareness suggesting that they are not purely cognitive constructs. Fear is central to

the 'fight or flight' process and as such is associated with the amygdaloid nuclei and increased blood flow to the right frontal lobe. However anxiety is characterised by increased blood flow to the left frontal lobe and facilitated by the stria terminalis. Fear is accompanied by dilated pupils and orbital frontal stimulation but anxiety is not. Fear is also characterised by reduced pain sensitivity due to increased levels of beta endorphins, adrenaline and noradrenalin during flight and fight responses. This is in contrast to the notion of anxiety as an emotion which results in increased sensitivity to external stimuli due to heightened vigilance (Orsini et al. 2011; Sylvers et al. 2011).

Fear is present, focused and manifest in the presence of a clear perceived threat and is characterised by avoidance behaviour or a rush to action. Avoidance behaviour may continue after the threat has become extinct even although this is irrational. Such a response to a 'knowing state' is regulated by the hippocampus (in the role of knowledge organiser) amygdaloid process (in the role of arousal short circuit) and the prefrontal cortex (in the role of reasoned decision maker) (Orsini et al. 2011; Sauerhofer et al. 2012). On the other hand anxiety is future focused. It is not associated with avoidance behaviour but with anticipatory hyper vigilance in the face of uncertainty. It is an emotional response to an 'unknowing state' in the shape of unresolved fear or the inability to avoid fearful stimuli. In the mind of the anxious person reality may not match expectations or a potential threat may be overestimated because of a lack of information on future options leading to indecision (Sylvers et al. 2011). The consequent stress is explained by the energy spent on framing scenarios that may never happen; the situation is governed by a 'what if' state of understanding. This is called "catastrophising" (Meeton et al. 2012:691).

Anger

Anger is an aroused state of displeasure and resentment in response to perceived threats or injustices with an identifiable source of blame (Rivers et al. 2007). Physiological arousal is triggered in preparation for a behavioural response. Anger is associated with non-specific skin conductance responses, small heart rate acceleration, small increases in stroke volume and cardiac output and large increases in total peripheral resistance, facial temperature and finger pulse volume (Larson et al. 2008). Anger also increases cortisol output (Denson, 2012). Anger rumination is defined by Denson (2012:103) as "perseverative thinking about a personally meaningful anger-inducing event".

In a critical review of the literature Denson (2012) explores a multiple systems model of anger rumination with cognitive, neurobiological, affective, executive control and behavioural levels. The anger regulation effort is a tripartite mechanism; cognitive involving suppressing anger provoking thoughts, affective in regulating emotions and physiological in controlling behaviour. Attention to one aspect of self-control temporarily compromises the ability to operate another and poses a risk of aggression. Poor executive self-control can mean yielding to rumination, which in turn leads to aggression. At a cognitive level a person may choose to focus on the aspects of the anger inducing event or on the implications for the self. Cognition also governs the choice of processing mode in that an analytical approach is preoccupied with the causes and consequences of the cause of provocation. This is distinct from an experiential approach focusing on the details of the event and the feelings it arouses. An individual's vantage perspective is also relevant to their anger experience. Viewing the root of one's anger in the first person can cause one to relive the anger inducing incident while viewing in the third person can induce emotional detachment. However this latter rule applies only when taking an analytical stance. An experiential examination in the third person such as learning of injustice or persecution suffered by another may still induce anger. At a neurobiological level anger is associated with increased activity in the thalamus (the neural seat of arousal), the dorsal anterior cingulate cortex and the amygdala (associated with cognitive control) (Denson, 2012). In addition to these cortical and sub cortical structures, anger rumination is linked to increased activity in the lateral prefrontal cortex (responsible for emotional regulation) and dorsal medial prefrontal cortex (linked to self referential processing). At an affective level the duration and intensity of the anger experience can be greatly increased by rumination.

Although there are few differences in emotions experienced by men and women, there are differences in how those emotions are expressed. Women are more likely to express their sadness and conceal their anger. Men are more likely to express their anger and conceal their sadness. A range of anger regulation strategies have been identified including verbal and non-verbal expression, leaving the situation, passive strategies such as waiting for an apology or some other change in the environment or cognitive reappraisal of the situation. In attempts at regulation women were more likely to effectively regulate anger through distraction. Men were more likely to ruminate over anger (Rivers et al. 2007). Rivers et al. (2007) suggest a cultural underlying cause for this linked to perceived gender norms.

Frustration

Frustration refers to the emotion experienced in the face of stemmed progress in spite of the best efforts being made and has been defined by Berkowitz (1981:83) as “an unexpected barrier to goal attainment”. The emotion has been shown to be destructive to health and productivity in the work place with Maslach et al. (2001) identifying frustration as the penultimate phase of a downward spiralling process leading to burnout: a syndrome characterised by reduced personal achievement, emotional exhaustion and depersonalisation. Raised immunological protein S-1gA and cortisol consistent with the anticipation of stress have been shown to be present in frustrated mental states. The accompanying feeling of ill being has also been shown to lead to a range of compensatory poor health behaviours including binge eating and substance addiction. The behaviour is compensatory in that excessive release of self-control in another area seeks to ‘compensate’ for the suppression of autonomy in another (Vansteenkiste and Ryan, 2013). Need frustrated individuals will also choose between a path of rigid rule setting consisting of unreachably high standards to prove one’s worth and a position of oppositional defiance.

Lewandowski (2003) conducted a study of 141 health, social care and education professionals who attended workshops designed to raise awareness of workplace frustration and completed questionnaires using a Likert Scale. 43% attributed their frustration to decreased time to care for clients. The greater the sense of isolation the less likely the worker would be to seek organisational redress due to their perception of frustration as a private matter. 36% took this view. 29% of variance was explained by frustration arising from bureaucracy, specifically the disproportionate burden of bureaucracy and the suppression of good practice by corporate rules.

Lewandowski’s findings have been in part confirmed by others. A survey analysis of more than 95,000 nurses and patients by McHugh et al. (2011) found a direct correlation between raised nurse dissatisfaction and low patient satisfaction.

In view of these findings it is not surprising that workplace frustration is a predictor of intention to leave a profession. A one year longitudinal study (Li et al. 2011) of 30,619 nurses in 7 European Countries found that 8.2% of the total sample were nurses who had expressed no intention to leave at the beginning of the study but expressed this intention at the end. Low reward exerted the strongest influence on intention to leave. Overall nurses with low rewards and high frustration were two and

half times more likely to leave. The authors laid great store by the negative influence on nursing morale of working hard and receiving little or no reward in return. Referring to Siegrist and colleagues' model of effort reward imbalance (2004) Li et al. (2011:629) argued that:

This model of an adverse psychosocial work environment is based on the fundamental principle of reciprocity in contractual social exchange, such as the work contract. It posits that failed reciprocity in terms of high effort and low reward elicits strong negative emotions and stress reactions with adverse long-term effects on health and job satisfaction.

It is interesting that Li et al. (2011:629) also comment on the role of personal resilience as a buffer between effort reward imbalance and occupational health. They suggested that:

in addition to the imbalance caused by these two extrinsic factors (effort and reward) an intrinsic factor, a distinct motivational pattern of people's coping with work demands (over commitment) may modify the effects of effort–reward imbalance at work on health and job satisfaction.

This opens up a debate on the intertwining and competing nature of factors which predispose to or protect from workplace frustration. In addition it raises questions as to what extent professional frustration is a public or private matter. Lewandowski (2003:177) proposed that the women who constitute the majority of the "person centred working population" may have specific problems in relation to workplace frustration. She argued that the "other focused" personal element essential for their role may undermine their ability to communicate their own needs. Whinghter et al. (2008) draw a distinction between mastery goal orientation and performance goal orientation. The former is associated with individuals who believe in self-improvement and possess the drive to develop competencies to master challenging roles. The latter is associated with individuals who wish to demonstrate and validate their competence. The two are not mutually exclusive but mastery goal orientated individuals have been shown to be less prone to frustration. The authors commented that avoiding goal orientation is also linked to lower levels of frustration but this option is not available to a deontological and process driven practice such as nursing. This

may account for the high levels of moral distress experienced in nursing arising from ethical conflict where the ability to do what is right is far removed from the knowledge of what is right (Burston and Tuckett ,2012).

In a review of the literature, Vansteenkiste and Ryan (2013) built on self determination theory to show that human potential for growth and integrity and vulnerability toward ill-being and psychopathology are explained by a single underlying principle: need satisfaction and need frustration. Autonomy, competence and relatedness contribute to proactive movement, integration and wellbeing. Frustration of the same needs from significant others lead to passivity fragmentation and ill-being. Self determination theory asserts that humans are benevolent and self actualising when their psychological needs are met but have a propensity toward defensive functioning when placed in environments which block these needs: controlling critical or rejecting social contexts. Interestingly abilities such as mindfulness and autonomous functioning are themselves products of receiving early positive care. Lewandowski (2003), Li et al. (2011) and Vansteenkiste and Ryan (2013) all concur that a work environment which acknowledges and actively supports employees' difficulties and autonomous thinking forestalls frustration and boosts satisfaction.

Satisfaction

Satisfaction, developed from a combination of the Latin adjective 'satis' meaning 'enough' and the verb 'factore' meaning 'done or achieved' describes the feeling that one's desires and needs are met in a way that leave no cause for complaint. It is closely linked to a state of happiness, life fullness and wellbeing together with a sense of personal reward (Davern et al. 2007).

The conceptual structure of satisfaction and wellbeing is interesting. Davern et al (2007) investigated the connection between emotion, cognition, personality and satisfaction in two quantitative studies. In the first study a sample of 478 participants between 18 and 72 years old scored themselves on a scale of 0-10 across 31 affective descriptors. The totals for each descriptor were plotted on a circumplex with 2 axes from pleasant to unpleasant and activated to deactivated. In the second study the authors used a combination of three scales and inventories to measure subjective wellbeing, cognition, core affect and personality in 854 respondents aged between 18 and 86 years old. Results from both studies showed affect to be a

dominant construct in the articulation of satisfaction. In particular the first study showed that wellbeing was far more closely related to mood than to arousal. Furthermore 6 core affective descriptors: energized, happy, content, satisfied, stressed and pleased accounted for 64% of the variance in life satisfaction showing a powerful pleasant affect in relation to the construct. This is in opposition to much previous work suggesting that subjective wellbeing is most strongly linked to personality. Interestingly too, Davern and colleagues (2007) found that there was little psychometric separation between satisfaction contentment and happy and concluded that these adjectives could be used interchangeably. Adams and Bond (2000:536) agree with this in their study of satisfaction with employment. They define job satisfaction as “the degree of positive affect towards a job or its components”. The close psychometric positioning of happiness and satisfaction was also confirmed in a group of quantitative studies (Rafaelli and Revelle, 2006), which disputed the bipolarity of happiness and sadness.

Seligman (2002) argues that we must journey through three phases of happiness before achieving genuine satisfaction. In the ‘pleasant life’, one learns to savour experience and reflect positively on our past with a sense of gratitude and forgiveness, accepting people and circumstances for what they are rather than for what we would wish them to be. This mindset empowers a person to develop powerful positive emotions which enable them to look to the future with confidence and optimism. In the ‘good life’, the positive attitude helps one develop core personal qualities and strengths such as wisdom and courage. Seligman argues that virtuous characteristics are more powerful than talents because rather than being developed from what is inherent, they are developed through effort from nothing. Yet the virtuous traits themselves nurture other qualities. For example, senses of humanity and justice thrive on each other. This raft of virtues equips a person to move effectively and positively in the world in a way which brings meaning to others as well as to the person themselves. The individual is then ready to enter the most fulfilling phase: the ‘meaningful life’. Here the individual becomes influential beyond any level of personal reward and gratification they may enjoy as a result; immersing themselves in a project much larger than they are which will reach beyond their lifetime. In doing so the psychological state that has been called “flow” (Csikszentmihalyi, 1999:824) is achieved as the person becomes immersed in a given activity and loses their sense of self. Afterwards reflection on the flow experience yields a sense of fulfilment and wellbeing. The life phases while hierarchical are also interdependent in that the components of each enfranchise

reasoning in the others. Peterson et al. (2005) showed through the use of a questionnaire completed by 845 participants that happiness and satisfaction were not consistent with an empty life but with one full of activity. However the results also suggested that life pursuits related to hedonism and 'meaningful' pursuits were not incompatible with each other. This is consistent with the caution offered by Csikszentmihalyi (1999) to the effect that immersion in autotelic flow through meaningful pursuits has limitations; a person can become so preoccupied with one particular interest so as to deprive him of other sources of satisfaction. Workaholic approaches are an example of this. An additional noteworthy finding in the work of Peterson and colleagues (2005) was that a leaning towards hedonism was higher in the unmarried younger section of the sample supporting Seligman's argument that an appreciation for meaningful activities is developed largely in later life.

If personal life goals are important to wellbeing then so it seems are the reasons for pursuing them. Sheldon et al. (2004) drew on self-determination theory to test the hypothesis that intrinsic and extrinsic factors exercise independent variance to predict wellbeing over and above the influence of autonomous versus control motives. Three studies using a combination of inventory based scales within questionnaires tested the hypothesis that extrinsic versus intrinsic goal contents would contribute independent variance to the prediction of wellbeing over and above the influence of autonomous versus control motives. Sample size ranged from over 800 participants in study 1 to over 200 in studies 2 and 3. Participants' attitudes to hypothetical and self-generated goals were measured along self-reports of current wellbeing. In a third longitudinal study aspirations and commitment at Time 1 were compared with aspirations commitment and health outcomes a year later. The results presented a convincing picture that intrinsic goals and intrinsic motives act independently of each other and personality type to predict wellbeing.

The importance that an individual places on a life role or roles is also significant. Perrone and Civiletto (2004) measured life role salience by participation (the amount of time spent in a particular role), commitment (the importance of a role in an individual's life) and values expectation (the extent to which a person is able to express their values in a role). These indices were placed against 5 life roles: work, study, family and home, community and leisure and integrated within a questionnaire using a 4 point likert scale. Role strain (the distress and negative health outcomes experienced as a result of competing life roles) was measured using the family job role strain scale estimating the levels of stress and emotion regarding multiple life

roles as communicated by the responses of participants to 16 items listed against a 5 point Likert Scale. Coping efficacy was measured using a problem focused style of coping scale in which 18 items were listed against a 5 point Likert Scale. 125 participants completed the questionnaire package. There was no variation between gender in role strain but in participation women invested more time in the family and home. There was no variation for gender in the other roles. Role commitment was the only aspect of role salience which was related to role strain. High role commitment was associated with high role strain. High role strain was linked to low coping efficacy and high coping efficacy was linked to high life satisfaction. So although a high level of role salience for multiple roles can result in role strain and in distress and negative health outcomes, the authors also showed that the feeling that one is coping with multiple life roles increases life satisfaction.

Cortese et al. (2010) found that work family conflict and emotional distress were declared by all 351 respondents to their questionnaire but that job satisfaction was sustained in the presence of these factors when countered by family friendly employment policies, supportive management and supportive colleagues. These arguments sit in opposition to those of Seligman and colleagues who posit implicitly if not explicitly that satisfaction is chiefly a matter of personal resilience taking no account of health and social inequality or circumstance.

Enquiries into job satisfaction among nurses have been conducted both quantitatively and qualitatively. A qualitative interpretative study through the use of 8 focus groups and 8 face-to-face interviews with district nurses in a Scottish Health Board was conducted by Stuart et al. (2007). The personal nature of care, the ongoing relationships with patients and the application of clinical skills and knowledge provided the greatest job satisfaction.

In a review of the literature (Utrainen and Kyngas, 2009), the quality of co-worker and inter-professional relationships together with teamwork were found to be major predictors of satisfaction in the workplace. The quality of patient care being delivered; the belief among nurses that they were doing a good job and tangible visible evidence that this resulted in progress in the wellbeing of patients and their families were strong indicators of satisfaction in practice. The "deep human connection" (2009:1006) developed with patients arising from advocacy and the preservation of personhood and reciprocal gratitude were highly valued. Alternatively, organisational support, sound leadership and investment in nursing staff were identified as the

criteria for job satisfaction among nurses in a quantitative study by Al-Hussami (2008). These findings concur with Shaw and Degazon (2008) who argue that when nurses are able to integrate their personal values with their work related ones, commitment motivation and consequently job satisfaction increase.

Shaw and Degazon's arguments match the findings of research into satisfaction among service users in healthcare. Patients and their relatives have repeatedly been found to value the sense of personal security supplied by the nurse patient relationship as much if not more than positive treatment outcomes alone (Reiman 1986; Attree 2001; Williams, 2001; Berg et al. 2007). In fact positive outcomes have been found to be associated with nurse patient relationships built on mutual respect (Berg et al. 2007). It is also significant that raised frustration among nursing staff (discussed elsewhere) is synonymous with patient dissatisfaction (McHugh et al. 2011).

These themes along with the opportunity for career development have also featured prominently in studies into job satisfaction among paediatric nurses (Wyatt and Harrison, 2010) and adult nursing in the acute hospital setting (Hayes et al. 2010). In mental health nursing Wilson and Crowe (2008) also found a similar value system sustaining job satisfaction but participants' narratives provided a more sophisticated description of the relationship between professional practice and factors impacting on role performance. For these nurses practice was built on a therapeutic relationship comprised of three components: establishing a relationship of trust on which an enabling plan could be negotiated, self awareness of values, skills and prejudices to ensure that the use of the self had a positive rather than a negative impact on practice and the combined use of formal and informal knowledge in clinical decision making. This professional movement was in turn mediated by three variables impacting on role performance. These were first the sense of belonging to an organisation in which one's role was either visibly recognised or where time and energy were squandered, managing internal relationships and seeing off institutional needs rather than needs of patients. Secondly the maintenance of a work life balance kept both professional and personal life roles in check. Finally, team membership in which trustworthy professional relationships produced informal mentoring networks was found to successfully weather favourable and unfavourable times. Such relationships fuelled problem solving. Alternatively team membership could be a negative factor if work place values were not shared or workloads were inequitable.

The maintenance of an equilibrium emerged from this work in which dissatisfaction with role performance could be counterbalanced by satisfaction with therapeutic work and vice versa. Where nurses espouse spiritual values it seems that this augments their job satisfaction. In a study of 120 nurses in an Israeli Hospital, Lazar (2010) found that spiritually minded individuals gleaned greater satisfaction from nursing. These findings appeared to arise from the way the nurses' emotional needs were met and how the transcendent aspect of religious belief helped them cope with the stress of a caring role.

This need for a 'human connection' in our lives would seem to extend into old age and take on special significance there. Trang (2003) argues that healthy ageing is positively linked to immersion in one's human community and that conversely attitudes to the old, dependent on personal experience, are more positive when social exchange between generations is frequent. Hence, intergenerational socialisation is mutually enriching.

Joy

Vaillant (2008) acknowledges that joy is the least studied of all the emotions yet it is one that holds potential for mental wellbeing. Joy has been described as a feeling of suffering removed; the essence of having been freed from captivity; of gaining or having restored to one something that may have been considered out of reach or lost. Joy is closely associated with a long sought after goal come to fruition; the release from anticipation after a sustained effort. The birth of a child and excellent exam results are both examples of such causes for joy (Vaillant, 2008).

Similar causes of joy were found by Gilat and Rosaneau (2012) in a content analysis of the written description of practice success stories by school counsellors and Pooler et al. (2014) in semi-structured interviews with 26 social workers who claimed to find joy in their practice. In both studies the sources of joy were less often final outcomes than significant outcome points which represented breakthroughs sitting within the process of practice. These included promoting change and empowerment, coping with resistance to change, facilitating academic success and unique learning experiences (Gilat and Rosaneau, 2012). For social workers (Pooler et al. 2014) forming relationships with other agencies and clients, having one's point of view valued, seeing the fruits of one's sustained effort, being present with people in times of distress and the contribution of work to life's purpose were all causes for joy.

Pooler et al. (2014) concluded that sources of joy in professional practice should be actively sought to promote mental wellbeing and protect practitioners from burnout. These claims are given additional merit by Astor et al. (2013) who used psychological measures of skin conductance and heart rate to assess the reactions of 78 subjects while they took part in a series of online first price sealed bid auctions. The findings showed a stronger response to winning than to losing with the experience of winning being processed more intensely. The higher the price of the item for sale the more intense was the experience of winning and losing. The authors make the distinction between the anticipated joy of winning and the joy of winning as it is immediately experienced. The identification of frustration in relation to joy as an alternative outcome to prolonged ambitious effort is peculiar to the context of Astor et al.'s study (2013) i.e. a bidding situation. In other settings such as nursing practice the impact of other variables such as a personal knowledge of the patient and family may mean that a range of other emotions such as sadness and anger may also come into play in the advent of loss.

This concept of joy as a reward for effort has also found support in neuroscience studies. Kawamichi et al. (2013) whose work with the empathic joy hypothesis has been discussed earlier in relation to empathy provide examples of how the urge to help another provides joy in the realisation that one's needs have been met. This was demonstrated by fMRI patterns which showed activity representative of positive feelings in the dorsal striatum upon both anticipation and realisation of the subject of one's efforts being helped.

Sadness

Sadness is an affective state associated with feelings of loss, sorrow and regret in the face of an event with no blameworthy target (Rivers et al. 2007). Sadness is the resultant emotion from a fruitless search for a source of accountability aimed at righting a wrong. Rochman and Diamond (2008:96) describe the experience of "unfinished business": a stage of pointless anger and bitterness. During this phase sadness is a remedial but inaccessible state for the person. At the point at which sadness is accessed, the physiological and cognitive process is decelerated permitting a recovery period when support can be sought (Rivers et al. 2007).

The view that sadness is a powerless state lacking agency (Fischer, 1993; Tiedens et al. 2000; Tiedens, 2001) has recently been challenged (Bower, 2013; Zawadzki et

al. 2012). In a review of the literature, Bower (2013) confirms the role of sadness as a necessary and beneficial affective retreat in the aftermath of loss. Sadness was only damaging to judgement and wellbeing when it stretched beyond the background feeling of a few days or became more frequent to more closely resemble a longer term depressed disposition. Sadness seems to carry social benefits in that people in a sad mood were found to act with greater fairness and give greater attention to detail. Zawadzki et al. (2012) also demonstrated in a series of studies that sadness in a controlled state was a valuable resource which contributed to emotional competence and labour. Participants were repeatedly perceived as more competent when displaying managed authentic sadness in situations both related and unrelated to the emotion provoking event. This would explain why both Bower (2013) and Zawadzki et al. (2012) found that resourcing present sadness and remembering past sadness states fuelled empathy.

The position of sadness on the affective spectrum has also been revisited and clarified. Rafaeli and Revelle (2006) demonstrated in a series of studies using a motivational states questionnaire on 182 participants that a previously held consensus that sadness was the affective opposite of happiness was premature and ill-informed. On a circumplex graph sadness was not shown to be related to happiness in the way that has been suggested in the past. Sadness was found to sit in its own affective dimension of activity and inactivity at a distance of 120 degrees from happiness. Changes in happy and sad states were not always reciprocal. Indeed happiness and sadness could be experienced simultaneously.

There are some gender differences in the way sadness is managed. Women are more likely to express their sadness than men who are more likely to conceal it. However women struggle to regulate their sadness through rumination while men are more successful at regulating sadness through rumination (Rivers et al. 2007). Rivers et al. (2007) also found that sadness was commonly regulated by verbal emotional expression and seeking more information about the source of the emotion. Unlike frustration the tendency to indulge in compensatory risk taking behaviour or hedonism is uneven. In a series of behavioural studies, Salerno et al. (2014) found that sadness promoted hedonistic indulgence (for example drinking or eating more) only when the hedonistic goal preceded the sadness experience. When the sadness was not preceded by a hedonistic goal, this resulted in concentration on the feeling of loss and the desire to prevent further loss by resisting indulgence. However when the hedonistic goal was perceived to be harmless then sadness did not preclude

indulgence. Salerno et al. (2014) also acknowledged that as with other affective states social competence and the ability to cognitively appraise an emotive situation in advance reduces the subjective and physiological experience of an emotion.

Conclusion

In this chapter an examination of the extant literature on the ten core themes arising from the data collection has produced an interesting contemporary evidence base with which to compare complement and contrast the theory arising from this research.

First it seems that each emotion has its own conceptual structure and character traits. Second, these structures and character traits influence human physiology, cognition, behaviours and pathology in a range of different ways. Third, none of these emotions has a purely negative impact on ontology but each has potential to benefit judgement. Fourth, there is substantial body of evidence relating to the roots of some emotions in professional practice but a paucity of work in others. Finally there is no evidence as to any commonality of emotions across practice far less any potential for their use.

This knowledge of emotion structure and character profiles informs the examination of emotion patterns experienced within a community of practice. In the following chapter, the practitioner centred perspective housed by this work on emotion will serve to determine how emotions find value and purpose in professional movement.

Chapter Five

The Emotion Map of Nursing Life

Introduction

This chapter contains the data analysis arising from the first phase of data collection. In the course of data analysis, a pyramid hierarchy of meaning emerged consisting of 19 main categories and 18 clusters of 110 subcategories parenting a further 46 subthemes. Within the 46 subthemes a further 9 variations on meaning were isolated.

There were ten categories relating directly to emotion. Three categories related to the dynamics of generalised emotion. These themes were: emotional intelligence describing the use of emotion as part of good practice, emotional labour, the management of emotion for practice, and emotional impact describing overall weight of practice on emotional wellbeing. Seven further categories representative of emotions (fear, anxiety, anger, frustration, satisfaction, joy and sadness) were also identified. The findings of the literature search pertaining to the identified themes were integrated into the allied discussion.

Formation of Themes and Theme Clusters

In line with the interview question the focus of the analysis was the emotions experienced and the root causes of these emotions. A sample of coded transcript is provided in appendix five. Consistent with a position of situated cognition, a discussion of emotions essentially mirrored how these emotions were experienced and expressed. In addition, the data reflected Damassio's arguments (1999) on the cascading and escalating dynamic of emotions. This dynamic was exposed in the following way. Nurses talked progressively through experiences of anger, frustration, fear, anxiety, satisfaction, joy and sadness speaking simultaneously about the causes of these emotions. The prominence of these seven emotions justified their foregrounding in the data analysis. Integral to this, some relationships between emotions often showed themselves as reversible. Consequently, while certain emotions appeared as core themes in some contexts the same emotions would sometimes correspondingly present elsewhere in other contexts as subthemes to emotions identified as core themes. In this respect decisions were taken as to core

and subtheme status depending on which emotion acted as the inducer and which emotion was secondary to an emotion or (in the case of emotional labour) an emotion tool.

For example, sadness was spoken of as part of emotional labour through the use and control of a sad personal presentation to show empathy with patients and families but it was clearly experienced as an emotion in practice separate from any emotional engineering. 'Regulating sadness' was therefore a subtheme of sadness when nurses spoke of feeling sad in relation to an experience but it also featured as part of the subtheme landscape of emotional labour ('managing conflict'). In 'regulating sadness' the emphasis was not on management but on seeking some type of private restoration such as discussion with friends and colleagues. These separate ways of using and controlling sadness are consistent with the psychology literature (Rivers et al. 2007). This same principle applies to how anger featured in the data. When anger was the focus of a passage of narrative along with its root causes in practice, anger was taken as a core theme. Anger also featured as an emotion which had to be regulated as part of emotional labour. In the latter case emotional labour was the core theme. Subthemes were also formed at the distal end of theme clusters to reflect related characteristics or other further variations in meaning. For example many nursing texts relating to the core theme 'satisfaction' focused on the 'power to do good' which formed a subtheme to 'satisfaction'. Within the narratives relevant to 'power to do good' were some espousing spirituality including one pertaining to Christian belief. This formed a subtheme to 'power to do good'. However spirituality is a broad multifaceted concept linked to purpose and life meaning (Lazar, 2010). In view of this, the importance attached by one nurse to a good name that outlived her justified a further variation in meaning to spirituality. In addition a number of nurses referred to their personal work ethic. So both 'a good name' and 'work ethic' became subthemes to 'spirituality'. This is in keeping with Corben and Strauss's (1990) metaphor of grounded theory as rich tapestry of meaning incorporating many different shades and textures. It is also in keeping with the value placed by Colliazi (1978) on evidencing variance within qualitative data.

With the progression of each narrative a character profile for each emotion including a distinction between structure and behavioural process became evident. Each emotion spawned different sets of attitudes behaviours and not infrequently, skills. The talk exposed how emotions interacted with other emotions to produce positive and negative mental states along with corresponding enhanced or diminished skills.

Captions representing oft spoken phrases were added to the title of themes and subthemes where this helped to capture the essence of meaning. For example 'let us do our job!' was added to 'Restrains on practice'; a subtheme of 'practice undermined' in the frustration theme cluster.

'Frustration' described a feeling of stemmed progress despite best expertise and effort. 'Frustration' was referred to as producing anxiety, anger, and disappointment in a powerful combination which impacted progressively across a wide range of episodes on self esteem, thinking, autonomous practice and wellbeing. Frustration arose from having to delay plans for care and care management ('best laid plans') to address unanticipated obstacles to practice. This resulted in incumbent work being postponed increasing the workload planned for future shift teams ('workload drift'). 'Workload drift' resulted in nurses reaching the point of exhaustion earlier in a working week than would otherwise have been expected ('accelerated exhaustion') and a consequent increase in task orientation ('non reflective behaviour'). These factors caused a strain on relationships with colleagues and service users ('working relationship downturn'). 'Best laid plans' led to a feeling of loss of control over one's professional movement ('loss of autonomy'). Two further sub-themed characteristics of best laid plans were an extreme feeling of debilitation or 'emotional burn out' and a feeling of unwillingness to continue practicing or 'giving up'. Consequently these states are designated as subthemes to 'best laid plans' (see table 5.8. on page 161). The relationship between the states represented here as subthemes to 'best laid plans' is a separate issue. A wide range of data segments showed frustration interacting with the subject of these subthemes and other emotions with negative results. This 'toxic vortex effect' showed the ability of frustration to generate or 'draw in' other emotions such as anger, anxiety and distress. In recognition of this, a toxic depressive process within which these subthemes interact in a cascading sequence is illustrated as a vortex in figure 5.4. 'Workload drift', 'accelerated exhaustion', 'non reflective behaviour', 'working relationship downturn', 'loss of autonomy', 'emotional burn out' and 'giving up' are examples of selective coding pointing to evidence of a downward spiralling toxic vortex effect. This 'chain reaction' beginning with 'best laid plans' seemed to exert a 'domino effect' on other affects and behaviours. Additional evidence for this relationship between subthemes was observable in references to more than one subtheme within a piece of data. For example, while speaking of 'accelerated exhaustion' a nurse blamed 'not getting things done' on the previous day and 'having to catch up' [see page 172]. This is evidence of 'workload drift'.

Elsewhere in the data [Figure 5.3 (page 155) and page 156 under 'anger as a tipping point'], consistent with the messages in the frustration theme cluster, frustration is spoken of as a precursor to anger. While the constituent detail in this study is greater, the destructive effect of frustration leading to exhaustion, depersonalisation and burnout has been described in the literature (Maslach et al. 2001; Lewandowski, 2003).

Apart from this, the character profile of frustration included relationships with expectations, the ability to steal time from core nursing purposes and undermine practice. So the 'toxic vortex' effect which began with 'best laid plans' and progressed towards 'burn out' and despair or 'giving up' was a theme that was distinct from 'expectations', 'stolen nursing time' and 'practice undermined'. Nurses spoke of how their high expectations were non negotiable. As they did so they showed they understood that, given the challenges to practice, frustration was likely to feature strongly in their working day. So the theme of 'expectations' highlighted the ethical 'process driven' nature of nursing within which lowering expectations was an anathema and made nurses susceptible to frustration. Participants also spoke of frustration linked to time spent on work outside the remit of nursing practice or "stolen nursing time". The consequential resentment and feelings of unfairness made "a sense of injustice" a subsidiary theme to "stolen nursing time". Nurses also talked about the way deficits in the care process caused by 'stolen nursing time' adversely impacted on the quality of practice in the eyes of managers and the public. This made 'misplaced blame' a second subsidiary theme to 'stolen nursing time'. Much of the talk about frustration centred on how participants experienced frustration because they believed good practice was being undermined. This justified 'practice undermined' as the fourth subtheme to frustration. Nurses spoke of managers who did not listen to their concerns until it was too late and tended to patronise their expertise. This made 'non listening management' a subtheme to 'practice undermined'. The discussion on managers who did not listen did not stop here. Nurses also spoke about how this managerial approach left them feeling undervalued. So 'feeling undervalued' became a subtheme to 'non listening management'. Frustration was also mentioned in connection with the way the petty or insensitive behaviour of some colleagues proved a hindrance to care. This showed 'colleagues behaving badly' as a second subtheme to 'practice undermined'. Formal scientific and largely quantitative measures of practice were at the centre of much frustration. Nurses repeatedly pointed to the inadequacy of such measures and to how the requirements they inherently instilled actually skewed the purpose of

practice. So 'system-reality incompatibility' became the third subtheme to 'practice undermined'. In this subject area there was a distinction between systems which inadequately measured practice and systems (for example contractual commissioning agreements) which restrain how much practitioner expertise can be used. This fourth subtheme to 'practice undermined' was called 'restraints on practice'. Nursing frustration over patients' deteriorating conditions which defied best efforts to promote recovery featured in relation to 'practice undermined' under the subtheme 'patient condition'

Just as anxiety and fear are often discussed together in the literature (Orsini et al. 2011; Sylvers et al. 2011; Meeton et al. 2012; Sauerhofer et al. 2012) so nurses often discussed both of these emotions within the same segments of narrative. This was reflected in theme formation and in the combined nature of the discussion within the analysis section. Participants' narrative also betrayed (although not always consciously) the distinction between anxiety and fear. Fear presented as an emotion focused on a clear and present danger with many nurses describing their experience of the 'flight or fight' physiology. So 'fight or flight' and 'present time related' formed characteristic subthemes of fear. A perceived 'healthy' form of fear was found within the data relating to accountability which nurses believed caused them to be more vigilant. This was a third subtheme of fear: 'protection against complacency'.

Anxiety showed itself to be a more complex emotional concept than fear in that it could be experienced across a continuum in response to different degrees of urgency in different situations. At the less acute end of the continuum the words 'anxiety', 'worry' and 'concern' were used interchangeably. Nurses were able to compare and contrast anxiety level states; preoccupation and awareness over accountability for daily management as apposed to higher levels of anticipatory unease such as concern in the face of clinical warning signals and anxiety in response to a rapidly deteriorating situation. Panic was discussed as a point of realisation at the end of a period of anxiety. This continuum was one characteristic of anxiety but there were also others discernible within the data. Nurses also spoke of the need for perpetual watchfulness or 'hyper-vigilance' that issued from the anxiety experience. So 'hyper-vigilance' was placed as a subtheme of anxiety. In turn nurses talked about how hyper-vigilance fuelled perpetual planning for numerous possible outcomes in the face of uncertainty. This 'catastrophising' is discussed by Meeton et al. (2012) and formed a subtheme of 'hypervigilance'. Anxiety was sometimes discussed with particular reference to future repercussions of possible past errors. This involved the

nurse revisiting recent practice in her mind and was sub-themed 'anxiety with hindsight'. Nurses also talked about a mental preoccupation with future possibilities related to an issue they 'held in their head'. As a subtheme of anxiety this was called 'concern' because of the way mental commitment was required of the nurse. Again this bore semblance with the literature (Benner and Wrubel, 1989). Just as fear was sometimes seen as a protection against complacency causing diligent action in the present so anxiety was spoken of as relating to future consequences of current possible practice deficits. Fear spurred reflection in action to ensure accountability. Anxiety spurred proactive behaviour to ensure accountability. They were discussed together to afford this comparison.

Panic was also discussed 'as characterising the moment' when someone speaks of being afraid of experiencing a sudden event. So panic was related both to fear in the present time frame and to an endpoint of anxiety when the present merges with the past. Therefore panic was a background theme to both fear and anxiety theme clusters as it was related to both.

This 'overlap' of meaning was consistent with current arguments in the literature (Orsini et al. 2011; Sylvers et al. 2011) that while anxiety and fear share some neural pathways they are also neurologically distinct from each other in a number of ways.

Anger qualified as a core theme because it frequented participant texts provoked by a range of factors in practice. Nurses' description of anger supported the psychological profile constructed by Rivers et al. (2007) in addition to the physiological and behavioural profiles provided by Denson (2012). Anger was experienced as an explosive arousal state following contemplation or rumination on various sources of anger which could not be regulated by endurance [figure 5.3].

One characteristic which attracted discussion was the tipping point of exasperation at the end point of endurance. So this became sub-themed 'tipping point'. In addition nurses believed that anger had a number of different sources. Some nurses talked about anger arising from injustice and so 'anger from injustice' formed the second anger subtheme. It was noted in the data pertinent to anger from injustice that the emotion was often harboured on behalf of others particularly when health or social policy was involved. This revealed a significant characteristic of this subtheme which was called 'anger by proxy' and formed a further variation on meaning of 'anger from injustice'. Some nurses talked about the anger of having one's trust betrayed and this

led to anger with self for having been deceived. So 'anger with self' was a further variation on meaning on 'anger from betrayal'. There was also talk of anger resulting from the lack of consideration given by service users to nurses' own predicament and this formed a subtheme called 'anger from denied empathy'. A fifth subtheme to anger, 'anger displaced', was formed out of texts describing anger which was aimed at individuals who were not the true source of blame in a situation.

All participants without exception talked at length about the depth of satisfaction they derived from nursing. The core theme was related chiefly to the sense of fulfilment provided by achieving positive outcomes via the nurse patient relationship (Hayes et al. 2010). Some nurses talked in simple terms about the satisfaction that came with completing small parts of patient care and this formed the subtheme 'end focused' because of the frequent use of the expression 'getting things done'. A further variation of meaning on this was successful steps which were small in proportion to the overall goal or challenge. This was called 'success in context'. A range of other uplifting feelings formed subthemes to satisfaction. Nurses spoke of the 'excitement' partnering the satisfaction of success along with the feeling of autonomous practice or being 'in control'. The feeling of being 'valued and respected' by others also partnered from satisfaction. Closely allied to this were comments about how positive feedback from patients and their families or 'service user gratitude' contributed to feeling 'valued and respected' and so this was a further variation on the meaning of this subtheme. The contribution of feeling 'valued and respected' to general 'self esteem' made the latter a second subtheme to 'valued and respected'. A surprising amount of time was spent by many nurses talking about the feeling of 'smugness' or 'vindication' that comes with having one's judgement proved right in the face of doubting others at an earlier stage. This justified 'vindication' as a further variation on 'self esteem'. Sample members also spoke of the satisfaction that comes from being part of a coordinated team effort making 'teamwork' a fourth subtheme. Issuing from the satisfaction of 'teamwork' was the appreciation of 'peer support' and the cheer provided by 'camaraderie'. The subtheme 'power to do good' and variations on this have been discussed earlier. The sixth subtheme captured the notion of satisfaction as an uplifting process or 'spiral', which aligns with the work of Vansteenkiste and Ryan (2013). Nursing texts showed how the initial feeling of success fuelled by supportive work settings and intervening episodes of positive feedback promoted wellbeing and resilience.

Joy was one of the smallest core themes but the way in which it was repeatedly referred to separately in the data indicates earned foregrounding status. The character of joy as good news arising out of uncertainty is supported in the literature (Vaillant, 2008) and the experience of joy in nursing practice was similar to studies in other professional disciplines (Gilat and Rosaneau, 2012; Pooler et al. 2014.). Joy was experienced following a successful operation in theatre or a small 'gain' in the progress of care of a person with a long term illness. Separate to this, intensive care nurses spoke of the 'joy of keeping busy'. This was related to the 'rush' experienced when a hectic period of practice ended a quiet shift which seemed to 'drag'.

At times the focus of discourse was not any specific emotion per se but emotion as a broad concept in terms of how it was apprehended. There were three core themes formed in this area: emotional labour, emotional impact and emotional intelligence.

Emotional labour (EL) emerged as a core theme when the talk was on the resourcing and managing of emotions as part of the skilled use of the therapeutic self. Here there was some alignment but also some variance with Mazhindu (2003). Subthemes reflected the way participants talked about how EL was applied, managed or compromised. Examples of EL application included 'regulation for clinical judgement' referring specifically to the contribution of emotional labour to assessment and decision-making. Distinct from this, 'complete engagement' referred to the mindfulness of the nurse that he or she was affecting an optimum clinical performance amid an emotionally charged environment. The participants laid store by not being overcome by the emotions of others or what Zembylas (2005:95) calls "emotional contagion." Nurses spoke of 'ownership' of emotions by others as if sharing overzealously in those emotions constituted some form of trespass. This subtheme was called 'resisting emotional contagion' and this was believed to help sustain a sound use of self. Narratives also evidenced nurses maintaining a calm therapeutic exterior in one situation while knowing that their clinical priorities lay elsewhere. This was sub-themed as 'managing internal conflict'.

It also seems that for these nurses there were points at which emotional labour could no longer be sustained at an optimum level. One cause of this was being denied rest, food or hydration by the perpetual pace of work and this resulted in mood swings including irritability. This emotional labour subtheme was called "lack of sustenance and mood alteration". Allied to this was another subtheme in which nurses described moments when emotional labour could no longer be sustained. This was not

necessarily in the shape of an explosive loss of temper but indicated a faltering of the use of self. This subtheme was called “emotional overload” because it described how the real personal feelings of the nurse ‘spilled over’ to taint professional practice. Alternatively nurses often spoke of the need for personal respite from emotional labour and discussed a range of ways they had devised to recover from the emotional taxation of the working day. This sub theme was called ‘recovery’.

While ‘emotional labour’ involved the resourcing and management of emotion, elsewhere in the data the emphasis of the talk was on the chaotic impact of complex emotions on nurses’ ability to regulate emotional compoment. These narratives were often characterised by the emotional price of caring, conflict and hurtfulness. This was called ‘emotional impact’. A number of types of emotional impact were described. For example, children’s nurses spoke at length about the stressful experience of being constantly watched, monitored and questioned by parents. This subtheme of emotional impact was named after the simile used by the nurses themselves: ‘being on stage’. In other places nurses talked about conflict between two opposing emotions because of a conflict of values at work in an experience. This formed a second subtheme called ‘ambivalence’. Some sections of narrative also related tragic experiences in which emotional pain in the self or others was too deep to countenance. At times this state would fragment or paralyse professional as well as personal function. This subtheme was called ‘traumatised’. Nurses also spoke about the experience of being ‘upset’. This described a feeling of emotional turmoil or disturbed composure arising from perceived injustice or imposed arrangement divorced from common sense. ‘Upset’ was a separate subtheme distinct from ‘traumatised’ because being ‘upset’ challenged coping and ‘traumatised’ disabled it. A fifth subtheme of ‘emotional impact’, ‘emotional cascade’ confirmed Damassio’s argument (1999) on the ability of one emotion to surface another in a chain or cascade which could positively or negatively affect wellbeing. The ‘cascade feature’ emotion dynamic and ontology had implications across the whole data transcript but this subtheme concerned the nurses’ awareness of its existence. Within this part of the narrative nurses talked correspondingly about their ability to consciously reverse or arrest the direction of a mood. This was called ‘emotional cascade arrested’ and formed a subtheme of ‘emotional cascade’. Where ‘emotional cascade’ concerned the chain of emotions issuing from one situation, participants also referred to how emotions quickly fluctuate in response to a range of situations in the course of a day. This was called ‘emotional rollercoaster’. The final subtheme of ‘emotional impact’ was related to the ‘relief’ that came with the end of a period of prolonged emotional

stress. This was sometimes mentioned in connection with the end of an arduous shift or even when death ended a patient's suffering.

Beyond talk of emotional labour and emotional impact there was a broader discussion around the skills and tools involved in navigating a personal path in practice. This social competence or emotional intelligence (Goleman, 1995) was another main theme. Nurses betrayed their interpersonal and intrapersonal skills of being, knowing and doing. At an early stage in interview a number of nurses expressed their discomfort in discussing their emotions or disclosed the discovery of their emotions as a new experience. This 'pre-reflective emotional state' was the first subtheme to emotional intelligence. Nurses also talked about compassion expressed toward patients and their families and this was characterised by a desire to make things better. So 'compassion "wanting to make things better"' was the second subtheme to emotional intelligence because of the intention to reach out toward others. However feelings of compassion were often coupled with an acknowledgement of helplessness; a limit on or an inability to make a difference to the suffering of patients and families. So 'with helplessness' became a subtheme to 'compassion'. In the context of interpersonal skill empathy was referred to as a means of understanding the perspective of another person and this became a third subtheme to emotional intelligence. In the course of talking about empathy nurses referred to some case histories and revealed the ability to simultaneously express empathy for more than one person. This subtheme to empathy was called 'plural empathy'. Nurses' talk also showed that knowledge of a patient's life history facilitated empathy and this was sub-themed as 'biographical empathy'. The data also revealed an ability in nursing to draw on ones own life experience to develop an 'emotional kinship' which fortified empathy and informed practice. This was sub-themed as 'life experience'. The narrative on empathy was punctuated with descriptions of skills which nurses deployed to achieve empathy. These skills seemed to form a systematic process and so 'as a process' was the final empathy subtheme. The constituent skills of empathy as a process: engagement, listening and echoing, have factual knowledge of another's circumstances ('cognitive'), imagining ownership of another's circumstances and fellow feeling or affective empathy all formed subthemes of 'empathy as a process'. Engagement was characterised by 'giving a bit of yourself' and 'making yourself approachable'. 'Listening and echoing' captured the nurse working with the patient to check the accuracy of her understanding. 'Imagining' highlighted the importance of mental representation of a patient's perspective in the nurse's mind (Scott, 2000). Whenever nurses struggled to achieve empathy the term 'I can't imagine' was invariably used in discussion and so

this formed a subtheme of 'imagining'. 'Imagining' leads to affective empathy. Affective empathy was found to have 2 distinct properties categorised as subthemes: 'informs practice' relating to the way empathy helps the nurse tailor patient care and 'libidinal' describing the way in which empathy motivates person centred care.

Notwithstanding this shape of presentation in the talk, the data is not concerned solely with seven emotions. Other emotions such as the awkwardness experienced by junior children's nurses practicing in the presence of parents ('being on stage') and despair (or 'giving up') experienced by nurses distal to repeated waves of frustration also featured significantly. Disappointment also featured as a part of a downward spiralling cascade of emotions. However 'being on stage' was one form of emotional impact and despair was mentioned as a derivative of frustration. This indicates that those emotions are subthemes of emotional impact and frustration respectively and not the other way around.

At macroscopic level, a picture emerged [figure 6.3] of the seven core emotions 'suspended' or 'controlled' in a 'net' of emotional labour under an umbrella of emotional intelligence. A range of work pressures cited in the data exerted a pressure on this 'net' creating a tension between nurses' ability to practice in an emotionally intelligent way and the potential for dysfunction.

Participant Representation in the Data

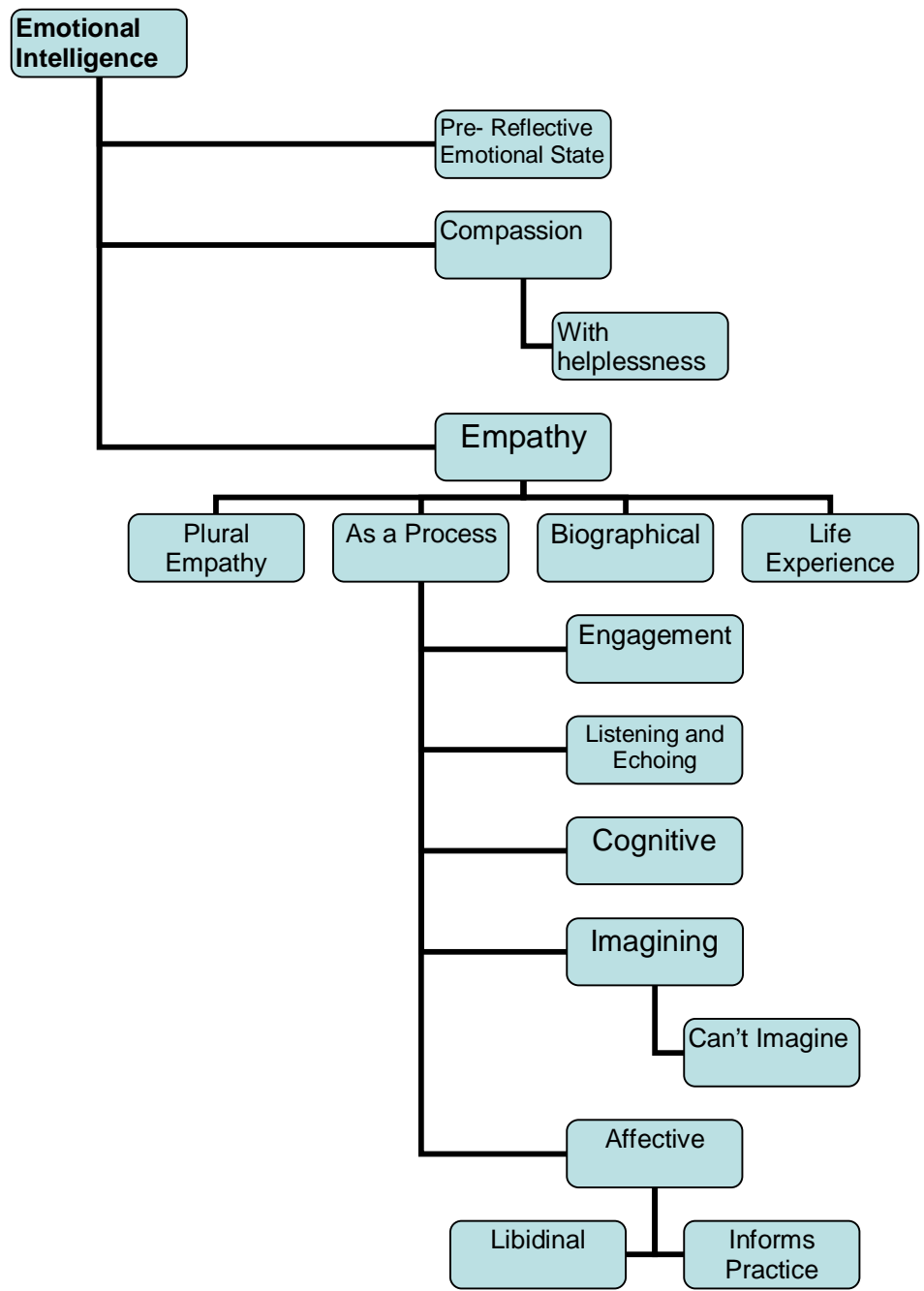
The interviews lasted between 25 and 75 minutes with an average length of 45 minutes. The length of individual interviews, the personality of each participant, whether they were shy or outspoken, together with their personal circumstances at the time (for example tiredness and hunger) and their ability to articulately express their values beliefs and feelings can all be expected to impact on the richness of the data provided. This in turn can be expected to influence the extent to which the data of any one participant is sampled.

Emotional Intelligence [see Table 5.1]

The definition of what one nurse close to retirement calls 'instinct' matches Goleman's definition (1995) of emotional intelligence.

I think that when you are talking though about instinct, and emotion in that I think that is through life's experiences of sensing when things aren't right .. anger in somebody else, or sensing an emotion in somebody else. I think that has certainly developed with experience. I can certainly pick up very quickly if somebody is saying one thing but their body language and their eyes might be telling you something completely different DN1 (56-61)

Table 5.1: Emotional Intelligence Theme Cluster



As the nurse continues to talk at length on this subject her own self awareness and reflexive ability become apparent.

I am sensitive to other people and I think to be able to do that you have to be open if you like to listening and feeling what other people are feeling. 'cause I know, I've often been aware if I've got a lot on in my personal life I can't do that as well, because I'm distracted. You have to be able to be open and receiving and that's when you can get a true sense of what the other person is feeling. Yeah, and I mean you have to be able to read a person's face, the body language, what they are saying, what they are doing but you yourself have to be open to that and have an open mind and a clarity in your mind to be able to feel that.... I think, I suppose, maybe it's, maybe it is just that, being just that type of person. Because if I think of the people who I feel aren't particularly caring nurses it's because I think they are quite hard people, quite insensitive people. So that they are not actually, they are not even opening their mind to the patient that they are with. They are you know, yes they are doing their job and dealing with the task in hand but they are not actually being open to people and what they are actually saying and telling each other. DN1 (81-97)

The nurse offers a glimpse of her self awareness at work when she talks about how 'a lot going on in her personal life' can compromise her sensitivity to the needs of others (Eckroth- Bucher, 2010). Her point on the essence of caring and non-caring is at the heart of emotional intelligence and its use in nursing. The nurse draws a distinction between the epistemology of nursing and its tasks; between the technical and human skills of practice and the art of resourcing these appropriately in the right place and the right time (Malloch, 2000; McQueen, 2004).

Nurses across the full range of practice settings talked about how they used emotional intelligence to enhance the care they gave to patients and their families. It was noteworthy that health visitors were sensitive to the lone nature of their practice in the home and the privileged position they hold to practice in such a private setting. An awareness of this led to an appropriate use of emotional intelligence; particularly in the area of safeguarding children.

Sometimes they're (*the parents*) not honest with information but you've got the information from other agencies to say this is the case., then again you give them benefit of doubt you're a new person. They've only just seen you and won't divulge all information without actually knowing you so you give them room to know you better; be comfortable with you before they tell you. That's the emotion part of it. HVSN1 (159-163)

The skill that the health visitor refers to as "emotional part of it" involves the putting on hold of case foreknowledge from previous records and professional liaison while a mutual knowledge by acquaintance develops out of a growing therapeutic relationship (Goding and Cain, 1999). The health visitor is aware that premature disclosure of foreknowledge may derail her fledgling relationship with the family in question so she gives them "room to know her better". This too is emotional intelligence.

In mental health nursing, active emotional intelligence is described by a nurse consultant when talking about a recent session with a patient who self harms.

He is somebody that often says he doesn't like to talk about how he feels, or talk about things, so you can open up things a little bit but then you haven't got to push him too far because that can become too difficult for him. I didn't pursue too much about what all the sadness was about because he started to block off his face and kind of close down a little bit and didn't want to give me, you know non verbally that he didn't want to persist with it so we only stuck with it for a few minutes and then he kind of, I suppose composed himself and wasn't tearful anymore. He then started talking about related things and other things that were important, it wasn't like an avoidance, but it was taking it down a level is what I would say. My emotions in amongst all of that were just to try and keep things calm and on an even keel and to try and I suppose support him but at the same time, challenge him slightly about the way he was thinking and certainly about the way that he behaves sometimes. MH2 (221-235)

Note the way the nurse is aware of her own ability to use strategies to draw out her patient but her knowledge of the man involved as one who "doesn't like to talk about how he feels" is the check on those strategies. The nurse takes note of the patient's

body language as he 'blocks off his face' and when the patient resumes talking, she implicitly works within the tacit boundaries he has set.

The nurse knows that to 'push him' further would be to risk damaging the fragile relationship of trust she has with him. This is the embodied listening and engagement referred to by Stickleby and Freshwater (2006). The nurse's comments as to her 'emotions in amongst all of that were to try to keep things calm' reveal the close relationship between cognitive and affective understanding as argued by Scott (2000). Indeed people often talk about how they 'feel' rather than 'think' they should do something. The role of emotion as a rudder for judgement in the social domain (Immordino and Damasio, 2007) is clear from the way in reference to a tense situation she describes her "emotions" rather than her thoughts as lending sensitivity to her professional movement.

While Eckroth-Bucher (2010) argues for self awareness as a tool for addressing the influences of cultural and personal bias on practice, in other situations such awareness leads the nurse to withdraw from clinical settings in which his or her prejudices cannot be suspended. Note the comments of a mental health nurse who has elected to work only with female patients with a personality disorder.

there is that sense of that, I felt it a lot more strongly with the men particularly when, like I say I became a father, which is why I don't work with the men anymore, one of the main reasons why I left the males to work with the females because I have generally got more time for them, because I don't, for the reasons I just said, because I genuinely see the females as victims and the males as perpetrators, but that is a different story in itself, but I think it comes from being a dad.

So the males, have they not come from backgrounds of abuse themselves?

Of course they do which is my prejudice.

So you are declaring that?

Absolutely. MH3 (313-324)

The nurse is aware that his change of life role in becoming a father to two young girls makes it too difficult for him to maintain unconditional positive regard in relation to male patients with personality disorders who have abused young girls. The nurse acknowledges the prejudice instilled by his role as a father to girls and accepts that many men with personality disorders have also been victims. However he feels the need to declare his prejudice and work in another area to practice effectively and non-judgementally.

Pre- reflective emotional state.

It was noteworthy how many nurses did not recognise the emotions they experienced in practice or the role of those emotions prior to reflecting on them. I have called this 'pre-reflective emotional state'. This describes the perception of the nurse at a point prior to exploring the emotions that accompanied practice. Mezirow (2003) has argued for the importance of de-compartmentalising of experience in bringing our emotions and their meaning to surface consciousness en route to an emancipated or enlightened learning state. However, Mazhindu (2003) points to the history in nursing of habitually suppressing emotions and suggests that reflection on practice can prove a disabling process. She argues that the socially constructed ideal nurse to whom nurses aspire is prohibitive to effective reflection.

At different stages in their narratives different nurses showed themselves at different points in the process of de-compartmentalisation. Some showed themselves completely unaware of the emotions they experienced or any role they might play in their working day. One school nurse saw her practice as divorced from emotion yet it was clear that she did experience emotion in her practice.

When you talk about emotions, I don't like to think I've got strong emotions at work. It's not the place to have emotions, although they are there, I don't think I'm tuned into them to be honest. HVSN5 (485-487)

It is interesting in view of Mazhindu's work on suppressed emotion in nursing (2003) that the nurse does not believe emotions to be appropriate in practice. She acknowledges the *presence* of emotions but does not seem to appreciate their value or not "being tuned into them". A health visitor whose narrative revealed a range of core emotions expressed a similar lack of awareness but acknowledged the role of 'tuning in' to them.

And I think that's why I probably struggle to explore what emotions I experience because I don't really think about them to be honest.
HVSN3 (155-156)

For one ward sister the opportunity to discuss her emotions awakened a realisation her emotions were compartmentalised.

It is something I haven't thought about, emotions, I haven't thought about it in those terms you know that is that emotion and it is making me feel this, there must be millions of emotions I feel. AU4 (5-7)

This latter nurse's comments that while declaring a lack of forethought in recognising her emotions there is a suggestion of a willingness to explore them. Mazhindu's argument (2003) about the need to reflect on emotions is also borne out by a nurse's expressed surprise toward the end of her interview.

God, I do feel angry at work, I didn't think I felt that angry at work I thought I was quite happy. I think it is just I remember the things that piss me off more than the other things that don't. PD8 (825-830)

It may seem surprising that such powerful forces as emotions should not appear obvious to the conscious being until we remember that usually it is thought processes which preoccupy us and not the emotions which guide those processes (Damassio, 1999).

Compassion – “wanting to make it better”

Gilbert and Choden's definition of compassion (2013) as a libidinal entity sensitive to the misfortunes of others was borne out in many nursing narratives. A mental health nurse recalls a young patient he nursed as a novice.

..he was only sixteen, and he was having florid hallucinations and he was, I was the only, one of the only people he trusted, I was a bit older than him, but when I used to work nights he used to ask me to sit on the end of his bed because he trusted me and he could get a good nights sleep if I was sat at the end of his bed for a few hours. He said to me, he said you are the only person who sits down and talks to me....I felt

this lad's got nothing and if I could sit on the end of his bed for an hour and give him a good nights sleep then I have done a good job there.
MH3 (691-698)

Chan and Mak's view (2012) of a nurse's acceptance of a patient's story regardless of its delusional features constituting a basis for trust finds credence in this narrative. The young patient's "florid hallucinations" are the source of his fear. His fear is therefore not founded on any reality except his own. He trusts the nurse because the nurse has accepted the patient's experience as reality. So the patient's request for the nurse to "sit at the end of his bed for an hour" is reasonable to both parties. The story confirms the findings of Shattell et al. (2007) whose mentally ill participants highly prized compassion along with personal warmth in their nurses. The nursing knowledge of this young patient combined with the nature of the patient's request are the stimulants of the nurse's compassion. These are the intra-relational elements of compassion as spoken of by Ballot and Campling (2011). The nurse realises that 'this lad is only sixteen and has nothing'. This in turn provides the motivation to address the fear, and destitution and loneliness that are often the features of psychotic illness. These are the inter-relational elements of compassion (Ballot and Campling, 2011).

Compassion with Helplessness

One experienced senior nurse spoke of the centrality of compassion in nursing for him.

I think as nurses we all came into the profession because we want to help people and make things better, even though, in twenty -five years of nursing, you do realize that that's not going to happen but it doesn't stop you having those same emotions, which I am quite glad about. I think the time I stop feeling anything is the time I should get out because I am obviously not being very good at the job. NIC3 (120-124)

The nurse acknowledges that compassion brings with it emotional pain but that this is to be expected in nursing life and work. This resignation by nurses as to life course injustice: the realisation that despite best efforts the desired outcome was "not going to happen" for everyone was evident in the data. Compassion tinged with a sense of helplessness characterised many of the narratives. This helplessness was in itself a

painful experience of conflict for professionals whose motivation to bring about change for the better is at the heart of their working life. One mental health nurse working in a secure unit talked at length about the cruel life histories of his patients and described this feeling,

with one or two patients I have had....just having this sadness and wanting to make it all better for them and just knowing that you can't so there's helplessness I suppose, (470-472) MH2

A school nurse talked in more detail about how children who have suffered abuse impacted on her.

And I just find that very, very difficult and I have the sense of wanting to make it right and knowing I can't. Erm, and it's painful.
HVSN5 (460-462)

Notice that once again there is a trace of helplessness within the compassion; “the sense of wanting to make it right but knowing I can't”. There is significant evidence here of “sensitivity to pain in ourselves” as described by Gilbert and Choden (2013:44). In terms of perception, compassion has its limitations. Compassion may be aroused from what a person sees or hears without accurate ownership of another's frame of reference.

Empathy - “in her shoes”

The concept of placing oneself in the shoes of another featured heavily in all the narratives. Further to this the data indicates that empathy is not an emotion but a tool for identifying and comprehending the mental and emotional state of another. While compassion is the experience of ‘pain in oneself’ through knowledge on another's circumstances, empathy is the experience of someone else's pain. People often speak of feeling empathy for someone but it is the feelings of the other they are really feeling. Empathy is the means not the end. This is illustrated by the way an experienced children's nurse seeks to explain the hostile and critical behaviour of a mother.

I would say, well put yourself in her shoes for 5 minutes, how would you feel living your life in front of every body else knowing that no matter what we do for her son, nothing seems to be working. PD3 (332-336)

The nurse does not take the mother's behaviour as a personal affront but uses her knowledge of the woman's situation to provide insight into situated cognition.

Plural Empathy

There were also examples of nurses who could empathise with both parties in a situation of conflict. A specialist nurse speaks of a young woman who has suffered a stroke and living with her parents.

The young girl that I've just had is just over twenty who wants to throw herself down the stairs; she can't go out with friends, she can't dance, she can't go to the pub, she can't drive her car. She is living with parents who are cosseting her, and you can understand why because of the devastation to their lives. Nobody expects a 21 year old daughter will have a severe disability. DN6 (55-59)

The nurse understands the ingredients of the conflict, the different perspectives of each family member and crucially for practice how those perspectives shape and explain contrasting behaviours and conflict. A senior ward sister in a renal ward spoke with empathy for her patient group.

they have never been in hospital before, they're frightened, we get young patients here who have stone disease, they might have had their first stone at 18, 19 and they look around and most of the other male patients on the ward are 70 plus, that maybe frightens them. It's just, they are just bamboozled by what is going on. AU4 (116-120)

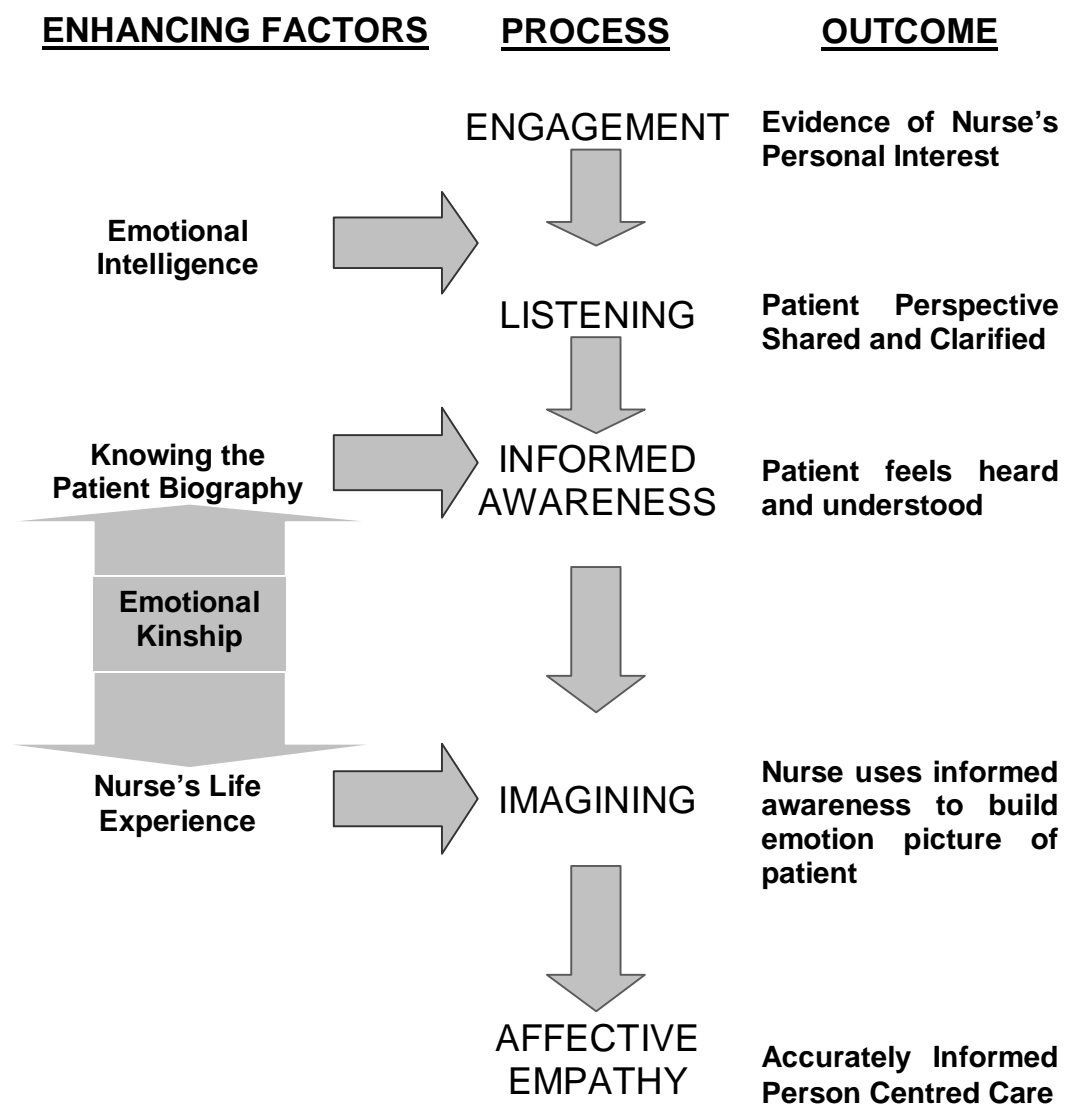
It is tempting to rush to judgment on the sister's comments as a blanket description rather than empathy but one must ask where she procured such knowledge if not from individual patient perspectives. Hence, we conclude that she speaks with empathy built on experiential knowledge of her patient group. But how is this done? How is the awareness reached and how is the awareness related to the self?

Empathy as a Process – Engagement

Within the data the necessary antecedents of empathy form a process [see Figure 5.1]:

1. Engagement
2. Listening and 'echoing'
3. An informed awareness of another's circumstances (cognitive empathy)
4. A good imagination
5. Relating the product of that imagination to the self (affective empathy)

Figure 5.1: Empathy: Process and Dynamics



The narratives of a nurse specialist for patients suffering cerebral vascular accidents, a mental health nurse and a school nurse are technically revealing in this respect.

And for that patient to be open, to tell you experiences and how they are feeling, if you don't come across as approachable and that you are human... So you engage a little bit and you have to give a bit of yourself. ...I often wonder how some colleagues that I see who are very clinical very much 'I'm here to do this job, and this is what I want to do, and this is the answers I want' and they give the information and they don't relax. I don't know how patients know that you have empathy if you don't give a little tiny bit. DN6 (129-131;138-144)

The role of engagement (Berg et al. 2007) en route to achieving empathy is illustrated here. The evidence that the nurse wants to share the patient's perspective; that they care about the person as well as care for them must be sufficiently convincing for the patient "to be open" hence the need to "come across as approachable" and "human"; to "give a bit of yourself". The nurse's reference to the emotional coldness of some colleagues endorses the importance of humanising the tasks of nursing; revealing fallibility to permit a mutually informing relationship (Hunynh et al, 2008). This in turn requires emotional intelligence borne of self-awareness (Eckroth-Bucher, 2010)

Empathy as a Process – Listening and Echoing

A mental health nurse consultant related another necessary behaviour with a particular patient.

Whereas if you are in a more difficult session things maybe aren't going so well or the person is telling you some really difficult stuff to hear and it is quite painful then that would be more when you slow down and I guess it is the echoing between where they are at and where you are at so the pace would be maybe very different and slower. MH3 (72-77)

A description of this setting captures the nurse applying the work of both Stickle and Freshwater (2006) and Egan (2002) in artful listening en route to achieving empathic understanding. The nurse demonstrates her engagement by adjusting the pace of this discussion and 'slowing down' the rate of the exercise appropriately (Stickle and

Freshwater, 2006). In order to ascertain the patients 'painful' perspective she must 'echo' or repeat back what has been said in order to afford the patient an opportunity to confirm or clarify their position (Egan, 2002). The nurse is striving to find 'where the patient is' in terms of his perspective. She seeks a mirrored parity between 'where they are at and where she is'. At the point of parity the nurse has an *informed awareness* of her patient's mental emotional and cognitive state. This is *cognitive empathy*.

This glimpse of practice is reminiscent of Peplau's theory of nursing (1988) in which both parties share perceptions to aid recovery. But more is needed to have affective empathy.

Empathy as a Process - Imagining

A school nurse spoke of her ability to empathise with a child with challenging behaviour and in doing so reveals another key quality needed to own another's frame of reference.

I can sort of put myself in their shoes in a way. I can imagine, I can try and imagine what it must be like for them. HVSN2 (382-384)

So professional knowledge and accurate personal understanding may arouse compassion but it is *imagination* that is needed to be able to 'place the self in someone else's shoes'. The nurse uses her informed awareness to build an emotion picture of her patient. She is then able to relate this to her emotional self. Scott (2000) called this representational thinking. The end result is affective empathy. This is the empathy referred to by Kirk (2007) as a less ambitious form of empathy: that which seeks to grasp the nature of the lived experience of another within a short segment of time.

Biographical Empathy

Kirk (2007) takes the view that a more ambitious or skilful form of empathy is to place oneself in the position of another, having first embraced that person's biography. The logic in this is that the more information one has about a person the more one will be able to understand and empathise with them. Kawamichi et al. (2013) showed that affective empathy increases with the length and intensity of a relationship. However,

this data shows that biographical knowing brings one closer to someone, acting as a virtual substitute for the length and intensity of a relationship. A school nurse talked about an eight year old girl who was an only child who gained two half siblings when her father remarried.

..she's been wetting the bed and doing this and doing that and she never used to do it. And I said "it's all signs of emotional distress. She's missing what she had. You know, imagine she's an only child, she had Mum and Dad there, thinking she was the centre of their world and she's gone to sharing you with another woman and 3 children. So at that age they can't always tell you how they are feeling. She's not going to say 'well I'm fed up because ' she's not going to be that articulate. But the behaviour she is displaying is signs of emotional upset and distress, and that's what they do. Because she wants you, she wants the attention." HVSN5 (445-454)

The school nurse's intervention leans toward the advanced empathy that comes from assimilating the life history of a child together with the child's stage of development and allowing this to frame the child's behaviour within an ontological context. The nurse perceives that the child has been the focus of her father's attention all her life and that the life-changing event that is divorce has resulted in an ambivalent attachment behaviour pattern (Belsky and Cassidy, 1994).

Libidinal Property of Empathy

A mental health nurse seems to achieve the same level of empathy when he talks about women who self-harm and harbour blanket hostility toward men.

you see abuse that they have gone through and they have never had a chance since the day they were born really and you feel sorry for them and you think, if they are self-harming, you know if they are acting in a way that's out of the norm, if there is such a way then, you can understand why they self-harm you can understand why they would want to be violent towards men because men have abused them from pillar to post. MH2 (293-299)

Through reflection on the abusive life history of such women the nurse comes to a point of informed awareness. He is able to comprehend the pain resentment and bitterness among a patient group that is so easily misunderstood. But what is the impact of this on his practice? The nurse explains:

The fact that I have got this empathy for a lot of the patients does drive me on. I would probably want to go that extra mile for them whereas I probably wouldn't have done You are going to want to see them have some sort of meaningful life. Yes, so I guess the empathy thing can play a part there if you channel it in a professional and objective way. MH2 (612-619)

Like compassion, empathy is a libidinal entity which motivates care. However while compassion may drive caring it does not inform practice accurately on the patient's perspective. The compassionate practitioner by comparison is at least partially 'working blind'. Empathy is more accurately informed, promotes compassion and motivates progress in care; It is libidinal. It "drives him on". In reference to a specific patient with a personality disorder who deliberately engages in self-destructive behaviour the same nurse was also clear about how an inability to feel empathy affected care, which might otherwise be of good quality.

With the best will in the world I find that hard to understand, no matter how much she was abused and no matter how bad her life has been, how many self-states she has got, or what's in it for her I can't get my head round that because it is easy, sometimes it's the fact that if I could put myself in somebody's shoes, or understand their life history and how it fits into their current way of being, I can work with them a lot better but those that I can't, I can still work with them, but deep down there is that sense of frustration and that sense of not being able to hook into them as a person because if I don't understand you as a person I'm not going to be really much good to you on a really deep and meaningful level. MH2 (356-365)

So empathy is the key to precision in person centred care. A patient with whom the nurse cannot empathise may still be understood in terms of theory applied in practice. However care which is truly person centred will issue from empathy because the nurse 'can get inside the head' of the patient (Eckroth-Bucher, 2010).

Struggling to have Empathy - “I can’t imagine”

There were also narratives in which nurses felt compassion but struggled to capture the frame of reference of their patients for their own understanding. It is significant that without exception those narratives featured the words: ‘can’t imagine’. This was particularly the case when discussing traumatic events. A health visitor talked about the unknown emotional territory of having one’s own child removed.

You can only really relate it to how you’d feel yourself can’t you? I just think I can’t imagine that happening, someone taking my children away or me getting to that point in my life where I cant, I wouldn’t be able to cope, you just kind of do it from your own personal experiences, and you just think, God, I can’t imagine what they must be going through.
HVSN3 (219-222)

A nurse in emergency care spoke similarly about the parents of a child who could not be revived by the resuscitation team.

All I could think was, looking at those parents, going this is your child, you just literally lost it, I didn’t have any children at the time and I don’t have any children now but, I can’t imagine what you are going to go through, this must be the worse thing. You could just see it on their faces, they were just like the most scared people, PD8 (65-69)

Both these nurses discuss the loss of a child in different ways. The first nurse struggles to empathise despite her own role as a mother. The second nurse experiences the same struggle but does not have children. This raises the question as to what extent empathy in nursing is augmented by personal life experience.

“I know myself ... maybe” - Empathy from Life Experience and Emotional Kinship

The extent to which the nurse is able to transfer principles from experience to other situations flexibly without rigid generalisation would appear to be the core issue in empathy generated by life experience. There is no question among the nurses who spoke of the use of personal life history that feelings of loss affected the way they approached loss in their practice. Nowhere was there the suggestion that relevant life

history is essential but there is a sense of emotional kinship in which a bridge is formed between one's own biography and the patient experience. A district nurse's account of how her empathy changed is helpful in illustrating this.

I know for myself I thought I knew what it would feel like to be bereaved when I visited bereaved patients having done all the courses. I felt that I could empathize with them. But then when I lost my father I felt very different and so my empathy now is different, because I've got that lived experience of loss in somebody that you've cared about. So I would say that could only come from living through an experience and you can't learn that from a book. And that's made me a different person, emotionally, to go and see somebody who is bereaved. DN1 (65-72)

This nurse had always strived to empathise with her bereaved relatives through reflection on theory and use of an empathic process but her lived experience of bereavement has resulted in a transformation in her and the way she works "emotionally" with grieving families. An experienced children's nurse is more specific as to the professional use of her own life experience.

I have 3 children of my own and one of my children was diagnosed at the age of 6 months with a very rare condition. To this day, I can still remember those feelings and I can remember what was happening around me and I can remember what TV programme was on. When I am in with families receiving bad news I am always conscious of how the setting is because I can remember, 18 years on that feeling I got when I was given my bad news and where I was sitting, I can remember I was sitting at home and I can remember what was on the television. It was as if time stood still for that minute, so when I am giving bad news or I am involved in giving bad news to families I always try and be really aware of the setting of where we are. PD3 (31-42)

This nurse's comments are all the more interesting within the context of this study in that her 'feelings' or 'emotions' act as signposts for her detailed memory of receiving bad news. The nurse does not comment on how well her own needs were met. Instead her focus is on how this has increased her empathy for parents in similar situations. This is emotional kinship [see Figure 5.1 above]. She does not claim to know how every parent in receipt of bad news feels. Hers is a principle that is applied

broadly to embrace a specific situation. As a result of her own experience she is more mindful of the setting in which she gives bad news.

Another children's nurse talked about how the recent loss of his mother had informed his practice positively.

Having had loss recently I suppose it makes you, although its slightly different, it makes you understand maybe how parents are feeling, though I've not lost a child so its different but you know, it makes me realise the support they need. NIC2 (164-166)

The nurse's acknowledgement that his loss was of a "slightly different" kind at a different point in his lifespan from his patients indicates that he is careful not to make sweeping generalisations. He goes on to explain further with some emphasis on the care given to his mother in her last days of life.

... having seen the way my mother at points was cared for helps me make sure I do a better job for my patients than she always got from some of the staff that were looking after her. NIC2 (169-171)

So it is not solely the nurse's sense of loss which informs his empathy but his need as a relative to have good end of life care for his loved one; something that his mother did not receive. It is the feeling of being in want of good nursing care in the face of loss that informs his practice. The nurse continues:

I've maybe got a small idea of how they might be feeling and the emotions they're going through at the time that they perhaps suffer their loss. ... I suppose I can make decisions on the next of care or the next step so they feel that we've provided or I've provided for them what they've needed, even if it's something as simple as holding the baby or making sure they have the opportunity afterwards to properly say goodbye. NIC2 (180-185)

This is empathy shaped by an awareness of service user need in the face of loss informed by life history. Despite feelings of emotional kinship the nurse remains cautious about the extent to which his own experience can inform his empathy. He

stresses that ‘*maybe* he has a *small* idea of how a dead baby’s parents may be feeling’. “Something as simple as holding the baby or... the opportunity to properly say goodbye” are the parts of the nurse’s practice that have been impacted by reflection on his own personal loss.

Consistent with the notion of affective empathy, in all these narratives it is the familiarity with certain feelings which inform, rather than the context in which the nurse first experienced these feelings. This is consistent with the arguments of Bower (2013) and Zawadzki et al. (2012) who valued sourcing past and present sadness states in fuelling empathy. It seems that emotional life experience may indeed inform empathy in nursing practice but care must be taken to make cautious use of emotional memory in informing professional movement rather than assuming certain knowledge of certain individuals (Eckroth-Bucher, 2010). In this way emotional kinship must respect other parts of the empathic process such as active listening.

Emotional Labour

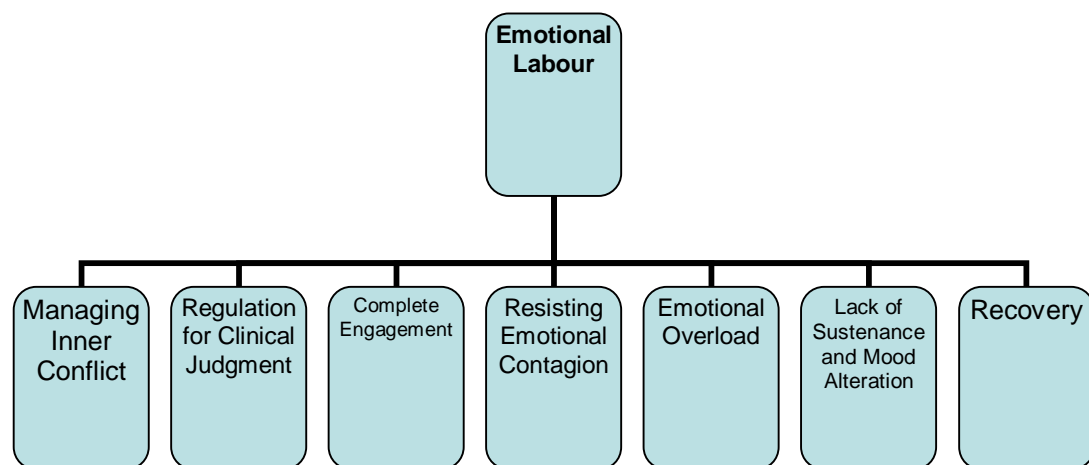


Table 5.2: Emotional Labour Theme Cluster

Emotional Labour featured strongly in the data [see Table 5.2 above]. Participants’ texts revealed emotional work to facilitate holism and person centred care through the empathic recognition of service user meanings and concerns (Gray, 2009b). Far from a predictable exercise, caring is fraught with human fallibility and unpredictable entrance and exit points, which require empathic insight to respond appropriately to need. The sum purpose of emotional labour in nursing is contained within a statement made by a mental health nurse working in the community.

All of those kinds of things but of course, you've got to feel those emotions and recognize those emotions but then contain them put them to one side and not allow them to, in any negative way, influence the people you work with and despite of what other people won't do, you have still got to do your job with that person and that family as best as what you can. MH2 (29-34)

Many nurses spoke specifically about the need to suppress powerful negative emotions to maintain a demeanour fit for professional practice. One senior sister described her ability to project an image of calm in the course of a busy evening shift when any number of factors is causing her to feel anxious. This is the surface acting referred to by Hochschild (1983).

I am in charge of 6 nurses, 26 patients, it's 7 o'clock at night and I can't get hold of a doctor and that can sometimes, people will be surprised to hear me say that, they always say, you are so calm, you know, but on the inside I am not really, I can be quite anxious. AU4 (143-147)

Complete Engagement

A mental health nurse concurred, drawing on classic English Literature to illustrate his point.

when it's busy it's like that Rudyard Kipling thing when people all about you people are losing their heads, it's that I don't, I just don't lose my head. MH3 (269-270)

This vision of the nurse in complete control while multi-tasking was described by Mazhindu (2003) [see also appendix 2] as complete engagement. The criterion for the state seems to be the extent to which the nurse believes she is making a positive difference in peoples' lives despite a fraught emotionally charged situation. Efficacy in practice would appear to compensate for any stress caused by the pace of practice.

Managing Inner Conflict

A ward manager's narrative described how he maintains a controlled emotional front while trying to secure shift cover in the face of raised sick leave levels on his team.

I had 3 sick calls in for the night but I had 2 like literally one after the other. I managed to replace them and get the unit covered for the night and then someone else calls in and I am thinking "for Christ's sake" but all the time you are being nice to the person on the other end of the phone, you know, look after yourself, take care and get better, all the time thinking, 'shit, shit, shit!' NIC3 (87-92)

This text shows how nurses often exercise emotional labour with their colleagues as well as their service users. This too is surface acting as part of collegial emotional labour (Theodosius, 2008). There are shades of what Mazhindu (2003:260) [see also Appendix 2] called "going through the emotion aspect" here. The charge nurse is pressed to move quickly to arrange cover at short notice for his unit in the face of a string of phone calls by colleagues reporting sick, which he finds exasperating. Nevertheless he strives for amicable relations with his sick colleagues who have contributed to his situation by extending his best wishes and maintaining a caring approach in the face of more urgent priorities.

A health visitor narrative revealed how beneath intimate clinical practice she often mentally sifts through her timetable and other priorities for the day.

...because you've constantly got things running around in your mind of things to do, I'm a very listy person, so I have like lists stuck around the computer that you need to be doing and so even when you're out on a visit if you're supporting for breast feeding you've got things going on in the back of your mind thinking, "I can't just sit here", even though you are doing something and you are making a difference to somebody else, you think I've been gone an hour already (HVS4 151-156)

Again this is surface acting but it is likely that there is a greater level of emotional dissonance at work and greater degree of labour effort (Zammuner and Galli, 2005) being required of the health visitor, as she experiences conflict over a period of one

hour between her need to attend to a breastfeeding mother and other demands on her practice time. Once again there is some similarity with what Mazhindu's progress through the emotional aspect of practice (2003:260) because the nurse's narrative suggests that she is able to work towards and achieve a positive outcome despite experiencing inner conflict.

Emotional intelligence can be described as the 'umbrella term' for emotional labour and other skills associated with the use of emotion. However the relationship between the two concepts is more complex than this. The data showed that while emotional intelligence informed the measure of emotional labour required, emotional labour also permitted the nurse to exercise emotional intelligence. In an account of how she helps the medical team support parents whose child has died, a children's nurse talked about how it is important to be able to empathise with the parents first in order to produce the appropriate measure of emotional labour.

.. you're sitting down with the parents telling them that you know, their child is brain dead and that there is no way they're going to come back from this. And I think that's a time to be sad, and you need to show the parents that you are also sad without obviously not sitting there blubbering away, but that you are upset with the outcome as well, and I think that's very important for them to then allow you into what their thinking and discussing about, that you were there when their child was awake, and so I think you need to show that you are sad that they aren't going to survive this, so the parents can discuss things with you. I think if you've got a shared emotion, with the parent, then they're much more likely to be open about it it comes out it as controlled. Because you need to show that you are sad that this event has happened, but you also need to be controlled so that they can rely on you, if they think you're a mess their not going to start relying on you, and that's the role of the nurse, I think if you're too sad you're not actually fill that role that that parent needs you to fill. PD5 (141-149; 154-157)

The nurse is not describing a crafted surface or deep performance here in the way described by Hochschild (1983). Nor are the emotions experienced at a level which is necessarily appropriate. The nurse acknowledges the 'control' required to prevent her 'blubbering away' and appearing a 'mess' to her family and therefore unable to practice effectively. This is a nurse labouring emotionally to facilitate a relationship

with her patient's parents which permits them to "open up". This is consistent with the arguments of Mazhindu (2003), Mann and Cowburn (2005) and Hunynh et al. (2008) on emotional labour as it finds application in nursing. Deep acting is rejected as a disingenuous notion in place of ubiquitous genuine caring emotions tempered and finely tuned to suit the moment and sustain an atmosphere conducive to continuing care.

The genuineness of emotions experienced and managed in nursing is borne out by the account of a senior sister on a children's ward as she talks about the aftermath of a child death, occurring as another child was also terminally ill. The case related by the sister is particularly significant because it describes how in the aftermath of tragic loss nurses must care for themselves while they continue to care for others; those affected as well as those unaffected by the loss.

That was a really hard time for the staff, to get the morale up and just, the unexpectedness of it didn't help, they were trying to live with the grief of that child all the time looking after the other child who, on a day to day basis, took up a hell of a lot of nursing time. PD3 (320-323)

The nurse's description of the sense of loss collectively experienced by her team and the corresponding impact on morale is reminiscent of Stayt's study (2008) in that simultaneous attention to the grief of other children and to the emotional needs of each other means that the time left for constructive approaches to the latter is reduced. Such experience and expression of sadness and grief is out of kilter with ideas of deep acting. Any theatrical performance of emotion would not predispose to the associated sadness and grief described here. Instead this data is evidence of the emotional pain that accompanies a genuine sense of loss.

While most of the evidence contained within themes of emotional labour supported claims in the nursing literature that emotional work in nursing takes place in a form that is adapted from Hochschild's theory, occasionally there was a piece of narrative which did imply deep acting to project a positive persona. This account of a district nurse showed how emotional labour was used to produce positive thinking to generate a more cheerful disposition. This was done to ensure that the negative emotions resulting from one episode of care were not carried over to another.

..... your work schedule is such that you have to move to the next patient and you can't carry how you feel. So I think when you get into your car you almost have to think 'right – put that aside and what's next?' Although you feel sad when you're there and you walk out the door you can feel a bit under par for the rest of the day, when you've had a really bad day. But you put on the smiley face and go on to the next patient just the same because they need the smiley face and the positivity because every day is a bad day for them. DN3 (176-183)

Once again it is noteworthy that while positive thinking benefits the individual who adopts it, the nurse's main concern is for her patients.

Resisting Emotional Contagion

A sense of altruism sometimes means that emotional contagion spoken of by Zembylas (2005) needs to be resisted by nurses. This is not primarily to maintain a professional demeanour. Emotional contagion is resisted out of respect for the patient or relative as 'owner' of the emotion. Emotional contagion does not describe emotion that is shared out of empathy but emotion that spreads unsolicited through the stimulating of unconscious emotional memory (Theodosius, 2008). It is sensually rather than cognitively powered. The nurse discerns that this moment is not one which calls for empathy or sharing of emotions. Instead the nurse observes the service user's need for personal emotional space and privacy.

It is not my role to be crying with mum, to do stuff like that, because that is her emotion and those are her feelings. PD8 (17-19)

Where some occasions in practice call for shared emotion, others require the patient to feel safeguarded and reassured. At such latter times shared emotion is inappropriate. Shared emotion is appropriate as a tool to permit the service user to express and off load feelings. Emotional contagion was seen as something that should be resisted when the patient's needs call for duties which require stoicism.

Reflecting on Mazhindu's subtypes of emotional work, there are traces within the narratives of resisting emotional contagion of automatic pilot where the focus of practice is action rather than feelings. However there is some variance with

Mazhindu's description in that the nurse is not seeking safety or refuge from emotion for her own personal good. The nurse's forced composure equips her to consolidate her role as guardian and advocate of the patient and patient's family. One ward sister put it this way:

...it is not my right to be sad, it isn't actually my life, I am sad for a third person rather than sad for myself. I have to shake myself, think, get out of it you know, it's not about you. PD3 (485-487)

Emotional Regulation for Clinical Judgment

Narratives aligned with Damasio's argument (1999) that the tempering or regulating of emotions was thought to be crucial to aid clinical judgement and decision-making.

So you have to learn to manage your emotions and not to be too afraid to make the decisions and sometimes after you have had a difficult patient or a difficult death that can impact because you almost feel afraid of making those decisions because you are afraid of getting it wrong. DN3 (32-36)

As the nurse continues, it becomes clear that emotional regulation relies on analytical reasoning to reduce uncertainty. This in turn levels emotion.

often you have to think well I've done all that I can and I've spoken to my colleague and I've looked at all the aspects. They've not seen anything different so then you have to lay it to rest really. DN3 (74-77)

Words such as 'detach', 'putting it in a box', 'laying it aside' and 'putting it aside' characterised a sense of enforced and intense focus on analysis, decisions and tasks. There was an awareness that a lack of emotional labour would reduce the quality of judgement and the likelihood that essential praxis would take place. For many nurses this meant postponing consideration of emotional aspects of work.

... life has to carry on really so I suppose we put it into a box and deal with it at a later date. DN3 (171-172)

Another nurse spoke of the need for economy of time and effort with negative emotions. She represents her emotional regulation in a soliloquy.

... just calm down, don't let that frustration become all encompassing so that you can't do anything else, rather than rant and rave about it, sometimes it almost takes over, the frustration takes over because you want to be able to change it, you feel frustrated with it so, rather than, I just have to say you know you can't change it, you cant do anything with it, put it to one side for the moment and deal with it later. You won't be able to get on with what you need to get on with now if you are going to rant and rave. PD3 (428-435)

In addition to postponing acknowledged emotions there is a sense of 'lock down' in the latter nurse's recognition of the need to 'get on with what you need to get on with'. This is automatic piloting in emotional labour but it is not as Mazhindu (2003) describes: a seeking refuge in tasks primarily for the needs of the self [see Appendix 2]. Emotional regulation for clinical judgement is a primarily internal process to secure effective action. This was supported by the latter nurse's peers. Again the focus on what needs to be 'done' is clear.

when things do happen I almost as I said before I do switch into auto pilot which becomes super calm like we've got to do this, this and this, and I don't flap in that way. PD1 (171-172)

In a discussion about safeguarding children a school nurse spoke about emotion as a potentially deceptive element of practice which may result in losing focus on the welfare of the child. Again there is a detachment and a locked down focus is clear.

It's difficult about emotions because you try not to have – to get emotionally involved. Because once you start doing that it's when you lose perspective and then you are not doing what's best for the child then because you might get sucked into one side or another. Then you lose your objectivity. So I don't – I try and cut off my emotions in some ways. HVSN6 (342-346)

This illustrates the appropriate place of detachment not as something which undermines empathy but which parallels temporary disengagement with emotions to ensure an effective focused clinical performance. These value and behaviour patterns partly align with the findings of Henderson (2001) who found that for many nurses emotional labour was something which could be engaged and disengaged.

Emotional Overload

There was evidence across clinical settings that emotional labour cannot be sustained indefinitely supporting in part the findings of Zammuner and Galli (2005). A point at which the power of an emotion or multiple emotions disables thought and articulate expression was identified as 'emotional overload'. One nurse tearfully described her despair at being the subject of a formal complaint by a patient's relative when on an exceptionally busy day working an hour past the end of her shift she allowed exasperation to show in her face in response to the relative's request.

Yesterday I felt that we were doing our best than nearly an hour after I should have left the ward I made the mistake in so far as I raised my eyebrows and eyelids at a patient's relative and I automatically knew that was wrong.....at 10 to 9 after you should have left the ward at 8 o'clock, I just didn't want to get involved in that conversation, I was too tired to be involved in that conversation and I realized I shouldn't have been there, I was just, I was hurt that after a full days work when you have put in everything that you go and slip up. You slip up and now, after your shift should have finished as well. AU1 (13-15; 52-57)

The exhaustion meant for this nurse that eventually she could no longer sustain surface acting and her real feelings emerged at the wrong time with the wrong people. The low self esteem, morale and undermined satisfaction, which Niedenthal et al. (2006) argued result from relentless emotional labour, are also evident in the nurse's narrative. The nurse's tearful state during interview also evidences the place of conscious emotional memory in the recall of such accounts (Theodosius, 2008).

Mood Alteration and Lack of Sustenance

The data featured comments referring to the negative impact a lack of sustenance or rest has on the nurses' emotional and mental state (Zammuner and Galli, 2005).

..like I know if I don't have my break I will start being very agitated. AU5
(25-26)

One nurse spoke of how the impact was greater when tiredness and hunger combined.

it was just that fluster, can't cope, need something to eat, too tired to do
all of this all at once sort of feeling. PD8 (241-243)

A nurse in an acute surgical ward called this her 'tipping point': a limit beyond which she struggled to function.

if I am feeling just a little bit tired, or I'm hungry, it can tip it over, you think " oh god I just want to get out of here".....when I say "tip it over", that is just me being quite dramatic, you know when you feel you are going to be, you are going over the edge sort of thing.....I get frightened that I am going to lose it yes, that I am going to snap, I could snap at someone. AU4 (65-66; 70-71; 79-80)

The findings of Folkard (2008) with respect to emotional stability and a maladjusted body clock during night shift were endorsed by nursing experience.

I think something that has a big impact on emotions is tiredness, it is not an emotion obviously but I think working long shifts, doing nights, body clock, it can cause emotions to be felt at a greater extent sometimes, and if you are, flagging at 3 in the morning, it can be completely different compared to the same situation during the day time. If you are tired emotions can be felt to a greater extent. NIC1 (458-463)

These findings indicate the importance of rest and sustenance in nursing if sound emotional labour as well as sound practice is to be maintained.

Recovery

While nurses spoke collectively about the need for respite from emotional work they sought such recovery in different ways. For some nurses physical rest was important.

time to refocus – I just need to lie down for a little while, or I just need my own space because you feel like you have reached a limit. AU3 (285-286)

Many nurses found travel from work therapeutic. This travel time allowed them space to deescalate their feelings or 'wind down'; preparing them to talk to someone close about their day.

it might take 10, 15 minutes or my tube ride home , then I am alright.....I will go home and maybe want to talk about things that have made me anxious.....it wasn't until I stopped talking about it at work that I realized I need to offload some of this sometimes. AU4 (46-49;149 ;151-152)

Community nurses often used their cars as 'recovery houses'. One school nurse spoke about a specific place where she stopped between commitments following a morning in which she uncovered and referred a severe case of child neglect.

Over the Bridge I found a really quiet spot, the tide coming in, I just opened the window, the wind coming in and the sky. It wasn't sunny. It was a horrible day but it didn't really matter, just trying to find some calm in the day. I think that's really important. I don't always achieve it because there isn't always the time or space to do that, it just happened having been to this meeting, before I had to go on anywhere else, I had that half hour slot where I was able to do that. HVS6 (522-528)

The nurse speaks fondly of the place as holding comforting memories for her as inanimate objects and places often do as stimulants of conscious emotional memory (Theodosius, 2008). A peaceful place provided space in which to recover peace of mind.

Most recovery strategies were devised by the nurses themselves with no contribution from management. There was however one exception: a ward sister remembered the collective struggle with grief and loss experienced by her whole team following the death of two children in succession.

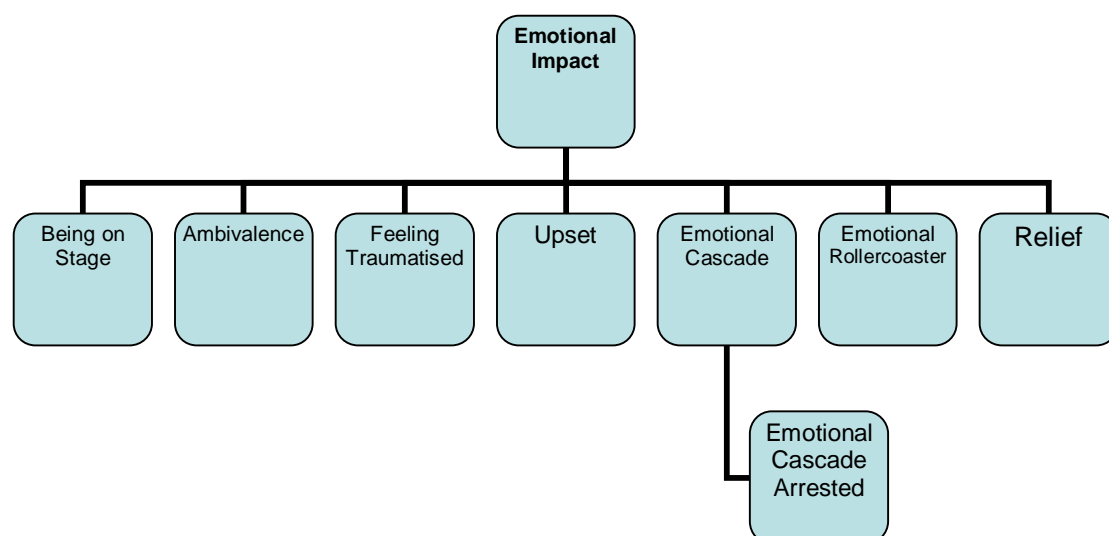
We did lots of different things , we did psychologist things, lots of reflective things. It has recently been the anniversary of those two children so the staff have been reliving, there has been lots of conversations about what had happened a year ago. PD3 (339-342)

The pain was still etched on the face of this highly experienced nurse as she discussed how she and her colleagues are still coming to terms with the sense of loss over one year after the death of the children in question. It seems that the severity of the loss defied usual methods of recovery necessitating more structured means.

Emotional Impact

Mazhindu (2003) speaks of emotional impact as part of emotional labour but the pervasiveness of this aspect of emotional regulation in the data of this study means that it deserves separate consideration [see Table 5.3].

Table 5.3: Emotional Impact Theme Cluster



This category describes times when the nurse experiences emotions which have a chaotic effect and often prove challenging to effective management. The narratives peculiar to this theme are punctuated with words and expressions such as 'heartbreak', 'heartache', 'upset', 'hits you hard' and 'hard to deal with'. The emotions experienced are unpleasant but also complex in nature. Because they prove difficult to reason through or manage in a way that augments care they are often internalised in order to continue practice. This proves exhausting. As a theme, 'emotional impact' reveals an intensity and frequency of hurtful emotion endured in nursing practice.

One school nurse describing occasions when she witnesses emotional abuse relates this to the impact on her own feelings

...particularly when people are emotionally cruel to children. The physical side of things I can almost take that, but the woman that stands there with a little tot and says 'well I've never loved him, I never wanted him in the first place', and they look up with their big eyes full of tears, and I think I can't bear it. You know that's the stuff that I find really hard. HVSN6 (370-374)

This demonstrates the compassion and empathy at work in nursing practice but also the emotional price. Shortly afterwards the same school nurse explains why.

...got too involved in listening to them and buying in to their angst and their worries. HVSN6 (415-416)

Empathic caring exposes the practitioner to the emotional 'fall out' from the situation they inhabit. Experience would not appear to be a protection from the emotional impact of practice events. The school nurse quoted above had been practicing for over 25 years.

The death of a child or a baby ranked high among the events that caused nurses distress. One nurse in a neonatal intensive care unit describes his feelings.

For example we had a baby who died on Friday who, it was very unexpected, and I actually cried when I saw the person which I felt, it was distressing for all the staff, they were all very affected by that.....It

was, it was just a shock to the whole unit, we were all affected by it.
NIC3 (37-39; 77)

There were a number of sub categories to emotional impact which capture specific types of emotional stress.

Being on Stage

You have got parents watching over you and, there is a fear that the parents are watching your every move. PD4 (281-282)

McKlinDon and Schlucter (2004) have spoken of the importance in recognising the crucial place of the parent as guardian, carer and interpreter for the child together with the feeling of emotional security that these roles supply. Consequently in modern healthcare parents have continual access to their children in hospital. But the data in this study exposes the apparent omnipresence of parents as an added source of emotional stress for some nurses. Caring for children while being constantly watched and scrutinised by their parents and even by the children themselves was a common source of stress for recently qualified children's nurses. The highly informed anxious mental disposition of a parent with a hospitalised child means that they are quick to question the practice of nurses they believe are falling short in their duty to care. Recently qualified children's nurses called this 'Being on stage'.

So you can feel quite stressed doing certain interventions, and you know like, when you're doing things and sometimes we as nurses forget a little bit that they are watching us when we're talking to our nurse colleagues and sometimes you just feel like you haven't got that freedom at work. PD7 (68-72)

This is an invidious situation for children's nurses. The clinical setting including the constant presence of parents in which they work is familiar to them. They feel 'at home' there. They must learn to develop a seamless clinical and emotional performance that copes with the constant presence of parents. They can never totally relax at a personal level in a way possible for some nurses in a less publicly exposed environment. The greater the workload the lesser the chance of respite and the more intense the experience of 'being on stage' becomes.

you don't have that quiet place to go, there's always an intense stressful situation and often if you don't get a break as well, you're there all day on the front, looking at these people and it can be really difficult. Like my friend the other day she, after work just sort of had an absolute crying break down, she couldn't really explain why she felt like that but she felt as though the pressure of being watched all night and demanding parents just became too much. PD7 (72-76)

The impact of 'being on stage' cannot be reduced to a feeling of mere awkwardness. In the case of the nurse's colleague 'being on stage' was a source of emotional overload. However the emphasis is different. 'Emotional overload' is concerned with the point at which a nurse's powers of emotional management are overwhelmed. 'Being on stage' describes a unique combination of behaviours and circumstances and the intensified perpetual emotional labour required to respond to such a situation. The nurse provides further clarification on this.

...probably the most hard thing I find at work like that being on a stage thing is that, you can never show how you really feel PD7 (128-129)

'Being on stage' describes more than the feeling of being constantly watched and scrutinised by parents and some challenging children. For these nurses there is no let-up in the emotional performance required of them; no chance 'to show how they feel'. The opportunity open to nurses in other fields to confer privately with colleagues is closed to them.

Ambivalence

One of the most difficult emotional states to manage was ambivalence: the coexistence of opposing emotions in a person's mind which makes forward planning arduous. In the experience of these participants, ambivalence arose out of awareness of conflict of values or need. A simple example of this was found in the comment of a recently qualified nurse on the readmission of a patient well known to him and his team and with whom they had formed a positive relationship.

When it is like that, I am not happy she is here but I am happy to see her ... 'oh you are back here, why are you back?', I am happy to see

her but , like I know if she is here it is because something is wrong. AU5 (151-153)

The nurse experiences happiness as a result of being reunited with the person in the patient but knows that readmission to his ward means that the patient's health has faltered. This causes him to be unhappy. The connecting factor in such ambivalence is the human attachment which accompanies care as the nurse goes on to explain.

Yes, you can't say you are not going to get attached to patients, you see them, you become attached to them. AU5 (168-169)

Such attachment is necessary to provide empathy and compassion in care but it comes at a cost. Seeing emotional need in another does not mean that the nurse is able to respond to that need effectively nor would such a response necessarily be appropriate. This was particularly the case in the area of child protection where the nurse or health visitor maintained a child focused approach despite having recognised the loss suffered by a parent whose capacity to care for their child was inadequate. A health visitor expressed this ambivalence while discussing her ongoing relationship with a mother whose child had been placed in care.

I do feel upset sometimes with, you know, situations I've come across for example obviously child protection, some situations are really upsetting I've been in tears sometimes because of what I've seen children going through HVSN1 (7-10)

Returning over and over to the emotional turmoil of managing a case of child abuse the health visitor talks about how confusing the complex weight of feelings can be arising from the conflict she experiences. The conflict she experiences in turn means that she struggles to remain child focused.

Sometimes caught in these difficult situations, where you don't really know how to describe your feelings really sad upset angry, you know 'how can a parent allow this to happen to their child?' and all that stuff and sometimes you feel sorry for the parent. HVSN1 (17-20)

The holistic nature of the health visiting service to the family means that while the welfare of the child is held to be paramount the practitioner also understands the perspective of the parent. This carries its own 'emotional baggage'.

I felt happy, but at same time I felt really sorry for mum, sort of a crossroads as to how I could support her, and you feel guilty that she probably feels her children were removed because of me. HVSN1 (66-68)

From a deontological perspective the health visitor has done her job. The greater good of safeguarding the child outweighs the pain caused to a neglectful or abusive parent who has had their child removed. But the ability to focus on the greater good means that one must first be able to weigh other considerations in the balance. This exposes the nurse to mixed emotions arising from a child's life being saved and the compassion extended to a parent for their loss. A focused 'ethical compass' does not stem the health visitor's awareness of the heartache this greater good has brought to the parent. Practice focused on accomplishing the greater good is discriminatory. The human predisposition to care for another is not. Ambivalence is therefore evidence of a nurse's generalised compassionate attitude to all those in her care.

Feeling Traumatised

There were isolated occasions where nurses talked about tragedy that had a lasting effect. They are in effect traumatised by the emotional 'fall out' of highly demanding care that requires the use of judgement in the face of human tragedy or conflict. These events are deeply imprinted on nurses' memories and reap painful emotions.

I have known kids who have died and you go home in tears or you hear they have gone into intensive care and it is like you have worked so hard and got to know them really well, it just really upsets you and you just feel so sad. You can think of them all the time, you don't forget these cases. You don't forget any of them that you have come across that have died. PD4 (73-77)

One nurse recalls a time following a failed resuscitation of a child when the trauma of witnessing the distress of a parent caused her to stop in her tracks, suspending her ability to perform a simple practical task.

I was the most junior person so I just gave her the adrenalin it was fine it was going and then one of the other nurses turned round to me and said “go and get mum a chair”, basically we were going to take her off the ventilator and giving her to mum, in her arms, I remember walking out to get the chair and literally just bursting into tears outside the door.... It is just not the sort of thing I would think I would do, I am very much a, ‘oh I don’t cry’ but I just went outside the door and I remember thinking I can’t take this chair back into this mum because all I can see is her pain. PD8 (52 -56;58-60)

The nurse cannot countenance the pain and trauma of a mother’s grief in the face of an unexpected child death. A simple task of giving a relative somewhere to sit down is derailed by the emotional trauma experienced by the nurse. She is forced to withdraw from the situation. In this the nurse displays the characteristics of ‘complete removal’ in Mazhindu’s typology (2003) [see Appendix 2].

Upset

The word ‘upset’ featured frequently in the data describing a feeling of emotional injury or turmoil and disturbed composure. While being upset does not carry the long-term consequences of being traumatised it involves an emotional preoccupation with a perceived injustice or disorder. The impact of this preoccupation is such that it lowers self-esteem and reduces the motivation to continue. One nurse talked about how new office arrangements had affected her composure.

we’re hot desking these days, and for me as someone who is quite an ordered person that’s very upsetting. DN3 (193-194)

The same nurse distinguished between emotional turmoil resulting in mistakes or events in practice, which were within her control, and could have been prevented and events outside her control which could not have been prevented.

I suppose it is out of your control isn’t it, whereas the mistake was under your control. It’s circumstances, it’s life, you can’t do anything about it, whereas some things are easily corrected, it won’t be corrected but it

should be corrected, you can't correct cancer in that sense. AU1 (205-214)

Another nurse described her disturbed emotional state in the face of poor staffing and unfair protocols imposed by management.

You are upset because you couldn't give the care you wanted to give. It makes me very upset because I can't believe they will prioritize money more than health, I am not sure if it is this trust but, or probably this department, they don't, they don't really care about their staff. AU5 (24; 76-78)

It seems that 'being upset' may have roots in the injustice or in the chaos of frequent change, which challenges coping. The result however is the same: low motivation and morale.

Emotional Cascade

Damasio (1999) has demonstrated how emotions in the conscious mind beget other emotions in a commutative cascade between affect and cognition in which emotions give rise to feelings and feelings give rise to thoughts but in which thoughts also generate feelings and emotions. A number of nurses reported experiencing a process in which one emotion begot another emotion in a chain interaction, with each emotion affecting behaviour, including professional performance and judgement. 'Emotional cascade' describes a causal relationship between a series of emotions and related reasoning which makes emotional labour and self-management more difficult. Some nurses described this simply. Others gave examples from practice.

..you get angry at times with the frustration and you get upset because you 're angry. AU1 (1-2)

One nurse repeatedly returned to the theme in the space of a 45 minute discussion. He reveals a conscious evolving process, which can impact on relationships with colleagues.

frustration rises out of just not knowing what else I am going to be thrown into, and then the ward either being short staffed or not having enough stock or just being a bit chaotic I think. Anxiety rises out of that, its like I'm not quite sure I will get these things done that I need to get done and it becomes a recurrent pattern. AU3 (64-69)

Preoccupation with one's feelings arising from uncertainty in combination with the rapidly changing pace of events creates a clutter of emotions which may affect judgement in what the nurse says and how he says it. So external factors are internalised by the nurse in the shape of one negative emotion, which leads to another and still another. These negative emotions at different points in the cascade result in behaviour of varying degrees that is ill judged.

I think sometimes the fear, it is more the frustration and then turns into anger sometimes, and then sometimes it becomes easier to say things, make flippant comments. AU3 (133-135)

Again the interpersonal conflict arising from emotional cascades reveal nursing as a process driven community of practice, living with multiple accountabilities, which experiences negative emotions when that process is thwarted or hindered. The nurse also revealed the emotional cascade as a cyclical process, which increases in severity.

It is ongoing cycles within cycles really, frustration leading to feeling anxiety that you cant get things done, then anger when you are being criticized for things that you feel you were trying to do but couldn't get done, so each one kind of feeds onto the other. AU3 (272-275)

Nurses were able to describe the sorts of situations that would result in the emotional cascade experience. One nurse talked about the array of negative emotions he experienced when a patient deteriorated while in his care.

I am annoyed with myself and disappointed with myself and I am frustrated with myself yes, I think first of all I feel disappointed in myself and then after, annoyed, and then frustrated after, in quite quick succession. PIC1 (451-453)

For many nurses frustration was at the root of the emotional cascade describing how this impacted on their clinical performance.

I know if I don't have my break I will start being very agitated, it is so easy to make mistakes when it is like that because you are already upset, everybody will be upset that day and you know that, so when you tell somebody to come and help you or do something, because they don't have time to help, they will say, "oh I don't have time, what do you want?" and just walk away and you just feel frustrated, When you go, because you are upset, maybe you won't look at the job properly, you can't relax, and you easily make mistakes because of your emotions.
AU5 (26-33)

So a negative emotional cascade disrupts clinical judgement and may lead to errors and to conflict that would not otherwise have taken place.

Emotional Cascade Arrested

One nurse talked about how she recognised a downward spiralling series of emotions within herself as a result of being overly critical of her actions and worked to arrest this.

I think your more anxious afterwards than at the beginning, because at the beginning you don't know its coming apart from that tiny bit before they actually do something, but afterwards there is a lot, and that's when I normally get myself into a flap over something, and you then, that's the moment when you need to have your 5 minutes and just have a glass of water and calm yourself down a little bit and talk yourself out of being so anxious and then go back and carry on with the rest of the shift. PD5 (289-295)

Arresting an emotional cascade is an exclusively internal exercise managing emotions arising from other internal emotions. This should be differentiated from resisting emotional contagion that involves managing the influence of other people's emotions on one's own. It is also different from emotional regulation for clinical judgement, which is concerned with steadying internal processes with a corresponding effect on one's behaviour in the social domain.

Emotional Rollercoaster

In nursing practice there are times when the pace of diverse events arouses a range of emotions. Because of the unpredictable direction of these changing feelings this subcategory has been called emotional rollercoaster. Emotional rollercoaster is distinct from emotional cascade in that it describes the range of emotions aroused as a result of diverse situations and events in practice. Emotion cascade describes the way one emotion begets another as a result of any one event or situation in practice. A school nurse briefly described this as a continuum with negative emotions at one end and positive ones at the other.

..there are two opposites, there's the frustrations and there's the satisfaction. So they are the two there – and everything in between
HVSN6 (6-7)

A neonatal intensive care nurse explained how the varying pace of work is matched by a variety of emotions of varying intensity.

you can go from all the different swings from all the different emotions, might start off with nice easy day so you feel sort of quite relaxed and you're working your way through what you need to then something might happen and suddenly can shoot you into almost an adrenaline rush, not panic but, almost hyper alertness. I suppose when you're trying to get work done and the task done and that comes to end almost and you can ease down and unwind a little bit more. I suppose it's like an oscillation really between I can be almost a semi-relaxed state up to that hyper alertness when you're trying to provide complex care. NIC1
(126-132)

The nurse becomes animated as he demonstrates with his hands a rising and falling motion along a horizontal plane emulating the effects of the sympathetic and parasympathetic nerve pathways as they respond to perceived external conditions. These are the physiological effects of emotional rollercoaster.

Relief

It is interesting that amid the extensive narrative about the impact on practice of repeated waves of negative emotions there was also evidence that nurses experienced and enjoyed the feeling of relief. Relief described the alleviation or deliverance from a period of emotional stress. In talking about relief nurses often used expressions that referred to the physical sense of wellbeing throughout the body which accompanies it. Expressions such as ‘weight off your shoulders’, ‘weight off your chest’ were often used to help illustrate the feeling.

A number of community nurses spoke of relief in the context of providing a peaceful dignified death for a patient who had suffered from a chronic condition for years.

I think it's difficult because sometimes it can be almost a relief to admit that we are actually moving into managing some symptoms in the last days of life because it's been a struggle for that patient. And you just feel that they've come to a point where they have had enough. DN3 (166-169)

Although death of a loved one is a time of sadness for the living, this nurse sees the facilitation of a peaceful dignified death in the context of her practice as the approach to an ultimate positive outcome for her patient.

A nurse in intensive care spoke of his relief at the end of a shift and again physical metaphors were used. Notice too that the nurse speaks of the relief being a gradual process, which accompanies his journey home.

a sense of relief almost sometimes, to walk out the door, even if you'd rather be inside you know, when you get the sense of relief of ‘oh I've finished’ and you hand over to the night staff or the day staff and I can go home to bed, to recover to relax to spend some time with the family...something lifting of your chest and you can almost feel yourself unwinding as you walk out the door and down to the train station or wherever. And you know sometimes you have that feeling of, “yes I've had a good day” ...I suppose but generally as you walk out that door you get that sense of almost a weight lifting off your shoulders and even

if you know you're coming back the next day you know a new day will start from fresh. NIC1 (109-122)

After talking about how her colleagues provided some relief in the sense of humour, a health visitor explained why this was important.

Because it makes you feel better. Otherwise life would be quite boring and mundane if you sort of where miserable all the time so its sort of just, and because of the jobs we do they are tense jobs, and you do take on a lot of other peoples issues; worries and things, so you need a bit of light relief through the day as well. HVSN4 (266-269)

Relief is not the same as arresting an emotional cascade or recovery discussed earlier. Arresting an emotional cascade involves strategies by the nurse to pause, compose herself, collect her thoughts and move on. Arresting an emotional cascade provides neither relief nor recovery. It is an urgent and temporary augmentation of emotional labour. Recovery is the active provision of a resting period from emotional labour and is sought or planned. In contrast to both emotional cascade and recovery, relief often comes unexpectedly or quickly as in the case of a positive care outcome, handover or a patient's sudden but peaceful death. Relief is the connection between endured negative emotions and satisfaction. As in the case of ambivalence, the presence of relief as a subcategory goes to show the level of commitment and engagement with care by these nurses.

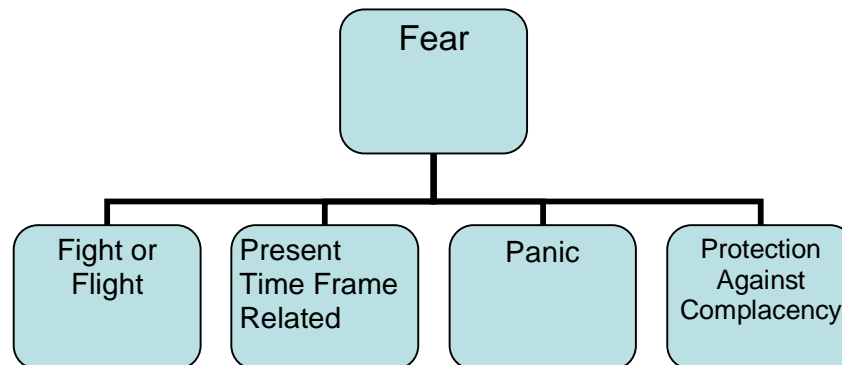
The presence of both active emotional intelligence and emotional labour in the data raises some telling points about modern nursing practice. First, emotions and emotion management are ubiquitous in everyday nursing practice. Second, emotions are highly relevant to clinical judgement in that they accompany, influence and are influenced by judgement and decision-making. This takes place in a way that is often not obvious to the nurse at the time. Finally this cognitive affective symbiosis is suggestive of a potential for the deliberate use of emotion in informing judgement.

Fear and Anxiety

Fear [see Table 5.4] and anxiety [see Table 5.5. on page 140] were strong themes in the data and are being presented and considered here together because of the distinction between the two emotions despite the strong relationship they share

(Orsini et al. 2011; Sylvers et al. 2011; Sauerhofer et al. 2012). It is noteworthy that these nurses distinguish between fear and anxiety, although both emotions are aroused by thinking about accountability.

Table 5.4: Fear Theme Cluster



Flight or Fight

The nurses confirmed physical symptoms of fear in a way that aligned with the ‘fight or flight’ syndrome. These include peripheral symptoms such as trembling and visceral symptoms such as a cardiovascular response and the ‘adrenalin rush’. One nurse described how she felt in fearful expectation of a patient whose condition was rapidly deteriorating in front of her.

You can just feel that something is going to go wrong, you know you just feel, you lose your appetite, you’re not hungry, just feel sick to your stomach, that is my feeling.

Is there an emotion that goes with that?

Yes, I think it is just fear, I think my way of expressing fear, I am the sort of person, you know my stomach reacts to everything, so if I am feeling unwell, I feel nervous or I feel excited, I cant eat because I feel high emotion I must feel sick.PD8 (171-180)

One senior children’s nurse describes the physical symptoms of sudden fear when a child goes into cardio respiratory arrest unexpectedly.

Sometimes, a few occasions in the past, there has been fear, you know a child has collapsed all of a sudden and it is that adrenalin rush, oh my god, what do I do now? I am frightened. PD3 (502-504)

Present Time Related

The mention of an 'adrenalin rush' is consistent with the 'fight or flight' aspect of fear (Orsini et al. 2011; Sylvers et al. 2011). The present time framed nature of fear becomes clearer as the nurse continues to relate what is happening around her and to her physical feelings.

...the times it has happened usually it is because of something out of your control. I think that is always a difficult thing when control gets taken out of you, out of your, when control gets taken away from you it makes it more, it is harder to deal with those circumstances, so fear to me, a parent or relative has been really aggressive. Or when a child has suddenly collapsed at 4 a.m in the morning and there is no one around, you are trying your best to cope with it and the adrenalin kicks in and there is a fear of what is going to happen...It is almost like a feeling of panic, of you know, your heart is pounding, your mind is racing, you don't seem to be able to, you know that things are happening around you but you are actually unable to put everything in neat little boxes at that time. PD3 (511- 525)

Notice the nurse's awareness that present events are beyond her control. Instead of hyper-vigilance, the nurse is 'frozen'; aware of events requiring action but unable to interpret and prioritise them with sufficient speed or precision to move forward effectively. It is also interesting that the nurse reinterprets her fear as "almost a feeling of panic". This is a concept that is shared between fear and anxiety and which will be explored later.

Another mental health nurse recalls how as a newly qualified practitioner he experienced fear of an aggressive patient who was targeting him.

...so I was coming into work and I can remember really vividly walking down to the villa, on a cold dark winter morning, and I had just sort of qualified, and I was... sometimes physically shaking, not the fact that I

felt in physical danger but it was like mental warfare that this patient was waiting for me. MH3 (41-45)

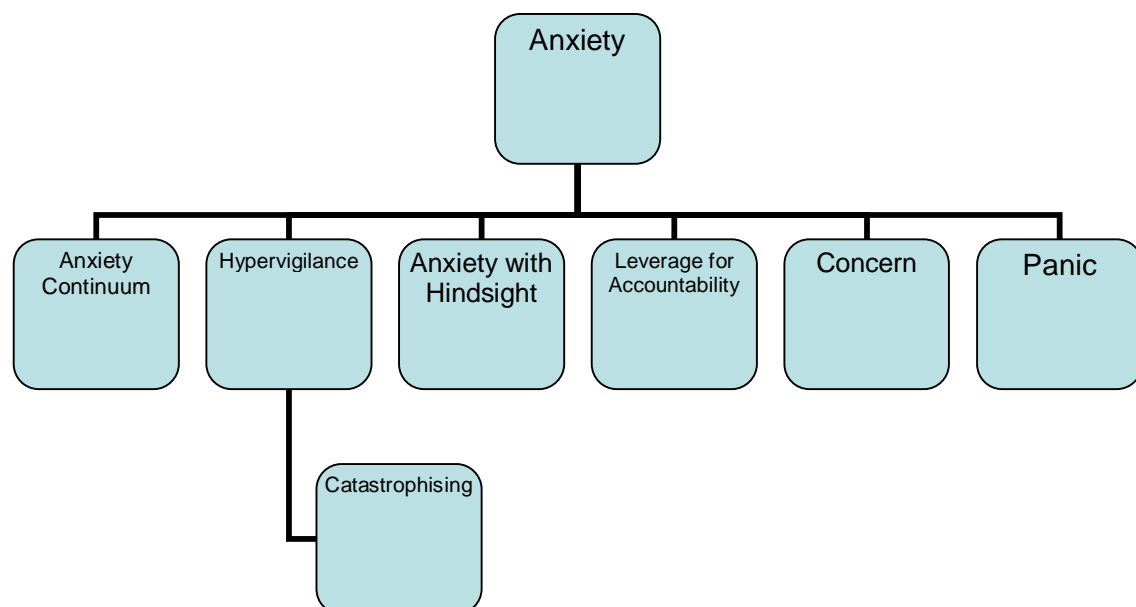
Note that there is no doubt *in the nurse's mind* that the patient in question 'is waiting for him' and that this is the source of this fear. His emotional stress is focused in the present (Orsini et al. 2011; Sauerhofer et al. 2012).

Fear, Anxiety and Accountability

During a discussion on accountability the difference between fear and anxiety was clear from the way nurses expressed fear of accountability as a certain threat to their professional life. Anxiety was expressed as a determined hyper vigilance in a search or review of practice to confirm an absence of error, which had previously been uncertain and unconfirmed. There were a number of examples of this. Notice the way a ward manager in a secure mental health unit describes her mixed experience of anxiety and fear in the face of a patient becoming agitated.

My emotions would include a bit of anxiety, sort of anticipation perhaps a bit of fear and dread if I know that a patient is particularly disturbed anxiety about whether there will be physical implications.. you might have to restrain somebody. MH1 (33-36)

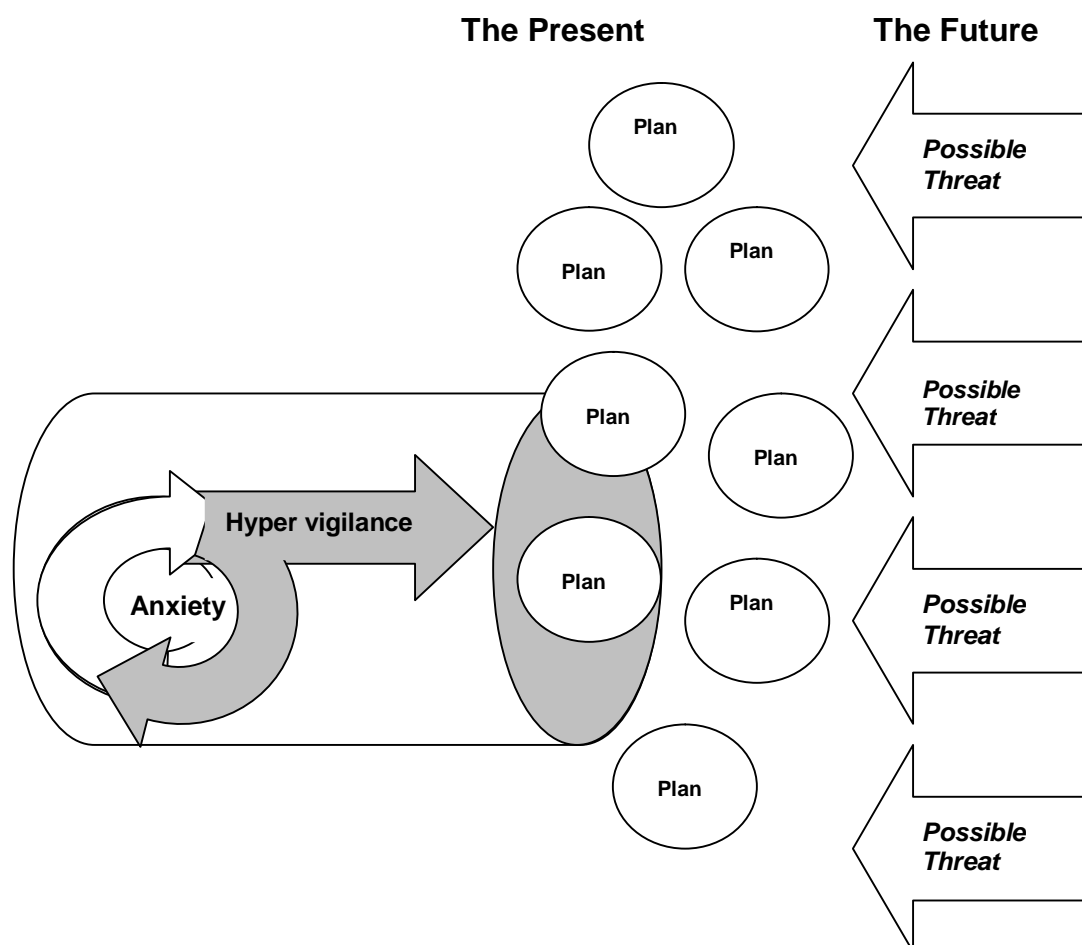
Table 5.5: Anxiety Theme Cluster



The nurse expresses fear of what she *knows for a certainty* (the patient in question is disturbed) and anxiety *in relation to uncertainty* (whether there will be physical implications if the patient has to be restrained). So her fear is experienced in the face of what she knows she has to deal with. Her anxiety is experienced in the face of a lack of certainty relating to what will follow. The consequent stress is explained by the energy spent on framing scenarios that may never happen; the situation is governed by a 'what if?' state of understanding. This is "catastrophising" [see Figure 5.2 below] (Meeton et al. 2012:691).

I was very worried this morning about that boy because I thought any minute now he's just going to arrest on us, and you feel anxious that the doctors aren't taking you seriously enough and that you're going back to them, then you feel anxious that PICU team aren't going to get here quick enough so there's a lot. PD7 (227-231)

Figure 5.2: Catastrophising



A recently qualified nurse working in paediatric intensive care describes the source of his anxiety.

I would say a little bit of anxiety because of not knowing what is going to happen and during the normal course of the day you can say, they are going to remain intubated and you don't expect anything really untoward to happen. You set your mind up, because you look after one on one, you set your mind up for, by the end of the day I want this to happen and pretty much you know it is going to happen. The child is stable, the situation is how you want it to be, but when a child is on the cusp of, (because this child wasn't intubated) and that made things harder because you didn't want to re-intubate for the sake of it but you didn't want to let things go too long without intervening. PIC1 (159-167)

Here again, the anxiety is rooted in uncertainty "because of not knowing what is going to happen" with a child "on the cusp" who is not intubated but whose respiratory status requires close monitoring. The nurse contrasts this with his feelings relating to the care of a relatively stable child who is already intubated. In the case of the latter, the nurse 'sets his mind up' for a working shift providing one to one care, which is expected to pass without event. In such cases goals are more easily set and achieved. In the case of the former patient constant vigilance is required to ascertain at what point intervention in the shape of intubation may be needed. In such an uncertain scenario goals are more frequently revisited and changed.

The classic ambiguous source of anxiety defying precise definition but nevertheless real is found in the narrative of a sister on a busy acute surgical ward when the pace and pressure of work is at its height.

In my case it is time constraints and the workload is just too massive and the time is running out....It does make me anxious, once it's done it's done, so it is during it, when I am in the moment and everyone is calling my name. AU4 (38-46)

The nurse's reference to being 'in the moment' and to the fact that 'once it's done it's done' confine the source of her anxiety to future events in the course of the remainder of her shift. As the window of opportunity to meet the needs of practice

shrinks and the needs of practice increase, “time is running out” and her anxiety levels rise. But what is she anxious about? She cannot be exact.

Something is going to go wrong and I am ultimately responsible or I will be held responsible....Sometimes it feels a bit like you are spinning plates, you are just trying to keep them all up, and that can lead to anxiety because you never know when one is going to fall. AU4 (164-172)

The nurse’s anxiety is a product of a combination of four factors:

1. Awareness that the likelihood of achieving the required outcomes of care and management reduces with time.
2. Multitasking to keep pace with events leads to the possibility that “something is going to go wrong”.
3. The time and nature of what is “going to go wrong” is uncertain and “because you *never know when*”, hyper-vigilance is required but proactive responses are therefore very limited. So powerlessness in the face of a nebulous threat also generates anxiety.
4. The nurse’s awareness that she is “ultimately responsible” and “will be held responsible” accompanies awareness of factors 1-3.

There is therefore a corresponding relationship between high anxiety, high workload, reduced time window, frequently changing scenarios together with unpredictable events including errors and accountability for those events.

Protection against Complacency and Leverage for Accountability

The talk about fear, anxiety and accountability was not wholly negative. Nurses also spoke of the fear a sense of accountability fuels as a protection against complacency.

Making a mistake...getting it wrong....doing something that compromises the patient’s quality of life, making the condition feel

worse. And really we're very experienced nurses in the field we are in so that I think if we weren't afraid then that would be more worrying because then it would suggest that you are not aware of how serious the decisions you are making are. DN3 (55-60)

A public health nurse pointed to anxiety as providing some welcome leverage for commitment to guarding against complacency in her practice.

...anxiety but in a controlled way, I'm not saying that that impacts detrimentally on practice, I think it's quite a healthy thing because if you're feeling quite anxious and feeling and yeah anxious and worried about things I would hope that would stop you becoming complacent about my role which I would never want to feel like that's good enough, I always want to feel like I've done the most I can I guess to limit then me feeling anxious because I know I've done everything I should and then I will stay later come in early to make sure I have done everything I can so I'm not so worried about any repercussions. HVSN3 (104-111)

It seems that anxiety over accountability leads to greater evaluation and monitoring of practice and at the point at which safe practice is ascertained anxiety levels drop. The idea of emotions in assisting judgement and decision-making is supported by these experiences in which nurses refer to emotions themselves as protecting them from a wayward course. Much anxiety was experienced as a result of engaged concern for the welfare of patients. One specialist community nurse's anxious train of thought was initially in relation to her sense of accountability but in conversation with a colleague she realises that her anxiety is really connected to concern for her patient.

So I'll go in and say 'I've done this, that and the other and I've seen this blood test and I'm worried that I have missed this' and they'll say "why are you worrying about that? Because even if you have missed that it's not going to make a difference to their health overall. Because "... and actually they are right, and I'll say "yeah you're right.", because you know, you're always wanting to do the best for the patient. DN3 (284-289)

Just as anxiety serves as leverage for raised vigilance when facing uncertainty in practice so it seems that fear serves as leverage for clearly defined action when facing a threat that is clearly defined. This is revealed in the way the experience of a recently qualified nurse whose lack of confidence in his knowledge and clinical ability create anxiety. Again his feelings are closely linked to accountability.

I meet a situation and I'm not sure, I'm not sure what I need to do. I need to double check that with someone. I have a clinical idea of what maybe I think I should do but I always kind of think, you know, in this day and age it is always better to be safe than sorry. Or as I put it, it is better to be safe than caught, so it is better to check things first. There is a lot of kind of like, okay, I'm really not sure and I'm a bit apprehensive about doing this, I better go check, so again it kind of feeds into the anxiety. AU3 (81-87)

So the nurse's inability to ascertain whether his knowledge and ability match the clinical situation he encounters leads to further 'checking'. The 'checking' within other nurses' experiences involved a revaluation or self-auditing of practice but in this latter case the nurse seeks support from a colleague. However, while the nurse experiences anxiety relating to uncertainty over his ability he experiences fear over his certain lack of knowledge.

I find it quite hard to read up on things I need to read up on, that is quite hard, that is a fear as well, I feel I don't have the time when I am at work and I don't have the time when I am at home as well. Then I get in the situation where I feel I don't know enough or I don't feel confident enough so it is a bit of a catch 22 I think sometimes, I am slowly getting on and catching up with my reading on things so that should be helping with the fear I think. AU3 (107-113)

The insufficient knowledge base to meet the changing needs of practice and the lack of time to address this are perceived by the nurse as certain threats that generate fear, but the fear is expected to diminish as the nurse addresses the threat by 'catching up on his reading'.

As in the case of fear so in the case of anxiety nurses talked about the physical experience of the emotion showing some of the libidinal characteristics shared with

fear. Anxiety was consistently presented physically as a stomach cramp, dry mouth, rapid heart beat and tightening of the chest or breathlessness.

...full anxiety would be the dry mouth, raised pulse, quite tacky slight tightening in the chest, and that would be brought about by more specific circumstances such as the threat of violence or raised voices or someone pulling their pin alarm and not quite knowing what you are going to find when you get to them. MH1 (75-79)

Particularly for inexperienced nurses even while off duty and removed from the practice setting, the very thought of a possible omission at work triggered an anxiety response.

....in my stomach its like butterflies, like the blood's just rushing away from my stomach its like stress, then my heart, I don't know I feel like its in my chest as well, and just that's all I feel like and I just cant let it go once I've got that feeling its hard to let it go, once I get the feeling that perhaps I did forget something then I've got that feeling in my stomach which will keep coming back every time I think of work, like all of a sudden it zooms back. PD2 (57-62)

One nurse's narrative gives evidence of the brain and body as a seamless unit. As her anxiety mounts with prolonged expectation of the type of patient she will be allocated her mental state is accompanied not only by an autonomic response but by body sensation and movement (Immordino- Yang and Damasio, 2007).

...you can feel your heart, not palpitations, but you know that your hearts beating faster than normal. And you feel your chest is a bit tighter, a bit more, you don't feel short of breath but you feel you have less breath in you than you had previously. And I always tap my feet when I'm nervous, my feet will be doing this because it's a kind of restlessness, I think when they're coming in about to have the hand over sheet my feet's going because I just want to have a look. Yeah, you're thinking about something in the future and it's almost an impatience to know what that is, and once you've got that if that's the right answer then its, then you kind of lose that anxiety I think. PD5 (200-209)

Sylvers et al. (2011) distinguish between state anxiety (anxiety as a temporary response) and trait anxiety (anxiety as an embedded part of someone's personality). Substituting the words acute and chronic for state and trait respectively a few nurses made mention of experiencing both.

Do they do different things to me? Yes, I think they do, they must do because the acute worry would stop me sleeping and make it harder for me to switch off so I would be on overdrive, whereas the chronic worry, well worryingly it becomes a bit normal, so ... it is part of you. MH2 (444-447)

As the causes of anxiety were more nebulous than those of fear so the role of anxiety in practice was more complex.

Anxiety with Hindsight

Anxiety presented in the data as serving reasoned thought over uncertainty in the past as well as the future. Specifically this is anxiety experienced and expressed in relation to the possibility of acts of misjudgement or omission. I have called this subtheme "anxiety with hindsight". This type of anxiety was particularly common following handover and higher among recently qualified nurses in children's nursing where the margin for error is reduced.

...when you've made a clinical decision or when, you know in my case, seen a patient in their home and you're driving away it's whether you've done your best for that patient and whether you've made the right decisions. Or whether, you know that, you've missed something that you know, you haven't dealt with. So it's the omissions as well as the actions that you worry about. DN2 (10-15)

A children's nurse described her trait anxiety and how it shaped her state anxiety in relation to anxiety with hindsight. First, this manifests itself in not being able to disengage from work even in the absence of any suspected errors or omissions.

I've always been a worrier and its been difficult, like with leaving the ward and handing over and not taking everything home with me and

worrying about it whilst I've been at home and waking up in the night remembering things. PD2 (9-11)

The nurse's trait anxiety evident in her identity as a 'worrier' leads to self doubt and where state anxiety would lead to targeted hyper vigilant monitoring, anxiety as a trait propels her into a state of hyper vigilance over omissions that may not have taken place.

I can't leave things here, I'm always, and even if I haven't forgotten anything I still walk home thinking, I must have forgot something is there any, and I'm really racking my brains I cant leave it, I cant just forget. PD2 (31-33)

Another children's nurse explains how difficult it is to disengage her mind from work and how reflects on her actions by virtually revisiting her shift in her mind like mental audiovisual footage.

I often go home from a shift and think, 'oh I'm not happy with that patient and just something is not right', and I have to try to remove myself from it at home but I often replay the day from the start so I often feel worried about patients even though I'm not even here, so I sometimes think, 'I've told that nurse this but is she really going to pick up on it and do something, or I hand over, like I've been practicing being in charge of the night shifts, and I've handed over the ward and then I go home and think, 'oh God have I forgotten something?' PD7 (211- 216)

All this would initially seem out of kilter with the literature (Sylvers et al. 2011), which defines anxiety as future focused. However a closer examination of anxiety with hindsight shows that while past events are the focus of attention that arouse anxiety the emotion is expressed in relation to the future consequences of possible errors. Hence the latter nurse's reference to whether the nurse on the subsequent shift is "going to pick up on it and do something". In addition rumination has been identified as a common feature of anxiety and in nursing the need to reflect on one's practice can only contribute to this.

Meeton et al. (2012) demonstrated that intolerance of uncertainty increases anxiety

and the reduction of such uncertainty intolerance decreases anxiety. However this data shows that nursing practice in the frontline of a social world filled with uncertainty means preparation for possibilities is an essential constant and that anxiety is a natural companion to this.

Panic

Panic was associated with both fear (mentioned earlier) and hindsight anxiety and it appears that it is integral to both but with its own identity. If anxiety with hindsight was a hyper vigilant audit of or reflection on one's practice, panic was a point of realisation distal to anxious thought.

..you could probably say that , probably anxiety first and then it is followed by panic that is hasn't been done and I need to do it now. AU2 (180-181)

So the nurse is anxious as she carries out a mental trawl of her work load 'scanning for omissions' and experiences panic when she discovers an omission. The point of 'discovery' explains the double relationship between fear, anxiety and panic. In fearful states such as those experienced on witnessing cardio respiratory collapse, panic is experienced simultaneously at the point of sudden realisation that a threat is present and real. In anxiety, panic is experienced when an anticipated threat becomes a real one.

Concern –“Holding it in your head”

Concern is a prolonged and subdued form of anxiety rooted in the object of one's engagement; a preoccupation arising from the way one interprets their situation which informs on what matters to that person (Benner and Wrubel, 1989). A number of nurses described this 'mental preoccupation' as 'being in your head' or 'holding this in your head'. While this expression was used interchangeably with 'worry' the description of the feeling matches the definition of concern.

You know that something could potentially be a problem or is a problem. And it's having to think it through and knowing what to do for the best...It's having that thought in your head and knowing that

something has got to be thought through and you've got to make a decision about it. DN5 (149-156)

Some texts carried a suggestion that concern involved assessment of risk across a range of patient cases.

You are holding it in your head, different risks to different people so you would hold in your head, risks involved in a person absconding, somebody who is at risk of self-harming, somebody who perhaps has a history of violence, somebody who was violent the day before, and so you would have that in your head. MH1 (86-90)

So concern is also knowledge held in a state of readiness: a diverse stock of histories, behaviours and clinical presentations suspended against the risks they collectively pose ahead of major decision-making. It is a sign of commitment in practice. One cannot lack commitment and be concerned.

The Anxiety Continuum

An experienced mental health nurse talked about the anxiety she suffers relating to a troubled patient in her care mentioning levels of anxiety equating to levels of risk.

You worry that ultimately the person is going to be ok and nothing bad is going to happen to them, that is your biggest worry: that they are not going to kill themselves. And then you worry, a bit down the scale from that is that even if they don't do something as drastic as kill themselves you worry that their life is going to turn out alright and that it, it's not going to be sort of too bad, their quality of life. MH2 (395-400)

On further discussion evidence of different levels of anxiety and concern emerged, which formed a continuum [see Table 5.6].

Well, the worry about them killing themselves is almost the ultimate worry, but it's a worry that doesn't come along every day but when it does it is bad. That is specific about that whereas the worry about whether things are going to turn out ok for them comes along every day but it isn't as big. So, they are angled in different ways if that makes

Table 5.6: The Anxiety Continuum

Panic	Anxiety	Concern	Preoccupation
Imminent Danger	High Risk	Medium Risk	Low Risk
A Point of Realisation Practice Omissions (Including Drug Errors) Not Coping Plurality of Crises Accountability implications	Suicidal Behaviour Deteriorating Patient Health Status Heavy Workload Rapidly Changing Multi-factorial Demands Multitasking Rapidly Reducing Time Window Associated Accountability	Welfare of Chronically ill Clinical Decision Making in Indeterminate Situations Significant Changes in Patient Health Patterns Concern about Individual Colleagues Associated Accountability	Vulnerable Patient Status Team Health Team Organisation Care Management and Planning Staffing Maintenance Equipment Maintenance Stock Maintenance Awareness of Accountability
Unusual	Infrequent	Regular	Daily

sense. And with colleagues, it's a little bit of a mix of both, so sometimes it can be really quite acute and a bit more like, I am not saying a colleague is going to kill themselves but it can more in the field of, this doesn't happen very often but sometimes people are really on the edge and then there are other times when every day you get more of a low key kind of level of concern...I just mean that one is more acute and one is more pervasive, so one is, it doesn't happen very often but when it does it shoots up the graph if you like, whereas the other it's just there constantly somewhere between the middle and the end. So it is like having a chronic illness as opposed to an acute illness, is what I would say and they have both got their downsides, so acute is horrendous when it lasts but you know it is going to go whereas chronic you have got it day in, day out. MH2 (416-440)

So the level of concern emerges as commensurate with the seriousness of the matter in practice that has engaged the nurse's attention. An acutely depressed patient and a colleague whose level of work or life stress is affecting their health will generate greater levels of concern. These are "ultimate worries" which occasionally 'spike' on a figurative 'graph' and register at the extreme end of a continuum of engagement. Concerns about the long-term welfare of patients are present daily but do not supply the same level of preoccupation. They register at a more proximal point on the continuum.

A nurse caring for cardio-respiratory patients in the community also talked about the continual assessment of risk and in doing so revealed another dimension to the continuum of nursing concern. The context of the discussion is the environment of squalor and poor hygiene often inhabited by patients with long term or end stage cardio-respiratory conditions because of the level of exhaustion they experience.

the clinical decision making more ... worry would come into it if you are having to leave someone and walk away. The other difference is that you leave them in that environment having seen that environment and wondering how they are going to continue to cope when you are not there. So it's either getting services in but if they refuse additional services then you are leaving with them managing in a poor situation. Whereas if you've not seen that poor situation its not there to worry you. That's been an issue at times. You feel like 'can I leave this person?....

....I think the more you know, the more things are not right and the more problems there are that could do with solving but there are not enough resources to solve those problems so you have to manage them with the resources we have. DN4 (333-342; 355-348)

The nurse is not consulting in a hospital or clinic. She is consulting in the patient's home and therefore fully aware of the impact of the patients' disease on their lives. This detailed nursing knowledge of a patient's world comes from a larger practice interface with patients. In turn the detailed knowledge fuels greater awareness of the complexity of risk and greater concern. The nurse is aware that her patients value their independence and have the right to exercise their autonomy regarding the level of support they accept into their own homes. Furthermore the amount of social care support available is in question. So the nurse's concern is based on an ethical dilemma supplied by greater personal knowledge of her patient and this causes greater concern.

Concern also helped a nurse focus on priorities at the beginning of the working day as she entered the care setting. The nurse calls this 'tuning in'.

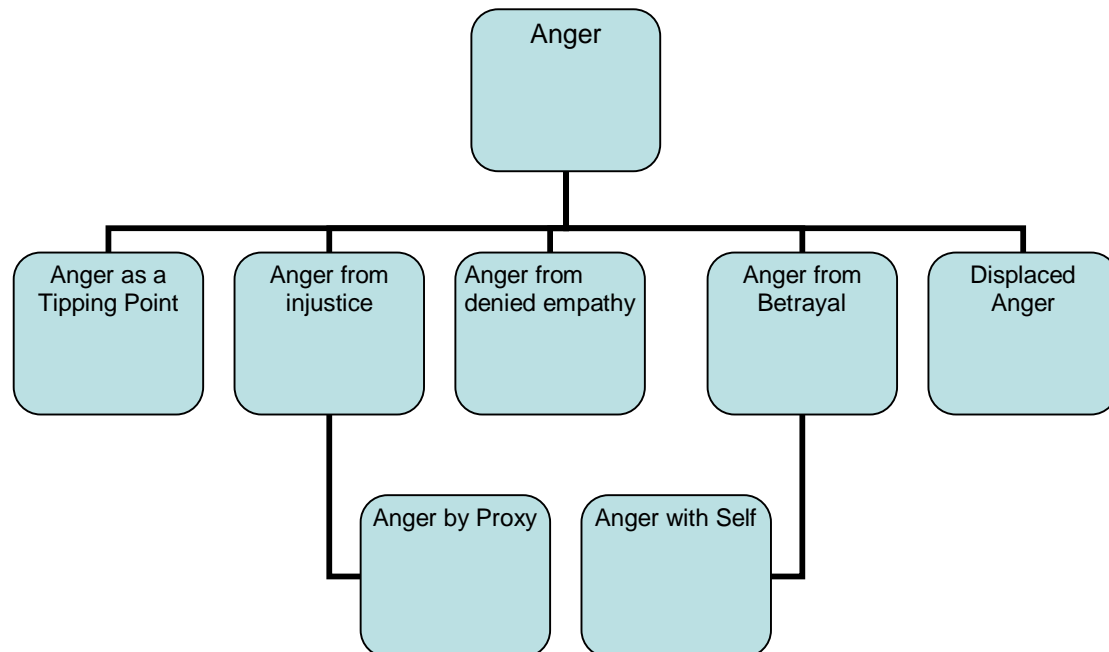
So I would say it would be about, concern maybe kind of heightened awareness really, it's not uncomfortable feeling it feels like I am just getting myself geared up ready for work. I am kind of tuning in. MH1 (69-71)

While concern is clearly a useful emotional instrument to guide prioritising in practice it is also clear from the data how mentally burdensome it can become. It is an indication of the level of commitment at work in nursing.

Anger

Anger [see Table 5.7] featured strongly in the data, and in line with the extant literature (Rivers et al. 2007) there was always an identifiable cause with an accompanying feeling of loss.

Table 5.7: Anger Theme Cluster

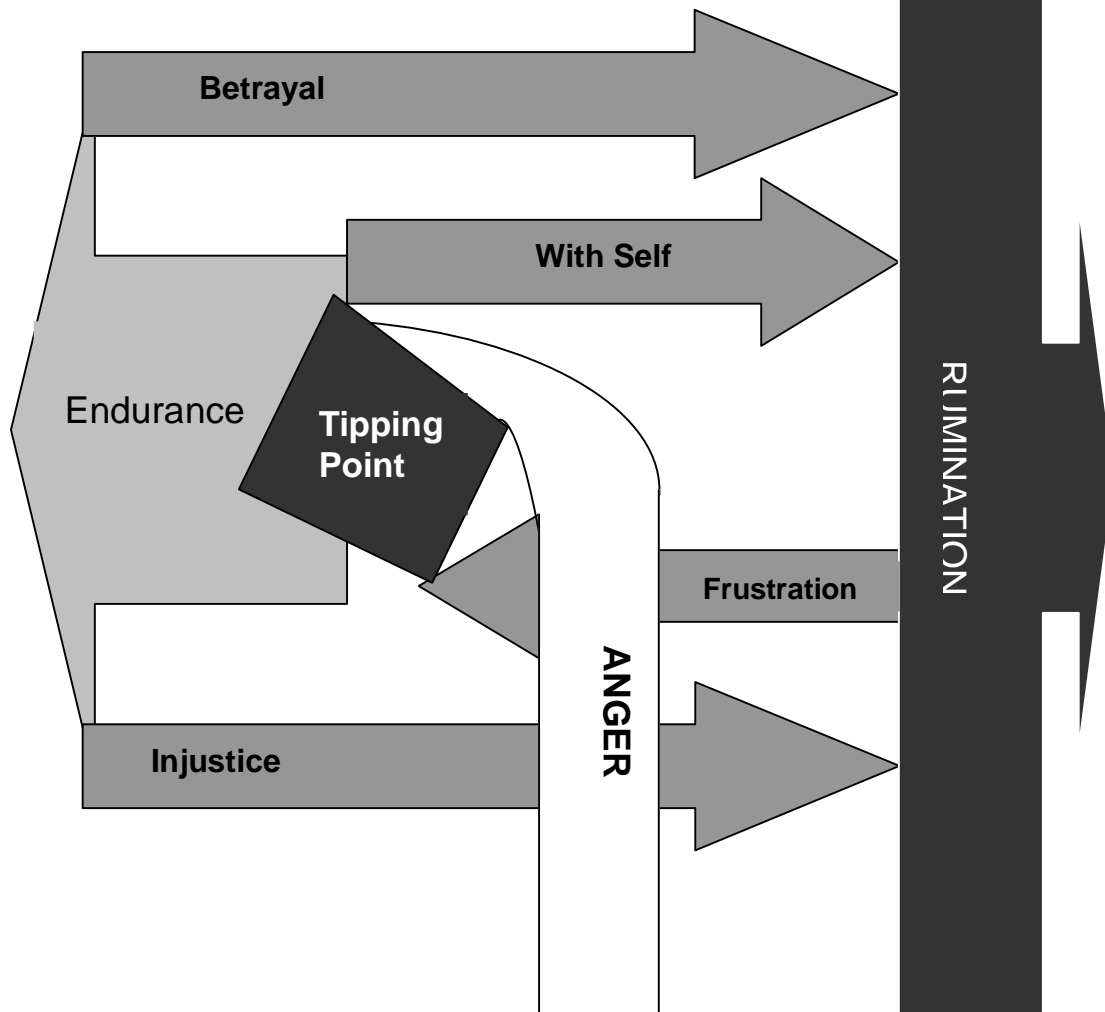


Anger was expressed as a single emotion but also as part of a cascade where one emotion would lead to another. One nurse described anger as the end product of enduring pressure that can be endured no longer [see Figure 5.3].

I've got to the point where I want to shout about it or I want to you know, express or offload and I feel like you know you feel hurt you feel upset you feel like you want to cry, those sort of feelings, but, I feel like I want to say something, when I feel angry like that I often just remove myself from the situation for a little while. PD7 (186-183)

Given the range of anger regulation strategies provided by Rivers et al. (2007) it is interesting that within the data only 'leaving the situation', 'verbal' and 'non verbal expression' are used by nurses. This may be cultural in the sense of socially conditioned gender roles but also in relation to the limited options available to them. An expert nurse in mental health defined anger as she experienced it. Notice that the nurse links the emotion of anger to the stress experience (Larsson et al. 2008; Denson, 2012). It is significant that what Denson (2012:108) calls "interoceptive awareness", the perception of one's own physiological activity, can increase emotional arousal.

Figure 5.3: Anger Experience



...it (*anger*) is a bit on the anxiety spectrum isn't it, it is the sort of intenseness of feelings in your chest and you might have palpitations, dry mouth, it might make you sort of want to get up and stride about, might make your voice sound different, might clench your fists, feel muscular tension in your body. MH1 (336-340)

These pieces of narrative are suggestive of the anger process as a 'tipping point' or a feeling of breaking through tempered endurance.

Anger as a 'tipping point'

Nurses' comments indicated a fragmentation of coping. Anger was experienced as a 'tipping point' at the end of an accumulative process in which the nurse becomes

exasperated with the amount of time and effort required to deal with events attitudes and policies that are obstructive to practice and process [see Figure 5.3].

Whereas anger is usually, it's probably hormonal when you just think ugh...why? Why do we have to keep ... why do people change things without thinking things through first? You know why can't we just be sensible about things? DN3 (216-220)

Asking the question 'why?' features frequently. Anger arises from the fact that the nurse cannot always make sense of what is going wrong and strives to take an analytical approach (Denson, 2012). The nurse's use of the word 'hormonal' shows she acknowledges her anger as an arousal state and her consecutive rhetorical questions reveal her exasperation. Another nurse takes a different perspective.

when I'm wound up I think its like, lots of little things that aren't a big deal; nothing you feel like you need to go to your manager about nothing like that, but just small little things throughout the day that build up and that's when I feel like wound up.. its like little things that upset me or make me feel frustrated, like not necessarily angry but by the point of the it all coming together I get to that point where I do feel quite angry and think, oh like why? PD7 (159-163)

The nurse's comments show that her rumination increases the intensity and the duration of her anger from 'build up' to the 'point of it all coming together' (Denson, 2012).

There were also different shades of meaning within the sources of anger.

Anger from Injustice

One nurse gave an informative example of anger arising from injustice.

...if it is in relation to politics or government policies that will have implications for things in the longer term, I suppose I would feel that it is a bit of sort of a lack of control and being cross that people don't look into the longer term, look into the distance to consider the long term implications and that you know, the government makes changes now

but it will be nurses in health care in 10 years that will be picking up the pieces. That makes me angry but I can't quite define it any other way really, I suppose, maybe that is about feeling a bit powerless and not being able to influence the people who make the decisions, in that context. MH1 (345-354)

Inherent in this nurse's anger is discerning a short-term approach in current national political decisions that is not necessarily discernible by others. The nurse is able to see future social or professional consequences of such decisions that create needless additional burdens in nursing practice. Anger arises from the fact that at some future point the profession may bear the brunt of poor decisions that were not of its making. So this anger is linked to a sense of injustice.

Anger from Injustice- Anger by proxy

We should note that this anger from a sense of injustice was not necessarily felt on behalf of the self but for the whole profession. As one nurse expresses it, it is not a personal but a professional anger; an 'anger by proxy' experienced in the role of representative or advocate.

I suppose it is a different level of anger it doesn't feel like such a raw anger because it isn't a personal anger it is a professional anger, I don't know if that makes any sense but you know I suppose the difference is it is like secondary anger, I am getting angry about something that has happened to somebody else, so either the injustice of the things that have happened to that person in an organizational context but is on behalf, sort of like by proxy almost because of their circumstances. MH2 (105-112)

So this nurse's anger is the product of experiential rumination. Her immersion in anger rumination means that despite adopting a self distanced vantage perspective, her anger experience is intense (Denson, 2012).

Anger from Denied Empathy

Anger was experienced from the lack of appreciation of others for competing demands on the nurse's time. This is the anger of being misunderstood; a wish for empathy denied.

Maybe sometimes, if a patient doesn't always, sometimes if their relatives don't understand, sometimes if you are very busy and you have explained to them what you are going to do but they just won't understand that you're, you are doing it but it's just that you have got to give me time to sort it out; if they are always in your face when you are trying to look after another patient as well. AU2 (48- 51)

So in a profession from which empathy is always expected nurses often wish in vain for empathy from users of their service. Wishing for empathy takes place in the knowledge that care would be improved if somehow they could better secure the understanding of patients and their families.

Anger from Betrayal

Nurses experienced anger in the face of broken promises over resources, which undermined the nurse patient relationship and jeopardised high standards of practice. This is the anger of betrayal.

... and along with that when you did eventually manage to get together to talk with people, about the issues particularly about staffing and they say that they are going to do this and that and then nothing happens. Then again that makes me extremely angry. DN2 (267-270)

Anger of betrayal was also coupled with anger with self. Note the comments of a ward sister who discovered she had been deceived into believing a non-urgent admission was urgent.

I cant believe somebody did that, I can't believe that, so and so said they needed a bed for an urgent patient and then he comes in and he is not urgent, you know that they lied, and that is very much a, it just angers me, I am like, ooh, I cant believe that people can let you down and that you cant trust people even though you know you give them enough rope to hang themselves and stuff. I think anger is something I experience, it is weird, not in an angry, 'grrrr' way but angry at myself for trusting somebody....angry at allowing that to happen. PD8 (193-200)

Anger Displaced

Nurses acknowledged that their anger was occasionally displaced arising out of frustration. One nurse explained that this anger is different from anger she might experience in her private life away from the work setting.

I guess if it was out of work and it was a more personal issue to do directly with me, although I don't particularly get very angry out of work either, but I am hypothesizing that I might, I would feel more able to let it go because I wouldn't be in a professional position. MH2 (112-116)

It would seem that anger may be more stressful in a professional domain than in private life because it cannot always be accommodated in professional practice. Displaced anger was found in the face of tragedy as the comments of a Senior Ward Sister reveal.

When children die, there is anger, anger at your self, not you personally but us as a team hasn't managed to stop that child dying. Fortunately in this job, this environment that I work in, there are not many, but we had a very bad run last year where we had 2 children die, one very long term patient and one child died very unexpectedly after a procedure... Angry that you know, it happened, angry that we weren't able to change what happened. PD3 (286-293)

A nurse gives an example of displaced anger in the shape of behaviour by a neighbouring team, which she considers to be mean and petty.

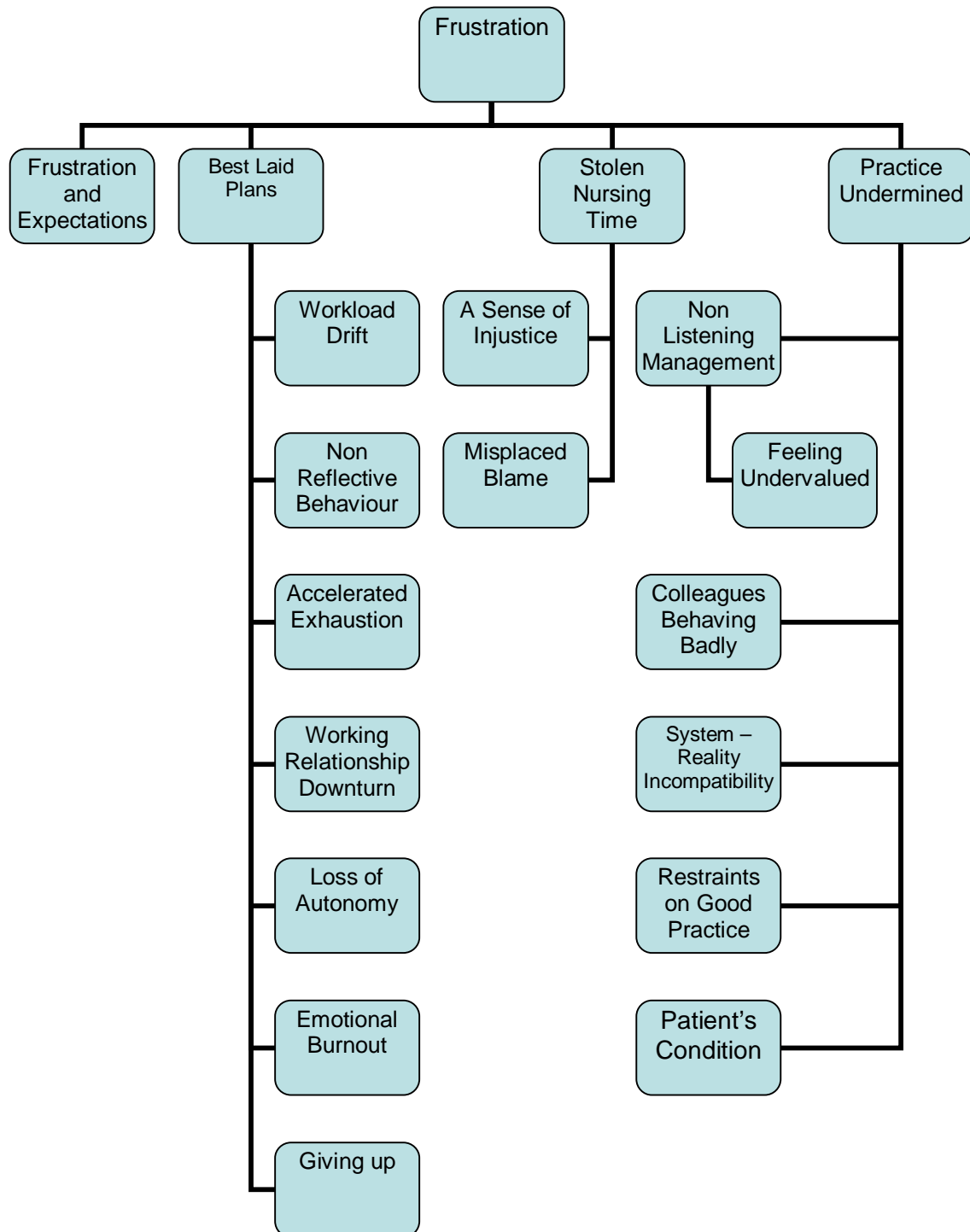
And you know just a simple thing like ...yesterday somebody rang up and said "you borrowed some pads off us last month. We're getting short we want them back". And I thought well you are our suppliers for these pads and we don't actually owe you. So I just put a little message on the answering machine to this member of staff at the clinic and, you are actually our official buffer stock and but we have got some and we'll let you have some so come and fetch them. DN5 (171-178)

These latter three pieces of data show how shortages and limitations within the system can potentially pitch colleagues against each other. Time dealing with such conflict is time that could otherwise have been spent with coordinating care; a theme that will be revisited later.

Frustration

Frustration [see Table 5.8 below] featured in the emotional cascade and like the notion of being upset it was also experienced in isolation.

Table 5.8: Frustration Theme Cluster



This was one of the strongest themes in the data. Berkowitz's definition of frustration (1981) as an obstacle to goal attainment was confirmed by the lived experience of many nurses.

I suppose it's possibly a barrier that stops you from doing your job. DN4
(243)

One nurse's comments captured the feeling of many in relation to frustration : feeling stuck.

...feeling like you are stuck really, you want to kind of give but you feel like you are stuck in concrete. AU5 (305-306)

Frustration was often shown as arising from dysfunctional or insufficiently sensitive systems or malfunctioning equipment. This supports the extant literature on frustration (Maslach et al. 2001; Lewandowski, 2003; Whinghter et al. 2008; Li et al. 2011; McHugh et al. 2011; Burston and Tuckett, 2012; Vansteenkiste and Ryan, 2013) but also informs on the detail of the lived experience of the emotion. As in the case of nurses discussing their anger there was a consensus that frustration was experienced with inanimate things and situations but anger was experienced in relation to people or groups.

And I guess the differences might be that the photocopier is inanimate then therefore there is no point in getting anything more than frustrated with it because it can't get its own paper. Whereas one could be irritated with a human being because they might have chosen to behave in a different way or they might have done things differently. MH1 (223-227)

Frustration was the emotional response of the nurse to obstructions to good care. At times this was malfunctioning equipment.

...feeling frustrated that I can't get things done I want to get done and then also on the back of that there is the ward; lack of materials, lack of drugs, having to go chasing things having to go borrowing stuff from other wards.... the stores are always running low, we only get deliveries on Wednesday and by Friday things are already running low so it is a constant source of frustration really and then set against that you are still trying to deliver the best care that you can deliver really.....

Sometimes the fax machine doesn't work or I have got to fax something over to the other wing because it is the weekend and they haven't got a pharmacy so again it is frustration in that sense. AU3 (14-21; 38-40)

At other times frustration arose from a lack of resources.

...you are trying to do a job, you are trying to do the best you can and you are thwarted by either administrative restraints, restraints of resources, staffing restraints. PD3 (12-14)

The data also permitted exploration of the characteristics, dynamics and root causes of frustration in nursing practice.

Frustration and Expectations

Frustration arose from the contrast between the nurse's ideal of how systems should be and the reality. The expectations while often based on carefully planned preparation do not match reality and the reality is one where demand on resources dwarfs the supply of those resources.

Frustration is more just I suppose you have a lot of expectations about how things should be, I think that is where frustration basically comes from but I kind of expect equipment to work, I kind of expect doctors to write things clearly, a lot of things like that I expect, then frustration things are not very clear or there isn't enough stock or I have to run around and find things and then frustration is, 'why is this happening? it shouldn't be happening'. AU3 (31-36)

A mental health nurse spoke reflexively about her frustrations at work.

When I am talking like this I'm not really thinking about work with any clients I am thinking more about the sort of outskirts of the work but thinking clinically about the actual work with young people, it is strange that I have very different emotions there so it is about expectations I think and what my expectations are. My expectation of a professional is very different from my expectation of a 16 year old young person that I

am seeing so, because my expectations are different my levels of frustration reflect that. MH2 (142-148)

In line with the arguments of Whinghter et al. (2008) frustration in nursing is linked to expectations and by lowering one's expectations one could experience a corresponding reduction in frustration. However, most nurses would find the lowering of expectations unrealistic as a strategy and an anathema in terms of professional ethics. Frustration in nursing has been shown to arise from small unpredictable elements which cause simple taken for granted processes to malfunction. So lowering expectations cannot realistically protect against this. Furthermore today's highly educated nurse is supposed to have high expectations in order to bring about continual service improvement.

Best Laid Plans

A significant feature of nursing frustration was the consistent inadequacy of care coordination plans to account for unforeseen events, no matter how much nurses might attempt to build anticipation of future intervening factors into such planning.

I can set an agenda of things I need to do but I know there is always going to be another collection of 'black box things': things I need to do that I don't know I need to do, things just kind of appear so it is always like, it is almost setting things against the things I know I need to do, and unknown crap that arises all the time just from being on the ward. AU3 (57-61)

The nurse gives some examples of what he terms the 'unknown'. These include matters which need to be prioritised over what has already been planned.

Patients ask you things and that's fine. But some of it can be a major thing, you know patient care hasn't been done properly or, maybe, frustration arises out of just not knowing what else I am going to be thrown into, and then the ward either being short staffed or not having enough stock or just being a bit chaotic. AU3 (63-66)

The numerable and diverse shape of elements contributing to care processes (staffing levels, incomplete care giving by others, stock availability and the sheer unknown shape of the shift ahead), together with the complex health states of those being cared for, means that care planning rarely reflects the exact shape of care implementation. Uncertainty is once again revealed as the one predictable feature of practice. The nurse's emotional response to frustration is also telling.

Anxiety rises out of that, its like I'm not quite sure I will get these things done that I need to get done and it becomes a recurrent pattern, every shift you have an agenda of what you want to do for your patient and then, the best laid plans of mice and men, it never happens really. There are always other things going on, there is always something out the blue, it could be some thing minor, or something major. Anxiety rises out of that it is never quite a feeling you can get the things you want to get done, done. AU3 (68-74)

'Stolen' Nursing Time

The amount of extra work and time consumed in nursing practice that could be better resourced in patient care was a major source of frustration. This is nursing time 'stolen' from the real needs of practice by bureaucracy or unfilled ancillary needs in frontline care. Within this context a number of nurses spoke of a cycle in which they became increasingly frustrated with each predictable turn. Office work was high on the list of causes of this, underlining the arguments of Lewandowski (2003). School nurses and health visitors talked of how time consuming data inputting to a computer system threatened to overtake the time they spent in practice.

..you know we have a computer system now that we feed like an angry beast. We spend a long, long time feeding in data that's both physically tiring and frustrating really just so that people can number crunch. I mean when I look at the percentage of the job that I actually do now it's got to about 10% contact and about 90% sitting at a computer feeding in data about how long it took and all the little details about it. I think that is very frustrating, the time element of that. HVSN6 (10-16)

Another community nurse gave an account of the time she wastes at work because of a hot desk policy.

I find that really difficult to deal with, the fact that everything's not where it should be and that I come in and sometimes I can't find a desk, and so I have to find another desk somewhere else and I have to link to another printer and I have to walk constantly round the building because all my notes are filed in different places in that building. DN3 (195-199)

Nurses practicing in a hospital emphasised the disproportionate amount of time- and energy-filling roles that sit within the remit of others in order to fulfil their own.

I just get fed up when I am doing stuff that I shouldn't have to do, not being able to do stuff that I should be doing, I have to run around in a circle before I can walk in a straight line. I am constantly having to do things that I shouldn't have to do and then do the things I want to do.... I am always doing the things I shouldn't be doing, spending too much energy there and not enough energy is going into the things I should actually be doing. It's like a waste of time really... I feel like I am wasting my time doing things I shouldn't have to be doing but I am doing them. AU3 (43-47; 267-268)

An experienced ward sister argued that there was an irony in the excessive drive to make economies that actively removed nurses from patients. This resulted in a seemingly endless line of meetings she was required to attend which served no lasting purpose.

The other frustrating part is going to meetings about meetings about meetings! You know you go to a meeting and there's an action plan. You go to the next one and no one did their action plan other than you and you go back to another meeting and it just goes on and on. Then they say to you, "Have you got any way to save money?" Well yes, stop having these meetings about rubbish! You would save a fortune. We would all be at work doing the job and it would be fine, but no! Let's have another meeting about how to save money! PD3 (225-231)

'I shouldn't have to do this' - Frustration with a sense of injustice

Care plans are made contingent upon certain reasonable expectations that cannot take account of unpredictable events. The presentation of unforeseen obstacles to due care process brings with them feelings of injustice in that 'people should be dealing with this stuff' but instead 'the nurse has to deal with it'.

I think that is a common theme and then you get frustrated because, it is like constant cycle, of every day there is something that shouldn't be happening in your mind, I shouldn't be doing this, this should already have been done for you, the stocks should be there, I shouldn't have to go hunting for things, I shouldn't have to go hunting for drugs I shouldn't have to go running upstairs to find things. And, also, I shouldn't have to be trying to fix this machine. There's a lot of things I shouldn't have to do but I am doing them and then you get frustrated based on that. AU3 (240-248)

The nurse is clear that broken or insufficiently maintained equipment, low stock and illegible prescriptions written by doctors, are not his responsibility, yet as a frontline coordinator of care he must take up responsibility for all of these issues in order to achieve the desired care outcomes. There is no available option to refuse such additional work. Inevitably this situation leads to a reduced time window in which to deliver care as it was originally planned, which in turn means that some care will remain undelivered or delivered at a suboptimum standard.

Misplaced Blame

While the sources of frustration are often invisible to other parties, the consequences of addressing the sources of frustration in the shape of incomplete care are very apparent. At this point the nurse recalls feeling other destructive emotions.

Then anger when people criticise you for things that haven't been done and you feel like 'Well I am trying my best.' AU3 (253-254)

Nurses' experiences support McHugh et al.'s (2011) assertion of a positive correlation between nursing need frustration and patient dissatisfaction. Moreover the link between these two concepts is revealed to be a failure to achieve the patient

care or 'what you were supposed to do': a dilemma of supply and demand.

In a range of different ways nurses experienced frustration with the expectation that they should respond to need regardless of the disproportionate size of that need compared to limited and diminished resources.

I think it's the amount to do, because of the level of need the level of risk or deprivation, rather than the work that needs to be done. I think time is quite a big pressure and that can make you feel quite anxious if you've got a full diary and you have three case conferences coming that you weren't expecting then you've got to fit that in. HVSN3 (64-69)

Another health visitor described the relationship between volume of work and standards of care in this way:

.. if your busy at the time and you've got a lot of things to do, you might not always give as much as you can to people and you sort of want to move them along a bit and with that, it's pressures of time isn't it, you feel like you're not doing a worthwhile job and you're just sort of ticking boxes rather than giving people the time. But then on the other scale when things aren't quite so busy, then you can give more time to people. HVSN4 (142-147)

A district nurse described her stress response to addressing the 'supply-demand gap'.

So you walk out the door having had to put together the best plan you can, but knowing that it's not really what you'd want if you had ideal resources. So you worry about where it's going to fall down. ... it is expecting the best and not being able to have it.." DN3 (358-362)

So the frustration of misplaced blame from supply versus demand is the dilemma of knowing that the quality of care will suffer in the process of attempting to do more with less in less time. A mental health nurse talked about how messages from policy document reviews and other reports can cause frustration over the lack of understanding as to the limits of the service. The nurse goes on to explain that this can take its toll on self-esteem and that the source of the misplaced blame can be oneself.

you get serious case reviews, enquiries and god knows what coming out with one long list of recommendations that services should be delivering on and you just think, 'just come into my world for a small amount of time and you tell me if you think anybody can do that!'...What can happen is that if you take it on board too much there's, you can start to feel blamed or guilty or you can start to feel that you are not doing a good enough job even though you believe that you are doing the best that you can. MH2 (373-376; 388-391)

In declaring this, the nurse refers to an attitude suggestive of Whinghter et al.'s (2008) performance goal orientation. The nurse struggles against internalising responsibility for planned outcomes that are not met, despite realising that the blame does not rest with her. She speaks with resignation of the failure of nurses to return the blame to its correct place.

..and yet individuals sometimes kind of feel responsible for that rather than being able to say 'well actually, I haven't got a space in my diary and it's not actually my fault but this is how many people the service employs.' MH2 (42-44)

These 'properties' of frustration are a prelude to emotional burnout, which has a number of features.

Workload Drift

The extended time period caused by unanticipated obstacles to progress means that yesterdays work 'drifts' on to today's work and what was planned for today must be postponed till tomorrow.

..feeling a combination of sort of irritation because something hasn't been done and a little bit of anxiety because I have got to do it again which means something else I was going to do won't be able to get done. MH1 (173-174)

This statement by a mental health nurse points to evidence of a second point in a 'chain reaction' which begins with 'best laid plans' with a 'domino effect' on other affect and behaviour.

Non-Reflective Behaviour

The pace of work issuing from unforeseen demands of practice leads to 'autopilot' behaviour that focuses on tasks rather than people and lacks forethought and reflection. The satisfaction of 'making a difference' for individuals is diminished.

I think it becomes harder and harder to think. You kind of find yourself running from task to task and never really getting a chance to stop and take stock. Usually at the end of the day you look back and think, oh yes I should have done this, and this, and this but usually it is just constantly running between one task and then being frustrated that you cant get it done as efficiently or as patient friendly as you want. AU3 (21-27)

As a district nurse relates, during busy times reflection in action never happens and reflection on action does not take place until after the working day is over. This is stressful because judgement is compromised and the opportunity to adjust practice is gone.

...you're doing things much quicker, you don't have the time to think and mull it over and that creates a lot of anxiety for me at night time. Because I then, that's when I do all the thinking and then that's when I do all the worrying.... you can't see the wood for the trees. You can't see what you can put off or what you can do differently because you're so busy just getting on with it, DN2 (54-67; 341-343)

Accelerated Exhaustion

This sub category describes a situation in which the nurse experiences exhaustion earlier than might have been reasonably expected in different working circumstances. This can occur when the pace of work is intense.

Last week I worked on Monday, we were really short staffed on Monday, I did four days last week, Monday; Tuesday; Thursday; Friday, just by the end of Monday I was run ragged .I didn't have many patients to look after but I was so stretched and a lot of running around, and in

the week it was always like, Monday we didn't get things done and then you feel like you are catching up so I was exhausted by Monday and then I still had the rest of the week to go. AU3 (289-295)

In the community, nurses experienced accelerated exhaustion from working longer hours to meet higher demand.

feeling quite sick, that 'how are you going to do it all?' But you do you just stay later and come in earlier. And it always seems to work out in the end but it's quite exhausting. HVS3 (70-71)

Another nurse explained the same feeling in mental terms tracing his exhaustion state to a prolonged period of hyper-vigilance.

and that I was always, I was completely mentally shattered, because I was always really alert and hyper vigilant. MH3 (99-100)

Working Relationship Downturn

Feelings of frustration impacting on mood were reported to have a corresponding impact on relationships between colleagues.

it is more kind of like feeling like you are being attacked and I noticed a lot of my colleagues and myself, tempers are quite short and then I find myself getting at people, it starts to become much easier to say something flippant like you should have done it, you know those jiggly back hander comments people make when they are tired, fed up or frustrated and I think that, I have noticed that has increased a bit more as well, the kind of back biting, things people wouldn't normally say, they start to creep out and you start to take it out on your colleagues. AU3 (148-155)

The insidious nature of 'working relationship downturn' is exposed by the use of the term "start to creep out" in relation to 'the things people wouldn't normally say', as part of the frustration process "when they are tired, fed up or frustrated".

Frustration and loss of autonomy

Anxiety was identified by many nurses as a by-product of frustration on a frequent rather than occasional basis.

If not everything's going to plan and not, I don't know what word to use, its not panicky, its like, I just feel like not in control. PD2 (82-83)

The element spoken of as 'everything not going to plan' is synonymous with the lack of progress characterised by frustration. The nurse shows discernment in her discrimination of experienced emotion, dismissing 'panic' as an unsuitable definition for her feeling state. The nurse's feeling that she is 'not in control' points toward a consequent loss of autonomy. This emotion pattern is consistent with the raised stress levels and loss of autonomy; 'feeling not in control' associated with frustration described by Vansteenkiste and Ryan (2013).

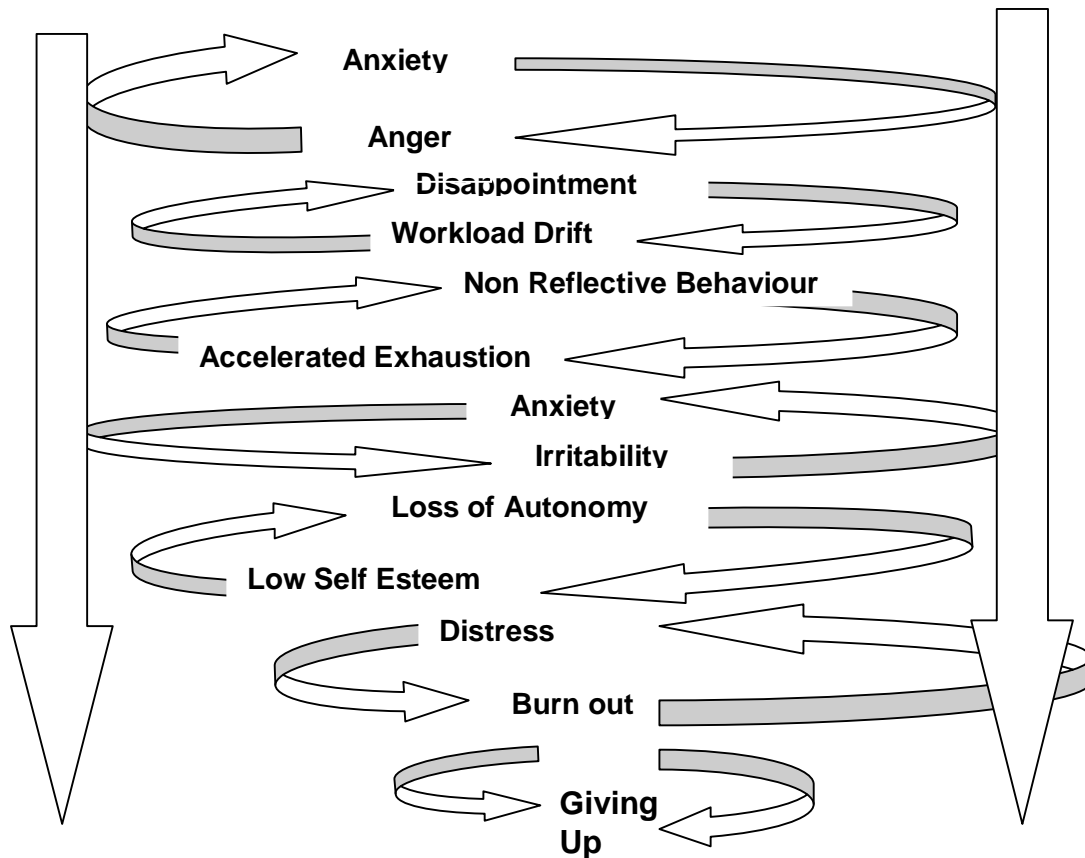
Frustration and 'Burn out'

Frustration as a lack of progress toward preset goals while stressful is therefore revealed as not debilitating in itself. Rather debilitation occurs as a result of the repeated waves of other negative emotions, disappointment and anger which parallel frustration. Conscious awareness of the root of frustration gives rise to other negative emotions such as anxiety, anger and distress in the cascade mechanism discussed elsewhere in the data and in the literature (Burston and Tuckett, 2012; Damasio, 1999). The 'drawing in' and intertwining of powerful negative emotion in a vortex of frustration [see Figure 5.4] is physically, mentally and emotionally exhausting. Nursing descriptions are consistent with the pivotal point at which prolonged stress progresses to burnout as described by Maslach et al (2001). More specifically the effort reward imbalance described by Siegrist et al (2004) and its consequences described by Li et al (2011) are also explicit. It is interesting that one mental health nurse described the feeling of being "flattened".

I think if you got a plan into place and is a good plan and you have tied up the loose ends and you ask somebody to follow it, it's kind of disappointing and frustrating if it doesn't happen... flattened maybe, I am trying to think of the physical symptoms and I can only think of

disappointment being, you know dropping shoulders and the sort of, it is quite hard to articulate how that feels inside...sort of enthusiasm squashed out of you. MH1 (36-39; 200-207)

Figure 5.4: The Frustration Vortex



A nurse in an acute surgical ward used a similar metaphor prior to using the clinical term of depression.

...energy wise it feels like I am running around for no real gain I think, that is how I would put it really. You feel a bit deflated or kind of like, yes depressed I suppose. AU5 (318-320)

There was evidence that emotional burnout has a cascade effect of its own; such as increased sickness rates which in turn place pressure on those nurses remaining at work. This in turn impacts negatively on patient care.

At one point I was getting burnt out, my colleague was too, and a number of people had gone off sick and you're still trying to provide this service to the high standard that you want to provide it yet you physically can't...therefore you feel that you're putting your patients at risk. All those things that you feel are important, like building a relationship with the patient and them believing in you and feeling that you are accessible, they all go down the drain because there's nobody there. Then all that you work for, everything that you work hard trying to provide just goes. DN2 (271-279)

The work of Maslach et al (2001) also finds support in this part of the data forasmuch as frustration not only precedes burnout but a 'domino' effect on staff morale and health. For some nurses this cycle leads them to the brink of a decision.

Giving Up

Li et al (2011) showed a link between continued high levels of frustration and the intention to leave. This found support in a sub category called 'giving up' which describes nurses for whom the impact of frustration means that they are on the brink of leaving.

..you feel like the ward isn't functioning properly and then its like you feel it just isn't worth it sometimes or it is a lot of hassle to get things done. AU3 (251-253)

A health visitor talked about how some families do not respond to interventions and efforts to influence child rearing practices or health behaviour.

..sometimes you go back and you just feel it doesn't matter how much effort you put in it doesn't make a difference. So you just feel like your just constantly going over the same ground day after day and not getting anywhere, which can make you feel quite demoralized sometimes as well because you can only keep chipping away for so long. HVSN2 (23-26)

A children's nurse admitted that there were days when she questioned the purpose of her practice.

Then you get days where you think 'why do I do this?'. Days like that are more when things have gone wrong or you have got some bad news about a patient. PD4 (62-63)

None of these nurses voiced their intention to leave but their narratives show that for many, resilience in the face of thwarted practice is not permanently sustainable and how frustration can cause practitioners to reflect on their career choice. Lewandowski's feminist perspective on the frustrations of caring (2003: 177) is at some variance with the messages from this data. Although the "other focused" disposition of women as a barrier to communication of carer need is biologically and socially credible, the mixed gender composition of the sample would suggest that this is the universal dilemma of carers and caring rather than being specific to carers who are women. In summary the frustration cycle appears to have 5 phases:

1. Making sound logical plans to meet aims (associated with certain expectations).
2. Having the plans thwarted by unpredictable developments (the unexpected needs of other patients, a lack of progress by colleagues, the failure of systems or equipment on which the nursing team is reliant) and/or political or corporate systems and structures.
3. Being forced to suspend or delay plans while the nurse compensates for the systems deficit (for example waiting while equipment is repaired, using up time borrowing the equipment from elsewhere or doing work which should already have been done by someone else). This provokes negative feelings such as disappointment, injustice, anger and anxiety.
4. Failing to meet the desired outcome on time.
5. Having the negative outcome attributed to their practice which in turn leads to more frustration, anger and low self esteem and debility.

A closer exploration of the data revealed a range of other causes of frustration in nursing practice: factors that threatened to thwart success in practice at the outset.

Practice Undermined – Non-listening management

Frustration arose from having to deal with managers who did not engage in any meaningful listening with their staff. This is the first of a number of subcategories which contributed to the undermining of good practice as opposed to hindering it. Nurses talked about the uneven contract that existed between themselves and their managers in which much was expected from frontline staff with little heed paid to their needs.

...they want you to give the best care possible to the patient but they don't provide everything for you to give the best care. And then at the end of the day when the patient complains they (*managers*) come and blame you for it and I find that very disappointing. You try your best but you feel they are not there to help you. AU5 (52-56)

Nurses often complained of being 'talked at' or patronised rather than listened to.

...all my manager will say is "it's nothing to do with you, don't worry."
I said "I'm not worried I'm a bit upset". "Don't worry" she says, I said "I'm not worried", and she went on 3 times. You know that made my hackles rise because she talks at you but she's not actually listening to you. They might say "I hear what you say" but they're not actually listening. DN5 (512-516)

One ward sister talked at length about her frustration when managers kept placing the responsibility for adequate shift cover with her following sick leave and her own failed attempts to appease the situation. The sister's grievance centres on managers' failure to listen to her advance warnings of unsafe staff numbers and responding when it is too late.

when you speak to more senior people, it is just like they say 'Well reorganize your staff.' Well actually the staffing has been organized the best we can. There isn't any more in the pot. Everyone has already reorganized their shifts; somebody has gone off sick so people have moved this way and that way. I can't move it any more and if you told me yesterday that it would be fine to put a call out to somebody then I

might have had a chance of finding somebody half decent to fill that extra shift. If you had said to me, even the day before, I would have the chance of finding somebody but now you are telling me on the morning that you now need somebody else. I knew I needed somebody else yesterday but I was told we couldn't employ anyone else, now today has come. PD3 (148-161)

Non Listening Management- Feeling Undervalued

The frustration in the last piece is not purely about talking and not being heard. It is related to having one's working knowledge of the needs of one's clinical setting ignored. This in turn leads to a feeling of being undervalued. Undervaluation arises from having one's worth validated in the fulfilment of prophecy arising from one's expertise.

A district nurse put it this way:

They tell you what you can't do, but not once have we been praised or given ... I say, well not once, but only in a minor way. You get all the brick bats but not the bouquets, is that the phrase? You get told what you're doing wrong but rarely do you get patted on the back when something is going well. It makes you feel undervalued. DN5 (487-491)

The nurses' reactions are predictable given the findings in the literature (Lewandowski, 2003; Li et al. 2011; Vansteenkiste and Ryan, 2013) to the effect that staff whose needs go unaddressed will experience frustration and dissatisfaction. A staff nurse expressed her dissatisfaction with her workplace culture in this way:

the people above us, the authority, if they give us that dignity if they value us that much, just like we're being told to do everything in a dignified way for our patients, they need to dignify us as human beings as well, working in this environment and if you're dignified in your work environment, then you want to do more you feel proud of yourself you feel 'yes, I'm worth something.' you know, and if there's like changes that we're meant to do or things that we're meant to do to improve things and you're just told, 'Well do that!' without them coming back to us and saying 'Okay what do you think? What's your opinion about this?'

People coming together to make decisions rather than somebody sitting up there making the decision and just laying it down and saying 'Okay tell them we need that that and that done.' I don't think its dignifying enough. I think it could be better. PD9 (219-227)

This experience of a system in which respect appears unilateral and management has ownership of change is consistent with Li et al's argument (2011) that an effort-reward imbalance has a negative impact on job satisfaction.

Practice Undermined - Colleagues Behaving Badly

The behaviour of other colleagues proved undermining for many of the nurses. There was no personal edge to their comments but negative attitudes and a lack of social or technical skill were at the root of their frustration. These negative elements of daily working life were seen as inhibitive to good practice and practice learning. For one nurse specialist lead the propensity on the part of some colleagues for protest and critique for it's own sake rather than on any evidence based grounds aroused frustration.

Why don't they just get on with it? People are questioning. It's like management if they want us to do this, this and this. Yeah you question it, you don't just go off and do things, but at the end of the day patients come first. If management want you to do something in a certain way you've got to sort of try it haven't you? Some people just continually fight and question. And I just say look at the end of the day we are here to do a job, we are paid to do a job to the best of our ability, the more you fight against it the worse you make things for yourself. Then you get all churned up over nothing really, it's a waste of energy... because if you do it and then say 'Look we've tried it we've done it but this would be better' management are much more likely to listen to you. Half the time it's not the patients it's often who you work with really. They haven't got the same sort of ethos of working. DN4 (194-203; 253-258)

The nurse perceives futility in criticising a new initiative for practice before it has been tested. But it should be remembered that oppositional defiance is one of the products of a culture of suppressive management (Vansteenkiste and Ryan, 2013). Nurses also showed themselves frustrated by colleagues who would not take their fair share

of the workload or who saw work purely in terms of what was assigned to them, rather than something shared and balanced across a team.

...when other agencies or colleagues are not pulling up their weight it does really frustrate me. HVSN1 (288-290)

Nurses were often frustrated by the way doctors acted insensitively in a way that undermined the nurse's fragile relationship with patients. Note the comments of a children's nurse in this respect.

A registrar comes down and says "oh I will go and speak to them (*the child's family*)". This registrar isn't always tactful, and I don't think she is purposely being not very tactful it is just her way, she is like 'Oh everyone is fine.' She goes off to speak to the parents and basically leaves them distraught, basically saying, 'your child is fine. It's fine, there is nothing we are going to do, and it should be fine, whereas I am thinking 'You can't be like that with someone!' PD8 (219-224)

As the chief frontline coordinator of care the nurse will always bear the brunt of any disruption in care whether or not the nurse is responsible for that disruption. This is frustrating because patient dissatisfaction can easily issue forth from such disruption despite best practice on the part of the nurse.

Practice Undermined - System Reality Incompatibility

Frustration also arose from systems in place to measure quality and practice that lacked the capacity to do this sensitively and accurately. Some nurses complained that record keeping systems were too rigid, allowing insufficient space for the 'free text' essential for observation and intuition.

Even now when we come to do the report writing we have to put it all into the boxes you know, everything. There isn't a lot of room for 'that didn't just feel right' and why it didn't feel right, because it didn't' you can't put that in the box. It's too sort of clinical, too rigid. It's hard and I sometimes find it quite hard to explain to people, and they don't always get it. HVSN6 (184-188)

The view that practice measurement was devoid of any qualitative dimension was particularly common. A nurse in a high dependency unit expressed her despair over the limitations of a quantitative formula to calculate an acceptable workload.

There is no automatic indication of who needs what, how much care is required by X amount of staff... it might still look as though you have got 4 beds free, but you have got 3 people that need 2 nurses to look after them but you have only got 4 qualified on. AU1 (8-9;244-246)

The notion that success in public health practice is greater than the sum of its parts that are measured featured strongly. Notice how a diabetes nurse lead spoke about the chasm between the targets she is required to meet.

... we've got Key Performance Indicators to do. So you know, after the end of March next year they are going to audit how well we have done. So then it will be about how much of the HP1C has come down, how quickly were they seen and all this. Which is good in a way, but it's all number crunching isn't it....it doesn't take account of what you do with those people once you see them quickly. We can all see people quickly within 4 weeks, but if we don't review then regularly enough then you are not getting to go where you need to go with that patient really. So perhaps there is going to be more taking charge of them which is really not the idea. You know it's going back to the medical model really we are there to tell them what to do. And we've got to get round to thinking about goals 'what do you want to achieve, what are your goals? DN4 (72-88)

The nurse does not dismiss the key performance indicators as valueless acknowledging that they are "good in a way". Her grievance is over the missing qualitative measure of the nursing time effort and skill in building a relationship with patients which can lead to empowerment (McKinnon, 2013). A school nurse gave an account of a long term working relationship with a vulnerable teenage girl.

It's the bits that you can't put into a Scoping Exercise. It's the bits that people feed back to you; the little personal things that people feed back to you. Like I had a girl once, and I have to remember these things when I'm feeling really fed up. I can remember a girl at the High

School; she was always coming in for the morning after pill. You know, low self esteem, let anybody use and abuse her really. Things weren't very good at home, she even let herself go physically, she wasn't washing and her hair wasn't right. And I worked with her for months and months; did loads of self esteem type stuff, really trying to get her to think. She wasn't going to stay on at school, she did in the end stay on to do her A Levels, gradually began to sort of value herself a little bit. And then it was about, I don't know 2 or 3 years later I saw her in town and she shouted out to me and she said 'Oh Mrs P.... I just wanted to say I like me now.' And I thought nobody is interested in that, you know that isn't the sort of comment that ticks a box anywhere. HVS6 (105-121)

The source of the nurse's frustration in the shape of positive care outcomes which will never be measured or recognised points to an effort reward deficit consistent with the undervaluation of practitioners (Siegrist et al. 2004). Frustration is borne out of knowing positive outcomes that can never be evidenced in a way that would capture political interest. The feeling of being under valued is what results from this.

Let us do our job: Frustration – Restraints on Good Practice

I've wanted to shake someone and say 'let us do our job! Just give us the tools and we'll do a fantastic job. DN3 (201-202)

In addition to labouring under systems that did not accurately measure practice, a separate source of frustration concerned systems that restricted good practice. Contractual rules and political structuring numbered among these and again this aligns with Lewandowski's findings (2003). There is a discernible relationship between such restraint and the systems incompatibility with the practice world they measure in that much contractual directives are based on the very data produced by the systems nurses believe to be flawed. A health visitor talked about the gap between health commissioning contractual priorities and the needs of families in her caseload as she perceived them to be 'on the ground'.

..not all families fit into a commissioning criteria.. which is really frustrating and I think that's because as a nurse you're coming very much from quite a caring and emotional point of view, whereas the trust

are running it very much as a business which is quite difficult to balance it out really. HVSN3 (29-32)

The NMC code (2015) requires that in situations of conflict nurses place accountability to their patients ahead of contractual obligations. So from a 'caring or emotive' point of view there is an ethical clash between negotiated contractual directives and the findings of a search for health needs. This is particularly the case in proactive health practice where the 'trawl' of need is a more comprehensive one when compared to a reactive biomedical setting. Nurses working in community health settings will daily uncover needs which they have the expertise to address at a level of primary prevention but are restricted by contract from doing so.

Paperless record systems seem to present their own problems for nursing practice. A health visitor referred to a recent technical malfunction and the mushrooming implications for her daily practice.

...last week in our office our computers were down for nearly a whole week, and you cant do anything without the computers anymore because we're paperless, and you do your visits come back and you've got lots of messages, you cant even ring the clients because you cant get on the system to find the number! So obviously it's impacting on your work load because there's just more and more work piling up, so you get more and more stressed, and think these clients think I'm not going to bother ringing them because I'm not bothered, and I can't actually ring them because I can't get the numbers off the system. And then Wednesday this week, the whole of the county's computers went off, GP's and everybody, and again, I'd put the morning out to write a child protection report and sat there twiddling my thumbs, because we'd got no computers again. HVSN2 (147-156)

The nurse fears her clients will think her silence indicates a lack of commitment on her part when in fact a computer malfunction is at the root of the problem. Bureaucracy and paper work have been shown to be a low priority with community nurses who deal with such matters in private time (Stuart et al. 2007). While other narratives have shown the causal relationship between high nurse frustration and patient dissatisfaction as argued by McHugh et al. (2011), this latter piece of data

captures the causal link in the shape of unsatisfactory system support for modern nursing.

“I can’t make it right.” - Frustration with Patient’s Condition

An inability to make a lasting difference in a patient’s life despite best efforts registered as a source of frustration. A district nurse described a patient with chronic obstructive pulmonary disorder.

I said ‘you know I can’t make it all right for you’ and he said ‘I know you can’t’. I can’t give a new pair of lungs! So I suppose that’s a feeling of frustration; a feeling that you can’t do as much as he would like you to do because you haven’t got a magic wand. You know, I think I’m doing what he thinks, the limits to which medicine and nursing can do. But I can’t make it all right for him. DN2 (500-505)

Frustration often stems from not being able to make a difference but also from an inability to understand the root cause of the patient’s problem. Frustration with a patient’s condition is closely linked to a feeling of powerlessness or having no control. One children’s nurse described how she felt her autonomy and competence slip away as a child deteriorated in front of her eyes.

I felt a little bit out of control in that situation I think and I didn’t like the way that made me feel at all. It was just a horrible sort of feeling, that is the most emotional I have ever been in work, ...when you just see something spiralling out of control and you have no control of it.... you can see her before your eyes, she is swelling, she is getting bigger, nothing is making any difference, her blood pressure is now in her boots, her oxygen saturations are dropping, just that panic of ‘I need to do something to stop this but I cant do anything to stop it, because I can’t, who am I, I cant do anything to stop it.’ So that is just an overwhelming feeling of ‘what do I do?’ PD8 (87-91;156-161)

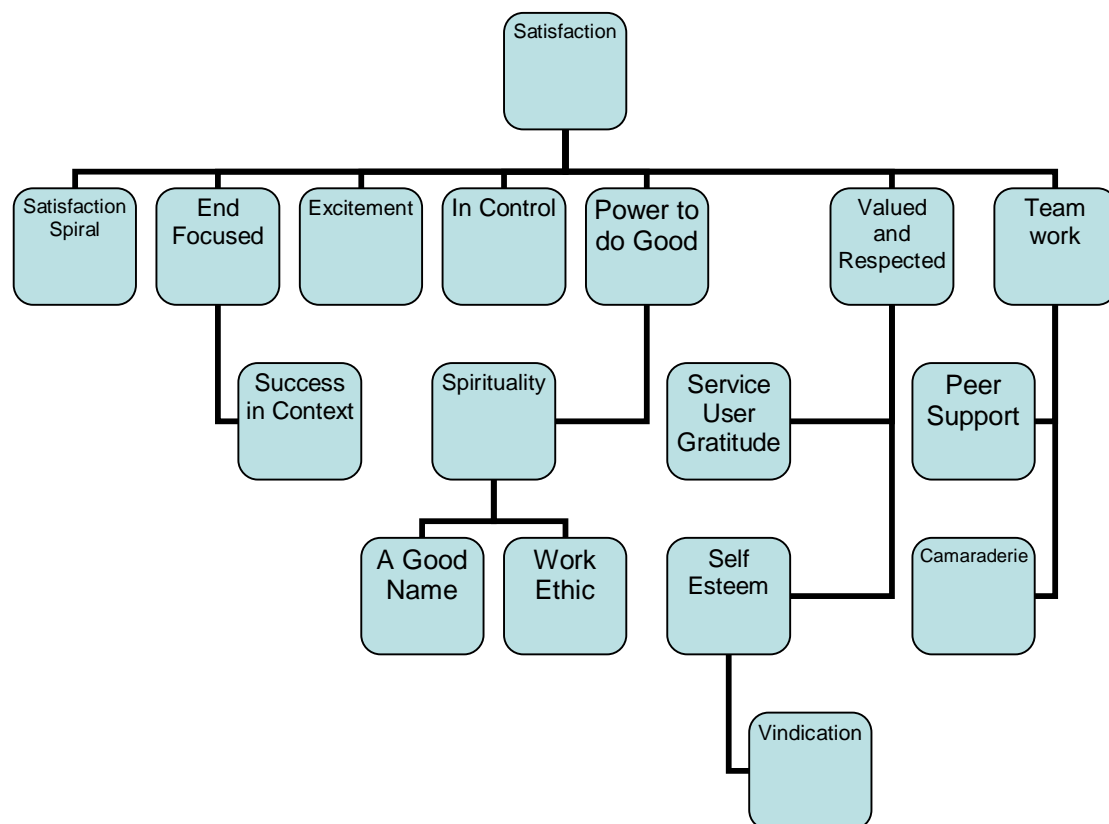
The transition is evidenced in this nurse’s experience from the polished proactive integrated performance that is autonomy and competence to diminished wellbeing and fragmentation. The despair in her story is clear as she realises that she is ‘lost in unknown territory’. The nurse knows that she ‘needs to do something to stop it but

can't .. what does she do now?' Her experience is an endorsement of Vansteenkiste and Ryan's (2013) work showing the role of 'not knowing' in the loss of autonomy and the accompanying sense of frustration.

Satisfaction

Without exception each nurse spoke about the high level of satisfaction, happiness, sense of wellbeing, fulfilment or reward they derived from their job [see Table 5.9]. The data confirms the findings in the literature (Adams and Bond, 2000; Davern et al, 2007) to the effect that the foregoing terms are interchangeable. What was remarkable from the beginning was the way that satisfaction was entirely related to patient care and practice. At no point was there any mention of ambition for the self through promotion or further study although many of the participants had clearly benefited from both.

Table 5.9: Satisfaction Theme Cluster



I do actually love nursing and love my job and I get an awful lot of pleasure out of the job, and I think the thing I get the most satisfaction

from is that feeling that you've made a difference to somebody. DN2 (70-72)

The 'feeling that you've made a difference to somebody' was pervasive in the data as a powerful motivator in practice. Consistent with the findings of Utrainen and Kyngas (2009) awareness that a dramatically positive response to treatment has issued from the powerful self was seen as the ultimate reward in practice. A diabetic lead nurse put it this way:

...you know it's a rewarding job. You get somebody who is really keen and their blood sugars are high and you put them on insulin and 6 months time everything is fine and hunky-dory, they are feeling better, they've lost weight, blood sugars are good, you've reduced the risk of complications. You do feel you've helped them along the way DN4 (48-52)

The nurse patient relationship and the work relating to it were powerful sources of satisfaction (Hayes et al., 2010). Providing individualised and holistic care yielded a sense of wellbeing among nurses across the range of specialties.

...just quite fulfilled really, because you've had a positive outcome because you've made a difference to a family, because hopefully that child's in a better situation than they might have been in if you hadn't had that input. HVSN3 (83-88)

This latter comment from a health visitor expresses satisfaction issuing from a 'positive outcome' at the end of planned care. The notion of satisfaction at the point of completion is being examined separately but it was clear from the range of narratives that satisfaction characterised more than this.

sometimes it is just nice when you help a patient with information, you might give them, they may be feeling a bit anxious and you explain what the procedure is about or you explain how they may be in pain or whatever, if you explain that it isn't unusual and that they are doing really well it is nice to see the patients anxiety levels come down. AU3 (212-216)

These comments reflect the value of the “deep human connection”: the preservation of personhood and the reciprocal gratitude at the root of nurse satisfaction in Utrainen and Kyngas’ study (2009:1006). The satisfaction from making a difference features throughout the duration of the practitioner-patient relationship, not just at the end. A host of points at which success is experienced in the care process generate a sense of happiness in nurses engaged in that process.

The Satisfaction Spiral

Satisfaction emerges as having the opposite effect to frustration and the characteristics of frustration. Frustration acts like an emotional vortex drawing in a negative emotional cascade consisting of anxiety, low self-esteem, distress and anger. This leads to poor self confidence and fragmentation of skills and knowledge. In contrast satisfaction creates a spiralling updraft, which generates a positive emotional cascade [see Figure 5.5]. This cascade results in positive personal and professional growth and development. A sense of achievement recognised, respected and rewarded in a supportive environment promotes autonomy, the swift assimilation of new knowledge and skills, creativity and innovation (Vansteenkiste and Ryan, 2013).

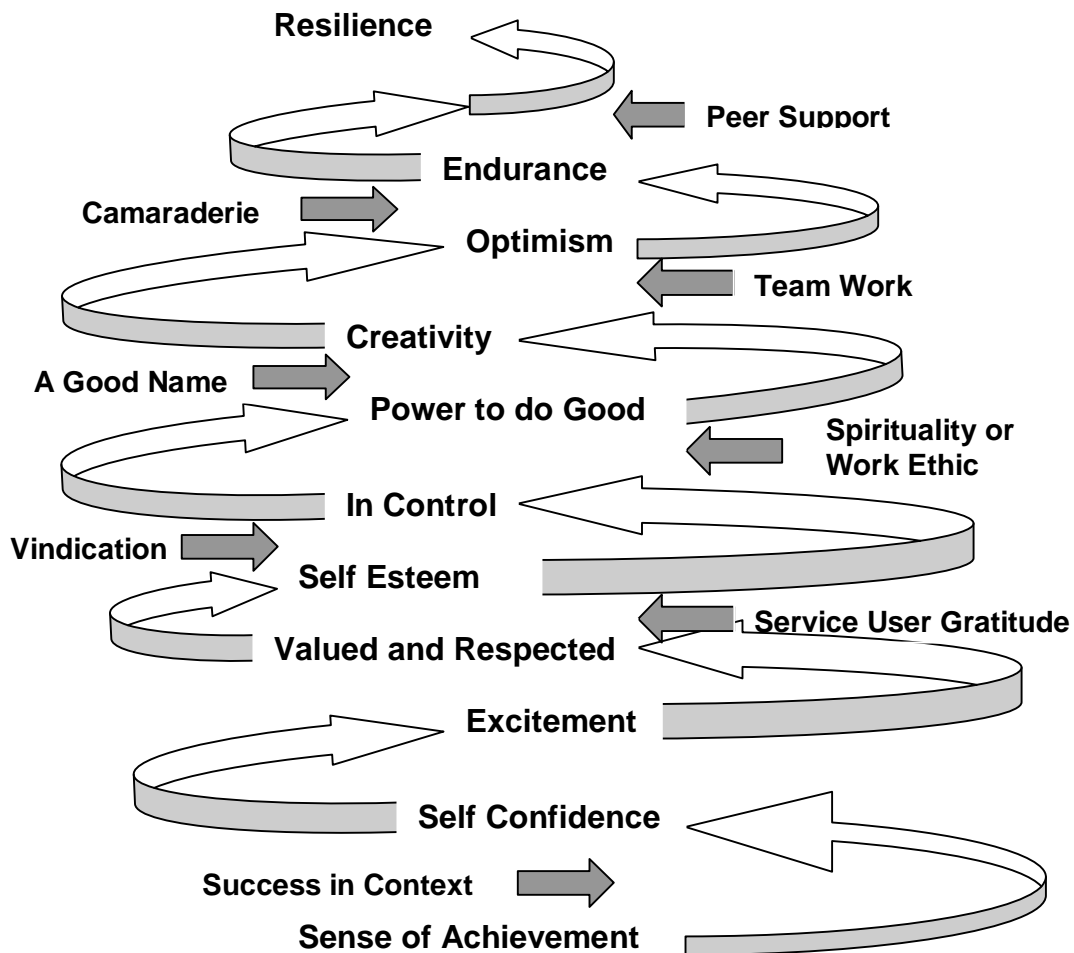
That sort of happiness and that is a good feeling and it makes you feel like you could literally do anything, it gives you the confidence to carry on. It gives you the cycle doesn’t it, it gives you the confidence to keep carrying on doing what you are doing and keep going round in that same cycle of happiness. PD8 (278-282)

So it seems that the positive emotional cascade from satisfaction, “the good feeling”, leads to increased optimism, self-esteem and confidence; ‘feeling like you can do anything’ and endurance; “keep carrying on”. This in turn builds resilience (Hayes et al, 2010; Wyatt and Harrison, 2010).

I’ve got a lot of coping mechanisms now because no matter what sort of buffers you at work it’s like I have got a lot of resilience. MH3 (630-631)

There were a number of factors which contributed to the growth of the satisfaction spiral.

Figure 5.5: The Satisfaction Spiral



“Getting things done” Outcome Focused

Practice is a structured process driven place (Orem, 1991). Plans are purposefully made following a diagnostic assessment and continually reviewed in order to produce a positive outcome. It should not surprise us that the notion of completion was highly valued by all the participants.

Again, just want to get things done; I am the sort of person who likes to get things done. AU2 (111-112)

The nurses' comments are open to misinterpretation. There should be no sense of task orientation here. The 'things needing to be done'; the 'i's that are dotted and t's that are crossed' refer to services to patients; pain relief that needs to be provided and fluid and nutrition that needs to be given. The nurses' comments signal that

success in practice is not always estimated by its size but by the context within which it was achieved.

End Focused - Success in Context

'Success in context' describes practice situations in which small measures of success are recognised within a setting of huge and complex adversity. This is a subcategory of end achievement focus within the theme of satisfaction but it also relates strongly to the frustration subtheme concerned with expectations (Whinghter et al. 2008). Nurses showed a realistic attitude to goal setting particularly in the social field. For example a school nurse talked about making a small difference in the lives of disadvantaged youngsters.

We haven't got magic wands and we can't say I'm going to take you out of your home and I'm going to put you into this wonderful house and have a wonderful Mum and Dad and you are going to have lots of holidays every year. Your life is going to be fantastic, because you can't do that. You've got to work with what you've got and hopefully... We're never going to get to an ideal situation for them but maybe help to make their lives a little bit better and communicate. HVS5N5 (284-288; 385-386)

The nurse acknowledges the limitations of the service she offers and avoids making extravagant promises. Never the less she is able to point to the value of active listening in the lives of young people who have no one else to talk to. Success in context is neither about lowering expectations nor lowering standards. It is the reframing of positive achievement relative to the gravity of a particular situation; a realisation that a 'war' is not 'won' before many 'battles' are won first. At times success in context is also about bringing great pleasure to someone who is terminally ill.

You feel quite high and quite happy because it might be a little thing compared to what other people deal with but for us if you are working towards someone's special day and trying to keep them stabilised so they can go to a wedding or something and that patient achieves it you feel quite elated and I know its only a little thing but you have to look at the bigger picture ...otherwise you could get quite down. DN3 (132-138)

The overall 'picture' for this nurse's patient may be bleak but when strategies result in their quality of life being increased it is success against a backdrop of hardship. A mental health nurse spoke of patient behaviour that might prove frustrating in another setting as a success.

Sometimes she will text me and say I am still on the second bus or I am waiting for my second bus, so that doesn't actually frustrate me at all because I have to learn that that is how she is and that is how it is and she's completely fighting against the odds and it's nothing less than a miracle that she does what she does. So to me she is over-achieving by what she is doing and therefore I have no sense of frustration or anger or any of those negative things. It's an acceptance and an encouragement and I am just pleased to see her when she comes and that is the kind of text that I would send her back, whereas if that same scenario was in a different setting then my emotions would be completely different. MH2 (156-168)

The nurse is aware that her patient's disposition predisposes to a lack of agency. So in this context the patient's willingness to attend appointments keeping her nurse abreast of her delayed arrival is a 'miracle'. So success in context is measuring success commensurate with the scale of the challenge in hand. As part of the satisfaction spiral, such success generates excitement.

Excitement

Excitement is an arousal state brought about by anticipation of positive things hoped for. The combination of passion for an aspect of practice and the promise of success arising from this practice generated excitement.

Excitement: you know, if for example you're running a group you know, you feel, oh I'm really doing something worthwhile. Like for example if I'm running a group on an antenatal class its quite, its something I love doing teaching, I love doing that and say if I'm doing a group on breast feeding its worthwhile you know I'm passionate about it, so I feel happy to do it..... I think if you're passionate about something you obviously enjoy it. You're hoping it will yield good results so that's the excitement. HVSN1 (2-6; 155-116)

So in addition to a sense of reward there is passion and excitement in doing what one likes to do in practice. This confirms Shaw and Degazon's central message (2008) that nursing practice is at its best and most satisfying when nurses are able to infuse their personal values into professional projects. Also when successful practice is set in motion other feelings are generated by an awareness of how one's practice is impacting on others.

Valued and Respected

The need to be valued and receive respect is integral to human development (Rogers, 1999) as it shapes our view of ourselves, our level of self-esteem and self-confidence. Received value and respect also shape our view of the social world and the level of generosity with which we measure others (Belsky and Cassidy, 1994). Considerable space in the narratives given over to satisfaction was rooted in value and respect. The desire to be respected and valued by others in the context of professional practice was clear.

Nobody wants to be seen to have done a bad job or been found to be wanting. You want people to have a regard for you, don't you? DN1 (187-189)

But received value and respect existed for different reasons although practitioners often spoke of them together.

I feel quite valued and I feel quite respected as well, that makes me feel happy.

How do you know that you're valued and respected?

The way people speak to me and the feedback they give to me: "I like working with you because you always make sure that, you know because you will always make sure that I am not overloaded with my work"....Just that people come to me and say "Can I have a word with you? I know I can trust you. I know I can rely on you." That does make me feel very good. AU4 (193-208)

So for this senior nurse value and respect from others came as a result of positive

feedback on her sound team leadership, trust and discretion. She is valued because of her management style. She is respected because of her trustworthiness. For some nurses being listened to was a sign that people valued their opinion.

The consultants are absolutely fine all the time and they'll listen and your part of the team. I mean that's one of the really good things about working here and it is satisfying and you do feel valued PD1 (126-128)

Value and respect was also fuelled by positive appraisal feedback from users of the nursing service.

Service User Gratitude

The gratitude and appreciation of patients and their families ranked high on the list of sources of job satisfaction for nurses.

a little thank you makes like a million times, your job worthwhile.
PD8 (250)

The gratitude of patients served as confirmation that good practice was in place. When nurses spoke of this the thanks they referred to was most often of a qualitative nature. Patients and their families would give their own account of a successful care outcome as it had meaning for them. Letters, phone calls and thanks expressed in person were appreciated when they showed *why* service users were grateful.

There's nothing ever nicer than somebody telling you that you've made a difference, or the nice letter that you get, because you know it's just wonderful. It makes you feel that you've done a good job and that you've got it right, and that you actually have made a difference to people. DN1 (387-391)

The superlatives used here demonstrate a place of primacy for positive service user feedback by virtue of the way such praise and thanks validate the difference nurses make in the lives of patients and families (Wilson and Crowe, 2008). This theme also validates the singleness of purpose in care highlighted by nurses who spoke of this as their chief source of satisfaction. Service user gratitude confirms that the "deep human connection" (Utrainen and Kyngas, 2009:1006) manifest in the nurse patient

relationship is mutually valued. Appreciation for care housed within clinical intimacy is the evidence for quality care often overlooked and undervalued by clinical audit mechanisms (Reiman, 1986; Attree, 2001; Williams, 2001; Berg et al. 2007). So service user gratitude consolidates the feeling that one is valued and respected and further fuels the spiral of satisfaction by creating self esteem.

Self Esteem “I must be good”

The value and respect with which these nurses were viewed by others had a corresponding positive impact on their self-esteem. Much of this came simply from reflection on achievement and awareness of a skilled use of self (Wilson and Crowe, 2008).

I have made a difference; gosh it must mean that I'm good then if I have made a difference. If I'm good, it is like that kind of approval thing isn't it, I *am* good, I have done something and that makes you happy and I think it is just a basic instinct of, you have made someone happy therefore you are good. PD8 (275-278)

One nurse close to retirement obtained self-esteem from reflecting on how as an older woman she had successfully gained promotion.

Well just before I came back I was asked to go for a Continence Nurse Specialist post, and you think to yourself “am I good enough?” and I thought “Yes, I am good enough.”. DN5 (452-454)

It is clear then that while self-esteem arises from outcomes that satisfy it also forms a circular causal link with satisfaction. Nurses gain self esteem from satisfaction and that increased self esteem is very satisfying. But there was another theme in the data that contributed to self esteem and the evidence for this collected around a particular word used with surprising frequency.

Vindication “I feel smug”

The feeling of smugness and the expression “I feel smug” was a surprising feature in the data not because of its presence per se but because of the frequency with which it appeared. Within this subcategory the feeling of smugness was a partnering of

awareness of one's professional competence and expertise and the lack of recognition by other disciplines. This lack of recognition preceded vindication of nursing judgement.

When I'm trying to communicate with social care regarding my concerns about a child, and they're just brushing me aside, and then something happens and then you feel like saying "I told you so you didn't listen to me you know." HVS1 (290-293)

The feeling of vindication was free of any churlish malice but was borne out of an awareness of having one's judgement affirmed by events that followed disagreements between agencies, which had hitherto been unresolved.

It's not that you want someone to get told off but it's kind of a sense of achievement but in a kind of a warped way where you just think, "yes I won that one". That's what it is, it's about thinking "yes you should have listened to me in the first place". MH2 (307-310)

The assumption repeatedly underpinning 'I feel smug' was the experience of having one's judgement and expertise dismissed as of little worth; a lack of due respect on the part of less experienced practitioners (often junior doctors) for accumulated wisdom in clinical practice.

Someone has doubted you or said "no everything is fine" etc, then you are proved right. There is a kind of smugness that 'well, I am not so stupid after all'. We find out, a lot of our SHOs who come to the neonatal unit never having done neonatal before, after 2 months of having their feet under the table they think they know it all, that is quite, it probably isn't a very good thing to say, but I think most nurses would say, well actually, you know, you can learn from us and we do know what we are talking about, we cant always articulate it but then not all things can be articulated. NIC3 (291-298)

The experience of this senior nurse in a neonatal intensive care unit would suggest that the tendency to dismiss nursing clinical opinion is common among doctors who are inexperienced. The wisdom at work in nursing practice was revealed with the passing of time, provoking the reaction by the nurse, that "I am not so stupid after

all". The question of articulating concerns goes to the heart of intuitive practice in a profession that is able to experience emotional concern based on long hours in intimate constant contact with patients. This prolonged contact produces a detailed familiarity, which in turn may elicit subtle signals and messages which cannot be articulated, at least not without reflection. Such expertise will not be immediately apparent to an inexperienced doctor whose epistemology is founded on logic and controlled predictable areas of scientific knowledge. It was interesting that this lack of respect among doctors was far from universal and that particularly in specialist units expert nurses were held in high esteem by consultants. Note the account of an experienced nurse in a haemodialysis unit.

Sometimes I feel smug...a new registrar who'd just come here and she didn't want me to put this child on plasma exchange, and she couldn't tell me why not and I knew what she was getting at that it would have made absolutely no difference whatsoever, and she wouldn't have it. So in the end I just phoned her consultant who said that I needed to be more patient and that I'd been here however many years and she's been qualified about ten minutes and I need to give her a chance, so anyway, I still put her on and did what I wanted to do. PD1 (120-125)

So nursing judgement *did* carry weight where experienced practitioners from other disciplines worked closely with the nurses and were familiar with their depth of knowledge and skill. Nursing judgement was more commonly dismissed out of hand by practitioners whose experience of nursing knowledge was limited.

In the wake of the self-esteem that emerges from success in practice that is often hard won a different type of nurse develops; one that feels ready for anything that the day might hold for her. This formed another level on the upward spiral of satisfaction: one which validated the feeling of being an expert.

In Control - "I know what I'm doing"

A high value was placed on autonomy, personal power and coping by a wide range of nurses. This was a very visceral sense of satisfaction. The freedom to work autonomously and effectively as a nurse has been previously shown to be satisfying in practice (Hayes et al, 2010). Wilson and Crowe (2008:818) single out two

particular skills from others which yield satisfaction: “knowing oneself”; efficacy in the use of self to enhance practice and “knowing how” (p819); the mix of formal and informal knowledge in a fluid professional movement. The latter type of knowing recognises and responds to patterns and relationships in practice through the application of experience informed by formal evidence. The phrases “In control” or “I know what I’m doing”, used repeatedly in satisfaction discourses refer to a powerful combination of both of these.

And although I haven't got my outstanding things done I do feel in control, and I'm a person who doesn't like not being in control. I need to feel that I know what I'm doing. DN5 (402-404)

Within this category there were different shades of meaning. For some nurses being in control was about their preference for a certain type of role. Note how one community nurse speaks about her current role as a complex case manager in comparison to her previous role as a community nurse with a more acute caseload.

I'm much more in control in this job, because it's not the immediate 'it's got to be done today' type of Community Nursing. It's a bit more long term planning. Part of my role is about seeking work, about going to GP meetings and talking to them about patients that might be good for me.....Yeah, I am a person who likes to be in control. I like to be on top of everything, and I like to do everything well and I like to be in control. DN2 (323-327; 336-338)

The nurse prefers a role involving the care of patients with chronic disease requiring “long term planning” to less predictable acute situation where deadlines are closer together. She feels more “in control” of her practice. For other nurses being in control was about the match between their practice and their expertise; the ability to work sensitively, flexibly and effectively in unpredictable situations.

A&E I suppose this is my area, I know this and so I feel in control of this situation. I have seen this before. I know where this is going...This is what I know. This is my safe place. I know that I can make a difference by doing what I am doing and I know that I can make a difference...I have the confidence to know what I am going to say, confidence to

know what I am going to do in order to give this a good outcome. PD8
(129-134; 136-138)

The nurse's reference to her specialist practice as her 'safe place' does not signal complacency on her part. Instead it underlines the sense of personal security that accompanies an awareness of expertise and mastery within the self in a situation that is familiar to her (Benner, 1984; Rogers, 1999). A mental health nurse who discussed this phenomenon at length spoke about the conspicuous absence of anxiety and fear which he experienced in his practice setting despite its obvious dangers.

even though I work in a high secure unit, it's been a breeze because there is none of that sort of self-doubt or the fact there is no anxiety nothing that can come up that I don't feel I can handle MH3(185-187)

For these nurses mastery in practice means that there is no present concrete threat (which could provoke fear) or future uncertainty (which might provoke anxiety) that is able to shake their confidence (Vansteenkiste and Ryan, 2013).

Yes, coming to work and knowing that no matter what the day throws at you, you can cope with it.; the fact that you are coming to work and there is no anxiety. There is no fear like there used to be. MH3 (238-240)

The cognitive notion of self assurance; certainty relating to appropriate knowledge and skill in the face of the uncertainty which characterises modern practice is paired with a contented affect which these nurses called 'serenity' or 'calmness'.

I have got a sense of sort of serenity which comes from the fact that I do know what I am doing and I have done a lot of training and I have done a lot of supervision a lot of support and I have worked across a lot of different settings. MH3 (218-220)

A satisfying sense of comfort or serenity arising from being equipped to cope in an unpredictable environment is explained by the findings of Perrone and Civiletto, (2004) which showed that an ability to cope effectively offsets the stress that accompanied one's role. Meeting the challenge of stress is satisfying. Benner (1984)

spoke of the powerful expert in nursing who could feel, see and think their way in practice by means of intuitive and reflective knowing. Therefore it is no surprise that the nurses who spoke of experiencing this 'serenity' were all experts. It is significant that the mental health nurse above speaks of anxiety and fear as features of the past. This was deeply satisfying and forced forward the evolution of satisfaction toward awareness of the power the nurse possessed.

Power to do good

Actual awareness of potent beneficence within the expert self was a source of fulfilment for nurses. Nurses derived a great deal of satisfaction from their ability to use skills and knowledge as a force for good. Seeing the good arising from the power to do good was also a source of satisfaction.

I love the fact that I have got the skills to help make children better, I have got the skills to help families get together, to help families live through their experience and to come through the other side and to adjust with their new way of life PD3 (116-119)

"Power to do good" also brought satisfaction in the way that the nurse saw herself in the role of benefactor who responded to expressed need.

we have a lot of power, I think, as nurses. Especially in some areas; I think in A&E and in intensive care. These are specialist areas where people are literally at their worst. You do have a lot of power, because if someone comes rushing into you, they are looking to you for help and to them you are the person who is going to help them. PD8 (399-406)

'Power to do good' is distinguishable from 'in control'. Both themes are concerned with power. 'In control' refers to the nurses' ability to cope and respond to any situation in a familiar setting of practice. Power to do good relates to the resources the nurse can muster and the securing of outcomes as part of that response. 'In control' places emphasis on the possession of power in the form of knowledge and skill. 'Power to do good' places emphasis on the use of power; the application of knowledge and skill in the art of caring toward a fruitful end. It was also clear that other principles espoused by nurses also fuelled "power to do good".

Work Ethic

A robust work ethic was consistent across narratives of senior experienced practitioners and junior novices. Every generation of nurse across the breadth of specialties spoke of their commitment to hard work and optimum practice. A district nurse close to retirement described herself in this way:

I think probably I am quite a perfectionist. I will only be happy with a good job, not with anything less than that. DN1 (220-222)

The work ethic was often combined with an awareness of personal failings.

And I am a diligent person, and you know I, you like to put plenty into work. I won't work the unpaid overtime like I did, but I like to, I like to do a good job and I like it done well. I'm one of these people who have grand ideas. I'm great at the start but not quite so good at the finishing. But if I say I'm going to do something I will do it and I will do it to the best of my ability. There are no half measures. If I'm going to do it I'm going to do it. DN5 (260-266)

A sound work ethic embodied in clinical nurse leaders was also seen as fulfilling an exemplary role for junior members of staff.

I think that I have got quite high standards, I like to see that in everybody else, I also think that you lead by example, so other people can see the standard of nursing care you provide they will follow. NIC3 (143-145)

Evidence of the trans-generational nature of work ethic was evident in many of the recently qualified nurses in the participant sample.

I think, when you work, you can, there are elements of pride and reward. Being happy in the job you are doing is for a good cause, this is one of the reasons that attracted me to nursing because there was something in the job that you could get out of it, what you are doing is definitely worthwhile. It isn't just a money making exercise. Yes I want

to do my best and work hard and do everything in the best way possible. PIC1 (13-17)

Although presented purely as a set of values, in the literature (Lazar, 2010) an ethic of life long hard work was represented within a multidimensional definition of spirituality in the sense of supplying purpose and fulfilment in life. A work ethic was closely linked to two other themes: 'a good name' and 'spirituality'.

A Good Name

For those nurses 'power to do good' extended to the notion of having a good name, which outlived them. This notion was particularly strong among African Caribbean Nurses.

In that situation, last Sunday I had a really ill baby and today that baby is doing a lot better. That has made me happy knowing that I was the one that helped look after that baby. My name is written on that child's notes to say I actually cared for that baby so that makes me quite happy to know that when I go home, I did do something, I can relate that to friends and relatives at home. NIC2 (47-52)

Spirituality

It is interesting that while many narratives can be included within a spiritual theme only one nurse spoke of religion in her life supplying satisfaction.

It's an inner feeling of wanting to help people. Erm, I don't know it... I suppose if you dig down deep in me it's, it could be linked to faith because I am a religious person. Not over religious, but I am a Christian person. Erm, and I feel if you like my Christian life is to do with nursing. Erm, that's a link that's very important in my life because I think that I'm probably – my vocation comes from maybe from that side. And that's something that I've always had. DN1 (407-413)

The nurse's comments on something 'deep within her' as 'something she has always had' sit well with others who speak of personal life values. Work ethics, the wish for a lasting good name and overt religious faith, are all aspects of spirituality in its

broadest sense as defined by Koenig et al. (2001) and cited by Lazar (2010).

Three threads of data informed on the dynamics of working together in practice as a source of satisfaction. These were 'team work', 'camaraderie' and 'peer support'. Each aspect fits within the working relationships predisposing to job satisfaction among nurses as described by Utrainen and Kyngas (2009) and Wilson and Crowe (2008).

Team Work 'Cover and Coordination'

'Team Work' referred to the actual coordination of skills within a team in response to the needs of practice. Emphasis here is placed on the effectiveness of this coordination and its impact on nurse satisfaction. One health visitor spoke with great warmth about her fellow team members.

Because you spend a lot of time at work and I think if you didn't get on with your colleagues, your working day would be awful. Ok we go out and we work on our own, but you're there at the beginning of the day, we come back for lunch and you're around at the end of the day, so if it wasn't a very nice place to work, the job wouldn't be so nice. Because if they weren't supportive a lot of the things, for example clinics and covering clinics and things, if there was only you to do it and you needed to go to the doctors or you needed to go to a child protection meeting, then there'd be nobody there to take over the clinic so you're then rushing around to be in three places at once, when actually because you have a supportive team, I know that I can come in and say this has come in for me can I have this date, and my colleague would say yes, and vice versa or I can come in and say I need this time off because we're going on holiday would you cover, you know-yes and vice versa as well. HVSN4 (246-256)

This discourse identifies two levels of team work (although they are intertwined): the professional and personal. At the professional level the health visitor values how the existence of a team permits flexibility in juggling practice commitments such as 'clinics, liaison with doctors or child protection meetings'. The 'cover' that colleagues provide means that expertise can be spread appropriately across practice commitments. For example attendance by a specific health visitor at a child

protection meeting may be essential but any team member can cover a clinic. This flexibility reduces practitioner stress in that the chaos and pace of 'rushing around trying to be three places at once' is averted. At a personal level the health visitor expresses her appreciation for the professional support supplied by social interaction at "the beginning of the day", "lunch" and "at the end of the day". This compensates for the isolation experienced during the rest of the day. In particular it is the *willingness* on the part of the colleagues to work flexibly that is valued. Elsewhere in the data nurses provided a more detailed description of a coordinated team approach. This was evident in an account of an emergency situation in an acute mental health unit.

if somebody has ligated so they have cut off their oxygen supply with a view to self-harming or to committing suicide so the best person that would get there would do first aid to stop that, to reduce the risk and people coming behind would bring the knife to cut the ligature off so depending where you are in that queue of people getting to the patient, would alter the way I think you can see the event or perhaps, alter your anxiety levels a little bit maybe. MH1 (106-111)

The nurse describes how each team member adopts a different role depending on the point at which they join the 'queue getting to the patient'. Each role is expertly known so each nurse is able to adapt to what is required of her as she 'arrives' at the scene. This coordinated approach reveals teamwork to be greater than the sum of its parts. Team members think as individuals but are able to act as one. "Teamwork-cover and coordination" is the catalyst for creativity. It is a finely tuned response which uses power to do good in each nurse selectively to meet the needs of practice.

Camaraderie 'Nice people in small family'

While 'Team Work' concerns coordination, 'Camaraderie' relates to the contribution to job satisfaction of personal friendships formed within a team. Here the emphasis is on the humour and bonds of warmth and attachment that result from working relationships.

The people I work with are very nice, and they are very nice people to work with. So that's always very positive. And my colleagues are absolutely fantastic, I couldn't ask for more. And... so it's quite a

privilege to work with the people I do. I think that makes us quite proactive and a very positive team. DN3 (229-233)

The holism of the practitioner work experience and the positive part played by camaraderie in the satisfaction spiral is borne out in the connection made by the nurse between the 'privilege' of working with 'very nice people' and proactive practice. For some nurses these bonds of friendship stretched beyond their working life.

We didn't want to let our colleagues down because we all pulled together and, you know, we act like a small family; the nursing team. You know it's a sense of social inclusion. I have most of my friends from the nursing world. You know I've got one or two out of it, but most of them are in the nursing field. So it's a social support network and we all support each other, it's like our own informal supervision. DN5 (41-46)

These comments by an experienced district nurse reveal the strength of Wenger's argument on the meaning and identity that characterise communities of practice and cause community members to 'pull together' in a 'social inclusion' as a 'small family'. It is perhaps unsurprising that life long friendships issue out of relationships built on common values of caring. This is reinforced when the nurse speaks of most of her friends coming from the 'nursing world'. The use of the term 'informal supervision' is also revealing as it introduces the notion of the restorative aspect of supervision provided by colleagues. A health visitor elaborated on this notion.

You've got your colleagues that you can have a laugh with... because it makes you feel better. Otherwise life would be quite boring and mundane if you sort of where miserable all the time so its sort of just, and because of the jobs we do they are tense jobs, and you do take on a lot of other peoples issues worries things, so you need a bit of light relief through the day as well. HVSN4 (261-262; 266-269)

The idea of 'colleagues that you can have a laugh with' feeding the need 'for a bit of light relief' from 'tense jobs' is in line with the findings of Zammuner and Galli (2005) who stressed the importance of resting practitioners from the weight of emotional labour. The health visitor ponders over the boredom and melancholy which would

prevail were it not for informal interaction with colleagues who inject humour and warmth into professional life, offsetting the stress involved in addressing health and social ills.

Peer Support ‘knowing what you’re going through’

The restorative ethos underpinning ‘Camaraderie’ also underpins ‘Peer Support’. However, while ‘Camaraderie’ concerns the informal social humorous slots in working life given over to relaxing with colleagues, ‘Peer Support’ reveals the detail of humanity within team membership relating to expert practice. Both ‘Camaraderie’ and ‘Peer Support’ rely on positive working relationships but ‘Peer Support’ necessitates a specific knowledge and appreciation for the demands of practice within a special field. Within the data there were many examples of peer support being offered and received.

when there is an incident of a crash call, I usually go up to the person that has dealt with the crash and ask them how they are.....I have said to a couple of people before now, do you want to go and have a drink, do you want a cup of tea or, after work, not even always been my best buddy colleague if you like but you feel for people and what sometimes they have gone through experiences. AU1 (173-175; 181-184)

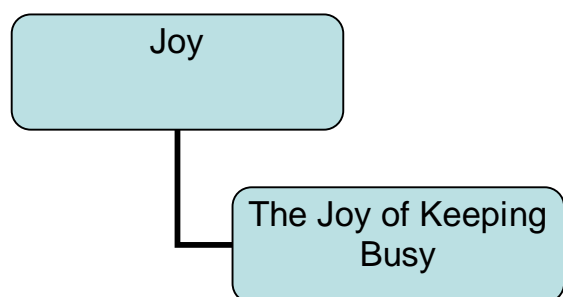
The nurse’s comments show an awareness of the stress and emotional ‘fall out’ associated with managing a cardio pulmonary resuscitation or ‘crash call’ which fuels her empathy and spontaneous act of compassion toward a colleague who although not a ‘best buddy’ is still a fellow team member. The essence of ‘peer support’ promoting work satisfaction is captured by a children’s nurse.

It is nice to just get it out with some colleagues, people who know how you feel about work and what sort of things are going on. It is nice to know that there are ways to relieve your stress and forget about it. It is nice to have some people who understand that at the same time or know the difficulties you are going through. That support again, is really valuable to nurses, I don’t think I could do it without the support of colleagues, PD4 (356-364)

So 'peer support' is not merely a positive social state of relationships at work (as described by 'camaraderie') nor expert skills delivered in a coordinated way (as described by 'team work'), but a combination of both to produce an ad hoc form of empathic restorative supervision informed by a knowledge and appreciation of the demands of practice. Peer support and camaraderie promote and sustain optimism and endurance in the satisfaction spiral of nursing life.

Joy

Table 5.10: Joy



Joy [see Table 5.10] carried a celebratory meaning for the nurses who experienced it which contained the element of surprise. The occurrence of tears is symptomatic of emotional relief from the 'captivity by anxiety' that can characterise not only those attempting to successfully treat a sick child but also those passive bystanders such as parents and team members (Vaillant, 2008).

...joy in the fact that the children get better. I celebrate with the families when they get better, I think it is fantastic to have a child come in and they are really, really sick and they have ended up in intensive care. They have been on a ventilator, really poorly and they come to you and you make them better. PD4 (104-109)

The nurse's comments concur with view of joy in the literature (Vaillant, 2008; Astor et al. 2013) as a end concept which follows a process in which anxiety and hope compete for dominance in the minds of those involved

Joy: a warm feeling: lovely warm feeling that just catches you at the back of your throat. You just, I am not a weepy person, I don't come to tears easily but joy to me is that sort of feeling you get before you want to cry. PD4 (444-445)

Joy in nursing was shown to be the affective response to a positive outcome following a period of uncertainty in which people hope and believe the best but harbour the dread of a less positive outcome. This was clear from the account of another children's nurse in which sudden success follows uncertainty.

You never know. You can't just say 'they're going to be fine' or whatever, you know because what if they're not fine. You don't want to put yourself in a situation where the parents will turn around and say, 'but you told me that they were going to be fine', But when we get the call from recovery to say that, 'oh their child is in recovery, can I have mum and a nurse', and then I go to tell mum that the child is in recovery then that's the joy, the child is in recovery, the child is awake its in recovery and they want us, and the mums leap up and they're happy and you know, and I'm happy because 'yes!' And the success! So that's joy. That's the emotion that's like, 'yes! You're child is well and they come upstairs and their eating and drinking and peeing.. 'PD9 (116-123)

A mental health nurse distinguished between joy and satisfaction saying that while satisfaction can be deliberately sustained by deliberate actions over a period of time, joy carries an element of surprise. Note the sudden nature of the presentation the nurse describes and the way words such as 'flash' or 'burst' of joy are used to describe the way the emotion presents itself.

Happiness? I think you can have a sort of happy disposition, so that might be akin to sort of being positive, not letting things get to you or addressing things when they do, trying to take a positive outlook on things, trying to do things to sustain your feelings of happiness. So that might be going out and meeting people, engaging in your hobby, choosing a new book, things that maintain a level of happiness whereas joy comes in flashes. So if you are actually working with a patient and they do something and you just feel immense joy, joy in a burst suddenly because they have just done something that has worked out really well for them. MH1 (303 -311)

All of the foregoing narratives in this theme are reminiscent of similar findings in counselling (Gilat and Rosaneau, 2012) and social work (Pooler at al. 2014) in which

joy is experienced as the fruits of labour. However one other type of joy was identified within the data which is not mentioned in extant work.

Joy of Keeping Busy

While joy was for the most part experienced and expressed in relation to patient outcomes, it was also related to the pace and nature of practice. One charge nurse in an intensive care unit talked about the importance to him of a busy shift.

When I say busy, I like busy with lots of sick babies that need a lot of stuff doing, I suppose it is that ER (*emergency room*) syndrome that some nurses have. It isn't the high drama but it's that you see people performing their best if a baby is arresting, we get a lot of cardiac arrest babies here and they can go off quite quickly, it is like the doctor might be screaming, I want A,B,C,D and E NOW! I like being part of that and I quite enjoy supporting the junior nurses, as the charge nurse, taking a step back but being there supporting them, especially the edgy ones who think that they cant do it. You just have to say, 'you can.' and you, not make them do it but you will stand by their side. I just like the whole 'busyness' thing because it makes the shift go by really quickly, I can't bear sitting down not doing anything for long periods of time. You are just sitting behind a desk and nobody wants a hand with anything and then the girls also get quite bored and will say that themselves. NIC3 (196-207)

Davern et al. (2007) expressed surprise that in their results stress was used as a positive descriptor of satisfaction in the context of keeping busy and feeling important and productive. The nurse frames his reason for joy within the culture of intensive care where prolonged periods of hectic practice can be interspersed with equally long periods of inactivity.

For this nurse 'people perform at their best' when they are busy and 'busyness' is 'enjoyed' because he is able to be 'part' of the hectic process driven emergency care that is the nature of his chosen setting. The hours of a shift appear to fly by. The joy of keeping busy is the elation experienced in smooth running fast and effective practice performed speedily. This is compared positively to "sitting down not doing

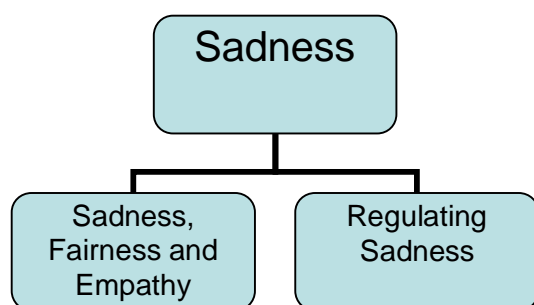
anything for long periods of time” which is deemed “unbearable”. The nurse feels unproductive because “no one wants a hand with anything”.

Sadness

The messages from the data on sadness in nursing [see Table 5.11] leaned toward the thinking on the emotion as rendering the person reduced in power (Fischer, 1993; Tiedens et al, 2000; Tiedens, 2001).

Sadness to me is, when I feel sad, I feel, it’s a weird thing to say but I always feel smaller than I am, when I feel sad, almost as if I have shrunk a bit – a bit of me missing. To me, when I feel sad, whether it is something to do with work or sad that something that has happened in my personal life, I always feel as if I am smaller; that I have shrunk a bit.
PD3 (453-461)

Table 5.11: Sadness



While there were variations in the data as to description of the intensity in the experience of sadness, there was consensus as to the nature of the emotion. Nurses spoke of a feeling of ‘heaviness’ or ‘emptiness’ and figurative references to the ‘heart’ were common.

you have a heavy heart that is the only physical way I can say it and just, that feeling of sadness, the heavy heart, the pit in the bottom of your stomach NIC3(114-116)

One nurse’s set of sadness descriptors gave a clue as to the rationale for the nature of sadness as a response.

it is more of a quieter emotion really, a sort of sense of resignation....I guess sadness feels quite heavy doesn’t it, and quite, it can make you feel quite tearful, MH1(65-66)

The use of the words 'quieter' and 'resignation' suggest defeat and loss. This intuitive perspective matches the psychometric measurement of sadness in comparison to anger by Rafaeli and Revelle (2006) in which sadness exhibited the same angle location as anger but registered as having a 30% less positive skew. Nurses were also clear about the nature of sadness as an affective state distinguishing it from a long-term mood (Bower, 2013).

It's different from feeling down and depressed to me, sad is really more of the moment, for me I think...It's more happening quickly, whereas depression is more of a long term thing. Sadness would be more of a thing that you would feel for a short amount of time, DN2 (752-759)

While all the emotions discussed had commonality across the sample of participants sadness was discussed more often by those nurses caring for older people and children. In line with the findings of the extant literature (Rivers et al, 2007) nurses experienced sadness at moments of loss and regret at the hands of events for which a source of accountability proved elusive. This is clear in the narrative from a district nurse in which she laments over one of her terminally ill patients.

He's dying of lung disease very slowly. And he said something to me the other day, he said, he was talking about his family and I asked and he said 'I'm dying too slowly for them'. And I thought, I thought you know that's so sad but it's so true. That is so sad because it would be so much better if you died fairly quickly now because he's got absolutely no quality of life. Erm, but obviously I can't do anything about that either. And those sort of things make you make you feel sad. DN2 (387-394)

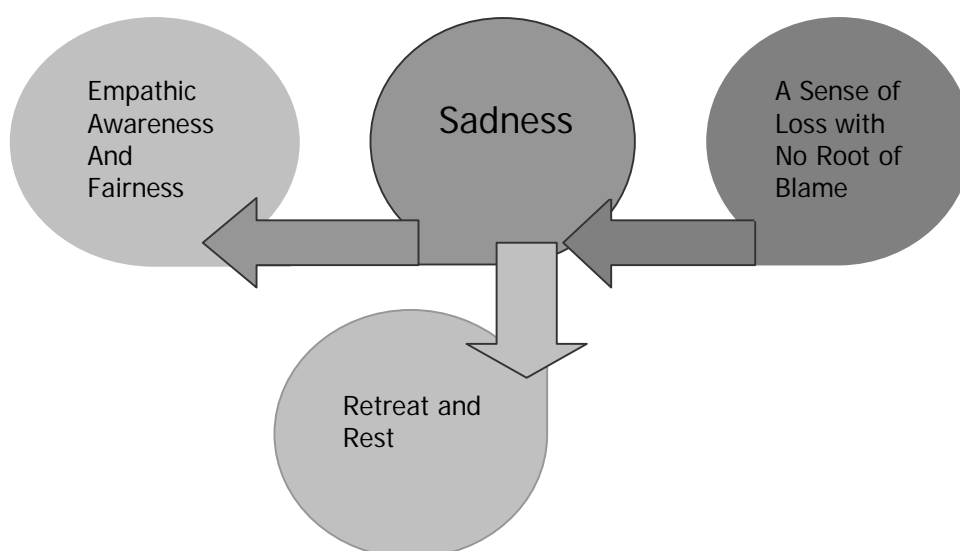
Where attachment is involved, a void exists when the object of attachment is no longer there (Belsky and Cassidy 1994). Nurses spoke about this as a sadness pertaining to a sense of loss. This sense of loss was present in community nursing.

You know I do feel sad, and I'll probably go to his funeral if his wife wants me to. I think she will. And I will feel a sense of loss because he's gone because I care about him. DN2 (447-449)

The sense of loss was present when nursing children.

I guess, it is not being able to say or speak to the person who has gone any more, if you wanted to say anything and them respond you have feedback you know, a conversation. There is no longer the opportunity. Especially if you were to leave, if you saw someone and they died and the way you left it, you can't change the way you left it. You couldn't say, you wouldn't be able to say 'goodbye' that last time and really mean it. I think it was difficult because I wanted to go and see him and lots of different people did, so I never got to say goodbye to him, I only saw him once he had died – once he had passed away. PIC1 (105-112)

Figure 5.6: Sadness Dynamic



The sense of loss is one of many themes which underlines the genuineness in professional care. If emotional labour in nursing was pure performance no sense of loss would be experienced. There is no source of blame in this situation and therefore nothing and no one to be angry with. The nurse 'can do nothing about' the patient's ultimate end situation. Regardless of the subject this sense of loss which the nurse had no ability to retrieve was reflected in all the narratives in this theme.

Sadness, Fairness and Empathy

Some nurses talked with resignation about the cyclical psychological and social processes in some communities and groups that resulted in a sad end. The link between sadness and fairness becomes clear here [see Figure 5.6 above]

You feel sadness because people have pretty rubbish lives, many of them and they are sort of products of that up bringing or their environment. MH1 (41-43)

One health visitor talked at length about the outcome of care proceedings involving families she had worked hard to support.

Sort of sadness really, for whatever reason the parents can't adequately care for their children so if they have to be removed, and I suppose its sadness as well if they've been a lot of work but actually it hasn't achieved anything, through whatever reason and the children then have to be removed and put into care, so that's sort of quite feelings of sadness.

Sadness for what or whom?

For the children because they, for some parents its not that they don't love their children they just don't have the parenting capacity which is sad So sadness for the children but then I suppose a bit of sadness for the parents in things like that because if she hasn't got the parenting capacity and everybody has done everything they can to support her with that but she just can't physically do it, its sadness for her. HVSN4 (276-284)

Past "rubbish lives" filled with abuse in place of love and approval together with serious deficits in parenting capacity and children lost to the faceless system of local authority care, all have profound socio-economic roots which might provoke anger. However the focus of these nurses' concerns and the source of their sadness are disembodied from this. Theirs is an emotive perspective on ethical practice; an approach in response to the knowledge that acting to protect children from abuse or providing optimum mental health care to adults with an abusive past cannot avert emotional desolation in the lives of all concerned. It is a perspective which acknowledges the importance of fairness in appraising the roles of those involved in a situation; a positive quality of sadness which has been acknowledged elsewhere (Bower, 2013). These are situations where a search for blame serves no purpose as it cannot undo what has been done. Sadness is therefore expressed for what cannot

be undone rather than what should have been done instead in some other place in some other time.

The appropriateness of sadness as distinct from that of anger is evident in the account related by a senior children's nurse on a child who had made progress following renal failure but who died in theatre suddenly and unexpectedly following post transplant complications. Here another positive quality of sadness emerges: empathy.

sad for the family, sad for the children, I had known them a long while.
Sad that we were unable, sad for the family and that was the outcome
for them, angry with the way it happened. PD3 (293-295)

The nurse feels anger that after a marked improvement in the child's care in the face of adversity the child died 'needlessly' in the course of a relatively simple procedure. Conscious that the child died as a result of treatment rather than a disease process the nurse is "angry for the way it happened". However she is sad for the family and sad that the paediatric team were "unable" to prevent this. The expression 'feeling sad for someone or some people' used repeatedly in the data denotes the power of empathy in singular and plural measure supplied by sadness (Zawadzki et al., 2012; Bower, 2013). It is as if the humanity expressed in the nurse's sense of loss strengthens her propensity for emotional kinship.

The nurse's anger is with the cruel twist in the circumstances of the child's death (Rochman and Diamond, 2008). Her sadness is for the loss (Rivers et al, 2007). Further clarification comes in her extended comments.

Sadness is a bit of a dark sort of feeling; I would describe it as feeling a bit empty; something a bit missing. Sometimes the sadness, you know with, maybe a bit of frustration comes with sadness as well. You are sad about things that you can't change so I think sometimes sadness and anger come together. PD3 (453-456)

So anger is feeling what should have been in place of what is. Frustration and anger are feeling what should be changed but cannot (Rochman and Diamond, 2008). Sadness is about a sense of loss and the acknowledgement of "things you can't change" (Rivers et al., 2007). While there was no explicit evidence of greater

attention to detail issuing from a feeling of sadness within the data as in the literature (Bower, 2013) it is noteworthy that all the nurses were able to explore the practice roots of their sadness thoroughly.

Regulating Sadness

There was support in the data for Rivers et al.'s typology (2007) of strategies for regulating sadness. Verbal expression and seeking comfort both featured in one district nurse's approach.

I suppose, my way of dealing with things is to talk about it so erm, so if I was feeling sad about something I would then usually talk to somebody about it, anybody who would listen. DN2 (763-765)

As the nurse continues there is some support for Salerno et al.'s argument (2014) that increased indulgence only follows sadness when it is not deemed harmful.

Erm, because that is how I would come out of that sort of feeling, to talk about it or have a big glass of wine (Laughs). DN2 (765-767)

The "big glass of wine" was not planned in advance of the sad mood. For the nurse alcohol consumed moderately has a remedial function and does not constitute risk-taking behaviour.

Conclusion

The data presents a composite picture of nursing life and how it endures and engages a wide range of contemporary challenges in health and social care. More than this, an emotion map has emerged which demonstrates seven emotions as having commonality across the community of practice. Each emotion relates to a particular set of source circumstances. Given the symbiotic relationship between emotion and cognition discussed in chapter two, this has implications for the shape of reflection within nursing communities. Commonality of emotion and the extent of its relational spread across the spectrum of practice holds potential for use within a framework of reflection. These implications and potential value of this will be discussed in the following chapter.

Chapter Six

Messages from the Emotion Map of Nursing Life

There are three main messages from the emotion map of nursing [see figure 6.1] which will be discussed here:

1. A Commonality of Emotions in Clinical Practice.
2. The Potential of a Common Set of Core Emotions for Clinical Practice.
3. The Political Implications of the Emotion Map for Practice.

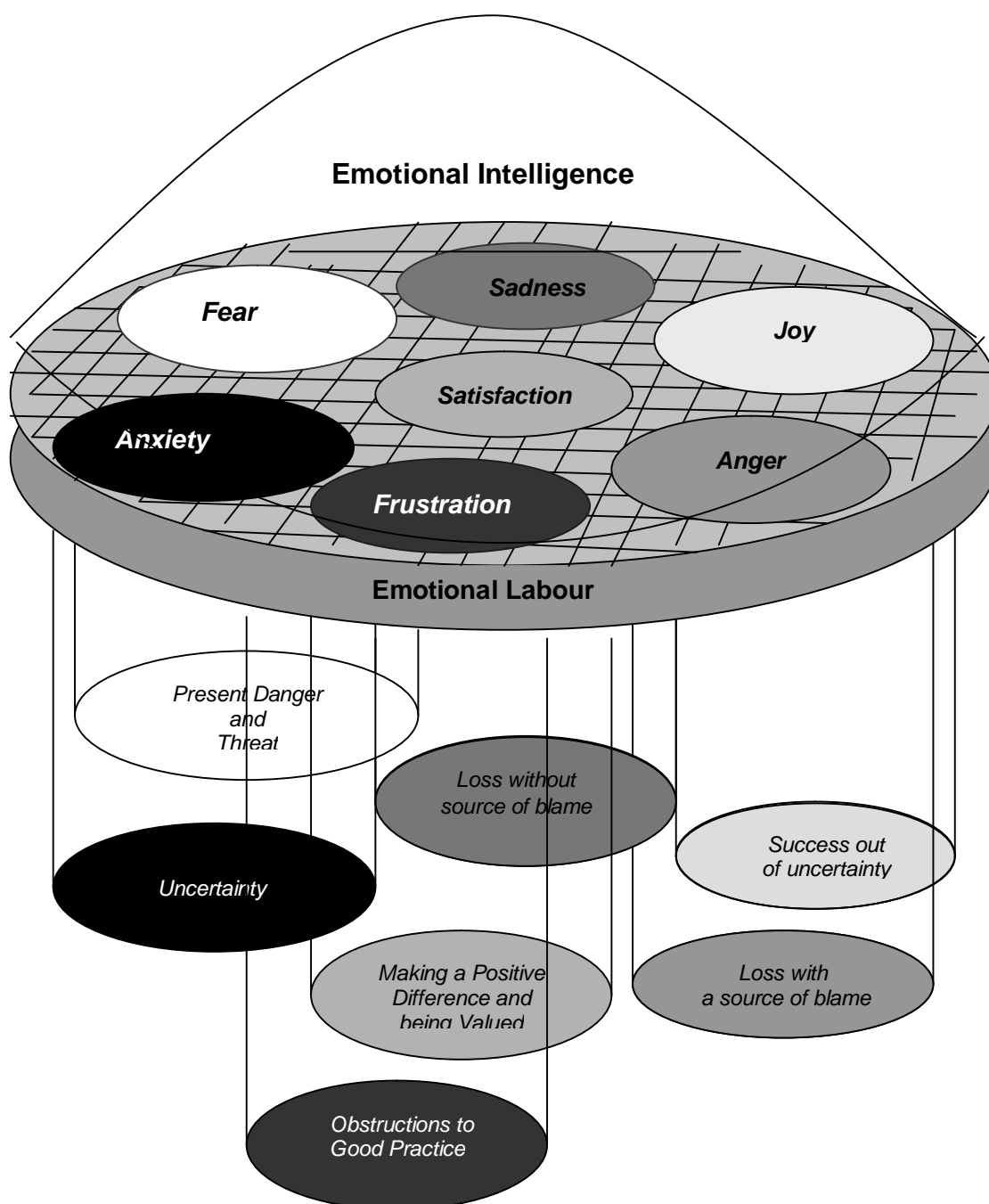


Figure 6.1: The Emotion Map of Nursing Life

Commonality of Emotions in Clinical Practice

In terms of clinical judgement, the patterns and dynamics of emotions revealed in the data point to a new way forward for the professional use of self. The data reveals a common set of seven emotions; satisfaction, frustration, fear, anxiety, anger, sadness and joy experienced across nursing practice. This core set of emotions exist in every specialist setting regardless of the level of experience of the nurses who practice there. Reference to any one emotion as negative or positive is simplistic because each emotion has a character profile that can be harnessed for a meaningful purpose. Each emotion can be experienced separately but also in combination with others and often as part of a cascade leading to a more negative or more positive mood than previously experienced. Each of the seven emotions relates to a separate area of experience in practice life. Hence: the appropriateness of the term 'emotion map' of nursing life [see figure 6.1].

Satisfaction points to policies, logistics, systems and behaviours that serve good practice and produce positive outcomes. Joy issues from positive outcomes, which may have seemed unlikely or impossible, produced on the back of perseverance in the face of adversity. Frustration relates to policies, logistics, systems and behaviours, which are obstructive to good practice processes and outcomes. Anxiety concerns areas of uncertainty where confidence fragments over the exactness of judgement or where a range of negative possibilities call for preparation in advance. Fear points to areas of danger or threat. While most of the emotions identified are not thought of as positive, they have been demonstrated to have positive uses. Both anxiety and fear were shown to produce leverage for accountability. Anxiety increased vigilance and enhanced watchfulness. Sadness and Anger both point to situations of loss; sadness results when no source of blame can be identified but anger results when there is an identified source of blame.

The commonality of these emotions together with their corporate representation of the practice world suggests potential for a framework for reflection.

The Potential of a Common Set of Core Emotions in Clinical Practice

Although concepts organise our thoughts and aid our interpretations (Margolis and Laurence, 2000) they cannot populate a framework unless they meet certain criteria.

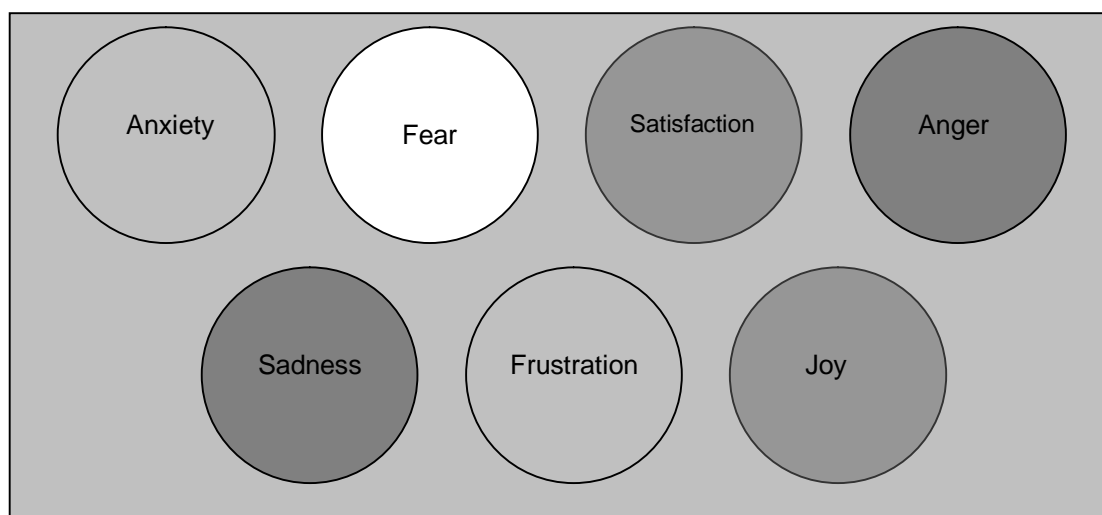
First they must have commonality of meaning in the minds of the framework users who form a community of practice. All framework users must be able to form the same value relationships between the concepts and their practice world. For example in the world of photography light measurement, focus and shutter speed are all related concepts which will produce shared value thinking in that community of practice.

Second, concepts must be repeatable and consistent in their use and application. Notice that this can also be said of the photography concepts. Finally there is economy of membership. Economy of membership is important to be useful to the user in providing pivotal thought mechanisms that are representative of diverse experience. Polanyi (1999:78) called this the “law of poverty” in language. If framework membership were limitless there would be no point to representativeness. A situation known as infinite regress would exist (Benner, 1984).

Comprehensive representativeness means that as concepts the emotions constitute points of mental navigation for every area of praxis. All seven emotions hold potential as markers or triggers for reflection from which all of nursing practice can be explored as a lived experience [see Figure 6.1]. Satisfaction is a positive motivating affective force over time, which musters optimism and nurtures professional skill through increased self esteem and self confidence. Satisfaction also fosters resilience which can facilitate a reframing of experience. It persists in the face of cause for more negative emotions and compensates for them. Pondering on satisfaction can therefore assist reflexivity and reframing of practice in the context of one’s biography (Shaw and Degazon, 2008; Wilson and Crowe, 2008; Hayes et al. 2010; Wyatt and Harrison, 2010). Joy highlights areas of practice deserving of commendation and celebration. It follows that joy can pinpoint minor victories in practice which might otherwise have been eclipsed by impatience with systems and the protracted nature of the care process (Pooler et al. 2014). Frustration has the opposite effect to satisfaction over time; fostering an array of negative thoughts ultimately resulting in physical exhaustion and poor mental wellbeing. However frustration experienced temporarily in an interim period can foster greater determination to develop alternative strategies in an effort to find a way forward. This is useful when facing off powerful forces such as bureaucracy or institutional hierarchies (Maslach et al. 2001). In a similar way to frustration, fear and anxiety are experienced as negative emotions but nurses utilise positive aspects to both.

Fear is a present time focused state which produces responsive protective action (Orsini et al. 2011; Sylvers et al. 2011) yet a measure of fear is seen as a positive characteristic in terms of awareness of accountability (Sauerhöfer et al. 2012). The identification of threat is an important part of any situational analysis. Anxiety is a future focused state in the face of negative possibilities which have the potential for a range of negative outcomes.

Table 6.1: The Emotion Framework for Reflective Practice



Guidelines

- The supervisee is encouraged to explore the 'menu' of emotions and choose to talk about the ones which they have experienced. The discussion should move quickly to the supervisee's identified choices.
- The supervisor and supervisee should explore together the root causes of the emotions experienced. The supervisor may use brief but repeated probing questions such as 'why?' and 'how?'.
- The supervisor and supervisee should discuss the impact on practice and agree goals arising from this discussion
- The next supervision session should begin with a review of the goals set at the last session

The emotion framework needs to be approached and managed differently from other models of reflection. Instead of a pre-structured pathway of thought, the feeling state of the user is the constant object of enquiry. The opening question should be "How are you?". The question simultaneously respects the personhood of the user and begins the reflection process. Socratic questioning (repeatedly asking 'why?' or 'how?' to encourage elaboration) is all that is required to maintain this process which will be informed by the situation to which the user's emotion is attached.

Anxiety spawns hyper-vigilance and catastrophising in an attempt to achieve a state of constant preparedness by creating a range of mental templates as responses to a range of possible outcomes. Still, anxiety possesses valuable properties of watchfulness, sensitivity and discernment in nebulous uncertain situations (Meeton et al. 2012). This holds promise for lending shape to features of practice which have

previously defined definition such as observed behaviours in the practice of safeguarding children and adults at risk or judgement of levels of consciousness or deterioration in trauma units. Two further emotions traditionally labelled as negative have positive properties for practice. Anger holds similar potential. As the endpoint arousal state of burgeoning resentment, anger apportions blame to a cause of loss or injustice. Moreover anger will fuel advocacy (Rivers et al, 2007). Sadness reflection will help us identify causes of loss without a blame and the need for restoration. It will also help us to sustain emotional labour and empathise with patients and colleagues (Bower, 2013; Zawadzki et al. 2012). Reflecting on anger will help us identify injustice and how we might address it.

A framework for reflection on seven core emotions taken from a qualitative map of practice [see Table 6.1 above] holds promise for enhancing self-awareness, emotional intelligence and informing practice. The model does not exhibit one directional signposting or 'layers' as has been the custom in past framework designs. Instead, decisions as to direction are left with the user. The fundamental place of emotions in judgement and decision-making mean that a common set of core emotions is a powerful composite tool for practice. Such a tool should prove flexible beyond what might be expected from other prescriptive frameworks. It combines the freedom of intuitive thinking with the specificity of a checklist.

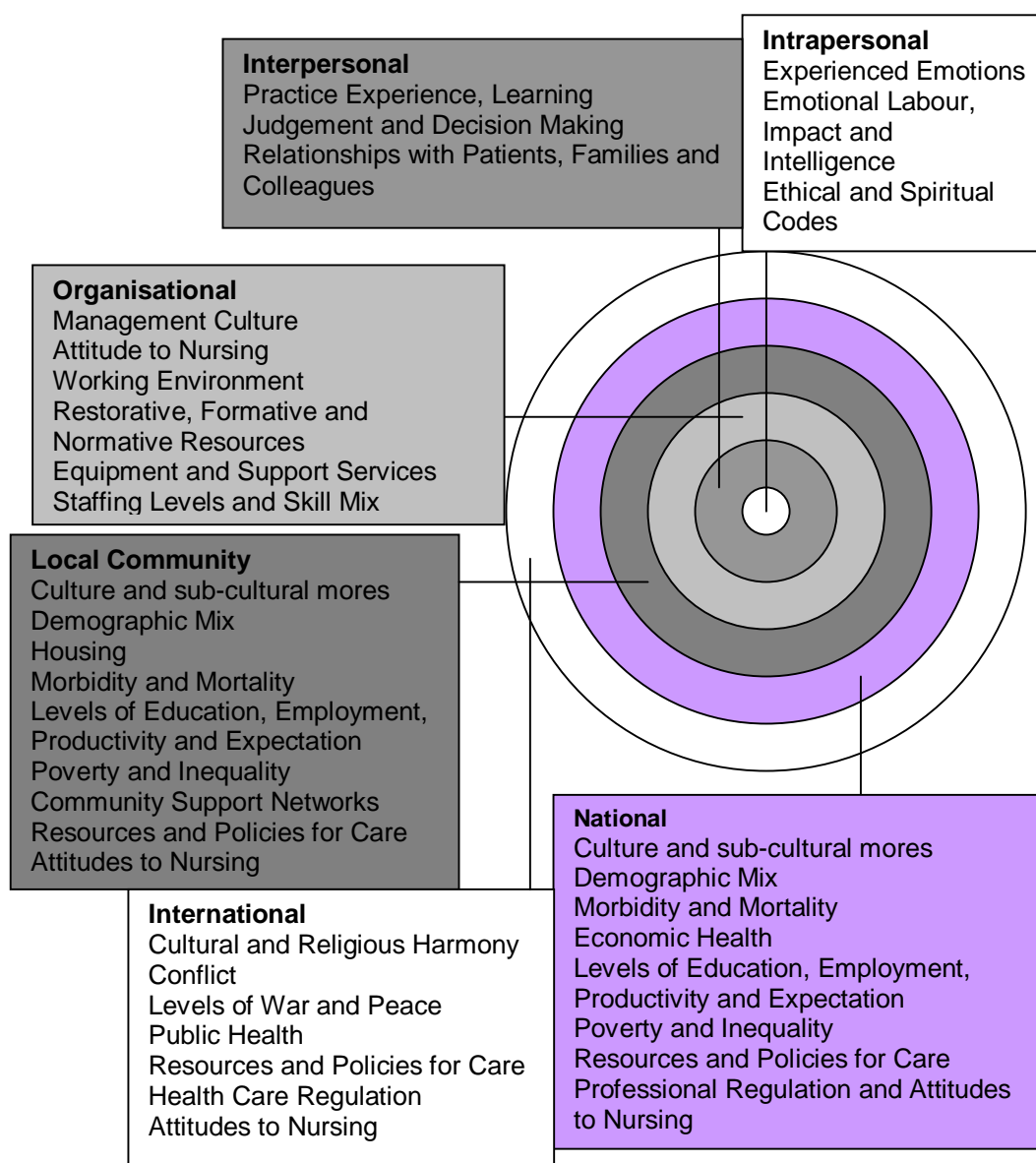
The emotions have core validity because they have commonality across the practice community. The emotions also have specificity because they are experienced by the user in their contextualised world. The relationship between emotions and judgement mean that reflection is not restricted by the limited scope of the reflection point. Emotion as a descriptor of experience is limitless.

The Political Implications of the Emotion Map of Nursing Practice

The findings of the first part of this study take on special significance as they are being documented in the aftermath of the Francis Report on the public enquiry into the failings in care in the Mid Staffordshire Hospital NHS Foundation Trust (2013). Indeed the data collection took place simultaneously with the preparation of that report. The nursing strategy (Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser 2012), which arose from the preliminary findings of the Francis Report (DH, 2009), was aimed at promoting compassion, care, commitment,

courage, communication and competence in nursing. The inference contained within this strategy was that nursing had somehow lost its moral compass and was now in want of its original core values. The findings of this study do not sit well with these inferences. Instead, nursing presents as a profession proving true to its historical, social and ethical values despite a rapidly changing care environment. Messages from the data offer a range of alternative explanations endorsed elsewhere (Royal College of Nursing, 2013) as to why nursing care in the NHS has faltered and at times has failed the patients and families it was designed to serve [see Figure 6.2].

Figure 6.2: Conditional Matrix



The emotion map of nursing shows a workforce characterised by compassion and commitment; placing patients at the centre of its purpose across a range of specialist

areas. A comprehensive sense of commitment was shown in a standard corporate willingness to delay breaks and defer the end of shifts in order to meet the needs of patients. Person centred relationships were evident in narratives in which nurses' use of personal knowledge of patients along with empathy informed the care they provided.

Practice was placed far from a position of prioritising tasks, targets or self over people. Nurses discussed the use of emotional intelligence sourcing humanistic psychology; sensitising care to time, circumstance and service users' mood and ability to absorb or share different forms of information (McKinnon, 2011). The genuineness and humanity at work in these therapeutic relationships was confirmed in the sadness and sense of loss experienced by nurses when their patients deteriorate, die or are discharged.

Empathy showed itself to be a central tool of emotional intelligence; a libidinal force which informed person centred practice. The development of such an important tool for caring needs to be fostered in undergraduate and post graduate study and practice. Reflection on biographical narratives both fictitious and non-fictitious together with the sharing of personal narratives between learners will aid empathic skill construction. In addition, service user participation in learning through seminars and living libraries provide students with biographical information with which to fuel empathic practice.

If emotional intelligence has been shown to be a rudder for nursing then emotional labour has been shown to be its fuel. Emotional presentation and deportment, finely tuned to suit colleagues and service users alike in a range of situations were shown to sit at the heart of practitioner work. Furthermore, consistent with the genuineness observable in nurse patient relationships, emotional labour was an appropriated genuine adjustment, levelling and self-monitoring by nurses responding to the emotional demands of the moment. The extemporaneous nature of this activity together with its ethical underpinnings make emotional labour a higher art form than the acting to which it has been frequently compared in the literature (De Raeve, 2002; Mazhindu, 2003; Hunynh et al. 2008; Theodosius, 2008).

The deceptive complexity inherent in the skilled use of self before a single clinical procedure takes place also has implications for socio-political perspectives on nursing. Such complexity means that simple gender orientated notions of care and

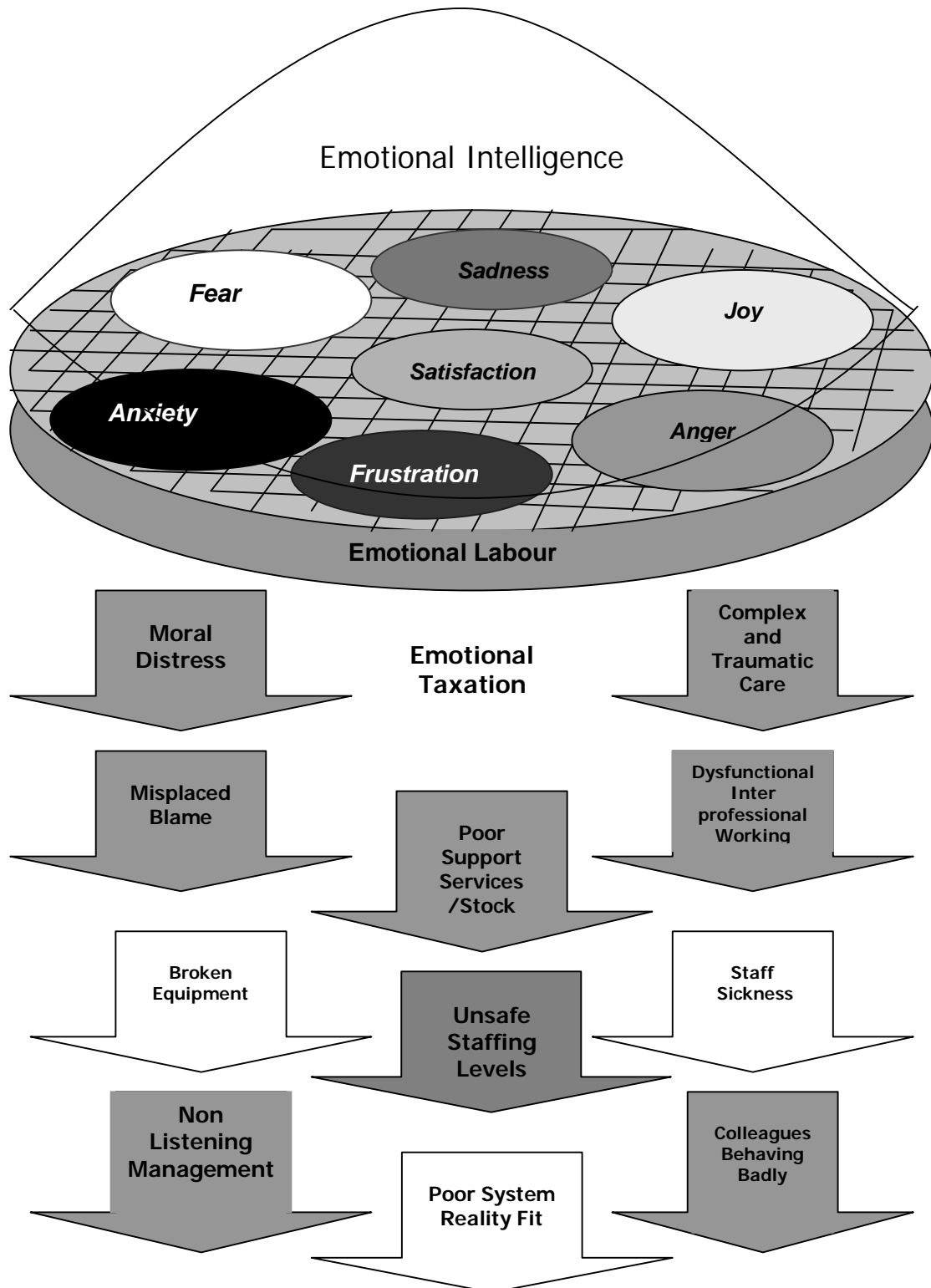
caring should be permanently ejected from any decision and policy-making forum on nursing. Instead 21st century perspectives on caring should acknowledge that integration of the professional self within any clinical practice is only effective when it is informed by the ontology of health and illness. It is therefore professional practice in an advanced state.

The psychosomatic costs of sustained emotional labour documented in the literature (Mann and Cowburn, 2005; Zammuner and Galli, 2005; Niedenthal et al. 2006; Stayt, 2008; Gray, 2009a) are not surprising when one considers the daily assault on a nurse's sense of composure. The emotion map has exposed anxious patients with complex needs and correspondingly complex therapeutic profiles together with planned and unplanned admissions along with angry grieving relatives as the order of any working day. In addition ubiquitous ringing telephones, administration and audit, liaising with medical staff, social workers and practice teaching contribute to a landscape of potential mayhem. It is against this standard kaleidoscopic backdrop that nurses, still with the largest patient interface of all health professionals, are held accountable.

However this study has shown that there is another wave of emotional demand on nursing. The care process is often frustrated by deficits in support and practice measuring systems which are unfit for purpose. Such deficits require immediate compensatory measures from nurses. They must substitute their own efforts for resources originally in place to support care giving rather than detract from it. The consequence is nursing time that is 'stolen' from patient care. Inadequate staffing levels, malfunctioning equipment, allied professionals who fail to play their part, eight hour a day services supporting twenty four hour care along with unanticipated sick leave are all examples of such 'time thieves'. Nurses have no choice but to compromise and comply with the need to compensate as patient care cannot proceed without their improvisation.

The consequent frustration nurses experience when desired outcomes prove elusive or take longer to achieve can prove toxic and adversely affect the quality of their practice.

Figure 6.3: Emotional Taxation



This frustration is exacerbated when as frontline care coordinators they prove easy targets of blame for an unsatisfied public and for managers and politicians who previously failed to listen or act on their concerns. Burston and Tuckett (2012) argue that longstanding relationships and prolonged contact time with patients increase nurses' sense of moral distress. Moral distress arises from being continual eye

witnesses of suboptimum care over which they feel powerless. Nurses' relatively low position in the hierarchy of healthcare intensifies this feeling of "responsibility with no authority" (Burston and Tuckett, 2012:316).

Emotional labour has been shown to act as a disciplined supportive 'net' suspending and maintaining emotions at a desired level. However deficits in resources exert excess 'taxation' on emotional discipline making emotional labour harder to sustain [see Figure 6.3]. Frustration generates anger over injustice leading over time to bitterness and cynicism along with worthlessness and despair in the face of failed best efforts. This emotion cascade arising from moral distress can be detrimental (Burston and Tuckett, 2012) and cause 'breaks' in the 'net' of emotional labour. Emotional intelligence falters. Preoccupation with multitasking and the feeling of losing ground against a tidal wave of competing demands can disable empathy because nurses become preoccupied with their own unmet needs. Expressions of anger, as an 'end point' reaction, 'breaking through' the emotional labour 'net' in inappropriate settings can impact on fragile relationships with patients, their families and with other nurses. These short and long term feeling states are major contributors to poor health among nurses (Vansteenkiste and Ryan, 2011) and their desire to leave the profession (Li et al. 2013). This is a picture of a toxic system pitching nurses against their patients and against each other.

In view of the challenges to sound integrated practice the dominance of satisfaction as a theme in the data is testimony to resilience within nursing. The basis for job satisfaction in the shape of doing good, earning a good reputation through optimum practice and mutual support and affection among colleagues is also evidence of the survival of the profession's core values.

The ability of satisfaction to engender other desirable qualities and forge a more confident innovative workforce should not escape the notice of managers, health care executives and politicians.

It is intriguing that across four NHS trusts varying greatly in their resource wealth that the same emotions were evoked over much the same issues. This means that while adequate funding is important there are issues within nursing which transcend fiscal policy. These issues relate to how professional carers are supported and cared for. If the public have been at times ill served by nursing, then this study shows that nursing

is a poorly served and undervalued public service. An unprecedented period of time in the history of the NHS characterised by increasing throughput, diverse demand and a shortage of resources would seem to have been paralleled by failed clinical governance measures in respect of sustaining staff health and morale. A socially constructed imbalance between responsibility for care and the power to forge standardised care is evident which does not served nurses or society well (Burston and Tuckett, 2012).

These findings highlight a false economy inherent in the paradox of a highly skilled nursing workforce ill equipped and insufficiently supported to deliver the care expected of them. A mismatch between the administrative and clinical services that are available and those required to match the 24 hour nature of patient care has resulted in substantial and expensive time that is 'stolen' from clinical practice. This work also points to a disparity between the staff patient ratios in place and the intensity of the care required. The levels of apparent frontline frustration and feelings of undervaluation raise questions about the viability of many models of management currently operating in healthcare. The importance of informally and formally rewarding innovative and productive practice is clear (Li et al. 2011; RCN, 2013).

These messages also imply that neither public nor fiscal good is served by pushing practitioners, or allowing practitioners to push themselves beyond the limits of reasonable endurance. Such practices result in raised sickness levels and rapid workforce turnover, necessitates expensive contingency plans such as agency nurse cover and places patient safety at risk through the increased likelihood of professional error. The need for rest and sustenance to maintain emotional labour would not appear to be adequately addressed (Bond and Holland, 1998). The demonstrated link between sound nursing practice and nurses' emotional health supports the notion of collective responsibility for these matters. This raises the status of rest sustenance and restorative provision beyond the issues of rights at work to what is universally beneficial practice.

Conclusion

The previous chapter described the common patterns of emotion at work in nursing practice. This chapter has argued for a potential for reflection in such a commonality in the shape of a framework for reflection using the constituent emotions as 'meta

cognitive triggers'. In addition an alternative discourse on professional care and caring has been tabled which sits in opposition to the social and political stereotypes which currently abound in the media about nursing. This discourse is a modern picture of person centred practice being delivered in the face of complex adversity.

The next chapter introduces the second phase of the research and describes the user experience of the new framework by a second sample of nurses.

Chapter Seven

Using an Emotion Framework for Practice

Introduction

This chapter contains the data analysis arising from the second phase of data collection. In this second phase a new sample of nurses are exposed to the framework as it was presented in chapter six.

This second phase rests on the assumption that the commonality of seven core emotions experienced and relating to the shared values of practice life, their consistency of use and economy of membership make for the potential to be used as a framework for reflection. The framework is therefore being introduced as a new experience housed within a supervision system. This part of the study does not constitute an experiment in the logical positivist sense. In line with a phenomenological stance, the users of the framework select what is significant and useful for themselves (Dowling, 2007; Flood, 2010). Their lived experience of framework use is being sought. For this reason the focus of the research question is also the framework not the supervision system. The personal dynamic and flexible use of the framework's structure and process in practice is at the centre of enquiry. In this way, true to the purpose of grounded theory, chapter seven is the definitive development of the theory generated in chapters five and six for a refined use through theoretical sampling (Corben and Strauss, 1990). There is strength in exposing a new sample of nurses to the framework as there is in a second group perspective in the shape of the practice educators. However there are limitations in that professionally extant emotions not mentioned anywhere in the analysis of the first phase have no place in the framework. In addition the framework is the collation of core emotions experienced by nurses practicing under the auspices of humanistic values. Like all frameworks of professional practice implementation is disabled in the absence of these values and the presence of malevolence or indifference. The framework's efficacy or the lack of it can only be within the perception of these participants. Claims of efficacy beyond this require repeated exposure of the framework to other nurses.

Four qualified nurses in the paediatric wing of a major teaching hospital in London volunteered to take part an intervention built on the commonality of seven emotions

across nursing practice. Two practice educators agreed to provide supervision once a month for four months using the framework. The nursing directorate agreed that the four nurses could be released for one hour per month to receive supervision. The four nurses were asked to keep the framework in mind while in practice and keep brief daily diary notes on their experiences. Practice Educators also kept personal records of their experiences of the supervision sessions. At two sets of individual interviews (one half way through the intervention and another at its conclusion) the participants (practice educators and nurses) talked exhaustively about their experience of using the framework.

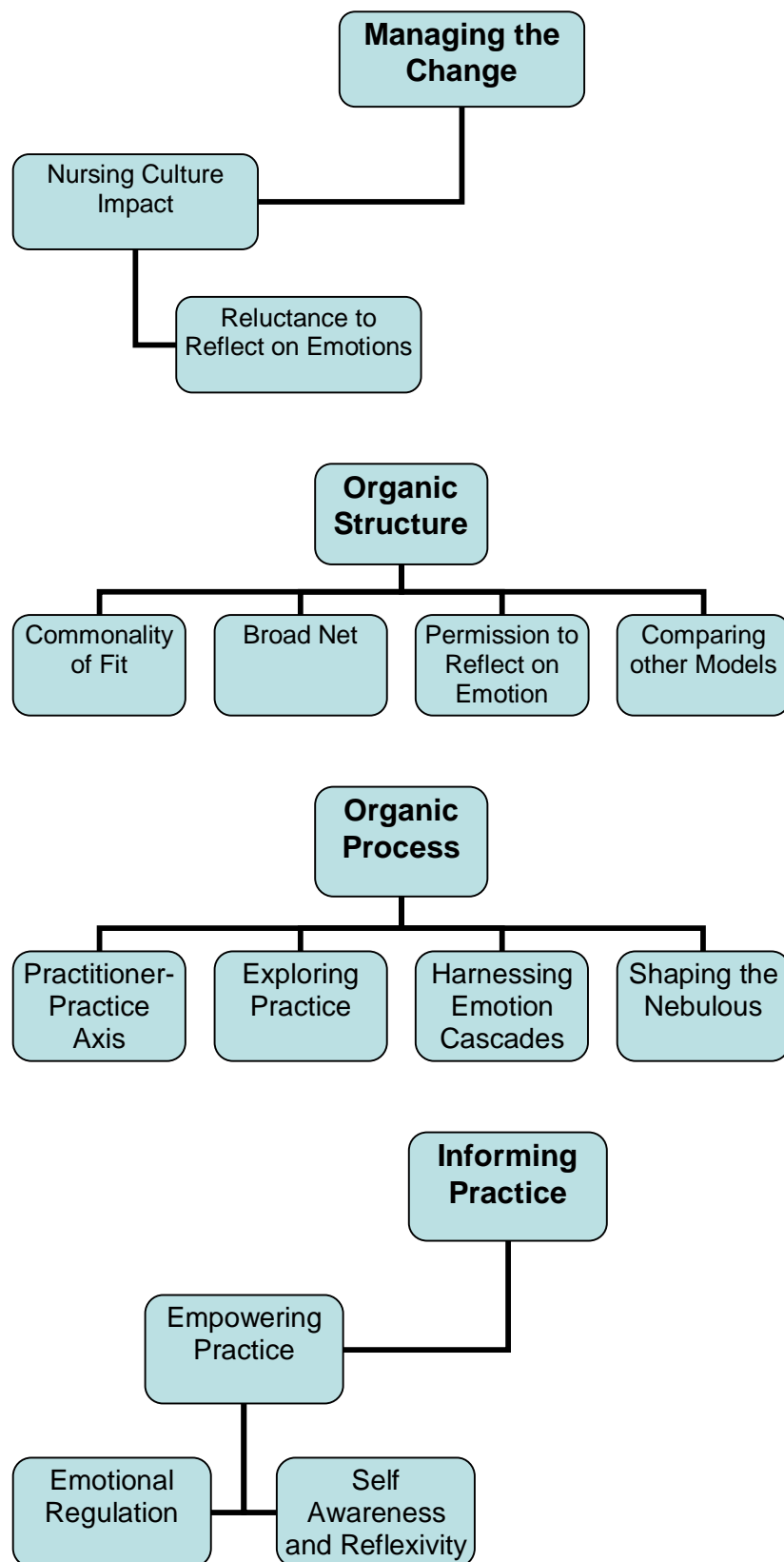
Because the four nurses were recruited at different times the overall length of the pilot was ten months. A second nurse attended for a second interview following a close family bereavement while still on annual leave but only declared this afterwards. The nurse believes that this affected her ability to speak effectively about her experiences at that time.

The interviews were recorded on audiotape, transcribed verbatim and then analysed using grounded theory method. Four categories: managing the change, organic structure, organic process and informing practice, emerged along with four clusters of ten subcategories. Within two of the clusters there were three further variations in meaning [see Table 7.1 below].

Managing the change

The narratives show that supervisors initially struggled to adjust to a framework which lacked the cyclical or layered signposting which characterise many models of reflection used in practice and supervision. Behaviour consistent with the initial phases of transformative learning was evident. As in the case of any new experience that challenges established ways of thinking and working, there was a need to manage discomfort before moving on towards change (Robertson, 1997). Participants (both supervisors and supervisees) were initially baffled by a system that requires a less prescriptive more fluid approach.

Figure 7.1: Framework Intervention Theme Clusters



I found it very daunting at first because it was different, so there wasn't a structure and it was different to the structure that I had used before.....if I've supervised before you tend to start off with a problem and explore it but then your goal is how to get around that problem in future or to do it differently. So picking out the stuff that was going to be useful was difficult I found the first time. PE1 (1:60-61; 74-77)

The practice educator finds the new process "daunting" not because she lacks the necessary skills but because she struggles to adapt her skills to a framework with an unfamiliar structure. Indeed at first it seems to her that the framework has no structure at all. A choice starting point is afforded the user and this is a departure from other frameworks used in nursing. Note her later comments in the same interview in this respect.

I kind of don't know where to start, I think that is the first kind of erm, because you start where you want to start. PE1 (1:413-414)

Such a radical change of method meant that for some supervisees more than one session was needed to impress the process as a habit of the mind.

I think I had almost forgotten how we had done it the first time round like I think the first session at first was stilted but definitely the last half it felt more organic. P1 (1:157-159)

The use of the term 'organic' in reference to the fluidity of the framework structure was pervasive in the data and will be discussed later. It is suffice to state at this stage that a framework of this nature was perceived as a radical change by the participants. The comments of the second practice educator in a supervisor role give weight to this.

I think it's because it's new to us that I've found it difficult, because initially I thought, "Oh it could be just a general chat", but I think more you use it, the more you'll learn how to use it properly. PE2 (2:85-86)

The practice educator's mention of 'difficulty' relate to her reservations about the capacity of the framework to facilitate meaningful reflection. She fears that "it could just be a general chat." This reveals her ingrained habit of associating a particular

structure with meaningful reflection. However she adds that proficiency comes with use as in the case of any knowledge in a behavioural context (McKinnon, 2016).

Managing the Change - Nursing Culture Impact

Variables working to oppose change were also decipherable in the data and these were recognised as being part of the culture of nursing as a community of practice. Despite the extensive literature on the relevance of emotion and emotional labour in nursing (Henderson, 2001; Mazhindu, 2003; McQueen, 2004; Mann and Cowburn, 2005; Hunynh et al. 2008; Stayt, 2008; Theodosius, 2008; Bradbury-Jones et al. 2009; Gray, 2009a) traces of the legacy of practice as an essentially emotionless entity were present in the narratives. Despite this, there was awareness among participants of the need for practitioners to divorce themselves from that legacy.

So much of what we do and what we are, is started with an emotion. We as human beings feel emotion and we are taught very quickly that actually we need to take that emotion out of what we are doing to practice in order to be a better practitioner. I don't think that is the case, I think you need to have emotion.....We are very much focused in, as a professional and in our training that we have got to be able to separate that emotion and so we get very used to pushing it away. P3 (1:451-454; 463-465)

A practice educator acknowledged the centrality of emotion in nursing and showed herself aware of the health dangers of failing to give place to such a central component (Zammuner and Galli, 2005; Niedenthal et al. 2006; Gray. 2009a).

With nursing, everything's about emotions isn't it, everything we do is about emotions and if we don't recognise our emotions, and deal with our emotions, it can only cause personal stress. PE2 (2:151-153)

Another participant also shared her view on the propensity for negativity in nursing suggesting that this was borne of frustration with barriers to better care and care delivery.

the problem with nurses is that we are all very good at moaning and complaining and you get a group of nurses together and you will complain but you all still work in the job and you enjoy it...They do tend to start with frustration and whether that is because it is a big part of how we feel when we are nursing and the obstructions we come up against. PE1 (1:205-207; 418-19)

The nurse's viewpoint coincides with that of Davies' (1995) feminist perspective on nursing as a potentially powerful profession whose power is restrained and frustrated by social suppression. Nurses routinely release their frustration at opportunities for informal dialogue (or "moaning and complaining") as part of a meaningful routine which characterises their community of practice. This 'dialogue of complaint' is not in conflict with their love of their role and the sense of purpose it supplies. The dialogue of complaint is symptomatic of a predominantly female profession enduring structural political and institutional obstacles to optimum care while perceiving that they are powerless to change or overcome them. Davies (1995) also argues that the time consuming responsibilities of complex caring and allied clinical judgement demand a level of commitment in time and energy. The size of this commitment results in a corresponding reduction in the time and energy which remain for seizing power for themselves. In this respect Lewandowski (2003:177) makes the point that women carers by virtue of their person centred concern are "other focused" and this hampers their ability to communicate their own needs. The consequent preoccupation with caring work creates a plight not dissimilar to that of non-professional informal carers who have little time or resources to attempt or sustain the necessary political activity required for structural change.

Managing the Change - Nursing Culture - Reluctance to Reflect on Emotions

Shortly after commencing the intervention one nurse disclosed her reluctance to reflect on emotion; particularly emotions that adversely affected her mood.

I have been in bad situations here and I have got myself in a rut with work, I try not to negatively reflect on my day, I try to flip and try to get everything sort of positive or try and get a good thing from it because otherwise I ended up going home, getting just totally wound down by it all. I do find it difficult to reflect and go 'that was bad and that made me

feel like this' because I don't want to be thinking negatively I want to be thinking positively. Yes, it might have made me feel sad but I did this to improve it or this made me feel better, I do find it difficult to reflect because of ... where I have been in the past. P2 (1:162-171)

Painful experience in practice that the nurse chooses not to disclose persuades her to maintain a positive disposition but this is at the cost of self-knowledge. The nurse continues to explain how her lack of confidence in her own abilities causes her to associate reflection on emotion as a negative activity.

I do find it very difficult to have self satisfaction and be like "yes I did a good job today". I will always try to find fault in what I have done... So, to continually go home and then go: "oh I should have done this and I should have done that" I find that really difficult and I want to switch off and be more positive if I can. P2 (1:175-179)

The nurse is not describing an optimistic outlook. Her use of the term 'switch off' betrays a form of perpetually enforced emotional labour in which any negative emotions are not 'heard' by her. Mann and Cowburn (2005) spoke of nurses artificially producing positive emotions to replace negative ones they had suppressed, calling this a misuse of emotional labour in an attempt to manage stress. The nurse's proclivity towards self-deprecating behaviour supports Hargreaves (2010) who laments over the way self-criticism dominates reflective narratives in nursing. Hargreaves (2010) argues that a lack of self-esteem originating with Victorian values of control and unquestioning obedience is a constant theme in nursing culture and that this is stifling to effective critical reflection. Mazhindu (2003) takes a similar perspective arguing that the iconic and socially constructed image of the ideal nurse to which nurses aspire is prohibitive to effective reflection. She tables the idea of reflecting on emotions rather than outcomes currently beloved of nurse educationalists and argues that learning will not take place without due attention to feeling states.

These narratives and the aligned discourse in the literature highlight a need for a framework of reflection that assists self awareness and harnesses rather than suppresses specific emotions to inform practice.

Organic Structure - “its free willed”

The term ‘organic’ used in a quotation from one participant above came to be used frequently along with ‘flexible’ and ‘free willed’ to describe the framework structure: the means by which users engaged with the model. For participants these adjectives described the way the structure of the framework gives itself to the natural development of thought rather than imposing a prescribed set of one directional signposts. In this respect the comments of one of the supervisors is telling.

I think at first I thought there was a lack of structure but there *is* some structure there because if you explore them all (*the emotions*) ... it doesn't matter where you start but you go through them all; that *is* a structure. PE1 (1:161-163)

In contrast to her initial impressions the practice educator realises that while the framework possesses structure it is one that has no designated starting point. The start point of reflection is left with the user and is dictated by *their* hierarchy of experienced emotions. This leads her to conclude that her formerly held notion of absent structure was in fact testimony to the flexibility of the framework.

I think the framework is very flexible PE1 (1:369)

One nurse explains her rationale for the use of the adjective ‘organic’.

I saw frustration and I went straight to my terrible shift that I had had the day before. So, for me that's organic, because those words promoted memories in me, you know they actually invoked something out of me. P1 (1:216-219)

The flexibility of the framework would appear to lie in its sensitivity to user need. The emotional concepts act as triggers that engage with the concerns of the user. Another nurse elaborated on what flexibility meant for her in the shape of the freedom of cognitive movement supplied to her reflection.

you're not tied down to constraints, you're not you know, you're not following a rigid pattern, its there you have a look at it and its what jumps out at you first, you know, and you find you go through from one

thing to the next. I like it because it's not rigid. P4 (1:221-223)

The same nurse continues to explain that while some may argue that signposting in models of reflection is important to provide focus, this framework's minimalist structure built around key emotions supplies all the focus that is needed.

Too much signposting is too much direction; too much guidance whereas, *this* framework you've got there now there's no real guidance on it, it's almost like it's free-willed, P4 (1:260-261)

This freedom was witnessed by one of the practice educators who noticed that less intervention was required of her at the beginning of the supervision session.

sometimes you might feel like I'm being like it's a personal review that you're having and you come in with your structured, 'tell me how you feel', whereas you don't have, so to speak, you don't have a structure to it, because you can allow it just to flow, PE2 (2:310-313)

It is clear that the freedom to reflect inherent in the framework structure was valued. However the question arises as to how focus is supplied despite such minimalist structure.

Organic Structure - Commonality of Fit

The commonality of the seven core emotions across nursing practice identified within the first wave of data collection seems to have been validated in the framework for which it formed the base. At no point in the data was there evidence that any other emotion was worthy of inclusion. The core emotions functioning as a 'menu' of pivotal points of reflection showed themselves fully representative of practice.

those are all emotions that you feel at work and you can relate to, you know. P4 (2:106)

The ability of participants with no prior involvement in the shaping of the framework to "relate to" the component emotions is testimony to those components' representativeness.

Looking at the words particularly on the left hand side of the page I was able to really kind of think, “Okay, those words, yep, that’s how I feel and this is how I felt at this point and this point”. P1 (1:16-18)

The practice educators conducting the supervision also agreed on the representativeness of the framework components.

..because you can see in front of you, these are all the emotions that you might have in life, but actually in clinical practice as well. PE2 (1:31-32)

Such comprehensive representativeness had positive implications for the ‘trawl’ and diversity of relevant narratives as discussed in the next subtheme.

Organic Structure - Broad Net

The capacity within an emotion populated framework for an infinitely wide and deep reflective ‘trawl’ or ‘broad net’ of subject matter did not go unnoticed by the practice educators at different points in the intervention. Both supervisors talked about the benefits of including issues from their private as well as professional lives.

I found that some of the things they’ve put up haven’t necessarily been clinically focused and it *has* given them that opportunity to talk about things that are going on outside of work, PE1 (1:37-39)

Both practice educators believed such a broad net was important in view of the difficulty in maintaining a work life balance and how the private and professional roles formed a seamless landscape.

Some say ‘well I’ve got something in my private life’, but again that impacts on your practice, so there’s no reason why you shouldn’t talk about it... There’s no barrier in that because I’ve got such a wide net to look at. I’ve got it in front of me: all the different emotions I can talk about. PE2 (2:15-16; 113-114)

There was also recognition that the framework’s ‘broad net’ played a proactive health promotion role in allowing practitioners space and time to address concerns.

This was quite good to identify because things at home do affect your work... There were definitely things at work that affect home life and I think if you are having a tough time at work it was easier to talk about leaving it at work and going out of that door and closing it off and having your home time, but if something is having quite a big emotional effect on you at home it was hard to leave that at home.

PE1 (2:389-390; 394-398)

Emotional representativeness also worked to address a longstanding problem rooted in nursing culture: the suppression of emotion

Organic Structure - Permission to Reflect on Emotion

The visual impact of seven emotions empirically demonstrated to have represented nursing practice appears to have implicitly 'granted permission' to some nurses to talk about their emotions. This is important given the concerns expressed by Mazhindu (2003) and Hargeaves (2010) about suppressed emotions inhibiting reflection in a nursing culture.

it gives you permission to feel emotion. P3 (1:494-495)

At her final interview one nurse who at an earlier stage of the pilot had talked about her reluctance to acknowledge negative emotions spoke about how knowledge of the framework's emotional representativeness helped her overcome her reluctance to reflect.

because I know that that framework was developed from what other nurses have said, so I do feel like I'm not totally on my own, and it's also helped, it's also given almost that sense of reassurance, it is okay to feel these things, because you know, we are only human we have feelings and it is okay. P2 (2:42-44)

It is ironic that humanity is often viewed in nursing as weakness rather than strength. A plethora of suppressed emotions in nursing through perpetual emotional labour together with a historical cultural mandate to contain these appears to have resulted in undermining the self awareness necessary for empathy and person centred care (Eckroth-Bucher, 2010). Alternatively the framework pilot seems to have worked to

help this nurse liberate these emotions.

Organic Structure – Comparing other models

The organic structure of the framework invited favourable comparison with Gibbs' Cycle of Reflection (McKinnon, 2016). Nurses believed in line with the discussion about a wider reflective trawl that a more in depth discussion resulted.

I did use the framework and kind of found it better than the Gibbs framework which is more rigid. This seems to be a lot more, a lot more fluid..... it's more fluid. There's a lot more to it, it goes a lot more in depth into how you feel, how things affect you, whereas I think the other model kind of skirts around you know, 'what happened?', 'what could you have done better?', 'what could you have done better to help the patient?' Whereas this looks at your feelings; 'how you are, how do I feel about what happened?' P4 (2:7-8; 28-31)

One practice educator believed that the fluid properties of the model made for a more relaxed opening to the discussion.

I find using the Gibbs model I will find silence in the room. So if there are three four or five of us sitting there and I ask, we'd normally start with 'tell me about your week or tell me about a patient anything that's happened over the week', they find it difficult to get going. And sometimes I'll have something up my sleeve so I can actually say something has happened to me and then they open up, so it's easier to open with this model. PE2 (2:356-361)

Of course the structure of the model is very simple so user's experience of fluidity is not in the model itself but in the way the affective cognitive mental process is harnessed. Moreover, these fluid properties were not limited to the structure alone.

Organic Process - "Working backwards from the emotion"

If the term 'organic' aptly described the framework structure it also described the process: the means by which the framework facilitated the internal development of reflection. Once again words such as 'natural' and 'free willed' featured in the data. One of the supervisors explained this so:

When they thought of a time that they had been frustrated or upset or whatever, then you could look at why what had happened had made them feel like that way, and sort of take it on from there. (PE1:2:83-85)

“Taking it from there” involved reflecting on a specific emotion within the framework to identify the reason for the emotion and reveal the detail of the underlying situation. A nurse described this as “working backwards” from the emotion.

Often times when you are having a bad day or you are having an emotion, a good emotion, feeling really satisfied with what you have done and actually you work backwards and you think, why am I feeling satisfied and you work back, what have you done to feel that. So I sat with a child, I have listened to the family, we’ve, using an example I taught a child how to count to 5 and that day I focused quite a lot on the psycho social aspects of his care. P3 (1:99-104)

The emotion components of the framework act as portals through which the user is able to peer into their practice. The ‘menu’ of emotions is sufficient as a signpost system for reflection providing the user with a sense of freedom in the reflective process permitting choice of reflection point and direction. This means that progress from negative emotions to positive emotions (or vice versa) as points for reflection was also made with ease.

I do think there was a natural progression into that as well; into the positives. P1 (1:154-155)

In addition direction of thought was not forced but is under the control of the user.

You don't feel as though you're going round in a circle you don't feel as though you're moving through one thing to the next you can talk about one emotion come back to it, go to the next . P4 (1:251-253)

This is consistent with the view of Finger and Asun (2000) in that although phases of reflection can be placed in a meaningful relationship, spontaneous focus may take place in no particular order. The challenge to any model aimed at effective facilitation of reflection is to provide a representation of the meta-cognitive process in the mind of the user. Over zealous representation will prove restrictive and prevent tangential

thinking. No representation at all will give insufficient guidance (Illeris, 2008). This emotion-based framework would appear to provide both guidance and freedom. But what are the dynamics and the detail of this process?

Organic Process - Practitioner–Practice Axis

The framework seems to successfully harness the axis which has been identified (Damasio, 1999; Immordino-Yang and Damasio, 2007) as running between experienced emotions, the experiences to which they are attached and judgements contained within practice. Nurses spoke of how discussion of their experienced emotions inevitably led into discussions of their practice.

You look at it and you relate it instantly to yourself, and then link it in with practice, those emotions that you are feeling. P4 (1:183-184)

At a later date the nurse elaborated on this.

It makes you unpick things a bit more, so things happen throughout the day, you can look and like you say, 'what brought joy to the day? What made you frustrated?' and the whole day is about different emotions and not just one. So you can recognise what's happening to you: through work, through everyday life. P4 (2:268-270; 287)

The nurse describes routes from experienced emotions each connected to an area of practice that requires analysis, de-compartmentalising or "unpicking". One nurse spoke at length about how her feeling of frustration revealed that she is not being valued as a member of her team.

One of my main frustrations is that I have a lot of ideas to help change how, not how the service is run because that's a big one, it's a multi speciality unit but just little things that can help to improve practice and help to improve the patient experience and patient experience for me is the big one because at outpatients we don't do a lot of clinical stuff apart from what I was doing this afternoon, there's not a lot of clinical skill involved but it is all about providing a good experience and being a communicative nurse and identifying with your patients and, I have got

a lot of ideas that I think if they were listened to in the right way they really would make a difference. P1 (1:267-274)

The nurse's discourse is an example of how a rich portrait of practice concern can be traced from the core emotion that it arouses and to which it is attached. Frustration has been shown to be an overwhelming emotion, which can disable personal investment in practice (Maslach, Schaufeli and Leiter, 2001; See Figure 6.1). The use of this representative emotion as a reflection pivot exposes a practitioner-practice axis which connects affect with cognition. The practitioner-practice axis indicates how personally owned emotion can inform on personally owned practice experience. It provides the extrapolation spoken of by Daniels (1996) between the intrapersonal and the interpersonal planes of learning. It is the point at which framework structure and process meet.

Organic Process - Exploring Practice “the being able to see”

The practitioner-practice axis provided the awareness needed to explore clinical approaches. The comments of a nurse are evidence of this; made against the background of her administrative error in the course of history taking leading to a patient being wrongly removed from a waiting list.

I suppose the fear of it happening again. I didn't want it to happen again, so I had to look at the way I did things and do things differently.
P4 (2:244-245)

So the emotion 'fear' was a reflection point which provided the nurse with sufficient insight into her practice to discern the urgent need for risk management. This led to an exploration of her practice.

Once a practice issue was identified via a particular emotion, participants reported on how the framework helped them explore that practice issue.

It does help you to explore that and look at what you can do to make changes and that would benefit patient care.....I think it does give you the space to explore them and how they are impacting on your work whether that be negatively or positively. The being able to see if there is anything there that you can change or make easier with work and

certainly you can make changes at work that can take the pressure off your home life or vice versa. PE1 (1:275-276; 377-380)

The “being able to see” and navigate the detail of a situation via reflection on an emotion finds credibility in neuroscience. A symbiotic and commutative relationship between feeling, knowing, deciding and doing was described by Damasio (1999) and has been confirmed and clarified by subsequent work (Immordino-Yang and Damasio, 2007; Paynter, Reder and Kieffaber, 2009). This relationship makes it possible for an emotion-based framework to facilitate exploration of and discrimination between events.

a degree of anxiety in relation to what I was doing and sort of you know, the nature of it, like I've been doing a lot more on the plasma exchange machine which is actually quite a complex machine to be dealing with, and that did make me anxious but it wasn't like it, you know it was more anxious about the technique rather than actually what I was doing in my job. P2 (1:33-38)

This nurse's comments are a powerful witness to the potency of the framework particularly when her prior struggle to reflect on her emotions is taken into account. Anxiety is a future focused emotion which is aroused by uncertainty in the face of limited information and which results in hyper-vigilant behaviour (Sylvers et al, 2011). As a point of reflection anxiety serves the nurse well in pinpointing the exact source of her lack of confidence. Notice that by reflecting on the root cause of her anxiety the nurse is able to identify and discriminate between aspects of her role which generate unease and those which do not; between her proficiency with the technical management of a plasma exchange machine and her overall competence relating to patients requiring plasma exchange which was not a cause for concern. The representativeness of the core emotions in practice makes such discriminatory reflection possible.

Organic Process - Harnessing Emotion Cascades

It has been interesting seeing how well it went and what things they come up with for the emotions really, the feelings. It has been interesting, and how they overlap as well. PE1 (1:80-83)

Immordino- Yang and Damasio (2007) argued that higher reason and rational thought are informed and enhanced by emotional thought which is the overlap between emotion and cognition. Furthermore emotions give rise to other emotions which in turn stimulate other thoughts in a cascade formation (Damasio, 1999). This emotion cascade explains the organic way by which the framework guides the reflection process from one area of interest to another. Related thoughts also provide 'feedback emotions' experienced by the user, which in turn can provide further insight into the situation or event of interest. As each emotion is allied to a different part of an experience so reflection on an emotion reveals other aspects of a situation worthy of discussion. In turn discussion of a practice situation rooted in one's emotion surfaces other emotions in conscious awareness.

when you start unpicking, even if you start on say sadness when you unpick the emotion actually you are probably feeling a chunk of all the other ones and you probably felt joy or happiness somewhere in there as well, so you then actually talk about all of them. So you start on one emotion but that doesn't mean you continue only on one emotion. P3 (1:286-291)

In one narrative the nurse recalls how reflecting on one emotion informed her of a situation in practice. The significance of her story is in the comparison she makes between the likely outcome of the story being told in an informal setting and the improved understanding provided by the cascade mechanism of the framework.

I was talking about one particular incident and it would nearly always start with frustration and then from that I think I was able to link those other feelings and think actually there were elements of that in that, within that one situation. So the fear, the anger the anxiety they all came into the same kind of bracket whereas I probably wouldn't have recognized that if I was just having a discussion say with a friend or a colleague I probably wouldn't have had those other links. P1 (1:121-126)

Reflecting on the dominant emotion provides the nurse with a two dimensional view of her experience but surfacing other emotions provides additional dimensions with additional meaning. For this nurse the framework helped her maximise emotional awareness to gain a richer understanding of her situation. Another nurse discussed

how a kaleidoscope of emotions characterised her day and with the help of the framework provided a rich array of reflection points.

You can't go through your working life having just one feeling, there are other elements that are going to come into your work in practice. Every day, from one minute of the day to the next, I might be in here now and I'm full of joy and walk out there and you know, I think, someone's just made me really angry, so the whole day, is not just about one emotion, it's about several different emotions but I think sometimes we pick up if we've have a bad day, we will pick up on that one bad emotion and go with that, and the whole day's based on that feeling upset or whatever, whereas the whole day is not based on one emotion. Its all different emotions. The value of the framework I think is that it makes you look at your different emotions throughout the day. And, it also I think...it also helps you look at different emotions in different situations, to unpick your emotions, or the emotions that you're going through at that time.
P4 (2:61-73)

The nurse is able to examine the root of her initial concern through reflection on her dominant emotion. However the 'menu' system within the framework helps her uncover other emotions representative of more positive experiences in her working day; helping her to gain a more balanced view of her practice.

The emotion cascade is the mechanism that permits user 'movement' within an experience in order to maximise learning from it. The user can choose to 'surf' the cascade reflecting on each emotion as it surfaces from subsequent thinking. Alternatively each emotion reflection point can be engaged separately in an order chosen by the user. It seems that the participants in this study used both approaches.

Organic Process - Shaping the Nebulous

The process inherent in the use of the framework also appears to help users lend definition and shape to concerns represented by emotions, which may previously have defied articulation. Expressions such as 'solidify', 'identify' and 'verbalise' featured strongly in narratives associated with this subcategory. Note the way this

process is described by a nurse who had felt overwhelmed with negative emotions at work.

It feels like there was no readily available solution. A lot of it is putting in the time with my manager and having those sorts of discussions with the administration team and that sort of thing. The framework.. it just helped me I guess just kind of solidify what I was feeling...I have spoken to my manager and I don't feel like I am being listened to which is one of the reasons why I feel so frustrated...I feel underused here which is again why frustration was a really big thing for me. It (*the framework*) has given me a chance to actually structure my emotions, I actually think that helping to me to organize my thoughts a bit more because now I actually have words to place my experiences under. P1 (1:93-96;280-281; 381-383)

Prior to using the framework the nurse has only experienced nebulous negative emotion in the face of a range of failed attempts to introduce innovative approaches to her practice setting. Reflection on frustration as part of the framework helps her to 'structure her emotions' and give 'words' to define her experiences. At this stage her reflection has not helped her *address* the problem but it has helped her *frame* her problem. Lending shape to nebulous experiences is not limited to the negative. In her second interview the nurse who had struggled to confront her emotions also speaks of lending structure to reflection on a positive day.

Due to the fact that we did have a mix of emotions that we weren't necessarily in touch with.....it really got you thinking about, 'What causes you satisfaction?' and, 'what was your anxiety? How did you get over it?', Do you know what I mean? It really helped to actually analyse the situation and go: 'Yes that was fear, that was anxiety or that was joy', whereas before, you'd be going, 'Oh I've had a good day at work', but what does a good day actually portray? P2 (2:150:154-157)

Using the framework has helped this nurse to look beyond a mere 'good feeling' experienced at the end of her shift to the positive emotions, which contributed to that good feeling and the practice underpinning it. This nurse who had shied away from emotional self-awareness (218-219) is now "in touch" with her emotions. She is also using emotional self-awareness to analyse, clarify and understand her experiences. It is transformative learning in action.

Informing Practice

Following an exploration of practice there was evidence showing that practice had been informed. Practice educators commented to this effect.

They realized what they wanted to do and what they would strive to do, in some cases looking at what they could change to do that, so potentially making changes for the future that would benefit the patients.
PE1 (2:270-273)

The other practice educator explained how this took place giving the hypothetical example of a drug error.

Using that model, you've got a whole array of feelings there that you will have if you've made a drug error that I would expect you to have if you've made a drug error and, if they were actually telling me that they didn't have these feelings then I would be very concerned about their practice. And more often than not most people will have all those feelings of anxiety and fear and worrying that it's going to happen again and, anger as well with themselves. So that certainly will inform practice... because you start asking 'how can you reduce the risk of this happening again?', so that immediately goes back into my patient safety, PE2 (2:194-198; 206-207)

So the anxiety relating to the uncertainty of how an error came to be made and fear linked to accountability and the possibility of the error being repeated motivates the practitioner toward more robust risk management. The essence of this 'practice informing principle' is found when the narrative of the nurse who made a crucial administrative error is revisited.

I relied on our tick-list a little bit too much... so the parent had ticked a 'no' to everything. But the child had a trachea-oesophageal fistula. And I didn't then expand on that, 'Has the child had any previous dilatations done? If so, where had they had them done? Had they had them done here?' I didn't pick up on that. I didn't expand on it. So now, I don't look at this tick list, I ask the questions that are on- here (*pointing to her own notes*). So, 'has your child ever had any problems with their airways?

Has your child ever had any problems with their breathing?' and then I'll expand on that- asthma, hay fever, and they will often tick 'no', then when you expand a little bit it's actually 'yes'. Taking the birth history, I'll ask were there any concerns at the birth, 'no', I expand on that. Were they ever in paediatric intensive care or neonatal intensive care? Were they ever ventilated? Did they have oxygen? And generally, when I do that I actually get a better picture...so that way hopefully I can get more information from them as opposed to, 'Has your child ever had breathing problems?-No'. The tick-list is supposed to cover this, but sometimes parents, I don't know if they don't quite understand what we mean by, 'has your child ever had any airway problems?', or do they actually read it? I don't know. But a lot of the time generally, they will tick 'no', and every single column of this tick-list will be 'no', and then that makes you think, 'well okay, so why are you here?' Obviously they are here for a reason, when you expand a little bit, then they tell you a bit more or you'll get to the end of the process and, 'Oh yeah and by the way they have...'. So you have to be really in tune with what they are saying and sometimes it could be the slightest comment. P4 (2:115-131)

Reflection on her fear of repeating this error has caused the nurse to revisit her interview process and identify the deficits that need to be addressed. Her practice has been informed on the importance of combining analytical tools and checklists with professional judgement (Dhami and Thomson, 2012). This comprises valuing recognition of inconsistency between questions answered in the negative on a form and key features of a medical history including a child's very presence at an assessment clinic. She has a new awareness that the accuracy or investigative capacity of a tick list is built on a parent's comprehension of it. This requires her to "expand a little" probing the detail of the child's past treatment at which point she finds that the parent 'tells a little more', reversing many of their previous negative answers in the process. Furthermore the nurse rediscovers the centrality of active listening in assessment (Stickley and Freshwater, 2006) because "it could be the slightest comment" which provides the clue as to 'why they are here'. All these changes in practice can be traced to the use of fear as a reflection point.

In a similar way one nurse informed her practice through reflection on her frustration at not being able to provide care that is sufficiently holistic. This helps her realise the importance of collaborative inter-professional working.

I enjoy being able to actually care for the child in the most holistic manner, so that's made me think about practice in terms if I'm frustrated when I don't have so much time that I need to involve the play specialists a bit more or maybe get the school team involved, so the child still receives that but perhaps not from me. P3 (1:110-115)

So the source of the core emotion (in this case frustration) is identified through reflection and this informs practice by helping to broaden her response.

Informing Practice - Empowering Practice

There were also signs that that practice was being empowered through the development of innovation and skills. A nurse explained how using anxiety as a reflection trigger showed up the paucity of protocols and guidance in her department. This led to the introduction of a peer designed dressing template, which led to greater team cohesion.

There was a lot of anxiety in the department down here; people not quite knowing exactly what their roles were, so for example, you know new nurses starting, being put in charge you know, exactly what are their roles when they're in charge? I did a dressing database, like a template for it ...and then gave it to the girls and said, "Okay I want your input on this as well now, because obviously we're all going to be doing this so you know have a look at it, what things do you think we could take out, what should we put in, what could we do better?", and that made them feel like you know, they were involved in it as well, which was good....and that kind of relieved a little bit of the anxiety, because there was a lot of the anxiety out there, you know a lot of bickering and arguing and, since I've done that, the atmosphere down here is definitely, it's dramatically changed actually, because people feel like they're more involved in things, more involved in the management of things which I think is good, so its good for them you know, they have some input, P4 (1:21-23;27-35;)

For the nurse participating in the intervention this experience was sufficient validation of the framework's value to take matters further.

the next day I went to my matron, and said, "We need to get everyone down here having clinical supervision, using this model... its just so much more relevant to me, to my work, to my practice". Yeah, it made me look at my practice and what I do and how I could change it, how I could change towards my colleagues. P4 (1:293-298)

The nurse perceives from her own experience of the pilot that the benefits of the framework are applicable across all nursing practice, not just her own. She has witnessed how reflecting on emotions representative of nursing practice as a feeling state has led to the development of new skills and improved team working. For another nurse the framework has helped her see the futility of remaining in her current post after a prolonged period of frustrated plans for practice in what she described as a suppressive environment.

For me I have gone past the place where I feel down about things, now I am just so keen to move ahead, there is some other stuff that has been going on with me that has really pushed me to think, "Well no, I can do better than this".... I can't change a whole culture which is imbedded in this department so it (*the framework*) has made me realize that I want to move on to a different role P1 (1:365-369; 415-416)

Friere (2005) argued that while critical reflection does not always produce solutions to adversity it does provide a clear perspective of adversity. The nurse has stopped blaming herself and has left off negative feelings. She recognises that a stalled suppressive 'culture embedded in her department' is stifling her development. Realising her true worth; that she "can do better than this", she has taken charge of her situation and decided to change her job.

Empowering Practice - Emotional Regulation "bring that emotion back in"

It seems that there were other ways in which the framework supplied empowerment namely through emotional regulation in the face of challenge. One of the practice educators described it this way:

They both brought up some of the fear of doing new things, or being pushed to do things that they weren't quite sure of. The fear was there but then it tended to get moved around into something more positive because they realized the opportunities that were there. Although you could be scared about doing things or having a busy day but actually when you go to the end of that, what you had learned and that you had survived was actually a positive thing that they could take away. PE1 (1:557- 563)

Reflecting on the fear of new challenges in practice had revealed opportunity. This provided sufficient courage to meet the challenge in the knowledge that at the end point of 'survival', learning and a sense of fulfilment could be 'taken away' from the experience. Realising this helped 'move the fear around into something more positive'. For one nurse the detail of how she overcame such challenges lay in her new ability to know and express her feelings.

I was able to verbalise better like, 'look I need help with this thing and I need help with that thing', and with doing that and by saying that ; actually highlighting that I ended up reducing my anxiety which meant you know that I felt I was doing better again and with more satisfaction that I had done it and I'd completed it well, and then the next time round, although I was still a bit anxious, I definitely reduced that anxiety and I was like, 'No I'll troubleshoot this one myself but I know I can just ask', and it really like having that awareness it was so much easier. P2 (1:49-54)

The nurse is able to distinguish between the fear of breaching the boundaries of her competence; "look I need help with this thing" and the fear of challenge requiring further assessment and judgement within the boundaries of her competence: "I'll troubleshoot this one myself". This is empowerment through increased self-knowledge and self confidence. At her second interview another nurse emphasises the capacity of the framework to assist with emotional regulation.

I think this framework helps you to look at your emotions and to, sometimes keep them in check. Because I think you can get too focused on one emotion, and get bogged down on that one emotion, and let that one emotion influence your whole day. P4 (2:280-282)

Damasio (1999) has spoken of the alliance between tempered emotions and sound judgement and decision-making. The nurse speaks from experience of one negative emotion arising from a negative experience polarising her whole feeling state or getting “bogged down on that one emotion”. However, the framework keeps her emotions “in check” by balancing the negative with the positive. Another nurse elaborates on this.

I think what this does is make you bring that emotion back in and allow you to examine how it's made you feel, what it's made you feel, what it's made you do and behave like so you can then, in those periods where you need to temper an emotion P3 (1:465-468)

'Bringing that emotion back in' refers to the ability to examine the rationale for that emotion revisiting the judgement and decision-making set to which it is attached. This is possible because the framework harnesses the defining relationship between emotion and judgement.

Empowering Practice - Self Awareness and Reflexivity

Peshkin (1988;1993) found that reflecting on emotions in different situations greatly increased his self awareness. Bradbury-Jones et al (2009) experienced similarly beneficial results applying Peshkin's approach with undergraduate nursing students. In view of these it was unsurprising to find that a framework based on core practice emotions yielded similar results.

I'm more aware of my feelings, I'm more self-aware of how my job affects me, as a result my self-esteem has improved because you know, I feel better about my job. P2 (2:174-177)

The transformation in this young woman at the end of the intervention is not easily captured on paper. She talks freely about her new insightful emotional self. Her face and body language are more confident and relaxed. She maintains eye contact during the discourse where once she would avoid it and her speech is concise and flows where once it was disjointed. The framework has served her at a more basic level than the other participants because she started in a different place. She had been afraid of her feelings and reluctant to reflect on her emotions (p. 231-232).

Consequently she practiced in an emotionally suspended state unable to fully grasp the impact different parts of her job were having on her self-esteem. At the end point of the pilot she is self aware and confident where she was once afraid.

Conclusion

This chapter has described the user experience of the new framework for reflection on practice simultaneously informing on its functioning structure and process. The framework has demonstrated 'organic' properties which permit a harnessing of the sense of salience that is central to human judgement. In addition, a high level of flexibility in use sensitive to the need of the individual user has been evidenced. Framework use has also been shown to inform practice through empowerment, emotional regulation and self awareness. These positive outcomes have been achieved despite transparent reservations on the part of the participants relating to culturally based expectations about declaring one's emotions and models of reflection.

The implications for learning of the measured success of phase two will be discussed in the final chapter.

Chapter Eight

Conclusion

Introduction

This chapter will set out the main contribution of this thesis to the existing body of knowledge within the context of the current critique of reflection as a tool for professional learning. A reflexive section will consider the impact of doctoral study on my personal development.

The Integrated Shape of the Findings

The framework for harnessing a common set of emotions for clinical judgement is new theory applied in practice. The participating nurses practiced in a variety of clinical settings and applied diverse integrated bodies of knowledge. The resultant emotion map on which the framework sits is representative of the nursing community of practice and has shown itself fit for generic application across the profession. The theory generated by both phases of data collection is a unified one in that the commutative properties of the emotion map are revealed. In the first phase a common set of situation types were shown to give rise to a common set of emotions. In the second phase the common set of emotions were successfully used as points of reflection for the same common set of situation types. So the reflection process at the centre of this work is shown to be integrated and robust.

The Temporal Context of the Findings

This work has been developed at a time when the long esteemed value of reflection to professional practice is being questioned. Boud (2010) points out the extent to which reflection and journals of reflection have been misused in education within rigid and suppressive rules and guidelines which fail to acknowledge the highly fragile and individual shape of the process. This includes the denial of students the time, space and solitude to adequately reflect on experience (Welland and Bethune, 1996) and overlooking ethical concerns about intrusion on privacy and the consequences of 'emotional fallout' (Rich and Parker, 1995). Attention has also been drawn to problems with the cognitive process at the heart of reflection. For example memory plays a crucial role despite evidence raising questions about its reliability. The tendency among human beings to simplify and reduce information to make it more

manageable would appear to be partly responsible for this (Talbot, 2012). Much reflective practice contains the implication that all the constituents of an experience are predictable and that the 'lessons' of such 'failure' to anticipate events can be transferred to other similar situations. Such "hindsight bias" is misleading as practice and social life are heavily influenced by time and circumstance which defy prediction and anticipation (Jones, 1995:783). Self justification and the perceived need to address cognitive dissonance have been shown to take priority over the search for meaning in experience. This partners confirmation bias in which the student will search only for evidence which supports their existing views or performs a compliant academic study task which tells their lecturer or mentor what they believe they want to hear (Talbot, 2012). Introspection bias in which the learner has an exaggerated view of their own objectivity in relation to that of others also threatens the validity of reflection (Pronin and Kugler, 2006). However despite this, human reflection still compares well with artificial intelligence in a variety of forms.

No human intellectual activity is perfect but neither is it usually incompetent (Polanyi, 1998). Personal knowledge such as records of lived experience, intuitive judgement and reflection while not infallible have some advantages over artificial intelligence units such as pathways and protocols based on disembodied scientific evidence. This structured systematic analysis is time consuming. Reflection and intuition are swift and frequently accurate within safe boundaries (Standing, 2008). Artificial intelligence units seek to impose disembodied research evidence on an environment assumed as identical to the one in which the research was conducted. This is a significant weakness. On the other hand human beings are not passive recipients of information who respond to stimuli in predictable ways. They are not mere carriers or managers and manipulators of information in the way that an electronic system might be defined. Humans are interpreters and creators, equipped to respond flexibly and imaginatively to the challenges of practice. Artificial intelligence units are preprogrammed to react and address certain fixed templates. Beyond this context there is no meaning for such units. The symbols which trigger a response from a computer system have no unified meaning for the computer. Computed actions always follow programming. Robotic pathways carry no evaluative component and have no way of discerning a language system rendered inadequate by a changing environment. Neither can such units discern the different meanings and senses supplied to the same word by context. On the contrary they continue to perform as programmed (Bredo, 1999). Artificial intelligence units (AIU) have no 'common sense understanding' with which to embrace the wholeness of a matter with all its

anomalies. They cannot pause to reconsider or reflect in the face of new information or unforeseen circumstances which may serve to mitigate or alter action as required. AIU cannot have empathy or discern changes in human behaviour. This is the frequent source of frustration for nurses who must work with systems which do not possess human insight.

A discourse exists which implies that artificial intelligence or imposed guidance and directives give us our understanding of our world addressing the deficits in human judgement. In fact the relationship between artificial intelligence and human judgement is much more of an equal partnership. Both have deficits. Artificial intelligence, imposed guidance and directives are impotent without the human judgement they are designed to assist. In nursing life this is evident in the use of clinical pathways and other evidence based guidance. For example Appleton and Cowley (2004) found that the use of evidence based guidance for the identification of vulnerable families produced many false positives when health visitors' contextual knowledge of their communities was brought to bear on assessment. Alternatively local contextual knowledge meant that community practitioners were often concerned about families who did not register with official vulnerability criteria. Research has also shown that the Liverpool Care Pathway cannot ensure the optimum end of life care it was designed to promote without effective team communication (Messam and Pettifer, 2009), judicious professional monitoring of its application (Preston, 2007) or the provision of emotional intelligence and compassionate care (Murphy, 2011).

Humans exist in a world of situated cognition where "a situation in which an expression is used helps disambiguate a situation" (Bredo,1999:36). Humans possess common sense understandings which balance prescribed guideline pathways and protocol directives and recommendations for categorised situations against the unique variations of those situations. They are able to supply context to the interaction between evidence based guidance and the additional information emerging from contextualised behaviour and the contingent responses they require.

Through their interaction with their world their thoughts, actions and very being are refined by the world and by their own entrances. Speakers reflect on their speech and amend it (Standish et al. 2006), artists are continually refining their art in progress (Laurence, 2012) and writers are molded by their reflections on their written work (Bredo, 1999).

Personal or propositional knowledge as evidence takes many forms including eye witness account and testimony, expert opinion, autobiographies, diaries and letters. Personal knowledge can be tainted by bias and prejudice but it may also be corrected by ethical awareness and caring. Its imperfections have never prevented the police and the courts using it in large measure to help convict, dismiss or acquit individuals suspected or accused of crime. Many eye witnesses have remained robust in court in the face of scrupulous cross examination by barristers using methods fuelled by the very evidence utilised by critics of reflection. When expert witnesses are called to court they are required to demonstrate that their interpretation and application of scientific evidence is valid. However often the scientific evidence they use is also questioned as to its reliability and fitness for application. On the other side of the judicial process, Pennington and Hastie (1986;1988) have shown how jurors sift information of different types and quality; forming theory like the assembling of a jigsaw to create a cohesive probable narrative. At each juncture the ubiquitous role of interpretation and reflection in accessing evidence is recognised.

The subjective nature of letters, diaries and minutes from the past has not prevented them being hailed as historical artefacts and used by historians to construct history (Bruner, 1999). Propositional knowledge in the form of eye witness testimony for all its acknowledged flaws has also proved reliable when standing in opposition to scientific judgement. For many years survivors of the Titanic sinking insisted that the ship broke in half as it sunk. Structural marine engineers claimed this was impossible in a ship of the Titanic's size. Yet when the wreck of the ship was eventually found eye witness testimony was validated.

So rather than be concerned about the feasibility of reflection as a tool for learning we need to be concerned about the ground rules and principles such as honesty, creativity, time, space and collaborative enquiry negotiated with students in advance of its use. Students need to understand the importance of reflexivity which cannot truly be falsified, at least not with any benefit to the falsifier. We also need to be concerned with the acceptance within assessment of the expressed informal personal and individual dimensions which would not be acceptable in other more traditional academic work. The imperfection of human judgement needs to be acknowledged but so do its strengths and unparalleled flexibility. The usefulness of scientific knowledge and evidence based tools to nursing practice cannot be underestimated but the role of professional judgement and reflection in accessing and deploying all forms of knowledge must also be respected.

This has been the main achievement of this thesis: to harness intuition via emotional intelligence and give greater credence to personal knowledge. The notion of pivotal emotion concepts as tools of reflection and decision-making opens up a new frontier in perception and learning. The details of experience are the outcome of reflection on emotions rather than the reverse. Components of the continuum of clinical judgement (Standing, 2008) are all applied in the social world through the skilled use of self: the application of interpretation, reflection and emotional intelligence manifest in embodied skill (McKinnon, 2016). Utilising the “feeling of knowing” identified by Damasio (1999:26) the emotion framework has helped practitioners trace and lend shape to the origins of their feelings in the social world which had previously eluded them. This lends a rare level of credibility to a tool for judgement located at the intuitive end of the continuum of decision-making (Standing, 2008).

Two new terms relating to the use of emotion can now be added to the vocabulary of the use of self alongside ‘emotional intelligence’ and ‘emotional labour’. These are ‘emotional potency’ and ‘emotional relevance’ and they relate to the role of emotion in reflection. Emotional potency describes the power of a given emotion to pinpoint the detail of part of an experience. Emotional relevance describes the area of life experience to which the emotion can be used as a tool for reflection. For example we might say that anxiety’s emotional relevance is uncertainty and that its potency is articulating uncertainty.

Overcoming the influence of long established expectations of guidance using signposting cycles and layered models is not easy in a profession preoccupied with such methods. Yet sample members loyal to such thinking structures worked successfully within the emotion framework and found its flexibility refreshing and liberating. Flexibility was observable not only in the breadth of the reflective trawl but in the way the framework served different people at different levels. This was particularly true in the area of self-awareness.

The lack of emotional self-awareness identified within the literature (Mazhindu, 2003; Hargreaves, 2010) as a factor inhibitive to reflection in nursing found some representation in both samples of participants. However the framework showed itself worthy of addressing this challenge as its organic structure and process were laid bare. In the space of a few months one nurse declared herself as more self-aware through use of a framework which helped her identify her emotions and the roots of these emotions. Consequently she was able to discriminate as to which areas of her

practice needed further work. All the participants welcomed the feeling of having been granted permission to speak about the role of emotion in their lives. This indicates that the restraints on emotional reflection are not merely personal but cultural and possibly organisational. The framework has presented a solution to all three. The framework has overcome nurses' personal inhibitions because of the way its member concepts interface immediately with the nurse's emotional memory. Cultural notions of the 'good nurse' detached from emotion are also breached because of a method of reflection, built purely on emotion, grants permission to consciously use emotion as a cognitive tool. While the framework pilot had the endorsement of the NHS Trust in which it took place, the private way in which the framework can be used defies any forbidding regulation.

In addition the use of emotions as points of reflection permitted exploration of practice through the practitioner-practice axis. The components of practice life were explored and determined. Furthermore practice was informed and the need for innovation identified. This in turn led to a more empowered practitioner.

There are many highly specialised communities of nursing practice within this broad community. It is possible that other groups of pivotal emotion concepts for reflection (including sub types of those populating this framework) would be suited for specialised use within sub communities. However, ascertaining this is outside the remit of this study. Furthermore there are grounds for hypothesising that the framework could be applied or amended for use within other professions working with humanity. These might include social work, teaching and the police. But such enquiry is also outside the scope of this work.

Reflexivity

As in the case of all experience this thesis has been a learning journey impacting on my personal development. As a nursing academic on an undergraduate nursing degree programme I realise I had grown cynical in my attitudes toward my colleagues in practice. I had listened to stories of resistance to change and stifled innovation experienced by my students and alumni members. I had reflected on the figures and findings on bullying and prejudice within the profession and despaired as to how anyone could be cared for by us effectively when we did not seem able to care for one another. I was aware of nurses struggling to cope with workloads that

threatened to overwhelm them in circumstances of scant support. Such situations made me angry and caused me to wonder why nurses did not take more pronounced action to enable change. Moreover I perceived many nurses to be politically naïve and lacking professional resolution. The experience of chief investigator across thirty-three interviews has resulted in a perspective transformation within me.

Participants included practitioners on the brink of retirement possessed of old fashioned values that I do not always share. In addition, expert nurses leading large teams in challenging settings numbered among the sample members. The sample also included newly qualified nurses at the threshold of their careers; knowledgeable, inspired and ambitious but still struggling with professional and personal insecurities. The personal acquaintance that accompanies qualitative data collection means that I have been able to observe and listen to these people at very close proximity. I have been privileged with personal information about them that I would never otherwise have known. A disarming truth I have learned about this body of remarkable young and not so young men and women is that they share far more in common than that which divides them.

The breadth and depth of practice wisdom they own built on a vast body of integrative knowledge informed by a current evidence base is impressive. Practice is tempered by awareness of accountability and housed within skilled use of themselves as agents of care and empowerment. The extent of their compassion and empathy in action is heartening and works to dispel the cynicism I had previously harboured. It is not that the grounds for my previous concerns do not exist or had been exaggerated. Rather I had allowed these concerns to eclipse the universal goodness in nursing and its impact on the world. In the face of perpetual political and social change that surrounds them and shapes the need of their patient groups, their rootedness in practice life is inspiring. Furthermore such resilience in the face of trauma, adversity and obstructive organisation might prove unsustainable in some other professional forums. Those who ponder nostalgically over some mythical golden age of optimal care should remember that resilience in 21st century nursing life unlike previous times is sustained across multiple roles, not just one. Moreover standards of care are richer, not poorer for this (McKinnon, 2016). Today's nursing excellence is coordinated on the back of emotional labour in a carefully crafted therapeutic relationship both of which were suppressed or forbidden in past years.

The copious reading essential to doctoral study has also increased my own self-awareness. I have discovered that I am integrally an anxious person and that this has been manifest in many adversarial relationships I have endured in my life. Knowing this makes my trait anxiety much easier to manage. Nowadays I am more philosophical about the future and I reserve my energies for more worthy causes avoiding the contemplation of negative possibilities that will likely never be realised.

The idea which gave birth to this thesis arose from a crude tool I developed for safeguarding children practice over fifteen years ago; one which was quickly ridiculed and rejected by my manager of that time. The original concept has evolved considerably since that time. Contemporary neural theories pertaining to the psychology of emotion and learning have been sourced. Relatively narrow concepts borrowed from a practice manual and used while studying for my master's degree have been rejected in favour of concepts grounded in theory built on practitioner perception. Framework membership has been justified by the commonality the concepts shared in the nursing community of practice. Findings have been aligned with the extant literature and the framework has shown itself effective.

There is a sweet sense of natural justice that my sustained faith in my own ideas has been rewarded.

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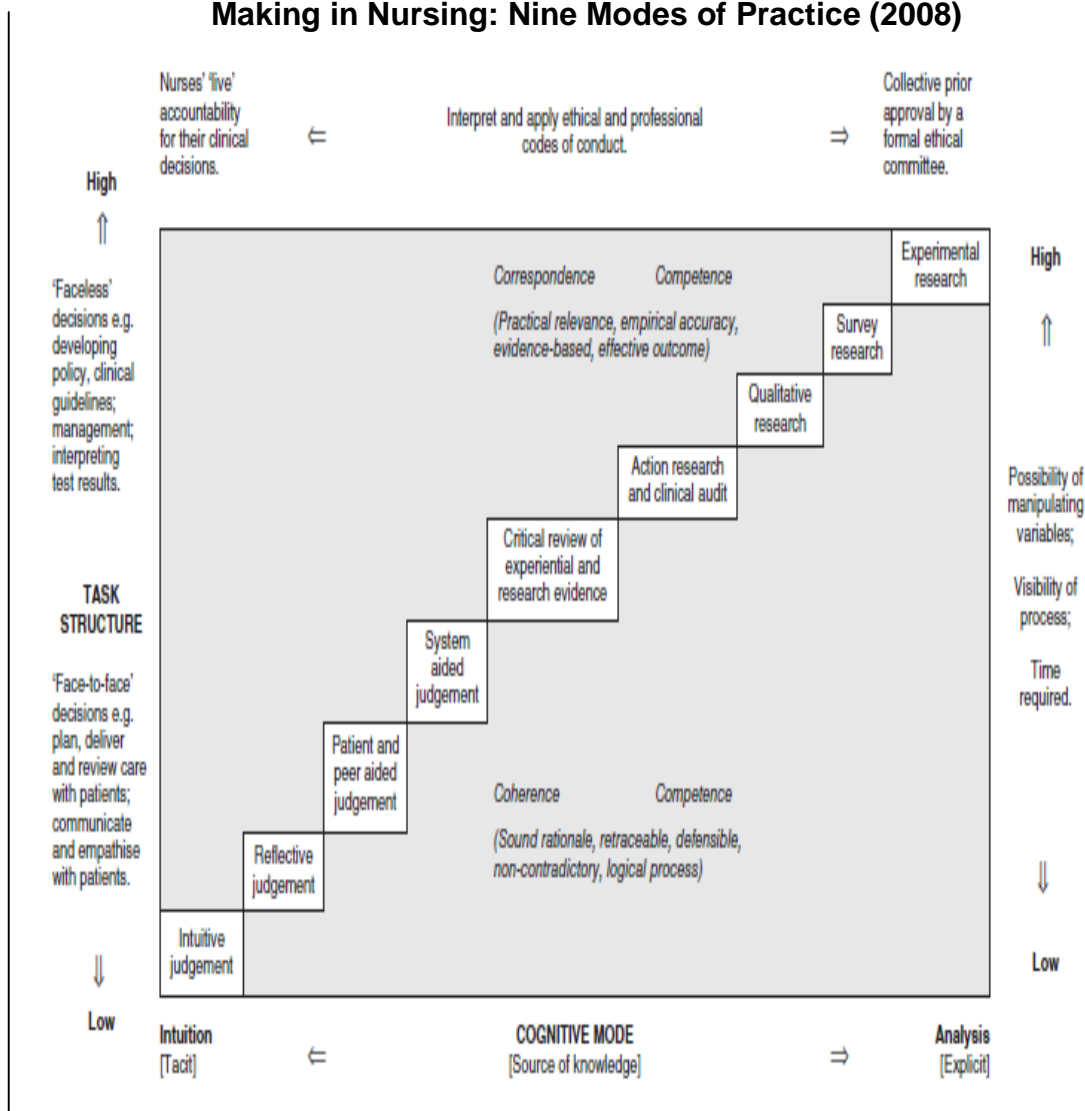
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Appendices

Appendix 1

Standing's Revised Continuum of Clinical Judgement and Decision Making in Nursing: Nine Modes of Practice (2008)



Standing's continuum of judgement and decision making illustrates the range of forms of knowledge which are resourced in nursing judgement and decision making. The horizontal axis illustrates the different ways of sourcing knowledge. The vertical axis illustrates the level of reliability set against the context of the task at hand and the time required to use the mode. The left hand side of the table houses forms of thinking used 'in the moment' which operate without access to formal scientific knowledge. These judgement modes are associated with human ability to adapt and survive through social learning in changing situations. On the right the continuum ranges from randomised controlled trials with a high level of demonstrable rigor through quantitative and qualitative research to action research and audit. On the far left of the continuum are forms of personal or propositional knowledge so called

because they are subject to bias and are more open to question than knowledge confirmed by structured scientific methods. The right hand side of the table leans toward knowledge built on logic, mathematics and the application of computer technology to factor in predictability in judgement. The intuitive end of the continuum is characterised by frequent but relatively small errors. The analytical end is characterised by infrequent but sizeable errors such as false positives and false negatives in a screening programme. Cognitive modes on the left hand side of the table form a picture of the autonomous practitioner who draws on the knowledge of experience to respond to clinical need for which they stand accountable. This is part of propositional knowledge, an aesthetic use of personal knowing described by Carper (Cloutier et al. 2007) in her model of different forms of knowledge. Propositional knowledge includes intuition ; “the ability to perceive or know things without conscious reasoning” (Lawrence, 2012:5). Intuitive knowledge enables pattern recognition and relating wholes to the parts of experience and vice versa (Benner and Tanner, 1987; Benner et al. 1996). Intuition also involves embodied knowledge through the ‘knowing in the doing’. Reflection also sits in this category because it is knowledge induced from the interpretation of experience and therefore personally owned. Peer aided judgement or collaborative enquiry is also a form of propositional knowledge because it arises from peer exploration discussion and debate of a subject .

Appendix 2

Mazhindu's Typology of Emotional Labour (2003)

1. **'Complete engagement'** describing the nurse at optimum functioning level. The nurse anticipates events, recognises patterns, displays high affect and feels in control. The nurse feels that she is making a difference to patient wellbeing by her practice
2. **'Actively monitoring'** in which the nurse deliberately selects interventions which help maintain power and control. The nurse is able to cope with and contain feelings of conflict caused by others. The nurse anticipates and checks with the aim of being able to act to address risk. She is not able to make a difference but able to execute thoughtful action.
3. **'Automatic pilot'** describes when the nurse feels 'on show'. Concentrates on actions not feelings and acts out a role. Avoid feelings of conflict by emotional distancing. Safety found in routine checking behaviours.
4. **'Going through the emotional aspect'** in which acting is necessary to conceal conflict with perceived feelings. Feelings of conflict are just beneath the surface. Some somatic responses cause discomfort in the shape of anger frustration and humiliation. The nurse is struggling to maintain control slipping from her grasp.
5. **'Passive spectator'** in which the nurse resources deep acting and subjugates her real feelings, relabelled in order to make them more palatable. Somatic responses to feelings of anger and frustration are painful and cause anxiety on recall. The nurse feels powerless to make a difference to the situation and deep acting is necessary to maintain the role. However this cannot be sustained for a long time.
6. **'Complete removal'** in which the nurse is overwhelmed by emotional conflict and the somatic responses, feels inadequate to the task, makes no attempt at deep acting and wishes to exit the situation.

Appendix 3

Framework Intervention Impact Charted by Participant

Participant	Time 1	Time 2	Outcome
Practice Educator 1	Described and experienced a struggle to adjust to a perceived lack of structure. Recognised emotional concepts as representative of practice.	Reports that nurses were able to use the emotion concepts to reflect effectively on their practice. Believes the framework has potential to guide practice but needs more guidance for supervision.	Positive View of value of framework with some reservations
Practice Educator 2	Described and experienced a struggle to adjust to a perceived lack of structure. Recognised emotional concepts as representative of practice.	Described the superiority of framework over Gibbs Cycle. Realisation that interviews must begin with the feelings of the supervisee to use framework effectively. Reports that nurses were able to use emotion concepts to reflect effectively on their practice and guide professional judgement. Wishes to adopt framework for clinical supervision across the hospital.	Positive view of value of framework to practice.
Nurse 1	Recognised framework as intuitive and concepts as representative of practice. Coined the descriptor 'organic'. Helped to recognise the extent of her negativity toward her practice setting and the reasons for it. Pivotal emotions were frustration, anger and anxiety	Recognised the pervasive suppressive culture in her current department and the need to 'move on' to another post. Participation disrupted by bereavement.	Reflective practice and self awareness aided.
Nurse 2	Misunderstood framework design. Tried to find an experience to fit every emotion in the framework instead of vice versa. Struggled to talk about her emotions.	Markedly more self aware and socially competent. Able to use framework to discriminate between parts of her new role which cause her anxiety and address these.	Developed increased self awareness and able to reflect on parts of practice causing anxiety.
Nurse 3	Initially experienced difficulty in adjusting to a lack of structure. Able to "work backwards" from the emotions she experienced and evaluates her practice.	Used full range of emotions as pivotal concepts. Able to Identify more flexible ways of working to permit holistic care.	Reflective Practice and clinical judgement aided
Nurse 4	Recognised concepts as representative of practice. Enjoyed freedom in lack of signposting. Described the superiority of framework over Gibbs Cycle. Enabled recognition of a lack of guidance in her department as the source of her anxiety and anxiety among her team members. Designed new guidance templates for practice.	Used the framework to conduct significant event audit of her practice in the aftermath of an administrative error which caused a patient to be wrongly removed from a surgical waiting list. Developed a more exploratory patient interview method. Main pivotal concept was fear. Recommended to Matron that framework should be adopted by the department	Reflective practice and clinical judgement aided

Appendix 4

Glossary of Codes

Phase One

Participant	Participant Code
District Nurse or Specialist Nurse with District Nurse Qualification	DN
Health Visitor / School Nurse	HVSN
Sick Children's Nurse	PD
Paediatric Intensive Care Nurse	PIC
Neonatal Intensive Care Nurse	NIC
Mental Health Nurse	MH
Adult Urology Nurse	AU

Phase Two

Participant	Participant Code
Practicing Nurse using the framework and in receipt of supervision	P
Practice Educator providing supervision using the framework	PE

Appendix 5 Sample Section of Coded Transcript

